

## **UNAIDS Background Paper**

# **THE ROLE OF MICROFINANCE IN THE FIGHT AGAINST HIV/AIDS**

**A report to  
The Joint United Nations Programme on HIV/AIDS (UNAIDS)**

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**15 September 2000**

## **Acknowledgements**

The authors are indebted to the 35 microfinance institutions who participated in discussions about microfinance and HIV/AIDS during the summer of 2000. These institutions have opened the door to frank and open discussions about the meaning of HIV/AIDS for microfinance institutions and their clients, and pointed the way for initial action.

Thanks go to Anita Alban of UNAIDS, for her insights and candour on this issue. The report also benefited from the excellent advice from USAID's Paurvi Bhatt and UNDP's Benjamin Quinones, Jr., who reviewed drafts of this document. Finally, the authors appreciated the constant support of John Jepsen, who smoothed the way throughout.

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## Abbreviations and translations

ACOMB	Association pour Auto-promotion Communautés Base (Association for Community-Based Self-Empowerment)
AIG	American International Group
BSF	Belgian Survival Fund
CETZAM	Christian Enterprise Trust of Zambia
CRO	Child Restoration Outreach
CRS	Catholic Relief Services
DAI	Development Alternatives, Inc.
DCOF	Displaced Children and Orphan's Fund
Faulu	English translation = Success
FCC	Fundo de Credito Comunitario (Fund for Community Credit)
FINCA	Foundation for International Community Assistance
FOCCAS	Foundation for Credit and Community Assistance
IFAD	International Fund for Agricultural Development
MBT	Micro Bankers Trust
MEDA	Mennonite Economic Development Associates
MFI	Microfinance Institution
NGO	Non-governmental Organization
PLWA	People Living with AIDS
ROSCA	Rotating Savings and Credit Association
SEF	Small Enterprise Foundation
STD	Sexually Transmitted Diseases
UDP	UWESO Development Project
UGAFODE	Uganda Agency for Development
URWEGO	English translation = Ladder
USAID	United States Agency for International Development
USCS	UWESO Savings and Credit Scheme
UWESO	The Ugandan Women's Effort to Save Orphans
WOCCU	World Council of Credit Unions
Zambuko	English translation = Bridge

## **Introduction**

HIV/AIDS is a health emergency, but it has created a development crisis of devastating scale—for households, communities, countries, and entire regions. Estimates of the economic impacts of HIV/AIDS show that it has reversed many of the gains in development created over the last 30 years (World Bank, 2000). Poor families are among the most vulnerable, as they have few strategies for coping with the economic impacts of the disease. And families who climbed out of poverty are pushed backwards by HIV/AIDS as they lose productive adults, face crippling health expenditures, and expand household size to take in orphaned children.

Microfinance is designed to fight poverty by strengthening the economic position of households at, or below, the poverty line. Microfinance is the provision of small loans (called 'micro-credit') or savings services for people excluded from the formal banking system. In the right environments, microfinance can accomplish the following in the fight against poverty:

- broaden poor people's economic choices
- diversify household income, to make households less vulnerable to downturns in the economy or personal or health set-backs
- facilitate income flows within households to improve quality of life throughout the year
- strengthen the economic position of women so that they can take greater control over decisions and events in their lives.
- build household assets: from houses to business equipment and land.
- sometimes provide savings, allowing poor households to accumulate safe but flexible cash accounts from which to draw when needed.

Microfinance strives to 'scale up' to serve as many households as possible. To date, estimates show that microfinance institutions serve approximately two million African households, with aspirations for significant further expansion. Because of its poverty-fighting agenda and its goal of reaching scale, microfinance is considered a significant tool in the fight against the economic effects of HIV/AIDS, as described below.

## **Microfinance in the AIDS context**

Sorting out when microfinance is—and is not—an effective tool is the first step in properly mobilizing microfinance practitioners in the fight against HIV/AIDS.

Microfinance is most useful to households before they are deeply affected by AIDS. At an early stage, households can still make use of loans and can still save money. At this point, microfinance services play an important role in strengthening households' economic safety net to draw upon in the later stages of AIDS. Through its focus on women, microfinance may also play a role in reducing vulnerability to HIV/AIDS by keeping women and their daughters away from high-risk behaviours based on economic necessity.

Once HIV/AIDS gains a foothold in a household, the role of microfinance changes. At this stage, the role of microfinance is primarily to support the productive activities of healthy family members: those who care for the family's sick and for any orphans living with the family. In this situation, as long as the household undertakes income-earning activities, there may be a role for loan services to help these activities along. The greater the ability of the household to maintain an income stream during this period, the more likely they are to withstand the economic devastation of the disease without selling land or other assets, taking children from school, or breaking up the family.

Finally, after AIDS sweeps through a family, survivors (often grandparents and older children) must rebuild the economic base of the remaining household. As these individuals become prepared to take on the tasks and risks of entrepreneurship, microfinance may be able to play a role in supporting their efforts.

### **An expanded role for microfinance?**

Today there is some debate over how active microfinance institutions (MFIs) should be in the fight against HIV/AIDS. Most observers and practitioners agree that the most important role of microfinance is to continue to serve those households that can make use of financial resources. Even in countries with the highest HIV-prevalence rates among adults, the majority of adults are still able to undertake productive activities.

Some argue that MFIs can go beyond their traditional role, offering a range of additional services to their clientele. Because microfinance often uses a 'group methodology' that brings together groups of poor people—predominantly women—on a regular basis, it is seen as an effective avenue for distributing health services, such as prevention information about HIV/AIDS. When provided through a partnership with a health organization, health services may be added to basic microfinance transactions at a minimal cost to both the MFI and its clients.

The same argument may extend to other services that are important in an HIV/AIDS context: legal advice to women on inheritance and children's rights; counselling; or training on the care of sick family members. If provided through a strategic partnership, these services may be channelled to MFI clients at little or no additional burden to the MFI.

Microfinance institutions can also innovate in their core practice area by improving the fit of financial products to better meet the needs of HIV/AIDS-affected households. This may mean reducing compulsory savings requirements (often required as collateral for micro-credit), which may be out of reach for HIV/AIDS-affected households, given their new financial status.<sup>1</sup> It may mean loosening the conditions under which clients may make withdrawals from their compulsory savings accounts for health emergencies; or it may imply greater flexibility on loan sizes and payment schedules. Finally, as clients

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<sup>1</sup> UNAIDS data from Africa indicate that household incomes drop 30-60% due to HIV/AIDS. On average, household expenditures on health quadruple, while school fees fall by half, and the amount spent on food consumption drops by 41%. In this context, asking poor households to make regular payments of loan principal, interest, and a mandatory savings deposit may force many households out of the microfinance programme.

become sick, MFIs may consider allowing healthy teenagers or young adults to take over the business and the loan for a sick parent—perhaps with mentoring from others.

Finally, MFIs may add new financial services to their portfolio: brokering relationships with burial societies, creating trust funds, or linking clients to insurance. As a cautionary note, health and life insurance is rare in an HIV/AIDS environment, as the necessary premiums are generally too costly for poor households to bear.

### **Leaders in innovation**

Where is microfinance innovation occurring? There is no question that MFIs in those countries most affected by HIV/AIDS are the most actively innovating. Innovations appear in Uganda, Zambia, Rwanda, Namibia, Kenya, Togo, Zimbabwe and Malawi—countries with between 6% and 25% of adults (age 15-49) living with HIV/AIDS at the end of 1999 (UNAIDS, 2000).

Leadership in microfinance innovations appears to have emerged most intensively in the country where national leadership has openly confronted HIV/AIDS—namely, Uganda. In this country, microfinance organizations can speak more openly with clients about health concerns in general, HIV/AIDS specifically, and their changing household needs.

Finally, while HIV/AIDS innovations occasionally emerge from larger, more established microfinance organizations, the bulk appear in those MFIs that pursue a 'double bottom line': institutional financial sustainability and client welfare. Although these organizations rarely reach the scale of those financial organizations singularly focused on financial services, they serve as an important incubator of ideas for the entire microfinance community. However, to be broadly valuable to the largest number of households, these lessons need to be communicated to larger microfinance organizations that can provide mass coverage, or 'scale'.

### **Examples of innovation**

For microfinance institutions, innovation often implies added risk and cost. But in a situation where HIV/AIDS is fundamentally changing the economic fabric of communities, doing nothing may also imply risk—the risk that credit clients will default and/or leave the programme prematurely; and the risk that households will not withstand the crisis intact. In these cases, some microfinance institutions have decided that the risks and costs of inactivity outweigh the risks and costs of innovation.

Below are two examples of microfinance programmes that have quietly taken the lead in response to HIV/AIDS. The first case—the Foundation for International Community Assistance (FINCA) in Uganda—shows an MFI that is well on the way to pilot testing innovations—both financial and non-financial. The second case—the combined efforts of Opportunity International affiliates across Africa—shows innovations at the early implementation or planning stage.

## Financial products plus education: the case of FINCA/Uganda

FINCA/Uganda was launched in 1992 with funding from the Displaced Children and Orphan's Fund (DCOF) and operates in high prevalence locations in Uganda. The financial services represent modifications of the traditional FINCA International methodology and product line. Likewise, its HIV/AIDS prevention education represents an expansion of the 'empowerment' efforts usually found in Village Bank programmes. FINCA has developed several products in response to the health needs of its clients:

**Health insurance:** In October 1999, FINCA introduced a health insurance product for clients, their spouses and dependents that includes coverage for AIDS treatment, but not medication. This programme was initiated as a pilot effort through a partnership with Nsambya Hospital Healthcare Scheme. As of 1 January 2000, 235 individuals were covered under this pilot effort. Although coverage is optional, at least 60% of FINCA clients in a given Village Bank must join to initiate coverage. The plan pays for up to three weeks of hospital care for an individual in any one three-month period, or up to \$206 in total medical costs during the same time period. Co-payments are also used to minimize excessive use of the plan's services. Based upon high client satisfaction, FINCA is now considering expanding this programme to its other branches within Uganda, and is searching for funding in order to add this product line to FINCA programmes in Tanzania, Malawi, and South Africa.

**Savings plan:** In 1992, FINCA launched a savings plan (not specifically designed to meet medical needs) which is used by clients to accumulate savings above the amount required to collateralize their loans. These funds may be particularly useful to FINCA clients who know they will be faced with large illness-related expenses or declines in household income in the future. For example, these funds may be useful to buy medication, pay for funerals, or meet expenses when household income declines due to AIDS. This product highlights the value of savings that are not held as collateral, and are available to clients as needed.

**Life insurance:** FINCA offers its clients life insurance through a partnership with American International Group (AIG)—a large multi-national insurance company. As of 1 January 2000, more than 123,000 individuals had some form of life insurance coverage. As part of this policy, all clients are insured for their outstanding loan balance at time of death, which protects clients' family members or co-borrowers from assuming the burden of the deceased's outstanding loans. It also has the beneficial effect of protecting FINCA's portfolio from defaults due to death. Beyond outstanding loan balance, the policy only covers accidental death, thereby excluding deaths related to illness or AIDS. To be eligible for accidental death insurance, the spouse and up to four dependents to be covered must be registered with FINCA at the beginning of the loan cycle. This accidental death coverage may be an essential part of risk management strategies practised by the 75-80% of clients now raising and supporting AIDS orphans.

**AIDS education seminars:** FINCA has developed a partnership with the Church of Uganda Doctors to provide clients with HIV/AIDS education through awareness seminars. These seminars are usually conducted simultaneously with Village Bank meetings, as and when requested by the clients of the village banks. The costs of the seminar leaders' time for preparation, presentation, and travel are borne by the group members. The training is not exclusively targeted at clients; family members can attend the training as well.

## **A range of innovations across Africa: Opportunity International**

**Opportunity International** (hereafter called 'Opportunity') has been involved in microfinance in Africa since 1992 and currently serves more than 30,000 clients throughout the continent. Opportunity has observed the effects of HIV/AIDS on both clients and its partner institutions. In response, it has initiated several financial and non-financial services to address the health concerns of its clients. These are presented below, and include four financial products and two non-financial services.

**Mandatory loan insurance:** In one of its programmes, and in others currently under development, Opportunity charges clients a one-time fee of approximately \$0.30 that covers loans outstanding in the case of client death. This fee mitigates the impact on the affected household in case of client death, since the MFI assumes responsibility if a client dies. Clients appreciate this feature, because the "stress of the loan is reduced."

**Mandatory death benefit insurance:** Starting 1 October 2000, one Opportunity partner is planning to offer clients death benefit insurance that covers burial and related costs for clients and up to five dependents. Insurance will be provided through a local insurance company, and the MFI will earn commission income on each of the insurance policies purchased by clients, which will cover processing costs. The decision to introduce the product was made in response to high client demand as well as a series of detailed focus group sessions conducted by the MFI. The insurance will be offered to solidarity groups, and will cover participating members and five dependents for a maximum benefit of \$167 per household. Clients will pay a monthly premium of \$1.50. Purchase of insurance will be mandatory for clients, although the MFI is trying to find ways to provide it on a voluntary basis. There are no exclusions for clients with AIDS.

**Emergency loans:** Opportunity is now considering ways to offer loans to clients to deal with emergencies, both health-related and otherwise. Furthermore, it is looking at ways in which it can extend this service to the general public as well.

**Education trust for minors:** Opportunity is examining ways to establish an education trust. This facility would allow clients to make payments into a trust fund that could be accessed as an annuity at a later date for educational purposes.

**HIV/AIDS prevention programme:** In 1999, Opportunity initiated efforts to disseminate AIDS prevention information to its clients through partnerships with several community groups: the AIDS Information Centre in Uganda, Planned Parenthood of Ghana, Family AIDS Caring Trust in Zimbabwe, Society for Family Health in Zambia, and AID for AIDS of Scripture Union throughout Africa. These organizations provide health education through peer education at weekly meetings that clients are required to attend. The programme has been well received by clients and the MFI is seeking to formalize this activity as a permanent part of its efforts to address client needs in a more holistic way. This programme will continue to be provided by partnering organizations specializing in health issues, as Opportunity has opted to concentrate its own efforts on the provision of financial services to the economically active poor in Africa. One of its Technical Advisors stated, "We have determined that we are not capable of providing AIDS education ourselves, especially when there are NGOs experienced in providing this type of education. We know a lot about giving out loans and working in poor communities and we believe it is unrealistic for loan officers to develop this kind of specialized knowledge."

**Legal services:** Opportunity works with organizations that provide legal advice on issues such as wills and inheritance laws for women, to ensure that women and children will have full legal protection after a husband/father dies. Opportunity offers these services through strategic partnership with groups such as the National Society for Advancement of Rural Women in Uganda, the Legal Resources Foundation of Zimbabwe, and the Zambian Legal Aid Foundation.

Both of these cases demonstrate the use of strategic partnerships to keep the MFI's staff focused on financial service provision and to keep costs of new services low. These cases mark the high point in the innovations seen among the MFIs. Notably absent from these cases, however, is information on the viability of these new experiments in terms of their value to clients or their costs to the MFI. Matching innovation with results will be the next step for the microfinance industry.

### **The limits of microfinance actions**

The greatest disadvantage of microfinance is its limited scale. By best estimates (the Microcredit Summit, 1999), microfinance is now available to under two million households across Africa. Even if this estimate undercounts clients by half, one would still conclude that microfinance covers only a fraction of poor households in Africa. Although microfinance is young, and likely to grow significantly over time, institutional capacity is limited, as is funding for expansion of existing programmes.

In addition, there is an inherent tension in microfinance between 'scale'—the number of clients served, and 'scope'—the depth of services provided to clients. MFIs that have successfully scaled up their services to above 15,000 clients have done so primarily by standardizing and mass-producing a few services. Those MFIs willing to provide auxiliary services to clients (such as education) may do so at some cost in terms of numbers of clients served. But in an AIDS context, increasing the scope of services may improve the ability of households to withstand crises—a core goal of microfinance and the fight against HIV/AIDS.

Finally, microfinance cannot serve the most needy. It is premised on the explicit agreement between MFI and client that loans will be repaid in full and on time. In short, each microloan is a commercial financial transaction. For this reason, households most negatively affected by HIV/AIDS may need to leave the microfinance institution until they are back on their feet. Indeed, accepting additional debt (loans) under those conditions may further harm the household's economic position. At this point, a household may shift from microfinance to a grant or other form of relief, often provided by churches, community groups, governments, or nongovernmental organizations.

### **Who can assume leadership?**

Senior managers of MFIs are under great stress, striving to meet stringent operational requirements of programme scale and financial self-sufficiency. They operate in complex political, social and health environments. They are often personally affected by HIV/AIDS and its consequences. But it is these individuals who can assume leadership on this issue. They can start by researching the health concerns of their main clientele. If they discover that they are operating in a high-prevalence HIV/AIDS environment, they can then decide how to provide the best services to their clients within that context. They should identify and liaise with health and social service organizations in order to direct their clients towards appropriate non-financial or grant-based support, if the need arises.

Health professionals can help by circulating information to MFIs, and by offering to provide training to microfinance staff and clients in ways that do not disrupt microfinance operations.

International donors can support these efforts. Microfinance donors should take the immediate step of breaking their silence about the effects of AIDS on microfinance institutions and clients. As long as microfinance donors remain silent about HIV/AIDS, MFIs will remain unwilling to discuss the challenges it imposes on their operations, and opportunities will be lost. Donors can also provide seed money to test innovations in financial service technologies, strategic partnerships, or other experiments that make microfinance more relevant in an HIV/AIDS context. And donor support is essential in assessing the impact and costs of these innovations, and disseminating the information gleaned as a result.

Finally, African governments can play a leadership role in supporting all efforts to confront HIV/AIDS. A government commitment to conduct a 'war against HIV/AIDS' encourages leadership in all institutions working in that environment—including microfinance institutions. More specifically on the microfinance front, governments can help by promoting a credit culture whereby borrowed money is expected to be repaid on time and fully, to help microcredit programmes retain their capitalization over the long term and expand to serve as many poor households as possible. Governments can also help in the regulation and supervision of microcredit and savings institutions by developing a set of guidelines that is neither too onerous nor too lax.

For microfinance institutions to safely join the fight against HIV/AIDS, it is important that all stakeholders see microfinance as one discrete tool in the arsenal against the economic effects of HIV/AIDS. Stakeholders must also do everything possible to support the continued availability of microfinance to communities and households affected by HIV/AIDS.

### **A note on the appendices**

The above paper was based on an extensive interview process with a range of African-based microfinance institutions. The detailed findings from these interviews are provided in the appendices that follow.

Appendix A: This section provides a description of the UNAIDS-funded survey that supported this report effort. The survey was instrumental in identifying the specific innovations by MFIs to date. This section also provides a list of MFIs that participated in this survey effort and a map of these MFIs relative to HIV prevalence rates.

Appendix B: This section provides a closer look at on-going MFI initiatives to provide HIV/AIDS education and prevention information.

Appendix C: This section explores microfinance efforts to provide expanded financial services to clients, including insurance and savings. Although most of these efforts were not designed explicitly to respond to HIV/AIDS, they can be evaluated in that context.

Appendix D: Concurrently with this UNAIDS-funded effort, the United States Agency for International Development (USAID) contracted DAI to conduct a desk survey of a range of microfinance institutions to determine the effects of HIV/AIDS on their clients and operations. Initial results of this survey (for Africa only) are presented in this section.

Appendix E: This section provides a list of references for further reading on microfinance and HIV/AIDS.

## **Appendix A: A description of the UNAIDS survey**

In June 2000, microfinance institutions from across Africa were invited to share their experiences in addressing HIV/AIDS. By August 2000, over 30 MFIs had responded to the call, representing Burkina Faso, Ghana, Kenya, Malawi, Mozambique, Namibia, Rwanda, Somalia, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

Subsequently, 19 of these MFIs participated in extended dialogues to tell a more complete story for UNAIDS and the African Development Forum 2000. Their experiences are documented above or in Appendices B, C, and D. Some MFIs shared their experiences by name, while others requested anonymity <sup>2</sup>.

In all, only a small percentage of MFIs in Africa participated in the survey. The research team used multiple channels to encourage further participation, but both the absence of field interviews and the short time available limited these efforts.

### **List of respondents**

Association for Community-Based Self-Empowerment (ACOMB)—Togo  
CARE Pulse—Zambia  
Catholic Relief Services (CRS) Burkina Faso—Burkina Faso, Togo  
Catholic Relief Services (CRS) Rwanda—Rwanda  
Christian Enterprise Trust of Zambia—Zambia  
Faulu Kenya Limited—Kenya  
Foundation for International Community Assistance (FINCA) Malawi—Malawi  
Foundation for International Community Assistance (FINCA) Uganda—Uganda  
Foundation for Credit and Community Assistance (FOCCAS) Uganda—Uganda  
Fundo de Credito Comunitario (FCC) (World Relief)—Mozambique  
Kenya Rural Enterprise Programme (K-Rep) Holdings Ltd—Kenya, Somalia, Ghana, Tanzania  
Mennonite Economic Development Associates (MEDA)—Tanzania  
Micro Bankers Trust (MBT)—Zambia  
Namibia Development Corporation (NDC)—Namibia  
PRIDE Tanzania—Tanzania  
Small Enterprise Foundation (SEF)—South Africa  
Uganda Agency for Development (UGAFODE)—Uganda  
URWEGO, World Relief—Rwanda  
Zambuko Trust PVTO Ltd—Zimbabwe

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<sup>2</sup> Funding for the initial survey was provided by the United States Agency for International Development (USAID). Funding for the subsequent detailed interviews was provided by the Joint United Nations Programme on HIV/AIDS (UNAIDS). This report was prepared by Development Alternatives, Inc. (DAI) for UNAIDS, based on both sets of information.

Insert Map 1

## **Appendix B: Initiatives in HIV/AIDS education and prevention**

HIV/AIDS education and prevention programmes are by far the most common innovation currently practised by microfinance organizations. The survey identified ten of these programmes across Kenya, Malawi, Namibia, Rwanda, Togo, Uganda, Zambia and Zimbabwe. In addition, MFIs in Burkina Faso, Tanzania and South Africa reported that they are planning to implement these programmes in the future.

Most commonly, an HIV/AIDS education component is added to regular client meetings. In some cases, the training is also made available to MFI staff and clients' families. It is usually provided through a partnership with a health-based nongovernmental organization (NGO) or local hospital. In some cases, the information is provided by the MFI's loan officers (after an extensive training programme).

### **A closer look: strategic partnerships**

Directly addressing health concerns, and HIV/AIDS in particular, is difficult for MFIs that focus strictly on the provision of financial services. These finance-only MFIs are prime candidates for strategic partnerships with health organizations, which allow the MFI to meet their clients' changing needs, while minimizing the MFI's cost and administrative burden of providing the services. Below are four examples of current or planned MFI strategic partnerships with health education providers.

#### **A strategic partnership: ACOMB, Togo**

The Association for Community-Based Self-Promotion (ACOMB) in Togo began microfinance services in 1995, and currently serves about 1400 clients. ACOMB operates in two very low-income districts that have experienced especially high rates of HIV/AIDS and that receive little government or outside assistance. In these districts, loan officers were noticing a change in client behaviour, including an increase in the number of clients missing credit meetings, a rise in the number of widows and female-headed households among clients, increasing client household size, and an increase in the number of clients exiting the programme.

As a response, ACOMB initiated a pilot partnership with a local hospital in each of the two districts. Initially, the goal was to provide health education, information and referrals to clients as an important complement to financial services. The partnership has since grown into a more extensive relationship. Now loan officers are accompanied into the field by hospital staff, who provide information on HIV/AIDS as well as basic health care and support to clients. In addition, hospital workers provide information on the care of sick relatives, and can refer clients to the hospital or clinic nearby. Depending on the skills of the health worker, they can also provide counselling to sick clients and/or their family members.

So far, clients have given very positive feedback to the new programme. Another sign of success is that the partnership has grown to involve a network of other related and non-related NGOs operating in the area.

Insert Map 2

### **A strategic partnership in design phase: anonymous, East Africa**

One MFI that wished to remain anonymous told a story of the effects of HIV/AIDS and their decision to launch a strategic partnership. "AIDS has been around for quite some time. And even now that the rate of new infections has been brought down, the rate of people falling ill or dying from previously contracted cases of HIV is very high," says the respondent.

Their programme, which offers group-based loans to primarily women clients in urban, periurban and rural areas, has seen an increase in the number of widows among clients and the number of clients caring for orphans. Clients are frequently absent from group meetings. Programme exit rates have risen to 20-25% per year, placing tremendous burdens on staff and the programme because of the time and cost invested in attracting replacement clients. Moreover, given the demographics of HIV/AIDS, they expect the client exit rate to continue to rise.

For these reasons, and also to respond to client requests for help with HIV/AIDS, the MFI decided to create a partnership with a reputable AIDS prevention/counselling and care organization. The MFI plans to have representatives from the organization present information and provide referral services to clients at weekly meetings. The sessions will not be mandatory, but since the clients requested this service, participation is expected to be high. The MFI has yet to determine exactly how the partnership will function or how the organizations will share the costs of the service. However, the manager emphasized that the relationship will be mutually beneficial. For example, the MFI is considering the possibility of offering special services to the clients of the HIV/AIDS organization as part of the partnership.

### **Strategic partnership at the planning stage: Small Enterprise Foundation, South Africa**

The Small Enterprise Foundation (SEF) began financial services in 1992, and currently serves approximately 8000 individuals, 97% of whom are women. Thus far, SEF has not detected a clear impact of HIV/AIDS on its operations, perhaps given its location in lower-prevalence areas of South Africa. Even so, SEF is planning on starting an HIV/AIDS awareness and education programme aimed at all staff members, clients, and their families in the next two-to-three months. It is envisioned that this programme will be implemented with the help of a local health NGO and funded through a grant recently received by the MFI. The details of the partnership and programme are yet to be determined. However, it has been decided that, in order to achieve maximum impact, information dissemination is best done by an HIV-positive individual. The director of SEF suggested that this could best be done through a consultant type of arrangement in order to take into consideration the special needs of these individuals. The broader HIV/AIDS education programme will begin with staff sensitization, and will be followed by client awareness-building. In all probability, the information sessions will be provided at the periodic meetings that clients are required to attend.

### **A closer look: informal arrangements**

Some MFIs have chosen to use informal arrangements for providing health information to clients. These responses are more common from institutions retaining a singular focus on the institution's financial goals. Two examples of such informal arrangements are presented here: Faulu/Kenya and PRIDE/Tanzania.

#### **Faulu/Kenya**

Faulu Kenya currently has an informal HIV/AIDS education programme that consists of gathering materials available from several anti-AIDS NGOs and disseminating them among staff and clients. The MFI has noted client interest in receiving information about HIV/AIDS prevention. The MFI foresees exchanging this kind of information in connection with Faulu Health Care—the medical insurance programme currently under development (see the 'New products' section for more information). Faulu is considering inviting medical staff to give clients information on preventive medicine, including HIV/AIDS issues, which might constitute a shift towards a strategic partnership.

#### **PRIDE/Tanzania**

Initiating lending in 1994, PRIDE/Tanzania is the largest institution (with nearly 38,000 clients) to participate in this survey. To date, PRIDE has observed few signs of AIDS among clients or staff. Although they are currently seeing high exit rates, this is believed to be related more to their methodology than to health issues. However, the respondent posed the following question: Why is PRIDE not seeing more HIV/AIDS? Could it be because solidarity groups are excluding clients affected by HIV/AIDS as 'poor risks'?

Although PRIDE/Tanzania does not provide an education component, some branch managers have been approached by outside health organizations to use the weekly meetings as a way of disseminating HIV/AIDS information to the population. To date, a few branches have participated in these informal arrangements.

PRIDE/Tanzania has no plans to enter into a formal partnership with regard to AIDS education. The management of the MFI believes that the institution should focus its efforts on providing financial services. However, the management is willing to allow other groups to come in on a case-by-case basis and use branch facilities at the weekly meetings.

### **A closer look: adding an internal HIV/AIDS education capacity**

Several MFIs have chosen to provide HIV/AIDS education and prevention information through their own staff. In-house education and prevention efforts are a more comfortable fit for two types of microfinance organizations, for two reasons. Firstly, many MFIs follow the 'credit with education' approach, which marries credit services with nonformal adult education on issues of health, nutrition and business. Freedom from Hunger is one international organization that follows this approach, and two of its affiliates participated in this survey. Secondly, many MFIs are members of larger multi-objective organizations with health objectives and health staff. Although health objectives have traditionally been pursued separately from microfinance in these institutions, HIV/AIDS has led to new

efforts to integrate these practice areas. This is the case for Catholic Relief Services, World Relief, and CARE International, all of which have African affiliates that participated in the survey.

Providing HIV/AIDS education and prevention information within a microfinance organization takes several forms:

- the international affiliate may develop a curriculum for the MFI to adapt and use locally
- a local health organization may train MFI staff to provide health information
- the local MFI staff may develop the curriculum itself.

The examples below all show in-house programmes that are still in the planning or design stage. This reflects the additional time requirements for developing specialized training modules in addition to pursuing regular microfinance and development tasks. By making this investment, the MFIs hope to retain more control over the information presented to the clients. The MFI can decide specifically which types of health education are most important to which clients and can be much more flexible in incorporating the information into the normal functioning of the programme.

**Fundo de Credito Comunitario – World Relief  
Mozambique**

FCC is in the initial stages of adding a health education component to its credit programme. Fourteen staff members are currently receiving training by World Relief on HIV/AIDS and other health issues.

**FOCCAS Uganda**

FOCCAS Uganda has been in operation since 1996, and now provides village banking services to more than 11,000 clients. FOCCAS uses the Freedom from Hunger 'credit with education' methodology. Since the beginning of its programme, FOCCAS has included information on HIV/AIDS prevention as a component of the health education. The initial HIV/AIDS curriculum met with limited success. A subsequent curriculum has been developed, which has benefited from technical support from Freedom from Hunger/US.

At this point, FOCCAS would like to go beyond education to provide additional services, including referrals for HIV/AIDS testing and counselling by linking with local providers. This linkage could be made through limited participation with local NGOs. A more extensive, formal partnership, however, would be difficult because FOCCAS operates in rural areas, making it difficult for smaller NGOs to overlap their services with the organization.

**URWEGO – World Relief Rwanda**

URWEGO, a three-year-old MFI with nearly 5000 clients, has recently begun research on how to integrate prevention programmes relating to malaria and AIDS education into their credit programme.

The institution has received funding to develop this programme and is in the process of drafting a detailed proposal for the long-term health education component of the overall programme. The Project Manager of URWEGO plans for the MFI staff to be trained by the staff of World Relief's Rwanda-based health organization. The project manager estimates that once the staff has been trained, the health education sessions that staff will present at credit meetings will require about a half hour of time per loan officer per week (15 minutes of preparation and 15 minutes for presenting the education session). The sessions will include written material as well as interactive learning exercises.

The HIV/AIDS education session at the loan meetings will be mandatory and will be presented as often as the village bank meets (each bank sets its own meeting schedule).

Despite the greater control and guaranteed staff inherent in an in-house education programme, this approach raises certain issues. Firstly, development of an in-house curriculum is costly for the MFI, and requires significant lead time. To date, most MFIs have developed their own HIV/AIDS curriculum, leading to additional cost and time requirements. Secondly, quality of the information provided by such programmes is likely to be uneven, and will depend on the level of MFI investment and commitment. Thirdly, unlike other health issues (such as malnutrition or cholera), HIV/AIDS is more difficult to address, given the culture of silence and social roots of the disease, and therefore may require types of intervention that are new to MFIs. Fourthly, MFI staff are already severely stretched by HIV/AIDS—whether through changing client behaviours or in their own families—and adding an additional training burden to their other duties may be too much for them to bear. However, it is too early to rule out any given approach.

## **Appendix C: Financial product innovations**

The surveyed MFIs revealed a rich variety of experiments in adapting or adding new financial products in response to clients' HIV/AIDS-related concerns. Most of these experiments were initially conceived by the MFIs to address other risk factors facing poor people in Africa. Innovations have appeared in the entire range of products currently offered by MFIs, including:

- addition of health and life insurance products
- changes in savings products, both voluntary and compulsory
- other product innovations, including death benefits
- refinements of standard methodologies to assist HIV/AIDS-affected clients.

Examples of each are provided below.

### **A closer look: insurance products**

Insurance products have traditionally worked well to provide coverage for risks that affect individuals on a relatively random basis and at a low incidence rate, which allows many small premiums to pay for only a few large payouts. But HIV/AIDS is not a random event, and is not restricted to a miniscule percentage of individuals. On the face of it, insurance that covers HIV/AIDS appears, by definition, to be too expensive for poor households to afford.

Despite the odds, several MFIs are experimenting with health and life insurance products that include HIV/AIDS for clients and/or staff, as shown in the FINCA/Uganda example provided in the main report. Because of MFIs' general lack of actuarial experience, these products are generally provided through a partnership with a formal insurance company, or on a limited pilot basis until the MFI gains experience.

The case described below is still at the investigation stage to determine whether the service can be provided at a reasonable cost.

#### **Faulu Health Care Medical Prepayment Plan: Faulu/Kenya**

Started in 1991, Faulu Kenya (Faulu means 'success') currently serves 13,000 clients, 52% of whom are women. Faulu staff have noticed that clients face increasing economic strain and difficulty in repaying loans due to health-related causes. To ameliorate clients' health concerns, Faulu has decided to create an outpatient healthcare package for clients and up to ten dependents in order to help them access outpatient services and medications at a reasonable cost. Faulu will finance the package up-front for one year, and pass the cost of the package along to clients in the form of a loan. If successful, Faulu will offer this product as a standard service.

Faulu is also exploring the idea of providing coverage for inpatient expenses by linking with an external health provider.

Insert Map 3

Life insurance is even more difficult to provide in an HIV/AIDS environment. As illustrated in the four examples below, the most frequent type of life insurance is limited to coverage for the amount of the loan outstanding at time of death. This coverage provides little to the family to offset such costs as burial or medical expenses or to replace the deceased's lost earnings. Even so, loan insurance may play a critical role in keeping HIV/AIDS-affected (but productive) individuals within the microfinance programme by reducing the risk to their peers of including them in solidarity groups. Indeed, this insurance has been provided by some institutions specifically to respond to concerns that solidarity groups are excluding HIV/AIDS-affected individuals because they are seen as high-risk for default on payments.

#### **Borrowers' Protection Fund: CARE Pulse, Zambia**

On 1 July 2000, CARE Pulse in Zambia introduced a *Borrowers' Protection Fund* that covers clients' loan balances in the case of death. The product is aimed at protecting peers in solidarity groups as well as clients' next of kin from having to assume the loan liability of deceased clients. Participation in the fund is mandatory: all clients are required to contribute 2% of the loan amount to the Borrowers' Fund at the time of joining the programme. By protecting surviving members, the MFI is able to encourage groups to include infected or affected individuals within their loan group. This programme is notably less expensive than the example from Southern Africa, and includes clients who die of HIV/AIDS. It remains to be seen if this fund is sufficiently capitalized to respond to future needs.

#### **Life insurance for outstanding loan balance: anonymous, Southern Africa**

A Southern African MFI offers clients the option of purchasing 'death cover' that insures the loan outstanding at the time of death. The cost of this insurance is usually 2-3% of the loan amount, with a maximum cost of 5% of the original loan amount. Clients infected with HIV/AIDS are not eligible to purchase Death Cover Insurance, as stipulated by the insurance company partner in the programme. This is perhaps the most limited and most expensive of the loan insurance plans reviewed, which may reflect the high incidence of HIV/AIDS in this country.

#### **Difficulty with life insurance for staff: FOCCAS Uganda**

FOCCAS Uganda has been unable to offer life insurance to staff and clients in the past, due to the high costs involved. In response to recent staff requests for life insurance, the organization is now offering an accidental death policy to its staff, which provides the family with one year's salary.

Clients have also been requesting insurance products, and FOCCAS is currently considering the different types of insurance available, as well as clients' willingness to pay. At this point, it is considering both a life insurance product, as well as a health insurance package, but the latter is expected to be unaffordable for clients.

## **A closer look: savings products**

Savings are an important product for HIV/AIDS-affected households. If savings are initiated when the household is still able to put aside money for future use, then the household can draw on those savings during financially stressful times—when medical costs rise, when expenses go up as orphans are absorbed, and as income streams fall.

In microfinance, savings fall into two very distinct categories. Voluntary savings are flexible accounts to which clients have access as needed. To protect savers, voluntary savings are typically only available through regulated financial institutions—a requirement that very few Africa-based MFIs can meet. However, MFIs worldwide have found creative ways to provide more flexible savings, one of which is described by FINCA/Uganda in the main report.

Alternatively, many MFIs take compulsory savings—regular deposits required for participation in the programme. Compulsory savings are generally held out of reach of the client until he or she exits the programme. These funds serve as an individual or group guarantee against default, and are used by the institution as a source of lending capital.

When HIV/AIDS-affected households face periods of extreme financial hardship, they must examine all available sources of cash. In fact, nearly half of the institutions involved in this survey reported that their clients were increasingly asking for access to compulsory savings, and might even be leaving the programmes in order to retrieve those funds. An example of this is provided below.

### **Changes in compulsory savings products: PRIDE/Tanzania**

PRIDE/Tanzania uses compulsory savings as a tool for guaranteeing loans. Clients are required to contribute \$1.50/week into this account, and cannot access the funds till they exit the programme. Currently, PRIDE/Tanzania is observing a high client exit rate, some of which may be due to clients' desire to access these savings. The MFI is now considering limited withdrawal options or predetermined savings cycles to keep clients within the programme while meeting their need for access to savings.

### **Clients opt for voluntary savings: anonymous, East Africa**

In the case of this MFI, clients maintain an informal fund used for emergencies among group members. Recently, clients have requested that the MFI help them to establish a more formal and safer fund to be administered by the MFI. The fund would be used for a variety of medical and other emergency needs. The MFI is seriously examining ways in which to respond to this request.

Trust funds are another form of savings currently being explored by a range of MFIs. The objective of the Trust Fund is to allow HIV-positive clients to protect and direct their assets for their children's use after their death. As described in the main report, Opportunity International is one institution exploring this option. The question remains

whether poor people have sufficient discretionary funds above and beyond their current savings to enable them to contribute to a Trust Fund.

### **A closer look: other product innovations**

While credit and savings are the predominant microfinance products, one MFI in South Africa—the Small Enterprise Foundation—told of a free death benefit that they provide to clients. As explained below, this product has obvious relevance to an AIDS context.

#### **Death benefits for clients: Small Enterprise Foundation, South Africa**

The Small Enterprise Foundation (SEF) of South Africa serves a very poor clientele, who face pressures of medical expenses, school fees, burial expenses, and social events such as weddings and baptisms. Recognizing this, SEF has provided families of deceased clients a one-time payout of \$33 towards burial and other expenses, at no cost to the client.

SEF notices that the aggregate amount that the MFI has paid for this service has increased over the past two years. In 1998, the MFI paid a total of 6000 Rand; in 1999, 4,300 Rand, and in 2000, 10,800 Rand. So far, SEF considers the costs of this benefit minimal to the MFI, and in fact has considered raising the amount of the benefit. SEF is concerned, however, that this benefit may create an incentive for sick clients to stay on in the programme at all costs.

### **Initial lessons in product innovations for HIV/AIDS**

In sum, MFIs have primarily focused on innovations around insurance and savings products to improve their offering to individuals and households affected by HIV/AIDS. Two closing points on these products are in order. Firstly, each of these innovations serves a broader purpose of protecting poor households from a range of health and other emergencies, not just HIV/AIDS. In fact, it is worth noting that not one of the above products was designed specifically to respond to HIV/AIDS. Secondly, all of the above programmes serve HIV/AIDS-affected households without targeting people living with AIDS. The overall conclusion can be stated as follows: MFIs should strive to provide a range of services that respond to clients' perceived needs, and should do so without targeting or excluding HIV/AIDS-affected households.

## **Appendix D: Preliminary findings from USAID survey**

This appendix provides initial survey findings for the USAID survey of microfinance and HIV/AIDS. Responses received after 23 August 2000 were not included in this analysis. Funding for this study was provided by USAID's Office of Microenterprise Development. The work was conducted by Development Alternatives, Inc. of Bethesda, Maryland.

Between June and August 2000, senior managers of 22 microfinance institutions (MFIs) from across Africa responded to a voluntary USAID survey exploring (1) the effects of HIV/AIDS on MFIs and their clients, and (2) MFI responses to the HIV/AIDS crisis. Although the survey is on-going, this sheet provides initial findings up to 23 August 2000.

### **Survey respondents**

The 22 MFIs represent Burkina Faso, Ghana, Kenya, Malawi, Mozambique, Namibia, Rwanda, Somalia, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe. Of these, 54% provide financial services only, and fully 95% strive for full financial sustainability. On average, the MFIs have been in operation for over five years and have 7500 clients, 79% of whom are women.

### **Economic stress and behavior change for microfinance clients**

Without exception, all programmes reported that their clients were under extreme economic stress. MFIs cited medical expenses as the greatest economic stress on their clients (95%), followed by feeding the family (86%), and then paying for funerals (77%). In addition, 50% cited the costs of caring for orphaned children. At the same time, clients' ability to respond economically to these challenges is compromised by increasing illness; 60% of MFIs report higher rates of illness among their clients over the last 12 months.

Is growing economic stress translating into changes in microfinance behaviour? It appears that client behaviours are changing on several levels. MFIs report observing the following trends over the last 12 months:

- increased difficulty in loan repayments (57% of MFIs)
- increased requests for access to compulsory savings (47% of MFIs)
- higher client absenteeism at meetings (45% of MFIs)
- increased requests for smaller loan sizes (29% of MFIs).

In addition, clients are exhibiting signs of difficulty in saving, lower productivity on the job (due to both illness and growing household responsibilities), regular diversion of enterprise loans for health care or funeral expenses, and more frequent 'pausing' in use of microfinance services.

Of the survey respondents, 36% are currently tracking clients by indicators that can be used to shed light on the changes HIV/AIDS is generating in households, such as number of dependents per household, number of female-headed households, or number of households caring for orphans.

### **Effects on the MFI**

Defaults are definitely on the rise due to HIV/AIDS. Over a quarter of MFIs noted this change explicitly. Others mentioned that loans diverted to pay for health emergencies are more frequently leading to defaults. The number of clients withdrawing savings and/or no longer borrowing because of HIV/AIDS is not clear at this time. Although 77% of the MFIs responding do monitor client exit rates, they do not know why these clients are leaving their programmes. Some programmes are now adding exit surveys that include health information.

At this time, MFIs have not begun to separately track the impact of HIV/AIDS on their financial bottom line, so it is impossible to estimate the overall effect of the disease on MFIs' ability to cover costs. However, when MFIs were asked whether their overall cost structure was rising due to HIV/AIDS, 41% answered in the affirmative. The most frequently cited areas of cost increases are in loan loss provisions and in staff benefits (both reported by 27% of respondents). A third area is new client induction costs (14% of respondents), which reflects the need to continually replace exiting clients with new clients to remain on the same expansion curve.

### **Effects on the MFI staff**

None of the MFI staff is immune to this disease or its consequences. Forty-three per cent of MFIs reported that staff household sizes were rising as they absorbed orphans. Twenty-four per cent reported an increase in staff absenteeism, and another 24% reported increases in staff illness over the last year. In addition, 29% of programmes reported 'other' indicators of how HIV/AIDS is affecting staff: requests for transfers to be closer to sick family members; requests for higher salaries to compensate for rising medical and funeral costs; increasing staff concerns about benefit packages; and reduced productivity on the job.

### **Pro-active MFI responses to HIV/AIDS**

While AIDS clearly takes a toll on MFIs and their clients, microfinance can also be used to combat the disease. The survey identified several areas where MFIs are already active.

To date, the most common response is provision of health information to clients and their families. Fully 43% of MFIs report participating in an AIDS education and prevention programme, primarily through partnerships with health organizations or hospitals. MFIs that launch these programmes through partnerships (rather than as an integrated part of the microfinance methodology) appear to be able to initiate them more quickly, more effectively, and at lower cost to themselves or their clients.

A few MFIs have begun to launch new financial products to respond to HIV/AIDS. Two MFIs have piloted health care plans with local HMOs to provide basic medical support for all illnesses, including HIV/AIDS. This responds directly to the finding that medical costs place the single largest economic strain on households.

More common is loan insurance, designed to cover the loan balance outstanding in the case of client death. This insurance is primarily designed to protect the quality of the MFI's portfolio, but also helps those legally bound to repay the client's debts, whether family or solidarity group members. This death protection comes at a significant cost to the client—typically a fee of 25% on the face value of the loan—which adds significantly to the cost of borrowing.

But perhaps the most valuable role of microfinance in the face of the epidemic is that of continuing to do what it does best: offer still-productive adults an opportunity to strengthen the household's economic base through access to financial services. The more aware the MFI is of the needs of HIV/AIDS-affected communities, the more likely the MFI is to be appropriately flexible in how it delivers these basic services so that clients get the most from these services.

### **Final survey results**

These preliminary results will be replaced by the formal survey report, due for completion in November 2000. The final report will be posted on the Microenterprise Best Practices website ([www.mip.org](http://www.mip.org)), along with other papers on this topic. For further information, contact Joan Parker at DAI, [joan\\_parker@dai.com](mailto:joan_parker@dai.com).

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