



**Paving the Way Forward for Rural Finance
An International Conference on Best Practices**

Case Study

Rural Finance in the Age of HIV/AIDS

**HIV/AIDS and Rural Microfinance—
A Matter of Survival**

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This case study was made possible by support provided in part by the US Agency for International Development (USAID) Agreement No. LAG-A-00-96-90016-00 through Broadening Access and Strengthening Input Market Systems Collaborative Research Support Program (BASIS-CRSP) and the World Council of Credit Unions, Inc. (WOCCU).

All views, interpretations, recommendations, and conclusions expressed in this paper are those of the author (s) and not necessarily those of the supporting or collaborating institutions.

ABSTRACT

This paper examines the impact of the worldwide HIV/AIDS epidemic on microfinance institutions (MFIs), with an emphasis on rural finance, and reviews the options and strategies MFIs can employ to protect their safety and soundness. The safety and soundness of an MFI depends on the quality of its loan portfolio and its funding base (capital or deposits). These are strongly affected by client behavior, and client behavior is, in turn, strongly affected by the HIV/AIDS epidemic.

Traditional MFI mechanisms for ensuring safety and soundness may be inadequate to deal with the magnitude of risk presented by HIV/AIDS. Most of these coping strategies are designed for relatively low-risk situations, whereas the HIV/AIDS epidemic represents a large-scale threat to the institutions. Recognizing the magnitude of the problem and adopting appropriate strategies to meet that threat are key to an MFI's survival. This paper examines specific strategies for ensuring the survival of an MFI.

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INTRODUCTION

More than 42 million people are infected with HIV/AIDS, 28.5 million of whom live in Sub-Saharan Africa. More than 20 million have died from AIDS, and 2.7 to 3.0 million more die each year. In Sub-Saharan Africa, seven countries currently have infection rates of greater than 20 percent of the adult productive-age population.

Although the incidence of HIV/AIDS is highest in Africa, other areas of the world are experiencing significant increases in the number of HIV/AIDS cases. Latin America and the Caribbean now have the highest growth rates of HIV/AIDS cases in the world. As bad as these statistics appear, the situation worldwide is going to get worse. The U.S. government estimates that more than 100 million people will be infected with HIV by 2010, with major outbreaks in countries such as Nigeria, Ethiopia, Russia, China, and India. More than 67 million will have died by that time. And the epidemic still will not have peaked.

To date, most attention has been on the current and future victims of HIV/AIDS—on treatment, support, services, and prevention. Even microfinance has been called on to assist households affected by HIV/AIDS.

But individuals are not the only victims of HIV/AIDS epidemic. Health systems, school systems, and other government services have been severely compromised by the HIV/AIDS epidemic. Large and small businesses have witnessed increasing employee absenteeism and declining productivity as well as the need to replace and retrain workers lost to the disease.

Microfinance institutions (MFIs) also run a high risk of falling victim to the effects of this epidemic because their traditional mechanisms for ensuring the safety and soundness of their portfolios and capital are inadequate for coping with the widespread consequences of the disease. MFIs need to look at the present epidemic in terms of survival because the consequences of HIV/AIDS threatens their very existence. This paper explores coping mechanisms that MFIs, especially those working in the rural sector, need to consider as they face a client base that is left impoverished by the ravages of this epidemic. The paper also advocates strategies for protecting the assets (loans) of MFIs and their resources (savings or capital).

Although the focus is on the effects of HIV/AIDS epidemic on rural financial institutions, most of the observations and conclusions of this paper should hold for urban-oriented MFIs as well. Because of the high prevalence of HIV/AIDS in Sub-Saharan Africa, much of the literature and many of the examples are drawn from that area. Again, the basic concepts should prove valid for other areas of the developing world as well, especially because Latin America, the Caribbean, and Asia are witnessing a rapid explosion in the number of HIV/AIDS cases.

We must remember that “rural” and “agricultural” are not synonymous. Rural society is complex: many rural households are not engaged in agriculture because many rural inhabitants hold jobs such as small merchants and petty traders, teachers, and police. Conversely, rural teachers, small merchants and petty traders, and police do engage in

smallholder agriculture as well. Most of the examples in this paper are drawn from agriculture because there is a vast body of literature available on the effects of HIV/AIDS on smallholder agricultural households. However, because agriculture is an integral part of rural society, even those MFIs that specialize in petty trading and other non-agricultural lending will be affected by events in the agricultural sector. Moreover, some underlying trends reported here may well have relevance for the urban sector.

UNDERSTANDING THE SIGNIFICANCE OF THE HIV/AIDS EPIDEMIC

To understand the need for MFIs to build protection against the effects of HIV/AIDS, one must first understand a little about the impact of the disease on rural microfinance clients and their households, and the interdependency of the two. A great deal has already been written about this, so this paper only highlights some major points that have direct relevance to the threat HIV/AIDS poses for MFIs.

Immediate Impact on the Household

HIV/AIDS is a deadly disease. Already more than 20 million people have died. In Kenya, AIDS has lowered life expectancy from 65 to 46 years.¹ In the rural northeast of South Africa, 80 percent of deaths from communicable diseases were caused by AIDS. In small towns of Uganda, 75 percent of adult death is because of AIDS.²

One major impact of HIV/AIDS for poor rural families is the loss of labor.³ Approximately 75 percent of all HIV/AIDS-related deaths occur in the most economically productive age brackets (20-40 years).⁴ Often, these deaths occur among heads of households or other primary members of the family.

A family with an HIV/AIDS-infected person loses not only the labor of that person but also the labor of others in the family. Caring for an infected family member is labor intensive. In a family with an HIV/AIDS-infected member, 29 percent of household labor on average is spent on AIDS-related activities. If there are two care-givers in the family, the loss of household labor can be as much as 43 percent.⁵ Care giving often involves caring for orphans or minor children. Unfortunately, care-givers are usually adult income-earners, who must reduce their own income-generating activities to care for the infected person.

¹ Jill Donahue, Kamau Kabbucho, and Sylvia Osinde, "HIV/AIDS—Responding to a Silent Economic Crisis Among Microfinance Clients." Nairobi: MicroSave-Africa, p. 2

² Takashi Yamano and T.S. Jayne, "Measuring the Impacts of Prime-Age Adult Death on Rural Households in Kenya." Department of Agricultural Economics Staff Paper 2002-26, East Lansing: Michigan State University, p. 6

³ John Stover and Lori Bollinger, "The Economic Impact of AIDS." Washington: The Futures Group, pp. 3-4.

⁴ Donahue et al., p. 2

⁵ Stover and Bollinger, p. 5.

With HIV/AIDS, there has been a great increase in the number of families that have individuals of productive age who have died, who are caring for chronically ill family members, or who are caring for orphans. A study of credit union members in Kenya found that 73.5 percent of the respondents either had experienced the death of a family member from AIDS or knew someone who had, whereas 100 percent of the respondents interviewed were caring for chronically sick family members or knew someone who was. Sixty-three percent of the respondents knew families caring for orphans.⁶ Twenty-five percent of families in Uganda were caring for a child from another family because of an AIDS-related illness.⁷

Other losses to family labor occur as well. The AIDS-related death of a male household head causes older daughters to leave the household to get married, with a further decline in household labor.⁸ Death from HIV/AIDS represents not just a loss of labor but also loss of skills. Younger workers and others taking over the business often do not have the same skills and knowledge as the person who died.⁹ In addition, although a woman may become the head of household as a result of the death of her husband, local inheritance rights may require that household and business assets be transferred to relatives of the dead husband.

Impact of HIV/AIDS on Agriculture and Agricultural Practices

An HIV/AIDS infection in a family has a profound impact on its agricultural productivity. One study showed that the death of a male household head between 16 and 59 years is associated with a 68 percent reduction in the household's net crop production and a 57 percent decrease in the gross value of crop output.¹⁰ In Thailand, one-third of HIV/AIDS-affected rural families experienced a 50 percent decline in agricultural output.¹¹ In Zimbabwe, an AIDS-related death in a rural family led to a 61 percent reduction in maize output, a 47 percent reduction in cotton output, a 49 percent reduction in vegetable production, a 37 percent decrease in groundnut production, and a 29 percent reduction in the number of cattle owned.¹²

Agricultural tasks were frequently interrupted when women needed to care for household members ill with AIDS-related conditions. The reduced activity of a female family member in agriculture, through death or incapacity or because of the need to provide assistance to a sick family member, leads to a reduction in the production of food crops and cereals.¹³

⁶ Anna Cora Evans, "HIV/AIDS and Microfinance: Kenyan Credit Unions Face the Crisis." Madison, Wisconsin: WOCCU, p. 7.

⁷ Anita Alban, "AIDS and Development: Socio-Economic Perspectives." Speech presented at a seminar on HIV and Development/ Copenhagen: Danida, p. 1.

⁸ Yamano and Jayne, p. 23.

⁹ Donahue et al., p. 8.

¹⁰ Yamano and Jayne, p. 22.

¹¹ Alban, p. 2.

¹² Ibid., p. 7.

¹³ Stover and Bollinger, p. 6.

Because of the time-sensitive nature of smallholder agriculture, the loss of a few workers at critical planting and harvest periods can significantly reduce the size of the harvest.¹⁴

As a result of the loss in crop husbandry and management skills because of the death of a family member, especially the death of a male head of household, the family tends to shift from high-value, management-intensive crops to a relatively low-value or subsistence crops.¹⁵ The death of male head of household tends to reduce the amount of land devoted to cultivation of cash crops and causes a shift from cash crops to food crops, whereas the death of the core female household member decreases the size of cultivated land devoted to cereals.¹⁶

Because cash crops often require more cash resources and are more expensive to grow, there is a tendency to shift from cash crop production to food crop production.¹⁷ Cash income from the deceased person is no longer available to finance cash inputs, so there is a shift to less intensive production practices or to crops requiring less fertilizer or other inputs.¹⁸ A household may no longer be able to afford purchased seed or fertilizer, and the use of purchased inputs is reduced.¹⁹

Impact of HIV/AIDS on Household Financial Patterns

The magnitude and persistence of the effects of HIV/AIDS on a household are such that, to address the mounting impacts, households are forced to radically and often permanently alter their livelihood strategies. This has profound implications for MFIs that depend on these households either for reliable payments or for the savings that fund their loan programs.

Income

The most immediate impact of an HIV/AIDS-infected family member is a sharp decrease in family income. The household initially loses the sick individual's income-generating power. With death, there is a permanent loss of the person's income.²⁰ Changes in cropping patterns—especially the switching from high-value cash crops to cereals and other food crops after the death of a prime-age male—cause households to suffer a decline in cash income permanently.²¹ There is a general loss in remittances from family members working outside the rural area, especially if the infected person is a prime age male.

¹⁴ Ibid., p. 4.

¹⁵ Yamano and Jayne, p. 19.

¹⁶ Ibid., p. 20.

¹⁷ Patricia Bonnard, "HIV/AIDS Mitigation: Using What We Already Know." Technical Note No. 5, Food and Nutrition Technical Assistance. Washington, D.C.: U.S. Agency for International Development, p. 2.

¹⁸ Yamano and Jayne, p. 19.

¹⁹ Bonnard, pp. 2-3.

²⁰ Evans, pp. 7 and 26.

²¹ Yamano and Jayne, p. 20.

In addition to loss of income from the infected persons, the family loses at least part of the care-giver's earnings while he or she stays home to care for the ill person.²² The care of family members with AIDS has tremendous financial repercussions in terms of lost business income because most care-givers reduce their income-earning activities and draw from their business capital to meet expenses.²³

In addition, as other household members leave the immediate family, their contribution of income is lost. Future income is also affected as the family attempts to cope with immediate financial problems. Children often drop out of school to save money spent on school fees or to earn income in a local enterprise, resulting in severe loss of future income from greater income-earning opportunities.

The net effect of these reductions can be substantial. UNAIDS estimated from household surveys in Thailand and Côte d'Ivoire that rural families with an HIV/AIDS-positive member suffered a decline of 52 to 67 percent in income.²⁴

Expenses

As the income of families with an HIV/AIDS-infected person falls, their expenses rise. Medical expenses increase markedly during the intensive care period of an HIV/AIDS incidence. In Tanzania, expenditures for medical care and funeral care were 100 times higher in families with deaths during the year. In Côte d'Ivoire, households with an HIV/AIDS patient spent twice as much as other families did on medical expenses. In Ethiopia, the average cost of treatment, funeral, and mourning expenses amounted to several times the average household income.²⁵

With the death of the infected person, there are funeral and burial expenses. The costs of transporting a body to obtain a death certificate and of mortuary services are high.²⁶ Because cremation and other practices are often not part of local custom, burial and funeral costs remain high, especially in cultures where the mourning process is considered an important rite of passage. Mourning costs can undermine the family's grain or other food stocks.

Families that inherit the orphaned children of HIV/AIDS victims are faced with increased costs for food, school fees, clothing, and the like.²⁷

To minimize expenses, affected families resort to extreme measures. Fifteen percent of families in Thailand had to take their children out of school, and outlay on school education

²² Evans, pp. 7 and 26.

²³ Donahue et al., p. I.

²⁴ Alban, p. 2.

²⁵ Stover and Bollinger, p. 4.

²⁶ In Zimbabwe, families had to obtain a legal certification of death before they could bury a family member who had died from AIDS. Since medical examiners were located only in major cities, the families had to pay to transport the body to town for death certificate and then back to the village for burial.

²⁷ Evans, pp. 7 and 26.

was halved in Côte d'Ivoire. Fifty-seven percent of elderly people in Thailand were left to care for themselves.²⁸

Assets

Assets can be classified as savings, household assets, productive assets, and land. Families caring for an HIV/AIDS patient find their cash resources become constrained as incomes decline and medical costs rise.²⁹ These families will first cut back on consumption to free up cash for treating the sick person.

Productive assets—such as irrigation systems and grain storage facilities—may be less well maintained as families shift expenses to cover health care for an infected individual. Livestock may suffer because families shift to lower-quality or lower-quantity of feeds and minimize treatments and vitamins.

The ability to save falls off dramatically because households need to use what cash they have to meet current expenses. As income fails to cover expenses, families begin to draw down their savings. As reported, families needing cash to cover expenses when caring for an infected family member dispose first of relatively liquid assets—specifically, savings.³⁰ In Cambodia, families caring for an infected family member drew down, on average, 29 percent of their savings. In Thailand 57 percent of AIDS-affected households used up all of their personal savings.³¹

When these measures fail, families must resort to disposing other assets.³² The death of a family member because of AIDS often results in the stock of food grain to be depleted to provide food for mourners. Other burial-related expenses are met most often by selling livestock.³³

After liquid assets are consumed, the family sells off household assets. They will sell productive assets only when they have run out of other options because selling productive assets compromises future earning capacity.³⁴ Land is sold only as a last resort.

One very important implication of this consumption of assets to meet current expenditures is that the family's collateral for borrowing disappears.

²⁸ Alban, p. 2.

²⁹ Bonnard, p. 2.

³⁰ See, for example, Donahue, p. 11; Bonnard, pp. 2-4; Stover, p. 4; and Yamano and Jayne, pp. 24-25.

³¹ UNAIDS, "AIDS Epidemic Update: December 2002." Washington: UNAIDS/WH -2002, December 2002.

³² Stover and Bollinger found that families with deaths that were not related to HIV/AIDS seldom had to resort to selling assets (p. 4).

³³ Stover and Bollinger, p. 5.

³⁴ Donahue et al., p. 11.

Borrowing Habits

Clients will initially attempt to take out larger loans to divert some of the cash for the treatment of the infected person. At the same time, the demand by these clients for loans related to running their businesses drops as they reduce business activities.

Later, they will resort to borrowing that allows them rapid access to cash. In Kenya, credit union members shifted from normal loans (which often required a four-month waiting period) to instant cash advances, even though these commanded a much higher interest rate. The demand for instant cash loans was driven by a need to pay emergency expenses, especially medical bills, and the instant cash loans offered a quicker disbursement time.³⁵

Because of the restrictions on withdrawing savings and the ready availability of emergency loans, credit union members can take out emergency loans up to the value of their shares and let the loan default—in effect, withdrawing from membership.

Loan Servicing

Clients will initially continue to service the loan as best they can from savings, the sale of assets, and gifts from relatives and friends.³⁶ MFI clients will actually go to great lengths to repay their loans to safeguard their future positions in their solidarity groups because they see their business and access to loans as the way to recover once the crisis is past.³⁷ There is at least some evidence that families will borrow from money lenders and other informal sources, at very high rates of interest, to keep their loans with the MFI current.

As a crisis continues, however, the care-giver will have difficulty meeting loan payments because medical payments assume priority over servicing their loans. Loans are most likely to become delinquent if the client (1) did not have much to draw on in the first place, (2) has a crisis that runs throughout the loan cycle, or (3) recently experienced another crisis from which he or she has not fully recovered.³⁸

If the crisis occurs midway through a loan cycle, the family is more likely to have invested the entire amount of the loan in the business, rather than diverting it. But if a crisis occurs at the beginning of a loan cycle, the greater the possibility the client diverts a significant amount of the proceeds to cover medical expenses. If the funds are diverted, the family is more likely to have difficulty repaying the loan.

³⁵ Evans, p. 16.

³⁶ Donahue et al., p. 17.

³⁷ Ibid., p. iii.

³⁸ Ibid., p. 17.

Other Impacts

The household financial crisis is also likely to affect the relations of clients with their MFIs in terms of loan repayment, borrowing patterns, savings patterns, attendance at meetings, and group cohesion.³⁹ Inability to attend group meetings is a particular problem for those institutions that require regular attendance: dropout rates increase dramatically in village banking scheme groups that expel members with irregular attendance.⁴⁰ Because credit union members often cannot withdraw their major savings from the credit union unless they withdraw from the credit union itself, the need to obtain cash to meet medical expenses sometimes results in a decline in credit union membership.

IMPLICATIONS FOR RURAL FINANCIAL SERVICES

Many look to microfinance as one mechanism for helping HIV/AIDS-affected families, addressing the topic from the point of view of what microfinance should do for affected clients.

Donahue, for example, talks about the role of microfinance in “meeting the coping needs of clients” and in improving microfinance services to “strengthen clients’ coping strategies” (p. iii). Microfinance loans serve a critical role that enables clients to enhance their business volume and diversify their economic activities. The resulting increase in income facilitates the creation of savings and asset accumulation. According to Donahue, loans also provide an important source of lump sums of cash, which helps clients avoid eating into their business capital. Bonnard points out that small loans expand cash resources and help households manage their cash needs, maintain and restock household and productive assets, cover operating expenses, and increase or diversify income (pp. 5-6). Although these suggestions are consistent with microfinance best practices, none of the authors examines the increased risk to MFIs in such lending nor do they address the issue of credit-worthiness.

Yamano goes even further, arguing in favor of concessionary credit to reduce the need for a newly single female-headed household to sell productive assets or prematurely let go of productive family members (p. 29). MFIs are not charitable institutions, however. Their primary goal must be sustainability, and although providing loans and other services to benefit their clients is in their own best interest, MFIs can afford to do so only if these loans are profitable. Concessionary credit, by definition, erodes the capital of the institution granting the credit.

³⁹ Ibid., pp. 17-20

⁴⁰ Ibid., p. 4.

IMPACT ON FINANCIAL INTERMEDIARIES

The disruption of the social system and household finances of rural families has a significant impact on their relationships with MFIs. Clients have difficulty attending meetings, meeting repayment schedules and contributing to savings activities, and often must divert loans to meet other expenses. As a result, the HIV/AIDS crisis that has so devastated individuals and households also has had a profoundly negative impact on the financial health of many MFIs and threatens many others.

One of the most significant changes is the increase in drop-outs from the various programs. Evans, for example, found that membership in the five Kenya credit unions she studied has been shrinking, and much of the decline can be traced to AIDS-related deaths. In one credit union, as much as 97.2 percent of the decrease in membership could be attributed to these deaths (p. 34). Donahue noted that members of group-based MFIs are being forced to drop out of their groups because of their inability to attend meetings with the required frequency and because they cannot afford to borrow from the program during a cycle (p. 4).

A second major impact could be a significant increase in delinquency and defaults. Unfortunately, very little data are available on the impact of HIV/AIDS on loan delinquency, and few institutions collect or assess data on this relationship. Microfinance clients apparently do their best to maintain their loan payments, even incurring more expensive indebtedness from the informal sector to meet payments, but as cash and assets are depleted during a prolonged illness, resources are increasingly diverted toward covering medical and survival expenses. More information is needed on the impact of HIV/AIDS on portfolio performance, and this is an area of operations that MFIs should be monitoring closely.

Not only are clients having difficulty meeting loan payments, but their diminished capacity to save has also resulted in a decline in voluntary or compensatory savings. Evans reports an “alarming . . . pattern of dis-savings in most of the credit unions” (p. 34). Although other depository institutions may face a similar constriction in savings, the situation is especially difficult for credit unions, which depend entirely on local savings for their loan funds. Reduced savings means fewer funds available, and when these funds are lost to defaults, the result can be a catastrophic downward spiral that cannot be stopped.

Client borrowing patterns have also changed dramatically. In Kenya, credit unions saw a dramatic increase in emergency loans, instant cash advances against salaries, and borrowing to cover medical bills and hospital fees.⁴¹ The instant cash advance for paying emergency expenses, especially medical bills, has outpaced the demand for emergency loans because of the quicker disbursement time, despite the greater interest rate.⁴²

The increased number of deaths from HIV/AIDS in many countries is putting great pressure on a most ubiquitous and venerable institution in African society—burial societies. These organizations used to be a pillar of cohesion among the population, providing an insurance to

⁴¹ Evans, p. 6.

⁴² Ibid.

cover the costs of transporting a deceased person to his or her native village for burial (often from another country) and a basic sum to cover funeral and mourning costs. Before HIV/AIDS, the burial societies typically witnessed 4 to 5 deaths a year; now, they are burying 40, 50, or more per year. And with rapid inflation in many countries, the amount of coverage they provide has steadily declined. In Zimbabwe, for example, most burial societies now provide only a small stipend to cover the cost of a minimal casket. The regular contributions are no longer sufficient to cover even this small stipend; the societies must have a special assessment each time a person dies to cover the costs.⁴³

Thus, the HIV/AIDS crisis poses a serious threat to MFIs. Low-risk borrowing in the form of small business or productive loans declines. Higher-risk borrowing to meet current consumption needs increases, and loans are diverted to pay for medical and other current expenses. The material wealth, and hence the credit-worthiness, of the households decline. Increases in delinquency threaten reserves and capital. And, for deposit-taking institutions, savings to fuel loan growth is stymied.

COPING STRATEGIES FOR MICROFINANCE INSTITUTIONS

The HIV/AIDS epidemic challenges the very survival of MFIs in areas with a high incidence of infection. Normally, MFIs have a natural protection in the diversity of their clients, but the HIV/AIDS pandemic is akin to a severe drought for farm credit programs that have a concentrated portfolio in a single crop; it overcomes the MFI's natural diversity by its widespread nature. With HIV/AIDS, an entire portfolio can quickly become at risk.

The HIV/AIDS pandemic is occurring at a particularly vulnerable time for MFIs. Although a few may be fortunate enough to have a benefactor willing to cover portfolio losses and replenish funds, most do not. The major world donors in microfinance are increasingly unlikely to finance portfolios—or the rebuilding of damaged portfolios—stressing instead projects and programs that support internal reforms, improved governance, efficiency and economies of scale, internal systems, and policy reform and regulation. Thus, an MFI facing a severe erosion in its portfolio because of the impact of a widespread HIV/AIDS crisis, is left to deal with that crisis largely with its own resources. How well it survives depends on the success of the coping strategies it adopts.

Insurance-based Coping Strategies

Traditionally, MFIs use strategies based on insurance principles to cover loan losses and to protect the institution's core capital. Because HIV/AIDS has such a devastating, widespread impact, however, these traditional strategies for coping with delinquency and defaults are easily overwhelmed by the magnitude of the problem.

⁴³ Personal interviews in two burial societies conducted in 2002.

Loan Loss Provisions

Loan loss provisions typically represent an MFI's core mechanism for managing defaults: adequate loan loss provisions represent the first line of defense to protect the MFI from the defaults associated with illness, death, poor business outcomes, and bad-faith borrowers.⁴⁴ A prudent MFI sets aside a percentage of its overdue loans to cover the risk implied by the level of delinquency. Regulated financial institutions are required by government supervisory agencies to set aside loan loss provisions according to set percentages of the aged distribution of its portfolio—beginning with a minimal percentage for any loans with any payment over 30 days in arrears. Non-regulated MFIs typically follow a less-rigorous provisioning policy. The PEARLS standards promoted by WOCCU, for example, sets a target of 100 percent provisioning for loans with any payments over 12 months in arrears, with no intermediate provisioning for arrears of 30 days, 90 days, or 180 days.⁴⁵

Under normal circumstances, loan loss provisions are adequate to protect the MFI against loan defaults. Typical default rates for group-based lending programs have generally been 1.5 to 4 percent. Credit unions have always tolerated a slightly higher rate of default than the new microfinance programs. With HIV/AIDS, however, if default rates climb dramatically, loan loss provisions are likely to prove inadequate to cover the increased losses.

Institutional Capital

Institutional capital is the second line of defense (after loan loss provisions) against losses incurred as a result of delinquency and defaults.⁴⁶ As in the case of loan loss reserves, institutional capital represents an ability to write off loans without jeopardizing the solvency of the MFI or putting its savings clients (in the case of deposit-taking MFIs) at risk. It is important to note, however, that loan loss reserves and institutional capital are really the same thing: loan loss provisions are funds that could have been added to institutional capital had the losses not occurred, whereas use of institutional capital to cover losses is tantamount to increasing the amount of loan loss provisions. Both result in a decrease in the capital of an institution and in its ability to make loans. Also, in both cases, the extraordinary increase in defaults experienced by MFIs because of HIV/AIDS threatens to overcome the ability of loan loss provisions or institutional capital to deal with the crisis.

Self-Insurance Schemes

Both credit unions and other MFIs have turned to self-insurance schemes to provide protection against exceptional loan losses.

⁴⁴ Evans, p. 35.

⁴⁵ Donahue et al., p. 28.

⁴⁶ Evans, pp. 30, 36.

Credit unions have traditionally held that the debt dies with the debtor, using insurance to cover any losses stemming from the death of a member. In Kenya, this insurance scheme was expanded to cover burial costs—fulfilling the role traditionally played by burial societies. Unlike in the United States and other developed-country credit unions where the insurance is provided by large insurance companies that spread the risk over a large number of institutions, credit unions in Africa and other parts of the world have attempted to do this through self-insurance. The problem is that the monthly fees charged by the credit unions have not been sufficient to cope with the increased rate of death because of AIDS. In one credit union in Kenya, a fund that had accumulated 6 million shillings in the 23-year period, from 1977 to 2000, had to pay out 5 million shillings in 2001 alone. And in another credit union, premiums totaling 1.5 million shillings were insufficient to cover the 5.5 million shillings it had to pay out in death benefits in a single year.⁴⁷

Many group-based MFIs either have an emergency fund built into their rate structures or encourage clients to create emergency funds within their MFI groups to help them cope with financial pressures stemming from HIV/AIDS.⁴⁸ These funds tend to be small and can sustain only a small crisis.

Limitations of Insurance-based Coping Strategies

All of the three strategies presented above are essentially self-insurance schemes. The underlying premise of any insurance program is that very few people are actually affected by the risk being covered at any one time. Therefore, a very large number of unaffected persons paying a reasonable premium can cover the damages occasioned by the few insured individuals who do suffer damages at any one time. But HIV/AIDS presents a very different scenario in which a large number of borrowers are affected, and the cost of the insurance is covered by a relatively small base of clients. The primary limitation of self-insurance schemes is that any major, widespread disaster—such as HIV/AIDS—can quickly overwhelm the ability of the funds to cover the losses. Self-help groups of 5 to 15 people are especially incapable of spreading the risk sufficiently to cover losses. Even large institutions with tens of thousands of clients may not be able to spread the risk adequately. Insurance schemes generally depend on an extremely large client base, which most MFIs simply do not have.

The second limitation of self-insurance schemes that causes them to fail is that the institutions are unwilling or unable to charge a premium high enough to cover the risks. The cost of self-insurance (especially institution-run emergency funds and loan loss provisioning) is built into interest rate charged on loans or added on as a separate premium. Grameen Bank, for example, charges an additional 0.5 percent as an emergency fee to cover losses. If an institution has a loss rate of 1.5 percent, then 1.5 percentage points in the interest rate represents the premium for the loan loss provisioning. Under normal circumstances, these rates might cover losses, but with HIV/AIDS losses can easily balloon to 10, 15, 25, or even

⁴⁷ Evans, p. 15.

⁴⁸ Donahue et al., p. 10.

50 percent of the loans outstanding. An increase in defaults from 1.5 percent of the outstanding portfolio to 25 percent requires that an MFI increase its interest rates by 23.5 percentage points to cover the increased loss reserve requirements. Few institutions have responded adequately to this challenge, and at some point the increased interest rate may trigger a significant decrease in loan demand.

Coping Strategies that Can Help

Given the magnitude of the HIV/AIDS crisis, MFIs need to take an active, aggressive approach toward protecting themselves. Just as individual families need to build an array of coping mechanisms to deal with the HIV/AIDS crisis, so do MFIs. To date, there is not much literature suggesting that MFIs are fully aware of the threat posed to their survival by the HIV/AIDS crisis or that they have begun to develop effective best practices for managing the threat.

To survive the HIV/AIDS crisis and the threat it poses to their portfolios, MFIs will need to adopt multiple strategies and tactics. Many of these strategies, and even the most important, may not be traditional MFI activities. What is required are strategies that address the factors that influence the client's relationships to the MFI. These activities -- including actions to prevent new infections, promoting savings, offering more suitable loan products, increasing contact and supervision of clients, placing loans at risk in special portfolios, reducing the time commitment required of clients, and encouraging practices to improve household finance.-- may be beyond the scope of traditional microfinance. The following examples illustrate the range of options that MFIs need to consider, but are by no means an exhaustive list of possible strategies.

Prevent New Infections

HIV/AIDS is a preventable disease. People who do not contract the disease will not suffer the household and income deterioration discussed earlier and will face less of a problem in maintaining their business and financial relationships. The most effective response to reduce portfolio risk in the face of HIV/AIDS is to help members and clients avoid the disease.⁴⁹

Many authors have pointed out that MFIs should not try to become HIV/AIDS support institutions. At the same time, they have recognized the MFIs are often local meeting or assembly places and are well positioned to reach an HIV/AIDS-vulnerable population. With a large, publicly funded HIV/AIDS awareness and support campaign underway in most countries, MFIs should access these campaigns for publicity materials, brochures and other literature, and referral materials for display and distribution in their offices. Such an activity requires little effort and expense on the part of the MFI and can be used to promote a closer bond of service between the MFI and its clients.

⁴⁹ Stover and Bollinger, p. 11.

One study of credit union members found that HIV/AIDS prevention information was the single most desired service, with 100 percent of the survey respondents requesting this service from their credit unions.⁵⁰ In Zimbabwe, credit unions were encouraged to place information about AIDS prominently in their offices and to stock brochures on AIDS awareness and referrals. The key methods for disseminating HIV/AIDS information include:

- Displaying HIV/AIDS awareness and referral information in public areas;
- Including talks about HIV/AIDS at regular group meetings;
- Distributing information from the AIDS support institutions with loan applications and encouraging members and clients to seek HIV/AIDS information and counseling from AIDS support institutions during the loan application process; and
- Including credit-with-education techniques.

Health insurance schemes can also provide a valuable service to members and encourage more frequent contact with the health system. The Zimbabwe credit union federation negotiated a group health insurance scheme for its member credit unions through a local insurance company. It was hoped that more affordable access to the health system would encourage members to make greater use of those services and reduce the incidence of HIV/AIDS.

Although preventing additional HIV/AIDS infections is undoubtedly the single most effective strategy an MFI can take to protecting its portfolio, it should do so by utilizing other, existing networks and suppliers of these services, rather than trying to develop its own materials and programs.

Promote Savings

As Boomgard and Parker point out: “In communities gradually being drawn into an HIV/AIDS crisis, the most important services are those that create personal safety nets through savings or build-up of assets. If the MFI is able to provide it, savings may be the most important service for clients in these communities.”⁵¹

Focusing on savings has a dual benefit for an MFI—especially a deposit-taking MFI like credit unions. First, it helps strengthen the clients’ own coping mechanisms which, in turn, improves their ability to manage the crisis, provides resources to support the costs associated with funerals, and increases their ability and willingness to service their loans.⁵² Having

⁵⁰ Evans, pp. 27-28.

⁵¹ James J. Boomgard and Joan C. Parker, “Recognizing and Responding to HIV/AIDS in Microfinance: A PowerPoint Presentation with Speaker Notes.” Bethesda, Maryland: Development Alternatives, Inc. for USAID Microenterprise Best Practices Project, October 2001, p. 20.

⁵² Mercy Butao, “The Impact of HIV/AIDS on Agricultural Production Systems and Rural Livelihoods in the Central Region of Malawi.” Draft. January 2002, p. 81.

savings has been recognized as a most important coping mechanism available to microfinance clients, and any effort to build savings before crises occur will have a beneficial impact on the clients and hence on their continued relationship with the MFI. For credit unions and deposit-taking MFIs, building savings is primarily an issue of developing appropriate products, pricing them correctly, and promoting them to clients; for non-deposit-taking MFIs, stimulating savings takes the form of promoting voluntary informal savings arrangements (welfare or emergency funds) within the groups and working to establish a banking relationship for clients with a deposit-taking institution.⁵³

Second, for credit unions and perhaps other local deposit-taking MFIs, savings (whether in the form of shares or voluntary savings) represent the only source of loanable funds. Only by increasing savings can a credit union hope to meet its loan demand. However, mobilizing savings has become more difficult because HIV/AIDS-affected families have lost the ability to save. The dilemma for credit unions is how to generate funds internally to meet loan demand when they have fewer members and those members are less interested in and less able to save.⁵⁴ Some mechanisms that might work to stimulate savings include:

- Create children's accounts to facilitate the transfer of savings to surviving children in the absence of adequate inheritance rights;
- Create contract savings (for Christmas or other special occasions) that cannot be withdrawn until the contract expires;
- Pay competitive real interest on voluntary savings accounts; and
- Offer greater withdrawal flexibility on savings accounts that are not guaranteeing loans.

Zimbabwe credit unions were encouraging burial societies to join the credit unions as group members and to deposit their permanent savings in the credit union. This approach helps strengthen the credit unions' financial base while providing the burial societies with a source of short-term loans to cover immediate burial expenses. Given the uncertain future of the burial societies, however, this may not turn out to be a workable long-term solution.

It is important to note, however, that no client should save in or through an MFI unless the institution protects the value of those funds. A rational client should not increase savings if poor loan administration increases delinquency and defaults and if the institution is not paying a rate of interest at least equal to the rate of inflation on those funds.

Offer More Suitable Loan Products

Loan products that strengthen the ability of clients to cope with their household financial burdens have the dual benefit of helping to protect and stabilize the household and to

⁵³ Donahue et al., p. 10.

⁵⁴ Evans, p. 25.

decrease the likelihood of default. The key to matching loan products to client needs lies primarily with increasing the flexibility of the loan products.

Product and service development and refinement in an MFI need to reflect the financial situation and coping strategies of its clients. Clients with a wider range of coping mechanisms are able to service their loans more effectively for a longer period of time.⁵⁵ MFIs that recognize these characteristics in their clients are in a much better position to design and offer products that reinforce the clients' ability to meet cash needs, maintain income flows, avoid selling productive assets, and retain access to financial services.⁵⁶ MFIs need to be able to recognize and assess the clients' range of coping strategies and incorporate that into loan appraisal.

Specific actions to make loans more responsive to the clients' situation and enhance repayment prospects include:

- Reduce the size of loans to care-givers, especially when the care-giver has cut back her or his own income-generating activity. This reduces the amount of indebtedness of individuals and makes it easier for them to service their loans. Too many microfinance programs require ever-increasing loan amounts and penalize clients who do not keep up.
- Shorten the term of loans. Donahue points out that, in Kenya and Uganda, most MFI loans are for three to four months. Care-giving clients tend to exit the programs between loan cycles, not taking a new loan they know they will have trouble repaying. The same appears to occur for HIV-infected clients who begin to suffer severely from AIDS-related illnesses (p. 17). Shortening the loan cycle provides more exit points.
- Permit fluctuating loan sizes and terms. Many programs apply a standard product rigidly, even when this does not coincide with the client's business cycle.
- Permit short-term personal or consumption loans for emergency uses. Many MFI programs limit loans to productive business purposes, but care-givers in a household often have periods in which their businesses are dormant and their real need is for medical, burial, or other consumer purposes. Permitting clients to borrow outside of the normal loan cycle can significantly strengthen a client's coping strategies and help the client recover.
- Allow clients to rest between cycles without pushing them out. Some group-based MFIs force a client to drop out of the program if they do not take a loan in every cycle. HIV/AIDS care-givers frequently find they do not need or cannot afford a loan for a period of time but need access once the infected person has passed away.

Another technique to improve loan performance is to work with affected households to transfer loans from an infected client to another member of the household. This might require

⁵⁵ Donahue et al., p. 17.

⁵⁶ Ibid., p. iii.

modifications to internal policies to permit younger family members (say, between 14 and 18 years of age) to be the client, perhaps with a co-signer.

Increase Contact and Supervision of Clients

Screening loan clients to eliminate HIV/AIDS-infected borrowers or to restrict loans to care-givers is impractical, if not illegal—a person who is not infected today may well be infected next month, and screening would not be able to detect this.

However, identifying the situation of an AIDS-affected household and recognizing the stage of the crisis and the household's coping strategies may well help an MFI tailor its support to that household so it strengthens the household's coping mechanisms. MFIs should train loan officers to recognize households in crisis. As these households are identified, the MFI can work with them to structure a financing program and repayment schedule that best helps the family meet its diverse financial needs during the crisis.

One way to identify households in crisis is to increase the frequency of loan payments and visits to clients. Successful MFIs have generally used weekly or biweekly payments with group meetings, thus bringing loan officers into regular and frequent contact with their clients. Identifying clients that are encountering financial problems is facilitated by this frequent contact.

Credit unions, in contrast, normally have monthly payments, and loan officers have minimal contact with their clients once a loan has been made. Credit unions need to modify their practices to increase their contact with clients and, once a client has been identified as having a risk, to work with that client to modify loan terms, adjust payment schedules, or take other actions to provide a better opportunity for the client to meet his or her payment obligations.

Place Loans at Risk in Special Portfolios

One technique pioneered by the Zambuko Trust in Zimbabwe involves placing the loans of high-risk clients in a special portfolio that is managed by the branch manager rather than the original loan officer. This allows the manager to take special steps to modify loan terms and conditions or to provide other assistance related to the unique condition of each family that is encountering difficulty to better secure the outstanding loan.

Reduce the Time Commitment Required of Clients

Many microfinance methodologies require regular attendance at meetings and lengthy approval processes. Many group-based MFIs force clients to withdraw if they fail to attend meetings. Time, however, is often the most critical constraint to a care-giver. MFIs should be

flexible in permitting care-givers to miss meetings as long as they send in payments on time.⁵⁷

Encourage Practices to Improve Household Finance

Anything that reduces the costs of HIV/AIDS care and treatment or helps families generate income will better position rural households to maintain their financial obligations.

Funeral and mourning customs place a severe burden on poor rural households. Modifications to these social customs (cremations, simple burials, and reduced mourning obligations) can limit costs to the financial burden of AIDS-related deaths.⁵⁸ Reducing costs in these areas will help protect the MFI's loan portfolio by freeing household funds to service loans.

Some government regulations also increase the costs of funeral and burial services. In Zimbabwe, all deaths have to be recorded with a certificate of death issued by a qualified medical examiner. These examiners are located only in major towns, so the family has to arrange to transport the body to the town and then transport it back to the village for burial. This represents a significant cost. Allowing medical examiners to issue certificates of death for known AIDS-infected persons or other practices, such as delegating authority for AIDS-related certification to local officials, can significantly reduce these expenses.

Stressing, even before a family is affected by HIV/AIDS, that families need to diversify income streams can help families build a more stable base from which to confront an HIV/AIDS situation.

CONCLUSIONS

The worldwide HIV/AIDS pandemic poses a major threat to MFIs. The reduction in business volume caused by the disease, the increasing inability of affected households to save, and the increased delinquency and default that may outstrip the ability of traditional portfolio risk management tools on which MFIs have relied. MFIs in seriously affected areas and in areas where the incidence of HIV/AIDS infections is rapidly increasing need to recognize the threat the epidemic poses and to explore more robust strategies to protect their portfolios.

⁵⁷ Ibid., p. 17.

⁵⁸ Bonnard, pp. 5-6.

BIBLIOGRAPHY

Alban, Anita. "AIDS and Development: Socio-Economic Perspectives." Speech presented at a seminar on HIV and Development. Copenhagen: Danida, 1999.

Bonnard, Patricia. "HIV/AIDS Mitigation: Using What We Already Know." Technical Note No. 5., Food and Nutrition Technical Assistance. Washington, D.C.: U.S. Agency for International Development, October 2002.

Butao, Mercy et al. "The Impact of HIV/AIDS on Agricultural Production Systems and Rural Livelihoods in the Central Region of Malawi." Draft. January 2002.

Donahue, Jill, Kamau Kabbucho, and Sylvia Osinde. "HIV/AIDS—Responding to a Silent Economic Crisis Among Microfinance Clients." Nairobi: MicroSave-Africa, September 2001.

Evans, Anna Cora. "HIV/AIDS and Microfinance: Kenyan Credit Unions Face the Crisis." Madison, Wisconsin: WOCCU, 2002.

Mutangadura, Gladys and Duduzile Mukurazita. "A Literature Review on Household and Community Responses to Alleviating the HIV/AIDS Epidemic in the Rural Areas and their Documented Costs and Effectiveness." Draft Report. Submitted by SAfAIDS to UNAIDS, November 1998.

Stover, John and Lori Bollinger. "The Economic Impact of AIDS." Washington, D.C.: The Futures Group, March 1999.

Topouzis, Daphne. "Measuring the Impact of HIV/AIDS on the Agricultural Sector in Africa." New York: UNAIDS, December 2000.

UNAIDS. "AIDS Epidemic Update: December 2002." Washington: UNAIDS/WHO-20002, December 2002.

Yamano, Takashi and T. S. Jayne. "Measuring the Impacts of Prime-Age Adult Death on Rural Households in Kenya." Department of Agricultural Economics Staff Paper 2002-26. East Lansing: Michigan State University, October 2002.