

Impact of HIV/AIDS on Microfinance

With a Case Study on HIV/AIDS Mitigation

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Introduction

This paper examines some of the impacts that HIV/AIDS has had on microfinance institutions and their clients. It highlights four examples of mitigation measures in the industry. The paper then shifts focus into the main case study: an action research partnership in HIV/AIDS mitigation – a project currently underway in Mozambique. It examines factors leading up to the project, presents a profile of the participating institutions, the various mitigation measures that they are implementing, the obstacles and opportunities that they have encountered and how they addressed these. Finally, the paper looks at outcomes of the mitigation activities on the institutions and their clients.

SECTION 1

HIV/AIDS, POVERTY AND THE LINK TO MICROFINANCE

HIV/AIDS: A Global Epidemic

"Like a pebble dropped in a pool, HIV sends ripples to the edges of society, affecting first the family, then the community, then the nation as a whole."

UNAIDS 2006

The HIV/AIDS epidemic continues to claim thousands of lives even as massive campaigns to halt and reduce its spread continue. By the end of 2005, over 40 million people were living with the disease globally, of whom about two thirds were living in Sub-Saharan Africa.¹ Numbers of people living with HIV/AIDS in the world continue to rise overall, with new infections rising almost everywhere except in the Caribbean. A few regions have shown no change in their overall prevalence rates and some countries like Uganda have drastically reduced their infection rates. There are fears that India and China, some of the world's most populous countries, are going to experience an explosion of people living with HIV/AIDS in their countries. Latest estimates show some 8.3 million people (2.4 million among adult women) were living with HIV in Asia at the end of 2005—more than two-thirds of them in India.² Approximately 650,000 people in China were living with HIV in 2005. Research indicates that prevalence is rising, with injecting drug users fuelling a good part of this increase.³

¹ *AIDS Epidemic Update 2005*, UNAIDS

² *Report on the Global AIDS Epidemic*, UNAIDS 2006

³ *Ibid.*

Poverty and HIV/AIDS

Research and statistics show that the most affected demographic are those in the productive ages of 24-49. Patterns of infection have also shown that while people in all economic groups are affected, the disease has disproportionately impacted the poor. While there is no direct link between poverty and HIV/AIDS, studies have shown that poverty contributes to, and is a consequence of HIV/AIDS. The World Bank recognizes a relationship between GNP per capita, income inequality and HIV infection. High HIV infection rates occur along with high-income inequality, whereas countries with a high GNP per capita have lower rates of infection.⁴

Research by various institutions has also shown that there is a strong link between poverty and poor health. Poor families are likely to be less educated, more vulnerable to the myths surrounding HIV/AIDS transmission, increasing their likely exposure to unsafe sexual practices; are likely to work as migrants and therefore at greater risk because they cannot live with their families. Some poor children see sexual work as a means of survival. Many poor are also disenfranchised, and are least likely to have reliable access to information, health care, nutritious food and other important resources for less vulnerable lifestyles.

"... women, have proved to be leaders in the struggle to rid our world of AIDS, but have also paid the highest price..."

Rwandan First Lady and President of the Organization of First Ladies in Africa, Mrs J. Kagame⁵

Of the 1.2 billion people living on less than US \$1 a day, 70% are women. Women have also been disproportionately impacted by the disease. In Sub-Saharan Africa, women make up nearly 60% of adults ages 15-49 who are living with HIV/AIDS. This disparity is experienced all over Asia, Oceania and

⁴ There is a strong correlation between poverty and HIV prevalence. Poverty-related factors such as migration, the status of women and their (lack of) access to economic resources, general health care, etc. are all important factors. Inequality is also a crucial factor e.g. rich men buying sex from poor women. South African Council of Churches, Parliamentary Office: *HIV/AIDS, Poverty and Basic Income Grant (BIG)* 5 May 2003: Summary of meeting held at ODI – 29 November 2000 ODI, 2000.

⁵ Step Up the Pace of HIV Prevention in Africa Campaign: *Africa Launches Bold, Renewed Effort To Step Up Pace Of HIV Prevention*. April 12, 2006

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in Eastern Europe (UNAIDS 2005). Poverty can prevent women from gaining information about or access to means of protection. The relative lack of power of such women in the home can further reduce their ability to negotiate about condom use with sexual partners. Poor women and children are also in greater danger of being sexually assaulted or engaging in unsafe sex in exchange for money, housing, food or education.

Poverty, HIV/AIDS and Microfinance

Many of the world's poor earn their income from self-employment. Poor entrepreneurs are more likely to be working in the informal sector and have a greater need for microfinance services. The microfinance industry currently serves over 80 million poor entrepreneurs globally, about 70% of who were among the poorest when they took their first loan. These clients fit the profile of those at most risk of contracting HIV/AIDS. Women, who bear the brunt of global poverty, are also the primary beneficiaries of microfinance.

Microfinance has typically targeted women-led microenterprises and today, over 55% of MFIs serve more women than men.⁶ This is understandable especially given the fact that women make up about 83% of the poorest clients served by MFIs.⁷

The microfinance sector, which serves the poor, is responding to global poverty and factors that cause poverty. The AIDS epidemic presents an additional threat to clients and microfinance institutions. While a disease like malaria kills more people in sub-Saharan Africa than AIDS, the multifaceted impacts of AIDS threaten to diminish the economic gains made by poor entrepreneurs around the world.

One of the best practices in the microfinance industry is achieving operational and financial sustainability. The impact of HIV/AIDS on clients

⁶ A review of data collected by the MicroBanking Bulletin showed that the financially self-sufficient MFIs in the survey had a client base that was on average 61% female, comparable to the proportion of active female clients found in the total population of MFIs surveyed (62%). *Supporting Women's Livelihoods: Microfinance that Works for the Majority*: UNCDF SUM, 2002

⁷ The Microcredit Summit Campaign defines "poorest" as those who are in the bottom half of those living below their nation's poverty line, or any of the 1.2 billion who live on less than \$1 a day adjusted for purchasing power parity (PPP), when they started with a program.

presents an additional financial risk for MFIs operating in areas of high HIV prevalence. Institutions that do not implement appropriate mitigation measures that will enable their institutions and clients to surmount the challenges brought on by the impacts of HIV/AIDS may find themselves dealing with increased and/or new risk factors including delinquency, staff absenteeism and related costs, attrition and decline in group cohesiveness.

SECTION 2

IMPACTS OF HIV/AIDS

"The impact of AIDS may be felt as an immediate shock, as when a family loses a breadwinner, or an organization a key worker. But at the wider community or national level the impact is felt as the gradual accumulation of losses, and diminution of resources and options for change."

UNAIDS 2006

Impacts of HIV/AIDS on Microfinance Clients

Affected households go through often predictable cycles when a member is infected. There are periods after infection, but prior to illness (8-10 years) when a household can save and build up their business assets. However, the family may already be experiencing some financial strain from indirect AIDS-related causes, for example, it is estimated that 75% of households in sub-Saharan Africa are affected by AIDS. Households may have taken on the economic burden of supporting extended family or orphaned children.

In the second stage, there may be frequent, but not serious, illness. This can lead to infrequent absences in meetings, some loans may be late, and the household may start to experience evolving financial needs. Such households continue to build assets and remain productive, but may also start to divert some loan money to offset some reoccurring costs, apply for an emergency loan, withdraw savings or save less than usual. Clients with access to health insurance will be able to use this to offset their medical costs.

In the third stage where there is full-blown AIDS, a household faces chronic illness, increased medical costs and often, prolonged hospitalization of the ill household member. If the ill household member was the productive member, they will have stopped the business activity by now and cannot bring in any income. At this stage, increased and constant financial pressure leads to withdrawal of savings, often complete default on loans and eventually client

dropout. Assets are also liquidated at this point to pay for expenses. A client may also be asked to leave a group, especially if group members have exhausted their resources from supporting the affected member. This last stage often leads to death and a funeral with related expenses using up any income or assets left in the household or as is most often the case, using borrowed funds to cover this expense. This stress continues in pressure to provide for the household, including school fees for children and possibly orphans taken in earlier, without the financial support from the deceased breadwinner (or major financial contributor).

Impacts of HIV/AIDS on Microfinance Institutions

Microfinance institutions operating in areas of high HIV/AIDS prevalence are reporting various impacts of HIV/AIDS. While there are often few verifiable links between the reported impacts and HIV/AIDS (mostly due to the stigma still associated with HIV/AIDS in many countries, and to factors that could be unrelated to HIV/AIDS), many of the MFIs reporting impacts provide a certain level of verifiable social indicators that they monitor, such as increase in household expenses, often related to medical expenses, increased number of household members from orphans taken in or reduced business activity due to illness. The impacts listed below are in one way or another, related to the impacts of HIV/AIDS on the institutions' clientele and market.

1. Risks to Financial Sustainability

- MFIs experience higher rates of delinquencies and arrears when clients are too ill to work or are caring for ill family members. Business income, profits or loan funds may be diverted for health care costs, to sustain the family when a major source of income is depleted or comes to an end, or when clients succumb to the disease, leaving behind unpaid loans.
- Frequent late repayments and increasing default and write-offs have an impact on the MFI profitability. There are increased costs for monitoring and follow up on late loan repayments. When an MFI

generates less interest than expected, it occasionally needs to write-off uncollectible loans. While write-offs are often a last resort, they do increase the financial risk of the MFI, particularly if loans are not priced to cover the cost of write-offs or if the write-offs have not been adequately provided for. The challenge is to estimate the extent of loan losses that MFIs may experience in the future, and try to mitigate them without pricing loans so high that clients cannot repay.

- Some MFIs have taken on education or other non-financial support services for their clients to help mitigate the impacts of HIV/AIDS. If not well planned, this may lead to increased costs and operational inefficiencies, especially when loan officers are expected to take on these additional tasks e.g. educating clients on HIV/AIDS and other health and nutrition programs. While the intention is commendable, inefficiencies brought on by such tasks could lead to increased costs for the MFI.
- Some institutions are also seeing changes in borrowing trends, with increases in applications for emergency loans (for medical/hospital fees, funerals, burials, etc.).
- Institutions report seeing more clients with multiple loans, either through the MFI (e.g. a client having a business loan as well as an emergency loan) or holding additional loans from other institutions, relatives, moneylenders, etc.
- Some institutions are also seeing increases in withdrawal of, or decrease in, voluntary savings. These changes affect the bottom line of the institution.
- Many MFIs design their budgets based on graduation in loan sizes by clients. Such budgets are thrown off when challenges posed by external situations, including HIV/AIDS, may result in clients choosing not to graduate to larger loan sizes or choosing to rest in-between loans.

2. Risks to Operational Efficiency

- Increased workload and more time is often needed for loan officers to track down absentee clients from mandatory credit meetings, as well as to monitor and follow up on delinquent clients.
- Many MFIs do not have the tools or expertise to monitor and track their performance on more levels than just the portfolio. Tracking a few key points could help them better assess the impact of HIV/AIDS on their client base and on their operations. For example, the number of orphans that clients are caring for, the number of client deaths, and the number of clients' spousal deaths. Tracking such trends can enable an MFI to take prudent measures to respond to the new challenges that they present.
- Many MFIs are not linked to HIV/AIDS information networks and resources that would keep them informed about external factors such as regional prevalence trends, which have potential impacts on the MFI operations.
- MFIs find that their staff is affected by the pandemic. The leading reported problem is absenteeism by staff that is ill, attending to ill household members or attending funeral and burial ceremonies. Increased absenteeism leads to lower productivity for the institution.
- MFIs lose skilled staff and capacity when infected staff succumbs to HIV/AIDS-related illnesses. Increase in staff turnover, recruiting new staff, training and building their capacity add up costs for MFIs that may already be operating on slim margins.
- Personal stress is leading to decreased staff productivity and lower grade performance. Staff may be burdened emotionally and financially by the responsibilities of taking on the care of orphans left behind by family members who have died, taking care of ill household members, or may be personally concerned about their own health.

3. Risks to Financial Products

- An MFI thrives by continually expanding its client base, lending out increasingly bigger loans to its clients, and/or expanding the range of products and services provided. MFIs that are used to serving the 'typical client' may experience new challenges in serving youth and older clients, who present a new profile of client with different needs and expectations. A good number of MFIs serve poorer populations that cannot afford to take big loans, so expansion of the productive client base is essential for these institutions. Illnesses and deaths caused by the disease are changing demographics in some operating environments. Typical clients of MFIs are generally in the age range of 25-49, among the most productive age group in any population.⁸ Some institutions operating in areas of high prevalence have reported seeing more younger and elderly clients as the pandemic hits the productive age hard.
- Rigid requirements may also lead to attrition, delinquencies and default when clients cannot meet the terms of the products offered. Affected clients are looking for more flexibility in the financial products offered. Flexibility of products allows them to adjust their utilization of financial products to suit conditions that may be affecting their businesses e.g. a client who is ill or taking care of an ill household member may want to take an emergency loan or may choose to rest in between loans.

4. Risks to Group Delivery Methodologies

- More than 60% of MFIs practice solidarity and village banking methods to serve their clients. Group lending methods are based on risk management that relies on peer pressure and the solidarity of members who support each other. The strength of groups is evident when members, for example, make payments for another member

⁸ Amankwah, Frank A. 'Baseline Survey, Impact Assessment and Client Satisfaction Study' MEDA, 2001
In a study conducted on MEDA MFI clients in Mozambique and Tanzania, Amankwah found that the average age of clients in Mozambique was 33.7 years, with the youngest client aged 17 and the oldest 56.

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who may temporarily be unable to make their payments in order to ensure that the group remains in good standing with the MFI and continues to receive loans. However, when the burden of debt becomes too much for non-affected group members to handle, this affects their ability to repay, affects group morale, and may lead to breakdown in group cohesiveness, peer dynamics and guarantee mechanisms. Ultimately, it may lead to increased attrition rates as the sick and weaker members are rejected from groups.

Response from MFIs

The microfinance industry, like most other sectors that are being impacted by HIV/AIDS, is working on various innovative ways to reduce the (potential) impacts on their institutions and clients. Innovations to deal with the challenges brought on by the epidemic have to benefit both clients and the institution in order to be effective.

To deal with the (potential) impacts, an MFI may need to consider, discuss and develop an HIV/AIDS policy and mitigation strategy. The DAI-developed training module *Microfinance and HIV/AIDS: Defining Options for Strategic and Operational Change* outlines issues that an MFI would need to consider to develop an HIV/AIDS mitigation strategy, including clients, external environment, financial management and performance monitoring, administration, credit, savings and product management, and human resource management.

In the next section, the paper briefly examines four examples of HIV/AIDS mitigation in microfinance, and then delves deeper into the process of implementation of mitigation activities using the Action Research project as a case study.

SECTION 3

HIV/AIDS MITIGATION IN MICROFINANCE

Examples from the MF Industry

HIV/AIDS Mitigation in Microfinance Institutions

Innovative measures to reduce and halt the spread of the epidemic are currently being piloted through thousands of activities around the world. Because of the intricate nature of the impacts of the disease, innovation is coming from every sector of society, including the MF industry, to address the health, social, economic and cultural impacts of HIV/AIDS.

Based on anecdotal and verifiable evidence from studies that have been conducted in the sector, a large number of MFIs have taken measures to respond to the challenges posed by HIV/AIDS on their institutions and clients by implementing various mitigation measures.

Following are four examples of microfinance programs that have taken measures to address the impacts of HIV/AIDS on their institutions and clients. These examples simply highlight the methods of intervention and did not seek to evaluate the impacts of these programs.

1. CARE SIMBA PROGRAM - ZIMBABWE

- **The CARE *SIMBA* program** in Zimbabwe was designed and built on lessons learned from the previous *Kupfuma Ishungu* program, a self-managed, village savings and lending scheme. *Kupfuma Ishungu* aimed to assist poor households to better deal with the impacts of HIV/AIDS by diversifying their income sources and protecting and enhancing their household assets. Similarly, *SIMBA* is designed to promote economic development in the target communities and to reduce the economic vulnerability of households in the face of AIDS.

In a distinct move, *SIMBA* targeted five vulnerable groups: widows, orphans and youth, commercial sex workers, care providers and people living with HIV/AIDS. *SIMBA* supports basic income and needs of the HIV/AIDS affected individuals and households through an Internal Savings and Loan program (ISAL), which are community-based, self-managed and savings-led groups. Self-management allows the members to design products and services that fit their needs and provides members, often victims of social exclusion and stigma, with a social support network.⁹ The rationale behind *SIMBA*'s savings-led program model is based on experience that has illustrated that for the very poor, access to savings services can be even more critical than access to credit. Additionally, the program noted that the targeted groups tend to lack prior experience in undertaking economic activities. This, together with the economic impacts of HIV/AIDS meant that the targeted groups had a higher credit risk profile, unlike the economically active and stable profile that is more attractive to formal microfinance institutions.¹⁰ *SIMBA* therefore provides training on selection, planning and management of income generating projects, all of which can have a significant impact on their capacity to earn income.

In addition to the business and financial services, *SIMBA* creates linkages with AIDS Service Organizations (ASOs) that provide multi-dimensional services such as Voluntary Counseling and Testing, Home Based Care and other support to the clients and their communities.¹¹

2. SEF/RADAR IMAGE PROJECT

- ***Intervention with Microfinance for AIDS and Gender Equity (IMAGE)*** was a three year pilot project implemented through a partnership between the South African based MFI Small Enterprise

⁹ Jain, Anuj. *SIMBA: An initiative supporting the basic income and needs of HIV/AIDS-affected households and individuals*. CARE Best Practices, Atlanta, GA.

¹⁰ *Ibid.*

¹¹ *Ibid.*

Foundation (SEF) and the Rural AIDS and Development Action Research Program (RADAR) of the Witwatersrand University.

SEF was registered as a non-profit in 1991 and disbursed its first loans in 1992. The institution's clients, who are almost 100% women, live in a region in Limpopo Province where almost 60% of households live below the poverty level. In 1996, in addition to its existing Microcredit Program, SEF started a special program - the Tshomisano Credit program - to target the very poor.¹²

SEF began early on to monitor factors such as client dropout rates and reasons, as part of standard financial risk management. While it did not observe any trends on loan performance that could be directly related to the impacts of HIV/AIDS, SEF nevertheless realized that the high HIV prevalence rates in South Africa, coupled with vulnerability factors such as the gender and poverty status of their clients presented a credible risk to the institution.¹³ RADAR's driving objective was to develop an innovative approach to the prevention of AIDS by addressing the key structural factors driving the epidemic, such as poverty and gender based violence and inequalities.

In 2002, the first phase of the IMAGE collaboration started, taking on the issue of HIV/AIDS prevention by addressing the roles that poverty and gender based inequalities and violence play in fuelling the epidemic in South Africa. It sought to address explicitly key structural factors driving the HIV/AIDS epidemic by integrating Gender and HIV education into an existing microfinance institution. Among its objectives was:

- To expand access to an existing microfinance initiative to women from the poorest households in a region in rural South Africa in order to improve their welfare and empower them;
- To develop a participatory approach to gender awareness and HIV education and to mainstream this into existing microfinance program activities; and

¹² Small Enterprise Foundation: www.sef.co.za

¹³ Ibid.

- To investigate whether, in combination with social and economic benefits, the attitudes and skills gained through participation in the program could support patterns of decision making that reduce vulnerability to both gender-based violence and HIV.¹⁴¹⁵

Gender and HIV awareness training called Sisters for Life (SFL) was mainstreamed through participatory learning and community mobilization sessions into fortnightly centre meetings with SEF's clients. A first phase of the project involved one-hour training sessions based on participatory learning and action (PLA) principles. The curriculum examined issues of gender, domestic violence and HIV/AIDS issues identified as priorities by rural women and topics discussed includes gender roles, gender inequality and cultural beliefs, the body, sexuality and relationships, domestic violence, and more conventional topics relating to HIV prevention. The second phase was an open-ended community mobilization program, which allowed women to develop and implement responses appropriate to their own communities. Based on a parallel service delivery model, staff of SEF delivered and dealt with all microfinance activities and staff of RADAR delivered all the activities related to the IMAGE project.

3. CETZAM OPPORTUNITY

- **Christian Enterprise Trust Zambia (CETZAM Opportunity)** was founded in 1995 as an independent MFI affiliated with Opportunity International. In 2001, the Opportunity Network conducted a series of client surveys from its partners in Africa and found that there was an increasing demand for access to insurance among borrowers. The study confirmed an already existing reality for many sub-Saharan households: that on average 40% of their clients could expect a death in the family within the course of a year. This, in addition to the high cost of funerals,

¹⁴ Kim, J., et. al. *Social Interventions for HIV/AIDS with Microfinance for AIDS and Gender Equality* :IMAGE Study. RADAR Monograph No 2: Intervention. Acornhoek. 2002.

¹⁵ Donahue, Jill (Ed.). *Efforts to Address the Impacts of AIDS on Clients, Households and Enterprises – IMAGE/SEF/RADAR*. The SEEP Network Promising Practices Case Study Series. Washington DC. (Unpublished).

was a driving factor for the provision of insurance.¹⁶ In a number of African countries, the costs for a funeral can equal the annual income of a micro-entrepreneur.

CETZAM partnered with NICO Insurance Company in Lusaka and started a funeral benefit - "Ntula" - for its clients. Clients paid a weekly premium to CETZAM, which acted as an agent on behalf of NICO, in order to qualify for the insurance that helped offset the overwhelming costs of funerals. It also prevented diversion of working capital towards payment of funeral costs. The premium was a fixed amount (\$0.25 per week of the loan) and was deducted from the disbursed loan. It covered death arising from any cause, including AIDS for the client plus five additional family members. Later research showed that 81% of clients thought that the insurance helped them in a time of stress and to protect their business assets.¹⁷

CETZAM also offers credit life insurance provided through the Madison Life Insurance Company, to individual loan clients.

4. FINCA Uganda

- **FINCA Uganda (FU)**, an affiliate of FINCA International started operating in 1992 as a non-profit village banking organization. In 2004, it became a regulated, formal financial institution and to date has over 2,000 village banking groups and over 40,000 clients, almost 90% of who are women. FU reported that it was affected by the AIDS pandemic and their evidence was in the high delinquency rates, increase in drop-out rates, insecurity of group savings due to default by ill and affected members or their deaths, among other impacts. FU also estimated that over 75% of their clients were caring for orphans, most of who were AIDS orphans.¹⁸

These findings led FU to develop a number of financial products designed around principles that balanced its sustainability goals and that responded to the unique challenges and changing needs of their AIDS impacted client base. FU offers a range of products to its clients:

¹⁶ Leftley, Richard. 2005. *Technical Assistance for the Promotion of Microinsurance: The Experience of Opportunity International*. CGAP Working Group on Microinsurance, Case Study No. 11.

¹⁷ Ibid.

¹⁸ Lule, R. M. *Targeting Vulnerable Populations through Product Innovations: A Case of FINCA Uganda. Impact of HIV/AIDS on Microfinance: With a Case Study on HIV/AIDS Mitigation*
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- Clients have access to credit insurance that pays off the balance of a group member's loan in case of death or disability and accidental death insurance that pays out an amount in the death of a client, their spouse or child. These products are provided through a partnership with AIG Uganda.
- In a unique partnership with Microcare, FU provides optional health insurance to its clients, regardless of their HIV status. The premium of approximately US \$60 is extended as a loan payable within an agreed reasonable term. With this insurance, clients benefit from a range of health services that would otherwise be too costly for them, including casualty, in and outpatient care, surgery, X-rays/ultra-sounds, laboratory tests and diagnoses, access to drugs from prescribed pharmacies and basic dental care and optical consultations.¹⁹
- FU has also modified its delivery methodologies. Changes include greater flexibility in loan amounts and repayment terms, including a grace period for the first loan; flexibility in group meetings; access to savings and top-up loans; village phone loans for serving clients in remote areas; and Western Union Money Transfer services. FU is also exploring a number of new technologies, including various modes of electronic transactions that will provide better and faster services at lower transaction costs to their clients.
- In addition to all of these products, FU provides HIV/AIDS education and prevention services through local ASOs.²⁰

¹⁹ Lule, R. M. *Targeting Vulnerable Populations through Product Innovations: A Case of FINCA Uganda.*

²⁰ "Ntula" *Funeral Benefits Insurance*: from case study provided to the SEEP Network by Richard Leftley, Opportunity International Network, Technical Services Division

SECTION 4

HIV/AIDS MITIGATION IN MICROFINANCE

The MEDA/DAI Action Research Project

The case study highlighted in this paper is an Action Research project on HIV/AIDS mitigation in microfinance institutions. The project, a partnership between Mennonite Economic Development Associates (MEDA) and Development Alternatives Inc./ECIAfrica (DAI/ECIAfrica), is providing technical support and limited financial assistance to four microfinance institutions in Mozambique to help them implement HIV/AIDS mitigation strategies. The project is documenting the process, from planning and implementation to results and lessons learned. This initiative, funded by USAID Accelerated Microenterprise Advancement Project - Financial Services Knowledge Generation (AMAP) and the Canadian International Development Agency (CIDA), includes a Learning Agenda that will examine obstacles and opportunities faced by the institutions implementing the activities, how these are overcome, and the results. The different profiles of the participating institutions will provide invaluable lessons that will be applicable to a wide cross-section of MFIs operating in areas of high HIV/AIDS prevalence. The first phase of the project started in September 2005 and the second and final phase – the Action Research – started in March 2006 and will end in November 2006.

Project Background

Mozambique

Mozambique is a country that is deeply affected by the HIV/AIDS epidemic. One of the ten most infected countries in the world, Mozambique also borders three countries with some of the highest national prevalence rates: South Africa (21.5%), Zimbabwe (24.6%) and Swaziland (38.8%).²¹ Mozambique's national HIV prevalence rate was projected to grow to 16.2%

²¹ 2004 Report on the Global AIDS Epidemic, UNAIDS, 2004

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by the end of 2004, with the Sofala, Manica and Maputo provinces each having provincial infection rates above the national average. In the capital city of Maputo, nearly 20% of the 15-49 age group is infected with HIV. Roughly 500 new infections occur everyday in Mozambique and 90 new infections occur among children through mother-to-child transmission. Life expectancy at birth has dropped below 40 years, one of only nine countries in Africa with this alarming statistic.²²

The disparity in infection observed among the genders also holds in Mozambique. According to figures from the government, an estimated 58% of people living with HIV/AIDS in Mozambique are women and girls, and 75% of those living with HIV in the age group 15–24 are female (Impacto Demográfico do HIV/SIDA em Moçambique, MISAU/INE 2002). Of the 25% of total households that are female headed, about 40% of these have orphans.

The Action Research Project

In the first phase of the project, the action research MFIs, together with eight others, participated in the *Microfinance and HIV/AIDS: Defining Options for Strategic and Operational Change (Defining Options)* training workshop. Through the USAID AMAP Financial Services Knowledge Generation contract, DAI and its partner ECIAfrica designed the *Defining Options* training course. In 2004-2005, DAI/ECIAfrica rolled it out in a number of countries in sub-Saharan Africa, and more than 75 institutions participated in the course. The course, designed for managers of MFIs focuses on how the institutions can address the institutional challenges of working in environments with a medium to high prevalence of HIV/AIDS. These challenges include working with AIDS-affected clients, forming strategic alliances with local HIV/AIDS support organizations to better serve clients and staff, monitoring the financial impact of HIV/AIDS on an institution's portfolio, refining products to

²² Life expectancy at birth has dropped below 40 years in nine African countries – Botswana, Central African Republic, Lesotho, Malawi, Mozambique, Rwanda, Swaziland, Zambia and Zimbabwe. All are severely affected by AIDS ((UNDP, 2004) UNAIDS and WHO, AIDS Epidemic Update 2004).

meet financial needs of a changing clientele, changing workplace policies to address HIV/AIDS and handling internal staff issues.

In the three-day workshop, a trained MF facilitator and a local HIV/AIDS specialist lead participants through exercises and training tools that assist them in thinking about, planning, and making changes to address the economic impact of HIV/AIDS at the institutional level. As part of the course, participants are expected to create a draft action plan to help their institutions better understand and cope with the risks associated with HIV/AIDS.

The *Defining Options* **course objectives** are to:

- Educate and sensitize MFI leadership to the social and economic impact of HIV/AIDS on the MFI;
- Provide strategies to mitigate the internal institutional and external operational risks of working in an HIV/AIDS affected environment;
- Expose a larger number of MFIs to the concepts and tools of *Defining Options*, so that they might proactively make internal changes that will positively respond to the changes in the market and to the internal financial, human resource and systemic pressures; and
- Help participants prepare for action with a better strategic understanding that will lead to operational improvements.²³

The **goal** of the three day workshop is to:

- Help participants identify myths and learn the facts about HIV/AIDS
- Help participants recognize the impact of HIV/AIDS on MFIs and their clients
- Show participants how to hone in on/monitor internal and external factors affected by HIV/AIDS
- Help participants understand the institution's options for responding to the disease
- Provide participants with strategies to mitigate the internal institutional and external risks of operating in an HIV/AIDS environment

²³ Green, Colleen et. al. *Microfinance and HIV/AIDS: Defining options for Strategic and Operational Change Training Course*. AMAP. Washington, DC. 2004.

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- Prepare for action with an increased strategic understanding that will lead to operational change.²⁴

In September 2005, MEDA partnered with DAI/ECIAfrica and conducted the *Defining Options* workshop in Maputo. Twelve institutions participated in the four-day workshop and developed HIV/AIDS Mitigation Action Plans as part of the workshop outputs. Evaluations from the workshop indicated a high interest in implementing some of the course's recommended activities that address the impact that HIV/AIDS has on operations. The greatest challenge for the MFIs that had participated in the workshop was taking the action plans from concept to action. This often requires keeping on track, getting buy-in and direction from the board and dedicated management to move it forward. It may also require the expertise of an external specialist who can provide know how to improve the institution's response to HIV/AIDS. The Action Research project was designed as a follow-up to the training workshop and to build on ongoing work by MEDA and DAI to create awareness around the impacts of HIV/AIDS on microfinance institutions and their clients, to explore innovative models for tailoring microfinance products and services to a client base that is affected by the pandemic, and to disseminate lessons learned on efficient and effective ways to make institutional changes that will mitigate the impacts of HIV/AIDS.

Objectives of the Action Research Project

The Action Research project has three main objectives:

- **Provide limited funding and technical assistance to four (4) MFIs** to support them in implementing activities that mitigate the impact of HIV/AIDS on their institutions and clients.
- **Create a learning network** with the aim of sharing experiences among the MFIs.
- **Document and publish lessons learned to the wider microfinance industry** based on emerging practices from the Mozambique experience.

²⁴ *Ibid.*

The project is administered out of the offices of the Mozambique Microfinance Facility (A MEDA/DevPar project). A Project Coordinator and Technical Assistant at the office provide ongoing support to the MFIs. Two Southern Africa-based Microfinance Consultants are providing customized technical assistance to the four MFIs to help them implement their objectives. The Consultants and local TAs work directly with an 'Action Research Champion' (ARC), the person designated by the MFI to lead the implementation process in their institution and who will serve on the Learning Network.

The technical assistance team followed up and reviewed action plans developed at the training workshop with the managers of all the institutions that participated in the workshop, and assisted them to prioritize and select key mitigation measures. In March 2006, an Expression of Interest was sent out to the MFIs, seeking applications for technical assistance and limited funding in implementing their action plans. The project selected four applications that demonstrated innovative and cost-effective HIV/AIDS mitigation plans in their proposals, including effective use of the technical and financial assistance offered.

MFI Objectives and Expected Results

The four institutions participating in the Action Research Project are Hluvuku-Associacao de Desenvolvimento Socio-economico de Matutuine (Male Yeru), Banco Oportunidade de Moçambique S.A.R.L. (BOM), Caixas das Mulheres de Nampula (CMN) and Ophavela. Each of the institutions has a set of objectives for responding to the risks posed by HIV/AIDS to their institutions and clients, and expected results of their mitigation activities.

a. Male Yeru is the separate, registered microfinance operation of Hluvuku, a community development organization. **Male Yeru** first started financial activities in 2001 and operates in Southern Maputo Province. It has about 1,200 clients and specializes in microenterprise development loans for individual clients.

Objectives:

1. Create procedures to monitor the external and internal effects of HIV/AIDS and other chronic illnesses on the clients and institution.
2. Address Human Resource issues by developing an HIV/AIDS policy and training plan, and promoting Voluntary Counseling and Testing among staff members.
3. Conduct a market study in order to refine loan and insurance products and to address increasing savings needs from clients.

Expected Results:

1. At the end of this project, all clients and staff of Male Yeru will be aware of and informed about HIV/AIDS and will be able to use this knowledge to improve their quality of life.
2. Control the financial impacts of HIV/AIDS and create greater security for the institution against infected clients.
3. Male Yeru will be prepared to confront the challenge of HIV/AIDS by responding effectively to the needs of its clients that are either affected or infected by HIV/AIDS.

b. BOM is a registered and regulated microfinance bank, and is one of the biggest MFIs in the country serving over 2,700 clients in Maputo, Zambezia, Sofala and Manica provinces. It offers individual, group loans (3-7 members) and village banking (10-30 members) in areas with some of the highest HIV prevalence rates in the country. Prior to its participation in the Action Research project, BOM had already begun to offer HIV/AIDS training sessions to its staff in order to better equip them to respond to questions and tackle the challenges of dealing with infected and affected clients. BOM clients are also currently receiving HIV/AIDS awareness education through a partnership with Health Alliance International, and funded by PEPFAR.

Objectives:

1. Provide HIV/AIDS awareness training for all BOM staff members.

2. Design an integrated program to provide HIV/AIDS trainings to all clients in the communities and to ensure that all clients and staff have adequate access to HIV/AIDS educational material.
3. Regularly engage in presentations with the HIV/AIDS service provider.
4. Monitor and evaluate the economic, social and cultural impacts of the HIV/AIDS education and awareness program.

The first three objectives are funded by PEPFAR/other funds. The Action Research funding will be used for conducting an impact assessment of the education and awareness program.

Expected Results:

1. The HIV/AIDS education and awareness training will lead to positive impacts on clients, staff and the institution.

c. CMN is an association of some 2,000 women that focuses on issues of economic and social development while teaching their members how to properly utilize small enterprise loans. It is currently in the process of becoming a credit cooperative. CMN has noticed a significant increase in client deaths over the past few years, and increases in member absenteeism in meetings and in the number of clients that are dropping out of the program. CMN believes that these are indicators of the impacts of HIV/AIDS on the community in Nampula. Since HIV/AIDS disproportionately affects women more than men in Mozambique, this particular institution is understandably anxious to implement mitigation measures to benefit their members.

Objectives:

1. Identify the impacts of HIV/AIDS on its portfolio.
2. Conduct a client satisfaction analysis and dropout study.
3. Raise awareness among members and staff on HIV/AIDS issues.
4. Address specific issues surrounding women and HIV/AIDS in Nampula.

Expected Results:

1. Greater HIV/AIDS awareness among members and staff.
2. Better understanding of client needs regarding savings and loan products.

Results from the study will assist CMN to design appropriate products that will respond to the needs of its members.

d. Ophavela is a member-based (MBO) non-profit private entity that promotes creation of Accumulating Savings and Credit Associations (PCR groups). Ophavela's PCR groups operate in some of the poorest districts in rural regions of Nampula province where very few NGOs operate. It currently serves nearly 15,000 clients organized in 700 groups. In addition to the credit and savings fund, PCR group members make regular contributions into an interest-free Social Fund, which lends for emergencies only.

Ophavela has been experiencing a problem related to PCR groups' interest-free Social Fund:

- a) Some leaders discourage members from contributing to the Social Fund. They want members to give to the credit and savings fund instead, so that the money can be re-generated with interest;
- b) With rising health problems (e.g. HIV/AIDS, malaria) and their associated costs, groups are seeing more and more borrowing from the Social Fund. In some cases, the Social Funds have been depleted while others have abused it for non-emergency, non-compassionate causes.

Objective:

1. To adapt the policies manual in order to meet groups' changing needs.

Expected Results:

1. A modified group Policies Manual that appropriately meets the demands and needs of the group members.

2. Reduce vulnerability to and impacts of HIV/AIDS and other terminal illnesses on its PCR member groups.

Project Learning Agenda

The Learning Agenda is a key part of the project for the purposes of documenting lessons learned throughout the process for each of the participating institutions. The agenda is focused on four broad themes with related sub-themes, and seeks to understand issues around:

1. Adoption of mitigation measures
2. Implementation of mitigation activities
3. Outcomes and impacts of the mitigation activities
4. Wide dissemination of the lessons learned within the microfinance industry and among AIDS Service Providers

Within each of the above major themes, sub-themes and questions that are guiding the research/learning aspect of the project include:

1. ADOPTION OF MITIGATION ACTIVITIES

- Identify internal and external policy barriers and benefits
- Identify operational barriers and benefits
- Identify institutional and regional socio-cultural barriers/challenges and benefits/opportunities
- Identify opportunities and constraints to the Technical Assistance (consultants and funding) offered

2. IMPLEMENTATION

This aspect of the learning agenda will seek to document the implementation process, challenges, obstacles, opportunities and innovations in three areas:

- Social and workplace programs
- Product development and refinement
- Participation by clients and staff

3. OUTCOMES and IMPACTS

This aspect of the learning agenda will research and document results/ outcomes of the activities. Some activities may have immediate results, while some will take a while to manifest. Impact level data may not be immediately available at the end of the project period in November 2006. The project will document outcomes and impacts on three levels:

- Institutional level
- HR level
- Client level

4. LEARNING DISSEMINATION

Learning in the project is organized around two Learning Workshops, one at the beginning of the project, and one at the end. A mid-project meeting is also scheduled to bring together the participants and address any issues that need be resolved and for the participants to share their experiences with each other. The Learning Workshops involve the participating institutions (represented by the ARC), the Project Coordinator, a Learning facilitator and the consultants and TAs and are organized around the Learning Agenda. The institutions also provide regular updates on their progress through reports submitted to the Project Coordinator.

Learning Workshops

The first Learning Workshop to launch the project was held at the end of March in Maputo, allowing the MFIs to meet each other, the project facilitators and the primary consultants who would be assisting them in implementing their action plans. During the Learning Event, the MFIs met with the other participating institutions/the ARCs, the project consultants and TAs, and a representative of MONASO - Mozambique's national association of HIV/AIDS Service Providers. Objectives of the project and of each institution was discussed and agreed on, questions were clarified and a recap of the key issues in the *Defining Options* workshop was presented. The ARCs also had

one-on-one meetings with the consultants to discuss their Action Plans and set up a work plan and schedule of activities.

The final learning workshop will be held at the end of the project. It will provide the opportunity for everyone to participate in an evaluation of the process, to share lessons and to discuss ways forward.

Opportunities and Challenges

The Action Research phase of the project started in March 2006. At the time of submitting this paper in July, the MFIs and the technical assistance team had experienced various challenges and opportunities, including:

1. The March 2006 launch date of the Action Research phase was much later than had been planned. Delays were unavoidable and largely the result of administrative detail involved in creating the collaboration between MEDA and DAI/ECIAfrica.
2. The Expression of Interest had a relatively short response time - initially three weeks with a one-week extension later added on. This short response time was a result of the administrative delays.
3. The initial word-of-mouth feedback on the EOI was encouraging. However, actual applications were slow coming in from the MFIs and the deadline was extended by one week to give institutions more time to complete their applications. Nevertheless, only one-third of the eligible institutions responded to the EOI with applications.

The project's coordinator followed up with the institutions that did not respond to find out why they did not apply. They had varied reasons:

- One MFI felt that they did not have the freedom to form partnerships outside of their sponsoring agency. Moreover, their sponsoring agency was conducting some HIV/AIDS related activities within their network.
- An institutional restructuring process precluded involvement of one MFI.
- Senior staff members of one MFI who would have responded to the EOI were away during the specified response period.

- Three institutions could not commit/delegate representatives with the requested criteria - senior, qualified, and the autonomy to implement the action plan. Staff that fit these criteria was fully committed on their work.

4. Coordinating schedules for activities and meetings between the consultants, the ARCs (all of whom have other jobs within the institution) and/or their staff/clients has been a challenge due to everyone's busy schedules and travel.
5. Language barriers have presented a communication problem. Some of the ARCs have very limited understanding of English and some of the project staff has very limited understanding of Portuguese. This has caused delays in documents that have to be translated to and from English and Portuguese, including simple e-mail messages.
6. Technologies such as e-mail and fax machines are not always immediately available to some of the MFIs.
7. One of the ARCs does not seem to have the requisite authority that the project expected. For this reason, all project inquiries to the ARC have been deferred to their manager, causing some delays. The project has had to bypass the ARC on several occasions, particularly in urgent situations and directly communicated with the ARC's manager who has the decision-making authority.
8. BOM and Male Yeru are based in Maputo province, are within easy reach of the project office and have excellent communication mechanisms. Ophavela and CMN are based in the Nampula in the Northern region. Reaching them physically is more difficult and expensive, and communication has been limited to fewer visits and more phone and e-mail usage. However, they have also had the greatest need for on-going support from the locally based TAs.

CONCLUSION

The Action Research project is in progress at the time of submitting this paper and will end in November 2006. A project results update will be provided at the Summit through an addendum to the paper.

In the end, the project aims to have four examples of MFIs that have successfully implemented mitigation measures against the impacts of HIV/AIDS on their clients, staff and operations. The diversity of institutions represented, types of clients served, and the range of mitigation measures implemented will provide practical lessons to a wide cross-section of MFIs in the industry that are considering implementing mitigation activities.

While the project does not expect that all outcomes will be immediately obvious, surveys will be conducted towards the end of the project to capture any early outcomes of the mitigation activities. The project will attempt to collect impact data in a planned follow up survey in 2007.

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