MICROFINANCE
STRATEGIES FOR HIV/AIDS MITIGATION AND PREVENTION IN SUB-SAHARAN AFRICA

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Executive Summary

In November 2000 a resolution was adopted at the 88th session of the International Labour Conference concerning HIV/AIDS and the world of work. The resolution noted with concern that "HIV/AIDS is at present a universal pandemic that threatens all people, but….it disproportionately impacts on economically and socially disadvantaged an excluded". The resolution made a clear the devastating impact that HIV/AIDS was having on employment and called for urgent action from all quarters of the ILO. More specifically the Director General has proposed, "it is intended to include an HIV/AIDS dimension in all major ILO events and meetings". The call is one of "all hands on deck in the crisis". This paper represents a part of Social Finance programme's response to that call. HIV/AIDS undermines decent employment provision not only through its immediate and devastating effects on the health of the labor force, but it undermines the health of the financial institutions that provide the crucial element of finance which keeps the wheel of enterprise and employment turning. This paper explores ways of ensuring the health of microfinance institutions in the context of the pandemic. Microfinance as a tool can play a much larger role in HIV/AIDS pandemic.

Microfinance institutions are well positioned and equipped to reach the informal sector in an efficient and sustainable way. Microfinance cannot, by itself, change the face of AIDS. It can help ease the financial and other burdens of those living with HIV and can help to promote behaviour change, vital to stemming the tide of infection and preserving a future for generations of Africans to come.

A number of MFIs operating in Sub-Saharan Africa are offering products designed to mitigate the impact of the epidemic on either the institution itself or on its clients, or both. Among the products currently being offered are credit and health insurance, as well as conventional loans and savings products. Organisations such as FINCA, FOCCAS/Uganda and Opportunity International have begun to think strategically about the impact of HIV and the consequences for sustainability and client survival. Operating results to date indicate that the provision of microfinancial services in an HIV context is not incompatible with the MFI's goal to reach operational and financial sustainability. FINCA/Uganda reports financial sustainability of 126% as of July 2000.

The paper is intended to expose a more comprehensive range of product, service and operational devises that can be incorporated into a mitigation strategy as well as to offer some insights into how best to configure the most appropriate product/service mix. This involves not only offering a broader array of products and services (e.g. health and funeral insurance) but also adapting conventional products, services and operational tools to an HIV context.

In terms of prevention efforts, some MFIs in Sub-Saharan Africa offer HIV/AIDS education, conducted by either their own staff or via partnerships with AIDS service organisations. While this is a critical element of any effort to stem the rate of new infections, it very simply is not enough. In many Sub-Saharan Africa countries, prevalence rates are not abating despite active education campaigns. Prevention efforts must go the next step, that is, they must attempt to stimulate actual behaviour change, if the epidemic and its deadly consequences are to be halted.

Behaviour change is a long and challenging process. Many would argue that such endeavours are not the business of MFIs. However, MFIs have two built-in advantages that enable them to serve as a key component in the effort to save lives by promoting such change. The first is that the regular loan repayment meeting of clients can be utilised to facilitate community empowerment and interaction, two key elements of a behaviour change intervention. The

second is that MFIs, unlike most other development organisations, are designed to become sustainable. This means that the "life span" of an MFI is well matched to the lengthy process of behaviour change and that the sustainability premise of MFIs means that they, unlike other development organisations, are not subject to donor fatigue and changing priorities of donors over time. These points will be more fully developed below. The key point is that MFIs operating in Sub-Saharan Africa have not fully exploited the range of possibilities for either mitigation or prevention strategies. And, most importantly, given the current stage of HIV/AIDS crisis and the dire predictions of impacts to come, MFIs operating in Sub-Saharan Africa *must* do more.

I. Introduction

Overview:

In November 2000 a resolution was adopted at the 88th session of the International Labour Conference concerning HIV/AIDS and the world of work. The resolution noted the with concern that "HIV/AIDS is at present a universal pandemic that threatens all people, but it disproportionately impacts on economically and socially disadvantaged an excluded". The resolution made a clear the devastating impact that HIV/AIDS was having on employment and called for urgent action from all quarters of the ILO. More specifically the Director General has proposed, "it is intended to include an HIV/AIDS dimension in all major ILO events and meetings". The call is one of "all hands on deck in the crisis". This paper represents a part of Social Finance programme's response to that call.

The Social Finance programme of the ILO is concerned with among things, helping to ensure more and better work for those in the informal sector. Due to the very informality of the sector is is difficult to quantify the numbers of people employed in the informal sector. Including informal agriculture it is quite possibly the largest source of employment in the world. Whether the larger or smaller than the formal sector its importance in global employment is self-evident. A necessary condition for the existence of the informal sector is access to finance whether from formal or informal sources. Many of the institutions that that provide financial services to this sector are under threat from HIV/AIDS. In the face of the pandemic financiers are becoming increasingly reluctant to make medium and long term loans, loan portfolio quality is undermined because entrepreneurs are sick and their repayment capacity diminishes, informal insurance arrangements break down because of reductions in the risk pool etc. The net effect of this is that financial services crucial for sustaining informal sector employment are becoming either more costly or unobtainable. In order to sustain levels of informal sector employment we need to ensure that critical financial services remain available to informal sector.

Microfinance can contribute to diminishing the spread of AIDS more directly. Microfinance organisations in many parts of the world have access to large numbers of borrowers. It is possible that HIV/AIDS organisations could use this distribution channel to spread the prevention message.

Finally, microfinance can help restore employment levels after HIV/AIDS has affected communities. By helping to establish or by helping existing microfinance institutions to survive, communities whose enterprises and sources of employment have been have been destroyed, can make use of the access to finance to rebuild their enterprises.

The latest UNAIDS statistics on HIV prevalence rates in Sub-Saharan Africa (SSA) are harrowing. In sub-Saharan Africa in 2000, over 25 million adults were living with HIV and nearly 4 million people died, leaving some 12 million orphans. The fact that in most Sub-Saharan Africa

countries. Very little progress has been made in stemming the tide of new infections and, continue to increase. The impact on the lives of Africans, particularly the poor, stand to not only arrest but most certainly to reverse the continent's nascent development progress. The ILO and its tripartite partners advocate a multi-dimensional approach to the epidemic and the formation of partnerships to extend the reach and durability of interventions to address the pandemic. Key to this effort is devising sustainable mechanisms to reach workers, their families and dependants. Because the majority of the labour force in Sub-Saharan Africa is in the informal sector, a special effort must be made to reach this mass of population. Microfinance institutions (MFIs) are well positioned and equipped to reach the informal sector in an efficient and sustainable way. Microfinance cannot, by itself, change the face of the AIDS epidemic. However, it can help ease the financial and other burdens of those living with HIV and can help to promote behaviour change, vital to stemming the tide of infection and preserving a future for generations of Africans to come.

The literature on HIV/AIDS mitigation and prevention through MFIs is nascent as MFIs in Sub-Saharan Africa have only recently begun experimenting with the types of strategies analysed in this paper. This paper is an attempt to more fully explore the adaptability of microfinance to an HIV context and to explore the potential for microfinance to successfully incorporate mitigation and prevention strategies. The paper is based on a desk review of relevant microfinance initiatives, basic research into HIV/AIDS prevention and behaviour change initiatives, and the author's microfinance and HIV field experience.

In this paper, I will first make the case that MFIs are well suited and capable of engaging in HIV/AIDS prevention and mitigation efforts. I will then discuss strategies that MFIs can employ to help to not only mitigate the effects on the institution providing services in a high prevalence area but also to help mitigate the impact of the disease on the MFI's client base and, potentially, on the wider community. Finally, I will discuss prevention strategies that can be utilised by MFIs to not only promote HIV/AIDS awareness and education but also to facilitate actual behaviour change. I conclude with recommendations for further research and steps forward.

Background on the epidemic:

Since the epidemic began, an estimated 14 million Africans have died from HIV/AIDS. In 2000, 25.3 million people were living with HIV in Sub-Saharan Africa, some 9% of the adult (defined as age 15-49) population. Sub-Saharan Africa accounted for 70% of the total number of adults living with HIV in 2000 and for 75% of those who died of HIV/AIDS in 2000 world-wide. In nearly half (42%) of Sub-Saharan Africa countries, the epidemic is considered generalised, with infection rates among adults in excess of 7%.[1]

Prospects for the current generation of young Africans (those aged 15-24) are gruesomely dim: half (22 of 45 countries) of all Sub-Saharan Africa countries report prevalence rate estimates for young girls at more than 7%. In seven countries[2] the estimated prevalence rate among young girls is 20% or higher.

The fact is that most of those currently infected will die within the next ten years, some much sooner. And, chillingly, UNAIDS reports that "in most sub-Saharan countries adults and children

[1] All HIV/AIDS statistics are from the UNAIDS *AIDS Epidemic Update: December 2000*, unless otherwise indicated.
[2] Botswana, Lesotho, Namibia, South Africa, Swaziland, and Zambia.

are acquiring HIV at a higher rate than ever before: the number of new infections in the region during 1999 was 4 million" (UNAIDS: June 2000). HIV is a macabre fact of life in Sub-Saharan Africa. No development programme, including microfinance, can operate outside its reach.

Impacts on development:

HIV has the capacity to not only slow down but also to reverse the nascent development of sub-Saharan Africa. The near term (over the next 3-5 years) macroeconomic effects will at a minimum *arrest* the rate of growth to date. Foremost among these effects are:

- A deepening and overall increase in the number of people living in poverty. This will arise from two primary expenditure effects as (1) household expenditures increase due to medical and health related expenses as well as funeral costs and (2) as total household income simultaneously decreases due to illness-induced productivity declines of household income earners and, ultimately, the deaths of household income earners.
- Reduced labour force productivity. Labour force productivity will be diminished by increased illness and absenteeism of those living with HIV, increased absenteeism of those caring for HIV positive individuals, and a significant increase in deaths among the workforce. Compounding this impact on productivity is the loss of skilled labour (most likely to come from among 15-49 year olds, with high and climbing infection rates), employer resources diverted disproportionately to recruitment and new skill development among replacement workers, etc.
- The Human Development Index will worsen. The Human Development Index measures achievements in basic dimensions of human development via a composite index of life expectancy at birth, adult literacy rate, combined school enrolment ratio and adjusted per capita income. According to UNDP's 2000 Human Development Report, sixteen countries have experienced reversals in human development and/or economic stagnation since 1990 due to HIV/AIDS and most of these are in Sub-Saharan Africa.
- The income dependency ratio increases. As the 9% of the adult population currently infected become ill and die, the number of individuals in a household dependent on the surviving income earners will increase, clearly reducing the income apportioned to any one household member and deepening the poverty of that household.

The longer-term (the next 5-10 years) macroeconomic effects may well *reverse* the development progress in Sub-Saharan Africa. Foremost among these potential effects are:

- School enrolment decreases. As the income dependency ratio increases and households sink further in to poverty, school fees will become increasingly unaffordable and it will be increasingly necessary for the young to forego education so as to make an economic contribution to the household. As a direct result, literacy rates decline, skills base erodes and important socialisation processes are impeded.
- Further reductions in labour force productivity. Because in most Sub-Saharan Africa countries infection rates are expected to rise, the drag on productivity is also expected to continue.
- Infant and child survival rates and health status are likely to decline. One key determinant of infant and child survival and health is the education of the mother. As the high infection rates among young women in 1999 translate into high death rates, the number of orphans will increase. In addition, the economic and social tolls on households will likely mean that more girls are taken out of school, including orphaned girls, thus, lowering literacy and educational achievement rates among girls in the current and next generation and, perhaps, beyond. One indirect effect will be a negative impact on child health.

- The Human Development Index will continue to worsen. With large numbers of adults dying, children being taken out of school to work and the income dependency ratio increasing, it is clear that this measure of human development will also worsen. UNDP projects that nine countries in Africa will experience a loss of 17 years of life expectancy by 2010, back to life expectancy levels of the 1960s (UNDP: 2000).
- Economic development is impeded. If the epidemic imposes a drag on the rate of accumulation of knowledge (reduced total factor production growth) or the rate of accumulation of capital (through a switch from savings to current expenditure) these effects become amplified over time (Lewis and Arndt: 2000). Expectations of declining school enrolment, increased expenditures on direct and indirect costs of the disease and decreased household income support the probability of both reduced rates of knowledge and capital accumulation. Thus, over the course of a decade, the implications for macroeconomic performance are substantial.

The structure of most Sub-Saharan Africa country's economies is such that the labour force impact of HIV/AIDS will be negative. About 70% of Africa's poor live in rural areas and the rural population will continue to outnumber the urban population for nearly three decades to come (World Bank: September 2000). Agriculture accounts for 35% of the region's GNP, 40% of exports and 70% of employment (World Bank: September 2000). Much of the agricultural employment is subsistence agriculture and falls within the informal sector. These fragile agricultural systems cannot easily absorb the lost labour productivity or the increased expenditure associated with HIV/AIDS.

The development implications of the pandemic extend out in to the future, as the effects are inter-generational. The current 12 million AIDS orphans in Sub-Saharan Africa (UNAIDS: June 2000) and the UNAIDS projections for many millions more in the next ten years comprise a significant portion of the next generation of Africans. Research indicates that, in all probability, these orphans will be less educated, less skilled, less socialised (growing up as orphans without traditional role models and support systems) and thus, less able to make a productive contribution to society (Varghese and Peterson: 2000). Thus, without immediate and massive intervention, the epidemic will have a multi-generational effect.

If the impact on development is to be stemmed, HIV/AIDS interventions will have to be: (a) fast as millions more become infected each year; (b) capable of attaining massive scale to have any impact on the sheer numbers of those infected and at risk of becoming infected; (c) multi-sectoral as the greatest effects are on economic potential/output, education, health, etc.; and (d) at least partially financially self-sustaining as it will take many years, perhaps decades before prevalence is no longer of epidemic proportions.

Role of the ILO:

HIV is seriously impacting the world of work. This is evidenced through the increased number of orphans, increased incidence of child labour, decreased productivity of the informal sector and small- and medium-sized businesses, depleted human capital, etc. In response, in 1999, the ILO and its tripartite African partners committed to a Platform for Action, which included elements such as social inclusion, income and job security and solidarity. The ILO and its partners advocate a multi-dimensional approach and the formation of partnerships to extend the reach and durability of interventions to address the pandemic. The ILO agreed to support a number of actions including (ILO: 1997):

- Raising awareness of the incidence and impact of the disease
- Eliminating stigma and discrimination

- Empowering women economically, socially, and politically in order to reduce their vulnerability
- Promoting the transformation of gender roles, norms and cultures
- Building capacity to address the dilemma facing AIDS orphans and child labour
- Promoting income and employment opportunities for persons living with HIV/AIDS through informal sector and small enterprise development

Key to this effort is devising sustainable mechanisms to reach workers, their families and dependants. Because the majority of the labour force in Sub-Saharan Africa is in the informal sector, a special effort must be made to reach this mass of population. As argued in Section II below, microfinance institutions offer a very good mechanism through which the ILO can intervene in the informal sector and at the community level to diminish the impact of HIV in Sub-Saharan Africa.

The contribution of the ILO's Social Finance programme centres around a combination of action-research to link knowledge on the impact of HIV/AIDS on both clients and microfinance institutions with practice and technical assistance programmes. This is done in an effort to build the capacity of microfinance providers to cushion the impact in terms of prevention and mitigation strategies. Specific attention is paid to the role of informal finance, including different forms of microinsurance such as funeral insurance. The role of microfinance in the ILO's world of work should be seen in the context of decent work, poverty alleviation and the quality of livelihoods.

II. Why utilise MFIs in an HIV/AIDS prevention and mitigation strategy?

1. Microfinance can help affected individuals and households to mitigate HIV-related costs

The microfinance industry's guiding principle is to increase access to financial services to the poor. The Microcredit Summit challenge for the industry is to reach 100 million of the world's poorest families with credit and other financial and business services by the year 2005 and to do this in a financially sustainable way. As discussed above, one devastating consequence of the epidemic in Sub-Saharan Africa is that the resulting income effects of an individual's positive serostatus on the household could well sink that household into poverty, or in many cases, deeper into poverty. By providing access to financial services, MFIs enable clients to mitigate these income effects and in so doing, preserve household assets, stores of wealth, and income streams.

UNAIDS data from Africa indicates that household income drops 30-60% due to HIV/AIDS effects, household expenditures on health quadruple, expenditures on school fees drop by half and the amount spent on food consumption drops by 41% (Parker et. al.: September 2000). Access to micro-financial services can help to alleviate the economic burden to the household of HIV/AIDS. The provision of loans, savings products, funeral insurance, and health insurance are all mechanisms by which MFIs can help alleviate these direct financial burdens on the household.

The most significant opportunity cost is the reduction in household income as an HIV+ individual must reduce his/her number of hours worked or cease working altogether. Alternatively, an uninfected bread earner in the household may also need to reduce the amount of time he/she

spends working in order to care for a sick member of the household. MFI products can help those members who are still able to be economically productive to maximise the returns from their business by providing working capital for expansion, making improvements to the business, or building up savings. Microfinance practitioners widely recognise the "fungibility" of money. It may well be that the client uses the loan money to pay some of the direct expenses of HIV and diverts other household income streams (often with different timings) to the repayment of the loan. In any case, the ability to access a diverse array of income/resource streams (via loans, savings, insurance products, etc) enables the household to better manage the costs of HIV by employing a range of coping strategies.

Indirect costs are numerous and have the potential to not only increase the risk of deeper poverty among the current generation but also to put the next generation at increased risk of poverty. One example of this inter-generational effect is the common coping response to take a child out of school in an effort to cut household expenses, to deploy that child in the care of an HIV+ household member, and/or to put the child to work to increase household income. In this case, the child's future economic potential is reduced via a cessation of schooling. Other examples of indirect costs of HIV/AIDS on the household are negative effects on household food security, increased hunger and decreased health status. These costs arise from commonly employed coping strategies to skip meals, eat less expensive (and most likely less nutritious) foods, and reduce the quantities of caloric intake, all of which overtime contribute to decreased health status. Microloans and savings products can supplement total household resources and may enable a household to continue to afford a plentiful and nutritious diet, continue to pay school fees, etcetera, provided the household has the capacity to repay loans and/or to participate in other microfinancial products.

MFIs' depth of outreach is often limited as the concept of delivering financial services to the poor presupposes the existence of at least one economically active household member. In very high prevalence areas, it may be possible that this basic criterion cannot be met. Transfers or grants may be the only feasible and appropriate mitigation mechanisms in such environments. In these environments, MFIs can at best act as a first line of defence against the effects of HIV, or, at worst, a first alert. Close cooperation between MFIs and other AIDS service organisations and donors/governments is necessary to muster rapid and appropriate response and assistance in high prevalence areas.

Importantly, financial services, which assist households in coping with HIV-related costs, address the root causes of vulnerability by dealing with some of the very factors that allow the epidemic to spread (i.e. poverty, inability to afford health care, etc.). Thus, MFIs, by their very goal, are well positioned to help people mitigate the direct and indirect of HIV.

2. Microfinance principles and practices support HIV best practices criteria.

Microfinance industry objectives emphasise the need to promote microfinance institutions that provide access to financial services in an efficient and sustainable way. Inherent in this objective is a long-term view, economies of scale and a goal to successfully combine outreach with sustainability. Similarly, UNAIDS' best practices criteria for HIV/AIDS interventions call for "… ethical and effective interventions that are efficient, sustainable and relevant for AIDS prevention in the resource-constrained settings of Sub-Saharan Africa".

The microfinance industry's "best practices" operating guidelines and mission are in accord with UNAIDS best practice criteria for interventions in the Sub-Saharan Africa pandemic.

We must accept the reality that given the current status of the epidemic and the expectation for deleterious effects to multiply and extend out over the next 10-20 years, aid and donor generosity alone cannot provide sufficient resources to mitigate the economic, human and social consequences of the pandemic. Microfinance, by extending access to financial resources to the poorest and helping to mobilise savings empowers the poor to help themselves to mitigate these effects. By focusing on sustainability, microfinance can ensure that this access is preserved for the duration of the epidemic and beyond.

3. Families and communities are the first line of response to HIV/AIDS.

The impacts on individuals, households, communities and nations of HIV are complex and interrelated and are deeply rooted in the local cultural context. As such, it is families and communities that provide the primary social safety nets in the epidemic. In light of widespread poverty, limited health care availability and affordability, and the strong family-centred cultural tradition in much of Sub-Saharan Africa, families and communities are the first and often the only means of support and care for those infected or affected by HIV. MFIs, which often operate at the community level and interact with a substantial cross-section of the community, are therefore well placed to reinforce the grass-roots focus.

Importantly, it appears that close relatives (extended family) offer help to HIV-impacted households even when the morbidity and mortality of the epidemic has been sufficient to weaken wider community responses (Varghese and Peterman:2000). Microfinancial services can help strengthen family and community coping mechanisms and alleviate the negative impacts of HIV on the household.

4. Microfinance as a vehicle for sensitisation.

Key to effective interventions is mobilising communities for action. Regular MFI meetings for loan repayment provide a powerful platform for community forums to discuss, analyse and propose solutions to the HIV crisis. MFI methodologies that bring groups of clients together on a regular basis for loan payment provide an excellent forum for education, information exchange, care and support, etc. By facilitating discussion on the community's perspective on epidemic-related issues and problems and by promoting community action, this forum can serve as a foundation for empowerment and community-generated responses. Lessons learned from HIV prevention and mitigation strategies indicate that more emphasis needs to be placed on mobilising communities for action, rather than focussing on the individual, based on the idea that change is needed in the living and working environment of people (workplace, marketplace, schools, communities) (Schapnick et al.: 2000). Soliciting community discussion of HIV-related topics creates potential for community members to overcome traditional taboos about this subject matter, a key element of any prevention effort.

Providing Education

At FOCCAS/Uganda, health and nutrition education (including HIV/AIDS education) is incorporated into every weekly meeting of its clients. Taking about 30-45 minutes per education session, this model has proved to be cost-effective and to have positive impact on health and nutrition indicators. The study proved that the combination of credit and education had a positive impact on women's incomes, household food security, and the nutritional status of women. (Freedom From Hunger: 1998; Dunford: 1999). Thus, it may be possible to affect behaviour change/modification via a combination of microfinancial services and HIV/AIDS education.

Other MFIs, like FINCA/Uganda, utilise the weekly meeting to bring in AIDS organisations to conduct prevention education. AIDS service and other social service organisations (family planning, women's health, etc.) often like to work with MFIs because this gives them access to pre-existing groups of interested clients. Thus, the relationship can be beneficial to both the MFI and the outside organisation.

Whether education is done in-house or is outsourced, the important point is to not only provide information but also to create a forum for discussion and group mobilisation.

5. Linkages with other services and resources are vital to sustainable, multi-dimensional interventions. MFI delivery mechanisms provide an efficient and effective conduit for establishing linkages.

There are two main reasons why linkages are an essential component of any effort to combat HIV in Sub-Saharan Africa. First, the scale of the epidemic far outweighs available resources and thus, resource constraints are an unavoidable fact. Thus, governments, communities and organisations involved in creating solutions must build on each other's competencies, avoiding duplication as possible, and instead forge coordinated and inter-linked interventions. This strategy is endorsed by the World Bank and UNAIDS, among others. The second reason is a gradation of the first. That is, the root causes of the epidemic are multi-dimensional and if the epidemic and its effects are going to be not only stopped but also reversed, a simultaneous and multi-faceted solution must be formed.

There is a wide-variety of formal microfinance delivery methodologies ranging from village banking, to solidarity group lending to individual loans as well as a host of informal mechanisms such as ROSCAs[3] and ASCAs[4]. Group-based delivery models may be best suited to forming linkages in Sub-Saharan Africa. There are two factors in support of group-based models. The first is that the group models build on the group/communal nature characteristic of Sub-Saharan Africa community culture and of common informal loan schemes (e.g. ROSCAs). Thus, the group lending methodologies provide a familiar format for clients and create a conduit for community forum to discuss issues and address community needs. The second is that these models bring together a group of people on a

[3] Rotating Savings and Credit Associations, common across much of SSA, are savings clubs whereby an association forms with each member making regular monetary contributions to a fund that is given, in whole or in part, to each participant in rotation.

[4] Accumulating Savings and Credit Association, a variation on the ROSCA, whereby not all members necessarily borrow from the fund, some simply save and benefit from the interest paid by borrowers via interest on the money they deposited for savings in the ASCA fund.

regular basis (often weekly) for loan repayment. This gathering can be utilised as an effective platform for linking these clients to other resources/products/services of the MFI and/or of other, outside NGOs, and government agencies. The regular meeting of organised groups are attractive to other organisations that then do not have to incur the time and expense of outreach and organisation. Thus, the construct of the MFI weekly meeting for loan repayment is conducive to forming linkages for a multi-dimensional intervention. The weekly gathering of clients can serve as a platform to link clients to legal services, orphan care, food programs, educational programs, and HIV testing and counselling.

The essential criterion is the regular gathering of a group to facilitate a multi-dimensional approach via linkages. For instance, ASA in Bangladesh provides individual loans but each week, the group of individuals meets together to make a repayment. It is also possible to create linkages in individual lending methodologies in which the clients do not meet together on a regular basis. From the perspective of MFIs and other service providers, individual lending methodologies may prove a less efficient and far less economical proposition as it is more labour intensive to provide information on an individual basis. This methodology also makes it more difficult to promote community mobilisation and community responses to the epidemic. Thus, while it is possible to create linkages via any lending method, group methodologies are likely more efficient than individual methodologies and are more conducive to promoting community forum and action.

III. Designing an effective response to the epidemic

It is important that an MFI understands the current and future potential for HIV/AIDS to affect the institution. Before any mitigation and prevention strategy design can take place, the MFI must map its financial landscape. Much of the information necessary for such a mapping is available through UNAIDS, local/national government and existing in-country AIDS service organisations. Only once this context and the inherent risks are understood can the MFI management team make informed decisions about the most appropriate product and service portfolios to offer.

Map the financial landscape:

The first step is to map the level and scope of demand, population density, existence of a market, existing supply of formal and informal financial services, etc. Besides the justification for microfinance support based on a gap between demand and supply, the financial map information provides the information on existing microfinance providers. To the extent that linkages can be made with such organisations, substantial economies can be realised in terms of time and resources otherwise used for setting up new institutions. In addition, the key issue of ownership would thus be circumvented. The mapping should include factors particular to the Sub-Saharan Africa context like:

- HIV prevalence rate
- Vulnerability and susceptibility of the population to HIV
- Presence of other NGOs, health services, AIDS organisations, etc.
- General prevalence of the extended family system
- Willingness of community leaders to be involved in addressing HIV/AIDS issues
- Cultural norms and traditions, especially relating to beliefs about the causes and treatments of HIV and the role of women
- Religious composition of population and associated views of HIV, sex, and the role of women

- The extent and nature of social capital in the community (willingness to work together, ethnic divisions, political tensions, etc.)

The estimated *prevalence rate* in the area characterises the level of risk borne by an MFI operating in the community. Higher prevalence is associated with more challenging operating conditions and more difficulty reaching operational and financial sustainability due to any combination of the following factors:

- Reduced loan portfolio growth as clients drop out or default due to illness
- High client turnover
- Slow loan growth, greater demand for smaller loans
- Difficulty meeting compulsory savings requirements
- Increased absenteeism
- Break-up of solidarity groups
- Increased portfolio at risk due to higher arrears and delinquencies
- Higher operational costs

Susceptibility and vulnerability refer to the individual's or community's predisposition to infection and to those features of the community that make it more or less likely that HIV-related illness and death will have an adverse impact on the community. For instance, if polygamy and/or male migrant workers are commonplace, this could mean the population is at higher risk of infection, as each of these is considered a high-risk factor. Susceptibility/vulnerability and other risk factors in a given community can serve as proxy indicators of current and future prevalence. With this information, the MFI can better assess both the systematic and unsystematic market risk attributable to HIV. High prevalence or the likelihood of high prevalence in a community *does not* necessarily indicate that an MFI should not or cannot operate in that community. What it *does* indicate is:

(a) Cultural/other obstacles to successful prevention efforts. Higher prevalence rates are likely to arise from deeply imbedded cultural norms that act as conduits for the spread of HIV. As examples, the cultural expectation that men should have sex with a wide variety of partners or that women should be submissive, each contribute to an environment conducive to the spread of HIV. The MFI would have to carefully consider whether it is possible to begin a process of overcoming these barriers to behaviour change.

(b) The need for specific financial products like funeral insurance[5] and credit insurance (discussed below), should be among the first offered as they will help to mitigate the costs of serving a population with a high prevalence of HIV.

(c) Linkages with outside organisations with, for example, orphan care programmes and health care organisations should be given a higher priority.

The *presence of other NGOs, health services, AIDS organisations, church groups, etc.* is an indication of the scope for a multi-dimensional approach to HIV prevention and mitigation. If few organisations are present in the community, the MFI would have to either provide the non-financial services it deems most in demand and most important itself (like FOCCAS/Uganda does with HIV/AIDS education) or form a relationship with more distant organisations to travel to the MFIs client meetings at intervals. One other consideration in this scenario is to recruit credit officers with backgrounds relevant to these other non-financial services. For instance, the MFI

[5] See Roth, J. Informal Micro-Finance Schemes: the case of funeral insurance in South Africa. Working Paper No. 22. International Labour Organisation. October 2000.

could recruit as credit officers individuals with HIV/AIDS prevention backgrounds to conduct education sessions or a legal background to assist widows in understanding their inheritance rights.

The *general proximity of extended family* gives an indication of the accessibility and strength of the family safety net. In some communities, often in urban centres, extended family members are a significant distance away in villages, leaving those in the urban centre more isolated in the wake of HIV. The proximity of extended family gives an indication of the community's ability to utilise existing, indigenous mitigation mechanisms and informs the MFI of what kinds of additional products and services would best strengthen this base. For example, the existence of an extended family network may signal a stronger community capacity to take in AIDS orphans.

The *willingness of community leaders to be involved in the intervention* can indicate the rate at which prevention messages will be adopted and transformed into behaviour change. While in certain cases traditional healers contribute to fallacious beliefs about the cause, spread and treatment of HIV (e.g. that HIV is spread via witchcraft or that having sex with a virgin will cure HIV) there is evidence that traditional healers can help dispel myths about transmission. In a number of countries, traditional healers have been trained in the treatment and prevention of STDs (UNAIDS: September 2000a). Because some 80% of people in Africa rely on traditional medicine for their health care needs and because traditional healers are culturally close to clients (which facilitates communication about HIV and related social issues), traditional healers are an excellent means of reinforcing and promoting prevention and behaviour change mechanisms (UNAIDS: September 2000a). In addition, village elders can also be integral to the strength and effectiveness of HIV prevention, mitigation and behaviour efforts. The endorsement by village elders/leaders of prevention practices (e.g. using a condom every time or postponing the age of first sex) can hold great sway over the community and lend considerable credibility to these practices and behaviours.

Strategy design:

Once the mapping is completed, the MFI can make informed choices about the most appropriate products and services. For those clients already infected with the virus, the challenge is to provide products, services and delivery mechanisms that mitigate the impact of HIV on both the MFI and on the client (including his/her household and community). For those that are not infected, particularly youth, the challenge is to not only promote prevention and education but also, critically, to facilitate actual *behaviour change* to protect this next generation from the pandemic.

A combination of mitigation and prevention strategies must always be incorporated into the MFI's operations. The emphasis on mitigation needs to be greater:

- the higher the current prevalence rate or expected prevalence rate
- the more vulnerable and susceptible the population
- the greater the distance between community members and their extended family
- the less willing local leaders and traditional healers are to become involved in the intervention

Strategy Design
The mitigation strategy needs to take in to account the following factors:

- **The current prevalence rate or expected prevalence rate**. In areas where the epidemic is considered generalised (more than 7% of the population is HIV positive), there will be greater, immediate need for mechanisms to preserve household income streams, store wealth for expected increased HIV-related expenses and to access insurance products.
- **The degree of vulnerability of the population**, the more likely it is that the virus will spread quickly and that the population will need to mitigate the financial impacts of the disease
- **The distance between community members and their extended family**. The greater distance may imply that family assistance (financial, caretaking, etc.) is more difficult to arrange, making the affected household more dependent on its own resources and thus, the in greater need of microfinancial products and services.
- **The willingness of local leaders and traditional healers to become involved in the intervention**. If leaders are not willing to assist in prevention and behaviour change interventions, then the impact of such interventions will take even longer to materialise. In the interim, the MFI should focus on mitigating the current and expected impacts of the epidemic.

From the MFI's perspective, mitigation and prevention each work in two directions. For one, MFIs seek to prevent and mitigate the impact of HIV on program operations, sustainability and, ultimately, on the survivability of the institution. For another, MFIs choose products and services to prevent and mitigate the impact of HIV on its clients. If done successfully, these efforts translate into (1) a healthy MFI capable of reaching sustainability and (2) in a client base that is able to secure a livelihood sufficient to provide for its needs, even in the midst of an epidemic. A potential outcome of successful mitigation and prevention efforts is the community-wide spill over of this success. From the client's perspective, a successful microfinance program can better equip them, in terms of financial resources, increased self-confidence, and empowerment, to actively participate in creating and sustaining safety nets for themselves *and* for others in their community.

The MFI must be careful not to take on too large a product portfolio without assessing concomitant costs and risks. Thus, the best mechanism for extending an MFI's impact is to maximise (1) linkages with other NGOs and service providers to enhance the breadth and overall effectiveness of mitigation and prevention strategies while easing the MFI's own financial/staff/other resource requirements and (2) to empower clients to devise and fund their own mitigation and prevention strategies. Mitigation and prevention are in the MFI's best interests because these efforts (which can be viewed as investments in the future of the MFI's business) not only protect the current portfolio but also, by reaching out to those as yet unaffected by HIV/AIDS, preserve the potential for the MFI to continue operating in the future.

IV. Mitigation Strategies

The impact of HIV/AIDS on the MFI as an institution:

As discussed previously, HIV impacts the financial resources of individuals and households via direct and indirect costs, productivity losses, and inter-generational effects, among others. Taken together, these factors increase the risk to the MFI of serving an HIV+ population. More specifically, there is a greater risk that the client will default on his/her loan as loan monies are diverted to expenses such as health expenditures and/or as the client is unable to work or to work consistently. In addition, the risk of providing insurance products such as life, credit or

funeral insurance, increases do to adverse selection. As the prevalence of HIV intensifies in a given client base, the MFI is exposed to far greater risk which, of course, can jeopardise the institutions ability to reach operational and financial sustainability goals. One final consideration is the impact of the epidemic on the MFI's staff. Illness and deaths will decrease productivity and costs will increase as the frequency of new hiring increases and the institution absorbs training costs. The heightened risks of operating in a high-HIV prevalence area may induce MFIs to avoid these areas altogether. However, given the current and expected rate of infections in the majority of SSA countries, this would be equivalent to saying that microfinance is not a suitable development activity for most of the region. However, if these risks can be mitigated via product innovations and portfolio mix, then it may be possible for MFIs to continue their role in SSA and still be able to achieve the institutions' sustainability objectives.

Choosing a product mix that maximises the mitigation effect for the MFI does not necessarily go hand in hand with reaching out to the poor. By making credit or life insurance mandatory or by raising compulsory savings requirements, the client's cost of accessing microfinancial services is increased; as costs rise, poorer clients may be priced out of the market. Moneylenders charge interest rates to the very poor that far exceed the rates charged by most microfinance institutions. This may imply that the poor have capacity to absorb a greater amount of debt and/or can afford to pay fees for insurance and other products. However, more rigorous studies on debt capacity must be conducted to test this hypothesis. Second, this wider array of products may actually *increase* the MFI's depth of outreach. If there is no (or only limited, in the case of mandatory credit insurance) requirement that clients must apply for a particular set of products or must necessarily take out a loan in order to have access to other products, then this wider array may enable the poorest to access the products they need most. Thus, products like life, health and funeral insurance that may have been completely unavailable/out of reach to the poorest in theory could now be within their reach. It is important to bear in mind that a diverse/extensive product portfolio will likely translate into higher training costs for staff and more time to explain and market the product array to clients/potential clients.

Finally, if, as part of the community mapping and programme design efforts, the MFI decides to target those living in extreme poverty (defined as those below 50% of the nation's poverty line), it may take that MFI longer to reach operational and financial sustainability. The extra cost of insurance and/or higher savings requirements to the client combined with the direct/indirect costs of HIV may mean clients can only afford to take out small loans and/or that loan growth is slower than for conventional MFIs operating in low/no prevalence areas.

This may not be the case, however, if the mitigation mechanisms help improve the quality of the loan portfolio. For example, if clients can afford health insurance, they may suffer fewer business disruptions due to illness or if the client has funeral insurance, the household may not be financially devastated when a bread winner dies and thus, the MFI may experience fewer arrears/defaults.

In the sections that follow, I will discuss what kinds of innovations are currently being utilised by MFIs in SSA. I will then describes how microfinance can be adapted to better accommodate the provision of microfinancial products/services to a population in the midst of an HIV/AIDS epidemic. First, the micofinance products/service features that serve to mitigate the impact of the epidemic on the microfinance institution are described and followed by a review of the features that mitigate the impact on clients and their households are detailed. Finally, a range of products is assessed with regard to the pros and cons to both the MFI and the client.

Existing Microfinance mitigation strategies:

A number of MFIs operating in Sub-Saharan Africa are offering products designed to mitigate the impact of the epidemic on either the institution itself or on its clients, or both. Among the products currently being offered are credit and health insurance, as well as conventional loans and savings products. Organisations such as FINCA, FOCCAS/Uganda and Opportunity International have begun to think strategically about the impact of HIV and the consequences for sustainability and client survival. Operating results to date indicate that the provision of microfinancial services in an HIV context is not incompatible with the MFI's goal to reach operational and financial sustainability. FINCA/Uganda reports financial sustainability of 126% as of July 2000 (Microenterprise Best Practices: September 2000).

The sections below are intended to expose a more comprehensive range of product, service and operational devises that can be incorporated into a mitigation strategy as well as to offer some insights into how best to configure the most appropriate product/service mix. This involves not only offering a broader array of products and services (e.g. health and funeral insurance) but also adapting conventional products, services and operational tools to an HIV context.

Mitigation mechanisms to reduce the impact of HIV on microfinance institutions:

A survey conducted by Development Alternatives, Inc. of MFIs operating in Africa indicated that 41% responded that their overall cost structure was increasing due to the impact of HIV/AIDS. The three most commonly cited causes of cost increase were: increases in loan loss provision (27% of respondents), increases in staff benefits (27%), and new client induction costs (14%) (Parker et. al.: September 2000). Thus, there is a need for MFIs to develop products to mitigate the impact of HIV on the institution itself.

A. Products

- **Loans with built-in flexible terms**
  - The MFI may allow clients the option to "rest" between loan cycles. Clients should retain the option to *not* take a loan in a given cycle, remain a client of the MFI, and continue to participate in savings (both making contributions to savings and being able to withdraw voluntary savings). This helps reduce the probability that the client will take out a loan he/she cannot afford in an effort to preserve his/her access to MFI products/services.
  - The MFI can also give clients the option to take out a smaller loan in subsequent cycles, without pressure or requirements to "graduate" to larger loan sizes. This flexibility can help decrease the likelihood a client will take out a loan he or she is not able to repay as the time the client has to put in to his/her business is reduced due to illness and/or increased care-taking responsibilities.
  - The MFI can provide smaller, shorter-term loans to meet "emergency" needs of clients. However, providing new loans before the current loan is repaid increases repayment risk to the MFI and may feed a cycle of ever-increasing debt. Another option for emergency loans that can work within village banking and solidarity group lending methodologies is to allow group funds (built up from fees, fines, or additional interest charges) to be lent out for this purpose. This alternative has the advantage of reducing information asymmetries to the MFI, as the group members are in a better position to judge the merits of the emergency loan request.

- **Insurance**
  In general, the provision of insurance products by an MFI is an expensive endeavour. In an high prevalence area (or an area expected to be so in the short- to medium-term), insurance is even more expensive. HIV is not a random event and the actuarial risks to the insurer may well result in premiums too high to be afforded by the typical microfinance client. Thus, the MFI must carefully weigh depth of outreach (e.g. reaching the poorest) against the mitigation benefits afforded by insurance products.
  - **Credit insurance** products protect the MFI portfolio from defaults. These products can be either mandatory (Opportunity International) or voluntary (FINCA/Uganda). In communities with higher prevalence rates, mandatory insurance will provide greater protection to the MFI and will help alleviate the potential adverse selection effects. In Zambia, CARE Pulse has used credit insurance to protect solidarity group members from loan liability of deceased members and to reduce solidarity group members' incentive to exclude those living with or expected of living with HIV (Parker et.al.: September 2000).
  - **Life insurance** products have the potential to mitigate the financial impact of HIV-related client illness and death on the MFI. Family members who receive insurance proceeds will be in a better position to repay the outstanding debt, assuming they are so motivated. If access to credit and other products/services of the MFI is contingent upon a clean household credit record, this provision may provide the necessary incentive to use insurance proceeds to pay off outstanding debt.
  - **Health insurance.** By enabling the client to maintain better health status and reducing the financial impact on the household/individual of HIV-related illness, health insurance reduces the risk of serving an HIV-positive clientele. Like life and credit insurance, the MFI can make the purchase of health insurance mandatory or voluntary. The provision of health insurance, whether done via a third party or directly by the MFI, is expensive. The insurance provider must carefully set premiums, co-payments and limits of coverage to deter adverse selection and over-utilisation and to maximise efficiency and effectiveness.
  - **Funeral insurance** Funerals in Sub-Saharan Africa are major life cycle expense. For example, in one township in South Africa, households spent approximately 15 times their average monthly household income on a funeral (Roth: 2000). By comparison, if an American household with monthly income of US$3,000 spent the same proportional amount on a funeral, it would spend US$45,000 (Roth: 2000). Often, communities have a variety of informal schemes that offer such insurance and it may be possible for the MFI to link its clients to these services, should the MFI decide it is not in its strategic interests to offer the insurance itself. Funeral insurance reduces the need for clients to liquidate assets or divert business funds to cover the very high cost of funerals. By preserving clients' financial and material asset base, funeral insurance also reduces the risk to MFI of serving poor clients whose households are impacted by HIV.
  - **Insurance policies as emergency loan collateral.** Clients holding mandatory or voluntary insurance policies could post them as collateral against an emergency loan. The MFI should limit the size of an emergency loan so that the insurance collateral posted is at least equal to the combined face value of the emergency loan plus the client's conventional loan. In this way, the MFI minimises the amount of additional risk it incurs by providing emergency loan products.

Opportunity International

Opportunity International (OI) has been providing microfinancial services in Africa since 1992 and now serves more than 30,000 clients.

OI offers a variety of products designed to mitigate the impact of HIV/AIDS on both the institution and on its clients. Among these are two mandatory insurance products.

Mandatory Loan Insurance. OI charges clients a one-time fee of approximately US$0.30 that covers the client's outstanding loan balance in the event the client dies before repayment is completed.

Mandatory Death Benefit Insurance. OI is working with local insurance companies to design an insurance product that will cover burial and related costs for clients and up to five dependents with an expected monthly premium of US$1.50.

- **Savings Products**
  - **Compulsory savings** in theory can help ease the financial impact of default/arrears brought on by a variety of circumstances, including HIV. However, in general, the amount of compulsory savings is small, too small to be of any real consequence to the MFI in the event of a major default or rapidly increasing default experienced in a high prevalence area. One option is for the MFI to raise the amount of compulsory savings in high prevalence environments to strengthen portfolio protection. While this option provides the MFI with more meaningful protection, it could also reduce depth of outreach as the client must "pay" more to access financial services. Another option is for the MFIs to eliminate the requirement altogether. While this would increase depth of outreach (by reducing the client's cost of taking out a loan) it would do nothing to mitigate the impact of default on the MFI. In addition, via this option the MFI would forego the repayment incentive that the compulsory savings component was designed to instil. However, if clients are dropping out of the programme in an effort to access their compulsory savings (for HIV-related reasons or otherwise), then it may be in the economic best interest of the MFI to drop the requirement. This would only be the case if the "cost" to the MFI of eliminating compulsory savings benefits (some cost mitigation and the repayment incentive/discipline) are outweighed by the cost to the MFI of new client recruitment costs. Finally, MFI could maintain the compulsory savings requirement, but allow clients the option to liquidate the compulsory savings in an emergency situation. If the emergency is temporary, then this mechanism may help protect household productive assets or business funds/assets from being utilised (liquidated) to cover the emergency and would preserve the client's income generating (and thus, repayment) capacity for the future. If the emergency is not temporary or if the amount of compulsory savings is not sufficient to cover the emergency need, then the MFI stands to loose this limited protection and to erode the discipline and repayment incentive. Gauging the extent of the emergency and the adequacy of compulsory savings to meet this need is wrought with difficulty but it may be possible for credit officers, who are in closer and regular contact with clients, to discriminate among client demands for the liquidation of these savings.
  - **Voluntary savings** enable the client to store wealth to ease the financial burden of the direct costs of HIV/AIDS. Voluntary savings (especially when the savings can be freely

and easily accessed) reduce the incentive for clients to divert loan funds to cover these costs or, more importantly, reduce the incentive to divert more than a manageable (e.g. repayable) portion of loan funds to these expenses. Of course, voluntary savings also provide a source for loan repayment.

- **Dedicated savings accounts or fixed term deposits.** Clients can opt to make weekly contributions to a savings fund with restricted access to accumulate funds for lumpy expenditures (large, infrequent expenses like school fees, wedding expenses, asset purchases, etc.). Opportunity International is currently examining ways to establish education trusts for minors, one form of a fixed term deposit product (Parker et.al.: September 2000). This, too, protects the MFI from arrears or defaults arising as the consequence of large debt positions that are diverted to non-income generating activities.

B. Delivery Mechanisms

- **Group vs. individual lending methodologies**. Clearly, any of the above referenced products can be offered in either a group (village banking, solidarity group lending, etc.) or an individual client setting. However, group formation helps (1) to form linkages between MFI clients and other service/product providers and (2) facilitates mobilisation toward behaviour change and community initiated mitigation. Advocates of peer education assert that group formation for talking about HIV/AIDS information is key (Population Council: 2000c). Thus, even if the MFI chooses an individual lending methodology, it may be best to have groups of individuals come together at regular intervals for loan repayment, as does ASA in Bangladesh.
- The MFI can design methodologies that **limit the liability of any one solidarity group member** when another member defaults. It has been noted that in high prevalence areas, solidarity groups break up under the strain of numerous defaults (Versluysen: 2000). The prospect of incurring high and uncapped amounts of debt due to group members' illness may cause healthy (uninfected) group members to defect, thereby increasing the risk profile of the group for the MFI. Under this scenario, the MFIs could guarantee clients that each person is only responsible for some pre-determined maximum amount of group member debt. This limited liability design may encourage healthy members to stay on as clients of the MFI, reducing the overall HIV-related risk of the group. This helps preserve both the solidarity groups and the collateral substitutes on which group-lending MFI models are based, as increased defaults due to HIV/AIDS would not motivate healthy clients to drop out of the programme. Of course, this option also limits the financial protection against default for the MFIs. However, it is one potential option to consider in a high prevalence environment.
- **Team loans**. By making the loan to a team of people rather than to an individual, the MFI can protect itself from defaults or arrears arising from HIV-related illness and death. Should one team member become ill or die, the other team members know how to run the business and can step in to complete loan payments.

  The MFI could choose to impose that team members are female and/or are from the same family, to bring it in line with programmes that lend only to women. By restricting team loans to family members from the same household, the MFI may be able to construe an inter-generational succession effect by incorporating both young and old household/family members. This is an ideal way to mitigate risk as those outside the 15-49 year old age bracket are far less likely to contract HIV and thus, the business can be passed on to those more likely to survive.

  The structure of such a delivery mechanism could include a team contract whereby each team member promises to contribute some minimum number of hours to the business each month and to assume the obligation of a team member who becomes ill or dies. It could be

further stipulated that anyone of school age work fewer hours that do not conflict with school hours. It would only be necessary for one team member to attend weekly meetings but it should be required that the attending member share the education/information with the other team members.

C. Operations

MFIs operating in high prevalence areas should also consider reviewing operational procedures such as the monitoring and reporting system, staffing and portfolio tracking. Changes can be made to these operational factors that could (a) help flag growing prevalence among the client base, giving the institution time to prepare for consequent impacts and/or (b) better prepare the organisation to absorb HIV-related impact.

Monitoring and Reporting Mechanisms:

Proxy indicators of prevalence and its impact on the MFI. The MFI can adopt a number of operational mechanisms to help estimate current and future prevalence and, in so doing, better gauge its inherent risk and appropriately structure its product and service mix. These mechanisms would be in addition to UNAIDS or governmental HIV monitoring programmes. The prevalence monitoring devices are often imprecise and are intended only to give an indication the direction and speed of prevalence increases. When combined, the following tools can prove a workable proxy.

- **Monitor client drop out.** The monitoring and reporting system should track the number of dropouts and the reason for dropping out. When a client informs the credit officer that he/she is leaving the program, the credit officer simply notes his/her reason why on a form that can be entered into a database at the head office. Tabulation of the number of dropouts due to illness can serve as a proxy indicator of increased prevalence. This is an imperfect measure as the client may be motivated to misstate the reason for leaving the programme (e.g. due to fear of stigma about HIV/AIDS). FOCCAS/Uganda has recently begun utilising a drop-out monitoring system and is tracking the reasons leaving the programme, including reasons related to illness and death.
- **Monitor client group meeting attendance, excused absences and reasons.** Track absenteeism due to funeral attendance or due to illness. This can act as an early warning indicator that the impact of HIV in the community is getting worse.
- **Conduct client exit interviews.** Loan officers may wish to solicit accurate information about a client's reasons for leaving the programme. This can help guide the MFI in new product and service development, and gauge the appeal of products designed to mitigate the impact of HIV/AIDS. If a subset of clients who leave the programme are interviewed, this pool of information can be used as a check on the prevalence proxy developed from the dropout questionnaire.
- **Track arrears and defaults by loan cycle.** This may indicate the "saturation point" for loan sizes, which may become smaller as the impacts of the disease become greater. Also a large number of arrears/defaults occurring together may indicate a surge in the impact of the virus on the community.
- **Track information to gauge the impact of the disease on households.** In a survey conducted by Development Alternatives, Inc., 36% of MFI respondents reported tracking this type of data (Parker et. al.: September 2000). Examples include number of households caring for orphans, number of dependants per household, and number of female-headed households.

- **Portfolio**
  - **Increases** in the provision for bad debt as the "early warning indicators" show signs of potential for increased defaults.
  - Investigate opportunities for **portfolio insurance**.

- **Staffing**
  - **Target MFI employees.** Provide employees with HIV/AIDS education information, health insurance, funeral insurance, etc.
  - **Training.** Field staff can be trained to conduct HIV/AIDS education sessions (and thus, learn about the virus themselves).
  - **Hiring practises.** Where possible, the MFIs can opt to hire credit officers with backgrounds in HIV/AIDS education, in counselling, nursing and other skill sets that may can better enhance the effectiveness of a HIV/AIDS mitigation and prevention strategy.

Mitigation mechanisms to reduce the impact of HIV on microfinance clients:

A. Products

- **Loans**
  - For **women**, access to capital and the ability to make an economic contribution to the household has several effects including improving self-esteem, instilling a sense of empowerment, increasing the woman's decision making capability in the household and enabling women to direct income towards health, nutrition and education expenses. Each of these factors addresses the root causes of vulnerability and confronts the very factors that allow the epidemic to spread (World Bank: September 1999). Whether the loan is to a man or to a woman, it can help them to improve their economic situation and thus, increase and/or preserve more resources and mitigation capability in the face of HIV/AIDS.
  - **Team Loans**. From the client's perspective, a team loan can be one mechanism to ensure that the illness or death of one member does not result in an opportunity cost (e.g. lost household income source) for the others. At the same time, one loan invested in one business may not generate income streams sufficient to make the team loan worthwhile for all members. If clients view the team loan as a mechanism for succession planning, household income preservation and as a household survival plan, it may be more attractive. Clearly, more research on the viability and market potential for this product needs to be conducted.
  - **Loans to youth.** Most MFI have minimum age requirements for loans. Given that the number of AIDS orphans is rapidly rising and that the Sub-Saharan Africa landscape is increasingly characterised by child-headed households, MFIs may want to consider lowering minimum age requirements. It may be best, where possible, to combine loans to youth with business development services and/or vocational training to (1) to ensure youth have sufficient marketable skills and (2) to can help minimise the risk of default. One difficulty with lending to youth is that if the youth is involved in an income generating activity, he/she is far less likely to attend school. In Kenya, the school day is arranged to leave youth with sufficient time for income generating activities (Hunter and Williamson: 2000). In this type of environment, loans to youth could be used to help pay for school fees.
  - **Loans to those who care for orphans.** The MFI could make a special effort to target those who care for AIDS orphans. Often, caretakers are elderly women, who become

responsible for their daughters' and sons' children (Mutangadura: 2000). Again, where possible, the addition of business development services may be helpful as elderly caretakers may have fewer skills and need more assistance in business start-up to better ensure they have the capacity to repay.

- **Reduced interest rate loans.** The MFI could offer loans at reduced interest rates to caretakers of AIDS orphans and to orphans themselves as they reach an age and ability appropriate for starting an income generating activity. These subsidies would ensure that caretakers, who are essential components of the community's safety net, could access one means of support for their vital community service role. The subsidies to orphans would target a very vulnerable group and help to prevent them from also becoming HIV positive. MFIs would need to weigh the costs of social objectives achieved via subsidised interest rates against the need to reach operational and financial sustainability. Depending on the overall client mix, cross-subsidisation of higher margin products to these lower-margin products could negate any impact on sustainability. It may also be possible to appeal to donors to finance this type of subsidisation.
- **Emergency loans.** Shorter-term loans available on an ad-hoc basis can help households to cover temporary gaps in income flows and/or income-expenditure mismatches. The availability of emergency loans may mean that the household does not need to take more drastic and less reversible steps such as selling assets or cutting expenditures like school fees.

- **Insurance**
  - **Health insurance.** For those that can afford the premiums, health insurance can alleviate the financial burden of HIV on the household. In addition, it gives clients access to treatment of opportunistic infections enabling the client and/or other household members covered under the plan to maintain a better health status and to continue economic activity.
  - **Credit insurance**. This product ensures that the household members left behind in the event of death and/or who lose a source of income generation due to illness do not have to bear the additional consequence of unpaid debt.
  - **Life insurance.** This product can be utilised by the client as a means of succession planning. Life insurance enables the client to direct financial resources to those he/she feels are most in need. This is one mechanism with the potential to ease the impact of HIV/AIDS related death of parents on their children.
  - **Funeral insurance** can prevent the household from sinking further into poverty when a bread-winner dies and the household must adhere to the costly burial ritual because of cultural traditions. Insurance also helps to minimise the possibility that the household will engage in detrimental coping strategies like taking children out of school, selling assets, or reducing food intake.

Analysis of Insurance Premiums in Uganda

Health Insurance. FINCA Uganda charges 27,000 Ugandan shillings (about US$15.17) for coverage for a family of four for four months (Microenterprise Best Practices: September 2000). On an annual basis, this amounts to US$45.51, or 14% of the Ugandan GNP per capita of US$325 or nearly 11% of FINCA's average loan size of US$142.

Credit Insurance. In general, credit insurance premiums are in the range of 2-5% of the outstanding balance of the loan.

Death Benefit Insurance. Opportunity International charges a monthly premium of US$1.50 which covers the client and five dependants for a maximum benefit of US$167 per household. On an annualised basis, the premium (US$18 per annum) is equal to approximately 6% of Uganda's US$325 GNP per capita.

- **Voluntary savings and fixed term deposits** each enable the client to store up wealth to be used as a source of funds to alleviate the direct, indirect and opportunity costs associated with HIV.

B. Services

- **The MFI can encourage discussion among clients of problems and issues associated with HIV/AIDS to facilitate group-generated solutions**. UNAIDS states that one of the basic principles for building an effective and sustainable response to the HIV/AIDS epidemic is to enable communities to assess their situation, to identify problems, to prioritise these problems and to come up with their own solutions to those problems (UNAIDS: October 2000c). The MFI weekly meeting can act as a facilitation mechanism for this type of interaction. Formalised group discussion sessions at the weekly MFI meetings can create an enabling environment at the group level for taking action in the epidemic and create a sense of group empowerment and ownership over the issue. Changing current behaviour to avoid a future illness requires the belief that it is possible to have some control over what happens (Hunter and Williamson: 2000). Group discussions facilitated via the MFI weekly meeting can foster this sense of control. Credit officers can encourage group discussion and facilitate dialogue to identify problems and pose solutions. Once problems are identified, the MFI can serve as a link to other organisations and resources to assist the group in devising a solution. In sum, the meetings can help empower group members to take action--to act collectively and/or to support the actions of other group members.
- **The MFI can facilitate group savings accounts to be utilised for programs such as orphan care**. The loan officer can suggest this type of action as one possible solution/action the group can adopt. The MFI can collect the weekly contributions and assist the groups by keeping the appropriate accounting records. Importantly, the groups should discuss and decide for themselves what projects (if any) to undertake. This is essential if a sense of community ownership of the problems is to take root.
- **The MFI can refer groups to NGOs or others with related, specific experience**. The NGO should build the capacity of the group members to run the project on their own. The MFI acts only as a conduit and in this way does not become involved in activities/projects outside its domain or area of expertise.
- **The MFI can assist client groups to finance group initiated and run programs**. Realistically, MFI clients in most cases will not be able to raise large sums for group projects beyond each client's own business endeavour. And, due to the discordant cyclicality of household income (crop seasonality) and expenses (school fees), MFI clients may not be able to contribute a continuous flow of funds for such projects, dooming projects to an early failure. These practical constraints may undermine the group's sense of empowerment/ownership and their motivation for action. One way to strengthen the group's effectiveness and to boost their desire for action is for the MFI to assist in coordinating a matching fund type of mechanism. Donors and/or governments could contribute funds to help groups actualise their ideas for action. The mechanics, requirements, oversight and operation of such a scheme necessitate further study. Importantly, however, this is one way of not only leveraging group and donor/government resources but also of ensuring group support, ownership and participation in the project. CARE International and Zambia's Family Health Trust offer technical and financial assistance to community initiated orphan care programmes, thus leveraging community initiative and resources into well structured and meaningful AIDS orphan projects (Family Health International: June 2000a).

Community Assisted AIDS Orphan Project

A USAID funded Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children (SCOPE-OVC) Project in Zambia is a good example of community generated solutions to the impacts of HIV assisted by financial and technical assistance from NGOs. Community participants determine which children are the most vulnerable and in need of support. With technical and financial assistance from Family Health International and CARE International, the communities will design support programmes for these vulnerable children. In addition, the community will be assisted in developing monitoring and evaluation plans. (Family Health International: June 2000a)

Mitigation facilitated by clients to reduce the impact of HIV on the community:

- **Home based orphan care**. As the number of AIDS orphans increases, communities' capacity to absorb the additional costs and commitments of orphan care is greatly diminished. Setting up and running an orphanage is not only generally outside the cultural context of Sub-Saharan Africa but also is unlikely to be sustainable on financial grounds (Mutangadura: 2000). Foster care may be more appealing and sustainable if the community can raise some funds to help those caring for orphans. As examples, the community could make a contribution to school fees, provide bedding/clothing, or contribute food to the foster household. In this way, community members may be more inclined to take in AIDS orphans.
- **Vocational Training**. The MFI group could help fund vocational training programmes for AIDS orphans as does Zambia's Family Health Trust does for child headed households (Family Health International: June 2000a).

V. Prevention Strategies

Existing Microfinance prevention strategies:

In terms of prevention efforts, some MFIs in Sub-Saharan Africa offer HIV/AIDS education, conducted by either their own staff or via partnerships with AIDS service organisations. In general, MFIs utilise the regular loan meeting to deliver the education. There is a clear incentive for MFIs to offer education as it ultimately promotes the MFI's long-term sustainability. While this is a critical element of any effort to stem the rate of new infections, it very simply is not enough. In many Sub-Saharan Africa countries, prevalence rates are not abating despite active education campaigns. Prevention efforts must go the next step, that is, they must attempt to stimulate actual behaviour change, if the epidemic and its deadly consequences are to be halted.

Behaviour change is a long and challenging process. Many would argue that such endeavours are not the business of MFIs. However, MFIs have two built-in advantages that enable them to serve as a key component in the effort to save lives by promoting such change. The first is that the regular loan repayment meeting of clients can be utilised to facilitate community empowerment and interaction, two key elements of a behaviour change intervention. The

second is that MFIs, unlike most other development organisations, are designed to become sustainable. This means that the "life span" of an MFI is well matched to the lengthy process of behaviour change and that the sustainability premise of MFIs means that they, unlike other development organisations, are not subject to donor fatigue and changing priorities of donors over time. These points will be more fully developed below. The key point is that MFIs operating in Sub-Saharan Africa have not fully exploited the range of possibilities for either mitigation or prevention strategies. And, most importantly, given the current stage of HIV/AIDS crisis and the dire predictions of impacts to come, MFIs operating in Sub-Saharan Africa *must* do more.

Against the clear benefits to the MFI and to its clients of education and behaviour change efforts, is the cost to the MFI of offering these services. These costs are twofold. First, the cost of training staff in HIV/AIDS education/behaviour change and adding on such a responsibility (in terms of time and resources) to an organisation attempting to reach sustainability. This cost can be overcome by outsourcing education to an AIDS service organisation, as FINCA/Uganda does for education. The second cost is the potential impact the MFI's client base as some potential clients may choose another MFI because he/she is only interested in financial services and not in HIV/AIDS lectures. Market demand studies, which could be incorporated into the initial mapping exercise, would bear out the true cost to market potential.

Prevention mechanisms to reduce the impact of HIV on MFIs, MFI clients and their communities:

The basic group lending methodology employed by MFIs throughout Sub-Saharan Africa can be adapted to create an effective prevention strategy with a focus on promoting actual behaviour change.

Most prevention methods used in Sub-Saharan Africa and elsewhere today are based on the assumption that the dissemination of knowledge and information will necessarily lead to behaviour change and thus, to declines in prevalence rates. IEC (Information, Education and Communication) campaigns have done an excellent job of raising awareness of HIV/AIDS. Studies in Tanzania noted that IEC campaigns led to impressive awareness levels but their influence on behaviour change was marginal, as the epidemic continued to spread (Shapnick et al: 2000). Given that many Sub-Saharan Africa countries continue to experience unabated increases in HIV prevalence, it appears that IEC campaigns have not been sufficient to change behaviour and thus, to reduce infection rates. For example, over the 1994-98 period, prevalence increased from 14% to 19% in Kenya, remained constant in Zambia at about 19% and, in urban Lusaka, increased from 24% to 27% despite active HIV/AIDS education and information campaigns (Stoneburner: 2000).

Best practices literature on HIV prevention calls for the creation of enabling environments that will reduce individual's susceptibility and vulnerability and allow them to change their behaviour based on HIV prevention information and education (UNAIDS: October 2000c). Current research on best practices in HIV prevention calls for a social mobilisation process to be combined with traditional IEC campaigns, availability of condoms and more accessible and effective health systems (Schapnick et. al.: 2000). Key to this social mobilisation paradigm is the empowerment and full participation of the group or community to plan and implement a response to the problem and to move beyond mere awareness raising to actual behaviour change (Population Council: 2000c). Referred to as empowerment theory or empowerment approaches, these models assume that health behaviours, including HIV/AIDS related behaviours, are not totally

under the individual's control and are, rather, inextricably intertwined within the social, cultural and economic context.

Among best practices approaches to HIV prevention and behaviour change are those interventions that enable and empower communities to "…assess their situation, vulnerability and exposure risk, in order to take appropriate action to fight and stop the disease" (UNAIDS: October 2000c). MFI client meetings are one way to facilitate such a process. A widely noted and studied "spill-over" effect of microfinance for women is its ability to "…change the power relationships in favour of those who previously exercised little power over their own lives" (UNIFEM: 1998). In this way, MFI's by their construct already have achieved significant progress towards increasing empowerment, especially of women. It is argued here that MFIs can foster and extend this empowerment "side effect" of group based MFI methodologies by using the group meeting as a tool to shift the prevention strategy focus from individual action to community ownership of the problems and, in so doing, shift the prevention emphasis from awareness creation to behaviour change facilitation. Most experts regard such shifts as the best approaches to HIV prevention strategies (Schapnick et. al.: 2000).

MFIs are well suited to integrate empowerment models into their operations. Again, the group structure acts as a cornerstone combined with:

- access to financial services and, thus, economic empowerment,
- relatively easy incorporation of basic HIV education into the group format,
- the potential to link groups of clients to other outside resources, and
- the opportunity to facilitate group discussions, identification of problems and exploration of solutions

Taken together, these features make MFIs natural conduits for empowerment based prevention and behaviour change interventions.

- The MFI can **facilitate the involvement of local officials** in prevention efforts.

  The support and involvement of **local officials** can act as a catalyst to behaviour change by reducing stigmatisation, encouraging discussion and lending credibility to new, life saving behaviours. If leaders are willing to talk about and participate in discussion of HIV, this can reduce stigma and encourage action among the community. In Uganda, President Museveni's willingness to talk about HIV/AIDS helped facilitate the breakdown of social taboos on the discussion of HIV and its impact on communities. In Kenya, the support of imams and other religious leaders in HIV/AIDS education campaigns has helped build community trust and acceptability of community education programmes and has lent credibility to the behaviour change recommendations. (Family Health International: June 2000b). The MFI can invite **traditional healers** to talk with group members, encouraging them to adopt preventative practices and to overcome stigmatisation and denial. UNAIDS research indicates that traditional healers can serve as a lynchpin in a prevention strategy.[6]

[6] UNAIDS research supports the incorporation of traditional healers for the following reasons: (1) about 80% of Africans utilise traditional healer services; (2) traditional healers work within the local cultural context and are often best positioned to bridge the gap between HIV prevention mechanisms and cultural norms and beliefs around sex, gender roles, myths about transmission, etc.; (3) traditional healers command the respect of the community and are perceived as credible sources of health information; and (4) in resource constrained settings such as SSA the indigenous health system can be leveraged to increase effectiveness of prevention interventions. According to UNAIDS, traditional healers outnumber doctors by 100:1 in much of Africa.

There have been numerous examples in SSA of successful collaboration with traditional healers in STI (sexually transmitted infection) control and treatment, including promoting the use of condoms. Thus, it should be possible to transition from involving traditional healers in STI interventions to including them in HIV interventions. Working with

- **Gender targeting.** Many MFIs in Sub-Saharan Africa lend only to women. The justifications for focusing exclusively on women are (a) the majority of the poor (those living on less than $1 per day) are women, (b) experience has shown that women are a good credit risk, and (c)

FOCCAS/Uganda

FOCCAS (Foundation for Credit and Community Assistance) is a Ugandan MFI utilising Freedom From Hunger's *Credit with Education* microfinance model. FOCCAS utilises a village banking methodology to provide credit and savings products to rural women. Each week when the women meet for loan repayment, they receive a 30-45 minute education session on a health or nutrition topic, including HIV/AIDS.

Loan officers are trained in adult, non-formal education methods and to facilitate education in a participatory and discussion-oriented manner. Loan officers must be comfortable talking about sex and HIV with women, some of whom are elders. The HIV/AIDS component of the education is designed to provide members with information and to emphasise that HIV is a community problem. Loan officers encourage women to consider how to use this information to change their behaviour to remain healthy and uninfected and to help others in their community affected by HIV.

The *Credit with Education* has been shown to be a cost effective and efficient mechanism for delivering HIV/AIDS education. It can serve as a basis for prevention strategies that move beyond basic education and information to actively promote behaviour change. With a few adaptations this prevention model can move beyond an awareness creating emphasis to an effective and cost-efficient strategy for behaviour change.

that women invest their income toward the well being of their families. However, in the context of HIV/AIDS in Sub-Saharan Africa, it is extremely difficult to maximize the effectiveness of prevention and mitigation strategies without also including men, as men control decisions about condom use. In addition, polygamy is not only accepted but also expected of men and women have no power to enforce monogamy. At the same time, however, women's lack of empowerment and their subservient social position may dissuade them from actively participating in discussions of the causes, consequences and problems of HIV in the community if men are present. Thus, men must be carefully incorporated into an MFI's prevention strategy to strike a balance between the desire to empower women and the need to design a meaningful, gender balanced prevention strategy

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traditional healers over time can strengthen the actual behaviour change arising out of prevention interventions. That said, incorporating traditional healers is no easy task as HIV prevention efforts to promote behaviour change do run up against some deeply rooted cultural traditions such as the cultural acceptance of high fertility and of men having sex outside of marriage. While many challenges to this intervention strategy exist, there is enough evidence in STI efforts to indicate that it is possible. In the context of massive pandemic, it is a tactic worth exploring. More research must be done as the concept has merit.

If the MFI chooses to target only women, it could consider holding special HIV/AIDS education and prevention sessions for the husbands and other male relatives of its female clients. Where possible, an outside AIDS service organization could be brought in to limit the financial and other resource burdens on the MFI. If the MFI chooses to target women and men, it may decide that prevention interventions are most effective if done in single gender settings. Although some lending methodologies make incorporating men into prevention strategies challenging, it is a task that must be undertaken if prevention efforts are to lead to behaviour change and to reduced prevalence.

VI. Conclusions

Microfinance can play a major role in mitigating the impact of the HIV/AIDs epidemic on informal sector employment. No individual, no development program, no government policy and, most of all, no microfinance programme can operate in Sub-Saharan Africa without adopting a prevention and mitigation strategy. Thus, the question is not *if* microfinance institutions should engage in HIV/AIDS interventions it is, imperatively, a question of *how much* can any single MFI do.

FINCA/Uganda's success in providing a number of products intended to mitigate the impact of HIV/AIDS on both the MFI and on its clients demonstrates that such interventions can be done in an effective, efficient and self-sustaining way. Further, FOCCAS/Uganda (a Freedom from Hunger affiliate) has managed to deliver credit with education without sacrificing scale. FOCCAS had 13,000 clients as of November, 2000, and continues to exhibit strong growth.

The most important questions are:

- What mix of products and services?
- What delivery methodology?
- What are the most vital linkages to establish?

In an environment characterised by overwhelming demand and seriously constrained resources, the biggest challenge is for the MFI to try not to take on too many different programs. Prioritising products and services by adhering to clients' needs and demands is the best starting point for this decision process. Clearly, incorporating mitigation and prevention strategies into a microfinance format will be challenging. However, in Sub-Saharan Africa where the HIV/AIDS epidemic continues to devastate the population, MFIs simply must rise to this challenge and adapt conventional products, services and delivery methodologies to better serve these communities.

MFIs operating in Sub-Saharan Africa should map the presence and progress of HIV in their operating areas and adapt their product portfolios to better mitigate the impact on the institution and on its clients. Given the current stage of the pandemic and UNAIDS' predictions for increasing prevalence, it is imperative that MFIs act immediately. At present, estimates indicate that only two million Africans have access to MFI services (Parker et. al.: September 2000). While MFIs are capable of reaching massive scale, clearly there is an urgent need to scale up more quickly so as to have a meaningful effect on the heavily affected Sub-Saharan Africa populations. The following call for further clarification:

- The debt capacity of Sub-Saharan Africa's poor. There is a lack of information on what how much debt SSA's poor can reasonably absorb. This is important to determining the prices of various microfinancial products.

- The structure of and potential for a loan product which would allow clients to liquidate compulsory savings as a source of emergency loans
- The most appropriate and effective product mix(es) to maximise mitigation effects while still accommodating depth of outreach
- The structure and potential for limited liability solidarity group mechanisms
- The structure and caveats of a team loan lending methodology
- The most effective skills sets to look for when hiring loan officer staff in an HIV context. This will depend on the product and service portfolio chosen by the MFI. It is important that either skill sets of staff are compatible with a given product/service portfolio or that the MFI is committed to training the staff to effectively market and manage the portfolio.
- Loan structures for youth that do not compromise educational attainment
- Mechanism for funding orphan caretakers and other vulnerable groups, including client capacity to fund, MFI's ability to co-fund, and/or willingness of donors/other NGOs to jointly participate in such projects.
- Donor interest in funding matching funds for community generated responses to the epidemic
- Demand for the array of potential MFI products and services by those infected by HIV, those as yet uninfected and the dependants and family members associated with clients
- Assessing the impact of HIV/AIDS on the performance of MFIs operating in SSA
- Examine the consequences of HIV/AIDS on solidarity group formation
- Examine how informal financiers are adapting to increased prevalence in their communities
- More research in to the feasibility of microinsurance among a high-prevalence population, including:
    - Excluding, based on testing, those who are positive and the inherent ethical issues of such a tactic
    - Measures to increase the size and spread of the risk pool
    - Effects of increasing premiums and the consequent impact on depth of outreach and overall demand
    - Mechanisms to decrease the benefits of insurance policies, the consequent impact on demand for these products and the impact on mitigation to the client and to the institution

Finally, it must be recognised that microfinance will not always be an appropriate component of a mitigation and prevention strategy, particularly environments characterised by high prevalence rates. It is important for the MFI to (a) monitor the impacts of HIV via operational "early warning systems" and (b) work closely with donors and governments so that they can step in when microfinance programmes are no longer capable of assisting clients' coping strategies.

It is hoped that adoption of these measures will play a significant part in operationalizing the HIV/AIDS resolution adopted at the 88th session of the International Labour Conference in November 2000.

Microfinance Products and Services
Comparison of Mitigation Mechanisms from the MFI's Perspective and from the Client's Perspective

MFI's Perspective	Client's Perspective
Conventional loans	**Conventional loans**
Conventional Loans: MFI can build in more flexibility to conventional loans by allowing client to "rest" between loan cycles (e.g. not take out a loan in every cycle) or to take out a smaller loan in subsequent cycles to better match the client's ability to generate income to repay a loan with the amount of debt incurred by the client. This helps mitigate financial risk to the MFI by reducing the probability a client will default (or enter into arrears) due to inappropriate timing or amount of loan products.	Conventional Loans: Enables client to maintain access to microfinancial services while empowering the client to better manage his/her financial resources. Greater choice in the timing and amount of conventional loans allows clients to match income generating activities and household expenses with debt capacity.
Emergency Loans	**Emergency Loans**
MFI can allow clients to have access to more than one loan at a time either from the MFI's loan funds or, in group methodologies, from group funds. This increases the indebtedness of the client and thus, the financial risk to the MFI. However, if access to an emergency loan prevents the client from either liquidating income generating assets (source of future repayment streams) or helps the client to bridge a temporary cash flow gap (i.e. sudden HIV-related health expense) and the client is able to repay both loans, then it may ultimately mitigate the MFI's financial risk by helping the client to avoid arrears/default. One way for the MFI to offer emergency loans without increasing its financial risk is to allow clients to post insurance policies as collateral against the loan.	Access to shorter-term, ad-hoc loans can help households cover temporary gaps in income flows and/or income-expenditure mismatches. Ability to access these loans may mean the household avoids more drastic and less reversible steps such as selling assets (esp. income generating assets) or cutting expenditures like school fees and medical expenses.

Microfinance Products and Services
Comparison of Mitigation Mechanisms from the MFI's Perspective and from the Client's Perspective
(continued)

MFI's Perspective	Client's Perspective
Funeral Insurance	**Funeral Insurance**
The provision of funeral insurance reduces the need for clients to liquidate assets or divert business funds to cover the high cost of funerals (in South Africa, as much as 15 times the average monthly salary). By preserving the client's financial and material asset base, it also reduces the risk to the MFI of serving poor households in high prevalence areas.	Enables the client household to uphold cultural traditions regarding burial rights without sinking the household into deeper poverty to do so. Enables the household to preserve income generating assets to ease the income burden of the death of a bread winner.
Credit Insurance	**Credit Insurance**
The MFI's risk of serving a client base with high rates of HIV infection can be mitigated if credit insurance is mandatory. In this way, the MFI is not subject to greater risk of default arising from higher death rates associated with high HIV prevalence.	Credit insurance ensures that the household members left behind do not have to bear the additional consequence of unpaid debt. However, the additional costs of credit insurance (esp. mandatory credit insurance) may price some out of the microcredit market and thus, reduce the MFI's depth of outreach.
Health Insurance	**Health Insurance**
The provision of health insurance reduces the financial risk to the MFI of serving HIV-positive clients because the insurance reduces the economic burden on the household of medical/health costs and enables the household to maintain a better health status. Thus, loan funds are less likely to be diverted to pay for health expenses. However, the provision of health insurance is expensive, particularly in areas of high HIV-prevalence, and may be difficult to arrange.	Access to health insurance reduces the direct costs of HIV to the household and may mean the client has more time and energy to run his/her business and thus, maintain household income. However, not all clients will be able to afford health insurance premiums. The ability to achieve depth of outreach with this type of product is still not clear.
Life Insurance	**Life Insurance**
The provision of life insurance means that the family of the client will have access to financial resources that can potentially be used to repay the outstanding debt of the deceased client. This mitigates the impact of increased death rates characteristic of high prevalence areas.	Life insurance policies enable the client to engage in succession planning, and thus, direct financial resources to those he/she feels are most in need. In particular, it can empower women (who typically have little say over succession/inheritance planning) to help ease the impact of their untimely death on their children.

Microfinance Products and Services
Comparison of Mitigation Mechanisms from the MFI's Perspective and from the Client's Perspective
(continued)

MFI's Perspective	Client's Perspective
Compulsory Savings	**Compulsory Savings**
Conventional compulsory savings schemes are utilised to instil a repayment incentive among clients but are often too low to provide true financial protection to the MFI. To reduce the risk of operating in a high prevalence area, the MFI can mandate an amount of compulsory savings sufficient to cover the expected financial loss of default, given the probability of HIV induced illness/death in the operating area.	Compulsory savings obligates the client to have forced, illiquid savings. This money can be used to fall back on for loan repayment. While higher savings requirements mean the client does have a larger amount to "fall back on" for loan repayment, it also increases the cost of accessing loans and may price some clients out of the market. Further, the inability to access these funds during the course of the loan cycle reduces the client's ability to manage his/her flow of funds and may force the client to revert to coping strategies with longer-term negative implications (e.g. skipping meals, taking children out of school, selling income generating assets, etc)
Team Loans	**Team Loans**
This lending methodology structure requires that the loan is made to a team of clients rather than to an individual. Thus, the team is jointly responsible for a single loan. The team can be comprised of household members, neighbours, etc. This methodology provides default/arrears protection to the MFI because if one team member becomes ill or dies, than the other team members know how to run the business and can step in to complete loan repayments.	If the team is comprised of household members, this methodology can ensure that if one household member dies, the others are able to immediately resume the business and thus, preserve household income streams. At the same time, one loan invested in one business may not generate income streams sufficient to make the team loan worthwhile for all members. If clients view the team loan as a mechanism for succession planning, household income preservation and as a household survival plan, it may be more attractive.

BIBLIOGRAPHY

Asian and Pacific Development Centre. "Developing Strategic Linkages between Microenterprise/Small & Medium Enterprises and Providers of Strategic Resources". Best Policies and Practices in Poverty Alleviation and Enterprise Development.

Botswana Institute for Development Policy Analysis. Impacts of HIV/AIDS on Poverty and Income Inequality in Botswana. 31 August 2000.

Centre for Disease Control and Prevention. *Bright Ideas: Innovative or Promising Practices in HIV Prevention and HIV Prevention Community Planning.* March 2000

Centre for Disease Control and Prevention. *Compendium of HIV Prevention Interventions with Evidence of Effectiveness.* November 1999.

Connolly, M; Lorey, M; Mahalingam, M; Sussman, L; Williamson, J; *Principles of collaboration for Realising the Rights of Children and Adolescents Affected by AIDS* forthcoming.

Connolly, Mark. *Principles to Guide programming for Orphans and other Vulnerable Children"* Draft 2. November 2000.

Dunford, Christopher. *"The Case for Integrated Delivery of Group –Based Microfinance Services and Health/Nutrition Behavior Change Education for Cost-Effective Impact on Chronic Food Insecurity and Malnutrition, Draft"*. Davis, CA: Freedom From Hunger. 1999.

Family Health International. IMPACT on HIV *Building Community-Based Partnerships to Support Orphans and Vulnerable Children*. Volume 2, No. 1, June 2000a.

Family Health International. IMPACT on HIV *Kenyan Youth Take the Stage to Challenge HIV/AIDS Myths and Stigma* . Volume 2, No. 1, June 2000b.

Fisher, Andy. *Horizons Report: Operations Research and HIV/AIDS: Mitigating the Pandemic Through Applied Research.* Population Council. Spring 2000.

Freedom From Hunger. *Research Paper No. 4: Impact of Credit with Education on Mothers' and Their Young Children's Nutrition: Lower Pra Rural Bank Credit with Education Program in Ghana*. March 1998.

Gondwe, Kennedy. "Zambia's future lies in children" The Post 8 November 2000

Hope for African Children. "Hope for African children Developing Programs for Children Affected by HIV/AIDS". Press release, 19/10/00.

Hunter, Susan and Williamson, John. Children on the Brink: Updated Estimates & Recommendations for Intervention USAID, 2000.

ILO. *Jobs for Africa: A Policy Framework for An Employment-Intensive Growth Strategy.* August 1997.

Lewis, Jeffrey D; Arndt, C. The Macro Implications of HIV/AIDS in South Africa: A Preliminary Assessment. June 2000.

Lloyd, Cynthia; Kaufman, Carol; Hewett, Paul. The Spread of Primary Schooling in sub-Saharan Africa: Implications for Fertility Change. Population Council. 1999, no. 127.

Microenterprise Best Practices. The MBP Reader on Microfinance and HIV/AIDS: First Steps in Speaking Out. September 2000.

Montgomery, Mark; Casterline, John. Social Networks and the Diffusion of Fertility Control Population Council. 1998, no. 119.

Morris, Chester; Burdge, David; and Cheevers, Edward. Economic Impact of HIV Infection in a Cohort of Male Sugar Mill Workers in South Africa form the Perspective of Industry.

Mutangadura, Gladys. Household welfare impacts of mortality of adult females in Zimbabwe: Implications for policy and program development. International AIDS Economic Network Symposium. Durban, SA. July 2000.

Parker, Joan. "Discussion Paper: Microfinance and HIV/AIDS". USAID Microenterprise Best Practices Project. May 2000.

Parker, J.; Singh, I.; Hattel, K. *The Role of Microfinance in The Fight Against HIV/AIDS.* A report to The Joint United Nations Programme on HIV/AIDS (UNAIDS). Development Alternatives, Inc. 15 September 2000.

Population Council. *Horizons Report: Does Early Intervention Improve Orphan Support Programs?* Spring 2000a.

Population Council. *Horizons Report: Positive, Engaged, Involved: The Participation of People Living with HIV/AIDS (PLHA) in Community-based Organisations.* Spring 2000b.

Population Council. *Peer Education and HIV/AIDS: Past Experience, Future Directions.* 2000c.

Roth, Jimmy. Informal Micro-Finance Schemes: the case of funeral insurance in South Africa. Working Paper No. 22. International Labour Organisation. October 2000.

Schapink, D.; van Poelje, R; Reerink, I.H.; Delion, J.; Gurung, D. Strategy to Involve Rural Workers in the Fight Against HIV/AIDS Through Community Mobilisation Programmes". Royal Tropical Institute (KIT) Amsterdam, The Netherlands, Tanzania Netherlands Support Program to Control AIDS, World Bank Africa Region Rural Development and Environment. May 2000.

Steele, Fiona; Amin, Sajeda; Naved, Ruchira. The Impact of an Integrated Microcredit Program on Women's Empowerment and Fertility Behaviour in Rural Bangladesh Population Council, 1998 No. 115

Stoneburner, R. *Analysis of HIV trend and behavioral data in Uganda, Kenya and Zambia*. Paper presented in Durban, South Africa, July 2000.

UNAIDS *AIDS Epidemic Update: December 2000.* December 2000.

UNAIDS Best Practices Collection. Collaboration with Traditional Healers in HIV/AIDS Prevention and Care in Sub-Saharan Africa: A Literature Review. September 2000a.

UNAIDS Best Practices Collection. Costing Guidelines for HIV Prevention Strategies. October, 2000a.

UNAIDS Best Practices Collection. Guidelines fro Studies of the Social and Economic Impact of HIV/AIDS. September 2000b.

UNAIDS Best Practices Collection. Innovative Approaches to HIV Prevention. October 2000b.

UNAIDS *Report on the global HIV/AIDS epidemic.* June 2000

UNAIDS. "Civil Society Essential to Fighting AIDS, UNAIDS Says". Press release 2000. www.unaids.org/whatsnew/presseng/cotonou091000.html.

UNAIDS. Objectives and Ideas for Action. 2000 World AIDS Campaign. September 2000c.

UNAIDS. *Sexual Behaviour Change: Where Have the Theories Taken Us?* June 1999

UNAIDS. *International Conference on A Cultural Approach to HIV/AIDS Prevention and Care* Nairobi, Kenya, 2-4 October 2000c.

UNDP. Human Development Report 2000.

UNIFEM. *Press briefing: importance of microcredit for women's empowerment*. 24 June 1998.

USAID. "Making Progress in Africa: Challenges Old and New". 1999.

Varghese, Beena and Peterman, Thomas. Test and Protect: HIV testing and counseling for HIV prevention in Africa. International AIDS Economic Network Symposium. Durban, SA. July 2000.

Versluzsen, Eugene. East and Southern African Microfinance Institutions and The AIDS Epidemic Trip report submitted to USAID-funded Microenterprise Best Practices Project. May 2000.

Von Pischke, JD. *Structuring Credit to Manage Real Risks*. The Financial Landscapes Reconstructed: The Fine Art of Mapping Development. Edited by FJA Bouman and Otto Hospes. [dates??]

The World Bank. *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis.* September 1999.

World Bank. *Sub-Saharan Africa Regional Brief,* September 2000.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
FOCCAS	Foundation for Credit and Community Assistance
FINCA	Foundation for International Community Assistance
FFH	Freedom From Hunger
HIV	Human Immuno Deficiency Virus
IEC	Information, Education and Communication
ILO	International Labour Organisation
MFI	Microfinance Institution
OI	Opportunity International
SSA	Sub-Saharan Africa
STD	Sexually transmitted disease