**COVALENCE INTERN ANALYST PAPERS**

# Economic mitigation and prevention of HIV/AIDS through microfinance strategies

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## 1. Background

Microfinance provides Financial services (savings and credit) to the world's working poor, primarily in developing countries. Microcredit, currently the most well-known product within microfinance, is the extension of small loans (often less than $100) to people too poor to qualify for traditional bank loans or other forms of credit. In contrast to charities, these small loans enable the working poor to lift themselves out of poverty through their own hard work and entrepreneurial spirit. Started in 1974, microfinance is now a proven solution to global poverty worldwide with more than 100 million people from dozens of countries borrowing microfinance loans, who consistently repay at rates of more than 97 percent. The idea that the working poor can lift themselves out of poverty with dignity appeals to people of all political, social and economic backgrounds (*Calvert Foundation*).

Microfinance Institutions (thereinafter MFIs) only recently began to strategize how to face the challenges involved in providing financial services in high prevalence HIV/AIDS areas.

"HIV/AIDS is at present a universal pandemic that threatens all people, but it disproportionately impacts on economically and socially disadvantages and excluded"[1]

Not surprisingly, the first experiences were gained in countries that are most affected by HIV/AIDS - Sub-Saharan Africa. One of the hypothesis[2] on this subject suggests that access to income can play a vital role in tackling HIV/AIDS at both the community and household level.

This paper explores this hypothesis by trying to answer the following questions:

1. **Is microfinance an appropriate tool for prevention and mitigation of the effects of an HIV/AIDS-affected population?**
2. **How can the microfinance industry remain sustainable in high-prevalence HIV/AIDS areas?**

This paper also adds some valuable examples of MFIs which have tackled this huge threat to human beings, human rights and, last but not least a fundamental challenge development.

[1] International Labour Conference, 2000 88th session.

[2] Study of FINCA held by DR. Stuart. "The role of Microfinance in the fight against HIV/AIDS"- report to UNAIDS

## 2. Introduction to Microfinance

Those who benefit from Microfinance services are resource-limited individuals or groups of individuals who operate in the informal sector such as street vendors, artisans, small farmers and service providers. The most important products offered by MFIs are the following:

- **Small loans** (microcredit): the most common financial service, normally provided for working capital.
- **Compulsory savings:** cannot be withdrawn before the loan has been repaid and are often used as a guarantee against loans
- **Voluntary savings:** The banking legislation of many countries prohibit banks from mobilizing savings. In order to overcome this legal limit, many MFIs create ways to provide flexible savings products which are critical for the very poor, helping them to cope with livelihood shocks and using them for investment.
- **Micro insurance:** A relatively new product, this includes life, health, disability, loan property, and funeral insurance. These financial products can be provided by MFIs themselves or by specialised insurance companies in cooperation with MFIs. Through Micro insurance products, clients are expected to increase their ability to repay their loans and, consequently, protect the portfolio quality of the MFIs.

Micro financial services can be provided by many parties (with different roles and scopes) such as informal providers, non-governmental organisations (NGOs), credit unions, governmental and commercial banks, or non-banking financial institutions. Some NGOs offer microfinance products in combination with training, health education and business advisory.

The Microfinance industry's guiding principle is to increase the access to financial services in a sustainable and efficient way (unlike other development organisations). Inherent in this objective is a long-term view, economies of scale and a goal to successfully combine outreach with sustainability. Theory and evidence encourage the organisations to separate financial services from non-financial in order to increase the MFI's efficiency. It is of paramount importance to operate a MFI as a business and therefore cost recovery is obviously vital for its survival.

Another important difference between traditional banks and MFIs is that MFIs accept alternative collateral, including, for example, household equipment, jewellery, or peer pressure of solidarity groups, who cross-guarantee each other's loans.

## 3. Microfinance and HIV/AIDS

According to some empirical research[5], many clients see risk management as a major goal of participating in a Microfinance programme, referring to death or illness of a household member.

Savings and loans can play an important role in reinforcing the safety net of a household by diversifying income and enabling the building of assets. In response to a crisis situation, a household can sell its assets and keep children from attending school in order to contribute to the household. Participating in a microfinance program reduces the risk that a household will need to adopt these strategies.

HIV/AIDS has the capacity to not only slow down but also to reverse the nascent development of poor countries, notably sub-Saharan Africa. Many economists, in the medium term (over the next 3-5 years) foresee that the rate of growth to date will, at minimum, arrest, thus depicting a terrible economic scenario. Foremost among these effects are:

- Huge increase in the number of people living in poverty. This rise is mainly due to two primary effects:

  (1) household expenditures increasing due to medical and heath related expenses (including funerals which, due to its social importance, are particularly expensive in Africa);

  (2) simultaneously decreasing the total household income because of reduced productivity of earners (illness induced) and, at the same time, the deaths of household earners.

- Reduced labour force productivity (LFP) - increased illness and absenteeism of PLHIV will lower the LFP, significantly increase deaths among ill people and, last but not least, increase absenteeism of those caring for HIV positive individuals.
- Worsening of the Human Development Index (HDI). Many sub-Saharan countries have experienced reversals in human development and/or economic stagnation due to HIV/AIDS.
- Increase of income dependency ratio (IDR). As 9[6]% of the adult population currently become ill and die, the number of individuals in a household. Dependency on the surviving income earners will increase. It will reduce the income apportioned to any one household member and it will deepen the poverty of that household.

Regarding the long term (5+ years) the macroeconomic scenario for many sub-Saharan states is even worse than the one for the medium term. The development, due to HIV/AIDS effects, may well reverse with the following potential effects:

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[5]Institute for Financial Management and Research Exploratory Work in Orissa Who is the marginal client for Microfinance? Why do people repay so well?, 2005

Though, the aforementioned paper analyses the micro financial services in India, its conclusions about the main reasons of joining a micro financial program or who the marginal client is can be largely accepted for Sub-Saharan countries.

[6] All HIV/AIDS Statistics are from UNAIDS AIDS Epidemic Update

- Dramatic decrease of school enrolment rates. As the IDR increases, many students will not be able to afford anymore the school fees and may be obliged to forego their educational projects in order to contribute to the household.
- Contraction in LFP;
- Reduction of health status in general and, more specifically, children and infant survival rates (see Table 1 and 2 in the Appendix). According to many studies[7], the key determinant variable is the education of the mother.
- Worsening of the Human Development Index. UNDP projects that nine countries in Africa will experience a loss of 17 years of life expectancy by 2010, back to the African life expectancy rates of the 1960.[8]

## 4. MFIs and HIV/AIDS. Can they be utilised to define a prevention and mitigation strategy?

Given the strong relationship between household resources and HIV/AIDS, MFIs are uniquely positioned to help affected families cope with HIV/AIDS. The Microfinance industry is capable of engaging in HIV/AIDS mitigation efforts based on two fundamental characteristics of microfinance programs. First, because the Microfinance industry's client base is disproportionately vulnerable to HIV/AIDS, MFIs have access to the households most in need of assistance; this is something that other development sectors lack (Interagency Coalition on AIDS and Development, 2005). Second, MFIs are founded with the goal of sustainability in mind, and therefore are well suited to help in what is certain to be a very long fight against HIV/AIDS (Interagency Coalition on AIDS and Development, 2000).

According to UNAIDS data, due to HIV/AIDS effects, on average the household income in Africa, has fallen by 30-60% while the expenditure on health has quadrupled, the school fees have been reduced by half and the amount of money dedicated to food consumption has dropped by 41%. Access to microfinance financial services can help to protect the economic resources of households affected by the pandemic. The most relevant opportunity costs are the contraction of the income (for PLHIV) and the reduction of working hours (if not ceasing work altogether). It often happens an uninfected member (and bread earner) of the family is forced to reduce the number of working hours to take care of the sick member(s) of the household. In this common situation, MFIs can provide, to healthy members of the family, working capital for expansion thus making improvements for the business and, in the end, maximising the return. The final aim is to increase the possibilities to gain access to a diverse array of income and resource (loans, savings, insurance products) in order to better deal with the costs of HIV, by putting in place different strategies.

Indirect costs are present and numerous as well. They can increment not only the risk of deeper indigence among the current generation but among the next one as well. An example of this intergenerational deterioration is the response to cut household expenses by taking children out of school and putting them to

7 UNIFEM, Press Briefing: importance of microcredit for women's empowerment
Njoku, Harnessing women and youth's commitment for positive HIV/AIDS response and sustainability of financing in Northern Nigeria using the peer education training and microfinance approach, Anti HIV/AIDS Reproductive Health Community Development Service Group
8 UNDP:2000- extract from ILO, Working paper no. 25

work in order to increase the household income. Other examples are the negative effects on household food security, increased hunger and worsened health status. These expenses arise from common strategies put in place to cope with the reduced income: reducing quality and quantity of food. By acting so, and reducing the daily intake of calories, the health status can only decrease. At this point, the contribution of MFIs can be of paramount importance. Provided the household can fully and on time repay his loan and/or participate in other Microfinance products, MFIs can extend the total household income with microloans and savings thus enabling them to have a proper qualitative and quantitative food intake, pay school fees, etc. It can also help by modifying the mechanism of their products to better suit the MFI clients' needs. For example, it can offer loans with built-in flexible terms that allow clients to rest between loan cycles and do not demand that clients continuously graduate to larger loan sizes (McDonagh 2001). This role of MFIs presupposes the presence of, at least one, healthy and economically active household member who can be the final remittee of the financial service. If this condition can not be met (and in very high HIV/AIDS prevalence area, it may not be met) the role of MFIs should be limited to a defence line against HIV/AIDS and to act as a first alert. The only feasible strategy, in this situation, is the transfer of grants in conjunction with an appropriate mitigation mechanism. Close cooperation with specialised aid agencies or NGOs is necessary as MFIs personnel may lack the required skills for the appropriate response and assistance. According to experts forming a strategic partnership with an organisation that can provide health or health education delivery may be the most effective design for a MFI to implement (Parker 2000).

The following is an example of a successful strategic partnership with a health organisation which helps a MFI to meet its clients' needs but, at the same time, reduces its administrative cost and burden.

**A strategic partnership - ACOMB - Togo**

The Association for Community-Based Self Promotion (ACOMB) in Togo started its activities in 1995 mainly operating in two very low income area where the HIV/AIDS prevalence rate is particularly high. In those districts, loan officers remarked some changes in clients' behaviour, more specifically:

1) rising number of clients missing credit meetings;
2) increment of the number of widows and female-headed households among clients;
3) increase in the number of clients quitting the program.

In order to tackle this negative trend, ACOMB started a partnership with a local hospital. The main target was to provide health education, information and referrals to clients as an important complement to financial services. It is structured on two levels of conjoint action. First, loan officers are accompanied into the field by hospital staff who give information on HIV/AIDS as well as basic health care support. Moreover, hospital staff holds specific informative sessions about the care of sick relatives and can refer clients to the hospital or clinic nearby. In some cases, depending on the status of the health worker, they can also act as counsellor to sick clients and/or their family members.

So far the feedback from clients has been very positive and from MFIs' personnel as well. They all remarked how this partnership has evolved into a network of other related and non-related NGOs operating in this area (McDonagh, 2000).

Unlike ACOMB in some cases health and nutrition education (including HIV/AIDS education) can be provided by the MFI itself, by incorporating this complementary service into every meeting of its clients. FOCCAS (Foundation for Credit Community Assistance), described below, is a good example of how a MFI can affect behaviour change and through a combination of micro financial services and HIV/AIDS education.

**FOCCAS, Providing education and credit in Uganda**

The Foundation for Credit Community Assistance (FOCCAS) was founded as an international NGO in 1996 and then as a Company Limited by Guarantee in 1998. It serves economically active rural women through a village-banking product with education services (Credit with Education) in six districts of Eastern Uganda. Onsite technical assistance from the American-based NGO Freedom From Hunger (FFH) ended in 2001. As of March 2003, FOCCAS has a loan portfolio of approximately EUR 775,000 for 16,965 borrowers (Planet rating, 2005).

FOCCAS loan officers combine credit and health education topic in their weekly session with customers (30-45 minutes per session). According to FreedomfromHunger, (an international development organisation working in 17 countries across the globe, which provided FOCCAS with technical assistance until 2001) the model was particularly successful in impacting women's incomes, household food security and the nutritional status of women. FOCCAS would like to extend its services by providing referrals for HIV/AIDS testing and counselling by linkage with local NGOs. This partnership may prove to be difficult because FOCCAS operates in rural areas, making it difficult and too expensive for small NGOs to overlap their activity with FOCCAS's one. (FreedomFromHunger, 1999).[7]

7 FreedomFromHunger, Credit with Education, Status Report 2006 for a detailed report about a methodology set up by FreedomFromHunger and used by FOCCAS)

## 5. Setting up an effective response to the pandemic

To fully capture the importance of the current and future potential of the epidemic to affect the MFI, it is important that the MFI, before designing a strategy in mitigation or prevention, designs its financial landscape, a roadmap of the context where it is operating and of the inherent risks.

### 5.1 Mapping the financial landscape

The first stage consists of mapping the level, scope and gap between demand and supply, existence and depth of a market, presence of a formal and/or informal financial services, population density and, last but not least, information about competitors. In a context such as Sub-Saharan Africa, the map should take into consideration the following factors:

a) HIV prevalence rate;
b) Vulnerability and susceptibility of the population to HIV;
c) Presence of other NGOs, health services, HIV/AIDS organisation;
d) General prevalence of the extended family system;
e) Willingness of community leaders to be involved in addressing HIV/AIDS issues;
f) Cultural norms and traditions, especially relating to beliefs about the causes and treatments of HIV and the role of women;
g) Religious composition of population and associated views of HIV, sex, and the role of women;
h) 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 a 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:

a) Reduced loan portfolio growth as clients drop out or default due to illness;
b) High client turnover;
c) Slow loan growth, greater demand for smaller loans;
d) Difficulty meeting compulsory savings requirements;
e) Increased absenteeism;
f) Break-up of solidarity groups;
g) Increased portfolio at risk due to higher arrears and delinquencies;
h) Higher operational costs.[10]

Other factors to take into consideration to get a complete "financial viability" are the susceptibility and vulnerability of the local society. This refers to the strong or less strong predisposition of the single household or

[10] All points are an extract from: Amy Mcdonagh, Microfinance strategies for HIV/AIDS mitigation and prevention in Sub-Saharan Africa, ILO

the entire community to be particularly affected by the pandemic. Polygamy and/or a strong presence of migrant workers are common examples of those cultural factors which increase the risk of infection and, from the MFI point of view, the market risk attributable to HIV. High prevalence should not necessarily imply a strict "no-go" for the MFI but it simply indicates the presence of cultural obstacles acting as barriers, that require specific financial products (credit insurance, funeral insurance, etc) and the need of a linkage with other organisations strongly specialised in orphan and health care[11].

**The intervention with Microfinance for HIV & Gender (IMAGE) - Lessons from the IMAGE study**

IMAGE is a community-based structural intervention for HIV prevention that links gender and HIV/AIDS awareness to a microfinance programme. It attempts to engage poverty and gender inequality as key structural determinants of the HIV epidemic[3.] IMAGE has reached more than 4,000 people in six years. It incorporates health components (use of condom, sexual behaviour, HIV among youth households, etc) into its microfinance program and weekly meetings with clients.

*Assessment among IMAGE participants suggests changes in perceived social and economic well-being. Despite initial discomfort in discussing gender and sexuality, growing relevance of these issues is emerging, resulting in constructive engagement of men and youth. Community mobilization efforts have been initiated - engaging schools, the police, and health services.*

*In this rural African context where poverty and rigid gender norms fuel HIV, early evidence from the IMAGE intervention suggest shifting individual perceptions, communication and power dynamics - and the potential to influence community-level processes.*[12]

Other important factors to be included are the physical proximity of extended family members (as in many communities the members of the family who live in urban centres are far and isolated from the rest of the family settled down in villages) and the role of community/religious leaders which can play an important role in transforming a prevention message into a social accepted change.

### 5.2 Designing the strategy

Once the map is complete, the MFI can decide the most suitable products and services for its clients. The final choice will be different according to the health status of the clients: For those already infected, the MFI will provide with products and services which mitigate the impact of HIV on both itself and the client (including family members). For those not infected the role of the MFI will be different. It will promote prevention and

[11] Nassouri, Lievens, Van Renterghem, *Microfinance Scheme for individuals and household affected by HIV/AIDS in Burkina Faso,*
Pronyk PM, Phetla G, Hargreaves JR, Makhubela MB, Kim JC, Watts C, Morison L, Busza J, Porter JD; The Intervention with Microfinance for AIDS & Gender Equity (IMAGE) - *A structural intervention for HIV prevention in rural South Africa: early results from a community randomised trial*- International Conference on AIDS (15th : 2004 : Bangkok, Thailand)

[12] conclusion from Rural AIDS and Development Action Re*search Programme, School of Public Health, University of the Witwatersrand, Acornhoek, South Africa*

education but, above all, it will encourage an actual behaviour change which will protect the next generation from the pandemic.

From the MFI point of view, mitigation and prevention (co)work in two directions. One direction leads to prevent and mitigate the impact of HIV on programs, financial stability and sustainability of the MFI. The other one aims at mitigating the impact of the pandemic on its clients. If applied correctly these two strategies can lead to a healthy and sustainable MFI and to a "safer" client base, which is able to provide for its basic needs.

Assessing costs and risks of extending the product portfolio must be done in a very cautious way to avoid financial disequilibrium. To maximise the impact, the MFI should look for complementary linkages with other NGOs and service providers to enhance the effects of the strategies (mitigation and prevention) and easing the MFI's staff requirements. Besides that, a partnership with other NGOs would increase clients' empowerment in order to project and fund their own mitigation and prevention strategies. It is important to stress the fundamental role of those two strategies for the MFI. A winning mitigation and prevention strategy is an investment for the MFI as it protects the quality and size of the current portfolio as well as ensuring the continuation of operation in the future.

# 6. Mitigation strategies and mechanisms

HIV/AIDS mitigation activities include the innovation of financial products and delivery methodology, the review of operational procedures and linking with other services. MFIs need not develop new products but can change their existing products, to better meet the needs of HIV/AIDS affected households[11].

Clients require more flexibility with the terms of the loan and/or the developments of new products (in those underdeveloped markets) such as micro insurance, trust funds and brokering services with burial societies (see point IV, page 11 for further explanation about the role and subsequent cost of funerals in Sub Saharan Africa),.

Effective strategies to reduce the impact of HIV on the institution itself can be implemented with regards to products (loans with extended flexibility clause, insurance products, savings products) delivery mechanisms, operations. The next chapters will go through the aforementioned three points, highlighting the necessary modifications for the MFI to meet clients' demand.

## 6.1 Products

### 6.1.1 Loans with embedded flexible terms

**I.MFIs can let clients take a "rest" between two loans cycles while still being in the program**.

The majority of microcredit programs oblige clients to start a new loan after finishing the old one if they want to remain in the program (the so called loan disbursement and reimbursement). By giving HIV clients the

[11] Interagency Coalition on AIDS and Development, *HIV/AIDS and Microfinance*

opportunity of a "credit break", MFIs will help clients to stay in the program without exposing them to an excessive and increasing debt.

**II. Embedding in the credit structure a "smaller loan" option.**

Many MFIs initially provide their clients with small loans with the opportunity to move on to subsequently larger loans. Because of illness, many clients can not afford this rising amount of credit; therefore MFIs should respond to the needs of clients by allowing them take out smaller loans.

**III. In case of emergency, MFIs can provide smaller, shorter term loans and/or lending out to solidarity groups.**

It is important to note that granting new loans before the previous one has been extinguished can dramatically increase the repayment risk and should be carefully assessed by MFIs managers. Providing loans to a group of people, instead, can reduce this risk and has the advantage of decreasing the information asymmetries to the MFI as the group members are in a better position to judge the merits of the emergency loans[12]. Solidarity groups are responsible *in toto* for the repayments of the debt. This strategy can be particularly successful within village banking and offers some advantages for the community itself as it will be able to continue to run the business of the affected member and to raise funds to repay the loan.

**I. Credit to younger clients**

Because of the HIV/AIDS epidemic, many households are headed by children or teenagers who may be the only survivors or healthy members. This demographic shift has led many MFIs to lend money to people who are already involved in business and are under 30 years of age. In order to empower healthy people, MFIs should allow even younger people, often the ones with the highest chances to not get infected and therefore capable of working, to gain access to microcredit and link their loans to training and basic skills reinforcement.

[12] UNAIDS Background Paper, *The role of Microfinance in the fight against HIV/AIDS, Maryland USA 15/09/2005*

### 6.1.2 Insurance Products

Generally speaking, insurance products in a high HIV prevalence area are too costly for MFI clients because HIV is not a random event and the actuarial risks to the insurer may well result in premiums too high to be afforded by a typical microfinance client. Thus, the MFI must carefully weigh depth of outreach against the mitigation afforded by insurance products[13].

#### I. Health Insurance

Having a health insurance enables the MFI client to maintain a good health status and to reduce the impact of the epidemic on the household. MFIs can decide whether to make the purchase of a health, life and credit insurance mandatory or voluntary. This choice must be carefully assessed and, in case affirmative, a detailed analysis and control of premiums, co-payments and limits of coverage must be performed.

**FINCA UGANDA - Health Micro insurance in Uganda**

FINCA (a leading Microfinance institution, a truly global organisation with wholly-owned subsidiaries on four continents) in Uganda introduced a pilot health insurance which provides health care to clients, their spouses and dependents through a partnership with a hospital in Kampala. Demand for this product is high. FINCA counts on attaining sustainability by reaching a high number of participants and keeping the up-front premium relatively low, coupled with a co-payment of out-patients. The burden of cost is therefore placed on those who use the product most. The insurance does not cover, among other things, HIV/AIDS medication[14].

*For more technical details about the health insurance instrument see Appendix n ° II, § 1.*

#### II. Life Insurance

Life insurance products aim to help the surviving family members of the dead client who, due to the insurance, will be in a better position to repay the debt and, possibly, to continue to run the business.

An excellent example of a successful life micro insurance is the one held by TSKI in Philippines. (See *Appendix n ° II, § 2 for more details about the insurance scheme- source: TSKI website)*

#### III. Credit Insurance

[13] UNAIDS Background Paper, *The role of Microfinance in the fight against HIV/AIDS, Maryland USA 15/09/2005*

[14] Coalition on AIDS and Development,, *HIV/AIDS and Microfinance*.

The main goal of credit insurance products is to protect the MFI portfolio from defaults. These products can be either mandatory (Opportunity International) or voluntary (FINCA/Uganda)[15]. In communities with higher HIV prevalence rates, mandatory insurance will provide greater protection to the MFI and will help alleviate the potential adverse selection effects.

In its simplest structure, this insurance covers the outstanding part of the loan(s) at the time of death and, therefore, it protects the MFI's portfolio against insolvency. It also protects the solidarity and village bank from an unexpected or excessive debt burden.

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 alii). It requires that all borrowers allot 2% of their debt to a special fund called the Borrowers' Protection Fund. Instead, Opportunity International, demands an upfront (one time) fee. A unique (and so far successful) approach to credit insurance has been put in place by FINCA. In addition to the credit insurance, it has developed an accidental death insurance which covers the client and the family. In case of death, the sum will be paid to the pre designated member of the family.

(REFERENCE)

Whilst credit insurance is perhaps the simplest and most common product offered by MFIs there is a surprising amount of variation that can be achieved. It is beyond the scope of this paper to illustrate all the different typologies of credit insurance schemes and all the subsequent problems arising from practical application. However, some of the issues include the following: What to cover under credit life? How to collect premiums? Medical questionnaires? How to make premiums affordable? To have an idea of the different solutions see Richard Leftley and Shadreck Mapfumo, Opportunity International Network Effective Micro-Insurance Programs to Reduce Vulnerability,2002.

**IV. Funeral insurance**

Informal funeral or death benefits are relatively common in Africa as the average funeral can cost up to 15 times a monthly salary. Given such high costs, people often sell their main assets or divert business funds to cover them. By preserving their clients' assets, MFIs are reducing the risk to serve poorer clients impacted by HIV. For example, Opportunity International offers its clients an insurance product which covers burial and related costs for the deceased client and up to five related members through a local insurance company. In return the MFI will receive a fee for each new policy.

[15] The debate on Compulsory vs. Mandatory scheme is still on among academics and practitioners. For more information, (though the author is clearly for a compulsory scheme to all people joining the loan program) see Richard Leftley and Shadreck Mapfumo, Opportunity International Network Effective Micro-Insurance Programs to Reduce Vulnerability (page 12-12)

### IV. Insurance Policies as Emergency Loan Collateral

An increasing number of MFIs accept voluntary or mandatory insurance as collateral against an emergency loan. As a rule of thumb, MFIs limit the size of the emergency loan to the sum of insurance collateral plus the standard loan required allotted to the client. This policy aims at minimising the marginal risk represented by the emergency loan products.

## 6.1.3 Saving Products

### I. Compulsory savings

Clients may need to withdraw cash from their saving accounts once they became affected by HIV/AIDS as health costs rise and the income stream may fall. Compulsory savings can act as a cushion in case of default/arrears which may be brought by such an illness.

In practice, the amount of compulsory savings is very small and can not act as protection in case of default. MFIs have normally two options to choose. The first consists of raising the amount of compulsory savings in high prevalence areas. By acting so, they increase the protection against default but, at the same time, they reduce the "*depth of outreach*" as the client has to pay more to gain access to it. The second option, would totally eliminate this requirement. The consequences are diametrically opposite to the previous scenario, with MFIs losing the mitigation effect on the credit but it increasing the "*depth of outreach*" because clients are not charged extra to take out a loan. To avoid that too many clients quitting the program just to withdraw the savings, some MFI, though keeping the compulsory savings requirements, let their clients withdraw money in case of emergency. If the emergency is temporary, the effect of this clause is positive even for the MFIs. In fact it refrains clients from liquidating their productive assets to cover the emergency thus preserving the client's income generation (and thus repayment capacity). If the emergency is not temporary or, even worse, the amount of money is not enough to cover the emergency, then the MFI stands the risk of losing this protection and eroding the discipline and repayment incentive. Assessing the clients' demands to discriminate for the liquidation of these savings is not an easy task and it can only be made by credit officers on the ground.

### I. Voluntary savings

Voluntary savings schemes are particularly useful as a means to store value which can be used to mitigate the financial burden of the direct costs of HIV/AIDS. If these can be freely and easily accessed (and it is often the case), clients may not feel the pressure of diverting loan funds to pay medical costs or, even worse, diverting a repayable portion of loan funds to meet these expenses. Of course, they can also act as a source for loan repayment.

### II. Fixed term deposit

Dedicated savings account can be set up in order to meet (under certain conditions) large and infrequent expenses (such as wedding, asset purchase, school fees). In many cases, clients can weekly contribute to their saving funds with restricted access to accumulate more. The fixed term deposits help can be key not only for clients but for the MFI as well. They protect MFIs from defaults and arrears stemming from large debt positions that are diverted to non-income generating activities.

### 6.2. Delivery Mechanisms

#### I. Lending Methodologies: Group vs. Individual

All the products above can be offered to a single person or to a group (i.e. village, banking, solidarity group lending, etc). According to many academic and MFI managers, lending to a group is to be preferred to lending to an individual client. It has a beneficial impact as it eases the creation of partnership/linkages between MFI clients and other service/product providers. Besides that, it encourages the entire community to opt for a behavioural change.

#### II. Limiting the liability (for solidarity group)

In high prevalence areas, solidarity groups are likely to break up under the burden of numerous defaults. To limit the extent of the crisis, many MFIs design methodologies that limit the liability of any one solidarity group member when another member defaults (Versluzsen, 2000).The probability of facing high and uncapped debt because of group members' illness may lead other members of the group to defect, thus increasing the overall risk of the MFI. A common solution, mainly in a high prevalence environment, is limiting the individual liability (a pre-determined amount) of each member thus encouraging healthy members to remain in the loan scheme. This help has proved to preserve both the solidarity groups and the collateral substitutes on which group-lending MFI are based, as increased defaults due to HIV/AIDS would not act as an incentive clients to quit the programme. Unfortunately this option reduces the financial protection against default for the MFIs and, practically, it is only worthwhile in very high prevalence areas.

#### III. Team loans

The risk of defaults or arrears can be reduced by giving the loan to a team of people rather than to an individual. This simple strategy has proven efficacious in limiting the effects of HIV/AIDS and related illness on the MFI and its clients. In fact, if a member becomes ill or dies, the other members know how to run the business and can work to repay the loan. The MFI may chose to target only women (team members are all women), only members of the same family or people involved in the same kind of business. By acting so, the MFI is both mitigating the risk (as people outside the 15-49 year old age are less likely to contract HIV and they, who will most likely survive, can run the family business) and building a sort of inter-generational succession by incorporating and empowering both young and aged household/family members. The standard structure of the loan states the minimum number of hours per month each member should allow to the family business and the obligation, for each active member, to assume the duties of a team member who becomes ill or dies. Specific

clauses are set up for school age members who can dedicate less hours to the business and must prove it does not conflict with school hours.

### 6.3. Operations

The review of its operational procedures, such as monitoring and reporting system, staffing and portfolio tracking, is very important for all MFIs running their businesses in high prevalence areas. Innovations and changes should be implemented to these operational factors which help to realise the growing prevalence among the client base and/or prepare the MFI to absorb HIV-related impact.

#### 6.3.1. Monitoring and Reporting Mechanisms

##### 6.3.1.1. Proxy indicators of prevalence

The MFI should adopt some mechanisms to better estimate the current and future prevalence rate, thus gauging its risk and designing appropriate strategies and mix of services. These mechanisms should be adopted in conjunction with UNAIDS or governmental monitoring programmes. Only by combining them is it possible to have a workable proxy. It must be clear that these devices are imprecise and can only give an idea of the direction and speed of prevalence increases.

**I. Client drop-out**

The reporting system should monitor the number of people and the reason for leaving the loan program. When a client informs the credit officer of his intention to drop out, the MFI officer should carefully note the reasons and enter the information into a database. Credit Officers should accept answers as a proxy as the client may misstate the real reason due to stigma, fear of social exclusion, etc.

**II. Monitoring absences and reasons, regular attendance**

An abnormal and sudden rate of absenteeism should act as a early warning for the MFI managers who should get ready for the worse.

**III. Exit interviews**

Accurate exit interviews should be conducted about the reasons for leaving the program. It should then be used to improve the mix of products and services and to get a proxy of the prevalence rate.

**IV. Track arrears and defaults**

Tracking arrears and defaults can help by acting as indicators as a “saturation point” for loan sizes, which may soon become smaller as the impact of the disease grows.

### 2. **Portfolio**

Protecting the portfolio loan in terms of quality and volume is of paramount importance for each and every MIF. Therefore conducting some financial analysis to detect some signal of insolvency or credit deterioration should be done on a regular basis. For example, an expansion of provision for bad debt is an early warning indicator showing signs of likely increasing defaults. Besides that, Sales manager should always look for uncovering new opportunities for portfolio insurance

### 3. Staffing

**I. MFI employees**

Offering MFI employees a sound education in HIV/AIDS, health insurance, funeral insurance could be a well appreciated benefit.

**II. Training**

Staff on the ground should be trained to conduct educational sessions about HIV/AIDS.

**III. Hiring practices**

Whenever possible, MFIs should hire credit officers with backgrounds in health education, nursing and other skills which can be relevant to enhance the strategy of mitigating or assisting in the prevention of HIV/AIDS.

## 7. Prevention Strategies

Actively promoting HIV/AIDS education during the regular loan meeting is the most common MFI strategy to assist in preventing the spread of the epidemic. These sessions can be delivered to clients through MFI employees or via a partnership with other HIV/AIDS service organisations. Therefore, the MFI has strong incentive to create a "prevention culture" as, indirectly, it also promotes its long term financial stability. Unfortunately so far these types of efforts have not been successful in abating prevalence rates. On the contrary, in many sub-Saharan countries the prevalence rate dramatically increased. Prevention efforts must, then go to the next step which is, actively promoting a behavioural change, if the epidemic and its consequences are to be halted.

Behavioural change is a long and complex process and, according to literature on the subject, it is beyond the scope of a MFI. However, MFI has some built-in interests in acting as a key component in the effort to save lives by promoting such change. The first such interest is that a regular loan repayment can be used to reinforce the empowering of the community and promoting a better interaction among members (two key elements to push towards a behavioural change). The second is that MFIs, unlike other governmental and NGOs, must meet some criteria of financial stability and sustainability. This means that the "life span" of a MFI can well match the long process of behavioural change. In addition being a profit organisation, an MFI is not subject to donor fatigue and/or changing proprieties of donors over time. Against the clear benefits to the MFI of being actively involved in education training and behavioural change, there are the costs of offering those services. The first expense item is staff training in HIV/AIDS which can be quite a relevant burden for an institution aiming to be financially sustainable. The burden can be overcome by outsourcing it to external HIV/AIDS organisations. The second cost is the potential impact to the MFI's client base as some potential client may prefer to invest in another MFI less (or not at all) involved in HIV/AIDS lectures.
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 this region 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[16].

Campaigns have done an excellent job of raising awareness of HIV/AIDS. The UNAIDS highlighted the importance of HIV prevention which 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).

The six pillars of this new prevention strategy are the following ones and, according to some MFI's experience are well suited to combine support and care with socioeconomic insertion:

1) economic empowerment through, mainly, a better access to financial services;

[16] *IEC Information, Education and Communication-WHO Programmes 119- http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/a1.pdf*

2) embedding basic HIV education into the group structure;
3) linkage of groups of clients to other external resources;
4) easing group discussion, identifications of issues and finding of solutions;
5) facilitating the involvement of local officials. Involving local officials and/or healers[17] can be determinant in reducing HIV/AIDS stigma, in encouraging open discussions and in giving credibility to new social values and behaviours;
6) gender targeting. Many MFIs in Sub-Saharan lend only to women as they are the majority of poor and, at the same time, they have little credit risk embedded. Last but not least, women invest their income keeping in mind the well-being of their families. Unfortunately, given the cultural contest in many Sub-Saharan countries, it is not possible to exclude men, without compromising the effectiveness of prevention and mitigation strategies. Men often have the last word about condom use and business decisions. In many cultures polygamy is also expected from men and women have no power to enforce monogamy. Thus men must be incorporated in the program and in the prevention strategy to get a good balance between women's empowerment and the need to design a gender (meaningful) balanced prevention strategy.

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

# 8. Conclusions

Microfinance clearly has a role in fighting HIV/AIDS as it contributes to building a safety net for many households. It is still much debated as to what extent microfinance can be an effective tool for prevention and mitigation of HIV/AIDS in high prevalence areas while being financially sustainable in the long term.

The decision process is, thus, not easy, taking also into consideration the huge loan demand and the constrained resources (financial and non). According to many program managers and practitioners, the first important point for an MFI is not to enter into many different programs and to be able to prioritise products and services by undertaking a detailed analysis of clients' needs and demands.

The most important decisions concern the mix of products and services (to develop or not new products to meet clients' needs), the optimal delivery methodology and, last but not least, the most important links to establish with other organisations (i.e. incorporating or not a prevention and mitigation strategy into a microfinance format).

Finally it must be clear that Microfinance is not a panacea against poverty and HIV/AIDS in the world and the solution can only come from a joint effort of development programs, governments and MFIs.

Some caveats:

1) MFIs should neither target only HIV/AIDS affected clients nor exclude them for different reasons. First of all, targeting HIV/AIDS is not compatible with the MFI goal of sustainability. Moreover, in the majority of cases, it is impossible (unless the MFI opts for excluding, based on testing, those who are HIV+ or infected but in this case many ethical issues arise) to know how many or who is infected. In many cases, clients themselves may ignore it and because of cultural taboos they may be reluctant to openly discuss it.
2) MFIs can target high prevalence HIV/AIDS areas though ones with inadequate markets or economic, political conditions must be avoided.
3) Microfinance initiatives should not be launched within HIV/AIDS focused programs.
4) In the long term, the financial stability is of paramount importance for the MFI. Non-financial services directed at the HIV/AIDS issue can undermine the financial stability and represent a burden.
5) Provision of grants or free goods should not be offered in combination with loans as they underpin the loan repayment.

Appendix I

Table 1

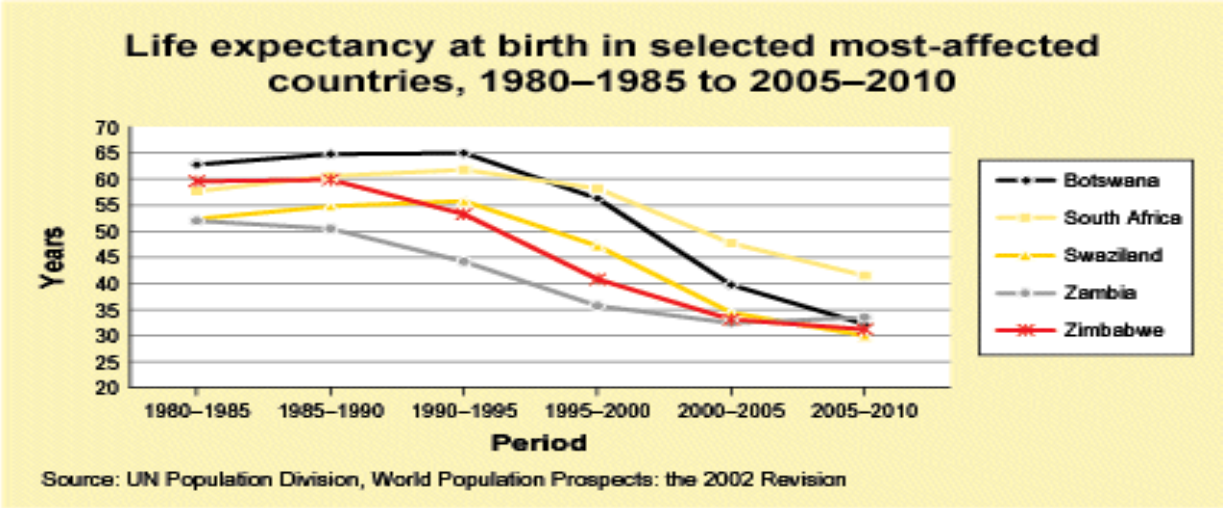
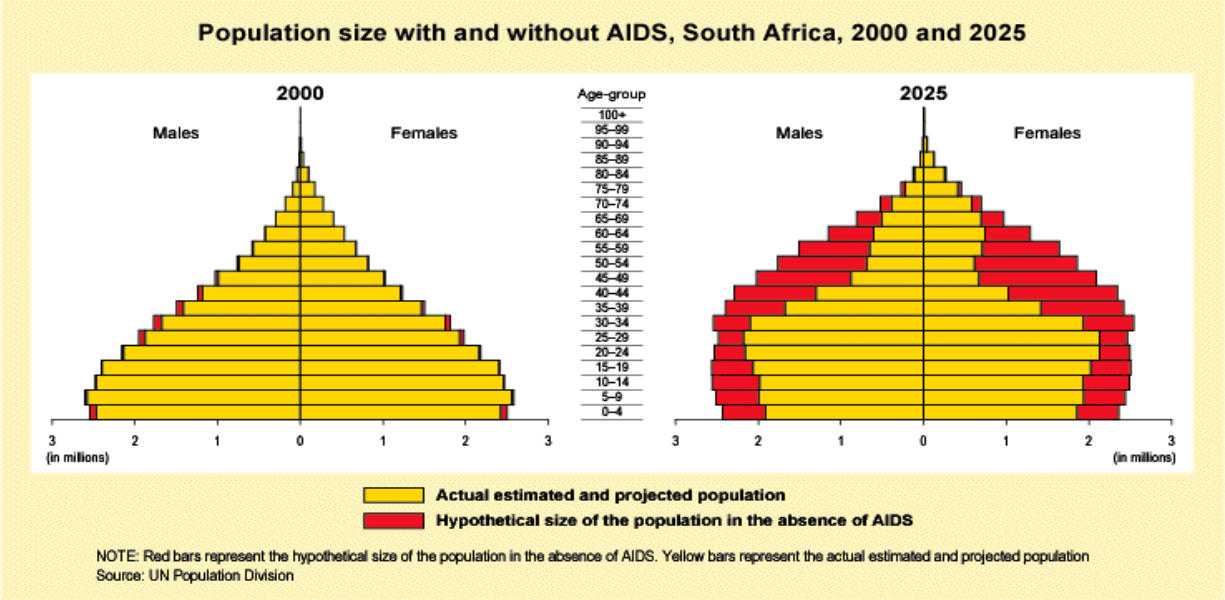



Table 2



Appendix II- Microfinance Product and insurance

§ 1-FINCA – Current Micro insurance activities

| **Amount of Coverage (in US$)** | |
|---|---|
| **Life** | |
| **Health (started in 2000)** | 180,000 |
| **Disability (started in 1999)** | 1,768,000 |
| **Property** | |
| **Other** | 43691886 |

| **Key Exclusions** | |
|---|---|
| **Life** | None |
| **Health** | AIDS drugs, most optical & dental treatment, any existing ailments, fertility, self-inflicted injuries, addictions, medication for chronic illnesses, plastic/cosmetic surgery, hearing equipment, or injuries from acts of war, riot or terrorism |
| **Disability** | Disability must be total and permanent |
| **Property** | |
| **Other** | There are some policy small print issues that are not relevant |

| **Key Limitations** | |
|---|---|
| **Life** | For credit insurance, limit is outstanding loan (principal and interest) at time of death - note no interest accrues thereafter; for accidental life, set amounts equivalent in local currency of $685 for client, $342 for spouse, and $171 for up to three dependants. |
| **Health** | Various; average of around $1,371 per family |
| **Disability** | Amount same as for life insurance (loan balances) |
| **Property** | |
| **Other** | |

| Premiums | |
|---|---|
| **Premium Amount Per Year of Coverage: (in US$)** | |
| **Life** | 0.0285 |
| **Health** | 0.0286 |
| **Disability** | |
| **Property** | 0.029 |
| **Other** | |
| **Additional fees/charges (in US$)** | |
| **Life** | |
| **Health** | $3 for membership card |
| **Disability** | |
| **Property** | |

§ 2 Effective term life insurance: TSKI, Philippines

Taytay Sa Kauswagan Inc (TSKI) or "bridge to progress" was established on 1st September 1986 and is registered in the Philippines as a non-stock, non–profit Christian development organisation based in Iloilo City. In 2004 TSKI along with other members of the APPEND network (Alliance of Philippine Partners in Enterprise Development) approached Opportunity (a UK MFI) to develop a new life insurance product to replace the in-house "Mutual Aid Fund".

In order to design the new product, quantitative and qualitative market research with clients from APPEND partners was conducted during June with 782 clients from OMB (Opportunity Microfinance bank), TSKI, ASKI (Alalay Sa Kaunlaran, a MFI from Philippines), RSPI (Rangtay sa Pagrang-ay, Inc, a MFI from Philippines) and DSPI (Daan Sa Pag-unlad, a MFI from Philippines). The main findings of this research were as follows;

1. The average family size was five; being two parents and three children;
2. Almost all respondents wanted life insurance for the whole family;
3. Analysis of incomes demonstrated that respondents were living on or below the "poverty line" defined as $1 (PHP55) per day per person;
4. Half of the respondents estimated that the cost of a funeral was less than PHP35,000 ($636);
6. 15% of respondents indicated that they had experienced a death in the family in the past year;
7. Respondents wanted to receive a benefit upon death of PHP100,000 ($1,818) for themselves; PHP60,000 ($1,090) upon death of their spouse and PHP50,000 ($909) upon death of a child;

8. 41% of respondents were willing to pay between PHP50-P75 per month for funeral insurance while the remaining 59% were willing to pay more.

These market research findings were used to design a product which was tendered to a range of local insurance companies. The final product was launched with the following features:

9.**Coverage**: Losses arising from death only. Covers client, spouse and maximum of three children or parents if client is single. Compulsory for all borrowers.

**Term**: Insurance term linked to the loan term, being six months.

**Benefit**: PHP 100,000 paid upon death of client, minus any outstanding loan; PHP 50,000 upon death of spouse and PHP 25,000 for death of child or parent.

**Age / health limitations**: Client 18-65; Parents less than 65; child 6 months to 21 years but must be living at home. All must be "in good health and performing normal duties", but no medical check or questionnaires are used.

**Premiums**: Calculated as PHP 1.06 of the sum insured for six months paid to the Insurance Company and PHP 90 administration fee paid to the MFI per loan cycle regardless of the number of people covered.

**Contestability**: No claim contestability for existing illnesses, but one year contestability for suicide.

**Documents required to claim**: Death certificate, birth or baptismal certificate and claim form.

To date the product has also been implemented at Opportunity Microfinance Bank (OMB) and KMBI (Kabalikat para sa Maunlad na Buhay, a MFI from Philippines) as well as TSKI in the Philippines. At the end of 2005 there were in excess of 260,000 active policies with 1,349,000 lives insured.

BIBLIOGRAPHY

***AA.VV*** *Planet rating*, Transparency for Microfinance development,

**Amy Mcdonagh**, *Microfinance strategies for HIV/AIDS mitigation and prevention in Sub-Saharan Africa, ILO 2001*

**Calvert Foundation**, *Annual Report 2006*

**Freedom From Hunger**, Dunfor, 1999

**Freedom From Hunger**, Dunfor, 2000

**FreedomFromHUnger**, *Credit with Education,* Status Report 2006

**Institute for Financial Management and Research** *Exploratory Work in Orissa Who is the marginal client for Microfinance? Why do people repay so well?*,2005

**Interagency Coalition on AIDS and Development**, *HIV/AIDS and Microfinance 2000*

**Interagency Coalition on AIDS and Development**, *HIV/AIDS and Microfinance 2005*

**KATHOLIEKE UNIVERSITEIT LEUVEN,** Microfinance institutions & HIV/AIDS - Flemish Interuniversity Council (VLIR) & Belgian Development Cooperation , October 2005

**KATHOLIEKE UNIVERSITEIT LEUVEN,** Microfinance institutions & HIV/AIDS - Flemish Interuniversity Council (VLIR) & Belgian Development Cooperation , October 2005

**Microenterprises best practices (2000),** *The MBP Reader on Microfinance and HIV/AIDS: First Steps in Speaking out*, Harare, Zimbabwe

**Nassouri, Lievens, Van Renterghem**, *Microfinance Scheme for individuals and household affected by HIV/AIDS in Burkina Faso*

**Njoku,** Harnessing *women and youth's commitment for positive HIV/AIDS response and sustainability of financing in Northern Nigeria using the peer education training and microfinance approac*h, Anti HIV/AIDS Reproductive Health Community Development Service Group

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

**Planet Rating**, *Transparency for Microfinance Development, April 2003*

**Pronyk PM, Phetla G, Hargreaves JR, Makhubela MB, Kim JC, Watts C, Morison L, Busza J, Porter JD**; The Intervention with Microfinance for AIDS & Gender Equity (IMAGE) - *A structural intervention for HIV prevention in rural South Africa: early results from a community randomised trial*- International Conference on AIDS (15th : 2004 : Bangkok, Thailand

**Richard Leftley and Shadreck Mapfumo, Opportunity International Network** Effective Micro-Rural AIDS and Development Action Research Programme, School of Public Health, Univeristy of the Witwatersrand, Acornhoek, South Africa 2002

Rural AIDS and Development Action Research Programme, School of Public Health, University of the Witwatersrand, Acornhoek, South Africa

**UNAIDS Background Paper**, *The role of Microfinance in the fight against HIV/AIDS, Maryland USA 15/09/2005*

**UNAIDS**. *"Civil Society Essential to Fighting AIDS, UNAIDS Says".* Press release 2000.

**UNAIDS**. *"Civil Society Essential to Fighting AIDS, UNAIDS Says".* Press release 2005.

**UNIFEM**, *Press Briefing: importance of microcredit for women's empowerment*

***Versluzsen**, Eugene East and Southern African Microfinance Institutions and the AIDS Epidemic USAID Microfinance Best Practices project, 2000*

## ACRONYMS

| | |
|---|---|
| MFI | Microfinance institutions |
| PLHIV | People living with HIV |
| LFD | Labour force productivity |
| IDR | Income dependency ratio |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |