

What will HIV/AIDS do to microfinance in Africa? It will demand our best

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Publication Date: 2003

Over the last decade, the reality of HIV/AIDS has cast a shadow over nearly all development efforts in Africa, including microfinance. Over 22 million Africans are now infected with HIV, most of whom fit the microfinance client profile to a frightening degree: individuals of productive age, most of whom are poor, predominantly in urban areas, and increasingly, women. In many countries of Southern Africa, between 25 and 40 percent of women entering anti-natal clinics are now HIV-positive; in Eastern Africa countries infection rates are lower, but (except in Uganda), still appear to be rising. Most of these individuals do not know they are infected with HIV.

Because of poverty, poor infrastructure, and lack of information, most people living with HIV or AIDS (PLWHA) are unable to access services to slow the progression of HIV and AIDS and to maintain their productivity. These basic needs include good nutrition and medicines to fight opportunistic illnesses. Unfortunately, the overwhelming stigma attached to HIV/AIDS results in denial, discrimination against PLWHA, and difficulties in communicating key messages about HIV prevention and care and support for PLWHA.

The economic picture is bleak as well. In HIV/AIDS affected households, which are already struggling with significant increases in medical expenditures, incomes plummet as more time is spent sick or caring for the sick rather than in productive labor. UNAIDS data for Ivory Coast show an average household income drop of 40% due to HIV/AIDS. On the aggregate level, falling incomes create a decline in demand for local goods and services, which affects informal sector enterprises and hence microfinance clients.

And though the story can hardly get worse, it does: estimates show that as many as 30% of African children will be orphaned by AIDS by 2010, many of whom are now withdrawing from school to care for sick parents or siblings, or to become primary income-earners. Stories abound of grandmothers raising as many as 12 grandchildren. Some churches and NGOs have mobilized foster care programs to match orphans with adults outside their families.

Microfinance institutions (MFIs) are affected directly by HIV/AIDS in multiple ways. First, clients caring for the sick or orphaned, or sick themselves, are unable to attend required meetings and more frequently miss payments. Increased client illness translates into higher MFI exit rates and rising operational costs including greater loan loss provisioning, a higher percentage of costlier new clients. This is hardly a new subject for MFI staff: in a recent USAID survey, many MFIs reported that their staff are dealing with HIV/AIDS in their home, and MFI staff themselves are vulnerable to infection. The same MFIs report falling staff productivity and higher staffing and benefit costs due to HIV/AIDS.

What does this mean for microfinance? Overall, these realities mean that many of the core expectations underpinning microfinance are disappearing. In the broadest picture, microfinance institutions expected that the vast majority of now-productive adults in a community would still be alive in the medium term and could plan realistically for the future. They also expected that the informal economy as a whole ? while vulnerable to setbacks ? would retain its potential for growth. Step-wise loan programs have expected that individual clients would be able to accumulate assets and gain economic strength over time to progress through project cycles. Group-based programs assumed that clients could assess their own risk as well as others? risks by looking at their current and historical economic

status. MFIs requiring compulsory savings expected that few of their clients would simultaneously be in periods of significant household dissavings. HIV/AIDS changes all of these expectations and more.

Microfinance can respond. For anyone living in or working in an HIV/AIDS-affected country, the option of "giving up" or "doing nothing" is simply not acceptable. Once that option is set aside, innovative ideas begin to emerge. Most of these are now in the discussion or pilot stages in isolated MFIs, with little monitoring of impact or costs. This is an essential moment for donor leadership: to coordinate dialogue and to fund the necessary innovation and evaluation.

To date, innovation have focused on the following areas:

Innovation around financial products: What financial products can smooth the spikes in medical costs in HIV/AIDS-affected households? How is this best structured (insurance products and pre-paid medical services plans are currently in pilot stage). Can this product ensure coverage to basic health care to fight opportunistic illnesses and keep PLWHA productive? Can a microfinance product be finance anti-retrovirals if they are available in the local market?

Innovation around groups: What mechanisms ? such as loan insurance ? can protect borrower groups from unseen risks due to HIV/AIDS, and reduce their incentive to exclude households dealing with HIV/AIDS? What would such mechanisms cost, and who should pay? Can group members play other support functions for each other, such as cooking more nutritional food for sick members or sharing child care duties?

Innovation around service delivery: Can more services be delivered directly to clients, reducing their need for time and travel to participate in microfinance? If group meetings are required, can other family or community members temporarily represent those clients who are busy caring for the sick?

Innovations around payment schedules: If HIV/AIDS-affected households face increasing numbers of HIV/AIDS-related medical emergencies, how can payment schedules become more flexible to account for sudden financial short-falls?

Innovations around membership: If clients fall ill, can MFIs or borrower groups mentor younger family members to take over businesses and replace sick adult as MFI clients? How can inter-generational business mentoring become a more broad-based effort to build youth entrepreneurship skills and to link youth to microfinance services?

Innovations around HIV/AIDS-related information: How can MFIs serve as a conduit for health information or services to clients in a way that is both effective and efficient? How can MFIs identify which HIV/AIDS-related information or services their clients most need? What are the cost implications of such services?

In looking over this list, it is striking that these innovations reflect goals the microfinance industry is already striving to achieve: new product development, greater service efficiencies, greater flexibility in methodologies, and deepening outreach. They also reflect a return to microfinance as but one part of a larger response package: where financing is linked to other services ? primarily through strategic alliances ? ranging from skill development to mentoring to health information and services. If the microfinance industry takes up the challenge to respond to HIV/AIDS, it will become a stronger, more flexible instrument in all environments.

Key Resources

The role of microfinance in the fight against HIV/AIDS

Parker, J. Singh, Ira Hattel, Kelly / Geneva, Switzerland: UNAIDS (2000)

Microfinance, grants and non-financial responses to poverty reduction: where does microcredit fit?

Parker, J. Pearce, Douglas / Focus Note No.20) Washington DC: CGAP (2001)