

**HIV/AIDS -Responding To A Silent  
Economic Crisis Among Microfinance  
Clients In Kenya and Uganda**

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**“AIDS does not kill suddenly, but it comes and takes a lot of money away with it”  
MFI client, Uganda**

**September 2001**

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### **List of Abbreviations Used**

ASCA	Accumulating Savings and Credit Association
ASO	AIDS Support Organisation
CBO	Community Based Organisation
CBS	Central Bureau of Statistics
DFID	Department for International Development
FGD	Focus Group Discussions
HBC	Home Based Care
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
KEPP	Kenya Enterprise Promotion Project
MFI	Microfinance Institution
NGO	Non Government Organisation
OI	Opportunistic Illness
OVC	Orphans and Vulnerable Children
PRA	Participatory Rapid Appraisal
PLWA	People (or person) living With AIDS
RoSCA	Rotating Savings and Credit Association
SACCO	Savings and Credit Co-operative
TB	Tuberculosis
UWFT	Ugandan Women's Finance Trust
WOFAK	Women Fighting AIDS in Kenya

### **List of Luganda/Kiswahili Words Used**

<i>Bubonda</i>	RoSCA (Uganda)
<i>Harrambe</i>	Fundraising event calling upon the resources of the household's extended family network and closest friends
<i>Munno Mukabi</i>	A "Friend in Need" Association – self/mutual help group
<i>Mwethya</i>	RoSCA (Kenya)

# HIV/AIDS—Responding to a Silent Economic Crisis Among Microfinance Clients in Kenya and Uganda

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## Executive Summary

### Purpose of study and research methods

Issues related to HIV/AIDS tend to evoke an image of concern for health and community welfare. Many microfinance practitioners see this as having nothing to do with them because of the apparent health and welfare focus. Yet, with the HIV prevalence, AIDS deaths and orphaning rates as high as they are in several African countries, it is a given that the pandemic has serious economic implications for the general population. This includes households that constitute the marketplace for microfinance institutions. Microfinance institutions (MFIs) may be missing important signals from their clients that would help them manage the risk of operating in an environment heavily affected by HIV/AIDS.

On the other hand, microfinance is widely seen as improving livelihoods, reducing vulnerability, and fostering social as well as economic empowerment. This makes it particularly attractive as a tool to help the poor (CGAP Focus Note 20). In the rush to mitigate poverty worsened by the impact of HIV/AIDS, donors may inadvertently pressure some microfinance institutions into activities without an adequate assessment of the implications to institutional sustainability.

Understanding the economic repercussions of AIDS could help ensure that institutions and donors develop rational strategies to respond to the pandemic. However, most studies and papers written about HIV/AIDS describe it as a health crisis and focus on the plight of people infected with HIV who then suffer from AIDS related illnesses and finally die. Not much light has been shed on the toll it exacts from those playing an economic support and care giving role for people living with AIDS and the children who are left behind.

Consequently, *MicroSave* commissioned a study in Uganda and Kenya on HIV/AIDS—The Economic Crisis. The study team used qualitative methods that relied on focus group discussions using Participatory Rapid Appraisal (PRA) tools. It set out to detect general trends in microfinance clients' economic coping strategies and patterns in their use of microfinance services. Specifically, the study examined:

- The nature of the economic impact of HIV/AIDS on clients;
- Clients' economic strategies to cope with HIV/AIDS related crises;
- The role of microfinance services in meeting the coping needs of clients; and
- Improvements to microfinance services that would strengthen clients' economic coping strategies.

### Nature of economic impact and coping mechanisms

Every MFI group the team visited had clients who had cared for and lost close family members to HIV/AIDS and/or were caring for the orphaned children. The care of family members with AIDS has tremendous financial repercussions not only in terms of medical costs, but also in terms of lost business income as most care givers reduce their income earning activities and draw from their business capital to meet expenses. Although crises not related to HIV/AIDS happen more frequently, they come in isolation. HIV/AIDS, on the other hand, triggers a series of crises that require an entire arsenal of coping mechanisms.

As the effects of the disease and care giving demands evolve within a household, there are distinct financial pressure peaks. In general, focus group participants defined these points as: (a) **early stages** when the family is first called on for assistance or the first signs of AIDS appear, (b) **frequent hospital visits**, where the person living with AIDS (PLWA) is in and out of hospital, (c) **bedridden**—either at home or in the hospital, (d) **death** and burial and (e) **care for orphaned children** including payment for their education. The most severe economic stress occurs:

- Before the care givers and the person infected with HIV know their sero-status when the family and the person with HIV spare no expense in looking for a cure;
- When the family member with AIDS is bedridden and the care giver assumes the financial burden for health and child care at the expense of time in her/his business; and
- When a care giver assumes responsibility (particularly school fees) for the children whose parent(s) have died.

The economic degradation experienced by care giving clients is not much different from that experienced by the person with AIDS.

### **Clients' coping strategies**

Clients described a very clear sequence of asset liquidation in order to cope with the impact of HIV/AIDS. They liquidate savings and protective assets first and sell productive assets only when they run out of other options. The sequence is as follows:

1. Savings accumulated outside of the MFI
2. Business income
3. Household assets
4. Productive assets
5. Land.

While individual assets and income play an important role, poor communities have developed a range of informal mechanisms that enables them to respond to crises. However, their economic burden continues after the person dies in the form of the responsibility for the orphaned children and repaying debts or outstanding hospital bills of the deceased. The severity of economic impact depends on:

- The economic resources (including strength of business) a client has when crisis begins to affect her/him;
- The duration of a given crisis, how many crises occur and the timing in between them;
- The relationship between the care giver and the infected person (clients caring for his/her spouse or adult children are generally affected more than the extended family);
- Quality and number of coping mechanisms available to the client; and
- Networks that client belongs to (especially informal) and knowledge of the resources available to her/him (both formal and informal).

These mechanisms serve as substitute buffers and derive their strength from the way clients weave them together—where one strategy falters, another sustains.

In Uganda, clients told the research team that they experienced less financial strain due to HIV/AIDS related crises now than they did five years ago. They attributed this to better coping mechanisms. A closer look at mechanisms that appear to reduce pressure should provide insight into how people are moving from coping over the short term to adapting or permanently changing the mix of strategies used to fulfil the household's basic needs. The following list summarizes the factors that participants felt contributed to improving coping strategies:

- Access to microfinance to start, improve or diversify their business activities;
- Better money management skills and savings discipline;
- More and better-organized informal support groups where members pool savings against future emergencies; and
- More readily available information<sup>1</sup> about treatment for family members with AIDS, which enables care givers to manage their family member's AIDS-related illnesses more rationally.

In Kenya, some of the trends in coping mechanisms seem to indicate a move towards adapting similar to that found in Uganda. For example, MFI clients reported increased reliance on informal support mechanisms such as Rotating Savings and Credit Association (RoSCAs) and Accumulating Savings and Credit Association (ASCAs). In addition, they often mentioned wanting more information about AIDS for their communities and for their own needs to care more effectively for family members. Access to

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<sup>1</sup> Information encouraged openness, which in turn reduced stigma. Those who no longer fear stigma tend to go for an HIV test, begin treatment earlier, maintain their health better and thus live longer. This reduces the burden on their care givers.

accurate information about AIDS also helps care givers avoid exhausting their meagre resources on dubious treatment or drugs.

### **Role of microfinance**

Microfinance loans serve a critical role that enables clients to enhance their business' volume and/or diversify their economic activities. The resulting increase in income facilitates the creation of savings and asset accumulation. Loans also provide an important source of lump sums of cash, which helps clients avoid depleting their business capital.

However, loans lose their attractiveness to clients as a coping mechanism when a client experiencing HIV/AIDS related crises has too many competing demands for lump sums of cash. Closing the business to fulfil care giving responsibilities exacerbates this situation because it disrupts the flow of income to the household.

Nonetheless, clients go to great lengths to repay their loans in order to safeguard their future position in their solidarity group. They see their business and access to loans as the ticket to “bouncing back” once the crisis has passed. Clients make a firm connection between access to loans and the restoration of their business activities.

### **Innovative microfinance**

During the study, some microfinance practitioners said, “Our services already reach clients who are affected by HIV/AIDS.” Simply reaching clients with a service is not synonymous with being responsive to their economic needs. In the words of one client, “Loans are only good if there are no problems. When there are serious problems, the loan becomes a burden.” Product or service development and refinement should capitalize on clients' ability to:

- Plan for future crisis (anticipate needs for lump sums of cash);
- Improve and maintain income flows;
- Avoid selling productive assets, which would undermine future income earning capacity; and
- Retain access to financial services, particularly post-crises.

Specific **refinements** include:

- Fluctuating loan sizes and terms to coincide with ebb and flow of business cycles;
- Encourage savings by:
  - (a) paying out interest on voluntary savings (where MFIs are able to intermediate such accounts);
  - (b) allowing frequent access to savings that are not guaranteeing the loan; and
  - (c) liaising between groups with banks. (Alternatively, the MFIs can encourage/support the development of ASCAs within their solidarity groups).
- Seek out connections to business development service organisations;
- Allow clients to miss meetings as long as they send in payments;
- Allow clients to not take out back-to-back loans (allowing for a “resting” period) while still maintaining current client status;
- Encourage informal, group based coping strategies that reduce financial pressure; and
- Allow clients to take out smaller loans without subsequent penalties.

Ideas for **product development** include:

- Providing access to medical, life and/or death insurance;
- Contractual savings products (especially for school fees);
- School fee loans;
- Emergency loans;
- Promoting informal coping mechanisms;
- Using a “*credit with education*” approach to provide direct exposure to HIV/AIDS education through MFI staff; and
- Cultivating links to:
  - ✓ AIDS Support Organisations (ASOs)
  - ✓ Home-based care (HBC) projects

✓ Other social service organisations

The last point on linkages deserves special mention. Throughout the focus group discussions, the team found examples of very poor people taking the initiative to mobilise external and community resources and networks in the face of seemingly insurmountable difficulties. Their spirit in so doing is an important indicator of potential approaches that could form the basis of linkages between MFIs and ASOs or other social service organisations.

### Conclusions

As financial institutions, MFIs should not provide AIDS support services or indeed relax lending discipline. On the other hand, as development institutions with poverty alleviation goals, they cannot afford to disregard the fact that HIV/AIDS is a major contributor to poverty and one that is already having disastrous economic effects on their market segment. Eliciting client feedback on how products mitigate (or worsen) this impact can reveal innovative ways to refine services. Similarly, seeking to understand clients' economic coping strategies provides an opportunity for MFIs to develop new products that reflect what clients value and find relevant.

Microfinance institutions and AIDS Support Organisations can best respond to the impact of AIDS by building on their respective institutional and technical strengths. Supporting income generation is important, unfortunately those who implement HIV/AIDS health and social based projects are not equipped to accomplish this with respect to systems, education and experience any more that MFIs are equipped to respond directly to the broad ranging social and medical impacts of HIV/AIDS.

The two most important individual resources to prepare for a crisis are savings or easily liquidated assets, and business volume or diversity in business activities. Clients also prefer mechanisms that provide regular and reliable access to lump sums of cash that do not negatively affect their future income earning capacity.

Where individual, financial capital (savings and/or business assets) is weak or drained, a variety of informal and community-based coping mechanisms can provide a substitute buffer. These elements can have the same effect as financial capital on strengthening a care taking client's safety net and avert a final slide into destitution.

While MFI clients value access to credit, credit alone is not enough. Microfinance institutions do not need to directly deliver social services to their clients in order for them to benefit from such services. Clients value linkages to non-financial service providers. Irrespective of which organisation delivers the service, clients attach great importance to having access to additional, non-financial services and, by extension, to the organisation that afforded them the access.

MFIs should not specifically target HIV/AIDS infected/affected people. Explicit targeting compromises the integrity and sustainability of their services. Client loan groups can absorb some losses, but concentrating the potential for defaults within loan groups undermines their viability. In addition, targeting client segments within a broader clientele with preferential loan terms or products does not get good results. It tends to create a negative dynamic where the general clientele resents the perceived preferential treatment of the targeted group. This will increase stigma when others feel that they also warrant special consideration.

### Changing the paradigm

During the study, several microfinance practitioners were wary about delving into HIV/AIDS related issues of their clients. A common refrain was, "We cannot get embroiled in the social problems of our clients. We can't solve all their problems for them." It is the team's hope that this study will catalyse a new attitude among mainstream microfinance—one of listening and learning from clients and seeking to create responsive services because HIV/AIDS has a significant influence on the environment in which MFIs operate. This does not mean that MFIs should forget sound practices and undermine institutional integrity. One participant at the team's presentation of their findings said it best, "Our clients are not mere transactions. They are valuable in good health and ill health—we must make an investment in them."

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## 1. INTRODUCTION

### a) General Background

Of the estimated 2.6 million people worldwide who died of AIDS in 1999, three quarters are Africans, and sub-Saharan Africa is home to more than 70 percent of the world's HIV-infected people. The death toll due to AIDS is numbing; 5,000 Africans die of AIDS *everyday*. HIV/AIDS puts enormous economic stress on households as they care for sick family members, experience the loss of productive adults and absorb the costs of taking care of orphans (Armstrong 2000). The greatest economic impact of HIV/AIDS comes from the high costs of treatment and assistance the “survivors”. In other words, families and communities coping with AIDS-related illness and death shoulder much of the burden, and the epidemic therefore takes the heaviest toll at the household and community level (Over 1998).

Many in the development community recognize that the ability of a household to mitigate the impact of HIV/AIDS relies largely on their capacity to stabilize or increase incomes. Consequently, NGOs are under tremendous pressure to develop income-generating schemes. Yet, NGOs involved with HIV/AIDS related issues tend to come from health and social development fields where experience with micro-enterprise development is limited (Donahue, 1998).

On the other hand, the microfinance field has evolved specifically to fight poverty by strengthening the economic position of households at, or below, the poverty line. Poor, and indeed not-so-poor, people coping with the impact of HIV/AIDS within their household represent a highly vulnerable group and one that is in particular need of microfinance services. Microfinance services are best positioned to serve those that serve as the safety net for people living with AIDS. Microfinance is also important to households not affected by HIV/AIDS, but which, at any given time, may well become so. Having access to financial services will enable them to shore up their resources ahead of time in an effort to cope financially with any crisis that may arise.

To date however, the microfinance industry has paid little attention to its role within a marketplace affected so severely by HIV/AIDS. If we want to understand how HIV/AIDS is affecting microfinance, we first need to understand how HIV/AIDS relates to clients' economic coping strategies and their everyday struggle to avoid poverty or slipping further into it.

### b) HIV Statistics in Kenya and Uganda

Among the adult population in Kenya, statistics report HIV/AIDS prevalence rates of 17-18% in urban areas and 12-13% in rural areas (1999). Infection rates in some districts are even higher, reaching 35 – 40% in some parts of Nyanza and Western Kenya. Reports further estimate that at the current rate, 1.9 million infected people in Kenya could rise to 2.5 million by the year 2005 (Kenya National AIDS Control Council, 2000). According to Kenya's Central Bureau of Statistic (CBS), AIDS has lowered life expectancy from 65 years to 46 years.

In Uganda, the HIV/AIDS prevalence rate has lowered from 14% in the early eighties to 8.5% in 2000. While the trend for new infections in Uganda are on the decline overall, indications are that the effects in the rural areas are on the increase.

The epidemic has exacted a terrific toll on the entire population. The fact that 75% of deaths occur in the most economically productive age brackets (20-40 years) creates a significant impact on economic resources of families and the community. The burden of caring is exacerbated by the increasing number of orphans as the majority of people in productive age brackets are also raising children. Estimates indicate that the number of children orphaned by AIDS in Kenya could rise from 900,000 in 2000 to 1.5 million in 2005.



### c) Objectives

When most people think of HIV/AIDS, their thoughts rush to people infected with the virus, sickness and death. Less attention is devoted to those in the care giving role. In Kenya and in Uganda today, many Microfinance Institutions (MFIs) are still reluctant to discuss HIV/AIDS—and understandably so. To them, asking MFIs to respond to HIV/AIDS related issues is asking them to target loans to HIV infected people.

However, this study is not about targeting people who are infected with HIV; nor is it about HIV/AIDS the public health crisis. Its purpose is to throw light on the **economic** effects of HIV/AIDS. The market segment for the study or unit of analysis is clients *affected* by HIV/AIDS; specifically those who—by providing care and/or financial support—serve as the safety net for: (1) immediate or extended family members with AIDS, and (2) children who have lost one or both parents. The research agenda was designed to understand the client’s perspective in four broad areas:

- 1) The nature of the economic impact of HIV/AIDS on clients;
- 2) Clients’ economic strategies to cope with HIV/AIDS related crises;
- 3) The role of microfinance services in meeting the coping needs of clients; and
- 4) Improvements to microfinance services that would strengthen clients’ economic coping strategies.

## 2. CONTEXTUAL FACTORS

### a) Economic Information

As stated in the introduction to this report, the extent to which clients will be able to cope financially with the effects of HIV/AIDS in the family will depend on the range and type of economic coping options available to the household before, during and after the onset of the crisis. The table below illustrates these options as three broad categories—savings, protective assets and productive assets.

Table 1. Family Economic Coping Strategies

Asset categories	Examples
<b>Savings</b>	<b>Cash</b> saved in formal financial institutions (banks), semi-formal institutions (MFIs) or via informal mechanisms Small <b>livestock</b> (chickens, goats, etc.) <b>Agricultural produce</b> (from small gardens or stored harvests) <b>Social capital</b> (goodwill from relatives, friends and neighbours)
<b>Protective</b>	<b>Houses</b> Residential <b>plots</b> <b>Household items</b> (TVs, radios, jewellery, furniture, clothing)
<b>Productive</b>	Agricultural <b>land</b> Small <b>business capital</b> (tools and equipment) Dairy and draft <b>animals</b> <b>Rental</b> properties

While these assets play an important role in helping clients cope with economic crisis, the team noted that acts of commission and/or omission by the government often leads to the loss of many of these assets—leaving individuals and communities bereft of coping strategies. In Uganda for example, the HIV/AIDS epidemic in Soroti and surrounding districts found a community whose economic base was already weakened by the 1980-90 insurgency. Widespread instances of cattle rustling during much of 1995 followed the insurgency and led to major losses of livestock—the most easily liquidated form of savings and productive assets among rural communities. In Kenya, politically instigated ethnic violence in many parts of the country has created internally displaced communities with no asset base. In urban centres, MFI clients participating in the team’s focus group discussions emphasized that demolition and burning of informal sector business and residential premises by government authorities is now one of the biggest threats to their economic welfare.

### b) Nature of economic crises created by HIV/AIDS

Asked to define the economic crisis that they experience once a family member is HIV positive, Ugandan and Kenyan clients in focus group discussions described a similar pattern of events that has caused severe financial constraints. These include the cost of initial diagnosis and treatment of opportunistic infections. In Kenya, this tended to cost more than in Uganda. Kenyan clients, especially in the rural areas, indicated that due to either tests being unavailable or medical personnel being reluctant to disclose the sero-status of a patient, families spent a lot of money at this stage looking for a cure. In both Uganda and Kenya, the cost of treatment in and out of a hospital during a prolonged illness coupled with the cost of special diets supplied and delivered by the patient's family constituted another major area of financial constraint. Given the high cost of medical care in Kenya (as compared with that in Uganda), the effects on the clients tended to be more severe than in Uganda where, in addition to lower costs, MFI clients seemed to have better access to support from community AIDS support organisations.

In both countries, the most severe economic constraints occur when the patient is bedridden either at home or in hospital. This stage inflicts a tremendous financial and emotional toll on MFI clients as their family member requires full time attention. Clients are often forced to partially close their businesses and commonly fail to meet their MFI group obligations to attend meetings, make loan repayments, and deposit savings. The financial demands of the illness alongside the day-to-day burdens of providing for the family at a time when the client is unable to devote time and energy to economically productive activities compounds her/his stress. Upon the death of the family member, there are often newly orphaned children who must be cared for when an MFI client is at her/his most economically vulnerable.

### c) Implications for the Microfinance Sector

Given the widespread poverty status in both Uganda and Kenya, HIV/AIDS has had a devastating outcome on the economic status of poor and low-income people who constitute the market segment of MFIs. As financial institutions, MFIs should not necessarily provide AIDS support services or indeed relax lending discipline. On the other hand, as development institutions targeting poverty alleviation, they cannot afford to disregard the fact that HIV/AIDS is a major contributor to poverty and one that is already having disastrous economic effects on their market segment. While the extent of the risk to MFI portfolios was beyond the purview of the scope of this study, indications are that MFIs are already affected as their clients experience AIDS-related economic crises.

Asked to state in what ways HIV/AIDS-related crises affect their ability to meet their MFI group obligations, clients listed areas such as:

- irregularity in attendance to group meetings and inability to fully attend to their business (especially when a client has a bedridden patient);
- diversion of loan money to meet demands for lump sum cash;
- inability to meet repayment schedules; and
- constraints regarding savings contributions.

None of these four difficulties can be viewed as self-contained. For example, given that attendance at meetings is central to the group-based lending methodologies adopted by the majority of the institutions participating in this study, increases in the number of MFI clients either taking care of sick relatives or adopting orphaned children, by implication, threatens the MFI's portfolio. The MFIs face the risk of increased dropouts as group members expel clients with irregular attendance. Similarly, since most MFIs expect group members to make payments for their colleagues who don't attend meetings or fail to meet repayment schedules, increasing incidents of affected clients could weaken the solidarity of the group thereby threatening the entire group portfolio.

## 3. METHODS

The nature of the research methods is deliberately qualitative and used the *MicroSave* "Participatory Rapid Appraisal for Microfinance" toolkit as well as *MicroSave*'s systematic approach to conducting Focus Group Discussions. The team selected groups of microfinance clients based on their availability and coincidence of regular weekly/monthly meetings. The study used Focus Group Discussions,

Participatory Rapid Appraisal (PRA) and Individual In-Depth Interviews to identify **common trends** and **patterns**, and **recurring issues** rather than to quantify data and information gathered.

**Box 1. Qualitative vs. Quantitative Research Methods**  
From Hulme, 1998

“According to this line of argument the scientific [quantitative] method fails as it ignores the complexity, diversity and contingency of winning a livelihood; it reduces causality to simple unidirectional chains, rather than complex webs; it measures the irrelevant or pretends to measure the immeasurable; and it empowers professionals, policymakers and elites, thus reinforcing the *status quo* and directly retarding the achievement of programme goals. At heart, PLA [Participatory Learning and Action] theorists do not agree that ultimately there is one objective reality that must be understood. Rather, there are multiple realities and before any analysis or action is taken the individuals concerned must ask themselves, ‘whose reality counts?’ The answer must be that the perceived reality of the poor must take pride of place” [p. 16]

#### 4. FINDINGS FROM FIELD RESEARCH

##### a) The nature of coping with the economic impact of HIV/AIDS

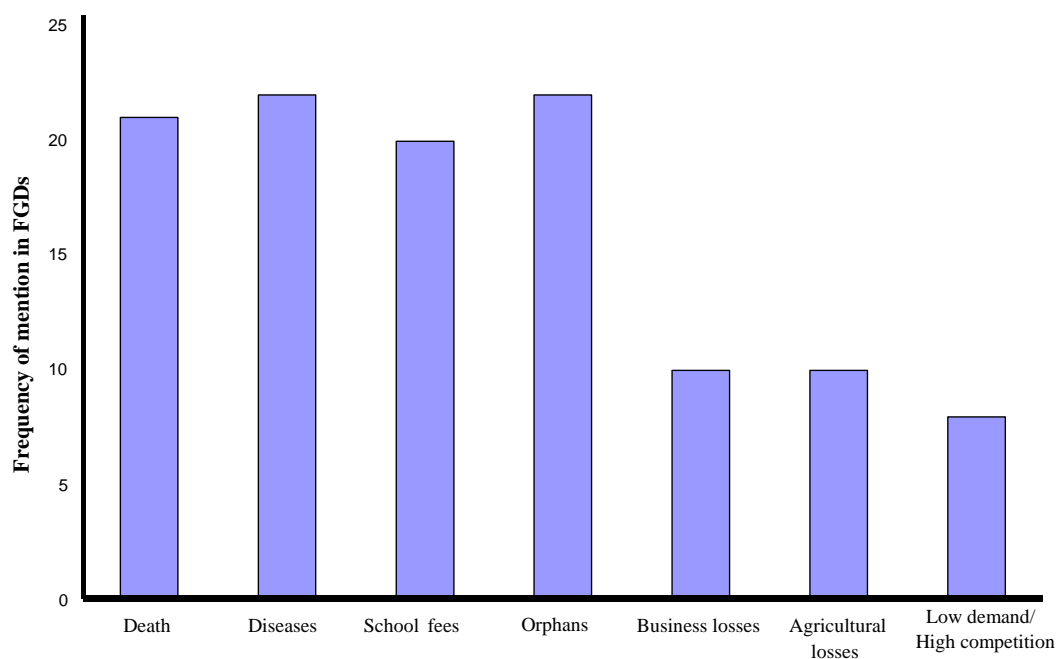
During focus group discussions (FGDs), the team asked participants to list the different crises that impose a financial burden on them (see Figure 1 below for the crises that were most frequently mentioned). At the mention of illness, disease or death, the moderator would probe for the major diseases and causes of death. Participants usually mentioned HIV/AIDS immediately. Without exception, every MFI group the team visited had clients who had cared for and lost close family members to HIV/AIDS and/or were caring for their orphaned children. They could speak from personal experience about the impact on their businesses, their income and their ability to manage credit. In some cases, it was as if clients had been waiting for just such a study so that they could describe the economic effects of AIDS upon their households.

**Box 2. Effect of HIV/AIDS-Related Crises**

- ✓ Prolonged illnesses of extended family member or spouse
- ✓ Multiple deaths in close succession
- ✓ Death and burial
- ✓ Care of orphans and the cost of their education.

Clients stated that crises not related to HIV/AIDS (i.e. business or agricultural losses) put financial pressure on them more frequently, however HIV/AIDS related crises tended to hit harder than the other types of crises did.

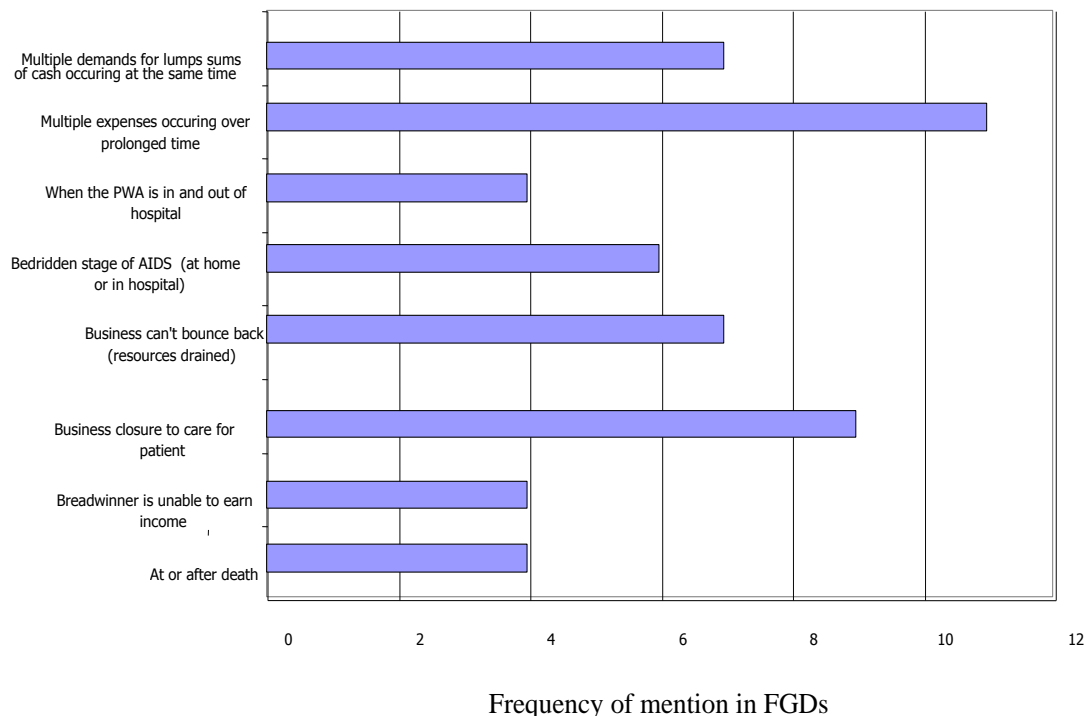
Figure 1. Most Common Economic Crisis as Mentioned in Focus Group Discussions (FGDs)



**i) Economic pressure points**

Figure 2 compiles Focus Group Discussion responses to the question, “which factors in HIV/AIDS-related crises cause the greatest financial pressure?” Clients described a domino affect, where the advent of an AIDS related crisis triggers multiple and unplanned for demands for lumps sums of cash that clients and their families are hard pressed to come by. The more economically vulnerable clients were before such crises, the more likely they were to fall through their safety net. The care of family members with AIDS has tremendous financial repercussions not only in terms of medical costs, but also in terms of lost business income as most care givers reduce their income earning activities (shutting down their businesses) or draw from their business capital to meet expenses.

Figure 2. Most Commonly Mentioned Financial Pressure Points of HIV/AIDS Related Crises



**ii) Stages of the HIV/AIDS care “cycle” and economic degradation**

During discussions with MFI clients, it was very clear that there is a pattern or a cycle to caring for AIDS patients. The events occurring within the cycle began to emerge (see figure 2 above) as focus group participants described the circumstances under which HIV/AIDS-related crises created increasing financial pressure for care takers. As the effects of the disease develop within a household, financial pressure occurs (to varying degrees) at points that seemed to be common across the board. In general, the participants defined these points as: (a) **early stages where the first signs of AIDS** appear in the form of opportunistic illnesses (OIs), (b) **frequent hospital visits** where the PLWA experiences more serious OIs, (c) **bedridden**—either at home or in the hospital, (d) **death and burial** and (e) **care for orphaned children** including payment for their education.

**The first signs of AIDS**—During this period, the HIV infected person is still economically active and experiences the first signs of weakening health. The person may or may not know, or wish to find out, her/his sero-status. The eventual care givers may not be aware of the crisis looming on their horizon, but this is where the first calls for financial assistance occur. Focus group participants in Kenya and Uganda said that the financial pressure experienced by care givers and extended families is low here as compared to later stages.

It is impossible to generalize how long this period lasts. However, according to MFI clients’ perceptions of when their financial burden as care takers escalates, this stage seems to be shorter in Kenya than in Uganda. The research team attributed this to the following reasons:

- Levels of awareness about HIV/AIDS have been high in Uganda for much longer and as a result, the stigma attached to having HIV and AIDS is significantly lower. Thus, Ugandan participants consistently mentioned that that people will generally go for a test as soon as they suspect they may be HIV positive.
- Uganda focus group participants said that people are less fearful now (as opposed to earlier in the epidemic) of being identified with the disease and more willing to enrol with or seek information from AIDS support organisations (ASOs). Participants in both countries mentioned that having access to counselling, better treatment and appropriate medication reduces financial burdens. Early detection and treatment enables a PLWA to manage OIs early on before they become debilitating. It also allows the PLWA and their family to learn where to get access to palliative care and medication, and what types of treatment are most effective. Traditional medicine can be effective and inexpensive but accurate information is imperative. All of these factors makes managing the illness easier and enables the PLWA to be productive for much longer, thus reducing the economic burden on family and relatives.

### **Box 3. Giving-up Prematurely**

A client of WOFAK, a Kenyan HIV/AIDS support organisation that also gives credit to its members through a revolving fund, related her story. As soon as it was evident that she had AIDS, her landlord threw her out and her community asked her to close her vegetable selling business for fear she would infect other people. Although her health was fragile, she was still economically productive and began running her business in another neighbourhood.

Unfortunately, her experience is all too common in Kenya. Many are unwilling to go for an HIV test because it signifies the start of extreme discrimination. WOFAK members shared their observations with the team that not many people have the courage to survive the psychological stress of stigma for long and they quickly begin to deteriorate after they find out their sero-status. In several Focus Groups, clients said, “In Kenya, once a person learns that they are positive, they lose all hope and stop trying to do anything. Instead, they begin to act like they are dying tomorrow even if they could still live and be economically productive for much longer.” This premature loss of productive capacity means that the extended family experiences a greater economic burden of their care much earlier.

However, in Kenya the stigma attached to being HIV positive is still very strong. Consequently, people are afraid to go for an HIV test and to seek help. Many infected people begin to face discrimination as soon as they exhibit symptoms identified with AIDS. In the worst cases, the community will drive someone they suspect has HIV out of their businesses. This speeds up the PLWA’s deterioration and, as described in box 3, they need to depend on their care givers much sooner.

**Frequent Hospital Visits**—At the point that the AIDS victim requires frequent hospital visits, his/her productive capacity declines sharply. Many of these patients have to close their businesses at this point and begin to sell off assets to raise money for treatment. However, PLWA who do not have much to start with begin to call upon their families early in this stage. Closer family members (spouse and siblings) tend to experience the financial pressure more severely and sooner than do more distant family members. Many households sell what is left of the infected person’s assets before they touch their own. As the disease progresses, the PLWA experiences less frequent periods of health and care takers have to spend more time taking care of the patient. This means more time away from the business and for MFI clients, time away from group meetings.

This phase of the illness can be particularly expensive when the patient and his/her family are in denial. There is pressure on the family to spare no expense because they want to believe that the ill family member will recover. They often liquidate not only all of the patient’s assets but also many of their own. MFI clients taking care of family members with AIDS often use a loan to cover lump sum medical expenses instead of drawing money out of the business or selling business equipment. Since clients see their business as the best way for them to bounce back once the crisis passes, they try to protect it at all costs. Nonetheless, clients continue to repay their loans in order to preserve their access to credit, but run the risk of over extending their ability to cover the loan payments.

**Bedridden, at home or in the hospital**—Ugandan and Kenyan focus group participants stated that the most financially strenuous time for households was when the family member suffering from AIDS becomes bedridden. At this stage, it is likely the care givers of the PWLA have exhausted most of their economic resources, especially if the patient is in hospital. Care givers are forced to shut not only their businesses to be with the patient, but they must also pay hospital and/or medication bills and other daily household expenses. If necessary, households will liquidate assets that remain to pay for the patient’s medical expenses. In the extreme cases, there are those who sell off their land. Households that sell land typically did not have much to fall back on in the first place, or they cared for someone during a particularly prolonged illness or cared for several family members in close succession. Households with significant levels of savings, household assets and/or livestock fare much better. In cases where the PWLA is a sibling or an extended family member, the care giver often takes over responsibility for their children. All of this occurs during an income lapse for the care giver (see box 4).

#### **Box 4. Spare No Expense**

“Mary” was an MFI client in rural Uganda who cared for two of her adult children throughout prolonged AIDS related illnesses. She spared no expense in trying to help them gain their health back, certain that they would eventually recover. When they did, she was sure that they would help her recover what she spent on their behalf. Unfortunately, her children did not get better. Instead, once her children had sold off all their assets, Mary found herself supporting them. When the first child became sick enough to be hospitalised, Mary had to sell her own small assets (livestock, household possessions). She also took time away from her business to attend to her child and started missing MFI meetings. Yet, she always sent someone to make her repayments.

Expenses began eating into her business capital while she was spending less time earning income because she needed to be at home caring for her child. When the first child died, the grandchildren became Mary’s responsibility. The second child fell sick and Mary felt helpless and sold some of her land to pay hospital bills. By the time her second child died, her business was dead too—and more orphans came to live with her. Still she did not default on her loan, even though she was absent from the meetings during most of her children’s illnesses.

She went back to her group only to discover they had pushed her out because of poor attendance at meetings. They allowed her to continue saving with them, but refused to accept her as a borrowing member. She says that, “I scratch around, but I can’t start anything big because I don’t have enough cash to restart my business. I cannot get that sum of cash by my own personal means. Caring for my children drained all my resources, but I still know how to run a business, I still have my skills.”

Some households decide to make their family member as comfortable as possible but otherwise not liquidate any additional assets for expensive treatment or hospital care. For many MFI clients, attendance of weekly meetings becomes very irregular. Some will have repayment problems as medical expenses assume priority over servicing the loans; others will lose their place within the group. Those who do lose their place and reach an extreme level of economic degradation seem to have trouble “bouncing back” as illustrated in box 5.

#### **Box 5. Expensive Treatment Eats Money**

“Margaret” runs a business in Kibera slum in Nairobi. In 1999, Margaret’s brother contracted AIDS. He was a wealthy man and was able to purchase anti-retroviral drugs for a whole year. He was bedridden on and off, but always managed to bounce back. Eventually he consumed his resources on the expensive treatment. Faced with the choice of school fees for his children over the anti-retroviral drugs, he decided to cut down on his expensive treatment. He began to purchase drugs quarterly instead of monthly. Consequently, his health deteriorated rapidly. Before the end of 2000, he had died.

It has been several months now since Margaret’s brother died. However, the family is still paying his medical bills. In addition, they must pay school fees for his children. Margaret carries some of this burden and has several coping strategies—including membership in two MFIs.

**Death and burial**—Ugandan and Kenyan MFI clients and the population in general have developed effective ways of handling the financial pressures imposed by death. The community, extended family members and other well-wishers share the financial burden of burial. Most people in both countries belong to burial associations. Everyone sees it as a reciprocal arrangement (i.e. contributors to someone else’s burial activities can count on support when death comes to their household). Nonetheless, despite this reduction in financial pressure, households affected by HIV/AIDS tend to be at their most economically vulnerable when the family member they have been taking care of dies of AIDS.

**Inheritance of orphans and care for them**— Many MFI clients in Uganda and Kenya equate care for orphans with the event of death. The death of an extended family member signifies the advent of a larger household.

**Box 6. Carrying the Burden**

“You may have followed family planning, but if your brother didn’t and he dies—you still get his children”.

“You don’t know about the burden that someone had to carry until they die and their burden becomes yours.”

“You don’t inherit the skills or the business of the person who died, just their responsibilities.”

“Your business is the same size, but you now have more people to support. Where you used to buy one kilogram of sugar, now you must buy three.”

“Your own child will accept going to bed hungry, but an orphan will cry and complain, ‘If my parents were alive, they wouldn’t allow me to go hungry’. This creates a lot of pressure on you. It makes for a very complex family.”

The financial pressure of this stage depends on whether the person taking in orphans also cared for their parents during a period of prolonged illness. If they did, then the pressure, though still very high, is not as severe as during the bedridden stage. If they did not, then the financial pressure at this stage grows more intense as the care taking household struggles to fit the new dependents in. Financial pressure manifested itself most commonly as school fees. Those individuals who retain their MFI membership tend to bounce back by taking a loan to re-build their businesses.

**Box 7. A Sister Through Thick and Thin**

“Anne” runs a tailor business in Kenya. She and her sister were very close. “She followed me (in age) and we grew up together,” she explained. So, when her sister called and asked for help, Anne didn’t hesitate. Her sister had been sick for some time and had exhausted her resources. “She first tried to solve her problems on her own. My sister was a successful businesswoman and her husband is in the trucking business. She wasn’t poor.”

Anne convinced her sister to get an HIV test. It came back positive. The hospital also told her she had TB. Anne gave her sister money for the drugs and her health improved. Unfortunately, after two months, Anne had to admit her sister to hospital, where she spent a lot of money on drugs and special food. After two weeks, the hospital staff advised Anne, “Your sister has AIDS, and we don’t have enough beds to maintain her. Besides, it is expensive here. You would be better off coming to the hospital for drugs and advice, but caring for her at home.” Anne’s sister went back to her own home, husband and six children. Anne saved something every week from her business proceeds so she could help her sister. Anne’s husband also helped as care giver, but she couldn’t expect him to take over.

During her sister’s prolonged illness, Anne spent six hours with her and the rest of the day at her tailoring business. She had to reduce her stock of materials so she would have enough money and time for her sister. She was lucky that her eldest son was able to manage the business so that she didn’t have to close it to tend to her sister.

When her sister died, the funeral ate into Anne’s resources even further. While Anne’s brother-in-law paid for the coffin, Anne covered the mortuary expenses. Anne also made a dress for her sister that cost a considerable amount of money.

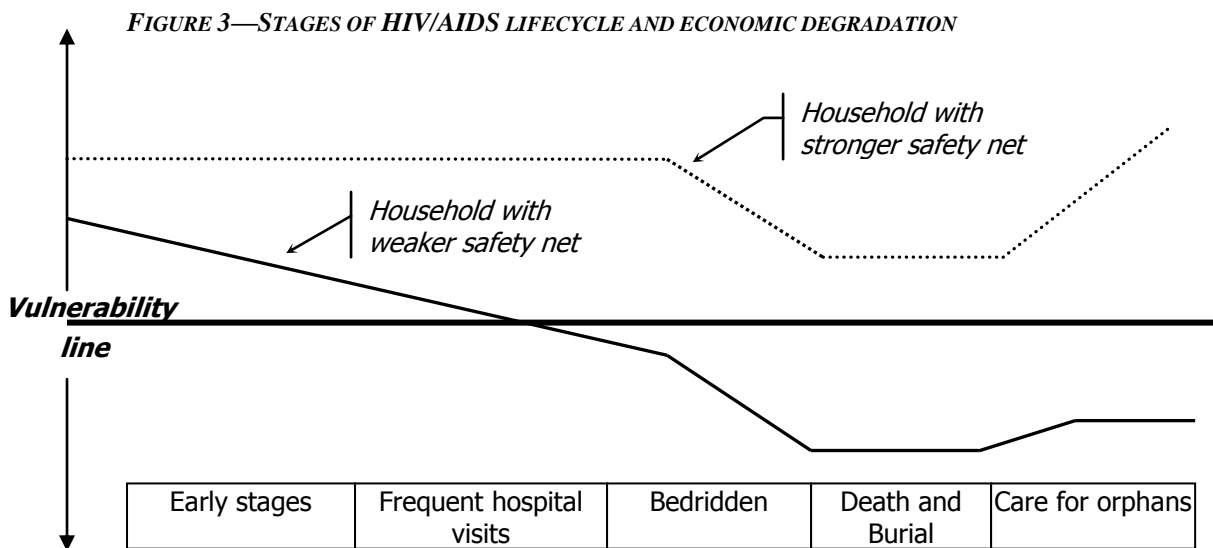


Anne’s brother-in-law is also HIV+ but spends all his money on treatment, leaving nothing to feed the children. Her eldest nephew took a job with his father’s trucking company, so between them, they manage to feed the children and pay for their school fees. She knows that her brother-in-law will die soon and that she will take in the children.

Clients like Anne are not likely to slip into destitution when and HIV/AIDS related crisis faces them. She has a successful business and a husband who receives regular wages. Aside from the week following her sister’s funeral, Anne never had to completely close her business. As a result, her business quickly recovered after her sister’s death. The micro loan she receives is expected to further boost her business.

Figure 3 is an illustration of the stages of the HIV/AIDS cycle and the levels of economic degradation as expressed by MFI clients<sup>2</sup>. Anne’s story (box 7) is an example of a household with a relatively strong safety net, while Mary’s case (box 4) is an example of a household with a weaker safety net. While clients do not always drop as far below the poverty line as Mary did, the drop will still affect borrowing and savings patterns and household economic portfolios. In addition, while Mary’s story might be an extreme situation, it is not outlandish. Households that are not economically vulnerable today can very easily find themselves beneath the poverty line tomorrow.

The two scenarios in Figure 3 represent better and worse case scenarios of economic degradation due to HIV/AIDS related economic crises. The different rates of degradation appear to pivot on the presence or absence of physical assets, business income and access to credit and/or savings opportunities.



However, there seems to be a third scenario. A few of the focus groups that the team interviewed developed exceptionally resilient support networks, largely in response to the effects of the HIV/AIDS related crises facing them. One of the first things they did for their own economic welfare was to form solidarity groups to access micro-credit. Some created emergency funds<sup>3</sup> within their MFI to help them cope with financial pressure due to HIV/AIDS related crises. Others sought out and received information on how to cope with AIDS and orphans. They took action by pooling their resources and labour to take care of orphans. One group mobilized outside funding to expand one of their day care centres into a feeding centre for vulnerable children. They received training in how to demonstrate palliative care for AIDS related illnesses to PLWA’s care givers. Another group added a community bank to their efforts so that women too economically vulnerable to access microfinance services could at least save. Some of the community bank members were able to eventually join the MFI because the tiny businesses they started out of their savings grew strong enough to make use of credit.

<sup>2</sup> This generalized representation illustrates overall trends as described by most focus group participants who responded to questions about care taking burdens. It is not meant to depict a scientific analysis of the progression of HIV/AIDS-related illnesses and death.

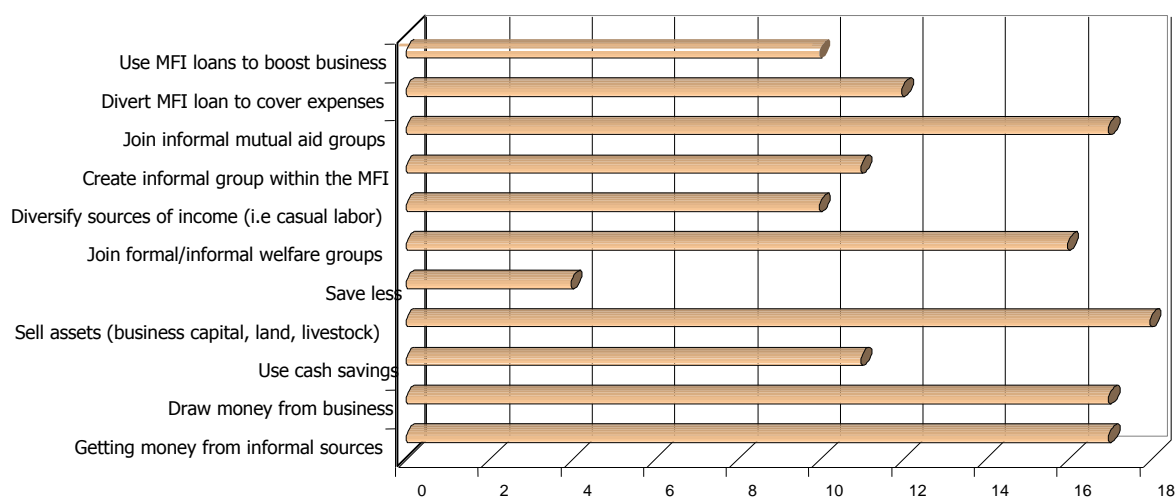
<sup>3</sup> In one case, a Ugandan group called their emergency fund *munno mukabi*, copying the traditional mechanisms of helping friends, family or neighbours in times of trouble. In Kenya, some groups called it a welfare fund.

It would appear, then, that in the absence of individual economic capital, membership within networks, access to a variety of informal mechanisms and knowledge of the resources available in one's community can offer a buffer. This social capital can play a subtle, but critical role in cushioning financial shocks by facilitating reliable access to lump sums of cash and equipping people with the information they need to plan and adapt as opposed to merely cope. None of the strategies (which includes membership in the MFI) would work as well individually. Their combined power to help during a crisis is exponential not additive offering the additional security that, woven together, if one falters another sustains.

### b) How MFI clients cope with the economic impact of HIV/AIDS

The description of the HIV/AIDS care cycle in the previous section highlights the economic impact of HIV/AIDS and the role that credit, clients businesses and household assets play in enabling MFI clients to cope with economic pressure. While these factors play an important role, poor communities have developed a range of informal mechanisms over the years that enable them to respond to crises. In Kenya and Uganda, there is a distinction between responses to HIV/AIDS related and other crises. Most other crises come in isolation and clients tackle them without calling upon the full array of available coping mechanisms. HIV/AIDS, on the other hand, triggers a series of crises and requires an entire arsenal of mechanisms to manage the crisis. Some of these mechanisms are economic in nature while others are not (fig. 4). This section discusses the different mechanisms—financial and non-financial—used by MFI clients and their communities.

Figure 4. Coping mechanisms used by MFI clients affected by HIV/AIDS



### i) Economic coping mechanisms

**Individual or household mechanisms**—Liquidation of assets is the most common coping strategy in both Kenya and Uganda. Accumulation of protective assets acts as a safeguard against liquidating productive assets<sup>4</sup>. Productive assets are important to protect because they represent future income generating potential. Clients said that they liquidate savings and protective assets first, whereas they will only sell productive assets when they have exhausted other options (see also Chen and Dunn 1996 and Sebstad and Cohen 2000). The clients described the following sequence of asset liquidation—starting with the liquid protective assets and gradually moving to the productive assets:

<sup>4</sup> See also description of protective and productive assets under Section 2, Contextual Factors

**Table 2. Productive Assets Available to MFI Clients**

<b>Assets</b>		<b>Description of Liquidation Process</b>
<b>1.</b>	Savings outside of MFI	<ul style="list-style-type: none"> <li>• Liquid protective asset—the first port of call</li> <li>• Clients hesitate to access savings in the MFI as this can jeopardize future access to credit</li> </ul>
<b>2.</b>	Business income	<ul style="list-style-type: none"> <li>• MFI clients protect their business capital because it is what will help them bounce back after the crisis.</li> <li>• Diversion of MFI loan to avoid liquidating business capital</li> </ul>
<b>3.</b>	Household assets	<ul style="list-style-type: none"> <li>• TV, radio, kitchen utensils, furniture</li> <li>• Chickens, goats</li> </ul>
<b>4.</b>	Productive assets	<ul style="list-style-type: none"> <li>• Business capital</li> <li>• Draft/dairy animals</li> </ul>
<b>5.</b>	Land	<ul style="list-style-type: none"> <li>• Affected households will only sell land when they have exhausted almost all other avenues</li> </ul>

Research conducted in Asia (Hickson 2001) also found that as vulnerable households slip deeper into poverty, they undertake a gradual but deliberate sale of their material and community resources. They first sell relatively liquid and less productive assets, and then call upon social assets (such as credit or favours from friends and relatives). These assets tend to be ‘used up’ before the household finally resorts to liquidation of productive assets. In the final stages in which all material and conventional social assets are exhausted, individuals exploit their last remaining social assets, the right to dignity and self-esteem, and resort to begging.

### *ii) Community-based coping mechanisms*

**Mechanisms within the MFI Group**—MFI groups often use informal mechanisms (RoSCAs, ASCAs etc.) to cope with HIV/AIDS related crises. These informal strategies exist within communal life and are not unique to MFI clients. However, in cases where groups have effective mechanisms, members seem better able to weather the impact of HIV/AIDS without it affecting the MFI at the institutional level.

#### **Box 8. Community Compassion**

“Five years ago, the majority of people could take care of emergencies, now everyone is suffering because of AIDS. You can’t have a surplus when your neighbour is going without, you must show mercy. Even if you have no surplus, you must help—after all, they are human beings just like you.”

These group-based mechanisms are especially attractive to MFI clients because they can access them repeatedly—unlike family, friends or relatives. They also afford access to lump sums of cash at a cost or risk that users are willing to accept. Some groups are able to effectively manage the additional credit even with infected members in the group. Rose’s group provided a concrete example of this.

The example of Rose’s group illustrates that MFI groups are likely to contain HIV/AIDS infected, affected and non-affected clients. It also shows that, while HIV/AIDS is a reality, it does not mean automatic default. MFIs are wary of serving clients affected by HIV/AIDS, but trying to screen out such people would be a futile exercise. The non-affected of today are the affected or infected of tomorrow. While MFIs might be reluctant to discuss issues surrounding HIV/AIDS, the fact is that they probably are already serving many HIV/AIDS infected and affected people. Acknowledging the effects of HIV/AIDS on clients does not equate abandoning sound practice. On the contrary, it is a call to combine sound practice with flexibility and product refinements so that services are more responsive to the circumstances of their clients.



### Box 9. The UWFT Soroti Story

Rose's group of 15 women is one of many accessing credit from an MFI in Uganda. However, the group's history and the circumstances under which it was formed make it unique. Rose was among the first women in her community to become an AIDS widow. "I had never run a business," Rose says. "All of a sudden, I found myself with 7 children to take care of and I realized I had to do something in order to provide for my children." Like many others, Rose earned money through casual labour during the planting and harvesting seasons. However, these proceeds were very meagre. So, with her savings and a gift from a sister in Kampala, Rose was able to start a business. Grace also lost her husband to HIV/AIDS. Rose paid Grace a visit and advised her to start up a business so she could take care of her children.

Later, when Apolot lost her husband to AIDS, two other older members of the community became very concerned. They wanted to help the three widows. However, their own means were constrained and they could not come to the widows' rescue continually. They called together 10 others in the community and discussed the matter. They decided to develop a way of assisting the three widows and mobilized another 10 people in the community to start a mushroom farming project in order to help the three widows care for their orphans. It soon became evident that the income from the mushroom project was not adequate and the members began to think of other ways to help the widows. In the meantime, a woman contracted HIV through caring for a sick brother. The group took her in and together they opened a savings account with the Ugandan Women's Finance Trust. They were later able to access credit. Rose started a second and larger business while Apolot and Grace expanded their businesses too.

When asked whether the HIV status of the infected women in the group influenced performance within the MFI Rose replied, "We realize we are in this together. When one of us is ill, the group makes a collection to fill up that person's weekly payment to fulfil the MFI requirements. Occasionally, one of us is too sick to keep her business open and the group puts together money from their own incomes and from the mushroom project to take that person to hospital." It is not easy for these women. However, the community's support makes all the difference. When asked what the performance of this group was like, the Credit Officer's reply was, "They are one of my best groups."

**Family and relatives**— In order to preserve extended family ties for real emergencies, many MFI clients said they usually relied first on their own personal assets. However, they did go to relatives to guard against the sale of productive assets such as livestock and land.

**Harambee**—Kenyans use *Harambee* as a fundraising strategy for a variety of significant lump sum cash needs. In the course of focus group discussions, participants mentioned its use for outstanding hospital bills after the event of death or to send older children to university.

**Munno mukabi**—The *munno mukabi* is a Ugandan informal, community-based, mutual help group that pools resources to respond to emergencies. In early days, it could consist of people carrying someone to the hospital on a stretcher when she/he had no other means of transportation. In case of death, people pool food and cash for the funeral. MFI clients said that it is most useful for small amounts of cash or to meet immediate needs. Some MFI clients in Uganda built a *munno mukabi* into their weekly meeting to pool savings for emergency needs or to top up their weekly repayments when cash is especially tight.

**Welfare fund**—Some Ugandan and Kenyan MFI groups have a 'welfare fund' to which they contribute weekly. When a group member is ill or has a sick family member and is unable to make their payment, the group will use the welfare fund to make the member's payment. Some groups will even take out an additional amount and send it to the affected member with a message of sympathy.

**Accumulating Savings & Credit Associations (ASCAs)**—ASCAs are common in and outside MFI groups. Each member saves a fixed amount and can borrow against their savings at an interest rate set by the group. In the case of MFI groups, a member can borrow against their savings if for any reason they are unable to make their loan payment. They pay it back once the crisis has passed. ASCAs are also a popular way to save for school fees.

**Rotating Credit and Savings Associations (RoSCAs)**<sup>5</sup>—Members contribute a fixed amount to a fund on a regular basis. Distribution of the fund rotates in turn to each member. It is not a loan and the fund does not accumulate. MFI members will often divide into sub-groups to take turns getting RoSCA collections. Clients use it for daily expenses like food and this then enables them to channel the savings for other uses. Clients often belong to several RoSCAs or ASCAs in and outside their MFI group. Those belonging to RoSCAs found them attractive because they paid no interest on the money saved as their ability allowed them and yet were able to access a significant lump sum of cash at a predictable time.

**Burial Associations**—Burial associations are long standing informal institutions. It exists specifically to help with funeral related expenses. They are similar to welfare associations and to *munno mukabi* groups.

### iii) Non-financial based coping mechanisms

**Aids Service Organisations (ASOs)**—According to focus group participants, services and information offered by ASOs played an important role in relieving some of the financial pressure that HIV/AIDS has placed on them. Counselling and medical care for infected people enabled PLWA to retain their productive capacity longer. This allowed those infected to not only stay healthy longer but also to acquire enough assets to cover their medical expenses and to care for their children after their death.

#### Box 11. KEPP Coping with HIV/AIDS

The chairperson for Tausi, a merry-go-round group that KEPP (Kenya Enterprise Promotion Project) linked to Family Finance’s microcredit facility, explained how AIDS has affected them. “Many of us have family members with AIDS, and when we visited them in the hospital, we became very scared. We had no idea how to care for the person and how to prevent contracting HIV ourselves. When you are poor and have to care for someone with AIDS, you really need help to find out how to cope.”

KEPP linked Tausi to the municipal council and the World AIDS Organization. In turn, these organisations provided training and information on “how to cope with everything”. Specifically:

- How to care for a PWA, including how to cope when you have very little money;
- How to avoid contracting HIV; and
- Counselling about AIDS and how to come to terms with it in your family (i.e. reducing “psychological torture”).

**Home-based care (HBC)**—In many countries heavily affected by HIV/AIDS, NGOs or government provides training-of-trainers to community health workers who then train family members. In the best programmes, the community mobilizes to pool labour for homecare (for those skilled in healthcare), and for household and childcare chores. For those that are unable to cover their medical expenses, access to training in home-based care for the family members provides the family with cheaper yet effective alternatives for patient care and thus reduces the financial burden. In communities where community-based care programmes are available, care takers can continue to work and to meet their obligations to the MFI even during the illness of a family member. The effects of HIV/AIDS are less severe on the family because, despite significant expenses, corresponding income lapses are reduced.

**Other Community Based Organisations (CBO)**—In some communities, MFI clients have access to other CBO services that address issues which, although unrelated to HIV/AIDS and not economic in nature, contribute towards MFI clients’ ability to cope with crisis. By offering training on a range of practical subjects such as malaria and pneumonia prevention, sanitation, civil rights, nutrition, and legal issues, these CBOs contribute to better health and less expenditure on medication, allowing households to divert these savings into strengthening their economic potential. In one MFI where clients received training and information, the result has been an increase in their confidence and esteem which has translated into increased confidence in their financial management abilities, better run businesses, increased business incomes and improved crisis coping mechanisms.

<sup>5</sup> Also known as merry-go-round and *Mwethya* in Kenya; *bubondo* in Uganda.

### c) When coping becomes adapting

#### UGANDA

In Uganda, the team asked participants to compare the financial strain they experience now from HIV/AIDS related crises to the strain they experienced five years ago. In urban areas, clients told the team that they felt the financial strain less now. They attributed this not so much to the decline in HIV prevalence rates as they did to better coping mechanisms. Most (but not all) of the rural focus groups described the opposite—financial burdens from HIV/AIDS related crises were on the rise for them. It seems logical that some of this difference is due to the fact that the impact from AIDS was felt first in urban areas, so that there has been a lag in the progression of the epidemic and in its corresponding financial effects. It also seemed reasonable to surmise that the urban population has had more time to hone coping mechanisms.

However, the team felt that it was worthwhile to probe into what focus group participants felt contributed to reducing financial strain. A closer look at mechanisms that appear to reduce pressure provides insight into how people are moving from coping—getting through a crisis in the short term—to adapting—permanently changing the mix of strategies used to fulfil the household’s basic needs (Wright, et al. 1999). The following list summarizes the factors that participants felt contributed to improving coping strategies:

- Over the last five years, access to microfinance has enabled participants to start, improve or diversify their business activities. Loans also increase access to lumps sums of cash that clients can use to resolve crises and pay back in small amounts over time. Participants prefer this to liquidating business capital or other productive assets like land or cattle.
- People are more aware of the economic impact of AIDS now than they were five years ago. Thus they are more likely to keep a buffer (savings) in case of eventualities—like funerals. Belonging to a microfinance group requires a client to learn financial discipline. Because of these two factors, participants said they are able to make their cash work better for them.
- Many focus group participants mentioned that AIDS made it necessary to rely more on informal support mechanisms. As a result, there are more and better-organized informal support groups—such as *munno mukabi*. In one focus group, their *munno mukabi* served a RoSCA or ASCA-like function where members pooled their savings against future emergencies.
- Access to and information about treatment for family members with AIDS is more readily available through the public domain (billboards, Newspapers, radio, television, schools, etc.), but also through increasingly accessible AIDS support organisations which provide specific counselling about caring for PLWA. This information enables care givers to manage their family member’s AIDS-related illnesses more rationally. For example, money and assets are not squandered on non-existent cures. Focus group participants said that such information enabled them to organize and plan in anticipation of crises, which in turn, improved their ability to cope when a crisis confronted them. They especially pointed to an enhanced appreciation of saving against future demands.
- Due to the reduced stigma of being HIV positive and improved access to information, people are much more likely now to go for an HIV test at the first sign of illness. If they are HIV positive, they start taking better care of themselves; plan for anticipated expenses and for the future of their children. This serves to reduce the burden on their and their children’s care givers.

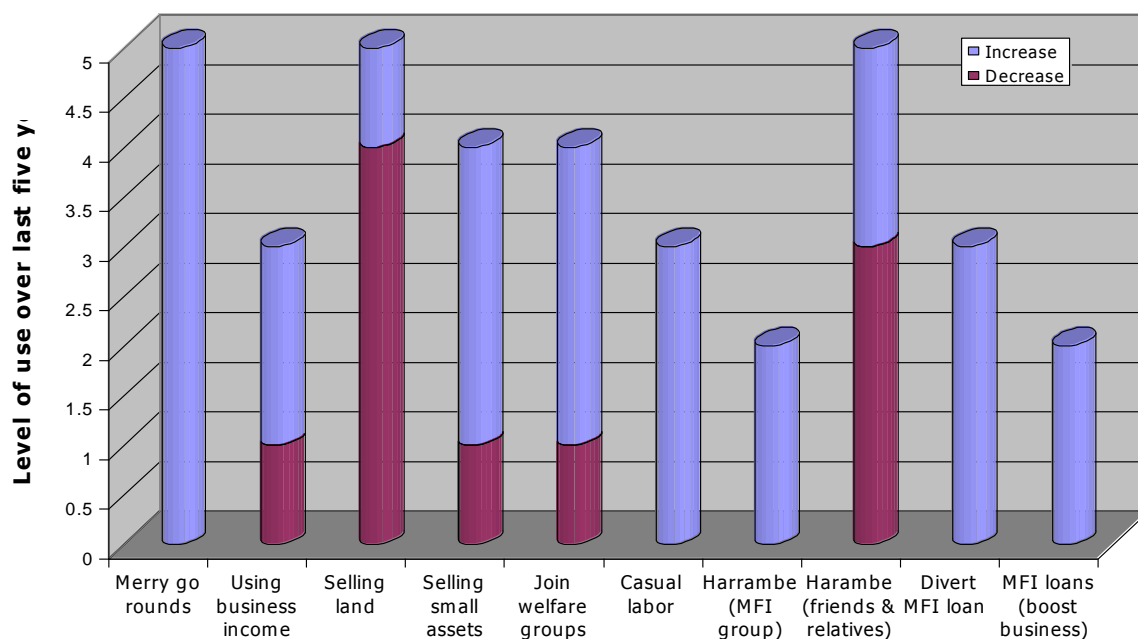
In addition, communities in Uganda have response systems to death that seem almost automated. Focus groups described how their community had a standard list of specific items that you are expected to contribute for funerals. For example, each person must contribute a pre-determined amount of wood, food and cash. This tradition of community participation at funerals is not unique to the AIDS crisis, however, people have honed procedures into an efficient system because the sheer volume of AIDS deaths forced them to do so. Burials also happen immediately after a death in Uganda, whereas in Kenya there is usually a lag of several days to coincide with culturally acceptable days of the week for burial activities. Many cultural practices also dictate where the family can bury the deceased. Transportation costs can be very high when the traditional home is far from where someone died.

**KENYA**

In Kenya, the research team got the distinct feeling from talking to MFI clients that people are struggling for ways to respond to the impact of AIDS. There is a furtiveness surrounding the search for, and the extension of information on, what AIDS really is. As a result, an entire extended family network can experience the economic degradation brought on by HIV/AIDS before they know what hit them—and then often it is too late to erase the damage. Medical care in Kenya is much more expensive than in Uganda and thus accelerates the drain on resources. Responses to AIDS related illnesses and death have neither been automated nor extensively/commonly planned for in Kenya. They cannot be automated or planned for when the ordinary person lacks the knowledge and access to information concerning the economic impact of AIDS.

Nonetheless, the research team wanted to determine whether there were any similarities in the coping mechanisms used in Kenya relative to those employed in Uganda. Figure 5 illustrates the results from focus group discussions concerning “coping” mechanisms that turned into “adapting” mechanisms. Of particular interest were trends that seemed to reduce financial strain.

**FIGURE 5—TRENDS IN THE USE OF COPING MECHANISMS IN KENYA**



**Increase in the use of group based mechanisms** to respond to HIV/AIDS related crises. This includes RoSCA and ASCA forms of merry-go-rounds, *harambees* and welfare groups. In the figure 5, clients’ use of *harambees* based on friends and relatives has declined more than it has increased. However, reduced use does not mean reduced importance. On the contrary, there was consensus among focus group participants that friends and relatives are still the most important mechanism by which to acquire lump sums of cash in times of crisis. It is flexible, speedy and least damaging to future economic welfare. Understandably, financial crises happen more frequently now in large part because of AIDS—and thus the number of occasions one needs to draw on coping mechanisms has increased. Since family and relatives are so important, there is a tendency to reserve the family and friends *harambes* until clients really need it.



**Box 12. Harambees Only Go So Far**

“Some of these mechanisms can’t be called upon too frequently. This is especially true of *harambee*. While friends are very helpful, you can’t call *harambees* too often because then your friends become weary and cease to respond eagerly to calls for help.”

At the same time, participants consistently spoke of the increasing use of merry-go-round savings mechanisms. These mechanisms, although not as speedy or flexible as families or relatives, are more resilient. Since members contribute money continuously, they can rely on it repeatedly without destroying the mechanism. One could say that it is a form of investment against future needs, whether planned or unplanned. The same goes for *harambees* within MFI groups. This reasoning is borne out by the fact that, according to focus group participants, the use of merry-go-rounds has not decreased, but increased<sup>6</sup>. *Harambees* within MFI groups has not enjoyed the same popularity, but they too, are increasing. The majority of focus groups stated that the use of welfare groups had also increased, particularly in the case of burial associations.

**Increase in the use of business income and casual labour.** On-farm income used to be the major source of income for most rural clients. Climatic changes, a downturn in world prices and government policies served to negatively affect the major cash crop industries of coffee, tea and milk, especially in Kenya. In addition, many formally employed people have lost their jobs. This reality has not only put economic strain on farmers and the previously employed, it also shrinks the purchasing power upon which the commercial sector relies. It has also catalysed the entry of many more people into the informal sector where, according to MFI clients that the team interviewed, saturation occurs rapidly. The increasing use of MFI loans to boost or start a business reflects the need to turn to off-farm income. It also reflects a growing dependence on debt to finance working capital because of a decline in business volume. In fact, the only focus group to state that they had decreased the use of business income to cope with HIV/AIDS related crises, attributed the decline to reduced market demands due to a reduction in purchasing power. Diverting MFI loans to respond to lump sum cash needs also reflects the limited capacity of businesses to produce enough income to handle unexpected needs for lump sums of cash. Clients see the diversion of loans as a way to avoid drawing on and eroding their business capital.

**Selling assets.** Similar to in Uganda, there was a definite distinction between selling small assets (household possessions or chickens) and selling productive assets (land, business capital cattle). All focus groups viewed selling land as a last resort, while the sale of small assets increased in the last five years, 1995-2000, (perhaps to cover the gap in what could be raised from friends, relatives and business income), selling land decreased. When asked why, participants invariably answered that, “once you know someone is HIV+, there is no sense in selling land to finance their cure—because we all know there is no cure and selling land is not going to help them.” Participants who stated that there was a decrease in selling small assets believed it was due to an increase of people who had no assets left because they experienced multiple deaths in close succession within their extended family.

**d) The role of microfinance in supporting the coping needs of clients**

Microfinance loans become less of a preferred coping mechanism once an HIV/AIDS related crisis begins eating into a household’s productive assets. The pace at which the “care-cycle” stage happens varies among households. However, the turning point of a loan changing from boon to burden seems to be when it increases pressure and competition for lump sums of cash just as a client experiences a dip in income flow—usually due to closing the business to undertake care taking responsibilities.

However, the declining health status of a PWA and the economic degradation of the care taking household do not happen at the same rate in every case. The severity of the strain and resulting economic degradation depends on:

<sup>6</sup> However, focus group participants also said that merry-go-rounds had more problems now than previously. There were more instances of people exiting merry-go-rounds immediately after their turn had passed. This significantly weakens the effectiveness of the mechanism. Nonetheless, when asked, many clients in Kenya said they belonged to one or more merry-go-rounds.

- The economic resources (including strength of business) available to a client when the crisis begins to affect her/him;
- How many crises occur;
- The duration of the crisis;
- The timing in between crises;
- Type of crisis (dealing with prolonged illnesses and then absorbing orphans is more economically stressful than absorbing orphans only);
- The relationship between the care giver to the infected person (clients caring for his/her spouse or adult children are generally affected more than the extended family);
- Quality and number of coping mechanisms available to the client; and
- Networks that client belongs to (especially informal) and knowledge of resources available to her/him to tap into (both formal and informal).

It is important to point out here that, because the typical MFI loan cycle is 3 to 4 months and AIDS related crises draw out over longer periods, many care giving clients will opt out of the programme before the loans place an inordinate burden upon them. In other words, since most MFIs strip clients of membership for not continuing to take consecutive loans, such clients will drop out between loan cycles and terminate their membership rather than take a loan they know they will have trouble repaying. The same appears to occur for HIV infected clients who begin to suffer severely from AIDS-related illnesses.

#### **i) Effects of HIV/AIDS related crises on the performance of MFI clients**

The coping mechanisms mentioned in the previous section all play an important role in empowering MFI clients to handle crises. The more coping mechanisms a client or group of clients have at their disposal, the better equipped they are to respond to crisis without their performance within the MFI being affected. However, because some clients or client groups have developed or have access to fewer mechanisms for these people, it is not long before crisis begins to take its toll on their performance within the MFI. It is difficult to separate the effects of HIV/AIDS on an individual group member's performance from the effects suffered by the group. Below is a broad description of how HIV/AIDS affects individuals and groups within an MFI.

#### **Effect on Loan Repayment**

**At start of a crisis**—When HIV/AIDS related crises strike, they tend to re-arrange clients' priorities. Suddenly, medical care assumes a much higher priority than loan repayment. Interestingly, it is usually not possible to detect this re-arrangement until clients' coping mechanisms begin to weaken. Initially, clients will continue to service the loan as best they can from savings, the sale of assets, gifts from friends and relatives, and even from the loan – if the client received the loan shortly before the crisis struck. Clients with a wider range of coping mechanisms are able to service their loans more effectively for a longer time before they begin to have repayment difficulties.

**In the middle of a crisis**—As a crisis progresses, a client will draw on one coping mechanism after another or several simultaneously. Some will need to draw on only a few coping mechanisms before the crisis ends. Others will have to draw on the whole range of coping mechanisms available to them. For those who experience a prolonged crisis, the middle of the crisis is the point at which most clients feel the heaviest financial burden because: (a) the business has been drawn down significantly; and (b) the client continues to experience the financial pressures of daily living in addition to the extra pressure placed on them by the crisis.

The following three factors mean that the client is particularly economically vulnerable and is thus more likely to have repayment problems. Loans are only likely to become delinquent if the client:

- did not have much to draw on in the first place;
- has a crisis that begins at the beginning of, and continues throughout, a loan cycle; and/or
- recently experienced another crisis from which they had not yet fully bounced back.

A vulnerable client is more likely to service the loan fully if the crisis strikes midway through the loan cycle because it is reasonable to assume that s/he had already invested the loan in the business. Chances are also good that they will not have exhausted the range of coping mechanisms available to them. On the other hand, if the crisis strikes just after loan disbursement, it is more likely to become delinquent because the client may divert the loan to the crisis at disbursement. Once a client exhausts individual coping mechanisms, the loan will become delinquent unless the group helps.

**At the end of a crisis**—Clients whose loans become delinquent after a crisis has passed are usually the minority. They tended to be those who:

- took out a loan just at the beginning of a crisis;
- took out the loan with the specific intention of dealing with the crisis
- diverted the entire loan to the crisis;
- were already vulnerable before the crisis hit; and/or
- did not have a very wide range of coping mechanisms available to them.

### **Box 12. Juggling Loans and School**

An MFI client in Uganda explained how he coped with paying for school fees for his and his late brother's children. "I can't send my children to school and not my brother's. So, I take a larger loan than I need for my business and use a third of it for school fees and the rest for my business. This has worked well for me."

#### **Effects of crisis on clients' borrowing patterns**

**At start of a crisis**—Clients who experience a crisis towards the end of one loan cycle sometimes try to borrow more than they need for the business in order to divert some funds into the crisis. They tend to carefully consider the implications of this course of action and usually manage to service the loan without trouble if the crisis is of a predictable nature (for example, knowing that you need to take in orphans). If the crisis is not predictable in terms of its intensity and duration, then the client is likely to have problems with repayment.

**In the middle of a crisis**—Clients who are mid-way through a crisis at the completion of a loan cycle are already vulnerable. For subsequent loans, such clients tend to take a smaller amount because they suspect that the loan will become a burden. Some will want to miss out an entire loan cycle altogether and borrow again when they are able.

**At the end of a crisis**—Those who have not left or driven out by their group by the end of the crisis are vulnerable, but need access to credit to recuperate financially. Therefore most of these clients want to take a smaller loan given their reduced ability to absorb debt. They have most likely balanced their previous loan against their savings and they therefore do not have much in their savings account with which to secure a loan.

### **Box 13. Robbing Peter to Pay Paul is a Rational Decision—Hajat's Story**

Hajat Kityo is a member of a Ugandan MFI that targets women. Hajat owns a coffee farm and runs a poultry business. She and the rest of her group members are primarily farmers. A few years ago, Hajat lost her brother to HIV/AIDS. He left her responsible for the care of 38 children. Shortly after that, her sister died of AIDS and left her with two more orphans. Then her daughter too began to weaken from HIV/AIDS related infections. "We took her to hospital and she was admitted for a while", Hajat reminisces, "but then when it looked like she certain to die, I brought her back home. She was gone within a few days, leaving me with her two children." Hajat now cares for 42 orphaned children. Asked how she manages to care for them all and keep them in school, her reply was, "The MFI loans have been very helpful. I know that they tell us we must use the loans for business and so I tell them what they want to hear when I apply for the loans. However, I use them to pay fees for my children. What do you expect me to do?"

Hajat inherited rental houses from her late brother. She uses the rent income and sales from her poultry farm to repay the loans. She feeds her 42 children from the produce of her farm. For Hajat and many like her, the decision to divert the loan is rational one. She has carefully considered her decision and is ready to take the risk. There are many like her for whom microfinance is a major coping strategy. Without the MFI loans, Hajat would not be able to send her children to school.

Microfinance is serving many HIV/AIDS affected people—perhaps unwittingly. Most clients are healthy, economically productive and repay their loans. While MFIs are wary of serving highly vulnerable clients, Hajat’s story demonstrates the value of credit to such people and their ability to manage credit.

HIV/AIDS affects the behaviour of MFI clients, as Hajat’s story demonstrates. MFIs need to acknowledge that they are serving many clients affected by HIV/AIDS. This could pave the way for product refinements that enable MFI clients, like Hajat, to reap increased benefits from microfinance.

### **Effect of crisis on clients’ savings patterns**

**At start of crisis**—Clients adhere to their normal savings patterns at the start of a crisis. They make their loan and savings payment as normal.

**In the middle of crisis**—The amount a client is able to save depends on (a) the range of coping mechanisms available to client before crisis (b) economic position of client before crisis and (c) the intensity and duration of crisis. If a client has a smaller range of coping mechanisms, was already vulnerable before the crisis and the crisis is intense and drawn out, clients might decide to balance their loans off from their savings. Most will then save less because of the other financial demands placed on them coupled with the decrease income. Generally, however, clients realise that they need to save in order to have future access to credit and many of them will continue.

**At the end of a crisis**—After a crisis, clients are ready to actively participate in the group and MFI again. If they have retained their membership and the group did not push them out, they will resume saving or continue to save within the MFI.

### **Box 14. Hang onto Life – The Saving “Boomerang”**

Betty is a single mother with one child. She is a member of an MFI in Eastern Uganda. Betty joined this MFI when it first began to extend its services to the people in her community and is one of its oldest clients. She has been through 4 loan cycles. She invested the first 3 loans into a brewing business. By the fourth loan, Betty’s business had grown significantly. She decided to purchase molasses in bulk in order to make an even larger profit from the loan. Unfortunately, Betty purchased adulterated molasses. The spoiled molasses severely affected the quality of her brew and Betty steadily lost customers. She still serviced the loan as best she could off her limited sales.

Midway through the loan cycle, Betty’s son fell ill and was hospitalised. She had to close her business to take care of him. She continued to make the loan payments off her savings even though her business was closed. Eventually, she exhausted her savings. She managed to repay the loan and was anxious to maintain her group membership. She realized that once the crisis passed, she would need a loan to bounce back. So, she put aside small amounts of money from contributions by sympathetic friends and relatives who came to visit her in hospital. Each week, she faithfully sent money to the group.

On her return, the group asked Betty to leave because she had been absent for several meetings. But because of the commitment she had demonstrated, she was able to persuade the credit officer and the group to let her stay. The condition was that she misses a loan cycle.

Betty is still a member of the group. She uses an old sewing machine to mend clothes for people. “It does not bring in much”, she says, “but it brings in enough to keep me and my son going and to make my weekly savings. When I am able to take a loan again, I shall rebuild my brewing business.”

For Betty and many like her, access to credit after a crisis makes all the difference between bouncing back or not. Many clients, like Betty, go to great lengths to retain access to financial services. The nature of financial services required by people hit by crisis changes as the crisis evolves. At certain points, they are no longer able to service credit because they do not have an income. Nonetheless, the MFI then plays an important role in enabling them to bounce back.

### **Effect of crisis on clients’ attendance**

**At the start of a crisis**—Initially, when a client has an HIV/AIDS infected family member that they are taking care of from home, they often are unable to attend some of the group meetings.

**In the middle of a crisis**—As the patient begins to weaken and to require more attention, the client is unable to attend weekly meetings. S/he may still send her loan repayment to the group. Nonetheless, some groups push the client out at that point, especially in MFIs that place emphasis on ability to attend meetings. The client would genuinely like to attend the meetings, however they are constrained by their circumstances.

**After a crisis**—After the crisis, those clients that still have loans to repay but have exhausted coping mechanisms tend to avoid their group’s meetings because they are unable to make the loan repayments. They know if they come to the group without their payment the group will not understand. Many clients however are able to fully repay their loans even during crisis times. In MFIs that do not require attendance as long as the payment comes in, the group accepts the client back.

#### **ii) Effects of HIV/AIDS-related crises on group performance**

Once an individual within a group is affected by a crisis, the effects inevitably spread out to the rest of the group. This is especially true if the crisis is severe or prolonged. Effects on the group include:

**Undermining Cohesion**—While not universally true, some MFI groups have reported decreased cohesion stemming from frequent absences of members experiencing HIV/AIDS related crises. This is especially true if the group has to cover the loan repayment instalments of absent members repeatedly.

**Making payments for affected members**—MFI groups often have to make payments for affected members who are unable to come to meetings. If she runs out of options and her outstanding loan balance is still larger than her savings, the group will cover or top-up her instalment. First, however, the affected member is obligated to service the loan and the group expects her to repay them.

**Delay in disbursement of subsequent loans**—In accordance with best practice, most MFIs will not disburse new loans when there are arrears within a group. Since a crisis in individual members’ lives will sometimes interfere with their ability to service their loan, the result is that the MFI will delay subsequent loan disbursement for the entire group. Usually, the group will cover the missing instalments so that this does not happen. If this occurs too frequently, it can discourage those members not in crisis and lead to their departure from the programme<sup>7</sup>.

## **6. MAINSTREAM MICROFINANCE SERVICES INNOVATIONS**

This section discusses how clients use microfinance services before, during and after HIV/AIDS related crises and what adjustments MFIs can make to business loan services to increase their relevance to care giving clients. The challenge of devising MFI responses to client care givers impacted by HIV/AIDS rests on three factors:

1. the financial needs and abilities of MFI clients change as HIV/AIDS-related crises evolve;
2. the fact that HIV/AIDS does not affect each client in the same way; and
3. the individual MFI’s capacity to innovate.

Therefore, it will not be possible or desirable for this study to propose a “one-size-fits-all” solution or a neat package of responses to financial stress brought on by HIV/AIDS.

In addition, the main purpose of this study is to illuminate the economic dynamics introduced by HIV/AIDS and the manner in which this affects client behaviour and, ultimately, the MFI. Understanding these dynamics serves as a foundation upon which further market research on new products or refinements should take place. Nothing can substitute for an institution doing its own homework about its

<sup>7</sup> See Stuart Rutherford’s discussion of the “unzipping” of groups in “Optimising Systems for the Client and the Institution” in Wright, 2000a.

clients. Each MFI needs to approach the process of product development in its own institutional context (i.e. what works for one MFI may not work for another because of different basic methodologies and institutional capabilities - see, for example, Wright 2000a).

Another important point worthy of clear, unambiguous emphasis is that MFIs should **not** be specifically targeting HIV+ clients with special loans. Microfinance programmes work best when they rely on client self-selection and focus on packaging financial services to attract the desired clientele. Artificially engineering or predetermining the composition of groups undermines the delicate mix of peer pressure and group accountability upon which many lending programmes build their success. Explicit targeting of HIV+ clients tends to increase stigma and has negative outcomes. In addition, targeting prevents clients from spreading the risk of default among their group members because they are all particularly vulnerable.

**a) Refining services to better respond to the economic crises of HIV/AIDS**

During the course of the study, MFI clients indicated that they highly value access to any service that alleviates financial pressure. Reducing pressure in just one aspect of their lives often is enough to enable clients to manage the rest. Reducing vulnerability and financial strain is in the best interest of the MFI because it will improve clients’ ability to repay and remain as clients in good standing. Even though HIV/AIDS affects clients differently and financial needs evolve during a crisis (or crises), the more economically vulnerable the client, the sooner they fall through her/his personal and extended family safety nets, and the sooner they have problems in the MFI programme.

The following sections focus on suggestions for capitalizing on clients’ ability to:

- Plan for future crisis (anticipate needs for lump sums of cash);
- Improve and maintain income flows;
- Avoid selling productive assets, which undermines future income earning capacity; and
- Retain access to financial services, particularly post-crises.

**Box 15. From the Client’s Point of View...**

“The best way an MFI can help people is to empower them to increase their incomes and profits so that they are better placed to handle multiple expenses.”

“Loans are only good if there are no problems. When there are serious problems, the loan becomes a burden; in fact, you may have to sell an asset to make repayments.”

“Others not in MFIs may get grants or welfare, but women in MFIs work hard and create wealth. They cope differently, like wells. You take out water from it, but the well does not dry up. It keeps refilling.”

The following table illustrates the role of financial services throughout an HIV/AIDS related crisis and the corresponding product refinements.

**Table 3. How MFIs Can Improve Clients’ Ability to Weather an HIV/AIDS related Crisis**

Crisis-cycle stage	Microfinance role	Suggested MFI refinements
<p><b>Before an HIV/AIDS related crisis occurs</b></p>	<ul style="list-style-type: none"> <li>• Encourage clients to build up savings and assets</li> <li>• Teach and require financial discipline and planning ahead for future lump sum needs</li> <li>• Assist clients to increase business volume or diversify business activities (vertical or horizontal growth)</li> <li>• Make networks more accessible (both social and economic)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Fluctuating loan sizes and terms to coincide with ebb and flow of clients’ business cycles throughout the year</b> such that clients can take out larger loans when market demand is high and their business volume is greatest. Then, when the purchasing power of the marketplace shrinks, clients would return to smaller loan amounts to reflect reduced volume. This is especially relevant for clients in communities where their customers’ cash income is tied to agricultural cycles.</li> <li>• <b>Spread interest out over the loan period</b> (for MFIs that charge interest up-front) as opposed to requiring clients to pay the entire amount of interest up-front even before loan begins to generate a profit for the business.</li> <li>• <b>Encourage savings</b> by: (a) <b>paying out interest</b> on voluntary savings<sup>8</sup>; (b) <b>allowing frequent access to savings</b> that are not guaranteeing the loan; (c) <b>linking up groups with banks</b> in which they can save (if the MFI is reluctant to take on the additional cost and administrative burden). Linkages are already within easy reach of MFIs given that most clients already service their loans through commercial banks. Some MFIs, already link their clients to banks for savings that exceed the mandatory amounts.</li> <li>• In some countries, the legal and regulatory framework does not permit MFIs to mobilize savings. <b>Alternatively, MFIs can encourage/support the development of ASCAs within their solidarity groups</b> that can then function as useful savings mechanisms and rapid emergency response facilities.</li> <li>• <b>Educate clients on the benefits of saving.</b> In order for MFIs to encourage savings, they will need to allow clients who are in crisis to stay within the group without taking a loan and to continue to save without taking a loan.</li> <li>• <b>Seek out linkages to business development service organisations</b> in the interest of stimulating the growth of clients’ businesses.</li> <li>• <b>Adapt orientation sessions</b> to include discussions about how the groups and individual will handle crises, particularly but not exclusively, when they are HIV/AIDS related.</li> </ul>

<sup>8</sup> However, paying out interest rates will only be possible for those institutions that can intermediate voluntary savings for their clients.

Crisis-cycle stage	Microfinance role	Suggested refinements
<p><b>Beginning to middle of crisis</b> (Early stages and Frequent hospital visits)</p>	<ul style="list-style-type: none"> <li>Protects clients by providing options other than selling productive assets to acquire lumps sum of cash</li> <li>Makes acquisition of lump sums convenient by providing loans that are repaid in instalments</li> <li>Promote client’s creditworthiness in the MFI as leverage to other sources of credit</li> <li>Group behaviour mitigates financial pressure</li> <li>Allows clients to draw on savings to respond to financial pressures</li> </ul>	<ul style="list-style-type: none"> <li><b>Allow clients to miss meetings as long as they send in payments.</b> It is possible that frequent absences of different group members could undermine the group guarantee mechanism. However, some MFIs have been able to exercise this type of flexibility without adverse consequences.</li> <li><b>Allow clients to rest between cycles without pushing them out.</b> This implies changing an MFI’s incentive system. Most MFIs tag loan officer incentives to the number of active loans and outstanding loan balances. This puts pressure on the loan officer to force clients to either take out a loan or exit. This can lead to delinquency, (because the client feels compelled to take a loan that s/he is not ready for) or loss of a trusted client with an established credit history (because they exit rather than take a loan they feel they will have trouble repaying).</li> <li><b>Encourage informal, group-based coping strategies that reduce financial pressure.</b> It is in the MFIs interests to pay attention to which informal coping strategies are effective and why. They can then encourage their clients to use effective strategies so that when crisis strikes, the individual crisis does not severely undermine group cohesion and group performance within the MFI.</li> </ul>
<p><b>Height of crisis</b> (Bedridden)</p>	<ul style="list-style-type: none"> <li>If at beginning of a cycle, the client diverts the loan to cover lumps sum needs for cash rather than using it for their business activities</li> <li>Loan repayment creates added strain, forcing client to sell assets</li> <li>Can undermine ties with group or informal group arrangements form a central part of clients’ coping strategies</li> <li>Client may exit MFI to access the savings</li> </ul>	
<p><b>After</b> (Death and care for orphans)</p>	<ul style="list-style-type: none"> <li>If client maintained her credit worthiness, she rejoins and uses credit to restore her business and “bounces back”.</li> <li>If pushed out, then it is unlikely she will be able to rejoin.</li> </ul>	<ul style="list-style-type: none"> <li><b>Allow clients to take out smaller loans without fear of penalties.</b> After a crisis, many clients want a smaller loan than they had previously. Some MFIs allow clients affected by a crisis to quickly move up through the loan cycles once they return. For others, the client has to work their way up again if they opt for a smaller loan. To avoid this, some clients end up taking a larger loan than they can service.</li> <li><b>Allow longer loan terms</b> so clients can spread smaller loan payments over a longer period—perhaps with reduced interest rates. The organisation would need to build in controls so that this does not become the norm for those not affected by crisis.</li> </ul>



## **b) Developing new products in response to financial pressure points**

In general, clients who participated in this study indicated that HIV/AIDS related crises had three major pressure points. This section will discuss how microfinance can respond to each of these pressure points in a way that enables institutions to mitigate their clients' financial pressure and thus reduce the risks to the institution.

### **Pressure Point 1—Before care givers and infected people know that they are to be affected by HIV/AIDS:**

This point is especially burdensome in Kenya where people who experience AIDS related symptoms tend to avoid HIV tests. This means that the family concentrates on treating each symptom in isolation without the benefit of knowing that they arise from a common and fatal cause. Consequently, the family spares no expense since they view each symptom as an isolated attack of a different disease. Taking care of sick family members often forces microfinance clients to close their businesses and liquidate personal assets. The convergence of high medical expenditures and dips in income at this and future pressure points constitute a major financial burden that affects the clients' ability to service credit.

According to the majority of focus group participants, the most effective way to relieve pressure at this point is to reach a level of awareness that enables a PLWA to disclose their HIV status without fear of discrimination. Clients felt that until people's attitudes changed, they (as extended family members, parents or spouses) would continue to endure the impact via caring for PLWA and taking in orphaned children almost in solitude. Thus, MFIs clients appeared to want organisations to deliver their general message on AIDS prevention and awareness to their community at large, not just to them.

Clients also had direct interest in practical topics relating to managing economic stress, and planning and caring for someone suffering from AIDS related illnesses. They specifically valued information about AIDS so they could prepare for and anticipate the financial burden brought on by the disease. They saw this as an important factor in reducing the economic effect of AIDS. Planning included devising better ways to save, such as organizing group-based mechanisms (for example emergency or welfare funds, RoSCAs or burial associations) that could respond to sudden economic stress. Similarly, clients wanted information about how to cope—economically and psychologically—with AIDS-related crises when they strike. Given the varied interests that clients reported to the team, an MFI should be sure they understand what information their specific clientele wants and communicate this with an ASO.

MFIs cannot directly respond to these needs without diverting some attention and resources from their core activities (i.e. delivering financial services). At the same time, they cannot ignore the effect of financial pressures on their clients and the subsequent impact on the MFIs themselves. Options for providing some relief for clients include:

- **Linkages with ASOs** that provide MFI clients and their communities with information and education that increases levels of awareness. It has the advantage of allowing both the MFI and the ASO to concentrate on their comparative advantages and individual mandates while jointly helping decrease their client's vulnerability to the risks created by HIV/AIDS related crises.
- **Direct exposure to HIV/AIDS education through MFI staff** (credit with education methodology). This does not have to compromise best practice. Only one (FOCCAS) of the MFIs that participated in the study had a credit with education approach. However, their credit officers' portfolio sizes, client numbers and performance levels were similar to those of a credit only MFI. Nonetheless, the dangers of this approach would be that: a) it could create additional strain to already over-stretched credit officers and compromise their effectiveness in managing their credit portfolio and b) the credit officers lack the specialized skills required to deal with the complex nature of HIV/AIDS related issues. However, in situations where ASOs are not readily accessible, this is a second best option.

## Pressure Point 2—Family member with AIDS is bedridden at home or in hospital:

As discussed earlier, in Uganda and Kenya the most financially burdensome stage of HIV for those MFI clients in a care giver position is when the person they are taking care of is bedridden. High medical expenses, loan repayments and ordinary household expenses converging during an income lapse (because the care giver is forced to close her/his business) create this burden. MFIs can help relieve some of their clients' financial pressure at this point by:

- **Providing access to medical insurance:** For many MFI clients, the costs of medical care caused significant financial pressure. One health emergency could wipe out their savings. Clients recognize that diverting the loan to pay medical expenses is not a productive use of the loan. In instances where they divert the loan anyway, it is because they find themselves with no other option. Some MFIs have sought to respond to this problem through an internally managed health insurance scheme<sup>9</sup>.

However, where MFIs have attempted to directly provide medical insurance, clients' perceptions have not been very positive. The clients of one MFI that participated in the study had had the opportunity of accessing health insurance first from an external service provider then later from the MFI. They pointed out that the conditions offered by the external service provider were much more generous and efficient. Many of them had subsequently not renewed their subscriptions once the external service provider phased out. It is therefore advisable for MFIs that are offering this product as well as for those who plan to offer similar products to take more time to understand their clients' needs in this regard in order to refine the product.

Clearly there is a general scarcity of appropriate insurance providers and products in the marketplace. In Uganda, MicroCare's use of MFIs as a vehicle for the provision of prepaid, preventative health care represents potential for the sector. In Kenya, there is limited coverage provided in-house by some MFIs<sup>10</sup>. In general, the insurance industry continues to exclude the sector both by their focus and by HIV/AIDS exclusion clauses, especially in Kenya. Nonetheless, a better option to internal management of insurance might be to create linkages with someone who specializes in providing that kind of service<sup>11</sup>. As is typical to the insurance industry, the methodologies explored in the course of this study use 'risk pooling.' This enables clients and their family members have access to a range of medical services for only a fraction of their cost and creates not only a saving for clients but significant relief in the financial pressure experienced at this point through eliminating the need to raise a lump sum in order to access medical care. These linkages would be mutually beneficial to the MFI and their client because the access to health insurance: a) Minimizes time away from the business for the client due to sickness; b) Eases the burden of medical expenses for clients - thus reducing the need to divert loans; c) Enables clients to pay for premiums over time through weekly savings and they would therefore not require large lump sums of money.

To the health insurance provider, the linkage with the MFI provides them with access to a pool of people who are not self-selected according to poor health and hence minimizes their risk. The group arrangement also allows the insurance provider reduce the transaction cost for collecting the premiums.

- **Linkages with home-based care (HBC) projects:** These are NGOs or CBOs that catalyse community members to respond to AIDS impact by providing training to family members in palliative care at home for AIDS patients. NGOs, often in collaboration with government field staff, provide training-of-trainers to community health workers who in turn train family members. Clients said they valued counselling, information on opportunistic illnesses and palliative care, planning for medical expenses, where to get advice and treatment and the types of herbal medicines to use. In addition, the best programmes mobilise the community to pool labour for home care (for those skilled in health care), for household or childcare chores (for others). This would allow clients caring for PLWAs to keep the business open longer and more often. MFI management should be aware of and prepared for the organisational politics potentially associated with linkages and partnerships.

<sup>9</sup> Although most experts would argue that MFIs have neither the technical skills nor financial resources to underwrite/insure this complex risk (see *MicroSave's* MicroInsurance Centre: [www.microinsurancecentre.org](http://www.microinsurancecentre.org).)

<sup>10</sup> Faulu/Kenya who reported progress in the area of forming a partnership with an external insurance provider.

<sup>11</sup> As is now being started by a consortium of K-Rep Development Agency, K-Rep Bank and the health management organisation African Air Rescue (AAR).

### **Pressure Point 3—Caring for orphans and payment of their school fees**

A third major pressure point occurs when MFI clients take in children whose parent(s) have died from AIDS. This pressure typically manifests itself in the form of school fees. Currently, some MFI clients cope by sending children to cheaper schools and/or diverting credit to pay fees. Because paying for school fees is a predictable expenditure for which clients can plan, this area offers opportunity for product innovation that would enable clients to accumulate lump sums for this expressed purpose. Options include:

- **Contractual Savings Products:** The team ran a very preliminary concept test (a series of focus group discussions to assess the acceptability of a product “concept” or idea – see Wright, 2000) with the clients concerning savings options that would allow for the accumulation of lump sums for fees. Most indicated that they appreciated the idea of a contractual savings product but would only be attracted to such a product if: a) it was coupled with another liquid savings account that can be used to respond to other more abrupt crises that cannot be easily planned for; and b) if there were adequate returns to justify tying up these savings. Another option to address emergency finance needs is to allow clients to borrow against their contractual savings account.
- **School Fees Loans:** In the preliminary concept test, most of the participating clients indicated a preference for school fees related savings rather than loan products. The exception was in case where the savings were less than what was needed and the savings could be used as leverage to obtain a larger amount of cash. However, clients acknowledged that, because of the financial pressures they faced on a day-to-day basis, there would always be those who were unable to save and for these, a school fee loan would provide financial relief. Besides the preliminary concept test, the team interviewed two MFIs that had school fee loans. They reported mixed experiences with this type of product. One institution treated the school fee loan as a non-income-generating loan and therefore charged a lower interest. This created an unintentional incentive to take the lower-interest, school fee loan and use it to invest in business. Staff from this institution also noticed that clients had trouble servicing two loans. Clients who pointed out that the additional loan did cause them problems corroborate this opinion. However, what was not clear during the study was since some MFI clients who take loans from more than one institution do not appear to have a significant difficulty servicing two loans, why does there appear to be great difficulty for those taking multiple loans from the same institution? One explanation could be that, for clients experiencing a crisis, such a loan comes at a point when the client is already economically vulnerable. While it does create immediate relief, the relief is short-lived and the client is likely to have difficulty servicing this loan in addition to the regular business/working capital loan from the MFI.

#### **c) Options to strengthen clients’ overall coping ability**

As mentioned earlier, clients with a more coping mechanisms are in a better position to manage HIV/AIDS related crises. Also, clients view their coping ability as an integrated issue; ability to cope in one area provides relief so that resources can be diverted to cope with another crises or pressing need. This section discusses options that decrease MFI clients’ overall vulnerability and hence strengthen their coping ability. With regard to options that are already available within MFIs, this section discusses possible refinements based on clients’ comments with a view to improve MFI’s responsiveness to clients.

### **New products**

**Insurance products**—Many of the MFIs that participated in the study offered some form of life insurance product. However, many of the clients who participated in this study felt that their MFI’s insurance products were abstract and related to situations that were the exception rather than the norm. For instance, some MFIs insurance covered death by accident and their clients pointed out that accidents were the least cause of death in their solidarity groups. Clients seemed to appreciate an insurance product that is:

- Clear, easy to understand and readily accessible;
- Yields tangible benefits to them; and

- Relevant to their circumstances (i.e. pay-out for crises they frequently experience as opposed to those they rarely experience).

MFIs might therefore consider:

- Allowing an insurance product to apply to all causes of death with the understanding by clients that once it has run out, they must resort to use of informal internal group mechanisms until the fund accumulates again. However, this is likely to increase the size of premium and make it unaffordable for clients. Therefore, the MFI should give clients the option to select a higher premium product that covers death from other causes;
- Allowing clients to have more input into the design of insurance products so that the result is products that they understand and find relevant; and/or
- Linking up with insurance companies to enable their clients access to types of insurance that they as an MFI deem too risky to provide directly<sup>12</sup>.

**Emergency loans**—Again, the experience with this product is similar to that of the school fee loans. In some cases, it creates an additional burden just when a client was at his/her most economically vulnerable. Absorbing more debt at such a point is not necessarily the wisest recourse, but is often too tempting to pass up. In addition, clients reported dissatisfaction with delays in disbursing this type of loan—cancelling out its effectiveness in responding to a crisis. MFIs need to conduct their own research to determine how to package such a product.

### Promoting informal coping mechanisms

**Group-based mechanisms**—Many client groups already use informal coping mechanisms that play a significant role in reducing financial strain caused by crises. While MFIs cannot and should not try to imitate these mechanisms, they can however influence clients to create and exploit them. It would be especially beneficial to encourage clients to become involved in developing strategies **before** crises occur. Another broad area would be to promote mutual support, but to assist the group to think through where this is beneficial and at what point an individual's crisis will pull the group down with her/him. Some specific types of informal arrangements that MFIs could promote include:

- **Burial funds** that are internal to the group and help take care of the expenses incurred by a group member who has lost a close family member, preventing death from becoming an overwhelming financial burden to that member.
- **RoSCAs** that finance daily household expenditures, rent and recurrent costs and can relieve some pressure for lump sums of cash. RoSCAs are an important part of clients' coping strategies. They are especially popular because they rely on small contributions that do not strain clients, at the same time they allow the client to access a lump sum of cash with no interest payments. The RoSCA is especially favoured for its predictability; the client knows exactly when it will be his/her turn and they can borrow against this money or plan ahead using this as a potential source of cash inflows. MFIs should encourage their clients to use these mechanisms because they strengthen clients' economic ability and provide something for them to fall back on during times of crisis. Thus, when crises hit, clients do not significantly risk their MFI membership with poor performance.
- **Internal Savings funds/ASCAs** that would provide something for clients to draw on in times of crisis while demanding little administrative time from the MFI staff.
- **Emergency Funds** to which all members contribute regularly and against which they can access 'soft loans'<sup>13</sup> to make loan repayments or resolve crises. Also, these can become ASCAs offering high interest loans from which members would share the profit. ASCAs are especially popular because of the notion of shared profits. Some MFIs have perceived group ASCAs as a potential competitor and have sought to abolish them. However, their role should be viewed as complementary rather than competitive. They provide a system in which clients can draw on lumps sums during an emergency unlike the scheduled administration of loans provided by MFIs.

<sup>12</sup> This has been started by FINCA-Uganda, which is working with American Insurance General to offer a life-loan-accident product (see *MicroSave's* MicroInsurance Centre: [www.microinsurancecentre.org](http://www.microinsurancecentre.org) for detailed documentation of this).

<sup>13</sup> At subsidised interest rates

Ultimately, each institution must choose which of these arrangements it will promote based on the institutional implications of the different arrangements. Similarly, each group must choose which of the arrangements it will adapt. Many MFI credit groups already have one or more of these arrangements existing informally among their members.

### **Cultivating linkages with social service organisations**

The more an MFI cultivates linkages on its clients' behalf, the better equipped they are to handle crises. This puts clients in a position to weather crises such that the affect on their performance within the MFI is minimized. Focus group participants ranked MFIs that pursued a 'credit only' approach as least important in their communities. On the other hand, clients ranked MFIs that created linkages between them and other organisations as very important. Even though clients were aware that an autonomous institution separate from the MFI delivered the additional services, they still ranked the MFI as one of the most valued organisations in their community. Clients appreciate **access** to the non-financial service and they saw value in an organisation that facilitated that access.

While one cannot expect MFIs to directly address the non-financial needs of their clients, they are in the position to facilitate linkages that would result in meeting these needs. Many interventions are already available through separate and specialised organisations in and around the communities in which MFIs work. The basis of the linkage would be a common geographic area where both organisations serve the market, but would remain operationally independent. These synergies would significantly empower MFI clients to deal with crises, which has a positive influence on their performance in the MFI. However, in order to build effective linkages, MFIs must take the time to listen to their clients and to understand the issues that affect them as these differ from one community to another. The following are linkages in which focus group participants expressed an interest.

- **Orphan and Vulnerable Children (OVC) projects**—These are frequently NGOs or CBOs that usually target widows and other care takers of orphans. General areas of emphasis are on affording orphans and vulnerable children access to education and on providing support to widows. They sometimes try to create scholarship funds and work with school officials to reduce financial requirements for especially needy children. The best projects also catalyse community action to address the needs of OVCs and widows.
- **Health care service providers**—This includes access to training and information on preventive health measures (e.g. nutrition, sanitation, malaria and diarrhoea). It also includes possible linkages to prepaid health care services—both preventative and curative.
- **Legal aid organisations**—This covers clients' need for information on their rights, how to write a will, and how to avoid "property grabbing" in order to protect the interests of widows and orphans.

## **7. TARGETED PROGRAMMES**

Although focus group discussion groups were comprised primarily of mainstream MFI clients, clients of programmes that mixed credit with targeted social welfare services to AIDS infected and affected people were also included. In each case, the organisations started out by providing social and health services to people infected with AIDS, to widows whose husbands had died of AIDS or to care takers of children whose parents had died of AIDS. In general, the programmes exhibited a common evolution towards credit as follows:

- Initial access to free goods and services;
- Inability to sustain services because of donor need to spread resources more widely and increasing pressure from target clientele to address the economic effects of HIV/AIDS;
- Decision to "help people to help themselves" through encouraging/supporting their income generating capacity using training, grants and/or credit; and
- (For those who started out serving PLWA) Eventual expansion of service from infected to affected care takers.

Common trends in supply side issues:

- **Poor repayment rates.** The repayment rate among the organisations interviewed ranged between 65 and 86%. Staff observed that when late payers suffered no consequences from non-repayment, those previously paying on time began falling behind in their payments.
- **Eroding loan capital and/or devolving loan fund.** Most programme staff referred to their loan capital as a revolving fund. However, in every case, the loan fund decreased by as much 50% in two years – primarily as a result of the repayment problems alluded to above. Eventually, they would need to replenish the capital—however plans to do so were sketchy at best.
- **Very limited outreach capacity.** Organisations have other services to provide to their clients. Staff typically divide their time among the various services (including credit). The numbers of clients they can reach is small. Organisations interviewed for this study served between 50 and 1,200 clients each. MFIs that specialise in delivering microfinance services in East Africa reach between 3,000 and 300,000 clients.
- **Mission drift.** Should MFIs consider themselves as NGOs providing social services or rather as being in the business of giving out and recovering credit? All programme staff reported that their clients identified the financial services with the social aspect of the organisation and consequently expected it to have “soft” policies on repayment. Over time, the organisations have been able to weed out people who were merely taking advantage of the policies. However, this has taken an inordinate amount of staff time. In one case, the organisation tapped into community knowledge of potential borrowers and avoided lending to opportunists. Another organisation observed that their target clientele no longer seemed interested in the original purpose of serving the best interests of children—they simply wanted access to credit.

Building credit into a programme with a social agenda has typically been a development challenge for social/community development-focused NGOs. Nevertheless, because of the strong demand for such services, organisations feel compelled to respond. On the other hand, social service organisations have also felt the need to provide microfinance services to the potential clients not yet reached by MFIs. Clearly, coverage has not yet reached its potential and services do not reach all potential clients – particularly in remote rural areas. As a result, in the absence of a specialized institution that knows how to deliver microfinance services, many take on the task without the benefit of experienced staff.

Over time, most organisations conclude that if they are going to offer financial services to their target clients, they need to create a separate mechanism to do so. They have also learned that such a mechanism needs to adhere to sound lending and savings practices. They discovered that serving the poor should not serve as an excuse for relaxed repayment policies or loan terms or peer pressure or the solidarity function. Relaxed policies have unpredictable consequences; it muddies the water for the operators of the scheme such that they can no longer clearly determine why people are not repaying. There are numerous examples in which slow or non-payers affect the repaying behaviour of other clients. When one person does not pay, and suffers no consequences, other clients wonder why they should repay. This attitude can then spread to other specialised MFIs in the area (or country).

In the end, some of these social development organisations conclude that they are not well suited to deliver microfinance services and either abandon the effort or seek out a specialized institution which can serve clients more effectively.

## 8. CONCLUSIONS

**AIDS is not just about the declining health and death of PLWA, it is also about those who care for them, who experience erosion of economic resources, but who must continue with the business of life.** The economic degradation experienced by a client who is a care giver to someone living with AIDS or to his/her child(ren) is not much different that that experienced by the person with AIDS. Their economic burden continues after the person dies in the form of the orphaned children and repaying debts, or paying any outstanding hospital bills of the deceased.

**Microfinance Institutions and AIDS Support Organisations can best respond to the impact of AIDS by building on their respective institutional and technical strengths.** Supporting income generation through microfinance services is important, but HIV/AIDS project implementers do not have the background for this. It would be difficult, at best, for an organisation whose purpose is social welfare or health services to manage a sustainable microfinance programme effectively. The clash of objectives at the community level between a compassionate response to those in need and loan collection are difficult to manage within a single programme. On the other hand, mobilising communities to respond to the impacts of HIV/AIDS is also crucial, but this is not the aim of microfinance. Attempting to design and manage HIV/AIDS initiatives and deliver microfinance services according to state-of-the-art principles is probably beyond the capacities of most any single organisation.

**The better MFI clients cope, the less it affects their performance within the MFI and the more likely they are to stay as a client.** Clients have developed very effective ways of dealing with crisis. MFIs should not underestimate this dimension. Understanding it provides an opportunity to develop innovative new products that reflect what clients find relevant and valuable.

**The more resources an MFI client has before HIV/AIDS-related crises hit them, the better able they are to cope with it.** A variety of coping mechanisms to gain and protect resources is also important. The two most important individual resources to build up ahead of a crisis are savings (or easily liquidated assets) and business volume or diversity in business activities. People cope by piecing together several mechanisms with the goal to reduce pressure in at least one area of cash needs. Their preference is for mechanisms that provide regular and reliable access to lump sums of cash that do not negatively affect their future income earning capacity.

**HIV/AIDS related crises are worst when multiple needs for lump sums of cash converge.** Pressure is especially acute when these needs are unplanned or repeated in close succession. A major preoccupation is to keep the business going and to avoid drawing on capital to convert to cash. Thus, **clients are likely to divert a loan to crisis needs for lump sums of cash at some point.** If the business is still stable, this is not particularly dangerous. When the loan is the client's sole source of steady income, it adds to their vulnerability. When economic stress is at its peak, it would be best for a care giver to not take out a loan or "rest" from the consecutive loan cycle, instead drawing on informal mechanisms (including non-financial linkages). After a crisis passes, access to credit is exceptionally important—it is a key factor to a care giver's ability to recover financially.

**Where individual financial capital (savings, business assets, etc.) is weak or drained, many informal and community-based coping mechanisms can provide a substitute buffer.** Belonging to a variety of mutual aid networks and knowing what resources and information are available can also make a significant difference in a person's ability to cope. These two elements can have the same effect on strengthening a care taking client's safety net and avert a final slide into destitution. In the face of seemingly insurmountable difficulties, very poor people have taken the initiative. Their spirit in seeking to mobilise external and community resources and networks is an important indicator of potential approaches that could form the basis of partnerships between MFIs and ASOs.

**While MFI clients value access to credit, credit alone is not enough.** Microfinance institutions do not need to directly deliver social services to their clients in order for their clients to benefit from such services. Clients value linkages to non-financial service providers. They attach great importance to access and by extension, to the organisation that afforded them the access.

**MFIs should not target HIV/AIDS infected/affected people.** Best practice in microfinance advises (with good reason) against deliberate targeting of loans to specific types of clients. When they do so, they compromise the integrity and sustainability of their services. This is a disservice to the other clients who genuinely want MFI services over the long term. In addition, targeting client segments within a broader clientele with preferential loan terms or products does not get good results. It tends to create a negative dynamic where the general clientele resents the perceived preferential treatment of the targeted group. This will increase stigma when others feel that their economic circumstances also warrant special considerations.

## Changing the paradigm

During this study, several microfinance practitioners were wary about delving into the HIV/AIDS related issues of their clients. A common refrain was, “We cannot get embroiled in the social problems of our clients. We can’t solve all their problems for them.” It is the team’s hope that this study will catalyse a new attitude among mainstream microfinance—listening and learning from clients to create truly responsive services. One participant at the team’s presentation said it best, “Our clients are not mere transactions. They are valuable in good health and ill health—we must make an investment in them.”

Clients value institutions that listen to them and treat them as a valuable asset. This does not mean that MFIs should forgo sound practices and undermine institutional integrity. However, it does mean that “business as usual” is no longer adequate. Innovation is urgently needed to inject flexibility and responsiveness into MFI systems such that clients are served and the institution thrives. Moreover, if the industry does not concern itself with the economic struggles of its marketplace, who will? And if not now—when?

## References

- Armstrong**, Susan, “Caring for Carers: Managing Stress in those who Care for People living with HIV and AIDS”, *UNAIDS Best Practice Collection*, 2000.
- Chen**, Martha Alter and **Dunn**, Elizabeth, “Household Economic Portfolios.” *AIMS Paper*. Harvard University and University of Missouri-Columbia, June 1996.
- Donahue**, **Jill**, “Community-Based Economic Support for Households Affected by HIV/AIDS”, *Discussion Paper on HIV/AIDS Care and Support No. 6*, Arlington, VA: Health Technical Services (HTS) Project, for USAID, June 1998.
- Hulme**, David, “Impact Assessment Methodologies For Microfinance: A Review”, *mimeo prepared for the CGAP Working Group on Impact Assessment, Institute For Development Policy And Management, University Of Manchester*, 1997.
- Kenya National Aids Control Council**, “AIDS IN Kenya: Background, Projections, Impact, Interventions and Policy”, 2000.
- Kenya’s Central Bureau of Statistics, 1998.
- Sebstad**, Jennifer and **Cohen**, Monique, “Microfinance, Poverty and Risk Management.” *AIMS synthesis study commissioned for the World Bank’s World Development Report 2000/01 (WDR)*. March 2000
- Over**, Mead, “Coping with the Impact of AIDS,” *Finance and Development*, April 1998. (This article was based on World Bank 1997.)
- Wright**, Graham A. N., Deborah Kasente, Germina Ssemogerere and Leonard Mutesasira, “Vulnerability, Risks, Assets And Empowerment – The Impact Of Microfinance On Poverty Alleviation”, 1999.
- Wright**, Graham A.N., “Market Research and Client-Responsive Product Development”, *MicroSave*, Nairobi, 2000.
- Wright**, Graham A.N., “MicroFinance Systems: Designing Quality Financial Services for the Poor”, *University Press Limited, Dhaka and Zed Books, London and New York*, 2000a.



## Appendix 1

### Research team

**Kamau Kabbucho** is the Director of **Fineline Systems & Management Ltd**—a Kenyan-based consulting firm specialized in institutional capacity building of microfinance and MSE development institutions. He has twenty years' hands on experience in training curricula development, training and institutional capacity building for organisations involved in microfinance and micro and small enterprise (MSE) development. An educationist by profession, he has been involved in the design and implementation of training for informal sector entrepreneurs and staff of microfinance and MSE support institutions. For ten years up to 1998, he worked for K-Rep with major responsibility for the institutional development and staff training of K-Rep and its partner institutions. As K-Rep's consultant for training and institutional capacity building, he has been involved in technical support of MFIs locally as well as in the Eastern, Central and Southern Africa regions to design or redesign their credit schemes and identify suitable institutional mechanisms.

**Sylvia Osinde** has 6 years' experience in Microfinance work. She has worked in the industry both as a practitioner and as a provider of consultancy and training services to MFIs in the East African Region. Ms Osinde has carried out training for staff from MFIs in East and Central Africa in the development of Business Plans using Microfin a CGAP developed programme, in addition to carrying out consulting in the area of Market Research. Studies carried out this year include one into the potential for development of leasing products and a more recent one on HIV/AIDS and microfinance.

**Jill Donahue** is a microenterprise development specialist with 16 years experience in project design, management and evaluation. Ms. Donahue has been an independent consultant since 1994, focusing on select NGOs interested in employing sub sector analysis methodology to stimulate market linkages and create business development services. In addition, since 1996 Jill has acted as a part time technical advisor to USAID's Displaced Children and Orphan's Fund (DCOF). Her assistance to DCOF funded projects concentrates on analysing household economics and the role of microenterprise services to improve the ability of families and communities to cope with the impact of the HIV/AIDS epidemic.

## Appendix 2

### Research locations

Uganda	Kenya
Kampala	Nairobi slums
Mbale	Thika
Kumi	Matuu
Soroti	Machakos

## Appendix 3

### Microfinance institutions participating in the research

Uganda	Kenya
<b>FINCA</b> —Foundation for International Community Assistance	<b>WEEC</b> —Women's Economic Empowerment Consortium
<b>Feed the Children</b>	<b>KEPP</b> —Kenya Enterprise Promotion Project
<b>Action for Children</b>	<b>Feed the Children</b>
<b>Faulu</b>	<b>JCS</b> —Jitegemea Credit Scheme
<b>UWESO</b> —Uganda Women's Efforts to Save Orphans	<b>Faulu</b>
<b>FOCCAS</b>	<b>WOFAK</b> —Women Fighting AIDS in Kenya
<b>PRIDE</b>	<b>KWFT</b> —Kenya Women's Finance Trust
<b>UWFT</b> —Uganda Women's Finance Trust	<b>SISDO</b> —Small Investors Development Organisation
	<b>BIMAS</b>
	<b>SACCO</b> —Machakos Trader's SACCO

**Microfinance staff interviewed**

Faulu Credit Officers and Branch Manager—Kampala, Uganda

Faulu Product Development manager—Nairobi, Kenya

Feed the Children—Kibera, Kenya

FOCCAS—Mbale, Uganda

UWESO—Kampala and Soroti, Uganda

**ASOs delivering awareness and AIDS education training of trainers**

ACET—David Kabiswa, Director

**Health care financing**

MicroCare—Dr. Gerry Noble

**ASOs delivering credit to targeted clientele**

AWOFs—AIDS Widows and Orphans Family Support, Kampala, Uganda

Action for Children—Kisera, Uganda

COBAP—Community Based Assistance to People affected by AIDS, Nankulabye, Uganda

WOFAK—Women Fighting AIDS in Kenya, Nairobi, Kenya

**Appendix 4****Research programme and methods**

<b>Issues examined</b>	<b>Methods used to address them</b>
Types of crises that create financial pressure	Focus group discussion Time series Wealth ranking
Nature of HIV/AIDS-related crises and relative financial pressure (as compared to other crises)	Focus group discussion Time series Crisis ranking Life cycle Wealth ranking Individual interview
Point of most severe financial pressure	Focus group discussion Life cycle Wealth ranking
Coping mechanisms and clients preference	Focus group discussion Coping ranking Coping trends analysis Venn diagram Individual interview
Affect of crises on client performance in the MFI	Focus group discussion Life cycle Coping trend analysis Wealth ranking Individual interview
Role of microfinance services	Focus group discussion Time series Coping trend analysis Venn diagram

**Summary table**

<b>Method</b>	<b>Instrument</b>	<b># of Sessions</b>	<b># of Participants</b>
Focus Group Discussion	Prepared questionnaire	11	91
Participatory Rapid Appraisal	Crises time series	5	44
	Coping trend analysis	5	47
	Wealth ranking	2	16
	Venn/chapati Diagram	2	14
	Life cycle and coping	2	21
	Crisis ranking	2	18
	Coping ranking	1	8
Individual In-Depth Interviews	Product attribute ranking	3	20
	Life cycle	1	1
	Prepared questionnaire	1	1
<b>Total.</b>		<b>35</b>	<b>281</b>

**Participant numbers disaggregated by gender**

<b>Men</b>	<b>Women</b>	<b>Total</b>
56	225	281
<b>19.93%</b>	<b>80.07%</b>	<b>100%</b>