Expert meeting on

Microfinance and HIV/AIDS

An initiative of Hivos in cooperation with EIBE / University of Nyenrode, Share-net and the PSO knowledge centre

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Introduction

This is a report on the expert meeting on Microfinance and HIV/AIDS organised by Hivos in cooperation with EIBE / University of Nyenrode, Share-net and the PSO knowledge centre. The main objective of the workshop was to share experiences between microfinance institutions (MFIs), financial corporations, donor organisations and HIV/Aids organisations on effective strategies and possibilities for co-ordinated efforts to address the consequences of the HIV/AIDS pandemic. The report starts with an abstract summarizing the debate on microfinance and aids and the main conclusions reached during the one-day meeting. Subsequently, a short summary of the ten presentations is given. This report is written by Joke van der Ven from FACET BV. The full text of the presentations can be found on the Hivos web-site www.hivos.nl under 'Economy'.

Abstract

Microfinance institutions provide small loans and in some cases saving products to low-income people. Their client base is dominated by women who are characterized by poverty, low literacy levels and poor access to information. Sub-Saharan Africa is the region worst affected by the crisis; the average prevalence rate among the economic active population is 20% meaning that 1 in every 5 people is HIV positive. Because of their characteristics microfinance clients are more vulnerable to the aids pandemic and without any doubt the HIV/AIDS crisis has a major impact on the microfinance institutions both on the level of clients and staff:

Clients

- Infection of clients or their family members leads to higher number of dropouts, increased absenteeism from group meeting and breakup of groups increasing the MFI's costs to maintain and expand the client base.
- Sick clients or clients that have to care for the sick have to divert funds and time from the business leading to reduced repayment capacity, higher default rates and difficulties to meet compulsory savings requirements. The reduced business activity also lowers the demand for repeat loans.
- Clients have to deplete their savings, business income and assets in order to buy medicines and take care of family orphans.
- High numbers of aids victims among clients forces MFIs to write off outstanding loan balances increasing the overall costs.

Staff

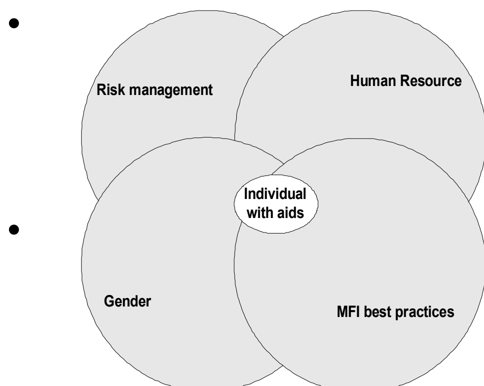
- Staff and their families are also affected leading to high staff absenteeism due to frequent attendance of funerals, sickness, caring for sick. Staff expenditures rise because of increased staff turnover, funeral assistance for staff, medical costs and costs of recruitment and training of new staff.

Dilemmas

Many MFIs have not established HIV/AIDS policies and do not seem to know how to deal with the complexity of the crisis and the numerous dilemmas that exist in relation to the HIV/AIDS problem.

The HIV/AIDS crisis is a complex problem and a number of overlapping and conflicting aspects surround the individual infected with the virus.

- Many MFIs feel the HIV/Aids pandemic is first of all the responsibility of the government.



- Their methodology often ‘promotes’ exclusion of infected people, which is in conflict with the ILO Code of Conduct on HIV/AIDS in the workplace, which has recently been adopted by a number of African governments.

- MFIs discover more and more that the costs of the effects of the disease is threatening their viability as an institution. At the same time the costs of the extra activities to prevent/mitigate the effects of the disease are high and there is the moral question is whether these costs can be transferred to the client? MFIs have to find ways to manage the risk of the disease, mitigate the effect on clients and staff while at the same time follow microfinance best practices and maintain financial sustainability.

- In order to develop strategies MFIs need to know more about the HIV infections of their clients and staff. Marang and other MFIs experienced that people are unwilling to disclose their status out of fear for stigmatization and the process to create openness is long and expensive.

- A conflict of interest exists between gender and culture both on level of the family and the society whereby traditional customs and subordinated position of women lead to further spread of the disease. MFIs have to determine which role they can and want to play in this regards.

- The introduction of health insurance to improve access to drugs brings up the major dilemma whether clients can be expected to pay the high insurance premiums and who will pay for the extra costs of HIV/AIDS treatment.

Strategies and efforts

Prevention and awareness

Staff:
- The MFI Marang in South Africa has developed an awareness creation and education program for their staff to prevent them from infection complemented with the introduction of a health insurance scheme for staff providing their families improved access to drugs including care for HIV-positive staff.
- Sanlam a financial services company in South Africa developed a comprehensive aids policy including education, counselling, voluntary testing and condom dispensing.

Clients:
- MFIs are well placed to influence and communicate the HIV/AIDS problem with their large and organised client base. Radar works with SEF, a large MFI in South Africa to integrate community mobilization and aids education in the microfinance programme to stimulate behavioural change among clients. Similar efforts such as

Project Hope and Freedom for Hunger show that MFIs can play an important role in promoting behavioural change and can fight the aids problem. More research is needed to deal with the challenge to maintain the sustainability of the organisation despite of the additional costs of the educational activities. Possible solutions are subsidization of the additional activities or integration of the educational tasks in the work of the credit officers.

- Marang decided to build linkages with aids support organisations allowing the NGO staff to work directly with their microfinance clients through the group meetings.

Financial products

- *Special loan funds:* Some MFIs have experimented with special loan fund targeting exclusively aids patients. Other MFIs offer loans to family members to compensate for the loss of income of the diseased.

- *Product innovations:* Several MFIs such as Finca Uganda have started to adapt their products and develop new products in order to provide more flexibility to their vulnerable clients including changes in repayment schedules, flexible access to forced savings, allowing clients to rest between cycles. The offer of flexible and convenient savings products also has proven to be important for clients to deal with the unexpected expenditures in relation to aids in their families.

- *Family focus:* Some few MFIs allow family members to take over the loan of the diseased client in order to continue the business.

Insurance products

- *Loan insurance:* Many MFIs have established loan insurance funds to offset loan balances for clients that passed away. Additional research is necessary to investigate whether these funds are covering all costs and are managed effectively in the light of the pandemic. At the same time investigations are difficult because many families are not willing to disclose the real cause of death. In some countries insurance companies provide the loan insurance and sometimes in combination with a life insurance policy whereby additional funds will be paid to the bereaved family.

- *Health insurance:* There is a general agreement that MFIs should not offer micro insurance but form partnerships with insurance companies. However a big gap exists between the clients served by the mainstream insurance companies and the microfinance clients. The few examples of partnerships show different insurance models such as the medical providers that established the Diamond Health scheme in Namibia, the communities in West Africa that set up the mutuals or Microcare in Uganda that started off as a donor project and is now being transformed into an insurance company.
  - Partnerships enable the insurer to reach economy of scale maximizing their client base and minimizing administrative costs while reducing the lending risk of the MFI and increasing client retention. They can be established in many ways: the MFI can be the super policyholder on behalf of the clients, the loan officers can market the insurance products or the MFI the example of Finca Uganda can provide loans to enable the clients to pay the insurance premium to Microcare.
  - Insurance schemes deal differently with HIV/AIDS: Daimond Health emphasizes prevention through education and provides testing, aids treatment and

counselling. They claim the aids treatment is cheap compared to other diseases such as tuberculoses but other schemes exclude aids treatments because of the high costs. Microcare excludes chronic medical treatment (including aids) and limits hospitalization coverage but HIV clients are not excluded and HIV counselling and homecare are covered. An insurance scheme in Zimbabwe established a special fund from its surpluses and donations to cover the costs of HIV/AIDS treatments.

- In rural areas providers find it difficult to design insurance packages, find health providers and calculate premiums. Community models might be a solution however efforts to replicate the West African community model to Uganda failed because group cohesion and willingness to show solidarity are different.

Ideas for further actions

- Microfinance is not a panacea for every problem, and as said microfinance is a commercial activity and costs of additional activities in relation to HIV/AIDS cannot be put on the heads of the poor clients. The aids crisis can only be tackled through partnerships and linkages between HIV/AIDS organisations, gender organisations, microfinance institutions and insurance companies. These partnerships might provide MFIs a chance to tap in to available HIV/AIDS funds, which up to now are mainly channelled through the government and health sector.

- MFIs should develop new products and adjust existing products to assist the clients to reduce their vulnerability. Product development in relation to the aids problem is currently hampered by lack of research on best practices and effective monitoring systems. Donors should support research to evaluate the impact of aids on MFIs and even more importantly document best practices on how MFIs could deal with the pandemic. Considerable amount of information is already available within the MFIs and need to be systemized.

- Special guarantee funds could be established to support infected clients and their families. It would furthermore be interesting to investigate and extract the lessons-learners from the few experiments targeting loans to people and/or families with aids.

- There is a need establish more partnerships between MFIs and insurance companies to develop micro insurance products. Donors should finance the establishment of the partnerships in order to increase the availability of micro insurance products, which are expected to play an important role to reduce the people’s vulnerability to the aids epidemic.

- The corporate sector should become more actively involved in the debate and efforts to find solutions both insurance companies (development of micro insurance products) and corporate companies (protection of their staff from HIV infection). National and regional business coalitions should be financially supported in order to disseminate information. Donors should fund platforms between corporate sector and NGOs to promote partnerships to fight the HIV/AIDS problem. Finally consumers might also have a role to play in forcing corporate sector especially the multinational companies to get more actively involved.

Summary of the presentations
Full presentations can be found on www.hivos.nl.

Role of MFIs in Sub-Sahara Africa in regards the aids problem - by Theresa Moyo, Zimbabwe

HIV/AIDS is a serious challenge in Sub-Sahara Africa. The most affected are poor women who are not in a position to demand for safe sex and extra burden of sick people is often shifted to them. Customs such as wife inheritance and polygamy contributes to spread of the virus. Responses of MFIs have been limited either because they don't know how to intervene or because they consider HIV/AIDS not to be their core business. MFIs experience several negative impacts such as:

- Savings depletion – high expenditures on medicines and extra costs of orphan care;
- Higher default rates – reduced repayment capacity because loss of incomes of sick family members and reduction of labour time because of care for the sick;
- Reduced demand for repeat loans – reduced business activity because time and funds are diverted from the business to care for the sick and buy drugs;
- Increase staff costs – high costs of absenteeism, reduced productivity, financial support for funerals, medical costs and recruitment and training costs.

Surprisingly, MFIs reported that their portfolio have not been severely affected by HIV/AIDS. Possibly groups exclude infected people through self-selection but more likely it is due to that fact that MFIs have difficulties to monitor the impact, as their MIS systems don't include information on HIV/AIDS infection. It has to be concluded that systematic research into the effects of HIV/AIDS on MFIs is lacking. Research is furthermore being hampered by unwillingness of MFIs to disclose because of fear to scare away investors, culture of denial on the side of the clients and scarcity of donor funds for this activity.
Anecdotic feedback shows that clients try to cope through various strategies such as multi-borrowing, withdrawal of girls from school and selling off assets. There is a dire need for more flexible microfinance products including grace periods, flexible repayment periods, emergency credit and possibility to 'rest' between cycles. The few strategic MFI responses involve among others:

- Awareness creation and education among clients;
- Special loan funds - one MFI in Zimbabwe provides loans to people with aids identified by a HIV/AIDS support organisation and surprisingly the infected clients were reported to have a better repayment rate;
- Loan insurance funds to cover outstanding debts of clients that passed away.;
- New loan products and adjustments to give clients more flexibility;
- Flexible savings products;
- Access to health insurance products.

Responses are limited and there is clearly an urgent need for a strategic intervention framework for MFIs including capacity building for staff and further research to develop tracking indicators.

MFI Marang dealing wit HIV/AIDS - by Yvonne Radinku, Marang, South Africa

In 2001 the MFI Marang in South Africa decided to start an HIV/AIDS project in collaboration with a HIV/AIDS-supporting organisation including staff and clients. The project started with a number of workshops to raise awareness among staff. In 2004 a medical aid scheme was introduced for the staff providing 100% coverage for the

staff members and 50% coverage when family members are included. The staff awareness workshops are held each year and are followed up with questionnaires to monitor the change in knowledge, practise and attitudes. Both the health scheme and the other work are partly subsidised by donors.
In 2002 branch managers of Marang followed by a university research team made various attempts to interview clients on HIV/AIDS without any success and only after Marang organised a three-days workshop clients could be convinced to discuss the topic. Marang concluded that the work with clients is very labour intensive and would compromise sustainability if carried out by the MFI. Therefore, recently, memorandums of understanding were signed with a few supporting NGOs to work with the clients during the promotion meetings. Staff was educated on the need to actively refer clients to the NGOs. Marang is currently exploring how they could offer insurance products.
Marang concluded that MFIs could not afford policy development and implementation of HIV/AIDS activities on their own costs. Local HIV/AIDS NGOs should be used as partners and implementers of the training, research and awareness activities and funding should be secured. They also experienced that collaboration between private MFI and NGOs implementing donor projects causes tension because of differences in priorities and time lines. The time of institutionalization of the programme causes conflict with the staff performance targets.

The development of an Aids policy by the financial company Sanlam - by Marlene Bossett, Sanlam, South Africa

Sanlam is a major provider of life insurance, retirement annuities, savings products, unit trusts and trust services in South Africa. The timeline of attention for HIV/AIDS problem within the company started back in 1988 with the publication of a brochure and later mandatory HIV/AIDS workshops were introduced for the staff. In 1994 a first aids policy was drafted resulting in a number of activities in the following years such as sponsoring aids education and NGOs.
The management started to realise that the impact will affect company's ability to achieve its business objectives and there was a need for a more comprehensive approach. In 2000 an aids consultant was contracted and a multi-disciplinary team was set up to develop an HIV/AIDS policy and a plan for institutionalization. Key considerations for the policy were the national HIV/AIDS policy, external aids advisory bodies, consultations with staff and external stakeholders especially government and NGOs.
In 2001 the company strategy on HIV/AIDS was finalized focusing on:

- Reduction of the impact on the business through actuarial analysis of potential impact on staff, shareholders and clients, knowledge & attitude research among staff, analysis of human resource polices and voluntary pre-benefit testing;
- Evaluation of products including the insurance benefits for staff;
- Infection prevention through education, information sharing and condom dispensing;
- Delaying disability through promoting voluntary testing, counselling and support;
- Elimination of discrimination;
- Stakeholder engagement including active participation in national fora to influence the legislative process.

Ethical dilemmas facing MFIs in the context of HIV/AIDS in Africa - by Eunice Kamaara, Moi University, Kenya

60 – 80% Of microfinance clients are poor women and extra vulnerable to become infected with HIV through heterosexual contacts and mother-child relationships. Without any doubt there are a number of ethical perspectives to make about the relationship between microfinance and aids. Within the African context the family is central consequently aids is a family challenge. The vulnerability to aids depends on the characteristics of the family such as its education, size, gender relations, their coping strategies and MFIs dealing with the HIV/AIDS issue will have to focus on the family as a whole. The major ethical dilemmas faced are:

- Disclosure of the client status – the individual right to privacy versus the group right (including the spouse) to protect themselves against the infection. This dilemma is closely related to stigmatization. Prevention and controlling campaigns are often hampered because infected people don't want to disclose their status to avoid stigmatization.

- There is the ethical issue of the protection of the family. Empowerment through microfinance might empower women to separate from their unfaithful husbands. However the MFI might want to exclude women with infected husbands as they might be infected themselves.

- Some cultural practices such as Female Genital Mutilation and use of Traditional Birth Attendants contribute to spread of the virus. While wife inheritance contributes to the spread, so can 'disinheritance' whereby the impoverishment can force the woman to go into commercial sex for survival.

Ethical issues around microfinance and HIV/AIDS have to be discussed in order to find an ethical balance to tolerate the lesser evil for the greater good. To fight stigmatization there is need for educational programmes and at the same time there is need for a policy to protect individuals from stigmatization. Many government policies on aids protect the individual and many MFIs therefore 'secretively' promote a policy to exclude HIV/AIDS patients. It would be more effective if each MFI could develop a practical open policy on HIV/AIDS to guide staff and clients in operations. The presenter concluded that church organisations could be used more effectively in fighting HIV/AIDS because of the frequent gatherings, their holistic and community-oriented approaches. During subsequent discussions it was observed that the church has also been an obstacle in addressing the HIV/Aids pandemic.

MFI Finca Uganda facing the scourge of HIV/AIDS - by Robert Magala Lule, Finca Uganda

Finca a large MFI in Uganda currently serves 38,000 people mainly women with a total loan portfolio of $24.7 million and average loan sizes of $72. 60% of the borrowers are single mothers, 75% care for aids orphans and 72% of the clients are located in the rural areas.
Finca believes that HIV/AIDS has numerous negative impacts such diversion of funds leading to late or none-repayment, poor attendance of meetings, reducing average loan sizes, savings behaviour and high dropout rates (43%). Finca has responded to the crisis through the introduction of:

- Product adjustments: flexibility to repay and meet bi-weekly instead of weekly, larger first loans, rebate of 10% to borrowers with on time repayment, flexible access to compulsory savings and allowing clients to rest between cycles without having to exit.
- New products: loans for emergencies, smaller groups and working capital for individuals
- Introduction of a flexible saving product: including established of mobile and satellite offices to facilitate the saving mobilization.
- Policy of non-discriminatory staff and client recruitment.
- Insurance against death: members including spouse and four children are insured against death and outstanding loan balances are covered.
- Linkage with Microcare to provide insurance product: Finca provides loans to clients to pay the insurance premium for the Microcare health care scheme. Since 2001 2400 clients have benefited from the insurance scheme and the increased access to drugs.
- Medical scheme for Finca staff.

Finca measures and tracks the impact of HIV/AIDS through exit interviews, focus group discussions, and information on the insurance claims. More research on best practices in the intervention of HIV/AIDS would be needed. The mayor challenge remains the institutionalization of the process and in this area additional donor assistance continues to be needed. With the support MFIs can improve their saving products to assist clients to mitigate risks and loan guarantee funds can be established for affected families.

Micro health insurance - Uganda - by Ingrid van 't Hof, Microcare Uganda

Microcare in Uganda offers health insurance to low-income people. The minimum income is about USD 30 per month and according their experience is the lowest income where people can still afford an insurance product. Microcare provides insurance to the microfinance clients of Finca in collaboration with a number of hospitals/clinics affiliated to the programme. Finca provides a medical loan to the clients to pay the insurance premium charging their regular interest rate, but cash payments are also possible. The insurance product costs USD 60 per year and covers 'out patient' care and a maximum of 3 weeks hospitalization in 3 months for four members of the family. Clients are not tested on HIV/AIDS and therefore not excluded furthermore extended family such as aids orphans are also covered. Chronic medication whether related to aids or not is excluded but HIV counselling and homecare is provided.
Labour intensive and expensive marketing is needed because the insurance principle is difficult to sell to the clients and if they don't fall sick they tend to drop out. Furthermore, to avoid that only the sick people join (adverse selection) a minimum of 50% of the group has to join and this requirement is difficult to achieve.

The success factors of the linkage are flexibility for the clients to choose their health provider, the economies of scale for Microcare, the intensive control to avoid abuse both by clients as by the health service providers and benefits for Finca in the form of reduced risk of lending and the improved client retention.

Finca's clients have limited capacity to pay the premium. At the same time to achieve full cost recovery including administration and underwriting the premium would have to be increased with at least 25%. Therefore in order to become profitable Microcare needs a larger client base and they want to diversify to formally employed low-income

people who tend to have a much lower hospital utilization because the employers pays the premium. Started off as donor-funded pilot Microcare intends to transform into a commercial company whereby it hopes to be able to attract reinsurance, which will be guaranteed by Cordaid.

Micro health insurance Nambia - by Pierre Niekerk, Diamond Health Services, Namibia

Diamond Health services was established in 2004 by a network of medical doctors in order to provide affordable health insurance to employed people through corporate schemes. The product covers Out Patient care only and aids treatment is provided if the patient enrols into the HIV/AIDS programme. Furthermore doctors provide counselling and education to their patients in order to prevent HIV infection. The premium of Eur20 per member consists of the fee for the service provider, funeral plan, a legal required medical aid fee, software, network administration and an equalisation reserve to cover regional differences. In general the employer pays half of the premium.

The scheme has built in several incentives for the doctors to keep the patients healthy. Service delivery is managed at the doctor's office for example. All providers are paid upfront on the basis of the number of insured patients. Consequently there is no claim administration and the administration costs are low. The delivery systems are standardized with protocols and drugs formulas to avoid under delivery. Software was developed to monitor current practices and to adjust the drugs and protocol standards when necessary. Working through corporate companies enables Diamond Health to operate sustainable focusing on small towns with a minimum of 20 patients per doctor.

The scheme is the first initiative of it kind in Namibia where over 70% of employed people do not have access to health care and new in its approach to give doctors the responsibility to manage health care.

Community-based insurance systems in West Africa – by Chris Atim, United Kingdom

Since the eighties the major focus in West Africa has been on *Mutual Health Organisations* consequently the term micro insurance is rather unknown. Many community associations and trade unions established mutual funds based on solidarity to cover health and/or funeral costs. To maintain the principle of solidarity, the mutuals are normally limited in size with an average of 5000 members although in Ghana the largest scheme has over 70,000 members. Communities are able to manage the scheme on the basis of their group traditions and only the larger schemes have to employ external managers to run the scheme.

Premiums are community rated rather than risk rated and based on average experience of the community not of the individual. The entire family must join to avoid adverse selection; exactly the opposite of MFI's practice to avoid the whole family to join because of the risk that all default at once.
This mutual system starts from the basis of what the members can afford to pay. On the other hand the provider-based systems presented earlier start from basis of what services the clients want or needs. Mutuals deal with the constraint of available funds by limiting the number of health services. The quality of the health care provided under the scheme is one of the key factors for success.

Promoting community mobilization among microfinance clients - by Paul Pronyk, University of Witwatersrand, South Africa

In 2001, the Rural Aids and Development Action Research (Radar) Programme in collaboration with SEF, a mayor South African MFI set up a programme to build awareness and mobilize the community to fight poverty and aids, as the SEF management believed that microfinance should not be an end in itself but be a means to wider development strategies. The programme started providing 1-hour sessions on gender and HIV to the female clients of SEF during their bi-monthly meetings. In addition from each group two women would be selected and trained to become facilitators to develop an action plan for the community.

Over the last three years over 1000 women were monitored to measure the impact. Preliminary results show that the access to loans has led to an improvement of the social status of the women. The additional education and training has led to numerous changes in the women's lives: they talk more freely about sex related issues; women are in a better position to negotiate condom use and testing and they use group members to educate their own children about sex and aids. The women have become social mobilizers using their own strategy to fight problems in the village while at the same time they perform better as SEF clients in terms of savings, repayment and attendance.

In order to allow replication of the approach there is need for a better integration and harmonization of the educational and promotional activities in the microfinance methodology to minimize the extra costs and the negative effect on the sustainability of the MFI. Donor funding might be needed on longer term to finance these additional activities. Another challenge is to develop training and monitoring system to maintain and improve the quality of the training of the women. Recently, the corporate company Anglo Platinum has indicated to be interested to copy the Radar approach to the villages where their workers live in order to avoid HIV infection of their workforce.

Partnerships with the corporate sector to fight the HIV/AIDS problem - by Barbara Heinzen, Business Exchange on Aids and infectious Diseases (BEAD), United Kingdom

During a 1993 conference the idea was born to establish a partnership on the social-economic impact of HIV/AIDS in Africa between corporate business organisations, NGOs, universities and donors. The partnership was called Business Exchange on Aids and infectious Diseases (BEAD) and started organising quarterly seminars where all stakeholders met to discuss the various aspects of the aids problem. Different expectations especially about the role of the corporate sector in terms of funding hampered various initiatives to bring the partnership to a different level and start implementation of more concrete projects. Recently BEAD started a new initiative mobilizing corporate funding to duplicate interventions that have proven to be working well. A system of accreditation of service providers will be established in order to monitor the quality and impact with the overall goal to minimise the spread of HIV/AIDS and manage the consequences.

Annex 1 – List of participations

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Annex 2 – Organizers of the expert meeting

This expert meeting is organised by Hivos, in co-operation with Universiteit Nyenrode/EIBE, PSO Knowledge Centre and Sharenet.

Hivos

Since 1991 Hivos is active in the field of HIV/AIDS. From the start our major focus has been on the prevention of HIV/AIDS and on rights aspects of people with HIV/AIDS. Over time, as the extent of the pandemic and its effects became clear, it was increasingly realised that HIV/AIDS is a cross-cutting issue. For instance, it influences women rights programme given HIV related gender violence and women's particular vulnerability. Also programmes focussing on agricultural production and microfinance are influenced as people can spent less time in their business as they are sick or have to care for sick relatives. As a result, Hivos is paying more and more attention to the relationship between HIV/AIDS and the other Hivos' sectors (gender, women and development, human rights, environment and sustainable development, economy and culture). We want to build the capacity of the people and organisations to deal with the challenges of HIV/AIDS.

An important part of Hivos activities within the economic sector focus on these microfinance institutions. Grants, loans and equity are provided to financial institutions in the South. These financial institutions provide small loans and sometimes saving services to relatively poor groups that do not have access to mainstream banks. In some cases the MFIs also offer insurance services, merely as agents of insurance companies. Data suggest that the spread of HIV/AIDS follows existing patterns of poverty, inequality and exclusion. Clients of MFIs are therefore exposed to the risk posed by the HIV/AIDS endemic, such as income loss, need for lump sum of cash to cover medical expenses, loss of working time for female lead SMEs as women often care for the sick. As a result MFIs, in particular in Africa, are confronted with the effects of the HIV/AIDS pandemic. In November 2003 Hivos organised a workshop on this topic in Southern Africa. This expert meeting draws from the resource persons and case studies presented during this workshop.

It will be one of the activities that Hivos will organise as an active member within the Netherlands Micro Finance Platform. The Netherlands Micro Finance Platform unites different donor organisations, investors, banks and insurance companies active in the field of microfinance and to a limited extent microinsurance. The aim of the platform is to share information among its membership and to promote learning. For 2004, the issue of HIV/AIDS and microinsurance are on the agenda.

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Universiteit Nyenrode / Institute for responsible business (EIBE)

EIBE is an expert centre on business ethics and corporate social responsibility (CSR). EIBE advises and supports companies, governmental and non-governmental organisations on the development and implementation of social responsible policies. Starting points are the development of a specific moral and value system, (inter) national laws and a responsive attitude towards relevant stakeholders. Another competence of the institute is specific research on subjects like child labour, human rights, fair trade, partnerships, and stakeholder relationships.

Since HIV/AIDS is a cross-cutting issue also international corporations as well as SMEs with operations in the South and local SMEs have to find a way to deal in a responsible way with the challenges posed, as part of their corporate social

responsibility. Several international corporations already developed policies on the issue and not only have gained some general experience already from which lessons can be learned, some of them have micro credit schemes as well as part of a community development program. Their insights and contributions would be useful input for the expert meeting. Lessons learned by MFIs (output of the conference) can also serve as input for other companies.

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PSO Knowledge Centre

PSO the Association for Personnel Services Overseas links Dutch civil society organisations active in the domain of capacity building in developing countries. We are an umbrella organisation with close to forty members, and all of them support organisations in developing countries with the structural reduction of poverty. We define capacity building at three levels: human resource development, strengthening the organisation and institutional development. During 2003 PSO embarked on a major transformation process that amongst other aims, led to the development of the Knowledge Centre.
The centre has a limited size and focuses on areas where an 'added-value' can be made to our members and their partners in the South. We operate in two - synergistic – roles of knowledge broker and of facilitator for knowledge development. HIV/AIDS is one of our annual themes for 2004.

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The Netherlands Network on Sexual & Reproductive Health and AIDS (Share-Net)

Share-Net seeks to contribute to improving the international sexual and reproductive health and rights situation as well as the HIV/AIDS situation, guided by principles of human rights, equity and equality and empowerment. Increased collaboration and exchange of knowledge, information, views and experiences on sexual & reproductive health, rights and HIV/AIDS, and policy advocacy are key activities. The participation of Share-Net in this expert meeting of organisations and experts on micro finance and HIV/AIDS will offer an opportunity for exchange of experiences, will strengthen synergy in the (daily) professional activities and enhance the HIV/AIDS mainstreaming capacity of its membership.

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