

Recognizing and Responding to HIV/AIDS in Microfinance:

**A Powerpoint
Presentation with
Speaker Notes**



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MICROENTERPRISE BEST PRACTICES

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Recognizing and Responding to HIV/AIDS in Microfinance:

A Powerpoint Presentation
With Speaker Notes

by

James J. Boomgard and Joan C. Parker

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Joan Parker is a senior economist at Development Alternatives, Inc. with 10 years of experience in microenterprise development and microfinance. Under her direction, the MBP project developed a new area of research, namely, protecting the microfinance industry against a range of environmental shocks and examining the potential for microfinance to serve as a protective mechanism for clients affected by these shocks. Dr. Parker is currently serving as Principal Development Specialist for the HIV/AIDS Response Team at DAI that seeks to develop strategies to respond to the developmental and economic impact of HIV/AIDS.

Both authors extend their gratitude to Laurie Liskin, Director of the HIV/AIDS Response Team at DAI, for technical review of the HIV/AIDS content in this presentation.

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USERS' NOTES

“RECOGNIZING AND RESPONDING TO HIV/AIDS IN MICROFINANCE” A POWERPOINT PRESENTATION WITH SPEAKER NOTES

This slide show is designed as an advocacy tool to build awareness and spark discussion within microfinance forums about HIV/AIDS. Originally presented to a microfinance industry gathering of 300 individuals from around the world, it is designed to speak to microfinance specialists who have never considered the impact of HIV/AIDS on their industry or their own institution. It is hoped that microfinance professionals who hear this presentation will be increasingly open to future discussions about HIV/AIDS, and may in fact take specific actions to respond to HIV/AIDS.

The slide show has three sections:

1. Section One provides an overview of the AIDS epidemic using UNAIDS data available in September 2001.
2. Section Two provides a sketch of how HIV/AIDS negatively affects clients, their microfinance behaviors, and the microfinance institutions themselves.
3. Section Three outlines options for action for microfinance donors, practitioners, and analysts.

If used in its entirety, the slide show requires roughly 45 minutes of presentation time, but users may choose to use only certain slides, depending on their audience and purpose.

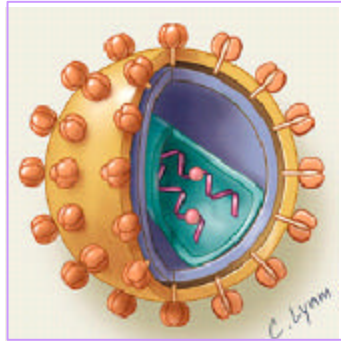
Each slide has a complete set of speaker notes attached that explain the meaning of the slide's content. Many of the notes provide too much information to cover in the actual presentation, with the objective that presenters can pick and choose which information is most important to highlight.

To print both slides and speaker notes, users should print the slides in the “Notes Pages” format (an option under the “File/Print/Print What” menu). To view and alter notes on the screen, users should switch to the “Notes Page View,” accessible by clicking on the icon at the lower left hand corner of the screen.

This slide show can be used without permission, and may be modified as the presenter sees fit. If used for a country-specific audience, a specific slide outlining the country's HIV/AIDS situation can be added based on UNAIDS Country Profiles (www.unaids.org). As time passes, statistics in the presentation may also be updated based on information found at this website.

For smaller groups prepared to consider action on HIV/AIDS in microfinance, the MBP product “Microfinance and HIV/AIDS: Defining Options for Strategic and Operational Change” provides a complementary follow-on training guide to help MFIs identify and prioritize first steps to respond to HIV/AIDS.

Recognizing and Responding to HIV/AIDS in Microfinance



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Microenterprise Best Practices Project
Development Alternatives, Inc.

Presented at:

Fourth Seminar on New Development Finance
Frankfurt, Germany
September 2001




This presentation was originally given at the Fourth Seminar on New Development Finance, Frankfurt Germany, in September 2001 by two DAI staff members.

It draws on the work conducted by DAI through USAID's Microenterprise Best Practices (MBP) Project, combined with work for UNAIDS, for USAID in Zimbabwe, and for the National Microfinance Bank in Tanzania.


This presentation is designed for microfinance donors and practitioners who may not yet have considered HIV/AIDS in their program. It provides factual information about HIV/AIDS, as well as an overview of the impact of HIV/AIDS on microfinance clients and institutions, and suggestions for responding to HIV/AIDS within the microfinance industry.

These slides may be used without permission. Attribution to USAID's MBP Project and DAI are appreciated.





Three Big Topics – Briefly Considered

- I. The HIV/AIDS Crisis
- II. HIV/AIDS & microfinance
 - Economies
 - Customers
 - MFIs
- III. How to Respond?
 - Donors and Investors
 - MFIs
 - Analysts and Experts



"Not Enough Time," 1999
 Tim Lonergan
 Artwork by artists living with HIV/AIDS





The presentation is structured in three sections:

First, it provides basic information about HIV/AIDS and an update on the state of the epidemic globally (as of the end of 2000).

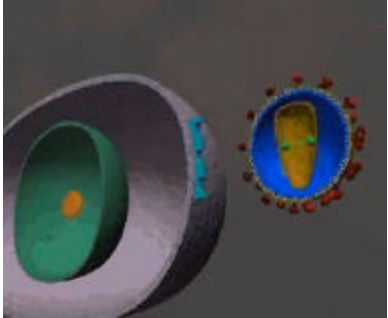
Second, it examines what HIV/AIDS means for the microfinance industry, in terms of the national economy, microfinance customers, and microfinance institutions.



Third, it lays out suggestions for microfinance responses to HIV/AIDS, looking briefly at donors, then microfinance organizations, then analysts and experts. These suggestions can help the industry move from communal hand-wringing to communal action.



Part I: The HIV/AIDS Crisis: What Is HIV/AIDS?

- HIV is a virus: the *Human Immunodeficiency Virus* (HIV)
- HIV attacks and gradually destroys the immune system, leading to symptoms and opportunistic diseases defined as *Acquired Immune Deficiency Syndrome* (AIDS)
- AIDS diagnosed from one or more of these opportunistic diseases
- There is no cure or vaccine for HIV infection.



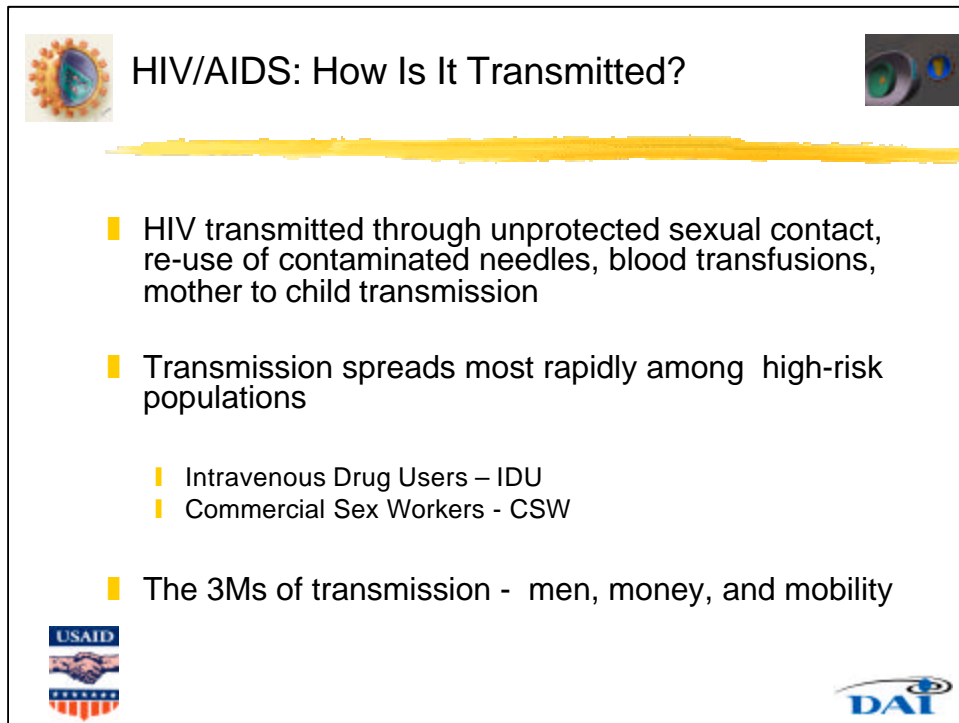



First, what is HIV/AIDS?

HIV is the human immunodeficiency virus, which attacks and gradually destroys the human immune system. Without access to special forms of treatment, HIV leads to a constellation of symptoms and opportunistic diseases that are defined as AIDS, or the “acquired immune deficiency syndrome.”



Because few people know that they are infected with HIV, AIDS is usually diagnosed by the appearance of one or more of these opportunistic diseases - such as tuberculosis.

Moreover, the HIV virus mutates rapidly, leading to strains resistant to known HIV/AIDS therapies. Ten separate strains are already recognized. All of this leads to the difficulty in developing a cure or vaccine for HIV. An effective vaccine is probably decades away.



HIV/AIDS: How Is It Transmitted?

- HIV transmitted through unprotected sexual contact, re-use of contaminated needles, blood transfusions, mother to child transmission
- Transmission spreads most rapidly among high-risk populations
 - Intravenous Drug Users – IDU
 - Commercial Sex Workers - CSW
- The 3Ms of transmission - men, money, and mobility

USAID  


HIV is transmitted through four major paths:

- # Unprotected sexual contact
- # Reuse of contaminated needles
- # Blood transfusions
- # Mother-to-child transmission before, during or after birth


HIV usually spreads most rapidly in high-risk populations, such as intravenous drug users or commercial sex workers. In turn, these high-risk populations and their clients then transfer the virus to their sexual partners - including spouses who may not be engaged in high-risk behaviors.

Another way to define “high risk” is to look for situations defined by the “three Ms” - men, money, and mobility.



- Men: men have more power to control the frequency and conditions of sexual activity;
- Money: availability of money allows the purchase of sex, while the need for money drives the sale of sex.
- Mobility: men’s jobs frequently take them from home for sustained periods, increasing the likelihood of engaging in commercial sex;



From Transmission to Epidemic



- Epidemic increasingly involves the poor
- AIDS symptoms develop on average 8 to 10 years after initial HIV infection.
 - 90% of the infected unaware
 - Disease often advanced before recognized
 - Spreads far before impact seen – a slow wave event
- Flash point: “the 5% rule” - once HIV rates hit 5% of general population, epidemic takes off
- Not clear how the epidemic ends.





As the HIV/AIDS epidemic spreads through the general population, it increasingly involves the poor. They are most likely to engage in high-risk activities such as migratory labor (either permanent or seasonal), or to engage in transactional sex to meet basic household needs (even for school fees or food). The poorest segments have less access to HIV/AIDS information and health services or products (such as condoms) that would protect this group. Finally, HIV transmission rates are also higher for people with certain “co-factors”, such as poor nutrition or untreated sexually transmitted diseases, both of which are more likely to affect the poor.


HIV does not reveal its presence quickly. Based on U.S. studies, it may take eight to ten years for AIDS symptoms to develop, during which time the infected individual may have multiple sexual partners. Because in developing countries only 1 in 10 people know they carry HIV, the disease is able to spread far before its impact is seen. This is one of the reasons that HIV/AIDS is called a “slow wave event.”

The HIV/AIDS epidemic appears to have a “flash point” - after which it spreads rapidly and becomes nearly impossible to stop. According to UNAIDS, this flash point is when HIV infects 5% of the general adult population. As of the end of 1999, 27 countries had reached that flash point (US Census Bureau data).



To date, it is not clear how or when the epidemic will end.



The Extent and Distribution of HIV/AIDS



- The number of people living with HIV or AIDS at the end of the year 2000 is 36.1 million -- 50% higher than projected by the UN and WHO in 1991.
- 21.8 million cumulative deaths due to HIV/AIDS, 3.0 million in 2000
- In 2000, 5.3 million people were newly infected with HIV, 95% in developing countries
- Regional variations are significant and important.

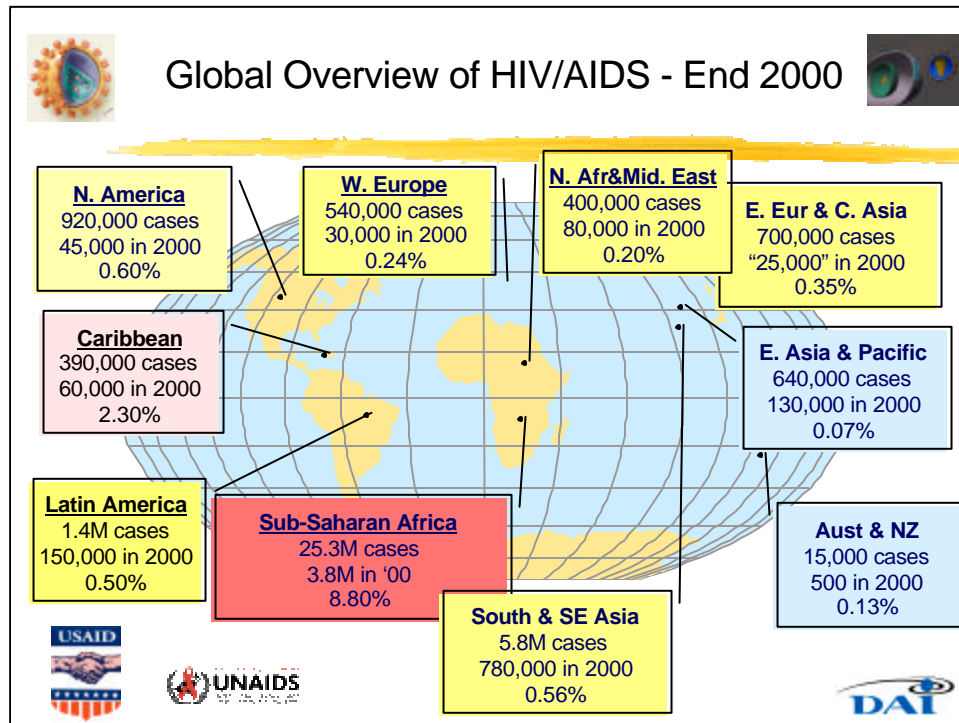
How far has HIV/AIDS spread to date?

UNAIDS estimates that as of the end of 2000, 36.1 million people are currently living with HIV/AIDS worldwide - a figure that is 50% higher than the 1991 projections made by the UN or WHO.

As of the end of 2000, an estimated 21.8 million people have died of HIV/AIDS, including 3 million in 2000 alone, leaving an estimated xx million children orphaned.

And in 2000 alone, an estimated 5.3 million individuals have contracted HIV, 95% of whom are in developing countries.

The HIV/AIDS picture shows some important variations by region, which help us to understand the epidemic better.



HIV/AIDS follows different patterns in different regions.

In Africa, infection is generally spread through heterosexual contact and increasingly during childbirth and breast-feeding, affecting not only adults but youth as well. Different regions have different levels of HIV prevalence: highest rates are in Southern Africa, where in 1990, 1% of adults were thought to carry HIV, but as of 2000, 20% are thought to be HIV-positive. Eastern and Central Africa show lower rates, and Western Africa has the lowest rates to date - though Nigeria (with 3 million cases) is an important country to monitor. The most dramatic illustration of the extent of HIV/AIDS in Africa is the drop in life expectancies seen in high-prevalence countries (shaving up to 15 years off life expectancy in some countries, according to UNAIDS statistics).

In Asia, prevalence rates are low, but numbers of infections are huge. This is particularly true for large countries like India or China. Using China as an example, HIV has been reported in all 31 provinces. A major indicator of how fast HIV/AIDS may spread - namely, the increase of sexually transmitted diseases - shows a 144-fold (from 5.8K to 836K) increase in China over the last 15 years. Moreover, of 3 million Chinese intravenous drug users (IDUs), 45% share needles, and as many as 77% of IDUs are HIV positive in some of the 19 surveillance sites. Data from India show an equally distressing story, and many experts fear that India is heading for one of the worst HIV/AIDS epidemics seen to date.

In Latin America, prevalence rates are climbing fastest in Central America and the Caribbean. Because this region has many small countries, global financial assistance to each country to curb the disease may be limited. To date, data show increased prevalence rates in Haiti, Honduras, Belize, Guatemala, and El Salvador. Of particular concern is the high mobility of Central American and Caribbean population, which may increase HIV prevalence.

Finally, in Eastern Europe and the former Soviet Union, HIV incidence and prevalence are accelerating, particularly in Ukraine, Russia, Belarus, Moldova, Uzbekistan and Estonia. More HIV cases were registered in 1999 and again in 2000 in Russia than in all previous years put together. Transmission is fueled by increasing intravenous drug use (now practiced by 3 million in Russia alone), and by commercial sex. In Ukraine, 30% of a combined intravenous drug users/commercial sex workers population are now HIV positive; in Belarus, the same type of population has a 60% HIV prevalence rate. In sum, HIV is poised to break out into a full-blown epidemic.



The News Is Not All Bad...





"Prayer of Hope," 1999
 Joyce McDonald
 Artwork by artists living with
 HIV/AIDS



- Possible signs HIV incidence stabilizing in a few African countries, but data limited
- More countries are acknowledging problems and starting to act
- Cost reductions for *Anti-Retroviral* drugs
- More public and private resources starting to flow
- ...but, the crisis will get worse, much worse, before it gets better....




Though data are scarce, there is hope that a few countries have managed to stabilize the rate of new HIV infections: In Uganda and Zambia, youth campaigns have decreased rate of new infections in youth ages 15-19, but it is not known if this will ultimately keep these individuals HIV-free.

In addition, more governments are acknowledging the extent and causes of HIV/AIDS, which is the first step in formulating a comprehensive response that is needed to stop it.

Drug companies have reduced the prices of anti-retroviral drugs, and lower-cost generic drugs are appearing, putting these drugs in closer reach of poorer people (currently at the cost of US\$200-300/year). How to distribute and monitor these drugs effectively on a large scale in developing countries remains a major concern.


And there are signs that new public and private resources are beginning to flow for prevention, care and support for the sick and orphans. On the public side, the United Nations has played a pivotal role in collecting and channeling resources. On the private side, corporate foundations sponsor ever-larger HIV/AIDS-related programs and services.

But even with these positive signs, the HIV/AIDS crisis will get worse before it gets better.





Part II: HIV/AIDS and Microfinance

- The impact on nations and economies
- The impact on customers
- The impact on MFIs



"Bodhi," 2000
Clifford Smith
Artwork by artists living with HIV/AIDS





These figures are daunting - even numbing.


It is important to examine the implications of these figures for the microfinance industry - both to make it more tangible, and to get enough information to be able to formulate potential responses.

This section briefly touches on three topics:



- # The impact of HIV/AIDS on national economies
- # The impact of HIV/AIDS on customer households
- # The impact of HIV/AIDS on MFIs



Impact on Nations and Economies



- Declines in economic growth (GDP)
- Diversion of public attention and resources to crisis management
- Risks to political stability and rule of law
- Progressively depleted workforce, increased cost of doing business, reduced competitiveness
- Future generations – all of the above

At the national level, HIV/AIDS is wrecking havoc. Country-specific studies predict that economic growth rates may fall by 25% over a 20-year period in high-prevalence countries (Bollinger and Stover, Futures Group, 1999).

Both the impact and the requirements of HIV/AIDS divert public attention and resources away from development objectives and toward crisis management, including replacement of teachers, soldiers, and government workers. Over 70% of hospital beds and health funds in some poor countries are already spent treating HIV/AIDS-related illnesses.

There is concern - as a new generation of orphans appears, vital services are threatened, and poverty and hunger increase - that HIV/AIDS will spawn political instability and failure of the rule of law.

What is clear is that above all, HIV/AIDS progressively depletes the national skill base and workforce, which increases the costs of doing business, lowers productivity, and lead to an overall reduction in competitiveness for all businesses.


As we look forward to a future generation of less-well-educated and less socialized AIDS orphans as the new labor force and civil society, these patterns are likely to intensify rather than reverse.

Example of Economic Impact on Agricultural Sector


Reduction in production in a household with an AIDS death, Zimbabwe

| <i>Crops</i> | <i>Reduction in output</i> |
|----------------|----------------------------|
| ● Maize | 61% |
| ● Cotton | 47% |
| ● Vegetables | 49% |
| ● Groundnuts | 37% |
| ● Cattle owned | 29% |


00001-E-26 - 27 June 2000 Source: Stover & Bollinger, 1999





This slide - from UNAIDS - illustrates the aggregate sectoral impact HIV/AIDS can have, using Zimbabwe (1999) as an example.



Impact on Households - Issues







- Infected and Affected

- Impact varies over time
 - Infection and Pre-illness
 - Illness and Dying – progressive decline
 - Death
 - Those left behind

- Data Complexities



"Living With the Epidemic,"
1997, Judy Ann Seidman
Artwork by artists living with
HIV/AIDS



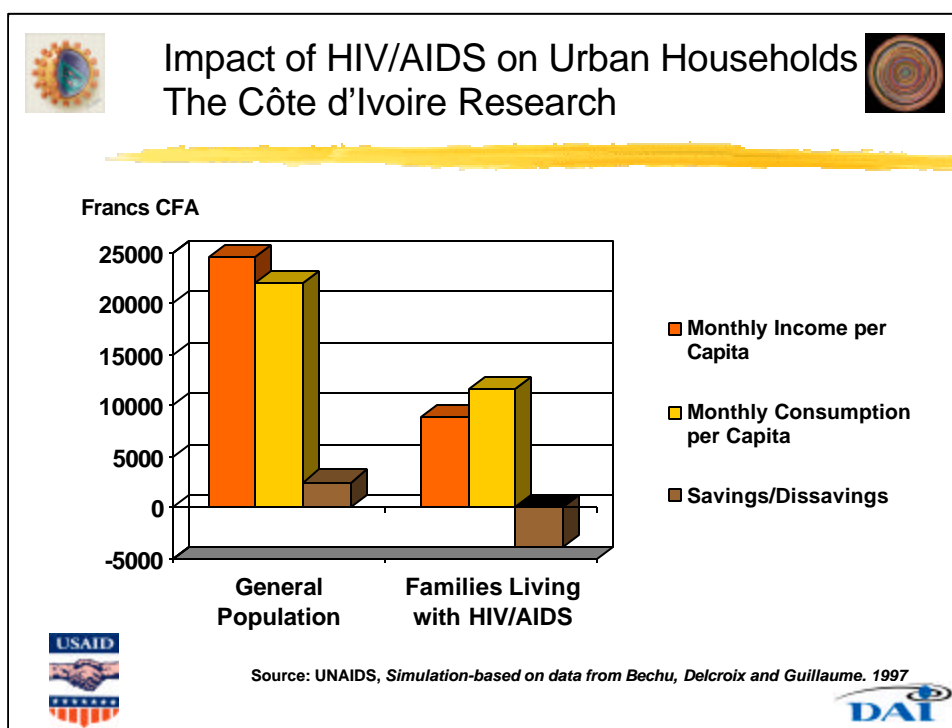
Before we examine household-level impacts of HIV/AIDS, a few issues need to be clarified.

First, the statistics provided earlier show the numbers “infected” with HIV/AIDS. For each of these 36.1 million estimated infected individuals, there is a circle of family who are affected: either as family members and income-earners die, as children leave school to care for the sick or to earn money, as grandparents step in to raise grandchildren. If we assume that for each infected individual, there are another five affected household members, we are currently looking at an HIV/AIDS-affected population of 180 million individuals. As much as the “infected”, the microfinance clientele includes the “affected” as well.

Second, HIV/AIDS’s impact on the household changes significantly over time. Before illnesses set in, HIV-infected individuals lead productive lives as workers, entrepreneurs, and parents. The next stage - of illness and dying - is much more difficult on the household. This is a prolonged period, where assets and savings are drawn down to care for the sick, time is reallocated from productive activities to care-giving. This is the hardest financial period on the household. The third stage centers around the death of the person with HIV infection. This event causes a shorter but significant financial burden for the family, in terms of funeral costs. This is also the time when assets are re-allocated among family members (and often away from surviving widows). Finally, the fourth stage is the reconstitution of the family and the family economy by those left behind.


A single family may go through these stages multiple times - as one infected individual follows another.

Finally, data shared in the next slides is understandably sketchy. It is nearly impossible to identify HIV-affected individuals or households. Those few surveys that do are rare, conducted in single geographic areas, and may have been carried out early in the epidemic. Even so, the overall information on hand is sufficient for this discussion.




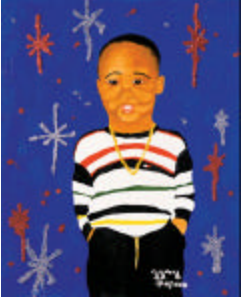
This slide, based on 1997 data from Cote d'Ivoire, shows the impact of HIV/AIDS on the economic position of urban households.

- # The first (orange) bar illustrates the 40-60% drop in income, as HIV/AIDS affected households lose income-earners, and remaining productive adults spend increasing amounts of time on care-giving, etc.
- # The second (yellow) bar shows how this translates into reduced well-being of the household, where consumption (primarily food) drops nearly by half.
- # The third (brown) bar shows how the family goes from being able to save small amounts to much larger "dissavings" - or draw-down of savings and assets - when HIV/AIDS is present.
- # What this graph doesn't show is that at the same time income and consumption have plummeted, medical expenditures increase at least 400%. Overall, HIV/AIDS compromises the economic position of the household, reduces their ability to save, etc.




Changing Customer Behavior






Portrait of Love, 2000
Ronald Casanova
Artwork by artists living
with HIV/AIDS




- Enterprise takes backseat to crisis management
- Family needs access to cash for medical needs: from loans, savings, gifts, or sales of assets
- Despite need for cash, difficulty managing debt during extended care-giving phase of crisis
- Tendency to divert loan capital to medical needs
- Desire for smaller loans
- Increasing demands for “special treatment”





When microfinance clients come under this sort of economic stress, what happens to their behavior in terms of their enterprise and their participation in microfinance programs? The main results appear to be:

- # The enterprise becomes a lower priority than crisis management (fall in productivity, income, etc.)
- # At the same time, the family needs cash for medical expenses, which they might get from loans, savings, gifts, or sale of assets (either household or business)
- # While they may take a loan to meet their crisis needs, clients report that debt repayment is particularly difficult during the prolonged care-giving phase of the crisis.
- # Not surprisingly, those affected by HIV/AIDS who continue to borrow are more likely to divert loan capital to meet emergency needs, such as medical crisis or food for the family.
- # Clients may ask for smaller loans or from a break in borrowing (resting)
- # Greater numbers of clients ask for “special treatment” - extra time to repay, access to compulsory savings accounts, etc.





The Impact on MFIs






- ⌘ Portfolio Quality
 - ⌘ Repayment Capacity
 - ⌘ "Diversion"
 - ⌘ Increased exit rates
- ⌘ Deposits at risk
- ⌘ Staff and Employees
 - ⌘ Absenteeism
 - ⌘ Productivity, Attention, and Morale
 - ⌘ Turnover and retraining
- ⌘ Fringe Benefit Costs
 - ⌘ Life Insurance
 - ⌘ Health Insurance
 - ⌘ Sick and Caregiving Leave
- ⌘ Risk of fraud and increased control costs

All of these client behaviors translate into an impact on the microfinance institution itself. In interviews with over 30 MFIs, five main categories of impact were described:




1. Drawing on the changing customer behaviors, MFIs see a decline in portfolio quality, driven by a decline in clients' repayment capacity and a diversion of loan funds. Increased client exit rates may negatively affect the portfolio's quality.
2. For MFIs that take savings, HIV-affected households are more likely to withdraw savings from the institution. At the same time, new deposits are likely to slow as more households become HIV-affected.
3. MFI Staff and employees are affected as well, which appears as increased absenteeism; reduced productivity, attention or morale while at work; and greater staff turnover and retraining. Loan officers are also the front line in the MFI's response to HIV/AIDS - and must deal with moral dilemmas of whether to serve or exclude individuals from MFI services, which in turn affects morale.
4. MFI fringe benefit costs are rising, including life and health insurance premiums and increased sick and caregiving leave to HIV-affected and infected staff.
5. Finally, there is some evidence that fraud controls break down when clients and staff are economically stressed or find that they are HIV-positive.

Overall, these translate into increased risks and costs for MFIs working in HIV/AIDS-affected communities.




Part III: How to Respond?


- Donors
- MFIs
- Analysts and Experts




Facing this scenario, how can the microfinance industry respond? This section provides initial guidance on responses that donors, MFIs, and analysts can take in the face of this disease.





Donors' Response



- Keep expectations low on ability of microfinance to help those now affected by HIV/AIDS
- Be realistic about cost structures in AIDS-affected countries
- Reward MFIs that monitor impact of HIV/AIDS on portfolio and plan accordingly
- Support cautious experimentation



"Living With the Epidemic," 1997,
Judy Ann Seidman
Artwork by artists living with HIV/AIDS





Donors' main responsibility is to adopt appropriate expectations about the ability of microfinance to directly help families affected by HIV/AIDS. Microfinance may play a role before HIV/AIDS hits (in shoring up assets and diversifying income sources), and may play a role after HIV/AIDS passes through the household (in reconstructing household assets and income flows), but it is unlikely to be of major value to households in the midst of the HIV/AIDS crisis.

Donors can help by remaining realistic about the higher cost structures and lower profit levels of MFIs operating in HIV/AIDS-affected countries, and taking these realities into account in deciding funding levels.

Donors can support training for MFIs about the impact of HIV/AIDS on their clients and institutions (building on the products already funded by USAID). Following training, donors can provide incentives and rewards for MFIs that both monitor the impact of HIV/AIDS on their portfolio and that plan accordingly (in terms of staff training, fraud controls, etc.)

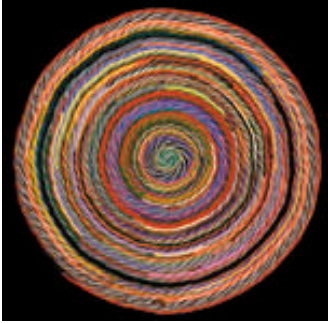
Finally, donors can provide financial support for cautious experimentation by MFIs that try new products or services for HIV/AIDS-affected populations, or that link their microfinance clientele to better HIV/AIDS prevention and care services.





MFIs' Response: *The Big Five*



- Acknowledge and Measure HIV/AIDS risks
- Refine and Align Products
- Refer Clients to AIDS-Related Services
- "Risk-proof" Operations
- MFI Workplace Policies



"Bodhi," 2000
Clifford Smith
Artwork by artists living with HIV/AIDS





Based on a range of efforts to date in the microfinance industry*, MFIs' responses to HIV/AIDS can be grouped into five categories. Some are designed to reduce MFI risk, others to improve client services. They are:

1. Acknowledge and measure HIV/AIDS risks
2. Refine and align products to be more effective in an HIV/AIDS environment
3. Refer clients to AIDS-related services
4. Take steps to "risk-proof" operations
5. Review and amend MFI workplace policies to respond to HIV/AIDS.



The next slides will take each of these in turn.

* Two surveys shed light on the range of efforts across the industry: the USAID/MBP 2000 survey of MFIs, published in the MBP Reader on Microfinance and HIV/AIDS; the UNAIDS 2000 survey of MFIs (both available from DAI). This is complemented by DAI's own efforts in Tanzania and Zimbabwe.




1. Acknowledge and Measure HIV/AIDS risks

- Understand HIV/AIDS prevalence in market
- Monitor patterns in customer behavior
- Add HIV/AIDS indicators to loan applications or renewals
- Share information with others in industry





1. Acknowledge and measure HIV/AIDS risks



- # The first step is to acknowledge that AIDS is an issue, and find out what the HIV prevalence rates are in the markets the MFI serves.
- # The MFI can then monitor patterns of customer behavior - from increased delinquency, to increased exits, to breakdown of borrower groups, or demands for smaller loans.
- # Add AIDS indicators to loan applications or renewals, asking such questions as “is the household currently dealing with a chronic, long-term illness?” or “has the household recently expanded to care for more children?” (The goal of this exercise is to understand the number of clients facing certain types of economic or financial hardships in order to serve them better. The goal is not to exclude these clients.)
- # Share information across the industry: other MFIs may have information about the epidemic that you are missing, and vice versa. A national network may play an important role here in collecting and disseminating information about HIV/AIDS.



2. Refine and Align Products




- Savings, savings, savings
- Product innovations?
 - life insurance on loans
 - product to help smooth health expenses
 - long-term trust fund product to hold assets of sick clients for their children
- Review product requirements.





2. Refine and align products to reflect the HIV/AIDS environment.



- # In communities gradually being drawn into an HIV/AIDS crisis, the most important services are those that create personal safety nets through savings or build-up of assets. If the MFI is able to provide it, savings may be the most important service for clients in these communities.
- # Consider product innovations that serve HIV/AIDS-affected households, such as:
 - life insurance on loans
 - products that help to smooth health expenses such as a health-care financing product
 - long-term trust funds that protect household assets of sick clients for the future use of their children
- # Review the requirements for clients to use existing services. Are they too restrictive for an HIV/AIDS-affected client? For example, clients from HIV/AIDS-affected households may not be able to attend weekly meetings, particularly if serving as the primary caregiver for a terminally ill family member.



3. Refer Clients to AIDS-Related Services




- HIV prevention education for clients and their families
- Care referral for those with HIV/AIDS
- Legal and financial planning to protect assets for surviving family members

3. Refer clients to AIDS-related services

MFI's may find opportunities to provide HIV/AIDS information and services within their doors - such as information pamphlets, or access to a health educator at weekly meetings. To remain productive throughout the various stages of the crisis, however, clients need more than this. Rather than provide services within the MFI, the MFI may refer clients to the following sorts of services:



- # HIV prevention education for both clients and their families (which requires carefully prepared communication materials and skills in dealing with both adults and youth)
- # Care information and referrals for those already dealing with HIV/AIDS. Information may focus on how to prepare nutritious foods for someone with HIV/AIDS, or basic questions of home care. Referrals may include where to find medications or family counseling.
- # Referrals to legal or financial planning advice. This is particularly useful for women clients whose husbands may be sick in order to protect the household's assets after the husband's death. This service may be one of the most valuable long-term aids to clients dealing with HIV/AIDS.



4. “Risk-proof” Operations

- Track staff absenteeism and changes in fringe and operating costs
- Tighten fraud controls
- Portfolio insurance
- Staff redundancy planning

➔ Higher prices for higher risk populations?


4. “Risk-Proof” Operations

How can the MFI reduce the costs and risks due to HIV/AIDS? Some of the steps an MFI may take immediately are:


- # Begin to track staff absenteeism and changes in fringe benefits and operating costs
- # Tighten fraud controls
- # Explore the availability of portfolio insurance (which may be an option only where the prevalence of HIV/AIDS is limited)
- # Begin to identify critical staff functions and cross-train staff around these functions.


All of these steps entail costs, but these costs need to be compared to the cost of not preparing for possible events such as staff loss, fraud, etc.

Can the higher costs of working in an HIV/AIDS-affected area be passed on to clients? If microfinance institutions are to strive for full cost recovery even in these environments, must MFIs raise their interest rates for these more vulnerable and higher-risk populations?





5. MFI Workplace Policies






- Establish HIV/AIDS non-discrimination policy
- Staff HIV/AIDS education program
- Provide risk-reducing services to staff
- Review fringe benefits and revise as necessary


5. Implement MFI workplace policy on HIV/AIDS.

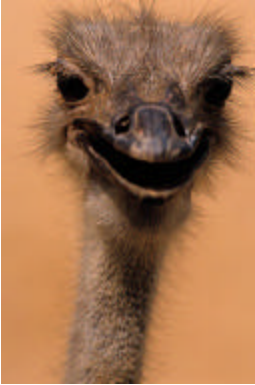
One of the most damaging aspects of HIV/AIDS is the stigma and discrimination attached to the disease. The more people can openly discuss HIV/AIDS, the more infected and affected individuals can lead productive, healthy lives even in the midst of the crisis. Over the last several years, workplace policy standards have been created that foster this environment. Major elements of these policies may be:

- # A stated HIV/AIDS non-discrimination policy
- # A staff HIV/AIDS prevention and care education program
- # Services to staff that reduce their risk of infection, or reduce the likelihood that they will infect others (such as anonymous voluntary HIV testing and counseling, or free access to condoms in the workplace)
- # A review of fringe benefits to ensure that it adequately reflects the needs created by HIV/AIDS (from funding HIV testing and counseling, to appropriate leave policies, to treatment of illnesses the result from HIV or that increase the risk of HIV infection).
- # Assistance to loan officers who have to deal with HIV/AIDS within their client groups.





Experts' and Analysts' Response





- Become informed about HIV/AIDS
- Recognize need for multi-sectoral, long-term response
- Bring informed support to microfinance industry
- Incorporate HIV/AIDS planning as integral with, not a threat to, “best practice” work.

Finally, what is the role of analysts and experts, consultants and academics?

This group of individuals and institutions are responsible for setting the standards of “best practice” in the microfinance industry, and for providing the technical support for implementation of good planning, policies, and products. Because of this role, they play an important part in spreading the word about HIV/AIDS - and how to respond - within the microfinance community.

Specific steps for analysts and experts include:

- # Become informed about HIV/AIDS as a disease, and its impacts on poor households and economies
- # Recognize that the response to HIV/AIDS involves every individual and institution in HIV/AIDS-affected environments, including microfinance institutions, staff, and board members. Recognize also that HIV/AIDS is a long-term problem.
- # Bring this informed support to the microfinance industry - to improve monitoring, products, risk-proofing, referral systems, and workplace policies.
- # Incorporate HIV/AIDS into microfinance planning as an integral part of - rather than a threat to - “best practices” of microfinance.



Concluding Remarks

- HIV/AIDS is a real concern for all of us globally
- HIV/AIDS will affect the microfinance business (much more than microfinance will affect HIV/AIDS)
- HIV/AIDS is a systemic risk to our industry, but one that we are able to prepare for.



How do we conclude?

- # First, by recognizing that HIV/AIDS is real and is rapidly spreading globally, and will be an increasing concern over time.
- # Second, by recognizing that HIV/AIDS will affect our industry and our business (in fact much more than we can affect HIV/AIDS). Even so, we can work on both fronts.
- # Third, by recognizing that HIV/AIDS is part of the fabric of systemic risk facing our industry, but one that we are able to prepare for.

Additional MBP sources of information on microfinance and HIV/AIDS:

1. “The MBP Reader on Microfinance and HIV/AIDS: First Steps in Speaking Out,” compiled by the Microenterprise Best Practices Project, DAI, Bethesda, MD. (Available in pdf format at www.mip.org/pubs/mbp-def.htm under “Managing Risks.”)
2. “Microfinance and HIV/AIDS Training Guide: Designing Options for Strategic and Operational Change,” Microenterprise Best Practices Project, DAI, Bethesda, MD. (To be released in November 2001 in pdf format www.mip.org/pubs/mbp-def.htm under “Managing Risks.”)