

Microcredit and Households Coping with HIV/AIDS

A Case Study from Zimbabwe

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Abstract: This study seeks to better understand the ways chronic illness and death, possibly associated with HIV/AIDS, negatively affect households and the impact microcredit has had in helping affected households. This is achieved through analyzing data from clients of Zambuko Trust and from nonclient microentrepreneurs, using proxy indicators of HIV/AIDS affected households. It also investigates the vetting of members by loan guarantee groups and the ways these groups deal with individuals affected by illness and death. Since members of loan groups serve as gatekeepers to loans, the internal dynamics of these groups as well as the MFI's policies and loan terms and conditions are important to understanding any push factors that might exclude HIV/AIDS-infected and -affected individuals. Suggestions are provided from clients and other key stakeholders about changes that might assist microfinance institutions and their clients address the negative effects of HIV/AIDS.

In Africa, HIV/AIDS affects millions of households. More than 20 million Africans have died, 12 million have been orphaned, and 29.4 million are living with the virus. The infection and death of a household member creates economic stresses at the household and community levels (UNAIDS/WHO, 2004; Stanecki, 2004; Over, 1998; Dayton & Ainsworth, 2002).

Outside the health sector, the microfinance community has been in the forefront in addressing HIV/AIDS prevention, care, and mitigation (Donahue & Sussman, 1999; Parker, Singh, & Hattel, 2000; McDonagh, 2001). Preventive education for microcredit clients is now common. Furthermore, microcredit has been promoted for its potentially positive impact on those faced with the risk of becoming HIV infected or affected, and those already affected. Solid evidence, based on qualitative methods, has been provided of the ways microcredit clients in Kenya and Uganda cope with the effects of HIV/AIDS (Donahue, Kabbucho, & Osinde, 2001). New financial products—emergency loans and health and life insurance—have emerged (Balasubramanyam, 2001; McDonagh, 2001; McCord, 2000).

Underlying the attention to the potential of microcredit and other financial products to address HIV/AIDS is the premise that microfinance institutions (MFIs) are or can become financially self-sustainable. Nevertheless, HIV/AIDS can have a negative financial impact on MFIs (Manje, 2000; Evans & Radu, 2002).

This study, conducted in Zimbabwe, seeks to better understand the ways that chronic illness and death, possibly associated with HIV/AIDS, negatively affect households and the impact microcredit has had in helping affected households. Special attention is given to the dynamics within loan co-guarantee groups to determine if the groups explicitly exclude individuals infected and affected by HIV/AIDS. Since members of loan groups serve as gatekeepers to loans, the internal dynamics of these groups as well as the MFI's policies and loan terms and conditions are important to understanding any push factors that might exclude HIV/AIDS infected and affected individuals. Recommendations from clients and other key stakeholders are provided on changes that might assist microfinance institutions and their clients in addressing the negative effects of HIV/AIDS.¹

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Study Methodology

Zambuko Trust's microcredit program was chosen as the focal point for this study because Zambuko has more clients than any other organization in Zimbabwe providing credit to microentrepreneurs. The study involved reanalysis of data from longitudinal surveys of Zambuko clients and nonclient microentrepreneurs conducted in 1997 and 1999,² as well as focus group sessions, individual interviews, and a forum with key stakeholders.

Because HIV infection was hidden under a veil of silence in Zimbabwe, proxy indicators were used to identify survey households that were possibly affected by HIV/AIDS. The initial step in reanalysis involved classification of the client and nonclient respondents' households as possibly affected by HIV/AIDS during the 1997–1999 period if they met one of the following criteria: (a) a member was chronically ill and unable to work in the six months prior to the 1999 interview, (b) the household absorbed one or more of the following since the 1997 interview and the person remained for more than six months: a sick person, an adult due to death in a prior household, or a child due to one or both parents having been sick or died, (c) the respondent, spouse, or household member 20 years old or older was seriously ill, which caused a financial crisis since the 1997 interview, or (d) the spouse or household member 20 years old or older died, which caused a financial crisis since the 1997 interview. These households are referred to as possibly HIV-affected households or as affected households.

This classification system facilitated analysis of the effects of chronic illness and death on households and the ways that microcredit impacted affected client households.³ The survey data were analyzed using an analysis of covariance (ANCOVA) approach that took into account differences between the comparison groups in 1997 on values for specific, moderating variables: poverty level of the household, household economic dependency ratio, whether or not the household was affected by illness or death between 1995 and 1997, and the 1997 value for the variable analyzed. The ANCOVA procedure statistically "matches" individuals in the comparison groups (e.g., affected clients and affected nonclients) on their 1997 measures on the

variable analyzed (e.g., household income level) and on the moderating variables. It then uses the average difference between the matched groups on their 1999 measure of the variable analyzed to estimate impact.

The classification of the survey respondents as clients and nonclients is based on their status in 1997.⁴ The reader should note that between the two surveys approximately half of the 1997 clients did not take another loan from Zambuko; hence, in 1999 half of those classified as clients were former clients. The analysis is based on a database of 579 respondents: 338 clients and 241 nonclients from Harare, Chitungwiza, Bulawayo, and Mutare.

To better understand dynamics within loan guarantee groups, in late 2000 and early 2001 focus groups were held in the same geographic areas covered by the survey. A randomly selected sample of current clients and of clients who had already participated in the survey were invited to participate. In total, 140 microentrepreneurs participated in the sessions. Also, 33 loan officers and branch managers from the regions surveyed participated in focus group discussions, and 7 senior managers of Zambuko were interviewed. In addition, 32 persons from microfinance institutions, HIV/AIDS support organizations, and donor agencies participated in a one-day forum in Harare on September 13, 2001. After the study's findings were presented, the participants met in small groups to discuss the implications of the findings in relation to what is currently being done and what else might be done.

Most of the survey respondents were women (85%). In 1997 the respondents averaged 39 years old, with 8 years of education. The majority were married and 10% were widowed. Seventy-five percent of the respondents' households were poor and one third were extremely poor, measured by global standards for determining per capita, per day income and taking into account purchase power parity.⁵ Their households averaged five to six members.

By applying the proxy indicators, the findings indicate that 40% of both the clients and the nonclients were from households that were possibly HIV-affected in 1999. Illness of spouse, self, or another household member 20 years old or older was the most common

indicator. Clearly 34% of the affected client households and 24% of the affected nonclient households had experienced the death of an adult member in the past two years. One fifth of the affected households reported a chronically ill member and slightly more than one quarter had absorbed a person into their household that was ill or as a result of illness or death in that person's previous household.⁶

In 1997, 60% of the client respondents were on their first loan. After the completion of their 1997 loan, half of the 1997 clients took an additional loan. The impact analysis below includes both those who took an additional loan and those who left the program. The average sum of all loans taken by HIV-affected clients was Z\$5,821 compared to Z\$6,435 for the other clients, but the results are not statistically significant.

Country Context

The HIV infection is widespread in Zimbabwe, with an infected population estimated to be between 9 to 11.9 million persons in mid-1999. While life expectancy prior to the AIDS epidemic was 65 years, it was projected to decrease to approximately 39 years by 2005. In 1999 an estimated 25% of the adults aged 15 through 49 were HIV/AIDS infected. Overall, an estimated 1.5 million adults and children were infected by the end of 1999. Deaths due to AIDS were estimated to be 130,000 in 1997 and 160,000 in 1999. Some 624,000 children under age 15 are estimated to have lost their mother or both parents by the end of 1999 (UNAIDS & WHO, 2000). Ten out of every 100 children die before they reach age 5 (Central Statistical Office, 2000).

The high incidence of HIV/AIDS and its negative impact on households has been exacerbated by the negative impact of the political and economic environment. Since the mid-1990s, weak economic policies, governance problems, unsustainable levels of public spending, and high levels of domestic debt have negatively affected the Zimbabwean economy. Examples include government intervention in the conflict in the Democratic Republic of the Congo from August 1998 onwards, political tensions, and disrupt-

tions associated with the direction of land reform and resettlement (IMF, 2001).

Inflation has soared. The cost of living, as measured by the Consumer Price Index (CPI), in the 12 months after the launching of the survey in September 1997 increased 32%. From September 1998 through August 1999 the annual increase in the CPI rose to 70% and in the next 12 months the annual increase in the CPI was 62% (Central Statistical Office, 2000; Reserve Bank of Zimbabwe, 2000).

Zambuko Trust

Zambuko Trust, which began operations in 1992, had branch offices in all of the major urban centers and key secondary towns and had five regional offices by late 2000.⁷ Initially Zambuko provided loans to individuals backed by a guarantor, but in 1995 it started providing group-guaranteed loans (Figure 1). After participating in a group scheme, a client might be approved for an individual loan. However, resistance to group-guaranteed loans outside of Harare and Chitungwiza led Zambuko to continue to issue loans to individuals who would pledge a nonessential asset and who had a co-guarantor.

Figure 1. Zambuko Loan Products

Group-based Loan. Given to individuals in a self-selected group of 5-10 who co-guarantee the loans to its members. Each member pledges a nonessential movable asset against his or her loan. Prior to formal loan application, individuals must attend a half-day training session that covers basic business management. Loans are usually for 9 to 12 months, repaid on a monthly basis. The groups are not required to hold meetings on a regular basis. Loan officers informally provide business management advice.

Individual Loan. Individuals must have a personal guarantor and pledge a movable asset against the loan. Loans tend to be from 9 to 12 months, with monthly loan installments. Prior to formal loan application, the person is required to attend a half-day training session that covers basic business management. Informal business management advice from loan officers is provided.

Trust Bank Loan. Self-selected groups of 10 or more individuals that co-guarantee loans to its members; these loans are targeted to the poor. A potential borrower must attend a one-hour training session for eight weeks prior to receipt of the loan, and biweekly meetings during the loan cycle. Loan size is smaller than other products, and loans are for six months, with monthly installments.

Both individual and group members are required to attend an initial half-day orientation session prior to receipt of the loan, whereas the Trust Bank program involves more intensive training on good management practices.

In 1997, the average Zambuko loan was Z\$2,537 (equivalent to US\$213) and carried a 32% per annum interest rate. In 2000, the average loan size was Z\$10,162 (equivalent to only US\$185, due to a decline in the value of the Zimbabwe dollar). By late 2000, the interest rates had increased to as high as 52%, depending on the loan cycle and repayment record, as an attempt to keep up with the high rate of inflation.

Approximately 45% of Zambuko's clients were traders and 40% were engaged in manufacturing, such as knitting sweaters and sewing. The others were engaged in services, agriculture (livestock rearing and market gardens), and food preparation. Approximately 80% of Zambuko's clients were women.

An effort was made to ascertain the effect of HIV/AIDS on Zambuko's financial performance. At the end of 2000, less than one-half of 1% (0.32%) of Zambuko's outstanding loans were written off because of the death of clients. Beyond these data, the institution does not have a basis for estimating the impact of HIV/AIDS on its program and among its borrowers. Yet responses from clients and loan officers participating in the focus group sessions document that the effect goes beyond the death of clients to difficulties with loan repayment and to leaving the program.

Findings

Economic Effect of HIV/AIDS on Households

HIV-affectedness appears to be negatively associated with the proportion of the household's members who were economically active, the role of enterprise income in the household's economic portfolio, and the ability to seek medical treatment (see Table 1). These results are based on an analysis of changes between 1997 and 1999.

Moreover, when controlled for specific differences between respondents in 1997, the ANCOVA results point to specific, negative

Table 1. Key Differences between HIV-affected Households and Other Households (percentage distribution)

	HIV-affected	Other	Statistical significance
Economic dependency ratio	N=228	N=351	
1997	31	29	
1999	40	32	<.01
Gain score change	8.6	2.8	<.01
Ratio of enterprise income to total household income	N=221	N=282	
1997	75	66	<.01
1999	55	57	
Gain score change	-20	-9	<.01
Did not seek medical treatment when needed in past 6 months due to lack of funds (1999)	N=228	N=351	
Yes, unable to seek treatment	18	9	<.01

economic impacts on households. The monthly household income level for affected households was estimated to be Z\$525 less than for other households (<.15). Also, the monthly net revenue for the household's enterprises was Z\$521 less a month for the affected households compared to other households (<.05). The findings suggest that illness and death influence the amount of income the household earns from its enterprises, which in turn affects their overall monthly income level.

On a number of other economic indicators, the ANCOVA results suggest that the affected households were similar to other households. For example, no statistically significant differences were found between affected households and other households on the following: per capita monthly income; the frequency of the consumption of specific, nutritious food items; the proportion of the household's girls and boys aged 6 to 16 who were enrolled in school; and the number of person-hours worked in household enterprises.

Impact of Microfinance on Affected Clients

This section presents data on selected changes between 1997 and 1999, as well as the results of the ANCOVA tests that signaled the

impact of microcredit (see Table 2). The average total net revenue from household enterprises declined between 1997 and 1999 for both the affected client and affected nonclient households, when measured by the revenue earned the month prior to the interview and controlling for inflation. In 1997 the household enterprise revenue averaged Z\$2,672 for affected clients compared to Z\$1,822 for affected nonclients ($P < .05$). When measured in 1997 constant values, the amount in 1999 was Z\$456 less for client households and Z\$192 less for nonclient households.⁸ Although the drop was greater for the affected clients, they still had a significantly higher average in 1999 than did the affected nonclients ($P < .10$).

In 1999 the affected clients averaged 37 hours of work in their household enterprises during the week prior to the interview, which was nine hours less than in 1997. In comparison, the affected nonclients averaged 46 hours of work, which was two hours more than in 1997. When controlling for initial differences, the affected client respondents had worked significantly fewer hours in their household

Table 2. Impacts of Microfinance on Affected Clients

Suggested by the ANCOVA Analyses of the Survey Data

Findings (1999 compared to 1997) ¹	Statistical significance
<i>At the household level</i> , HIV-affected clients compared to HIV-affected nonclients had:	
• greater number of household income sources (.23)	<.01
• greater proportion of the household's boys aged 6–16 in school (5%)	<.10
<i>At the enterprise level</i> , HIV-affected clients compared to HIV-affected nonclients had:	
• worked fewer hours the previous week in household enterprises (8 hours)	<.05
• greater proportion that insist on a deposit when extending credit to customers (13%)	<.10
<i>At the individual level</i> , HIV-affected clients compared to HIV-affected nonclients had:	
• saved in more ways (.43)	<.01
• greater proportion with an individual savings account with a formal institution (16%)	<.01

¹ The analysis took into account specific initial differences in 1997, including household poverty level, household economic dependency ratio, and whether the household had a crisis due to illness or death of a member between 1995 and 1997.

enterprises in 1999 than had affected nonclients. Nevertheless, the ANCOVA results did not suggest a negative relationship between microcredit and the total amount of net revenue from microenterprises, and the average net revenue from enterprises in affected client households was significantly higher than the net revenue earned by the comparison group. Because the findings on total hours of work in the enterprises do not suggest substitutes for the labor of the clients, the results imply that the affected client households managed their enterprises more efficiently.

When all sources of household income were considered, the affected clients averaged 2.5 sources in 1997, and this average increased to 2.8 by 1999. In comparison, the affected nonclients averaged 2.1 sources in 1997, and this average rose to 2.3 by 1999. The ANCOVA results suggest that affected client households had more sources of income in 1999 than the affected nonclient households, indicating that microcredit had enabled these client households to follow an income smoothing strategy.

Also, the ANCOVA results point to microcredit having a positive impact on affected client households sending their boys aged 6 to 16 to school, indicating investment in the human resources of its members. The proportion of affected client households with boys aged 6–16 in school had increased from 91% in 1997 to 99% two years later. In contrast, the affected nonclient households had gone from 93% to 95% of their boys in this age range enrolled in school.

Zambuko's program also appears to have had an impact on the way that affected clients manage their finances (see Figure 2). In 1999, 13% more of the affected clients than the affected nonclients insisted on a deposit when they extended credit to their matched enterprise customers. Also, 16% more affected clients than affected nonclients had an individual savings account with a formal institution. In addition, the average number of ways the respondents saved was higher for the affected clients than affected nonclients. These differences imply that Zambuko's microcredit program had a positive impact on the way affected clients manage their money.

Vetting of Members of Loan Guarantee Groups

The focus group discussions indicate that loan groups apply basic criteria in the selection of members: the trustworthiness of the candidate, whether the candidate is hardworking, and whether the candidate is someone whom they know. These criteria are the ones recommended by Zambuko. Participants explained how they define each of the criteria. Trustworthiness means a commitment to meeting obligations. It also implies that the person will be diligent in meeting loan obligations. Hardworking relates to the effort put into the enterprise to generate revenue and savings, which would enable the borrower to repay his or her loan. Knowing the person is also important. To many, this means that the person is a neighbor or works near other members.

Those owning or purchasing their residence tend to be preferred, although some groups accept renters who have resided at the same place for a long time or who have a relative nearby who is known to the group. Renters are considered high risk because they are difficult to track down if they move. The ability to relate to and communicate

Figure 2. Improved Financial Management

In May 1997 when she received her first Zambuko loan, Ms. Mlanga, a 32-year-old divorcee with a 4-year-old son, had few household assets and lived in one room that she rented. In late 1998, Ms. Mlanga took in her chronically ill and widowed sister. The sister's in-laws sent her away when they took over her deceased husband's property and the care of her children. To accommodate the sister, Ms. Mlanga moved into a two-room rental unit without electricity. Ms. Mlanga attributes her ability to manage her meager financial resources to the training she received from Zambuko. Using the budgeting skills she acquired, she is able to pay her rent on time, and she buys groceries in bulk. She says that if it were not for Zambuko, she would not have achieved what she has so far.

Mrs. Chikaro started borrowing from Zambuko in 1994. Prior to becoming a client, she did not have any confidence in her enterprise and herself because her enterprise was struggling to survive. Her husband, the household's main income earner, became ill and then died in early 1997. During his illness, her enterprise activities were disrupted, since she devoted time to caring for him. After her husband died, she continued to borrow from Zambuko. Her savings and loans enabled her to buy a knitting machine and build a rental unit adjacent to her house. She has managed to support herself and her four children. She reports, "someone coming into my house would not know that there is no man," since she is doing well meeting all of the household expenses by herself.

with members was also often mentioned as important. Groups did not want a member who would cause problems.

Other criteria may also be applied. In one instance, the health status of the individual was explicitly stated as a criterion. A member of a Harare loan co-guarantee group, formed in 1999, stated that they look for “one who is not constantly ill because it would give us repayment problems.” Later participants were asked: “If Zambuko had a policy of writing off the loans of deceased clients, would your group allow sick persons to join?” The answer was “no,” because the sick people would probably be unable to work enough in their enterprises to enable them to meet monthly loan installments. This was considered important because Zambuko requires group loans to be paid in full or else each member is assessed a late fee. The response also indicates a recognition that HIV-infected individuals experience a number of health problems as the infection progresses. The focus group findings mirrored Zambuko’s policy against loaning to persons who are ill, because of the risk associated with the ability of the individual to repay their loans.

Nevertheless, there were notable exceptions to exclusion of the chronically ill. An example was given in Mutare of a group with a sick person who had “worked hard to the end and would struggle and still managed to pay her installments.” This loan group incorporated the 23-year-old daughter of the deceased member because her mother was such a hardworking and trustworthy person. In another case, a borrower confided to her loan officer that she was HIV-positive. At her request, he talked with her group members and they consented to allow her to remain in the group for the next loan cycle.

Loan Repayments and Illness and Death

Loan co-guarantee groups have responsibilities for the debts of their members. Since mid-2000, Zambuko has enforced the group guarantee loan condition: each group’s installment must be paid in full, otherwise each member is charged a late fee. Also, for loans extended prior to January 2001, the loan group was responsible for paying the outstanding loan of deceased members (see Figure 3). Group responsibility meant that if the group did not collect the money from

Figure 3. Examples of Loan Co-Guarantee Groups Dealing with Death of a Member

A Mutare group member had left instructions that her children should pay off her loan using the money generated from renting one of the rooms in her house. She had the written instruction “stamped” (notarized) at the police station. When she died, her instructions were implemented without difficulty. This group makes a practice of discussing with members what should be done to recover the loan money if they die. Instructions are written in their savings passbook, and the members are expected to inform their spouse or another family member about these instructions.

A Highfield group member died only three days after receipt of her loan, so the funds were still in her bank account. Neighbors informed the husband, and upon their advice he withdrew the money and would not honor the wife’s debt. In spite of appeals to the husband and mother-in-law, the group members ended up repaying her loan.

Two Trust Bank groups reported paying the loans of deceased members because the deceased had paid their installments on time prior to their death. Another group paid off half of the deceased member’s loan and then Zambuko wrote off the remaining balance.

the deceased person’s family, group members had to pay. As a participant explained, “Initially Zambuko wrote off loans of people who had died, but they stopped after realizing that some people would go to the officers and lie that some had died when she/he was alive.”

Group members normally assist members who have difficulty meeting their loan installments because they are ill or coping with illness or the death of a family member. The group, however, normally expects to be reimbursed. Some groups have established special group savings accounts to enable them to provide short-term assistance. Group members may also lend support to members in other ways, although this does not appear to be a normal practice. It depends on the situation, personal ties, and the ability of the members to assist.

Clients in the focus groups reported that loans help microentrepreneurs to improve their ability to cope with future illness and death. However, borrowers with individual loans and many group members consider loans a burden if serious illness or death occur when the microentrepreneur has a loan outstanding. Their view is also held by Zambuko officers. Both Zambuko officers and clients tend to agree that loans should be for the economically active.

Illness and Death Affecting Continuation in the Program

Focus group findings indicate that the loan product influenced the way groups treat members who are ill or have experienced difficulties due to illness or death in their household or among extended family members. For the non-Trust Bank groups, as long as the individual had been a good member and met loan installments in a timely manner before experiencing problems due to illness or death, the person is normally allowed to remain in the group during the next loan cycle. As the Chitungwiza participants remarked, “We must do this because it might be one of us the next time.” A woman from Bulawayo who had told about her group helping a member whose husband was ill and then died explained that “the group said that she should feel free to continue as a group member since her repayment problems were not of her own making.”

The amount of the subsequent loan, however, might be more modest. The Mbare participants advise members who have had repayment difficulties due to illness or death to take a smaller-sized loan, but they do not drop them. In another session, a group member recounted how one of their members wanted a larger loan but the others appealed to the loan officer to recommend a smaller amount, because the individual was likely to die. The loan officer agreed. The group members were correct and the member died that year.

The Trust Bank participants expressed a different approach, possibly because they have shorter loan cycles and the burden falls on a larger number of people due to the larger sized co-guarantee groups. Trust Bank groups gave examples of advising members who had experienced difficulties making repayments to “rest” from the program during the next loan cycle. One Trust Bank group, however, had problems because a member insisted on getting another loan after failing to repay the previous loan. The loan officer was unaware of the problems the woman had caused the group, because there was no record of them having paid for her. In this case, the participant telling the story dropped out of the loan group because she did not want to be in a group with such a person.

Figure 4. Leaving the Program to Care for the Sick

An elderly former Bulawayo client made dresses and knitted sweaters. She traveled to rural areas where she sold them for cash or bartered for maize that she would then bring into town to sell. Then her unmarried son fell ill with tuberculosis (probably associated with HIV infection), and she had to relocate to the rural areas to take care of him. Then her son-in-law also fell ill with tuberculosis. When her son died, she moved to Masvingo to assist her daughter in caring for the son-in-law (who also had signs of being HIV infected). This meant that her business activities were disrupted because she had to spend a lot of time caring for the sick, so she was unable to continue in Zambuko's program. She intends to borrow again once her caretaking responsibilities are completed.

Some persons self-select to rest between loans or drop out of the program. For instance, two of a group's five members did not want to take another loan due to illness in their households, so the other members decided to stop borrowing until they were all ready to seek another loan. The remaining members made this decision rather than to add new members to their group that they did not trust as much to repay their loans on time.

Program departure in 1999, voluntarily or involuntarily, was associated with having a chronically ill household member or recent widowhood. Thirteen percent of departing clients compared to 5% of continuing clients had a chronically ill household member ($P < .05$) at the time of the 1999 interview (see Figure 4). These data mirror focus group findings that clients and loan officers have found that loans are burdens on those in the midst of a crisis. Also, among those who had become widowed after 1997 and had not remarried, the continuation rate was only 38%, compared to 49% of those who were not widowed in 1997 nor in 1999. These findings suggest that certain types of affectedness influence program departure.

The focus group sessions also revealed instances in which members of the group left the program because of the burden of paying for other members. The Trust Bank participants in particular talked about the burden and problems associated with the group co-guarantee. They felt that smaller, more cohesive groups would be better than what they have (10 to 28 members in their loan co-guarantee groups).

Knowledge of HIV/AIDS Support Organizations

Focus group participants were asked if they knew of any organizations that assist people caring for those affected by AIDS. In the Highfield's session, 9 out of the 10 participants stated that they were looking after orphans whose parents, they believe, died as a result of AIDS. One woman reported that she used to go to the Highfields (a section of Harare) social welfare office but it no longer assists them. Another said that her church tries to help such individuals. One person explained that her brother died of AIDS and left orphans, but to get help is difficult because on the death certificates they write reasons other than AIDS. Other participants in the Highfield session did not know of any organization.

In the sessions in Bulawayo, most participants did not know of any HIV/AIDS support organizations. A few had heard about the New Start Center on the radio and on television, and one person had heard of the Matebeleland AIDS Council; however, none of the Mutare participants knew of any HIV/AIDS support organizations. One participant remarked that during the year 2000 people came and asked them to register children that had lost both parents. Those who registered had to pay a Z\$20 registration fee. "Up to now we have not heard anything from these people and nothing has happened."

Recommendations

Suggestions by Microentrepreneurs

The last part of each focus group session elicited participants' suggestions on services aimed at helping those who take care of or support people with long-term illnesses and those who lost members of their family. The suggestions given all focus on Zambuko. Although the participants were encouraged to think beyond Zambuko, they gave suggestions focused on the organization that they know and in which they have confidence.

The provision of a grace period and deferring a loan installment payment were mentioned in most groups as ways to help those affected by HIV/AIDS. The responses were associated with suggestions that Zambuko accept partial payment of group loan installments, especially

if only one person had not paid. Participants in nearly all sessions also suggested that Zambuko institute an insurance policy that would write off the loans of deceased clients.⁹ They thought that Zambuko should ask for proof of death, such as a death certificate. Only the Highfield participants did not like the idea of paying another fee, even if it were to pay off the loan of a deceased client.

Participants in Bulawayo expressed interest in workshops on how to care for HIV-infected people because they are afraid that if they have physical contact with an infected person they will get the disease. Also, Bulawayo participants suggested it would be good if informational workshops were held for Zambuko clients so they would know where to go for assistance related to HIV/AIDS. Their request mirrors the type of sessions Zambuko's Trust Bank officers had organized for members who meet on a scheduled basis to learn about HIV/AIDS prevention from a Ministry of Health HIV/AIDS specialist.

A couple of sessions in Harare and Chitungwiza with group members ended with participants stating that they had learned a lot from the experiences shared by others. They felt that it would be good for group members to come together more often to share their experiences in dealing with difficult situations.

An interesting observation from the focus groups with clients was that the Mbare female and male participants were more business-like in their attitudes, approaches, and opinions than those in the other groups. Mbare clients work in one of the most vibrant microenterprise market areas in Zimbabwe. Mbare participants seemed to regard Zambuko as a banking, not a social, institution and weighed suggestions against this standard (see Figure 5). The reason is probably associated with their having no other options for credit.

Figure 5. Zambuko Viewed as a Financial Institution

A suggestion in Mbare that Zambuko assist if a member dies, such as buying a coffin, was met with an immediate "no" from the others. "I think you are asking for the impossible. Let us say that you have an account with Standard Bank, would you ever go to Standard Bank to say bury me?" The participants indicated that it would be bringing shame to them if they expect Zambuko to carry their personal problems as if "it is a crime to make us their members."

Suggestions by Other Stakeholders

The above findings stimulated discussion and elicited suggestions by key stakeholders participating in a forum in Harare. No attempt was made to reach a consensus or to prioritize the suggestions. Nevertheless, microfinance participants tended to regard these as good suggestions. Overwhelmingly the participants felt that there was greater need for communication and networking between the microfinance institutions. Those institutions already doing something related to HIV/AIDS should be given a platform to share their experiences so that the sector can advance on the learning curve. Also MFIs should develop a common policy and an appropriate culture and be proactive in establishing ways of addressing the impact of HIV/AIDS on their programs and clients.

These participants also suggested that MFI managers discuss HIV/AIDS as both a client issue and a management issue. More attention should be focused on delinquency management and how to manage risks. For example, managers should consider the household, not just individual microentrepreneurs, when giving loans. They should permit one loan to fund start-up activities and different economic activities by household members. Upon the death of a client, another person from the household should be eligible to fill that person's place in a loan group or with the loan institution, although the person should receive the loan amount for first-time borrowers. Microfinance institutions might consider providing loans to households rather than individuals.

Another suggestion was that microfinance boards of directors and donors should reconsider their policy on the time frame for financial sustainability, profitability, and productivity. They need to be realistic about the impact of HIVs on microentrepreneurs and in turn upon their microcredit programs. Tools are needed to enable them to track the changing impact of HIV/AIDS on clients and their institutions. Client-focused tools would permit MFIs to better understand their outreach and impact on those most vulnerable to HIV infection and those already affected by the virus.

Loan officers often encounter situations related to HIV/AIDS. They ought to be trained on how to communicate in these situations

and on the importance of verbal and nonverbal behaviors. They might also be provided with basic counseling skills and be updated on a regular basis on HIV/AIDS-related services so that they may inform their clients and others in need.¹⁰

The forum participants agreed with the following suggestion made by Zambuko loan officers: MFIs should encourage borrowers to train one of their teenage children to operate the enterprise. The objective would be twofold. First, if successful it would provide a fallback position if the client has to take time away from the business due to illness or death. Second, it would help to teach business knowledge and skills that could assist the child in future years, especially if economic hardships befall the household due to the death of the adult income earners.

Participants felt that under certain conditions, there may be scope for a special loan product for microentrepreneurs who are caring for orphans and helping those affected by HIV/AIDS. For example, loans might be extended to persons who are committed to caring for the abandoned terminally ill in their rural community. (However, in an unstable economic environment, this type of loan ought to be for enterprises that involve products or services that have a relatively stable market.)

Conclusions

Findings based on proxy indicators of HIV/AIDS reveal that between 1997 and 1999, 40% of the survey client and nonclient households were possibly affected by HIV/AIDS. These households appear to be in a worse economic situation than those not affected. They had a higher economic dependency ratio and were less likely to seek medical treatment when needed due to a lack of funds.

When controlling for selected initial differences, the study found that microcredit from Zambuko enabled affected client households to smooth their income flows through the diversification of their income sources and to invest in the education of their boys aged 6 to 16. Moreover, it had an impact on the way affected clients manage their finances. There also appears to be a relationship between participation in Zambuko's credit program and a decrease

in the number of hours worked in household enterprises, but not a negative impact on the net revenue from these enterprises.

Loan groups normally assist members having difficulty making their loan installment, but they expect to be repaid. Persons who had difficulties making their loan payments due to illness or death in the household are normally permitted to remain in the group for the next loan cycle, although Trust Bank members may be asked to wait a while. Until recently, the groups have borne the responsibility of paying the outstanding loans of deceased members. Both loan officers and most clients tend to believe that a loan is a burden when the clients are in the midst of a crisis.

A number of modifications to existing credit products and procedures were suggested that are worthy of exploration to determine their financial viability. For example, there appears to be merit in testing a new approach to loaning for microenterprise activities. Currently organizations tend to loan to an individual for a specific, existing enterprise rather than for a set of household enterprises. MFIs might pilot test loans that would cover existing and new enterprises and assess applicants on the ability of the household to repay the loan, possibly with the contract cosigned by two adult household members. This approach could be combined with encouraging young adults in the household to learn skills in managing and operating an enterprise.

Zambuko reaches poor households and households that are or become affected by HIV/AIDS. However, just because a program operates in a country with a high HIV prevalence rate does not automatically mean that the program reaches and benefits HIV/AIDS-affected households. The loan products, terms, and selection criteria are likely to influence the extent to which microentrepreneurs from these households participate in a microcredit program. The case study from Zimbabwe indicates that credit products and terms could be modified to be more appropriate to the constraints faced by microentrepreneurs in countries with high HIV prevalence rates.

By joining associations or formal networks, institutions providing microcredit can work together to advance their understanding of appropriate terms and conditions for microcredit products in countries where HIV is widespread. These industry-wide groups might

also work to curb approaches and activities that would undermine their microcredit programs. A potential threat comes from programs providing grants to HIV/AIDS affected individuals, when these programs call them loans. The microcredit industry in Africa has made great strides in establishing a culture of discipline in the repayment of debts. Greater attention needs to be given to demarcate the appropriate role of grants and credit in efforts to mitigate the negative impacts of HIV/AIDS on individuals and households.

Notes

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1. Suggested new products are found in Barnes (2002).
2. See Barnes (2001) for the results of the longitudinal assessment carried out for USAID's Assessing the Impact of Microenterprise Services (AIMS) Project.
3. The analysis also included the other clients and other nonclients, but only the results for the two affected groups are discussed.
4. The nonclients were randomly selected from those who met Zambuko's basic loan criteria, had not received credit from a formal institution for their enterprise, and were matched by gender and enterprise sector with a client in their community. Nonclients who had become Zambuko clients since the 1997 interview were excluded from the database.
5. In 1997 two thirds of the client households were below the \$2 a day per person poverty line, and one third of the client respondents were from extremely poor households (below the \$1 a day per person poverty line).
6. The cases of chronically ill persons are also captured in the more general question on serious illnesses. These cases suggest an advanced stage of HIV infection.
7. Registered under Zimbabwe's Money Lenders Act, Zambuko is not permitted to accept voluntary deposits.
8. One U.S. dollar was equal to Z\$11.9 in September 1997 and to Z\$38.1 in September 1999.
9. Since Zambuko had just initiated its loan insurance scheme on new loans, the

participants were unaware of the most recent policy change.

10. See Dunford (2001) for a discussion of options for educating clients on HIV/AIDS.

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