

## Microcredit for people affected by HIV and AIDS: Insights from Kenya

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### Abstract

Consequences of HIV and AIDS are exponential in Kenya, touching not only the health of those infected, but also depleting socio-economic resources of entire families. Access to financial services is one of the important ways to protect and build economic resources. Unfortunately, the norm of financial viability discourages microfinance institutions from targeting people severely impacted by HIV and AIDS. Thus, HIV and AIDS service NGOs have been increasingly getting involved in microcredit activity in recent years for economic empowerment of their clients. Despite limited human resources and funding in the area of microcredit activity, these NGOs have demonstrated that nearly 50% of their microcredit beneficiaries invested money in income-generating activities, resulting in enhancement to their livelihood security. In the short term these NGOs need to improve their current practices. However, this does not mean launching microfinance initiatives within their AIDS-focused programmes, as financial services are best provided by specialised institutions. Longer-term cooperation between microfinance institutions and other AIDS service organisations and donors is necessary to muster appropriate and rapid responses in areas experiencing severe impacts of HIV and AIDS.

**Keywords:** Microcredit, HIV and AIDS, Kenya.

### Résumé

Les conséquences du VIH/SIDA sont exponentielles au Kenya, ne touchent pas seulement la santé des infectés, mais aussi réduisent les ressources socio-économiques de la famille entière. L'accès aux services financiers est la manière la plus importante de protéger et de bâtir leurs ressources économiques. Malheureusement, la norme de la viabilité financière décourage les établissements microfinances à viser des personnes sévèrement atteintes de VIH/SIDA. De ce fait, les ONG de service sont de plus en plus impliqués dans l'activité de microcrédit depuis les années récentes avec le but d'autonomiser leurs malades. En dépit de ressources humaines limitées et le financement du domaine de microcrédit, ces ONG ont démontré qu'à peu près 50% de bénéficiers ont investi l'argent dans des activités à profit ce qui, par la suite, améliore la sécurité de leur gagne-pain. A court terme, ces ONG doivent améliorer leurs coutumes actuelles. Cependant, cela ne veut pas dire lancer des initiatives de microfinance à l'intérieure de leur programme visant le SIDA. Les établissements spécialisés sont les mieux placés à fournir des services financiers. De ce fait, une coopération à long-terme entre les établissements de microfinance, d'autres organisations de service de SIDA et les donateurs est nécessaire afin de rassembler des réponses appropriées et rapides dans des régions sévèrement atteintes de VIH/SIDA.

**Mots clés:** Microcrédits, VIH et SIDA, Kenya.

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## Introduction

Literature on the effectiveness of microcredit for people affected with HIV and AIDS is still nascent. The aim of this paper is to provide a comprehensive look at this particular field and share experiences from two local partners of Concern Worldwide Kenya (hereafter referred to as Concern).

Poverty is both a cause and a consequence of HIV and AIDS in Kenya. Poverty increases the risk of contracting HIV and increases the impacts of AIDS, and *vice versa*. Often, women are more vulnerable to infection because of their subordinate role in society. A majority of women are poor and less educated and thus lack power to negotiate safe sex. Many women engage in survival sex and selling illicit liquor to earn a living, activities that put them at high risk of contracting HIV (ZONTA, 2001). Since the poor have limited access to quality treatment and care they experience high levels of morbidity and mortality. An additional consequence of the ongoing HIV and AIDS pandemic is the growing number of children who are affected in different ways: children are living with sick parents or sick relatives, children are left without one or both parents, and children themselves are HIV positive (Boler & Carroll, 2003). The burden of care is overwhelming for affected households and more so for women and girls, the traditional caregivers.

Literature on the impact of HIV and AIDS on households points to microfinance as one of the ways in which the effects of the disease on households can be mitigated. Unfortunately microfinance institutions<sup>d</sup> have rarely taken structural initiatives to respond to the special needs of affected households, which is surprising especially for a continent like Africa that is extremely affected by HIV and AIDS (Huybrechts & Fonteneau, 2005). According to Parker (2000), a financial viability perspective discourages microfinance institutions from exclusively targeting people living with HIV and AIDS or the groups affected by it. Although a few microfinance institutions seem to be engaged in targeting affected people, they usually offer the option of non-financial services. Financial services offered to people living with HIV and AIDS (PLWHA) are rare. Barnes (2005) adds that loan products, terms, and selection criteria also influence the extent of participation of these households in microfinance programmes. So, just because a microfinance institution operates in an area with high HIV prevalence does not automatically mean that it reaches and benefits the affected households.

## Results from Concern's initiative

Concern, in partnership with HIV and AIDS service non-governmental organisations (NGOs), is working in Nairobi slums and Nyanza province, areas that have registered the highest HIV prevalence and most severe impacts of AIDS. In

Nairobi, slum residents constitute 55% of the nearly 3 million city population (CBS, 2005). HIV prevalence in Nairobi slums is estimated at 20% (NAS COP, 2004). In Nyanza, HIV prevalence is estimated to be 15.1%, compared with 7% nationally (KDHS, 2003). Nyanza is also the poorest province in Kenya and is characterised by poor health coverage and a high number of orphans. NGOs operating in these high-prevalence areas are inevitably overwhelmed by the number of welfare-oriented activities they are running to address prevention, treatment and care services. These resource-intensive activities leave very limited space for these NGOs to run income-generating activities that directly contribute to enhancing livelihood security of the clients enrolled in their programmes. However, the silence of microfinance institutions is pushing these NGOs to attempt to bridge the gap. They have adopted different models and serve the target group in many different ways; for example, some NGOs give business capital as a loan, while others give it as a grant.

In 2005 Concern decided to support its local partner NGOs in providing microcredit or small business grants to their most needy clients to start small-scale economic activities. For the purpose of the study we selected two local partners, namely WOFAK and MMAAK, as they were the only partners who adopted a microcredit model in running income-generating activity for their clients. Their brief profiles are as follows:

- *Women Fighting AIDS in Kenya* (WOFAK) was founded in August 1993 by a group of ten women who came together to give support to one another and to other women who were experiencing problems like rejection, stigmatisation and discrimination after their spouses' death as a result of AIDS. It provides prevention, treatment and care services to women and children living in the slums of Nairobi, Mombasa and Kisumu, and in the rural areas of Homa-Bay in Nyanza province. It initiated microcredit activities in Kisumu in 2004 to support clients in meeting their food requirements and to provide three meals a day for orphans. It expanded microcredit activity to Homa-Bay in June 2006 with support from Concern.
- *Movement of Men against AIDS in Kenya* (MMAAK) was established in 2001 to increase male participation in prevention, treatment and care initiatives in Korogocho slums of Nairobi, Manyatta low-cost estate, and Kano Angola village in Kisumu East district of Nyanza province. Since 2006 it has been providing microcredit and training in entrepreneurship to members of the People Living with AIDS Support Group in all three sites.

**Table 1. Total disbursement and realisation**

NGOs	District	Year	Total beneficiaries	Total loan disbursed	Total loan realisation
WOFAK	Kisumu	2004	75	US\$2 254	US\$225
		2005	75	US\$2 254	US\$526
	Homa-Bay	2006	31	US\$2 254	US\$727
MMAAK	Kisumu	2006	10	US\$601	No realisation
		2007	10	US\$601	No realisation
	Nairobi	2006	10	US\$601	No realisation
		2007	10	US\$601	No realisation

As a part of the study process we conducted a series of focus group discussions and semi-structured interviews with microcredit beneficiaries of the study NGOs. Moreover, we conducted wellbeing grouping analysis to understand the effectiveness of targeting and impact flow diagram<sup>iii</sup> to capture the impact of microcredit. We also interviewed staff members located in both the head and field offices, and reviewed a number of record-keeping documents of NGOs to triangulate our field findings.

### Loan disbursement

Clients of WOFAK and MMAAK are selected through their home-based care and treatment activities. In order to target the neediest clients, as well as to enhance the effectiveness of microcredit activity, they give priority to those who (a) are HIV positive and on TB and antiretroviral therapy;<sup>iv</sup> (b) who have a business which went down due to illness, and (c) are taking care of orphans. About 90% of WOFAK microcredit beneficiaries are women. Although the key target group of MMAAK is men, about 18% of their microcredit beneficiaries are women.

Based on the availability of funds, WOFAK and MMAAK identify a certain number of needy clients, in line with the above-mentioned targeting criteria. They provide 3 days of training in bookkeeping, small-business management and daily cash analysis to the selected clients. This is followed by facilitating the beneficiaries to develop their business proposals including budget, site of business and competitors.

Our study revealed that in most cases beneficiaries did not receive the loan as per the business proposal. The requested loan amounts ranged on average from US\$120 to 225 (US\$1 = Kenya Shilling 66.5) in Kisumu and Homa-Bay, and US\$300 to 675 in Nairobi, but they received on average US\$60. So, in most cases the beneficiaries had to change their business plan based on the approved size of the loan. The key reason of such a big difference between the requested loan in the business proposal and the actual disbursement was the intention of NGOs to reach a maximum number of clients with the limited funds available for this purpose.

### Performance in loan realisation

WOFAK and MMAAK have adopted different approaches in different places to ensure realisation of interest-free loans on time. In Kisumu WOFAK organises the beneficiaries into groups of five, where they guarantee each other's loan. WOFAK beneficiaries in Homa-Bay and MMAAK beneficiaries in Kisumu are requested to bring along a guarantor who undertakes to pay the loan in case of default.

WOFAK beneficiaries in Kisumu were supposed to repay the loan within a year of disbursement through weekly instalments. As indicated in Table 1, WOFAK has realised only 10% and 23% of the total loan from year 2004 and year 2005 beneficiaries, respectively. The loan repayment improved slightly in 2005 when clients were promised more loans upon timely repayment. WOFAK beneficiaries in Homa-Bay were given a 1-month grace period. The average weekly repayment rate was set at about US\$0.75 for every US\$30 amount borrowed. Of the total US\$2 254 loaned out in 2006, US\$727 has been paid back already. Out of 31 clients, only 4 have totally defaulted. The performance of WOFAK in Homa-Bay was better than in Kisumu because of the engagement of a designated staff member to look after microcredit activity. The staff member goes to the client's business premises to collect repayments, to provide hands-on training in keeping business records, and to advise on business strategy.

MMAAK beneficiaries in Kisumu and Nairobi were given a 6-month grace period. The beneficiaries were given the space to decide how much they would repay in every monthly instalment. The study revealed that none of the beneficiaries has repaid any instalment to date. However, it is worthwhile to mention here that our focus group discussions revealed that most of the beneficiaries invested money in business and generated good profit, but MMAAK failed to set up a proper loan realisation process.

### Impact of microcredit

As one partner implemented microcredit in 2004 and the other started in 2006, it is too early to gauge the impact of the intervention. In addition, our field research revealed that only

49% of total beneficiaries invested microcredit in business (Table 2). We therefore have tried to capture the varying degree of change only in the lives of those who invested the microcredit in business.

**Table 2. Proportion of microcredit beneficiaries who invested money in business**

NGOs	Total number of credit beneficiaries	Total number of beneficiaries who invested money in business	% of beneficiaries in business
WOFAK	181	72	40.0%
MMAAK	40	36	90.0%
Total	221	108	49.0%

Discussion with the beneficiaries revealed that the benefit of microcredit was not only confined to improvement of economic wellbeing, but reflected also in improved social standing, and physical and psychological wellness of the clients. The microcredit improved the capacity of individuals and communities to cope better with shocks arising from the impact of HIV and AIDS, thus creating resilience.

Restoration of lost income and meeting basic needs were the most commonly mentioned indicators of economic empowerment. Some of the beneficiaries have been in business for a long time, but prolonged illness and attendant costs led to the collapse of their ventures. With additional training and the microcredit they received from the programme, clients have been able to pick up where they left off and move on with life. Although their businesses may not have recovered to the level before illness struck, they were at least able to generate enough money for transport to hospital or medicine that may not be available in the health centres, buy food, pay rent, take care of their children and take treatment regularly.

When the business ventures collapse as a result of prolonged illness, or when a client is bedridden, clients become destitute. In the market they suffer unkind gossip from other vendors, as the collapse of their businesses is associated with a stigmatised illness. Support to these people to restart income-generating activity has already restored their standing in the market place and society at large, and has uplifted their psychosocial wellbeing as well, thus reducing stigma and discrimination against people affected by HIV and AIDS. Beneficiaries of successful income-generating activity have also become agents of positive living and are encouraging other affected persons to seek treatment and support services, and live positively.

Some of the beneficiaries were previously involved in survival sex and/or illicit alcohol trade, activities that they confess led to their infection with HIV. These activities led clients to re-infection and impacted negatively on their ability to comply with treatment. The microcredit enabled clients to shift to new business activities, thus changing their behaviour and reducing chances of infection and re-infection, in addition to promoting their ability to adhere to treatment.

The beneficiaries have benefited significantly from training and/or mentoring in micro-business development, bookkeeping and saving. A client indicated that although she had been running a business before, she would spend all her money including capital, and as a result the business kept failing. With new business skills she set aside her capital and her business was growing strongly in spite of her illness. Conscious of their health status, the majority of clients involved trusted relatives and children in their business, and these too benefited from the mentoring process.

Beneficiaries of income-generating activities are awakened to the challenges of an ever-increasing number of orphans and vulnerable children (OVC) in their families and community and are responding in their own small way with the meagre resources available to them. Although not intended, income-generating activity support has proved a very big incentive to those caring for OVC. Field level investigation showed that successful beneficiaries of income-generating activity had taken proactive roles in sending OVC to school. Some of the beneficiaries were not only supporting orphans and vulnerable children at household level, but also extending their hand at community level.

### **Case study 1: Educating orphans and vulnerable children through microcredit**

Philgon Atieno, a 43-year-old HIV-positive widow and a mother of two, lives in Manyatta, a low-income estate on the outskirts of Kisumu. She learnt her serostatus in early 2000, following the death of her husband due to AIDS. At that time Philgon worked as an early-childhood teacher at a prominent school in town. Philgon began suffering from a persistent cough and skin rashes, and as other people suspected her of suffering from AIDS she was subjected to emotional abuse. At school the management, fearing the parents would withdraw their children, allocated her duties cleaning the bathroom, where she stayed all day. Owing to her deteriorating ill health Philgon lost her work in October 2000, faced rejection from her late husband's family, gave up on life and wished she could die. In 2001 a friend, Mary Mumba, who was also HIV-positive, came to her rescue

and admitted her to the provincial hospital, where doctors put her on antiretroviral therapy. The turning point in Philgon's life came in 2002 when Mary introduced her to WOFAK, where she joined a support group of women living with HIV and learnt about positive living from other members who spoke openly about their status. Moreover, she received monthly food rations and immune boosters from WOFAK.

Buoyed by improved health, she brought together women affected by HIV and AIDS in Manyatta and they formed the *Pearl Omega Positive Test Support* group in 2004. The group is involved in providing nursing and psychosocial care and support to affected households in Manyatta. In the course of interaction with members of the group and their children, she realised that, just like adults, children affected by HIV and AIDS suffered stigma, so that they may be denied entry to pre-school centres. Towards the end of 2004, with a loan of US\$100 from WOFAK, she converted her small house into a pre-school by admitting 7 children of women living with HIV.

Luckily, in 2005 she received terminal benefits from her former employer amounting to US\$136, which she invested in the construction of semi-permanent classrooms. She mobilised support from the mayor, who donated more chairs and toilet facilities to the school. Due to public demand in 2006, the school opened its doors to children from the wider community who could pay school fees. Today there are a total of 85 children in three levels, 35 of whom are orphans and 19 are HIV-positive. Currently only 25 pupils pay school fees in full, amounting to US\$4.5 per term, 17 make partial monthly payments and 43 children are studying free of charge. This has helped Philgon to recruit 2 more teachers for the school and to earn financial sustainability. Philgon is paying US\$18 to each teacher per month.

Philgon's outlook on life is very positive, she is motivated by the desire to see her two sons get higher education and take charge of their lives. Thus she follows her treatment strictly. In order to ensure proper treatment of the infected children at the school, Philgon counsels their parents and guardians and links them to several health facilities that provide paediatric HIV and AIDS care. She liaises with health facilities that give immunisation, anti-worm drugs and multivitamins as appropriate. In addition, Philgon conducts HIV and AIDS sensitisation for teachers in other local pre-schools and primary schools to reduce stigma towards orphans and infected children.

### ***Case study 2: Enhancing livelihood security through microcredit***

Samuel Owino Arot, a 59-year-old man, lives in Ngalo village

in Homa-Bay district. He retired as a clerk with the fisheries department in September 2001, after 30 years of service and received meagre retirement benefits amounting to US\$2 239. Retirement provided him with an opportunity to realise his cherished dream of becoming a renowned small-scale tomato and kale farmer. However, everything rapidly changed in early 2002 because of his continuous illness. He would be treated for one infection, only to go down with another soon after. As a result all his pension benefits and savings were exhausted in seeking treatment from private clinics and traditional medicine men. He even sold off his animals, including the oxen on which he depended for ploughing. Since his condition was rapidly deteriorating, he was willing to try one more suggestion. That is why, when a doctor recommended that he take an HIV test, he readily complied. Samuel did not however contemplate that he could be infected by HIV, despite his first two wives having died in 1998 and 1999 respectively. He was diagnosed with advanced AIDS and was started on the life-saving antiretroviral drugs. He was referred to WOFAK for continuing treatment education, adherence counselling, psychosocial support and monthly food rations.

With improved health, Samuel was eager to restart small-scale cultivation to become self-reliant. Queueing for food rations at WOFAK was degrading to him and attracted ridicule from members of the community. In late 2005, he approached WOFAK for a loan to rekindle his dream. In early 2006 he received a loan amounting to US\$35, with which he purchased fertiliser and seeds. In the absence of his ox he had to till the land by hand. His first tomato harvest in May yielded nine crates valued at US\$135. In order to ensure a regular income, the agricultural extension workers advised him to stagger his tomato crop so as to have a monthly harvest. Subsequently he has maintained a steady income of US\$30 per month from his tomato plots. The first maize crop returned 280 kg in July, which fetched him US\$188. He has already paid back the loan, and has applied for a new one to purchase a hand pump, with which he plans to expand the land under irrigation. He now hires labour to assist on the farm.

Microcredit has elevated Samuel's standing in the community from a sickly dependant to a healthy productive benevolent. He attributes his success not only to WOFAK but also to his only living (third) wife, who despite being HIV negative, has remained very supportive and provided for the family when he was very ill. In order to give something back to the community, Samuel has gone public with his status. With training from WOFAK he is now a very active peer educator and has helped many of his neighbours to agree to go for HIV testing and care. He shares some of his produce with needy relatives and

neighbours, and is taking care of four orphans and ensuring their education.

### Challenges of income-generating activities

Frequent sickness of the beneficiaries is the most challenging factor to survival of micro-enterprises. The beneficiaries are often forced to use the business profit and capital to meet treatment-related costs. In addition they have to meet the needs of orphans and/or ailing persons who may be under their care. This means there are so many needs competing for meagre earnings. Moreover, beneficiaries have to split time between business and their care roles, and so cannot invest enough time in business. In some instances clients opt to buy food with business capital instead of investing it in business. Sometimes beneficiaries are bedridden and are forced to delegate running of the business to children, relatives or friends who might be dishonest and/or incapable, and as a result they register heavy losses. When the client is bedridden the business runs a high risk of collapse. Due to power dynamics women are forced to give money to their male partners who are not in the programme and this may be squandered.

Many beneficiaries find the micro-credit offered inadequate to do business, they lack the motivation to continue, and so simply do not invest or drop out. Inadequacy of business capital is also linked with high transport costs, as well as statutory and illegal levies. Beneficiaries in rural areas and urban centres that are far from sources of merchandise or market places have to contend with high transport costs. These, coupled with treatment-related costs, means that the beneficiary will not be able to attend all market days or have enough stock to compete favourably in the market. In addition, beneficiaries are forced to conduct their businesses at designated market places where they have to pay daily rates to the county councils. Unfortunately the beneficiaries may incur transport cost or walk long distances to designated market sites, a situation made worse if the market is not strategically situated to attract customers. In order to operate in more lucrative places the beneficiaries have to bribe council officers. In the slums clients are forced to pay protection fees to vigilante groups, the failure of which means frequent harassment and having their wares stolen. Thus official and non-official levies eat into their meagre earnings.

Welfare-oriented activities, such as feeding programmes, home-based care, etc. of HIV and AIDS service NGOs have created a dependency mentality among some beneficiaries. They expect assistance from NGOs in every step of running the business. Some beneficiaries feel that because the money is donated it is supposed to be free from any condition, as 'it is their money'. So, they don't believe in loan repayment. In addition, there are

instances where clients who default on repaying the loan feel guilty and drop out of other prevention, treatment and care services. NGOs have to reassure them that failure to repay a loan does not deny their right to access to the other HIV and AIDS services. This puts the NGOs in an awkward position as they have to strike a delicate balance between enforcing compliance with the microcredit scheme and at the same time ensuring access to prevention, treatment and care services for the clients. Finally, doubts among microfinance institutions discourage donors from funding income-generating activity, and hence NGOs rarely can afford designated staff for this activity.

## Results from literature review

### Effectiveness of microcredit in strengthening livelihood security

The overall effect of HIV and AIDS on the economic wellbeing of affected households depends on the availability and size of household financial safety nets. For households without a financial safety net, HIV and AIDS can draw the household from relative stability to catastrophe, as income earners fall sick or die, and as costs of household maintenance rise. The stronger the household safety net, the better the chances that the household can withstand the crisis without resorting to coping behaviours such as liquidation of long-term assets, reduced purchases of basic necessities, removing children from school, or migration of family members (Donahue, 1998). The size of the household safety net depends on two factors: the initial financial standing of the household, and the ability to build a financial base over time. Microfinance – both credit and savings – strengthens the second of these, offering households opportunities to build assets, diversify income sources, and generally strengthen their financial footing. Thus, even in its most basic form, access to microfinance services gives households a way to both prepare for and cope with crises (Parker, 2000).

However, apart from some success stories, very few data exist related to the effectiveness of microcredit in enhancing livelihood security of households affected by HIV and AIDS. For the purpose of this paper we draw lessons from the outcome of a pilot project on economic empowerment of female sex workers in Majengo slums in Nairobi.

The STD/AIDS Control Project of the University of Nairobi, which was developed as a pilot project in 1999, provided small loans, business training, and HIV and AIDS education to 209 female sex workers. HIV prevalence was as high as 80% among these borrowers. An assessment was conducted after 18 months of loan disbursement. Of the 209 enrollees, 90 had left the programme, and 6 women had died. Failed businesses were

hindered by insufficient demand for services, health problems of clients, and household and family needs. Surviving micro-enterprises (representing about half of all businesses started) were concentrated in the trading of agricultural products and sales of second-hand clothes. The loan repayment rate was 72%. There were notable reductions in sexual risk behaviour among the borrowers. Almost 20% of the women left sex work completely, and those who remained in the industry dramatically reduced their average number of clients. There was a remarkable decline in sexually transmitted infections among the clients (Costigan, Odek, Ngugi *et al.*, 2002).

It is important to note here that the outcome of this project dramatically matches one of our key finding, that at least 50% of the target beneficiaries were able to improve their economic wellbeing. Our study findings also match the fact that microcredit significantly reduces the vulnerability of women to HIV and AIDS, by offering an alternative to high-risk behaviour based on economic necessity. This behaviour does not only include prostitution – it includes engaging in sex with men in exchange for support, such as payment of school fees. Thus it can be argued that the role of microcredit in economic empowerment of households affected by HIV cannot be ignored.

### Current position of microfinance institutions

Not much accurate information exists or is available on the impact of HIV and AIDS on microfinance institutions, not even in countries with high HIV and AIDS prevalence (Huybrechts & Fonteneau, 2005). However, the donor briefing paper of the Consultative Group to Assist the Poor<sup>7</sup> (CGAP, 2003, p.1) argues that 'launching a financial intervention specifically to target persons with AIDS would not be appropriate, given that financial services depend on the on-going ability of clients to earn income'. Subsequently, CGAP proposes that donors should avoid pushing microfinance institutions to launch operations in markets specifically to respond to the HIV and AIDS crisis. Alternatively, donors may support organisations able to provide grants instead of financial services.

Our research findings confirm the current position of microfinance institutions in relation to targeting households affected by HIV and AIDS. Although a significant number of microfinance institutions are active in Kenya, based on our research it can be argued that microfinance institutions rarely reach the affected people living in severely impacted areas<sup>8</sup>. The key reasons for exclusions are:

- *Attitudes:* Microfinance institutions disburse loans in clusters of five for the security of loan money, and there is a tendency for people to shun very sick people out of fear that they

might die. Moreover, better-off group members believe that households affected by HIV and AIDS are economically vulnerable and that they will not be able to repay loans on time. So they usually do not want to take the liability of loan repayment by becoming the guarantor of loan money.

- *Rules and regulations:* As explained by the participants in focus group discussions, the rigours of microfinance schemes are beyond the capacity of people affected by HIV and AIDS who are wrestling with medical, economic and psychosocial problems. The affected people often fail to comply with the requirement of regular group meetings and savings in order to obtain a loan. Sickness has been identified as a common reason for not attending weekly groups meetings and skill building trainings on a regular basis. In addition, the loans attract high interest rates, ranging from 15 to 19 per cent, and this coupled with the savings puts a heavy financial burden on the affected people (CARE, 2004).
- *Financial sustainability:* Discussions with a number of officials of microfinance institutions highlight the fact that household income drops when an adult becomes sick with HIV and AIDS, household medical expenses rise substantially, and household food consumption drops significantly. So, the considerable risk to microfinance institutions is that the affected clients will default on their loans, may not continue to borrow, or will want to withdraw their savings, which is not compatible with microfinance institution aims of financial sustainability (Donahue, Kabbucho & Osinde, 2001; ICAD, 2001).

In a nutshell, although many in the development community recognise that the ability of a household to mitigate the impact of HIV and AIDS relies largely on their capacity to stabilise or increase incomes, microfinance institutions have by and large taken a back seat. Consequently, HIV and AIDS service NGOs are under tremendous pressure to develop income-generating schemes. They believe microcredit represents a potentially powerful tool to support income-generating activities. However, lending methodologies and practice need to be flexible to suit the socioeconomic wellbeing of clients (Anderson, Gugerty, Levine & Weaver, 2002). Yet these NGOs involved with HIV- and AIDS-related issues tend to come from health and social development fields where experience with micro-enterprise development is limited (Donahue, 1998).

### Conclusions

The study findings demonstrate that micro-credit activities of the HIV and AIDS service NGOs are targeting the most vulnerable households. If an HIV- and AIDS-affected person

invests microcredit in a successful income-generating venture, it does not only contribute to improving economic wellbeing, but also reduces stigma towards the infected. It also contributes to mobilising support for orphans and vulnerable children, as well as capacity building and cushioning financial activities and assets of other family members. Successful income-generating activities also contribute to strengthening the household safety net that is ultimately drawn upon when clients reach the late stages of AIDS. So, the role of microcredit in economic empowerment of households affected by HIV and AIDS cannot be overemphasised.

At the same time evidence showed that HIV and AIDS service NGOs are not the right organisations to manage microcredit to people living with HIV and AIDS. In the absence of good microcredit management systems, only half of loans went toward the intended purpose, adequate loan amounts were not disbursed in line with business proposals, loans attracted no interest and the repayment system was extremely weak.

Finally, the effects of HIV and AIDS on the operations of microfinance institutions cannot be wished away, because working with this target group requires a flexible approach, which in turn does not offer financial sustainability to microfinance institutions.

## Recommendations

As a long-term strategy we do not recommend launching microfinance initiatives within an HIV and AIDS-focused programme run by NGOs; rather, links with microfinance institutions should be established. Microfinance services are best provided by specialised institutions. So, close cooperation between microfinance institutions and other AIDS service organisations and donors is necessary in order to muster appropriate and rapid responses in high-prevalence areas (McDonagh, 2001). Donors have a significant role to play in strengthening coordination between microfinance institutions and AIDS service organisations, and strengthening capacity of microfinance institutions. More specifically:

- Donors can raise concerns with microfinance institutions, encourage information exchange between AIDS service organisations and microfinance institutions, and insist that microfinance institutions become knowledgeable about HIV and AIDS (Parker, Singh & Hattel, 2000).
- Donors can also encourage innovations in linkages, and broker strategic partnerships between strong microfinance institutions and AIDS service organisations, including seed funding for cross-sectoral collaboration, such as

experimenting with separate-but-linked finance and livelihood security projects (CGAP, 2003).

- Donors can invest in strengthening microfinance institutions, so that they can better serve communities severely affected by HIV and AIDS in general and their clients in particular.
- Donors can provide funds to test product innovations, to assess their impact, and to create better monitoring systems.
- Donors can support local advocacy initiatives. For example, there is a need for all stakeholders to engage with local authorities to address the issue of levies, business sites and harassment by county council. The local authorities should be lobbied to be sensitive to challenges facing people affected by HIV and AIDS.

There is a growing demand for credit support from people affected by HIV and AIDS, and it is not easy for AIDS service organisations to ignore this pressure. So, in the short term, NGOs should partner with microfinance institutions with training capacity, so that they can benefit from skills transfer and mentoring, in order to enhance the effectiveness of their existing microcredit activities. In addition, NGOs can undertake the following two sets of measures to improve their current practices.

Firstly, the big gap between the required amount of funds needed to start a business and the actual amount of credit a beneficiary receives demotivates the beneficiary from starting the business. So, we recommend disbursing the actual amount of credit in line with the business proposal. This strategy will reduce the number of beneficiaries, but it will contribute to enhancing the effectiveness of microcredit activity. Beneficiaries need to be encouraged to repay the loans in small remittances on a weekly basis, as this enhances compliance. A long grace period is not advisable, as clients start feeling that there is a lot of time left for loan repayment. Beneficiaries should also be encouraged to inculcate a culture of flexible savings. Relating to this, NGOs may need to facilitate opening deposit facilities to put the system in practice. The advantages that deposit facilities show over informal savings are efficient liquidity management, accessibility to cash during crises, and security (Wisniewski, 1998).

Secondly, it is always good to assign specific staff to manage microcredit activities, to be responsible for product development, loan disbursement, mentoring beneficiaries, monitoring and loan realisation. As there are financial implications of designated staff, NGOs can pick committed community volunteers to provide support on income-generating activity. Moreover, in line with

the argument of Christopher Dunford (2001), NGOs can explore the possibility of integrating microcredit and business education into HIV and AIDS prevention, treatment and care service packages, to be delivered by one field staff member. This requires management to make an extra commitment to staff recruitment, training and supervision.

More than 80% of those infected with HIV in Kenya are between the ages of 20 and 49, the most economically productive age group. HIV and AIDS reduces the ability of the infected to earn a living, as they lose jobs and their businesses collapse, thus reducing their ability to provide for their families. In the absence of a vaccine to prevent new infections, HIV and AIDS must be fought through education, treatment, poverty alleviation, and improving the socio-economic status of infected and affected households, especially women. Income-generating activity is a simple, yet powerful concept for economic empowerment. When HIV and AIDS is devastating the little income that men and women have, just a few dollars in loans can make a life-changing difference.

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## Footnotes

- i Infected people are those who carry the HIV virus. Affected people include not only the infected, but individuals who care for the sick, who have lost family members, who have lost income due to the illness or death of someone in the household, or who care for AIDS orphans.
- ii Microfinance is described as the provision of financial services (savings and credit services) to low-income people. Microfinancial services are delivered by informal providers, NGOs, credit unions, governmental and commercial banks, or non-banking financial institutions. Some NGOs provide microfinance in combination with other services such as education, health, etc. These microfinance institutions often prefer to separate financial services from non-financial services. A microfinance institution operates as a business; cost recovery is vital for its survival. Another important difference between traditional banks and microfinance institutions is that microfinance institutions accept alternative collateral, including, for example, household equipment, jewellery, or peer pressure of solidarity groups, who cross-guarantee each other's loans.
- iii Both wellbeing grouping and impact flow diagram are tools of participatory research technique, commonly known as PRA (Participatory Rural Appraisal). These tools enable people to participate in studies by expressing and sharing their opinions and information; these tools also stimulate discussion and analysis (IDS, 1996). Wellbeing grouping exercises categorise the people of the community into groups of economic status. The clearly set criteria for each category allow these exercises to identify the exact number of households belonging to each category by considering the financial wellbeing of the households. The criteria set to define the categories are not merely confined to the financial wellbeing of the households, but also include socioeconomic aspects related to the overall quality of life; some exercises often include criteria like happiness, the ability to provide a good upbringing for the children, trustworthiness, respect, etc., in carrying out wellbeing analyses. The impact flow diagram displays the classification of the results, outcomes and impacts of what is intended from the implementation of the programme.
- iv Clients on TB and ARV therapy in the target area are usually in the third or fourth (final) stage of AIDS, while the treatment requires food to be effective. The clients are either bedridden or too weak to work. They are put on food support for a couple of months and when their situation stabilises they are given a microcredit for income-generating activity so that they can buy their own food and can take care of other family members, specially orphans.
- v The Consultative Group to Assist the Poor (CGAP), is a consortium of 33 public and private development agencies working together to expand access to financial services for the poor, referred to as microfinance.
- vi We have identified a pilot project that was specifically initiated by a microfinance institution to provide financial services to HIV- and AIDS-affected households. In 2001, K – Rep initiated this pilot project, called 'FAHIDA' with support from USAID. The project ended in 2003. Through this project they supported a total of 17 groups with a membership of 457 clients living in Nairobi slums and Western Kenya. They mainly targeted community volunteers, caregivers, young single mothers and people living with HIV and AIDS. However, too few data and studies exist to understand the successes and failures of this pilot project.