

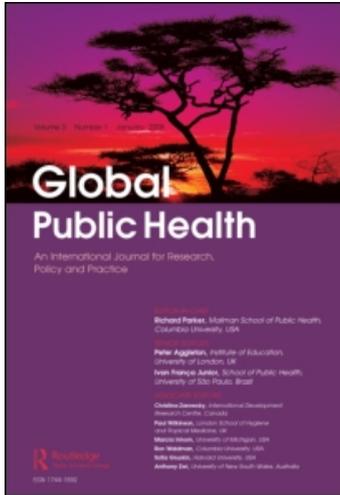
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### Microfinance and HIV mitigation among people living with HIV in the era of anti-retroviral therapy: Emerging lessons from Côte d'Ivoire

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## Microfinance and HIV mitigation among people living with HIV in the era of anti-retroviral therapy: Emerging lessons from Côte d'Ivoire

Kathleen Holmes<sup>a\*</sup>, Kate Winskell<sup>a</sup>, Monique Hennink<sup>a</sup> and Sybil Chidiac<sup>b</sup>

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The effects of HIV/AIDS have been far-reaching in Africa. Beyond adverse health outcomes and the tremendous toll on life, AIDS has serious economic impacts on households, increasing livelihood insecurity while simultaneously depleting socio-economic resources. Although microfinance is believed to have the potential to mitigate the economic impacts of HIV by helping affected households and communities better prepare for and cope with HIV-related economic shocks, little empirical research exists on this subject. This qualitative study examines the socio-economic impacts of economic strengthening activities on people living with HIV (PLHIV) in the era of increased access to anti-retroviral therapy to determine if savings-led, community-managed microfinance is a justified activity for HIV programmes. Findings from a village savings and loan programme, implemented by CARE International in Côte d'Ivoire, revealed that when appropriate medical treatment is available PLHIV are capable of participating in and benefit from microfinance activities, which increased HIV-positive clients' access to money and economic self-sufficiency. By bringing individuals with similar experiences together, savings and loan groups also acted as self-support groups providing psychosocial support while reducing stigmatisation and increasing members' sense of dignity and self-worth.

**Keywords:** microfinance; HIV; stigma; psychosocial well-being; Côte d'Ivoire

### Introduction

As HIV primarily affects adults in the prime of their working lives, the epidemic's economic impact has been particularly devastating, increasing livelihood insecurity while simultaneously depleting households' socio-economic resources. When people living with HIV (PLHIV) are no longer able to work due to chronic illness, other household members also reduce the amount of time they work in order to care for their sick family member. Diversion of financial, human and other resources away from livelihood activities decreases productivity and revenues, eroding the household's economic base (Bachmann and Booyesen 2003, Hilhorst *et al.* 2006, Rajaraman *et al.* 2006).

As affected households struggle to deal with diminishing incomes and escalating medical costs, family members are forced to find ways to cope in order to meet their needs. Microfinance, the provision of financial services by microfinance institutions

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(MFIs) and some humanitarian organisations to individuals who otherwise would not have enough collateral to receive loans from commercial banks, is frequently cited as one possible HIV economic mitigation strategy. It is believed to have the potential to alleviate the economic impacts of AIDS by helping affected households and communities better prepare for and cope with HIV-related economic shocks. Credit for income generating activities (IGAs), for example, enables clients to expand and/or diversify their economic activities thereby increasing revenue and ensuring a stable stream of income throughout the year. Saving before the point of economic crisis also allows clients to better plan and pay for future medical or funeral costs and may enable affected households to meet increased financial demands without employing irreversible coping strategies that inhibit their future earning potential (Donahue 2000, Parker *et al.* 2000).

While many MFIs work in high HIV-prevalence areas, most have been hesitant to target HIV-affected/infected individuals (Jain and Muvandi 2002, Barnes 2005, Huybrechts and Fonteneau 2005, Nyamandi 2005, Datta and Njuguna 2008). They fear doing so could undermine the viability and sustainability of their organisation as clients become sick or divert time and money towards care-giving, resulting in greater absenteeism, loan default, repayment delinquency and higher drop-out rates (Parker 2000, Donahue *et al.* 2001, Evans and Radu 2002). MFIs that do target HIV-affected/infected individuals tend to provide non-financial services such as education rather than financial services even though health conditions of many PLHIV have greatly improved with care and treatment (Huybrechts and Fonteneau 2005).

Consequently, economic strengthening activities for HIV-affected/infected individuals have largely fallen upon humanitarian organisations, many of which employ savings-led, community-managed microfinance. These organisations offer an important source of diversification from the traditional credit-led approach taken by MFIs by increasing emphasis on savings and shifting management of funds from a formal institution to group members. This is particularly well adapted for PLHIV because it promotes a savings and entrepreneurial culture in addition to the provision of loans, which helps clients establish savings as well as revenue that they can draw upon during times of economic crisis. It also allows clients to provide smaller flexible loans than those offered by MFIs, which diminishes the risk that taking out a loan will become an economic burden rather than an asset. Humanitarian organisations, however, do not necessarily have technical expertise or extensive experience in the provision of financial services (Datta and Njuguna 2008).

Most discussions on microfinance and AIDS over the past decade have revolved around whether microfinance is an appropriate HIV prevention and mitigation strategy, how MFIs can adapt to meet the needs of affected clients and how AIDS will affect the sustainability of MFIs (ICAD 2001). Little empirical research, however, exists on this subject and virtually no published studies or programme evaluations have measured the impact of microfinance on the socio-economic well-being of PLHIV (McDonagh 2001, Anderson *et al.* 2002, Morgan 2004, Huybrechts and Fonteneau 2005, Datta and Njuguna 2008). Improving understanding of how microfinance helps mitigate the socio-economic impacts of HIV will contribute valuable information useful to organisations currently mainstreaming microfinance into their AIDS programming, such as CARE International, Concern Worldwide, Catholic Relief Services and World Vision.

The purpose of this exploratory study was to assess whether, in the context of increased access to treatment, savings-led, community-managed microfinance helps mitigate the socio-economic impacts of AIDS among PLHIV. We were particularly interested in HIV-positive beneficiaries' motivation for participating in, and their experiences of, CARE's village savings and loan associations (VSLAs). Our objective was to determine: (1) if microfinance is a justified activity for HIV programmes in the era of HIV prophylaxis and anti-retroviral therapy (ART); (2) how microfinance mitigates the socio-impacts of AIDS; and (3) how organisations can further adapt economic strengthening activities to better meet the needs of HIV-positive clients.

## Background

HIV prevalence in Côte d'Ivoire is the highest in West Africa with an estimated 3.9% of the adult population infected (UNAIDS 2008). CARE International, a non-governmental humanitarian organisation, is working with local community, religious and AIDS service organisations in central, northern and western regions of Côte d'Ivoire to provide HIV prevention and care. Health services in this region, which came under rebel control in 2002, were devastated by a 5-year civil war which resulted in more than 75% of government health officials relocating to the south of the country, medical supply transportation chains being severed and an estimated 80% of health facilities being abandoned (Betsi *et al.* 2006).

In 2007, CARE Côte d'Ivoire launched pilot village savings and loan (VSL) activities as a part of their HIV prevention and mitigation programme. Since this time, CARE has established 35 VSLAs for PLHIV comprising 831 members. Under this microfinance methodology, CARE provides self-selected groups of 15–30 members with basic business and financial management training. Members establish their own constitution and rules, including fixing savings and interest rates, and save on a weekly basis or per their constitution. Typically, 4 weeks after savings have commenced, groups provide small, flexible loans (US\$5–\$10) with interest rates of 5–10% in the currency of Cote d'Ivoire to members to develop IGAs. Mobilised savings and interest earned from loans are divided between group members, uniformly or per member's savings, at the end of each 1-year VSL cycle. Within the VSL methodology, many groups also offer microinsurance to their members through a social fund that covers emergency expenses, which are given to members as an interest-free loan or grant.

## Methods

### *Research design*

Qualitative research methods were used to explore in depth the social and economic effects of microfinance on HIV mitigation. In-depth interviews (IDIs), focus-group discussions (FGDs) and key-informant interviews (KIIs) were employed in order to gain a broad range of viewpoints from both an insider (client) and outsider perspective as well as to elicit both sensitive information about participants' own experiences and a broad range of viewpoints about microfinance and HIV.

### ***Study setting and participant population***

This study was conducted by CARE from June to August 2008 in all four sites, where CARE Cote d'Ivoire is implementing both HIV and VSL activities: Bouaké, Korhogo, Man and Abidjan. These sites are all urban centres ranging in size from 60,000 to 5,000,000 residents (Defense Language Institute Foreign Language Center [DFI] 2007). Each site is located in a different geographical region within Cote d'Ivoire, which provided ethnic diversity among study participants, and included participants from a range of economic environments, including from the poorer cocoa-producing West and agrarian North, and more economically advantaged capitals of the North (Bouake) and South (Abidjan).

Six IDIs and six FGDs were carried out with 66 HIV-positive CARE VSLA clients. IDI participants were all middle-aged and elderly female VSLA loan recipients on ART. FGDs comprised clients who had not yet received a loan but had been members of VSLAs for many months and thus had experienced the social benefits of VSL activities. Demographic information was not consistently collected for a minority of FGD participants; however, the majority of participants were middle-aged women with a minority of elderly and/or male participants, which reflects the general makeup of HIV-positive CARE VSLAs. These VLSAs were all associated with local AIDS service organisations, where study participants were receiving HIV care (cotrimoxazole) or treatment. KIIs were carried out with five leaders in the field of HIV economic mitigation in Cote d'Ivoire, including directors and coordinators from four different non-governmental organisations and HIV networks.

### ***Participant recruitment***

To take part in the study, participants had to be at least 18 years of age, HIV positive, and a member of a CARE VSLA. VSLA loan recipients were recruited in Man with the assistance of a gatekeeper who was from a local AIDS service organisation. Man was chosen for IDIs because VSL activities were first initiated there thus enabling a focus on participants who had more experiences with VSL. FGD participants were recruited from each of the pre-existing VSLAs, from across the four study sites, scheduled to hold a regular meeting during the study period by asking interested members to participate. The main advantage of using pre-existing VSLAs for FGDs was that group solidarity can lead to greater trust within the group and therefore better-quality discussions (Hennink 2007). Key informants were selected based on their experience in HIV economic mitigation activities for PLHIV. A limitation to recruitment was that the sample only included active VSLA members and did not include dropouts or non-participants.

### ***Data collection***

Interviews and discussions were conducted in the local regional language via an interpreter who also spoke French or English, depending on the preference of the study participant. Oral consent was obtained from all participants prior to any data collection and permission was sought from participants to digitally record the interviews. When permission to record was not granted, only detailed field notes were

taken. For this reason and due to minor technical difficulties, data analysis relied heavily on these detailed field notes. Data collection and analysis of this study, which was part of a midterm CARE programme evaluation, were deemed Institutional Review Board (IRB) exempt by the Emory Institutional Review Board.

IDI were conducted by the lead author in a private consultation room at a local medical centre and lasted between 45 and 90 minutes. Given that HIV is a highly sensitive topic, IDI solicited personal information from the participants about how HIV has affected their lives both socially and financially and about their experiences and opinions of VSLAs and IGAs. The lead author and two CARE field staff moderated FGDs, which lasted 60–90 minutes, in the normal VSLA meeting location. FGDs comprised 8–12 participants and were employed to collect a broad range of perspectives from HIV-positive VSLA members on community perceptions of PLHIV, the benefits and challenges of VSLAs and suitable IGAs for PLHIV. Lastly, five KIIs were conducted by the lead author, in face-to-face interviews or via the telephone, to identify organisational perspectives on perceived benefits and barriers of VSLAs for PLHIV and sustainability of these initiatives.

### ***Data analysis***

Interviews, group discussions and field notes were transcribed verbatim in French or English. Data were de-identified by removing any unique identifiers prior to data analysis to ensure anonymity. Data were analysed in both English and French with the qualitative software programme MaxQDA2007 using the grounded theory approach (Corbin and Strauss 2008). Analysis involved reading and rereading the data, identifying 30 inductive and deductive themes and developing a ‘thick description’ of each theme. The data were then coded using these themes and collapsed into six conceptual categories: socio-economic environment, economic impacts of microfinance, economic empowerment, perceptions of PLHIV, social impacts of microfinance and war. The methods of constant comparison and pathway analysis were used to analyse the intersection between core concepts and the sequence in which events were described. This led to the development of several inductive conceptual frameworks (shown in Figures 2 and 3), that illustrate how savings-led community-managed microfinance may be able to mitigate both the economic and social impacts of AIDS.

### **Results**

In this paper, we address the socio-economic realities faced by PLHIV to contextualise the needs of HIV-positive clients and their rationale for joining VSLAs, before describing the experiences of HIV-positive clients participating in VSLAs.

#### ***Socio-economic environment***

Most study participants, the majority of whom are middle-aged women, provided a primary source of income in their households as they were either widowed or their husbands had lost their jobs during the war. Prior to falling sick, all study participants reported carrying out IGAs. The majority of participants were either

merchants or farmers, while a minority were engaged in trades such as sewing. These economic activities were subsequently destroyed during the war and/or negatively impacted by AIDS. Poor health and loss of financial support from late husbands forced the vast majority of VSLA members to reduce the scale of their activities or to stop working altogether. Participants, however, indicated that HIV treatment had dramatically improved their health and most had started working again or expressed the desire to do so.

VSLA study participants reported receiving ART or the prophylactic antibiotic cotrimoxazole. During the war, NGOs provided ART free of charge to PLHIV in the rebel-held north of Côte d'Ivoire. After the conflict ended in 2007, the cost of ART, under the national AIDS policy, increased to 1000 FCFA (US\$2) per month. Many participants, however, reported paying up to an additional 1000 FCFA each month for medical consultations, which they needed in order to receive their ART. The majority of participants reported paying for HIV-related medical expenses themselves via revenues from IGAs, asking family or community members to cover the costs, or receiving assistance from NGOs. To increase adherence, some hospitals also provided ART to participants on credit when they did not have sufficient funds. A minority of participants sold assets or removed their children from school to cover medical expenses and a couple of participants reported forgoing treatment or strict adherence to treatment due to lack of financial means.

All study participants commented that HIV continues to be perceived as an imminent death sentence in Côte d'Ivoire. Regardless of their health condition, PLHIV were thus perceived by others to be on the verge of death. One participant shared:

When I told [my uncle] that I have HIV . . . he gathered all of my brothers and sisters and told them to prepare [my coffin] because I was going to die soon. . . . I told [my younger sister] to tell our uncle that I am not dead yet. I am alive and in good health. I was very shocked by my uncle . . . Two days later my uncle called my younger sister and told her to tell me that we would be having a family meeting. I responded that I was in my tomb and I had not left yet. When I leave, I will come to the meeting.

Key informants felt that this perception of PLHIV as the living dead, in turn, caused economic discrimination, known more formally as resource-based discrimination (Patient and Orr 2003), which limited their access to community economic safety nets. When family and community members learned or suspected that an individual was HIV positive they refused to loan them money because they feared that the person would die before they were able to repay the loan.

### ***Motivation for participation***

IDIs with HIV-positive clients revealed that their principal motivation for participation in VSLAs was three-fold. First, participants perceived VSLAs as a more secure means of accessing money as there was no guarantee that family and friends would help them financially. VSLAs were also seen as a dignified alternative to begging or always having to ask family and friends for money, especially given the informal lending culture in Côte d'Ivoire which requires borrowers to expose all of their problems before being considered for a loan. Finally, most members, many of

whom were the principal breadwinners in their families, emphasised that they joined VSLAs to access loans to re-start or expand their IGA in order to pay for ART, food and education for their children.

### *Economic impacts*

#### *Increased access to money*

Study participants revealed that VSLAs are an important source of money for clients by expanding their social support networks. This proved to be particularly important for HIV-positive clients whose access to economic resources within traditional social networks was limited by resource-based stigma. In times of need, members mobilised and offered financial support to one another via emergency social funds to pay for ART or other medications. It should be noted, however, that social funds proved to be insufficient for larger expenses, such as hospital bills.

VSLAs also stimulated members' access to loans both within the economic association and the community. Through weekly savings, VSLAs successfully pooled their resources and provided members with small loans to develop IGAs. During the first year, 831 HIV-positive VSLA members from Man, Bouaké and Korhogo saved 2,076,440 FCFA (US\$4135), 66% of which has been loaned out for group (US\$1509) and individual (US\$1237) IGAs. In total, 109 individuals, or 13% of members, benefited from individual loans. Both FGD participants and programme staff noted that due to the financial vulnerability of PLHIV, however, savings proved to be difficult. Compared to other VSLAs, HIV-positive clients had lower weekly savings and therefore it took them substantially longer to accrue enough money to provide members with loans. This delay in access to loans was discouraging to clients.

Outside the economic association, VSLAs indirectly stimulated access to community economic safety nets by helping ensure that clients could access and adhere to ART. ART, in turn, improved their health status, which increased PLHIV's access to loans because community members presumed they had regained their health. Business and financial training provided by VSLAs also improved access to loans by increasing community members' confidence that clients would repay a loan.

#### *Greater economic self-sufficiency*

Among study participants who benefited from credit, the most common type of IGAs developed were small businesses in which members bought and re-sold goods, such as charcoal and palm oil, for a small profit. Most members reported using revenues from IGAs to repay their loan and to pay for monthly ART and food expenses. Further research, however, is needed to determine to what extent profits generated from IGAs associated with VSLAs are sufficient to cover basic household needs.

Despite health improvements from treatment and a renewed desire to work, participants felt that adverse health effects associated with HIV, primarily fatigue, limited the types of IGAs they could undertake. Nearly all study participants reported that PLHIV could not easily conduct IGAs that required considerable physical strength or energy, such as agricultural activities and work that required frequent travel. Additionally, half of the participants noted that PLHIV are unable to

tolerate heat and thus found it difficult to work under the sun or next to a fire all day. Key informants also believed that community members' unfounded fear of infection undermined clients' ability to sell food. However, clients dismissed the idea that stigma limited their ability to complete IGAs. Even within these constraints, VSLA members noted that hiring help to clear agricultural fields, the most labour-intensive aspect of farming and working in groups allowed them to complete many of the aforementioned activities.

### ***Social impacts***

#### *Improved perceptions of people living with HIV (PLHIV)*

Findings suggest that increased economic independence, which allowed clients to provide for themselves instead of being forced to rely upon hand-outs from family and community members, reduced resource-based stigmatisation faced by PLHIV. Key informants reported that due to reduced work capacity PLHIV are generally perceived as non-productive or non-contributing family and community members. Limited economic contribution, in turn, engendered negative attitudes towards PLHIV and diminished their status and respect within the household and society. One key informant explained:

In Africa, and especially in poor families in Côte d'Ivoire, if you have nothing, you are nothing. That is to say if you have nothing you are not able to take care of yourself and thus you are nothing . . . meaning you are not considered or regarded in the family even if you are the first born. From the moment that you can take care of yourself, however, people start to see you in a different light. From the moment that you are capable of providing [financial] help if there is a problem people view you again in another light. A woman living with HIV is disregarded, disrespected and insulted before being given 1000F [for her ART]. Today, she does not need to wait for handouts.

VSLAs have contributed to changing perceptions of PLHIV. By saving weekly and taking out loans for IGAs, HIV-positive clients were no longer perceived as the living dead but rather as contributing members of society. Among PLHIV who implemented IGAs key informants felt that family members were more likely to turn a blind eye to AIDS and afford them greater status and respect within the household.

#### *Improved psychosocial well-being*

By bringing individuals with similar experiences together, savings and loan groups also acted as self-support groups providing psychosocial support. Newly formed groups benefited from novel psychosocial support while groups that originated from already existent self-support groups benefited from more consistent social support. Nearly all study participants reported that group members' psychosocial well-being had improved since joining VSLAs. Prior to participation, many VSLA members expressed feeling hopeless, lonely and worried. Members now, however, claimed that they had regained their morale and *joie de vivre*. Key informants also noticed a positive change in participants' psychosocial well-being. One VSLA project manager, for example, noted:

We noticed [the first day] a certain sadness, a certain melancholy in the participants' faces. But today when we visit the groups, the women participating in the meetings are well dressed and made up. If one were to tell you that they have HIV you would not believe it. The participants sing, dance, are more energetic, carry out activities, and exchange their experiences.

VSLA members and key informants both attributed improved psychosocial well-being to participation in the association. Group members reported feeling a sense of belonging because they shared a common experience. Members reported checking up on each other, celebrating children's births and rites of passage together and attending funerals of deceased members. For some this was of great importance because, prior to participation few HIV-positive mothers celebrated their child's birth due to lack of funds and funerals of people who had died of AIDS were poorly attended on moral grounds. Thus membership, by increasing funeral attendance, helped mitigate the fear PLHIV had of dying alone. It also signified to community members that PLHIV are important just like everyone else, as a well-attended funeral demonstrates that the deceased was well-respected. A minority of IDI participants, in turn, attributed improved physical well-being to enhanced psychosocial well-being. Several members reported gaining weight as a result of VSLA membership. Other members observed that the ambiance of group meetings would relieve their aches and pains.

Beyond social support, economic strengthening activities also positively influenced participants' outlook on life. Prior to participation, HIV-positive clients acted as if their lives were over, prematurely undermining their economic potential because they stopped setting goals and carrying on with their lives. VSLAs helped change this perspective by forcing HIV-positive clients to think about the future in order to save weekly, develop IGAs and recuperate their savings after a year.

### ***Improved reach***

Key informants reported that one significant advantage of microfinance is that it is able to reach and provide social support to HIV-positive women who have not disclosed their status. It can be difficult for these women to attend traditional HIV support meetings as they are either forced to lie to family members about their whereabouts or must demand permission to attend meetings thereby disclosing their status. Microfinance, however, provides a cover for HIV-positive individuals, allowing them to participate in an economic association thereby benefiting from the psychosocial support without having to disclose their status.

### **Discussion**

Although this qualitative study is of modest size and the findings are not generalisable, as one of the first and only studies of its kind, it provides useful lessons for organisations engaging in savings-led, community-managed microfinance that are likely applicable across settings. A rigorous assessment of the impact of microfinance among PLHIV is still needed to validate these findings across settings and to better tailor economic strengthening activities for PLHIV and inform sound HIV-prevention and mitigation policy.

***Appropriateness of microfinance for people living with HIV (PLHIV)***

A review of microfinance and HIV-mitigation literature revealed significant scepticism by MFIs towards extending financial services to PLHIV. Many of these articles, written before the mass provision of ART to Africa, discounted PLHIV as too sick to complete economic activities thereby jeopardising the sustainability of MFIs (Parker 2000, Barnes 2003, CGAP 2003). The Consultative Group to Assist the Poor (CGAP), an independent policy and research centre housed at the World Bank, argued in 2003, for example, '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'. While many initial economic mitigation interventions for HIV-infected/affected individuals failed catastrophically (Parker 2000), today, an increasing number of PLHIV are accessing care and treatment and, as a result, are economically active and capable of participating in savings and loan activities (CARE Rwanda 2007).

To our knowledge, the study by Datta and Njuguna (2008) is the only published study that has evaluated the impacts of microfinance on PLHIV. Our study findings are consistent with theirs and with unpublished microcredit programme evaluation results from CARE Rwanda and CARE Zimbabwe, which found that microfinance increases HIV-positive clients' financial security and social well-being. Even when the benefits were small and insufficient to restore business to pre-illness levels, microcredit still provided clients with a means to pay for food and medicine (Jain and Muvandi 2002, CARE Rwanda 2007, Datta and Njuguna 2008). Likewise, discussions with CARE microcredit participants in Zimbabwe revealed community members were more willing to loan HIV VSLA clients money thereby increasing the number of income sources available to HIV-affected individuals (Jain and Muvandi 2002). While no robust data on loan repayment were available for our study, as clients had not yet completed a loan cycle, repayment rates for HIV-positive clients in Kenya and Rwanda ranged from 87 to 95% (CARE Rwanda 2007, Datta and Njuguna 2008).

Although CARE beneficiaries' motivations for participating in VSLAs in Côte d'Ivoire were economic, members predominantly emphasised the non-economic benefits of participation. This is likely in part because the majority of participants had not yet received loans and many VSLAs were formed from pre-existing self-support groups. Nonetheless, HIV-positive members who had benefited from credit and members of VSLAs that were formed as unique economic associations (not from pre-existing self-support groups) also emphasised the same psychosocial impacts. This suggests that the social benefits of VSLA participation were not merely acquired through pre-existing social support.

***How microfinance mitigates the socio-economic impacts of HIV***

Datta and Njuguna (2008) reported similar social impacts among Concern Kenya microfinance clients, including increased social standing and psychological well-being and decreased stigmatisation. No explanations have been put forth thus far, however, to explain how microfinance mitigates the social impacts of AIDS.

Our analysis of the broader socio-economic context of HIV in Côte d'Ivoire (Figure 1) revealed that economic environment, perceptions of PLHIV and health

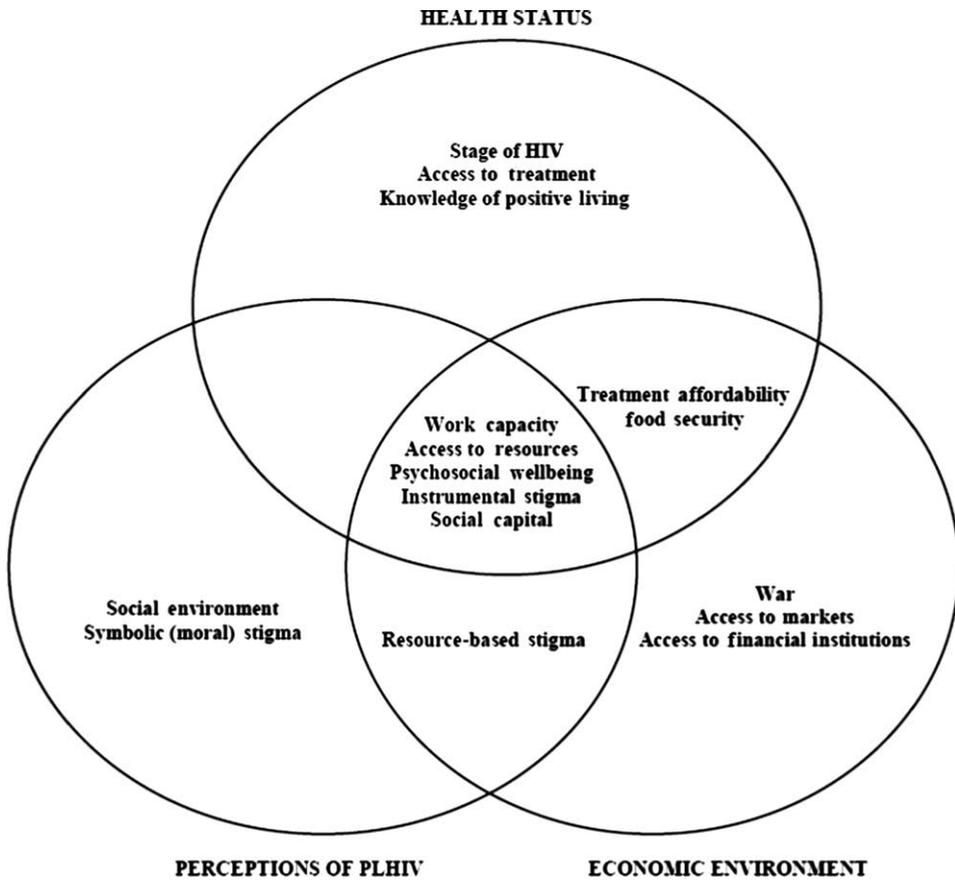


Figure 1. Relationship between economics and stigma in the context of HIV/AIDS.

status influenced access to treatment and resources, and affected social capital, work capacity, stigmatisation and psychosocial well-being of PLHIV. We postulate that by mitigating the economic burden of HIV, savings-led community-managed micro-finance also simultaneously mitigates the social and psychosocial impacts of AIDS among CARE VSLA clients. The relationship between these components will be elucidated further.

This study suggests that perceptions of PLHIV are both driven and engendered by economics. Participants described a self-perpetuating economic cycle (Figure 2) composed of four components: access to money, treatment, health and work capacity. This economic cycle, in turn, is propelled or engendered by perceptions of PLHIV at nearly every step. Each component, beginning with access to money, contributes to the next step either perpetuating or mitigating the socio-economic impacts of AIDS until a shock or intervention breaks the cycle.

Participants reported that access to resources, in the first step, was limited by resource-based stigmatisation. This is consistent with HIV economic research from Zimbabwe, Zambia and Nigeria which also noted the tendency for community members not to invest in PLHIV due to the perception that they would die soon (Jain and Muvandi 2002, Gillespie 2006, Hilhorst *et al.* 2006). Microfinance

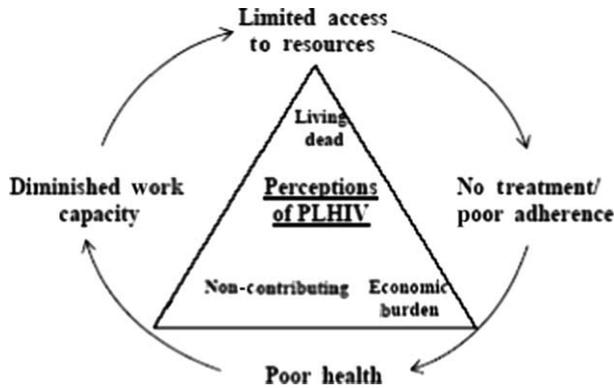


Figure 2. Negative socio-economic HIV/AIDS cycle.

evaluations also indicate that stigma limits access to group-based microcredit as members, who fear HIV-infected/affected members will not be able to reimburse their credit, refuse to co-guarantee their loans thereby barring them from participation (Datta and Njuguna 2008). Limited access to resources, in turn, inhibits the ability of PLHIV to procure and adhere to treatment. Poor health resulting from a lack of treatment limits the ability of PLHIV to work and thus pay for their own treatment and contribute to household finances. This engenders negative perceptions of PLHIV who are perceived to be a financial burden and non-contributing and thus unproductive members of the household.

Savings-led community-managed microfinance, however, turned this cycle on its head (Figure 3). By providing PLHIV with access to money, this cycle actually mitigated the negative socio-economic impacts of AIDS. Participants reported using social funds and revenues from IGAs to pay for ART, thereby increasing their access and adherence to treatment. Improved health, in turn, increased the likelihood that community members would loan them money and increased their capacity to carry out economic activities. Use of revenue from IGAs to pay for medical and household expenses, in turn, improved perceptions of PLHIV as they were now seen as contributors.

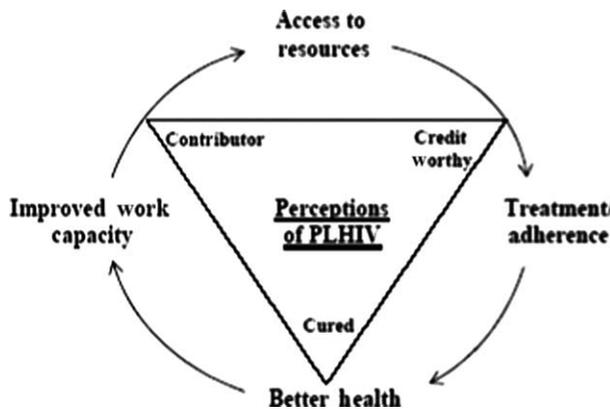


Figure 3. Positive socio-economic HIV/AIDS cycle.

**Implications for practice, policies and future research**

In response to the AIDS epidemic, microfinance-related financial services have been refined and innovative products and delivery methods developed that specifically seek to meet the needs of HIV-affected households. These adaptations have been described in detail in microfinance literature and include greater flexibility in loan size, loan terms, age of clients and meeting attendance, as well as offering voluntary or mandatory savings, emergency loans and insurance (Parker *et al.* 2000, Donahue *et al.* 2001, ICAD 2001, Barnes 2003). Innovations in microfinance delivery methods also include team loans, group-based microfinance and greater linkages between MFIs and AIDS organisations (Magill 2003, Nyamandi 2005). Based on experiences of HIV-positive VSLA clients in Côte d'Ivoire, several additional lessons emerged from this study that could help inform microfinance programme development and implementation. Specifically, this study suggests that:

- It is difficult for PLHIV to complete extremely physically demanding IGAs. NGOs should consider conducting informative research to determine which IGAs are most feasible for PLHIV given their health condition and how to encourage appropriate IGAs in such a way as to avoid generating stigma. Encouraging HIV-positive clients to choose IGAs that are economically viable and appropriate, rather than donor-driven, will likely improve members' productivity and profitability.
- Collective business activities allow PLHIV to undertake economic activities that prove difficult for an individual alone, such as physically demanding work, help ensure members do not overexert themselves thereby compromising their health, and help ensure the sustainability of group funds as other members are able to continue the IGAs and repay the loan even if one group member falls sick. Therefore, NGOs may want to encourage VSLA clients, small groups of three to four members, to put their loans together and invest this money in a collective IGA.
- HIV-related expenses are routine in the case of monthly medical and food costs or urgent in the case of illness. Thus, activities that yield profit during one part of the year may not be well suited to covering the expressed needs of HIV-positive clients. NGOs may want to encourage diversification of IGAs and/or IGAs that yield regular earnings throughout the year. While agricultural activities provide an important source of nutrition and unsold stock can be consumed, crop diversification, rotation and conservation should be considered to ensure profits year-round.
- If clients are really economically vulnerable, this may result in meagre weekly savings. Further research is needed to determine how best to expedite the loan process for the most economically vulnerable groups to ensure that members remain motivated and are financially benefiting from microcredit within a reasonable timeframe. Provision of seed funds for IGA initiation or matching funds for savings to help facilitate credit for IGAs could provide possible solutions for VSLAs identified by needs assessments as economically vulnerable.

Further research is needed to develop a better understanding of HIV-related stigma specifically within low-resource settings.

## Conclusion

Billions of dollars in new funding for AIDS initiatives are now available through organisations such as the WHO, UNAIDS, the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR). This evaluation suggests that savings-led, community-managed microfinance is an appropriate HIV-mitigation intervention for NGOs. While most MFIs have specifically avoided targeting financial services to PLHIV, NGOs can play a significant role in the promotion of microfinance among PLHIV using a community-managed savings-led model. Likewise, ART has made participation in microfinance possible for PLHIV. In light of the potential threats to HIV/AIDS funding, this study furthermore suggests that by increasing access and adherence to medication, microfinance may represent a valuable means of ensuring the effectiveness and sustainability of ART programmes in resource-poor settings.

This exploratory study sought to elucidate the impacts of microsavings and loans on HIV mitigation among PLHIV. It is our hope that the issues and ideas raised in this paper will act as a springboard for further research in order to better tailor economic strengthening activities, including savings, loans and microinsurance, to the needs of HIV-positive clients, to inform sound HIV-mitigation policy decisions, and to better understand and respond to resource-based stigmatisation.

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