

Microfinance and HIV prevention – emerging lessons from rural South Africa

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Do the gains in confidence and economic well being that can come from participation in a microfinance programme reduce clients' vulnerability to HIV infection? Until now practical experience and an evidence base relating to such activities have been limited. This article reviews the evidence supporting an enhanced role for microfinance in HIV prevention activities. It describes the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) – a South African case study that has been specifically designed to explore these relationships. The paper discusses the operational integration of microfinance and HIV prevention – highlighting challenges, emerging lessons and limitations in the light of international best practice and several years of field experience.

THE HIV EPIDEMIC is taking its toll on health and development in much of the world. At the end of 2003, an estimated 40 million people were living with HIV/AIDS, with over three million people dying on an annual basis (UNAIDS, 2002). The relationship between HIV/AIDS and under-development is said to be bi-directional – just as poverty fuels HIV transmission, so does HIV/AIDS deepen poverty. Globally, 90 per cent of new infections occur in poor countries, with two-thirds of those in sub-Saharan Africa. Adult HIV prevalence rates have risen higher than thought possible in this region, with over one-third of adults currently infected in a number of countries.

In these settings, decades of development gains are being rapidly eroded as a result of the pandemic. Premature death and disability undermine already fragile household economies. Employers face escalating costs and declines in productivity. At the national level, in worst-affected countries, HIV/AIDS has seriously compromised the attainability of broad development targets for poverty reduction, education and health (Barnett and Whiteside, 2002).

In the midst of these challenges, microfinance has been put forth as a potentially powerful development tool. Through improving access to credit and savings services, microfinance institutions (MFIs) have charted impressive development gains in a diverse array of settings, with the

Poverty fuels HIV transmission, and HIV/AIDS deepens poverty

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potential to reduce household poverty and improve livelihood security among those living in extreme poverty (Johnson and Rogaly, 1997; Wright, 2000).

The convergence of poverty and HIV/AIDS has prompted the microfinance sector to ask how it can more effectively engage with and respond to the epidemic. There are three main areas where microfinance and HIV/AIDS clearly intersect. The first relates to developing strategies that reduce the financial impact of HIV/AIDS on MFIs. A survey of 22 MFIs in 14 African countries suggests HIV/AIDS is already hurting the bottom line – resulting in poorer loan performance and higher staff costs (Parker, 2000). To minimize the negative impact on MFIs and clients alike, a number of different strategies have been introduced. These include workplace HIV/AIDS policies; the introduction of early warning systems to monitor loan performance; developing insurance products to reduce the risk of loan default; acting as a referral point for services such as information campaigns, health care, or legal assistance.

The second point where microfinance and HIV/AIDS come together is the potential for microfinance to reduce the negative impact of AIDS on household economies. Programmes that foster savings and stimulate the development of income-generating activities have the potential to strengthen both social and financial safety nets. Death or disability of a family member, particularly economically productive adults, are among the greatest shocks faced by poor households. A study from Zimbabwe suggests that microfinance participation may indeed be protective – microfinance clients and their households had a greater diversity of income sources, improved savings patterns, and were better able to keep children in school following the death of an adult household member – a proxy for AIDS-related mortality (Barnes, 2002).

A third area where HIV/AIDS and microfinance come together is the role of microfinance in HIV prevention. It has been suggested that participation in microfinance has the potential to reduce economic and social vulnerability to HIV. In many settings, donors, practitioners and international stakeholders have made energetic calls for MFIs to mainstream HIV/AIDS further into microfinance services and to enhance prevention activities. However, there are few best-practice models and little evidence to support these efforts.

The aim of this paper is to review the evidence supporting an enhanced role for microfinance in HIV prevention activities. It goes on to describe the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) – a South African case study that has been designed to explore these relationships in detail. The final section draws from several years of field experience to discuss emerging challenges, lessons and limitations of such approaches in the light of international experience and in response to a rapidly evolving policy and practice environment in high HIV prevalence settings.

Vulnerability to HIV infection – the role of structural factors

With more than two decades of experience with HIV prevention in developing countries, success stories are few. While the reasons for this are complex, there is broad recognition that prevention activities focused primarily on changing individual risk behaviour – through awareness raising, education or condom distribution – have been of limited value when acting in isolation (Fee and Krieger, 1993; Parker, 1996). There is growing awareness that these strategies need to be reinforced with attempts to

Microfinance participation may be protective for households affected by HIV/AIDS

Prevention activities have been of limited value when acting in isolation

Structural factors help explain why HIV incidence rates are higher in some countries than others

Refusing sex, or suggesting condom use, are 'triggers' for domestic violence

address underlying structural factors – aspects of the physical, socio-economic, or cultural environment that shape the 'context' in which sexual behaviour and HIV transmission take place (Sumartojo, 2000).

In relation to HIV/AIDS, numerous structural factors have been identified that help to explain why some communities or countries have higher rates of HIV than others. These primarily include: poverty and under-development; gender inequalities; and mobility and migration. While individually important, such factors are inter-related and mutually reinforcing. Thus, despite the uniqueness of each local epidemic, the same general structures interact to shape vulnerability to HIV in areas as diverse as Africa, Asia and Latin America, as well as certain groups in North America and Europe (Parker et al., 2000).

South Africa is a compelling case study in how all three of these structural factors have fuelled a rapidly growing epidemic. In the wake of apartheid, land expropriation and the forced introduction of a migrant labour system has eroded the fabric of rural communities, shaken the stability of household and community life, and exacerbated gender inequalities. In relation to mining and other industries, migrant labour continues to separate families for long periods of time, and workers are often housed in bleak, socially alienating conditions. In this context, many men initiate sexual relationships with multiple partners, including commercial sex workers (Campbell, 2003). Widespread poverty and unemployment leave many families dependent on remittances and government grants. In addition, economic crisis has driven many women, either formally or informally, to exchange sex for resources as a means of survival. Gender-based violence, well documented in South Africa, continues to both directly and indirectly impact on women's vulnerability to HIV infection. (Garcia-Moreno and Watts, 2000). Refusing sex, inquiring about other partners, or suggesting condom use have all been described as 'triggers' for intimate partner violence – yet all are intimately connected to the behavioural cornerstones of HIV prevention (Rao Gupta, 2002). In South Africa as elsewhere, the interplay of these factors has critically limited the impact prevention efforts based on modifying individual risk.

Microfinance – a structural intervention?

Traditional public health interventions are poorly equipped to address the complexity of these structural factors and their influence on HIV transmission. When viewed alongside drugs, vaccines and condoms, structural interventions often seem abstract and unapproachable. However, in the light of limited success of conventional approaches, there is a critical need to widen the scope of HIV prevention activities, and look creatively at where development policies and practice might influence specific health outcomes, including HIV/AIDS.

Microfinance, as a development intervention, has the potential to concretely engage structural vulnerabilities to HIV infection at a number of levels. There is substantial evidence from diverse settings that microfinance has the potential to play an important role in reducing poverty through improving household and business management, increasing productivity, and smoothing income flows (Wright, 2000).

There is also evidence to suggest that the benefits of microfinance go beyond purely economic returns. In particular, several studies have demonstrated that microfinance has the potential to enhance autonomy and resilience among women participants – where newly acquired economic and business skills translate to improvements in self esteem, larger

Microfinance participation has been associated with concrete health outcomes

IMAGE integrates a curriculum of gender awareness and HIV education within an established microfinance programme

social networks, and wider control over household decision-making (Cheston and Kuhn, 2002).

Finally, microfinance participation has been associated with concrete health outcomes. Studies have suggested that microfinance has the potential to lead to improvements in the nutritional status of children relative to non-participants (Khandker, 1998). With respect to reproductive health outcomes, work from Bangladesh suggests that microfinance participants are more likely to use contraception than controls and that these benefits may 'diffuse' into non-participating households, supporting more widespread improvements in practice (Schuler and Hashemi, 1994). While this shifting of social norms may also carry important lessons for HIV/AIDS control, the application of microfinance as a vehicle for HIV prevention has not yet been formally studied.

The Intervention with Microfinance for AIDS and Gender Equity

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) is a structural intervention for HIV specifically designed to explore the interaction between microfinance, gender inequalities and HIV prevention. Based in Sekhukhuneland, a densely settled rural area in South Africa's Limpopo Province, the IMAGE intervention integrates a curriculum of gender awareness and HIV education within an established microfinance programme. It seeks to create an enabling environment for behaviour change that engages poverty and gender-based inequalities as key structural factors driving the HIV epidemic. The project brings together complementary expertise from a South African MFI and a university-based HIV/AIDS research and training programme. Each component of the programme is described in more detail below.

Microfinance. As part of the IMAGE intervention, the MFI (Small Enterprise Foundation) offers poverty-focused microfinance services through a Grameen-style group-lending model for the development of income-generating activities. The client-base is exclusively women. Using participatory wealth ranking methods, it identifies and recruits the most economically disadvantaged members within a target area. While businesses are run by individual women, groups of five women act to guarantee each other's loans. All members must repay together to move up to the next loan cycle. Employing this methodology, repayment rates are generally high (over 99 per cent), with loan sizes increasing in line with business value. Approximately 40 women (eight groups of five) comprise one loan centre, which meets fortnightly to repay loans, discuss business ideas and apply for new loans.

Gender and HIV training. It is during these centre meetings that facilitators conduct Gender and HIV training sessions (see Table 1). Termed Sisters-for-Life (SFL), the programme comprises two phases: Phase One is a structured series of ten one-hour training sessions, and Phase Two is an open-ended programme geared towards community mobilization. Based upon Participatory Learning and Action principles, the SFL sessions cover a range of topics including gender roles and gender inequality, cultural beliefs, relationships, communication and domestic violence. Sessions are structured to give participants the opportunity to strengthen confidence and skills relating to communication, critical thinking and leadership. The training deliberately emphasizes this broader exploration before turning to and linking with topics relating more directly to HIV/AIDS.

Building on the theory that group-based learning can foster solidarity and action on HIV prevention in the wider community, the second phase

Sessions help build confidence and leadership skills

For each woman in the IMAGE intervention, a similar woman is selected from a comparison village to provide a control

of the training attempts to expand the scope of the intervention to reach both youth and men. In order to sustain the community component of Phase Two, key women who have been selected by their loan centres in the previous phase as 'natural leaders' are brought together for a further training on leadership and community mobilization. Taking these skills back to their respective centres, they are then responsible for developing initiatives within their families and communities, with the aim of implementing what they regard as appropriate responses to priority issues (RADAR, 2002b).

The IMAGE Study impact assessment. The design of the IMAGE Study draws on lessons and best practice from the fields of microfinance and HIV/AIDS and has been described in detail elsewhere (RADAR, 2002a). Briefly, the study uses a prospective design to capture changes and minimize recall bias over a three-year period. Prior to the intervention, no village had significant access to microfinance services, and the penetration of HIV education had been low. Paired villages have been assigned at random either to receive the intervention immediately, or at the end of the three-year evaluation period. Within each intervention village, approximately 10 per cent of eligible households have been recruited to participate in the intervention. For each woman participating in the IMAGE intervention, a woman eligible for microfinance of similar age is selected from a comparison village to provide a control for the evaluation.

The evaluation is designed to examine changes at three levels: with individual participants (and controls), their households and the wider community. Numerous social and economic benefits are being assessed alongside a detailed examination of intra-household communication, decision making, gender relations and gender-based violence. Reproductive health outcomes being assessed include reported sexual behaviour and HIV infection among the 14 to 35 year-old 'highest risk' group. Quantitative data is supplemented by extensive qualitative data intended to capture the process of change, and the relative strengths and limitations of the approach.

Perspectives and emerging lessons on microfinance and HIV prevention

The IMAGE programme was designed and piloted between 1998 and 2000, with full implementation commencing in 2001. While the study is nearing the mid-point of a complex evaluation process, several years of programme experience have highlighted a number of important operational and policy issues. Given the pressing need to begin engaging the interface between microfinance and HIV/AIDS, and the paucity of field-based experience, the remainder of this paper will highlight key challenges, lessons and limitations emerging from the programme to date. These will be presented within the context of growing international experience, and will focus on three themes of relevance to microfinance programme planning and implementation:

- the structure and content of programmes activities
- the nature of partnerships and implementations strategies
- issues of policy relevance to wider application of the IMAGE approach within the microfinance sector.

Table 1. Sisters-for-Life – Phase 1 training curriculum

<i>Session</i>	<i>Goals</i>	<i>Activities</i>
Introductions	<ul style="list-style-type: none"> ○ Help participants and facilitators to get to know one another and to feel comfortable ○ Overview of programme 	<ul style="list-style-type: none"> ○ Introductions ○ Overall goals and programme ○ Expectations and concerns ○ Ground rules
Reflecting on culture	<ul style="list-style-type: none"> ○ Consider traditional wedding songs, names, and proverbs about women, and explore their content and meaning ○ Understand how gender roles and conditioning are reinforced from an early age 	<ul style="list-style-type: none"> ○ Wedding songs, names and proverbs ○ Girls do's and don'ts
Gender roles	<ul style="list-style-type: none"> ○ Consider the differential work loads and responsibilities of women and men ○ Analyse how much of women's time is devoted to others and how much to themselves 	<ul style="list-style-type: none"> ○ 24 hours in a woman's day: map out hourly activities for a typical day
Women's work	<ul style="list-style-type: none"> ○ Explore the implications of women's heavy workloads on their health and well being ○ Understand the difference between 'sex' and 'gender' ○ Explore and challenge the notion of 'culture' and how it reinforces gender roles and stereotypes 	<ul style="list-style-type: none"> ○ Continued group discussions: 24 hours in a woman's day
Our bodies, our selves	<ul style="list-style-type: none"> ○ Become more comfortable speaking about the body, sexuality and women's feelings in relation to these. ○ Explore women's understandings of their bodies, particularly in relation to menstruation and sexual intercourse 	<ul style="list-style-type: none"> ○ Group discussion: defining 'womanhood' and what it means to be a woman ○ Body mapping: menstruation, sexual intercourse
Domestic violence	<ul style="list-style-type: none"> ○ Explore a range of experiences which constitute domestic violence ○ Explore attitudes, beliefs and experiences of such violence ○ Understand how it is perpetuated, and link this to prior sessions on gender roles and culture 	<ul style="list-style-type: none"> ○ Group discussion: forms of violence experienced or witnessed ○ Role play: mother-in-law speaking to daughter-in-law who has been beaten by her husband
Gender and HIV	<ul style="list-style-type: none"> ○ Cover basic understanding of HIV/AIDS, including prevention, transmission and myths ○ Explore reasons why women (especially young women) are at high risk ○ Link social context of women's risk to previous sessions on gender roles, culture, domestic violence 	<ul style="list-style-type: none"> ○ Group discussion: HIV basic information ○ Trends and statistics: women and HIV ○ Who is at risk? Discussion of two stories
Knowledge is power	<ul style="list-style-type: none"> ○ Introduce VCT (voluntary counselling and testing) and where it is available ○ Prepare women for thinking about VCT, reasons for testing, and fears and concerns ○ Bring home the reality of HIV by speaking to a PWA 	<ul style="list-style-type: none"> ○ VCT demonstration ○ Visualization exercise: finding out HIV status of yourself or someone you love ○ Disclosure session: PWA tells her story
Empowering change	<ul style="list-style-type: none"> ○ Explore why negotiating safer sex with a partner is difficult ○ Explore why speaking to youth about sex and HIV is difficult ○ Practice communication skills, and exchange strategies/personal experience 	<ul style="list-style-type: none"> ○ Role play 1: Speaking to your partner about safer sex ○ Role play 2: Speaking to a young person about sex
Way forward	<ul style="list-style-type: none"> ○ Summarize and link all previous sessions ○ Explore obstacles and opportunities for greater involvement of youth and men ○ Link Phase 1 to upcoming leadership training and Phase 2 	<ul style="list-style-type: none"> ○ Review of previous sessions and appreciation of progress ○ Group discussions: what can we change? What can't we change? ○ Next steps and closure

These observations and lessons are derived from a number of data sources including: structured non-participant observation of loan centre meetings; in-depth interviews with IMAGE participants and drop-outs; routinely collected microfinance loan performance and attendance data; and field diaries of HIV trainers.

The structure and content of programme activities

Within high HIV-prevalence countries, there have been numerous previous attempts to integrate health promotion and HIV prevention activities within microfinance programmes. The concept of 'tie-ins' that link credit with skills building and education as core components of the development package has been around for a long time (Khandker, 1998), and in the face of HIV has been receiving increasing support (Dunford, 2001). A survey of 22 MFIs in 14 African countries noted that 43 per cent provide some form of health information to their clients (Parker, 2000). Proponents of such approaches argue that access to credit and the solidarity groups that form as a consequence of microfinance involvement may act as stimulus for wider discussion and community mobilization around pervasive public health problems such as HIV. They suggest that such a package provides both the means (income/empowerment) and the knowledge to improve household well-being. In addition, such a combined approach may offer an incentive for individuals to participate in public health programmes, which, in the absence of credit, they probably would not.

However, a number of uncertainties remain around the optimal content and structure of these initiatives. The duration of training modules previously cited in the literature is quite variable, with 15 to 30 minute sessions being a common standard. The content of these sessions has ranged from a series of quite basic informational sessions on HIV, to a more diverse curriculum where HIV is one in a series of topics, ranging from respiratory disease and immunizations to breast feeding. Questions remain as to whether participation in such programmes should be compulsory or whether such integrated approaches should only be undertaken at the invitation of clients. Finally, while MFIs may act as conduits for the referral of HIV positive clients or family members, questions have been raised regarding the appropriateness of specific targeting of microfinance-based interventions to the HIV-infected.

The IMAGE intervention has been designed as a compulsory programme, where the training and microfinance are delivered as an integrated package. Prior formative research with microfinance clients and staff suggested that in order to avoid the temptation for clients to leave early to attend to their businesses, HIV training sessions should take place prior to loan repayment activities during centre meetings. In this way, pre-existing codes of conduct for punctuality and microfinance participation have been transferable to participation in the training programme. Furthermore, although the trainers are technically employees of the HIV organization, in order to promote the concept of a unified package, they have been presented to clients as microfinance staff (albeit with different roles), an image encouraged by their adaptation of institutional cues such as wearing microfinance staff T-shirts and reciting the staff pledge.

Experience within the HIV field suggests that effective training interventions need to go beyond dispensing technical information (e.g. how HIV is transmitted and prevented) to engage the broader social beliefs and cultural norms that shape vulnerability to infection. In this respect,

Many MFIs provide some form of health information to their clients

The IMAGE intervention has been designed as a compulsory programme

As the training progresses, clients pay greater attention during sessions as they become aware of their own vulnerability

Centres which have participated in the IMAGE intervention tend to outperform the average microfinance centre

addressing sensitive issues such as sexuality, traditional gender roles and domestic violence may present new challenges. In relation to the SFL training, non-participant observation during centre meetings has revealed an initial discomfort and reluctance to discuss such topics, which may be perceived as irrelevant or inappropriate for discussion, particularly among women of diverse ages. However, as the training progresses over the course of several months, clients display a growing awareness of the importance of the issues related to HIV, and to their own vulnerability (and that of their children) and an important shift in attitudes towards the training is apparent. Observations such as these raise important questions about the required skill level of trainers, their mentorship and support, as well as the duration of time needed to engage these deeper and more sensitive issues.

Training sessions are one hour in length: a duration felt, after piloting, to be both the minimum time necessary to meaningfully engage challenging subject matter, and the maximum allowable extension of regular centre meetings. An ongoing concern is that any additional time burden placed on loan clients may discourage them from taking additional loans. However, to date, quantitative data monitoring microfinance performance indicators suggests that drop-out rates from the IMAGE loan centres have actually been substantially lower than the average for the MFI as a whole: a consistent 50 per cent reduction that has been sustained throughout the intervention. Furthermore, in-depth interviews with loan recipients who have left the programme suggest that they have done so for reasons other than the training component of the intervention, such as business failure, new social commitments or migration. Furthermore, centres which have participated in the IMAGE intervention tend to outperform the average microfinance client centre with higher savings, lower portfolio-at-risk and better attendance at centre meetings. These findings were not anticipated. While it is hypothesized that gender and HIV Sisters-for-Life training strengthens group solidarity in ways that may improve financial performance, a detailed exploration of these potential mechanisms is the subject of ongoing research.

Finally, with respect to the 'HIV-targeting' of services, it is recognized that some proportion of clients are likely to be HIV positive. However, in the context of the IMAGE intervention, concerns about financial risk and stigma have weighed against recruiting, identifying or providing specialized support to these individuals outside the scope of normal programme activities.

The nature of partnerships and implementation strategies

In some respects, MFIs may be an important entry point and vehicle for conducting HIV-prevention activities. They often operate in communities where high rates of poverty and HIV coexist. Loan centres and solidarity groups, if well disposed to health-promotion efforts, have the potential to be an energized platform for community-generated responses to the epidemic. Furthermore, MFIs by their nature contain an element of financial sustainability and work towards continuous outreach and economies of scale – critical for cost-effective interventions aimed at changing complex and deeply rooted social norms.

However, for most MFIs, introducing HIV/AIDS programming is outside the scope of their core business and may present a real or perceived threat to their institutional mandate. Establishing effective partnerships is one means of balancing these distinct but complementary agendas. The

The microfinance and HIV/AIDS activities were delivered as an integrated package

IMAGE programme has been conceived as a collaboration between a MFI and an HIV/AIDS-focused organization. Such partnerships must benefit both parties to work and to be sustained in practice. In the case of IMAGE, the microfinance partner had a desire to respond more effectively to a growing epidemic, and was concerned about the impact on its financial and institutional well-being. The HIV/AIDS partner was interested in the design and evaluation of broader social responses to the epidemic. Organizationally, each institution runs independently and administers its respective component of the intervention. However, at the level of programme implementation, the intervention is viewed by both field staff and clients as an integrated package. To operate effectively, staff from each organization have taken ownership over the whole – with microfinance loan officers supporting and participating in the training, and HIV/AIDS staff present during microfinance activities.

Previous international experience suggests that such partnerships may meet with numerous challenges – from a lack of understanding between sectors, to the long-term practicality of partnerships, to fundamental differences in the scale of outreach and resources between programmes. In addition, the optimal way to structure these relationships may not always be clear. In some cases, organizations simply share a client base (linked service) where, for example, an NGO may work with existing microfinance clients, though not necessarily during the same meetings. The NGO may conduct training, or offer HIV-related services, such as home-based care or nutrition programmes to eligible clients. Conversely, as in the IMAGE case, partnerships may function in parallel, using a combined approach for delivery. This allows for each organization to maintain its sector focus, provide specialized support to clients and staff, and maintain discrete cost centres (see Table 2).

While such a parallel system may be useful for evaluating the impact of an intervention programme such as IMAGE in the context of a pilot programme with a limited number of clients, moving the intervention to scale may require a greater harmonization within existing microfinance systems. In order to address these issues more effectively, some have argued for a unified approach where both services are fully integrated within the core operations of a MFI, and furthermore, delivered by the same staff (Dunford, 2001). However, such approaches raise additional concerns including the need to develop institutional capacity within MFIs to respond to HIV effectively. A new set of skills would need to be developed, including the provision of adequate staff supervision and support for activities that have not traditionally been the purview of MFIs. Moreover, adapting curricula and tools to respond to different contexts and phases of the epidemic, and maintaining training quality over time may pose additional challenges. Finally, the potential exists for there to be tension between institutional cultures and mandates: enforcing credit discipline among clients on the one hand, and encouraging empowerment and independent thinking on the other. Striking an optimal balance between parallel and unified programmes remains an important area for further operational research.

If MFI programmes were to deliver HIV/AIDS training themselves, staff would need considerable training and support

Issues of policy relevance to wider application within the microfinance sector

As donors and policy makers explore the potential for microfinance to play a more meaningful role in HIV prevention, several important questions need to be asked. Firstly, is microfinance truly an effective way to

Table 2. Models for integrating MF and HIV/AIDS

	LINKED	PARALLEL	UNIFIED
Institution	MFI HIV	MFI HIV	MFI-HIV
Programme		MF-HIV	
Clients	clients	clients	clients
Description	<ul style="list-style-type: none"> ○ Integration at the level of shared client base i.e. referral service for education, home-based care, etc 	<ul style="list-style-type: none"> ○ Integration at programme level: co-ordinated delivery of combined approach 	<ul style="list-style-type: none"> ○ Integration at institutional level: single institution and staff delivers both programmes
Advantages	<ul style="list-style-type: none"> ○ No financial risk to MFI or HIV organization 	<ul style="list-style-type: none"> ○ Maintain sector-specific focus ○ Maintain disciplinary expertise ○ Discrete cost centres ○ Minimal financial risk to MFI 	<ul style="list-style-type: none"> ○ Full ownership by MFI ○ Sustainability ○ Can build in incentives for client and staff participation and performance ○ Maximal potential for synergy of agendas
Disadvantages	<ul style="list-style-type: none"> ○ Minimal motivation for clients to attend ○ Difficult to move to scale ○ No taking advantage of synergy ○ Limited impact 	<ul style="list-style-type: none"> ○ Difficult to move to scale ○ Staff must work together effectively ○ Potentially conflicting priorities and institutional cultures ○ Sustainability 	<ul style="list-style-type: none"> ○ Need to develop cross-disciplinary skill base ○ Potential risk to MFI sustainability ○ Need to maintain quality of non-MF programme critical

address the needs of those groups most vulnerable to HIV infection? If so, who should fund it? And finally, will such activities not compromise the emphasis on financial and operational sustainability that currently dominates the microfinance sector?

The epidemiology of HIV in high prevalence settings suggests that those most vulnerable to HIV are the young – particularly women between 15 and 25 and men between 20 and 30 years of age (UNAIDS, 2002). As a consequence, those at highest risk are often not the direct beneficiaries of microfinance programmes. In fact, for many MFIs, young people are seen as a credit risk, with little enterprise experience, and frequent out-migration for school, employment seeking or marriage. In our setting, approximately two-thirds of microfinance clients are older than 35 years.

One strategy for increasing the exposure of vulnerable groups to prevention programmes might be the active recruitment of younger clients to microfinance programmes. While this strategy may have merit, a central hypothesis of the IMAGE intervention is that maintaining standard recruitment procedures for MFIs may be just as effective. Older women, while not themselves at highest risk, have the potential to be important brokers for change in their communities. Many rural communities in southern Africa are characterized by high levels of economic migration,

Those most vulnerable to HIV are usually too young to qualify for microfinance

Older women have the potential to be important brokers for change in their communities

particularly amongst males. In this setting, half of adult men do not regularly sleep at home. With these individuals absent for long periods, the authority to define and address priority issues often rests with older women. They are respected in their communities and may be a powerful force for shifting social norms. With respect to HIV, this can take place directly through improved communication or collective action, or more subtly via mentorship and role modelling for the young.

Early findings from the qualitative components of the IMAGE Study reinforce the importance of these hypotheses. There are numerous themes emerging around improved intra-household communication – both with partners and children alike. Participants appear more critical of traditional social and cultural norms around gender, and have challenged these norms on numerous occasions. Finally, loan centres have served as vehicles for social mobilization activities including:

- Establishing village rape and crime committees in partnership with the South African Police Service.
- Numerous HIV-oriented educational activities in a number of different settings, including primary schools, churches, burial societies, soccer clubs and taxi ranks.
- Protests have taken place to improve the quality of local clinics, to stop local bars from selling alcohol to youths, and to raise awareness around issues of gender violence in communities.

The full extent of these experiences, their sustainability, and their impact on vulnerability to HIV will be explored in detail as the quantitative results of the work become available.

Perhaps the most significant obstacle to the mainstreaming of HIV/AIDS within MFIs relates to the substantial pressure imposed by donors for MFIs to become financially sustainable. While microfinance creates an important opportunity to engage public health issues, critics suggest that MFIs should avoid trying to offer a development panacea. Public health interventions are outside their immediate area of expertise. Training staff to offer such a service will carry costs, and it is argued that MFIs should avoid offering too many products and services. Rather, they should stay focused on their core activities: pursuing efficiency in their operations with the goal of financial sustainability.

In many instances, access to microfinance loan capital, operational costs and expansion resources from donor organizations are linked to MFIs approaching or achieving financial and operational sustainability. As a consequence, this may inhibit the ability of MFIs to innovate and take on new initiatives, such as HIV/AIDS programming. Strengthening the capacity of MFIs to integrate health and development perspectives clearly requires additional inputs including expertise, training, staff and time. However, while the incremental costs may be significant, so might the associated benefits and savings. A single HIV infection or AIDS death has a dramatic and far-reaching effect, draining resources from both household economies and health sector services alike. In order to support innovations in HIV/AIDS programming, donors may need to offer MFIs the flexibility of accounting for these additional inputs separately from routine core financial business.

At the same time, it is worth noting that billions of dollars in new funding have recently been made available for HIV/AIDS programming in countries most affected by the epidemic. Major investments for enhanced programming over the next five years have been announced by a number

The drive for financial sustainability may discourage MFIs from taking on HIV/AIDS training

of actors including the WHO and UNAIDS; the Global Fund against AIDS, Tuberculosis and Malaria; the World Bank MAP programme; the US Presidential Emergency Plan For AIDS Reduction (PEPFAR), several large philanthropic foundations, bilateral development agencies and others. In addition to financing initiatives to improve access to care and support, this unprecedented commitment of resources also has the potential to re-invigorate prevention programmes. This in turn may present another 'external' source of funding for integrating HIV/AIDS programming into MFIs – and one that does not directly compete with the drive towards institutional sustainability. While generating an 'inter-sectoral response to HIV/AIDS' has become common parlance in many settings, there are few concrete examples of programmes that work, particularly among the marginalized, high-risk communities in which MFIs routinely operate.

Conclusion

The provision of effective and sustainable microfinance services in high HIV-prevalence settings requires a critical re-appraisal of the 'business as usual' approach. While ignoring the epidemic may seem the simplest option, experience suggests the impact on staff and clients could compromise the quality of loan portfolios and the viability of MFIs themselves. By establishing better monitoring systems and through innovations in product development, MFI providers may succeed, in the short term, in shifting the burden of HIV-associated risk back on to clients, their households or third-party insurers. However, in this context, any long-term impact on the epidemic may be limited.

The microfinance sector has the potential to play a much more substantial role in generating a comprehensive and pro-active response to the HIV/AIDS epidemic. Microfinance is one of the few interventions that can both mitigate AIDS impact and prevent new infections. Through mainstreaming HIV/AIDS perspectives within MFIs, this combined approach has the potential to address significant population-level vulnerabilities to HIV – particularly poverty and gender-based inequalities. An evolving understanding of the intersection of microfinance and HIV has been presented, highlighting both operational and policy-level challenges alongside model approaches and novel implementation strategies. A 'one-size-fits-all' product is perhaps neither desirable nor possible. However, much has already been learned to support the potential for MFIs to move beyond conventional practice, carrying important implications for future microfinance programming in areas where the HIV/AIDS epidemic continues to threaten both health and development agendas.

Microfinance is one of the few interventions that can both mitigate AIDS impact and prevent new infections

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