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## Report of the Workshop

# HIV/AIDS and Microinsurance in the microfinance sector in Africa



Organised by:  
AFMIN  
Hivos

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## EXECUTIVE SUMMARY

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AFMIN and Hivos organised the workshop on the theme: "HIV/AIDS and Microinsurance in the microfinance sector in Africa". During three days, microfinance and microinsurance experts shared experiences on strategies developed to reduce the effects of HIV/AIDS on their clients.

### ***HIV/AIDS pandemic and the need for concerted efforts***

Because of the high prevalence rate and the far-reaching social, cultural and economic consequences, the HIV/AIDS epidemic can no longer be ignored. It affects not only the health situation of individuals, but households, communities and society as a whole. As a result the market place of microfinance institutions (MFIs) and microinsurance companies (MICs) changes, and hence the demand for financial products. The care for sick relatives and orphans has tremendous financial repercussions in terms of medical costs and lost business income as most caregivers have to reduce their income earning activities and draw from their business capital to meet expenses. In addition women often divert their attention from the enterprise as they care for the sick.

Although crises not related to HIV/AIDS (like malaria and other diseases, death of relatives, loss of property) do happen more frequently, they come in isolation. HIV/AIDS, on the other hand, triggers a series of crises that require an entire arsenal of coping mechanisms. Or like a client of an MFI in Uganda said: 'AIDS does not kill suddenly, but it comes and takes a lot of money with it'. Furthermore the spread of HIV/AIDS is taking epidemic forms, asking for pro-active measures to address it when still possible. Participants agreed that it is not a matter of choice to pay attention to HIV/AIDS. If the organisation is demand-driven and aware of the problem it will take these issues into account. And as clients are the core asset of MFIs and MICs, healthy clients now and in the future is in their interest.

What can microfinance and microinsurance organisations do? It is not their task to provide AIDS support services. However as said, fighting HIV/AIDS is complex as gender disparities, traditions, lack of access to information, poverty, structural insecurity all play a role in the spread of HIV/AIDS and its impact. Concerted efforts are therefore needed. MFIs and MICs can play a role given their contribution to poverty alleviation, reduced vulnerability and economic empowerment of women. In addition MFIs and MICs can contribute to providing access to health care via insurance products.

Different categories of strategies for MFIs and/or MICs to deal with HIV/AIDS are distinguished, being:

- Prevention strategies (for MFIs and MICs)
- Product adjustments (for MFIs)
- Introduction of new products other than insurance (for MFIs)
- Introduction of insurance services (MFIs and MICs).

There is not one best strategy. Which strategy is (most) appropriate depends on the situation in a country and/or area of operation, the concerned organisation, and on the needs of the clients.

Participants stressed that an internal HIV/AIDS policy is a precondition and staff training needs to be held regularly (for new and existing staff) to develop successful HIV/AIDS strategies as an organisation. Only in this way you can prevent discrimination of people living with HIV/AIDS, expect staff to see and understand the influence of HIV/AIDS on clients, the relationship with gender disparities and to be comfortable to talk about HIV/AIDS with clients.

### ***Prevention strategies***

A lot of MFIs and insurance companies are already working on prevention of HIV/AIDS. As argued by FINCA Uganda, ACB, Microcare and AIG Uganda, prevention of HIV/AIDS makes economic sense for MFIs and MICs. For MFIs HIV/AIDS increases group absenteeism and negatively influences group coherence, lower retention rate because of financial constraints faced by ill family members and as well as they might be infected themselves, drop in repayment rates due to diversion of loans and other financial impediments, and reduced ability to attract new customers. The evaluation of the SEF/RADAR gender based violence and HIV/AIDS programme indicated that centres, where the prevention programme was run, showed faster recruitment of clients, better staff performance, higher loan sizes, less vulnerable centres (measured by attendance, arrears, savings) and less dropouts compared to centres where the programme was not running.

For MICs, it leads to lower claims for life insurance and health insurance. Furthermore in the case of health insurance, prevention is cheaper than cure, especially in the case of HIV/AIDS regardless whether the insurance covers the costs of anti retroviral medication (ARVs) as clients with no access to ARVs tend to be ill for quite a long time resulting in a lot of claims.

An additional advantage to work towards prevention activities via MFIs and MICs is their contribution to economic empowerment and reduced vulnerability, which enables an organisation to address poverty and lack of access to

information, two important factors in the spread of HIV/AIDS, at the same time. SEF/RADAR stressed the necessity to address the empowerment of women as well, as their vulnerability is another important factor in the spread of HIV/AIDS.

In the case of group loans, prevention activities can be integrated in the meetings like SEF, Finca Uganda, and Zambuko Trust are doing. Specific meetings for clients can be organised as well, like Akiba Commercial Bank (ACB) is doing in collaboration with PSI (Population Services International).

Almost all organisations active in the field of prevention activities are raising awareness on HIV/AIDS in cooperation with AIDS organisations. This is known as the parallel model, in which use is made of the technical strengths of each institution. Costs are partly or fully paid for by donor organisations (either via the MFI or via the AIDS organisation), or by the MFIs themselves.

Another model is the integrated model, in which MFI staff runs the programme. SEF wants to move from the parallel model to an integrated model. Main reasons are its desire to scale up its gender based violence and HIV/AIDS programme to reach all clients and to keep track of the rapidly expanding client base. Challenges to be addressed are: to develop sustainable management and implementation systems within MFI to maximise efficiency yet maintain quality and impact, institutionalize long-term commitment to addressing gender based violence and HIV/AIDS without compromising core microfinance targets, deal with inherent tension between empowerment and strict credit discipline, clarity on costs and savings, and the availability of funding to cover potential gap between additional costs and savings.

#### *Product adjustments for MFIs*

At FINCA Uganda, being demand driven was considered to be an important driving force to look at the effects of HIV/AIDS for its clients. Key characteristic of product adjustments made is *more flexibility* in products to give clients more time and possibilities to deal with (HIV/AIDS related) problems. This enables them to remain clients of the MFI. On the basis of careful assessments of clients' needs, FINCA Uganda among others improved frequency of payments to optional weekly or bi-weekly repayments, reduction of group size to ease formation of groups, allowing clients to send their instalments through a proxy and to rest after a loan cycle. Most common product adjustments are reduction of meeting frequency, no compulsory upgrading to higher loan levels and lower requirements for meeting attendance. In general product adjustments are not very costly and benefits tend to outweigh costs.

#### *Introduction of new products other than insurance*

Introduction of new products is another important instrument to offer clients more flexibility to deal with (HIV/AIDS related) problems. Possibly interesting products are: emergency loans, accessible savings and products for people living with HIV/AIDS.

ZAMBUKO Trust and KDA have developed special loan products targeting people living with HIV/AIDS. In its product design, ZAMBUKO selects only these clients that are keen to run a business. Furthermore the assessment is done on the basis of a family business unit and clients are encouraged to develop a succession plan.

(Continued) access to financial services helps infected people to live positively with HIV/AIDS, increases their life span and reduces discrimination. ZAMBUKO reports also increased group support for infected people, though experiences with group coherence at KDA are less positive. ZAMBUKO further reports that there is no evidence of high default rates.

Again introduction of new products needs to be preceded by identification of clients needs taking into account the effects of the HIV/AIDS pandemic and possibilities of MFIs. Pilot-testing is also important to ensure adequate product design and cost-recovery.

#### **Microinsurance**

Microinsurance is defined as: "risk-pooling products that are designed to be appropriate for the low-income market in relation to cost, terms, coverage, and delivery mechanism". Microinsurance is important to get balanced financial security.

Whereas savings and credit can help people improve their income and move out of poverty, microinsurance helps them protect the gains and hence prevents them from falling back into poverty. Savings go a long way to protect people. However insurance helps to spread risks not only over time but also across individuals. Hence it offers a better protection and even the only appropriate protection in the case of low frequency, high costs events.

Four main categories of insurance products can be distinguished, namely:

- Life insurance, including credit life (or loan) insurance and funeral insurance.
- Health insurance, which can include out patient care, hospitalisation, surgical, dental, and optical care.
- Disability insurance, including permanent, temporary, total, partial, credit disability.
- Property, such as fire, theft, floods, earthquake.

In the light of the HIV/AIDS pandemic the categories of life and health insurance products are most relevant. It is important to note that these are two totally different types of insurance, with the first one being more straightforward as risks are easier to determine and the latter being more complex as much more information is required to determine risk premium, more possibilities for fraud, and dependence on national health systems and health care providers.

The market potential for insurance is huge. Worldwide there are over 4 billion people without any formal insurance. Those are the poor, the ones that are the most vulnerable to risk. Access to insurance for the poor is a key theme that is important to a lot of people. The role of insurance companies is to bear the risks of the individual together, or in other words to organise solidarity. This goes hand in hand with reducing risks.

Experiences of Opportunity International and AIG Uganda with life insurance covering respectively 1.7 million and over 2 million lives via MFIs illustrates that it is possible to turn this potential demand into effective demand. Both organisations also managed to do this in a short period of time. First pilots took place 8 years ago. Opportunity International and AIG Uganda (so far) only deal with loan/life insurance. As risk of ill health is prioritized by the poor, it is likely that demand for health insurance is higher than the demand for life insurance. This need will only increase due to HIV/AIDS.

Basic premium components are risk premium, operational costs, profit margin/surplus and investment income. Determining risk premium is complicated (even more for health insurance). It requires the use of insurance experts, more specifically actuaries. High probability of correctness requires large scale.

Participants experienced that insurance is a difficult product to sell. In the first place the understanding of the MFIs and credit officers of insurance products is limited. Investing in training of staff and management in MFIs is a precondition to ensure that the insurance product is promoted and adequately explained to clients by credit officers. Keeping products simple (no/few exemptions) and accessible information enhances understanding of MFI staff and clients. In the second place marketing is important. It is worthwhile to invest in good marketing strategies. Don't ask people saying "*Do you want insurance?*" but ask the following: What risks do you face? How do you address them now? What could be more effective? Social Re has developed a game called 'Wealth and Health' which is a very intuitive and convincing game to show why insurance is better than choosing to be uninsured. It has been successfully tested in Mali. You can play it yourself on <http://socialre.free.fr/>. In the third place, a well designed product matching client's needs is a precondition for any marketing strategy to be successful in the long-term.

Another issue that participants considered to be a hindrance for demand of insurance products is the lack of trust of insurance companies. Building trust starts with: understanding one another (clear and easy accessible information, simple products), willingness to collaborate (for common goal), communication (to talk to one another and to be transparent), commitment, and competence. Regulation also assists to build trust among clients.

Regulatory issues that came up and need attention when offering insurance products are:

- Do agents have to be registered and which regulations apply?
- Are banks / MFIs allowed to sell insurance? Is it legal to offer it as a compulsory product?
- Legality of banks to require the use of one particular insurer?
- Are MFIs allowed to add to the premium as they sell insurance to their clients?
- Licensing, noting differences between regulations for life versus general insurance.
- Legality of mutual societies and community-based initiatives.

#### *Life insurance*

The Hivos questionnaire carried out with 19 MFIs in East and Southern Africa indicated that 60% of the MFIs are offering credit life insurance. This is often extended with life insurance, i.e. paying out of benefit in case of death of client, spouse and four dependents to deal with burial costs and potential loss of income. It is also possible that insurance company offers the service in kind, i.e. coffin and other funeral expenses etc. instead of payment.

Reasons for MFIs to offer life insurance are:

- Credit life is essential to any lender as it eliminates the risk of non-repayment in case of death of client;
- It has a positive effect upon portfolio at risk (PAR);
- It generates income for the MFI via commissions. At the same time commissions of MFIs also tend to increase the price for clients. OI charges between 10-20% commission, but it is known that some MFIs charge much higher commissions. Which commission is still reasonable?
- It is an additional product feature that clients might find attractive in an increasingly competitive market-place;
- Though it ultimately has to be driven by *client demand* (determined via market research).

Life insurance in East and Southern Africa is mostly offered in collaboration with an insurance company, i.e. via the so-called partner agent model. As well AIG (an insurance company) as Opportunity International (MFI) use this model.

### *Health insurance*

Health insurance is considered to be relevant for the poor (clients of MFIs) for the following reasons:

- It helps the poor to spread risks not only over time but also over individuals.
- The poor have a low ability to absorb shocks. In India one out of four people admitted to the hospital, fall below poverty. Sickness and poverty are inextricably linked.
- The poor cannot benefit from economies of scale when paying directly to providers as they buy the service at spot and in need of treatment. Insurance separates the point of payment from the point of services and enables negotiations due to larger volume.
- Uninsured poor tend to delay treatment due to ignorance and poverty, thereby aggravating medical conditions and cost-effective care.
- Access to health insurance will make products offered by MFIs more relevant for clients, reduce workload for female clients to caring responsibilities, clients are less likely to face repayment problems. This is likely to contribute to improved well-being of clients.

Another major advantage of offering insurance is that it creates solvent demand that draws more and better providers. Hence creating access to insurance and therewith capacity to pay is more effective than direct support to health care. Experiences of Microcare and community-based insurance initiatives in India and Philippines have shown that access to health insurance increases health care utilization and improves the equity of access.

MFIs benefit from offering health insurance because of lower default rates, higher retention rate due to more relevant services and longer term contracts, improved performance of clients, and possibility to receive interest on loans given to cover premium.

But then, if health insurance is so relevant for the poor and benefits MFIs and the health sector, why is low-cost health insurance so rare?

- High barriers to entry: Capital requirements tend to be high as claim loads and costs can exceed premiums collected. To guarantee service delivery, large reserves are required.
- Furthermore costs (especially administration) can be high, especially for small scale insurers.
- Lack of knowledge/information on probability of risks, variance of risks, variance of unit costs. Health risks and costs are especially difficult to determine and hence required capacity to offer health insurance is high.
- Lack of "industrial infrastructure" for insurance illustrated by among others uncontrolled drug distribution resulting in high overhead cost and high cost of administration (collection, claims processing, and payments).

The following issues are key in health insurance:

- Give clients a choice for health care providers. It allows for competition and increases the likelihood of good quality services. Furthermore clients want to have a choice, designating them to clinics for poor people will not work; furthermore it is desirable to spread the risk between rich and poor clients.
- Prevention of fraud by clients and providers is important. Control systems are expensive, though will pay back. Furthermore costs of control systems decrease as scale increases.
- Pay health care providers direct as it gives important data, allows for an additional check, eases administration, prevents fraud and is in the interest of clients.
- Need for a good and efficient administrative system.
- Client and service provider contracts must be simple and sound.

- Importance of having a computerized database to allow analysis of data, proper costing of products, quality audit of clinical services, and to minimize risk of fraud at client and health service provider level.
- In case of direct payment to health care providers, computerized database allows for timely payment of bills (even before invoice is sent).
- Importance of relevance of product for the target market. Market research is crucial. Small community based groups ease product design as product can be adjusted to specific local needs.
- Microcare is combining offering of microinsurance to (low-income) formal and informal markets. It helps them to reach scale easier. The demand in the formal sector is high and uptake is quicker.
- Microcare combines the provision of insurance services with health management services. This saves costs for both the insurance company and the health care provider and is an additional source of income for Microcare.
- Testing, counselling, and antiretroviral medication as well as supervision of HIV/AIDS treatment can be part of an insurance package. It is already included in Microcare's product for corporate clients. Subsidisation of ARVs (by donor organisations or government) can also be considered. At the same time, insurers acknowledge that prevention of HIV/AIDS (or risk reduction) is most cost-effective. For this reason Microcare organises workshops on HIV/AIDS awareness and technical assistance in developing and maintaining HIV/AIDS programs for companies. It considers this as one of its strengths.

During the workshop, two examples of health insurance were presented, being Microcare and Social Re. While Microcare is using the partner-agent model, Social Re is advocating for the community based model provided that they break away from solitary activity to meet re-insurance and capacity requirements.

#### *Models to offer insurance:*

Different models can be used to offer insurance to clients, being:

- *Community-Based Model* (CIDR, ILO STEP) Organisation offering insurance is owned and managed by members.
- *Provider Model* (GRET Cambodia, Grameen) - Organisation that provides health care or funeral services is the insurer.
- *Partnership Model* (AIG & Microcare with Ugandan MFIs) MFI links with regulated insurance company and acts as its agent. No risk to MFI, administrative burden minimal

Other models that are being used are full service insurer, mutual, and cooperative models.

Key difference between different models is where the risk is placed.

No matter which model is used, it is commonly accepted that MFIs should not offer microinsurance within the MFI entity, as it:

- Puts MFI reserves at risk by carrying unlimited insurance risk;
- Insurance financial management, accounting and auditing is different from banking and needs specialised staff;
- Bank regulations may not permit MFIs to be insurers;
- Potential conflicts of interest; and
- Ethical / confidentiality issues (especially with health insurance e.g. Knowledge of clients HIV status)

Models discussed during the workshop were the partner-agent and the community-based model. Advocates for the partner-agent model, stress that:

- it is the quickest way to get a product launched,
- it reduces regulatory issues and eases regulatory compliance,
- you do not need the capital that is required to set up mutual or community based model,
- lowest risk (financial & reputation),
- flexibility from African insurers in product design, price and service standard,
- technically should be cheaper for user,
- providing microinsurance diverts focus from core banking business,
- insurers already have the required insurance expertise (underwriting, claims, pricing),
- MFIs have limited options to share risk as their scale of operations is lower and cannot access commercial re-insurance as they are not registered insurance companies, and
- the community-based initiative puts the risk with the clients while they are not the ones that can best manage risk.

Important issues to discuss with potential partner insurance companies are: willingness of partner to provide product that addresses clients need, price which is found less important than service, speed of claims payment, simplicity of client application, exclusions & claims process, and reporting and premium requirements of MFI (and its MIS).

Advocates for the community-based model argue that it is better to have multiple (small) insurers instead of one single insurer, as

- Small groups easier strike a balance between the collective good and the individual interests of each member (this advantage disappears in large groups).
- Multiple micro insurers can adapt their package to the local needs better than a single large insurer. Hence it eases product design. Relevance of product is likely to be higher than in the partner-agent model, especially if product is compulsory for clients of MFIs.
- Micro (health) insurance units can evolve by using existing groups.

Furthermore they argue that the identified problems related to size, costs of control systems, administration, access to risk sharing options, capacity and actuarial knowledge can be addressed if the community based groups do not operate in isolation but are part of a network that pools risks, resources and technical capacity. Social Re is an example of such a network.

#### *Lessons learned*

Important lessons learned include:

- Product design should be done on the basis of market research, products should be kept simple, group based to deal with adverse selection, and price (premium) should be set by insurer. Small community based groups can ease product design. Furthermore it can be interesting to offer service instead of payment.
- Product delivery: staff training and appreciation of insurance is necessary for significant sales growth, spend money on client education and marketing, compulsory products can leave customers with very little understanding, compulsory products DO NOT reflect demand, performance of agent in delivering claims as well as payment of insurer is important.
- Importance of computerization for data mining and efficiency.
- Separate insurance and other business and focus on core competencies.
- Microinsurance must be treated with the same business approach as regular insurance.
- Limits to management capacity can be expanded with reinsurance or outsourcing.
- Follow your calculator, not your heart.

#### ***The role of network of MFIs***

Networks of MFIs play a crucial role in promoting the effective implementation of strategies dealing with HIV/AIDS. Initially, their task is to do research on effects of HIV/AIDS, lobby at government for good HIV/AIDS policy, raise awareness on the effects of the pandemic with MFIs, train MFIs in potential strategies that can be developed, facilitate linkages with AIDS support organisations and with successful prevention programmes. Furthermore, access to microinsurance is almost non-existent. Networks can improve access to microinsurance by doing market research on the demand for insurance products and by linking insurance companies with microfinance institutions and/or community based insurance initiatives with organisations that are able to provide technical know-how and reinsurance. AMFIU in Uganda encourages dialogue and facilitates linkages between microfinance and insurance organisations by inviting insurance companies to become associate members of the network and to take a seat in the Board.

#### ***The way forward***

As said, fighting HIV/AIDS asks for consorted efforts from different organisations building on each technical and institutional strengths. All presenters highlighted the need for cooperation. Cooperation between MFIs, networks of MFIs, HIV/AIDS organisations, insurance companies, clients, health service providers, re-insurers, technical assistance providers is crucial. A lot can be gained by all parties. Working from a win-win situation is crucial. Or in other words all efforts should be based on the five Cs: cooperation, coalition, communication, commitment and competences.

The workshop HIV/AIDS and microinsurance in the microfinance sector in Africa resulted in the start of several consorted efforts judging by the joint plans made during action planning. Both AFMIN and Hivos are confident that all participants are dedicated to follow-up their plans made and are looking forward to see the results of this work. On our turn, AFMIN and Hivos will continue raising awareness and promoting the development of strategies dealing with HIV/AIDS, promoting linkages between all relevant actors, increasing the capacity and knowledge to offer access to insurance services for the poor, sharing good practices and supporting promising initiatives in this field!

# PART I INTRODUCTION

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## 1.0 Introduction

The African Microfinance Network (AFMIN), in collaboration with the Humanist Institute for Development Cooperation (Hivos) organized a workshop on HIV/AIDS and Microinsurance in the microfinance sector in Africa. The Workshop was held from April 25 - 27, 2005 at Global Hotel in Addis Ababa, Ethiopia. Association of Ethiopian Microfinance Institutions (AEMFI) had hosted this workshop and provided logistic support. Participants of the Workshop were 54 from 43 different organizations in 16 countries. Names of participants can be found in annex 3. The Workshop was inaugurated by Dr. Wolday Amha Board Chairman of AFMIN and Executive Director of AEMFI.

Part I of this report gives an introduction and elaborates on the relationship between microfinance and HIV/AIDS. Part II deals with the strategies that MFIs and their networks have developed, including prevention strategies, product adjustments, and introduction of new products (apart from microinsurance). Part III of the report focuses on microinsurance, especially on loan, life, funeral, and health insurance.

## 1.1 Background and workshop Objectives

### 1.1.1 Problem definition

Many households in Africa are confronted with family members with HIV/AIDS. Data suggest that the spread of HIV/AIDS follows existing patterns of poverty and exclusion. Clients of MFIs, being lower income population, are therefore highly exposed to the risk posed by the HIV/AIDS endemic. The care of family members with AIDS has tremendous financial repercussions in terms of medical costs and lost business incomes as most caregivers have to reduce their income earning activities and draw from their business capital to meet expenses. In addition women often divert their attention from the enterprise as they care for the sick. Although crisis not related to HIV/AIDS do happen more frequently, they come in isolation. HIV/AIDS, on the other hand, triggers a series of events that require an entire arsenal of coping mechanisms.

### 1.1.2 Relationship between HIV/AIDS and Microfinance

Being part of society as a whole, microfinance institutions (MFIs) and insurance companies cannot ignore the HIV/AIDS pandemic. They are feeling the effects of the HIV/AIDS pandemic via staff members and clients infected with or affected by the HIV/AIDS pandemic (through sick and deceased family members), changed needs of clients, and the economic effects at community and society level. At the same time, MFIs and insurance companies do have an influence on the HIV/AIDS pandemic. They can reduce the effects that are being felt by clients by taking into account changed needs to revise current products and develop new products. In addition they can link with other organizations to prevent further spread of the disease as well as to reduce other effects. Given the extent to which MFIs and insurance companies are affected themselves, acting on this pandemic does not only make sense from a human perspective, but also from a long term business perspective.

Fighting this epidemic is complex as gender disparities, traditions, lack of access to information, poverty, and structural insecurity all play a role in the spread of HIV/AIDS and its impact. Strategies that take these different issues into account and consorted efforts are therefore needed.

### 1.1.3 Concrete strategies implemented by MFIs

The potential role of microfinance institutions might be clear. But to be effective, concrete strategies are needed. During the workshop the first day was allocated to prevention programmes (innovations around HIV/AIDS related information and linkages) and product adjustments and new products with awareness of changes in the costing of products. The second and third days of the workshop focused entirely on the strategy of insurance products.

### 1.1.4 Goals and objectives of the training workshop

The overall goal is to share information and experiences on the relationship between HIV/AIDS and Microfinance and to enable participants to develop strategies (especially offering microinsurance products) to deal with the HIV/AIDS pandemic.

More specifically, the following objectives are identified:

- Increase knowledge on:
  - relationship between HIV/AIDS and microfinance,
  - possible strategies to deal with HIV/AIDS pandemic and its widespread impact on a society as a whole,
  - relevance of microinsurance products and key issues to offer these services in a professional and financially sustainable way

- All participating organizations have action plans elaborating on strategies they want to adopt and/or further refine to adequately deal with HIV/AIDS
  - Networking between MFIs, networks of MFIs and insurance companies
  - Exchange of experiences.
- Exchange of experiences on:
  - relationship between HIV/AIDS and microfinance and microinsurance,
  - lessons learned during the implementation of strategies to deal with HIV/AIDS.
- Networking between MFIs, networks of MFIs, and insurance companies from different countries.

## 1.2 Opening, AFMIN Board Chairman, Dr. Wolday Amha

On behalf of AFMIN and AEMFI, Dr. Wolday began the address by expressing his profound gratitude to Hivos of the Netherlands, particularly Carolijn Gommans, for supporting AFMIN both financially and technically in organizing the workshop on HIV/AIDS and Microinsurance in the microfinance sector in Africa. He explained about Hivos and AFMIN, the collaboration between the two and the objectives of the workshop.

He also mentioned the role MFIs, their development partners and networks can play in addressing the problems faced by the infected and the affected. According to his speech these include: (a) educating clients on HIV/AIDS during the group meetings, (b) Delivering financial services such as loans, savings and insurance products to both HIV/AIDS infected clients and caregivers by using innovative approaches, and (c) lobby and advocate in order to increase the commitment of government and donors to contribute towards addressing the problems of HIV/AIDS in their respective countries.

Acknowledging what have been attempted by many MFIs in Africa to address the needs of the victims and caregivers he assured the participants that the issue of HIV/AIDS and microfinance in Africa is one of AFMIN's top priorities in the business plan. Furthermore, he mentioned as AFMIN would also bring this issue of HIV/AIDS and microfinance to the attention of African Union, so that the high-level policy makers of each country support the initiatives of MFIs, partner organizations and networks in contributing towards educating and providing financial services to HIV/AIDS infected persons and caregivers.

With these remarks he thanked all and introduced to participants Carolijn Gommans, mentioning what she has been doing in the areas of rural development, gender, microfinance and access to market, HIV/AIDS, HIV/AIDS mainstreaming and the development of a program on Microinsurance at Hivos. Finally, he declared the workshop opened and the moderator of the day took the floor.

## 2.0 Relationship between HIV/AIDS and microfinance/insurance

### 2.1 Experiences in Uganda by AMFIU, Ms. Caroline Tuhwezeine

Ms. Tuhwezeine explained in her presentation that in Uganda over 1000 microfinance services outlets are serving over 890,000 clients. The percentage of the rural population with access to financial services (savings/credit) is estimated at 10%.

According to the presenter, though, the industry has a shared vision to spread sustainable microfinance services to the underserved areas in Uganda, their business focus have made some MFIs keep integration of health education out of their activities.

In Uganda until the government had realized that the problem of AIDS was beyond the health sector and adopted a multi-sectoral approach, the infection rate was 18.5% of the total population and about 30.5% of the pregnant women. Still, AIDS remains the leading cause of death in the economically productive age group 25 to 44 in Ugandan.

The effects of HIV/AIDS on MF operations, steps that have been taken by MFIs on HIV/AIDS and the role of AMFIU are discussed below.

Effects of HIV/AIDS on MFI clients are under-researched area that needs urgent attention according to Ms. Tuhwezeine. Sickness and death in households due to HIV/AIDS, is one of the key factors constraining the positive impact of MFI on clients' households.

According to the presenter effects of HIV/AIDS are reflected through the following ways:

- Absenteeism through AIDS related illnesses, taking care of the sick, attending funerals;
- Loss of experienced workers fall in productivity;
- New employees take long to become as productive as their former counterparts,
- Cost of replacing the workers;

- Increased health costs to MFIs;
- Loan Officers affected psychologically- their incomes are affected by not recovered loans;
- Loss of good clients;
- Inconsistent borrowers- quality of clientele;
- Diversion of loans into unproductive activities-medical, looking after orphans; and,
- Needs for access to wider ranges of financial services- strain on MFIs to create more products.

Efforts of MFIs in Uganda to integrate HIV/AIDS in their activities include: partnership with health insurance companies, AIDS prevention campaigns, and development of HIV policy at workplace.

AMFIU as a network undertook the following to minimize the effects of HIV/AIDS in the country: encourages member MFIs to be more client focused, i.e. beyond credit, organized for members an information exchange on micro health insurance; introduced and prompted health integration in collaboration with the Microcredit Summit, trained MFI managers to integrate HIV/AIDS education in their services, and discussed with some of AMFIU's partners like, GTZ and Hivos to advocate for a workplace policy on HIV to members.

## **2.2 Outcomes Hivos' questionnaire effects of HIV/AIDS, Ms. Annegien Wilms**

Ms. Wilms explained that Hivos is a Dutch organisation providing financial support to over 800 organisations in 30 countries. It has three policy domains are Sustainable Economic Development, Civil Voices and Civil Society Building. Hivos is active in the field of financial services and enterprise development, which includes of course microfinance and micro-insurance. Equity, loans and grants are provided to organisations with proven commitment to low-income groups and women and aiming for financial sustainability. It also works on networking, lobbying and knowledge sharing by linking relevant stakeholders like MFIs, formal banking institutions, rating agencies, experts in microfinance and micro-insurance, private and public players and organisations specialised in issues regarding gender, the environment and HIV/AIDS.

As presented by Ms. Wilms factors contributing to HIV/AIDS pandemic are: gender disparities, traditions, lack of access to information, poverty and structural insecurity. The consequences are felt at societal level at large, hence also by the MFIs. This presentation discusses the effects of HIV/AIDS in the MF sector.

A questionnaire on the effects of HIV/AIDS in the MF sector were distributed to 20 Microfinance Institutions in 7 African countries and 95% responded while out of the 20 country level and 3 regional networks in 8 African countries 48% responded. The output of this questionnaire gives an idea to which extent MFIs and their network organisations do experience the effects of the HIV/AIDS pandemic.

As it was indicated in the presentation, the prevalence rate per country estimated at the end of 2003 depicted that, Zimbabwe had the highest number of infected people, almost one out of four people was HIV infected. UNAIDS reports that the epidemic has grown over the last 15 years. Uganda used to have a high rate, 22%. Due to effective strategies (health and awareness program) Uganda succeeded to reduce the prevalence rate to the lowest, 4.1% out of the 8 countries under discussion.

A large majority of MFIs (77%) and networks that responded to the questionnaire have felt effects of the HIV/AIDS pandemic. One conclusion that we can draw from the responses is that in countries with prevalence rates higher than 8%, the problem of HIV/AIDS is widely acknowledged. Probably, this is due to the fact that the problem becomes too big to be coped with and effects become much more apparent.

The network responses on the observed effects in their country depicted that: 36% of the demand for type of products has changed. Many felt (73%) that drop-out rates increased due to the HIV/AIDS pandemic. 64% felt that meetings were affected as they were less frequent and attendance was lower. 27% indicated that the ability to attract new customers was lower. Staff is affected as well, turnover increases and moral changes. One network observed that the size of the loan became smaller. And lastly, many see other effects like: drop in repayment rate, stigmatisation of clients with HIV/AIDS and the break-up of groups.

Average drop-out rate among respondents is 38% at the end of December 2004. Not all drop-out because of HIV/AIDS. Reasons for drop-outs that were mentioned and are related to HIV/AIDS are: poor business, death of family members, illnesses, frequency of meeting (weekly), and group sizes.

Effect on product demand identified were: clients demand more often individual loans, longer repayment periods, grace periods, short-term loans, life insurance, funeral insurance, the capacity to save has gone down, and counselling services were requested.

HIV/AIDS prevention programs for staff at network and MFIs are considered to be a precondition to develop effective strategies on HIV/AIDS. Respectively, 37% and 36% of the MFIs and of the MFI network organisations have an HIV/AIDS policy for their staff.

### **2.3 Key issues resulting from plenary discussions**

During the presentation and in the plenary the relationships between HIV/AIDS and microfinance clearly came out.

- As most of the MFIs clients and staff members of MFIs and networks are either infected or affected by the HIV/AIDS pandemic it wouldn't be a matter of choice not to be concerned with the issues of HIV/AIDS. If an MFI is demand driven it will / should take these issues into account;
- As the effects of the HIV/AIDS on MFIs are less researched, networks need to focus on this issue;
- Bringing insurance companies, HIV/AIDS organizations and MFIs together would also be a natural role of the networks. Networks can also facilitate information exchange between insurance companies and MFIs, by doing this they can encourage insurance companies to work with MFIs. AMFIU in Uganda has invited insurance companies to become associate members and will also ask them to take a seat in the Board. This facilitates a common understanding as well as the establishment of linkages.
- MFIs are also expected to lessen the effects of HIV/AIDS on their clients through training and awareness raising; changing existing products and including new products to their programme in order to suit the demand of the infected and affected clients. These would minimize the burden both on the institution and the clients.

Challenges raised were:

- the capacity of the clients to pay for the insurance premium;
- the issue of financial sustainability, the costing of additional services provided, and supporting the clients in cost sharing of HIV/AIDS training;
- lack of expertise and knowledge in the network to support information exchange between insurance companies and MFIs were raised.

## **PART II : STRATEGIES TO DEAL WITH HIV/AIDS OTHER THAN INSURANCE**

### **3.0 Prevention strategies**

#### **3.1 The experiences of SEF/RADAR, Dr. Julia Kim**

As presented by Dr. Kim it is possible to draw important lessons from the successes of the collaboration between SEF and RADAR, in the IMAGE project (Intervention with Microfinance for AIDS and Gender Equity). SEF and RADAR use a parallel model (i.e. agreed collaboration with clients by staff of SEF for all activities related to microfinance and for staff of RADAR for all activities related to issues related to gender and HIV/AIDS).

*Driving forces for collaboration* from the point of view of SEF were the impact of HIV/AIDS on clients, staff and hence on the MFI, the desire to deal with this issue and the realisation that it should be a long-term strategy and not a one-off activity. Driving forces from RADAR were the realisation of the limitations of the common ABC prevention strategy (Abstinence, Be faithful, and Condom use), the importance to empower women to address the underlying vulnerability (poverty, gender based violence, and gender norms), and the opportunity to use microfinance as an entry point, and thereby addressing the issue of poverty.

Dr. Kim *recommended the following issues for training programmes:*

- Prepare training well with extensive consultations with management, staff and clients and by starting with a pilot. Focus of RADAR's training programme was on gender and HIV (gender norms, domestic violence, sexuality, HIV/AIDS) and skills (communication, conflict resolution, solidarity and leadership).
- Do not jump into the HIV-subject immediately, but instead begin with broad range of issues relevant to rural women such as gender roles (e.g. wedding songs), women's workloads, domestic violence, sexuality and the body, and communicating with husbands, children.
- Training should be participatory, no "lecturing", do not rely on literacy (e.g. role plays).
- Must not be longer than 1-hour.
- Cannot take place outside of fortnightly centre meetings (women won't come) and should happen *before* loan repayments (or women will leave), be seen as *part of the centre meeting* (not an optional "add on"), and should build on *existing structures* (loan groups centre leadership) and *values* (respect, leadership, accountability).
- "Health talks" during training meetings should be mentioned during initial client recruitment and orientation as being part of the programme, it should be seen as part of the organisation's mandate by the staff of the MFI, HIV trainers seen as SEF staff: T-shirts, recite pledge, etc. and same centre rules apply (e.g.) fines for being late.

Dr. Kim stressed that getting results was not easy. Initially several problems were faced and resistance was met from clients and sometimes also staff.

RADAR/SEF has observed impact at different levels, being:

- Clients' attitude: Initially resistance was met but client's attitudes toward the training changed over time.
- Individual and community response Such as more openness on HIV status of that of family members, negotiating condom use, voluntary counselling and testing, engaging young people and men, actions at community level.
- Performance MFI: Centres that participated in RADAR training showed faster recruitment, better staff performance and 20% increase in average loan, fewer dropouts, and less vulnerable centres (measured by attendance meetings, arrears and savings mobilized) compared to centres that did not participate in training programme.

The presenter explained that through interviews & focus group research social problems, migration, and business failure come out as the main reasons for dropout. Training was not mentioned as a reason for drop-out.

#### *Key Challenges & Lessons Learned*

- Challenge: MFI staff themselves may not be aware of gender/HIV issues, don't make assumptions. Need training workshops for management and staff at start & periodically
- Challenge: Clients may resist extra training time if program not introduced properly. Present it from start as mandatory part of package. Helpful to have old clients come to speak about training
- Challenge: MF staff may unwittingly send mixed messages about training. Avoid temptation to settle loan issues during training. Be present & supportive during training
- Challenge: High turnover of clients impacts on training (missed sessions, need to catch up) Wait to start training until centre has grown to stable size
- Challenge: Hard to train when centres too large, or lack of privacy (noise, interruptions) Need to keep size down (e.g. split centres) and choose appropriate venues
- Challenge: If centre struggling with repayment problems, clients cannot concentrate. Trainers need to be sensitive to this dynamic & accommodate it

- Challenge: Hard to deal with sensitive issues (culture, sexuality, domestic violence) beyond superficial discussions  
Trainers need to be carefully selected; ongoing support & mentorship critical
- Challenge: Inherent tension between “empowerment” and “strict credit discipline”?  
Argument for separate staff roles - keeping parallel model?
- Challenge: Community mobilisation unpredictable, takes time  
Flexible “weaning period” from trainers...hand-over to MF staff?

#### *IMAGE project Expansion Phase:*

*Key question is whether this intervention can be successfully scaled up to reach thousands of clients? Issues at stake are:*

- What delivery model capable of growing in proportion to rapidly expanding MF client base?
- What sustainable management & implementation systems needed within MFI to maximise efficiency yet maintain quality and impact?
- How to build MFI organisational capacity and ownership? Possible to institutionalize long-term commitment to addressing GBV and HIV without compromising core MF targets?
- MFIs feel gap in addressing HIV. Yet donor pressure for financial sustainability:
  - What is incremental cost of IMAGE relative to a “minimalist” microfinance package?
  - How does this change in response to economies of scale?
  - How does intervention impact on MF performance indicators (potential cost savings)?
- Given limited resources in developing countries, what are cost-effectiveness and cost-benefits of IMAGE model relative to competing HIV prevention initiatives and alternative poverty alleviation strategies targeting MDGs?

Currently RADAR/SEF are in a transition phase, changing from research intervention delivered *in parallel* to a sustainable *fully integrated model* in MFI (SEF)

### **3.2 Experiences of Akiba Commercial Bank, Mr. Meltus Rwsa**

After a short introduction on Akiba Commercial Bank's (ACB) history and financial products, Mr. Rwsa explained that ACB is also offering non-financial services such as organising trade fairs to link clients with business development service providers, legal services, environmental organisations etc.

ACB collaborates with Population Services International (PSI) to raise awareness among clients on key health issues, especially malaria and HIV/AIDS. The parallel model is being used. Main driving force for ACB to collaborate with PSI was to improve the client's livelihood as well as maintaining a sustainable business relationship with the bank after realising the vulnerability of its clients to diseases, especially malaria and HIV/AIDS

The awareness raising activities are targeted at individual clients as well as group clients. Separate seminars, outside the group meetings are organised. ACB informs clients on the seminars and encourages them to come. PSI takes care of the contents of the seminars. So far three seminars have been organised and the response from clients has been encouraging.

After the current pilot of one year, it will be decided whether or not to formalise the current informal collaboration. In that case a contract will be agreed, in which ACB will pay PSI to train a certain number of clients for each ACB branch in one year.

### **3.3 Key issues resulting from plenary discussions**

- From the experiences of RADAR's IMAGE program it is understood that integrating HIV/AIDS and gender into the microfinance programme would enhance the impact of the financial services. RADAR found that the common ABC strategy has its limitations. Women often are not in the position to negotiate for condom use. In addition be faithful seems not to be very realistic in a country like South-Africa where a lot of men work in the mines and do not stay with their families.
- As the capacity of the staff on the HIV/AIDS issues improves, it becomes possible to shift from the parallel model to integrated approach. Major advantage is that it increases the possibilities to scale up and hence to improve the impact of the efforts.
- Don't jump to the subject of HIV/AIDS immediately but first focus on broader issues influencing people's lives.
- Though it might be best to start training in some cases by focusing on women, it is crucial to involve men later on;
- Effect of religion and polygamy;

- Knowledge and attitude of staff is important, underlining the idea that staff policy on HIV/AIDS is a precondition for a successful HIV/AIDS strategy of any organisation;
- Importance to link, coordinate and communicate with other organization.

#### Challenges:

- How to make the programme sustainability- not only depending on donor funds;
- Cost of integration are mentioned as challenges;
- Cultural, social and religious barriers.

## 4.0 Strategies of product adjustments and introduction of new products

### 4.1 Experiences of FINCA Uganda (FU), Ms. Millie Kasozi

Ms. Kasozi explained that FU has been providing microfinance services for more than a decade using group-based lending methodology and it has been also using the Village Banking methodology which is developed by its partner FINCA International Inc. She also explained that 99% of its clients are women engaged in road side food crop vendors, second hand clothes dealers, simple groceries and kiosks, charcoal dealers, simple poultry producers, make shift restaurants etc.

She further explained that as HIV/AIDS is affecting the economically productive age group, 15-45, who are the target market of MFIs, the impact of HIV/AIDS on FU clients is high. On top of affecting the sick person, the entire family is affected including the community and these results in wide spread dropout rates of up to 50% per year, deterioration of loan quality, diversion of funds to caring for the sick ones and loss of confidence and social empowerment.

#### *Adjustments in existing products*

Ms. Kasozi explained the changes made in the in the existing products and the efforts made to introduce new products in order to minimize the effects of HIV/AIDS both on the clients and the institution. Key characteristic is *more flexibility* in products to give clients more time and possibilities to deal with (HIV/AIDS related) problems.

The changes are made in different ways, like:

- reduction of members size in a group to make it easier for clients to form groups,
- opening additional outlets reducing travel time,
- transferred the disbursement of money from the clients meeting venues to FU's offices,
- increment in the base loan,
- increased the ceiling loan,
- introduced a grace period,
- increased repayment period,
- frequency of payments was improved to optional weekly or bi-weekly repayments,
- clients can send their instalments through a proxy,
- access to savings,
- special loans or top up loans are offered, and
- clients are allowed to rest after a loan cycle.

It is important to adjust products on the basis of careful assessments of the clients needs.

#### *Introduction of new products*

Where existing products do not meet needs of clients, the introduction of new products becomes relevant. Finca Uganda introduced individual loans, salary-based loan, village phones (clients access health information on their phones and community mobilization for workshops becomes easier), clients are compulsory insured at the costs of 1% of the loan. Furthermore FU introduced a health insurance product which is being managed through a partnership with Microcare Uganda, which is allied with various hospitals and health service providers in the country. The health insurance loan product is given out to clients who need to pay for the premium to enrol into the health insurance scheme. The scheme enables the clients, their spouses and dependants to access a medical coverage that includes AIDS treatment, but not medication.

Furthermore Ms Kasozi explained that, the Village banking product has been made much more flexible than it used to be in order to allow clients who are burdened by medical demands related to AIDS to have time to solve those problems while at the same time continue being beneficiaries of the village banking product. Being demand driven was considered to be an important driving force to look at the effects of HIV/AIDS for its clients.

#### *Challenges Ahead*

- Despite all the measures carried out to mitigate the impact of AIDS to the micro-finance service provision, there still remain a number of challenges as life insurance does not solve the problem.

- Minimising the impact of the scourge has cost implications, for example the insurance premium paid. These costs tend to increase the cost of borrowing to the clients, which may make the micro-finance services less attractive to the poor.
- It is a challenge to sensitise the general community about AIDS so that discrimination among the population is eliminated. There is continuing stigmatisation of AIDS victims which makes them lose confidence and social empowerment.
- It is also still difficult to identify an insurance scheme which insures against AIDS including medication.
- Most clients that we deal with have limited levels of education. This makes credit administration and training on AIDS related issues difficult.
- Involving a number of agencies in the mitigation of the AIDS impact tends to make the patients believe that they are being used as trade/business objects, since very often these partnerships involve donor funding. Also the involvement of donor funding in most of the partnerships makes sustainability of the arrangement a challenge.
- It is still difficult to make clients appreciate the concept of health insurance. Clients may not realise the benefits of health insurance until they fall sick.
- The introduction of new products still has its challenges as each product has challenge.

## 4.2 Offering services to people living with HIV/AIDS

### 4.2.1 Experiences of Zambuko Trust, Ms. Bridget Kazembe

Ms. Kazembe briefed the participants about values and mission of her organization and mentioned that 74% of the clients are women. She also discussed the HIV/AIDS situation in Zimbabwe, which has with 24.6% the highest prevalence rate (UNAIDS, 2003). Most of the affected and infected people live in the rural areas, which constitute 70% of the total population in Zimbabwe

#### ZAMBUKO'S INTERVENTION

As explained by the presenter, ZAMBUKO Trust developed an HIV/AIDS intervention policy which includes the following:

- Introduction of innovative and targeted products e.g. Adolescents Apprenticeship and the partnership with AIDS support organisation (ASO) Hope Humana.
- Increased HIV/AIDS awareness at Trust Banks. Trust banks have partnered with various organizations involved in advocacy, prevention, care and support e.g. LRF, PSI, and invited infected guest speakers to share their testimonies, held discussions on HIV/AIDS during weekly meetings. In addition HIV/AIDS was the theme of the Trust Bank Congress of 2004.
- Expansion of branch network
- Changed the business conditions

This presentation will deal with the products that Zambuko has developed targeting vulnerable groups such as people living with HIV/AIDS (in the case of the HOPE HUMANA project) and adolescents in communities with a high HIV/AIDS prevalence rate (in the case of the SHAZ project).

#### *HOPE HUMANA project*

Zambuko entered into a partnership with Hope Humana in 2002. Hope Humana provides psycho- social support to people living with HIV/AIDS and training for Home Based Care programs in rural communities. This program was undertaken as a conscious decision to financially empower the affected and infected people living in the rural areas.

- Hope Humana identifies the economically active clients within their support groups and refers them to Zambuko for funding.
- Zambuko trains the prospective clients, assesses projects and then funds clients in groups of 10 - 15 people.
- Any person running a project can approach the offices of Zambuko and get help regardless of his/her HIV status. Zambuko has put in place a clear AIDS policy, which supports this.

#### *SHAZ project*

Zambuko partnered with three other Zimbabwean organisations through its program called SHAZ (Shaping the health of adolescents in Zimbabwe), which is a youth program targeting teenage orphaned girls in two urban centres where HIV/AIDS prevalence rates are as high as 15 % of the 14-19 age groups. The objectives of this program were to empower young girls economically so that they do not get dependent on men for financial assistance; equipping teenage girls with life skills, business skills and business finance; providing reproductive health education and providing mentorship.

The SHAZ Program was not successful because the clients had no experience in business, lacked a business

attitude, family and community was not involved and a too long grace period was granted.

#### *Achievements*

Zambuko's experience to date as explained by the presenter is that intervention has promoted acceptance of positive people by the communities served and beyond hence reducing discrimination, no evidence of high default related to HIV/AIDS lending, and there is increasing level of acceptance of positive clients among Trust Banks. The presenter discussed some impact on client, which are, rural clients are gainfully running income-generating projects, they have become testimonies of positive living in their communities, Trust Bank women are able to talk about HIV/AIDS openly and clients support and help each other during times of sickness and or death.

#### *Lessons learned*

Finally, the presenter has shared the lessons learnt in the process to participants as follows:

- Importance of the Family Business Unit
- Customers are encouraged to have a succession plan in the business.
- Living positive for the infected becomes easier when one is financially empowered.
- Group lending creates lifelong relationships
- The infected people live longer because they have a source of income and support from their fellow community members
- Experience in business and business attitude is precondition for success. Hence selection must target those keen to run business.
- Involvement of family members and the community is crucial.
- Trust Bank Leaders have to be trained in HIV/AIDS to enable them to address HIV/AIDS effectively.

#### **4.2.2 Experiences of KDA's FAHIDA project, Ms. Marcelina Obuya**

The FAHIDA project was initiated in 2000. The project rationale was that a family's ability to cope with the impact of HIV/AIDS depends on the state of household's economic resources before, during and after the disease affects them. FAHIDA project cooperates with people living with AIDS, people affected by HIV/AIDS, high risk groups, volunteers working with AIDS programmes. KDA lends directly to these people. They are organised via partner organisations, such as: pathfinders, Family Health International, Population Service International (PSI), Family Planning Association of Kenya, Red Cross, NCKK, peer educators, home based care and SWAK, Corporate Insurance Company.

At March 2005, 2106 clients were reached, 1796 loans disbursed amounting to Kshs. 23 million. 1640 active savers with an outstanding balance of Kshs. 3,530,000.

#### *Challenges*

- The group mechanism has been ineffective as a tool for default management due to debilitating and yet repetitive nature of crisis. In addition group cohesion tends to suffer from frequent absence of members who are bedridden.
- The savings base of the project has remained very weak.

#### *Lessons learned*

- HIV/AIDS exerts difficult financial crisis or burdens ranging from deteriorating health conditions, eventual death after which the family is forced to cope with devastating stigma.
- The family or next of kind play a central role in the event of emergencies. They are relied upon to step in to fulfill the fortnightly loan installments as well as offering psychosocial support.
- Occasionally, informal fund raising is held by relatives to solicit funds needed to offset the hospital bills, school fees etc.
- Merry-go-round is applied as an effective tool for coping with HIV/AIDS precipitated economic crises.
- Strict application of best practices requires deferments of subsequent disbursement in case of arrears within a watano
- The FAHIDA project has demonstrated that the HIV/AIDS infected and affected have the capacity to borrow, save, manage business activities and finances and repay loan

#### **5.0 Outcomes Hivos questionnaire strategies developed, Ms. Carolijn Gommans**

After hearing the experiences of different organisations with the implementation of strategies to deal with HIV/AIDS this presentation gives an overview of the frequency of different strategies that MFIs have developed to deal with the issue of HIV/AIDS. Type of strategies distinguished are prevention strategies (section 3), product adjustments, new products and products targeting people living with HIV/AIDS (section 4), as well as offering of insurance products that will be addressed in the next part (sections 8 to 11, part III) of this report. In addition strategies that the networks of MFIs have developed to deal with the issue of HIV/AIDS will be mentioned as well.

Not one appropriate strategy exists. Relevance of each strategy depends on the situation in a country and/or area of operation, at the concerned organisation, and on the needs of the clients.

Ms. Gommans explained that MFIs and MICs are affected by the HIV/AIDS pandemic. Effects cannot be ignored. At the same time, MFIs and MICs do not have to watch passively at these effects to happen. Measures can be taken and strategies can be developed to prevent further spread of the disease as well as reducing other effects. Before developing strategies to deal with HIV/AIDS, it is important to understand the relationship between HIV/AIDS and microfinance. At the same time it has to be realized that MFIs cannot be considered to offer *the* solution for the HIV/AIDS pandemic.

Economic empowerment, coping strategies, easy access to savings, loans, and microinsurance, awareness raising, group coherence and continuity of financial services are mentioned as key issues in microfinance in relation to HIV/AIDS.

In the first place the level of economic empowerment influences people's vulnerability, including vulnerability to HIV/AIDS. To reduce vulnerability and exposure to risks people try to stabilize their household income, build-up their asset base and diversify their sources of income. Loans can help to build up asset base and to diversify income. As microfinance contributes to economic empowerment this contributes to reduce people's vulnerability. At the same time when a crisis is being faced, coping strategies become important. Loans might not be the most appropriate instrument at that moment. Easily accessible savings and insurance policies will be more appropriate to deal with crises, i.e. to pay for medical bills and funeral expenses.

Given their outreach to a large number of clients, MFIs can ensure that their clients get access to information on HIV/AIDS and on other issues that contribute to the spread of HIV/AIDS.

Continuity of financial services enables people living with AIDS (PLWA) and their families to live healthier and longer. Though some risks are involved, institutions like Zambuko and KDA piloting with this have shown positive results.

As discussed above MFIs are expected to scan their environments carefully, in order to develop strategies which would help them deal with HIV/AIDS. Four different categories of strategies for MFIs (client level) are being distinguished, these are, prevention strategies, product adjustments, new products (other than insurance), and insurance.

#### *Prevention strategies:*

Prevention strategies applied by the MFIs that participated in the questionnaire indicated that the following activities are being implemented:

- Providing reading materials
- Organizing education in group meetings by specialists and AIDS Support Organizations
- Lectures
- Testimonies from confessed positive clients
- Training some clients to be peer educators on HIV/AIDS
- Supply of condoms

The output of the questionnaire indicated that 47% have HIV/AIDS prevention programmes for their clients. So this is almost half of the MFIs. It is done most often in collaboration with an HIV/AIDS organisation. 37% of the respondents considers introduction and 16% has no activities and does not consider introducing it either. 73% of the networks indicated the prevalence of HIV/AIDS prevention programmes in their countries.

#### *Adjustment in the existing products and introducing new products:*

Around one third of the MFIs indicated to have made some adjustments in their products to deal with the HIV/AIDS pandemic. Most common are reduction of meeting frequency, no compulsory upgrading and lower requirements for meeting attendance.

New products that are offered are emergency loans, insurance, savings and products for people living with HIV/AIDS.

#### *Insurance products*

Credit insurance is the most popular insurance among MFIs. Almost 60% of the MFIs that were interviewed are offering it. It is clear that it mainly serves their own interest as it eliminates risk of non-repayment in case of death of a client.

Credit insurance is often offered in combination with life insurance and in most cases the partner agent model is being used. One organization, only offering credit insurance is doing it via a managed account, and one organisation works like a mutual.

#### *Strategies for network of MFIs*

The role MFI networks can play and the activities that they have initiated to deal with HIV/AIDS pandemic was also elaborated by the presenter based on the result of the questionnaire. These were: research, awareness raising on effects of HIV/AIDS, training on potential strategies for MFIs to deal with HIV/AIDS, linkages with organisations working on HIV/AIDS, promoting microinsurance, linkages with insurance companies, training in microinsurance, and training on HIV/AIDS programs for staff of MFIs. Most common activities implemented by MFIs were awareness raising on effects of HIV/AIDS on microfinance sector and the promotion of microinsurance. (Both activities were implemented by 45% of the networks respondents.)

### **5.1 Key issues resulting from plenary discussions**

- HIV/AIDS is not only a medical problem, its causes and consequences are much broader. Therefore it calls for strategies from all actors within society;
- Analysing the environment before embarking on HIV/AIDS programmes;
- Good product development needs good market research;
- As possible strategies: prevention programs, making adjustments on the existing products, introducing new products, including insurance have come out.
- Networking with organizations experienced in HIV/AIDS and/or insurance companies is crucial.
- Making products affordable to as many clients as possible.
- Targeting men as well for increasing the impact of training programs on HIV/AIDS.

### **5.2 Group work on potential strategies (Moderator Ms. Carolijn Gommans)**

Participants were divided into 5 groups to reflect on the basis of their own experiences on the strategies to deal with HIV/AIDS presented so far and to report on good practices, opportunities and threats.

#### **Good practices**

- a) Modifying or adjusting products to suite market/client needs who are affected or infected by HIV/AIDS
- b) Linking with health education providers/ parallel approach
- c) Introducing new products based on needs assessment
- d) Training staff, clients and communities on HIV/AIDS issues
- e) Creating alliance/coalition (with insurance companies or other organizations supporting HIV/AIDS initiatives)
- f) Developing special linked products and services targeting both the affected and infected e.g. (loan products /insurance/counselling/ behavioural change/ availability of drugs)
- g) Confronting and addressing the problem
- h) Having succession plan for clients infected with HIV/AIDS e.g. Zambuko Trust

#### **Opportunities:**

- a) Creativity and innovativeness (new products);
- b) Business opportunities- huge market for Microinsurance and Microfinance e.g. funerals, parlours, herbalists, prophets, MFIs insurance;
- c) Employment opportunities;
- d) Contribute towards greater social equity / cohesion - exercising corporate social responsibilities and contribute to a healthy society;
- e) Favourable government policies;
- f) Possibilities of synergies;
- g) Possibilities of networking with cooperatives in the rural areas;
- h) Fund raising for the different products - Donors are willing to support HIV/AIDS initiatives; and
- i) The use of groups for education on HIV/AIDS.

#### **Threats:**

- a) Decline in portfolio quality
- b) Increase in drop-out rate
- c) Loss of jobs / high staff turnover
- d) Isolation of the infected

- e) Societal imbalance - leading to economical instability
- f) Sustainability is compromised
- g) Loss of business for insurance companies which MFIs could have managed
- h) Loss of group coherence
- i) Lack of data (difficulty in pricing)
- j) Increase cost on MFIs and clients
- k) Risk of taking unscrupulous insurance
- l) Lack of experiences by MFIs
- m) Donor pressure to venture into new products
- n) Illiteracy of clients (knowledge on family planning)
- o) Lack of cooperation by the husband
- p) Mission drift (focusing on social responsibilities rather than the economic)
- q) Challenges of strategic partners e.g. SHAZ experiences
- r) Sustainability is in question when donors pullout

## 6.0 Main findings of day 1, Ms. Carolijn Gommans

Ms. Gommans raised the issue of why we discuss AIDS while more people die of Malaria and most medical cost are related to Malaria. And she further explained that Malaria comes in isolation, while a family, once hit by HIV/AIDS, is most likely to face a series of crises making it more difficult for them to cope. Furthermore HIV/AIDS is an epidemic and prevalence rates are rapidly increasing. It is running out of hand and consequences might no longer be controllable if not addressed now. Malaria has always been there and is more constant. At the same time, it makes sense to look to which extent you can deal with both problems at the same time. A prevention program can also deal with malaria, like in the case of ACB. And a health insurance product neglecting malaria will not be of any use.

She also mentioned that MFIs shouldn't go into HIV/AIDS intervention for getting donor support. It is up to MFIs themselves to implement it, and to make it successful. As each situation is different it is important to design interventions on the basis of good market research and to measure results in a management information system. And as some participants observed, MFIs that are demand driven often have developed a HIV/AIDS policy as the client is the core asset of an MFI. Take into account the costs when you do something and the costs when you don't do anything.

When coming up with a strategy on HIV/AIDS the following issues need to be addressed:

- What do you do with clients that are living with HIV/AIDS?
- In what way can you reduce infection among clients?
- How do you deal with stigmatisation in group?
- How do you reduce illnesses of people living with AIDS?

Linkages are important. One can not and should not have to do everything oneself. Linkages with insurance companies, AIDS support organisations, gender organisations given high infection among women and gender disparities contributing to the spread of HIV/AIDS are interesting. Ask with whom, under which conditions and how one wish to cooperate. It is important to know what both sides gain from the collaboration. The sustainability of the collaboration should be taken into account as well.

Another issue that came out is the important role network organisations can play by doing research on effects of HIV/AIDS, lobby at government for good HIV/AIDS policy, raise awareness amongst MFIs of the effects of HIV/AIDS on clients and hence the MFI, facilitate linkages with AIDS Support Organisations, facilitate linkages with insurance companies (for example AMFIU where insurers can become associate members), and train membership on product development of insurance products.

# PART III MICROINSURANCE AS STRATEGY TO REDUCE EFFECTS OF HIV/AIDS

## 7.0 Key issues in insurance, Microinsurance centre, Mr. Michael McCord

Mr. McCord commenced his presentation by defining Microinsurance. What is Microinsurance? “Risk-pooling products that are designed to be appropriate for the low-income market in relation to cost, terms, coverage, and delivery mechanisms.”

Financial Security depends on three pillars. A balance is attained when credit, savings and insurance are accessed. In this way people can move out of poverty and appropriate strategies to prevent falling back in poverty are reduced.



“Microfinance can help people improve their income, whereas, Microinsurance helps them protect the gains”

### Characteristics of an Insurable Event

- ✓ RANDOMNESS: The event must be unpredictable
- ✓ LOW CHANCE of occurring during the period of insurance
- ✓ INDEPENDENT STATISTICALLY from one individual to another
- ✓ UNCONTROLLABLE by the insured or a related party
- ✓ Direct ADVERSE FINANCIAL CONSEQUENCE leading to a CALCULABLE financial loss (cover must reflect that loss)
- ✓ UNEQUIVOCAL as to whether the event has occurred or not
- ✓ Beneficiary must have an INSURABLE INTEREST in the loss. The loss must impact the beneficiary, or there is no need for benefit.

Risk	Definition	Mitigation
Adverse Selection	Tendency of persons with a higher-than average chance of loss to seek insurance at standard (average) rates	Screening, underwriting (determination of risks and costs), exclusions, waiting periods, limitations
Fraud:	Intentional perversion of truth in order to induce another to part with something of value.	Claims Validation, operational audit, Client visits, client complaints
Moral Hazard	Hazard arising from a policyholder creating additional risk because they are insured.	Excess / deductibles, co-payments, exclusions
Covariant Risk	A risk or combination of risks, which affects a large number of the insured items/people at the same time.	Exclusions and Limiting Cover

Important insurance risks are:

As lack of awareness about the insurance is a common problem in the low income community; don't ask people saying “Do you want insurance?” but ask the following: What risks do you face? How do you address them now? What could be more effective?

Research indicates that poor people prioritize their risks as follows: health problems, death of breadwinner, death of family members, accidents and natural disasters such as theft, fire, etc. and then loan repayment and education.

Four main categories of insurance products can be distinguished, being:

- Life insurance, including credit insurance, funeral insurance.
- Disability insurance, including permanent, temporary, total, partial, credit disability
- Health insurance, which can include out-patient care, hospitalisation, surgical, dental, and optical care.
- Property, such as fire, theft, floods, earthquake.

Basic premium components are risk premium, operational costs, profit margin/surplus and investment income. The risk premium is determined by two factors: the probability of occurrence and the benefit amount. The probability of occurrence, especially the certainty with which this can be determined depends on the number of

clients insured. For this reason, having a large scale is very important.

#### Demand Factors:

Perception of insurance, understanding insurance concepts, product demand match, easy payment mechanisms (for clients selecting seasons when they can pay, pay in kind), cost of coverage, frequency of the event and income of the family play a role in the decision-making process whether or not to buy insurance services.

The insurance that is being offered by an MFI can be voluntary or compulsory, or something in between. There are advantages and issues for clients and insurers for voluntary and compulsory provision. Advantages of compulsory are: easy to handle, clearer products, higher risk pool excluding possibility of adverse selection, less marketing costs, and hence lower premiums, some clients do find it also easier as it gives peace of mind and encourages group cohesion. Major disadvantage of compulsory insurance is that it masks demand and does not encourage customer care. Hence good product design in case of compulsory products is essential (otherwise it can lead to dropouts of MFIs). Other issues are whether regulations allow compulsory insurance products.

An issue that clearly came out during discussions was the lack of trust of insurance companies. In general there is lack of understanding of products by users. Keeping products simple (no or very few exemptions) and providing clear and accessible information is therefore crucial. In addition to this regulation is important.

### 7.1 Different models and regulations, Mr. Michael McCord

*Most common models that are used to offer insurance products to clients are:*

- *Community-Based Model* (CIDR, ILO, STEP) In this model members own and manage the insurance scheme. MFIs could set up such scheme which would be managed by clients.
- *Provider Model* (GRET Cambodia, Grameen) In this model the organisation that provides the service, being a health care provider or a funeral company provides the insurance.
- *Partnership Model* (AIG & Microcare with Uganda MFIs) In this model the MFI works with an insurance company. The insurance company provides the insurance. For the MFI this means no risk and a minimal administrative burden.

Other models that are being used are full service insurer, mutual, and cooperative models

When deciding on which model to use it is important to ask yourself where you place the risk. This should be done at the place where it is managed best.

According to Michael McCord this should be with an institution that has:

- Large potential market (realistically assessed)
- Significant insurance expertise (underwriting, claims, pricing)
- Capital and reserves
- Access to reinsurance
- Regulatory compliance
- Strong management

#### Regulatory issues:

- What are regulations for agents? Do they have to be registered and which regulations apply?
- Are banks / MFIs allowed to sell insurance? Just from one insurance company? Also as a compulsory product?
- Legality of banks to require the use of one particular insurer?
- Are MFIs allowed to add to the premium as they sell it to their clients?
- Licensing: life versus general insurance.
- Legality of mutual societies and community-based initiatives.

### 7.2 Lessons learned in microinsurance, Mr. Michael McCord

There exists a working group on microinsurance and they have looked into 22 case studies and they will put the lessons learned into a synthesis book and produce a leaflet on it. This will be published on the internet site: [www.microinsurancecentre.org](http://www.microinsurancecentre.org).

#### Product Design

- Always assess the impact on the company of any new product
- Be very careful expanding to family members
- Keep it simple, group based, compulsory (?)
- Outsourcing improves design flexibility
- Can reduce lapses with less frequent payments

- Relate the premium to the benefit (benefits related to the loan should be priced based on the loan, those not should be priced differently)
- Insurer should set final premium
- Consider offering service instead of payment

#### Product Delivery

- Staff training and appreciation is necessary for significant sales growth.
- Creating one's own delivery channel may result in higher operations costs.
- Compulsory products can leave customers with very little understanding. Compulsory products DO NOT reflect demand.
- Product delivery became a minimum expected benefit to MFI clients
- Major problems can be the result of the agent (claims delays)
- Do not underestimate demand. Make sure you are ready for rapid growth.

#### Lessons learned in other fields:

- COMPUTERIZATION! For data mining and efficiency
- Separate insurance and other business and focus on core competencies.
- Must treat microinsurance with the same business approach as regular insurance.
- Limits to management capacity can be expanded with reinsurance or outsourcing.
- Follow your calculator, not your heart.

## 8.0 Life insurance, experiences of Opportunity International, Mr. Richard Leftley

Opportunity International (OI) officially started offering insurance in January 2002 in Zambia. The main motivation being client demand. The approach was to employ experts and work as registered insurance agents. The network of OI offers mainly life insurance. Currently, it is covering in excess of 1,700,000 lives. Some property, livestock and crop insurance are developed.

#### *Reasons to offer life insurance*

OI offers life insurance because credit life is essential to any lender, it has a positive effect upon portfolio at risk (PAR), generates income for the MFI via commissions, increasingly competitive market-place and ultimately has to be driven by client demand.

#### *Reasons to choose for partner-agent model*

OI works via the partner-agent model, hence they partner with an insurer, as it is the quickest way to get a product launched, reduces regulatory issues, you do not need the capital that is required to set up a mutual, lowest risk (financial & reputation), African insurers show flexibility in product design, price and service standard and technically should be cheaper for user.

The *product development process* is crucial. At OI it composes of the following components:

- a. Market research product parameters.
- b. Site visit focus groups, supply, and regulation.
- c. Prototype for management consideration.
- d. Pricing both external and internal.
- e. Operations management information system (MIS), manuals, marketing, training
- f. Pilot test to test it works as planned.
- g. Launch within 6 months.

Both organisations, i.e. the MFI and the insurer play a role in the product development process. The role of the insurer is especially important in activities b. (supply), d. (external pricing) and e. (MIS, manuals, marketing).

*Important issues discussed with potential partner insurance companies are:* willingness of partner to provide product that addresses clients need, price which is often found less important than 'service', speed of claims payment, simplicity of client application, exclusions & claims process, and reporting and premium requirements of MFI (and its MIS).

*Preferred characteristics to be fulfilled are:* flexible approach towards product & client, well capitalised with sound reinsurance, "Trustworthy" in the eyes of the client, and willingness to take a risk. In general OI has not found it hard to find insurers willing to partner, but not all have been suitable.

#### *Lessons learnt (the hard way!)are:*

- Use the experts it's cheaper!

- Keep it as simple as possible.
- Spend money on marketing.
- Client education is a sound investment.
- Invest in a suitable MIS system.
- Train the staff, and then do it again.
- Never lose sight of the P&L

#### *The challenges ahead*

- Distribution outside the MFI will be key.
- Development of a profitable stand-alone microinsurance agency in Africa.
- Development of index linked crop cover.
- A scalable, sustainable health solution.
- The 10m barrier the race is on!

### **8.1 Perspective of insurance company AIG Uganda, Mr. Patrick Rujumba**

Mr. Rujumba explained that AIG Uganda is a member Company of American International Group, AIG New York, with over \$ 80 billion in share holder's equity. AIG has one of the largest and strongest capital bases of any company in the industry.

AIG is active in the field of microinsurance, more specifically loan and life insurance since 1997 after realizing the need of MFIs to deal with the risk of default on loans and the possibility to reach low-income market via MFIs. Activities of AIG Uganda in the field of microinsurance started via FINCA Uganda. Their village banking approach assisted AIG to reach out to the grassroots in a profitable way for both partners. Nowadays AIG serves 339,000 clients across more than 22 MFIs. As the coverage includes four dependents, over 2 million lives are covered by AIG Uganda via MFIs.

The *insurance product* offered by AIG:

AIG pays the outstanding balance of the loan in case of death of the client, i.e. credit insurance.

Optionally, AIG offers a life insurance product, meaning that clients get a burial benefit. The benefit paid out in the event of death due to natural causes, i.e. sickness, AIG pays a "burial benefit" with lower value compared to "accidental death benefit". Majority of MFIs do not get the burial benefit because they are trying to keep costs low.

AIG Uganda is facing the following *challenges*:

- Incidents of forgeries by clients.
- The product is seen by some people as yet another cost to the clients.
- Illiteracy among clients of the MFIs.
- Some isolated cases of struggling for the death benefits have come up, hence destabilizing the family set up.
- Interpretation of some terms, e.g. accident, catastrophe, disability, has been mixed up.
- The death of clients out of natural causes or sickness is increasing and threatening the product profitability.

AIG see the following possibilities to deal with these challenges:

- a) Sensitization of vulnerable people on ways of preventing the spread of HIV/AIDS by AIG in partnership with MFIs. Economic empowerment and education
- b) MFIs and insurance companies can sponsor authorities in the fight against the spread of HIV/AIDS to reach the various groups and individuals.
- c) Sensitisation of MFI clients on the values of knowing their HIV-status.
- d) Though clients do not undergo any medical examination, AIG has asked MFIs to give out loans carefully, i.e. to fairly healthy looking clients.

### **8.2 Micro Insurance Association Netherlands (MIAN), Mr. Toon Bullens**

Mr. Bullens commenced his presentation by elaborating on the perception in the market on insurance companies: 'Insurance companies are huge and clumsy organisations who are just not there whenever you need them', 'If they help you they do it very slowly', 'you have to be very careful for the details', 'you are just a number' etc. All in all: one never knows what to expect.

Mr. Bullens stated that this is the old-fashioned way of doing business. The new paradigm is to build coalitions around themes which are important to people! Coping with risk is one of these important themes. According to the new paradigm, the role of insurers in society would be: 'Bearing the risks of the individual together .... organizing solidarity'. As a result this would entail:

- Risk reduction to reduce collective claims burden by means of prevention and by means of self regulation. In other words: risk management and insurance go hand in hand.
- Trying to cope with the great issues of today; such as safety, social insurance, liability, healthcare, terrorism, HIV/AIDS, etc.
- Stakeholder collaboration, i.e. creating platforms for discussions with all parties involved trying to address new challenges of all parties in society. Integration with local cultures.
- New forms of cooperation between public and private sector. Institutions and governments as the 'reinsurers of last resort'
- Change the image of insurance companies, move limits of insurability and crystal clear risk calculation models.
- Moving to be an economic *and* social centre

Worldwide there are over 4 billion people without any formal insurance. Those are the ones that are the most vulnerable to risk. Hence, this is a key theme that is important to a lot of people.

Mr. Bullens works for Interpolis. This insurance company helps to set up mutual insurance companies and cooperative insurance structures. In addition reinsurance is offered. This is done in cooperation with MIAN (Microinsurance Association Netherlands who works with volunteers recruited from staff of cooperative insurance companies in The Netherlands. MIAN's objectives are:

- To make co-operative insurance structures in developing countries work;
- To limit the consequences of individual and local risk factors; and
- To help the insured to reduce their collective claims level.

To work along the new paradigm and to increase access to formal insurance: cooperation, coalition, communication, commitment and competences are key.

For more information on MIAN and possibilities for collaboration, you can contact [ACJ.Bullens@Interpolis.nl](mailto:ACJ.Bullens@Interpolis.nl).

### 8.3 Key issues resulting from plenary session

- Use simple language to communicate with the community.
- Products need to be demand-driven and simple.
- There is a very huge gap in the insurance industry; 4 billion people are without any formal insurance and 1 billion are with rudimentary insurance.
- Who should take the lead? The MFIs or the insurance company?
- The issue was raised whether MFIs should not lend to people living with HIV/AIDS given request of insurance companies like AIG. It is a dilemma. The risks involved are higher, but on the other hand clients can live long with HIV/AIDS before falling sick and not giving them a loan would limit their coping strategies, and be discriminatory. Furthermore these clients can be beneficial and interesting for the MFI for several more years.

## 9.0 Main findings of day 2, Mr. Célestin Gatera

Mr. Gatera has summarized the discussions of the day 2 as follows:

- Which insurance for which demand? Loan, savings and insurance.
- There is huge demand for Microinsurance
- Product development inline with clients needs (demand driven instead of supply driven)
- How to market product and how to sell it
- Components of financial security = Credit + Savings + Insurance
- Products need to be flexible not standardized

Trust:

- Understanding one another (same language)
- Willingness to collaborate (for common goal)
- Communication (to talk to one another and to be transparent)
- Commitment
- Competence

Regulation:

- It is important for client protection
- It should enable offering insurance services for the under privileged
- Is the MFI licensed to act as an agent?

- Is the MFI licensed to force clients to buy insurance products from just one insurance company?.

## 10.0 Health insurance

### 10.1 Experiences of Microcare Uganda, Dr. Gerry Noble

#### *Reasons for MFIs to offer microinsurance*

Dr. Noble started with explaining the relevancy of different financial services for different situations. Savings and credit can help people move out of poverty. Savings also help people to deal with high frequency low costs events.

Microinsurance can help people protect the gains they have made and is especially important in the case of low frequency, high costs events.

So far, insurance like traditional finance has only been accessible for the wealthier parts of the population. Microinsurance, like microfinance targets the vulnerable non poor, moderate poor and poor people. The destitute do not benefit from microfinance and microinsurance.

MFIs should assist clients to access healthcare, the reasons are: sickness and poverty are inextricably linked, prevent redirection of loan capital for domestic (health) consumption, sickness of the client reduces performance, most MFI clients are women who are the primary care givers in the family, holistic approach to client welfare and improve client loyalty / retention.

The benefits for MFIs to partner with insurance companies are: avoiding risks and receiving administrative support fees (if legal), receiving interest on loans given to cover premium, providing their clients with an added value product, longer term contracts improve client retention, benefit as a recipient of payouts, e.g. loan guarantee, and improved well-being and performance of clients.

Dr. Noble stressed that he thinks that MFIs should NOT act as insurers, reasons being:

- Diverts focus from core banking business
- Should not risk MFI reserves carrying unlimited insurance risk
- Insurance financial management, accounting and auditing is different from banking and needs specialised staff
- MFIs cannot access commercial re-insurance; they are not registered insurance companies; limited options for sharing risk.
- Bank regulations may not permit MFIs to be insurers.
- Potential conflicts of interest
- Ethical / confidentiality issues (especially with health insurance e.g. Knowledge of clients HIV status)

#### *Microcare and the way it works*

Microcare aims to provide and facilitate affordable access to quality healthcare in both formal and informal sector. Microcare started in 2000 as a donor supported-not-for profit initiative (Microcare Ltd.) to research and develop alternative mechanisms of health financing for the low income market. Nowadays, Microcare composes of Microcare Health Limited providing health management services on a commercial basis with investor capitalization, Microcare Insurance Limited providing insurance products, particularly accident and health, and the original not for profit Microcare Ltd in the role of a research organisation rather than implementing organisation.

Today 27,000 clients are reached of which 17,000 in the informal sector and 10,000 in the formal sector.

Microcare insurance only works with groups in both formal and informal sector and microfinance institutions and non-governmental organisations. It designs and manages insurance schemes and self funded third party administration. Furthermore it has contracts with service providers (governance, private and mission hospitals / clinics), allowing for price negotiations given knowledge on prices in sector, quantity of services bought and guaranteed payment. Hence it allows clients to choose between different health service providers allowing for competition.

Clients get a photo identity card, registering themselves and potential family members. This allows for on site client identity verification. At each hospital / clinic with which Microcare works they have employed a staff member who receives clients (out of Microcare's staff of 60, 30 are nurses). Furthermore all data is entered into a database by the on-site nurses and printouts are being made for client, hospital and Microcare. This ensures a good control system, which is considered to be crucial to minimize risk of fraud at client and health service provider level. At the same time all data allows for timely payment of bills (even before invoice is sent) and quality audit of clinical

services received.

Another issue that is stressed is the need for big quantities. 50,000 clients are considered to be required. To build up expertise (for which a good computer database is indispensable), to be an interesting partner for different health service providers, to spread risks and to be able to finance a control system.

In 2003, Microcare started a pilot collaboration with MFIs. Premium paid in urban areas is 60 USD per year for a family up to 4 members. Coverage includes in and outpatient services, x-ray, ultrasound, electrocardiogram, laboratory, surgery, maternity cover, drugs according to protocol (chronic medications were not covered), HIV counselling and homecare, basic dental care and optical consultation. To avoid adverse selection greater than half of a group were meant to join.

Lessons learned by Microcare in offering insurance services to informal sector (via MFIs) are:

- Clients have great difficulty collecting up enough money to pay an adequate premium for an adequate coverage period.
- MFI loan schemes for premiums are very effective.
- 'Risk pooling' and 'insurance principles' are difficult for MFI clients to understand.
- This results in very labor intensive marketing, slow uptake and poor client retention.
- To avoid adverse selection greater than half of an MFI group should join, but this is often difficult to achieve.

Reaching out to low income formal sector has turned out to be easier. More specifically:

- High demand and rapid uptake
- Able to pay a realistic premium and pay promptly
- Adequate premium to cover administration costs and re-insurance
- Can pay premium for a long coverage period (1 year)
- Lower level of moral hazard
- Employers understand 'risk pooling' and 'insurance'

Some general lessons learned (pre-conditions to reach profitability) are:

- To achieve full cost recovery, requires 25 % + higher premium
- A large client base (over 50,000) is required for economy of scale
- Roll out to scale is much faster and easier in the formal sector
- High demand from employers for health insurance for low income workers and their families (e.g. Flower Export Companies)
- Avoid adverse self selection by small client groups (< 15 families)
- Abuse of system must be prevented aggressively
- Service provider costs and quality must be actively monitored
- Client and service provider contracts must be simple and sound

Strengths of Microcare are:

- The strong capital base of a licensed insurance company
- Supported by major re-insurers (Munich Re, Africa Re, PTA Re)
- Choice of service providers- over 50 approved hospitals/clinics
- Our own terminals and trained staff at check-in desks in 10 prime hospitals and clinics in Kampala to directly interface with clients
- Ongoing clinical audit to evaluate quality healthcare
- Establishing clinical protocols
- Fast and efficient processing of claims
- Tailor made range of programs covering formal and informal sectors
- Wellness programs through preventive healthcare and counseling
- Confidential professional management of HIV/AIDS

All in all, Microcare stresses the need to build relationships with the different people involved, i.e. companies or MFIs, clients, health service provider, and re-insurance companies. A lot can be gained by all parties from a good collaboration. Working from a win-win situation is considered to be crucial.

#### *Issues in relationship to HIV/AIDS epidemic*

Microcare has a huge database. Analysing the aggregate claims experience by age and sex shows that women experience impact of HIV/AIDS at a younger age than men.

The programme with MFIs started in 2003. Clients were not screened on HIV/AIDS. Though HIV/AIDS testing, counselling and homecare is included, ARVs are not (no prescriptions longer than 3 weeks). At the time of the pilot anti-retroviral were not cheaply available. Dependent children, who are not natural children of clients, were included (e.g. AIDS orphans). As a result Microcare's insurance services do assist clients in their coping strategies to deal with HIV/AIDS.

When targeting the formal market (i.e. via companies or so-called third party agreements), Microcare services directly related to HIV/AIDS are more extensive, and includes:

- Pre and post test counselling
- Diagnosis
- Consultation with doctor at a specialist HIV centre
- Supervision of HIV/AIDS treatment in specialist centres
- Workshops on HIV/AIDS awareness
- Guaranteed confidentiality
- Provide technical assistance in developing and maintaining company HIV/AIDS programs

These services are offered at no extra costs for corporate clients.

Next step will be to offer group HIV insurance (i.e. to the informal sector) that covers:

- At least first line ARV therapy
- Clinical monitoring by expert medical providers
- Regular specialist investigations and tests

## **10.2 Experiences of Social Re, South Africa, Dr. David Dror**

Why is health insurance relevant for the poor?

- Insurance offers better protection than savings, as risks are not only shared over time but also shared by different persons.
- The poor have a low ability to absorb shocks. According to a World Bank study, 25 to 35% of the people that were hospitalized in India suffer very serious financial prejudice, translating into complete poverty.
- The poor cannot benefit from economies of scale when they pay directly to providers as they buy the service at spot and under circumstances asking for treatment. Insurance separates the point of payment from the point of services and enables negotiations due to larger volume bought.
- Uninsured poor tend to delay treatment due to ignorance and poverty, thereby aggravating medical conditions and cost-effective care.
- Insurance creates solvent demand that draws more and better providers. Insurance ensures that the insured can pay for care, and thus the demand for care is likely to be higher. The provision of health services is likely to increase as a result, as demand creates supply. Therefore, we better worry to create the capacity to pay than for the creation of providers.

But then, if it is so relevant, why is low-cost health insurance so rare?

- High barriers to entry: Capital requirements tend to be high as claim loads and costs can exceed premiums collected. To guarantee service delivery, large reserves are required. Furthermore costs (especially administration) can be high when the value of claims is low.
- Lack of knowledge/information on probability of risks, variance of risks, variance of unit costs
- Lack of "industrial infrastructure" for insurance illustrated by among others uncontrolled drug distribution resulting in high overhead cost and high cost of administration (collection, claims processing, and payments).

Dr. Dror explained that it is possible to use lessons learned from MFIs to establish low-cost insurance which is relevant to the poor, as follows:

- MFIs started as small-scale grassroots entities
- The formula for success of MFIs has been to mobilize social ties to secure financial transactions.
- Social ties were relevant in small scale groups
- The MFIs started with very modest amounts
- Federative structures have enabled MFIs to graduate to more advanced transactions

As governments and private insurers do not offer affordable alternatives in low-income countries, there is room to offer micro health insurance. Evidence shows that community-level schemes make a positive difference and local schemes have successfully dealt with rationing of benefit packages. Examples of successes: improved access to hospitalization, supervised deliveries, consultations, diagnosis of chronic disorders and drug

compliance, improved equity of access, less household income spent on hospitalizations, and also less households for which medical costs were catastrophic.

At the same time, evidence with community based micro insurers, has faced the following challenges:

- Little efforts to increase membership, retain members and reduce free-riding.
- Inefficient administration Issues being data, information processing, data analysis, long and complex claims procedure. At the same time little investments were made in training and improvement of administrative human resources.

Data requirements are complex and not known to MIUs. Neither do they have the capacity to analyse them. Without data and analysis the MIUs are exposed to high risks of insolvency, fraud and abuse.

- Inaccurate calculation of premiums
- Low compliance rate partly resulting from weak administration limiting possibilities to police premium compliance. It can also be an indication of loss of clients.
- Higher variance of claim load and unit-costs.
- Solvency. Due to small size you have a lower spread of risk. Hence micro insurer is facing higher insolvency.

So what is better, having multiple (smaller) insurers or one single insurer? David Dror advocates for the first for the following reasons:

- *Small* groups can mobilize tried-&-tested social interactions in order to strike a balance between the collective good and the individual interests of each member (but this advantage disappears in large groups)
- When the insurer cannot cover everything, *rationing* of benefits is unavoidable; multiple micro insurers can *adapt their package* to the local needs better than a single large insurer
- The operation of micro (health) insurance can evolve as an *extension of existing structures*

The identified problems related to administration, finance and size could be addressed

- Solutions to ensure financial viability. This can be addressed by offering access to reinsurance. This gives MIU access to required knowledge on risks and variance of risks, contributes to spread of risk and assists MIUs to meet minimal capital requirements of authorities.
- Solutions to provide the necessary technical and administrative support structure. A data template / information technology software can be offered by assisting MIUs with administrative issues and ensuring availability of data.
- Solutions to create linkage to national health system by pooling risks, resources, and voice of micro insurance units (MIUs)

**Social Re** wants to use the existing (small scale) structures and address the challenges these microinsurance units face by providing the platform to convert isolated small organizations into such a sustainable network, by enabling all to pool risks, resources and technical capacity, in a win-win paradigm for MIUs and their clients. Currently Social Re is preparing to become active in India and South-Africa.

Conclusions:

- Micro health insurance units increase health care utilizations and improve equity of access;
- The strength of MIUs is amplified by their flexibility to offer benefit packages that responds to clients' needs;
- Successful MIUs are often tied to other activities within the community (distributional advantage of existing groups);
- Stand alone MIUs are vulnerable, and must therefore break away from solitary activity;
- Social Re is the sole project aiming to provide a uniform technical platform, reinsurance, and linkages to national systems.

HIV/AIDS can be part of a modular approach to package design and several insurance products (Namibia, Uganda, Ghana and South-Africa) are covering ARVs. Including access to medication seems to increase costs only initially and then drop due to lower expenses on treatment of HIV/AIDS related diseases. However administration costs are stable over time and higher than ARV, pathology or prophylaxis. It can also be considered to subsidise ARVs as part of an insurance structure.

## **PART IV : PLANNED FOLLOW-UP PARTICIPANTS**

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### **11.0 Action Plans developed**

At the end of the workshop, participants were asked to work out plans for their own organization as well as plans that they would like to work on with others to deal with the issue of HIV/AIDS and to increase the access to microinsurance services of the poor.

Nearly all participants indicated that before action plans can be formalized, information received at the workshop must be shared with board management and other relevant stakeholders within the organization.

#### **Action Plans MFIs**

The planned actions are structured in three strategies, namely prevention strategies, product adjustments and new products (other than insurance) and microinsurance products.

##### *Prevention strategies*

Three MFIs want to develop and implement a HIV/AIDS policy for clients in cooperation with ASOs and six highlight the implementation of a HIV/AIDS policy at staff level. Further, some MFIs indicate that technical advice and consultancy services from ASOs are essential in prevention strategies.

##### *Product adjustments and new products (other than insurance)*

MFIs feel the need to reduce the risks of their clients and with the objective to retain clients as much as possible, be more efficient by introducing better and more flexible services. The overall objective for MFIs with plans for product adjustments is to become more dynamic in general to increase protection for itself and its clients. Steps before developing strategies are, among others, research on HIV status among clients and research on market demand to determine essential product adjustments and potential new products. More than half of the MFIs want to cooperate with other MFIs, networks and donor organizations (especially financial support for research) to determine market demand, share knowledge and regulation issues. One MFI in Uganda, which already modified its products, plans to increase flexibility even more. One MFI wants to launch savings products

##### *Microinsurance*

All MFIs want to be involved with microinsurance. Twelve MFIs participating in the workshop intend to offer health care insurance in the future and few want to introduce a form of life insurance (loan, funeral or pure life) insurance. The lower score on life insurance can be explained by the fact that many MFIs already offer a form of life insurance.

When developing microinsurance products, MFIs mentioned the need to identify relevant actors and roles in the context of microinsurance and to lobby for favorable regulation on microinsurance. Lastly, technical advice by insurance companies, donor organizations and especially training on health care insurance to staff at MFIs are considered to be important before actually offering microinsurance.

Nearly all MFIs want to cooperate with an insurance company through a partner-agent model. Companies mentioned for partnerships are AIG, Opportunity International, Microcare, Madison, NICO Insurance, African Life Insurance and other companies yet to be identified. Some mentioned the intention to work with MIAN and Social Re for research and development of insurance models at MFIs. Six MFIs mention the need for cooperation with network organizations to increase opportunities to link up with insurance companies. Two MFIs want to cooperate with medical service providers.

##### *Objectives and conditions*

MFIs were asked to describe objectives and conditions of cooperation with other organisations (insurance and ASOs). Objectives for offering health care insurance are to expand outreach of health care and better protection for clients. One important condition sticks out. There must be a win-win situation. In health care insurance, for example, clients are more protected against risk. MFIs gain from more satisfied and healthy clients, hence, a lower drop out rate. Insurance companies benefit from a partnership with MFIs, because of larger outreach and lower transaction costs. Lastly, the health care provider benefits from large solvent demand for its services, what insurers can provide, and are willing to provide more services. Other conditions for collaboration mentioned are:

- Trust between MFI and insurance company
- Marketing of insurance products by insurance company
- Affordable premiums from insurance company

#### **Action Plans networks**

Actions indicated by the network participants are the following:

- Research on effects of HIV/AIDS and development of HIV/AIDS policies at all member organizations;
- Research on and development of microinsurance products, especially health care insurance products;

- Forum for MFIs to share/exchange knowledge and experiences on HIV/AIDS and microinsurance in the microfinance sector;
- Lobby for favorable regulation on microinsurance and for health care insurance;
- Identify and rate MFIs and microinsurance companies to improve potential partnerships and increase trust;
- Create strategic alliances between MFIs, microinsurance companies, health care service providers and AIDS support organizations. Inviting insurance companies to become associate members of the network was mentioned as one way to create strategic alliances between MFIs and insurance companies.

Objectives for the networks are to create a favorable environment (which includes favorable regulation and building of trust) for their members in order to have more dynamic institutions with flexible products (especially health care insurance) that benefit and protect both the MFI and their clients. Networks also described the conditions under which they would like to enter into partnerships. Most networks point out the importance of a win-win situation and fair partnerships, either in the creation of strategic alliances among members and between the network and other stakeholders.

#### **Action plans AIDS support organisations**

Planned activities for ASOs was to scale up awareness raising activities via current collaboration agreement with an MFI as well as by cooperating with other MFIs and exchanging ideas and experiences around how to increase HIV prevention within MFIs. In addition cooperation with other MFIs and insurance companies was planned. Condition for cooperation is that there is mutual interest between the two parties.

#### **Action plans insurance companies**

Four insurance companies attended the workshop, of which one health care insurance company.

Insurance companies mention the development of new products from the clients' perspective as an important issue for further action. Special issues of attention are how to take HIV/AIDS into account and integrate it in products, introducing health care products, making insurance affordable, non-discriminating and comprehensive, and making insurance product compulsory where possible. It entails research on market demand.

Lastly, one company wants to set up a forum through the national network of MFIs to articulate their needs and drive for products to satisfy specific client needs.

All insurance companies want to co-operate with other insurance companies, MFIs, re-insurers, AIDS Support Organisations, researchers and donors. The objectives mentioned were a win-win situation for both companies in the agreement and to develop and offer affordable, appreciated and useful products.

## ABBREVIATIONS

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ABC	Strategy in HIV/AIDS prevention referring to Abstain, Be Faithful, Condom Use
ACB	Akiba Commercial Bank
AEMFI	Association of Ethiopian Microfinance Institutions
AFMIN	Africa Microfinance Network
AIDS	Acquired Immune Deficiency Syndrome
AIG	American International Group
AMFIU	Association of Microfinance Institutions Uganda
ARV	Anti Retro Virals
ASO	Aids Support Organisation
CIDR	International Development and Research Centre
FU	Finca Uganda
GBV	Gender Based Violence
GTZ	German Agency for Technical Cooperation
HIV	Human Immunodeficiency Virus
Hivos	Humanist Institute for Co-operation with Developing Countries
ILO	International Labour Organisation
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
KDA	K-rep Development Agency
LRF	Legal Resources Foundation
MFI	Microfinance Institution
MIAN	Microinsurance Association Netherlands
MIC	Microinsurance Company
MIS	Management Information System
MIU	Microinsurance Unit
MDGs	Millennium Development Goals
OI	Opportunity International
PAR	Portfolio at Risk
PLWA	People Living With Aids
PSI	Population Services International
SEF	Small Enterprise Foundation
SHAZ	Shaping the Health of Adolescents in Zimbabwe
STEP	Strategies and Tools against social Exclusion and Poverty
RADAR	Rural Aids & Development Action Research

# ANNEXES

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## Annex 1: Background paper workshop, including programme

### HIV/AIDS and microinsurance in the microfinance sector in Africa Background paper Workshop Addis Ababa 25 - 27 April 2005

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#### 1. Problem definition

Sub-Saharan Africa is seriously affected by the HIV/AIDS crisis. The average prevalence rate among the economic active population is 20% meaning that 1 in every 5 people is HIV positive. Because of the high prevalence rate and the far-reaching social, cultural and economic consequences of HIV/AIDS, this epidemic can no longer be ignored. It affects not only the health situation of individuals, but affects families, communities and society as a whole.

Many households in Africa are confronted with family members with HIV/AIDS. Data suggest that the spread of HIV/AIDS follows existing patterns of poverty, inequality and exclusion. Clients of MFIs, being lower income population, are therefore highly exposed to the risk posed by the HIV/AIDS endemic. The care of family members with AIDS has tremendous financial repercussions in terms of medical costs and lost business income as most caregivers have to reduce their income earning activities and draw from their business capital to meet expenses. In addition women often divert their attention from their enterprise to care for the sick. Although crises not related to HIV/AIDS do happen more frequently, they come in isolation. HIV/AIDS, on the other hand, triggers a series of events that require an entire arsenal of coping mechanisms.

The most severe economic stress occurs:

- Before the caregivers and the person with HIV/AIDS know the HIV-status and spare no expense in looking for a cure;
- When the family member with HIV/AIDS is bedridden and the caregiver assumes the financial burden for health and child care at the expense of time spend on the business;
- When a caregiver assumes responsibility (particularly school fees) for the children whose parent(s) have died.

The severity of economic impact depends on:

- The economic resources (including strength of business, savings, economic diversity of household) a client has when a crisis begins to affect her/him;
- The duration of the given crisis, how many crisis occur and the timing between them
- The relationship between the caregiver and the infected person (clients caring for her/his spouse or adult children are affected more than the extended family)
- Quality and number of coping mechanisms available to the client;
- Networks that client belongs to (especially informal) and knowledge of resources available to him/her to tap into (both formal and informal). (MicroSave Africa 2001:ii)

#### 2. Relationship between HIV/AIDS and microfinance

Being part of society as a whole, microfinance institutions (MFIs) and insurance companies cannot ignore the HIV/AIDS pandemic. They are feeling the effects of the HIV/AIDS pandemic via staff members and clients infected with or affected by the HIV/AIDS pandemic (through sick and deceased family members), changed needs of clients, and the economic effects at community and society level. At the same time, MFIs and insurance companies do have an influence on the HIV/AIDS pandemic. They can reduce the effects that are being felt by clients by taking into account changed needs to revise current products and develop new products. In addition they can link with other organisations to prevent further spread of the disease as well as to reduce other effects. Given the extent to which MFIs and insurance companies are affected themselves, acting on this pandemic does not only make sense from a human perspective, but also from a long-term business perspective.

Fighting this epidemic is complex as gender disparities, traditions, lack of access to information, poverty, and structural insecurity all play a role in the spread of HIV/AIDS and its impact. Strategies that take these different issues into account and consorted efforts are therefore needed.

Some examples how microfinance and microinsurance can reduce the economic impact of the HIV/AIDS pandemic, and contribute to the prevention and other effects of HIV/AIDS:

- Poor people have difficulties to cope with economic stresses that occur, implying that they are often caught in the poverty trap. They can come out of poverty but often fall back once economic emergencies

occur. To reduce their vulnerability and exposure to risks and economic stress, people try to stabilise their household level income by diversifying their income sources and try to build up their asset base. Microfinance is a useful and effective instrument to assist people in implementing these strategies. A number of studies has demonstrated significant impacts of MFIs in reducing household vulnerability and poverty, and in improving livelihood security among those living at the margins of extreme poverty. As poverty and structural insecurity make people more vulnerable for HIV/AIDS, economic empowerment is one of the factors that need to be addressed to deal with the HIV/AIDS pandemic. At the same time access to microfinance assists people (to a certain extent) to reduce the economic impact of HIV/AIDS.

- Microfinance institutions often offer *savings accounts*. This is a way for clients to keep their money in a safe place. It reduces the risk of theft and diversion of income due to lack of discipline or social pressures. In addition, microfinance institutions often promote savings by having a system in which clients save regularly. Savings that are easily accessible are very relevant for clients facing a HIV/AIDS related or other crisis.
- Microfinance *loans* serve a critical role that enables clients to enhance their business' volume and / or diversify their economic activities. The resulting increase in income facilitates the creation of savings and asset accumulation. Loans provide an important source of lump sums of cash, which help clients avoid eating into their business capital.
- However, loans can lose their attractiveness to clients as a coping mechanism when a client is experiencing a HIV/AIDS related crisis and has too many competing demands for lump sums of cash. Closing of business to fulfil care-giving responsibilities exacerbates this situation because it disrupts the flow of income to the household. Nonetheless, clients go to great lengths to repay their loans to safeguard their future position in their solidarity groups. They see their business and access to loans as a ticket to "bouncing back" once the crisis is over; clients make a first connection between access to loans and the restoration of their business activities.
- Another service that can assist clients to reduce their vulnerability for economic crises more effectively than loan products are *insurances*. Credit insurance (the outstanding loan is cancelled if a client dies), life insurance, funeral insurance (both often linked to loan products and only available for the term of loan) and health insurance are especially relevant in the light of the HIV/AIDS pandemic.
- Clients of microfinance institutions have build-up experiences with money management skills and savings discipline, which will assist them to deal with the challenges faced in case of HIV/AIDS related crises. In case of group loans, meetings could be used to further improve these skills.
- More readily available information about treatment for family members with AIDS, which enables caregivers to manage their family member's AIDS-related illnesses more rationally. In case of group loans, meetings could also be used to raise awareness. In the case of individual loans and insurance companies, information can be provided to clients via information leaflets or by showing a video on HIV/AIDS near the cash point or in communal places. Insurance companies can also become active in the field of prevention activities, as prevention of HIV/AIDS will reduce number of claims.
- Group meetings and encouraging groups to work together on other issues affecting their position can be instrumental to deal with the different aspects explaining the rapid spread of HIV/AIDS. Group meetings and group coherence can therefore be used to discuss and deal with gender disparities, cultural factors encouraging the spread of HIV/AIDS, sexual rights of women, information on HIV/AIDS and how to prevent it, sexual education of their children, intergenerational business counselling for younger family members of people living with HIV/AIDS.

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<sup>1</sup>The majority of microfinance institutions focus on loans. The savings products that they offer are often compulsory and cannot easily be accessed. Only few MFIs offer flexible savings products. This is due to the costs involved and the restrictions put on on-lending of savings. These restrictions are important to safeguard the savings of clients.

<sup>2</sup>Please note that insurance is a totally different business than other financial services, requiring different supervisory/legal requirements. As a result it is generally recommended that MFIs look for an insurance provision partnership with formal insurers. In such a relationship the insurer maintains the insurance risks and the MFI provides sales and basic servicing for the products. There are some other models that might work as well, such as the provider model and the community based model. (See Cohen and McCord, Microinsurance Centre briefing note #6)

- Enabling people living with HIV/AIDS and their families to keep earning an income by continuing offering financial services to them. It will enable them to live healthier and longer. Though some risks are involved, institutions piloting with this have shown positive results.
- Insurance companies offering health insurance can look for possible strategies to promote testing and awareness raising on how to live with HIV/AIDS. In addition it might be interesting to look for linkages to get subsidized treatment (ARVs).

The focus of the workshop is on strategies targeting clients. Nevertheless it is important to realise that the presence and implementation of an internal staff policy on HIV/AIDS is a precondition to deal adequately with HIV/AIDS. Only then you can expect staff members to deal adequately with a complex and personal issue like HIV/AIDS.

### 3. Concrete strategies implemented by MFIs

The potential role of microfinance institutions might be clear. But to be effective, concrete strategies are needed. During the training workshop the first day is allocated to strategies 1 and 2. The second and third day of the training programme focus entirely on strategy 3: insurance products.

#### 1. *Prevention programmes*

- Innovations around HIV/AIDS related information and linkages by providing information to clients on HIV/AIDS in group meetings or by disseminating leaflets, showing videos etc, linking with AIDS organisation to raise the awareness on HIV/AIDS, encourage people to do tests to know their status, prevention programmes, programmes looking at underlying factors for the spread of HIV/AIDS, how to live positively with HIV/AIDS, home-based care projects, women organisations dealing with gender disparities and reproductive rights and other organisations that play a role in combating the spread of HIV/AIDS.

#### 2. *Product adjustments and new products (other than insurance) with awareness of changes in the costing of products*

- Refinements in loan products such as longer grace period, fluctuating loan sizes and terms, elimination of compulsory increase of loan amounts, allowing more flexible repayment schedules to account for sudden financial short-falls. In case of group loans, frequency of meetings and lower attendance requirement are also common measures to deal with the increased workload of especially women due to the HIV/AIDS pandemic.
- New products such as saving services, emergency loans, loan and saving products specifically designed for people living with HIV/AIDS.
- Refinements in saving products such as more favourable saving conditions and a more active promotion of savings.
- Group coherence promote groups to start other support functions for each other (such as cooking more nutritional food for sick members or sharing child care duties), stimulating, when clients fall ill, borrower groups to mentor younger family members to take over businesses. The younger family members can replace sick adults as MFI clients. Intergenerational business mentoring could become a more broad based effort to build youth entrepreneurship skills.

#### 3. *Insurance products*

There are several types of insurances, such as credit insurance (the outstanding loan is cancelled if a client dies), life insurance, health insurance and funeral insurance which are relevant in the light of the HIV/AIDS pandemic.

Demand seems strong and is indicative of an important potential market<sup>3</sup>.

At the same time microinsurance is a young financial service with few proven best practices. Before getting involved into microinsurance it is important to realise that it is a totally different business from credit, savings or money transfer services. Often legal and supervisory requirements exist at national level, requiring separation between banking and other activities. Though same front offices can be used, administration of premiums and all claims paid must be separated. In addition determining the right premium, getting a clear idea on claims that can be expected, and ensuring that you are able to pay all

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<sup>3</sup>(Cohen and McCord, Microinsurance Centre briefing note #6)

claims require other knowledge and skills that are present in most MFIs. An easy solution might be to delegate all these tasks and to look for collaboration with an insurance company. In such a relationship the insurer maintains the insurance risks and the MFI provides sales and basic servicing for the products. Other possibilities are the provider model and the community based / mutual insurance model.

#### **4. Goal and objectives of the training workshop**

The overall goal is to share information and experiences on the relationship between HIV/AIDS and microfinance and to enable participants to develop strategies (especially offering microinsurance products) to deal with HIV/AIDS.

More specifically, the following objectives are identified:

- Increase knowledge on the relationship between HIV/AIDS pandemic and microfinance, knowledge on possible strategies to deal with HIV/AIDS pandemic and its widespread impact on society as a whole, and to increase knowledge on relevance of microinsurance products and key issues to offer these services in a professional and financially sustainable way.
- All participating organisations have action plans elaborating on strategies they want to adopt and/or further refine to adequately deal with HIV/AIDS.
- Networking between MFIs, networks of MFIs, and insurance companies from different countries. Exchange of experiences on relationship between HIV/AIDS and microfinance and microinsurance and on lessons learned during the implementation of strategies to deal with HIV/AIDS.

#### **5. Participants**

Between 50 and 60 people are participating in the training workshop, to be held in Addis Ababa, Ethiopia. Participants are coming from different countries in Africa: Ethiopia, The Gambia, Kenya, Malawi, Mozambique, South-Africa, Tanzania, Uganda, Zambia, Zimbabwe, Europe (the Netherlands, Switzerland, and United Kingdom) and from the United States.

Majority of the participants (55%) work for leading MFIs in these countries. The remaining 45% compose of representatives of networks of MFIs and representatives from insurance companies.

## 6. Programme

<p><b>Monday 25 April</b></p>	<p><b>08.30 - 09.15</b>  <b>09.15 - 10.45</b>            09.15 - 09.45            09.45 - 10.15            10.15 - 10.30            10.30 - 11.00</p> <p><b>11.00 - 12.30</b>            11.00 - 11.45            11.45 - 12.15            12.15 - 12.30            12.30 - 13.30</p> <p><b>13.30 - 15.15</b>            13.30 - 14.00            14.00 - 14.20            14.20 - 14.40            14.40 - 15.00            15.00 - 15.15            15.15 - 15.30</p> <p><b>15.30 - 17.30</b>            15.30 - 16.45            16.45 - 17.30</p>	<p><b>Opening and Welcome</b>  <b>The relationship between HIV/AIDS and microfinance / microinsurance</b>            Experiences in Uganda (Caroline Tuhwezeine, AMFIU)            Outcomes Hivos' questionnaire on effects of HIV/AIDS pandemic (Annegien Wilms)            Plenary discussions  <i>Tea Break</i></p> <p><b>Prevention Strategies to deal with the HIV/AIDS epidemic</b>            The experiences of SEF/RADAR in South-Africa (Julia Kim)            Experiences of Akiba Commercial Bank (Meltus Rwasia)            Plenary discussions  <i>Lunch</i></p> <p><b>The strategy of product adjustments and introduction of new products to limit the effects of HIV/AIDS</b>            Product adjustments and new products            Experiences of Finca Uganda (Millie Kasozi)            Offering services to people living with HIV/AIDS, Experiences of Zambuko Trust (Bridget Kazembe)            Offering services to people living with HIV/AIDS, Experiences of KDA, Marcelina Obuya            Outcomes Hivos' questionnaire on strategies developed by MFIs to deal with effects of HIV/AIDS (Carolijn Gommans)            Plenary discussions  <i>Tea break</i></p> <p><b>Group work on effects of HIV/AIDS and potential strategies</b>            Group work (moderator Carolijn Gommans)            Reporting back of groups</p>
<p><b>Tuesday 26 April</b></p>	<p><b>08.30 09.00</b></p> <p><b>09.00 13.00</b>            09.00 10.30            10.30 11.00            11.00 13.00            13.00 14.00</p> <p><b>14.00 17.30</b>            14.00 15.00            15.00 15.15            15.15 16.15            16.15 16.45            16.45 17.30</p>	<p><b>Main findings day 1, Carolijn Gommans</b></p> <p><b>Microinsurance as a strategy to reduce effects of HIV/AIDS</b>  <b>Microinsurance Centre, Michael McCord</b></p> <p>Session 1 Michael McCord  <i>Tea break</i>            Session 2 Michael McCord  <i>Lunch</i></p> <p><b>Life insurance</b>  <b>Opportunity International Richard Leftley</b>            Relevance of life insurance, use made of it            Experiences of Opportunity International with insurance companies, Richard Leftley  <i>Tea break</i></p> <p>The perspective of an insurance company            AIG Uganda, Patrick Rujumba            Experiences of MIAN with life insurance, Toon Bullens            Plenary session</p>
<p><b>Wednesday 27 April</b></p>	<p><b>08.30 09.00</b>  <b>09.00 15.00</b>            09.00 10.30            10.30 11.00            11.00 13.00            13.00 14.00</p> <p>14.00 15.00  <b>15.00 16.00</b>  <b>16.00 17.00</b>  <b>17.00 17.30</b></p>	<p><b>Main findings day 2, Celestin Gatara</b>  <b>Health insurance David Dror and Gerry Noble</b>            Experiences of Microcare Uganda, Gerry Noble  <i>Tea break</i>            Experiences of Social Re, South Africa David Dror  <i>Lunch</i></p> <p>Plenary Session  <b>Action Planning</b> (accompanied by tea) (moderator Carolijn Gommans)            For each organisation including possible collaboration  <b>Presentations Action plans</b>  <b>Closing and evaluation</b></p>

## **Annex 2: Workshop Evaluation Summary**

### Introduction

The Microinsurance and HIV/AIDS workshop held in Addis Ababa on the April 25<sup>th</sup> - 28<sup>th</sup>, 2005 brought together 54 participants from 16 countries. They were mainly Microfinance practitioners, insurance service providers, Country Level Microfinance Network leaders, researchers and donors. At the end of the workshop, participants were asked to give feedback on various issues, including their level of appreciation in regard with the presentations and the presenters and conference organization on specific aspects. Responses from the two first categories of questions were analysed and their scores are below presented. Participants were also asked to tackle on what they liked most and least about the workshop, the three things that they will take home to their institutions, their suggestions about follow up actions by Hivos and types of activities they will be involved in during the follow up. After tracking all responses, they were summarised to capture the picture of the conference in general.

### THE AFRICA MICROFINANCE NETWORK

### MICROINSURANCE & HIV/AIDS IN AFRICA

ADDIS ABABA, ETHIOPIA : APRIL 25 - 27TH 2005

### CONFERENCE EVALUATION SHEET

Q1. How useful were the following:  
PRESENTATIONS

Names	Average	%
Experiences in Uganda by Caroline Tuhwezeine	3.48	70
The experience of SEF/RADAR in South-Africa by Julia Kim	4.13	83
Experience of Akiba Commercial Bank by Meltus Rwaso	3.35	67
Experiences of Finca Uganda by Millie Kasozi	3.54	71
Offering services to people living with HIV/AIDS, Zambuko Trust by Bridget Kazembe	3.62	72
Group work on potential strategies to deal with HIV/AIDS	4.05	81
Microinsurance as a strategy to reduce effects of HIV/AIDS Microinsurance centre, Michael McCord	4.17	84
Relevance of life insurance, use made of it with Opportunity International	4.18	84
The perspective of an insurance company AIG Uganda	3.40	68
Experiences of MIAM with life insurance	3.75	75
Key issues in health insurance with David Dror	4.72	95
Experiences of Microcare Uganda Gerry Noble	4.29	86

Q2. How would you rank this Conference in the following areas?		
a) Presentations	4.54	91
b) Organization	4.02	81
c) Networking	4.52	91
d) Success in achieving objectives	4.40	88
e) Topics and content	4.48	90
f) Materials and documents	4.68	94
g) Schedule	4.10	82
h) Workshop venue	4.02	81
i) Food	3.45	69
j) Accommodation	4.02	81
k) Logistical support	4.10	82
l) Other (please specify)	NA	NA

Q3: What participants liked most about the conference

Sharing experience between MFIs practitioners, microinsurance service providers and researchers comes at the forefront. Not only this sharing was useful, but also to some it was an opportunity to be enlightened on relation between microinsurance and microfinance. Presentations were of high level and professional, participants quoted even some names of presenters very often who marked the conference. These include Dr. David Dror, Dr. Julia Kim, Dr. Gerry Noble and Michael McCord. Eventually their presentations were scored higher than others. Further, participants highlighted the uniqueness of the conference that brought together different people (MFIs, Network, Insurance companies, researchers, micro health organizations). The workshop allowed participants to establish linkages and be educated about how they can do better what they were doing well. It eliminated the myth that insurance is for rich people. In that respect, participants appreciated the fact that microfinance clients can access microinsurance services even though they are HIV/AIDS positive, provided that awareness and education are integrated in microfinance services.

Q4. What participants liked least.

In regard with what people liked least, participants complained about some long sessions, and other presentations which were too academic. Some presenters were too fast and their accent could not allow the understanding of their message. The schedule was very tight, therefore participants did not get opportunities to visit Addis Ababa and do shopping. Other elements of concern were food in the hotel, the size of the room conference, and cell phone disturbances.

Q5. The three things to take back home:

In respect with the three things to take home, participants highlighted the knowledge gained, the skills and conviction that MFIs cannot provide microinsurance services, but only through professional institutions likewise microinsurance companies. They were also convinced that the

poor are insurable, scale is relevant, and insurance is business for professional institution with proven expertise.

Participants emphasised also on the importance of looking at the cost benefit before introducing microinsurance products in their organizations. Participants committed to share the information to their counterparts left behind, because they collected enough resource materials. The subjects that they will insist on are: the relationship between microfinance and microinsurance, healthcare insurance, co-operation, communication and commitment.

#### Q6: Suggestions on follow up by Hivos

Suggestions on follow up actions by Hivos were many and are at 5 levels.

- a) Participants mentioned the support of research on health insurance in the countries that are supported by Hivos, research on microinsurance product development and research on progress of action plan implementation after a period of 6 months and/or one year.
- b) Hivos should keep constant communication and constant collaboration (through e-mails) with the people who attended the conference so that they can keep sharing on progress and challenges encountered while implementing the proposed action plan. Participants believe that, in doing so; other institutions can also be encouraged by experiences of MFIs and others on how far they have gone.
- c) Support other conferences with the same objectives so that participants can keep on sharing what worked well and what did not.
- d) Support organizations on country basis so that they can organize such gathering and Hivos can bring in its financial and technical support,
- e) Other participants suggested to be visited by Hivos so that they can learn more on how they can take off in the implementation.

#### Q7: Are participants interested in follow up activities?

In regard with this question, almost all participants confirmed that they are interested and their responses were like, "Yes, yes definitely, yes certainly, very much interested, very much, yes so much"

#### Q8: Types of follow up activities

In regard with follow up activities that participants would be interested in, they are summarized bellow:

- Dissemination of workshops handouts back home,
- Implementation of agreed planned activities,
- Microinsurance development product i.e. life insurance and health insurance,
- Give briefing on how far we have gone and documents, share my experience with others who did not attend the conference
- Research, network building, training and product development research for MFIs clients in health insurance and life insurance,
- Promotion of technical support in the form of resource person for the planned activities,
- Networking, Awareness workshop that brings together MFIs and insurance service providers,
- Follow up on measuring implementation of discussed issues during the workshop,

- discussions through e-mail and support,
- Training , Exchange visits, Conferences, exchange of information on e-mail and visit by Hivos representatives,
  - Information on products that insurance companies develop after the workshop,
  - Further research and consultation,
  - Training on implementation of micro health insurance scheme and their management,
  - Survey on MFIs that introduced products on insurance,
  - Survey on companies involved in microinsurance,
  - Get more experience and knowledgeable people and use them by sharing their experience,

All in all, this workshop demonstrated that microinsurance in microfinance industry is a key issue, which offers opportunities for both microfinance institutions and microinsurance companies, and can play an important role in eradicating poverty. The workshop contributed to a better understanding between microinsurance service providers and microfinance institutions which will enable the establishment of partnerships between the two. It is likely to increase the access to insurance for the poor and hence reduce their vulnerability.

Prepared by Célestin GATERA  
AFMI N Programs Director

## Annex 3: List of participants

	Organisation	Name	e-mail address
1	ACSI	Tewab Ayshehim	tewabe2003@freemail.et
2	AEMFI	Wolday Amha	aemfi@ethionet.et
3	AEMFI	Tigist Tesfaye	aemfi@ethionet.et
4	AFMIN	Abdoul Anziz Said Attoumane	abdoul.anziz@afmin-ci.org
5	AFMIN	Célestin Gatera	celestin.gatera@afmin-ci.org
6	AIG Uganda Limited	Patrick Rujumba	prujumba.aig@utlonline.co.ug
7	Akiba Commercial Bank	Meltus Rwsa	Meltusr@yahoo.com
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