Review of African Political Economy

**Microfinance and HIV prevention**

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**Abstract**

This paper provides a brief overview of both the broader microfinance arena and also the current evidence on the impact of microfinance on HIV-prevention. The available information suggests that the impact of microfinance, as well as the impact of microfinance linked to HIV prevention programme in Sub-Saharan Africa show a mixed picture. This is not surprising given the very different contexts in which interventions have been implemented and the varied and sometimes questionable impact of microfinance for the poorest and the less-poor (women and men, older and younger) recipients. While there is little evidence that microfinance alone prevents HIV-infections there is information on unintended outcomes of microfinance as women face HIV-related risks as they struggle to repay debts. Structural changes remain a necessity if HIV prevention and development programmes are to respond to the broader economic and social issues poor women and men face, in Africa and elsewhere.

**Keywords:** Microfinance, HIV and AIDS, prevention, poverty, Africa

Writing a decade ago, Julia Kim and Charlotte Watts ([2005](#_ENREF_30)) suggested that HIV prevention initiatives could build on the successes of microfinance initiatives in many developing countries to bring about change. The provision of credit and savings to poor women was widely reported to be leading to improvements in household food security as well as individual benefits for the women involved who through the microfinance interventions acquired economic and business skills (see for example, [Hulme and Moore 2006](#_ENREF_22), [Kabeer 2005](#_ENREF_26), [Sanyal 2009](#_ENREF_47), [Swain and Wallentin 2009](#_ENREF_52), [Van Rooyen, Stewart, and de Wet 2012](#_ENREF_55)). There were direct benefits for reproductive health: Kim and Watts ([2005, 770](#_ENREF_30)) noted that women in Bangladesh involved in microfinance programmes were reporting an increase in their control over contraception and wider sexual and reproductive health decisions; control that they suggested might be translated in other settings to HIV-prevention initiatives. Anderson and colleagues ([2002](#_ENREF_2)) had also suggested that microfinance could have an impact on HIV-transmission. However, they sounded a more cautious note in the light of reported benefits of microfinance for HIV-affected households in Zimbabwe and Kenya. They concluded that `microfinance represents a potentially powerful tool [for HIV programme planners], but the precise benefits and effects of access to credit are often difficult to determine’ (p. 7). Much has happened since the papers by Kim and Watts and Anderson and colleagues were written – HIV interventions studies, which have included microfinance, have been put in place and impact assessments carried out. So, with a growing body of evidence on the impact of these interventions, where are we now in our understanding of the role of microfinance in HIV prevention? In this short paper I provide a brief (and inevitably incomplete) overview of both the broader microfinance arena and also the current evidence on the impact of microfinance on HIV-prevention. I focus on credit and savings and do not include conditional or unconditional cash transfer interventions ([see Pettifor et al. 2012 for a review of cash payment interventions to prevention HIV](#_ENREF_40)). I begin with some background on the growth of the microfinance industry, to provide some context for the discussion of the potential of microfinance for HIV prevention and mitigation.

Microfinance or microcredit is a term used to describe financial services which are available to people who may not have access to formal banking services through which to seek a loan. Microcredit, or microdebt (as Hulme [2000] reminds us it might more accurately be termed), can provide opportunities for poor people to access `“lumps” of money so that they can improve incomes and reduce vulnerability’ ([Hulme 2000, 26](#_ENREF_21)). Microfinance has a very long history, which includes both informal and formal institutions: money lenders, friendly societies and cooperatives, for example. Bateman and Chang ([2012, 14](#_ENREF_8)) note that these institutions:

especially those from the 18th and 19th century onwards, arose from a desire to transform the lives of the poor and the new industrial working classes, as they struggled to cope with the growing perils and exploitation associated with the rise of industrial capitalism.

The recent interest in the provision of microfinance services in developing countries grew out of similar aspirations. In Bangladesh in the 1970s Muhammad Yunus set up projects to provide small loans to village women, to test his idea that access to modest amounts of money could make a significant difference to poor people’s lives. This led to the formation of the Grameen Bank and similar microfinance organisations in Bangladesh and elsewhere. The aim of the Grameen Bank, and other non-governmental institutions such as BRAC and PROSHIKA in Bangladesh, was to provide financial services to poor men, but particularly women in a targeted, convenient and systematic way. Building on the Bangladesh experience there has, since the 1980s, been a proliferation of organisations supporting the provision of small loans to individuals and groups for micro-enterprise development or self-employment initiatives with an ever growing literature describing these projects (see, for example, [Rutherford 2001](#_ENREF_46), [Khandker 1998](#_ENREF_29), [Basu and Srivastava 2005](#_ENREF_6), [Hulme and Moore 2006](#_ENREF_22), [Duvendack et al. 2011](#_ENREF_17)). By the 1990s microfinance was being viewed by many international development organisations as a solution to poverty alleviation, a `golden bullet’ ([Bateman and Chang 2012](#_ENREF_8), [Morduch 1999a](#_ENREF_36)). However, as Bateman and Chang (2012, 25) remind us, the growth of microfinance as an international development tool came at a time when neoliberalism was being enthusiastically embraced in countries supporting that development. Microfinance initiatives foster small-scale entrepreneurship and competition in what is often a limited market, while encouraging borrowers to see a route to prosperity (or indeed out of poverty) to be through their own efforts, not through state intervention.

Microfinance thus offers to neoliberals a highly visible way of being seen to be addressing the issue of poverty, but in a way that offers no challenge whatsoever to the distorted structures of wealth and power that historically are mainly responsible for the creation and perpetuation of poverty (Bateman and Chang 2012, 25).

In addition to Bangladesh and India other early centres of this new wave of microfinance were Bolivia and Indonesia. In Bolivia from the mid-1980s microfinance organisations provided credit for micro-enterprises and in Indonesia, also from the mid-1980s, local outlets of Bank Rakyat Indonesia successfully sought to serve the whole population with access to microfinance (with no particular poverty focus). This difference in the target population for microfinance has led some commentators to make the distinction between Bangladesh where finance was provided for the `*poorest of the poor*’ and Indonesia and Bolivia where the target was `the *economically active poor*’ ([Rutherford 2001](#_ENREF_46)), a distinction I return to below[[1]](#footnote-1).

Given the enthusiasm shown by international development organisations for microfinance as a vehicle for poverty reduction, there has over the last 30 years been a plethora of microfinance activity in Africa ([Blavy, Basu, and Yülek 2004](#_ENREF_9)). But, as in South Asia, this has met with mixed results ([Buckley 1997](#_ENREF_12), [Van Rooyen, Stewart, and de Wet 2012](#_ENREF_55)).

Questions over the beneficial impact of microfinance projects on poverty are not new. Since the early experiences with microfinance in Bangladesh there have been many who have expressed concerns about assumptions that `microcredit is the answer to the problems of poverty’ ([Hulme 2000, 28](#_ENREF_21)). There is a large literature where questions have been raised about targeting, delivery and the content of microfinance interventions ([Chemin 2008](#_ENREF_13), [Banerjee et al. 2013](#_ENREF_5), [Hulme and Moore 2007](#_ENREF_23), [Morduch 1999a](#_ENREF_36), [2000](#_ENREF_38), [1998](#_ENREF_35)). Indeed, there has been a sometimes acrimonious debate on impact assessments of microfinance in Bangladesh and elsewhere (see, for example, [Pitt and Khandker 2012](#_ENREF_41), [Roodman 2012](#_ENREF_45), [Duvendack and Palmer-Jones 2012](#_ENREF_16), [Bateman and Chang 2012](#_ENREF_8)) which raises questions about the microfinance and assumptions that it benefits poor people and is particularly beneficial to women. Perhaps most important for the purposes of this paper, these debates serve as a reminder to look both at the context and timing of interventions as well as the sustainability of any beneficial change.

As noted above, there had been an assumption in Bangladesh in the 1970s/1980s that the microfinance projects of the Grameen Bank, BRAC and PROSHIKA, were targeting the `poorest of the poor’. Increasingly this assumption was questioned in the 1990s and 2000s both by the organisations themselves and the international donor community. David Hulme ([2000](#_ENREF_21)) in his paper on `the dark side of microfinance’ reminds us that microcredit organisations seldom work with the poorest because very poor people do not want to, and cannot afford to, get into debt[[2]](#footnote-2) nor do they have the time and resources to sustain involvement in microfinance group activities. The model for microfinance promoted by the Grameen Bank and similar organisations, for example, was based on women’s groups holding regular (often weekly) meetings where members deposited low-value compulsory weekly savings and received loans, which were intended for investment in new or existing businesses (but not necessarily for consumption needs ([Nourse 2001](#_ENREF_39))), which had to be repaid in weekly instalments. Loans were secured against the track record of the borrowers and with the support of fellow group members, sometimes with borrowers being liable for each other’s loans. Many poorer families could not afford regular savings, or the time to attend group meetings. In addition, existing group members might not welcome members who are not similar to them (by socio-economic or ethnic group, for example) and may pose a risk to the rest of the group ([Thorp, Stewart, and Heyer 2005](#_ENREF_54), [Bosher, Penning‐Rowsell, and Tapsell 2007](#_ENREF_11)). The realisation that microfinance organisations tend to benefit the `not so poor’ rather than the poorest has led over the last fifteen years to considerable efforts in Bangladesh, India and elsewhere, to develop interventions which may include some elements of savings and credit which are sensitive to the needs of the very poor ([Matin and Hulme 2003](#_ENREF_34), [Hulme and Moore 2007](#_ENREF_23)). Even for those who are not the poorest the necessity of ensuring repayments (with, as the sector has become increasingly commercialised, interest repayments ([Stewart et al. 2010](#_ENREF_51))) can place enormous pressure on individuals who may easily slip back into chronic or extreme poverty ([Hulme, Moore, and Shepherd 2001](#_ENREF_24)). If a microfinance intervention is coupled with a health or education project, people who drop out of, or have never been a part of, the microfinance initiative may also not access related components.

Microfinance is also seen as a tool for women’s empowerment. As Rankin ([2002, 2](#_ENREF_44)) observes the:

rhetoric of “solidarity” implies that women who participate in group lending will identify collectively to resist their common oppression […] Yet in practice, the financial imperatives for sustainability often lead microfinance programs to engage the collective only in the most instrumental manner – reducing administrative costs and motivating repayment – at the expense of the more time-consuming processes of consciousness-raising and empowerment. Mere participation in the group borrowing process is often considered a proxy for empowerment, and assumed to generate ample quantities of social capital (in the liberal sense of the term).

Rankin goes on to show through case material from Nepal how women’s groups formed to access microfinance fit within existing gender hierarchies, and are not vehicles for social transformation. Others have made similar observations ([Ballard 2013](#_ENREF_4), [D'espallier, Guerin, and Mersland 2013](#_ENREF_14), [Fouillet et al. 2013](#_ENREF_19)), urging caution over claims that poor people’s (particularly women’s) engagement in micro-credit programmes will necessarily be a catalyst for social change. Indeed, prevailing power structures, influenced by politics, history and societal norms, are not easily transformed by a financial intervention targeting poor people. More likely that intervention will contained within and shaped by those existing structures.

I now want to return to the discussion of the development of HIV prevention initiatives and microfinance. The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) study in South Africa was a `poverty focused microfinance initiative that targeted the poorest women in communities with a participatory curriculum of gender and HIV education’ ([Pronyk et al. 2006, 1973](#_ENREF_42)). This project was reported to have led to reductions in intimate partner violence among participants, but had less impact on rates of unprotected sexual intercourse or HIV incidence. Secondary analysis of the data did show evidence of an impact of the intervention on the sexual behaviour of young women ([Pronyk et al. 2008](#_ENREF_43)). A recent systematic review of income generation activities for HIV prevention by Caitlin Kennedy and colleagues has assessed the impact of the IMAGE study, and other microfinance initiatives on HIV prevention. In their analysis of the 12 studies which met the criteria for their systematic review, they looked at the impact of microfinance alone, rather than in combination with health education or other interventions, on HIV-related behaviours. In the two studies where this was assessed they found no consistent pattern of association between the microfinance intervention and HIV-related behaviour when compared to the control group ([Ashburn, Kerrigan, and Sweat 2008](#_ENREF_3), [Pronyk et al. 2006](#_ENREF_42), [Kim et al. 2007](#_ENREF_31), [Pronyk et al. 2008](#_ENREF_43)). In five studies where the impact of microfinance combined with health education was assessed ([Kim et al. 2009](#_ENREF_32), [Sherer et al. 2004](#_ENREF_49), [Ssewamala et al. 2010](#_ENREF_50)) changes in HIV-related behaviours as well as a reduction in intimate partner violence, as already described above for the IMAGE study ([Pronyk et al. 2006](#_ENREF_42), [Pronyk et al. 2008](#_ENREF_43)), were found. Kennedy et al. (2014: 671) note that even though only a small number of studies were included in the review they represented very different target populations, `settings, study designs and outcomes, we cannot know whether differences in efficacy were due to intervention components or other factors’. They conclude that `the evidence that income generation interventions influence HIV-related behaviours is inconclusive’ ([2014, 659](#_ENREF_28)). This assessment is not surprising when we look more broadly at impact assessments of microfinance initiatives in Africa and elsewhere.

A systematic review of the impact of microfinance in Sub-Saharan Africa, carried out by Rooyen, Stewart and de Wet ([2012](#_ENREF_55)) shows a mixed picture. They conclude that ` specific elements of microfinance seem to work in specific contexts’ but because of the variation in the nature of poverty as well as the types of intervention, `it is hard to draw generalizable lessons’ (p. 2258). Nevertheless, based on information from seven studies which included evidence of the impact of microfinance on health, they concluded that there was a positive impact on the health of poor people because they were sick less often and levels of nutrition had improved. They included the IMAGE study among those assessed and note, as Kennedy et al. (2014) had done, that that intervention `included far more than just micro-credit, with considerable investment in gender and HIV awareness training ([Van Rooyen, Stewart, and de Wet 2012, 2256](#_ENREF_55)).

I have thus far focused on HIV prevention and microfinance projects. There is another way that microfinance may be linked to HIV. Eleanor MacPherson and colleagues ([2015](#_ENREF_33)), writing in this journal, describe the experience with microfinance of women fish traders on the shores of Lake Malawi. The loan procedures followed a pattern in common with the operating procedures of microfinance programmes in many parts of the world: loans were provided to groups and the membership then assumed responsibility for loan repayment together. Larger loans could only be accessed if repayment was completed on time. Men could access loans, but women were preferred by the five organisations providing the loans in the study site because they were seen to be more trustworthy and reliable, and therefore more likely to repay. The microfinance organisations were only providing microcredit services; they were not linked to any health intervention. While most women appreciated the loans and valued being part of a micro-credit group, there was a negative side to the engagement in microfinance. A number of the women worried over loan repayment and the strategies that some had to employ to get money to repay. Women engaged in transactional sex to get the money to repay loans; a strategy which put them at risk of HIV infection in a context of high HIV-prevalence.

While some studies have noted a decrease in domestic violence when a woman joins a microfinance group, others suggest an increase in violence perhaps because of a spouse’s concern over a woman’s increasing independence because of access to money (or their failure to secure a loan for the household) and their involvement with the group ([Kabeer 2005](#_ENREF_26)). Other examples of adverse outcomes or adverse incorporation ([Wood 2003](#_ENREF_57)), may include accessing money at a high interest rate from a money lender or another loan source, in order to pay off a microfinance debt ([Anderson et al. 2002](#_ENREF_2)), or being a member of a group which places demands on an individuals beyond the microfinance activities which are hard to meet ([Howson 2013](#_ENREF_20)).

The considerable and varied experience with the implementation of microfinance projects and programmes in general and the more recent experience with microfinance initiatives linked to HIV prevention, points to the importance of not seeking a `“one-size-fits-all” approach to economic programmes linked to HIV ([Dworkin and Blankenship 2009](#_ENREF_18)). Recent trials of interventions such as SHAZ! in Zimbabwe ([Dunbar et al. 2010](#_ENREF_15)) which did include a microfinance component, and the SHARE and SASA! trials in Uganda ([Wagman et al. 2015](#_ENREF_56), [Jewkes 2015](#_ENREF_25), [Abramsky et al. 2014](#_ENREF_1)), which did not include microfinance but which built on the learning from the IMAGE study, point to the value of interventions that have a range of components, and which do not just target one particular group in a community. However, even these initiatives demand time which may be difficult for the poorest people, or marginalised ethnic/social groups to commit to. Women and men who are unable (or prefer not) to take part in group activities also need HIV prevention support tailored to their circumstances. The quest for a new approach, a new magic bullet, reminds me of Patricia Bonnard ([2002](#_ENREF_10)) short paper in which she suggested that the impact of HIV could be mitigated if we used what we know already to encourage general development, rather than looking for something new. Organisations engaged in microfinance need to continue to take and approach which is `based on an empirically-based understanding of the relationship between context, approach and impact’ ([Kabeer 2005, 4709](#_ENREF_26)) with HIV prevention interventions also building from this understanding. That is not to say that women like the fish traders on the shores of Lake Malawi should not have access to microcredit if that is what they want; there are many benefits from having access to loans. But, perhaps with the growing body of information on the unintended outcomes from such projects microfinance models might be adjusted or additional support put in place, to try to limit negative unintended consequences.

The intimate link between the enthusiasm for microfinance as a poverty alleviation strategy and neoliberalism should not be forgotten. Encouraging people, particularly women, to take loans may provide short-term benefits, including benefits to health, but does not transform the power structures in society if poor women and their families are locked into loan repayments (often at high rates of interest). The reality is that small adjustments will not be enough. Structural change is a necessity if HIV prevention and development programmes which include microfinance are to respond to the broader economic and social issues poor women and men face, in Africa and elsewhere ([Seeley et al. 2012](#_ENREF_48)); that may be an aspiration but it is one worth aiming for.

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1. Donor funding in Bangladesh enabled microfinance institutions to offer poor people rates of interest on loans that are significantly lower than those charged by microfinance institutions in some other countries ([Morduch 1998](#_ENREF_35), [1999b](#_ENREF_37)). [↑](#footnote-ref-1)
2. The consequences for people with problems repaying loans have been played out with tragic consequences in India, Bangladesh and elsewhere with a spate of suicides of people unable to repay their loans ([Bateman 2012](#_ENREF_7), [Taylor 2012](#_ENREF_53), [Karim 2011](#_ENREF_27)). [↑](#footnote-ref-2)