Economy and Epidemic

Microfinance and HIV/AIDS in Asia

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Foreword

In April 2004, The Foundation for Development Cooperation and World Vision International conducted a workshop in Chiang Mai, Thailand entitled 'Integrating Microenterprise Development and HIV/AIDS in Asia'. Objectives of the workshop were:

1. To raise awareness of the challenges of delivering microenterprise development services, especially microfinance, in communities impacted by HIV/AIDS.
2. To explore the role of microfinance in communities impacted by HIV/AIDS, especially in relation to financial innovations that can be employed to assist AIDS-affected clients.
3. To develop a shared understanding of ways and means that HIV/AIDS organisations and microfinance initiatives can collaborate.

The workshop brought together 40 microfinance and HIV/AIDS practitioners from eight Asian countries including Bangladesh, India, Mongolia, Nepal, Laos, Sri Lanka, Thailand, and Vietnam.

During the course of the workshop, participants presented their knowledge and experiences with respect to the impact of HIV/AIDS on their clients and on their microfinance activities. A number of HIV/AIDS-affected individuals from villages near Chiang Mai also shared their experiences of HIV/AIDS and the impact it has had on their household finances.

This paper is an output of the above-mentioned workshop. As such, the author wishes to acknowledge the inputs and contributions of each one of the participants that informed and/or confirmed much of what is written here. I offer special thanks to Dr. Frederick Christopher, Asia-Pacific Regional Advisor, Microenterprise Development.

The paper is written for, and from the perspective of, microfinance practitioners. As such, I have assumed that readers have at least a basic understanding of the principles and practices of microfinance. On the other hand, I have not assumed that readers understand the basic epidemiology of HIV/AIDS.

This paper is the second in a series of three papers prepared by the Foundation for Development Cooperation on 'Microfinance in Crisis Situations'. The three papers are:

1. Microfinance and Disaster Management
2. Microfinance and HIV/AIDS, and
3. Microfinance and Conflict.

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June 2004

The Foundation for Development Cooperation

FDC's mission is to strengthen partnerships for sustainable development and poverty reduction through action research, policy dialogue, advocacy and capacity building. Based in Brisbane, Australia, FDC's focus is on development cooperation in the Asia and Pacific regions and its work is undertaken in collaboration with regional partners and development networks. Through more than a decade of action-based research, advocacy, training and publishing on aspects of microfinance development in the region, FDC has won recognition as a leading Asia-Pacific microfinance support institution.

Since 1991, FDC's microfinance program has aimed to explore, demonstrate and publicise the scope for increasing the access of the poor to microcredit, savings services and other financial services on a sound commercial basis. This extensive program has involved research in twelve countries in the Asia-Pacific region and focused on different aspects of microfinance development.

The goal of FDC microfinance program is to improve the efficiency and outreach of sustainable financial services for the poor in Asia and the Pacific through:

- researching new standards for the industry
- exploring innovative practices in neglected regions; and
- encouraging further integration of microfinance in the global financial system

Additional information can be found on the FDC website (www.fdc.org.au), which lists publications and major achievements in recent years and on the website of the Banking with the Poor Network for which FDC currently serves as the Secretariat. (www.bwtp.org).

Executive Summary

Asia faces a serious AIDS epidemic. In the year 2000, the number of new adult HIV infections per year in Asia exceeded that of Africa for the first time. This paper explores ways that Microfinance Institutions (MFIs) can assist their clients to cope with the impact of HIV/AIDS. For MFIs in Asia, there is a window of opportunity to prepare policies and develop products now that will enable client households that are impacted by HIV/AIDS to fare better than they otherwise might.

Proponents of microfinance often state that its primary purpose is to provide investment capital for microenterprise development. Others, however, have noted that the role of microfinance is broader than that. Microfinance is more generally concerned with providing access to relevant, affordable financial services for poor households *so that they can manage their financial resources more efficiently*. This gives support to the idea that providing financial services that enable poor households to prepare for and cope with the economic impact of crisis events can be viewed as a mainstream microfinance activity. Financial risk management is a key purpose of microfinance, alongside microenterprise development.

In the course of its business activities, an MFI will encounter clients that represent Households Living with HIV/AIDS (HLWHAs). This paper enunciates policy recommendations to help MFIs embrace the reality of HIV/AIDS in meaningful and effective ways, support prevention of HIV/AIDS, and mitigate the economic impact of HIV/AIDS on affected households. These AIDS-related goals, products and services do not conflict with the overriding mission of the MFI. Rather, a well-considered response to HIV/AIDS assists the MFI to protect its loan portfolio and maintain sustainability while at the same time providing valuable services to HLWHAs.

The emphasis of the policy recommendations is not on specific, intensive intervention by the MFI on behalf of AIDS-impacted households. Rather, the emphasis is on providing product and service options so that AIDS-impacted households can make their own choices and chart their own course through a difficult period.

With just a few proactive policies, products and services, a HIV/AIDS–sensitive MFI can make the difference between utter devastation and survival for its AIDS–impacted clients. The best outcomes can be achieved when MFIs and HIV/AIDS Organisations (HAOs) take a collaborative approach, leveraging their particular expertise for the ultimate benefit of their respective clients.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CSW	Commercial Sex Worker
HAO	HIV/AIDS Organisation
HIV	Human Immunodeficiency Virus
HLWHAs	Households Living With HIV/AIDS Note: The more common acronym is PLWHAs (see below). This paper uses HLWHAs to reflect the reality that microfinance clients usually represent households, and that the whole household is impacted when one of its members becomes HIV^+.
IDU	Injecting Drug User
MFI	Microfinance Institution
NGO	Non-Government Organisation
PLWHAs	People Living with HIV/AIDS
STI	Sexually Transmitted Infection
TB	Tuberculosis

Introduction

Scenario 1:[1] Vanna and Sophiap live in Chak Angre Leu, a poor urban community situated to the south-east of Phnom Penh, Cambodia. They have two daughters. For income, Vanna drives a moto-taxi from early until late and Sophiap operates a road-side stall, serving a traditional breakfast porridge to the crowds of people heading to work each morning along the busy highway that bisects their community. They have no cash savings and they regularly utilise loans from moneylenders to smooth out peaks and troughs in their income stream and to pay for school fees, moto repairs and items for Sophiap's stall.

Over the last few months, Vanna has not been well. He has developed a persistent cough. He has been visiting a drug stall in the local market to purchase a cocktail of pills. The seller, who has no medical training, assures him that they will cure him of his ailments. The cost of the pills has consumed a significant portion of his income. Vanna and Sophiap consider it a necessary expenditure; unless he gets well soon he might have to stop riding the moto-taxi and this will have even worse impact on the family budget.

Over the next few weeks, Vanna becomes so ill that he is unable to work. Sophiap continues to operate her breakfast stall but the earnings are not enough to pay school fees. Their eldest daughter now stays at home to care for her father and perform other home duties, while the younger daughter 'assists' her mother at work.

Vanna's health has continued to deteriorate so Sophiap takes him to a local clinic, where he is referred to a medical laboratory for tests. Sophiap wants to keep things quiet so she pays for the tests by taking a loan from a moneylender rather than seeking help from relatives or friends. After a number of days the tests are available. They show that Vanna is HIV$^+$ and he has contracted Tuberculosis (TB). His prognosis is bleak.

Taking Vanna home is not an option because she cannot bear the shame of him being an AIDS sufferer. Vanna is referred to a local TB hospital, which has a bare ward with little medical or nursing care. Sophiap has to stay in the hospital herself to ensure that Vanna is fed and cared for, but it means that she is no longer able to operate her breakfast stall. She has left her children with relatives who have also offered to assist with medical and nursing costs, although their resources are very limited too.

The 'old' TB ward at Preah Ketoh Mealia Military Hospital, Phnom Penh (Photo: Cambodia Daily)

Three weeks later, Vanna passes away. Added to Sophiap's grief is her concern that she is unable to pay for a funeral. Her relatives offer to assist. She manages to organise a basic funeral for Vanna.

Sophiap has little time to grieve. She must get back to work as soon as possible to earn money for her living needs and to repay her debts. She goes back to the breakfast stall but discovers that many of her old customers are avoiding her for fear of catching AIDS through her food. She doesn't blame them really; she'd probably do the same.

Sophiap wonders if life will ever be the same again. Her daughters are not able to attend school, as they must work to supplement the family income. Her ability to earn income

[1] For Scenario 2 – see 'Conclusion'.

has been undermined by mis-information and mis-understanding. Her debts have accumulated and she sees no end in sight. Although her family have helped as best they can, she feels that she has called in enough favours and she doesn't want to be a burden on others. And then, one day, she starts to cough ….

Stories like Vanna and Sophiap's are all too common in many poor communities throughout the world. The downward spiral from a state of relative health and happiness to complete destitution highlights that one of the harshest realities of poverty is the degree of vulnerability to crisis events. Poor households are more vulnerable to crisis events and the resultant impact is likely to be more devastating. Poor households affected by HIV/AIDS often face utter devastation.

This paper explores ways that Microfinance Institutions (MFIs) can assist their clients to cope with the impact of HIV/AIDS. Sophiap's situation might have been a little less stressful if she and Vanna had some savings, if they had access to a more affordable source of credit, if they had access to accurate and timely health advice, if they had been referred to appropriate services rather than waste scarce financial resources on ineffective treatments, if there had been some form of insurance for her loans and/or for funeral expenses, and if the wider community had been more informed about HIV modes of transmission.

Proponents of microfinance often state that its primary purpose is to provide investment capital for microenterprise development. However, while this focus is important, others have noted that the role of microfinance is broader. Microfinance is more generally concerned with providing access to relevant, affordable financial services for poor households *so that they can manage their financial resources more efficiently*. This awareness has resulted in efforts to offer a wider range of financial services, such as savings and insurance, rather than loans for microenterprise investment only. Indeed, this is one reason why we now refer to 'microfinance' rather than the precedent 'microcredit'. Recognition of this broader role of microfinance gives support to the idea that providing financial services that enable poor households to prepare for and cope with the economic impact of crisis events can be viewed as a mainstream microfinance activity. Financial risk management is a key purpose of microfinance, alongside microenterprise development.

Financial Risk Management is a key purpose of microfinance, alongside microenterprise development

Nevertheless, the core activity of most MFIs is lending and while MFIs employ specific techniques that virtually guarantee loan repayment under 'normal' circumstances, there is no guarantee that these repayment rates will be maintained in the face of crisis events. For the sake of their clients and, by extension, for the sake of the integrity of their loan portfolios, it is important that MFIs offer products and services that enable poor households to prepare for and cope with the economic impact of crisis events.

MFIs that operate in communities affected by HIV/AIDS face numerous issues and questions. Should MFIs specifically target Households Living with HIV/AIDS (HLWHAs)? What kinds of financial products and services do HLWHAs need? Is it possible to modify standard service-delivery mechanisms in order to serve HLWHAs better? Should MFIs engage in HIV/AIDS education? Should MFIs provide non-financial support services to HLWHAs? How can MFIs best coordinate with HIV/AIDS organisations (HAOs)?

What is HIV/AIDS? [2]

HIV stands for **H**uman **I**mmunodeficiency **V**irus:

Human: because HIV can only infect human beings.
Immunodeficiency: because HIV causes deficiency in the body's immune system.
Virus: because HIV is a virus. A virus cannot survive in the absence of a living cell within which it can replicate itself. Viruses are harmful because their replication kills the cell they have infected. HIV is the virus that causes AIDS**.**

AIDS stands for **A**cquired **I**mmune **D**eficiency **S**yndrome:

Acquired: because AIDS is a condition that has to be contracted from another person. It cannot be inherited.
Syndrome: because people with AIDS experience a range of diseases and opportunistic infections. Technically, AIDS is not a syndrome but a disease. 'Syndrome' used to refer to collections of symptoms that do not have an easily identifiable cause; this name was appropriate 15 years ago, when doctors were only aware of the late stages of the disease and did not fully understand its mechanisms.

HIV is a fragile virus that does not live long outside the body. It is not an airborne or food-borne virus. It can be transmitted from an infected person to another through blood, semen, vaginal secretions and breast milk. Blood contains the highest concentration of the virus. Activities that allow HIV transmissions include unprotected sexual contact, direct blood contact, and mother to baby (before or during birth, or through breast milk). Since HIV is primarily sexually transmitted, many cultures find it difficult to discuss HIV/AIDS openly. This is a major obstacle to halting the spread of HIV.

The most common way to determine HIV infection is for the individual to undergo an HIV Antibody Test, usually via a blood test. Most people will develop detectable antibodies within three months after infection. In rare cases, it can take up to six months.

A positive HIV test does not mean that a person has AIDS. There may be no symptoms for years after HIV infection and, even then, symptoms are ambiguous. Over time, HIV weakens the immune system and allows other opportunistic infections to get a foothold. These opportunistic infections produce the symptoms of AIDS. For example, evidence has shown that HIV infection increases sevenfold the likelihood that someone carrying the tuberculosis bacillus will develop TB.

The time between HIV infection and the appearance of signs that could lead to an AIDS diagnosis varies from person to person and can depend on many factors including a person's health status and behaviours. There are medical treatments that can slow down the rate at which HIV weakens the immune system, and other treatments that can prevent or cure some of the illnesses associated with AIDS. Early detection of HIV offers more options for treatment and preventative health care. The incubation period is generally shorter in low development countries because people tend to be less healthy and less well nourished to begin with.

97% of HIV infected people do not know their HIV status

The sometimes-long incubation period between infection and illness means that persons who are infected with HIV can have years of normal productive life. Many people will not even be aware that they are HIV^+ and, unfortunately, this means that they might also spread the virus unwittingly during the incubation period.

[2] Source: www.aids.org

'Vulnerability' in the Context of HIV/AIDS [3]

Vulnerability to HIV infection arises from circumstances that are beyond the direct control of the people involved. Such circumstances include poverty, low social status, gender discrimination, marginalisation, and criminalisation. These circumstances reduce a person's access to HIV/AIDS information, services, and means of prevention and support.

Vulnerable populations include women and girls in countries where females are discriminated against, poor people, ethnic groups, refugees, migrants, prisoners, and children. Other groups, such as men who have sex with men, injecting drug users (IDUs) and commercial sex workers (CSWs) may combine risky behaviour with vulnerability. Their vulnerability usually arises from their marginalisation and/or the fact that their behaviour is deemed illegal or immoral. This marginalisation and criminalisation result in much less access to the knowledge, means and services necessary to avoid HIV infection.

Poverty is the single most significant variable contributing to both the spread and impact of HIV/AIDS

Most of these groups are also more vulnerable with regard to the impact of AIDS. They have less means to live positively with AIDS, because they cannot afford treatment, cannot access care, may lose their incomes and resources, and may face increased stigma and discrimination due to their HIV^+ status.

HIV/AIDS in Asia

Poverty is the single most significant variable contributing to both the spread and impact of HIV/AIDS. In light of this, it is sobering to note that approximately 60 percent of the world's poor live in Asia. Addressing the 2002 East Asia Economic Summit of the World Economic Forum, the UNAIDS Executive Director, Dr. Peter Piot, warned that:

> *'the epidemic in Asia threatens to become the largest in the world …. with more than half the world's population, the region must treat AIDS as an issue of regional urgency. The question is no longer whether Asia will have a major epidemic, but rather how massive it will be.'*

In terms of percentage adult HIV infection rates, the figures for Asian countries are currently low in comparison to the countries of sub-Saharan Africa.[4] However, the low national average figures should not be taken to indicate that HIV is not a significant problem in Asia. The reasons for this are outlined below.

First, it is absolute numbers as much as percentages that are particularly relevant. For example, current predictions for the spread of HIV in India suggest that, although the national infection rate is projected to be 'only' four percent in 2010, this would represent between 20-25 million people. In absolute terms, this is higher than for any other country in the world. China is expected to have 10-15 million PLWHAs by 2010.[5]

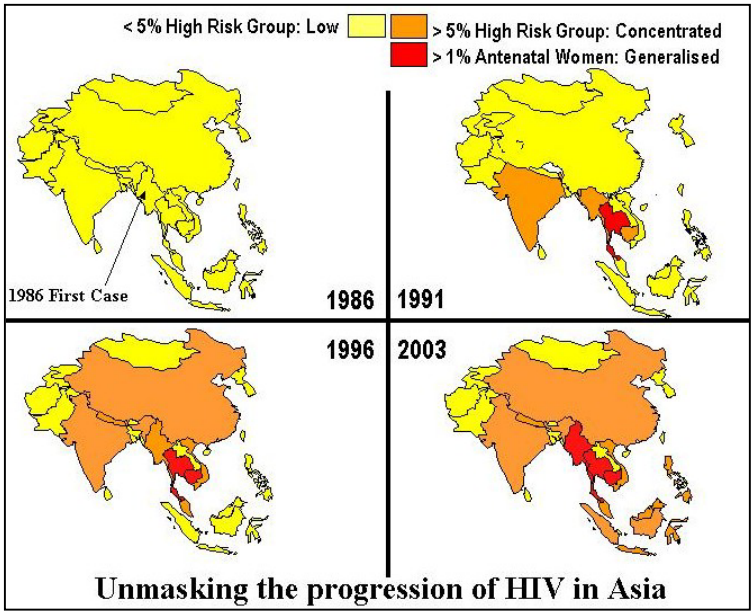
The epidemic in Asia threatens to become the largest in the world

[3] http://www.unaids.org/en/resources/questions_answers.asp#II

[4] For example, Botswana's adult HIV infection rate is 38.8 percent; Zimbabwe's is 33.7 percent.

[5] D.F.Gordon. 2002. *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China*. US National Intelligence Council. p3. http://www.fas.org/irp/nic/HIV-aids.html

Second, in modelling the spread of HIV, localised trends within specific high-risk groups are particularly relevant. It is common for a population to accumulate pressure for a sudden surge of HIV infection, following what appears to be a period of little growth. While these figures have little impact on the national average, they represent momentum for spread of HIV. [6]



Unmasking the progression of HIV in Asia

National averages for HIV infection conceal the fact that in countries like China, India and Indonesia, many of their regions have larger populations than most countries of the world. In some of these regions, HIV prevalence is quite high in the general population, indicating that the virus has started to move from high-risk groups into the wider community. For example, the Indian state of Maharashtra has registered HIV prevalence of four percent among the general population in some areas. The states of Andhra Pradesh, Tamil Nadu and Karnataka have registered similar figures.[7]

In addition to high populations and population densities, another key factor in Asia's particular susceptibility to a major AIDS epidemic is the mobility of the populations, both internal and external. One of the drivers of this mobility is poverty / lack of food security. For example, there are an estimated 120 million internal migrant workers in China. Another driver of mobility is, paradoxically, regional development. For example, the ASEAN Highway, comprising 23 highways stretching some 37,000 kilometres, adds to the risk of the spread of HIV in the region.[8]

Appendix 1 provides a summary of the AIDS situation in various Asian countries. India is the most worrying case. The other South Asian countries also face the prospect of widespread AIDS epidemics, although they do have opportunities to stem the spread of the virus.

The epicentre of HIV/AIDS has moved from Africa to Asia. Asia faces a serious AIDS epidemic. It is, however, still early days in the development of the epidemic. A window of opportunity exists where countries in Asia can take action now to significantly reduce the ultimate impact of the epidemic. For MFIs, there is opportunity to prepare policies and develop products now that will enable client households that are impacted by HIV/AIDS to fare better than they otherwise might.

In the year 2000, the number of new adult HIV infections per year in Asia exceeded that of Africa for the first time

[6] Notes and figure from a presentation by Dr. Sri Chander, Regional Health Advisor, World Vision International.
[7] Gordon. 2002. *The Next Wave of HIV/AIDS*. p13. http://www.fas.org/irp/nic/HIV-aids.html
[8] Notes from a presentation by Dr. Sri Chander, Regional Health Advisor, World Vision International.

The Economic and Social Impacts of HIV/AIDS

In countries where a full-blown AIDS epidemic has taken hold, public resources are diverted from active development to crisis management, productivity of the workforce is reduced as it becomes depleted, traditional family and community structures may breakdown, and there may be risks to political stability and the rule of law. Adverse impact is not restricted to households that are directly touched by HIV/AIDS; everyone is impacted at least indirectly.

Economic growth rates in India between now and 2025 will be cut by 75% if India has an AIDS epidemic of 'intermediate' severity

Source: American Enterprise Institute

Of particular interest to MFIs is the economic impact of HIV/AIDS on clients and their households. This impact can be exacerbated by misinformation and misunderstanding about the nature of HIV/AIDS, by lack of access to the most effective options for treatment and care, and by lack of access to relevant, affordable financial services.

When a person first becomes infected by HIV, there might be no impact on their health and economic productivity for a significant period, depending on the health status of the individual and availability of affordable, effective treatments.

Once the health of the infected individual begins to deteriorate, economic productivity will be reduced. It will be more difficult for the infected individual to work, and the care demands of that person will reduce the productivity of other members of the household.

HLWHAs might spend increasing proportions of their income on medical treatment. However, if the treatment is unnecessarily delayed, inappropriate, and/or ineffective, the expenditure might be wasted completely.

When the combined cost of medical treatment and living expenses exceeds household income, the household will need to employ specific strategies to cope economically. 'Low-stress' strategies include reducing consumption, using accumulated savings and calling in debts from neighbours and relatives. 'Medium-stress' strategies include selling non-essential household assets and obtaining loans. 'High-stress' strategies include selling productive assets and loan default. The difference between these strategies is that low-stress strategies are easily reversed whereas high-stress strategies are difficult to reverse.

Eventually, the AIDS patient will die. Death is expensive. The household will likely cease all economic activities for a period of mourning. Funeral costs can be high, depending on cultural practices. It may take some time for the remaining members of the household to restructure their lives and return to economic productivity.

To protect their economic position, poor households need to avoid high-stress coping strategies. There are, however, limits to the low and medium-stress adjustments a household can make. Reduced consumption over long periods can negatively impact health and this can affect earning capacity. Non-essential household assets are not always easy to sell, and loans might not be available or they may come at exorbitant interest rates. Even without providing any products or services that are specifically designed for AIDS-impacted clients, MFIs contribute to the risk management options of their clients simply by providing sustainable, affordable financial services. In this sense, the first and most important way in which MFIs can prepare for the impact of an AIDS epidemic is to improve its outreach and sustainability. Strong MFIs are better placed to provide relevant and helpful services to their clients. Successful MFIs have effective governance, strong human resource management, accurate management information systems, and effective portfolio management. They offer services that fit the preferences of poor households, they are efficient, and they operate on a business-like basis.

HIV/AIDS Policy Recommendations for Microfinance Institutions

Key Themes:

AIDS-Sensitive
Non-discriminatory
Flexible products
Collaboration
Public awareness

The overriding mission of an MFI is to provide financial services to poor households on a sustainable basis. In the course of its business activities, an MFI will encounter clients that represent HLWHAs. The purpose of the following policy recommendations is to help MFIs embrace the reality of HIV/AIDS in meaningful and effective ways, support prevention of HIV/AIDS, and mitigate the economic impact of HIV/AIDS on affected households. These AIDS-related goals, products and services do not conflict with the overriding mission of the MFI. Rather, a well-considered response to HIV/AIDS assists the MFI to protect its loan portfolio and maintain sustainability while at the same time providing valuable services to HLWHAs.

The emphasis of the policy recommendations is not on specific, intensive intervention by the MFI on behalf of AIDS-impacted households. Rather, the emphasis is on providing product and service options so that AIDS-impacted households can make their own choices and chart their own course through a difficult period.

Identity as a HIV/AIDS-Sensitive Microfinance Institution

An important general objective in the fight against HIV/AIDS is to overcome the fear and ignorance that surrounds the disease. An MFI can contribute to this objective by clearly identifying itself as a HIV/AIDS–sensitive institution. In doing so, the MFI can become known as an institution that is dealing pro-actively and openly with the disease:

Policy 1: The MFI will include an explicit HIV/AIDS commitment in its mission statement and bi-laws.

Policy 2: The MFI will identify itself clearly on its publications and literature as 'a HIV-sensitive, Gender-sensitive and Inclusive MFI' (or some similar slogan).

Policy 3: The MFI will have a non-discriminatory policy for board and staff recruitment.

Households Living with HIV/AIDS as Microfinance Clients

Policy 4: As a demonstration of its identity as a HIV/AIDS–sensitive institution, the MFI's client selection policies will be non-discriminatory. The MFI will service existing and potential clients irrespective of HIV status.

Policy 5: The MFI should make concerted effort to reinforce this policy by sensitising management, staff and clients about HIV/AIDS, developing ways to ensure that AIDS-affected clients do not face exclusion or discrimination from other clients on the basis of their HIV status, and developing ways to work pro-actively with AIDS-affected clients.

Policy 6: In accordance with standard loan assessment processes, the health status of a prospective borrower or of any person on whom the prospective borrower is wholly or significantly dependent is of valid and vital interest to the MFI. Loan officers will request appropriate health assessment of a prospective borrower or person on whom the borrower is dependent if there is reason to believe that ill-health may hinder successful repayment of a proposed loan.[9]

[9] This policy relates to any and all adverse health conditions and is not specific to AIDS-affected clients. The policy is included here only because HIV/AIDS is a particular health issue.

Policy 7: An MFI client's health status, including HIV status, is the private and confidential information of the client. If the client's health status is disclosed to the MFI as part of the loan assessment process or for any other reason, the MFI shall respect and protect absolutely the confidentiality of this information. This confidentiality extends to information that might imply HIV^+ status, such as access to certain special products or services.[10] Maintenance of this policy requires strict guidelines for loan officers, and constant emphasis of its importance.

Financial Products and Services for Households Living with HIV/AIDS

Policy 8: The MFI will highlight products and services that are likely to be of particular relevance to HLWHAs and will actively market these as a package of special products and services available to HLWHAs. These products and services will allow HIV^+ clients, in conjunction with their household members, advisors, and loan group members, to construct a financial strategy that reflects the situation of the household, their enterprise activities, and the impact of declining health on the economic productivity of the HIV+ individual.

Policy 9: The existence and details of these special products and services, and criteria for accessing them, will be marketed and promoted irrespective of demand.

Policy 10: Criteria for accessing these special products and services will include standard clinical HIV tests for the applicant. In defining these criteria, the MFI will consult fully with local HAOs, including government and/or non-government organisations (NGOs). Only clients that meet the specified criteria are entitled to access the special products and services.

(In the face of an emerging AIDS epidemic, it is important that individuals who suspect they may be HIV^+ undergo a clinical test. The MFI will promote HIV^+ testing by insisting on this as a condition for accessing special products and services).

Specialised Financial Advice

When a person returns a positive HIV test, it is common for that person to receive counseling regarding the implications of being HIV^+. Sound financial advice offered at this time can have significant benefit. Key financial issues faced by HLWHAs include:

a) Development of enterprise strategies that can survive beyond the HIV^+ individual. That is, enterprises that other household members can operate both now and in the future.

b) Potential for wasting significant financial resources on ineffective medical interventions.

c) In light of the threat of opportunistic diseases, some income-generating activities, especially those that involve the raising of certain livestock, might not be suitable activities for HIV^+ persons.

d) Accumulation of cash savings for future periods of low (or no) economic activity due to declining health of the HIV^+ individual.

e) Accumulation of cash savings to meet future expenses including medical and funeral expenses.

f) Transfer of ownership of assets to surviving beneficiaries/nominees.

[10] This requirement has implications for the design of these special products and services.

Policy 11: Specialised financial advice should be an integral part of counseling provided to persons who test HIV$^+$. Specialised financial advice should also be provided to all economically active members of the affected household.

Policy 12: The delivery of AIDS counseling services is managed by HAOs but MFI representatives can be part of a collaborative effort to assist HLWHAs make pro-active financial decisions.

Policy 13: MFI loan officers should be aware of the key financial issues faced by HLWHAs so that they can provide initial and on-going informal advice to HIV$^+$ clients.

Policy 14: MFI loan officers should be aware of formal counseling services that are available to HIV$^+$ persons, and they should explicitly and formally refer any client that presents as HIV$^+$ to these service-providers.

Policy 15: HAO staff should be aware of the products and services offered by the MFI, including and especially those products and services that are offered to HLWHAs.

Loan Products

Policy 16: It is uncertain how long the HIV$^+$ individual will be able to remain economically active, and it is not a *fait accompli* that HLWHAs will cease to be economically productive. Therefore, provided the HIV$^+$ client heeds advice relating to key financial issues faced by HLWHAs, there is no reason for the MFI to stop or reduce lending to that client. Loans are approved on the basis of risk assessment and the viability of business plans, and not on the basis of pre-conceived assumptions about vulnerability and/or reduced productivity.

Policy 17: While the MFI seeks to offer a range of flexible loan products that meet particular needs of their clients including HLWHAs, these products and services will nevertheless be drawn from the standard menu of loan products. The loans of HLWHAs are provided on the basis of standard terms and conditions.

Savings

Households that have accumulated cash savings will be better placed to cope financially through a health crisis such as AIDS. Many MFIs, however, are not licensed to accept deposits. Furthermore, some MFIs decide that they will not offer deposit services, irrespective of their legal position, because this adds a level of prudential complexity they do not wish to accept.

Policy 18: Irrespective of whether or not they accept deposits themselves, MFIs should encourage their clients to accumulate savings as a buffer against crisis events.

Policy 19: MFIs should encourage HAOs to facilitate savings groups to assist HLWHAs to accumulate savings for specific purposes such as lower income during times of reduced economic activity, and for medical and funeral expenses. This is over and above any standard requirement by MFI clients to demonstrate savings history for the purpose of accessing loans.

Insurance

Policy 20: All but the simplest and focused insurance measures are difficult to implement and control. Therefore, it is best if the MFI acts as a link between clients/groups and reputable insurance companies who can provide general insurance.

Policy 21: As an alternative to insurance, MFIs can encourage their clients (including HIV+ clients) to maintain savings in order to meet needs that arise in crisis situations. (see 'Savings', above).

Grants

Policy 22: The MFI operates according to business principles and does not, under any circumstances, offer grants either in cash or in kind. All loans are to be recovered either from the borrower or from the borrower's guarantor(s).

Collaboration between Microfinance Institutions and HIV/AIDS Organisations

Microfinance and HIV/AIDS are specialist fields with distinct missions and specific goals. There are, however, numerous opportunities for strategic collaboration that are mutually reinforcing, allowing MFIs and HAOs to concentrate on their core competencies and to leverage their particular expertise for the ultimate benefit of their respective target communities.

Policy 23: Any collaboration between the MFI and HAOs will be based on open recognition of the strategic interests of the partnering organisations, and will seek to exploit and combine their respective core competencies to the ultimate benefit of poor families and HLWHAs.

Policy 24: To ensure that communication lines between the MFI and HAOs remain open and functioning, the MFI will become a member of the local HIV/AIDS committee (or similar umbrella organisation/network).

Promotion of Public HIV/AIDS Awareness

Policy 25: HAOs will be invited to:

- **a)** Provide awareness and training for MFI loan officers so that they are able to constructively engage clients in informal discussions about HIV/AIDS.
- **b)** Provide promotion materials (e.g. such as posters, pamphlets, 'advertisements' in passbooks, condoms, etc) for distribution in appropriate contexts offered by the MFI.
- **c)** Provide advertising materials for upcoming HIV/AIDS events for dissemination through the MFI context.
- **d)** Suggest other promotional activities to be delivered by the HAO through the MFI context, which the MFI will consider for implementation.

Policy 26: Promotional activities delivered by the HAO through the MFI context will be subject to the following constraints:[11]

- **a)** If MFI clients are compulsorily required to attend meetings for any purpose other than the completion of financial transactions, these will be explicitly defined in the loan contract and thus formally agreed to by the client.
- **b)** Non-financial educational activities targeted at MFI clients will not be disruptive of MFI operations and must be considered by the MFI to be a cost-effective activity that adds real value to the institution and its clients.

[11] Note: These constraints apply generally to any and all non-core activities, not only for HIV/AIDS promotional activities.

Conclusion

Scenario 2:[12]

Vanna and Sophiap live in Chak Angre Leu, a poor urban community situated to the south-east of Phnom Penh, Cambodia. They have two daughters. For income, Vanna drives a moto-taxi from early until late and Sophiap operates a road-side stall, serving a traditional breakfast porridge to the crowds of people heading to work each morning along the busy highway that bisects their community.

Sophiap is a client of a local MFI. The MFI loan officers provide Sophiap with basic financial advice, especially concerning microenterprise development and financial risk management. She and Vanna have accumulated some savings, which have been deposited with the MFI. They occasionally obtain loans from the MFI to smooth out peaks and troughs in their income stream and to pay for school fees, moto repairs, and items for Sophiap's stall. The interest rate charged on these loans is reasonable, especially in comparison to interest charged by moneylenders. Included in the interest charge is a premium that is contributed to a 'funeral fund' - in the event that either Vanna or Sophiap should die, the MFI would make a pre-determined cash contribution to help cover funeral costs. Representatives of a local HAO have visited her loan group on a number of occasions to provide education about HIV/AIDS.

Over the last few weeks, Vanna has been feeling unwell. He has started to develop a cough. Thanks to the education received from the HAO representatives, Sophia recognises the warning signs of TB. She discourages Vanna from purchasing medicines from the market sellers. Instead, she takes him immediately to a specialist clinic where she knows Vanna will at least receive a proper diagnosis. The clinic takes a number of tests that indicate that Vanna is HIV$^+$ and he has contracted TB.

The clinic starts Vanna on a course of medication that will at least keep the TB at bay for some time. The medication is expensive, but they have enough savings to cover this cost. Vanna is careful to wear a mask over his mouth and nose so that he does not infect others with TB. (Wearing a mask is a common practice among moto-drivers, so this does not draw particular attention to Vanna). He is still able to drive his moto-taxi occasionally, especially in the early morning and late afternoon when it is less physically demanding. He stays at home during the heat of the day, but doesn't require Sophiap to look after him.

This situation continues for nine months, after which his condition begins to deteriorate. Vanna becomes so ill that he is unable to work. Sophiap continues to operate her breakfast stall. Their eldest daughter stays at home to care for her father and perform home duties.

After three agonising weeks, Vanna passes away. The MFI officers are aware of the situation. They arrange for an immediate payment to help Sophiap cover funeral costs.

Sophiap has little time to grieve. She must get back to work as soon as possible to earn money for her living needs and to repay her debts. She goes back to the breakfast stall and begins the slow road to recovery. Her friends and neighbours seem especially keen to buy from her, as they know it will help her get back on her feet again.

MFIs should include a risk management perspective to their mission and goals, to complement the microenterprise development perspective. With just a few proactive policies, products and services, a HIV/AIDS–sensitive MFI can make the difference between utter devastation and survival for its AIDS–impacted clients. The best outcomes can be achieved when MFIs and HAOs take a collaborative approach, leveraging their particular expertise for the ultimate benefit of their respective clients.

[12] For Scenario 1 – see 'Introduction'.

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Appendix 1 – Country Details – UNAIDS Extracts

A brief synopsis of the HIV/AIDS situation in various Asian countries follows. Extracts are from the UNAIDS website (www.unaids.org). This website information is updated periodically, so the reader may wish to consult the website directly to obtain further information.

Bangladesh

'Bangladesh, with a population of 130 million, is a country with low HIV prevalence but high vulnerability. UNAIDS estimates that the number of HIV^+ cases is approximately 13,000. Bangladesh has documented the lowest condom use, very high numbers of clients of CSWs, low knowledge of HIV/AIDS, and extensive needle/syringe sharing by IDUs in the region. In spite of this, national commitment to AIDS prevention and care is high. Bangladesh has the key ingredients for a successful response: a nationwide network of NGOs implementing effective interventions, examples of effective government/NGO collaboration, a sector-wide approach to health with mechanisms for donor collaboration, and an enabling multi-sectoral policy'.[13]

Cambodia

'Cambodia is faced with significant development challenges. These challenges include a lack of skilled human resources and infrastructure, as well as rampant poverty. Health and community services are working hard to cope with the burden. Cambodia has, nevertheless, made progress in its fight against AIDS. Over the last two years, Cambodia has achieved a decrease in adult HIV infection rates from over four percent to 2.6 percent. Contributing factors to this success include political commitment, a strong response from civil society and a range of activities by the Ministry of Health. HIV transmission is mainly via heterosexual intercourse, although more research is needed to better understand sexual behaviour contributing to the epidemic. Scaling up successful projects is crucial for sustaining the reduction in HIV transmission and the impact of AIDS'.[14]

China

'China has a population of 1.28 billion. It is currently experiencing one of the most rapidly expanding AIDS epidemics in the world. Since 1998, the number of reported cases has increased by about 30 percent annually. At the end of 2002, the Ministry of Health estimated that there were more than one million PLWHAs in the country. Unless there is effective intervention, by 2010 China could have as many as 10 million PLWHAs and 260,000 orphans.

Until recently, the most frequent modes of HIV transmission have been sharing of contaminated needles among IDUs and unsafe practices related to blood plasma collection. However, the spread of HIV is also gaining momentum through both heterosexual and homosexual intercourse and it is feared that it will soon start spreading rapidly among the general public. Underlying vulnerability factors include poverty, large-scale labour migration, lack of knowledge and life skills, gender imbalances and widespread stigma and discrimination'.[15]

India

'India, with a population of 1.027 billion, has an HIV infection rate estimated at 0.7 percent of the adult population. In 2001, it is estimated that four million adults were infected. With the

[13] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/By+Country/Bangladesh.asp
[14] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/cambodia.asp
[15] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/china.asp

current disease burden, AIDS will emerge as the largest cause of adult mortality this decade, together with an additional one million TB cases.

India is one of the few countries that initiated prevention activities in the very early stages of the epidemic, and the country has maintained its commitment to this. However, due to the vast size of the country, there are many challenges involved in expanding the high-level commitment to all states and to the grass-roots level, involving ministries other than health, and scaling-up interventions to meet the projected needs for prevention and care. Despite a strong intervention strategy, the number of infections is still on increase in the high prevalence states due to inadequate coverage of high-risk population. Those states that still have low HIV prevalence are vulnerable because of migration patterns'.[16]

Indonesia

'Indonesia, with a population of 231 million people, is recovering from the regional economic slump, political and social turmoil, and inter-ethnic conflict. For many years, very few HIV infections were found in Indonesia, even among vulnerable groups such as CSWs and IDUs. Over the last two years this has begun to change. HIV has risen to alarming levels among IDUs (47 percent in Jakarta, 2002), CSWs (26 percent in one site, 2002), and prisoners (22 percent in Jakarta, 2001). A national estimation process in October 2002 estimated that 80,000 to 120,000 Indonesians nationwide HIV$^+$. Modelling indicated that without significant behavioural change, another 80,000 Indonesians would become infected in 2003. Priority areas for action include reducing the vulnerability of specific populations, promoting safer sex behaviour, promoting and distributing condoms, prevention and treatment of STIs, safe blood transfusion, treatment and care of PLWHAs, mitigating the impact of AIDS, and laws and regulations'.[17]

Lao PDR

'Lao is a country where HIV prevalence has remained low, with estimates of around 0.05 percent. However, with high HIV prevalence rates in all of Lao's five neighbouring countries (including Cambodia, Myanmar and Thailand) and population mobility increasing within and across borders, the vulnerability of Lao is clear. The spread of HIV is now becoming more apparent. Efforts of national and international partners over recent years have resulted in an increase in awareness of HIV/AIDS among the general population and behaviour is changing, as evidenced by the increase in condom use. With heterosexual intercourse being the primary mode of transmission, CSWs and mobile populations are the most vulnerable groups. Activities such as peer education, life skills training and other behaviour change activities are already targeting these groups'.[18]

Nepal

'Nepal is one of the least developed countries in the world. The population is estimated to be 23 million with approximately 85 percent living in rural areas and over 40 percent living under the national poverty line.

Nepal has recently recognised HIV/AIDS as a burning development issue. The AIDS epidemic is concentrated among CSWs, IDUs and labour migrants, with infection rates rapidly increasing in recent years. Stigmatisation, political turmoil, poverty, gender inequality and competing developing priorities fuel the AIDS epidemic and may make it the leading cause of death among 15 to 49 year-olds over the next 10 years. Key challenges include the rapid scaling-up of behavioural change interventions among vulnerable groups and young people, establishment of an adequate care and support system, rapid expansion of multi-sectoral response both at

[16] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/india.asp
[17] Extract from http://www.unaids.org/nationalresponse/result.asp
[18] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/lao+pdr.asp

national and decentralised level, capacity-building, second generation surveillance, and monitoring and evaluation'.[19]

Mongolia

'Mongolia is a land-locked country in Central Asia with a population of 2.4 million. The country shfited to democracy and a free market economy in the 1990s. This transition continues to result in social and economic changes. Financial difficulties experienced by the Government in the last few years has resulted in reduced support to all sectors, especially education and health. Widespread poverty is associated with ill health, homelessness, hampered access to education and increasing numbers of sex workers. There has also been an increase in internal migration. Mongolia is in a very early stage of the HIV/AIDS epidemic, with only 3 reported cases. The estimated number of PLWHAs is less than 100. The high STI prevalence in the general population is indicative of the threat of HIV spread in the country'.[20]

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Pakistan

'Unlike many other countries, Pakistan has a window of opportunity to prevent a generalised AIDS epidemic. While HIV prevalence is still low at 0.1 percent, Pakistan must move rapidly to protect the future of its 152 million people. There is potential for rapid increase in HIV prevalence due to widespread unsafe sexual practices, sex work, and injecting drug use, against a backdrop of poverty, gender inequalities, low literacy and large refugee and migrant populations. Pakistan's many competing needs and priorities have made resource mobilisation for HIV/AIDS difficult. Despite these challenges, political commitment to HIV/AIDS has significantly increased in recent years. The government has undertaken a comprehensive and participatory strategic planning process, which has resulted in a multi-sectoral National Strategic Framework'.[22]

Philippines

'The Philippines has an AIDS epidemic that has huge explosion potential. Risky behaviour is a major concern. A large sex industry exists throughout the country. Casual sex is prevalent among the youth. Regular and correct use of condoms is low. Many of the country's seven million migrant workers are vulnerable. HIV infection among CSWs, IDUs, and overseas workers is increasing. Condom use remains low.

[19] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/nepal.asp
[20] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/mongolia.asp
[21] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/nepal.asp
[22] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/pakistan.asp

The country is still trying to recover from a serious economic crisis and much of its scarce resources have been committed to other social and development priorities. A decrease in government funding due to the economic downturn has hampered HIV/AIDS interventions. There is, however, a persistent multi-sectoral effort to accelerate the national response. Pilot projects involving local government units, NGOs and the private sector have demonstrated success in HIV/AIDS education and counselling, condom promotion, STI prevention and management, and surveillance. With the enactment of the Philippine AIDS Law (Republic Act 8504), the policy environment has become conducive to bringing interventions up to scale'.[23]

Sri Lanka

'Sri Lanka has low HIV prevalence but is highly vulnerable to a substantial increase. Approximately 23 percent of the 19 million population lives in urban areas, and 25 percent live below the poverty line. With a literacy rate of 94 percent for males and 88 percent for females, health messages readily penetrate to the public. The HIV rate among CSWs is thought to be under 1 percent. Nevertheless, the country is considered vulnerable due to a range of risk factors, including: a growing sex industry (particularly where armed forces are stationed and along major trucking/transportation routes), low use of condoms, high and growing number of STIs, external migration, internal mobility and displacement of populations due to conflict, tourism, and young women working in the Free Trade Zone areas'.[24]

Thailand

'There are very few developing countries in the world where public policy has been effective in preventing the spread of HIV on a national scale. Thailand is an exception, where a massive program to control HIV has reduced visits to CSWs by half, raised condom usage, curtailed STIs dramatically, and achieved substantial reductions in new HIV infections. Thailand's efforts to slow the AIDS epidemic have shown the potential impact such programs could have worldwide.

Although Thailand has shown prevention successes with strong political commitment and the promotion of a multi-sectoral approach, the country faces demanding socioeconomic consequences with the large number of PLWHAs. One in 60 people out of the country's population of 62 million is HIV^+. AIDS has become the leading cause of death. Challenges for the country include reviving intensive HIV prevention efforts, providing care and support to PLWHAs and maintaining political commitment at the highest level and in every government ministry. Unless past efforts are sustained and new sources of infection are addressed, the striking achievements made in controlling this epidemic could be put at risk'.[25]

Viet Nam

'Viet Nam has high HIV prevalence among CSWs, clients of CSWs and IDUs. As many as 50.5 percent of total HIV infected cases reported are young people aged 20 to 29 years. It is estimated that by the year 2005, there will be 200,000 PLWHAs. Critical issues for the response to AIDS is the establishment of a supportive policy environment, scaling up programmes for national coverage and building local capacity'.[26]

[23] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/philippines.asp
[24] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/sri+lanka.asp
[25] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/thailand.asp
[26] Extract from http://www.unaids.org/Unaids/EN/Geographical+area/by+country/viet+nam.asp