Economy and Epidemic. Microfinance and HIV/AIDS in Asia

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Abstract

Proponents of microfinance often state that its primary purpose is to provide investment capital for microenterprise development so that clients can grow their income and assets. A complementary microfinance strategy is to assist clients to *protect* their income and assets from the impact of crisis events such as AIDS, natural disasters or conflict. Financial risk management is, or at least should be, a key goal and activity of Microfinance Institutions (MFIs).

Asia faces a serious AIDS epidemic and the people most at risk – the poor in general, and poor women in particular – are also target groups for microfinance initiatives. MFIs in Asia cannot ignore the reality of HIV/AIDS given the impact it does and will continue to have on their clients. This paper describes ways that Microfinance Institutions (MFIs) in Asia 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, products and services now that will enable client households that are impacted by HIV/AIDS to fare better, especially in financial terms, than they otherwise might.

This paper enunciates policy recommendations to help MFIs embrace the reality of HIV/AIDS in meaningful and effective ways, support the prevention of HIV/AIDS, and mitigate the economic impact of HIV/AIDS on affected households.

Introduction

Scenario 1:[2] Vanna and Sophiap live in Chak Angre Leu, a poor urban community situated to the southeast 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 going 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.

Vanna has not been well lately, having 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 the pills 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 costs. Their eldest daughter now stays at home to care for her father, 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 Sophiap 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 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 offered to assist with medical and nursing costs, although their resources are also very limited.

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, and she manages to organise a basic funeral. However, she has little time to grieve. She must get back to work as soon as possible to earn money for living needs and to repay debts. She goes back to the breakfast stall but discovers that many of her 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 has been undermined by misinformation and misunderstanding. Her debts have accumulated and she sees no end in sight. And then, one day, she starts to cough ….

Stories like Vanna and Sophiap's are common in 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 high 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 impacted by HIV/AIDS often face utter devastation.

This paper explores ways that Microfinance Institutions (MFIs) can assist their clients to cope with the financial 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 been referred to appropriate health care 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.

Introduction to Microfinance

Microfinance is the provision of relevant and affordable financial services to poor households that do not have access to the services offered by 'traditional' financial institutions. The 'micro' prefix refers to the size of the financial transactions; it does not imply that the MFIs themselves are small.[3] Microfinance is primarily concerned with credit and savings although, in recent times, allied services such as insurance, leasing, payment transfers and remittances are being introduced to the mix of services. Demand for microfinance services usually comes from 'microentrepreneurs'; people who survive by generating income for themselves in very small business activities.

Providing microfinance services to poor clients requires innovative operating methods to manage risk and reduce transaction costs. Poor households do not usually have physical assets to offer as collateral for loans, so microfinance providers have developed substitutes. The most common form of substitute collateral has been the formation of groups of borrowers and the establishment of joint-liability procedures, where loan group members effectively guarantee one another's loans. To reduce transaction costs, microfinance providers primarily deal with these loan groups rather than with individual clients, and they outsource various administration tasks to the groups.

Some MFIs have developed from existing community-based savings and loans cooperatives. In India, for example, these are often referred to as village "self-help" groups. Other MFIs have evolved out of the revolving loan programs of charitable non-government organisations, which offered loans to help beneficiaries develop income-generating activities. Other MFIs have been established by commercial banks or government-owned development banks, either as a response to their observation that providing financial services to the poor could be a suitably viable business opportunity, or as a response to government edict that they provide financial services to all segments of the community, including the poor.

Since the early 1990s, a major emphasis within the microfinance sector has been on institutional development, including building the quality and capacity of the governance and management of MFIs. This institutional development is necessary for a number of reasons. First, if MFIs accept client deposits, they are generally required to meet the prudential and regulatory requirements as defined in local banking laws. Essentially, they are required to become licensed banks. Second, institutional maturity is needed to enable growth in client outreach. Growth in the client base allows the MFI to reap advantages of scale, thereby achieving a greater degree of financial sustainability. (Financial sustainability for an MFI means that it is generating enough revenue

from interest charges and fees to cover all direct and indirect costs, including operating expenses, provision for loan losses, and adjusted cost of capital).[4] Third, institutional maturity is necessary to attract capital investment, whether concessionary or commercial, from external sources.

The overriding mission of an MFI is to provide financial services to poor households on a financially sustainable basis. While most MFIs have a pro-poor, development-oriented emphasis, they are more correctly understood as banks rather than as charitable development organisations. Indeed, many MFIs are licensed banks.

Introduction to HIV/AIDS in Asia

Poverty is perhaps the single most significant variable contributing to both the spread and impact of HIV/AIDS. Across the world, HIV/AIDS is becoming increasingly concentrated in poor populations and communities. The poor have less access to information, education and health services, and they are therefore more likely to make sub-optimal choices that expose them to HIV (Bloom 2002, pp.14-15). In light of this, it is sobering to note that more than 60 percent of the world's poor live in Asia (UNDP 2003, p.53). Addressing the 2002 East Asia Economic Summit of the World Economic Forum, the UNAIDS Executive Director warned that *"the question is no longer whether Asia will have a major epidemic, but rather how massive it will be"* (UNAIDS 2002).

While the percentage adult HIV prevalence rates for Asian countries are currently low in comparison to the countries of sub-Saharan Africa, this should not be taken to indicate that HIV is not a significant problem in Asia. For example, current predictions for the spread of HIV in India suggest that, although the national adult prevalence rate can be 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. Similarly, China may have 10-15 million People Living with HIV/AIDS by 2010 (Gordon 2002, p.3). These projections suggest that, unless there are significant advances in the effectiveness of the treatment of AIDS, and unless these treatments are readily accessible to AIDS sufferers, then by 2015 Asia may well have experienced an AIDS-related death toll equivalent to one hundred Boxing Day Tsunamis.

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 already relatively 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 (MAP 2001, p.1; Gordon 2002, p.13).

Another key factor in Asia's susceptibility to a major AIDS epidemic is the mobility of the populations, both internal and external (MAP 2001, pp.23-25). One of the drivers of this mobility is lack of food security. For example, there are an estimated 100 million internal migrant workers in China (Gordon 2002, p.11). Another driver of mobility is regional development. The ASEAN Highway, comprising 23 highways stretching some 37,000 kilometres, adds to the risk of the spread of HIV in the region (Chander 2003).

These observations suggest that the epicentre of HIV/AIDS has moved from Africa to Asia. However, it is still early days in the development of the epidemic. A window of opportunity exists where countries in Asia can take action to significantly reduce the ultimate impact of the epidemic. For MFIs, there is opportunity to prepare policies, products and services that will enable client households that are impacted by HIV/AIDS to fare better, especially in financial terms, than they otherwise might.

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 break down, and there may be risks to political stability and the rule of law.

Of particular interest to MFIs is the economic impact of HIV/AIDS on clients and their households, which 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 the 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 economic productivity of other members of the household.

AIDS-impacted households 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. As the cost of medical treatment increases and economic productivity decreases, the household will need to employ specific strategies to cope economically. 'Low-stress' strategies might include reducing consumption, using accumulated savings and calling in debts from neighbours and relatives. 'Medium-stress' strategies might include selling non-essential household assets, removing children from school, and obtaining loans. 'High-stress' strategies might 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 activities.

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.

HIV/AIDS Policy Recommendations for MFIs

In the course of its business activities, an MFI will encounter clients that represent AIDS-impacted households. 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. A well-considered response to HIV/AIDS assists the MFI to protect its loan portfolio and maintain financial sustainability, while at the same time providing AIDS-impacted households access to valuable financial services.

Even without providing products or services that are specifically designed for AIDS-impacted households, MFIs contribute to the risk management options of clients simply by providing 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 their outreach and financial sustainability. MFIs that are institutionally strong are better placed to provide relevant and helpful services to their clients.

In April 2004, The Foundation for Development Cooperation and World Vision International conducted a workshop in Chiang Mai, Thailand entitled 'Microfinance in Communities Impacted by HIV/AIDS'. The workshop brought together 40 microfinance and HIV/AIDS practitioners from eight Asian countries. The following policy recommendations are an output of the workshop. The author acknowledges the inputs and contributions of each one of the workshop participants that informed and/or confirmed much of what is written here.

The emphasis of the following policy recommendations is not on specific, targeted, intensive intervention by the MFI on behalf of AIDS-impacted households. It is not practical for MFIs, who are financial intermediaries, to be directly engaged in public health intervention. Rather, the emphasis of these policies is on providing products and services so that AIDS-impacted households can make more effective financial decisions than might otherwise be possible. This should be seen as just one aspect of society's broader institutional responses to the AIDS crisis.

AIDS-Sensitive Public Image of the 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 AIDS–sensitive institution. In doing so, the MFI will be known as an institution that is engaging 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 'an 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. This will include a guarantee of confidentiality and privacy.

AIDS-impacted Households as Microfinance Clients

Policy 4. As a demonstration of its identity as an HIV/AIDS–sensitive institution, the MFI's client selection policies will be non-discriminatory. Positive HIV status does not preclude the AIDS-impacted individual or household from becoming, or continuing as, a client of the MFI.

Policy 5. The MFI should make concerted effort to reinforce Policy 4 by sensitising management, staff and clients to HIV/AIDS, developing ways to ensure that AIDS-impacted 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-impacted 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.[5]

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.[6] Maintenance of this policy requires strict guidelines and specific training in bioethics for loan officers.

Financial Products and Services for AIDS-impacted Households

Policy 8. The MFI will highlight products and services that are likely to be of particular relevance to AIDS-impacted households and will actively market these as a package of special products and services. These 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 HIV/AIDS Organisations (HAOs), including government and/or non-government organisations. 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. Specific financial issues relevant to AIDS-impacted households include:

(a) Accumulation of cash savings for future periods of low (or no) economic activity due to declining health of the HIV^+ individual and care demands placed on other members of the household.
(b) Accumulation of cash savings to meet future expenses including medical and funeral expenses.
(c) Potential for wasting significant financial resources on ineffective medical interventions.
(d) 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.
(e) 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.
(f) Transfer of ownership of assets to surviving beneficiaries/nominees.

Policy 11. MFI loan officers should receive formal training regarding the specific financial issues relevant to AIDS-impacted households so they can provide on-going financial advice.

Policy 12. Specialised financial advice should be an integral part of counseling provided to persons who test HIV^+. This advice should also be provided to all economically active members of the affected household.

Policy 13. MFI loan officers should be aware of counseling services available to HIV^+ persons, and they should explicitly and formally refer any client that presents as HIV^+ to these service-providers. While counseling is managed by HAOs, MFI representatives can be part of a collaborative effort to assist AIDS-impacted households in making pro-active financial decisions.

Policy 14. Staff of HAOs should be aware of the products and services offered by the MFI, including and especially those products and services that are offered to AIDS-impacted households.

Loan Products

Policy 15. It is uncertain how long the HIV^+ individual will be able to remain economically active, and it is not a *fait accompli* that AIDS-impacted households will cease to be economically productive. Therefore, provided the HIV^+ client heeds advice relating to specific financial issues relevant to AIDS-impacted households, there is no reason for the MFI to stop or reduce lending to that client.

Policy 16. The MFI may offer concessionary loan terms to AIDS-impacted households (e.g. extended term, repayment grace period, etc). These concessionary terms need to be clearly defined in policy, rather than issued in an ad-hoc manner.

Policy 17. Outstanding loans are never cancelled. All loans are to be recovered from the borrower or from the borrower's guarantor(s).

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 may 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. MFIs should encourage AIDS-impacted households to commit to a savings program to accumulate cash reserves for specific purposes such as lower income during times of reduced economic activity, and for medical and funeral expenses.

Insurance

Policy 19. All but the simplest and focused insurance measures are difficult to implement and control. Therefore, it is best if the MFI acts as a broker between clients/groups and reputable insurance companies who can provide general insurance.

Grants

Policy 20. The long and wide experience of microfinance practitioners is that grant-making always undermines the integrity of lending activities. Therefore, beyond the specific products and services mentioned here, the MFI does not, under any circumstances, offer cash grants in response to crisis events.

Collaboration between Microfinance Institutions and HIV/AIDS Organisations

Policy 21. Microfinance and HIV/AIDS are specialist fields with distinct missions and specific goals. Mutually reinforcing 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 AIDS-impacted households.

Policy 22. 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 23. 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 channels.
(d) Suggest other promotional activities to be delivered by the HAOs through the MFI context, which the MFI will consider for implementation.

Policy 24. Promotional activities delivered by the HAOs through the MFI context will be subject to the following constraints:[7]

(a) Attendance at HIV/AIDS awareness meetings will be optional unless explicitly defined in the loan contract and thus formally agreed to by the client. (This policy reflects the reality that "time is food" for poor clients who need to work today to eat tonight. It would be unethical for MFIs to require clients to attend meetings unless these are defined in loan contracts).
(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.

Conclusion

Scenario 2:[8] 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 going 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.

Vanna has not been well lately, having developed a persistent 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. 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 some time, 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.

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, an MFI can make the difference between utter devastation and survival for its AIDS–impacted clients.

MFIs should present a public image as an AIDS-sensitive institution, and they should reinforce this image with non-discriminatory policies with respect to board and staff recruitment and client selection, through the promotion of public HIV/AIDS awareness, and through offering products and services to support AIDS-impacted clients and their households. These products and services might include specialized financial advice, concessionary loan products, incentives to accumulate some savings, and insurance.

References

Bloom, D.E., River Path Associates and Sevilla, J. 2002. *Health, Wealth, AIDS and Poverty*, Manilla: Asia Development Bank.

Chander, S. 2003. *HIV/AIDS in Asia*, A presentation delivered to the FDC / WVI workshop entitled 'Microfinance in Communities Impacted by HIV/AIDS', Chiang Mai.

Donahue, J. 2000. *Microfinance and HIV/AIDS ... It's time to talk*, Washington: Displaced Children and Orphan's Fund.

Dunford, C. 2001. "Building better lives. Sustainable integration of microfinance and education in child survival, reproductive health and HIV/AIDS prevention for the poorest entrepreneurs", *Journal of Microfinance*, vol. 3, no. 2: 1-25.

Gordon, D.F. 2002. *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China*, Washington: US National Intelligence Council.

MAP 2001. *The Status and Trends of HIV/AIDS/STI Epidemics in Asia and the Pacific*, Washington: Monitoring the AIDS Epidemic (MAP) Network.

Parker, J., Singh, I. and Hattel, K. 2000. *The role of microfinance in the fight against HIV/AIDS*, Maryland: Development Alternatives.

UNAIDS 2002. *AIDS Epidemic in Asia May Become the Largest in the World, Says UNAIDS: Investing in Prevention and Care makes Good Economic Sense*, Press Release, 7 October 2002.

UNDP 1999. *Microfinance and HIV/AIDS. A consultation on joint involvement in effective responses to HIV & AIDS*, Penang: UNDP Regional Bureau for Asia and The Pacific.

UNDP 2003. *Human Development Report 2003. Millennium Development Goals: A Compact Among Nations to End Human Poverty*, New York: UN Development Program.

[1] The mission of the Foundation for Development Cooperation (FDC) is to strengthen partnerships for sustainable development and poverty reduction through action research, policy dialogue, advocacy and capacity building. 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.

[2] This scenario, while fictional, nevertheless reflects a typical story of a household impacted by HIV/AIDS in Phnom Penh. The author lived in Chak Angre Leu for three years, working to establish a microfinance cooperative in this community and surrounds. The HIV prevalence rate in this community was around five per cent of the adult population.

[3] In Bangladesh, for example, a number of MFIs – ASA, BRAC, Grameen and Proshika - each have in excess of one million clients.

[4] The adjusted cost of capital refers to the cost of maintaining the value of the institution's equity relative to inflation and the cost of accessing commercial funding rather than concessional loans.

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

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

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

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