

The Positive Partnerships Program in Thailand: Empowering People Living with HIV

UNAIDS BEST PRACTICE COLLECTION



UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
UNICEF
WFP
UNDP
UNFPA
UNODC
ILO
UNESCO
WHO
WORLD BANK

Research for this report, including interviews with Positive Partnership Program (PPP) participants, was conducted in September and October 2005. The majority of the report was written in October and November 2005. In specified instances, updated information was added based on input provided by the Population and Community Development Association in January 2007.

A handful of organizations have supported various PPP projects since the Population and Community Development Association initiated the programme in 2002. This report focuses on the largest project, which was launched in January 2004 and is supported by the Pfizer Thailand Foundation. Unless specified otherwise, discussion of PPP in the report refers to the Pfizer-funded project only.

Cover photos: UNAIDS / Photographs by members of the Positive Partnerships Program, Thailand.

UNAIDS/07.22E / JC1260E (English original, July 2007)

© Joint United Nations Programme on HIV/AIDS (UNAIDS) 2007.

All rights reserved. Publications produced by UNAIDS can be obtained from the UNAIDS Information Centre. Requests for permission to reproduce or translate UNAIDS publications—whether for sale or for noncommercial distribution—should also be addressed to the Information Centre at the address below, or by fax, at +41 22 791 4835, or e-mail: publicationpermissions@unaids.org.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of

UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by UNAIDS in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

UNAIDS does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

WHO Library Cataloguing-in-Publication Data

The Positive Partnerships Program in Thailand: Empowering People Living with HIV.

(UNAIDS best practice collection)

"UNAIDS/07.22E / JC1260E".

1.HIV infections – psychology. 2.HIV infections – prevention and control. 3.Financial management – economics. 4.Poverty – prevention and control. 5.Social justice. 6.Prejudice. 7.Thailand. I.UNAIDS. II.Series: UNAIDS best practice collection.

ISBN 978 92 9173 593 8

(NLM classification: WC 503.7)

UNAIDS – 20 avenue Appia – 1211 Geneva 27 – Switzerland
Telephone: (+41) 22 791 36 66 – Fax: (+41) 22 791 48 35
E-mail: distribution@unaids.org – Internet: <http://www.unaids.org>

The Positive Partnerships Program
in Thailand: Empowering People Living
with HIV



Acknowledgements

UNAIDS and the report's authors are grateful for the assistance and feedback provided regularly by staff members at the Population and Community Development Association (PDA) in Thailand during all phases of this project. Among them are the following from PDA's Bangkok headquarters, listed in alphabetical order: Kipper Blakeley, Alex Duke, Urai Homthawee and Mechai Viravaidya.

Amal Naj and Anutra Sinchaipanich from Pfizer Global Pharmaceuticals in Thailand provided a donor perspective.

Alberto de La Paz and Lucy Huang were consistent and cheerful interpreters during site visits. Daniel Stefanski's insights and photography skills were invaluable.

The authors are highly appreciative of guidance and support from UNAIDS' Patrick Brenny.

Table of contents

Acknowledgements	2
Foreword	4
Executive summary	5
Introduction	9
The Positive Partnership Program: background and rationale	13
HIV: a last frontier for microcredit	17
How the Positive Partnership Program works	20
Impact, monitoring, constraints and evaluation	28
Lessons learnt and recommendations	36
Appendices	
Appendix 1: PPP loan disbursement amounts and repayment rates	39
Appendix 2: PPP project members' businesses	40
Appendix 3: Changes in knowledge about HIV, and anxiety towards people living with HIV	41
Appendix 4: Changes in attitudes regarding people living with HIV	42
Appendix 5: Thirty years of growth: how and why microcredit can reduce poverty	44
Appendix 6: Other HIV-focused microcredit projects	46

Foreword

It has long been clear that people living with HIV face significant and often debilitating social, economic and legal discrimination in many countries. Recognition of this fact has far too rarely translated into decisive action with substantial and measurable results. In most societies, people living with HIV remain disproportionately poor, stigmatized and isolated from their communities. This situation limits the effectiveness of HIV prevention and treatment efforts, thus hampering awareness and education campaigns and perpetuating devastating health trends.

An innovative new project in Thailand has taken direct aim at these obstacles. The project, the Positive Partnership Program (PPP), has two distinct yet complementary goals. The first, to enable people living with HIV to lift themselves out of poverty, is achieved through the provision of microcredit loans that allow people to set up small businesses in their communities. The second goal is to reduce HIV-related stigma and discrimination against people living with HIV. The project relies on a deceptively simple construct: business partnerships between one HIV-positive person and one HIV-negative person.

As noted in this best practice publication, PPP has shown remarkable progress in meeting these goals since its current structure was launched in January 2004. At its core, the project acknowledges and validates the importance of economic security in providing a base from which individuals and societies can successfully tackle other issues affecting their well-being. The enthusiastic response to PPP from people living with HIV and funders alike serves as a useful reminder of the need to develop comprehensive strategies in response to the AIDS epidemic that reflect a full range of economic, social, legal and political considerations—not just those narrowly based on health. Individuals and communities heal, grow and thrive for a number of reasons that at first glance may not seem connected, but upon closer scrutiny are indubitably linked.

Furthermore, projects such as PPP exemplify local solutions for problems that, while national and global in many respects, are to an even larger extent intensely local and personal. Ingenious in design yet easy to replicate in nearly any society, partnerships of the sort created through PPP in Thailand support universal concepts of individual and communal responsibility. HIV often frays these social bonds, but they can be strengthened with well-targeted assistance and programmes such as PPP. Such steps are vital in supporting the ways individuals and communities cope with HIV, which ultimately provide a road map for regions and nations to more effectively respond to the epidemic.

Executive summary

Nearly 600 000 people are living with HIV in Thailand. As in every other country, most are poor and many are isolated from their communities. Breaking down the mutually reinforcing barriers of poverty and stigma they face has proved immensely difficult.

These barriers are not insurmountable, however. A new project rolling out in rural Thailand, the Positive Partnership Program (PPP), has shown that targeted economic assistance can boost self-esteem, ambition and hope—all of which help reinvigorate community bonds and have a major, positive impact on HIV prevention and treatment efforts.

The core of PPP is the provision of microcredit loans to resource-constrained HIV-positive individuals who otherwise have no access to credit in conventional, affordable ways. These loans are intended to support the efforts of people living with HIV to lift themselves out of poverty by setting up small businesses in their communities. Closely linked to this poverty-reduction goal is another vital objective: the reduction of HIV-related stigma and discrimination.

As conceptualized by PPP's implementing entity—the Population and Community Development Association (PDA), a Bangkok-based nongovernmental organization—a unique aspect of the PPP project greatly facilitates progress towards achieving these two goals simultaneously: loans are given out not to people living with HIV alone but to partnerships between an HIV-positive and an HIV-negative person. By the end of 2005, a total of 375 partnerships had been formed since the project began in January 2004.

Such partnerships grant people living with HIV renewed hope for the future in terms of supporting themselves and their families while at the same time assisting their reintegration into communities. Through their interaction with an HIV-positive partner, meanwhile, HIV-negative partners become better educated about HIV, including how and why it is transmitted. Surveys indicate that their attitudes towards people living with HIV become far less judgmental and fearful after they begin working and living with them on a regular basis.

Initial results for PPP, still in its early stages, point to some startling and profound improvements in quality of life for many people living with HIV. Many report that they no longer feel that they must accept being discriminated against or that they must hide. They have found support and assistance from others who understand their experiences. They are leaders in their communities' HIV awareness campaigns. They are more inclined to seek out treatment when needed, which is now easier due to the increased availability of low-cost or free antiretroviral medicines in Thailand.

Equally impressive have been the financial results, which offer quantifiable proof that people living with HIV and microcredit need not be mutually exclusive. In the period since the project was launched, 91% of loans have been repaid on time. This indicates that people living with HIV are just as likely (if not more so) to meet financial obligations as those not facing a life-threatening illness.

PPP is still a work in progress, yet there are many lessons to be learnt from this initiative unfolding in Thailand that twins fiscal rigour and responsibility with social change. Population and Community Development Association and PPP funders, including Pfizer

Thailand Foundation, are extremely pleased with the results to date and have plans to increase the project's size and scope. One of their goals is to help people living with HIV create sustainable businesses that will attract the attention and resources of regular credit institutions, such as banks, that have generally refused to provide loans to them in the past.

This best practice document examines how and why PPP could serve as a flexible and adaptive model in other countries. It includes testimonials and case studies from project participants throughout Thailand. It also identifies lessons learnt and resulting recommendations. Designed to help other implementing entities and funders to structure HIV-specific microcredit programmes along the lines of PPP, these lessons include the following (which are expanded upon in the full text).

1. A project that emphasizes openness and direct interaction among HIV-positive and -negative people can have a major effect on improving HIV awareness and prevention efforts. This development may not only improve public health and save lives, especially among young people and others at greater risk of becoming infected with HIV, but can also lay the groundwork for lower HIV prevalence in general.
2. A microcredit project's effectiveness is enhanced through the involvement of a strong, independent and experienced civil society organization with established community roots and hard-earned trust.
3. A committed partner, brought in at the very beginning, can help ensure that funding availability remains consistent throughout the crucial early years of a microcredit project.
4. The provision of a basic level of skills-based business training is of great help to participants prior to beginning their businesses. Some may also need or benefit from ongoing training and assistance as they move forward.
5. Participants should get the right guidance to start enterprises that have a realistic opportunity to succeed in their community. Among the questions to consider are the following: What are the local needs? What are applicants' existing skills and interests? What kind of training are they open to receiving, and how can it best be provided?
6. Organizations seeking to replicate PPP should carefully analyse local conditions and identify ways to surmount potential problems. For example, they might consider holding workshops on entrepreneurship for the entire community; endeavouring to work closely with local and national officials (including those from health ministries) from the very beginning; setting a priority on transparency at all levels of operation (especially financial) and requiring that project participants follow suit; and creating links within government and independent media outlets to publicize the project as part of an effort to locate potential participants.
7. Although the majority of initial loans may be of a similar size—which makes sense because most businesses are new and therefore starting out from the same approximate base—some flexibility is appropriate in determining the size of subsequent loans. Such decisions should be based on close analysis of business sustainability and entrepreneurs' ability to demonstrate viable future plans.

8. Improving participants' access to potentially health-improving antiretroviral drugs can support important underlying factors crucial for business success. HIV medicines often help HIV-positive participants regain health and energy, thus giving them a vital boost in creating a thriving business.
9. From the beginning, project implementers should seek to create conditions in which borrowers ultimately "graduate" to more conventional lending institutions. The initial microcredit loans can provide borrowers with a credit history and the opportunity to build collateral (savings) that make them eligible for more standard loans, even at higher market rates.

Introduction

Worldwide, the search is on for effective ways to tackle the spread and effects of HIV. A central tenet of any pragmatic HIV response should be to assist those experiencing HIV-related discrimination and to seek to remove stigma against them.

Nearly 600 000 people are living with HIV in Thailand. As in every other country, most are poor and many are isolated from their communities. Breaking down the mutually reinforcing barriers of poverty and stigma they face has proved immensely difficult.

In 2002, the Population and Community Development Association (PDA), one of Thailand's largest nongovernmental organizations, piloted a project that would go on to tackle these twin barriers together with equal emphasis in a single initiative. That project, the Positive Partnership Program (PPP), has expanded out of pilot phase, and its impact has proven to be highly significant.

PPP's first goal is to enable people living with HIV to lift themselves out of absolute poverty. This is achieved through the provision of microcredit loans that enable people to set up small businesses in their communities. Examples of small enterprises thus far include selling snacks and cooked food, motorcycle repair, craft making, flower growing and massage.

Healing touch

Ban Pao village

Phuttaisong district, Buriram province

Nang Noi, 28, is a master of the art of complementary sales. Buy one of her dried seafood snacks and you'll end up with a massage. Order a rub-down and it'll be hard to resist a packet of shrimp crackers to munch on afterwards.

Juggling her mobile food and massage businesses, Nang Noi makes around US\$ 75 a month putting in long hours travelling to customers' homes on her slight red motorbike. There's no other way, says the mother of two whose husband is also HIV-positive. "If I'm lazy, there'll be nothing," she smiles. "I don't mind—it's so great to be earning money every day."

Nang Noi wasn't always so optimistic and energetic. Three years ago, she cried for five days straight after learning her HIV-positive status. Mainly she feared that she and her husband, who had returned from working as a boat repairman in Bangkok, would be ostracized in their village.

As he became weak and ill at home, Nang Noi wrestled with the need to transform herself from housewife into breadwinner.

There were few regular jobs and no normal credit lines open to people living with HIV. Together with other members of the people living with HIV club at a local PDA centre, Nang Noi grappled with the fog of stigma that had settled over north-eastern life like a smothering blanket. The first widespread roll-out of antiretroviral treatment in the country was just beginning; no one had yet seen the medicines take effect. People living with HIV were expected to die, or disappear. Many were banished from their villages.

Virtually symptom-free and desperate to raise money, Nang Noi jumped at the opportunity offered by PPP. She needed a partner and turned to an older sister with the fortuitous nickname "Money" (Ngeun). "I was happy to help her. And I was afraid no one else would, because of attitudes towards HIV," said Ngeun, 33.

The two began in 2003 with loans of US\$ 300 each under a six-month PPP pilot project. The deal was that Nang Noi would make a business of selling snacks and the massage skills she'd learnt at the PDA centre. Ngeun would expand her existing silkworm-raising business—and be an ambassador for her sibling.

"I talked to the neighbours about Nang Noi and her new business," Ngeun said. "I explained how it wasn't easy to get infected with HIV."

"It's hard to say what their reaction was. At the start, they were afraid to buy her food. But as time went on—and after PDA staff also came to the village—more people bought her snacks and wanted a massage."

The sisters are now on their second loans for the same amount, this time under the Pfizer PPP scheme. Nang Noi's husband has recovered enough on antiretroviral treatment to earn around US\$ 50 a month making hammocks at home.

Life is still tough, but now its challenges are balanced with promise. With more than 20 regular massage customers and more for her snacks, Nang Noi makes just enough to ensure her family survives.

Through sheer drive and a jaunty personality, she has smoothed away much of the old stigma. People still turn their backs—but now it's for a soothing massage.

The healing goes both ways. "I have courage. I got it from people—my sister, some neighbours and the PDA staff. Having a stable income is a huge psychological support for me. I feel I have a normal life again."

In Isan, nothing is more normal than having to take teasing on the chin. "The neighbours joke with me that I can't be infected, I'm too fat."

The second goal, to reduce HIV-related stigma and discrimination against people living with HIV, is already greatly advanced when HIV-positive people are able to earn their own living. But another key aspect of the PPP project makes a crucial additional difference. Loans are given out not to people living with HIV alone, but to *partnerships* between an HIV-positive and an HIV-negative person. Such partnerships are designed to catapult people living with HIV out of isolation and into a position of new visibility, integration and respect within their communities.

Initial results for PPP, still in its early stages, point to startling and profound improvements in quality of life for many people living with HIV.

In the period since the project began in January 2004 through December 2006, loans amounting to a total of 16.6 million baht (US\$ 477 000) had been disbursed to PPP partnerships. Moreover, data over the same period indicate that 91% of loans have been repaid on time.¹ This indicates that, contrary to a widely held wrong belief, people living with HIV are just as likely (if not more so) to meet financial obligations as those not facing a life-threatening illness.

Many people living with HIV report that they no longer feel they must accept being discriminated against. They are intensely relieved to feel as though they need no longer hide. They have found support and assistance from others who understand their experiences. They are leaders in their communities' HIV awareness campaigns.

¹ Both the total loan amount and the 91% loan repayment rates were reported in PDA's sixth Pfizer PPP progress report, prepared at the end of 2006. That rate is even higher than the 85% rate noted in the fourth Pfizer PPP progress report, prepared in October 2005. (The sixth report was released after primary research for this report was completed.)

At the same time, PDA surveys indicate that non-infected individuals in project communities are less fearful of contracting HIV and have far fewer qualms about interacting with people affected by the virus. They have a better understanding of how HIV is transmitted and how to prevent it from spreading. Many no longer think it is appropriate to discriminate against people living with HIV.

Additional aspects of the PPP project—including education and awareness-raising activities in project communities—have bolstered the anti-stigma effects outlined above and raised knowledge levels about prevention and treatment of HIV. The introduction of low-cost or free antiretroviral treatment in Thailand to an estimated half of those who need the potentially lifesaving medicines has also boosted the project.²

Antiretroviral availability and supply in Thailand

Antiretrovirals can save people's lives and offer hope and opportunity to individuals, families and communities affected by HIV. For a variety of reasons, including patent restrictions, prohibitive costs and inadequate health-care systems, millions of needy individuals do not have access to them today, especially in Africa and Asia. Millions of people therefore continue to die every year from AIDS-related illnesses.

A Thai state-owned drug firm, the Government Pharmaceutical Organization (GPO), began manufacturing a generic triple-combination, fixed-dose version of a commonly prescribed antiretroviral regimen in 2002. As of October 2005, some 60 000 HIV-positive Thais—including many in PDA's PPP initiative—were receiving the combination, called GPO-VIR, mostly for free or at low cost from other nongovernmental organizations or through various short-term government programmes.³ In September 2005, the government moved to consolidate and strengthen that ad hoc system when it unveiled a new national treatment plan aimed at providing antiretrovirals to 80 000 people living with HIV.

Under the new plan, which was fully implemented in 2006, antiretrovirals are covered by the public health sector's "30-baht scheme." In that scheme, patients pay 30 baht (about US 75 cents) each time they visit one of 900 designated hospitals and health clinics across the country to pick up medicines. A monthly supply of GPO-VIR therefore costs each individual about US\$ 9 a year. This of course represents an increase for those currently receiving antiretrovirals for free, but the annual amount is still thought to be within reach of most people.

The Government expects the number of Thais on antiretroviral regimens to increase to some 200 000 by 2010. A large part of the initial costs of going to scale with the new antiretroviral programme will be borne by funds from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which awarded Thailand an initial grant of US \$31 million in 2003 for HIV prevention and treatment.

Expanding affordable access to antiretrovirals is undoubtedly a good thing. However, there are lingering concerns about the limited nature of medicines currently available to most people in Thailand. GPO-VIR is considered an effective and acceptable first-line treatment for HIV, but not every patient responds well to it. Potential side effects such as painful neuropathy and gastrointestinal distress are extremely debilitating, and some individuals are infected with a virus strain resistant to one or more of the three drugs in the combination.

² In Thailand as elsewhere, there is little incentive to be tested for HIV when there is no access to therapy. Most people would rather not know than perhaps be forced to live under what they perceive to be a death sentence. Because antiretroviral availability offers hope, it can significantly increase the likelihood that many people get tested, especially those who have engaged in risky behaviour. Knowledge of HIV status has a great impact on prevention because it can help an individual make informed decisions to protect her or his own health and the health of others.

³ GPO-VIR is a combination of stavudine (d4T), lamivudine (3TC) and nevirapine (NVP).

Furthermore, the longer a person takes a combination, the greater the possibility that the virus will mutate in such a way to make the combination no longer effective.

There were some encouraging developments in 2006 for the more than 5000 Thais estimated to be in need of second-line antiretrovirals. In September, for example, US pharmaceutical firm Gilead announced that it would sell tenofovir, an antiretroviral drug with comparatively few side effects, at a price that was 90% cheaper than it charged in the United States and Europe. The Thai Government and HIV activists were continuing to seek other similar deals to increase the availability of different kinds of affordable antiretrovirals throughout the country, including where PDA's PPP operates.

PPP is still a work in progress, yet there are many lessons to be learnt from this initiative unfolding in Thailand that twins fiscal rigour and responsibility with social change. This best practice document examines how and why PPP may serve as a flexible and adaptive model in other countries.

The Positive Partnership Program: background and rationale

PDA, the developer of PPP, is one of Thailand's largest and best known nongovernmental organizations. Since its founding in the early 1970s, it has implemented numerous human development and social capital initiatives at the local level across the country in areas including family planning, water resource development and sanitation, environmental conservation and rural development.

It has also been a pioneering presence in helping build civil society involvement and influence in the response to HIV in Thailand since the 1980s, working closely with—and often prodding—the government to increase HIV prevention resources and education.

Back from the brink

Gao Noi Village, Ban Phai district, Khon Kaen province

When a doctor told Ed that his lungs had “gone dark,” he summoned family and friends to his sickbed and announced he was ready to die.

Life had been bitterly harsh since he found out he was HIV-positive in 1996. Severe illness forced him to quit his glass factory job in Bangkok and return to his community in Ban Phai district.

His wife died of AIDS-related illness in 1999, leaving Ed with no strength and no means to look after their young (HIV-negative) son. His friends had deserted him. By 2002, his physical health had crashed and his mind was confused. He was suicidal.

Relatives intervened to get him started on TB treatment, during which time he couldn't walk. Finally, in late 2002, he was able to begin antiretroviral treatment.

Still in weak condition, he joined the local people living with HIV club at the PDA's Ban Phai centre—and began to find reasons to live.

“I have very warm feelings for that club,” he says now. “When you are there, you don't have to worry that others won't like you. Everyone is in the same situation. It has given me courage.”

Adds PDA field officer Ratri Aengwanit, “The sparkle came back to Ed's eyes after he joined.”

As his health began to improve, Ed began to hope for something that had long seemed impossible—to return to work. Through the PPP at Ban Phai, he had a chance. He teamed up with his cousin, Boonmee, who had a fermented fish business, and with his first US\$ 250 loan he bought a tricycle to transport her products to the market. His aunt used her six-month loan of the same amount to expand the business, which is still recovering from debts incurred a few years ago.

Since then, the partners have received two additional six-month loans. Ed, 42, earns around US\$ 110 a month delivering fish every morning and sometimes almost the same amount again doing odd jobs as a painter.

“I feel strong enough to do even heavy physical labour,” says Ed, whose CD4 count was still a relatively low 170 the last time he'd checked, six months earlier. Though my memory still isn't great, I feel normal.

“My son is well and going to school. My friends all came back after I felt and looked stronger. They didn't understand about HIV before; now they do. I have a social life again.”

HIV has placed great strain on community cohesion in rural Thailand, where two thirds of the country's residents live. Fear and misinformation about HIV infection have ruptured longstanding economic, social and personal relationships, and have prevented new ones from forming.

PDA's chairman, Mechai Viravaidya, was convinced of the need for a microcredit project for people living with HIV by the stark evidence of barriers preventing them from improving their economic prospects. Restricted because of discrimination or ill health from joining the regular job market, the majority of HIV-positive individuals also had too few financial assets to qualify for a loan from banks and other conventional lending institutions to set up their own businesses.

People living with HIV have long been considered credit risks by mainstream lenders such as banks because of concerns that they may fall ill or die before paying back a loan. When lending officers are aware that an applicant has HIV, the application is frequently refused, regardless of the applicant's financial affairs or the quality of his business plan. In interviews with HIV-positive participants of PPP conducted in September and October 2005, some reported that they had been asked to provide a blood test—which would conceivably check for HIV—prior to being considered for a loan from such institutions, even those specifically mandated to assist poor people.⁴ Outside of PPP, the only remaining option for those desperate for capital, even just to buy food to stay alive, is often to approach informal money lenders. As might be expected, most money lenders charge exorbitant, above-market interest rates (individuals interviewed mentioned being charged rates ranging from 25% to 70%). Borrowing from such sources tends to push individuals and families deeper into debt and to create conditions in which they are even less likely to be able to support themselves.

In 2002, with funding from UNAIDS and others, PDA set up a pilot microcredit project aimed at helping people living with HIV lift themselves out of economic destitution. At first, loans were offered only to HIV-positive individuals. All people living with HIV were also guaranteed low-cost or free access to antiretrovirals through programmes sponsored by other civil society organizations or the government. Soon after, eligibility criteria were extended to include people affected by the disease, notably family members and orphans.

Nearly 200 people benefited from the pilot project, and its 70% loan repayment rate helped convince a new donor, Pfizer Thailand Foundation, of its financial soundness as well as its potential beneficial impact. "From the beginning this project held great promise in making an incredible difference in people's lives, and in a relatively short time," said Amal Naj, country manager of Pfizer Global Pharmaceuticals, and a board member of the company-supported foundation.⁵

⁴ A troubling and persistent trend was identified during an interview conducted on September 28, 2005 in Chiang Mai province with PPP participant Banliw Wongkhamdeng. He said an HIV test had been required for many years at the local branch of the Bank for Agriculture and Agricultural Cooperatives of Thailand (BAAC), a government-run institution with a specific mandate to increase the availability of loans and other financial instruments to rural residents. A similar claim was made during interviews on October 25, 2005 with HIV-positive PPP participants in Nakhon Ratchasima province. The bank does not have an official policy requiring such tests, which technically are illegal under Thai law. However, official antidiscrimination policies often take a long time to trickle down to all levels of an institution. Decision-makers at the local level often also have discretion to approve or deny loans without necessarily stating the real reason, which makes it easy for them to cover evidence of illegal discrimination.

⁵ Interview with Amal Naj, October 18, 2005 in Bangkok.

Keeping busy

Gao Noi village, Ban Phai district, Khon Kaen province

It's tough to make a comfortable income in rural Thailand—and infinitely harder if you're living with HIV.

Flexibility is a crucial requirement for survival in a rural economy where most survive on modest farm incomes, supplemented by tiny additional enterprises with slender margins.

Take mother of two Buasai Bonrat*, 34, a relatively new entrepreneur who is juggling three separate small ventures from her parents' home in Ban Ko Khai Noi village: fried cricket snacks, artificial flowers and cattle raising.

Unusually, Buasai had managed to keep her job in a local cigarette factory for nine years after discovering she had HIV during a pregnancy in 1994. However, in 2003, two years after her husband had died of an AIDS-related illness, Buasai developed eye problems and was forced to quit.

With a 12-year-old daughter and an HIV-positive son of seven to support, she urgently needed to be earning again. She felt little support in the village, where people sometimes walked away as she approached and where her son was sometimes refused service at the local shop. But there was plenty of encouragement at the nearby club for people living with HIV at PDA's Ban Phai centre. There, she learnt about PPP and decided to apply, together with her father, Put, 68.

"I wanted to be a friend to my daughter and to give her courage," he said.

With her first loan in 2004 of US\$ 250, Buasai invested in materials for artificial flowers, which she'd learnt to make at a PDA training session in the club. She also expanded her small cricket-raising enterprise with assistance from her mother, Panlong.

Her father's US\$ 250 loan went towards buying extra cattle to add to the three the family already owned. Since the wiry, near septuagenarian still works 10 months of the year in construction in Bangkok, Buasai took on much of the responsibility for the cattle enterprise as well.

In October 2005, all the enterprises were modestly profitable. Buasai said she earned a profit of about US\$ 50 a month making flowers, mostly for sale at people living with HIV-related events and venues such as the local hospital and Red Cross Centre. The fried crickets are a popular snack in the village and bring in another US\$ 75 a month. The cattle-raising was also going well; she now has six animals after selling two to help pay back the first PPP loan.

It's all a lot of work, and added to Buasai's active involvement in counselling and other activities at the people living with HIV club, there's little in the way of spare time.

Panlong, her mother, worries that her daughter is spreading herself too thin. "Maybe it would be better if she concentrated on one thing instead of doing so much...she never stops."

Far from slowing down, Buasai keeps finding new things to do. Right now it is dance practice at the club for people living with HIV for an upcoming event titled "Happy Families Day" at the provincial capital, Khon Kaen.

Part of her passion is visiting others living with HIV who still feel isolation and fear. "I want to tell everyone: "Please be brave. Courage is even more important than the medicine."

**Not her real name. A pseudonym was used for confidentiality reasons.*

Pfizer Thailand Foundation subsequently agreed to provide 12 million baht (US\$ 300 000) over nearly four years, from January 2004 to October 2007, to support an expansion of the project to at least 400 partnerships (800 people), thus making it PDA's benchmark PPP project.⁶

The Pfizer-funded project, whose full name is "Positive Partnership: Microcredit Loans for People Living with and Affected by HIV/AIDS", set out to offer small business loans to two-person partnerships comprising one HIV-positive and one HIV-negative person.

As of June 2005, not quite halfway through this initial grant, loans already had been extended to a total of 750 individuals in 375 partnerships in eight Thai provinces, nearly reaching the project target of 400 partnerships. That goal was surpassed by the end of 2006, when the total number of partnerships reached 422.

⁶ Other PPP projects are or have been supported by grants from other sources. However, as of October 2005 these other projects were each supporting fewer than 30 enterprises apiece, while Pfizer already funded some 375 projects in rural Thailand. One year later, the number of partnerships funded by Pfizer had grown to 422. Moreover, the other projects tend to emphasize niche markets. For instance, one gives loans only in the Bangkok metropolitan area, and two others provide loans to women only. Some grant priority to those who are "HIV-affected," a term that may refer to individuals who are HIV-positive themselves or have been directly affected by HIV, such as when a spouse, parent or other close relative has died of AIDS or is currently living with the virus. These non-Pfizer initiatives are much smaller in scale and funding and are not directly analysed in this report.

HIV: a last frontier for microcredit

For around three decades, microcredit projects have represented an increasingly common and successful intervention to alleviate poverty around the world. (Background information on the history of microfinance may be found in Appendix 6 of this report.) Today, it remains increasingly difficult to separate poverty from HIV. As Francesco Strobbe of the European Central Bank noted, “Poverty and HIV/AIDS constitute a vicious cycle. Poverty creates vulnerability to HIV/AIDS, and HIV/AIDS leads to poverty”.⁷

Yet in 2005, which was declared the UN International Year of Microcredit, microfinance and HIV had rarely been closely linked.

Many microfinance institutions (MFIs), even those created by nongovernmental organizations, may be more properly viewed as banks than charities. As such, they generally have eligibility policies that restrict access to those deemed a credit risk—which generally includes those living with or affected by HIV.

Making mats

Nong Suwan village, Nang Rong district, Buriram province

Two years ago, Nitaya Ampaipit wanted to give up.

“When I discovered that I had HIV, I didn’t want to continue living. I shied away from being seen and just stayed home.”

A stint in the hospital for TB treatment eventually revived more than her physical health. “Neighbours visited me, so I began to feel not quite so bad anymore.”

The front door began to open again in the small wooden house that Nitaya, 32, shares with her HIV-positive husband, Pramote, in Nong Suwan village. Village children were especially welcome to visit, and one wrote “love you” on the door in black pen.

Nitaya joined the Red Rose Club for people living with HIV at the PDA centre in nearby Nang Rong and discovered a chance to move away from daily farm work that paid little and was increasingly beyond her health capacities.

With her brother, Phichit, 27, as partner, she took out a US\$ 300 PPP loan in February 2005 to make colourful small mats. She had already trained in mat-making in a development programme run by the Bank for Agriculture and Agricultural Cooperatives (BAAC). Shortly afterwards, she went on antiretroviral treatment and has since added seven kilograms to her weight. Though she feels a good deal better, she is still not very strong.

But the mat business is taking off. Since Nitaya cannot make enough mats herself to fulfil the volume of orders from a wholesaler, she pays neighbours a modest amount to help out. She earns around US\$ 60 in profit a month, and hopes to expand the small enterprise next year with a new PPP loan.

“I feel so much better. I have friends who are in the same situation in the Red Rose Club. We help each other, and we have medicine. It’s like a new life for me,” she said.

⁷ Francesco Strobbe, “The Role of Microfinance in Addressing the HIV/AIDS Pandemic in Zambia: The Rainbow Model Provides a Future for AIDS Orphans”. From *Microfinance Matters*, the newsletter of the United Nations Capital Development Fund. April 11, 2005. Online: www.unCDF.org/english//microfinance/newsletter/pages/2005_04/news_pandemic.php.

For example, a brief from the Consultative Group to Assist the Poor (CGAP), a consortium for microfinance donors, warned in 2003: “Launching a financial intervention specifically to target persons with AIDS...would not be appropriate, given that financial services depend on the ongoing ability of clients to earn income....The more vulnerable a household, the less likely it will be able to use microfinance effectively. When faced with a crisis, families may find it impossible to continue investing in productive activities, saving, paying insurance premiums, or repaying loans”.⁸ The brief’s authors concluded, “While MFIs should not be averse to operating where the AIDS crisis is most pronounced, th[is] brief cautions against targeting people with HIV/AIDS as a single client group”.⁹

There are some indications that traditional microfinance institutions may be becoming more inclusive regarding HIV. For example, in April 2004 some 40 people, including HIV specialists and representatives from several microfinance institutions, attended a workshop in Chiang Mai, Thailand titled “Microfinance in Communities Impacted by HIV/AIDS”.¹⁰ Participants agreed on a series of policy recommendations designed to place microfinance institutions at the forefront of helping fight the fear, ignorance and stigma associated with disease. There were recommendations, for example, requiring microfinance institutions to include an explicit HIV commitment in their mission statements and by-laws; add a non-discrimination policy that specifically mentions HIV and confidentiality; train staff to be more sensitive; and devise financial packages specifically designed for potential borrowers affected by the virus.

However, one recommendation suggested that loan officers “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”.¹¹ This caveat could conceivably be used to deny applications from nearly all HIV-affected individuals and households, even if antiretroviral access were guaranteed.

Starting over

Nong Suwan village, ang Rong district, Buriram province

He was used taking knocks, but the Indian Ocean tsunami was just one blow too many.

As he clung to a palm tree, watching bodies and buildings go by in the giant wave that hit Phuket Island in December 2004, Puwadon Somkuan knew he’d finally had enough.

So he became someone else.

Meet Mr. “Good Hope”.

“I changed my name so I could change my life,” says the man who became Puwadon Wangdee (“good hope”) on his 30th birthday in June 2005. Puwadon hasn’t looked back—or failed to say a prayer whenever he passes a Buddha shrine—since.

⁸ CGAP Donor Brief, No. 14, September 2003. “The Nexus of Microfinance and HIV/AIDS”. Online: www.unctf.org/English/microfinance/newsletter/pages/dec_2003/news_hiv.php.

⁹ Ibid.

¹⁰ Stuart Mathison, “Economy and Epidemic. Microfinance and HIV/AIDS in Asia.” The Foundation for Development Corporation. Available in PDF format online from the web site of AusAID: www.developmentgateway.com.au/jahia/Jahia/pid/1982. The paper was presented at a workshop organized by the Foundation for Development Corporation and World Vision International.

¹¹ Ibid.

The highs of his eventful twenties had been studded with too many lows. Married and divorced by age 24, he'd had a few good years working in Bangkok restaurants and hotels before he started to suffer with "every symptom" of HIV. He bounced back on antiretrovirals to set up a motorcycle repair shop in a busy tourist area of beautiful Phuket—and then had a disastrous bike accident in April 2004. After months spent recovering from a head operation, he was forced to return, broke, to his home in the northeast. There, his attempts to get a loan through normal channels failed when a local bank demanded blood tests checking for HIV.

Through the local "Red Rose" club for people living with HIV at the Nang Rong PDA centre, Puwadon learnt of the Positive Partnership Program and applied, in partnership with a supportive aunt.

"I wanted to help him continue his life. He needed encouragement," said his aunt, Samai.

The two began in October 2004 with loans of US\$ 300 each. Puwadon set up a motorcycle repair shop and Samai expanded her potato-growing operation. She also has a small business selling meatballs in their village, Nong Suwang.

Puwadon's business was "up and down" before his terrifying tsunami experience on a working holiday back to Phuket. It remained sluggish, he says, until he changed his name in a Buddhist ceremony on his 30th birthday.

By October 2005, after he'd relocated to a new space at the PDA centre and factory compound, his income was significantly up. "In the last month I earned almost 6000 baht (US\$ 150)—the highest ever," he said.

Investments in new equipment meant that money was still tight, he said. Though he was able to repay the PPP loan every month, things would be a little easier if the repayment system were more flexible, he explained.

Still, Mr. "Good Hope" remained true to his name. "Life is much improved. My social life is back. I may have HIV, but I am still a human being. I have my self-esteem, and my honour."

"He's got courage and good spirits again. He gets up really early, works very hard and is doing a fine job with that shop," added Samai.

Such reluctance to consider HIV-affected people for loans is a major setback for the world's poor and credit-starved. Millions of them—and the number only continues to grow in tandem with the epidemic's spread—are excluded from conventional microcredit programmes simply because they are affected by HIV. Their needs reinforce the importance of specialized projects such as PPP.¹²

¹² Information about other HIV-focused microcredit projects may be found in Appendix 6. As noted in that section, similarities can be found between PPP and the other projects discussed. However, as also discussed in the appendix, there are significant differences based on the size and nature of the implementing entity as well as country-specific considerations.

How the Positive Partnership Program works

PDA's implementation stages

PDA has identified the following 10 distinct project implementation stages for PPP.

1. Conduct orientation meetings for PDA staff.
2. Collaborate with local government branches and local health agencies. During this step, potential HIV-positive participants are identified by PDA by working closely with hospitals, health centres, community councils, schools, groups of local people living with HIV, the mass media, other nongovernmental organizations and those involved in other PDA projects such as village banks. At hospitals and clinics, for example, PDA staff members distribute details about PPP and contact information to be given by caregivers to HIV-positive patients.
3. Establish a group of community volunteers (local government officials, village residents, health care workers, etc.) who will work with PDA on implementing the project.
4. Organize meetings to introduce the project to the target groups. Application information can be made available at this point as well.
5. Initiate decision-making processes. This includes reviewing applications, selecting those to be approved based on pre-determined criteria and agreeing on loan amounts to be offered.
6. Conduct a baseline survey and visit the homes of participants.
7. Arrange training on income-generation activities.
8. Establish local clubs (support groups) for people living with HIV and their families.
9. Provide loans to project participants.
10. Monitor and evaluate each stage of the project.

The programme is run by staff in 11 PDA rural development centres spread over eight provinces, as well as PDA headquarters in Bangkok.¹³

PDA staff members identify potential HIV-positive participants by working closely with hospitals, health centres, village banks, community councils, schools, local groups of people living with HIV, the mass media and other nongovernmental organizations.

¹³ The number of centres was reduced to 10, from 11, after the preliminary research for this report was conducted. That was accomplished by combining the centres in Lamplimat and Surin.

Home base

Kok Pra village

Kantalawichai district, Maha Sarakham province

Shaded by fruit trees, the rambling old house in Thailand's rural northeast evokes a timeless, traditional way of life.

A profusion of wooden outbuildings bursts with small projects and enterprises. Countless chickens, ducks, cats and dogs dodge around the feet of the three-generation family.

For HIV-positive Ning, 26, her parent's traditional home provides a safe and sheltering base to raise her daughter and earn an income.

In January 2005, Ning and her older sister, Maew, received US\$ 300 loans each from PPP to revive the family's dormant mushroom-growing business and help expand their mother's fermented fish enterprise. By October 2005, the two businesses were earning around US\$ 170–US\$ 200 a month, the sisters said.

Although Ning found out she was living with HIV in 1998, she has remained generally healthy in the years since, with periodic short episodes of debilitating illness. Her sister, a former teacher who's now a successful fortune-teller, believes that once-doubtful Ning has benefited from her advice to practice daily meditation.

Says Ning: "It was difficult at first, but I thought if I don't do it, I'll die. There was no choice."

Ill health prompted Ning to start taking antiretrovirals in September 2005, but she quit a few days later because of severe side-effects, against her doctor's advice. A month later, her CD4 count was 1200 and she felt "fine". The sisters hope that "mental strength" will enable Ning to continue without antiretrovirals for as long as possible. She tries to impart some of that strength to two other HIV-positive women in the district who "stay away from everyone" due to ill health and fear of stigma.

Almost by chance, the reserved Ning reveals the future she herself has lost, due to punitive attitudes towards HIV. Some five years ago, she was one term away from graduating in humanities, specializing in English, when an unplanned pregnancy revealed that she had HIV infection. The college removed her from an internship in a local museum and refused to let her finish her degree.

"It is lucky for me that I have a warm family. Everyone helps everyone here. No one says that because you're sick you must be separate. When I feel uncomfortable, my parents just say, 'Oh oh, another round coming again, how many days this time?'"

Ning planned to apply for a second PPP loan in January 2006 to expand the mushroom business.

"I need to make enough money to raise my daughter well."

Clubs of people living with HIV operating out of PDA centres are particularly important sources of support for PPP participants. Most are members of these clubs and frequently, a club was where they first heard of the project or became emboldened to apply after hearing about other participants' experiences. For many, the clubs provide a solid foundation from which they can leverage growing confidence as they come to terms with their HIV status. As part of the project's goal to reduce stigma and discrimination, from the very beginning participants are required to be open or semi-open about their HIV status and agree to assist in awareness efforts in their communities. The clubs are also important sources of information-sharing about medical treatment, especially antiretrovirals.

Selection criteria

All PPP applications are reviewed by a selection committee comprising some or all of the following: PDA staff members, health officials, local government representatives and school teachers. The committee makes a collective decision as to which applications to accept. The criteria for selection include applicants' regular attendance at meetings and briefings; clarity of business plans; and understanding of the expectation to repay loans on time (and stated agreement to do so). The selection committee also considers applicants' financial status—only individuals judged to be in need are deemed eligible.

According to PDA, selection committees' analyses of business plans focus on procurement plans for raw materials, investment costs, product pricing, profit analysis, business location and logistics, competitor analysis, and marketing/sales strategy. Their goal is to determine plans' feasibility to the best extent possible. In some cases, PDA staff members—acting on behalf of the full committee—have consulted external experts on the technical aspects of certain businesses so as to better assess a plan. Rejections generally occur because the business plans are vague or unfocused, or if a business is a duplication of that of other participants in the area (which would likely render an overall low success rate). If rejected, applicants are urged to consult with PDA staff to improve their business plans, which in some cases leads them to consider an entirely different type of income-generating opportunity.

The criteria mentioned above apply to all applicants. HIV-positive applicants, however, are required to meet one additional criterion: they must be willing to be open or semi-open about their HIV status. This requirement is considered vital to PPP's efforts to reduce HIV-related stigma and discrimination in local communities.

Partnership creation

Partnership creation is generally initiated by the HIV-positive person. As of December 2006, nearly three quarters of the 422 partnerships to date involved two people related to each other, including siblings, cousins, parents and children.¹⁴ Other partnerships pair neighbours, friends, employers and employees. Participants' ages range from the early 20s to over 50, with nearly one half between 30 and 39 years old. In some cases an HIV-negative individual who has heard about the project has searched for a positive partner.

The economic incentives and benefits to participants are obvious: each person receives a loan with an interest rate near or at the bottom of market rates.

The structure reduces discrimination and stigma through interaction and collaboration at a personal level and within a community. HIV-negative participants must work closely with the HIV-positive person to apply for a loan, receive training (if necessary) and devise a business plan. The HIV-negative partner is expected to attend all training sessions with his or her partner and to participate in HIV awareness campaigns in local schools and health fairs.

In general, HIV-negative partners are acutely aware that their ability to receive a loan is due at least in part to the HIV-positive individuals who chose to partner with them. This provides an incentive for him or her to work hard to make the project successful and the relationship fruitful. Moreover, given that the majority of negative participants are related to their partner, they are also highly motivated to help their HIV-positive counterpart. Their

¹⁴ As cited in PDA's sixth PPP progress report, December 2006.

close relationships with openly HIV-positive individuals serve to make them role models to other local residents and help break down barriers and fear caused by lingering stigma.

PDA's chairman, Mechai Viravaidya, said the strength of the model is that it establishes an equitable, one-to-one relationship between the partners, who each receive the same amount and share similar responsibilities. Because the HIV-positive person must make his own decisions throughout the process, with the expectation of financial rewards due to his own hard work and effort, the often condescending and potentially endless cycle of being sustained by charity is broken.

For many PPP participants, the income generated by PPP-supported business is all they have to support themselves and their families. Some have other regular sources of income—various part-time jobs or, in some cases, even full-time jobs—and use the loans to support or expand a business providing additional income to ensure greater financial security.¹⁵ For example, a project participant used his loan to set up a business installing gypsum board at construction projects. The slightly more than 3000 baht (approximately US\$ 75) he earns each month from that business adds up to 36 000 baht a year—almost equalling the 40 000 baht or so a year he earns from farming.¹⁶

The types of small businesses established since 2004 are quite varied and provide a glimpse into the wide range of income-generating activities available even in rural areas. Among them are the following:

- buying and selling (including lottery tickets, fruit, clothes, jewellery, souvenirs and second-hand goods);
- food preparation (both full-scale restaurants and ready-made meals to be taken away);
- livestock-raising (including cattle and pigs);
- motorcycle repair;
- craft-making (such as curtains, reed mats, candles and teak lamps);
- flower-growing;
- cloth-making.

Income requirements or limitations

There is no income ceiling or financial means test for either partner in a PPP relationship. However, all involved understand that the project's main beneficiaries should be those with inadequate current incomes and little or no opportunity to obtain credit or loans from other sources.

Because of the wide range of inconsistent income-producing activities in rural areas—such as occasional work picking crops, irregular transport provision and selling surplus food or livestock when available—it is not possible to screen all applicants thoroughly based on rigid income criteria. Therefore, PPP administrators rely not only on application materials to determine need, but also on input from community council members who have long lived among applicants and are aware of their economic situations.

¹⁵ PDA also plays a proactive role in helping some PPP participants obtain additional sources of income. In interviews conducted in September and October 2005, several HIV-positive PPP participants said they were employed part-time at PDA offices, providing services such as accounting and outreach.

¹⁶ Interview on September 26, 2005 in San Kong village.

It is expected that as the project expands, the gap between supply and demand will continue to narrow. This trend means that it should eventually be possible to provide loans to nearly all partnerships that apply.

Preparatory and ongoing training

Skills training is offered both to potential partnerships and to those ultimately selected. In the latter case, assistance is available on an ongoing basis throughout the course of the loan. There are two kinds of skills training programmes provided by PDA, generally by specially trained staff from the organization:

- *General micro-enterprise management skills:* Before the partnerships are chosen, all potential partners must attend a series of briefings and training sessions on business fundamentals, business planning, the processing procedures of the loan fund, financial discipline of a borrower, and stigma and discrimination reduction.
- *Skills relevant for selected business:* After the partnerships are chosen and the funds approved and disbursed, participants meet with project staff once a month to receive additional specific business training that is tailored to their businesses. During these meetings, they also discuss the progress of their businesses and any issues related to their health.

Both types of training include instruction in business fundamentals, such as book-keeping, marketing, advertising, inventory control, pricing strategy, managing employees and other co-workers, and arranging distribution outlets.

Moreover, additional training is often provided by volunteers from local and national companies' corporate social responsibility programmes. For instance, volunteers have offered direct business advice or technical assistance to individual partnerships and have held seminars for numerous partnerships during training days organized by PDA.

Ongoing health assistance

PPP staff also work to ensure that participants maintain optimum health levels. Participants are encouraged, for example, to have regular tests to determine their CD4 count. If this count falls below a certain level (usually 200 cells/mm³), or if patients otherwise exhibit debilitating symptoms of HIV disease, the primary health care provider may recommend commencing an antiretroviral regimen. PPP staff then work in conjunction with the caregiver (usually a local hospital) to access a steady supply of antiretrovirals and to offer ongoing assistance regarding regimen compliance, managing side effects and monitoring for treatment failure.

Though it is not a prerequisite for launching an HIV-specific microcredit project, antiretroviral access magnifies its positive effects through the often immeasurable health benefits to the individual and the impact of this clear change on his or her neighbours and the community. An additional benefit is that community members' willingness to be tested and to seek out information about prevention and behaviour change is increased where antiretroviral drugs are available.

In general, improved financial and physical health have been the norm among those participating in the PPP microcredit programme, with the former resulting directly from access to income-generating capital and the latter due to a combination of intangible (life-affirming community support and integration) and tangible (antiretroviral availability) factors.

Awareness-raising activities

In addition to the direct assistance offered to HIV-positive individuals and partnerships in general, PPP also implements awareness-raising activities intended to reach all members of local communities. Most of the activities focus on providing important HIV-related services. They include holding HIV education seminars and disseminating information, both in written form and verbally, about HIV and sexually transmitted infections—including how and why to seek testing and care.

Loan size and interest levied

Most PPP partnerships receive a 24 000 baht (approximately US\$ 600) loan for one year—split equally between the two partners—with an annual interest rate of 6%.¹⁷ The pair can decide whether to pool resources or to invest in separate business activities. If they work separately, the project's structure ensures that key links are maintained through regular training sessions, workshops and HIV-awareness events attended by both participants.

Individual participants are not held financially responsible should a partner default or experience business failure. They are, however, urged to share information about their economic situation as extensively as possible throughout the loan period. One strong incentive to offer and provide ongoing support to a partner is that if one fails to meet his or her financial obligations under PPP, the likelihood of either receiving an additional loan is significantly reduced. This is because in order to be considered for another loan, the partners must apply together or go through the inconvenience of dissolving their partnership and then seeking a different partner—in which case they would have to apply all over again anyway.

Both participants are generally required to make a monthly payment, with prorated interest. There are two main ways in which payments are made on a specified day each month: PPP staff or designated collectors visit participants' houses or workplaces, or in some areas participants are requested to drop off payments at a community centre or with the village savings bank.

¹⁷ As of December 2006, slightly more than 63% of all Pfizer PPP loans were in the range of 20 000 baht to 25 000 baht (US\$ 500 to US\$ 625) per partnership. Nearly 20% of loans were for a slightly smaller amount, between 15 000 baht and 20 000 baht. Loan terms varied much more widely in PPP initiatives funded by other entities.

Fighting back

Chamni village, Chamni district, Buriram province

Sopa Sa* is no stranger to hard knocks in life—or finding ways to fight back.

Sopa, 34, was pregnant when she discovered she was living with HIV in 1995. For seven years she managed to keep her status hidden in order to hold on to her job in a local shoe factory. But in 2002 an industrial accident mangled two of her fingers and she was forced to quit, with little compensation.

By then a widow with a child to support, Sopa started working in the fields as a day labourer. The local school barred her daughter when they discovered her mother's HIV status. Somehow, Sopa had to find the money to send the girl, who was not infected, to a local private school.

Things appeared to look up when Sopa found a new partner—but her mother disapproved and threw her out. "She didn't like him because he has a disability from birth and can't walk." The couple was forced to live outside the village for a time until her mother relented because she missed her grand-daughter.

One of the few welcome moments for a woman getting too used to doors slamming shut happened through the local Red Rose Club for people living with HIV at the PDA centre in Nang Rong.

Sopa received a loan from one of the first (non-Pfizer) PPP projects in 2002, which got her started in pig-raising. That broke even and the next year she received another loan to plant potatoes. But she was still looking for something more profitable and in January 2005, building on family connections in the weaving trade, got a US\$ 300 Pfizer-funded PPP loan to make cotton blankets. She bought a loom and hired an expert to teach her weaving.

In the meantime her mother had died and she was now sharing a roomy home with her elder sister, a successful tailor and Sopa's PPP partner, who used her loan to expand her existing business.

The house provides a solid base for the sisters' two enterprises. Sopa sells her attractive blankets for US\$ 3 each in the local PDA mini-mart and occasionally at local festivals. She once got an order for 50 pieces from the local village administration.

Even so, Sopa faces ongoing challenges—thread is expensive, and the client base is still narrow. Though she acknowledges "great support" from PDA project staff, Sopa feels she needs to upgrade her skills in marketing and accounting. She is unsure of her current income. "It's only ten months in and there's been a lot of setting up expenses, so it's hard to say."

**Not her real name. A pseudonym was used for confidentiality reasons.*

Additional loans

There is no policy limiting the number of consecutive loans to a partnership. In fact, many partnerships applied for and received a second loan after the first year, usually but not always for the same amount.¹⁸ Ultimately, according to Mechai Viravaidya, PPP administrators expect that excellent and consistent repayment data will help convince banks and other conventional lending institutions to pick up PPP clients after they have successfully repaid a first or second loan. If they meet their PPP loan requirements satisfactorily, participants will have a positive credit history and perhaps even some savings to use as collateral.

¹⁸ Partnerships are permitted to take out an additional loan once they have repaid the previous one. According to PDA, an estimated 80% of first-time borrowers had applied for a second loan.

After moving to a more conventional lending institution, most borrowers' interest rates will rise from PPP's 6% annual rate to market rates (which are usually set at a few percentage points above the prime rate, which itself hovered around 6% in Thailand in 2005).¹⁹ The likely rate would still remain much lower than what borrowers would get at the only other option—informal and often extortionate money lenders. There is also the possibility that the cost of capital will barely rise at all above what PPP charges, and may even be lower. Mechai in October 2005 said that officials at the government-run Bank for

Agriculture and Agricultural Cooperatives of Thailand (BAAC) had agreed in principle to take on PPP clients after they had paid off their second annual loan in a timely manner. The BAAC charges below-market interest rates to most of its rural clients.²⁰

Administrative costs

PDA defines administrative costs as operational expenses separate from the loan fund, which is used solely for funding partnerships. Expenses in this category include:

- salaries of administrators and a full-time project manager;
- workshops and technical training sessions, including business plan development for partnerships;
- ongoing meetings with partnerships regarding business progress and health-related issues;
- transportation and communication; and
- project monitoring and evaluation.

A maximum of 12.5% per annum of the loan fund is allocated to administrative expenses, with the actual amount varying by location based on indirect structural cost considerations. This amount is treated as separate by the donor; Pfizer, for example, provided US\$ 200 000 to the loan fund as well as an additional US\$ 100 000 to cover the administrative costs during the four-year implementation period.

¹⁹ According to the Bank of Thailand's web site, the prime rate at the end of August 2005 was between 5.75% and 6.25%. Online: www.bot.or.th/bothomepage/databank/EconData/Thai_Key/Thai_KeyE.asp. Accessed October 27, 2005. Banks also charge relatively high interest rates for small loans, such as those likely to be sought by PPP participants.

²⁰ The BAAC is no stranger to microfinance. According to its own web site, www.baac.or.th (accessed in October 2005), it has been "experimenting" with microcredit programmes for extremely poor farmers since the late 1990s. As noted elsewhere in this report, some people living with HIV said they had been turned down by the BAAC in the past because they were HIV-positive (thus considered a bad credit risk). Others, meanwhile, claimed that they had recently been told that staff at local BAAC branches (including in Chiang Mai and Nakhon Ratchasima provinces) were in some instances requiring applicants to take blood tests—and subsequently refusing loans to those who were found to have HIV.

Impact, monitoring, constraints and evaluation

Impact

A project progress report on PPP is created every six months. The sixth report was released in December 2006, near the end of the project's third full year.²¹ Key findings include these.

Total number of project participants: 844 (in 422 partnerships) in eight provinces, including Buriram, Chiang Mai, Chiang Rai, Khon Kaen, Maha Sarakham, Nakhon Ratchasima, Phitsanulok and Surin.

Total amount loaned since January 2004: 16.6 million baht (US\$ 477 000)

On-time loan repayment rate: 90.93%.²² This rate is more than 20 percentage points higher than that recorded in the initial PPP pilot project, which indicates that the on-time repayment rate is likely to rise even higher as PPP becomes more entrenched.²³ The remarkable results vindicate PDA's original assumption. According to Mechai, "The widespread notion that PLHA [people living with HIV] wouldn't pay back loans was completely untested—basically it was a prejudice. We felt it could be tested."

Gender of participants: Women comprised the majority of participants. More than 42% of all participants paired two women; 39% were composed of one man and one woman; and about 19% consisted of two men. Such results are not surprising when compared with similar data from other microcredit projects around the world, even though men make up an estimated two thirds of HIV-positive people in Thailand.²⁴ Women tend to be in greater need of economic assistance than men; they are poorer and more often excluded, culturally and economically, from access to other sources of credit or income-generating opportunities. They are also viewed, and view themselves, as primary caregivers for their children, thus adding even greater incentive to improve their financial and health prospects.

Another possible reason that men are represented less frequently in PPP partnerships may stem from them being more susceptible to shame related both to poverty and to HIV status. Most men consider themselves to be their family's primary breadwinner; it is often a great blow to their pride when they are unable to fulfil that role adequately. Participating in PPP may seem to them to be a public acknowledgement of their failure as providers. More anecdotally, interviews with people living with HIV indicated that men are less inclined to be tested for HIV and, if HIV-positive, more fearful of revealing their status—which is also required to join PPP. At a gathering of HIV-positive women at a community centre in

²¹ The sixth report was released after primary research for this report was completed. When and where available, updated data were added in January 2007.

²² As cited in PDA's sixth PPP progress report, released in December 2006.

²³ It is also worth noting that the vast majority of loans past due have eventually been paid; as noted in the sixth Pfizer PPP progress report, less than 2% of the 422 pairs of borrowers had not been able to meet their financial obligations. As a result, funds allocated originally for the project as a whole have been successfully recycled, thereby helping ensuring its longer-term viability.

²⁴ According to UNAIDS, about 220 000 of the estimated 580 000 individuals living with HIV in Thailand at the end of 2005 were women. UNAIDS, 2005 World AIDS Report. Online: www.unaids.org/en/Regions_Countries/Countries/thailand.asp.

Chiang Mai province in September 2005, the comment that most men would “rather die than know they have HIV” was greeted with widespread agreement.²⁵

Monitoring

Sustainability of enterprises

The effectiveness of most conventional microcredit projects can be determined by collecting and reviewing hard data about loan disbursements, repayment and business viability and sustainability.

As of December 2006, PPP participants were achieving on-time loan repayment rates of 90.93%. Comprehensive data on the businesses established had not yet been obtained, so it was not possible to determine precise indicators for the long-term economic sustainability of project enterprises.

Quality of life

Interviews conducted with some 20 participants in September and October 2005 indicated that the financial situation and economic prospects of nearly all had improved. For instance, one HIV-positive PPP participant, 56-year-old Khankam Udpasook, said that she had earned perhaps 80 baht (US\$ 2) a day as a day labourer before obtaining a PPP loan. She could barely support herself on such a wage, a situation that was exacerbated by the fact that on many days she was unable to work because HIV left her weak or sick. In early 2004, she began taking antiretrovirals and applied for and received a 7500 baht loan through PPP to start two small businesses, a fish farm and a flower-growing enterprise. The medicines helped her regain her physical health, and the loan launched her out of poverty. Her annual income during the year of her first loan reached 30 000 baht, and she expects to earn some 8000 baht over the period of her second loan (for 15 000 baht), which ends in January 2006.²⁶ (This report's case studies contain additional examples of improved economic and health conditions among PPP participants.)

Even in the absence of across-the-board criteria and data, it would be hard to deny the major impact that PPP has had so far on the lives of HIV-affected individuals, families and communities. The project has helped most participants move from persistent poverty to financial independence and improved security. Such developments have changed many lives completely, mitigating loneliness, isolation, hopelessness and shame stemming from being forced to rely on others for basic sustenance. Improvements in mental and physical health quickly followed, especially when greater access to antiretrovirals and other health-care services was also made a priority. As noted in this report's case studies, participants are grateful for the opportunity to remove barriers holding them down and preventing them from reaching their full economic and physical potential.

PDA attempts to measure some of the seemingly unquantifiable changes in participants' lives through a device called the Bamboo Ladder. Adapted from a United States model by PDA in the 1980s, the Bamboo Ladder is a 10-point scale in which respondents rate their perceptions, concerns and aspirations before, during and after changes in their lives and communities (in this case, the arrival of PPP). Such surveys filled out by PPP participants have nearly all indicated greater levels of contentment, ambition and integration into their communities.

²⁵ The informal interview with members of a support group for people living with HIV was held in Sankamapeng district of Chiang Mai province on September 28, 2005.

²⁶ Interview conducted on September 28, 2005 in rural Chiang Rai province.

The Bamboo Ladder

As a way of measuring perceived and actual changes in the lives of people involved in the PPP project, participants were asked in both 2004 and 2006 to take part in self-assessments using the Bamboo Ladder model.²⁷ PDA considers this model to be an important and useful way to monitor and measure PPP's success in improving its clients' lives.

Participants overwhelmingly recorded significantly higher levels of well-being, ambition and integration into their community.

Using a 10-point scale, respondents filled out diagrams assessing their perceptions of how their lives had changed, and their future aspirations, under five key topics: physical health, mental health, social condition, economic condition and quality of life.

The following excerpts and comments are from a Bamboo Ladder self-assessment by Nissara Panya from Ban Phai district, Khon Kaen province. Nissara, 42, is an HIV-positive PPP participant. (The results below are from two separate assessments from 2004, one taken before Nissara became a PPP partner, and another several months later.²⁸)

- Physical health: improved (along with antiretroviral treatment) from 2 points to 7 points on the 10-point scale. Nissara hoped in the future to reach 10 points, where she would be able to "act like a normal person. The project is of assistance to everyone; it will make my life be more meaningful."
- Mental health: improved from 0 points to 7 points. Nissara added: "After becoming a member of PPP, I got a stronger mental attitude due to receiving so much love from the project staff. I feel that I am not alone anymore. I want to live longer."
- Social condition: improved from 0 points to 7 points. Before the project, Nissara felt "unacceptable to society. People around me are afraid of getting HIV from me." After participating in PPP, she felt she could "get more acceptance from the community and other agencies. Can attend community events." For the future, she hoped to be able to "be admitted into any group."
- Economic condition: improved from a rating of 0 points to 7 points. In the past, Nissara said, "My economic status was so poor. I had to take care of my family. No one allowed me to work." After participating in PPP, she said "I am able to survive on my own."
- Quality of life: improved from 0 points to 7 points. In the past, Nissara said, "I could not take care of my family well, because I earned less money than we were spending." In the present, she commented, "My economic status is getting better. I do not think negatively. I am able to support myself."

²⁷ The original Bamboo Ladder was developed in the 1960s by Hadley Cantril, a professor of social psychology at Princeton University in the United States. Its 10-point scale, based on the Self-Anchoring Striving Scale (SAS), was designed as a culture-free method for assessing people's perceptions, concerns and future aspirations. In the 1980s PDA developed a Thai adaptation of the method.

²⁸ Results for individual Bamboo Ladder self-assessments from 2006 were not available at the time this report was completed.

Stigma and discrimination

Community surveys conducted by PDA have provided an indication of the impact of PPP's anti-discrimination and anti-stigma efforts at the community level. Respondents were queried about their knowledge of HIV and if and how their fears and concerns about people living with HIV and the disease in general have changed over the course of the project.

The most recent survey, from 2006, was completed by 166 individuals in communities across Thailand. That followed a larger two-part survey conducted in 2004. The earlier, more comprehensive survey reached the same group of 476 HIV-negative individuals at two different times, just prior to the launch of the project in January 2004 and then 10 months later in October.²⁹

The results of the two-part survey offered a direct indication of changes in the same community members' attitudes and knowledge of HIV. As reported in a December 2004 progress report, it covered a wide range of issues that can help gauge levels of awareness about HIV and attitudes towards those affected by it. Among the findings were the following (see Appendices 2–4 for more extensive results from PPP surveys).

- Respondents' anxiety level towards (or fear of) people living with HIV fell sharply, with a "high" level of anxiety declining from 47.7% in January 2004 to 14% in October 2004.
- In January 2004, just 13.5% reported having a "high" knowledge of HIV and AIDS; that increased to 50.6% in October 2004.
- Respondents exhibited a greater willingness to participate in activities with people living with HIV. For instance, more than 90% said in October 2004 that they would be comfortable working in the same building or sitting in the same car with an HIV-positive person; visiting his or her house; or attending a funeral of someone who died of AIDS. In January 2004, each of these rates was at least 20 percentage points lower.

Results from the 2006 survey indicate that these dramatic—and positive—trends in attitudes and knowledge about HIV have continued. Of the 166 people who filled out the 2006 questionnaire, 58.4% reported that their anxiety level towards (fear of) people living with HIV had decreased since October 2004. Nearly the same number, 57.6% of the total, said that their risk level of contracting HIV had declined over the same period. That result confirms the success of education and awareness programmes conducted at the community level, including by PDA.

²⁹ The 166 individuals surveyed in 2006 also participated in the 2004 two-part survey. However, direct comparisons between the 2004 and 2006 surveys cannot be made because of the difference in the number of respondents. Unless specified otherwise, the comparisons in this section refer to results obtained in January 2004 and October 2004, when the same 476 people were surveyed.

Shaping up

Nong Jok village, See Kieu district, Nakhon Ratchasima province

The buffalo head hanging outside the lonely one-room wooden house on stilts is no mere adornment.

"It tells people that this is the home of artists," says Supreeya Madanyoo*, 27, sitting on her porch and looking out at endless green fields and a distant mountain.

People are scarce in the isolated spot Supreeya moved to seven years ago with her former husband, who taught her to carve local sandstone into traditional-style sculptures. "I love it because it's art, and it's something women normally don't get to do."

When her husband died of AIDS-related illness in 2000, Supreeya pushed on alone for a time before falling in love with the couple's close old friend and one-time trainee, Nikorn Kithen, 33.

Nikorn was unfazed by Supreeya's positive status. "I've been close to HIV for a long time—I understand it. I am not frightened of it."

Together, the new couple carried on making elaborate carvings of Buddha images, animals and Cambodian-style female *apsaras* (angels) for customers including temples and a local politician. The business fluctuated and at times Supreeya was unwell; however, after starting on antiretroviral treatment in 2004 her CD4 count rose from 23 to 375 and she felt much better.

In June that year, the couple applied to PPP for loans of US\$ 300 each to buy new materials and equipment. Over the following year they made a modest income of around US\$ 1200 and in June 2005 received another pair of loans for the same amount.

Meanwhile, Supreeya was offered the post of accountant with her local 65-strong people living with HIV group based at the Chakkarat PDA centre some 60 kilometres away, where members are engaged in small enterprises making cakes, artificial flowers and scented bathroom sachets.

The job brings in another US\$ 75 a month but means the couple now live apart for much of the time, leaving Nikorn to do most of the carving.

They manage the new situation quite well, Supreeya says. She likes making friends through her job and conducting AIDS awareness training sessions in villages and factories. The local hospital refers around five new HIV cases a month to her for counselling and help.

"My message to others living with HIV is this: what you need most is courage. I get mine from my boyfriend, my parents, my family—and myself. There are many people in our situation. You can still do many things with your life. Fight the virus—live longer."

* Not her real name. A pseudonym was used for confidentiality reasons.

More anecdotally, many HIV-positive PPP participants report 180-degree changes in attitudes among their neighbours and friends. Fear and misinformation dominated many community members' attitudes prior to extensive HIV awareness efforts by PDA and other organizations, and before local people living with HIV began participating in the project. During interviews conducted in September and October 2005, several people living with HIV noted that when their HIV status became known over the past 15 years, many people refused to interact with them on any level, even crossing to the other side of the street when walking by their houses. Owners of local restaurants refused to serve them; longstanding friends stopped visiting, even going so far as to restrict their children from playing with the children of people living with HIV.

Most PPP participants who reported such instances of fear and discrimination among their neighbours said they occur less frequently now, and for some, hardly at all. A member of a support group for people living with HIV in Nakhon Ratchasima province, who is also a PPP participant, said that before the project came to his village, people who saw him killing chickens to sell would refuse to buy from him. Now they have few qualms in doing so.

There is still a long way to go in the wider society, however, where fear and misconceptions about HIV remain common. Local residents interviewed in Nakhon Ratchasima province mentioned another village where, they claimed, residents still refuse to allow HIV-positive individuals to draw water from the public well.³⁰ Such incidents of HIV-related discrimination are not necessarily isolated and infrequent occurrences, especially in large parts of the country where HIV awareness activities are limited or substandard. One way to help eliminate them is to expand the reach of initiatives such as PPP.

In addition to better and more consistent information about transmission risks, community members in villages where PPP operates appear to have greater respect for people living with HIV who have established businesses and are earning an income for themselves and their families. As one HIV-positive man in Chiang Mai province said bluntly, “People like to be around you if you have money”. Furthermore, many weak and sick people living with HIV have been restored to good health with the advent of affordable and more easily accessible antiretrovirals.

While the responses in the short term about stigma have been very encouraging, it is a long-term process, and the gains made in PPP will have to be maintained. Those associated with the project believe a longer-term evaluation will be very valuable.

Project constraints

Progress reports indicate that many participants, whether HIV-positive or -negative, initially lacked even basic business skills because of their past occupations as hired labourers. Sustained support and monitoring in the early stages of the new businesses is clearly vital, as some participants reported that their initial income-generating activities did not live up to expectations—for reasons including poor financial discipline and weak demand for the goods and services offered.

Declining health following loan approval has limited the ability of only a very small percentage of borrowers to allocate the time and energy to create a sustainable business and to pay back the loans. A tiny minority of participants died after joining the project; in such situations, loan repayment is not pursued and the remaining partner is assisted in finding another partner.

It is as yet unclear how sustainable some of the PPP enterprises will be over the long term. Several individuals interviewed during September and October 2005 expressed concern that their fledgling businesses could be in trouble if their efforts to obtain another annual loan were unsuccessful. Wherever a project similar to PPP is initiated, participants may need to be better prepared for such an eventuality—perhaps through more intensive training from the implementing nongovernmental organization or outside personnel with expertise in starting up and running small businesses.

³⁰ Interview conducted on October 25, 2005 in the Chakkarat district of Nakhon Ratchasima province.

Business concerns are important for a number of reasons, including their direct effect on the other key objective of lessening stigma. Poorly run or heavily subsidized businesses are not likely to be admired or appreciated by other members of the communities.

A general guiding principle for PPP may be to stress responsibility and compliance with loan repayment schedules, but to implement and operate more flexibly. In practice, this means that the financial requirements are made absolutely clear to all participants from the beginning. However, especially early on in a business, PDA provides a certain amount of leeway, such as allowing late payments—which is important given the seasonal nature of some of the businesses. PDA also grants extra training and additional resources for those who may need them. The popularity of this vital microcredit project and its long-term effectiveness in reducing debilitating HIV-related discrimination at the community level could possibly be jeopardized by administrators seeking to operate like conventional lending institutions, at least in the early years.

PDA reports that in instances when borrowers are unable to pay back their loans on time, the local PPP bank committee and sometimes PDA staff meet with them to determine how best to proceed. If the borrower is too ill to work, PDA tends to offer an indefinite grace period until the individual is able to begin working again. If loans are not repaid because businesses are not financially successful, PDA staff members revisit the business plan and help the borrowers make adjustments to their operations. Members of staff may also provide additional training (if needed) or request that the borrower explore new income-generating activities.

Ongoing and future evaluation

In addition to PDA's own activities in monitoring the project, a representative from Pfizer said a separate assessment would likely be carried out by an objective third party—such as an independent accounting firm—when more substantive data over a longer period is available.³¹ This assessment, to be funded by the Pfizer Foundation, will likely focus on loan repayment rates; sustained profitability of businesses; ability and willingness of businesses to expand; and lessons learnt from business failures.³²

In other countries and regions where similar projects are implemented, project funders' inclination and ability to be involved in monitoring, evaluation and direct support to businesses undoubtedly will vary greatly. Most likely, of greater importance in terms of business support to individual project enterprises will be entrepreneurs engaged in similar activities—including individuals not connected to the project. For example, it may be particularly useful for a successful food stall operator to impart tips, suggestions and guidance, based on his or her experience, to a project participant who also operates a food stall. Project staff can play an important role in arranging such interactions and increasing participants' access to relevant business expertise and assistance.

As noted previously, assessing the impact of a project's anti-discrimination and HIV-awareness goals is difficult because neither is quantifiable. Surveys and questionnaires about attitude changes—which PDA has conducted in the wake of PPP's launch—do not necessarily provide precise information about individual participants' experiences in terms of discrimination he or she may continue to face, for example. However, they can help determine broad trends, especially regarding awareness.

³¹ Interview with Pfizer's Amal Naj, October 18, 2005 in Bangkok.

³² *Ibid.*

Wood carving

Huay Sai village, San Sai district, Chiang Mai province

At last, Banliew Wongkhamdeng feels like he is turning a corner.

"It's good to feel normal," says the 32-year-old, whose friends call him "Bat".

Friends were in short supply three years ago after Bat discovered he was HIV-positive. Many deserted him when they saw how thin and weak he was. Villagers shunned him. "They thought I was dying."

However, his family was always supportive. Bat went on antiretrovirals, met his new wife at a local club for people living with HIV organized by PDA, and carried on making wood craft items like vases and candleholders. The US\$ 120–US\$ 170 monthly salary wasn't enough, he says, and it was frustrating working for others; he wanted a business of his own.

No local bank or village bank would lend to a person living with HIV. His only chance was the PPP programme, and in early 2004 he applied for a loan together with his cousin, Prasit Wongkhamdeng, 40. Each borrowed US\$ 200 for 10 months to buy equipment for a wood-carving crafts business.

The new business didn't earn enough in the first year to support them both, so when the pair applied for a second loan in early 2005, Prasit proposed using his share to set up a pig-raising business. That loan application, for US\$ 300 each, was approved—and Prasit now has 27 pigs (and counting). He said he had yet to see a profit, but expected good returns once he was out of the start-up phase.

By October 2005, Bat was earning between US\$ 200 and US\$ 300 a month, of which just a little was profit. His challenges included long waiting times to get paid from middlemen, and increased competition in the wood crafts business.

He was nevertheless optimistic. "Things have changed since I started feeling better and started my business. It's true that people like to be around you if you have money."

Lessons learnt and recommendations

The following lessons learnt from the first three years, resulting recommendations and other observations are designed to help other implementing entities and funders to structure HIV-specific microcredit programmes along the lines of PPP.

1. An equitable partnership comprising one HIV-positive and one HIV-negative person can achieve several important objectives in an overall response to HIV. A project that emphasizes openness and direct interaction among HIV-positive and HIV-negative people can have a major effect on improving HIV awareness and prevention efforts. This development may not only improve public health and save lives, especially among young people and others at greater risk for contracting HIV, but can also lay the groundwork for lower HIV prevalence in general. A healthy, hopeful population is of course better able to generate wealth and help reduce poverty in local communities and the nation overall.
2. A microcredit project's effectiveness is enhanced through the involvement of a strong, independent and experienced civil society organization with established community roots and well-earned trust.
3. A committed sponsor, brought in at the very beginning, can help ensure that funding availability remains consistent throughout the crucial early years of a microcredit project. The partner (or partners) should be encouraged to consider providing non-financial support and assistance where appropriate.
4. The provision of a basic level of skills-based business training is of great help to participants prior to beginning their businesses. Some may also need or benefit from ongoing training and assistance as they move forward. Implementing entities can create a comprehensive checklist that trainers are instructed to convey to all participants. Among the business skills that could be included on that list are book-keeping, managing cash flow, arranging supplies and distribution outlets, managing employees and other co-workers, and business-related legal and medical care issues.
5. Participants should get the right guidance to start enterprises that have a realistic opportunity to succeed in their community. Among the questions to consider are the following: What are the local needs? What are applicants' existing skills and interests? What kind of training are they open to receiving, and how can it best be provided? Those whose applications are denied should be encouraged to redo their business plans, with assistance as required, and apply again.
6. Organizations seeking to replicate PPP should carefully analyse local conditions and identify ways to surmount potential problems. For example, they might consider the following:
 - holding workshops on entrepreneurship for the entire community in advance, as part of an effort to increase acceptance of what may be considered unusual or suspicious behaviour in the local environment;
 - explaining the project thoroughly to, and endeavouring to work closely with, local and national officials (including those from health ministries) from the very

beginning. This can help to reduce bureaucratic stalling and to build important rapport over the long run;

- setting a priority on transparency at all levels of operation (especially financial), and insisting that project participants follow suit; and
 - creating links within government and independent media outlets to publicize the project as part of an effort to locate potential participants. Close links with such outlets can also help implementing entities identify and remove, if necessary, intractable obstacles (such as bureaucratic restrictions or harassment) that limit the project's effectiveness.
7. Some flexibility in loan amounts is appropriate, given differences in the scale of income-generating enterprises and clients' needs. Although the majority of initial loans may be of similar size—which makes sense because most businesses are new and therefore starting out from the same approximate base—subsequent loans could be greater if a newly established business shows great promise in expanding rapidly in a financially sound way and hiring additional people, for example.
 8. Improving participants' access to potentially health-improving antiretrovirals, if available, can create important underlying factors crucial for business success. HIV medicines often help HIV-positive participants regain health and energy, thus giving them a vital boost in creating a thriving business. Implementing entities may therefore find it useful to establish close links with local and regional health-care facilities, to which potential and current participants can be referred. Such links are helpful even when antiretrovirals are not yet available because they lead to greater overall attention to health and medical issues among all participants, regardless of HIV status. Microcredit project administrators may also consider establishing similar links with, and referring participants to if necessary, nongovernmental organizations that provide financial or health assistance to poor people in the area.
 9. From the beginning, project implementers should seek to create conditions in which borrowers ultimately “graduate” to more conventional lending institutions. The initial microcredit loans can provide borrowers with a credit history and the opportunity to build collateral (savings) that make them eligible for more standard loans, even at higher market rates. This development also opens the door for other potential applicants to tap into the microcredit project, thus increasing the number of people who can participate. An additional notable benefit is that such a trend can help move the project to a different phase, from one perceived as a subsidy to one governed by the regular marketplace. A knock-on effect will likely be further reduction in discrimination and stigma when community members see people living with HIV sustaining viable businesses that are self-supporting and subject to the same rules and regulations as the rest of the population.

The PPP experience in Thailand has much to offer donors and civil society partners throughout the world who are seeking innovative ways to help those whose lives are restricted by HIV. On a macro level, it complements most national HIV responses by directly addressing key objectives outlined by policy-makers everywhere, even those whose actions are far less notable than their words: improving the health and economic well-being of people affected by the disease; reducing stigma and discrimination; and increasing awareness and HIV prevention education.

Those goals and achievements only make sense when viewed through a smaller lens, however. The lives of 844 individuals have undeniably changed for the better since they began participating in PPP. They have picked up hopes and dreams put aside during years of destitution, isolation and fear. The ripple effect, beginning with their families and communities, impacts thousands of other people. PPP provides an excellent example of the virtues and benefits of thinking big and theoretically, while emphasizing and focusing on the lives of individuals.

Appendix 1: PPP loan disbursement amounts and repayment rates

The table below provides information on Pfizer-funded PPP loan activity from the beginning of the project, in January 2004, through December 2006. The information was gathered and recorded by the 10 PDA branches/centres with responsibility for overseeing the project in their respective provinces or districts.³³ Data in column five are derived from the cumulative amount of repaid loans from 2004 to the time of reporting in 2006.

Overall, since the project's inception, loans provided to 422 partnerships amounted to a total of 16.2 million baht (about US\$ 477 000). Repayment rates noted below refer to loans of 11.9 million baht, of which nearly 10.9 million baht had been repaid on time.

PDA centre	Number of PPP partnerships	Total loans given out 2004–2006	Total loans expected to be repaid this period	Actual loans repaid this period	Repayment percentage
Chiang Rai	35	1 678 000	1 678 000	1 656 000	98.68
Wiang Pa Pao	65	2 137 000	1 150 000	1 144 000	99.48
Chiang Mai	53	1 880 000	1 496 400	1 357 400	90.71
Phitsanulok	20	644 000	452 000	398 735	88.22
Maha Sarakham	48	1 390 000	614 718	451 650	73.47
Ban Phai	33	1 418 000	904 000	747 443	82.68
Nakorn Ratchasima	38	2 056 000	1 221 980	1 143 980	93.61
Nang Rong	54	1 713 500	1 307 440	1 207 520	92.36
Phutthaisong	37	2 856 000	2 292 000	2 244 000	97.91
Lamplaimat	39	840 000	792 000	477 500	60.29
TOTAL	422	16 612 500	11 908 538	10 828 228	90.93%

Source: PDA's sixth Pfizer PPP progress report, released in December 2006

³³ There were originally 11 centres. That number was reduced to 10 in 2006 when the centre in Surin closed and was combined with that in Lamplaimat.

Appendix 2: PPP project members' businesses

The following chart provides information on the types of businesses initiated by the 844 individuals in 422 Pfizer-funded PPP partnerships, as of December 2006. The data are grouped by PDA branch/centre in the order originally presented in the sixth Pfizer PPP report.

CR:	Chiang Rai	BP:	Ban Phai
WPP:	Wiang Pa Pao	NKR:	Nakorn Ratchasima
CM:	Chiang Mai	PSL:	Phitsanulok
MSK:	Maha Sarakham	NR:	Nang Rong
PTS:	Phutthaisong	LPM:	Lamplaimat
SR:	Surin		

PDA Branch/Centre

Occupation	CR	WPP	CM	PSL	MSK	BP	NKR	NR	PTS	LPM+SR	Number	%
Buying and selling*	26	28	19	8	33	16	7	38	6	22	203	24.05
Food business**	7	12	6	6	7	4	6	18	5	14	85	10.07
Agriculture	4	26		3	7		4	10		1	55	6.52
Cash crop production	3	28	5	6		6	12	9		3	72	8.53
Mushroom cultivation				2	5		2			4	13	1.54
Cattle-raising	15	12	26	12	10	11	31	18	47	21	203	24.05
Frog/fish/silk worm-raising/mini farms		18	4	2		10	5	1	2	5	47	5.57
Cloth-making			19	1	4	13	2	8	5	6	58	6.87
Photo-frame-making			20		20	4	2	2	8	1	57	6.75
Crafts, funeral flower production***										1		
Barber shop		1	1		8						11	1.30
Hired labour/construction	5		4		2						11	1.30
Motorcycle repair business	2	1					1	4	1		9	1.07
Others	8	4	2			2	4				20	2.38
Total	70	130	106	40	96	66	76	108	74	78	844	100.00

* Examples of buying and selling include owning a grocery store; buying and selling second-hand and recycled goods; and specializing in selling the following: lottery tickets, clothes, jewellery, souvenirs, fruit, dry foods, desserts and salt.

** Examples of food businesses include making and selling noodles, rice and curry, fried meatballs, tamarind sweets, coffee and cookies.

*** Examples of craft-making include curtains, reed mats, candles, photo frames, teak lamps, sculptures and flower arrangements for funerals.

Source: PDA's sixth Pfizer PPP progress report, released in October 2005

Appendix 3: Changes in knowledge about HIV, and anxiety towards people living with HIV

PDA's third Pfizer PPP progress report, which covered project activities through December 2004, contained the results of a survey of 476 HIV-negative individuals in communities where PPP operates. Respondents were asked to mark up the same questionnaire two different times, once in January 2004—as the project was about to get underway—and again in October 2004, several months later. The survey contained a series of questions intended to gauge respondents' knowledge about HIV transmission and attitudes regarding people living with HIV, and AIDS in general.³⁴

According to the first chart below, respondents' knowledge of HIV increased dramatically over the first 10 months of the project in their communities. Over the same period, as noted in the second chart, respondents reported that their anxiety levels regarding people living with HIV had declined sharply. Taken together, the results indicate that greater knowledge about HIV helps change attitudes that can lead to stigma and discrimination.

Note: "Before" refers to survey results obtained in January 2004, while "after" refers to October 2004.

Table 1. Knowledge on HIV

Knowledge Level	Before project (January 2004) (% of respondents)	After project (October 2004) (% of respondents)
High	13.5	50.6
Medium	40.3	39.9
Low	46.2	9.5
No knowledge	—	—
Total	100%	100%

Table 2. Anxiety towards people living with HIV

Anxiety Level	Before project (January 2004) (% of respondents)	After project (October 2004) (% of respondents)
High	47.7	14.0
Medium	33.7	40.0
Low	18.6	46.0
Not sure	—	—
Total	100%	100%

Source: PDA's third Pfizer PPP progress report, which covered the first year of the project through December 2004

³⁴ A subsequent survey was conducted in 2006 among 166 of the 476 participants in the 2004 surveys. However, the significant difference between the number of people surveyed in 2004 and in 2006 makes it impossible to directly compare their results.

Appendix 4: Changes in attitudes regarding people living with HIV

PDA's third PPP progress report, which covered project activities through December 2004, contained the results of a survey of 476 HIV-negative individuals in communities where PPP operates. Respondents were asked to mark up the same questionnaire two different times, once in January 2004—as the project was about to get under way—and again in October 2004, several months later. The survey contained a series of questions intended to gauge respondents' knowledge about HIV transmission and attitudes regarding people living with HIV, and HIV in general.³⁵

The survey responses noted in the chart below indicate that community members were more willing participate in activities with people living with HIV after the launch of the project. Such a trend seems to point towards increasing integration of people living with HIV into the community and a reduction in stigma-induced isolation.

Note: "Before" refers to survey results obtained in January 2004, while "after" refers to October 2004.

Activity	Willing		Unwilling		Not sure	
	Before (%)	After (%)	Before (%)	After (%)	Before (%)	After (%)
Stay in the same house with an HIV-positive person	55.4	84.2	26.6	7.3	18.0	8.5
Allow their children to study in the same school as children of people living with HIV	61.4	85.9	22.5	6.6	16.1	7.5
Work in the same building as people living with HIV	67.6	85.9	18.1	3.4	14.3	3.2
Sit in the same car with people living with HIV	74.5	94.2	14.9	2.4	10.6	3.4
Ride the same motorcycle as an HIV-positive person	63.8	87.3	26.1	5.6	10.1	7.1
Share the same meal with an HIV-positive person	42.9	69.5	40.4	17.3	16.7	13.2
Drink water from the same glass as an HIV-positive person	29.3	47.7	53.2	34.1	17.5	18.5
Join traditional events with people living with HIV	86.3	97.4	5.9	1.3	7.8	1.3
Wear the same shoes as an HIV-positive person	40.2	70.4	37.0	15.2	20.5	14.4
Wear the same hat as an HIV-positive person	40.2	65.1	38.5	18.5	21.3	16.4
Share the same room as an HIV-positive person	38.7	62.6	43.2	19.7	18.1	17.7
Use the same bathroom as an HIV-positive person	53.7	80.8	26.7	11.3	19.6	7.9
Buy products from people living with HIV	63.5	83.4	24.3	9.4	12.2	7.2

³⁵ A subsequent survey was conducted in 2006 among 166 of the 476 participants in the 2004 surveys. However, the significant difference between the number of people surveyed in 2004 and in 2006 makes it impossible to directly compare their results.

Buy food from people living with HIV	56.0	77.5	28.2	13.3	15.8	9.2
Eat food cooked by an HIV-positive person	35.4	58.3	45.5	25.5	19.1	16.2
Buy fruits/vegetables from an HIV-positive person	62.4	82.7	20.0	11.3	17.6	6.0
Use the same barbershop as an HIV-positive person	36.3	61.1	44.7	22.2	19.0	16.7
Touch the body/hand of an HIV-positive person	54.9	81.5	29.3	11.4	15.8	7.1
Visit an HIV-positive person at his/her home	77.3	95.7	10.3	2.4	12.4	1.9
Go to the funeral of an HIV-positive person	87.8	98.1	4.6	1.5	7.6	0.4

Source: PDA's third Pfizer PPP progress report, which covered the first year of the project through December 2004

Appendix 5: Thirty years of growth: how and why microcredit can reduce poverty

The world's first loans identified specifically as “micro” were extended in the early 1970s by ACCION International, a United States-based nongovernmental organization. Thirty years on, microfinance institutions now exist throughout low- and middle-income countries. Some are organized as, or operate as divisions of, strict profit-making institutions. Others are developed and managed by non-profit charities or government agencies. Microcredit's greatest impact continues to be among poor and unemployed people, especially women, who cannot meet the minimum requirements to obtain a loan from formal banks and other conventional financial institutions. Among other barriers to eligibility, these individuals frequently lack collateral, credit history, a job and savings.

ACCION and its successors saw potential even as established entities were blinded by these perceived limitations. They recognized that even a small loan could help many asset-starved people establish flourishing and sustainable entrepreneurial enterprises and work their way out of poverty. This approach has the further benefit of avoiding the long-term pitfalls that can accompany aid with no restrictions. From the perspective of many microfinance supporters, direct charity, although well-intentioned and necessary in severe crisis situations, does little to provide a long-term solution to desperate poverty and is often demeaning to individuals.

Microcredit is based on the belief that no matter how small, a business can have a disproportionate impact on an individual's life, meeting immediate physical needs (putting enough food on the table) as well as psychological needs (reinstilling confidence and ambition) that are crucial to the individual's long-term future. Clients often respond diligently to the confidence placed in them by showing great determination to meet financial expectations and avoid defaulting. For example, one longstanding microfinance institution, Grameen Bank in Bangladesh, reports a loan recovery rate of nearly 99% over the course of its three decades in operation.³⁶ That kind of result is particularly impressive when one considers that many microfinance institutions, especially relatively new ones, charge higher interest rates than do banks in their country of operation because of significant start-up costs and the small size of most loans. Experience nearly everywhere in the world indicates that poor people are much better credit risks than conventional wisdom once held.

The expansion of microcredit has been particularly rewarding among populations that face not only poverty, but also entrenched social and economic discrimination that place additional barriers to earning a living. The first loans from Grameen, in fact, were provided to one such population—poor women in rural Bangladesh, who initially formed small, informal groups to apply together.³⁷ Group members, who tended to be from the same

³⁶ According to a survey of microfinance in *The Economist*, “The Hidden Wealth of the Poor” (November 5-12, 2005), some financial analysts believe that such high loan repayment rates may be somewhat overstated. As noted in the survey, “There are widespread suspicions that some microfinance banks hide poor repayment rates by rolling over bad loans or extending their due dates indefinitely, which they can keep up as long as there is an inflow of donor funds.” The survey concludes, however, that even with such caveats it seems likely that most microfinance clients do in fact meet their repayment obligations at or above the same level as lenders from conventional banks.

³⁷ Grameen Bank's founder, Muhammad Yunus, was awarded the Nobel Peace Prize in 2006 for his pioneering work in microfinance.

village, agreed to guarantee each others' loans and to support their business efforts. Grameen's focus remains largely the same today: women have made up 96% of the bank's borrowers to date in Bangladesh.³⁸ Elsewhere, too, women continue to comprise the majority of micro-credit clients in most countries and regions. Microfinance institutions remain important community-building entities for them in many rural areas.³⁹

Microcredit can also be quite successful from a purely business perspective. According to an article in *The Banker* in July 2005, the average return on assets for micro-finance institutions globally is 3.9%, compared with just 2.1% for commercial banks.⁴⁰ The robust financial results achieved by many initiatives have not gone unnoticed. A 2004 report from the Asian Development Bank observed that an increasing number of conventional and specialized banks were developing financial services targeted for the poor that closely resembled microcredit initiatives.⁴¹ This development indicates that microfinance may cease being considered a niche market in the foreseeable future.

³⁸ *The Economist*, "The Hidden Wealth of the Poor" (November 5-12, 2005)

³⁹ Una Murray, "Promoting Gender-Sensitive Entrepreneurship via Microfinance Institutions." Murray's paper was presented on March 8, 2005 at the Food and Agriculture Organization (FAO) for events marking International Women's Day. Online: www.fao.org/sd/dim_pe1/pe1_050401_en.htm.

⁴⁰ Elizabeth Littlefield and Martin Holtmann, "Microfinanciers Overtake Their Commercial Peers." *The Banker*, July 4, 2005. Online: www.cgap.org/press/press_coverage19.php.

⁴¹ Anita Campion, Stephanie Charitenko and Nimal A. Fernando, "Commercialization of Microfinance: Perspectives from South and Southeast Asia." Asian Development Bank, Manila, 2004. Online through the Asian Development Bank: www.adb.org.

Appendix 6: Other HIV-focused microcredit projects

PPP is *sui generis* for a number of reasons, but other HIV-specific microcredit projects do exist in parts of the world—although in total they represent only a small percentage of the overall microfinance world. Some have been in operation for several years in especially hard-hit areas such as southern Africa, where adult HIV prevalence exceeds 20% in many nations. Among them are the following.

- In **Zambia**, the Rainbow Model of Care, established in 1997, focuses primarily on helping improve the lives and prospects of children orphaned by AIDS. It is a community-based project with four main activities: educational support, nutritional centres, shelter and housing for street children, and microcredit groups. According to a report in *Microfinance Matters*, the newsletter of the United Nations Capital Development Fund, nearly 750 vulnerable families were reportedly enrolled in the project's microcredit scheme in 2004, with repayment rates ranging from 65% to 86%.⁴² The report concluded, "All of the families that graduated from the microcredit programme show an increased number of meals per day from one to three, as well as a substantial increase in the number of children able to attend school. These results represent fundamental steps towards the objective of self-sustainability."⁴³
- In **Zimbabwe**, the Zimbabwe Ecumenical Church Loan Fund (ZECLOF) developed a pilot microcredit project in 2002 that was designed specifically for people living with or otherwise affected by HIV.⁴⁴ Participants receive four days of training in a community centre where they learn about record-keeping, business management and other key business-related procedures. They are also given extensive information on HIV prevention and treatment. The ZECLOF project offers loans to groups only, not to individuals. According to a report from mid-2004, a full 100% of loans had been repaid. Of the 170 participants at the time, more than 91% were women, and 40% were HIV-positive.
- In northern **Malawi**, World Vision initiated a microcredit project in 2000 called Finance Trust for the Self-Employed (FITSE) in three regions.⁴⁵ FITSE offers training sessions on business management, and HIV and other health issues to those receiving loans. The overall goal of the project is to simultaneously improve the financial status of clients and deliver extensive health education to help increase awareness of HIV transmission risks.

⁴² Francesco Strobbe, "The Role of Microfinance in Addressing the HIV/AIDS Pandemic in Zambia: The Rainbow Model Provides a Future for AIDS Orphans." From *Microfinance Matters*, the newsletter of the United Nations Capital Development Fund, April 11, 2005. Online: www.unCDF.org/english/microfinance/newsletter/pages/2005_04/news_pandemic.php.

⁴³ Ibid.

⁴⁴ Information about this project was obtained from the Ecumenical Church Loan Fund web site: www.eclof.org/english/newhorizon/nheng31/hivaidsmicrofinance.htm. Accessed October 18, 2005.

⁴⁵ Information about this project was obtained from the World Vision web site: http://domino-201.worldvision.org/worldvision/appeals.nsf/stable/im_malawi22. Accessed October 20, 2005.

All three of these projects share several characteristics with PPP. They are community-based and community-focused; they offer training in key business-related skills to help ensure sustainability; and they focus equally on the obligation to meet loan terms and to help spread awareness about HIV. Furthermore, all four projects are in countries where government assistance and support for people living with HIV have been sporadic over the years, for reasons as various but related as lack of financial and human resources and widespread, lingering stigma.

Even taking these similarities into account, however, there are notable and crucial distinctions between PPP and these other HIV-related microcredit projects. These differences do not limit the replicability of PPP in other countries. Instead, they illustrate the inherent adaptability of PPP based on the fact that its ultimate success—and the success of similar projects elsewhere—can be gauged at the local level, among individuals who ultimately share many of the same needs and aspirations. PPP can be implemented in any economic, social or political environment where people affected by HIV would benefit not only from greater access to income generation assistance and financial independence, but also from a concurrent reduction in stigma and discrimination directed towards them. That describes the needs of HIV-affected people almost everywhere.

For all the criticism of the Thai government's response to the epidemic in recent years, few would deny that Thailand has been relatively fortunate overall, at least compared with much of sub-Saharan Africa, in terms of how it has been affected by HIV. HIV prevalence in Thailand is much lower; antiretrovirals are much more widely available, especially over the past two years; and Thailand has a longer and more successful track record in designing and implementing HIV awareness initiatives. Other key differences between Thailand and the countries listed above include:

- despite significant regional disparities, Thailand is a middle-income country while all save South Africa in sub-Saharan Africa are much poorer;
- according to international surveys by organizations such as Transparency International, most forms of corruption are less common in Thailand, thus making it easier to start and maintain a legal business;
- Thailand is self-sufficient in food, which is also comparatively inexpensive for most residents; and
- Thailand's entrepreneurial culture has generally been regarded as one of the world's most flourishing in recent decades.⁴⁶

Another important factor identified as contributing to success is that PPP is administered by local staff from a relatively well-funded, national nongovernmental organization that has extensive experience at the community level across the country. Unlike international nongovernmental organizations, a locally run implementing entity such as PDA has a more targeted focus: the country in which it operates. Its attention and resources are therefore less

⁴⁶ These relative advantages should theoretically make it easier for the Thai government to stick to a consistent, comprehensive plan to respond to its HIV epidemic. Instead, since the beginning of the decade the government has shown little commitment to reinvigorating national HIV prevention efforts (particularly condom use) that helped drive down the number of annual new infections from a high of 143 000 in 1991 to 19 000 in 2003. This is a laudable achievement and for the most part Thailand deserves to be held up as a model of how to slow down and reverse the spread of HIV. Its undeniable success could be jeopardized by what many observers, including PDA's chairman, Mechai Viravaidya, see as the current government's failure to consider HIV an ongoing priority and its support of policies that have a questionable human rights impact.

likely to be drawn elsewhere; projects such as PPP therefore remain key priorities. PPP is consequently larger in scope and reach—involving 750 people directly and stretching into eight provinces in less than two years—than many other HIV-specific microcredit initiatives that still depend on a greater level of guidance and oversight from international nongovernmental organizations.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

Produced with environment-friendly materials

■ UNAIDS BEST PRACTICE COLLECTION

The UNAIDS Best Practice Collection

- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact-alleviation in multiple settings;
- aims at stimulating new initiatives in the interest of scaling up the country-level response to the AIDS epidemic; and
- is a UNAIDS interagency effort in partnership with other organizations and parties.

Find out more about the Best Practice Collection and other UNAIDS publications from www.unaids.org. Readers are encouraged to send their comments and suggestions to the UNAIDS Secretariat in care of the Best Practice Manager, UNAIDS, 20 avenue Appia, 1211 Geneva 27, Switzerland.

Research has shown that there are many complex links between HIV and poverty, and that the reality of poverty often denies people living with HIV access to the treatment and care they need. Poverty may also render prevention initiatives less effective and encourage the stigmatization of people living with or affected by HIV. Through providing microcredit, the Positive Partnerships Program in Thailand demonstrates an innovative way for people living with HIV to remove themselves from absolute poverty and rejoin the everyday world of work and trade. It also gives them a means to use talents that may have been left undiscovered. Through partnering people living with HIV with people who are not infected, the implementation of the Program has also made significant achievements in reducing discrimination against the infected and vulnerable.

UNAIDS
20 AVENUE APPIA
CH-1211 GENEVA 27
SWITZERLAND

Tel: (+41) 22 791 36 66
Fax: (+41) 22 791 48 35
e-mail: bestpractice@unaids.org

www.unaids.org