

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

UNAIDS BEST PRACTICE COLLECTION

Highlights



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

UNAIDS Best Practice



Questions to ask.



Points to note.



Information to carry.

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This publication gives a brief overview of the organization and progress of the Positive Partnerships Program in Thailand, and outlines some lessons learnt. A longer document giving more detailed information about the Network can be accessed on the UNAIDS website at <http://www.unaids.org/DocOrder/OrderForm.aspx>

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Overview

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.

A project rolling out in rural Thailand, the Positive Partnerships 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 beneficial impact in promoting enabling environments for HIV prevention and treatment efforts. This best practice document examines how and why PPP may serve as a flexible and adaptive model in other countries.

The project has two distinct yet complementary goals.

1. To enable people living with HIV to lift themselves out of poverty, through the provision of microcredit loans that allow people to set up small businesses in their communities.
2. To reduce HIV-related stigma and discrimination against people living with HIV through business partnerships between one HIV-positive person and one HIV-negative person.

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.

The project greatly facilitates progress towards achieving these two goals simultaneously: loans are made not to people living with HIV alone but to partnerships between an HIV-positive and

an HIV-negative person. By the end of 2005, 375 partnerships had been formed since the project began in January 2004.

PPP would be easy to replicate in nearly any society, partnerships of the sort created through PPP 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 respond more effectively to the epidemic.

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 business partner, HIV-negative people become better educated about HIV. 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 to access due to the increased availability of low-cost or free antiretroviral medicines in Thailand.

Financial results have been equally impressive, offering quantifiable proof that people living with HIV and microcredit need not be mutually exclusive. 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.

There is much documentation available to support microcredit-based projects and such guides should be consulted in planning new initiatives. However, there are specific lessons to be learnt from this initiative that twins fiscal rigour and responsibility with social change, as well as working with HIV-positive people. Lessons include:

1. A project that emphasizes openness and direct interaction between HIV-positive and negative people can have a major effect on improving HIV awareness and prevention efforts.
2. Bringing people living with HIV and HIV-negative people together through a microcredit scheme has an impact on the wider community, including the reduction of stigma and poverty.
3. Living with HIV does not in itself make a person a potential participant—they also need a basic level of skills-based business training before starting a business.
4. Living with HIV does not make a person a bad credit risk.
5. Improving participants' access to potentially health-improving antiretroviral drugs can support important underlying factors crucial for business success. HIV medicines often help people living with HIV regain health and energy, thus giving them a vital boost in creating a thriving business. Implementing organizations may therefore find it useful to establish close links with local and regional healthcare 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 nongovernmental organizations that provide financial or health assistance to poor people in the area (and referring participants if necessary).
6. 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.
7. A microcredit project that works with people living with HIV will find its effectiveness is enhanced through the involvement of a strong, independent and experienced civil society organization with established community roots and well-earned trust.



8. Organizations seeking to replicate PPP should analyse local conditions carefully 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 in the long term;
 - 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 overcome, if necessary, intractable obstacles (such as bureaucratic restrictions or harassment) that limit the project's effectiveness.

The PPP experience in Thailand has much to offer donors and civil society partners throughout the world that 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.

The situation in Thailand

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

The government expects the number of Thais on antiretroviral therapy to increase to around 200 000 by 2010. 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\$ 0.75) each time they visit one of 900 designated hospitals and health clinics across the country to collect medicines. A monthly supply of GPO-VIR (fixed dose antiretroviral triple therapy) therefore costs each individual about US\$ 9 per 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.

Despite some criticism of the Thai Government's response to the epidemic in recent years, few would deny that Thailand has been relatively fortunate overall in terms of how it has been affected by HIV, at least compared with much of sub-Saharan Africa. HIV prevalence in Thailand is much lower; antiretrovirals are much more widely available (especially since 2005); and Thailand has a longer and more successful track record in designing and implementing effective HIV awareness initiatives. Differences between Thailand and other countries include:

- Thailand is a middle-income country, despite significant regional disparities;
- most forms of corruption are less common in Thailand, making it easier to start and maintain a legitimate business;
- many Thais are self-sufficient in food, which is also comparatively inexpensive for most residents; and
- there is a well-established strong entrepreneurial culture.

The PPP project was conceptualized by the Population and Community Development Association (PDA), a Bangkok-based nongovernmental organization. The PDA 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. 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 urging—the government to increase HIV prevention resources and education.

Microcredit and HIV

Microfinance institutions (MFIs) now exist throughout low- and middle-income countries. Some are divisions of strictly profit-making institutions; others are managed by non-profit-making charities or government agencies. Microcredit is based on the belief that no matter how small, a business can have a positive impact on an individual's life, meeting immediate physical and psychological needs. Experience indicates that poor people are much better credit risks than conventional wisdom once held. The greatest impact of Microcredit continues to be among poor who cannot meet the minimum requirements to obtain a loan from banks and other conventional financial institutions, face not only poverty, but also entrenched social and economic discrimination.

Microfinance institutions are also successful from a business perspective. According to an article published in *The Banker* in July 2005, the average return on assets for microfinance institutions globally is 3.9%, compared with just 2.1% for commercial banks. A 2004 report from the Asian Development Bank observed that an increasing number of banks were developing financial services for the poor that closely resembled microcredit initiatives.

Many microfinance institutions have eligibility policies that restrict access to those deemed a credit risk—which generally includes those living with or affected by HIV. In 2003, the Consultative Group to Assist the Poor (CGAP)¹, a consortium for microfinance donors, warned that “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”. 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”.

However, in April 2004, some 40 people, including HIV specialists and representatives from several microfinance institutions, attended a workshop titled “Microfinance in Communities Impacted by HIV/AIDS”². 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 the 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 borrowers affected by the virus.

Such attitudes serve to reinforce the importance of specialized projects (such as PPP) and the lessons that can be learnt from them.

¹ CGAP Donor Brief, No. 14, September 2003. “The Nexus of Microfinance and HIV/AIDS”. Online: www.unCDF.org/English/microfinance/newsletter/pages/dec_2003/news_hiv.php.

² Stuart Mathison, “Economy and Epidemic. Microfinance and HIV/AIDS in Asia.” The Foundation for Development Corporation. Available in PDF format online from the website 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.

However, one recommendation caused concern as it 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”. This caveat could conceivably be used to deny applications from nearly all HIV-affected individuals and households, even if antiretroviral access were guaranteed.

Introducing the Positive Partnership Program

Initial results for the PPP indicate improvements in the quality of life for many people living with HIV.

- In the period since the project began (in January 2004) through December 2006, loans totalling 16.6 million baht (approximately 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.³ This indicates that, contrary to a widely held but wrong belief, people living with HIV can be just as likely (if not more so) to meet financial obligations as those not facing a life-threatening illness.
- Many people living with HIV reported that they no longer felt they must accept being discriminated against. They were intensely relieved to feel as though they need no longer hide and had found support and assistance from others who understood their experiences. They have now become leaders in their communities’ HIV awareness campaigns.
- In January 2004, just 13.5% reported having a ‘high’ knowledge of HIV; that increased to 50.6% in October 2004.
- There has been a reported greater willingness to participate in activities with people living with HIV. For instance, in October 2004, more than 90% said that they would be comfortable working in the same building or sitting in the same car with a person living with HIV; visiting his or her house; or attending a funeral of someone who had died of AIDS. In January 2004, none of the responses were better than 20%.
- At the same time, PDA surveys indicate that non-infected individuals in project communities are less fearful of contracting HIV and have far fewer fears about interacting with people affected by HIV. 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.



First steps

In 2002, with funding from UNAIDS and others, PDA set up a pilot microcredit project. 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 negatively affected by HIV, notably family members and orphans.

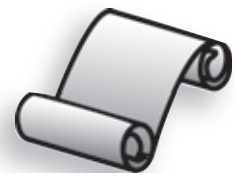
³ Both the total loan amount and the 91% loan repayment rates were reported in PDA’s sixth Pfizer PPP progress report, prepared at the end of 2006.

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.

Pfizer Thailand Foundation subsequently agreed to contribute 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.

The Pfizer-funded project, entitled “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 the initial grant period, loans had already been extended to 750 individuals in 375 partnerships in eight Thai provinces, approaching the project target of 400 partnerships. In 2006, the total number of partnerships reached 422.



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 for caregivers to give 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.

How the Positive Partnership Program works

The programme is run by staff in 11 PDA rural development centres spread across eight provinces, as well as PDA headquarters in Bangkok. A maximum of 12.5% per annum of the loan fund is allocated to administrative expenses. PDA defines administrative costs as operational expenses separate from the loan fund. Expenses in this category include:

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

There is a need for some flexibility in the loan repayment schedules (especially early on in a partnership), such as allowing late payments, which is important given the seasonal nature of some businesses. At the same time, the financial requirements are made absolutely clear to all participants from the beginning. There needs also to be available 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 of partnerships.

Gender of participants

Women comprise 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.

The role of clubs

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 this 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, participants are required to be open about their HIV status from the very beginning and to 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

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.

All PPP applications are reviewed by a selection committee comprising some or all of the following:

- PDA staff members
- health officials
- local government representatives
- 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.

The selection committee's 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 the feasibility of plans to the best extent possible. If rejected, applicants are urged to consult with PDA staff to improve their business plans.

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 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 person living with HIV. 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.⁴ Other partnerships pair neighbours, friends, employers and employees. The age of participants ranges from early 20s to over 50, with nearly one half aged 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 person living with HIV to apply for a loan, receive training (if necessary) and devise a business

⁴ As cited in PDA's sixth PPP progress report, released in December 2006.

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 choose to partner with them. This provides an incentive for them to work hard to make the project successful and the relationship fruitful. Moreover, given that the majority of HIV-negative participants are related to their partner, they are also highly motivated to help their HIV-positive counterpart. Their close relationships with people openly living with HIV serve to make them role models to other local residents and help break down barriers and fear caused by lingering stigma.

Many types of small businesses have been established since 2004 and provide a glimpse into the wide range of income-generating activities available even in rural areas. They include:

- 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 and candles);
- 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 seasonal crop picking work) it is not possible to screen all applicants thoroughly based on rigid income criteria. Therefore, PPP administrators determine need not only based on application materials but also on input from community council members.

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. Two kinds of skills training programmes are provided by PDA.



1. General micro-enterprise management skills, such as business fundamentals (bookkeeping, marketing, advertising, inventory control, pricing strategy, managing employees and other co-workers, and arranging distribution outlets) business planning, the processing procedures of the loan fund, financial discipline of a borrower, and stigma and discrimination reduction.
2. Skills relevant for a selected business. After a partnership is selected, the partners meet with project staff once a month to receive additional specific business training that is tailored to their business. During these meetings, they also discuss the progress of their business and any issues related to their health.

Sustained support and monitoring in the early stages of the new businesses is essential, as some participants reported that their initial income-generating activities did not live up to expectations because of, for example, poor financial discipline and weak demand for the goods and services offered.

Ongoing health assistance

PPP staff also work to ensure that participants maintain an optimum level of health. 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, the primary health care provider may recommend 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 adherence, 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. 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.

Awareness-raising activities

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 repayments

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%. 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 proportionally assessed 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 make payments at a community centre or with the village savings bank.

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.

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. 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.

Monitoring and evaluation

Alongside traditional monitoring and evaluation activities, PDA attempts to measure some of the seemingly unquantifiable changes in participants' lives through a tool 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). PDA considers this model to be an important and useful way to monitor and measure PPP's success in improving the lives of clients.

Respondents fill out diagrams assessing their perceptions of how their lives, and future aspirations have changed, under five key topics: physical health, mental health, social condition, economic condition and quality of life. Participants have overwhelmingly recorded significantly higher levels of well-being, ambition and integration into their community.

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 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

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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
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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 and also hampers awareness and education campaigns. A project rolling out in rural Thailand, the Positive Partnerships Program (PPP) has shown that targeted economic assistance can boost self-esteem, ambition and hope—all of which help reinvigorate community ties and have a beneficial impact in promoting an enabling environment for HIV prevention and treatment efforts. This Best Practice document provides a short introduction to the program and examines how and why it may be used as a flexible and adaptive model in other countries.

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