

# Microfinance assistance among Peruvians living with HIV/AIDS and extreme poverty

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## Issues

**Problem:** Vicious cycle of illness and poverty, particularly in resource-poor settings:

- Extreme poverty limits the ability of People Living With HIV/AIDS (PLHA) to adhere to HIV treatment, resume social roles, and have high quality of life.
- Illness with HIV/AIDS further depletes material and psychosocial resources, making it even more challenging to re-establish socioeconomic stability.

**Study setting:** Lima, Peru

- Geographic: Dispersed city limits; densely populated areas; majority of population living in informal settlements and shantytowns, often lacking basic services; heavy traffic, public transportation system.
- Economy: Per capita income 4,414USD; extreme poverty (13.7%); high levels of food insecurity; distrust in formal banking system due to previous failures of system and high user fee services; difficult to obtain/keep job because of competing priorities, such as frequent clinic appointments and child care in the setting of poverty and lack of social support.
- Health: <1% HIV prevalence rate; centralized, overburdened HIV care; free ART but patient must cover other costs (e.g. diagnostic tests, opportunistic infection treatment, etc); "universal health care" for women and children but many user fees.
- Cultural: gender inequality, conservatism, isolation despite proximity to neighbors and/or family (low social support), stigma towards PLHA.

**Background of project**

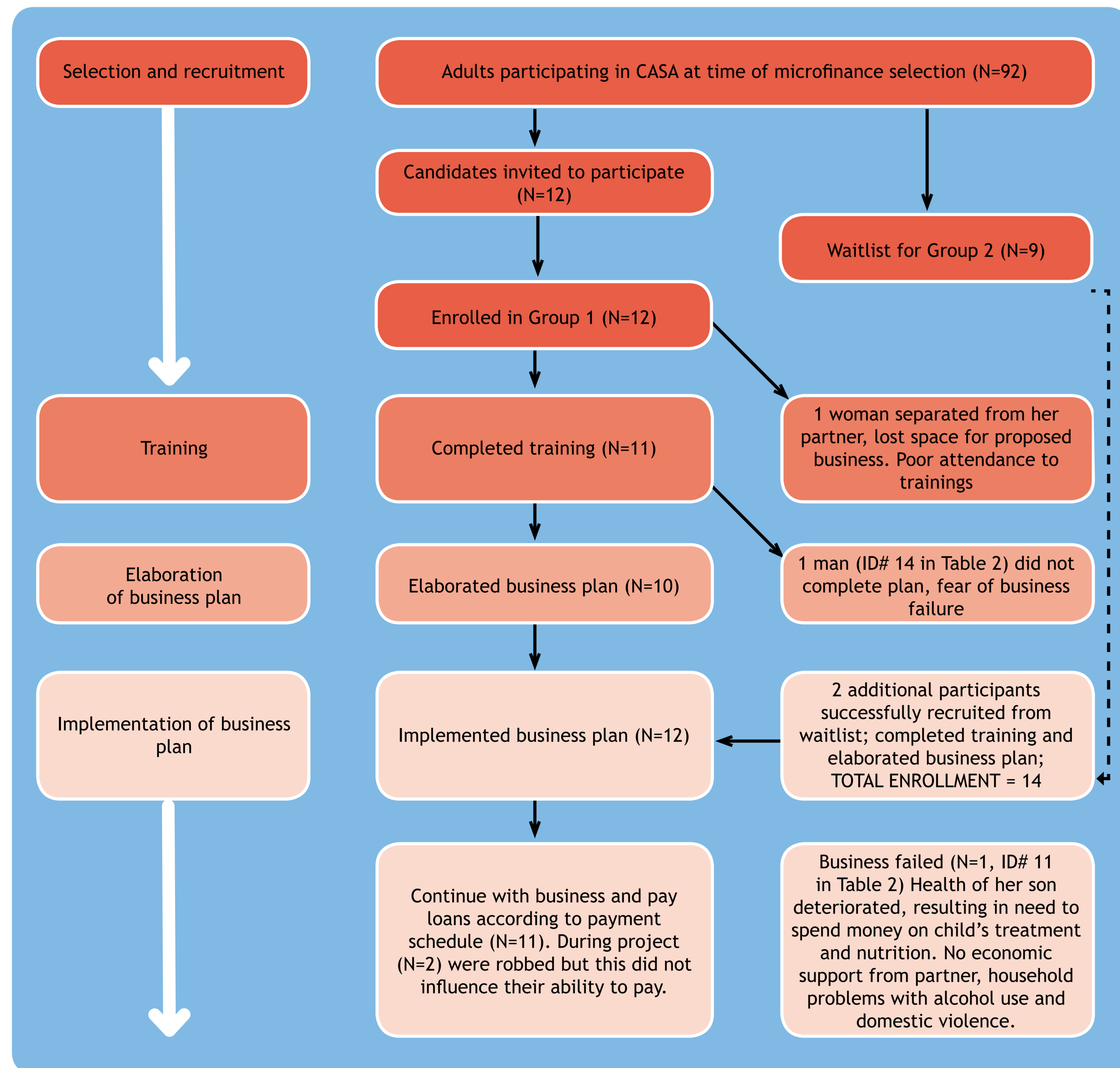
- In 1996, Socios En Salud Sucursal Peru (SES) and the Peruvian Ministry of Health started a partnership to provide community-based directly observed therapy for multidrug-resistant tuberculosis (MDR-TB).
- In 2005, based on this strong experience, we initiated a community-based directly-observed highly-active antiretroviral therapy (DOT-HAART) pilot to provide 12 months of community-based accompaniment with supervised antiretrovirals (CASA) support to 95 adults starting antiretroviral therapy in a health district of Lima, Peru.
- Among efforts to provide comprehensive socioeconomic support to patients, SES has aided workforce re-insertion of MDR-TB patients since 1996 and began a formal TB microfinance project in 2006.
- In 2007, SES adapted their TB model to provide microfinance assistance to PLHA as part of matched social support to allow patients in the transition phase CASA support.
- We report on preliminary efforts of a no interest pilot microfinance project for PLHA, a component of the larger CASA accompaniment intervention.



Table 1. Baseline characteristics of microfinance participants, N=14

Characteristic	N (%)	Mean ± STD
Female	11 (78.6)	
Age		34.8 ± 7.0
Married or living together	9 (64.3)	
Low education	1 (7.1)	
Occupational status		
Independent work	3 (23.1)	
Family business	1 (7.7)	
Sporadic work	6 (46.2)	
Unemployed	2 (15.4)	
Student	1 (7.7)	
Main household provider		
Patient	10 (83.3)	
Partner	2 (16.7)	
Psychosocial problems		
Alcoholism	2 (40.0)	
Domestic violence	1 (20.0)	
Housing status		
Owned	7 (53.9)	
Rented	3 (23.1)	
Family member	1 (7.7)	
Temporary/shelter	2 (15.4)	
# household inhabitants		4.5 ± 2.3
Average household income (USD)		139.5 ± 72.9
Lacking basic services (electricity, water and/or sewer)	6 (42.9)	
Reports food scarcity (at least 1 day without food in past 3 months)	6 (42.9)	
Baseline CD4		144.8 ± 77.6
Months on HAART when Microfinance assistance started		14.8 ± 2.6

Figure 1. Number of patients involved in Microfinance Group and process followed



## Description

Project-Microfinance assistance comprised was comprised of 5 phases:

- 1) selection period; 2) training period 3) elaboration of business plan; 4) implementation of business plan, during which time food baskets and no-interest loans were provided; and 5) accompaniment and follow-up. See Figure 2 for fuller description of each phase.

Figure 2. Description of Stages of Microfinance Project

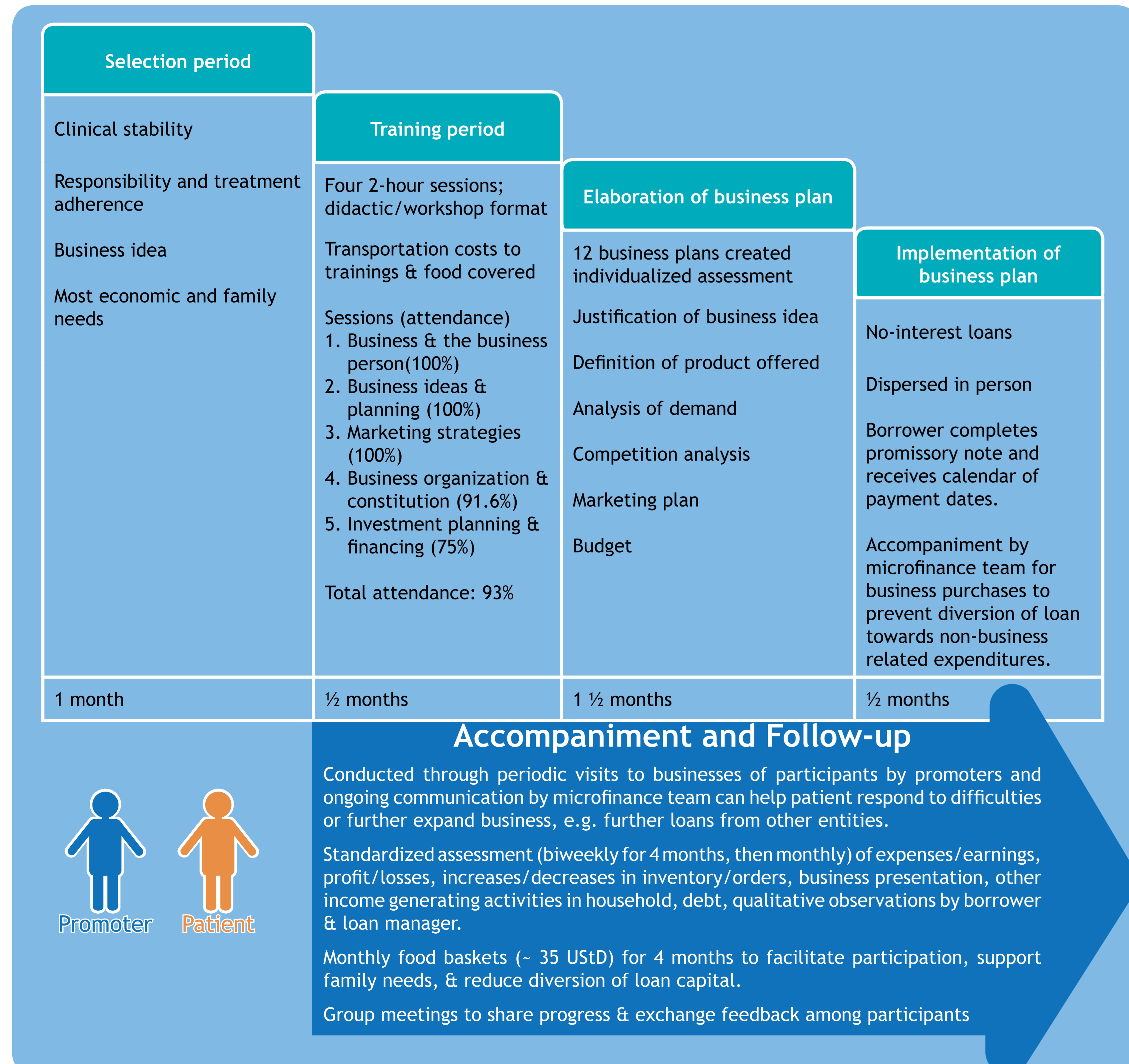


Table 2. Monthly Profit and loan amounts of Microfinance Participants (N=12)

Participant ID#	Gender & Age	Business type	Profit in USD Month 1	Profit in USD Month 2	Profit in USD Month 3	Profit in USD Month 4	Loan amount in USD & payment schedule in months
ID# 1	Female / 38	Convenience store	250	261	210*	190	526 / 12
ID# 2	Female / 25	Convenience store	113	118	110*	129	526 / 12
ID# 3	Female / 32	Convenience store	54	21	18	18	526 / 14
ID# 4	Female / 35	Convenience store		46	46	43	526 / 14
ID# 5	Female / 38	Convenience store			136	165*	524 / 12
ID# 6	Female / 36	Small clothing store	186	179*	196	200	526 / 12
ID# 7	Male / 38	Fruit store	196	200*	193	175	526 / 12
ID# 8	Male / 42	Carpentry	193	200*	195	196	526 / 14
ID# 9	Female / 34	Seamstress/tailor	161	186*	195	193	526 / 16
ID# 10	Female / 45	Outdoor food vendor			125	136	526 / 12
ID# 11	Female / 24	Public telephone stalls	20	11*	0	0	187 / 12
ID# 12	Female / 41	Taxi motorcycle	207*	179	186	186	604 / 12
ID# 13	Female / 42	Didn't start					
ID# 14	Male / 41	Didn't start					
Group average	79%F/36.5%	NA	153	140	134	136	506/13

F=Female; NA= Not applicable; (\*) Initiated payments

## Lessons learned

- Standardized selection criteria can be used to prioritize candidates for microfinance.
- High attendance during trainings attributed to paying for transportation costs and food.
- Provision of food baskets to PLHA in early phases of microfinance program may reduce diversion of loan to cover competing needs.
- Eleven of twelve participants were successful in the first 4 months of business implementation.
- Early experience with microfinance assistance appears to be largely successful due to intensive accompaniment (food support, feedback and trouble-shooting from microfinance team). A key component of success in our group appears to be social support from a family or partner.
- Microfinance is a widely practiced poverty fighting tool that can effectively address the vicious cycle of poverty and HIV/AIDS.

**Next steps**

- Longterm follow-up of cohort including quantitative and qualitative assessment.
- Repayment from Group 1 will be used to finance Group 2 participants.
- We plan to seek additional funding to expand program to other PLHAs in Peru.

## References

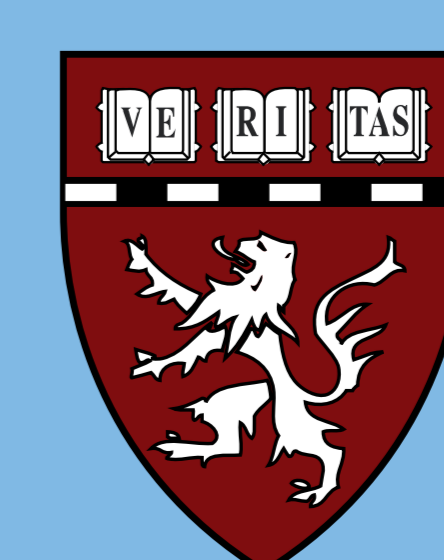
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