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Oosterhoff, P.; Nguyen, T.A.; Pham, N.Y.; Wright, P.; Hardon, A.

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Can Micro-credit Empower HIV+ Women? An Exploratory Case Study in Northern Vietnam

Pauline Oosterhoff¹ (Medical Committee Netherlands Vietnam) Nguyen Thu Anh (Hanoi Medical University)
Pham Ngoc Yen (Hanoi National University)
Pamela Wright (Medical Committee Netherlands Vietnam)
Anita Hardon (Amsterdam School of Social Research)

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Vietnamese women are subject to many restrictions related to gender and their position in the household that affect their ability to make strategic choices. For example, they have unequal access to capital and other resources. Studies have shown how gender inequities cause women, especially poor women, to bear the brunt of the HIV/AIDS epidemic. Micro-credit through women's groups has been reported to contribute to women's empowerment. This raises the question of whether and how micro-credit programs for women in the special circumstance of living with an HIV infection can empower these women and improve their economic status and their health. This article describes how a small group of HIV+ women in Hanoi followed over a period of two years gained in five dimensions of empowerment at the household level by micro-credit offered through a support group.

Linkages Between Access to Micro-credit, Women's Empowerment & HIV

Women's empowerment has been analyzed in economics, anthropology, demography and development studies. Older theoretical work on empowerment focused on structures, such as how socio-political institutions and property ownership shape the opportunities available to women (O' Barr, 1982). However, this emphasis might not have sufficiently recognized women's agency, their own capacity to act, to make choices; it might ignore changes that alter power configurations at grassroots level (Batliwala, 1994). Terminologies may differ across disciplines, but there is a conceptual consensus that empowerment is a process involving women's agency, starting from a baseline state of disempowerment. Women must claim power for themselves; it cannot be bestowed on them by others. Kabeer (1999, p. 437) defined empowerment as "the process by which those who have been denied the ability to make strategic life choices acquire such an ability."

Empirical measurement of a process requires documentation at least at two points in time. A review of 45 empirical studies on empowerment mostly in Asia showed that in spite of the theoretical consensus on the importance of process, only three studies used data from more than

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one point in time to assess empowerment (Malhotra, Schuler & Boender, 2002). Many studies have examined women's empowerment in relation to micro-credit, reflecting theoretical and empirical concerns about women's ability to access and control resources that may enable them to make strategic choices. Globally, women tend to have less access to credit than men do (Women's World Banking, 1995). Micro-credit programs target women because they are poor and because evidence shows that women are more reliable than men in repayment of loans (Yunus, 1984). Micro-credit programs for women in developing countries can contribute effectively to their empowerment (Malhotra, Schuler & Boender, 2002). By the late 1990s, more than eight million households in developing countries were receiving microfinance services (Morduch, 1999).

Micro-credit can change women's lives. It can be a health intervention tool, increasing the demand for formal healthcare (Nanda, 1999). Women in micro-credit groups can acquire greater health knowledge (Hadi, 2001). Families where women can make independent decisions tend to spend more on their children, on schooling, vaccination and emergency healthcare (Thomas, 1990). Women's involvement in microfinance groups may stimulate collective action on broader public issues (Velasco & Marconi, 2004). A women's credit group gives women opportunities to exchange many other experiences, which can contribute to empowerment in other spheres of life. It can promote reproductive health, enable women to travel independently and enhance their confidence (Tesoriero, 2006). Combined micro-credit and health programs have yielded particularly good results (Chavez et al., 2004). However, the evidence is not conclusive. Micro-credit sometimes fails to reach the poorest of the poor (Navajas et al., 2000). Micro credit may not address the structural causes of poverty. (Ahmad, 2003; Buckley, 1997) Increased income does not necessarily lead to increased reproductive freedom (Kabeer, 1998; Parker, 1994; Population Council, 2005). Variations in the empowerment potential of micro-credit have been found even within one country. For example, while some studies in Bangladesh found that micro-credit programs empowered women, (Hashemi et al., 1996; Kabeer, 1998) others reported that they reinforced gender inequities, because men often controlled loans given to women (Goetz & Gupta, 1996).

These differences might be related to different levels of analysis. Most studies on micro-credit and empowerment have looked at the household level. (Malhotra, Schuler & Boender, 2002) Micro-credit may give women more decision-making power at household level, while larger structural determinants such as access to labor markets remain the same. The effect of micro-credit may be to place more women in marginal positions in an informal economy.

Recently, micro-credit has been promoted as an intervention to prevent the spread of HIV by empowering women (Kim & Watts, 2005). HIV+ women may differ from other poor women in that their lives are

shaped not only by their gender and poverty but also by their HIV status (Paxton et al., 2005). Microfinance has been proposed as a form of social safety net for HIV/AIDS-affected households, with more flexible repayment schedules to meet their extra expenses (Mathison, 2004; Parker, Singh & Hattel, 2000). The links between HIV, empowerment and micro-credit are complex, as illustrated by the IMAGE study in South Africa (Kim et al., 2002; Pronyk et al., 2005). That micro-credit intervention had positive effects (e.g. reported reduction of domestic violence), but intervention and control groups did not differ on several key indicators, including condom use with non-spousal partners and HIV incidence (Pronyk et al., 2006).

Given the high expectations and significant financial investments in micro-credit by the worldwide donor community, a framework is needed to investigate women's empowerment in development practice. We have studied a micro-credit program made available to women's groups and explored women's empowerment at the household level. To do that, we have defined empowerment using the following framework of five dimensions:

Economic empowerment: Women and men have equal access to income and equal control over the means of production, including credit.

Socio-cultural empowerment: Women and daughters are not discriminated against and mothers share parenting duties with their mates or romantic partners.

Health empowerment: Women gain control over their own bodies, sexuality and fertility.

Legal-political empowerment: Women are able to join groups to cooperate and can organize themselves to access and contribute to the provision of services.

Psychological empowerment: Self-esteem and positive gender conceptions which legitimize women's sense of dignity and self-respect.

The Setting: Microfinance, Gender & HIV in Vietnam

Women in Vietnam, the study location, have fewer opportunities to borrow money from formal institutions than do men (Fyles & Thao, 2001; McCarty, 2001). Vietnamese women are more likely to borrow from informal sources, such as relatives, moneylenders or *Ho/Hui* (local savings and credit associations), than from formal institutions. Women work more than men, spending about twice as much time on household maintenance activities (Desai, 2000). This gender division of labor restricts women's opportunities for economic participation.

In 1986, shortly before HIV appeared in Vietnam, the country began the change from a planned to a market economy, the process called *Doi Moi*. Economic growth has been impressive, but research suggests that gender inequalities may have increased under *Doi Moi* (Werner & Belanger, 2002). Others report that the welfare of women in Vietnam has

generally improved (Tu, 2006). The introduction of indirect taxes such as user fees in schools and health facilities disproportionately affects women, who are considered responsible for paying them (Tuan, 2001). Privatization of Vietnamese state companies had gendered effects, because women work under better terms and conditions in the public than in the private sector, a discrepancy that does not exist for men (Akram-Lodhi, 2002). The structure of the labor market is gendered, with higher concentrations of men in capital-intensive industries (Akram-Lodhi, 2000). Only 16% of women work in the formal sector in urban areas, even fewer (7.9%) in rural areas (Tra et al., 2007). The proportion of women in wage employment is 24.5%, among men, 39% (General Statistics Office, 2005). *Doi Moi* has reportedly also contributed to the increased use of drugs and the spread of HIV/AIDS in Vietnam over the past fifteen years (Werner & Belanger, 2002). For example, migration, a key factor for young people, was limited by the state before *Doi Moi* and has since increased rapidly (DiGregorio, Rambo & Yanagisawa, 2003).

A study on HIV/AIDS-related expenditures and income losses found that the total health care expenditure for households having a person living with HIV/AIDS (PLHA) was 13 times higher than the average household's health spending (UNDP, 2005). Access to anti-retroviral therapy (ART) is increasing globally. In Vietnam, ART is available through international programs, but is still beyond the financial capacity of most PLHA. (Ministry of Health, 2006) ART tends to be provided free of charge, but people still have to pay for tests, transportation and food. Vietnamese women have less access to ART than men (WHO, 2006). HIV positive women are subject to strong social stigma, which also affects their employment opportunities. (Khuat, Nguyen, & Ogden, 2004) In this study we investigated the results of offering small but formal loans to HIV+ women in a mothers' support group, both as an income-generating program and to contribute to their empowerment. We present here the results of the program according to the five dimensions of empowerment and other aspects related to the women's HIV+ status. The pilot was aimed at women partly as an entry point to the family and its needs. We observed the HIV+ women in the group more closely than the other family members; they are the focus of the analysis.

METHODS

For two and a half years, we followed women in a support group for HIV+ mothers, members of the Sunflower support group in Hanoi, using participatory observation during bi-weekly program activities. The 14 women who borrowed money through the support group between April 2004 and January 2006 were followed for up to two years after their first loan. The group is small but the information is detailed because data were collected at frequent intervals.

Economic data such as income and capital assets were collected

every six months. Bi-annual health examinations provided medical data such as body weight and CD4 count. Bi-weekly participatory program observation allowed researchers to follow the wellbeing of the women, their partners, children and families. In this period, the support group grew from four to 150 members. The findings from the 14 women followed intensively for this study were checked against participant observations during program work with other women in the group and in three similar groups established later in other cities, of whom 58 made loans through the groups. Participant observation included joining weekly group meetings, reading meeting minutes, making household visits, attending social events such as weddings and funerals and observations at health care sites, workshops and public appearances by the group members.

Respondents

In 2004 there were no programs in Vietnam for HIV-infected women to address the complex interactions between poverty, AIDS and gender. This program helped infected mothers to organize themselves and to access existing social, health and economic services including loans and ART. The support group operated under the umbrella of the Vietnam Red Cross. All respondents were ethnic Kinh, the main cultural group in Vietnam. All except two were young, 20 to 30 years old and all were literate. All but three women had been diagnosed with HIV during antenatal care. One woman in the group came from a family of government officials and had attended college, but most came from families in lower educational and social classes, earning a living from small family businesses and informal private sector jobs. All of these women had married into households with marginal economic positions and often with histories of drug addiction. If their husbands worked, it was in areas such as construction or trucking, which reportedly put them at risk for drug addiction and HIV (Tran Hien, 2002).

All of the women had been or were still married and all of the husbands had a history of intravenous drug use, visits to sex workers, or both; they had probably infected their wives. The husbands were usually in worse health than their wives because of their IDU status, with drug-related health problems and a longer history of infection with HIV. The men needed more expensive tests and treatments. The program offered loans to the women as an option for improving their own and their households' incomes and thereby also their quality of life.

To qualify for a loan, each woman formulated a personal development plan describing and prioritizing their social, medical and economic needs. Women whose priority was to increase their income could get assistance to apply for a job or vocational training to improve their position in the labor market. Women planning to start a business could apply for an interest-free loan of up to five million Vietnamese dong

(approximately 300 USD) for nine months. Based on repayment, business performance and the proposed business plan, women could borrow repeatedly up to a maximum of 58 million dong (almost 5,000 USD). All loan applicants had to accept assessment visits to their household and to the proposed location of the business, looking into individual and family income, assets and business viability.

Women signed for the loans themselves, but when the business plan involved their families' property, time or other resources, the families had to confirm agreement, signing off on the repayment of the loan and guaranteeing that the woman borrowers would have access to the profits. The first loan was interest-free but interest increased with each renewed loan until the women attained sufficient financial stability to join regular loan programs of Vietnamese credit institutions. External evaluation of the loan program was carried out in 2006, including visits to all households and businesses involved, interviews with women and their families and assessments of individual and family income and the assets and performance of the business. The names of the women in this report have been changed to protect their privacy.

FINDINGS

Addressing Gender, Income & Health Inequities in HIV-infected Households

All of the original members of the Sunflower support group occupied marginal positions in the labor market. Two members worked in sales in the private sector, the others did housework, especially childcare. They contributed labor to small-scale family businesses, often belonging to their in-laws, as Vietnam is a patrilinear and patrilocal society, but they had no capital investment of their own in the businesses, which limited their access to and control over the business and income. In addition, the women reported having financial problems specifically linked to their HIV status. They and their husbands had suffered loss of income or jobs, while their health expenses were high. In some cases the family-in-law had a business, but clients lost trust in the business after the women's HIV+ status became known.

Women felt powerless economically and socially, as well as overburdened by their full responsibility for parenting tasks, which some felt resulted from their HIV status and their in-laws' fear of contamination. "I have to do a lot of housework. Nobody helps me to take care of my child, because they are afraid of our disease." (32 year-old HIV+ mother)

Women told us that they were able to join the group and meet other women because they explained to their families that the group was for mothers, to help them raise their children properly. During the first three months of the program, not one Sunflower member dared to take out a loan. Discussing their economic situation as part of their personal development plans, members said they were afraid to borrow because

they believed they might die soon. They did not want to leave their families or in-laws with debts.

The Vietnam Women's Union runs clubs for young mothers and sympathy clubs for mothers of HIV-infected children, mostly adult intravenous drug users (IDU). When we started, there were no clubs for HIV+ women infected by male IDUs. These women felt that the existing clubs did not suit their needs. "We are socially isolated by the neighborhood. I do not think that the Women's Union can accept members from households like ours." (32 year-old HIV+ mother)

The sympathy clubs target the mothers-in-law. The women in our clubs often lived with their mothers-in-law and often encountered difficulties with them, in part because the mothers-in-law usually had not informed their prospective daughters-in-law that their sons were drug users. Peer educators for community outreach in Hanoi targeted IDU and sex workers, not HIV+ mothers who were neither. With no organization to articulate their HIV-specific needs, these HIV+ women were legally and politically disempowered.

Women were allowed by their in-laws to join the support group in their traditional capacity of mother and caretaker, but with special HIV-related needs. The women lacked self-esteem; during the first few group meetings, women did not help each other. Those who claimed their husbands had not used drugs felt superior to those whose husbands had. In the cultural context, HIV+ women feel obliged to keep their husbands and children alive and to stay with the in-laws. They were healthier than their husbands but struggled to pay for his treatment.

"I have to keep him alive. His family does not take care of us because we are infected, but they cannot kick us out as long as he is alive. He is their son." (26 year-old HIV+ mother)

Key Results of the Loans in Financial Terms

Four months after the group was formed, the first loan taken out was used to buy pigs and chickens. During the next fifteen months, fourteen borrowers used their loans for various private small businesses: four food and beverage stalls, three animal husbandry projects, two garment businesses and others including scooter-washing and repair and partnership in a real estate agency. Four women asked for a loan but did not receive it because the plans they made were not realistic, for example, the planned expenses exceeded the expected profits, or they needed permission from their families, or from the state, that could not be obtained.

The borrowers often mentioned that they "still felt healthy." At the start, four borrowers had no income of their own and six had low incomes. Five had husbands who actively injected drugs, but two husbands were in a rehabilitation camp at the time of the loan. Five other husbands reported that they had not injected for more than a year and felt stable.

Table I. HIV+ Women Borrowers & Their Repayment Performance

N = 14	Paid all, on time	Paid all, but late	Partial repayment	Not paid
HIV-infected, 1 st time female borrowers <5,000,000 VND	8	1	2 paid 30%	1 died, 1 failed 1 got second extension

An evaluation of the program in early 2006 showed that of the 14 first women borrowers, all were still employed and their income had increased by an average of 50% (Thuy, 2006). Two women had not increased their income but had increased their autonomy because they used the loan to start a business independent of abusive relatives. Seven women paid the whole loan back on time; three were well ahead of time, at three instead of nine months. Two women had access to land belonging to their families-in-law. Lacking education and job experience, they used the loans for livestock kept on their in-laws' land. Both women did extremely well, selling their animals in the nearby city. Four women asked for an extended repayment period. Three expected to repay either through their businesses or through new jobs they found through the group. Two did not repay at all, one because she used her loan for consumer goods instead of business and the other because she died in a traffic accident.

The women used the loans to create jobs, for themselves and for family members, in small-scale businesses, often in or in front of their in-laws' houses. They reported that profits were used to pay for medicines, diagnostic tests, treatment and appliances (such as refrigerators to store the medications, or a motor scooter). Other uses included buying life insurance, or clothing and toys for their children and paying school fees.

Six women started to work as peer educators in addition to running their businesses and contributed that income to the loan repayment. Two peer educators repaid their loans and used the increased disposable income from their businesses to pay for urgent family health expenses. When their health became stable, they decided to leave the businesses they had established, because making a living as peer educator was easier than running a business. "I cannot stay in a shop all day to run the business; it is stressful also for my own health. I prefer to make money as a peer educator helping other women." (28 year-old HIV+ mother)

These women were both tailors, a competitive industry with low wages, low profit margins and mostly female workers (Kabeer & Van Anh, 2006). Two others left their businesses to relatives, who failed to

repay their loans. Of the three defaulters, only one is very clearly a defaulter as one died and the other one might still repay, though with a considerable delay.

Effects of the Loans on Other Dimensions of Empowerment

The successful women were able to reduce some of the socio-culturally prescribed burden of housework before they took out a loan. Nutrition counseling and cooking classes were provided for group members and their families. Women reported they had told their husbands that they could eat for free at the support group meeting room. When the husbands arrived for the free meals, they were told that project rules required everybody who joined meals also to either shop, cook, or clean up or have to leave the class. The result was that not only did the women and their husbands gain weight and improve their health, but the husbands also learned to cook. Some continued to prepare simple food at home which liberated their wives to do other work, including starting their businesses.

To gain time for business, women usually negotiated with their husbands to take over some household tasks. The husbands' acceptance might have been related to their own limited opportunities for paid work due to their weak health and poor reputations. While HIV+ women can sometimes hide their status from their communities; HIV+ men who are former IDU seldom can. Some couples were pragmatic in their division of labor. A father explained: "My wife sells vegetables and fruits that my parents grow on the market. But I cannot work at the market and I am too weak to be out in the sun. So I bring the kids to school and I can now cook a healthy breakfast." (32-year-old HIV+ father)

When husbands refused to share household work, the loan was welcome in the family, but it entailed a double burden. A widow who left her business to her in-laws reported: "When my son was one year old, I had to look after him and wash motorbikes to earn money while my husband went out. When I said I was too tired and couldn't do all this work, he hit me. When she heard me being beaten, my mother-in-law shouted from the first floor: "?? con ??" (What a whore!). I have a low position in the family." (24-year-old HIV+ mother)

All women increased control over their own bodies when they obtained access to lifesaving anti-retroviral drugs through the group and its support network. None of the women dared to take out a loan before they had seen that group members got access to ART.

By 2007, in the third year of the program, 13 of the 14 women (the 14th died in a traffic accident) were in good health physically and mentally. The health authorities were able to offer husbands with serious health problems free ART, though two of the women's husbands who began ART died because of liver complications that prevented drug intake. The loans helped these women to pay for the often very expensive lifesaving

medical treatment of their husbands, which gave them more status in the household, as this mother-in-law reported: "My daughter-in-law is a good woman. She has done everything to keep my son alive. I know I have treated her unfairly. I'll do my best to support her now." (Mother-in-law of 32-year-old HIV+ mother)

It is unlikely that the loans had impact on women's control over their sexuality and no progress was reported in this area. Two women who lost their children to AIDS decided to try for a healthy child, which could be seen as a sign of empowerment and increased confidence. However in both cases they also felt pressured by their husbands and in-laws to have a child. Individual women gained access to services through the network of the group before they took out the loan. With increased income, they could consider other options, especially peer education, which can provide HIV+ women with meaningful work and a reasonable income. "I was discriminated by doctors when I delivered my child because of my HIV status. Now I work with the same doctors to help other women like me. We have made such progress." (28-year-old HIV+ mother)

Peer educators are increasingly asked to comment on draft legal documents and policies regarding HIV/AIDS, which suggests legal and political empowerment. Several women have appeared in national and international public events. Five new groups were founded in three other provinces. But both peer education and the new groups depend on financial support by international projects of limited duration, over which women have very little political and legal control. It remains to be seen whether the groups survive once the projects are gone. The Sunflower women have become a strong group with an increasing number of members, giving them a positive view of themselves as women, wives and mothers. Not all members want or need loans, but the fact that some have been successful makes other group members proud, as this comment illustrates: "We all want to be like her. She worked hard and proved that an HIV+ woman can still be very useful in her family, the community and society." (26-year-old HIV+ mother)

DISCUSSION

In this paper we report the results of a study on fourteen HIV+ women who participated in an income-generating project as part of a comprehensive program implemented through a support group. Economic and medical data were collected bi-annually, allowing us to gain an understanding of the process of empowerment; we followed the women over time through participant observation in group meetings and repeated informal interviews. These borrowers were among the first women to join the group and might therefore not have been typical. The

findings were confirmed, however, by participant observation of the women who joined this and other groups through the following months and years.

We proposed five key dimensions of women's empowerment at the household level in a micro-credit program with women's groups: equal access and control to the means of production including credit and to income; lack of discrimination against women and daughters and shared mothering; control over own bodies, sexuality and fertility; ability to join and organize groups; and self esteem and positive gender conceptions. Looking at the loans' effects on the lives of the women who borrowed money, we could see changes in almost all of the five dimensions of empowerment that we proposed in the introduction.

1) *Economic empowerment*: Before taking out loans only two women in this study were employed. The others contributed their labor to the family. Most women in this study repaid their loan on time and their income did increase substantially. Most women reported more decision-making power in the household by the access to capital and technical assistance for business plans through the group. In a loan program given through a woman's group, women have more opportunities than men to create a business, which has gender equity benefits. These women all lived with their in-laws who increased their business opportunities when they supported her business with material and labor.

When a husband and his family was supportive of his wife's business plan, as was the case with most of the couples in the study, income and jobs for him, his family and even other people in the neighborhood also increased. Some families need time in order to be convinced of the woman's capacities. But when the husband and his family are not supportive some women may be faced with a double burden and even lose their capital after the husbands death. This is consistent with findings in Malawi, Dominican Republic and Bangladesh about how aspects of gender relations, both within the household and more widely, at the same time facilitate and constrain access and control of micro-credit. (Johnson, 2005) Our findings also suggest that women who have no support from family cannot be reached with micro-credit, which confirms the critique that micro-credit does not reach the "poorest-of-the-poor."

Women also used the group to find work for their unemployed husbands either in the new business that was started with the loan or through the group. Twelve of the 14 women had created jobs for others, though these were not in formal employment. This small-scale micro-credit program did not try to address the structural causes of poverty in the country, but only to investigate the effects of making credit available on the lives of these HIV+ women.

2) *Socio-cultural empowerment*: Women they felt and described discrimination because of their HIV status. Women who were married to ex-IDU could use the benefits of the project, especially loans and medicines, as entry points to initiate changes in the household tasks that increased their own and their husband's autonomy.

Some of these husbands, all ex-IDU, were able and willing to share household tasks. They had few other employment options because of HIV related stigma and their health was weak because of IDU. For them, a division of tasks which put them in a caring role while their wife went to the group to get services and support for both of them had practical and emotional advantages, such as being and feeling useful and getting access to medicine and loans. This confirms other studies, in which fathers were found to be able to be sensitive to children's needs as well as mothers. (Davis & Perkins, 1995; Lewis & Lamb, 2003) Several of these women also gained status in the households of their in-laws as a result of their increased financial contributions to the family and support for the sons of the family.

3) *Health empowerment*: These women had all been infected with HIV by their husbands, who themselves were mostly infected through drug use. In a Vietnamese context, with no good harm reduction programs for drug users, it is probably fair to say that these men were disempowered in the sense that they were unable to protect their bodies. In the case of these women, control over health means not only sexuality but also the control over their decisions about whether or not to have a child. None of the women reported change in control over their sexuality and the two women who became pregnant had been pressured by the husband and in-laws. We have documented the reasons for such pressure on HIV+ women in another study (Oosterhoff et al., 2007). Being in the group and getting a loan did not clearly increase women's reproductive freedom, which has also been reported in other studies (Kabeer, 1998). However, women would have increased control over the safety of their planned pregnancy, for both mother and child, by being able to access information, pay for health visits and diagnostic tests and access ART and prophylaxis free of charge. Women remained burdened by health care expenses. The research team did not encounter any women who had received money from their husbands or in-laws to obtain ART. In contrast, we met many women who had sold property or who went without lunch in order to save money to buy medicine for their husbands or children. We did not find indications that access to micro-credit provoked domestic violence in these households, as has been reported from studies in Bangladesh (Schuler et al., 1996; Schuler, Hashemi & Badal, 1998). The violence that women reported was clearly felt to be related to their husbands' addiction.

4) *Legal-political empowerment*: In many respects, the women in this study are not different from women in other micro-credit groups, in that a support group in conjunction with a credit program provided them with extra moral and practical support. Among poor rural women in Bangladesh who received micro-credit, it was found that just the fact of being in the group increased the demand and use of health services (Hadi, 2001). For the women in our group, other benefits contributed to their ability to profit from the income-generating activities. In a similar program in India, women in a self-help group providing credit perceived changes in their identity, working more collectively to effect change in their community. Being in a group expanded their political engagement in community and social action programmes (Tesoriero, 2006).

The Vietnamese political context is particular because grassroots groups like these cannot operate independently or organize protests and demonstrations as in some countries. But these women entered into discussion with the Vietnamese authorities and institutions to get access to more and better services, which is a form of political action. Our findings also suggest that starting by addressing women's practical needs can be an effective entry point to expand their interest and ability to become active in their communities and to contribute to improving health services. Micro-credit can be a catalyst to enable women to empower themselves in and with a group. All these female borrowers first took leading roles both in private, in their marriage and later in public as advocates for the support group and for HIV+ women. With extraordinary personal strength and practical and moral support from the group, these women were able to focus on the cooperation between these institutions and the community. They did not protest openly against those who inflicted injustice on them; instead their strength was to be extremely generous and caring to those who had wronged them.

5) *Psychological self esteem & positive gender conceptions*: The stories show that women actively used the gendered roles that assign care to women to mobilize and use resources for their family and for themselves in a private setting. While women could not escape these gendered caring roles and were very careful in what they said about changing power relations, they tried to subvert their roles. They organized themselves and accessed capital, legal help, social and health services all under the safe umbrella of Vietnamese motherhood.

What are the Special Aspects of These Issues in the Context of HIV?

Our findings suggest that access to health services and ARV are a necessary though not sufficient condition to using micro-credit to improve the income of HIV+ women and their families. HIV-infected women placed a high value on security; none of them dared to take out a loan unless they had had a health examination, knew their CD4 counts

and had access to ART when needed. This suggests that micro-credit programs for HIV+ women should be linked to ART and other medical care. It also suggests that fears that HIV+ women might be bad credit risks because of their HIV status are not well-founded, as long as appropriate health care is available for them.

Being publicly known as a person infected with HIV could limit the range of business ventures available to the women (they may be excluded from running food stalls, for example). But being HIV+ also opened the door to a few attractive job opportunities, such as working as a peer educator or HIV counsellor, which are not available to HIV- people. Such jobs are, however, usually dependent on international funding and therefore not very secure in the long term. Furthermore, these jobs are available in the urban centers where the numbers of HIV+ people are high enough to warrant the programs.

Another special aspect of a women's loan program in the context of HIV is that most of the husbands had weak health, which may have rendered them more willing to stretch traditional gender roles and allow their wives to work outside the home. Some of the men seemed to feel emasculated by their wives' success, but their discomfort might also have been due to embarrassment over their drug use and over having infected their wives (and possibly children) with HIV. The tensions faced by these husbands suggest that there is a need to address masculinity in loan programs for HIV-infected households and to offer men options to occupy themselves in a meaningful and constructive way.

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