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KEYWORDS: FINANCE, LIVELIHOOD SECURITY, RISK, RISK MANAGEMENT, VULNERABILITY, HIV/AIDS

LOUISE KENDI MAORE: COPING STRATEGIES OF HIV/AIDS AFFECTED HOUSEHOLDS WITHOUT DEMAND FOR FORMAL FINANCIAL SERVICES: A CASE STUDY BASED ON CHIANG MAI. ADVISOR: ASSISTANT PROFESSOR PAVIKA SRIRATANABAN, PH.D., 131, pp.

Access to finance is at the core of the development process and it is now widely accepted that well functioning financial systems are crucial for channeling funds for productive use, thus boosting economic development. Conversely, limited availability of financial services will have adverse effects, especially for those households made vulnerable by the effects of HIV/AIDS to livelihoods - making them resort to negative coping mechanisms. Drawn from the above scenario, this thesis therefore examines the need and availability of financial services at household level, their uptake of the same, and which coping mechanisms they engage in. This thesis also places risk perception to shocks in the broader debate of access to finance in households. Risk perception has always been viewed from the supply side, with financial providers being excessively risk averse, especially to certain subpopulations that are considered high risk like those affected by HIV/AIDS. Other reasons why households do not take up formal financial services except to analyze structural barriers have hardly been studied but interest has finally emerged for risk perception as an important predictor of demand for risk management strategies.

Key findings drawn from households affected by HIV/AIDS and NGO's in Chiang Mai show that households still experience the adverse effects of HIV/AIDS, though by most accounts HIV/AIDS has ceased having grave impacts on livelihood security as it did over 10 years ago in Thailand. This has been made possible through provision of free healthcare and antiretroviral drugs for affected households. But even with lowered health costs, vulnerability levels are high as there are few viable safety nets outside from the family networks; and there is a high dependence on government social protection mechanisms.

Household strategies were fine tuned by households utilizing a set of social practices and community arrangements that provided additional support when individuals and households experienced shocks. While these strategies are not necessarily negative in the short run, in the long term existing mechanisms, especially those that utilize kinship might become over stretched or collapse. Uptake of formal financial products is very low, even in the specialized financial institutions, which mostly target rural communities. A number of NGO's that are actively involved with HIV/AIDS programming provide economic and financial interventions in terms of seed capital, market access and micro-credit, and while they seem to produce results, sustainability is a key issue as programming is dependent on availability of donor funding.

Field of Study: International Development Studies Student's signature ……
Academic Year 2011 Advisor's signature ……...

หลุยส์ เคนดี้ มอร์: กลไกการรับมือโดยไม่ใช้บริการทางการเงินที่เป็นทางการของครัวเรือนที่ได้รับผลกระทบจากโรคเอดส์ : กรณีศึกษาจากบางหมู่บ้านในจังหวัดเชียงใหม่ (COPING STRATEGIES OF HIV/AIDS AFFECTED HOUSEHOLDS WITHOUT DEMAND FOR FORMAL FINANCIAL SERVICES: A CASE STUDY OF VILLAGES IN CHIANG MAI) อ. ที่ปรึกษาวิทยานิพนธ์: ผศ.ดร.ภาวิกา ศิริรัตนบัลล์, 131 หน้า.

การเข้าถึงแหล่งเงินทุน เป็นหัวใจสำคัญของกระบวนการการพัฒนา และในปัจจุบันเป็นที่ยอมรับกันอย่างกว้างขวางว่า ระบบการเงินที่มีประสิทธิภาพเป็นสิ่งสำคัญสำหรับการนำเงินทุนไปใช้ให้เกิดประโยชน์ อันจะเป็นการกระตุ้นการพัฒนาทางเศรษฐกิจ ในทางตรงกันข้าม บริการทางการเงินที่มีอยู่อย่างจำกัดจะมีผลในแง่ลบ โดยเฉพาะอย่างยิ่งต่อครัวเรือนที่ได้ผลกระทบด้านการดำเนินชีวิตจากโรคเอดส์ เป็นผลทำให้ครัวเรือนเหล่านั้นต้องหันไปพึ่งกลไกในเชิงลบ จากสถานการณ์ดังกล่าว วิทยานิพนธ์ฉบับนี้ จึงมุ่งศึกษาความต้องการเข้าถึงและการมีอยู่ของบริการด้านการเงินในระดับครัวเรือน และกลไกที่ครัวเรือนได้เลือกใช้ วิทยานิพนธ์ฉบับนี้ยังได้ขยายการถกเถียงเรื่องการเข้าถึงเงินทุนของครัวเรือนให้กว้างขึ้นโดยใช้มุมมองด้านความเสี่ยง เท่าที่ผ่านมา มุมมองด้านความเสี่ยง ได้ถูกมองจากมุมมองของผู้ให้บริการด้านการเงิน โดยเฉพาะต่อประชากรบางกลุ่มซึ่งถูกมองว่ามีความเสี่ยง เช่น กลุ่มผู้ติดโรคเอดส์ สาเหตุอื่นที่เป็นเหตุให้ครัวเรือนไม่ใช้บริการด้านการเงินที่เป็นทางการ แทบไม่เคยถูกศึกษาเลย แต่ความสนใจในเรื่องดังกล่าวได้เริ่มที่จะก่อตัวขึ้นภายใต้แนวคิดด้านความเสี่ยงซึ่งเป็นตัวชี้วัดสำคัญสำหรับอุปสงค์ของกลยุทธ์ในการจัดการความเสี่ยง

ผลการวิจัยจากครัวเรือนที่ได้รับผลกระทบจากโรคเอดส์และผลการวิจัยจากองค์กรพัฒนาเอกชนที่ไม่แสวงหาผลกำไรในจังหวัดเชียงใหม่ได้แสดงให้เห็นว่า ครัวเรือนยังคงประสบกับผลกระทบจากโรคเอดส์ แม้ว่าโดยส่วนใหญ่เอดส์ไม่ได้ก่อให้เกิดผลกระทบที่เลวร้ายต่อความมั่นคงของชีวิตเหมือนกับเมื่อ 10 ปีที่แล้ว นั่นเป็นเพราะว่ามีบริการสาธารณสุขฟรีและยาต้านไวรัสที่มีแจกให้แก่ครัวเรือนที่ได้รับผลกระทบ แต่ถึงแม้ค่าใช้จ่ายด้านสุขภาพจะไม่มาก ระดับความเสี่ยงก็ยังสูงเพราะครัวเรือนยังไม่สามารถสร้างเครือข่ายที่สามารถจัดการกับความเสี่ยงและความมั่นคงของชีวิตได้ดีนัก อีกทั้งยังมีการพึ่งพิงกลไกการช่วยเหลือทางสังคมจากรัฐสูง

ในอดีตกลยุทธ์ของครัวเรือนได้ใช้สิ่งที่ชุมชนและสังคมเคยทำกันมา ซึ่งจะช่วยเหลือเมื่อมีใครหรือครอบครัวใดต้องได้รับผลกระทบรุนแรง แม้กลยุทธ์เหล่านี้อาจเป็นไปได้ในระยะสั้น แต่ในระยะยาวแล้ว กลไกที่มีอยู่นี้โดยเฉพาะอย่างยิ่งกลไกการพึ่งพึงเครือญาติอาจล้มเหลวได้ ความเข้าใจในเรื่องสินค้าและบริการด้านเงินทุนแบบเป็นทางการนั้นมีต่ำมาก โดยเฉพาะอย่างยิ่งเกี่ยวกับสถาบันการเงินเฉพาะทาง ซึ่งส่วนใหญ่มุ่งเน้นชุมชนในชนบทเป็นกลุ่มเป้าหมาย มีองค์กรพัฒนาเอกชนไม่แสวงหาผลกำไรจำนวนหนึ่งซึ่งทำงานเกี่ยวกับโรคเอดส์ ได้จัดโครงการให้ความช่วยเหลือด้านเศรษฐกิจและการเงินในรูปแบบของเงินทุนเริ่มต้น และการเข้าถึงตลาดและสินเชื่อขนาดเล็ก ซึ่งดูเหมือนว่าองค์กรเหล่านี้ดูเหมือนจะประสบความสำเร็จ แต่ความยั่งยืนของผลลัพธ์ที่ได้เป็นประเด็นสำคัญเนื่องจากการดำเนินโครงการนั้นขึ้นอยู่กับแหล่งทุนที่จะสามารถหาได้

สาขาวิชา การพัฒนาระหว่างประเทศ…….. ลายมือชื่อนิสิต ……

ปีการ**ศึกษา** 2554…….. ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์หลัก ……..

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CONTENTS

Page

Page

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

ART	Anti Retroviral Therapy
ARV	Antiretroviral drugs
BAAC	Bank for Agriculture and Agricultural Cooperatives
BOT	Bank of Thailand
CD4	Cluster of Differentiation 4
CSW	Commercial Sex Workers
DPW	Department of Public Welfare
DFID	The UK Department for International Development
GMS	Great Mekong Sub -Region
GSB	Government Savings Bank
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IFPRI	The International Food Policy Research Institute
ILO	International Labour Organization
K-SME	Kasikorn Bank Small and Micro Enterprises
MSM	Men who have Sex with Men
NAPAC	National AIDS Prevention and Alleviation Committee
NESDB	National Economic and Social Development Board
NGO	Non-Governmental Organization
TNAF	Thai National AIDS Foundation
PDA	Population and Community Development Association
PLHA	People Living with HIV
PPAT	The Planned Parenthood Association of Thailand
PPP	Positive Partnership Project
SFI	Specialized Financial Institutions
SML	Small Medium Large Program
SP	Thailand Social Protection
THB	Thai Baht
TNAF	Thai National Aids Foundation
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UHCS	Universal Health Coverage Scheme
USD	United States Dollar
VDB	Village Development Banks
VRF	Village and Urban Revolving Fund
WHO	World Health Organization

CHAPTER I

INTRODUCTION

1.1 Background of the Study

Thailand currently faces a moderately severe AIDS epidemic. Driven primarily by a longstanding indigenous commercial sex industry, the spread of Human Immunodeficiency Virus (HIV) in Thailand continues after the first outbreak more than 20 years ago (UNAIDS, 2009). By 1995, approximately 800,000 Thais had been infected by HIV. To date statistics regarding HIV/AIDS cases occurring in Thailand between 1985 and 2006 show that an estimated 1,102,628 people (adults and children) were infected with HIV, and that 558,578 died of AIDS related complications. AIDS was the highest-ranking source of death among the working age population in Thailand, For example, an estimated 58,000 Thais died from AIDS-related causes in 2000 (UNAIDS, 2004; Sriwattanapongse et al, 2010).

The impacts of HIV/AIDS are many, affecting different wealth groups in different ways[1]; especially for low-income households, HIV/AIDS puts enormous economic stress. Studies show that in Thailand farm output and income fell between 52 and 67 percent in households affected by AIDS (Ross-Larsen et al 2004). More than 60% of HIV/AIDS cases are among laborers and agricultural workers who fall in the lowest income group, with half the reported cases being in the northern provinces of Chiangmai, Chiangrai, Lampang, Lamphun, and Payao (Pitayanon, Kongsin, & Janjaroen, 1997). The greatest impact of HIV/AIDS on livelihoods comes from the high costs of treatment and assistance to those left behind, as productive adults absorb the cost of taking care of orphans. Once the infected individual begins to deteriorate, it becomes increasingly

[1] The macro and micro economic impacts of HIV/AIDS are discussed in greater detail in Chapter 2

difficult to work and the care demands of that person will reduce the productivity of other household members. In other words, families and communities coping with AIDS–related illness and death shoulder much of the burden, and the epidemic therefore takes the heaviest toll at the household and community level (Armstrong, 2000; Over, et al., 2007). HIV/AIDS is unusual in that the impact continues over the long term, both for households, as more family members become sick, and for communities. HIV/AIDS can be seen as increasing vulnerability over the long term, for example through worsening dependency ratios or diminishing economic opportunities (Harvey, 2004).

To cope with the impact of the disease, households sometimes turn to negative strategies which may be damaging to livelihoods and increase current and future vulnerability such as transaction sex, withdrawing children from school and eating less, amongst others (Harvey, 2004). Many in the development community recognize that the ability of a household to mitigate the impact of HIV/AIDS relies largely on their capacity to stabilize or increase incomes (Donahue, Kabbucho, & Osinde, 2001; Donahue,1998) and availability of safety nets. The stronger the household safety net, the better the chances that the household can withstand the crisis without resorting to negative coping behavior (Donahue, 1998; Ross-Larsen et al 2004). The size of the household safety net depends on two factors: the initial financial standing of the household, and the ability to build a financial base over time. Microfinance – both credit, savings and insurance – strengthens the second of these, offering households opportunities to build assets, diversify income sources, and generally strengthen their financial footing. Thus, even in its most basic form, access to microfinance services gives households a way to both prepare for and cope with crises (Parker, 2000).

Access to financial services for low income household popularly known as microfinance, has been advanced as a mitigation strategy that might stave off the effects

of HIV/AIDS to households enabling households smooth consumption dips especially for poor and near poor households. Such programs are widely seen as improving livelihoods, reducing vulnerability, fostering social and economic wellbeing (Donahue et al 2001; Viravaidya et al 2008).

1.2 Statement of the Problem

Access to finance is at the core of the development process and it is now widely accepted that well functioning financial systems are crucial for channeling funds for productive use, thus boosting economic development (Levine, 1997; Rousseau, 2003; King & Levine, 1993). Conversely, limited availability of financial services will have adverse effects, especially for those households made vulnerable by the effects of HIV/AIDS to livelihoods - making them resort to negative coping mechanisms. Thailand is a bank-based economy with a relatively high portion of households having access to financial services though they do not use these services to procure credit products; a Bank of Thailand (BOT) survey indicates only 9.61% of households and small businesses do not have access to financial services and further disaggregated data shows that 19.77% do not have access to savings account and a larger portion of 33.93% do not access credit either from commercial banks or Special Financial Institutions (SFIs) (Setboonsarng, 2010; Ariyapruchya, Wilatluk, & Chutchotithamy, 2007). The BOT paper also reports that low-income rural households lack access to basic financial services due to low financial literacy, inadequate income, collateral constrains and unsuitable product design.

Drawn from the above scenario, this thesis therefore seeks to examine the availability, need and uptake of financial services at the household level for HIV/AIDS affected low-income households, and the coping strategies employed by these households. This thesis also places risk perception in the broader debate of access to finance in households. Risk has always been viewed from the supply side, with financial

providers being excessively risk averse, especially to certain subpopulations that are considered high risk like those affected by HIV/AIDS. Other reasons why households do not take up formal financial services except to analyze structural barriers have hardly been studied but interest has finally emerged for risk perception as an important predictor of demand for risk management strategies. There have been limited studies on this issues and even less targeting the HIV/AIDS affected sub population.

1.3 Objectives of the Study

The main objective of this study is:

- To examine the need for formal financial services to ensure households do not resort to negative coping strategies

Other objectives are:

- To assess the socio-economic impacts of households affected by HIV/AIDS
- To identify how risk and risk perception factors into access of formal financial services at household level
- To identify the available risk management mechanisms for households in Chiang Mai affected by HIV/AIDS

1.4 Research Questions

- To what extent do households affected by HIV/AIDS need financial services to ensure they do not resort to negative coping mechanisms?

To answer the main research question, other questions were formulated in order to shed light on the need and other factors that affect access to financial services:

- What are the socio-economic impacts experienced by HIV/AIDS affected households at household level?
- How does risk and risk perception factor into their need and access for financial services?
- What are the financial service interventions available to HIV/AIDS affected households in Chiang Mai?

1.5 Hypothesis

If low-income households affected by HIV/AIDS experience shocks[2], there is a high likelihood that they would resort to negative coping mechanisms if they do not have access to formal financial services.

1.6 Theoretical Framework

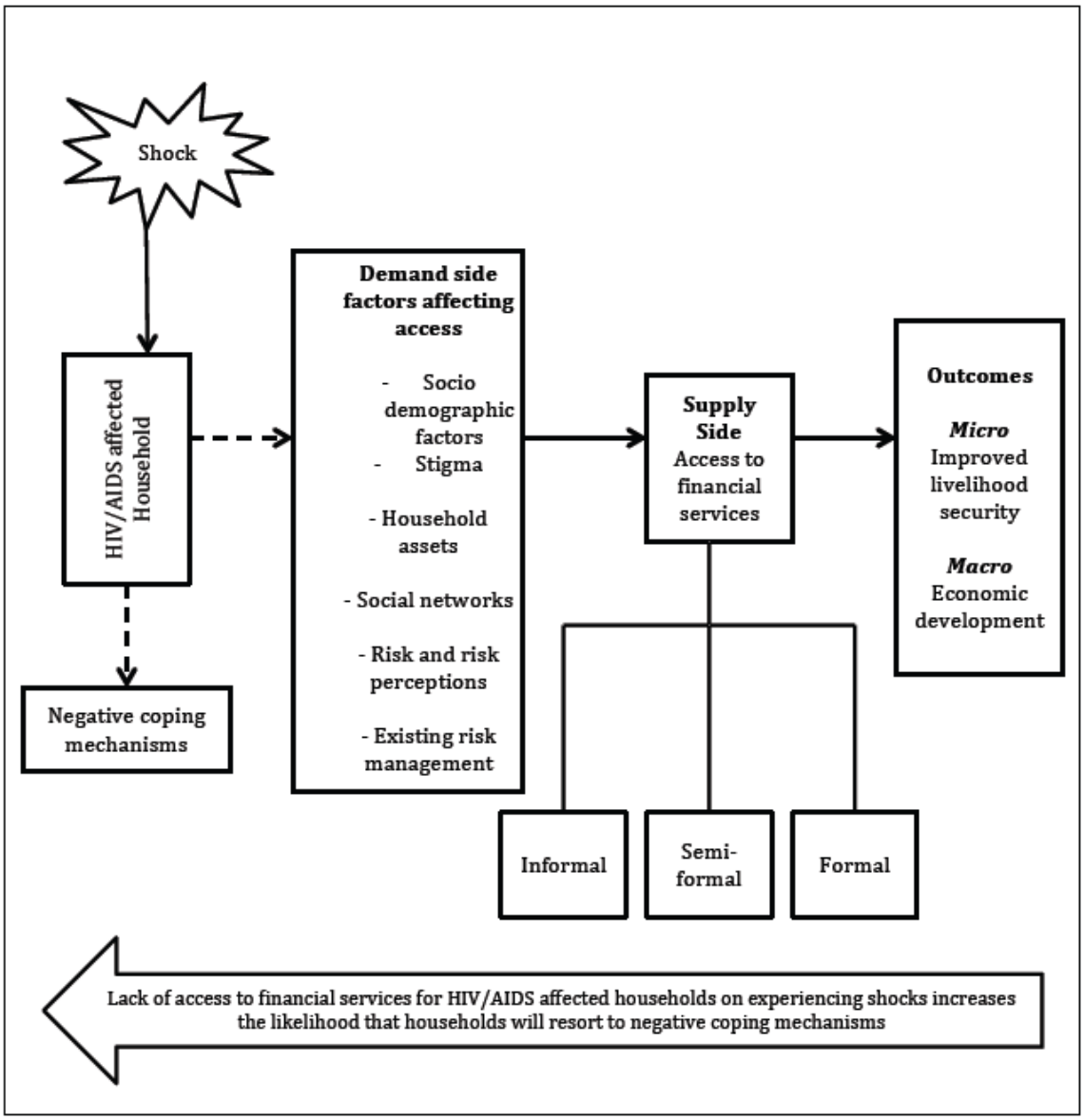
When low-income households experience shocks and need access to financial services, whether formal or informal, access to these services is rooted in several factors. Socio-demographic factors such as age, gender, education and income level is a predictor of financial access. For instance in Thailand, Townsend, (2011) finds that the highly educated constitute a small part of the population, but have high access to financial services. For most education levels, access to financial services is increasing with wealth, thus *ceteris paribus* increase in wealth and education increases financial access. Though the study shows that households with low education and female households are not more sensitive to idiosyncratic shocks – it concedes that low wealth households are consistently more vulnerable in both consumption and investment to averse shocks across regions and time periods.

[2] For this thesis a shock will be defined as the realization of a risk that can cause negative effects on livelihoods

Furthermore, household vulnerability is highly dependent on existing safety nets. Households with more qualitative assets are less likely to be negatively affected by shocks than households whose asset base is weak (Jutting, 2005). For poor and near poor households there is a heavy dependence on existing social support networks (Fafchamps & Gubert, 2007; Cox & Fafchamps, 2008), which may become stretched with a great likelihood of overburdening them. Access to financial services tailored to this sub-population would reduce vulnerability and ensure that affected households do not engage in negative coping mechanisms. Below is a depiction of the theoretical framework[3]:

[3] Concepts used in the above theoretical framework are more expansively explained in the literature review chapter.

Figure 1.1 – Depiction of Theoretical Framework



1.7 Research Methodology

1.7.1 Research Design and Strategy

The fieldwork was conducted in Chiang Mai Province and Bangkok, Thailand. Chiang Mai has some of the highest prevalence levels of HIV in Thailand (Sriwattanapongse, Prasitwattanaseree, & Khanabsakdi, 2010). Consequently, a strong NGO community emerged and the presence of several universities and research infrastructure in Chiang Mai have fostered HIV/AIDS related research and activities. As a result of the intensive research and intervention activities over the past fifteen years, selected risk groups and the general population in Chiang Mai have been exposed to HIV/AIDS interventions and prevention campaigns at a much greater level than the rest of the country (Im-em & Suranawat, 2002). Chiang Mai thus provided access to an area where innovations in HIV/AIDS care and prevention have been tested and implemented. Further, there was greater likelihood that there were financial and economic interventions due to the long-standing work by NGOs in this area, whereas Bangkok is the capital where most of the NGO headquarters are situated and where proposals are designed and policies drafted.

This research used both primary and secondary sources of information. Secondary research was collected from case studies, peer reviewed journals, academic articles, NGO reports, textbooks and newspaper articles. Primary data was collected through semi-structured questionnaires and in-depth interviews with key informants at two different levels. The table below gives a brief overview of the primary respondents:

Table 1.1 - Key Informants and Respondents Table

Key informant interviews
1) Ministry of Public Health official (1) – Baan Huay Sai, Mae Rim District 2) Local authorities – Tambon level (1) – Baan Wen, Hang Dong District 3) 5 staff from four NGOs providing financial and economic empowerment programs for HIV/AIDS affected households · Thailand National AIDS Foundation (TNAF) – Bangkok · Population and Community Development Association (PDA) - Bangkok · Sangha Metta Project – Chiang Mai City · The Planned Parenthood Association of Thailand (PPAT) – Chiang Mai City
4) HIV/AIDS affected individuals (6 Persons) – Baan Wen (1), Baan San Pak Wan (3) in Hang Dong District, Baan Huay Sai (1), Baan San Puag (1) in Mae Rim District 5) Community Health Volunteers (2) - Baan Huay Sai (1), Baan San Puag (1) in Mae Rim District

Two different questionnaires were designed to collect data;

1. Semi-structured interview guide – key informants

This questionnaire was designed and administered to key informants. The key informants for this research included two government employees – a local government officer and a public health nurse at tambon level - and five NGO staff from four NGOs that work with households affected and infected with HIV and AIDS with interventions that are centered around financial services and economic empowerment of affected households[4]. The questionnaire covered several topics ranging from how HIV/AIDS is considered an issue in their project areas and which interventions have been designed to

[4] Please see Appendix B for a more synthesized overview including dates and location of interviews.

tackle the gaps. More specifically there were questions centered on the need for economic empowerment and access to financial services, the need for specifically tailored products for this sub group and how this affected formulation and implementation of existing programs. In order to answer the research questions, the NGOs and other key informants gave a snapshot of the available financial and economic empowerment services targeting HIV/AIDS affected households, furthermore the uptake of the same would aid in answering the question of need and demand for these services.

2. Semi – structured questionnaire – in-depth interviews (HIV/AIDS infected affected households)

The second questionnaire was targeted towards respondents living with HIV and AIDS and community health workers[5] to gauge their reactions to household socio-economic shocks, their risk management strategies, and need for financial services. The HIV affected individuals were drawn from Planned Parenthood Association of Thailand (PPAT) groups, which had been established to provide members with support and disseminate knowledge and information to communities through the local communities and with the help of local government and the ministry of Public Health.

Due to the sensitivity of HIV/AIDS research, the interviews were conducted with the assistance of PPAT staff. As this study aims to focus on the long-term impact strategies of coping with the disease, interviewees were chosen accordingly. There were no incentives given to the interviewees, though as a gesture of goodwill and to create the required rapport, products were bought which were manufactured within these groups[6].

[5] Please see Appendix A for a more synthesized overview of the socio-demographic profiles of the interviewees
[6] For example soap, temple and Christmas decorations.

1.7.2 Qualitative Analysis

The interviews were conducted with the help of a semi structured questionnaire and in-depth interviews with the key informants[7]. Interviews were carried out in Thai, with the researcher asking questions in English, which were then translated to the respondents by the interpreter. Interviews were recorded and later transcribed and evaluated with help of a qualitative content analysis (Mayring 2000). This research method was chosen as it has distinct advantages for quantitative research such as following step models and a system of categorization that delivers criteria of validity and reliability. Deductive category application describes the process of applying the previously defined categories to text passages. The main purpose of this approach is to provide explicit definitions, examples, and, if needed, coding rules for each deductive category. This research is deductive, that is to say a hypothesis was formulated prior to the field research and used to test the hypothesis.

1.8 Research Scope and Limitations

Because of the language barrier while interviewing respondents living with HIV/AIDS, I relied almost completely on the services of a translator. This means that there might have been nuances in the language that were lost as data was translated and transcribed. Also because of the language barrier, there was a challenge in translating certain concepts, which had to be explained through examples both to the translator and respondents.

Some of the questions required the respondents to recall what had happened months to years before and this is subject to recall bias.

[7] See Appendix A and B

1.9 Significance of the Research

There are limitations to the literature on the impact of HIV/AIDS on livelihoods, especially on financial capital. While there is significant research on the impact of HIV/AIDS on rural livelihoods especially in East and South Africa, where the epidemic is still latent, in Thailand, it is not well understood how HIV/AIDS affects social and economic units, and how these interact with each other especially in terms of financial access - and how we can better understand these effects and processes in Chiang Mai. Furthermore, this thesis also includes risk perception into the broader debate of financial access and risk management strategies. There are almost no studies focusing on the risk perception from the demand side, meaning that many studies focus on managing risk from the supply side. For instance, banks or microfinance institutions (MFI) will at times use informational asymmetry to mean the lack of appropriate market and customer credit information in microfinance business, which makes it difficult for an MFI to determine whether a loan applicant already has a loan outstanding with another financial provider or has been blacklisted for bad payment records in order to cover or manage the MFI's risk.

1.10 Ethical Issues

Globally, the HIV/AIDS epidemic has presented unique health challenges to populations, including a host of ethical and moral issues related to human life and dignity. The disease has most affected the vulnerable groups of people in the world, often leading to stigma and discrimination. The ethical issues mainly revolve around the standard of care, informed consent across cultures, privacy and confidentiality, stigma and discrimination, protection of vulnerable groups, community consultation (Muthuswamy, 2005). For this research, participation was voluntary and I ensured that

the purpose of the study was clearly explained and that participants consented to the survey and recording of conversations for transcribing. There was no undue pressure to answer questions that respondents found uncomfortable and their right to privacy was guaranteed through use of pseudonyms.

CHAPTER II

LITERATURE REVIEW

2.1 Introduction

The first section of this chapter gives an overview of the evolution of HIV/AIDS in Thailand since the first wave of infection to date, delving into the reactions of the state to mitigate the impact of HIV/AIDS and identification of the affected populations. The second section gives an in-depth view on the impacts of HIV/AIDS at both micro- and macroeconomic level. The third part of this chapter provides an overview of the conceptual background that was used to construct the theoretical framework, and expands on the concepts used in the theoretical framework in Chapter 1, as it links to financial access and risk perception - while also providing an overview over concepts like social protection amongst others.

2.2 The Evolution of HIV/AIDS Epidemic in Thailand

The first wave of the HIV/AIDS infection was primarily considered a medical and health problem, since it had an impact on health similar to a chronic disease, and because the epidemic was concentrated only among risk groups. During this period, the epidemic was found among homosexuals and those who had sexual relations with foreigners. The epidemic then spread to injecting drug users (IDU) (Janjaroen & Khamman 2002). The public perception was that AIDS affected only these risk groups and the government focused on preventive actions for these groups. After 1988, the Royal Thai Government began to allocate funds to the program and slowly became more open to developing a policy to address HIV/AIDS. A medium term program was initiated from 1989-1991; the

strategy focused on individual risk and responsibility by providing information, raising awareness and sometimes delivering fear-inducing messages (Phoolchareon, 2006).

In June 1989, the first round of the national epidemiological surveillance found that 44% of brothel-based sex workers in the town of Chiang Mai situated in the northern region of the country were infected with HIV and the level of 1-5% among the 14 provinces sample. By 1994 HIV/AIDS spread to the general population (Janjaroen & Khamman, 2002). In 1990, the official AIDS policy was announced together with the establishment of a National AIDS Prevention and Control Committee under the prime minister's chairmanship. The committee concentrated on public information and education through mass media and mandatory one-minute AIDS education spots every hour on television and radio. The messages emphasized condom use and the epidemic was approached as a health problem, but also a social one. Other approaches were promotion of human rights for people living with HIV and AIDS, where the principle of voluntary, anonymous, confidential counseling and testing for HIV was established (Phoolchareon, 2006). As AIDS spread rapidly, it became clear that its impact would have far reaching social ramifications. A greater understanding emerged that AIDS was spread by individual behavior and reflected larger social problems in the society. AIDS was a social problem and deserved a high priority when it came to problem solving by multiple sectors of the society (Janjaroen & Khamman, 2002).

By 1996, the epidemic had spread more broadly through the population reaching families and groups originally thought to be at low risk – particularly housewives, women of productive age and their infants. The National Plan for Prevention and Alleviation of HIV/AIDS for 1997–2001, this plan was formulated to modify existing policy and strategy to meet new challenges. It emphasized efforts to mobilize communities and encouraged civil society to initiate their own activities. Based on Thailand's 1997

constitution, health is regarded as a human right. The National Health Insurance Act, promulgated in 2002, endorses the policy of universal healthcare coverage. Equal entitlement to health has been introduced for vulnerable populations such as the elderly, the disabled and abandoned children, as well as people with HIV/AIDS. There was also increased funding for HIV/AIDS research and HIV/AIDS vaccine research and development in order to transfer novel technology into the country (Phoolcharoen, 2006).

The policy plan for alleviating the AIDS problem during this period was reoriented to the holistic approach. It was well accepted that the HIV/AIDS problem was no longer the sole responsibility of the government. Strengthening the role of all related actors according to their specific missions will be very essential for success. This included full involvement of the private sector in preventing and controlling the disease, nongovernmental organizations for public service, and individual families such as home care programs and communities as well as groups of persons living with HIV/AIDS (National AIDS Committee, 1997; Janjaroen & Khamman, 2002)

At present

Thailand has successfully controlled HIV through a strong and early national response. The current response, guided by the national plan (2007–2011), includes four strategies: (1) improved management to integrate HIV/AIDS responses in all sectors; (2) integration of prevention, care, treatment and impact mitigation for each population group; (3) human rights protection; and (4) monitoring and evaluation with research to guide public policy. The government's response hopes to be supplemented by numerous national non-governmental organizations, community-based organizations and academic

institutions. The United Nations agencies, Centers for Disease Control and Prevention, and Family Health International are the key international technical partners (WHO 2009). Meanwhile in 2009, the National AIDS Prevention and Alleviation Committee (NAPAC) resolved that there will be an accelerated plan to reduce new HIV infections by 2011 by implementing increased public information campaigns and supporting sex communication at the family level, improving condom image and increase access to target populations, expanding and developing prevention interventions for groups showing increased transmission tendencies like the youth, sex workers, migrants and ethnic minorities.

Finally the national guidelines on the prevention and management of HIV/AIDS in the workplace were signed by the Prime Minister in August 2009, with the International Labour Organization (ILO) providing technical input during its development and also ensuring they reflected a rights-based approach (UNAIDS, 2009). Even though Thailand has rather good policies in place, these are not always implemented in practice. Human rights related to AIDS still don't receive optimal priority, and implementation at the peripheral level is often not consistent with national policy. There is still ignorance about the rights policies and their relationship to AIDS (UNAIDS, 2009).

2.3 Socio-Economic Impact of HIV/AIDS (Microeconomic)

Nearly 600,000 people are living with HIV in Thailand (UNAIDS, 2009). 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 (UNAIDS, 2007)**.** When one discovers that they have been

infected with the HIV virus, the initial reactions are shock, disbelief, anger and fear amongst other conflicting emotions (Im-em & Suwannarat, 2002). In 1996, suicide rates among people with HIV/AIDS rose steadily in the upper north to 60% over the normal rate as quoted in (Janjaroen & Khamman, 2002). Also Pitayanon, Kongsin & Janjaroen (1997) study of the epidemic in Chiang Mai found that 48% of 116 households with AIDS death mentioned that the sick person was discriminated by the community. 15% reported such discrimination against family members. For instance, family members were forced to quit their jobs and business slowed down because of decreasing customers. The report showed that 20% of the households admitted to their children not having playmates. Below is a more synthesized review of how households are affected by HIV/AIDS.

2.3.1 Income and Expenditure

Although most diseases undermine economic development and usually affect the poor disproportionately, HIV/AIDS is uniquely damaging because it is concentrated among adults that are in their most economically active years. In Thailand most of those affected by HIV/AIDS are between the age of 15-40 years and are self employed or wage earners, for example factory workers (Im-em & Suwannarat, 2002; Janjaroen & Khamman, 2002). Through its long-term process, the disease could lead to severe economic consequences.

Income declines as breadwinners fall ill and die and as other household members are obliged to take time off from other productive activities to care for sick relatives. At the same time, households have to reallocate spending and devote a much greater share to health care, including not only drugs and doctors' fees, but also supplies for home care. The impact of HIV/AIDS also extends beyond those households directly affected, to the

many other households who intervene to provide them with support (Haacker, 2004). A study in Chiang Mai and Rayong provinces (Im-em & Suwannarat, 2002) show that more than half of People Living with HIV and AIDS (PLHA) households had no savings and 80% were in debt in comparison to 60% of other Thai households, while another study in Chiang Mai by Janjaroen & Khamman (2002), puts the debt even higher for households that have an AIDS related death at 80-87%.

In later stages, AIDS patients are admitted to hospital 3 times a year and 12 days per each admission on average. This means that the patient would lose income at around USD 180 per annum, and the income would further be forgone in the case of death. Income forgone because of premature death of HIV/AIDS patients was calculated at USD 8.8 million in 1993 (Kamonmal et al 1995 as cited in Janjaroen & Khamman, 2002). Loss of labor and consequently income when a breadwinner falls ill, coupled with rising medical costs and ultimately funeral expenses, may plunge households into chronic poverty. Furthermore, the poorest households are most likely to resort to non-reversible coping mechanisms including the sale of land or livestock or withdrawal of children from school (Nolan, 2009).

2.3.2 Nutrition

There is a vicious cycle between HIV/AIDS and malnutrition, which increases the progression of HIV infection and may also increase the risk of transmission from mothers to babies (Harvey, 2004). Gaffeo (2003), contends that studies in developing countries highlight the fact that iron deficiency is typical of undernourished women, while the body's iron stores, which are partly depleted with each pregnancy, are often not fully replenished because of poor diet, short intervals between pregnancies and parasitic

infections. Further arguing that studies have shown that shortfalls in micronutrient intake at pre-school age can negatively influence physical growth and exacerbate illness, thereby reducing endurance to infections in adulthood[8]. The relationship between HIV/AIDS and nutritional status is a cumulative one, reduced income because of high health expenditure and depleted economic assets translate to reduced earning capacity of the household, which can substantially lead to the vicious cycle of malnutrition, and reduced work capacity that might lead to poverty. Furthermore, people with HIV or AIDS have different nutritional requirements[9] with those infected requiring diets rich in protein, energy and vitamins (Harvey, 2004).

2.3.3 Education

Girls are oftentimes the first to be removed from school when a parent or a caregiver falls ill and as such are the most vulnerable in the context of HIV/AIDS. Children orphaned and vulnerable in communities affected by AIDS are at increased risk of missing out on education, thus the next generation's capacity to climb out of poverty is significantly reduced (Nolan, 2009). Further, when an adult is affected by AIDS, household tasks are generally left to children, whose time for school related activities and learning is substantially reduced and even more so for orphans (Gaffeo, 2003). It follows then that poor parental health seriously affects the future supply of skilled labour and human capital accumulation.

[8] It is now well-established that sexually transmitted diseases substantially exacerbate HIV transmission, so that, *ceteris paribus* , higher morbidity as a result of current or past malnutrition is likely to increase susceptibility to HIV/AIDS (Gaffeo 2003)

[9] Though this is a source of heated debate as to what precisely constitutes the nutrient requirements needed (See Harvey, 2004, WHO, 2003)

2.3.4 Migration and Mobility

Located centrally in South East Asia, Thailand is a hub where many ethnic minorities and migrants from neighboring countries have migrated, attracted by higher wages and a stable economy[10] (Janjaroen & Khamman, 2002). Mobility increases risk to infection and episodic reports indicate that cross-border migration increases the likelihood of infection, due both to ignorance of risk and to physical and sexual abuse of migrants. However, sero-prevalence rates in border areas are among the highest in the region. For instance, the 1997 Sentinel Surveillance survey indicated that the sero-prevalence rate for Koh Kong, along the Thailand-Cambodia border, was alarming (52 per cent of commercial sex workers [CSWs] surveyed, 21 per cent of police, 10 per cent of the military, 19.5 per cent of pregnant women). In 1999, the rates were 42 per cent for CSWs, 24 per cent police and military (combined) and 8 per cent for pregnant women attending antenatal clinics (Im-em & Suwannarat, 2002).

2.4 Impacts of HIV/AIDS (Macroeconomic)

At the macro level, the impact of HIV/AIDS on households is often assumed rather than quantified in discussions of the economic outlook of countries in the planning of appropriate national and subnational responses to HIV/AIDS (Beegle and De Wert et al, 2008). Common sense suggests that all the AIDS-related microeconomic issues discussed are likely to have a negative effect on the growth of capital accumulation, labour inputs and total factor productivity in aggregate, which should in turn determine – in a typical growth accounting analysis – negative microeconomic performance (Gaffeo, 2003). It is therefore important to situate HIV/AIDS within the wider context of the

[10] In the mid 1990's it was estimated that one million migrants were in Thailand. The vast majority are from Burma

macro-level factors affecting livelihoods; and to understand the ways in which HIV/AIDS influences these macro-level factors (Harvey, 2004). In the micro environment, a range of factors influence the productivity and sustainability of agricultural and livelihood systems. Considering the direct impact of AIDS at all levels of livelihoods (human, financial, social, natural and physical), as well as the indirect impact that policies, institutions and processes have on livelihoods and the feedback loop generated by the epidemic, HIV/AIDS often negatively impacts livelihood assets and increases susceptibility and vulnerability to HIV/AIDS (World Food Programme, 2008).

While it may seem obvious that the negative effects of HIV at the micro level would translate to negative effects at the macroeconomic level, some studies have shown that the effects are minimal in comparison to other factors. The overall picture is that national economies are likely to grow more slowly as a result of the impact of HIV/AIDS, although the extent of this impact is unclear and disputed (Harvey, 2004). Even with conflicting views on the effect at the macro-level, what is clear is that HIV/AIDS erodes the primary production and consumption band of the population, while private and public sector impacts include reduced productivity due to staff illness and death, increased cost structures, reduced market size, market investments and saving patterns. Furthermore, public sector commitment to economic growth is reduced as a result of diminished revenue and diversion of revenue to respond to AIDS (Nolan, 2009).

2.5 Conceptual Background and Theoretical Concepts

2.5.1 Socio-Demographic Factors Affecting Access to Financial Services

The use of socio-demographic data in a study enables it to move from the one-dimensional to the multidimensional. (Kumar, 2005), including the measure of wealth, would permit the identification of how many people use a specific service and how many at the bottom or top quintile use the service. For instance, Ariyapruchya, Wilatluk, & Chutchotithamy (2007), in a BOT survey found that the main characteristics of households with no access to financial services were low income households, mostly in the lowest quintile consisting of labour workers, unemployed and agricultural workers living particularly in rural areas. Other factors like age affect usage, the cut off point is 18 years, which leads to high comparability as most banks or financial services providers require one to be of adult age. As mentioned before in Townsend (2011), education levels appear to influence access including voluntary exclusion and provider discrimination (Kumar, 2005). Other factors are gender, where it is expected that male and female profiles of access differ (Kumar, 2005).

2.5.2 Household Assets and Livelihoods

Many of the definitions of livelihood security currently in use derive from the work of Chambers and Conway:

"A livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living; a livelihood is sustainable which can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation" (Chambers and Conway, 1992)

Or, as later slightly modified by The UK Department for International Development (DFID):

"the capabilities, assets (including both material and social resources) for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base" (DFID, 1999)

The Sustainable Livelihoods (SL) approach is a framework that incorporates concepts of assets, capabilities and entitlements in recent analytical work around this issue. Here livelihoods are commonly defined as comprising the capabilities, assets (including both material and social resources) and activities required for a means of living. The SL framework has gained popularity among bilateral organizations such as DFID and international NGOs such as Care and Oxfam. As such the framework's importance relates as much to the operational processes that it proposes as to its analytical conceptualization.

HIV/AIDS is a shock that impacts all classes of assets. Human capital is lost through chronic illness and death of prime age labor as well as loss of skills and knowledge transfer. Financial capital is undermined due to: i) increased health care &

funerals expenditure, ii) reduced income (through loss of productivity) iii) decrease in assets ownership (assets are sold to make up for lost income) amongst others. Social capital is stretched due to reliance on social networks for support, but as calls on these networks increase, there is a likelihood of overburdening them and thus likely to increase vulnerability to other shocks.

The erosion of these capitals makes households more vulnerable and susceptible even to the slightest of shocks (Harvey, 2004). Living with few physical, social and economic assets, limited income and poor access to services, poor people [and near poor households affected by HIV/AIDS] are likely to be significantly more affected by socio-economic stressors than those that have, for example, insurance and greater financial capital. This is closely linked to the resilience of individuals, households and communities or their ability to cope with, recover from and adapt to stresses and shocks. This resilience is influenced not only by economic endowments, but also aspects such as nutrition and health status, political influence, access to decision-making and social networks (Segnestam, 2004).

2.5.3 Negative Coping Strategies

The literature of HIV/AIDS has increasingly recognized that the ways in which people are dealing with the impact of the disease are negative. At times households fail to cope and are forced into destitution. Some strategies are clearly damaging to livelihoods, such as reducing the quality of food being eaten, withdrawal of savings and sale of assets, which may increase current and future vulnerability (Harvey, 2004).

2.5.4 Risk Management

Risk management recently became a focus of interest in academic literature and for policy makers. The probability that a HIV affected household, which is exposed to shocks, actually falls into a state of destitution following a catastrophe, depends on the risk management applied. Where risk management works effectively, a vulnerable household can be classified as non-poor at one point in time – when its level of welfare exceeds a defined minimum level, and as poor at another when it falls below this line. Hence the probability of lying below or above this threshold is closely related to the quality and allocation of household's assets (Jütting 2005 P.13). Household risk management behaviour can be categorized into ex-ante[11] risk mitigation behaviour and ex-post[12] coping strategies. The goal of ex-ante measures is to prevent the shock from occurring, or, if this cannot be done, to mitigate the effects of the shock. Individual efforts, such as migration, can prevent risks, but in many cases, this requires support from the government (for example, disaster prevention). Mitigating the effects of risk through risk pooling by definition requires people to interact with other individuals - and poor people are typically less able to participate in formal and also informal arrangements. This leaves most poor households with the residual option of coping with the shock once it has occurred (ex-post). They are normally poorly prepared to do this and therefore often experience irreversible negative effects (Deveraux, 2001; Holzmann, Sherburne-Benz, and Tesliuc, 2003).

[11] Before the event
[12] After the event

2.5.5 Vulnerability and Shocks

There are many definitions of vulnerability and how it relates to poverty and risk. Vulnerability is a concept that combines exposure and susceptibility or sensitivity to adverse consequences (Deveraux, 2001). Chambers (1995) describes vulnerability as not lack or want but exposure and defenselessness with two sides: the external side of exposure to shocks, stress and risk; and the internal side of defenselessness, meaning a lack of means to cope without damaging loss. A shock is the realization of a risk that can cause negative effects on livelihoods in general and the degree of vulnerability related to the livelihood. Similarly, Segnestam (2004), puts forth that vulnerability is better understood in terms of exposure, sensitivity and resilience to stresses and shocks, while, Jütting (2005 P.11), contends that vulnerability is primarily a function of household assets endowment, type of risk exposure and available risk management strategies, therefore vulnerability is a measure of how effectively an individual or a household can handle shocks. For households that are affected by HIV and AIDS, each bout of illness presents a range of negative consequences including the loss of productivity in which the sick and their care givers are involved, reduced investment in human capital and where poor and vulnerable households are likely to resort to non reversible negative coping mechanisms (Nolan, 2009). It is worth noting the key difference between poverty and vulnerability to poverty. The latter involves future risks, is a forward-looking concept, and cannot be observed. One can, however, estimate the probability that a household may remain or become poor in the future due to various risks (Zhan and Wan, 2008).

There are many ways to measure vulnerability; in its simplest form, vulnerability for an individual can be measured as the probability that expected future consumption falls below some minimum level (that is socially acceptable). The concept of vulnerability can be discussed in the context of macro/national or household level. For

the purpose of this paper however, discussion will focus only on the socio-economic vulnerability at the micro level and how vulnerability and shocks are managed at the household level. Vulnerability will simply be defined as the probability of a household or individual falling into poverty[13] in the future.

2.5.6 Perceived Risk

The concept of perceived risk was first introduced by Bauer in 1960, as cited in (Mitchell, 1999) in studying consumer behavior, fifty years later, it has largely been used for several reasons. First, because of its appeal in facilitating marketers to see the world through their customers eyes. Second, it can be applied universally over a wide range of disciplines and applications. Third, it is powerful in explaining consumer behavior since consumers are often motivated to avoid mistakes rather than to maximize utility in purchasing[14] (Mitchell, 1999). Cunningham (1967) identified two major categories of perceived risk, (a) performance and (b) psychosocial. He broke performance into three types (i) economic, (ii) temporal, (iii) effort and psychosocial into two - (i) psychological and (ii) social. Cunningham (1967) further typified perceived risk as having six dimensions - (1) performance (2) financial (3) opportunity/time (4) safety (5) social and (6) psychological loss. He also posited that all risk facets stem from performance risk. A rich stream of consumer behavior literature (Cunningham, 1967; Jacoby and Kaplan 1972) supports the usage of these risk facets to understand consumer product and service evaluations and purchases. Jacoby and Kaplan (1972) also classified perceived risk into six dimensions (financial, performance, time, physical, psychological and social risks, closely related to Cunningham's dimensions. For the purpose of this thesis the definitions

[13] The United Nations describes one as poor if one falls below the threshold of USD 1.25 per day. In Thailand households in the first quintile make an income of approximately THB 3,860 which translates to about 4.3 USD per day at the current rate of 1 USD = 30 THB

[14] See Mitchell (1999) for a broader review of the various conceptualizations and models

on perceived risk will be borrowed from both dimensions and will be linked to risk perceptions of low-income households affected by HIV/AIDS and their access to financial services.

Researchers define performance risk as the inconsistency of product function, where goods or services might fail to deliver the desired benefits (Featherman & Pavlou, 2003). Financial risk is the potential monetary outlay associated with the initial purchase price, as well as the subsequent maintenance cost. For instance, for a poor household to open a bank account it is important to not only consider the initial deposit for opening the account, but also the cost of maintaining the account - and other issues like financial loss or fraud. Psychological risks is the potential loss of self image or self concept as the result of the item purchase, whereas social risk can be defined as the potential loss of self esteem, respect and/or friendship offered by other individuals - or potential loss of status in ones social group (Laroche, Mc Dougall, Bergeron, & Yang, 2004). Privacy risk was included in Featherman and Pavlou (2003) in their study of e-payments and is particularly salient for persons affected by HIV/AIDS, as they are continually afflicted by stigma - and the potential loss of control over personal information might restrict use of financial products. 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 (UNAIDS, 2007). In interviews with HIV-positive participants of Population and Community Development Association (PDA) 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 from those specifically mandated to assist poor people (UNAIDS, 2007).

Risk perception has rarely been used in analyzing the need for financial services for the poor from the demand side - I have used the concept of risk perception as a factor in the uptake of financial services for low-income households affected by HIV/AIDS.

2.5.7 Social Networks and Social Capital

Trust, social networks, and social norms are acknowledged in literature as the main mechanisms through which social capital reduces uncertainty and transaction costs, discourages opportunistic behavior, fosters cooperation and increases the efficiency of markets and organizations, thus affecting economic development (David & Li, 2008). The literature on social capital and development is expanding and evolving quickly and there are different perspectives that are commonly held of social capital.

The communitarian view equates social capital with local level organizations, namely associations, clubs and civic groups measuring the density of groups in a given community to imply more is better and the presence of many groups imply a positive effect. The second networks view stresses the importance of vertical as well as horizontal associations between people, and relations within and among other organizational entities such as community groups and firms known in current literature as “bonding” and “bridging” social capital. The institutional view argues that the vitality of community networks and civil society is largely the product of the political legal and institutional environment (Woolcock & Narayan, 2000). Last is the synergy view, which has been recently coined by scholars who recognized the disconnect in these views and proposed the synergy view, which attempts to integrate the network and institutional camps, (Woolcock & Narayan, 2000) developed the idea further to integrate the core ideas of bridging social capital and state functioning, arguing that different combinations result in different outcomes.

2.5.8 Stigma

One of the earliest scholars to write about disease stigma was Erving Goffman (1963), who provides an excellent entry point into the concept of stigma. Stigma, according to Goffman, is "a process of devaluation" associated with stereotyping and prejudice. It is employed by individuals to define certain attributes of others as "discreditable" or "unworthy", resulting in the person stigmatized becoming "discounted" or "tainted" (as cited in Vanlandingham, Im-Em, & Saengtienchai, 2005; Liamputtong, Haritavorn, & Kiatying-Angsulee, 2009; Li, Lee, Thammawijaya, Jiraphongsa, & Rotheram-Borus, 2009).

Often stigma is multidimensional - there are three broad types of HIV/AIDS related stigma. First, self-stigma occurs through "self blame and self depreciation" for those living with HIV and AIDS. Second is perceived stigma, which is related to the fear that individuals have if they disclose their HIV positive status that they may be stigmatized. Third is enacted stigma, which occurs where individuals are actively discriminated against because of their HIV status (Liamputtong, Haritavorn, & Kiatying-Angsulee, 2009). While both felt and enacted stigma may lead to negative consequences, some persons suffering from HIV may anticipate negative reactions from their communities and therefore have a more negative interpretation of the community reaction towards them than what members of the community in fact have (Vanlandingham et al., 2005).

Stigma maybe perceived, expressed and experienced differently across the life course (Maman et al, 2009). Qualitative data collected with 655 participants in 4 sites

(Tanzania, Thailand, South Africa, Zimbabwe) seeking to account for the various differences in HIV stigma across high prevalence settings show that variation in the availability of health and socio-economic resources designed to mitigate the impact of HIV/AIDS might help explain differences in HIV/AIDS stigma (Maman et al, 2009). The experience of caring for PLHA without adequate health and socio-economic resources plays an important role in shaping behaviors towards PLHA. Where HIV prevalence is high and very few resources are available to family members to care for PLHA at the ends stages of the disease, the study showed a contrast in settings like South Africa and Thailand, where resources helped shield PLHA from stigma and discrimination. For instance access to anti retroviral therapy (ART) helps PLHA avoid physical signs and symptoms of AIDS that often trigger stigma and discrimination and access to social grants provide material support to families that can help ease the burden of caring for PLHA. This said, physical and moral appearances are important in Thai society and shame is still experienced by those who are infected with HIV/AIDS (Liamputtong, Haritavorn, & Kiatying-Angsulee, 2009).

In addition, social stigma is often attached to sero-positive individuals and their families, so that the epidemic threatens to destroy social networks, civic associations and communal safety nets, or, in a word, all those kinds of interpersonal ties which constitute social capital (Woolcock and Narayan, 2000). With reference to this, Population Development Association (PDA) in Thailand uses microcredit as an entry point to reduce both individual and community stigmatization. In Asian societies, social status is accorded to persons who are able to support their families. HIV/AIDS has often reduced the ability of PLHA to work and obtain income, hence, reducing their self-worth and reinforcing stigma already attached to HIV. When PLHA are able to demonstrate to their communities and families that they are able to support themselves and contribute, levels of stigma and discrimination are reduced (Viravaidya et al, 2008).

2.6 Financial Access

Recently constructed measures of financial access fall under two broad categories based on provider and user information. The provider or supply side information on financial services is available from providing institutions or regulatory organs like the central banks. Analysis from this end only would not be able to provide information who the consumers are and what specific services they take up. Surveying consumers of these services adds other dimensions like the range of services used, personal attributes of the consumers, thus permitting a multivariate profiling of financial access, perceived challenges in obtaining these services (Kumar, 2005).

2.6.1 Demand side

Since 1998, microcredit has been observed to benefit households economically affected by HIV/AIDS (Donahue, et al 2001). While microcredit is generally concerned with the provision of loans, most recently awareness has increased with regards to the fact that access to loans is not enough and that a range of financial services including savings and insurance services are relevant. Furthermore, studies have shown that savings products are equally important if not more important than loans yet many poor and near poor have no access to safe, liquid savings products (Dworkin & Blankenship, 2009). Liquid savings allow one to meet future obligations like school fee payments, land purchases and payments for important life cycle events (marriage, child birth, and death) as well as smooth consumption for every day events and emergency-related expenses such as those created by the AIDS pandemic (Green, 2008).

Access is a deceptively simple concept, a person may be said to have access to financial services if they are able to use formal or semi-formal financial services in an appropriate form, at reasonable process and when such services are required. For instance in the *consumption or use* of financial services, some persons (group A) may not be equivalent to access to such services, and there is a group of persons (group B) who voluntarily exclude themselves from consumption. Thus the group with access would be greater than the group of current customers of services and would be defined by A+B (Fernando, 2007; Kumar, 2005). Involuntary exclusion can include those ineligible for services due to risk characteristics (e.g. bad credit history), as well as those who are excluded due to racial or ethnic discrimination (Kumar, 2005), or those excluded because of stigmatization by virtue of having contracted HIV/AIDS and their high-perceived risk as a debtor (UNAIDS, 2007).

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 (UNAIDS, 2007). 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. The only remaining option for those desperate for capital, even just to buy food to stay alive, is often to approach informal moneylenders. As might be expected, most moneylenders 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. Further, as mentioned before in the UNAIDS (2007) report, as recent

as 2005, HIV/AIDS affected people were being asked to take blood tests which in turn made them ineligible for financial services.

In Thailand 91% of households have access to at least one type of financial service, 85% had access to savings products and 64% had borrowed from a financial institution either formal or informal. Further disaggregated figures show that about 38% of low income families[15] have only used one or two financial services while another 16% do not use financial services at all. The study concludes that non-usage declines as income becomes higher and alludes to a positive relationship between income level and degree of financial usage with 80% of middle to high income households using three or more types of financial services (Asian Development Bank, 2011; Ariyapruchya, Wilatluk, & Chutchotithamy, 2007; Setboonsarng, 2010).

Demand for microfinance services by households affected by HIV have been demonstrated by high uptake and repayment in a program initiated by PDA that targets people infected with HIV/AIDS. Repayment rates have been consistently high, for instance repayment rates in 2006 span from 91% in rural areas to about 78% and 85% for urban areas (Viravaidya, Wolf, & Guest, 2008).

[15] For the rest of this thesis income groups (monthly income) will be grouped in quintiles as is the practice of BOT and as referenced in their 2007 report with Q1 as lowest income group and Q5 as the highest income group, Q1- THB 3,860.32, Q2 – THB 7,765.35, Q3 – THB 12,283.92, Q4 – THB 20,090.05, Q5 – THB 55,180.88 (Ariyapruchya, Wilatluk, & Chutchotithamy, 2007)

2.6.2 Supply side - Microfinance in Thailand

Microfinance development in Thailand began in 1966 when the government created the state-owned Bank for Agriculture and Agricultural Cooperatives (BAAC) to provide farm credits to decrease informal debt. In 1974, the Community Development Department initiated community savings groups to provide savings and credit to households. Since this time, while the government continues to provide financial services to low-income households, the range of services is limited and services are heavily subsidized and primarily focused on microcredit (Asian Development Bank, 2011). The Thailand microfinance industry has been heavily dominated by government programs and interventions, which have limited the growth of a viable commercial sector (Setboonsarng, 2010). The Thai government has long been providing services to assist the poor that are similar to microfinance activities through Specialized Financial Institutions (SFIs), such as the Government Savings Bank (GSB), Bank for Agriculture and Agricultural Cooperatives (BAAC), co-operatives, and other government schemes such as village funds and self-help groups among others (Setboonsarng, 2010; Pibulchol, 2011). An estimated 8.5% of the rural population (5.5 million) of Thailand's population lived below the poverty line[16], of these rural populations are considered most at risk with two thirds of those living under the poverty line concentrated in the north-east of the country.

Microfinance in Thailand currently comprises three main categories (Asian Development Bank, 2011)[17]:

(i) Formal and large microfinance institutions - bank and nonbank institutions

[16] USD 1.25 translating to THB 1,443 per month (Setboonsarng, 2010) citing from the National Economic and Social Development Board (NESDB, 2007)

[17] In Chapter 3 and 4, the same levels of formality for available financial services will be used to provide a snap shot of what financial services are available to households affected by HIV

that operate under prudential regulations - including commercial banks and special financial institutions

(ii) Semiformal microfinance institutions operating under non-prudential regulations that are member-based and can capture savings and investments within communities (includes agricultural, savings and credit union cooperatives, registered savings-for-production groups. and village and urban revolving funds

(iii) Informal independent and self-help savings, village banks and credit groups - community and member-based organizations - that are often supported by external entities including nongovernment organizations (NGOs) or local government agencies. Government-owned and subsidized special financial institutions have the dominant market share in the microfinance industry servicing low-income households

From a traditional point of view, servicing the poor through microfinance might not be attractive. In addition to lacking in expertise, most commercial banks in Thailand see these small transactions by a large number of small customers as incurring high operation costs and it is hard to evaluate the ability of these customers to repay loans, thus concentrate on corporate customers (Pibulchol, 2011). Because of strong government involvement in microfinance and a weak regulatory and supervisory framework for financial inclusion, entry of other microfinance institutions has been complicated, difficult and highly restricted. With very narrow options for service providers working under multiple regulators, private sector entry has been stifled, preventing necessary market competition, innovation, and service expansion. The key regulatory impediments to private sector participation include the interest rate ceilings for nonbanking financial institutions (NBFIs), licensing restrictions on MFI entry, and government-subsidized programs (Asian Development Bank, 2011).

Currently, microfinance licenses are only issued to domestic banks. Exemptions for pre-existing nonprofit NGOs are considered on a case-by-case basis and stipulate that the institution restrict its activities to group lending only, inhibiting financially sustainable growth and preventing the development of a range of products and services beyond credit that clients need. The lack of private sector participation in microfinance has also limited efficiency and innovation. Thailand's microfinance industry lags far behind those in other countries in the region[18] (Asian Development Bank, 2011). The Bank of Thailand has recently released a guideline on microfinance loans for commercial banks. The guidelines provide more flexibility for banks to initiate the business models that suit the needs of small businesses and people seeking new opportunities to start or expand business (Pibulchol, 2011). They allowed commercial banks to engage in microfinance, whereby there is no collateral requirement, with a credit limit of THB 200,000 at an annual interest rate of 28 percent. The Bangkok Post, a popular Thai newspaper, has indicated that though the regulations have been put in place, this does not seem to have induced commercial banks into lending to the low income and unbanked section - largely as the interest rate cap has dissuaded them from engaging in microfinance as it restricts their pricing options and involves lending to people thought to be in higher risk[19]category (Trivedi, 2011).

Due to the overabundance of inexpensive credit[20] in certain areas and low financial literacy, over-indebtedness and increased dependence on moneylenders has grown in some regions. In the current circumstances, financial service providers have little to no incentive to develop important financial services for low-income populations

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[18] Thailand ranked 50 out of 54 countries around the world in terms of its overall microfinance ranking and at the bottom of the scale in both global and regional comparisons based on an evaluation of the country's microfinance regulatory framework, investment climate and institutional development (Economist Intelligence Unit, 2010) as cited in (Asian Development Bank, 2011)

[19] The 1997 country's financial crisis severely affected all commercial banks in Thailand. High levels of non-performing loans made commercial banks more cautious in approving loans to potential high risk customers which are mostly small businesses

[20] Ministry of Finance estimates that credit supplied by formal financial services is about THB 7.73 trillion or 89.7% of the total credit in 2007 (Asian Development Bank, 2011)

(Asian Development Bank, 2011). This unbanked and underbanked group of people use semi-formal (Cooperatives Institutions and Savings for production groups) which are regulated by the Cooperatives Act of 1968 and the Village and Urban Revolving Fund (VRF), and informal channels (self help groups managed by NGOs, self managed self help groups, money lenders) to access financial services (Setboonsarng, 2010).

2.7 Financial Services and Economic Growth

In 1911, Joseph Schumpeter argued that the services provided by financial intermediaries, mobilizing finance, evaluating projects, managing risk, monitoring managers and facilitating transactions are essential for technological innovation and economic development[21]. While views differ between economists, there is a growing body of literature that suggests that financial instruments, markets and institutions arise to mitigate the effects of information and transaction costs. Furthermore, a growing literature shows that differences in how well financial access reduces information and transaction costs influence saving rates, investment decisions, technological innovation, and long-run growth rates (Levine, 1997). It also presents opportunities for individuals to borrow, save and insure against unforeseen shocks, helps in consumption smoothing and better integrates households into society as active economic and social agents (Ariyapruchya, Wilatluk, & Chutchotithamy, 2007).

In a historical analysis of developed countries that explores the relationship between finance and growth in pre-industrial societies; the main findings suggest that financial markets promote investment and commercial activities by mobilizing resources, pooling funds needed to start projects, payment facilitation and by providing working

[21] As quoted in (King & Levine, 1993)

capital (Rousseau, 2003). King & Levine (1993) also studied 77 countries over the period of 1960-1989 to measure the depth of financial development in relation to growth. Results indicate that financial depth in 1960 is a good predictor of subsequent rates of economic growth, physical accumulation and economic efficiency improvements over the next 30 years even after controlling for income, education and measures of monetary trade and fiscal policies supported the theory that finance does not simply follow growth; financial development predicts long run growth[22].

2.8 Social Protection

Investing in social protection and social security has been on the development agenda for the last 50 years, yet there exists no common definition of 'social security' in the literature with different approaches identified over the years. Though this may be the case, all definitions share the same objective, which is that social security should offer protection against risks; risk sharing should not be left solely to the individual but is a concern for society at large (Jutting 2005), with others focusing substantial attention on how to operationalize it (Devereux and Sabates-Wheeler, 2004). A common feature in social policy in wealthier countries, it has now emerged as a political possibility for developing countries, where HIV/AIDS interacts with other drivers of poverty to destabilize livelihood systems and family community safety nets (Adato and Basset, 2008). Social protection includes safety net-type protective features, but can also contribute to development processes in a more systematic, dependable and integrated way. It is often advocated as a right rather than a reactive form of relief (Adato, Ahmed, & Lund, 2004). There are many different perspectives on social protection, reflecting different positions on scope, timeframes, targeting, and the role of the state - as well as on

[22] The downside of this study is that it only focuses on one segment of the financial system - banks. They do not incorporate measures of other components of national financial systems

poverty, vulnerability, development and human rights. Social protection enables individuals, families and communities to reduce risk and vulnerability, mitigate the impacts of stresses and shocks and to support people who suffer from chronic incapacities to secure basic livelihoods because of factors such as age, illness, disabilities, discrimination, or their position within the social and economic structure of their society (Adato and Basset, 2008).

In the wake of the Asian financial crisis between 1996 and 2000, the incidence of poverty increased, resulting in higher unemployment; within four years, the unemployment rate increased twofold from 2.0% in 1996 to 5.2% in 1999 (Pongsapich, 2002) and with high default rates on farmer credit (Siamwalla & Paitoonpong, 2002). In light of these events, Thailand stepped up its social protection mechanisms. Thailand has a well-integrated risk management system under the Thailand Social Protection (SP) framework, the so-called "populist policies" which is based on a social welfare system and equal opportunity[23]. The present SP system in Thailand is a multi-pillar one, with a few schemes to cover different sectors of employment.

2.9 Summary of Chapter

This section highlights the challenges experienced by households affected by HIV/AIDS at both micro and macro levels, showing that the effects of HIV and AIDS do permeate every aspect of life and affects households in numerous ways which in turn affect the macroeconomic environment. Though this fact is contested, the question is not if, the question is more how much.

[23] http://thailand.prd.go.th/view_inside.php?id=5682

Studies on the need and availability of financial services to households affected by HIV/AIDS have usually emphasized the need for microfinance services. While views are certainly polarized on what microfinance and access to financial services in general can and cannot do, what cannot be denied is that microfinance - and even while evidence is accused of being anecdotal at best - continues to be one of the options that the poor and vulnerable use to smoothen consumption and ensure that they do not fall into the poverty trap.

The theoretical concepts were expanded to give definitions and the conceptual background of these concepts. In the event that households affected by HIV/AIDS experience shocks, it is anticipated that households access financial services to ensure that they do not resort to negative coping strategies. To access financial services there are several factors that affect demand and access, which have been explained above. Furthermore, there was an overview on the supply side issues of microfinance in Thailand and the different levels of formality that will be used for the rest of the thesis.

There are many informal groups in Thailand in the form of self-help groups; many of these self-help groups apply a solidarity group methodology, which is used in lieu of collateral. The solidarity group lending approach, which is built upon the Grameen model[24], at times has adverse effects on social networks; this is because the people who come together in the groups are usually friends with prior relationships. As it is a co-guarantee approach, if one is unable to pay up, this places an undue burden to other women (co-guarantors) in the group to pay the loan for the defaulting client, thus this might even put the co-guarantors deeper into debt. Further it might ostracize the client who is unable to pay, thus eroding maybe the only networks one has. Another point of concern is that it excludes those who are social network poor. It is widely accepted now

[24]Mohammed Yunus of the Grameen Foundation, Bangladesh, advanced the Grameen model of micro lending. One characteristic of the model is that it does not necessarily require women (clients) to have collateral to receive loans, women are organized in groups where they co-guarantee each others loans through solidarity.

that poverty is not only economic poverty, but permeates other aspects of life. And those who lack the appropriate social collateral (group co-guarantee) might not be eligible for credit.

Microfinance here is not advanced as a magic bullet for all the challenges that are faced by affected households but as one risk management strategy (depending on availability) that will draw the line between being above or below the poverty line, financial services alone cannot solve the reverberations of HIV/AIDS, access to a broad range of financial services and insurance can help a household build safety nets to deal with shocks and vulnerabilities

There are gaps in the literature on what precise interventions are there to ensure access to financial services for these households and if these households need financial services, and further gaps as to why households with access not take up these services. As most of the population in Thailand affected by HIV and AIDS are wage labourers and migrants, they will likely fall in the category of households that do not use financial services either through self exclusion or because of structural barriers. In the literature review links were drawn between the impacts of HIV and the need for financial services both at the micro level (to ensure livelihood security) and the macro level (economic development). Another factor was social protection mechanisms, which have been implemented in Thailand rigorously after the Asian crisis. Access to social welfare here is viewed as a complement to access to financial services as low income households accessing these government funded programs do.

CHAPTER III

SOCIO-ECONOMIC IMPACTS OF HIV, REACTIONS TO SHOCKS AND NEED FOR FINANCIAL SERVICES AT THE HOUSEHOLD LEVEL

3.1 Introduction

The effects of HIV/AIDS are many and have different permutations in different social, economic, political and geographical contexts. This chapter begins by giving a brief overview of Chiang Mai province followed by the prevalence rates and how it differs from the overall sero-prevalence[25] picture of the country. The next section synthesizes the findings of the socio-economic impact of HIV/AIDS at household level from primary data collected - supported by documentary evidence from other studies. The third section evaluates the shocks experienced, measures vulnerability in these households and how risk perception shapes the risk management strategies that they adopt. The final part of this chapter discusses access and need for financial services and how this improves livelihood security.

3.2 Chiang Mai Province

Chiang Mai province is about 700 km from Bangkok and is the second-largest province of Thailand, located in the north of the country. To the north it borders the Shan State of Burma. It has a population of 1,552,776[26] and of these 13.4% of the population are members of the hill tribes, among them the Hmong, Yao, Lahu, Lisu, Akha and Karen

[25] Study of the number of cases where HIV is present in a specific population at a given time
[26] As shown in (Im-em & Suwannarat 2002)

(Kulsrisombat, 2008). The gross provincial product by percentage is industry 17%, agriculture 11%, service 22%, and others 50% with a per capita income of THB 49,614[27] (Im-em & Suwannarat , 2002)

Since the late 1970s, Chiang Mai has grown rapidly, as it was designated a growth pole for the northern region. In the mid-1980s, from the National Economic and Social Development Board (NESDB) initiative, the proposal to establish the twin city of Chiang Mai – Lamphoon - was developed, followed by the economic quadrangle initiatives to integrate the economies of South West China, Myanmar, Laos and Northern Thailand. In the same plan, Chiang Mai designated a culture and arts center. In the 8th plan (1997-2001), Chiang Mai was designated as a hub for the Great Mekong Sub -Region (GMS) Economic Cooperation Program. Though decades of government policies have induced growth in Chiang Mai City, it has at the same time introduced new challenges to sustainability. Following the Bangkok model, Chiang Mai has become a primary city where all economic activities are concentrated, whereas other areas remain economically under-developed. For instance, in 2004 the total number of business activities in Chiang Mai City was 8.4 times larger than in San Kamphaeng district, which is the second most economically developed district of the province (Kulsrisombat, 2008).

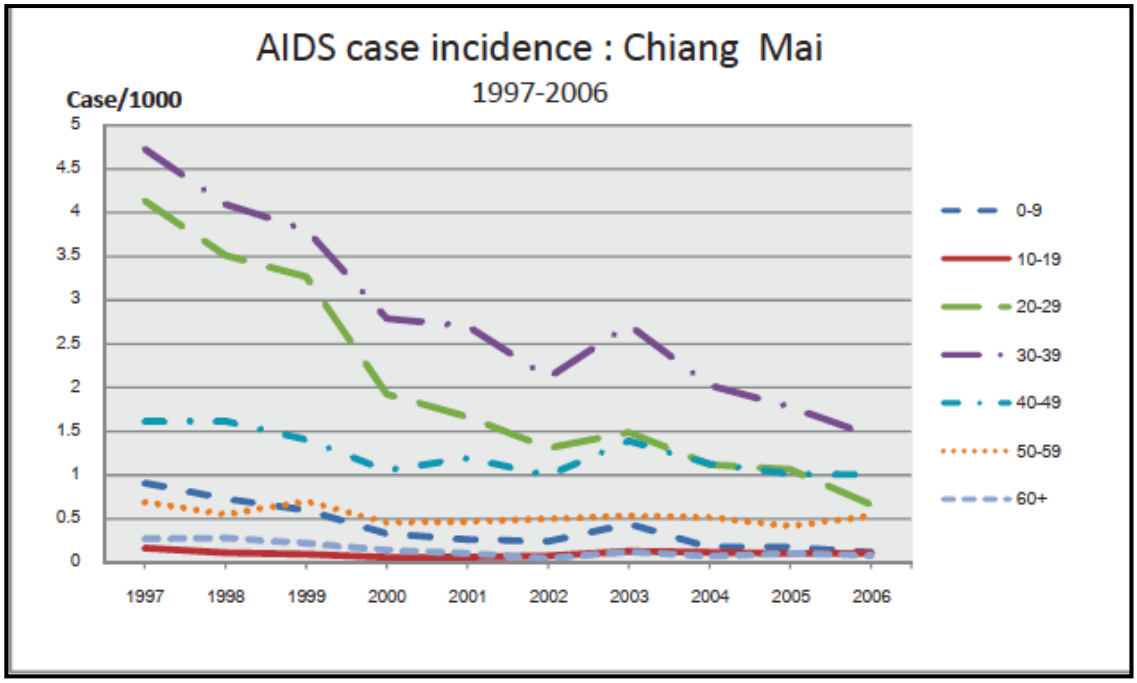
3.2.1 HIV and AIDS in Chiang Mai

By 2009 an estimated 600,000[28] people were living with HIV and AIDS in Thailand with a prevalence of 1.4%[29], with 41% being women (World Health Organization, 2009). Although it is common to speak of the HIV epidemic in Thailand,

[27] Data figures from 1999
[28] Numbers vary
[29] This figure masks the prevalence in different geographical areas within the country; for Instance in Chiang Mai, HIV prevalence among testers in voluntary testing centers was 4.9%, range from 1.1 to 8.4% by area (Surinda Kawichai, David D. Celentano, Suwat Chariyalertsak, Surasing Visrutaratna and Onsri Short, et al 2007)

there is considerable geographic variation in HIV prevalence within the country as shown in a study undertaken from 1997-2006 investigating epidemic patterns of hospital-diagnosed HIV/AIDS incidents by year, district and age group. Over this period, a total of 17,535 HIV/AIDS cases were reported in Chiang Mai Province. The study found the average incidence rate of AIDS appears to be the highest in at 2.10 per 1,000 people per year in Hang Dong District, Chiang Mai Province. It should be noted that Chiang Mai has an incidence rate 4.9% which is higher than the national average of 1.4%, denoting that HIV/AIDS is still a problem in Chiang Mai Province. This study also found the highest age-specific AIDS incidence rates to be in the group of 30-39 years (28.2 per 1,000 per year) (Sriwattanapongse, Prasitwattanaseree, & Khanabsakdi, 2010). Figure 3.1 gives an overview of HIV/AIDS infections by age in Chiang Mai between 1997 and 2006.

Figure 3.1 - AIDS Case Incidence: Chiang Mai



Source (Sriwattanapongse, Prasitwattanaseree, & Khanabsakdi, 2010)

The overall prevalence numbers shown in the graph above shows a downward trend in new infections. The UN Thailand Human Security Report for 2009 contends that the vulnerability to HIV/AIDS has lessened somewhat owing to medical advances, public awareness, and social campaigns, but vigilance is still required. The rising health threats are the diseases of lifestyle and environment – cancer, heart disease, stress – and international epidemics (UNDP, 2009). The UNAIDS report for 2010 paints a different picture, contending that epidemiological data, combined with data from ad hoc surveys, indicate a trend toward sustained spread of HIV with the possibility of a reverse to an increasing trend in some most-at-risk groups such as sex workers, men having sex with men (MSM), and intravenous drug users (IDU). These developments pose a threat to Thailand's ability to achieve its targets for reduction of new infections as specified in the national plan.

In line with this, NAPAC had set a target of halving the number of new HIV infections from the projected total and reducing the prevalence of HIV among pregnant women and Thai military recruits by at least 0.05 percentage points per year (UNAIDS 2010). In Thailand the average age at death from AIDS-related causes is 36, and the life expectancy at birth for 2000-2005 was estimated at 71 years – three years less than it would have been without AIDS (Rhucharoenpornpanich and Chamratrithirong, 2001; United Nations Development Programme, 2004).

3.3 Socio-Economic Impacts of HIV/AIDS at Household Level

3.3.1 Socio-Demographic Profiles

The majority of the respondents infected by HIV/AIDs were female (4), and (2) male. The respondents had lived with the virus between sixteen and four years. Age ranged from 34 years to 55 years; with most of them attaining primary level education except for one woman had secondary school level education. One respondent was widowed; one male was single whereas all others were married[30]. Income in the households varied from THB 3,000 to THB 8,000.[31]

3.3.2 Families' and communities' initial reactions

Once an individual realizes they are HIV positive, they go through a series of feelings from denial to finally acceptance. Many of those interviewed have lived with the disease for a long time (mostly over 10 years), except one, who was infected four years ago. All the respondents are members of PLHA groups started by PPAT and meet on a monthly basis to share experiences and support from others going through the same disease. Group activities are carried out, varying from home visits to income generating activities. Out of the six infected interviewed, four reported that they would consider their health to be good, whereas one was experiencing deteriorating eyesight and another one was blinded by the disease. Five of the households are comprised of extended family members and only one is a nuclear set up. Families, mainly parents, have been extensively involved in caretaking arrangements for older children infected by HIV in nearly all the cases. The Thai government over the last 10 years has greatly improved its

[30] For a tabular presentation of these profiles please see Appendix A
[31] Expanded in a later section

social protection programs, but there is still a heavy dependence on informal channels of care and support. Thailand has a sizable minority of people co-residing or living next to a parent and exchange services and material assistance with their parents, constituting an informal support system.[32] Reactions when HIV positive status is revealed to family and the community, is varied.[33]

" I have been living with HIV for the last sixteen year. When I discovered I was positive, my family stood by me both health wise and mentally. It was different with the community. In the beginning when I would go to the market and touch anything, no one would want to buy it after I had touched it, so I stopped going to the market. If I needed anything then my parents would have to get for me". (Interviewee 1, 41-year-old HIV positive female)

"My in-laws were always supportive and were there for me even when I married a new wife; I have a great relationship with my mother in law. I have lived with the virus for fourteen years. My wife was first to test positive, then the doctor advised me to get tested and I was positive too. We have been together for eight years [with the second wife] and we take care not to re-infect each other…[Laughing] PPAT makes sure we have condoms" (Interviewee 2, 41 year old HIV positive male)

" I was afraid to be with people because I did not know how they would react to me. At one time I became ill with a throat infection that would not go away, I lost weight from 63 kilograms to 37 kilograms, I became very weak. The ARV's help very much"(Interviewee 3, 55 year old HIV positive female)

Interviewee 3, a housewife, also a member of *San Pak Wan Group,* found out she

[32] For a more synthesized report on effect of HIV on older people in Thailand cited in Knodel et al. (2001)
[33] See (LeCoeur et al. 2005)

was HIV positive four years ago. Among her group members, she is one of those who have lived with the virus for the shortest time. She contracted the virus from her husband who knew he was HIV positive and did not inform her for a while. He has since admitted to it and has been living positively for a year. She feels better now; she says she is almost back to normal, though her eyesight is failing her. She admits to having resorted to traditional therapy of self-treatment by abstaining from eating certain foods like red meat, once she realized she was HIV positive, in the belief that this would help. She continues with her dietary restrictions and does not eat red meat and shellfish and believes this also helped her get better. This is inline with a study conducted in Chiang Mai and Rayong Provinces showing that many PLHA firmly believe that dietary supplements and other traditional therapies have helped them in dealing with the symptoms of HIV (Knodel & Im-em, 2004)

3.3.3 Changes in household structure and composition

The family structure and composition changed for all the cases. The main similarity was that they all moved back in with family, mostly with elderly parents or siblings. Research has started focusing on effects of HIV/AIDS on the elderly as they take back their adult children and provide social and economic support to them and their families (Knodel, VanLandingham, Saengtienchai, & Im-em, 2001). In the cases of all the informants, the parents, siblings or greater extended family were heavily involved initially when the disease was diagnosed and they all still heavily depended on family ties for assistance. Over time most of them have grown healthier by using ARVs and taking care of themselves and now it is their turn to return the favor. Interviewee 1 above has been living with HIV for sixteen years and received her parents support when she first became ill, but now she has the responsibility to care for them as they age. During my interview with Interviewee 4, another member of *Pakwan Ruam Jai,* reports her aged mother, who is now sick completely, depends on her. Interviewee 4 holds a part time job as a housekeeper at a tuition institute nearby, and her employer is kind enough to let her

go home to take care of her mother in the middle of the day when they are not busy or when there are emergencies.

Demographics in Thailand show that the elderly population will exceed 20% by 2023 and that the old will face financial insecurity from inadequate pension, as many of those employed in the informal sector are not insured (Suwanrada, 2009). Most of the research in Thailand points towards the burden on parents from adult children living with HIV/AIDS, (Knodel & Im-em, 2004; Rotheram-Borus, Stein, Jiraphongsa, Khumtong, Lee, & Li, 2009). All those interviewed had parents over the age of 60 and were also equally dependent on their children for financial support, showing a cyclical trend for those who have survived with the virus for many years. The studies mentioned above have highlighted the need to focus on elderly parents who have children dependent on them. Though not a focus for this thesis and the results might not be generalizable, it might be of use to look at the cyclical trend of adult children living with HIV/AIDS who are asymptomatic and taking care of older parents who took care of them at the onset of the disease.

3.3.4 Stigma and discrimination

For most of the respondents, over the years the disease has come to be considered like any other disease. People have a better understanding of the disease now (Project Manager, Sangha Metta, Chiang Mai) as many of the barriers and challenges experienced in the beginning have since been addressed. The major issue for HIV affected households now however is the issue of stigma. Though addressed via numerous information and education campaigns from the government and NGO's, there is still residual stigmatization and even more so self-stigmatization.

"Local people are aware of HIV as such but have varying level of knowledge on this and beliefs concerning transmission. Some people believe that people bring on HIV

themselves through their behaviour – also connected to a karma thing. Personally I feel that the general population would have limited knowledge on policies and programmes to support PLHA. Their knowledge may come from media of through the local clinic. Health authorities implement national ART, PMTCT programmes and also support PDA's work" (Interview, Program officer PDA, 26th July 2011, Bangkok)

On issues of discrimination at the community level, though they have continually been addressed, some PLHA are yet to get to the threshold, where stigma and discrimination is not an issue anymore. In some instances the community extended stigmatization to family members of the PLHA:

'My 7-year-old son last week after school asked me, what is AIDS? He was singled out by a teacher because of markings on his body caused by chicken pox, this is not the first time this has happened'. (Interviewee 5, 34-year-old female)

Even when the stigma was not explicit, in anticipation to people's reactions and in order to protect them, isolation was sometimes used to deter stigmatization and reduce exposure:

"I separated my son from others [in the community] because I was worried that they would discriminate against my son. I would not let him play with other children, I was afraid for him. That everyone in the community would think that if the father and mother had HIV, then the child also has it. I tried to protect him". (Interviewee 1, 41 year old female)

Stigma and discrimination and the fear of it manifest itself in different ways. In the cases of Interviewee 1 and 3, chose to protect their children by isolating them. While this might have further deepened the isolation, asked if the situation is still the same with

regards to her son and her isolating him for fear of discrimination, Interviewee 1 responds:

"No, I don't separate him anymore. He is happy and has many friends now from school. He had his blood checked when he was two years old and he was negative, also when he was going to nursery school, he had to get a test" (Interviewee 1, 41 year old female)

This might be because provisioning of concise information and raising awareness was localized by involving and mobilizing local communities and the civil society to initialize there own activities to deal with the scourge in their neighborhoods. By reaching out to people and families thought to be low risk, there was more awareness on what HIV/AIDS was and what it wasn't. Promotion on the television and radio from the government is considered to have helped immensely, as they recognized that HIV/AIDS is not only a health problem, but also a social and economic problem. By getting people together in groups like those of PPAT, members were able to overcome issues of stigma from members of the community.

Internalised stigma refers to the stigma felt by someone living with HIV as a response to stigma in the community. Stigmatized persons often accept some of the negative social judgments leveled against them and disqualify them from equal participation. Even when they are no longer treated unequally they are still unable to participate fully in social interactions:

"I go to community meetings but I do not eat or cook with them. They encourage me to join, but…" (trails off) (Interviewee 5, 34-year-old female)

"I am just careful with my life. I think the people they understand, it is better now… things have changed. Before I would not go to the temple to cook or work with the others, I felt that I should not and no one asked me to, but these days I can go if I want - though I still feel that I do not want to go. When I go, I prefer to clean the dishes and other things; I do not take part in cooking. But I can eat with other people in the community, we share food but I worry about it, I don't like to do it… when I make my handicrafts, they like them too" (Interviewee 1, 41 year old female,)

While both of them seem to understand and acknowledge that the perceptions of people against those with HIV/AIDS and them in particular have changed, they seem to experience a deep-seated level of self stigmatization.

Stigma seems to be experienced differently amongst the genders interviewed:

" No, I am a man, I have not been faced with discrimination, I think it is different for men, we don't have behaviors that women have, we don't have to be in groups, cooking together and do women things, or make things at the temple during festivals as they do," (Interviewee 2, 41-year-old male)

The above revelation that he had not experienced discrimination at the same level as the women suggests that the roles of women, such as cooking, working communally at the temple and the *'behaviors that women have'* make them more vulnerable to discrimination than men. This might suggest a feminization of stigma due to the nature of the roles adopted. Women are more prone to gossip and might adopt 'cutting out behavior' where women who are perceived to be HIV positive are cut out from activities they would usually undertake with other women in the community.

3.4 Household Shocks

The previous section of this chapter presented the socio-economic challenges that affect households affected by HIV/AIDS. This section discusses the shocks experienced, measures vulnerability by these households, and how risk perception shapes the risk management strategies that they adopt.

A shock is an exogenous event impacting households and often difficult to predict. The shocks are divided into collective shocks (also known as covariant shocks) and individual shocks (also known as idiosyncratic[34] shocks) that affect only a household. Households were asked if they experienced any unusual shocks that affected the economic status of the household over the past 12 months, leaving them better off or worse.

Collective Shocks

Amongst the collective shocks the most mentioned was the general increase in consumer goods especially food prices with one respondent saying:

" It has become so bad now, everything has become expensive before two eggs cost 5 THB but now one egg costs 5 THB. Before you could buy one litre of sticky rice at 15 THB and now it is 27 THB; almost double in one year!" (Interviewee 3, 55-year-old woman)

Other respondents (Interviewee 2; Interviewee 4; Interviewee 5) reiterated that other food prices had increased, for instance pork. Price shocks especially for basic goods have adverse effects on the household budget, as most low-income households use a large portion of their household income on food purchases.

[34] The effects of HIV can be considered covariant or idiosyncratic depending on if it affects an individual or many households in a community such that effects can be felt across the board (Jutting, 2005)

Individual shocks

Individual households shocks varied, but were concerned primarily with income stability, their health concerns or that of others in their household:

"My husband's income [electrical wiring wage laborer] is not stable, sometimes a job is seven days and sometimes it is twelve days in a month. Working is not possible for me anymore. My eyesight is failing me so I stay home" (Interviewee 3, 55 year old woman)

"I have only had this job [housekeeper at a nearby local school] for a month now, but I cannot work full time. My mother is bedridden and I have to take care of her. I have to come home every chance I get to make sure she is okay" (Interviewee 4, 45 year old woman)

"It is not easy these days, my brother gets sick nowadays, I have to help with the farm much more than I did before. My parents are old now so they cannot do work in the farm anymore though they help me in making the handicrafts when we get a contract" (Interviewee 1, 41 year old woman)

" I sit here all day and have to depend completely on my two brothers and their wives. I have no way to make money. I cannot see. I cannot even participate in the group anymore and depend on what I get from the government" (Interviewee 6, 47 year old man)

Before contracting HIV most professed to have had better quality of life by virtue of holding a regular job, whereas only one man chose the option "the same" before and after contracting the HIV virus.

"Life was better before. I had a job as a housekeeper with one of the former king's descendants. They are the elite in Chiang Mai and it paid well…"(Interviewee 3, 55 year old woman)

"I had a job in the factory, the pay was okay and I did not have responsibilities, but I quit when I realized I had contracted HIV" (Interviewee 1, 41 year old woman)

3.5 Household Vulnerability Mapping

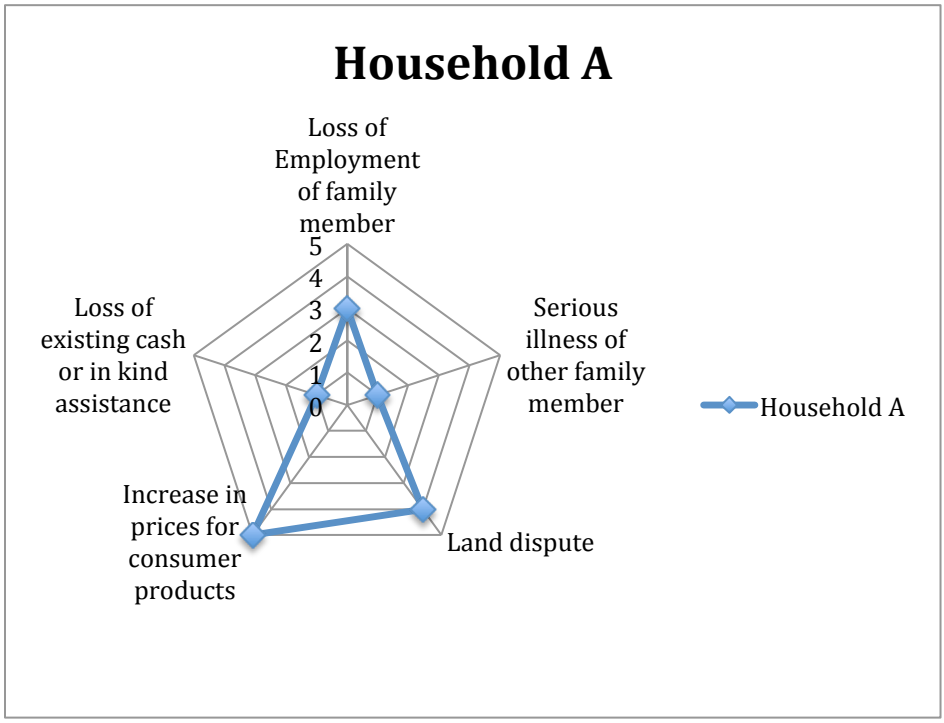
"A household can be vulnerable to future loss of welfare below socially accepted norms caused by risky events. The degree of vulnerability depends on the characteristics of the risk and the household's ability to respond to risk. Ability to respond to risk depends on household characteristics – notably their asset-base……Vulnerability also depends on the time horizon - a household may be vulnerable to risks over the next month [or] year. (Siegel, Alwang , & Canagaraj, 2001)*"*

I have used the above definition offered by Siegel et al (2001), conjoining a futuristic outlook of risk and time. It is also primarily a function of household asset endowment. The poor and near poor face greater exposure to livelihood threats and are more susceptible to shocks because their asset holdings are lower.

After identifying the individual and collective household shocks affecting households, this idea was expanded to include other anticipated risks. Anticipated individual risks were mapped using weights from 1 to 5 with 5 being the highest probability of these risks occurring in the next 12 months. 14 risk parameters were

identified from secondary data and previous interviews and these were mapped on a Likert scale to capture the intensity of the various anticipated risks should they happen.

Figure 3.2 - Household Vulnerability Map – Household A

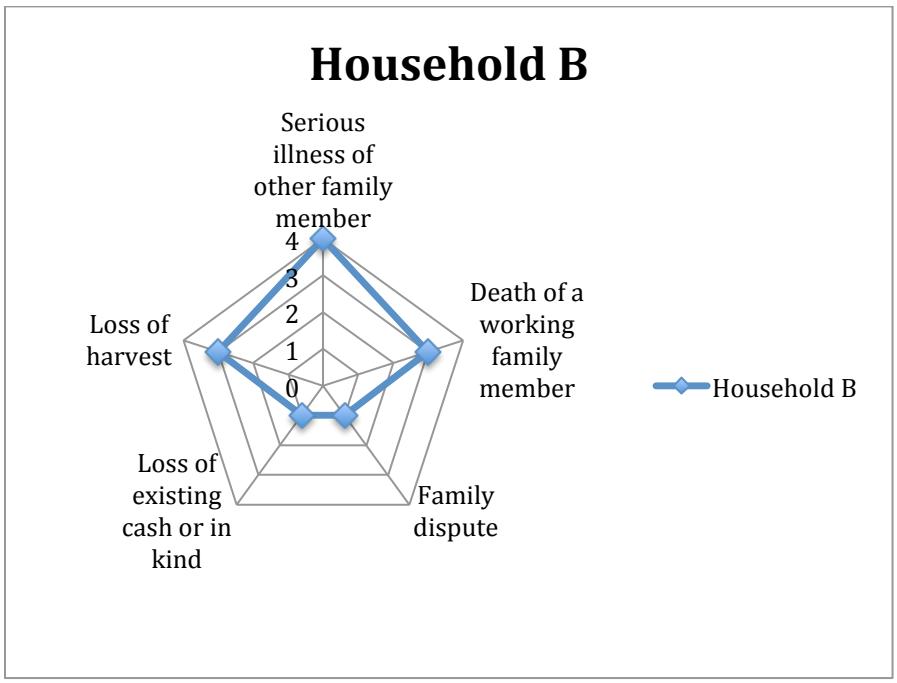


Profile Household A – Interviewee 3

This is a nuclear household (3 members) and unlike most of the other households, it consists of a father, mother both in their mid fifties and a thirty four years old son. The son works as a driver and is hardly ever home and sends remittances when he can. The wife does not work as her eyesight is failing and the husband is the main income earner of the household, who works as a wage labourer. The house is indebted and is struggling to pay off a THB 20,000 loan. Loss of employment of a family member is given a weight of 3, relatively high as the husband is an electrical wage labourer who averages at least

12 working days a month. A family member being seriously sick is given an unseemly low weight as both are HIV positive and the wife (interviewee 3) has failing eyesight. This could be because they have lived with the disease for four years only unlike the others in the group and hope to continue having good health with continued access of ART and other medical services. A land dispute is given a weight of 4 as it is already in existence. The dispute is centered on the fact that the respondents' house had no road access and they have to pass through their neighbor's property to access their house and this caused the dispute, especially the use of motorcycle through the property. Whereas this might not have any impact now, there is a probability that if this is not sorted out, the issue might escalate causing the household some economic stress. Increase in consumer prices is given the highest weight in line with increase in prices for basic consumer goods. The final parameter loss of existing cash or in kind assistance was also weighted 1, showing the trust that households have in the current in kind and cash assistance - for instance the couple anticipating that the son will keep sending remittances.

Figure 3.3 - Household Vulnerability Map – Household B



Profile Household B – Interviewee 1

This 5-member household consists of both parents (Age 64 and 70), their daughter aged 41 who is living with HIV, her 16 year old son and an ailing older brother. This same household is highly leveraged, they hold three loans from different sources and the loss of any one member of the family could mean that the household might resort to negative coping mechanisms if they were to loose an income earning member. Serious illness of a family member and loss of a family member are weighted at 4 and 3 respectively which gives an impression of what the household is currently experiencing and their expectation that the situation might worsen in the future. Family dispute and loss of cash or in kind assistance does not rank very high both given a weight of 1 whereas the loss of harvest is ranked higher weighted 3, this is a farming household and have a small rice farm and a backyard garden where they grow herbs for sale.

While it may not be possible to examine and compare the household vulnerability index parameter for parameter, as mentioned before, fourteen parameters were identified from secondary research - and households choose the most likely risk that might occur in their households. The risks identified vary and bear a close similarity to the current state of the household. From the above-identified risks one can infer that the anticipated risks of these two are similar, but the expected intensity of the shock is different. Also, households place different weights on the different vulnerabilities that are anticipated. In household A, one shock identified before (land dispute), was given a weight of 4, meaning that the situation already causing some problems might deteriorate even further with economic ramifications. Also, serious health issues are ranked at 4 in household B whereas in household A it ranks rather low with a weight of 1.

While the households were able to identify which vulnerabilities may be experienced in the future and provide tentative weights on the effects, risk management strategies were not actively sought, but there was belief that things would figure themselves out. It showed heavy dependence on existing networks, which they assumed would be available if the vulnerability came to pass. The lack of stable income is another factor, which will be discussed in the next section.

3.6 Access and Need for Financial Services

3.6.1 Household income

While all the households interviewed technically did not live below the poverty line, with incomes ranging from THB 3,000 to THB 8,000 per month, their income fluctuates depending on the various income streams that are utilized. These are mostly derived from business, formal employment, wage labor and the sale of handicrafts at fairs and the temple through the groups. This is combined for some of the households with

volunteering at the local health station especially for the women, where they receive a monthly stipend. All households receive THB 500[35], which is given to the HIV positive person once they have disclosed and 'proved' their status to local government offices via relevant doctor's paperwork.

Agricultural livelihoods were practiced by some of the households, but the person who was HIV positive in the household was a secondary contributor to this livelihood, especially in rice farming, which is considered labor intensive.

"I get some money making handicrafts with the group. I also get some money from the temple where I volunteer and we also sell 'kwang"[36]and help my brother with the rice farm, but it is not enough." (Interviewee 1, 41 year old HIV positive woman)

For instance even with all these streams of income, the household above makes at most THB 5000 a month for a household of five. With the highest expenditure going to food, access to medical services is not a major expenditure as Thailand provides comprehensive access to healthcare for those with HIV/AIDS[37]. Interviewee 1 is able to receive ARVs for free from the local public health clinic and PPAT.

All the respondents' highest level of education is primary school, except for one who attended secondary school. Coupled with HIV, this limits the income generating activities they can engage in.

[35] Social protection mechanisms supported by the state were discussed in Chapter 3
[36] They also rear fight beetles that are used in insect fights. Insect fighting using the Thai horned sugarcane beetle also known locally as '*kwang'* is popular in Chiang Mai with spectators placing bets for fights
[37] Social mechanisms discussed in the previous chapter

3.6.2 Household Assets

All the households interviewed held assets in the form of land, housing and durable goods (household furniture and electronics, motorcycles). The land holdings are in form of residential real estate, which accounts for most of the household asset base and serves as a store value as it provides shelter to the household.

3.6.3 Household Savings

Two households held savings accounts in a formal commercial bank:

" I put in little by little for me and my wife in Krung Sri Bank for when we can not work anymore. I may become disabled from this disease. The balance is high and I only get 2.5% interest per year, but it is stable" (Interviewee 2, 41-year-old male)

" When my husband died his parents sold his piece of land and gave me the money for my sons education. This I keep in the bank and do not touch except to top up his current school fees" (Interviewee 1, 41 year old HIV positive woman)

There was a marked lack of interest in using formal banks for savings, indicating that they would rather save in other places like their houses for ease of convenience. Savings were done for a certain purpose as seen above[38].

[38] See a more quotes on the need for financial services under formal vs informal financial services and linked to perceived risk

3.6.4 Household Debt

Households access credit from multiple sources, most of them informal, such as the million baht village fund, district cooperatives, SFIs[39], trader credit, community-based groups and loans from other family members. The level of household debt varies per household:

"I have a loan from the group[40], sometimes from the local government when I don't have enough. My brother is sick too and cannot work much in the garden, but we survive, my son has a loan from the Thai government for school fees, this helps us a bit…. But he has to pay it back when he finishes school…My brother also has a loan from the village fund and another one from the district cooperative through my father". (Interviewee 1, 41 year old HIV positive woman)

Interviewee 1's household is excessively indebted with income pegged at most THB 5000 per month from all income streams. While it is not easy to create a household balance sheet[41] from the information that is garnered from the interviews, it is not difficult to see that servicing multiple loans has an adverse effect on the household. Further the household is highly illiquid; the only savings held by the household are to be utilized for school fees in coming years for her son and other assets held in form of land.

Some households utilize existing networks to borrow in case of shortfalls or need for investment:

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[39] One respondent used her father's account to access credit as he was able to provide collateral in the form of land holdings

[40] As a member of Huay Sai Ruam Jai group she is eligible to access credit from their one baht-one-day scheme and she has some savings within the group. The one baht daily savings group idea was first established in Namkhao sub-district, Songkhla Province under the leadership of former school teacher, Mr. Chob Yodkaew in 2004

[41] The household balance sheet consists of two sides - the liabilities and assets. The balance sheet only considers stocks and not flows as stocks are more relevant in gauging the financial health of the household

“ I borrow from the group when I have problems it is cheap, I can borrow up to THB 1,000 and pay it back at an interest of 1% per month, if this is not enough then I can use my fathers account, he has an account at BAAC” (Interviewee 5, 34 year old HIV positive female)

Most households are able to access loans from informal networks and the government led village funds and make repayments, though others are struggling to make payments:

“I took a loan from the one million village fund of THB 20,000 in 2007, I then got sick and only paid back half of it, I was supposed to pay back THB 1,000 per month but they allowed me to pay back slowly, whatever I can get, because I became sick. I hope I will be able to finish paying it soon”. (Interviewee 3, 55 year old HIV positive female)

Difficulty in paying back loans is a strain on households, meaning that income flows are not able cover existing debt, the above respondent is unable to work as she has been weakened by disease, whereas the husband is a wage laborer.

3.6.5 Need Formal vs. Informal Financial Services

There was a marked lack of interest in accessing formal financial services among all the respondents. This falls into two categories, voluntary or involuntary exclusion - and though it might not be as simplistic as this, it enables this study to segregate the two aspects of access. Voluntary exclusion occurs when one professes no need for financial services, or a lack of awareness of the same, or assumed rejection due to price or income constrains. Involuntary exclusion occurs when one is rejected for bad credit history, even if one has access and those excluded because of different forms of discrimination.

Due to the marked lack of utilization of financial services in all the cases, a control question was included in the second round of interviews asking whether respondents accessed financial services through other family members as households were used as the units of response for these case studies. It revealed that one of the cases accessed financial services through other family members one accessed credit from the father's account via the BAAC bank.

Furthermore interviewees were asked if formal institutions provided financial services, like those provided by the groups (for example funeral insurance, education loans etc.) at affordable prices if they would be interested, the responses were similar, one respondent laughed quite hard at this questions and said

" I am very scared [of banks] what if I lost my job, how would I be able to pay them back?" (Interviewee 4, 45 year old woman)

Other reasons given for non-utilization were

"I have other places to borrow; for the bank I would need land, a business or stable income, I don't have any of them" (Interviewee 1,41 year old woman)

" I am not interested in bank services, how would I get there…how would I pay?" (Interviewee 6, 47 year old man)

There was a common string amongst all the discussions; banks are linked to credit and credit to collateral. This could be because of informational asymmetries where they do not know what products available in the market - or it could be the same reason shared by PDA members in the PPP groups that they were simply afraid that it might entail a long complicated process to access a loan and the expense of opening a bank account.

3.7 Financial Access Through a Perceived Risk Lens

Risk pervades everyday life, whether in the form of the weather, commodity prices, income fluctuations or illness. Risk has always been part of humanity. Even more so for low-income households that are affected by HIV/AIDS, which are vulnerable to fall into poverty traps. Accumulation of tangible assets like land, labor and capital helps generate returns and provide security. Besides its assets portfolio, rural households' perceptions and attitudes towards risk influence risk management strategies. From the theoretical framework, the use of perceived risk is drawn from Cunningham's (1967) dimensions of risk outlined as performance, financial, time, social and psychological risks with an additional dimension of privacy risk (Featherman & Pavlou, 2003). Framing risk at this section enables to introduce the concept of perceived risk to access of financial services. Access is viewed through the lens of the perceived risk dimensions mentioned above.

Table 3.1 - Financial services through a perceived risk lens

Perceived Risk dimension	**Description/ Reaction**
1. Performance risk	*" I put in little by little for me and my wife in Krung Sri Bank for when we can not work anymore. I may become disabled from this disease. The balance is high and I only get 2.5% interest per year, but it is stable" (Interviewee 2, 41-year-old male)*
2. Financial risk	*" I am not interested in bank services, how would I get there…how would I pay?" (Interviewee 6, 47 year old man)*

	" I am very scared [of banks] what if I lost my job, how would I be able to pay them back?" (Interviewee 4, 45 year old woman)
3. Psychological risk	*"I took a loan from the one million village fund of THB 20,000 in 2007, I then got sick and only paid back half of it, I was supposed to pay back THB 1,000 per month but they allowed me to pay back slowly, whatever I can get, because I became sick. I hope I will be able to finish paying it soon". (Interviewee 3, 55 year old HIV positive female)* *"I have other places to borrow; for the bank I would need land, a business or stable income, I don't have any of them" (Interviewee 1,41 year old woman)*
4. Social risk	*"I don't worry so much about such things, if my family can help, then they will help me if not them I have other people to turn to " (Interviewee 1,41 year old woman)* *" I borrow from the group when I have problems it is cheap, I can borrow up to THB1,000 and pay it back at an interest of 1% per month…." (Interviewee 5, 34 year old HIV positive female)*
5. Privacy risk	" *Uptake of formal services might not be that high – people may not want to take out loans as it is too formal and risky and also there is the issue of stigma and disclosure. More products I think would be needed that are tailored at the community level especially savings schemes" (Interview, Program Officer, PDA, 10th August, 2011)*

Looking at access to risk through the lens of these dimensions, it is clear that all the dimensions of risk come into play for the respondents at one time or the other in their desire to access formal financial services. The first dimension shows the respondent feels that the product fails to deliver, as the returns on savings are quite minimal, but stays because of the stability of the service. The second dimension is concerned with financial risk, and from the quotes above it is clear that respondents feel that the monetary outlay associated with the purchase price of the service and the cost of maintaining the service is too high for them. Psychological risks are linked to the stress of repayment and non-payment of loans, as one of the respondents is struggling to pay back her loan and this has a negative effect on her peace of mind. Psychological risks can also come from the fact that existing risks might cause the household to default on payment in the future, for instance in the previous section where we ranked vulnerability, household B is highly leveraged and the main income earner is ailing, this could also cause significant frustration.

Peers are important and are the first level safety net that is used by respondents to consumption gaps, conversely default on payment could lead to a potential loss of status in ones social group. Furthermore, low-income households affected by HIV/AIDS have a harder time accessing financial even from informal channels, as more often than not people have the tendency to shun those assumed to be sick out of fear that they may die or be unable to repay on time, leaving them with the liability of loan repayment by becoming a guarantor of their loan. Disclosure of personal information for instance HIV status inhibits adoption of formal financial services for affected households.

3.8 Linking Informal Financial Services and Kinship networks

There is a high dependency on the family for support. As mentioned earlier, all households except one were part of a larger extended family. Extended families are important just about everywhere, but especially for indigent households. Autonomy is not a likely option for a household struggling to make ends meet and affected by HIV/AIDS. From the study, it is also clear that households don't only pool risk but also labor especially those with agricultural livelihoods. Proximity is also a major determinant of such links (Fafchamps & Gubert, 2007) and all respondents live with or in the proximity of extended family.

The first level of safety nets were clearly at household level, for instance one family had an adult son working in a different province who, when the family experiences income strains, sends remittances. The extended family, neighbors and groups follow and transfer from networks of mutual support help to smooth consumption gaps. Strong social capital networks and belief that they can fall back on existing networks in the future as a risk management strategy seem to be rooted in most of the respondents. Demonstrated by a response from one of the interviewees when asked about risk management strategies put in place for the vulnerabilities identified

"I don't worry so much about money and other issues, if my family can help, then they will help me, if they cannot them I have other people to turn to " (Interviewee 1,41 year old woman)

Further, the informal groups are preferred in terms of credit access as nearly all households have accessed a loan at one time or the other from community based groups or any one of the many government interventions (the million village fund, SML amongst others). One notable thing is that all these loans need to be guaranteed by at least two people within the group. Asked if it was difficult to find guarantors, all who had accessed

loans from the groups said it was not difficult. Borrowing seems to be a commonly used coping mechanism to smoothen consumption but only utilized in instances where the households feel that they had the required flexibility and a certain benevolence in terms of payment; community based groups are attractive in that they have a personal relationship with the loanee facilitating reschedules and moratorium in times of stress. Perceived risk in all dimensions was quite low for the adoption of informal services thus making it the most accessed.

Lack of trust of financial institutions and lack of funds appears to be the major reasons why some the interviewees do not have bank accounts. Lack of funds for most respondents meant that the minimum amounts for opening an account or maintaining the account was too high for them. Another bearing to lacking funds is that the cost of operating the account is too high for some respondents. This coupled with the demanding processes of opening an account kept other respondents without an account and from interacting with financial institutions.

3.9 Institutional view on need and uptake for financial services

There were varying ideas on the need for formal financial services targeting HIV/AIDS infected households.

"The impacts of HIV are physical, emotional economic, social and developmental. All these impacts are integrated and should be addressed equally, as it is better to look at the quality of life" (Interview, Project Manager, Sangha Metta, 6th August 2011)

"There is a need for specifically designed products because this will encourage HIV positive families to save safely because then they could use the money for income generation" (Interview, Program Coordinator, PPAT, 19th July 2011)

" Uptake of formal services might not be that high – people may not want to take out loans as it is too formal and risky and also there is the issue of stigma and disclosure. More products I think would be needed that are tailored at the community level, especially savings schemes" (Interview, Program Officer, PDA, 10th August, 2011)

"They don't only need the access to loans and savings, market access is important and we do away with the middleman making sure that our members get the right value for their products" (Interview, Resource Mobilization Officer, TNAF, 9th June, 2011)

The outlook on the need for financial services is closely to each organizations mandate, for instance, Sangha Metta is more focused on the quality of life in line with Buddhist teachings whereas TNAF concentrates on providing market access alluding it is just as important as financial access.

3.10 Summary of Chapter and Conclusions

Some the key informants interviewed view the current HIV/AIDS situation as not serious in comparison to ten years ago, whereas others felt that there was varied recognition of HIV as an issue:

"Local people are aware of HIV as such but have varying level of knowledge on this and beliefs concerning transmission. Some people believe that people bring on HIV themselves through their behaviour – also connected to a karma thing. Personally I feel that the general population would have limited knowledge on policies and programmes to support PLHA. Their knowledge may come from media or through the local clinic.

Health authorities implement national ART, PMTCT programmes and also support PDA's work" (Interview, Program officer PDA, 26th July 2011, Bangkok)

Respondents also inferred that there has been a change especially in issues like stigmatization, which has lessened over the years due to concerted efforts by government, civil society and health organizations working in the field of HIV and AIDS. That said, there is still residual internal stigmatization that is experienced by some of the respondents, even if this does not curtail them from undertaking social activities. Some of the respondents quit willingly from their jobs willing to expose themselves to income vulnerabilities rather than reveal their positive status. All the respondents lived with their elderly parents who took part in their care when they were diagnosed. The situation remains the same with a nuanced change, whereby the asymptomatic children take care of their parents as they age.

The fourth section of chapter 3 discussed the shocks experienced by households both at household level and community level. The main shock at household level was the increase in food prices and income variability. The household vulnerabilities for two households were mapped through identifying 14 stressors and measuring their effect on a likert scale if it occurred, there were similarities though the weight given to each stressor was different as it related to the current state of the household.

Household income ranged from THB 3,000 – 8,000. Most of the households had no stable income and were mostly dependent on wage labour and farming. Most of the households had little or no savings. The savings for some were held in savings accounts in formal commercial whereas others held their savings at informal community groups. Household wealth, or net worth, defined as total assets minus total debt, is held as assets in the form of land and other movable assets, but some were also highly leveraged.

There was a preference for informal and semi-formal financial services over formal services. This was viewed through a perceived risk lens and quotes made by the respondents were studied alongside the dimensions of risk. Perceived risk over several dimensions emerged as a great determinant in accessing formal credit. There is continued positive support from the community groups in terms of access to informal financial services, which indicates that they continue to be esteemed.

CHAPTER IV

FINANCIAL SERVICES INTERVENTIONS AVAILABLE FOR HIV/AIDS AFFECTED HOUSEHOLDS IN CHIANG MAI

4.1 Introduction

Households can react to, or manage, risks in several ways. To respond to the risks and vulnerabilities, in this chapter discussions will center on what economic empowerment and financial services are available to ensure that households do not resort to negative coping strategies. In Thailand the most commonly used level of formality - there are formal, semi-formal and informal levels - depends on the access to these instruments. Livelihood strategies differ according to whether people have to deal with gradual changes or sudden shocks. In line with this, this chapter will give a snapshot of what is available by level of formality[42]. This chapter will also look at government social protection interventions and other large scale interventions that ensure households do not engage in negative coping strategies.

4.2 Formal Financial Institutions

These include bank and non-bank institutions that operate under prudential regulations - including commercial banks and special financial institutions (SFIs). In Thailand, banks have long been the major providers of funds for households and business enterprises (Anuchitworawong, 2007; Setboonsarng, 2010).

[42] See Literature Review page 33 and 34

As discussed before, at least 9.61% of the population did not have access to financial services, with lower income households relying mainly on government SFIs like BAAC and the Government Savings Bank and informal groups. Commercial banks have also begun targeting small and micro business (SMEs) through its retail banking operations. For example, Siam Commercial Bank introduced *'Speedy Cash'* and *'Speedy Loan'* for personal banking and the '*Chao Sua Noi Project'* or '*Little Tycoon Loan'* for SMEs. Kasikorn Bank launched 'K-Express Cash' for 'K-Personal Credit and the 'K-SME' program offering loans that are customized to fit each client's purpose and providing professional training for new entrepreneurs through its care center (Setboonsarng, 2010).

Thailand has a segmented finance market that has generally been successful at channeling funds to the rural poor (Ariyapruchya, Wilatluk, & Chutchotithamy, 2007; Setboonsarng, 2010). As discussed before, in comparison to other developing economies, Thailand's private microfinance industry is small, as it does not have the correct regulatory or legal environment to attract private investors or NGOs. The few NGOs that do exist target small and specific groups of people, such as those living in urban slums [or those with HIV/AIDS] (Setboonsarng 2010).

Typically when financial markets function well there is no need for government intervention, however there are several imperfections in the market. Lenders are typically reluctant to lend to loan applicants whose quality of collateral cannot be verified. In Thailand as elsewhere in the world, collateral is used by lenders offset their risk exposure to risky borrowers. To correct the imperfections, the Thai government has over the last 10 years initiated a number of schemes relating to welfare and access to financial services discussed later in this chapter.

4.3 Semi-Formal Institutions

Semi-formal institutions operate under non-prudential regulations, this means that member-based institutions can capture savings and investments within communities. These include agricultural cooperatives, registered savings for production groups and village and urban revolving funds.

4.3.1 Village Fund Program

The Village Fund Program is a microcredit project of the government of Thailand, which was created in 2001 when the government agreed to provide one million baht (approximately 22,500 US dollars) to every village (77,000) and urban community in the country as working capital for a locally run rotating credit organization. The total initial injection of capital into the economy involved about 75 billion baht, which is approximately 1.8 billion US dollars or 1.5 percent of Thailand GDP. Because of its scale, the Village Fund program is considered one of the most ambitious interventions in microcredit in the world. (Huerta, 2010).

The program is described as one of the government strategies to fight poverty for sustainable development. The objectives are: to develop the ability of communities to manage funds; encourage awareness and self-reliance for communities; benefit low-income families by providing start up capital for income generating activities; and stimulate the economic performance in the region. The program was mainly a credit intervention without other services like training or social services tied into the program. Townsend & Kaboski, (2011) saw a fractional increase in savings accounts averaging about THB 14,000. The respondents were also members of the village fund program. with one respondent experiencing challenges to pay back the principle.

4.3.2 Small Medium Large (SML) Program

This scheme was introduced by the Abhisist government with the aim of developing the potential of 'small, medium and large' villages in order to encourage villagers to take part in solving community problems in response to local needs. The money is provided in form of loans to members of the community[43]. The money is administered through groups, and the groups work closely with the staff from the local government, who provide advice and market access to the goods produced by the group by helping them showcase their activities during fairs organized by the local government. Individuals are also eligible and can access a limit of 20,000 baht per annum with an interest rate of 6% per annum payable in monthly installments (Interview, Local Government Official, Baan Huay Sai, 13th July 2011). Ruam Jai group in Baan Huay Sai are able to access SML funds through the local government staff.

4.4 Informal and Member based groups

These groups provide informal, independent and self-help savings. Village banks and credit groups - community and member-based organizations - are often supported by external entities including nongovernment organizations (NGOs) or local government agencies.

[43] For more information: http://thailand.prd.go.th/view_inside.php?id=3267

4.4.1 NGOs Implementing Financial and Economic Empowerment Interventions in Chiang Mai

Most NGOs in Thailand are operating either as foundations or associations, because existing laws are quite restrictive when applied to the provision of financial services. Therefore, most organizations might not publicly admit that they have microfinance projects, or they might only provide backup support both, in terms of finance (seed capital grants) and know-how (operation and management) without expecting any returns on funding (Setboonsarng, 2010). While involvement in the provision of financial and non-financial services is not a central mandate for the NGO's interviewed below, they have all been involved in the provision of these services because of the need to economically empower people living with HIV/AIDS tied in to their other mandates. Four NGOs working with households affected by HIV/AIDS in Chiang Mai were selected and interviewed to analyze innovative programs being implemented and the reach of these programs.

a) Planned Parenthood Association of Thailand

The Planned Parenthood Association of Thailand (PPAT) Northern region has been working in Thailand for more than 40 years and was involved in HIV/AIDS efforts right from the advent of the HIV epidemic in Thailand. HIV/AIDS became a central focus for PPAT within the emerging industrialization of Thailand in the 1990's with projects focusing on prevention activities for the community, especially health promotion in industrial factories, fisheries and prisons projects (Planned Parenthood Association of Thailand, 2010) The strategy gradually moved from an integrated approach which incorporated youth and gender to lending itself to a more community driven approach to

tackling HIV effects such as stigma through HIV clubs known as 'new aspirations'. (Interview PPAT, Program Coordinator, 19th July 2011, Chiang Mai).

Though PPAT is mainly a health-oriented organization, it has been involved in a number of projects that emphasize economic empowerment alongside health. "Capacity building for the HIV/AIDS Prevention and Care for People Living with AIDS and HIV Affected People in Chiang Mai Province" project sought to promote understanding among the targeted communities with regard to preventing HIV infection and providing care and support for AIDS patients in three districts in Chiang Mai Province (Mae Rim District –San Puag, Huay Sai sub districts, Mae Tang District- Som Pa Yang sub district, Hang Dong District- San Pug Whan, Baan Whan, Nong Tong sub districts). These groups are ongoing to date and formed the basis of the respondents in this study. This was done through providing information through mass media, designing a home visit and referral system, mobile clinics and promoting knowledge of HIV/AIDS in vulnerable areas like schools. For economic empowerment interventions tied in to the project, PPAT provided skills training, seed funding and providing exhibition outlets for the income generating activities by members. The main objective of these interventions is to reduce stigma and to a lesser extent improve livelihood security (Interview PPAT, Program Coordinator, 19th July 2011, Chiang Mai).

b) Population and Community Development Association (PDA) Positive Partnership Project (PPP)

PDA, the developer of PPP, is one of Thailand's largest and best-known nongovernmental organizations. Since it's founding in the early 1970s, it has

implemented numerous human development and social initiatives at the local level across the country in areas including family planning, water resource development and sanitation, environmental conservation and rural development (Population and Community Development Association, 2011).

The Positive Partnership Program (PPP), which provides loans to individuals affected with HIV, has two distinct yet complementary goals. The first is to enable people living with HIV empower themselves economically through the setting up of small and micro businesses, whereas the second goal is aimed at reducing stigma and discrimination. The project relies on a simple construct: business partnerships between one HIV-positive person and one HIV-negative person. The project has been implemented in three phases:

Phase 1*: Micro Credit Loans for People Living with and Affected by HIV/AIDS (2004-2007)*
Phase 2*: Economic Empowerment for People Living with and Affected by HIV and AIDS as a means of reducing stigma (2007)*
Phase 3*: Integrated HIV Prevention Services (2008-2010)*

The project was first supported by UNAIDS and subsequently by other donors, notably Pfizer. Using the existing community connections, PDA implemented the project with key activities being (1) Creation of PPP clubs, (2) Disbursement of Micro Credit Loans, (3) Provision of education through seminar/training/workshop, (4) Production of information, education, and communication (IEC) materials and public relations activities, (5) Establishment of village development banks (VDB), (6) Establishment of youth organizations and (7) Monitoring and evaluation. The target groups reached throughout the entire project were varied and included People Living with HIV/AIDS

(PLHIV), community members, public health officials, schools, youth, and workers (Interview, Program officer PDA, 26th July 2011, Bangkok).

By the end of the project in 2011, 844 persons (422 pairs) have benefited from the *Si-P* project disbursing loans of approximately THB 24,000 per pair every year (about USD 800 at the then exchange rate of THB 30 per USD), at an annual interest rate of 6%. During the project period over THB 10 million was disbursed. In 2006 repayment rates span from 91% in rural areas to a slightly lower level of between 78% and 85% for the urban areas. The project was implemented in eight provinces, including Buriram, Chiang Mai, Chiang Rai, Khon Kaen, Maha Sarakham, Nakhon Ratchasima, Phitsanulok and Surin.[44]

PDA contends that sustainability of the project depends on ongoing support from community leaders, local hospital and motivation of PPP member. Although the funding has ended, the project and the current revolving loan fund can be continued through the PPP club and the Village development banks (VDB)[45], as well as support from PDA staff. Sustainability challenges were identified by PDA in that although village development banks management has proved that it is a tool for strengthening community capacity, the lack of continued support, such as training courses or regular monitoring visits from project staff may lead to unsustainability (Program officer PDA, 10th August, 2011, Bangkok). PDA has through collaboration and advocacy tried to create forward linkages to commercial banks to accept loan applications from PLHA, but this has been met with mixed reactions from commercial banks and the loanees. Further, not many PLHA attempted to borrow from commercial banks as they felt that it might entail completion of a complicated process (Program officer PDA, 26th July 2011, Bangkok).

[44] Though this program was also implemented in Chiang Mai province, I was unable to get the numbers broken down by area and number of beneficiaries in the province
[45] Village development banks were developed by PDA

c) Thai National AIDS Foundation (TNAF)

TNAF was founded in 1999, established with the cooperation of people living with HIV/AIDS, non-governmental organizations, private sector businesses and governmental organizations. The foundation operates by coordinating the aforementioned sectors to raise funds to support operations in all regions in the country (Thai National AIDS Foundation, 2011).

Also called the Resource Mobilization Project, TNAF came up with projects that economically empower PLHA. In 2004, TNAF introduced the 'Products for life' program, which ran parallel with other HIV/AIDS prevention, care and support programs. The aim of the program was to support PLHA groups to earn an income by developing products that utilized local resources and skills. This program provides market access services for these groups by organizing the distribution chain and distributing the finished product at various events and venues - and also engaging the private sector to provide support to these products. TNAF works with five groups: three from Chiang Mai Province; one from Chiang Rai and another in Trang Province. Apart from generating income through these products, this is a channel that allows them to establish a solid relationship among other PLHA and the community at large further helping them regain their 'self-value' as they are able to take care of themselves and at the same time contribute to their communities and families. The programmatic attention to providing this market access service is a tool for HIV/AIDS stigma prevention as articulated below:

" The idea is to eliminate middlemen and provide logistical support; we also connect them to medium level and large businesses who buy these products from them for their CSR efforts" (Resource Mobilization Officer, 9th June 2011, Bangkok).

In 2009, TNAF introduced the "Coffee For Life" project, where PLHA groups and community organizations interested were selected and trained by the TNAF. A youth group in Chiang Rai called 'Baan Jittamet' produced the coffee beans. The income gained from selling the coffee beans and fresh ground coffee goes to an education fund for HIV/AIDS affected children. TNAF provides accessories in the form of machines and coffee stands, training and start up capital to the tune of THB 50,000. To date TNAF has started nine coffee projects in eight provinces (Bangkok, Ayuthaya, Chiang Mai (2), Chachoengsao, Khon Kaen, Kalasin, Mukdahan and Sakolnakhon). Also, as part of its effort, Standard Chartered Bank in 2009 invited the Thai National AIDS Foundation to open a coffee corner, selling coffee products in its office building in Bangkok. The proceeds go to fund HIV prevention activities and underprivileged children in the North of Thailand for their school expenses (Resource Mobilization Officer, 9th June 2011, Bangkok).

d) Sangha Metta Project

This project was started in 1996 in Chiang Mai funded by UNICEF, and involves monks in HIV/AIDS prevention and care. It is unique in that it was initiated by monks in response to the need for a more active role in HIV/AIDS prevention and care. Taking the Buddha's teaching as their inspiration, the monks concluded that a core aspect of HIV/AIDS was ignorance about the condition among both the sufferers and the general public. It has established a network of Buddhist monks in Thailand and South East Asia region, who are trained to work in their own communities, and from temples as educators and counselors, providing moral and spiritual support using Buddhist teachings.

Sangha Metta project was established to support communities and enable people living with HIV/AIDS to live normal, happy lives without fear and discrimination. They

also provided donations to the very poor and vocational skills training to help set up income generation activities. Training in line with Buddhist teachings was provided to monks to enable them to deal with the discrimination of PLHA in their communities. One such way was eating food prepared by PLHA to emphasize one could not get infected by sharing food (Interviews, Project Manager, Sangha Metta, 21st July and 6th August, 2011).

4.4.2 Informal Self Help Groups

Self-help grass roots savings groups in Thailand started in 1965 as a joint effort of community members and leaders – a response to the lack of access to formal financial services. HIV/AIDS support groups form the basis of the community-based welfare schemes. Though this group was initially started by PPAT; after the funding ended the community group continued its existence and strengthened its activities and linkages to other stakeholders

All respondents were members of a support group and all met monthly. In order to address the gaps in income and the formal social protection mechanisms, communities are using the support groups as a launch pad for community based welfare schemes.

A Case study of Huay Sai Ruam Jai Group – Baan Huay Sai, Mae Rim District

Ruam Jai group has been in existence for twelve years though their social welfare scheme was initiated only two years ago with assistance from an official at the local government office. The fund collects one baht per day from members[46]. All members pay one baht each day, though in practice members pay on a monthly basis during the

[46] The one baht daily savings group idea was first established in Namkhao sub-district, Songkhla Province under the leadership of former school teacher, Mr. Chob Yodkaew in 2004

monthly meetings. Other sources of income are income-generating activities - currently the group has a contract from a French company to produce Christmas ornaments using plastic drinking straws.

Table 4.1 - Welfare benefits Ruam Jai Group

Type	**Details**
Medical expenses subsidy	100 baht per night (limited to five nights per year)
Funeral expenses subsidy	- 3,000 baht to deceased family (from the one day one baht fund) - 500 baht from a project supported by PPAT
Access to savings	- One baht daily savings (individual savings accessible to members upon request)
Access to credit	- Members can access up to 5,000 baht - Repayment is done depending on income (monthly, annually) - Interest 10% p.a

The group works closely with the local government office with an officer attending meetings regularly and introducing new mechanisms and introduction to other linkages. The group consists of seven men and thirteen women. Members in the group are mainly PLHA, their families and a few community members. Ruam Jai group is one of

the better functioning groups with a range of activities and products for members. The groups were a common risk pooling strategy amongst all of the respondents – the funeral subsidy was especially mentioned - some members were members in two funeral expense groups, one in their PLHA groups and village groups. If families were considered as the first tier safety net strategy, the groups were a close second.

Community based groups are numerous in Thailand. By 2009, there were 13,453 registered cooperative institutions and self help groups, but despite the positive numbers these groups have limited services, inadequate liquidity and lack effective management systems. (Setboonsarng, 2010).

4.5 Government Social Protection Interventions

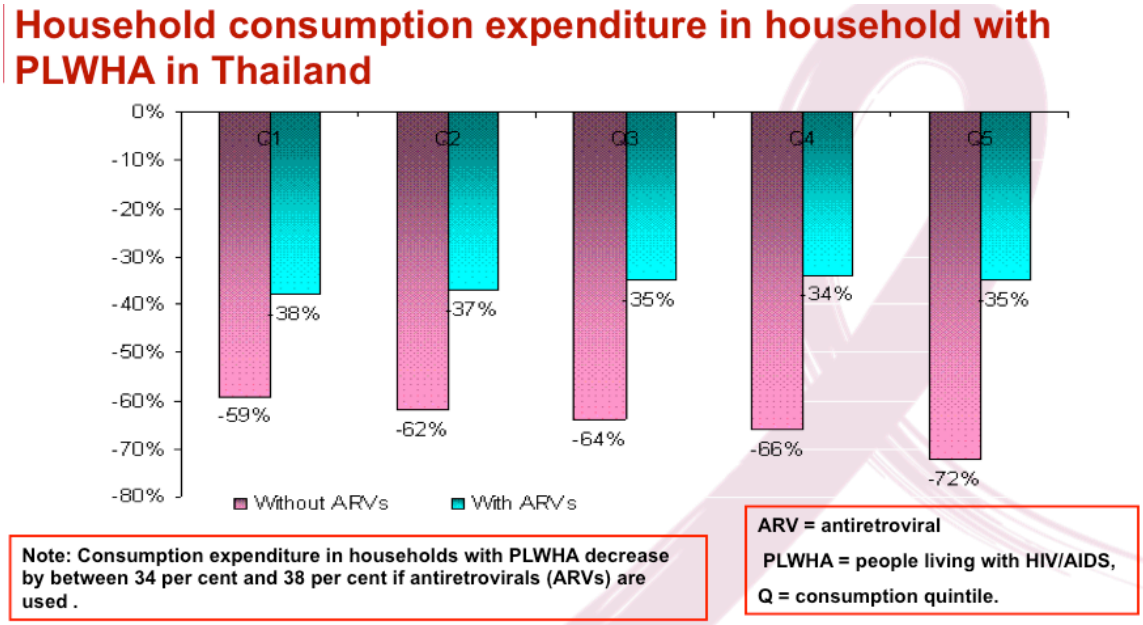
Given the limited capacity of poor households to sustain themselves through livelihood shocks and cycles, a strong case for social protection has emerged. Social protection mechanisms in Thailand took root after the Asian financial meltdown in the late 90's and with the introduction of populist policies by the Thaksin government. Some of the state programs utilized by the respondents are outlined below:

4.5.1 Universal Health Coverage Scheme

The Thaksin government in 2002 introduced the Universal Health Coverage Scheme (UHCS), popularly known as the 30 baht scheme. The 30 baht co-payment per doctor visit was later exempted in 2006 for outpatient visits and hospital admissions. The introduction of this scheme led to dramatic reduction in the prevalence of catastrophic healthcare expenditures, which is one of the reasons driving households affected by

HIV/AIDS into destitution. By the end of 2004, more than 80% of those living with AIDS were on public ART, a remarkable achievement. Since that year, the ART program has been able to raise peoples' CD4[47] cell levels until they are no longer suffering from AIDS, so that now the number of people on ART is more than double the number living with AIDS. In 2006, the Royal Thai Government announced a policy of providing universal access for ART through its health and social security funds (Over, et al., 2007).

Figure 4.1 - Household Consumption Expenditure in households with PLHA



Source: Martin G. (2006) Impact of HIV/AIDS on poverty in Cambodia, India, Thailand and Vietnam. ADB-UNAIDS Study Series, via aidsdatahub.com

Figure 4.1 above shows the difference in terms of consumption expenditure when households have access to free healthcare and ARVs versus when households have to

[47] CD4 cells are a type of white blood cell that fights infection. CD4 cells move throughout your body, helping to identify and destroy germs such as bacteria and viruses. Along with other tests, the CD4 count helps tell how strong your immune system is, indicates the stage of the HIV disease, guides treatment, and predicts how your disease may progress

spend a large part of their income on paying for healthcare arising from HIV/AIDS infection. For the poorest quintile one, there is a reduction of healthcare expenditure at 38%. The effect of access to healthcare is almost equal amongst households but is much more important for households in the first quintile as they would not be able to afford it without government help.[48] All the in-depth interviews carried out with households affected with HIV were members of the UHCS.

4.5.2 Income support

The state provides welfare assistance and a lifelong monthly allowance (THB 500 per person) to HIV/AIDS affected persons unable to earn their living, or whom other people in society have neglected. Registered disabled people who are poor, unemployed, and incapable of earning, are also entitled to a THB 500 monthly subsistence allowance. The allowance is also expected to enable people with disabilities to live with their families without needing care from the Department of Public Welfare (DPW) services. In 2000, there were 15 000 persons receiving the allowance contributing to a budget of THB 90 million. There is also an allowance for the elderly who are considered poor, abandoned by family or without relatives of THB 200-300 (Chunharas & Boonthamcharoen, 2003). The need to 'prove' your status to the local government offices in order to access the THB 500 subsistence allowance acts as a sieve thereby ensuring that only those who really need the allowance have access to it. It was indicated by one respondent that the wealthier individuals infected by HIV/AIDS are less likely to access welfare services or participate in group activities to ensure greater anonymity. Income support is used to supplement other sources of income except for one respondent who was wholly supported by his family due to a disability (Interviewee, 3 and 1)

Other channels of income support come from volunteer work done with the local

[48] Even for the bottom two quintiles, the US$842 or B33 680 cost of first-line therapy per year would be too expensive (Over, et al., 2007). Furthermore there are limitations to this scheme but that is beyond the scope of this thesis

government, churches amongst others. One respondent found a way of consolidating all the incomes from various avenues as in the case study below.

Case study income support *Interviewee no. 5

Interviewee number 5 is a housewife with primary level education. Her husband works as a construction worker and is the main income earner in the household. She has been living with HIV for 16 years. Her first husband infected her when she was 18 years old, and she has since remarried and has a seven-year-old son. At first sight her case looks quite ordinary but her ingenuity in making ends meet by utilizing existing mechanisms and opportunities makes her case unique. She calls herself a housewife with no income, but when the question on income was restructured it was clear that while she did not hold a conventional job by any standard she still managed to get by; by volunteering at the local hospital she makes 1,700 baht, she receives a 500 baht stipend from the local government welfare fund, volunteers at the public health station which gives her an allowance of 600 baht, she is also a member at the local church which entitles her to another 500 baht a month, she makes at least 3,300 baht per month by effectively utilizing whatever avenues and networks are available to her.

4.6 Summary of Chapter

Commercial banks have worked with PLHA as part of their corporate social responsibilities projects, but otherwise have fallen short of integrating products targeting PLHA. For instance, Standard Chartered adopting a coffee machine, but falling short of developing financial products for PLHA. Informational asymmetry is a major challenge because even with the new products introduced by various banks targeting low-income families, these families have no idea what is on offer in the market.

Informal member based NGOs are beset by various challenges i) it is difficult to assess reach and scope of the projects ii) The NGOs are not well versed in micro-credit issues except for PDA iii) impact assessments are usually qualitative and do not give hard figures to better assess the outcomes of the projects iv) sustainability is difficult to achieve - all the NGOs have built on existing semi-formal and informal mechanisms to ensure continuity v) though some of these programs are innovative, their reach is quite limited and dependent on donor funding. In the informal community based sector, lack of management skill can hamper growth and management funds.

All respondents received a monthly stipend of 500 baht from the local authority, but most admitted that it is more supplementary than an anticipated income stream that smoothens consumption. All the respondents continued to work (this ranges from a couple of hours a day to a few days a week), except one who has a disability caused by a HIV related opportunistic infection and is not entirely dependent on this stipend. The money is mostly used for consumption and is collected from the local government office. Access is easy as long as you 'prove' you are HIV positive. One respondent commented though that this might be a deterrent for people who were not ready to reveal their status, especially better off people who she felt had nothing to gain from revealing their status as they could afford to not receive the stipend and other perks.

CHAPTER V

DISCUSSION, CONCLUSIONS AND RECCOMENDATIONS

5.1 Discussions and Summary of Findings

This thesis set out to assess the need for formal financial services at household level, more specifically to answer the main question:

To examine the need for formal financial services to ensure households do not resort to negative coping strategies

To answer the main question, three secondary questions were formulated: First, what are the socio-economic impacts experienced by HIV/AIDS affected households at household level. Second, to identify how risk perception factors into access of formal financial services and third, what are the financial service interventions are available to HIV/AIDS affected households in Chiang Mai? This section begins by providing a summary of the findings for secondary questions in order to answer the main question.

5.2 Socio-economic impacts

"It is (HIV/AIDS) not the issue it was 25 years ago. Nowadays most people have a pretty good understanding about HIV and AIDS and it is just seen as an illness, most people don't think about it. They know of its existence and that it (symptoms) can be treated. Institutions, however, are more aware about the social issues, for instance

orphaned children, loss of work, perceived stigma and discrimination and work to prevent and solve those issues". (Project Manager, Sangha Metta, Chiang Mai)

The socio-economic impact of HIV/AIDS in the study area is somewhat less severe than when compared to other countries as described above, especially for poor and near poor households. Furthermore, access to ARV and proper diet also helps in alleviating physical symptoms of HIV/AIDS, which are less visibly manifested these days. A sense of belonging and emotional support is provided through the PPAT groups, which provide a forum to deal with the issues arising from being positive as well as receiving knowledge and information on HIV/AIDS. Most of the informants admitted there was a great change from the time that they contracted the virus to how people are perceived now, though some cases of internalized shame remain. These findings are being supported by a four country cross sectional study, which revealed that stigmatizing attitudes were not as prevalent in Thailand as in other countries and that people were more likely to express pity and sympathy to those affected - except those who continued to engage in risk behaviour (Maman, et al., 2009).

Household structures have also changed with most of those infected and affected moving back in with older parents. At the onset, the parents had to take care of their ill children, but more recently, as the parents get older and the 'old children' are still asymptomatic, there is a reversal in roles. The lengthening of life through ARV's and thus changing the structure of HIV/AIDS families, whereas ten years ago parents had to take care of their sick children, these asymptomatic children now take care of them as they age.

5.3 Shocks, Risk, and Vulnerability

Chapter 4 discussed the shocks experienced by households both at household level and community level. The main shock at household level was the increase in food prices. Commodity food prices in Thailand have been rising since mid-2010 (Sander &

Burgard , 2011) partly driven by oil as an input in agricultural production, use of some food crops as biofuels in the United States and on the supply side volatile weather patterns have led to more frequent shocks to commodity supply. Depending on how low income households earn their living, rising food prices can either reduce on increase vulnerability. For instance households that are engaged in farming livelihoods, the food commodity price increases could be a welcome income boost. On the other hand, wage laborers have to contend with the same income streams and the increased basic food prices. It is important to note that all households except one are dependent on wage labor as one of the income streams; one household is involved in farming of rice and herbs but this would only be an advantage for them of they sold more produce than they bought.

5.4 Income, assets, savings and debt

It is difficult to decipher a clear balance sheet for the households, as the income streams vary. Nearly all of the houses have little or no accumulated savings, which puts them in a riskier position. For instance if a household experienced a series of persistent economic shocks or one large one by loosing an income earning member of the family, this would have adverse effects on the households as they have few safety nets and the immediate ones are already stretched, especially with high indebtedness in some households.

Household wealth, or net worth, is defined as total assets minus total debt. This study finds that households might hold positive wealth by virtue of land holdings. Positive wealth implies that, should household liabilities being called in, households will remain solvent, as they hold sufficient assets to cover their liabilities. However, not all assets are liquid. First, movable assets like motorcycles and electronics, are subject to depreciation such that if these assets have to be liquidated they will most likely be sold at a loss. Further, assets such as real estate are sometimes difficult to facilitate sales and are

dependent on the market. As a result, households with positive wealth may be solvent but nevertheless illiquid.

5.5 Access to Financial Services and Perceived Risk

Informal and semi formal financial services were preferred over formal services; there was a marked lack of interest in accessing financial services. The quotes made by respondents regarding access to financial services were studied using a perceived risk lens and concludes that there is a high perceived risk on access to financial services on the performance, financial, psychological, social and privacy risks.

5.6 Access to financial Services and livelihood security

Increasingly HIV/AIDS is being recognized as more than just a health crisis, it poses numerous economic challenges for affected households. The pressures of caring for and treating PLHA and those affected by it can drive vulnerable non-poor families into destitution (Goss & Mitten, 2007)There has been growing popularity in integrating microfinance and HIV with the hopes that microfinance can play a role in addressing the vulnerabilities experienced by these households by providing financial services. Financial services for low-income households including loans, savings and insurance can help poor households mitigate the economics consequences for those affected by HIV/AIDS. For instance these services may be used to maintain an income stream, build a savings base, which may be liquidated to cover emergency expenses and to avoid selling productive assets such as land, which may have a devastating effect on future earning potential, and ability to manage future crisis. There is a recognized need for innovative structural approaches integrating economic/HIV programs (Dworkin & Blankenship, 2009). Easy access to credit from government funded welfare schemes

renders market based microfinance somewhat redundant for the respondents assessed. Few have formal personal bank accounts and these are just for savings with no access to other banking services.

5.7 Available risk management and financial interventions

All respondents have access to the government-funded interventions and easy access to the other informal and semi formal member based interventions at community level. The for profit interventions from commercial banks are mainly targeting entrepreneurs and business people and have no specific interventions targeting low income HIV/AIDS affected households, these loans require stable income or collateral.

What is remarkable is the availability of financial and economic empowerment intervention at the semi formal level through government programs like village fund discussed in chapter 4 and social protection programs. Conversely, NGOs, though having innovative financial and economic empowerment programs to assist households affected with HIV/AIDS, reach far less people than government programs due to donor funding constraints thus limiting sustainability and scalability of these projects. It is also difficult to assess reach as reporting is based more on anecdotal stories than factual data. Three of the NGOs interviewed involved with HIV/AIDS related issues tend to come from health and social development fields where experience and funding for micro-enterprise development is limited. PDA has a long history of micro credit and has the PPP project catering directly to PLHA credit needs. A high level of linkages and synergies have been established by all the stakeholders for instance PPAT works closely with the local government offices and public health clinics to ensure that the groups receive training when required and adhered to medical requirements. All the NGOs built on existing formal and informal mechanisms to ensure continuity for instance PDA used its existing

Village Development Bank strategy to ensure sustainability. In Thailand, Furthermore, NGOs that are actively involved in the provision of financial services (mainly micro credit) can only do so as long as the donor funds and interest lasts.

Commercial banks have worked with PLHA as part of their corporate social responsibility strategies for instance Standard Chartered adopting a coffee machine from TNAF but falling short of integrating products targeting HIV/AIDS sub population into their mainstream products.

5.8 Conclusion

Findings show that households still experience the adverse effects of HIV/AIDS, though by most accounts HIV/AIDS has ceased having grave impacts on livelihood security as it did over 10 years ago in Thailand. This has been made possible through provision of free healthcare and antiretroviral drugs for affected households. But even with lowered health costs, vulnerability levels are high as there are few viable safety nets outside from the family networks; and there is a high dependence on government social protection mechanisms.

The study discovered that household risk management strategies were fine tuned by households utilizing a set of social practices and community arrangements that provided additional support when individuals and households experienced shocks. While these strategies are not necessarily negative in the short run, in the long term existing mechanisms, especially those that utilize kinship, might become over-stretched or collapse. Uptake of formal financial products is very low, even in the specialized financial institutions, which mostly target rural low-income communities. Four NGOs actively involved with HIV/AIDS programming were interviewed, they provide economic and financial interventions in terms of seed capital, market access and micro-

credit, and while they seem to produce results, sustainability is a key issue as programming is dependent on availability of donor funding and interest. Consequently, the reach is negligible in comparison to government funded interventions, for instance PDA with the largest reach with its PPP program has 844 beneficiaries. The need for financial services is clearly demonstrated:

- Existence of informal and semi formal groups, clubs and associations whose main objective is to address the financial needs of the members;
- The demonstrated and expressed willingness of respondents to pay for affordable informal financial services (loans, savings and funeral funds)
- All households held loans from informal channels
- Some of people who have opened savings accounts in commercial banks in spite of the likelihood that they will not get loans from those institutions;

Households are averse to utilizing formal services due to the fact that most of their credit needs are for consumption smoothing whereas those provided by banks are considered investment loans, which would require collateral and a steady source of income, which, they do not have. This brings sharply into focus the question if there is actually a need for formal financial services targeting low-income households when there is an abundance of credit stemming from government interventions. Further, informational asymmetries are evident, which lead to respondents not knowing what is being offered by commercial banks and SFI's.

The hypothesis stated if low-income households affected by HIV/AIDS experience shocks, then there is a high likelihood that they would resort to negative coping mechanisms if they do not have access to formal financial services. This hypothesis is null as the households used existing informal and kinship networks and did not resort to negative coping mechanisms. That said the households are depending

heavily on these informal mechanisms and this might cause them to be stretched and finally collapse.

5.9 Further research

It is acknowledged that this is just an entry point in assessing the uptake of formal financial services for low income HIV/AIDS affected households through a perceived risk lens. Further research could scale up this study to include quantitative and qualitative data using a larger sample to make it representative. Also, a comparison of accrued and perceived accrued benefits from informal, semi formal and formal sectors could give a better answer as to why the respondents choose the different levels of formality.

5.10 Recommendations

People live with HIV/AIDS and grow older with HIV/AIDS, and their livelihood fortunes change over that time. Livelihoods approaches, therefore, require looking at the depth as well as the breadth of peoples' lives at all levels. What this should mean is that policies, projects and programs which seek to arrest the spread of HIV/AIDS and mitigate the impact of the epidemic, do so by recognizing the affect of the epidemic on all aspects of peoples lives, not just health, and seek to identify areas where support will have a positive impact.

Policy Recommendations Government

1. *Create an enabling environment for private sector players* - incentives like operational autonomy and lowering barriers to entry. This can be done by creating new legal identities for microfinance institutions (MFIs) and NGO MFIs thus

fostering competition and increasing innovative products in the market making them more affordable. Few NGO's have taken the form of NGO MFI's the main limitation being that the minimum capital requirement for a non bank company in Thailand is THB 50 million (approximately USD 1.4 Million) a figure beyond the capacity of many NGOs (Setboonsarng, 2010)

2. *Retraining and re-employment schemes* - it is only in 2009 that the government enacted the national guidelines on the prevention and management of HIV/AIDS in the workplace. While this is a step in the right direction, the government should also be developing strategies targeting even those who are self employed. It is worth noting that Thailand is largely driven by the informal economy (UNDP, 2009), thus most of those infected might not be in a position to benefit from this workplace policy. Many individuals suffering from HIV have since left their former jobs and are largely dependent on wage labor now.
3. *Training components in government driven interventions* – (Townsend and Kaboski, 2011) allude to the fact that the roll out of the million baht village fund did not have a component of training. This is imperative especially for such large scale roll out as it would give beneficiaries an

Commercial banks and SFI's

4. *Specialized accounts* – designing of specialized products for persons who are affected by HIV for instance, savings accounts providing a higher return on savings and lock down on savings but also providing access in times of stress. As this requires a high level of institutional complexity, sophisticated and diversified product design and a clear service orientation, commercial banks and savings-driven institutions are a better choice. These institutions often have more appropriate incentives in terms of ownership, sound governance and internal control systems as prerequisites for savings mobilization. Most programs by

banks and other formal financial providers not part of their integral programming but part of their corporate social responsibility programs

Member based organizations

5. *Strategic collaborations* - Donor-driven MFIs might be considered less permanent and reliable than financial institutions using commercial funds, creating moral hazard that reduces the quality of the loan portfolio. From this perspective, grants and soft loans, even though effective in the short run, constitute second-best options for sustainable funding in the long-term. Strategic collaboration between health oriented NGOs and commercial banks or SFI's where partners focus on their own competencies is an efficient response in mitigating the socio-economic impact of HIV/AIDS on indigent communities.

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APPENDIX

APPENDIX A

SOCIO-DEMOGRAPHIC DATA IN-DEPTH INTERVIEWS

Interviewee	Gender	Marital Status	HH Size	Children under 18	Level of Education	Age	HH Income THB	HIV Status
1	F	W*	5	1	Secondary	41	< 5000	+ve
2	M	M*	4	N/a	Primary	45	8,000	+ve
3	F	M	3	N/a	Primary	55	5,000	+ve
4	F	M	3	N/a	Primary	41	5,200	+ve
5*	F	M	5	1	Primary	34	500	+ve
6*	M	S*	5	N/a	Primary	47	>3,200	+ve
7*	F	M	3	-	Secondary	57	-	-ve
8*	F	M	-	-	Primary	-	-	-ve

* M – Married
* W – Widowed
* S - Single

5* - Interviewee 5 is blind and lives with his two brothers and their wives, the receives a disability check of 500 baht per month from the government and is not privy to his extended family's income though what can be inferred from the compound where they all live, is that they probably fall in one of the two bottom quintiles.

6* - Makes 3,300 per month from volunteer work at the local public health center and welfare checks from the government and her church. Her husband is a construction worker and the income is variant and she is also not privy to what he makes on a monthly basis

7* and 8* - HIV negative but are members in the HIV groups, have been affected but are not infected. They also act as 'consultants' who were meant to act as the leaders of these groups.

APPENDIX B

SERVICE PROVIDERS – KEY INFORMANT INTERVIEWS

Name	Organization	Designation	Date of interview
Khun Pimpida	Thai National AIDS Foundation (TNAF)	Resource Mobilization Officer	09.06.2011
Barbara Eagles	Population and Community Development Association (PDA)	Program Officer	26.07.2011 and 10.
Laurie Maund	Sangha Metta Project	Project Manager	21.07.2011 and 06.08.2011
Dr. Sampant Kahintapongs	The Planned Parenthood Association of Thailand (PPAT)	Director, Northern Office	20.07.2011
Benjawan Srivichai	The Planned Parenthood Association of Thailand (PPAT)	Program Coordinator	19.07.2011
Suntree Ngamlua	Baan Wen Public Health Station	Public Health Nurse	18.07.2011
Wanadee Kampusa	Local Government Office – Baan Huay Sai	Local Government Officer	20.07.2011

APPENDIX C

KEY INFORMANT QUESTIONNAIRE GUIDE - SERVICE PROVIDER

1. Background

- How is HIV/AIDS an issue in project areas areas?

- How do local people and institutions recognize HIV/AIDS as an issue?

  (i.e general awareness, as well as policy, programme and project context.)

- Who are the other important institutional stakeholders in relation to HIV/AIDS?

  (List those involved in prevention, care and mitigation of impact. Indicate the level they are operating at; their coverage; their activities relating to household livelihood security (skills training, savings and credit, insurance, etc; their constraints; and their collaborators.)

- Who are the important community stakeholders in relation to HIV/AIDS in?

  (List those involved in prevention, care and mitigation of impact. Indicate who participates, etc.)

- How does HIV/AIDS contribute to poverty, livelihood insecurity?

- How do poverty and livelihood insecurity affect the spread of HIV/AIDS within the community?

2. PDA Interventions

- Please name and outline the expected outcomes of PDA interventions targeting HIV/AIDS affected and infected households.

- How do/did PDA intervention strategies address the specific problems faced by HIV/AIDS affected groups? Do/did they build upon existing opportunities? If so, how?

- What synergies, linkages and partnerships are envisaged with stakeholders working on HIV/AIDS from other sectors in the past and present *(livelihoods (training & vocational institutions, savings and credit schemes, insurance companies, microfinance organizations, government, private sector, informal sector etc.)?*

- What changes in the HIV/AIDS context will/have affected the ongoing project activities? *(Consider negative and positive changes, such as increasing/decreasing numbers of support groups and local committees and new policies.)*

- Have partnerships been established with other organizations that carry out complementary work on HIV/AIDS? If so, at what level?

- How are field activities of different organizations and sectors coordinated?

- To what extent does the project build on and strengthen the capacity of existing formal and informal local institutions?

- What process and impact indicators have been included in the monitoring framework in order to adequately capture the changes in stigma and livelihood security among HIV/AIDS-affected households and people?

- How has the project contributed to mitigating the impact of HIV/AIDS on stigma and livelihood security and to the prevention of the disease?

- How sustainable are the outcomes of the project in view of the HIV/AIDS epidemic? *(Consider the outcomes at all levels - people, households, communities, local and national institutions.)*

- What is the potential for replicating or scaling-up the project's interventions?

- What lessons have been learned about mitigating the impact of HIV/AIDS on stigma, household food security and livelihoods?

3. Economic Empowerment

Access to Financial and Non-financial Services for HIV/AIDS Infected and Affected Households (Supply and Demand)

- What would you comment on the way HIV/AIDS infected and affected households access and financial services? *(Consider supply, quality, who provides the services)*

- Do you think there is a need for specifically designed financial and non-financial products targeted towards PLWA/affected/infected households? *(If yes/no, why?)*

- If your answer is yes, do you think these products would strengthen livelihoods security for HIV/AIDS affected and infected households?

- What kind of products do you think should be targeted towards these households?

- What kind of institutions should be in a position to provide these services? *(Government, private sector (banks, MFI's, insurance companies etc), NGO's)*

- Has your organization provided financial or non financial services to households affected/ infected with HIV/AIDS in the past or present? *(Kindly name the projects and how they were implemented, target groups, target areas, expected outcomes,)*

- Would you consider stigma as a major issue in access to financial and non-financial products for HIV/AIDS affected/infected households?

- Do you know of any informal financial or non-financial services/schemes that exist in this area? *(Kindly name them and the type of services provided if privy to information)*

- How involved are HIV infected and affected households in these schemes/projects? *(Both formal and informal)*

- What factors do you thing contribute to the lack of access to economic empowerment for infected/affected households?

THANK YOU VERY MUCH FOR YOUR TIME

APPENDIX D

INDEPTH HOUSEHOLD INTERVIEWS - SEMI-STRUCTURED QUESTIONNAIRE

How has HIV/AIDS affected your household socially and economically from when you were infected to date?

Socio-demographics

Gender:
Marital status:
Family size: Over 18
Under 18

1. In which type of dwelling/housing are you living in?

2. What is the tenure status?

3. How much money do you make on a monthly basis? Average

5. Income earned in 2010 (you and all members of the family)

6. How can one describe the main activity/work status of the highest income earner of this household?

7. What is their highest level of education?

8. How would you describe the income position of your household in comparison to others in Thailand?

9. Suppose you won 10,000 baht today, what would you plan to do with the money?

10. For the part of the 10,000 you would keep to yourself, what would you do with it?

Financial Questionnaire

11. Do you save?

12. Which of the following informal banking systems do you use?
    - *Keep at home*
    - *Give to relative or friend for safekeeping*
    - *In community bank*
    - *In group*

13. Do you have a line of credit?

14. If yes how much interest do you pay back?

15. What kind of installments?

16. Non/late payment charges?

17. Do you need someone else in the group to guarantee you?

18. Is this difficult to get guarantors?

19. If yes, why?

20. What is the principle reason that no one applied for a loan?
    - *No one offers loans*
    - *Do not know how to apply*
    - *They ask for too many requirements*
    - *Don't have goods to give as guarantee*
    - *Fear of not being able to pay back?*
    - *Interest rate too high*
    - *Prefer to work with own resources*
    - *There was no need*
    - *No sufficient income*
    - *They don't give loans to people like us*
    - *Other? What?.....*

22. Would you say that you are financially better off or worse off than you were?

	Better now	**Same**	**Worse now**	**Don't know**

1 month ago				
6 months ago				
12 months ago				
Before HIV positive				

23. Looking ahead do you expect any major changes in your family situation that will lead to higher earnings or lower earnings during the next

	Higher earnings	**No change**	**Lower earnings**	**Don't know**
1 month ago				
6 months ago				
12 months ago				
Before HIV positive				

24. Have you made any changes in terms of accessing and use of financial services since you contracted HIV?

25. If yes, do the changes have anything to do with the fact that you are positive?

26. Would you mind telling us what these changes are?

27. If a bank offered you a loan or other financial services like funeral insurance, education savings accounts, would you be interested in these products?

Defining collective and individual shocks

28. Has your household experienced any of the following problems in the in the last 12 months?

Collective shocks	***Individual shocks***
Earthquake	*Loss of employment of any family member*
Drought	*Lowered income of any member*
Flood	*Bankruptcy of any member*
Storms	*Illness or serious accident*

Business closing	*Death of working family member*
Massive lay offs (loss of jobs)	*Abandonment by household head*
General price increase in consumer goods	*Fire in house or property*
Other	*Land dispute*
	Family dispute
	Loss of cash or in kind assistance
	Criminal act
	Fall in prices of products in household business
	Loss of harvest
	Other

Household Vulnerability Mapping

29. Using the above parameters let us list the most likely shocks/stressors and its effects

	Individual HH shocks	*1*	*2*	*3*	*4*	*5*
1	*Loss of employment of any family member*					
2	*Lowered income of any member*					
3	*Bankruptcy of any member*					
4	*Illness or serious accident*					
5	*Death of working family member*					
6	*Abandonment by household head*					
7	*Fire in house or property*					
8	*Land dispute*					
9	*Family dispute*					
10	*Loss of cash or in kind assistance*					
11	*Criminal act*					
12	*Fall in prices of products in household business*					
13	*Loss of harvest*					
14	*Other*					

30. Of the above-identified stressors, do you have any risk strategies in place?

BIOGRAPHY

Louise Kendi Maore was born in Kenya in 1979 and holds a bachelors degree in commerce. Her interest in development issues begun with her first job as an intern working to encourage inhabitants of informal settlements in Nairobi to consider the advantages of acquiring micro insurance to protect themselves from shocks. Since then she has worked for various International NGOs in different capacities and the Food and Agriculture Organization of the United Nations. She has worked in several countries in the horn of Africa in livelihoods, microfinance and social protection programs. The decision to pursue Master's studies at Chulalongkorn University was driven by the need to gain academic level qualifications and to experience a different way of life in another part of the world, a decision that has greatly enhanced her outlook on global development issues.