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Empowerment of HIV-positive individuals - possible through microfinance?

A Case Study Of Microfinance And HIV Affected Households In Tuan Giao District In Dien Bien Province, Vietnam

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ABSTRACT

The prevalence of HIV has caused adverse impacts on rural households, not least in northern Vietnam where the problem has become a development issue. Despite a rapid economic growth leading to donor withdrawal, huge income disparities still exists. As a result, a person facing the additional burden of HIV has to cope with an even greater distress than before. The aim of this research was therefore to gain a better understanding of whether microfinance and training programmes have an impact regarding empowerment of households with HIV positive member(s). The research employed a single-case study design and was conducted in Tuan Giao district in Dien Bien province. Using empowerment theory sourced from Kabeer and power theory from Lukes as a foundation for its questions, data was collected through semi-structured interviews with HIV-positive households who had been members of the STU project for at least 1 year. The results point towards that microfinance can be used as a catalyst to an already started empowerment process, but cannot start it itself. Instead, the provision of ARVs together with an increase of the social status through trainings and building of human resources play a key role in enabling HIV-positive households to become empowered.

Keywords: HIV, households, empowerment, microfinance, stigma and discrimination, Vietnam.

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LIST OF ACRONYMS

AIDS	Aquired Immuno-Deficiency Syndrome
ARV	Antiretroviral Drug
CD4	CD4-count, number of CD4 cells/mm^3 in blood
CFRC	Community Finance Resource Center
FHI360	Family Health International 360
HIV	Human Immunodeficiency Virus
ICAD	Interagency Coalition on AIDS and Development
ICRW	International Center for Research on Women
IFAD	International Fund for Agricultural Development
ILO	International Labour Organization
MFIs	Microfinance Institutions
NGO	Non-Governmental Organization
PLHIV	People Living with HIV
STU	Standard Transaction Unit
VAAC	Vietnam Administration of HIV/AIDS Control
VNP+	Vietnam Network of People Living with HIV
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime

1. INTRODUCTION

"Microfinance is not a panacea. You need health. You need education."
Roshaneh Zafar, founder of Kashf, Half The Sky (Kristof and WuDunn 2009:191).

Minh lives in Dien Bien, a rural province situated in the northwest of Hanoi, Vietnam. She is a widow with one child. She belongs to the Thai ethnic minority group. For income, Minh works with rice farming and in the family business. Her economic condition is poor; she has no savings and regularly utilizes loans from her family to smooth out peaks.

The financial situation became worse when her husband died in 2009 and at that time they did not know the reason of his death. Minh was left to care for their child and became sick shortly after her husband passed away. She went to hospital for a check-up and learned that she had been infected with HIV. In hindsight she suspects that her husband got HIV because he was an injection drug user. She, like many other women in Dien Bien province, has been infected with HIV by unprotected sex with her husband.

Stories like Minh's are common in poor communities throughout the world. The initial state of relative health and happiness and subsequent plunge into a downward spiral towards destitution highlights that one of the harshest realities of poverty is the high level of vulnerability to severe events and crises. People living in poor households are more vulnerable to crisis events and the impact resulted from those are also likely to be more devastating; people living in households affected by HIV even more so, and are faced with utter desolation.

The first HIV case in Vietnam was identified in Ho Chi Minh City in 1990, since, the virus has spread rapidly across the country (Nguyen 2005:35; UNAIDS 2012a:14). According to UNAIDS (2012b), the estimated number of people living with HIV in

Vietnam had reached 260,000 by the end of 2012. This epidemic has become a serious health and development problem in some provinces such as Dien Bien, where injection drug users (IDU), female sex workers (FSWs) and men who have sex with men (MSM) are among the most at-risk populations.

From a global perspective, the effects of the HIV pandemic are not only an unprecedented humanitarian catastrophe but also a threat to global economic and geopolitical stability (Donahue 2000:V; Lyman et al. 2004). But for many people, particularly in poor countries such as Vietnam where HIV is an increasing problem, the everyday concern about sliding further into poverty *"subsumes the other effects of HIV/AIDS"* (Donahue 2000:V). HIV can cause affected households to become socially isolated. This can also include the loss of income, increased spending on medical costs, and the inability to resume works (FAO 2002:17; Caldas et al. 2010:987). Since the virus makes the financial situation even more volatile than it already is for these people, income and especially savings become the sharpest tools as families continue to struggle to build, protect and enhance their sparse economic resources (FAO 2002; Caldas et al. 2010).

Recently, microfinance has been promoted as a promising strategy to help HIV-affected households to mitigate the economic impact of the epidemic (Barnes 2003; Parker 2000 in Dworkin and Blankenship 2009:463). This attention to the potential role of microfinance built upon earlier research shows that microfinance is an effective and powerful tool for improving the living conditions of the poor and for reaching and surpassing several key Millennium Development Goals (Coleman 2005; Barnes 2003:7). Microfinance as a concept includes three main components, namely savings, loans (microcredit) and insurance for those who ordinarily would not have access to these services due to lack of any or all of the following: collateral, credit history, knowledge and interest (primarily from commercial lenders) (Sengupta and Aubuchon 2008:9). Therefore, microfinance has been suggested as a means of empowering poor people, especially people with HIV, by strengthening their financial safety net (Osterhoff et al. 2008:42). However, the evidence is not conclusive. Critics of microfinance claim that microfinance institutions (MFIs) sometimes fail to adapt their services to meet the needs of the poorest, including the interests and constraints of HIV-affected households (IFAD) 2014). Some scholars argue that poor people can

sink into a cycle of debt due to the high interest rates charged by lenders (Mayoux 2003).

Internationally there are many published studies on microfinance focusing on the impact it has on the economic conditions of its recipients. These studies however are mostly focused on people whose main problem is poverty. HIV-affected individuals may differ from other poor individuals in that their lives are shaped not only by their poverty but also by their HIV status (Paxton et al. 2005 in Oosterhoff et al. 2011:42). These individuals often experience isolation and discrimination from communities, workplaces or even their own families (Khuat, Nguyen and Ogden 2004), making them one of the most vulnerable groups in any societies. The linkages between HIV, access to microfinance services and subsequent empowerment are academically not very well documented, should there be any.

1.1 Scope of the study

The study is built upon the establishment of a microfinance project, Standard Transaction Unit (STU), which is undertaken by a local non-governmental microfinance organization, Community Finance Resource Center (CFRC). This research is conducted in the Tuan Giao district of the Dien Bien province, one of the areas heavily affected by HIV. The aim is to gain a better understanding of the relationship between microfinance, empowerment and HIV through a qualitative research approach. More specifically, this is a single-case study aims to investigate the impact a microfinance project has on the empowerment of HIV affected households. We will use Kabeer's *empowerment* framework and Lukes *power theory* as the theoretical backbone of this research. These theories were chosen because they complement each other in describing power relations, obvious as well as latent ones.
The research question this thesis will process is:

What impact do microfinance and training programmes have on the empowerment of households with HIV positive members?
- A case study of households in Tuan Giao district in Dien Bien province, Vietnam.

1.2 Definition

A *household* in this study refers to "the people in a family or other group that are living together in one house" (Merriam-Webster 2013).

When referring to the host organization (CFRC), its name will be used even though it might have been more applicable to write STU in the specific context. This is for readability, as well as the fact that at the time of publication, the two entities are so closely related that separating them is not really necessary for the intents of this thesis.

When using the term microfinance, we refer to the supply of credit (microloans).

When writing about HIV and AIDS, only HIV will be used as AIDS is just the terminal state of a HIV infection.

1.3 Delimitations

First, this study focuses on Tuan Giao district therefore cannot be generalized in other context. Second, we are aware that our household empowerment measurement is limited by only including the husband and the wife to represent a household. However, we believe that they can provide us with information needed to answer our research question. Although microfinance has been recognized as a potential economic empowerment strategy to assist HIV prevention, this is beyond the scope of the paper, and will not be discussed here.

Microfinance usually consists of three parts; loans, savings and insurance. STU deals with all these, and savings are a compulsory part of membership (ie getting a loan). However, we have chosen to focus on the loan, as that will be the main empowering measure.

Finally, there is something to be said for the applicability of the theoretical literature that we have chosen. Most of the literatures are of general nature, and the specific case studies are mostly done in radically different social contexts, meaning we might have to adapt the theoretical framework to fit our context. This should not pose much of a problem since the main theories we are using are of the general type. Further, since little to no studies have examined the specific area we have chosen to study (empowerment of HIV positive poor households through microfinance), but rather study one (social exclusion) or another (empowerment of the poor through microfinance) the theories used will have to be fused to be applicable.

1.4 Disposition

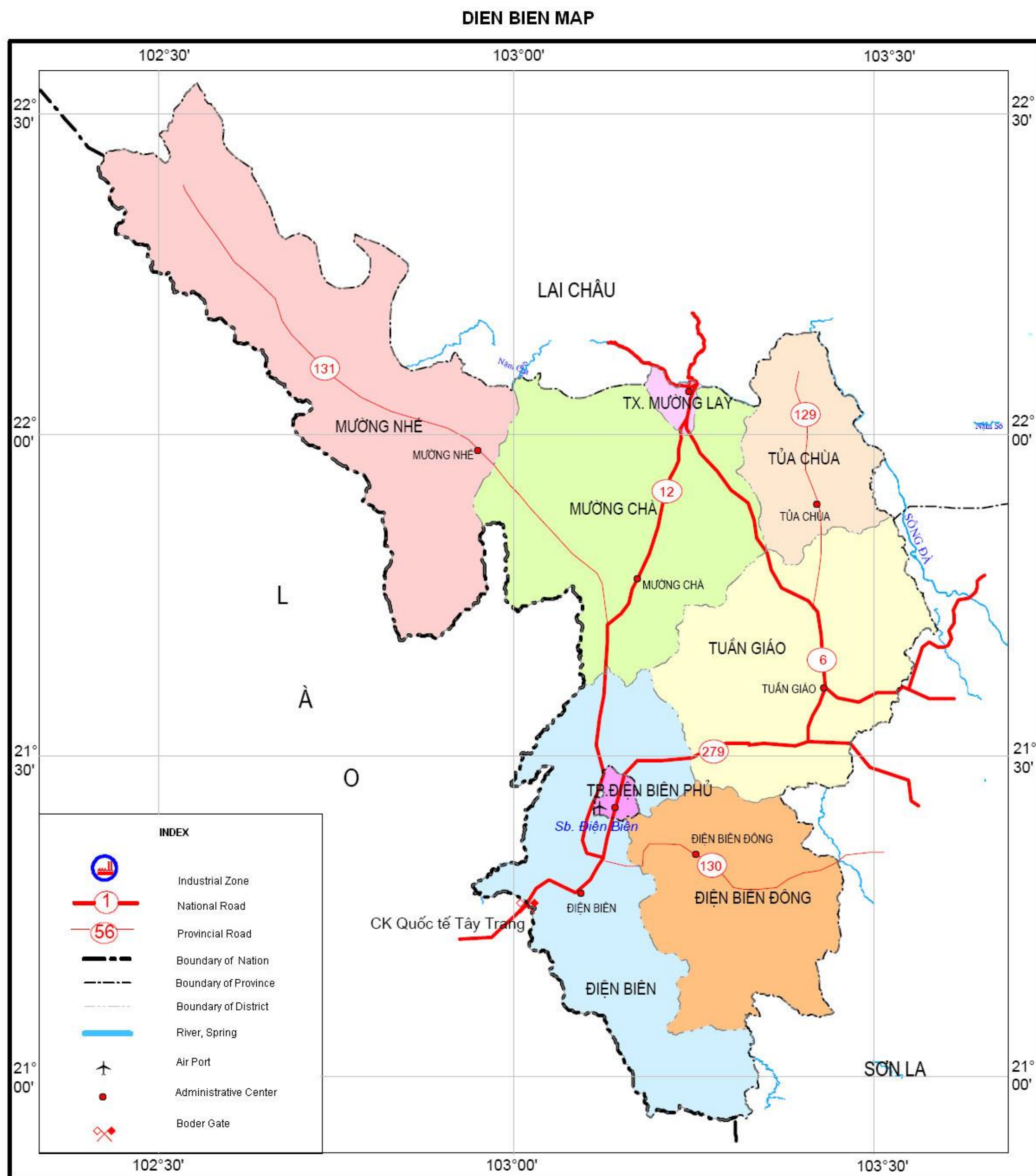
This thesis is divided into eight chapters. The introduction will be followed by a brief description of background of Vietnam with a special focus on HIV in Dien Bien province and stigma and discrimination. Chapter 3 and 4 will present literature reviews and key concepts and explain the theoretical framework which is used to guide analysis. The choice of methodology will be justified in chapter 5 and it includes a discussion of ethical consideration. The sixth chapter presents the analysis of empirical data. Lastly, the conclusion and our recommendation will be presented in the seventh and eighth chapters respectively.

2. BACKGROUND

2.1 HIV and Socio-economic development in Dien Bien province

Vietnam's mountainous Dien Bien province is home to the well-known battle of Dien Bien Phu, where the Viet Minh army won a 55-day battle decisively against French forces in 1954 (Nguyen 2013). Today, Vietnam is involved in another battle — against HIV — and Dien Bien has one of the highest HIV prevalence rates in the country, with 1918 per 100 000 people (Girard 2013:42; Nguyen 2013; VAAC 2013).

Dien Bien province is located in a remote area, northwest of Hanoi. It is home to 491 172 people from 21 different ethnic minority groups (UNODC 2012; Girard 2013:41) Thai people being the largest ethnic group in the area (Oosterhoff et al. 2011:7). Dien Bien province borders to Laos and China and is a hot spot for drug trafficking (UNODC 2012). Economic reforms, commonly known as *Doi Moi* (which can be translated as "renovation") in 1986 have underpinned an increase in cross-border trade with neighbouring countries which also indirectly facilitates heroin trafficking routes through the province (Girard 2013:42). According to Girard (2013:42) many ethnic groups have a history of traditional opium use, particularly among older men, but since the late 1990s the injection of heroin has become increasingly popular with younger men. A study conducted in three villages in Dien Bien reported that at least one of the male family members had used or was using heroin (Oosterhoff 2011:8; Girard 2013:42).



Source: investinvietnam.vn (2014)

The first case of HIV infection in Dien Bien was identified in 1998 and the virus quickly becomes a problem. But it was not until 2009 an international NGO, FHI360, established a project in the province to provide support in HIV care and treatment. Through the support and financial contributions of FHI360, healthcare centers started to get control over the situation and could provide more exact numbers of people affected by HIV in the area (Huang 2013). The cumulative number of people living with HIV (henceforth referred to as PLHIV) in the province was nearly 4000 and of those, 1500 have turned into AIDS. Moreover, 75 percent of PLHIV are ethnic minority people (Trinh and Nguyen 2010:17). As in the rest of the country, the HIV

epidemic is still concentrated among male injecting drug users (IDUs), but in Dien Bien the HIV infection rate among injecting drug users is twice the national average, reaching 43 per cent (Girard 2013:42). Wives of men who are injection drug users are at high risk of contraction, which is especially true of minority groups where the rates of injection drug use are high (ibid). Most HIV infected women in Dien Bien have contracted it through their husbands and they are often being informed about their husband's status only after they were married. This remains the main mode of HIV transmission among women (ibid) and is referred to as a "hidden HIV epidemic" (Nguyen et al. 2008). The cultural norms, gender disparities and economic dependence may limit women's ability to negotiate safe sex practices with their male partners (Rosenberg et al. 2010:911). Dien Bien is one of the provinces where the HIV epidemic is clearly growing (UNODC 2012), making it one of the most vulnerable regions in Vietnam.

As the second poorest province nationally, with nearly 40 percent of its population live below the national poverty line[1] (UNICEF 2011), the economy of Dien Bien relies heavily on the government support (Health Strategy and Policy Institute and Center for HIV/AIDS/STIs 2009:27). The Thai people are one of the ethnic groups that experience the worst socio-economic conditions. Up to 90.2 percent of Thai people are living in households classified as "poorest" or "poor" (UNFPA 2011:46). The majority of the people in rural Dien Bien live mainly off agriculture; rice farming and animal husbandry are the main activities. The overall development in this area is slower than the rest of the country and access to safe drinking water, health and educational facilities is still limited (AusAid 2002). The financial services are also limited in Dien Bien, making it difficult for the poor to borrow money from commercial banks (i.e. Vietnam Bank for Social Policy, Agribank). One of the reasons is that formal financial institutions might not find it profitable to operate in such remote areas. For banks to be self-sustainable they require both a minimum number of clients as well as a certain number of transfers per month. Therefore they generally cannot sustain themselves on a sparse population with a low as well as

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[1] National poverty line as of 2013 for rural areas: 400 000 VND/month (~19 USD), urban areas: 500 000 VND/month (~23.5 USD).
Source: http://www.moj.gov.vn/vbpq/en/Lists/Vn%20bn%20php%20lut/View_Detail.aspx?ItemID=10738

irregular average income (Angelow 2011). The vulnerable situation of people in Dien Bien has created a realization that more effort is needed to help this area develop sustainably. However since Vietnam got upgraded to lower-middle income status (World Bank 2013) donor withdrawal has increased due to ignorance of above facts. Hence NGOs are getting increasingly involved in the areas where the governmental and donor spotlight is weak/non-existent. Those organizations play an increasingly important role in assisting the Vietnamese government to continue to meet the needs of their poorest citizens.

Furthermore, these people are vulnerable not only to poverty and HIV but also the societal consequences of the virus - PLHIV experience stigma and discrimination on an ongoing basis.

2.2 Stigma and discrimination

Stigma and discrimination related to HIV have been recognized as a universal phenomenon, occurring in every country and region of the world (UNAIDS 2002:5). This phenomenon negatively affects the lives of PLHIV and their families (ICRW 2010:1). Stigma can be defined as a *"[...] process of devaluation that significantly discredits an individual in the eyes of others"* (UNAIDS 2011:27). Importantly, HIV stigma varies in different cultural settings (POLICY project 2003:123). Discrimination follows stigma and is *"any form of arbitrary distinction, exclusion, or restriction affecting a person ..."* (UNAIDS 2011:27). In traditional Vietnamese culture as well as in contemporary times, HIV has been linked to "social evils". The concept of "social evils" includes activities such as intravenous drug use, sex work and homosexual activity, which themselves are heavily stigmatized as well, not only from the risk of diseases being spread (Vietnam Network of People Living with HIV (VNP+) 2012:8; Khuat, Nguyen and Ogden 2004:14). These activities have been reviled in Vietnam, as well as most of the rest of the world, because they are regarded as activities which strongly deviate from the traditional moral norms and values. There is a strong cognitive linkage with regards to causality in the community between these activities and the contraction of HIV, further inciting the suspicion that

those with HIV likely contracted it from practicing these activities. People having HIV are thereby stigmatized both from preconceptions of the virus *as well as* preconceptions of contraction (a concept often referred to as 'double stigma'), both stemming from "social evils" (Khuat et al. 2004:14; VNP+ 2012:8; Li et al. 2008:431).

Given the incidence of 'double stigma', many PLHIV face a variety forms of discrimination and stigma including being abandoned by a spouse and/or family, job loss, social exclusion, loss of property, school expulsion, denial of health care, a lack of care and support, and even violence (VNP+ 2012:12). Verbal and physical abuse are also common especially among women (VNP+ 2012:9). The fear of these consequences often discourages people who suspect they might have contracted the virus from taking an HIV test, as this risks revealing their HIV-positive status, adopting preventive behaviours, seeking care and adhering to treatment (VNP+ 2012:12; ICRW 2010:1; Smart 2014:120). Fear and moral judgment *"[...] are considered to be the root sources of HIV/AIDS stigma."* (POLICY project 2003:4). According to VNP+ (2012:9) *"This stigmatization of HIV and of HIV-related behaviors affects people living with HIV in terms of social insecurity and isolation, which can be compounded by self-stigmatization"*. Further, a study by VNP+ (2012) shows that 60 percent of people who inject drugs in Dien Bien have not disclosed their HIV-positive status to anyone outside of their immediate family. Moreover, over 30 percent of MSM in Ho Chi Minh City reported that their partners did not know their status. This situation is further exacerbated and deepened by the government's programmes meant to combat drug usage and sex work, since they mainly also focus on the "social evils"-angle in order to solicit people currently performing these acts, as well as encouraging people around them to report them to the police (Khuat et al. 2004:14).

In the collective culture of Vietnam, HIV is perceived as bringing shame on to the family and community (Panos 1990; Warwick et al. 1998 in Parker and Aggleton 2002:7; Rapid Response Service 2013:3). The Vietnamese culture emphasizes the importance of family and community and when one member of a family becomes infected with HIV, the entire family is criticized heavily (Khuat et al. 2004:20). In worse cases, the whole family experiences rejection by their local communities (Li et

al. 2008:432). For instance, people tend to think that children get HIV because the family has neglected the education of its children, causing them to become "degraded" (Khuat et al. 2004:20). In other words, when one member of the family violates a social norm, the whole family is blamed for the individual's miscue (Li et al. 2008:436). Fears of negative social consequences become a heavy psychological burden to PLHIV (Li et al. 2008:436). As Li et al. (2008:434) state *"For a family living with HIV/AIDS, shame is a shared burden. HIV/AIDS is a disease that causes the entire family to lose face in the community"*. Thus many people living with HIV decide to keep their status secret within their immediate family to avoid embarrassment for the larger family and community (Rapid Response Service 2013:3).

3. LITERATURE REVIEW

This chapter will start with a discussion of the role of microfinance in women's empowerment, both the positive and negative impacts of microfinance. The chapter will continue with a discussion of the link between microfinance and HIV.

3.1 Microfinance and women's empowerment: an evolving debate

Since the early days of microfinance there has been a conscious effort from the organizations working with development to especially target women with their efforts. This stems from the fact that women are the ones most exposed to poverty, simply because they usually have less access to education as well as credit and financial services (ILO 2008). Thus microfinance organizations focus on providing small loans to women so that they can start an income generating activity, develop marketable skills and raise household income and welfare (Kim et al. 2008:61; Kiva 2013). Not only that, it is argued that microfinance programmes target women as a means for increasing cost efficiency based on the fact that women have higher loan repayment rates than men, and for delivering more effective poverty reduction because women are more likely to spend their income on family welfare needs such as food and children's education (Kim et al. 2008:62).

Beyond these economic benefits, there are studies suggest that microfinance may be an effective tool for women's empowerment. The topic is heavily contested however, and critics have questioned the efficiency of providing the financial services to women can be empowering on its own; without efforts to address broader topics such as gender inequalities and traditional beliefs, can perceptions be changed (Kim et al. 2008:62). In short, there has been an ongoing debate to what extent microfinance services have made an impact on women's empowerment (Al-Amin and Chowdhury

2008:16). At one end of the spectrum, it is assumed that there is a direct link between access to financial services and an increase in women's leverage within households and communities. Microfinance is believed to lead to the "empowerment" of women (Hunt and Kasynathan 2010:42; Al-Amin and Chowdhury 2008:22) in terms of significant increases and control of incomes and assets (Mayoux 2011:4). On the other end of spectrum, microfinance is claimed to bring negative impacts for women (Hulme 2000 in Al-Amin and Chowdhury 2008:16). Some scholars argue that microfinance, particularly microcredit, can lead to greater subordination of women by strengthening patriarchal norms which worsen the gender relations and lead to the disempowerment of women (Oosterhoff et al. 2008:41). This is because credit can impose debt burden on women. The pressure to pay back the loan on time can create new forms of *"social and institutional dominance over women by their families and microcredit organizations"* (Weide and Waslander 2007).

According to Goetz and Gupta (1996), the size of the loan is correlated with the loss of direct control i.e. the bigger the size of the loan, the more women lose control. This is because most of women's investment activities such as livestock are too small to absorb larger cash inputs. Therefore, women's loans are rather easily turned into household assets and incomes without leading to a subsequent increase in women's ownership of the household family assets. Women are highly likely to transfer their credit and its earnings to their husbands just to keep the stability of the family intact (Goetz and Gupta 1996). In patriarchal societies especially those actions are justified by the fact that conflicts and tensions within families are viewed as humiliation from other relatives and the community. Women's loss of control over the loans they do take increases their vulnerability and further serves to burden them (Al-Amin and Chowdhury 2008:19).

Another argument is that although the loans are registered in women's names it does not necessarily mean that they participate in decisions about loan application, as men may negotiate loans with male credit officers as an easier way of getting access to loans. Moreover, men may take the loans from women but women are the one that are responsible for repayments and household savings, which may come from their own basic consumption expenditure or from borrowing from other sources such as friends and relatives (Mayoux 2005:14; Mayoux 2010:584). This can make them more

vulnerable in cases of marriage breakdown or divorce (Mayoux 2005:14). Similarly, Rahman (1999:23 in Selinger 2008:32) claims that most female borrowers are not the direct benefactors of the credit extended to them. Instead, they appear to be mediators between the male members of the household and the bank. Not only that, microfinance institutions claim that they are helping poor household enhance their economic conditions but at the same time they charge the poor interest rates that are substantially higher than the rates charged by commercial banks (Rosenberg, Gonzalez and Narain 2009:1). Consequently, the impact of high interest rates on loans can drive many poor households into a debt trap (Mayoux 2003).

Nevertheless, microfinance has been recognized as a promising strategy for mitigating the economic impact of HIV for those who are affected by it (Parker 2000 in Dworkin and Blankenship 2009:463). This will be discussed in the next section.

3.2 Microfinance and HIV

The HIV epidemic poses a serious threat to the socio-economic development of the most affected countries. But of all units affected by the epidemic, individuals, households and families bear the largest burden (UN 2004:39).

HIV has a severe effect on livelihood of rural households. The impact on household begins when a household member starts suffering from the virus. Besides the social and psychological consequences, HIV has a major adverse impact on the economic situation of those households. The first impact is the loss of income of a productive household member, especially if he/she is the breadwinner. The second impact is the increase in household spending to cover the medical expenses. The third is the indirect cost resulting from the absenteeism of the family members from work or school to care for the sick person (UN 2004:39). Evidence shows that household incomes drop by 40 percent when a family member becomes sick with HIV and medical costs rise by 400 percent (ICAD 2001).

The overall economic impact of HIV on affected households depends on the availability of human capital and size of financial safety nets. For households without a financial safety net, HIV can push economically secure households into poverty, as income earners become sick or die, and as household maintenance costs rise (Parker, Singh and Hattel 2000:2). Thus HIV is often described as a "*disease of inequality, often associated with social or economic transition, rather than a disease of poverty itself*" (Kim et al. 2008:57). Similarly, Donahue (2000:2) argues *"[...] for most households, issues related to poverty subsume the other effects of HIV/AIDS — illness doesn't cause poverty, but it worsens its legacy"*.

The stronger the household safety net, the better chances that the household can offset the impact of HIV without sacrificing children's education or to reduce purchases of basic necessities (Parker et al. 2000:2). Thus increasingly and globally, microfinance has been proposed as *"a form of social safety net for HIV/AIDS-affected households"* (Oosterhoff et al. 2008:42). The potential role of microfinance builds on an earlier focus on microfinance as an approach to improving the lives of poor people (Barnes 2003). On a similar note, Caldas et al. (2010:987) and Pronyk et al. (2005:27) claim that microfinance services, particular savings, can help people with HIV to overcome economic and social chock. Having access to financial services will allow the poor to protect themselves against risks and take advantage of economic opportunities. While increased earnings are by far no means automatic, there are studies showing that microcredit provide a fundamental basis for planning and expanding business activities. Still, some argue that MFIs can go even further than the roles they traditionally have, offering a wider range of additional services to their clients. Because microfinance often works through bringing groups of people together - predominately women - on a regular basis, it could for example also be used to distribute health services and education, such as prevention information about HIV and other diseases (Parker et al. 2000:2).

According to Parker et al. (2000:1), microfinance services are most useful to households before they are severely affected by HIV, when they still can make use of loans for income-generating activities and can still save money. They argue that once the family has been affected by AIDS, the role of microfinance changes from proactive to supportive. Further, they note that microfinance from that point should

support the productive activities of the family members not affected. The reason is that the greater ability to generate an income stream of an affected household, the more likely they are to withstand the economic dire straits that they generally face due to the virus, avoiding having to sell land or other assets, being unable to pay tuition or ultimately the breakup of the family (Parker et al. 2000:2).

While microfinance programmes are successful at reaching the poor, the "very poor" or "most needy" are often neglected as they perceived to be a credit risk (Kim et al. 2008:61). For this reason, critics of microfinance argue that MFIs often fail to serve those who need it the most. In short, these programmes fail to reflect the needs and limitations of the poorest groups and the impact of the HIV epidemic on their activities. Consequently, the poorest groups (often disproportionately affected by HIV) are least able to take part in and benefit from the microfinance activities (IFAD 2014). Furthermore, since MFIs have a strict repayment policy i.e. the loans need to be repaid in full and on time. Thus families that are deeply affected by HIV may be forced to leave the programmes until they are back on track (Parker et al. 2000:6). This affect not only the HIV-positive individual, but also family members of the infected, who have lost income or have to look after for the family's sick or for orphans that are living with the family (ibid).

4. THEORETICAL FRAMEWORK

Seeing how this thesis mainly is concerned with empowerment, this chapter will explain how we intend to define it, as well as the parts that the concept consists of. First and foremost, we will discuss empowerment at large and how different people, actors and academics have defined it, after which we will discuss our chosen definition. Historically the empowerment concept have mainly been used to illustrate the process through which women gains a larger role in society; while this interpretation does not exactly fit with our intents, many lines can be drawn between the struggles facing women and households affected by HIV.

4.1 Conceptualizing Empowerment

Empowerment as a term may traditionally be used within a gender perspective (for examples, see: UN 2010; Chaudhuri 2013; Mullinax et al. 2013) but can also more broadly be applied to any phenomena that mitigate a disadvantaged position. This ubiquity of the concept makes it both very applicable and very problematic. First off it is important to clarify the meaning of empowerment.

Although *empowerment* is a concept that is widely discussed in literature and journals, there is no single accepted definition of it. Some scholars define empowerment as the process of *"[...] increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes."* (Krishna 2003:1). In short, empowerment can be a process and/or an outcome (ibid:6). Others refer empowerment as the expansion of freedom of choice and action; for example the World Bank (2014) which states *"Empowered people have freedom of choice and action. This in turn enables them to better influence the course of their lives and the decisions which affect them"*. Thus, empowerment is a complex and multidimensional concept. Empowerment has different dimensions including economic, socio-cultural, familial/interpersonal, educational, legal, political and

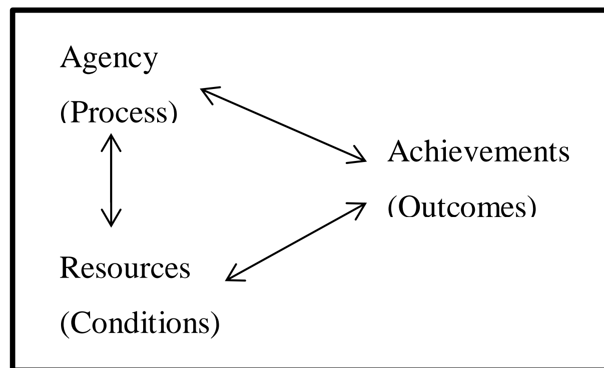
personal (Malhotra, Schuler and Boender 2002:12). More importantly, the perceptions of being empowered vary across time, culture, social setting and domains of a person's life (World Bank 2014).

Kabeer's (1999:436; 2005:13) definition of empowerment relates with power; *the ability to make choice*. She argues that to be disempowered means to be denied choices. Empowerment is then *the processes by which those who have been denied the ability to make choices acquire such ability* (Kabeer 1999:437). Empowerment is being understood as a process of change (ibid).

However, for there to be a choice, certain conditions need to be provided. Choice implies that there are alternatives, the ability to have chosen differently. Kabeer (1999, 2005) goes further and argues that not all choices are equally important to the definition of power. Certain choices are more important for the individual than other choices in terms of their consequences for the individual's life. Therefore, she makes a difference between first and second order choices, where first order choices refer to as strategic life choices. In other words, those choices are critical for people to live the lives they want including (presumably) choices where to live, whether to marry, how many children to have but also fulfilling one's basic human needs, and so on. Second order choices are less consequential ones, they are may be important for one's quality of life, but do not constitute its defining parameters. Finally, exercising choice should not impede others' ability to do the same (Kabeer 2005:14). Empowerment is thus defined as *"the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them"* (Kabeer 1999:437). Most authors agree that the following three dimensions are closely interlinked to empowerment, namely: agency, resources and achievements. The next section will discuss these dimensions in more detail. However, it is important to note that even these dimensions are contested for what their actual meaning is; Kabeer (2001:19) uses the terms in the following way:

- Agency is the *process* by which choices are made
- Resources represent the *conditions* under which choices are made
- Achievements are the *outcomes* of choices

Figure 1. Dimensions of empowerment



Source: Kabeer (2001)

All three dimensions are closely inter-dependent when it comes to achieving empowerment.

> *"These dimensions are inter-dependent because changes in each contributes to, and benefits from, changes in the others. Thus, the achievements of a particular moment are translated into enhanced resources or agency, and hence capacity for making choices, at a later moment in time."*
>
> (Kabeer 2001:19)

Finally it is important to emphasize that empowerment as a concept intimately deals with the concept of power. While a complex concept, power, can be boiled down to three different dimensions (from here on called forms of power) as defined by Lukes (1974), namely:

1) *Power to*, which refers to the classical pluralist approach to power, in which anyone who for example wins an argument has the power in said issue - A has *power to* make B do something, even if it is against B's (sometimes best) interests. This can be exemplified with a parent winning an argument over their child, and therefore having the power. In this form of power, an open conflict is apparent; the child (B) wants an ice cream, but the parent (A) notes that it is unhealthy and therefore the child should not have any.

2) *Power over*, where actor A controls the agenda in for example a meeting, and therefore can decide what is going to be discussed regardless of actor B's wishes. An example might be a chairman at a meeting - he has the *power over* the topics discussed, so if he wants to avoid critique, he can change the topic whenever he pleases. Here, the conflict can be both open and hidden - a meeting participant (B) wants to discuss the financial statement, but since the chairman (A) has the *power over* the agenda, he can choose at his discretion to skip the topic.

3) *Coercive power*, where actor A can persuade actor B to change his view in line with actor A's preferences, even if that is diametrical to actor B's real interests. Lukes, who was a Marxist, noted that an example of this could be the ruling class (A) convincing the working class (B) that their interests align and thus avoiding conflict. In this form of power, the conflict can be open, hidden as well as latent.

4.2 Kabeer's Empowerment Framework: Agency, Resources and Achievements

Kabeer (1999:437; 2005:14), as mentioned in section 4.1, conceptualizes empowerment as three dimensions: *agency, resources* and *achievements*. Below we will discuss each of the dimensions.

4.2.1 AGENCY

According to Kabeer (2001:21) agency is *"the ability to define one's goals and act upon them"*. She notes that the agency concept has two sides, which she denotes are diametrical in their effect on the individual. *Power to* in a positive sense refers to people's ability to make and act out different life choices, despite other's eventual disagreement. *Power to* can therefore be translated to control; the power to control your life, your actions, your resources. On the other hand, *power over* refers to the ability of external actors to affect another individual (Kabeer 1999, 2005). In other words, it is the negative sense of agency. However, the agency concept does not only concern the visible and open power relations, but also the institutional powers.

Kabeer (1999, 2005) notes that power also operates in absence of explicit forms of agency, and that institutional bias can constrain people's ability to make choices. Further she argues that cultural and ideological norms may be used as a base upon which inequalities or injustices might be based, by denying their existence. People belonging to groups affected by these prejudices are through group pressure inclined to agree and even enforce these standards if challenging them seems impossible or only can be done at a large personal and/or social cost. However, Kabeer does not explicitly link this to *coercive power*, which is what this thesis will argue. Exercising agency therefore becomes an individual task in not only making choices, but also doing so in ways that challenges existing power relations. As *coercive power* often will ensure status quo in regards to their perception of the virus from actors surrounding a HIV-positive individual, empowerment often has to start from within, meaning that the strength to challenge status quo has to emerge from the individual themselves. However, it is important to note that external actors could also exert *power over* and *coercive power* in a positive sense. In the same way, the same actors can also prevent individuals' ability to exercise agency. The challenging of status quo does not only encompass the individual's actual actions, but also their sense of agency in carrying those out, i.e. do they feel a purpose of each action they take? This has to be linked back to the three forms of power, especially the latter two where conflict is not always open but could be hidden or latent. Empowerment is intricately linked to perceived self-worth of the individual actor, something connected to how they are received by their peers and society at large, which encompasses more dimensions than the crude and open form of *power over*.

4.2.2 RESOURCES

Resources include not only material resources but also social and human resources. That is, it not only refers to traditionally thought of *economic* resources such as land, equipment, working capital etc., but also those resources which functions as enabling for the persons involved. It allows the individual actors to utilize their material resources to the fullest extent possible, through their knowledge, skills, creativity, imagination and so on. Human resources mainly focus on the knowledge aspect in a broad sense, where increased knowledge and skills in a particular field enables the actor to make better decisions as well as being more creative. In this sense, increasing

human resources can be seen also as increasing an actor's potential for *agency*. Social resources are made up of the claims, obligations and expectations which inhere in the relationships, networks and connections which might prevail in different areas of our lives (Kabeer 2001:20). In a positive sense, these then enable people to improve their situation and life chances beyond what would be possible through their individual efforts alone. In a negative sense, they might inhibit the same possibilities. Social resources are thereby closely linked to the factors discussed in the previous section regarding agency. The resource-aspect of empowerment is thus closely linked to *power over* as well as *coercive power* (where social aspects are important) in addition to *power to*, to which the more traditional meaning, i.e. material, of resources would imply.

Kabeer (2001:20; 2005:15) defines resources as the medium through which agency is exercised. She notes that resources are scattered throughout the various institutions and relationships in a society, and that through the positions individuals possess in these structures they are able to exercise power over others. This power can be displayed in different ways, but primarily though how rules, norms and conventions are interpreted and converted into practice. In this sense, heads of households, chiefs of tribes, directors of firms and elites within the community all have a decision-making power in different institutions by virtue of their position. The distributions of resources are thus dependent on the ability to define priorities and enforce claims, but equally important it also defines the terms upon which these resources are made available. In other words, *"Empowerment entails a change in the terms on which resources are acquired as much as an increase in access to resources."* (Kabeer 2001:20).

4.2.3 Achievements

While *agency* and *resources* make up the capabilities of people, i.e. their potential to live their lives as they want, achievements refer to the extent to which they fulfil/realize these wishes. This dimension is therefore focused on outcomes, and in the manner that they are achieved (Kabeer 2005:15). There are two major ways of measuring achievements; firstly it can be done through analysing if agency was involved in the outcome, secondly through analysis of the actual outcome and its

consequences. The two do not have to be connected to each other; an achievement such as becoming employed in some manner might be of positive nature when it comes to the outcome/consequences, but still not qualify as empowering as it was done out of desperation because of starving children at home. *Achievements* therefore have a duality to it, where an outcome must be the desired one (through *agency*) of the individual to become empowering; if not it is at best fulfilling a need, at worst actively disempowering the individual (Kabeer 1999; Kabeer 2001).

5. METHODOLOGY

The following chapter argues and explains the chosen research design and strategy. This chapter will also discuss in detail the data collection methods, semi-structured interviews, purposive sampling, transcription and data analysis that are applied to this thesis. Lastly, it will end with a discussion of ethical consideration.

5.1 Research Design: Case study

The research design chosen for this study is an interpretative single-case study that is analysed through a qualitative method (Creswell 2009:4, 7). This single-case study is characterized by an analysis of a contemporary phenomenon within a real-life context (Yin 2009:18). This method allows us to capture the details of particular individuals (HIV-affected members), which is relevant to the purpose of this study, in a contemporary event (Neale, Thapa and Boyce 2006). Similarly, Stake (1994 in Kettunen, Poskiparta and Liimatainen 2001:230) proposes that one should *"select a case that seems to offer an opportunity to learn and contributes to our understanding of specific phenomena"*. The defined case of this research is to investigate the effect of microfinance on household's empowerment, particularly on HIV-infected members, in Tuan Giao district in Dien Bien province. Since empowerment is a complex concept and has different meanings in different socio-economic and political context (Malhotra et al. 2002:4ff), the case study method is suitable to explore how the participants experience empowerment in a given context and time. Furthermore, unlike quantitative research, which seeks to make statistical generalization, this study strives *"to generalize a particular set of results to some broader theory"* (Yin 2009:43). In this respect, the findings generated from this study have the potential to contribute to some broader empowerment theory.

5.1.1 CASE STUDY AREA

The case study took place in Tuan Giao, a rural district of Dien Bien province and is one of the 62 poorest districts in Vietnam (Prime Minister, Socialist Republic of Vietnam 2013 in Tran 2013:4). Tuan Giao[2] consists of one town and 13 communes.

This area is also covered by an overwhelming burden of HIV infections. Despite the effort to raise awareness of HIV being made by local governmental agency and NGOs, HIV remains unabated. It is estimated there are 1400 people living with HIV in Tuan Giao and 609 of those are under treatment. It is also estimated that about 2-5 new HIV infections occur every month (Huang 2013). The primary route of transmission is intravenous drug use but unprotected sex is becoming an increasingly important factor. According to Huang (2013), 60 percent of injecting drug users are affected with HIV. Currently, some interventions of international NGOs are conducted in this area, such as FHI360, which provide antiretroviral (ARV) drugs, HIV testing and counselling services. The Sunflower Network established a project to support women with HIV by organizing community events to strengthen their self-esteem and increase awareness about HIV. The community events are mainly held through meetings where PLHIV can meet and discuss different issues facing them in daily life (Girard 2013:45). Additionally, Community Finance Resource Center, a local NGO, decided in 2011 to establish a project called *Standard Transaction Unit* providing microfinance services and training programmes to the poor, including HIV infected person, in the community with a special emphasis on access for rural women. CFRC believes that they can reach out to poor families through women since women are more likely to share the benefits with others in their household, especially their children. Thus most of STU activities directly target women (CFRC 2012). Seeing how this research focuses on people facing multiple aggravating circumstances, through their poverty, belonging to an ethnic minority *as well* as having HIV, their need for extraordinary measures are even greater than what “normal” circumstances demand of a microfinance organization.

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[2] The latest estimates of total population for Tuan Giao district is 77.446 people (People’s Committee of Tuan Giao district 2010 in Tran 2013:4)

5.2 Research Strategy

Due to the nature of this exploratory research, a qualitative research strategy has been applied as it has the potential to gather an in-depth understanding of the social world of the participants and to learn about their social and material circumstances, their experiences, viewpoints, actions and histories (Ritchie and Lewis 2003:7, 22). Similarly, Maxwell (2005:22) argues that qualitative research is relevant to studies that focus on specific individuals or situations and emphasis on words rather than numbers. Since our research is dealing with some sensitive topics as such HIV, stigma, discrimination and empowerment, a research design focusing on the particular and subjective is deemed like the most suitable alternative. Qualitative research allows us to explore the participants' experience with these issues and the way of doing it is to allow the participants to develop and express their own reality (Mack et al. 2005:1; Dickson-Swift, James and Liamputtong 2008:7). In other words, we seek to gain a deeper understanding of the topic being studied by having a close interaction with the participants and listening to their subjective stories (Creswell 2009:7). The focus will be on their thoughts, feelings and perceptions.

5.3 Data Collection Methods

This thesis seeks to employ two methods in order to answer the research question. The first one will be an analysis of secondary material, such as texts from the Vietnamese government as well as the host organization, CFRC. Seeing how neither of these entities should be viewed as an impartial source, they both deserve some justification. As for the Vietnamese government, their impartiality cannot be guaranteed because the system itself is not transparent (Transparency International 2014); as corruption runs rampant there is no guarantee that money spent and results reported have any correlation whatsoever. However, not all information is false/untrustworthy, but additional sources corroborating, especially for areas/results which could be seen as sensitive, would be beneficial for the reliability of this thesis. Mainly this corroborating data will be sourced from CFRC since the organization has a deep understanding of the area and the issues facing the people in it. That said, data

from CFRC/STU have to be treated carefully as well due to eventual bias; the documents, while factual, also sometimes serves as promotional material for the organization. All documents used are in English, and therefore no translation or interpretative issues should arise.

While a qualitative research is relying upon the secondary data to establish the context of the research question, the answers to the same are often to be found in analysis of primary data. For this thesis, *semi-structured interviews* were chosen. Because anonymity is of utmost importance when conducting interviews - especially with potentially sensitive information (Kvale 1997:109) - the interviewees will be given pseudonyms when referred to in this thesis (see Appendix 1 for a list).

By choosing the above described method for data collection two problems immediately appear. First off, since pseudonyms will be used for all participants, and interviews are recorded but held in Vietnamese (and then translated), reproducibility will suffer. Second, most or all data used for analysis will be based on interviews. That is, all data used except for official documents (secondary data, which will be assumed to be objective through corroboration of eventual controversial statements) will be subjective. The interviews especially suffer from this validity problem - it is a well-known fact within the field of psychology that the same situation might be perceived very differently between two people experiencing it (Munhall 2008). This will inevitably lead to some well-deserved questions regarding whether this thesis will be anything else than a subjective retelling of experiences and conclusions drawn from those being only applicable to the specific case studied. However, this critique comes out of a misunderstanding of the interview from a methodological standpoint, as well as a very negative view on qualitative science. An interview is in no way an equal form of communication (Kvale 1997:118) - despite a relaxed atmosphere and the possibility to opt-out of questions, our objective is to lead the conversation and get the answers to the questions we deem relevant. The methodological angle of attack should therefore not be on the outcome/data that comes out of the interview, but rather against the preparatory work that we have done. To avoid this kind of criticism to the largest extent possible, all interviews were conducted with the help of a document containing the same questions. This document can be found in Appendix 2. The questions were then adjusted to the answers received - questions might for

example be answered in conjunction to other questions and therefore not needed to be asked explicitly.

5.4 Semi-structured Interviews

Interviews are one of the most important methods for collecting information in case studies (Yin 2009:106), and it has been the major source of data in this study. Similarly, Mack et al. (2005:2) argue that interview is an effective technique for collecting data on topics that are sensitive such as HIV, stigma and discrimination. The interviews were collected during the period from November to December 2013. In total we conducted 10 interviews; 9 with HIV-affected households from Thai ethnic group and 1 with a healthcare professional working with the former in Tuan Giao, with each interview lasting on average between 45 and 60 minutes. The healthcare professional's interview was conducted before the interviews with the households; the reasoning behind this was for the information given by the healthcare professional to serve as a kind of background and support to the latter interviews. All interviews were recorded digitally; this was to ensure that no data would be lost and we thus would be able to fully concentrate on listening to our respondents (Bryman 2008:438; Bryman 2012:471-472).

Since we want to measure household empowerment, interviewing both husbands and wives made the most sense because they can provide us with different perspectives and insights into the experience of HIV, stigma and/or discrimination and microfinance. Although STU provides financial services only to women, it can have a wider impact on the household-level and not just individual-level. Therefore including husbands can add new dimensions in understanding of the phenomena being studied. Contraction of HIV often has wide implications for a whole family: it directly or indirectly affects people around the infected person, not only the HIV-positive individual. Leaving out the effects facing other household members would be reductionist, especially considering that Vietnam is a family-based society. What happens in the family (at large) affect all members, no matter the issue. However, we are aware that collecting perception and experience only from wives and husbands

risks losing perspective on how other family members (children, sisters, brothers and/or grandparents) view the issues discussed, but it was deemed too big of a project to include them.

There are cases where the only adult remaining is the woman (**6 out of 9** household interviews consisted only of the wife as the husband has died of AIDS or has migrated to other provinces in search of work). Nevertheless, interviewing both husbands and wives often means that one party's voice, most often the woman's, get lost (Jordan et al. 1992 in Arksey 1996). However, this has not been a significant problem for us. The women, despite being next to their husband while we interviewed them, have often spoken up in ways we did not expect; often speaking freely about their feelings, even if they were negative and directed towards their husband.

Our strategy of mitigating the possible tensions that the topics might arouse was primarily to ensure that we created a relaxed atmosphere before beginning the interview. Firstly, we always conducted the interviews at the participant's home. The participants have always welcomed us into their home with extreme hospitality and generosity. We also made some small talk before the interview officially began - asking questions about their age, occupation, family members etc. This usually opened up the conversation which made it easier to commence with the interview through a smooth transition towards more serious topics. The respondents gradually shared their experiences, feelings and opinions and revealed some of their innermost pains and aspirations. Our strategy was then to always show interest and respect to what the respondents said and actively listen to them (Kvale 1996:128).

Although one of us could speak and understand Vietnamese we still decided to have an interpreter when conducted the interviews. This was because despite knowing the language, she did not feel comfortable enough to conduct the interview by herself. The interviews were therefore done with the support of an interpreter from CFRC. This presented a delicate problem; while many of the participants were familiar with our interpreter due to her work at CFRC, thereby allowing us to tap into information we might not else have gained access to - it introduced a clear bias-problem. Like Creswell (2009:135) notes, qualitative research is interpretative by nature and by having our interpreter having a relation to the subjects studied add yet another layer of

interpretation into the mix. There were two major factors which contributed to us going for this option anyway, namely:

1. We estimated the gains to be larger than the drawbacks. That is, the bias introduced by choosing an interpreter known to the interviewees would be countered by the gains we got from having someone who the interviewees were comfortable around. It is also worth noting here that some of the participants interviewed also recognized us since we have had contact with them previously during our internship at CFRC/STU, thereby possibly reducing the negative impact of familiarity with the interpreter.

2. Capable interpreters were in extremely short supply, both due to generally poor knowledge of English amongst Vietnamese as well as the very remote location where the interviews were held. In general, the knowledge of English amongst Vietnamese borders on non-existence, even more so in the rural and poor areas, further limiting available choices. As a result, the interpreter chosen was the only one we deemed sufficiently proficient in English to complete our interviews.

Although it worked well with our interpreter there are several issues that need to be considered. Firstly, working through an interpreter provides an opportunity for the participants to express their feelings and thoughts in Vietnamese, but it also adds other dimensions to the interview process (Farooq and Fear 2003:105). Since all communication with the participants has to go through the interpreter it means that she has some influence on the process. Secondly, due to the inherent complexities of interpretation and communicating in English, the interpreter may not always be able to interpret word by word. Instead the interpreter has to convey meaning accurately to retain the meaning of what is being said (U.S Citizenship and Immigration Services (USCIS) 2012:20). This means that the original meaning may get lost in translation. Fortunately, our interpreter speaks English at an advanced level which leads us to trust her translation.

5.5 Purposive sampling

The selection of participants was done through a strategic selection (Teorell and Svensson 2007:84). In other words, we chose to perform a *purposive sampling* to maximize data relevant to research aim. The main advantage according to Patton (2002) of carrying out purposive sampling is the ease of selecting well-chosen participants; however he also notes that it can be time consuming. The sampling was based upon a few criterions, namely:

1) The participant household must have at least one member who has contracted HIV
2) The participant household must have completed at least one loan cycle of 1 year

The first criterion is necessary; the research question seeks for HIV-positive households. The second is probably less obvious, why it deserves a few words. It was decided, on recommendation from CFRC, that we would only use people who had completed at least one loan cycle, meaning they had completed one year of borrowing, repaying their first loan in full. The reason for this is two-fold - firstly it will have given the family time to understand the borrowing process, but more importantly, by only interviewing people with a longer period of time in the programme we also get access to experience over time. Empowerment by nature does not happen overnight (if it ever happens), which is why it was deemed to make sense to only include families with a longer time of involvement in the project (STU, as lenders).

We did not choose to employ a control group of interviewees, this was done because the selection of criteria upon which to establish inclusion in this group would have been arbitrary since we did not want to mix sampling methods, and therefore doing so would only have unnecessarily added more sources of potential critique. It could also be said that adding more interviewees to the process, either through an expansion of geographic area (including members from Dien Bien Phu where CFRC has a similar project going for several years) would have enabled us to gain a deeper understanding of the issues. However, this was deemed infeasible, mainly due to the fact that Dien Bien Phu and Tuan Giao are vastly different areas (DBP is urban, TG is rural) and as

a result we would have been trying to compare and analyse data from two vastly different sources. Since the nature of this thesis is qualitative, quality and depth over quantity was preferred, and adding another geographic area was therefore deemed out of scope. The authors therefore concluded that focusing on Tuan Giao would produce a better thesis, and suggest that further research is done on the same topic in Dien Bien Phu in order to produce comparable results between urban and rural areas, as well as expanding on the literature on the linkages between microfinance as empowerment for HIV-affected households.

As this thesis only focused on microloans, the full impact of microfinance could not be assessed. A more thorough study ranging over all the aspects of microfinance might reach a different outcome than this thesis. However, for STU there were no special perks or incentives given to HIV-positive households (such as better health insurance coverage, higher interest on savings or such), which is why the outcomes of these factors are probably not different from a non-infected household.

5.6 Transcription and Data Analysis

While all interviews were recorded, we also did a live transcription of the answers given to us during the interview. After all interviews were completed, the transcriptions were then double-checked through a complete re-listen of each interview where the transcription was compared to the recorded interview. The transcriptions were then read in full several times to get a clear understanding of the data (Bryman 2009:554). Since the interviews were done with a fixed questions template, sorting the data into different themes was less problematic than it would have been should we have chosen a more open-ended form of interview. Nevertheless, it was quite frequent the answers we received did not exactly "match" the question asked. To mitigate this problem all answers recorded in the transcription were thermalized and put into categories to give a general idea of the incidence of specific answers in areas deemed important by theory. Since the interviews were held in Vietnamese, it is of utmost importance to mention that all direct quotations are translated and subsequently might differ from the original context.

5.7 Ethical consideration

When we entered the field we were met with much curiosity along with suspicion and scepticism. We were frequently mistaken to be the project donors and it made us realize how important it is to clearly explain who we were, the purpose and intention of our fieldwork.

Some of the participants were curious about what we would do with the information we were collecting from them. We made sure they understood that our research was strictly educational and that any information they provided will be treated confidentially. We also ensured them that they would be anonymous in our research. We believe it is utmost important to protect the interest of the participants so that our research would not be a disadvantage for them or could harm them in any other way. Before we started the interviews, we gave them an oral informed consent which is

according to Mack et al. (2005:9) *"[...] one of the most important tools for ensuring respect for persons during research"*.

One of our main concerns was that the participants might not feel comfortable to express themselves in front of us especially since the topic is sensitive (HIV is often associated with *social evils* and shame). On one occasion the participant interrupted the interview as it was too painful for her to continue; at that point we immediately ended the interview. In response to this we tried to further ensure tact in order to comfort the participants and made sure to remind them that they were not obligated to answer any question that made them feel uncomfortable (Mack et al. 2005:40). We had met some of the participants several times during our internship which helped us to build up trust between us and the participants. Overall we found that most of participants were more welcoming than we would expect and were generally enthused to participate in our research. They responded a lot more openly to us than we expected, although this may partially have been due to the fact that they also saw it as an opportunity to voice their concerns.

6. Analysis/Discussion

This chapter will be divided into two parts. Firstly, we intend to discuss empowerment from the perspective of the research question. This will be followed by a brief summary on HIV and the household. Finally, we intend to discuss other factors important for empowerment which our findings highlighted throughout the process.

6.1 Economic impact on households

The HIV impacts on household begin when the member falls sick from HIV-related illness. The loss of a productive household member, which results in loss of income, is the first impact of HIV. This is followed with the increased cost of medical treatment for the sick member (UN 2004). The impact of HIV on rural households is undeniable, making them even more vulnerable than "normal" poor households.

A majority of the participants expressed their concern of having financial difficulties. The main sources of income are from agriculture and construction activities. Still, some families are struggling to afford food. One participant mentioned that although her husband works as construction worker and she stays home to raise pigs, ducks and chicken. The income is barely enough to live on. They suffer from one to two months of food shortage each year. Not only that, the participants reported having financial problems specifically link to their HIV-positive status. They have suffered loss of income or/and jobs, while their medical costs increased. Thanh (32 years) explained:

> *"Our financial condition has always been bad…. Before we discovered that my husband had HIV he used to work in Tuan Giao and we managed to keep our financial situation quite stable. But when he became too sick and could not work anymore we relied only on my income and it was tough. The financial situation became worse when he died and I became sick…"*

HIV is clearly affecting Thanh's family. While their financial situation has been bad enough, HIV has worsened their legacy. Our results showed that HIV has the potential to aggravate poverty by pushing affected households deeper into poverty.

> *"HIV has caused financial problems to my family. Especially when I was in the hospital for a month. We did not have much money. All our money went to my hospital bills. I have health insurance but it only covered a small sum of the hospital bills. When I came back home I was weak and needed to rest for a month before I could go back to work"*

(Ha, 32 years).

The economic consequences of HIV are even worse for households if the sick person is the family breadwinner (UN 2004). Thu's family has always been classified as a poor family. Her husband died in 2006 of AIDS and when she got sick in 2011 and was hospitalized, the family's financial condition became worse. At that time, she was the only breadwinner left to the household. She explained:

> *"When I was really sick I could not do anything or earn any income in one year. I had to sell everything that was valuable (new motorbike, earrings...) to pay for my hospital costs (48 million dong[3]). If I had died I would not have anything left in the house to give to my child."*

(Thu, 47 years)

Providing microloans and other financial services thereby becomes a way to empower people through supplying a resource they desperately need, and in our case it has done effectively. Microloans therefore gives the *power to* exercise choice, also building agency as a secondary effect.

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[3] 48 million dong approximately equals 2300 dollars (as of 2014-05).

6.1.1 THE IMPACT OF MICROFINANCE PROJECT: STU

In recent times, microfinance has been seen as a promising instrument to deal with the economic and social chock posed by HIV. Some scholars argue that microfinance can help the poor to protect against risks and allow them to take advantage of economic opportunities (Caldas et al. 2010:987; Pronyk et al. 2005:27). Hence, CFRC established the STU project in Tuan Giao and most of the participants reported that they have never borrowed money from a financial institution. STU is the first microfinance project that they have borrowed from. The participants use the loan to create jobs and/or invest in their business, often in farming and livestock activities. Some also use the loan to pay the school fees and hospital bills. They reported that borrowing from the project is very convenient. The profits were used to buy motorbikes, furniture for the home, to pay the school fees, to expand and reinvest in the farming business.

> *"I am happy that I can borrow money from the project (STU) to invest in my business and for other purposes. For instance, if I need the money to buy materials for my mattress business or things for the house I can use the loan for it and can work later to repay the loan. I think it is very convenient to borrow from the project to use in my business. Things are better now… The financial condition is better now; I do not have to worry so much about food or meal every day."*
>
> (Thu, 47 years).

The microloan taken by Thu as a form of *material resource* indicates that the project has a positive impact on the life of the participant. She described a satisfaction over the fact that she has now the money to invest in her business and be able to support her family financially. She experienced a change that had positive dimensions for her and for the family. In addition, one can say that the loan that Thu took was used to exercise her agency in a way that stimulates her confidence and financial independence. Thereby, the microloan also provided her with *achievement*, success through the utilization of the *agency* and *resources* available to her. She is the breadwinner in the family. Similarly, Van and Trang expressed their gratitude for the microloan:

> *"Thanks to the loan, I have a job now and can support my family financially. Before I did not have anything to do. Now I have pigs to raise. I feel happier and more active. I can go to find vegetables and food for the pigs."*
>
> (Van, 34 years)

> *"My children can go to school and I can feed them. Before I did not have the money to buy them breakfasts but now I can feed them three times per day."*
>
> (Trang, 30 years)

In both cases, microcredit has proven to have the potential to improve the quality of lives of borrowers by enlarging and enriching their source of income. Some of the participants expressed their satisfaction of being able to pay the school-fees for their children. This was a recurring theme amongst interviewees; many of them reported feeling an increased sense of importance, pointing to some kind of empowerment taking place through *achievements*.

Most of the participants have attended at least one training programme provided by STU. The most common training programmes are: how to raise livestock (pigs, chicken, ducks), soil training, business training and anti-discrimination. A vast majority described a satisfaction with the trainings attended; feeling trainings equipped them with knowledge. Lien (27 years) said: *"I have enjoyed all the trainings and I could apply some of the things that I learned to my business. I feel very happy to attend the trainings with other members"*. Lien described a satisfaction over the fact that she can apply this knowledge to her business but also how she enjoyed meeting with other members.

The gains from the training programmes are twofold. These training programmes can be seen as a way to foster social network and community cohesion especially for HIV positive members. The training programmes can be related to the *social resources* in the sense that it provides a social network for the participants. Most often, PLHIV isolate themselves from social events because of the fear to be stigmatized or/and discriminated. In addition, the trainings tend to enhance the participants' knowledge,

thereby increasing their *human resources*. These trainings enable them to make better decisions regarding their business as well as increasing the participants' potential for agency. Through providing *social resources* as well as *human resources*, these trainings are to be seen as building *empowerment*.

In regards to microcredit and trainings, they thereby seem to build empowerment to a certain extent. However, neither seems to be able to *start* an empowerment process, but rather build upon a process already set in motion by other factors. These factors often tie in to microfinance and especially training activities, but deserve to be discussed separately, since they are not always connected to STU.

6.2 HIV and the household

Although HIV has existed in Dien Bien province for more than one decade, the HIV and AIDS knowledge amongst the general populace is still limited. Most of the participants said that when HIV was introduced to their household they did not know much about the virus. Women reported being infected with HIV through injection drug use by their husbands or because the husband had unprotected sex with other women before the marriage; in none of the households interviewed were the woman the point of entry of the virus initially. Further, in most cases the husbands' infections were not diagnosed which caused a "hidden transmission" among women. Minh (25 years) explained: *"since both of us did not know about my husband's HIV status we did not use any protection"*. One participant got HIV from stepping on a syringe having been used by an HIV-positive person. Some participants reported that they did not know about their HIV status until they became sick and went for a check-up.

> *"My husband was sick and was hospitalized in one week. The blood test showed that he was infected with HIV. I went for a check-up right after I heard he got HIV. My husband was a drug user (since 2005) and got the virus through injecting drugs. It started when he worked far from home. I did not know he was using drugs. It was when he was hospitalized in 2009 that we discovered about the virus."*
>
> (An, 39 years)

The issue is further complicated by the fact that it is common that the husband migrate to other provinces to work, leaving the women with little knowledge regarding, for example, eventual drug use. All participants reported that once they heard that they were infected with HIV they took their children for check-up to make sure that the children are free from the virus. Minh (25 years) said: *"My child has been to the health-care centre three times for check-ups and he is healthy"*.

The projects undertaken by STU and FHI360 (the two main NGO-actors in the Tuan Giao area) primarily aim to ease the burden of HIV through direct means (providing ARVs and microloans respectively). As noted previously, both organizations do provide other services and some of those projects do not serve to primarily strengthen the *power to* aspect, but rather challenge the second and third aspect (the *power over* and *coercive power*). This is done primarily through education challenging the reigning prejudices and misconceptions surrounding the virus. The impacts of this will be discussed later in this chapter.

6.3 Access to antiretroviral treatment

Antiretroviral (ARV) drugs have only been available in Tuan Giao since 2009 but it has proven to be a key factor in empowerment of the people living with HIV. Although ARV drugs are not a cure, it allows the participants to remain healthy and live a normal length life. Thus, access to ARV drugs has been a crucial factor for PLHIV. A vast majority of the participants reported that they became seriously ill before getting diagnosed and subsequently getting access to ARV treatment. One

participant said: *"I became very sick and coughed a lot and if I did not have access to medical treatment I would have died. I was very weak"* (Van, 34 years). Moreover, the participants argued that since they have started with this ARV treatment their health conditions have stabilized and CD4 have improved. They are able to work again and support their families. The following are some examples:

> *"Now that we [my husband and I] have accessed to ARV drugs we can work again. If other people can raise pigs so can I... I hope my health will remain fine in the future so that I can continue to raise pigs and chicken to earn income to pay for my child's education."*
>
> (Lien, 27 years)

> *"I take my medications at the same time every day. My health condition is much better now. Before when I have no access to ARV I was very thin and I thought I would die. Between 2007 and 2009 I was very weak and could not do anything. I could not even cook so my mom had to bring me food."*
>
> (Thanh, 34 years)

Discussing this in the light with Kabeer's (1999, 2005) definition of empowerment where disempowerment is the first condition; the participants were disempowered when HIV took control over their life. Once HIV has taken hold it constrains a person's ability to make choices. It is very difficult for someone who is ill to carry on both the non-income and income generating activities. ARV drugs are helpful in terms of increasing the CD4-count and enhancing the lifespan of the participants. These drugs can be seen as a *material resource* in Kabeer's empowerment framework. Our findings showed that ARV drugs are essential for the participants to enhance their ability to exercise choices. Thus, having access to antiretroviral treatment can help the participants to expand their ability to make strategic life choices which was previously denied to them. These choices are vital for people to live the lives they wish (Kabeer 1999, 2005). In other words, one of the main components to coping with HIV is feeling empowered; feeling that a person has access to resources (such as ARV drugs) that compensate for life's challenges posed by HIV. Moreover, having access to ARV drugs can also be linked to *agency*

particularly the positive sense of power - the *power to*. It enables the participants to act upon their own goals. Hence, ARV treatments serve to strengthen both the resource and agency dimension of empowerment.

Emerging from both Kabeer's and Lukes theories, FHI360 is the main provider of material resources i.e. ARV drugs which signify that they have *power over* HIV-positive members. In other words, the participants are dependent on FHI360 to have access to this resource. In light with this view, the participants' capacity to make choices is likely to be limited; they are disempowered in the sense that they have been denied the ability to freely and independently make choices. For the moment however, this has to be seen as a necessary sacrifice to make, since there are no viable alternatives.

For HIV-positive households, the social environment around them therefore becomes pivotal in regards to their access to resources. They are thereby affected by *power over* through their peers, as well as *coercive power* through the societal values. *Empowerment* thereby does not only happen through the establishment of a stable economic ground, nevertheless a household's economic situation might be a vital part of an *empowerment* process.

6.4 Social impacts

As noted before, HIV is regarded as a *social evil* in Vietnam at large, and the individuals affected by the virus are likely to face discrimination. Therefore, according to Kabeer and Lukes theories, through the *coercive power* of the government and Vietnamese society at large, the HIV-positive members of STU should be affected by all three forms of power in a negative sense, only being able to exert *power to* in a positive sense.

In the interviews we did it was indeed confirmed that the HIV-related stigma and discrimination place a heavy psychological burden to the participants. Shame and fear of discrimination often prevent people from seeking treatment for HIV or disclosed their HIV status (VNP+ 2012:12; ICRW 2010:1; Smart 2014:120).

> *"When we [my husband and I] got the news we were very sad. I only saw darkness before my eyes. I was afraid and was shaking. I did not know what will happen next.... when I will die? I was also afraid to tell people because they might discriminate me if they knew about my disease."*
>
> (Lien, 27 years)

Lien also said that her husband did not want to go to the hospital because he was ashamed but she convinced him to seek treatment. At the beginning they did not dare to tell anyone, even to their families, about the news because they were afraid of stigma and discrimination that they might face if they disclosed their HIV status. Trang (30 years) shared similar story:

> *"When we [my husband and I] got the news that we were infected with HIV we did not tell anyone. It was not until my husband passed away that my told the parents about the disease."*

Driven by the fear of being rejected or abandoned, some of the participants seemed to occupy a position of limited power within their relationship with their family, friends, neighbors and communities. In short, fear can affect many aspects of a person's daily life. Thus, PLHIV tend to be disempowered mainly through a societal pressure, i.e. *coercive power*.

The participants identified the stigma and discrimination they encountered in many community settings as a significant factor affecting their quality of life. They described both actual experiences of discrimination based on their HIV status, as well as how their HIV status constrains their ability to work and earn income:

"At the beginning, many people in my community discriminated me. When they saw me they talked behind my back. People at my work did not want to work with me. I used to work in a restaurant but the people in the community kept telling to the owner that I have HIV and that the restaurant will lose it customers if I continue to work there. They tried to get me fired...
Now I work sometimes in Son La province as a construction worker. I actually do not want to work in Son La but it is too difficult to find a job here in Tuan Giao. There are still some people who talk behind my back so I have no choice. No one wants to hire me here. In Son La people do not know about my HIV status."

(Thanh, 32 years)

Although the virus is relatively common in the Dien Bien province, there still exist considerable barriers of entry to all sorts of markets for people infected. This includes not in the least the job market, where the HIV-positive people's eligibility is of constant question (due to negative prejudices from *coercive power*). However, it is also important to note that not all interviewees reported facing discrimination or social exclusion once their status as infected became known; Van (34 years) told us in response to the question how she felt when she got the news:

"I just wanted to die ... I was afraid that other people would discriminate and turn their backs on me [...] But my family showed me sympathy and supported me. I was afraid people would know about my disease, but now they have better knowledge about HIV so now I'm not afraid anymore"

Thu (47 years) also shared her experience:

"I was very sad but I tried to think positively [...] Thanks to many communication efforts within the community, people in this village have some knowledge of HIV so no one discriminate or stigmatize me or my family".

These narratives show that further education about HIV, either through peer-education or through an increased rate of STU-led seminars and workshops, should be emphasized as a possible solution to the rejection-problem: generally, knowledge about HIV is still subpar, and interviewees report that increasing knowledge generally also makes their peers more likely to accept them.

How has societal perceptions of PLHIV been changed and where is it heading? From our research, the answer is two-pronged:

First off, the work of FHI360 in providing antiretroviral drugs has enabled most of the HIV-positive families to think positively of the future. Equipped with the knowledge that their virus is not a death-sentence, they generally have a positive outlook on their future. This provides them with *agency* (the *power to*) and re-*empowers* them enabling them to exercise greater choice in their life. A person not ashamed of who they are will also be able to exert greater control and influence others to accept them. This, in combination with information about HIV being distributed to several "levels" of society (the first meeting arranged by STU we attended was for educating government officials on HIV) has started a shift in the reigning *coercive power* which associates HIV with *social evils*. This change may also in the long run shift the *power over*, where PLHIV still are discriminated against in a plethora of ways, not in the least in the job market. Should this change prove to be continuous, the economic outlook for the HIV-positive people will also improve through increased employability as well as less social pressure.

Secondly, the interviewees who have attended the sunflower network meetings all report that the group strengthened their sense of self-worth as well as their self-confidence. Talking to others in the same situation, exchanging experiences and information helps the affected, effectively empowering each other. Other meetings, such as centre meetings (where the borrowers of STU go twice a month to repay loans) and trainings were also mentioned as having the same effect, albeit not at the same frequency as the sunflower meetings. The meetings are not only business though - the participants also reported that they joke around and laugh a lot, thereby also possibly releasing tensions from daily life. This also binds into the argument made during the previous point: People who *feel* empowered (even if those are not the

words they would use to describe it) **are** empowered in an *agency*-sense; that is, as far as their resources will allow them to be.

Nevertheless there are some remaining problems. Vietnam is a strongly patriarchal society, and the empowering efforts by NGOs mostly target women (although access to ARVs is, of course, universal). Although many of the women share the information and knowledge with their husbands, empowering alone them might also challenge the prevailing gender norms. While this could be seen as a very large positive on a macro level, on a micro level there is a risk of it being a destabilizing factor, something which might mean individual women fare badly. Further, even though the women and family at large might be empowered, gender structures might still mean women fare badly despite other empowering measures; Huy and Thuy (47 and 37) told us:

> *"I [Huy, husband, HIV-positive] never used condoms and still do not use it. My wife only takes contraception pills. [...] I used to work as a nurse [...]"*

> *"I [Thuy, wife, HIV-negative] have told my husband we should use condoms but he refuses"*

So even though they are both equipped with sufficient information and knowledge, Huy even having worked as a nurse, they still do not use protection which could prevent the spread of the virus to Thuy. This might reflect the fact that women have little power to negotiate safe sex practices with male partners, especially in marriage (Rosenberg et al. 2010:911). Here, empowerment and knowledge plays second string to cultural and societal rules (the reigning *coercive power*), potentially leading to a very destructive outcome.

7. CONCLUSION

The HIV epidemic in Tuan Giao district has caused a severe effect on households with HIV positive member(s). HIV affects not only the health of infected individuals, but also pose emotional strain for their families and a major strain on household resources. On top of this, Tuan Giao is one of the poorest areas in Vietnam, making it even more vulnerable to HIV infections. There are currently some NGO interventions in the area provide ARV treatment and microfinance services. Inspired by these interventions, this research is built upon the establishment of a microfinance project, STU. The aim is to increase the understanding of the impact microfinance and the training programmes have on the empowerment on HIV-affected households in the local context of Tuan Giao district.

Our results indicate that microcredit and trainings have the potential to make a significant impact on the life of the participants, but it is not the delivery of microcredit in itself that would initially empower HIV positive members. Microcredit has little influence on a person that is sick with HIV if he or she does not have access to medical treatment. Having access to ARV drugs and stay healthy is more crucial for a HIV positive member than having access to microloan. In other words, microcredit can be understood as a second order choice which may be important for a person's quality of life but it is not an overall solution. Trainings can serve to build both *social* as well as *human resources*, by increasing the knowledge of participants and enabling them to utilize their resources more effectively.

Findings from the study show that access to ARV drugs is the main factor of empowerment for PLHIV. ARV drugs can be understood as *material resources* which are necessary for HIV-positive individuals to enhance their ability to exercise strategic life choices which was previously denied. Those choices are vital for people to live the lives they want. In other words, ARVs help to improve and stabilize the health conditions of the participants and enable them to work again and support their family financially. These drugs also help to strengthen the participants' *agency* - the

power to - which enables them to act upon their goal. This *agency* is both displayed through increased availability of choices, but also the self-confidence to act upon those.

The fear of being rejected or abandoned has discouraged the HIV-positive members to reveal their status to family, friends and community. One can say they are disempowered mainly a through societal pressure, that is *coercive power*. This study also finds that PLHIV experience stigma and discrimination specifically linked to their positive status, not in the least the job market which has constrained them from working and earning income. However, not all participants reported experiencing stigma, discrimination or social exclusion. The increased knowledge about HIV has improved the attitude towards those infected.

To overcome the sense of exclusion, most interviewees reported that different kinds of social interaction, be it with other HIV-positive members or "regular" STU-members through trainings and workshops helped them immensely to build *agency*. The key components appearing from the responses received identified the building of *social resources* (through for example meetings such as the sunflower group, trainings such as those arranged by STU as well as other social activities) as well as receiving ARVs and thereby regaining access to a pre-infection life-expectancy were the strongest factors in building empowerment overall. That said, microfinance does play a role in the empowerment process **once** these criteria have been fulfilled. In essence, microcredit can work as a catalyst of an already started empowerment process, but alone cannot start it for PLHIV. These results point towards that building *agency* as well as providing *resources* are more crucial to start an *empowerment* process than to enable people acquiring *achievements*.

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Trang (2013). Interview with person(s) living with HIV in Tuan Giao.

Ha (2013). Interview with person(s) living with HIV in Tuan Giao.

Huy and Thuy (2013). Interview with person(s) living with HIV in Tuan Giao.

An (2013). Interview with person(s) living with HIV in Tuan Giao.

APPENDIX 1 – LIST OF INTERVIEWEES

Alias	Husband/Wife	Age	Interview Data
Huang	Health-care professional	35	Nov 6, 2013
Thanh	Wife	32	Nov 25, 2013
Minh	Wife	25	Nov 26, 2013
Van	Wife	34	Nov 26, 2013
Lien	Wife	27	Nov 26, 2013
Thu	Wife	45	Nov 27, 2013
Trang	Wife	30	Nov 27, 2013
Ha	Wife	32	Nov 28, 2013
Huy and Thuy	Husband and Wife	47 and 37	Dec 16, 2013
An	Wife	39	Dec 16, 2013

Appendix 2 – Interview Template

Hello, we would like to introduce ourselves and explain why we are here in your village. We are Helena Nguyen and Viktor Söderqvist and we are students from Lund University, Sweden. We study a master programme in International Development and Management.

As part of our programme, we are required to do a internship in any developing country. We decided to do our internship in Vietnam with CFRC. The purpose of our field study is to collect data for our master thesis. We want to gain a deeper understanding of the impact microfinance have on your households in terms of social relations, family income and access to health care. Hence your subjective perspective and experiences are utmost important.

We want to ensure you that you will be anonymous in our study despite asking for your name and details. Moreover, we would like to ask for your permission to record this interview.

Name:
Age:
Children:
Occupation:

Date:
Time:
Location:

Questions:

Introduction / HIV basics

1 Personal introduction; name, age, occupation

2 How did HIV get introduced to the household?

- How long has the household been affected by the virus (when was first contraction?)
- How did it spread (this qn might be avoided through logic, but if unclear ask)?

3 Are any of the people affected taking any anti-retroviral medicines?

- If so, regularly?

- How long has the person(s) taking the ARV been doing so?

- Why/why not?

4 What's the status on the virus/disease, if any (still HIV - transitioned to AIDS)?

5 How did the member feel when he/she got the news of having contracted HIV (/their partner having contracted HIV)?

HIV and family

6 Does the family have children who have HIV?

- If so, how was it contracted?

7 Has the virus affected the children in any other way (such as bullying at school, friends not wanting to play etc)?

8 What are the member's thoughts around their children and the virus? Are there any plans or ideas what will happen to the children once one or both parents die?

HIV and economic circumstance / microfinance

9 What was the financial situation for the family before HIV was contracted?

10 Since contraction, did this situation change? If so, how and why?

11 Why did the member decide to borrow from STU? Did he/she receive what he/she requested?

12 Apart from borrowing, what other activities have the member attended?

13 After borrowing, have you experienced any change to yourself, your family, your economic well-being and social relations?

HIV and society

14 Have you experienced any stigma or discrimination against (or been treated badly) by:

- The community at large ("society")
- The community you live in (neighbors and such)
- Relatives
- Friends
- Employer(s)/employees

15 If yes to any of the above: In what way?