
# Revealing the difficulties AIDS affected households have faced in repaying the loan in DEPROSC's poverty reduction project in Rasuwa District, Nepal.

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## Acronyms

| | |
|---|---|
| AIDS: | Acquired Immunodeficiency Syndrome |
| ARV: | Antiretroviral |
| CO: | Community Organization |
| DEPROSC: | Development Project Service Center-Nepal |
| IG: | Income Generation |
| HIV: | Human Immunodeficiency Virus |
| PAF: | Poverty Alleviation Fund – Nepal |
| RF: | Revolving Fund |
| SCODEP: | Sustainable Community Development Project |
| UNAIDS: | The Joint United Nations Programme on HIV and AIDS |

Euro (€)1 = Nepalese Rupees (NRs) 110 (Approximately)

## Abstract

DEPROSC has implemented a poverty reduction project, which has facilitated income generation (IG) loan to poor agricultural households in the Rasuwa District of Nepal. Households have organized themselves in group (known as community organization). This IG loan is subject to repayment to their group's revolving fund. So far 3003 project beneficiary households have received the IG loan. The loan repayment period is 2 years. Generally, cent per cent repayment of the loan in revolving fund means there is no outstanding loan to be collected or crossed due date. But maintaining a repayment rate more than 95% is also considered as good for revolving fund (Project Report, 2012). However, by 2012 the outstanding loan in revolving fund had reached 27% (out of 3003 IG loan beneficiary households 1143 households are unable to repay the IG loan) and DEPROSC has not been able to trace out its embedded reason. So a literature review was conducted to study about the focal problem (of non repayment of IG loan) to identify its causes. Several literatures indicated that impact of AIDS can affect household livelihood because it pushes the household into debt, which ultimately increases the difficulties to AIDS affected households in repaying the loan. It also shows that impact of AIDS is likely to be seen in migrant households the most. Since, DEPROSC has insufficient information about the impact of AIDS in the household livelihood through this research DEPROSC wanted to investigate the difficulties AIDS affected IG loan beneficiary households have faced in repaying their loan in Rasuwa district because almost 78% of households in the project area have at least one member in the household who is a seasonal migrant. The study has employed qualitative approach to excavate data from field level and analyse them accordingly.

The research found that most of the respondents were already in debt before they implemented IG activity. So before implementation they had a big expectation from their IG activity. It was identified that they implemented their IG activity wisely. But gradually IG activity implementation became challenging as household did not receive the desired income. It was also found that due to heterogeneous IG activity selection by project beneficiaries, they were unable to produce in bulk to reach the market. Travelling 4 hours a day to sell two litres of milk was a very challenging situation indeed for a person who lives in a remote part of the district. At the same time, the household head became chronically ill and household expenditure on health care rise. Faith healing became the desired option for many respondents to cure the AIDS illness. As faith healing is expensive, without much of the option, respondents started selling items they purchased from IG loan. Both loan and credit of household increased dramatically within a year that now they have a negligible source of income. They are compelled to consume wild plants. This has further weakened the health status of whole family members, which directly affected the income source of household.

Based on the findings of the research some recommendations are made to DEPROSC, which are mainly to conduct a baseline survey to identify the demographic status of chronically ill household because AIDS affected households urgently need food support. Likewise it is also very necessary to organize awareness program on HIV and AIDS to project beneficiaries in the study area. The study has also made in general recommendation to develop strategies to build up linkages with markets as the key part of IG project implementation in future.

Furthremore, this research has identified another issue which require further examining. The issue is about those households where there is AIDS related mortality. There is need to study the loan insurance policy so that if the person living with AIDS dies then households can be supported with new IG loan to initiate next income generation activity. So the rest of the aspects and concerns are left for further research by the researcher.

# CHAPTER 1: INTRODUCTION

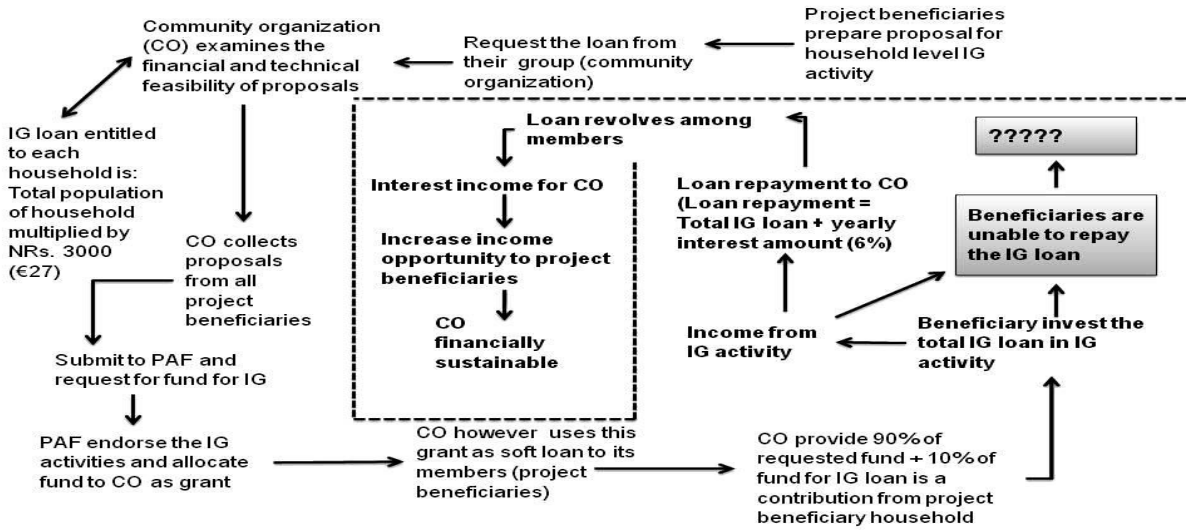
This introductory chapter is the beginning of a quest for me as a researcher. The chapter begins with the background of the study where a brief introduction of DEPROSC and poverty reduction project intervened by DEPROSC is highlighted. More specifically, the chapter has focused on the prevailing poverty in Rasuwa district along with the trend of male migration and its connection with HIV and AIDS. In the similar manner, the chapter has the overview of a poverty reduction project, its beneficiaries and status of the loan in the study area.

## 1.1) Background

Development Project Service Centre – Nepal (DEPROSC) is a non-profit non-government organization (NGO) established on 26 September 1993. With the mission of poverty reduction, since its inception, DEPROSC has envisioned micro-credit for the rural poor as one of the key tools in poverty reduction and bringing about social change.

Since 2006 under the financial and technical support from the Government of Nepal, Poverty Alleviation Fund (PAF-Nepal), DEPROSC is implementing "sustainable community development project (SCODEP)" for poverty reduction in three village development committees (VDCs) of Rasuwa district. The VDC is the lowest local government unit of Nepal (CBS, 2012). The target beneficiaries of this project are poor agricultural households with less than 12 months food sufficiency in a year. The households were selected applying participatory rural appraisal tools such as social mapping and well-being ranking in 2005. In each VDC, the identified beneficiary households have formed a group - (known as community organization). Each community organization has 31 project beneficiary households as members (on an average). Over the years, DEPROSC has facilitated people to form 96 Community Organizations (COs) and has covered 3303 households in these VDCs. In each CO the members are entitled to income generation (IG) loan, so that they can start income generation activity at household level.

**Figure 1: Situation overview of project**




Source: Analysis of Project Report (2012)

The implementation of IG loan policy is simple and understandable by project beneficiaries (Project Report, 2012). As shown in figure 1, PAF provided financial assistance in the form of grants to the concerned community organizations; this grant through becomes a soft loan

to CO's members who will repay after successfully implementing their IG sub projects. To get this loan beneficiary has to deposit 10% of the total requested IG loan as their contribution. They implement any one of the income generating activities such as goat farming, buffalo raring, beekeeping, poultry, tailoring and running small enterprises like local tea shop and retail shop from that loan at household level. With the income from IG activity they repay the IG loan in their group. The interest rate for IG loan is 6% (commercial bank charges 12 -14% interest rate on loan) and loan return period is 2 years. As the IG loan is subject to repayment in their group of households, the money revolves within the group members, which ultimately leads to financial sustainability of community organizations.

The progress of IG loan repayment was normal within the first few years of project implementation, by 2008-09, out of total loan disbursed only 1.6% of loans were outstanding in the revolving fund (Project Report, 2010). However, by 2012-13, the outstanding loan in revolving fund had reached 27% (out of 3003 IG loan beneficiary households 1143 households are unable to repay the IG loan) and the figure is increasing (Project Report, 2012).

**Table 1: IG loan beneficiaries status**

| S.N | Settlement | Total IG loan beneficiary (households) | Households that have not repaid their IG loan | Households that paid IG loan and taking further loan for more than one time | Loan repayment period | Yearly interest rate on loan |
|---|---|---|---|---|---|---|
| 1 | Yarsa | 866 | 438 | 429 | 2 years | 6% |
| 2 | Bhorle | 974 | 514 | 450 | 2 years | 6% |
| 3 | Dhaibung | 1163 | 191 | 973 | 2 years | 6% |
| Total | | 3003 | 1143 | 1852 | | |

Source: Project Report, 2012

The outstanding loan from the CO's revolving fund had reached 27% of the total fund. As shown in the table below,

**Table 2: Revolving fund status**

| VDC | Unit | Outstanding loan amount | Regular loan amount | Total loan amount |
|---|---|---|---|---|
| Yarsa | € | 47,577 | 76,970 | 124,547 |
| Bhorle | € | 48,258 | 106,313 | 154,570 |
| Dhaibung | € | 7,372 | 94,743 | 102,114 |
| Total | € | 103,207 | 278,025 | 381,232 |

Source: Project Report, 2012

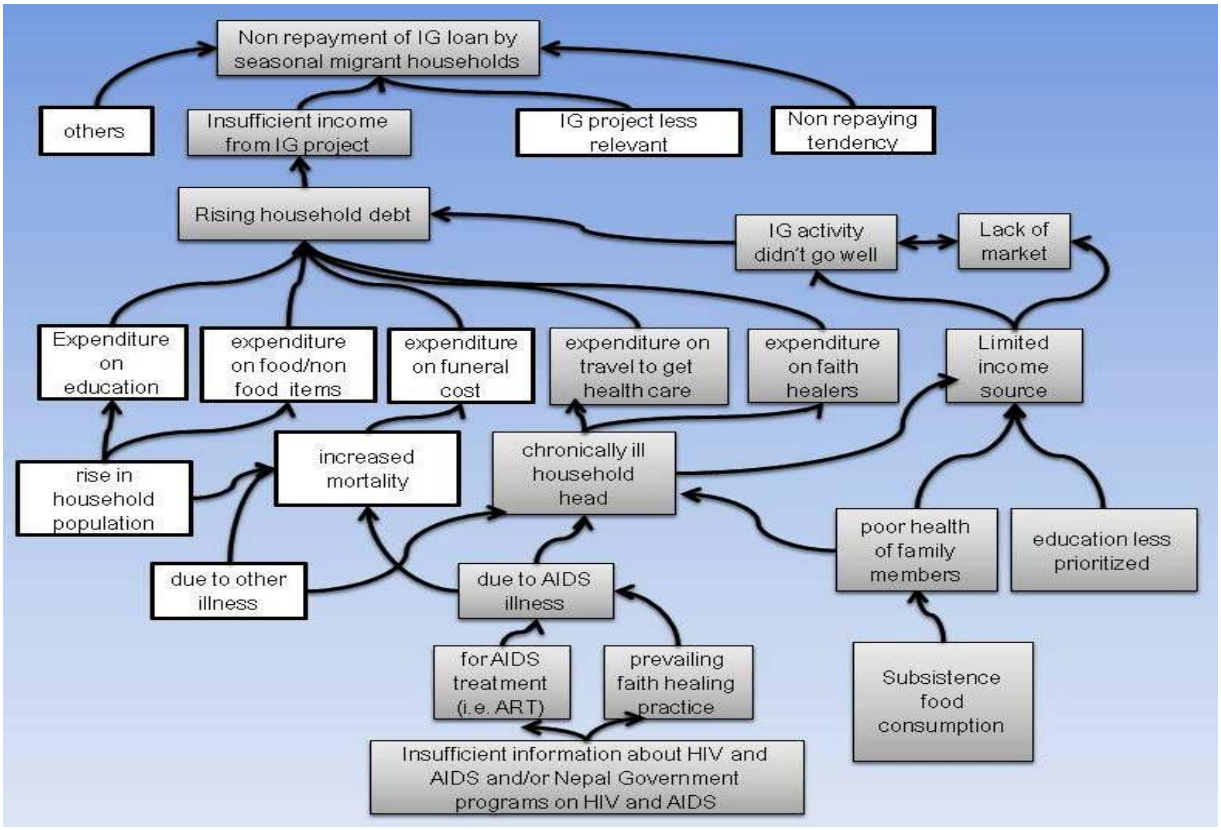
*The amount is converted from Nepali Rupees to Euro, here 1 € equals 110 Nepali Rupees.*

## 1.2) Statement of problem

DEPROSC has implemented a poverty reduction project, which has facilitated income generation (IG) loan to poor agricultural households in the Rasuwa District of Nepal. This IG loan is subject to repayment to their group's revolving fund. So far 3003 project beneficiary households have received the IG loan. The loan repayment period is 2 years. Generally, cent per cent repayment of the loan in revolving fund means there is no outstanding loan to be collected or crossed due date. But maintaining a repayment rate more than 95% is also considered as good for revolving fund (Project Report, 2012). However, by 2012 almost 1143 beneficiary households out of 3003 could not repay their IG loan and DEPROSC has not been able to trace out its embedded reason. So a literature review was conducted to study about the focal problem (of non repayment of IG loan) to identify its primary and root causes. As shown in figure 2, several literatures indicated that impact of AIDS can affect household livelihood because it pushes the household into debt, which ultimately increases

the difficulties to AIDS affected households in repaying the loan. It also shows that impact of AIDS is likely to be seen in migrant households the most. Since, DEPROSC has insufficient information about this, through this research DEPROSC wants to investigate the difficulties AIDS affected IG loan beneficiary households have faced in repaying their loan in Rasuwa district. In a context where almost 78% of households in the project area have at least one member as a seasonal migrant, a research becomes apparent for DEPROSC.

**Figure 2: Cause analysis of non repayment of IG loan**




Source: Author analysis (2013)

**Problem owner: DEPROSC**

## 1.3) Objectives

The objective of this research was to examine coping strategies that AIDS affected income generation loan beneficiary households have pursued so as to know the difficulties they have faced in repaying their loan by making recommendations based on analysis of the situation.

## 1.4) Main research questions

1) What are the coping strategies AIDS affected households have pursued?

**Sub-research questions**

1) What are the strategies aimed at securing food?
2) What are the strategies aimed at seeking health care?
3) What are the strategies aimed at raising and supplementing income to maintain household expenditure pattern?

## 1.5) Definition of concepts

***Income generation (IG loan)***
It means when income is generated (created) then it means wealth has been created. When value is added to something that already has a value, then wealth has been generated. This wealth gives the IG project beneficiary to implement any one of the income generating activities such as goat farming, buffalo raring, beekeeping, poultry, tailoring and running small enterprises like local tea shop and retail shop (Project Report, 2010).

***Project beneficiaries***
It indicates poor and agricultural households who are identified through social mapping and wealth ranking done by DEPROSC in 2005. Project beneficiaries are entitled to an IG loan (Project Report, 2010).

***AIDS affected***
After the bread winner of the family reaches the stage of AIDS illness, it first affects the welfare of households through illness and even death of family members, which in turn leads to the diversion of resources from savings and investments into care (Drimie, 2002)

***Coping strategy***
Coping in this research is indicated to survive. In the face of the impact of AIDS on households the family members develop different strategy to cope with the impact of AIDS. They are mainly strategies aimed at securing food, strategy to raise and supplement income to maintain health expenditure, and health care strategy (UNAIDS, 1999).

***Food based strategy***
Food is directly related with income of household. It is because most of the people in rural areas of Nepal are manual labours. They need to stay healthy so that they can earn money. But with the type of food they produce and consume, it has an effect on the health status of persons. If the person is unhealthy then he/she is unable to earn money. So food based strategy indicates the strategy to secure food for consumption at the household level which is directly linked with income of household. Decrease in income leads to increase household debt.

***Health based strategy***
It indicates the health care seeking practices followed by people living with AIDS. When the breadwinner or household head is chronically ill, household expends money to make sure that the illness is curable and the person return back to work (earn money). In this situation, when the illness does not cure then households expend lots of money in health care. Increase in expenditure leads to increase household debt.

***Income/expenditure based strategy***
When income sources decreases and expenditure needs increases, household develop a strategy to raise and supplement income to maintain household expenditure needs. It relates to income diversification (IG project), other sources of loans, sale of assets (UNAIDS, 1999). This strategy determines the increasing or decreasing household debt.

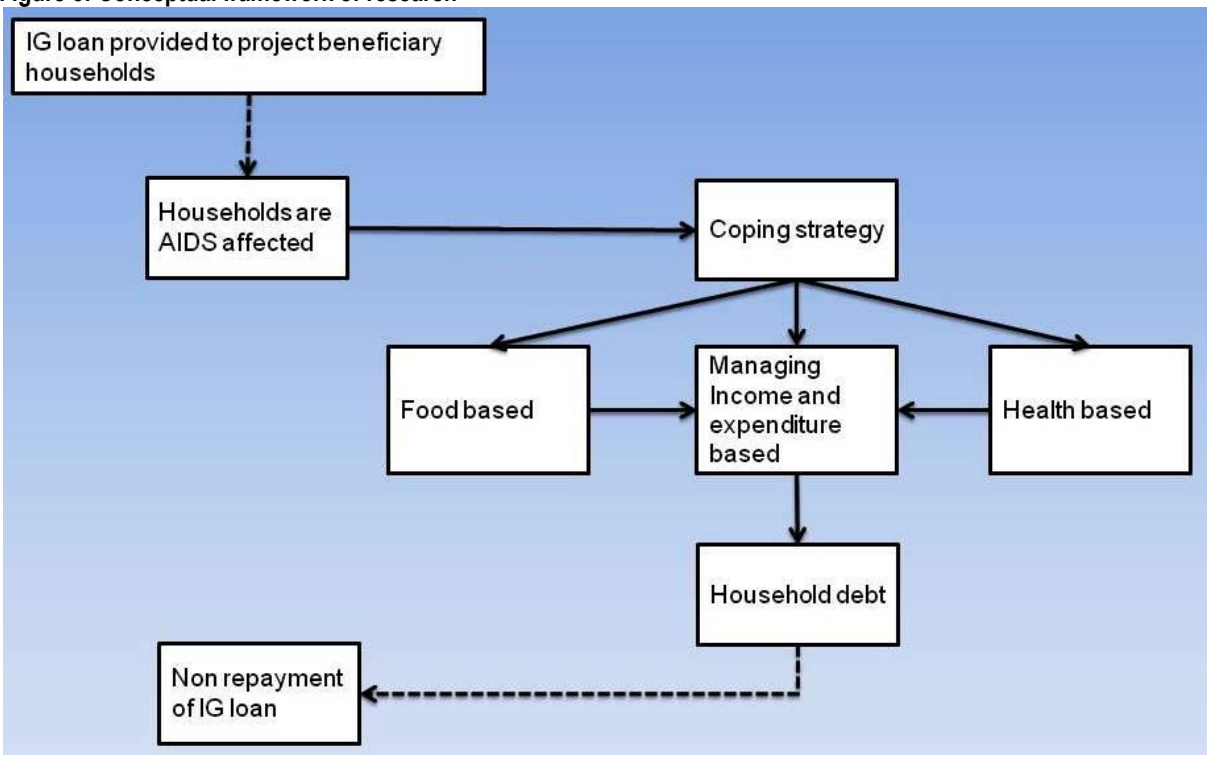
***Household debt***
It indicates an amount of money borrowed by the IG project beneficiary. The money includes both, borrowed from the revolving fund (from IG project) and from money lenders. The repayment period of IG loan is 2 years while local money lenders provide loans, which has to be repaid within one year. When the member will be unable to meet expenditure needs of household with own saving and income, they depend on loans. But when the expenditure increases excessively then household cannot repay the loan which leads to rising household debt.

***Non repayment of IG loan (outstanding loan)***
It means IG loan yet not been paid into the revolving fund by project beneficiaries, including interest and other charges. The non repayment of IG loan becomes an outstanding loan to revolving fund. (Project Report, 2012)

## Conceptual framework

As explained earlier, income generating (IG) activities are promoted as a strategy for poverty reduction. The scenario begins where the IG project beneficiary household is AIDS affected. This allows evolve various coping strategies household have pursued to reduce or even reverse the impact of AIDS on their livelihoods. But, the paradox emerges from the same context. In one hand, DEPROSC are compelled to make revolving fund sustained while on the other, people are large are trapped within the impact of AIDS. Thus, the question of, what are the difficulties AIDS affected IG loan beneficiary households have faced in repaying their IG loan in Rasuwa district is analysed reviewing the end effects of some of the major indicators of coping strategies of household – food based, health based and income/expenditure based strategy. In the whole process role of DEPROSC becomes crucial since it provides the ground for attaining the objective of poverty reduction.

**Figure 3: Conceptual framework of research**




Source: Author analysis (2013), the concept of coping strategies of AIDS affected households (UNAIDS, 1999) is inbuilt in this framework.

***Chapter summary:***

In this chapter researcher has described the context in which this research has evolved. Furthermore, researcher outlined the IG project of DEPROSC. The chapter provided an insight into the impact of AIDS in the livelihood of household that aggravated the outstanding loan. More particularly, the nexus between poverty, migration and HIV infection and AIDS illness was also highlighted briefly in problem analysis. Similarly, the researcher has problematised the statement followed by major and sub research questions to unfold the coping strategies AIDS affected IG beneficiary households might have pursued in the very chapter. Additionally, the chapter contains the definition of terminologies related to this study and the situation overview diagram along with the conceptual framework of the study.

# CHAPTER 2: LITERATURE REVIEW

### Introduction

In this chapter researcher has reviewed literatures of relevant previous researches which help the researcher to identify and indicate the causes for non repayment of IG loan to DEPROSC. All the reviewed literatures were related to the focal problem that helped the researcher to analyse the situation.

### 2.1) Livelihood and poverty

According to Chambers (2005) livelihood refers to the means of gaining a living, including livelihood capabilities, tangible assets and intangible assets. There are different ways to gain a livelihood. Among them one is employed, if the employment is sustainable then a regular source of income help to protect or even flourish the access to livelihood assets of households. Benefit from employment requires planning and management of time. However, one of the important factors limiting people's access to livelihood (especially in rural areas) is the time spent by rural poor (Rakodi, 2002). The amount of time they spend in collecting water, obtaining fuel, getting to the school, the clinic, the grinding mill or the market can be quite considerable. Due to this their livelihood is most of the time subsistence. This limits the capability of household to exploit livelihood resources, construct and pursue livelihood strategies towards achieving a desired welfare outcome (Ellis, 2004). Hence, the lower a household's capability, the more vulnerable it is to poverty, famine and low standard of living for rural people. Ellis (2000) defines that a household's choice of productive activity depends on its stock of livelihood assets: endowments that a household has and which entitle it to goods and services, whether through its own production or exchange.

**Table 3: Definition of livelihood**

| |
|---|
| Livelihood does not just mean the activities that people carry out to earn a living. It means all the different elements that contribute to, or affect, their ability to ensure a living for themselves and their household. This includes: |
| The activities that allow the household to use those assets to satisfy basic needs; |
| The different factors that the household it may not be able to control directly, like the seasons, natural disasters or economic trends, that affect its vulnerability; |
| Policies, institutions and processes that may help them, or make it more difficult for them, to achieve an adequate livelihood. |
| The livelihood strategies that households develop to ensure their livelihoods will depend on how they can combine their livelihood assets, take into account the vulnerability context in which they live, and the policies, institutions and processes that affect them. The livelihood outcomes that households achieve with their strategies can depend on any or all of these elements. |

**Source: FAO (2002)**

Literature state that poverty has different dimensions such as lack of skills, low production, low productivity, low income, poor health, poor education and low investment. Ellis (2000) adds that one of the important factors limiting people's access to livelihood is the time spent by the rural poor. The amount of time they spend on collecting water, obtaining fuel, getting to the school, the clinic, the grinding mill or the market can be quite considerable. This is aggravating the poverty even more.

According to the cost of basic needs (CBN) approach, the poverty line is defined as the expenditure value (in local currency) required by an individual to fulfil his/her basic needs in terms of both food and non-food items. The food basket of the poverty line is constructed by estimating how much the poor spend to reach a minimum caloric requirement of 2,220 Kcal per day. Based on this approach, the overall poverty line has been set to be annual NRs

19,261, (€ 175.1) which is composed of the food poverty line of NRs 11,929 (€ 108.45) and the non-food poverty line of NRs 7,332 (€ 66.65) (NLSS, 2012; CBS, 2012).

## 2.2) Poverty and migration in Nepal

Today, Nepal stands at the crossroads at redefining both nation and state', and it has been argued elsewhere that the country is on the 'cusp of major transformation' which is seeing the old feudal caste structures collapsing and a new social order emerging (Sharma and Donini, 2102:5, cited by Upreti., *et al* 2012). Since the signing of the Comprehensive Peace Agreement in 2006, five different governments attempted to streamline the transformation process. However, BTI[1]/ Nepal (2012), ranks Nepal in the position of 75 out of 128 countries in political transformation while at position of 112 out of 128 countries in economic transformations. Likewise, the 2010 UNDP Human Development Report ranks Nepal at position 138 out of 169 countries. Despite climbing up eight positions, Nepal's poor development score of 0.428 places the country in the low human-development category, BTI Nepal (2012) explains. The average annual GDP growth rate between 2003-2007 was 4.5% while between 2008-2012 was 4.3% (World Bank, 2013 a). Poverty is in place and Nepal is struggling with uncertainty and change.

Nepal-National census report, CBS (2012) stated that one in every four households reported that at least one member of their household is absent or is living out of the country and highest proportion (44.81%) of absent population is from the age group of 15-24 years. The same report also states that more than 82 % of Nepal's population of 26 million lives in rural areas where around 2 million people (especially from rural areas) are international male migrants. The report shows that the trend of migration has increased by three folds within the past 10 years (2001-2011). World Bank (2013b) state, the economic crisis at household level is one of the major driving factors behind migration in rural Nepal. Since wages are relatively high in India and work is also reportedly easier to come by for seasonal migrants, India becomes their favourite destination (DFID, 2003). World Bank (2012b) states that an estimate of internal and external migration for seasonal and long-term labour range from 1.5 to 2 million people and it is necessary for the economic survival of many households in both rural and urban areas. Remittance from international male migrants' accounts 22% of national GDP in Nepal in 2011 and according to the latest issue of 'World Bank's Migration and Development Brief,' remittances have contributed to lowering poverty and to the building up human and financial capital for the poor. The World Bank (2012a) states that poverty leads to poor health which affects nutrition through changes in metabolism, appetite loss and changes in feeding practices. This has severe consequences to household income in rural areas of Nepal because almost all able family members are manual labours.

## 2.3) Migration and HIV infection

In India as most male seasonal migrants are manual labours, with the type of food they consume most of them are undernourished. Apart from this, they are also the potential client of HIV infected female sex worker (USAID, 2010) in India. So, almost 27% of total estimated HIV infected populations in Nepal are from international male migrants (especially seasonal migrants) (NCASC, 2012). The latest national HIV/AIDS strategy 2011-2016 in Nepal has also mentioned mobile populations, particularly seasonal male migrants to India, as one of the most vulnerable groups for HIV infection (NCASC, 2012). This doesn't end here, the result also shows that, HIV infection among low risk population including wives and female sex partners of male migrants have drastically increased within this one decade, from 6% in

[1] Bertelsmann Stiftung's Transformation Index (BTI) 2012. The BTI is a global assessment of transition processes in which the state of democracy and market economy as well as the quality of political management in 128 transformation and developing countries are evaluated. The BTI combines text analysis and numerical assessments. The score for each question is provided below its respective title. The scale ranges from 10 (best) to 1 (worst).

2001 to 27.3% in 2011 in districts of Nepal. Rasuwa district is one among them (UNAIDS, 2012; NCASC, 2012). The 2002-2010 Integrated Biological and Behavioural Surveillance (IBBS) also found that the migration of people in India and other countries was the primary risk factor in the districts for spread of HIV infection, NCASC (2012) reports.

UNAIDS (2009) report state that the Labour and Transport Department of the Government of Nepal implemented pre-departure orientation as a mandatory component for migrant workers travelling for foreign employment (as stated in rule 27 of the Foreign Employment Regulation 2002-2003). Although this applies to everyone who visits outside country, this however, is not followed by migrants going to India because they do not require Visa documents and the surveillance system of government is weak.

To make sense of these relationships between poverty-migration-HIV infections the multidimensional characteristics of poverty are unraveled by different literatures. Such as, poor health, illiteracy, inadequate schooling, social exclusion, powerlessness and gender discrimination contribute to HIV infection. For example, an individual with poor health lacks capacity to productivity as a result of which reduces income. Likewise, undernourishment and lack of access to treatment practices services undermine immunity, which results in increased susceptibility to HIV infection in the sexually active population if they are exposed in a risky environment. Poverty leads to poor food consumption due to which most of the rural people in Nepal are undernourished (MOHP, 2011). Therefore, unless people find sustainable income sources through which they can justify their expenditure such as for nutritious food, they will persist with the factors which expose them to HIV infection. The situation is severe in the areas where there the frequency of seasonal migration is high such as in Rasuwa district (NCASC, 2012).

### 2.4) From HIV infection to AIDS illness

In Nepal, majority (74.5%) of HIV infection is transmitted through sexual transmission (UNAIDS, 2012). The HIV has a slow disease progression. The time period from the moment of infection to occurrence of AIDS usually takes a couple of years, around 10 years (Barnett and Whiteside, 2006). In this period, HIV infected person looks no different than the non infected person. Even if there is no effective treatment available it generally takes years for the immune system to become severely damaged and for the person to become seriously ill.

Literatures state that human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) though are spelled together in the research but they are not the same things. HIV is a virus that damages the immune system. Likewise, AIDS is the common term for the condition that arises when the HIV virus has damaged a person's immune system severely. For infection to occur the virus has to enter the body and attach it to the host cells. HIV attacks a particular set of cells in the human immune system known as CD4 cells (Barnett and Whiteside, 2006). Once the virus has penetrated the wall of the CD4 cell it is safe from the immune system because it copies the cell's DNA, and therefore cannot be identified and destroyed by the body's defence mechanism. This stage is the early stage of HIV infection also known as the window period. The window period is followed by a long incubation stage. HIV has a slow disease progression. Even if there is no effective treatment available it takes it generally takes years for the immune system to become severely damaged and for the person to become seriously ill. So far there is no vaccine against HIV or a cure for it. However, today antiretroviral (ARV) drugs are available which suppressing the HIV virus and stop the progress of HIV disease. But still this medicine only stops the HIV virus to do further destruction, it cannot kill the virus so once being infected by HIV the person will be HIV positive for the rest of his/her life.

Barnett and Whiteside (2006) also mentioned that when a poor person is infected with HIV then it seemed inevitable he/she would progress to AIDS faster. It is also because a poor

person has more challenges to their immune system, poorer nutrition and less access to health care. Hence, a person is infected with HIV it goes unnoticed for many years and by the time when the person is seriously ill or at the stage of AIDS, the AIDS disrupts the household welfare due to which money dries out fast which used to be a 'household's safety net' buffering households against hardship and crisis (Niehof, et al., 2010). This stage is also directly related to food security because due to AIDS, affected households' changes in diet pattern making them more vulnerable to further impact of AIDS (FAO, 2003).

### 2.5) Impact of AIDS in household livelihood

AIDS has a disproportionate impact on the morbidity and mortality of the most productive age groups. Because the disease has both a long incubation period and is accompanied by a lengthy period of illness, the socioeconomic as well as psychological impact will be felt over a prolonged period (Hilhorst *et.al,* 2006). This affects the welfare of households through illness and death of family members, which in turn leads to the diversion of resources from saving and investments into care (FAO, 2003). Barnett and Whiteside (2006) argue that the impact of HIV and AIDS should be seen from a continuum between sharp shock and profound changes. The loss of human resource (both from chronic illness and even death) is a sharp shock which leads directly to a loss of financial capital asset of household. Due to this there will be less income sources not only because the affected individual can't work but also because time is diverted to care of the sick. Likewise, illness increase expenditure on medical care, food, hygiene and so on. In these cases, incomes obviously decline further as HIV infections and AIDS deaths are disproportionately concentrated in the most productive age groups of (15-49) (FAO, 2003).

**Table 4: Impact of AIDS in agricultural households**

| Immediate impacts | Agriculture related responses by households | Assumed longer term consequences for agriculture and related activities |
|---|---|---|
| Loss of labour due to illness, death and caring | Decreases in area cultivated and changes in crop mix; less attention to care of livestock soil and/or water | Potential decreases in overall food production (food availability, access and stability) |
| Cutbacks in food availability and consumption | Decreased energy for farm or market tasks | Increased child and adult malnutrition (food utilization and access) |
| Loss of income and increased health care and funeral expenses | Disinvestment of assets including sale of livestock and equipment; renting of land' piecework on other farms | Increased socioeconomic inequalities and new or deeper impoverishment for some |
| Increased dependency with women and older adults assuming greater household responsibilities | Less time spent on farm production or marketing | Growing gender and age inequalities |
| Loss of knowledge and skills essential for agriculture | Not known | Loss of efficiency, greater stress on natural resource base, increased food insecurity |
| Loss of access to land and equipment/livestock for widows and children | Female-and-child headed households' dependence on non-farm employment and/or begging | Deepening impoverishment for affected household members |

Source: Gillespie et al. (2010)

FAO (2002) state, the impact of AIDS is most severe in rural households, who are dependent on agriculture as a source of livelihood. With the HIV and AIDS in households are also frequently forced to reduce their reliance on labour-or-input-intensive crop or livestock enterprise, and to focus on activities that are of reduced scale with fewer risks, but that also have lower output or provide less income (IFPRI, 2003). FAO (2003) shared that in there are different types of impact of AIDS such as a reduction in income from farm and off-farm

sources, liquidation of saving accounts, change in wage earning, change in income generating activities, borrowing from rural money lenders, often at exorbitant interest rates, exhaustion of credit resources and even sales of productive assets. Although, household attempt to conserve their productive resources in distress situation as long as possible, but once saving and credit resources have been exhausted and liquid assets have been disposed, household result of selling of other assets (FAO, 2003). The distress sales of physical capital leave households in a precarious position in terms of their ability to adapt to future shocks (Barnett and Whiteside, 2006). As the access to financial assets depletes, UNAIDS (2001) reported that households might lead to the reversion and increased consumption of wild foods, including fruits, nuts, leafy vegetables, fungi and protein sources such as bush meat and insects.

## 2.6) Household's strategies to cope with the impact of AIDS

Barnett and Whiteside (2006) said that AIDS affected households gradually adapt different coping strategies. But their welfare is largely dependent on the strategy that household applied. Mostly those households selling assets and borrow money as a short term measure to meet the expenditure needs are the one who is vulnerable to further impacts of AIDS.

When a poor family experiences shocks and downward trends, distress sale of physical assets to raise income is often seen as on the first coping mechanism through which a family avoid further declines in poverty (Lawson, 2009). However, selling assets in response to shocks today risks permanently lowering future consumption, it renders the household vulnerable to poverty. Although households respond initially by disposal of insurance assets that are reversible, including liquidating savings, seeking remittances from the extended family and borrowing from informal or formal sources of credit. The expenditure, however, goes in nonproductive activities. Sometimes the cash is diverted away from other productive and reproductive activities as most people in rural areas prefer to visit faith healer and not proper health care of infected person Drimie (2003).

In the face of the impact of AIDS, UNAIDS (1999) mentions that individuals and households undergo processes of experimentation and adaptation when adult illness and death impacts whilst an attempt is made to cope with immediate and long-term demographic changes. However not all people will be impacted in a same way. As Barnett and Whiteside (2006) mentioned that relative wealth reduces vulnerability at all levels from the individual to the nation. The resources are not purely financial they may include skilled labour or access to care. Therefore there are several factors will determine a household's ability to cope including access to resources, household size and composition, access to the resources of the extended family, and the ability of the community to provide support (UNAIDS, 1999). Poor people have to cope with the impact of AIDS as shown by UNAIDS (1999) in the table below.

**Table 5: Household Coping Strategies**

| Strategies aimed at improving food security | Strategies aimed at raising & supplementing income to maintain household expenditure needs |
|---|---|
| Substitute cheaper commodities (e.g. Porridge instead of bread) | Income diversification |
| Reduce consumption of the item | Migrate in search of new jobs |
| Send children away to live with relatives | Loans |
| Replace food item with indigenous/wild vegetables | Sale of assets |
| Beg | Use of savings or investment |

**Source**: UNAIDS (1999)

FAO (2003) also shared that there are different types of coping strategies to avoid and or minimize the impact of AIDS such as a reduction in income from farm and off-farm sources, liquidation of saving accounts, change in wage earning, change in income generating activities, borrowing from rural money lenders-often at exorbitant interest rates, exhaustion of credit resources and even sales of productive assets. As the access to financial assets depletes, UNAIDS (2001) reported that households might lead to the reversion and increased consumption of wild foods, including fruits, nuts, leafy vegetables, fungi and protein sources such as bush meat and insects.

### 2.6.1. Household's strategies aimed at securing food

According to the NLSS (2012), poor people spend 72% of their total consumption expenditure on food in Nepal. This shows that if the production from farm land is not enough then poor people have to depend on the market to purchase food. But with the recent food hikes prices it has a direct impact on households' purchasing power as it increases food deprivation and malnutrition. It is mainly because poor people cannot afford to buy protein rich diets such as meat, fish, egg etc. The report mentions that it may lead to reduced expenditure on health and education and also squeezes investment in agricultural inputs. These inputs include fertilizers, fuels and power which are required to increase food production.

The impact of AIDS is likely to be far and wide reaching in Nepal because this country has an agriculture-based economy with about 85% population dependent on agriculture (CBS, 2012). In the context of AIDS it intensifies the bottlenecks of existing labour and also increases undernourishment. With the less intensified farming practice, food productions are unable to provide sufficient protein and/or energy requirements thus susceptible to increased undernourishment (World Bank, 2012a). Children and adults in AIDS afflicted households are most likely to be less well nourished and more likely to be sick and die early. Due to this the reduction in household quantity and quality increases chances of both child and adult undernourishment without getting proper medication. Bonnel (2006) described that AIDS reduces the stock of human and physical capital, because it affects primarily the adult population in its most productive years, and it undermines its incentives to save and invest. With this we can understand that there are several mechanisms through which AIDS may have a potential impact on the economy. Such as, it has the susceptibility of working-age individuals leading to a potential reduction in savings rates and disposable income, which may have an economic impact in productive ages. At the household level AIDS also affects availability of disposable income used to purchase agricultural inputs and/or hire manual labours. This is a major cause for declining yields, productivity of both food and cash crops in AIDS affected households (FAO, 2003). This leads household to decrease food production. Likewise, in most cases, affected families reduce the cultivation of labour intensive crops and leave the farm land barren (World Bank, 2012a).

As the household head is chronically ill, the other able family members, especially the children, have to support of farm production. In this case, without sufficient knowledge, skills and experience, children cannot continue agricultural production at the same level as their parents did. This ultimately leads to a compromising stage of quantity and quality of agricultural production (FAO, 2003). Other household members are also under immense pressure to seek more from manual labour (major option to earn money) that yield a quick income. In either case manual labour is less available at critical moments in the season (Loevinsohn & Gillespie, 2003). In these cases it is most likely that the land may not be cultivated and certain types of crops may not be grown because of the loss and/or lack of labour. Forests may not be managed, with some areas being over harvested because they are close to home of labour starved households. Water bodies may be over-exploited as households with sick persons who require frequent washing require more water than normal (UNAIDS, 2006). Hence, poverty leads to poor health affects nutrition through changes in

metabolism, appetite loss and changes in feeding practices (World Bank, 2012a). This makes a person in poor health which directly affects household income.

### 2.6.2. Household's strategies aimed at health care

In Nepal, MOHP (2011) states that rural people do not have the required information about health facilities due to which a large segment of poor population still remains deprived of many basic health care facilities. Likewise there is also no health insurance provisioned for rural people and no service delivery service intact that fulfils health related expenditure in Rasuwa district at this moment, MOHP (2011). Hence, rural people are compelled to bear all the expenses including health related expenditure from their pocket. In line with this, the World Bank (2012) also reports that out of total estimated HIV infected population living in Nepal, around 60% of them are those who are unaware about their self HIV status. Barnet and Whiteside (2006), mention that interventions at the behavioural-change level are important but they do work only as long as they are maintained. At household level, it is less likely to monitor behavioural-change because condom use requires male compliance and women are less likely to talk about it. So, when people do not have proper access to treatment practices facilities, they mostly rely on faith healing (Shankar, P.R., 2007; Raut, B., 2011). Faith healing can be divided into a) *Dhami-jhankri* (Shamans) b) *Pandit-lamagubhaju-pujari* (priest of different ethnic and religious groups in Nepal) and c) *Jyotishi* (Astrologers). Sharnkar, P.R. *et al.*, (2007) adds that Shamans act as mediators between the spirit world and the material world of day to day life. In a context, when a person living with AIDS go to faith healers then the process of healing goes for life long and expenditure of household also soars. It is mainly because faith healers relate the illness with different types of spirits. The Shamans must diagnose the type of spirit so need to make an offering and placate the spirit or suck the offending spirit from the patient's body.

### 2.6.3. Household's strategies aimed at raising or supplementing income to maintain household expenditure pattern

As the concentration of HIV infection is in the productive age group of 15-49 years of age (NCASC, 2012), it has significant implications for the productive capacity and income source of AIDS affected households. Mainly AIDS affect the availability of disposable income. During episodes of illness to household head, financial resources are diverted to pay for medical treatment and if there is no access to medical treatment then to pay to faith healers. As loss of income and treatment practices expenses increases, it reduces the concentration of affected people and the soaring expenditure collectively makes poor households further vulnerable to poverty (UNAIDS, 2006).

Likewise, as mentioned above, when a poor family experiences shocks and downward trends, distress sale of physical assets to raise income is often seen as on the first coping strategy through which a family avoids further declines in poverty (Lawson, 2009). However, selling assets in response to shocks today risks permanently lowering future consumption, it renders the household vulnerable to poverty. Although households respond initially by disposal of insurance assets that are reversible, including liquidating savings, seeking remittances from the extended family and borrowing from informal or formal sources of credit.

Barnet and Whiteside (2006) said that in the areas where AIDS cases are increasing households may even resort to selling assets and borrow money as a short term measure to boost household financial resources. The money diverted to cater for caring the sick but not in income generating activities of household's means that most poor family ends up into borrowing further at exorbitant rates for survival and often lead to non-repayment of loans

(FANRPAN, 2007). Hence strategies aimed at increasing or supplementing household income to meet the expenditure needs determines the burden of debt for a household.

## 2.7) Impact of AIDS on loan repayment

Hammarskjöld (2003) also argues that poverty is driving factor behind migration which led to the rapid spread of the HIV epidemic. He adds poor people are less well-informed, have fewer opportunities to make choices, and fewer possibilities to change their behaviour. However, he also argues that the relationship between poverty (which leads to migration) and HIV infection is far from simple. Since poverty is said to fuel HIV transmission just as the incidence of HIV deepens poverty (Pronyk et al., 2007). By seeking to alleviate poverty, income generation activities have the potential to stabilize the economic situation of vulnerable individuals and households and thereby reduce behaviours that are associated with poverty and increase the risks of HIV infection (Pronyk et al., 2007). Mullins (2002) however stated that due to HIV and AIDS, organizational operation may become less relevant to or accessible by both infected and affected people because of increasing load of illness and death in household results changes in roles, responsibilities and assets of affected families. FANRPAN (2007) also mentions that coping strategies in the face of HIV and AIDS lead household to borrow at exorbitant interest rates and due to destitution for those households who have poor livelihood assets are the one who are unable to repay their loan as they become dependent on charity for the living.

A step directed towards mitigating the impact of the HIV and AIDS epidemic on those households and communities' already suffering from the effect of HIV and AIDS hence becomes the necessity of this moment. It is also necessary to note that mitigation strategies are not only needed to assist individuals and households in coping with the HIV and AIDS epidemic, but community organization also requires assistance (FAO, 2003). But, before mitigation it is first necessary to identify the impact HIV and AIDS will have in the households. As Parker (2002) in his discussion paper on microfinance and AIDS said, due to HIV and AIDS portfolio quality of household may change due to increased delinquency, particularly if affected households have been encouraged to borrow beyond their ability to repay.

### *Chapter summary*

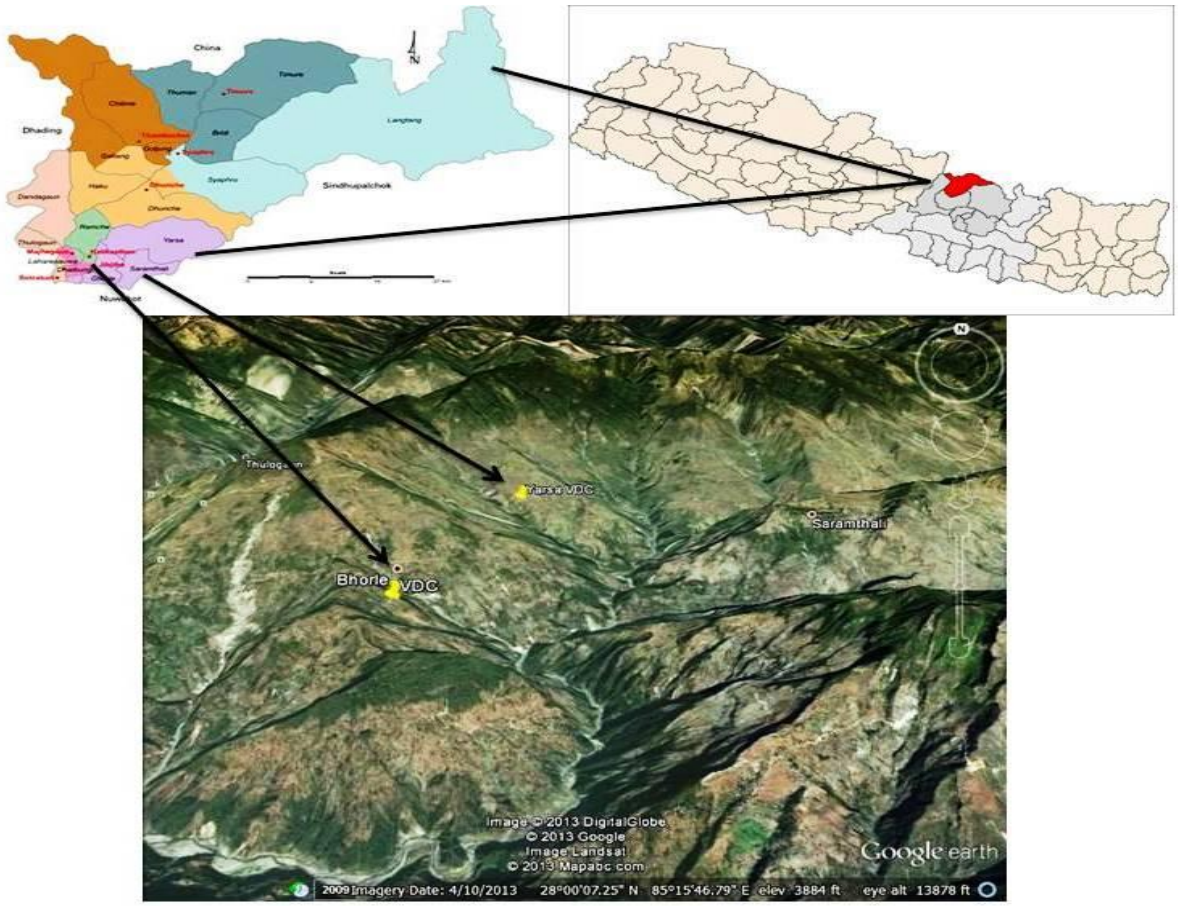
This chapter reviews the literatures followed by the various themes that best suited to this study. The chapter has explored about the livelihood and poverty, poverty and migration in Nepal, migration and HIV infection. From HIV infection to AIDS illness, the impact of AIDS in household livelihood and coping strategies of households to respond to the impact of AIDS are highlighted.

# CHAPTER 3: METHODOLOGY

This chapter overview the methodological part clearly showing how the study has been conducted. In this regard, the chapter discusses the practical steps of this study which researcher has passed to get the answers of the research questions. It also casts light on research design, sources of data, study area, data collection process and its analysis.

## 3.1) Research area

**Figure 4: Map of study area**




**Source: Google Earth, 2013 and District Profile of Rasuwa District, 2002**

The researcher selected Bhrole and Yarsa VDC of Rasuwa district because it has higher number of seasonal migrants than other VDCs where DEPROSC is implementing the IG project.

- In the Rasuwa district, the project is implemented in 4 VDCs, however researcher only selected two VDCs for this study because problem of outstanding loans is high in these two VDCs
- The population density is high in both Yarsa and Bhrole VDCs and almost 78% of households in these VDCs have at least one member as seasonal migrants (mostly male). In an area where seasonal migration is high there is the likelihood that many populations are HIV infected and AIDS affected (WFP, 2008).
- The researcher, also an employer of DEPROSC has been working in this area and is very conversant with the people in these VDCs.
- Unlike Dolpa and Rukum districts where this project is implemented, Rasuwa district is accessible even in rainy season.

### 3.2) Research design

A desk study was carried out prior to data collection to review existing literatures on causes of non repayment of IG loans. The literatures show that impact of AIDS can affect the loan repayment. Literatures also show how the impact of AIDS can aggravate poverty of people living in areas where migration and mobility has become a normal phenomenon to the researcher. With available information researcher then designed the conceptual framework and methodology for this research.

In this research, a case study was conducted to gather information from the community and from AIDS affected IG beneficiary households. A case study strategy was applied because it leverage subjective methods such as interviews and observations to collect substantive and relevant data from the field. Furthermore, the intention of case study research was to gain an 'in-depth' understanding of the concerned phenomena in a 'real-life' setting (Dobson, 1999).

### 3.3) Selection of respondents

WFP (2008) state that there can be challenges to identify HIV infected and or AIDS affected households because many people prefer not to disclose their HIV sero-positive status due to the risk of being stigmatized. So as recommended by this report, researchers chose proxy indicator to locate the IG loan beneficiary living with AIDS. The proxy indicator is - chronically ill household head for more than 3 months in the past 12 months. Further report also confirms that proxy indicator can be useful when the information about AIDS affected population is unknown. Cohen (2008) state that it is most likely that the person living with AIDS, if do not have proper medication then are subject to chronic illness for at least 3 months in the past 12 months. The researcher selected the sample based on self-judgment derived after going through the literatures and the purpose of the research.

Before going to collect field data, literature was again reviewed to gather further secondary information. Such as, the researcher collected the name of total IG loan beneficiaries who are unable to repay their IG loan from the project in Rasuwa district. Among the list researcher then tried to identify how many IG loan beneficiaries are chronically ill for more than 3 months. It was not possible to identify because the organization has not maintained the health status records of project beneficiaries.

Then researcher went to locate the primary respondents. The initial respondent was recruited purposefully by mobilizing staff. Further, the snowball sampling technique was then applied to identify the remaining respondents. The researcher chose this sampling also because the researcher was not aware about who and how many project beneficiaries were actually chronically ill for more than 3 months. As many chronically ill people visit the same faith healer in the community snowball sampling made easy for researchers to identify chronically ill people. The chronically ill people were asked if they were interested in a research. After the respondents indicated their willingness to be involved in the research, the interview was undertaken.

However, not all people located could become a respondent for this research. It is because not all chronically ill people were actually people living with AIDS. Some of them were chronically ill due to an accident, some had problems of veins, one person was mentally disabled and none of them were from seasonal migrant households. For this research seasonal migrant household member who is chronically ill for more than 3 months was only understood as household affected by AIDS. It is mainly because HIV is predominantly a sexually transmittable disease in Nepal. Seasonal migrants are potential clients of HIV infected female sex worker in India.

Boyd (2006) regards 2 to 10 respondents or research subjects as sufficient to reach saturation and Creswell (2011) recommends “long interviews with up to 10 people” for a case study. As researcher could only locate 9 IG project beneficiaries living with AIDS, within the stipulated time of research, researcher mark it as the saturation for this research.

### 3.4) Data collection procedure

#### One to one interview

Checklists of open ended questions were designed at first which was piloted with the office staff in head office. Office staff shared their feedback which helped researcher to be specific with probing questions. The researcher used checklist for this one to one interview which was in line with the conceptual framework of study, please refer to annex.

Then the same was done in the district office. Before going to meet the respondents, researcher briefed the objective of this research to district staff. The researcher also briefed about the research questions and facilitated staff how to take notes during the interview. One staff from the organization came along the researchers in the field to collect data so the briefing and facilitation proved to be vital during data collection. The idea to request one staff to participate in this research was justified as a researcher has been able to talk with more ease with the respondents Since in the areas where the researcher was doing the research, the network of mobile phone doesn’t work and there is no electricity facility, recording the information was only possible in few respondent households.

The data were collected by visiting each respondent’s house. Interview started in a non-contrived setting, where initial questions such as, what has happened to you now and since when you are suffering from this illness, helped the researcher to enter into the topic with the respondents. After when respondents shared what has happened to them further probing questions asked in accordance with the responses. The researcher asked about the employment status of persons before illness, such as where he/she worked, for how many years, and if the working area was out of the country then what was the living conditions in the area etc. to confirm whether AIDS is involved in their illness or not. The discussion was made as informal as possible so within interview researcher had a comfort to talk about cash income and expenditure (It is less likely that people would like to talk about their income with outsiders in Nepal). This activity made a respondent to become even more open with the researcher and discussions. Probing questions were asked in accordance with the response, something not like in a chronological manner, rather it was asked in between different discussion. Staff of DEPROSC who was supporting the researcher was transcribing all these things in bullet points in copy and sometimes in narrative form. The one to one interviews lasted for 45 minutes to one hour.

#### Observation

Observation was also the part of data collection. The researcher had a prepared checklist for observation (please refer to annex). Researcher use this tool because it was good at explaining ‘what is going on’ in the particular situation. This helped the researcher to verify the immediate economic condition of beneficiary households and aspects of their everyday life. It will also help the researcher to get inside view of reality and focus on the person as well as the setting

#### Focus group discussion (FGD)

One focus group discussion was organized with 7 people (3 men and 4 women). The researcher used checklist for this FGD which was in line with the conceptual framework of study, please refer to annex. The researcher chose FGD because this method helped to bring the issues in the discussion that was collected from one to one interview. All discussion

was done in a participatory way in a public setting. The FDG was conducted for 2 hours. Appointment for group discussion was not fixed in advance because researcher wanted to make it very informal. However, the researcher had consulted with staff about the time during which people can give time for FGD. In suggestion of staff researcher went to the settlement at 7:00 hours and invited people who were seen nearby. Staff confirmed that all households in that settlement haven't repaid their IG loan so everyone who participated in FGD became the respondents.

After ice breaking exercise the FGD started with the discussion on theme 'why are you unable to repay the IG loan'. The reason to ask this question is to know the response of community level. Since not paying the IG loan is not just a problem of a single house. The question helped people to share their constraints in public, in front of other people. In the mean time with probing questions, researcher also did the cross-checking of statements shared by respondents in one to one interview to verify their statements in the group. Researcher ensured that participants in FGD participate evenly, and everyone speaks not that one speaks for others. Before starting of FGD, permission of participants to transcribe their response in the copy was taken verbally and confidentiality was assured.

**Key resource persons interview**

Researcher also used key resource person interview to take out the more appropriate information. The idea was to do the unravel the status of different categories, such as socioeconomic status of AIDS affected households, health care and treatment practices, about VCT coverage and also the relevancy of IG project.

### 3.5) Ethical consideration

The researcher was aware about the ethical issue in every step of the study. So, ethical issues were properly addressed in the period of preparing a research proposal, data collection and interpretation. Before starting the interview, the researcher took the verbal consent of the research respondents to participate in the study. The researcher collected the data in mutual understanding between researcher and research respondents. Likewise, researcher didn't put any kind of pressure to provide the information that the researcher was seeking. The relation between researcher and the respondents were harmonious and environment was very democratic where they expressed their experience as per their interest. When respondents stop talking about any topic, researcher did not go beyond the interest and desire of respondents. The researcher was also aware about the 'do no harm principle' so researcher didn't use the respondents for self benefit so that they may in risk or even HIV and AIDS related stigma and discrimination. The researcher has maintained the privacy of the respondent's voices and experiences. Further researcher has respected their social and cultural diversity and the study is not biased by researcher's personal perception and attitude.

### 3.6) Methods of data analysis

After collecting the raw data, researcher organized the data by reducing the unnecessary data in order to make the data understandable. The sorted data were reviewed in order to identify the general ideas and information of the findings. The data were then summarized and aggregated in accordance with the conceptual framework as presented in figure 2.

The descriptive statistics like tables, graphs has been used for analysis. The quantitative data were presented in a descriptive way using tables graphs, likewise qualitative data are analysed and interpreted based on the facts and findings and is presented in the narrative forms.

### 3.7) Limitation

Although this research was carefully prepared, the researcher is still aware of its limitations and shortcomings.

- The proxy indicator used for the identification of AIDS affected households which might have underestimated the true differences attributable to people living with AIDS.

- In contrast to Africa, in Nepal people/organizations are not very aware of the epidemic and its impact on livelihood there are no studies and documents that can guide the researcher to identify the impact of AIDS in loan repayment in the Nepali context so most of the literature findings are based on the African context.

- Due to difficulty in locating respondents, the sample size for the research was small and the number of respondents in analysis was not sufficient to establish statistically significant difference for some outcome such as differences for man and woman headed households.

- The identified respondents living with AIDS and their household livelihood status was contextual. So the outcomes could not be generalized.

- The researcher is also a staff of DEPROSC and had conducted several monitoring visits in the past. Therefore respondent might have taken this research visit as periodic monitoring visit. So the information provided by the respondents might be a little bit of an exaggeration for example their explanation to sell their livestock and other assets bought from the IG loan.

***Chapter summary***

The design of this study is logically articulated in this chapter where researchers have the focus on methodological aspects and developed a more useful strategy to successfully complete my research process. According to the proposed research questions, the study employed the qualitative approach where one to one interview, observation, focus group discussion and key resource person interview were used as tools to collect the data from field followed by narrative analysis. Detailed about the sources of both primary and secondary data, site as well as participant selection etc. are also outlined. The chapter has mention the ethical consideration applied during research. Finally, the chapter has been closed with the limitation of this research.

# CHAPTER 4: RESULTS

This chapter is a researcher's endeavour to examine the coping strategies that AIDS affected IG beneficiary households have pursued. The results have unfolded the difficulties they have faced in repaying their loan. The researcher's findings were governed by my main and sub research questions followed by in-depth interviews, focus group discussion and key informant interviews while extracting data. The coping strategies the AIDS affected households have pursued were presented with the qualitative data approach. In addition, the researcher also incorporated personal observations gained during field visits to authenticate the statements/ opinions of the respondents. Likewise, the researcher has presented the field results in according to the research questions.

### *Demographic characteristics of respondents*

UNAIDS (1999) suggests that individuals and households undergo processes of experimentation and adaptation when the household head adult illness and death impacts whilst an attempt is made to cope with immediate and long-term demographic changes (1999). The report adds that several factors will determine a household's ability to cope including access to resources, household size and composition and access to the resources of the extended family. The interaction of these factors will determine the severity of the impact of AIDS on the household. So researchers opt to know the demographic status of respondents in the project area.

**Table 6: Demographic status of respondent households**

| Age of respondents (15-49) years old | Sex | Household size | Demography | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Spouse | Daughter in law | Daughter 15 years old or above | Daughter below 15 years old | Son 15 years old or above | Son below 15 years old |
| 30 | Female | 5 | 0 | 0 | 0 | 3 | 0 | 1 |
| 40 | Female | 4 | 0 | 0 | 2 | 0 | 1 | 0 |
| 35 | Female | 4 | 0 | 0 | 1 | 2 | 0 | 0 |
| 42 | Male | 6 | 1 | 0 | 2 | 1 | 1 | 0 |
| 32 | Male | 5 | 1 | 0 | 0 | 0 | 0 | 3 |
| 38 | Male | 9 | 1 | 0 | 2 | 3 | 0 | 2 |
| 45 | Male | 8 | 1 | 2 | 2 | 0 | 0 | 2 |
| 28 | Male | 4 | 1 | 0 | 0 | 2 | 0 | 0 |
| 37 | Male | 5 | 1 | 0 | 0 | 2 | 0 | 1 |

Among the identified respondents, most of the people living with AIDS were men aged 28-45 years old. While women age range was 30-40 years old. Male headed households are living with their spouse and children while women headed households are only living with their children. The number children also vary in the respondent's household. There are more girls in a household than boys. In these households children are supporting in household chores from their early childhood. These children are the helping hands of parents in agricultural activities and household chores. The effect of AIDS can be seen in the children. Almost all children are undernourished.

## 4.1) Household's strategies aimed at securing food

The researcher can observe that food production-consumption strategy has deteriorated the health of AIDS affected household members. This has also affected their income source because all respondents stated that their household members are manual labours, wherever

they work. As manual labour was the only way they knew to earn cash, most of the respondents stated that they chose IG activity that does not require skills. Such as livestock rearing, they are used to it so they thought they can manage it. Some respondent stated that they attempted to do something new in the settlement so they chose honey bee keeping and poultry as IG activity. During the first year of IG activity implementation, the income was a supplementing household income pattern. A respondent who participated in 6 weeks training on tailoring stated the tailor functioned well as there was satisfactory demand of stitching the clothes. She earned around NRs. 2000 (€ 18) for a few months. As the demand increased, she further took an advance tailoring course and also expanded her shop accordingly. She worked hard to earn money from tailoring. It was mainly because her husband was chronically ill and she required to take care of him, children are small so they could not support the tailoring. Within few months of her achievement, business declined as she could not give full time to the tailor. By the time she completely shut down her tailoring activity she could generate € 109. It is the same amount that was invested in the IG activity.

However, not all IG activity earned the cash income in the same way. The nine respondents have implemented seven different IG activities. As shown in the table below, only the respondent who implemented tailoring, retail shop and *aaran* (metal workshop) were able to receive quick income. For others, there was only a production but no sales, which means no cash income.

**Table 7: Types of Income generating activities implemented by nine respondent's household**

| Type of IG activity | Unit | Total IG loan | Provided by PAF | Self contribution | Items bought from IG loan | Progress of IG activity within one year | Present status of IG activity | Total income (including the amount they received after selling it) |
|---|---|---|---|---|---|---|---|---|
| Goat farming | € | 136 | 123 | 14 | 4 local-breed goats purchased | 3 kidding after one year | All 7 goats sold | 164 |
| Goat farming | € | 109 | 98 | 11 | 3 local-breed goats purchased | 1 kid after one year | All 4 goats sold | 82 |
| Goat farming | € | 245 | 221 | 25 | 5 hybrid goats purchased | Goat were sick | All alive 3 goats sold | 91 |
| Tailoring machine | € | 109 | 98 | 11 | 1 tailoring machine purchased | Tailoring business flourishes in settlement | Tailoring closed | 109 |
| Buffalo rearing | € | 164 | 147 | 16 | 1 buffalo purchased | 4 litres of milk everyday but no market to sell milk | 1 Buffalo sold | 227 |
| Honeybee keeping | € | 136 | 123 | 14 | 1 bee hive purchased | Bee dead | No cash income | 0 |
| Aaran keeping | € | 218 | 196 | 22 | 1 metal workshop | Agriculture tools and household utensils | Workshop closed | 82 |
| Poultry | € | 109 | 98 | 11 | 90 layers chicks purchased | 82 layers chicks didn't survive | Remaining 8 layer hen sold | 10 |
| Local shop | € | 136 | 123 | 14 | Retail shop | Credit sales of items, shop in the loss | Retail shop closed | 200 |

Source: Project Report 2012

Out of 9 respondents, only three respondent households earn a little bit more money than they invested in IG activity within a year. For other respondents they received cash only when they finally sold the items purchased with IG loan. A respondent who undertook buffalo

rearing as a household IG activity stated that he did not receive any cash income from this IG activity so he was compelled to sell his buffalo. He said buffalo gave only milk no money. He stated as follows,

> *We did not have a water source nearby, so I or my wife used to collect the water for the buffalo. Along with water we also used to give maize flour with a little bit of salt. Buffalo gave 4 litres of milk every day. For the first few weeks we shared the milk with our neighbours. Everybody enjoyed free milk. Later we tried to sell the milk but it was not possible. People could afford the milk. My wife also tried to sell the milk in the market but it is very far and we need to travel every day. We did for a few days but it was not possible daily because it is very difficult. Later when I became ill, we desperately needed money and for looking after buffalo was becoming expensive we were compelled to sell the buffalo*

Similarly, a respondent opined that he could not earn money as expected from the goat farming. He stated as follows,

> *I used to mange fodder from the forest to the goats regularly. My economic condition was slowly enhancing. I was being more optimistic to purchase further social assets. In this regard, I have bought some agriculture tools for my home also. My life was going okay. However, when I am ill for a long time, I am unable to mange fodder for goats and taking care of them. The goats suffered from various diseases like tapeworm and others. We were unable to provide them with medicine on time and they are also compounded with other sorts of unknown disease. Slowly and gradually the goats started dying and this has declined my economic conation. Within just a matter of months my income source was vanished. Now the situation is even worse.*

A similar story was revealed with other respondents. At the beginning they benefited from the IG project due to their enhancement in economic condition. However, when they were unable to contribute to those activities due to chronic illness, their business collapsed and they are looking for income sources since then. Apart from IG activity, income from seasonal migration was highest in respondent households. But it was before chronic illness. Now after chronic illness almost all the major income sources of households have depleted.

**An important quote participant stated during focus group discussion**
A participant in focus group discussion stated as follows,

*"We are not prepared to bear potential risk from involving in the IG project. I work and cooperate if we can discern immediate benefit. I cannot give time to projects that will only result in tangible benefit after several years. Because my only priorities are related to day to day subsistence living".*

As a major income source collapsed, their strategy aimed at securing food also changed. All respondents have less than 0.5 hectares of fragmented landholdings. These lands are also only *Bariland*[2] and agriculture is largely subsistence type. They are highly reliant on limited and less fertile land parcels, but their productivity remains low which is unable to meet their subsistence requirements. Though farming is one of the major perennial sources of their livelihood at this moment, with poorer health, people are unable to make use of it properly. One respondent stated that landholding is the most important basis for, or criterion of, socioeconomic stratification in his household. The respondent stated as follows,

> *Land is recognized as our primary source of wealth and social status. Our economy is mainly agriculture based; the household economic status has a direct correlation*

[2] Rain fed uplands

*with the landholding size and the quality of land (both Khetland[3] and Bariland) and their soil fertility.*

A similar story was revealed by another respondent who depends on smallholder farming for his livelihood. The landholding that he possesses is inadequate to produce enough annual food for survival. The respondent in his own words stated as follows,

*I used to manage landholdings within the adiya (sharecropping) system though I was obliged to turn over a significant portion of my harvest to the wealthier landholders. Despite this, I was earning my living however these days due to my deteriorated health condition, I cannot work in the farmland and need to purchase food. As most of us I possess small Bariland, and the food produced is sufficient hardly for 2-3 months. For the rest of the month, we need to look for help.*

Food is directly related to economic conditions in the study area because all respondents revealed that food production from their own farm is sufficient only for 2-3 months in a year. Respondents highlighted that due to low production from own farm they have reduced the food consumption quantity. During harvesting season they consume more food and in lean period they consume less. This case is applicable to the whole family member.

During the focus group discussion, a respondent opined about their food habit where they consume mostly potato in the morning and *dindho* (cooked maize flour or millet flour) in the evening. Other respondents of focus group discussion also have similar reality. Researcher's observation also proved this. As farming became difficult two respondents state that they have reduced producing maize quantity because it requires a lot of labour for tillage. They do not have an ox to plough land and labour is not affordable.

Besides, they were also adopting a variety of other mechanisms to cope with poverty and food insecurity. This includes reduction in their food intake and switch to less preferred food items.

During this research visit, researcher has been in their locality for weeks. When researcher visited their home for data generation, most frequently researcher found them having either potato or Dhido as their food staples. Moreover, most of the family members looked pale and under nourished. While inquiring them about their food security status, one respondent stated as follows,

*Only the lucky people have access to stomach full food throughout the year*

Though they have severe food insecurity problem however none of them has a habit of eating green vegetables with regular meals. When the food stuff at home is finished then they opt for wild vegetable such as *Sisno* (stinging nettle), bamboo shoot, mushroom, yams etc. as a substitute to their food staples. Although none of the respondents reported mortality after consuming wild plants but in Nepal every year dozens of people fall sick and even die due to consumption of poisonous wild vegetables (especially mushroom) as they do not have the proper scientific knowledge about the identification of edible and poisonous mushroom.

Similarly, they often rely mostly on retail shop they purchase non food items in credit and reimburse the money later. Likewise, affected households are also forced to reduce their reliance on labour or input intensive crop or livestock enterprises. As farming became difficult respondents stated that they have reduced producing maize quantity because it

[3] Irrigated fertile lowlands

requires a lot of labour for tillage. They do not have an ox to plough land and labour is not affordable.

At the same time the recent food price hikes in Nepal has made proteins enrich the diets even more difficult to respondents. One respondent stated that they do not generally consume diets rich in proteins, vitamins and minerals. This was also verified in other respondents also where almost all respondents told that they have not consumed fish, meat, egg and fresh fruit within a past one year. Likewise, despite their role as basic ingredients in Nepali diet, lentils and pulses were not consumed by almost all respondents.

With this type of food consumption they are exhausted, especially the children. Early from the morning children participate in household chores. One respondent stated that his seven year old son travel up to one hour to reach the nearest forest. From there he brings firewood almost every day. As there are no proper trials in and around the settlement, managing firewood is always a challenge for them. Due to the long walking distance, their education time is also cut off. So is the case with fetching water. Since they don't have access to private tap, they need to spend about half an hour to mange drinking water from those public taps. The case is more severe during the dry season as the water sources that lie in the vicinity of localities dry up, they need to spend additional time and effort it. Most of their productive time is spent in managing those resources. Indeed, this had overwhelmed their work load. During this research visit, researcher found the children managing those resources abandoning their schools. Additionally, purchasing other non food item such as oil, salt, kerosene (in rainy season when wood doesn't burn easily) is like a nightmare for them because their economic status has hindered them in purchasing it.

### 4.2) Household's strategies aimed at health care

With poor food consumption, all the family members of the respondents are unhealthy. The condition of household's expenditure pattern gave the researcher the status of wasted resources of households. Previously they used to spend almost 80% of their income in food consumption. There were limited money allocation for health care and education. However, after chronic illness respondents in group discussion stated that health expenditure have surpassed expenditure on food consumption. People said they do not have enough money to spend on food these days. As the health status of the chronically ill household head is deteriorating, all the money is spent for the ill person. The key resource person stated in most of rural households in the study area, household head is also breadwinner. So when the breadwinner gets ill, household spent all of their money in that one person to make sure that person get fit and start earning the money again. Their expenditure status however depends on the health care practice they adopt, he added.

Access to health service in the study area is poor in comparison to urban areas. There is only one sub health post (each one in two VDCs) and for population in these VDC they need to travel one day walking distance to reach the district hospital, which is in the district headquarter of Rasuwa district. Since the district hospital is far, respondents stated that they prefer not to go to district hospital for a check-up. As they have only one health post which also remains without the health assistant most often, they have limited access to modern medication. Moreover it can also be understood from their response that they don't have faith in modern healing system. Group discussion participants shared that they have a psychological belief in faith healing and it is also common practice in their community. Most of the respondents still think that only faith healing can solve any sort of their problem instantly if not then lately. Hence, despite their chronic illness, only one household is on antiretroviral (ARV) while 8 respondents are derived from an AIDS care program of government. In the light of this finding, researcher has tried to present here a case which would give reflection on healing practice of one respondent.

*Earlier (before chronic illness) the family status was good as he used to go India seasonally and make some earnings. Additionally there was also a supporting hand from his spouse. Gradually his household economy declines as he continuously became ill. In its inspection period, he got treatment from the nearby health post. But the medicine did not cure his disease. So, since the last year, he is going to Dhami and Jhankri[4] for treatment. He frequently visited them where the treatment was done by chanting mantras and shouting at the spirits to leave his body by giving offerings and sacrificing animals. The cost per visit was nearly NRs.15000 (€ 135). He visited the faith healers five times within a year.*

Despite this the illness hasn't been diagnosed so far. He stated that due to his illness, the roles and responsibilities of other household members have changed. Apart from all household works his wife also needs to give him support every time they visit faith healer. He stated as follows,

> *It is nearly 3 hours walk to reach the healer and my spouse gives company to me. This has reduced her time for agriculture and household chores*

The under mentioned case is the clearest reflection of the bitter reality of their increasing expenditure needs where a respondent shared how the expenditure of his household evolved. He stated as follows,

> *As my health got deteriorated day by day, in the advice of one of the friends I consulted sub health post, they gave me medicines but nothing changed. Then I went to the hospital in Kathmandu, but every time they say different things, sometimes they say this disease and sometimes some other. The huge amount of money is spent in my treatment as these days I have no more economic backup. Now I stay at home doing nothing and my wife is most of the time near and around me. I know it is difficult choice we have to face because my illness* prevents not only me from working but also my wife.

A respondent aged 37 stated his expenditure pattern after chronic illness, he added as follows,

> *The cost exceeded 80 thousand (approximately € 750), which was beyond my affordability, so I started exploring for the money but this also could not suffice for treatment, I am in a dilemma and could not think the way out. I want to go to hospital but going city for further check-up is also expensive.*

Both the physical and household economic status of the respondent deteriorated in such a way that they were unable to afford their children with their basic amenities and so do them. This has further aggravated their health.

One respondent stated his understanding about chronic illness as follows,

> *Punar janma ma thulai kunai paap gare chu ki yo janma ma pani bhugatnu pari ra cha." (Due to excessive sinful activities in a past life, he is paying the price in this life too).*

In study area people have deep faith in divine power. The notable thing to be mentioned here is that the changes in poor health are happening and he was facing the consequences of these changes. However, the way of his understanding and interpretation was different. He told he expended thousands of rupees in faith healings but do not like to realize that things are not changing.

[4] A traditional healer

According to one respondent who is seeking AIDS treatment (i.e. ART), the cost is relatively high even when the disease is identified. He stated as follows,

> *I am HIV infected so I need to CD4 count every 6 months and this facility is not available in my district. Hence, I need to go to the Teku hospital in Kathmandu. I do not have money as all their savings and belongings has been eroded. Additionally, the facility of liver function test (LFT) that should be tested every three months is also not available in my district. For this also I need to go to Teku hospital in Kathmandu and need to pay NRs.100 fee (€ 0.90). Medicines I will manage somehow but travelling to Kathmandu, living and accommodation and other associated cost are very expensive for me because I do not know anyone in Kathmandu. Travelling frequently to Kathmandu in this crisis period is a nightmare for me. He stated that despite knowing the self HIV status he is deprived of medication.*

Likewise, a key resource person of this research would like to categorize people in Yarsa and Bhorle VDC in accordance to their health treatment seeking practices. They stated that due to HIV and AIDS related stigma prevailed in these VDCs, people do not communicate about AIDS treatment with one another. This is also one of the major reasons why most of the rural people are seeking faith healing to cure the chronic illness. It is also why those households dependent only on faith healer have seen expenditure in health care skyrocketed as well as increasing loan.

**Table 8: Types of people living with AIDS in Rasuwa district**

| | |
|---|---|
| Type one | Those people who know about this infection, go to Kathmandu to collect ARVs but never talk about HIV and AIDS with other people |
| Type two | Those people who know that they are HIV infected but hesitate to go for AIDS treatment (i.e. ART) fearing household split. |
| Type three | They do not know that the cause of illness is due to HIV infection. They are also the one who visit a faith healer most. |

Source: Discussion with key resource persons (2013)

Within the 9 respondent's households, most of the people have insufficient information about HIV and AIDS. Respondents live in a house where there is no electricity, no mobile phone network, and no television. Only some of the respondents have radio in their home. They listen to the radio occasionally. According to one respondent, listening radio all the time comes costly to them as the consumption of the battery is high and they cannot afford for it. It reflects that respondents have negligible information on health care facilities. This was also the one of the reason key resource person stated why rural people are not considering AIDS treatment. As shown in table below households expenditure differs in accordance with their strategy they have sought to health care.

**Table 9: Yearly expenditure status of health care among respondent households**

| | | Expenditure on health care within a year (range amount is in €) | | | | | |
|---|---|---|---|---|---|---|---|
| Expenditure mainly on | Unit | 100-200 | 201-300 | 301-400 | 401-500 | 501-600 | 601-800 |
| AIDS treatment | Respondents | 1 | | | | | |
| Only faith healing | Respondents | | 1 | 1 | | | 1 |
| Both faith healing and hospital treatment but not AIDS treatment | Respondents | | | | | 1 | 2 |
| Only hospital but not AIDS treatment | Respondents | | | | 2 | | |

The research found that those households that are taking AIDS treatment have seen the least expenditure in health care than other households. Those households who are seeking treatment both from faith healers and hospital but are not taking AIDS treatment are the one who is losing money fast. The researcher can see that the household financial resources

have been wasted in three households who are only dependent on faith healing to cure AIDS illness. Likewise a respondent who has visited only hospital not faith healer but has not undertaken AIDS treatment has also expended more than 50 thousand Nepali Rupees (€ 450) in health care. With the income source from the IG project evaporated and at the same time with this pattern of expenditure, respondents are in a serious financial crisis. It is important to note that the money mentioned is spent within a year.

### 4.3) Household's strategies aimed at raising or supplementing income to maintain household expenditure patterns

As there was no proper farm production, IG activity was slowing becoming the important source of income for households in the study area. But due to chronic illness, they could not sustain their IG activity so they received one-time cash gains. Being in line with this the respondent stated as follows,

> *I started selling the livestock and other productive assets including land to cover medical costs. At least previously I was able to drink buffalo milk now that is also not possible.*

Only 2 out of 9 households were able to earn up to 30 thousand Nepali Rupees (€ 300). This money however was raised after they sold the livestock they purchased from IG loan. Likewise, other households also raised the money by selling their livestock. Out of 9 households, one household who implemented honey bee keeping did not earn any money from the IG activity. As shown in table below, 5 respondent households annual income was less than 15 thousand Nepali Rupees (€ 100). Apart from this three female spouse were so far managing to work as manual labour in settlement. They were able to supplement income to some extent.

**Table 10: Household's total income within a year**

| | | Annual household income (income range in €) | | |
|---|---|---|---|---|
| Household major income source | Unit | Less than 100 | 100-200 | 201-300 |
| IG activity | Respondents | 5 | 2 | 2 |
| Manual labour in settlement | Respondents | 3 | | |

As income sources depleted at VDC level, respondents stated that they started to draw loans especially from family and friends circles at first. These loans they received from friends and family circles were non-interest bearing loans asked during emergencies. A respondent stated that he first asked the loan from his friends and family circles. He stated as follows,

> *At first it was easy to draw loan because people had a trust in us. Friends who returned from India also provided us the loan. As we are hard working people, our friends and family circles provided loans when we asked for. We asked for cash help because we did not have any savings. We thought we could repay because once I get fit, I will go back and earn from India.*

The friends and family circles they have however are also economically poor like them. So taking a loan however was for a short period. When respondents could not repay the loan, gradually friends' circles became distant. One respondent stated that his friend don't talk with him because he could not repay the loan. He stated as follows,

> *When I have to go to a faith healer, no one comes to help me, I have to travel far. Only my wife is with me. None of the friends come for help even if they are in the settlement.*

One respondent stated that gradually the credit in retail shop increased. When the grains are finished then as per another respondent also said her request for food grains from retail shops in credit. However, in recent months they say retail shopkeeper does not give them things on credit so they are shifting towards wild plants for food. The case is also similar with IG activity beneficiary who implemented retail shop. He stated that many people took the items in credit which they did not pay. He stated as follows,

> *People repay the credit for items they purchased when they return from seasonal migration. It was the practice in the settlement, so selling items on credit was not a problem for me. At first it was okay. But gradually many people took items in credit and did not pay. Due to this I also need to draw loan to buy the items for my shop. Today, my shop is closed and I have heard that many people are also chronically ill like me, so I don't think they will ever pay my money.*

As loan amount increased excessively respondent household adopted other measures to raise income. There were also cases that children were leaving home at an early age (even earlier than their father) to go to urban city or India to earn money and remit. In three households, children less than 15 years of age are working in a restaurant and private homes. These children now have become the major players to raise household income. But without education as a backup they are working as manual labours mostly in a risky environment. Two respondents state that their daughters work in a restaurant in Kathmandu. Public places can be a risky environment for HIV infection to children especially young girls. They remit money but that is barely sufficient to meet expenditure needs. One key resource person stated that this is one of the major reasons why rural people are manual labours and they do not get the sustainable employment.

As they are debt ridden and also are not getting loans, households stated that they have also started to sell their physical assets to raise income. These assets also include livestock and other items purchased for IG activity. At this moment none of the respondents have own tangible assets that can be sold apart from their house where they are living. As the income sources decreased, all the respondent households stated that they are in serious debt. Almost all respondent states that they had repayment burdens before they implemented IG activity. One respondent states that before chronic illness he had to spend almost 80% of the cash he had on food consumption. Despite earning some money from IG and from the seasonal migration, he already had the burden of loan. This was also confirmed in group discussion where respondents stated that the rural people of the study area are not emancipated from loans. As shown in the table below, within a year 5 respondents have already drawn loan exceeding 50 thousand (approximately € 450). In a scenario where they were already in a debt, with this type raising household income respondent are pushed even further into the debt.

**Table 1: Money raised within a year from different sources to meet expenditure needs**

| A strategy aimed at raising household income | Unit | Range in € | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Less than 100 | 100-200 | 201-300 | 301-400 | 401-500 | 501-600 | 601-800 | More than 800 |
| Sale of items bought from IG loan | Respondents | 5 | 2 | 2 | | | | | |
| Through loans | Respondents | 3 | | 1 | | 1 | 2 | | 2 |
| Sale of agricultural tools and other ornaments | Respondents | 4 | | 1 | | 2 | | | 2 |
| Remit by children | Respondents | | 3 | | | | | | |

For most of the respondents there are no plans about how to manage the expenditure in the future. They say that it gives more stress to them. These respondents said they just simply react to the immediate need, which includes disposing of their assets when no other alternatives are presently at stake. As shown in the table below, almost all households are debt with loans.

**Table 11: Status of total payable loan by respondents**

| Source of loan | Unit | Range in € | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Less than 100 | 100-200 | 201-300 | 301-400 | 401-500 | 501-600 | 601-800 | More than 800 |
| **IG loan** | Respondents | | 5 | 2 | 2 | | | | |
| **Loan received from friend and family circles** | | | | | | | | | |
| Within one year | Respondents | 3 | 1 | 1 | 1 | | | | 3 |
| Previous | Respondents | 4 | 3 | 1 | | | | 1 | |
| **Loan received from money lenders** | | | | | | | | | |
| Within one year | Respondents | 4 | 1 | 1 | | | 1 | | 2 |
| Previous | Respondents | 6 | 2 | | | 1 | | | |

As the income sources decreased, all the respondent households stated that they are in serious debt. Repayment burdens are heavy due to debts already taken out. This includes the debt burden from both IG and with other money lenders. This has also led to limited consumption of food. Most importantly to note that household' debts are twice as much as total financial assets they own. Respondent revealed that debt have increased drastically after when the household head (breadwinner) became chronically ill.

### *Chapter Summary:*

The chapter came up with the findings of this research the difficulties AIDS affected IG beneficiary households have faced in repaying their loan. The first part shows the strategy securing food which has deteriorated the health of project beneficiaries and reduced income. The second part shows the strategies aimed to seek health care and show how expenditure on health care rises. Finally, as their health deteriorated, the income and expenditure pattern dramatically changed and the household debt also increased drastically. So the decreased income to meet increased expenditure pattern show how people are falling into debt trap.

# CHAPTER 5: DISCUSSION

In the chapter, researcher analysed the themes of the study making its linkage with literature. Moreover, the researcher has attempted to incorporate his personal opinion on the findings of the study.

## 5.1) Household's strategies aimed at securing food

All respondents were manual labours and belong to the productive age group of household. Most of the people living with AIDS were men aged 28-45 years old. While women age range was 30-40 years old. These findings support Hilhorst *et. al* (2006) where it is stated that AIDS has a disproportionate impact on the morbidity of the most productive age group. Before chronic illness, they chose the IG activity that can be implemented with the knowledge they have. Some of the respondents who implemented IG activity such as tailoring, retail shop earned quick income. However, not all the respondents earned the money from the IG activity in the same way. The cases show that respondents find difficulty to sell their products. In the study areas, market imprudence stemming from poor credit repayment records also demonstrates that probably due to heterogeneous ways of implementing IG activity has a direct correlation with non repayment of the loan. It is mainly because people could not find markets for their products. So, after when the household head is chronically ill, it was the first thing they sold because the IG activity was taking time but not giving desired income. These findings can be linked up with the literature as Loevinsohn & Gillespie (2003) stated that surviving household members are also under immense pressure to seek more from income generating activities, in search of quick income they pursue difficult steps.

Cases have also shown that the size of credit disbursed and borrowers' market place and income transfer from relatives and friends alone was a difficult choice undertaken by poor people to translate themselves to a successful entrepreneur. The investment the IG beneficiaries have been on the right track as they were able to earn some money initially. However their efforts went in vain when they suffered from the illness and cannot contribute it in full fledge. Likewise it also supports the statement mentioned by Mullins (2002) stated that due to HIV and AIDS, organizational operations may become less relevant to or accessible by both infected and affected people. This means the ability to effectively and efficiently achieve goals of the organization is always at risk due to HIV and AIDS because of increasing load of illness and death in household results changes in roles, responsibilities and assets of affected families.

In researcher opinion when able family members have to look after chronic ill household head, not only their IG activity but also their food production has affected to a large extent. In researcher opinion in either case labour available for on farm work is further reduced and less available at critical moments in the season.

According to the report of FAO (2003), in most cases, affected families reduce the cultivation of labour intensive crops and leave the farm land barren. In a coherence to this report, similar cases were found in the study area. When the housed member suffered from the chronic illness, s/he became weak and their agricultural contribution declined dramatically. In addition, other members of the household also cannot contribute to their farmland as they need to take care of the sick. Earlier the infection of the illness, the labour force was provided by the respective household. However after illness they need to hire it and as the trend of male migration for foreign employment is high, there is no availability of labour force which resulted that they need to discontinue their farming. The study found that the *Bariland* that posses need extensive effort for the production due to its low fertility. This finding also

agrees with what UNAIDS (2001) stated; When household head is chronically ill then most likely that the land may not be cultivated and certain types of crops may not be grown because of the loss and/or lack of labour. Forests may not be managed, with some areas being over harvested because they are close to home of labour starved households. Water bodies may be over-exploited as households with sick persons who require frequent washing require more water than normal. The researcher also found that from the perspective of a poor household, even growing annual crops can be risky. So hiring labour force was not that much easier for them because agriculture inputs come higher in the reciprocity of outcomes. Hence, the respondents have left their farm barren and the trend is alarming. This situation reveals the findings of (Loevinsohn & Gillespie, 2003) who mention that in this kind of situation food insecurity increases in agricultural households. IFPRI (2003) mentions that AIDS affected households are forced to reduce their reliance on labour-or-input intensive crop or livestock enterprises, and to focus on activities that are of reduced scale and with fewer risks, but that also have lower output or provide less income. In line with this similar cases were found in the study area. As farming became difficult the respondents have reduced producing maize quantity because it requires a lot of labour for tillage. They do not have an ox to plough land and labour is not affordable.

Though they have severe food insecurity problem none of them has a habit of eating green vegetables with regular meals. In researcher's views if the respondents have adopted the habit of eating green vegetables with their regular meal than their stuff food could extend for some additional months. When the food stuff at home is finished then they opt for wild vegetable such as *Sisno* (stinging nettle), bamboo shoot, mushroom, yams etc. as a substitute to their food staples. Although none of the respondents reported mortality after consuming wild plants in the study area but it could be risky for them. In Nepal, every year dozens of people fall sick and even die due to consumption of poisonous wild vegetables (especially mushroom) as they do not have the proper scientific knowledge about the identification of edible and poisonous mushroom. This has reduced their nutritional intake.

World Bank (2012a), which state that since poor people cannot afford proper food, which affects nutrition through changes in metabolism, appetite loss and changes in feeding practices. Though ill people need nutritious food however it is beyond their affordability. In coherence with this literature the research findings show that food production is barely sufficient for 3 months due to this the circumstances have forced them to replace dietary habits and even consume wild vegetables. As people do not have the income to purchase food, household members could not consume nutritious diet. Almost all households mentioned that they have not eaten protein rich food such as meat, fish, beans etc. for few years now. As people are more dependent on wild plants, they require more fuel to cook than normal food so cooking time has become another challenge. Fuel wood has been scarce. People spent time mostly in collecting firewood. Due to this their livelihood is most of the time subsistence. Likewise, even in the mountain region water sources are drying fast. Household members told that they need to travel further to fetch water these days. The springs are drying faster than in the past during the dry season. In a situation when a chronically ill member requires an increased quantity of water, accessing this has become harder. With this type of food consumption and meal type, AIDS affected family members are even becoming physically weak and unhealthy. They cannot work more to earn more. This has further hindered their chances to work efficiently. This has ultimately reduced their income. This is also one of the major causes why project beneficiaries are in increasing debt.

### 5.2) Household's strategies aimed at health care

AIDS affected families are eating *Sisno* (stinging nettle), bamboo shoot, mushroom, yams more than before. Though the researcher did not find anyone who has died due to consuming wild plants such as mushroom, but the risk always remains there in the study

area. In Nepal every year, dozens of people fall sick and even die due to consumption of poisonous wild mushroom as they do not have the proper scientific knowledge about the identification of edible and poisonous mushrooms. This situation relates to the report by MOHP (2011), which state that in Nepal, mostly in rural areas people do not have the required information about health facilities due to which a large segment of poor population still remains deprived of many basic health care facilities. In line with this literature, most of the respondents were unaware about the modern medicine. The study found that rural people are indifferent towards information on health facilities aired by mass media. Indeed the aim of airing such programmes was to share information about health issues and make rural people acquainted about modern health facilities. In researcher opinion, this has happened due to the poverty of the people which has hindered them for their exposure. Media could be another best option to make people aware about the disease and its curing methods. However, due to the prevailing poverty, only some of the respondents have radio in their home. They hear it periodically (especially for listening news only). Listening radio all the time comes costly to us as the consumption of the battery is high and we cannot afford for it, said one of the respondents. It reflects that respondents have negligible information on health care facilities. Besides this, as mentioned in an earlier chapter, there was no hospital facility in their locality and the only one health post also remains close most often. So, the people are deprived of the treatment practices facilities. This led them to go for the faith healer for their treatment. This can be correlated with Shankar, P.R., 2007; Raut, B., 2011, when people do not have proper access to treatment facilities, they mostly rely on faith healing. Likewise, in the study area it was also seen that faith healing was common practice of the respondents. They have the psychological impression that their disease might be cured fully by those healers. Respondent states that for the minor diseases, they cure it by themselves with the help of local herbal medicines and the severe case is treated by the faith healer (like d*hami, jhankris, lama gurus etc.).* In researcher opinion due to the lack of knowledge of modern healing and also poverty has led them to follow such practices. Besides this the social system also responsible factor in doing so because everyone prefers to follow the practices that exists in their community. It was quite pathetic to know that the respondents are still going to faith healers to cure AIDS illness. Hence awareness campaign seems apparent to make those ignorant people familiar with the disease and the treatment they need to adopt.

MOHP (2011) reported that rural people are compelled to bear all the expenses including health related expenditure from their pocket. The expenditure, however, goes on non-productive assets. Sometimes the cash is diverted away from other productive and reproductive activities as most people in rural areas prefer to visit a traditional / spiritual healer and not the proper treatment practice of infected person (Drimie, 2003). This relates to the findings of this research where respondents in the name of faith healing are spending money to sacrifice goats, hens, eggs etc. which comes costly for the respondent to afford it. However, in the hope of being fully cured, they offer it. In researcher's analysis the faith healing has further deteriorated the economic condition of the respondent. . Over 30% of Nepalese live on less than US$14 per person, per month, according to the national living standards survey conducted in 2010-2011. Most of these populations are concentrated in upper hills and mountain regions of Nepal like Rasuwa district of Nepal (CBS, 2012). Despite spending lots of money in treatment practice, their disease is not cured and the process of healing goes for life long.

### 5.3) Household's strategies aimed at raising or supplementing income to maintain household expenditure patterns

For many respondents, at this moment, survival is the only thing they are concerned about. Not about repayment of loans. Without proper access to AIDS treatment (i.e. ART) and

completely dependent on faith healers means household debt will increase further in coming years. With the present debt and within present circumstances they are not in a condition to repay any loans they are liable for. This situation confirms as UNAIDS (2009) stated, sometimes coping the impact of AIDS for poor people means they are simply surviving. In line with this, poor people who already have very limited income sources were already facing difficulty to manage household expenditure. Now after chronic illness for more than 3 months to household head means the situation became more challenging. Most households who used to go to India to raise household income cannot go anymore. They could have work of their own farm but they also cannot do that either. Most of the respondents never have any savings so any new expenditure in regular schedule means they need to ask for loan with near and dear ones. Respondents state that people do not easily give them a loan because they haven't paid the earlier dues. Respondent says that people ask for past dues to be cleared first then they are eligible for new one.

Barnett and Whiteside (2006) argue that the impact of AIDS should be seen from a continuum between sharp shock and profound changes. The loss of human resource (both from chronic illness and even death) is a sharp shock which leads directly to a loss of access to livelihoods capital asset - profound change. There are less income sources not only because the people living with AIDS can't work but also because time is diverted to care of the sick by other household members, who are affected by AIDS. Likewise, Drimie (2003) mentions that with the household head living with AIDS the productivity of the affected households is diverted. These literatures relate with the finding of this research. There are cases that when the household head became chronically ill one of the major areas which was affected is income sources of households. Seasonal migration was the major means to raise household income. There were also cases that most of the female spouses were involved more in caring the sick in the study area. The findings also relate with UNAIDS (2006) which state that when household experience decrease in income source and health care expenses increases, it reduces the concentration of affected people and the soaring expenditure collectively makes poor households further vulnerable to poverty.

Without proper income source households started to look for ways to raise income. Household seeks more loans family and friend circle. Likewise they also borrowed farm grains from this circle. To meet food consumption they also bought food grains in credit from the nearby retail shopkeeper. Later when they were unable to clear their dues, this strategy worked no more. At present all households are in a serious debt and it is mainly because they have borrowed money beyond their ability. In most of the cases household have debt two times higher than their total assets. It is amazing to know that despite their chronic illness, they were receiving the loan for a long time. This statement confirms as Parker (2002) in his discussion paper on microfinance and AIDS said, due to HIV and AIDS portfolio quality of household may change due to increased delinquency, particularly if affected households have been encouraged to borrow beyond their ability to repay.

Without considering that they have fallen into the debt trap, respondents have now started to sell household assets to raise income. They have sold the physical assets including their assets purchased with IG loan. They also sold other livestock and ornaments that they posses. However, that also could not cover their cost fully. This relates to Lawson (2009) who stated that when a poor family experiences shocks and downward trends, distress sale of physical assets to raise income is often seen as on the first coping strategy through which a family avoids immediate declines in poverty.

To raise income, project beneficiaries are taking difficult decisions. They are sending children far and wide to raise income. Two respondents state that their daughters work in a restaurant in Kathmandu. Public places can be a risky environment of HIV infection for children especially young girls. This reflects that the vicious circle of poverty will continue even in the succeeding generations. It is because unskilled children most probably suffer the

same and/or even worse case as their parents suffered. The findings correlate with the findings of FAO (2003) which shared that there are different types of coping strategies to avoid and or minimize the impact of AIDS such as a reduction in income from farm and off-farm sources, liquidation of saving accounts, change in wage earning, change in income generating activities, borrowing from rural money lenders-often at exorbitant interest rates, exhaustion of credit resources and even sales of productive assets.

**Chapter summary**

The discussion indicated the difficulties AIDS affected IG loan beneficiary households have faced in repaying their IG loan. Since the household head became chronically ill the loan amount increased drastically. Income sources have dried out. Previously they used to rely on families and friends circles for a loan, but these days finding loan from these sources have become difficult. The money lenders do not provide them loan because they already have payable debt. Likewise, households have also started to sell their physical assets to raise income. These assets also include items purchased from IG loan. All respondent households are in a serious debt.

# CHAPTER 6: CONCLUSION

This chapter outlines the conclusion drawn from the findings of the study as:

The study of context specific coping strategy in the Rasuwa District provided both; a warning and support to DEPROSC about the unnoticed problems (so far) and identify who is even vulnerable, thus specifying the need for mitigating interventions. The study also reveals that AIDS has increased the difficulties of IG loan beneficiary households. Most of the respondents were already in debt before they implemented IG activity. So they had a big expectation from their IG activity before implementation. It was identified that they implemented their IG activity wisely. But gradually IG activity implementation became challenging as household did not receive the desired income. It was also found that due to heterogeneous IG activity selection by project beneficiaries, they were unable to produce in bulk to reach the market. Travelling 4 hours to sell two litres of milk was a very challenging situation indeed for a person who lives in a remote part of the district. At the same time, the household head became chronically ill and household expenditure on health care rise. Faith healing became the desired option for many respondents to cure the AIDS illness. As faith healing is expensive, without much of the option, respondents started selling items they purchased from IG loan. Both loan and credit of household increased dramatically within a year that now there is a negligible source of income. Friend and family circles have become less supportive towards them. Respondents are compelled to consume wild plants. This has further weakened the health status of whole family members. They need food support to maintain the minimum caloric requirement. As earning like before became a distant reality to them, at this moment it is also necessary for the respondents get sufficient information about HIV and AIDS and linkage with Nepal Government's National HIV and AIDS strategic programmes.

# CHAPTER 7: RECOMMENDATIONS

Based on the findings and conclusion of the research, the following recommendations are made to DEPROSC for consideration.

- This research shows that it is the most appropriate time for DEPROSC to conduct a baseline survey and identify the demographic status of chronically ill households and their socioeconomic status.
- To address the cause of non repayment of IG loan it will be more appropriate to revise the IG loan policy specifically on the amount of loan to chronically ill households, interest rates and repayment period.
- It is necessary to organize awareness program on HIV and AIDS to IG loan beneficiaries.
- Concerning about the linkage development with Nepal Government's HIV and AIDS strategic programmes, it is suggested to facilitate community organizations to organize an outreach voluntary testing and counselling centres in Rasuwa district.
- AIDS affected households need urgent food support so it is necessary to inform the concerned district stakeholders about this situation and coordinate with them to develop AIDS response strategy at district level.
- In general, it is recommended to develop strategies to build up linkage with markets as the key part of income generating activities implementation.
- On the basis of the overall findings of the study, it is also recommended to establish a focal point of HIV and AIDS in DEPROSC.

Furthermore, this research has identified another issue which requires further examining. The issue is about those households where there is AIDS related mortality. There is need to study the loan insurance policy so that if the person living with AIDS (project beneficiary) dies then households can be supported with new IG loan to initiate next income generation activity. So the rest of the aspects and concerns are left for further research by the researcher.

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## ANNEX A: Checklist for one to one interviews

- Demographic characteristics (age, family size)
- Educational attainment
- Land holdings of the respondents
- Food consumption
- Food sufficiency
- Replace food items
- Access to other resources such as fuel wood, drinking water
- Income status of IG project
- Household's other major income source
- Major expenditure priorities of households
- Prevailing health care practice
- Know-how about household debt

## ANNEX B: Checklist for observation

- Farming inventories in the house
- Clothes people are clothing
- Health of AIDS affected household members
- Hygiene in and around household
- Distance of households from forest resources, drinking water spring, health post, schools, market
- Facial expression
- Status of other household assets

## ANNEX C: Checklist for key resource person interview

- Socioeconomic status of AIDS affected households
- Health care and treatment practice
- Common complaints of HIV infected population
- About VCT programme
- Relevancy of IG project

## ANNEX D: Checklist for focus group discussion

- **Relevancy of IG projects**
  - The anticipated benefit of IG project
  - Challenges associated with IG project

- **Trend of expenditure**
  - Major expenditure priorities of households in recent years
  - New infection or disease people have seen in recent years
  - Why do people still go to faith healer instead of a hospital

- **Knowledge about HIV and AIDS**

## ANNEX E: Photographs

**Photo 1: Researcher taking interview with key resource persons (Identifications of resource persons are hidden purposefully by researcher)**

**Photo 2: Glimpse of Yarsa VDC in the background**