

**THE IMPACT OF HIV/AIDS ON POVERTY AT
HOUSEHOLD LEVEL: THE CASE OF TWO
KEBELES IN ADDIS ABABA**

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TABLE OF CONTENTS

	Page
1 Chapter one: Introduction	1
1.1 Statement of the problem	1
1.2 Objectives of the study.....	3
1.2.1 General objectives.....	3
1.2.2 Specific objectives.....	3
1.3 Significance of the study.....	4
1.4 Research questions.....	4
1.5 Limitations of the study.....	5
2 Chapter Two: Literature Review	6
2.1 The concept of impact of HIV/AIDS	6
2.2 The link between HIV/AIDS and poverty.....	9
2.3 The impact of HIV/AIDS in Africa.....	12
2.4 Impact of HIV/AIDS in Ethiopia.....	13
2.5 Impact of HIV/AIDS on gender.....	16
2.6 Socioeconomic impact of HIV/AIDS on households.....	17
2.7 Coping strategies.....	20
2.8 Conceptual framework.....	23
Analytic framework for the study of impact of HIV/AIDS on households.....	26
3 Chapter Three: Research Design and Methodology	27
3.1 Description of the study area.....	27
3.2 Research design	30
3.3 Data collection and instruments	32
4 Chapter Four: Results of the Study	36
4.1 Socioeconomic status of HIV/AIDS affected households	36
4.1.1 Socioeconomic and demographic characteristics of the sample population.....	38
4.1.2 Availability of facilities for HIV/AIDS affected individuals.....	38
4.1.3 Income and expenditure of the households before and after HIV infection.....	42
4.2 Changes in household and family structure and burden of dependency	49
4.2.1 Female headed households	49

4.2.2 Child headed households	50
4.2.3 Dissolved households	50
4.2.4 Burden on extended families	50
4.3 Status of AIDS orphan children	51
4.3.1 Type of custody of AIDS orphan children	52
4.3.2 Access to basic needs	52
4.3.3 Family income of AIDS orphan households	53
4.3.4 Educational status of AIDS orphans	54
4.3.5 Orphans's involvement in income generating activities	55
4.4 The link between HIV/AIDS and poverty	56
4.5 Major findings from the cases	58
4.6 Coping strategies	60
5 Chapter Five: Discussions of the Major Findings	66
6 Chapter Six: Conclusion and Recommendations	72
6.1 Conclusion	72
6.2 Recommendations	75
Bibliography.....	78
Appendices	

LIST OF TABLES

Table 2.1:	Average life expectancy in 11 selected African Countries
Table 3.1:	HIV/AIDS affected individuals supported by CHAD-ET
Table 4.1	Age and sex of the respondents
Table 4.2:	Occupational status of the respondents
Table 4.3:	Size and number of rooms of the households
Table 4.4:	Monthly income of the respondents before affected by HIV/AIDS
Table 4.5	Monthly income of the respondents after affected by HIV/AIDS
Table 4.6:	Amount of expenditure for health treatment of the deceased family member
Table 4.7:	Amount of expenditure for funeral of the deceased family member
Table 4.8:	Monthly expenditure for food before HIV infection
Table 4.9:	Monthly expenditure for food after HIV infection
Table 4.10:	Source and size of current income of the households
Table 4.11:	Type of custody of AIDS orphans
Table 4.12:	Availability of sufficient food for orphans
Table 4.13:	Availability of sufficient cloth for orphans
Table 4.14:	Parents income before HIV infection
Table 4.15:	Monthly income of the orphans' caregivers
Table 4.16:	Educational level of orphans by age
Table 4.17:	Children who are currently in school and drop outs
Table 4.18:	Reason for involvement in income generating activities for orphans
Table 4.19:	Responses with regard to whether poverty expose one to HIV or not
Table 4.20:	Coping mechanisms of affected households
Table 4.21:	Access to social networks
Table 4.22:	Monthly payment for Iddir
Table 4.23:	Amount of money received to funeral from Iddir

LIST OF APPENDICES

- Annex 1: Case Anecdotes
- Annex 2: Questionnaire
- Annex 3: Socioeconomic status of the case studies
- Annex 4: Photographs
- Annex 5: Map of the study area

Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
CBOs	Community Based Organizations
CCF	Christian Children Fund
CHAD-ET	Children Aid Ethiopia
CRDA	Christian Relief and Development Association
ECA	Economic Commission for Africa
HIV	Human Immuno Deficiency Virus
MoH	Ministry of Health
NGO	Non-governmental organization
PLWHA	People Living with HIV/AIDS
SDPRP	Sustainable Development and Poverty Reduction Program
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program

Operational Definitions

Impact: A shock to an existing system of livelihood at the national, regional, communal, or household level, which reduces the levels and expectations of life and welfare. It may mean the dissolution of the unit and involve the loss of individuals from poverty related causes rather than as a direct result of HIV/AIDS illness or death (Barnett and Whiteside, 2000).

Acquired Immuno Deficiency Syndrome (AIDS):- A clinical syndrome (a group of various illnesses that together characterize a disease resulting from damage to the immune system caused by infection with the human immunodeficiency virus (HIV). HIV, which causes acquired immune deficiency syndrome (AIDS), principally attacks T-4 lymphocytes, a vital part of the human immune system. As a result, the body's ability to resist opportunistic viral, bacterial, fungal, protozoal, and other infection is greatly weakened.

Poverty: Poverty is economic condition in which people lack sufficient income to obtain certain minimal levels of health services, food, housing, clothing, and education generally recognized as necessary to ensure an adequate standard of living. What is considered adequate, however, depends on the average standard of living in a particular society (Microsoft, 2002).

Households: Any unit of habitual residence where some consumption and/or production may be undertaken in common and where some members may recognize culturally defined relationships of kinship and/or affinity where the members are related in some way (Barnett and Whiteside, 2000).

Gender:- refers to socially constructed roles of women and men ascribed to them on the basis of their sex. Gender roles depend on a particular socioeconomic, political and cultural context. They are learned and vary widely within and between cultures and can change (Common Wealth Secretariat, 2002).

Vulnerability:- This describes those features of a social or economic entity making it more or less likely that excess morbidity and mortality associated with disease will have adverse impacts upon that unit.

Idir: A community based association established on voluntary basis for the purpose of supporting each other with special attention to burial of the dead.

Kebele: The smallest administrative unit under the City Administration

Kifle-ketema: Administrative unit

Tella:- is local beer

Araki:- is local alcohol

Sex worker:- An individual who is paid money in exchange for sex

'Kot' :- is a sleeping place prepared under the ceiling to solve problem of space, in which the people can go up by the ladder.

Tsebel :- Holy water

Teskar: - is cultural and religious commemoration to invite and feed people who attended the funeral ceremony. It takes place at different time intervals starting from 12th day of funeral 40th, 80th, etc.

Coping:- is about the ways in which we all recognize that our normal expectations of how life is and ought to be are adjusted when we realize that 'normality' has, for whatever reasons, switched to 'abnormality'. In recognizing that such a transition has occurred, we search for explanations of the new circumstances in which we find ourselves; we adjust our expectations and we search for courses of action that will enable us to achieve whatever goals are culturally significant for us. These processes require us to develop not only practical strategies for coping, but also language and concepts to deal with the new situation (Barnett and Blaikie, 1992, as cited by Demele, 2004).

ABSTRACT

This research has focused on assessing the impacts of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) on poverty at household level with regard to issues related to challenges being faced by affected households and individuals. A survey was conducted on 100 households and 50 orphans, three focus group discussions, and interviews with key informants from relevant organizations in two kebeles of the Addis Ketema sub-city. Emphasis was put on examining the nature of the problems the household faced when the breadwinner is ill/die. Thus changes in income and expenditure patterns, on family structure, and coping strategies of households was analyzed.

The study has confirmed that the major problem of HIV/AIDS affected households which aggravate their poverty was lose of income. The majorities of the victims are unemployed, some stopped working because of illness and some of the unemployed revealed that they were discriminated in some organizations since they were asked a results of HIV test to be recruited. In addition, most of the households do not have access to basic facilities such as housing and other related facilities like water and toilet within the dwellings. As a result, households affected by HIV/AIDS need access not only to care and support but also to the means to maintain an income and pursue alternative livelihoods.

HIV/AIDS generated various types of households such as female headed, grandmother headed, child headed, and dissolved households. Women are found to be more vulnerable to HIV/AIDS mainly due to social, economic and cultural influences imposed on them. Since they cannot work in many types of jobs like men, HIV positive women go to charity organizations before being ill. 74.3 percent of the clients of the specific NGO in the study area are found to be women. They are also found to be abused by their husbands to the extent that they were forced to make sexual intercourse against their will by HIV positive husbands, become pregnant and give birth to HIV positive child.

The main coping strategies used by HIV/AIDS affected households are searching assistance from a charity organization, selling assets and using previous savings, dispersing siblings, returning to parents' home, and using holy water. The majority of the affected households cope with HIV by searching assistance from charity organization, though the support they get was not adequate to fulfil even the basic needs. A significant number of households dispersed the family member to various extended families such as grandmothers, aunts and uncles. Because of lose of income, some widowed women returned to parents' home with their children.

The major problem of HIV/AIDS affected households and individuals is shortage of income, as a result of which they lack basic necessities. Thus it is recommended that the financial assistance flow in the name of HIV/AIDS should properly reach the affected and infected individuals and households, and Antiretroviral drugs should be made available so that the infected individuals get them easily.

Key Words: Impact, Poverty, HIV/AIDS, Household, Income, Expenditure, Coping strategy.

Chapter 1: INTRODUCTION

1.1 Statement of the Problem

Ethiopia has a population of 71 million in mid-2004 (MOH, 2004), with per capita income of about US\$ 100 per annum, is among the poorest in the world and is ranked 169th out of 175 countries listed in UNDP's Human Development Report (2003). Over 80 percent of the population live below the income poverty line of US\$ 2 per day, 44 percent live below US\$ 1 per day, and 60 percent of the population are illiterate (MOFED, 2002). Ethiopia is the third largest country in the world, with 1.5 million people currently living with HIV/AIDS (MoH, 2004). Poverty combined with illiteracy and gender inequality, aggravated the spread of HIV/AIDS in the country (CARE International, 2002). Therefore, poverty and HIV/AIDS are the major challenges of economic and social development in Ethiopia.

Poverty contributes to HIV and HIV contributes to poverty, causation is bi-directional. There are two by-causal relationships between HIV/AIDS and poverty (Cohen, 1998). On the one hand, poverty fosters the spread of the illness and on the other hand, the illness increases poverty of affected people. In the first case poverty enhances the vulnerability of people to HIV infection. Apart from being associated with poor nutrition and a breakdown of immune systems, is also related to unsafe sexual practices as a result of lack of knowledge and lack of access to means of protection, due to women's inability to negotiate about condom use with sexual partners as a result of the socio-cultural as well as economic constraints to condom use.

In the second case HIV/AIDS can also make households and individuals to move into deeper poverty where its primary impact is visible mainly on the incomes and the expenditures of individuals and households (Bollinger *et al.* 1999, Booyesen, *et al.*, 2001, and Jackson, 2002). As adult members of the household become ill and are forced to give up their job, household income will fall. Moreover, the income effect of HIV/AIDS is the loss of incomes of infected household members who die of AIDS. Thus, household income declines mainly through illness and death of the breadwinner. The expenditure effects of households manifested in two kinds of additional costs. The increased costs of medical treatment for HIV positive members that developed symptoms of AIDS, and the cost of funeral for the death of AIDS patient (Bidpa, 2000). Since it

requires additional expense for health care, it reduces household income that could be used to finance other basic needs (Steinberg *et al.*, 2002, MOLSA *et al.* 2003, Mukiza-Gapere and Ntozi, 1995). As it affects most economically active members of the household, and as it reduces personal capacity and productivity, it may result in sell of assets to compensate loss of income. Therefore, HIV/AIDS and the associated burden of morbidity and mortality expose the already vulnerable households to further shocks, and locking those poor households already infected and affected by the epidemic in a vicious cycle of poverty.

In Ethiopia, the link between HIV/AIDS and poverty has been well understood and clearly shown in the Sustainable Development and Poverty Reduction Program (SDPRP) document. In the same document, the strategy for fighting HIV/AIDS in connection with the poverty reduction efforts has been well illustrated (MOFED, 2002). As part of the efforts to address the epidemic, the Government of Ethiopia has established HIV/AIDS Prevention and Control Offices at national, regional, zonal and sub-city/wereda levels. The overall objectives of the National office are to guide the implementation of the successful programs to prevent the spread of HIV/AIDS, decrease vulnerability of individuals and communities to the epidemic, provide care services for those living with the virus and reduce the adverse socio-economic consequences of the epidemic (National AIDS Council, 2001).

In Ethiopia, the impact is seen not only when an individual is sick, but it also happens after death. A study of 25 AIDS afflicted rural families found out that the average cost of treatment, funeral and mourning expenses amounted to several times the average household income (Bollinger, Stover and Eleni 1999). Since the effects of HIV is more severe in urban areas of Ethiopia, the mentioned costs are assumed to be much higher than that of the rural areas.

Addis Ababa is reported to have one of the highest concentrations of HIV/AIDS cases in the country. According to the Ministry of Health (2004), the HIV prevalence rate in Addis Ababa is estimated to be 12.4 percent, with 400,000 people living with HIV/AIDS and 79,000 orphans. Women in the age group of 20-29 years and men in the age group of 25-39 years showed the highest prevalence rate of HIV, whereas the overall ratio for infected male and female amounts to 1:1.2. AIDS patients occupy fifty seven percent of the hospital beds in the city. If the epidemic

continues with the same rate, it is predicted that there will be 40,000 to 60,000 new HIV/AIDS-cases every year.

Very few studies have been conducted on the impact of HIV/AIDS on households in Ethiopia, including the one done in 25 AIDS afflicted rural households by Bollinger *et al.* (1999). However, as Garbus (2003) clearly indicated, there are no studies/researches done on the impacts of HIV/AIDS on the existing poor Ethiopian households in urban areas and slums. Similarly, there are no studies on how the extended families are affected by the epidemic.

This study, therefore, explores and analyzes how HIV/AIDS affects households in two selected urban Kebeles of Addis Ababa by disaggregating into the following relevant categories. Changes in income and expenditure patterns, changes in the household and family structures and burden of dependency, situations of AIDS orphans, the link between HIV/AIDS and poverty, and coping strategies. Based on the analysis some recommendations are proposed on how to combat the effect of the epidemic on the poor households of Addis Ababa.

1.2 Objectives of the study

1.2.1 General Objective

The overall objective of this study is:-

To assess the impact of HIV/AIDS on poverty situation at household level, and its impact on orphans, elders, and extended families.

1.2.2 Specific Objectives of the study

- To explore the socioeconomic characteristics of the sample population disaggregated by gender,
- To assess the status of HIV/AIDS orphans; and to explore the changes in household and family structures, burdens of dependency within households and extended families, and patterns of household headship,
- To analyze changes in income and expenditure patterns of the affected households,
- To examine if poverty exposes one to HIV/AIDS as well as if HIV/AIDS increases poverty,
- To examine social and economic networks of the households that can be used as coping mechanism.

1.3 Significance of the Study

The household is an institution, which is the basis of any community and nation, and it is the most affected by HIV/AIDS. If AIDS affects more households, the country will face development problems. Many studies have mostly focused on demographic, psychosocial problems of PLWHA and orphans, clinical and epidemiological problems of the epidemic. Research on the nature of the problem at household level in relation to poverty as well as the impact of the epidemic on the extended families is desirable and deserves attention.

The study focuses on households selected from two kebeles. These included in the survey are selected from those individuals and households affected by HIV/AIDS receiving assistance from non-government organization. The study attempted to reveal the real situations/status of HIV/AIDS affected poor households in the selected two kebeles. The output of the study could be used as a record of how the HIV/AIDS affected households are responding to the epidemic and the financial implications of the epidemic for the household and the country at large. By analyzing and indicating the real facts, it highlights areas of attentions for policy makers and NGOs working in prevention and care to draw lesson for their future intervention plans.

1.4 Research Questions

- Do households affected by HIV/AIDS have access to resources and services?
- What are the sources of income for people with HIV?
- What is the size of the current income of households as compared with income before the problem?
- Does poverty increase HIV/AIDS susceptibility and aggravate poverty?
- Does HIV/AIDS affect women more than men?
- Do men have better coping mechanisms than women?
- Does HIV/AIDS affect extended families?
- Who are the caregivers for AIDS orphans?
- Have AIDS orphans access to basic needs?
- Are children involved in income generating businesses after the illness/death of parents?
- What are the major coping strategies of HIV/AIDS affected households and individuals?

1.5 Limitations of the Study

Since the study subjects are people affected by HIV/AIDS, which is assumed to be the consequence of somebody's sin, there was difficulty to simply get adequate information from individuals and households affected by HIV. Moreover, as the study subjects were households drawn from beneficiaries of an NGO that provide support to affected households, households which were not being supported, but affected by HIV/AIDS, were not included. And there was also problem of getting information about the dissolved households, because most of the time after death of the breadwinner some family members were dispersed to different places such as extended families and in search of traditional medicine such as the Holy Water. And also after death of parents, some children were dispersed to relatives and other places such as institutions in search of livelihood. Because of the mentioned reasons, this research may not be a very good representative of households affected by HIV/AIDS in Addis Ababa.

During the data collection of the survey, there was problem of getting exact information about many variables such as the income and expenditure of the households. The majority of the respondents result showed that their expenditure was greater than their income in both cases (before and after infection). This created some kind of difficulties during the analysis and interpretation of the data.

Chapter 2: LITERATURE REVIEW

2.1 The Concept of Impact of HIV/AIDS

The impact of HIV/AIDS is multidimensional, among others the main ones are demographic, health, education, gender, orphans and elders, and impact at the household level. The most direct consequence of AIDS is an increase in mortality. HIV/AIDS is now by far the leading cause of death particularly in sub-Saharan Africa. According to UNAIDS (2004), since the beginning of the epidemic more than 20 million people have died in the world. In 2003 in sub-Saharan African countries estimated 2.2 million people died which is 75 percent of the three million AIDS deaths globally that year, and five million people became newly infected with HIV. HIV/AIDS reduces life expectancy of individuals. The same source indicated that in seven African countries where HIV prevalence is more than 20 percent, the average life expectancy of a person born between 1995-2000 is now 49 years, that is 13 years lower than in the absence of AIDS. The following table depicts the average life expectancy in 11 selected African countries.

Table 2.1. Average life expectancy in 11 selected African countries

Country	Before AIDS	2010
Angola	41.3	35.0
Botswana	74.4	26.7
Ethiopia*	56.0	49.0
Lesotho	67.2	36.5
Malawi	49.4	36.9
Mozambique	42.5	27.1
Namibia	68.8	33.8
Rwanda	54.7	38.7
South Africa	68.5	36.5
Swaziland	74.6	33.0
Zambia	68.6	34.4
Zimbabwe	71.4	34.6

Source: Avert.org (2004). *Source: MoH (2004) projected for 2008

As a result of all this, since the vast majority of people living with HIV/AIDS in Africa are between the ages of 15 and 49 - in the prime of their working lives, AIDS weakens economic activity by squeezing productivity, adding costs, diverting productive resources, and depleting

skills. Thus, it has a negative impact on the process of development the African countries are attempting to achieve.

With regard to the health sector, HIV/AIDS is bringing additional pressure on the health sector of the affected countries, particularly to sub-Saharan Africans. In these countries including Ethiopia about half of the hospital beds are occupied by HIV patients. This has a negative impact on the non-HIV patients since it creates problems reducing their chances of recovery when they are forced to be admitted only at later stages of illness.

Education is a key to social, cultural, and political participation, personal and community economic empowerment, and national development. Its output is the human capital which constitutes the nations primary wealth and potential for growth (Badcock-Walters, 2002). HIV/AIDS has been a major threat for this process. The epidemic not only affects the workforce in the sector but it also increases the number of dropouts of children as a result of parent's death. Particularly girls are vulnerable to dropout to compensate for loss of income through parent's sickness and related expenses, to care for sick relatives and to perform domestic work.

HIV/AIDS is affecting women and girls in increasing numbers. In sub-Saharan Africa 57 percent of adults with HIV are women and girls while in the world they accounted for 50 percent in 2003. Women are 1.3 times more likely to be infected with HIV than their male counterparts. Especially young women aged 15-24 years are three to six times more likely to be infected than young men (UNAIDS, 2004). There are many factors contributing for women's vulnerability among others some are social and economic inequality, biological factors, cultural inequalities, violence and so on.

There were orphans in the past, are at present and will be in the future because there will always be children who have had the misfortune to lose parents in one way or another. However, children who lost one or both parents of HIV/AIDS are not the same as those who lost their parents by other cases. Not only does HIV/AIDS affected families mean children lose their parents or guardians, but sometimes it means they lose their childhood as well because of the trauma and hardship that children affected by HIV/AIDS are forced to bear. As parents and

family members become ill, children take on more responsibility to earn an income, produce food and care for family members. It is harder for these children to access adequate nutrition, basic health care, housing and clothing.

These children do not only suffer during their parent's illness but in the long run they will be orphaned. In African countries AIDS is generating orphans so quickly to the extent that family structures can no longer cope. Traditional safety nets are changing as more young adults die of AIDS related illnesses. The already poor families and communities need support for themselves, let alone take care of the orphans. Therefore, these orphaned children are forced to live either with foster parents, grandparents, and other relatives or live alone in child-headed households.

The impact of HIV/AIDS on households is severe. Morbidity and mortality of individuals impacts on various institutions to which they belong. The household is one of these institutions and is severely affected by the epidemic. The declining productivity of HIV-positive individuals is initially felt within the family. It is pointed out in AVERT.ORG (2004) that as a result of death of productive household members, there will be loss of income and productive capacity, as well as increased costs and changing expenditure patterns. Thus its impact will not end at the individual level. It further affects the household because most of the time in developing countries, it is the breadwinner who is primarily affected by AIDS. Therefore, the survivors will be forced to face not only the problem of loss of one of the family member but also lack of resources such as income for livelihood. Barnett, Whiteside and Desmond (2001) had defined impact as:

A shock to an existing system of livelihood at the national, regional, communal, or household level, which reduces the levels and expectations of life and welfare. It may mean the dissolution of the unit and the loss of individuals from poverty related causes rather than as a direct result of HIV/AIDS illness or death.

Therefore, this research is guided by the above definition as HIV/AIDS affects households by reducing their living standard in combination with the existing poverty. The impact of HIV/AIDS is not the same in all countries, communities or households. It depends on the level of development and coping mechanisms. Primarily, poor countries are vulnerable in general and

poor households in particular because of many reasons. These countries are so poor to the extent that many people do not have access to the mass media, HIV/AIDS has been widespread making its prevention and control difficult. Poverty aggravates its spread because many people in poor developing countries primarily care about what to eat first rather than how to prevent HIV/AIDS. According to UNFPA (2002), only about one in five people at risk of HIV have access to prevention information and services. Fewer than five percent of the people in need get anti-retroviral drugs. Barnett and Whiteside (2002) explained that in Africa, prevention efforts have failed, large numbers of people are infected, would fall ill, and die. These people are not only in need of care and support but they also leave behind families and orphans, many of whom will be impoverished. It is true that well resourced communities and households will be better able to cope than poor ones (Bidpa, 2000). Fenton (2004) noted that, as awareness of the epidemic has grown wealthier populations have been more able to access prevention messages and the means of prevention, and the pattern of infection might be shifting towards those with lower socioeconomic status.

HIV/AIDS increases poverty at all levels from individual to nation through its impact on working age population. At the global level there is a positive correlation between HIV prevalence and poverty (Fenton, 2004). Many other factors also contribute to poverty; among others: poor health, illiteracy, social exclusion, and gender discrimination are the major ones. The effect/impact of HIV/AIDS starts when an individual is infected and start to fall ill, which creates additional expense for health care, incapacitate the individual from working, and finally causes the death of the person. The morbidity and mortality among this working age group affects household incomes.

2.2 The Link between HIV/AIDS and Poverty

Poverty is defined as the inability to afford the basic necessities of life, such as unpolluted air and water, adequate balanced food, physical and emotional security, physical and mental well-being, and culturally and climatically appropriate clothing and shelter (Burkey, 1993 as cited by Moleko, 2003). According to Cohen (1998), there are two by-causal relationships between HIV/AIDS and poverty. In short it means that on the one hand, poverty fosters the spread of the illness; on the other hand, the illness increases poverty of affected people.

Firstly, the relationship between poverty and HIV/AIDS, which includes the spatial and socio-economic distribution of HIV infection and consideration of poverty, related factors, affects household and community coping capacities. The poor are characterized by weak endowments of human and financial resources, few marketable skills and generally poor health, all of which result in low productivity.

Secondly, the relationship between HIV/AIDS and poverty. This is understanding of the processes through which the experience of HIV and AIDS by households and communities leads to an intensification of poverty. As a matter of fact, the illness, throughout a complex socio-economic process, can aggravate poverty by reducing households' coping capabilities and thus increasing their vulnerability to the consequences of the illness.

To make sense of these relationships the multidimensional characteristics of poverty has to be understood. Among others, poor health, illiteracy, inadequate schooling, social exclusion, powerlessness and gender discrimination contributes to poverty. An individual with poor health lacks capacity to productivity as a result of which reduces earnings. An aspect of the poor health status of the poor is the existence among many developing countries of undiagnosed and untreated STDs which is now recognized as a very significant co-factor in the transmission of HIV. As Fenton (2004) has argued as to how poverty may increase susceptibility to HIV/AIDS in the same way it does many other infectious diseases. For example, malnutrition and lack of access to health care services undermine immunity, which results to increasing susceptibility to HIV infection and progression. The poor are more concerned with the problems they have at present, they are ignorant about the future. Therefore, unless they are helped to get sustainable livelihoods, they will persist with behaviors which expose them to HIV infection as a result of which they are vulnerable to themselves, as well as their families.

The poor may be exposed to HIV because of many reasons among other the main ones are: Firstly, there is high labor mobility among the poor especially from rural to urban in search of livelihood which contributes to the conditions of HIV transmission. Secondly, many of the poorest are women who are often heads of the households in developing countries. These women

are forced to engage in commercial sex work as a survival strategy for themselves and their dependents.

Another problem in relation to transmission of HIV and poverty is that the transmission of HIV from mothers to their babies through breast-feeding. To prevent this type of transmission requires the ability to buy baby foods and access to clean water, and the knowledge why these changes in practice are needed. The poor are unable either to purchase the necessary baby food or to access to clean water. Thus they are vulnerable to be affected and infected by HIV and AIDS.

Poverty is also associated with lack of education and illiteracy which leads to weak endowments of human and financial resources, results in low marketable skills, and low labor productivity. This means that messages regarding risk and prevention are inaccessible. Even if there is knowledge of risks, the cost of prevention may be high and unaffordable.

Moreover, women and men are not equally affected by poverty. More women are poor and illiterate than men, particularly in developing countries like Ethiopia. Educating and empowering women helps to the improvement of their own health as well as their children, and also it widens economic choices. As a result of getting higher income, the living environment will be improved, malnutrition reduced as a result of which the costs of poor health are reduced.

Another relationship between HIV/AIDS and poverty is that HIV/AIDS impoverishes the already poor individuals and families by diminishing their coping capacity. It starts when one or both parents is ill which at some time in the future leads them to experience morbidity and mortality. As a result of this many families' capacity to cope with the consequences of illness and death will lead families to experience distress as well as disintegrate as social and economic units. Poor families have reduced capacity to deal with the effects of morbidity and mortality than the rich ones because of many reasons. Among these poor people are not capable to keep savings and other assets which can help to cope with the problems they face when they are affected by HIV/AIDS. Well-off people are likely to have a bigger amount of resources, which enable them to cope, at least fairly well, with the consequences of the illness. HIV/AIDS infection is,

therefore, concentrated in poor communities, and the effects of infections within them make them more poorer.

In conclusion, HIV/AIDS aggravates poverty, in every social class since available income is reduced. Rich and poor families experience huge emotional and economic suffering. However, the difference lies in the initial availability of resources: well-off families will have the means to manage income reduction.

2.3 The Impact of HIV/AIDS in Africa

HIV/AIDS is becoming an obstacle for development efforts in African countries. It is deepening poverty, reversing human development achievement, worsening gender inequalities, hindering government efforts to give essential services and reducing the labor force (UNDP, 2001; ECA, 2003). HIV/AIDS is aggravating the already existing poverty in developing African countries. Moreover, it has been at the top of their agenda because it is a big challenge to achieve their millenium development goals. Among the eight-millenium declaration goals the first is to eradicate extreme poverty and hunger (World Bank 2004), while HIV/AIDS is depleting assets of countries by increasing consumption and health care expenses. And the other goal is to improve child health, while in most African countries let alone improving, child health is worsening because of loss of income of parents affected by HIV/AIDS in particular and health sector of the country in general.

According to UNAIDS (2003), a lot of money has been disbursed and commitments made for AIDS programs in developing countries. In 2003 the project spending by different international institutions and organizations was estimated to be US\$ 2.6 billion, as compared to US\$ 1.2 billion in 2001. The same source reveals that in May 2003, US President George W. Bush signed legislation authorizing an increase in US government spending on HIV/AIDS, from US\$ 5 billion to US\$ 15 billion over the next five years. For example as of end 2003, Ethiopia has got from the World Bank and Global Fund commitments of US\$ 59.7 million and US\$ 55.4 million respectively. From these figures we can see that the response to HIV/AIDS has forced these poor African countries as well as the donor agencies to divert their resources to fight HIV/AIDS. If this much resources were spent on development programs the millenium development goals

would have been reached to some extent. Therefore, it is certain that HIV/AIDS has a negative impact on poverty reduction strategies in developing countries. And also has been an obstacle to achieve the millenium development goals.

The impacts of HIV/AIDS in Africa are multifaceted. These include its impact on demography, the health sector, education sector, households, work place, etc. Impacts of HIV at household level reflect all the above mentioned impacts and this study focuses on the impact of HIV/AIDS on households, specifically in Addis Ababa. Impacts of HIV at household level are reflected in the following way: we can see the demographic impact when both parents die leaving children behind; the size of the members in the family will be reduced; and also when affected family members are ill, the cost for health care increased.

In response to the epidemic, three main coping strategies appear to be adopted among affected households. First, savings are used up or assets sold; secondly, assistance is received from other households; and thirdly, the composition of households tends to change, with fewer adults of prime working age in the households. In addition to these coping mechanisms, affected households and individuals are seeking/receiving support from different NGOs, government organizations, and also from different social networks such as the extended families. In most cases the burden of coping rests on women, as there is an increased demand for their labour for household work, childcare and care of the sick. As men fall ill, women often have to step into their roles outside the homes. In parts of Zimbabwe, for example, women are moving into the traditionally male-dominated carpentry-industry. This often results in women having less time to prepare food and for other tasks at home (AVERT.ORG, 2004).

2.4 Impact of HIV/AIDS in Ethiopia

In Ethiopia HIV/AIDS infections were first identified in 1984, and the first AIDS cases were reported in 1986 (Garbus 2003, Kloos and HaileMariam, 2004). The major mode of HIV transmission in the country is heterosexual which accounts for 87 percent of infections. Another 10 percent occur due to mother to child transmission. Since then the numbers of infections have been increasing to the extent that almost everybody is affected directly or indirectly by the epidemic. According to IRIN (2004), HIV/AIDS patients occupy almost half the 12000 hospital

beds in Ethiopia. By 1989, HIV prevalence among the general adult population was estimated to be 2.7 percent, 7.1 percent in 1997 and increased to 7.3 percent in 2000, and was 4.4 percent in 2004 of which 12.6 percent is urban and 2.6 percent rural. The decrease of the prevalence rate in 2004 may not reveal that HIV/AIDS infection has been reduced in the country.

There are many factors which contribute to the low reported incidences, among others some could be the following. Prevalence rates are very low in rural communities; people are already infected with HIV but are not yet showing any of the symptoms of AIDS-related illnesses; people are already sick with AIDS-related illnesses but their illness is misdiagnosed; people are already sick and dying from AIDS but the community is in a state of denial and maintaining a state of secrecy. It is indicated by Garbus (2003), that there is an estimation about 7 to 10 million Ethiopians will be infected by 2010 because of the high current rate of adult prevalence, widespread poverty, low educational levels, and the government's limited capacity to respond.

Ethiopia is one of the poorest countries in the world where about 85 percent of its population live in rural areas. This population is not only living in rural areas but also are illiterate and lack access to mass media, even to the radio. Poverty combined with illiteracy and inaccessibility to information has aggravated the spread of HIV/AIDS in the country. People are concerned more with the basic necessities such as food rather than HIV/AIDS, which is said to have an impact after a long time.

As a result, many people from rural areas are migrating to urban areas like Addis Ababa with the imagination that the city is more convenient for a living. However, when they arrive in the city, they find a different situation. Since they do not have anywhere to shelter, women are forced to work as housemaids. Then most of them find it difficult to continue this work because it becomes beyond their expectation. Thus, mostly they start to work in Bars, which exposes them to be sex workers, and finally get infected with HIV/AIDS. After they became infected and fall ill, they do not want to go back to their parents in rural areas because of the stigma and humiliation. They prefer to search support from NGOs or other organizations. Those with the better social networks will be lucky to get the support, while the other will go out the street.

Ethiopian women are not only infected and affected when they migrate from rural areas. They are also more vulnerable when a specific household is affected by HIV/AIDS. They are responsible to care for the ill member of the family, where most of the time, the first to be sick is the breadwinner. At this time they do not only lose their husband, but they will be responsible to take care of themselves and the rest of the family members, of course, if they are not also sick because most probably they are infected with HIV. After the death of both or one of their parents, children will be orphans and girls are more likely to drop out of school to care for the ill, for domestic activities and/or engage in income generating activities such as sex work.

The impact of HIV/AIDS at the household level increases the number of orphans. A UNAIDS report (2002) estimates that there were 990,000 AIDS orphans in Ethiopia at the end of 2001, and the MoH projected that the number of orphans would rise to 2.5 million in 2004. It is true that the increasing number of orphans will burden elders/grand parents, extended families and the community. Particularly the extended family is directly affected by the epidemic because usually they are the one who will take care of the orphans after the death of parents (Pankhurst, 2004). It is indicated in Garbus (2003) that there are few governmental institutions for orphans in Ethiopia, as extended families usually take the victims in. These families themselves are likely to be poor and have to share their resources with the orphaned relatives as well as to their own families. Thus they are being impoverished.

Even though the impacts of HIV/AIDS are revealed in the day to day life of individuals and households, as well as on different sectors, there is no report based on studies about the impacts of the epidemic on Ethiopian households and extended family system, particularly in urban areas. Since HIV/AIDS affects most economically active members of the household, it results in decline in income, savings and increasing expenditure for health care and funerals.

This study focuses on the impact of HIV/AIDS on poverty at household level in Addis Ababa with reference to two kebeles of the Addis Ketema sub-city. It examines how the already poor households are affected, how the epidemic generates new kinds of households such as female headed; child headed; grandparent headed and dissolved households; and so on, and how extended families in general and grand parents in particular are affected by the epidemic. It also

explores why women and girls are most affected within the family. Coping mechanisms of affected households and individuals was also explored.

2.5 The Impact of HIV/AIDS on Gender

The actual lives of women and men reveals that there is variation in personal, physical, social and economic power and capacities between them. This results in differential rates of risk, infection patterns, access to health knowledge and protection, intervention and management of illness (Commonwealth Secretariat, 2002).

There is a changing pattern in rates of male/female HIV/AIDS infections. According to UNAIDS (2004), in sub-Saharan Africa women are 30% more likely to be HIV-positive than men; 15-24 old African women, on average are 3.4 times more likely to be infected than their male counterparts. In Ethiopia also, the number of women infected by HIV is greater than men. It is indicated in the Ministry of Health (2004) that HIV prevalence among adult men during the years 1995, 2000, 2001, 2002 and 2003 was 2.8, 3.4, 3.5, 3.7 and 3.8 respectively; while for women in the same years it was 3.6, 4.4, 4.8, 4.8 and 5.0. This data reveals that women are more affected than men in Ethiopia. In Addis Ababa in 2002 and 2003 adult prevalence was 16.5 and 12.7; 16.4 and 12.6 for female and male respectively (CDC-Ethiopia, 2004).

The impact of AIDS on women is multifaceted. The existing inequality among men and women in combination with poverty and HIV/AIDS makes the lives of women worse than ever. In many countries including Ethiopia women are more vulnerable than men because of many factors among others the main ones being biological, cultural, social and economic. Women are caregivers, producers, guardians of family life, face greater economic insecurity because women are more likely to be poor than men (Commonwealth Secretariat, 2002). In addition, they have less entitlements to assets and savings, less secure employment, are uneducated, lack information, have little power in sexual negotiation, and so on. The societal expectation that women will be the prime or only caregivers for their infected family members creates disproportionate social and economic burdens on them. According to Steinberg *et al.*, (2002) in a study conducted in South Africa, in more than two thirds of households women or girls were the primary caregivers. A

quarter of caregivers (23%) were over the age of 60 and just less than three quarters of these were women.

In Ethiopia a study revealed that 50.9 percent of women believed that a husband is justified in beating his wife if she refuses sexual relations (Garbus, 2003). Because of their economic dependency, many women fear that they will be abandoned by their husbands or supporting partners if they try to exert control over how and when they have sex and whether their partner uses a condom.

In addition, women are also disadvantaged in having access to education that affects their personal income and lower their status, which creates greater vulnerability to HIV infections. In case of death of parents or loss of income due to illness, girls are more likely to be withdrawn from school to perform household work and care for sick family member. And especially female headed households tend to become poorer than households headed by men (Richter, 2004). In Ethiopia, girls who lost one or both parents are mostly forced to take care of the household and other siblings. In case of shortage of income, they are involved in income generating activities such as being housemaid and in risky works like prostitution. Sometimes, they are also vulnerable to be raped by a member of the extended family who was supposed to be responsible to take care of the orphans. Finally, girls like their parents are also exposed to HIV infection.

This particular study, with regard to gender, looks at how households have been affected by HIV/AIDS and become impoverished, how women are exposed to different problems such as economic, social, and cultural when their husbands die, how many households became female headed, how grandmothers are mostly responsible to take care of the orphaned grandchildren. And also why women are more vulnerable to HIV/AIDS than men because of economic dependency.

2.6 Socioeconomic Impact of HIV/AIDS on households

The socioeconomic impact of HIV/AIDS on households is multidimensional. As soon as one of the household members is affected by HIV/AIDS, the problem starts from psychological strain being afraid of the existing stigma. In addition to this income of the household will reduce

because of lack of employment or increasing cost for health care. Since income is reduced, the expenditure for basic necessities will be reduced as well. According to a study made in South Africa affected households allocated more of their resources to food, health care and rent, and less to education, clothing, personal items and durables (Booyesen, *et al*, 2001). Thus, unless there is another means of income and support outside the family, the affected household will be entering in deeper poverty in addition to the existing one. Apart from lack of income and basic necessities, after the death of the ill person, mostly the breadwinner, children will be orphaned.

In the household, women are the most vulnerable because of many reasons among them some are: they are responsible to care for the sick, for doing domestic work, and also to engage in income generating activities such as sex work and being housemaids. Therefore, the impact of HIV/AIDS and the coping mechanism of the households depend on different circumstances. According to Barnett and Whiteside (2002) and Baylies (2002), the effects of illness and death in households depend on the following. The number of cases the household experiences; the characteristics of the deceased individual such as age, gender, income and cause of death; the households composition and asset array, the attitude of the community to help the needy households, and also the availability of resources from the community, government and NGOs. From the above explanations we can identify the following two major issues to be considered in the study of social impact of HIV/AIDS.

a) Characteristics of the Household

A household is an institution, which is the basis for any community. It consists of parents and children and/or relatives living under the same roof, sharing resources. Barnett and Whiteside (2000) have defined the household as “Any unit of habitual residence where some consumption and/or production may be undertaken in common and where some members may recognize culturally defined relationships of kinship and/or affinity where the members are related in some way”. If we look at this definition carefully, when a specific household is affected by HIV/AIDS almost all members of the family are also affected in some way or another. However, some are specifically vulnerable to its impact. Primarily affected ones are one of the survivors of the partner especially the woman, orphans and the elderly. Secondly affected households are of the extended families.

Before the death of the breadwinner children are exposed to many problems. Because the income of the household declines either by loss of employment or by increasing cost of health care, the quantity and quality of food in the household can decrease. Thus there can be decline in nutritional status of the children as well. In addition to this, there may be school dropouts particularly for girls. Then after the death of one or both parents, children will be orphaned. These orphaned children will be forced to either join extended families, if they are well off; or to engage in income-generating activities. Girls may engage in high-risk activities such as sex work, and boys in criminal activities. Finally the increasing number of orphans affects the coping mechanisms in households and extended families in particular and in the community and the country in general.

The elderly are also the main victims of the effect of HIV/AIDS especially in poor developing countries such as Ethiopia. Even without HIV/AIDS, people in these countries are very poor and when the effect of the epidemic is added poverty will be worsened. Under normal circumstances the young are cared for by their parents, and later provide support for those parents. However, HIV/AIDS has changed this social order. Grandparents are exposed to the problem of caring for the children and children in law during illness. And after the death of their children they are left alone with the grandchildren being responsible to care for them. They are not only weak economically without the support of their adult children but they are also affected psychologically for loss of their loving children and face social isolation. James (2004) had concluded that the effect of HIV/AIDS has indirectly changed the role of the aged from being provided for to providers.

b) Resource availability from the Community, the government and NGOs

The main actors in the development process are the State, NGOs, and the private sectors. These organizations should also be partners to combat HIV/AIDS since the epidemic is the main challenge for poverty reduction programs. The epidemic affects them directly by reducing their labor force. Thus the coping mechanisms of HIV/AIDS affected households depend on the availability of resources in these organizations. It depends whether the community, the government and the NGOs have available resources to help the affected families. AIDS affected households primarily depend on relatives or community support systems to cope with the crisis.

Community support networks such as savings clubs, 'eddir' (burial associations) and 'eqqub' (rotating credit associations) in case of Ethiopia, labor exchanging schemes, etc. are important networks of the community during hardship such as HIV/AIDS hazards.

"Rich communities may cope; poor ones may not be at all lacking the resources to organize effectively" (Barnett and Whiteside, 2002). Poor people or households are not capable to access these networks because of the already existing poverty. Wealthier households have better access to those networks. Therefore, the poor households in addition to their poverty, affected by HIV/AIDS are vulnerable to be more impoverished than before. In poor developing countries like Ethiopia, even if there are social networks, it is difficult to the community to help the HIV/AIDS affected households because of their limited resources. It is not only the affected households that are impoverished, particularly in Ethiopia the social networks such as 'Iddir' are being depleted of their assets because of payments for funerals and other related expenditures.

2.7 Coping Strategies

Death of the breadwinner has devastating impacts upon families and households. Survivors suffer economically as well as emotionally. The result is shown as children become orphans, their nutrition status and health decreases, also there may be drop out of schools particularly for girls.

During the illness stage, one of the first responses for those working in the informal sector is to move from directly productive activities into service oriented jobs, such as selling goods which are usually lower paid. This change allows the infected person to work when they can, as service jobs are generally less physically demanding. Income falls, and as the illness progresses the ability to work decreases, reducing income down further. As the diseases progress the level of care required increases, creating increased demands on other members of the household. Women are especially most affected since they are particularly in developing countries responsible for domestic work and to care for the family. Thus, they are more likely to be either absent frequently or taken out of schools (Gow and Desmond, 2002).

Furthermore, withdrawing savings if available and taking on more debt is usually the major options by households that struggle to pay for medical treatment or funeral costs. Then as debts mount, precious assets, such as radios, televisions, livestock and even land, are sold to be used as a source of income. Not only these types of assets are sold particularly in poor households, but also furniture such as cupboard, bed as well as women's ornaments like gold necklaces are sold out. Gow and Desmond (2002) had noted that there is evidence from Tanzania and Uganda that suggests radio ownership increased in households with no deaths and decreased in households that experienced death. Once households sold their assets and used their savings, the chances of them recovering and rebuilding their livelihoods become difficult.

Assistance from other households

The other coping mechanism is receiving help from relatives and neighbors which is an important support to the efforts of households facing an adult death. A study conducted in Tanzania depicted that 80 to 90 percent of affected households were likely to receive assistance in cash or kind from other households (Ibid. 2002). This is only possible if the other households are relatively better off. However it is unlikely that in poor countries like Ethiopia, there are limited households which can help HIV/AIDS affected ones.

Altering household composition

As one or both parents die, the capacity of households to remain intact will be difficult. As a result of this relatives and friends of the family take in individual children where the resources are available to do so. Most commonly, grand parents, in particular, grandmothers seem to take over this parenting role. There may also be a situation where no able-bodied adult is available to provide resources and maintain households and families together. This leads to the dissolution of the family unit as a household being either a child headed household or displacement of children.

A study conducted on 215 households in Zimbabwe revealed that about 40 percent of the sample households had taken in orphans who had lost both parents. And sixty five percent of households where the deceased adult female used to live before her death were reported to be no longer in existence in both the urban and rural sites (Gow and Desmond, 2002). This shows that the worst

impact of HIV/AIDS on households could not be seen because of the dissolution of some households, which are not possible to be counted.

In order to examine the coping mechanisms of Ethiopian HIV/AIDS affected households, a survey of selected 150 households in two Kebeles of the Addis Ketema sub-city was undertaken. According to the results of this study all coping mechanisms identified by Gow and Desmond except 'doing nothing' are found to be applied by affected households of the study area. But in addition to these mechanisms, as mentioned earlier, some individuals and households use other mechanisms such as using holy water, searching assistance from an NGO, dispersing siblings, and searching assistance from community based organizations such as Iddirs.

2.8 Conceptual Framework

As we can see in the following framework, the impact of HIV/AIDS in affected households is multifaceted. Morbidity and mortality have exacted a more severe burden on affected households. Women are more vulnerable than men because of lack of access to resources and services such as education, employment, credit, information; they have little power to negotiate sex which exposes them to the epidemic and other sexually transmitted diseases. In addition, after illness/death of one of the household member women are responsible to care for the patient, for domestic chores. As a result of this girls may drop out of school and also may engage in income generating activities such as sex work.

Economically, HIV/AIDS has a dual impact: the expenditure and income effects of the household. With regard to the expenditure, firstly there is an increased cost of medical treatment for HIV positive members who are beginning to develop symptoms of AIDS, and are experiencing more frequent illnesses. However all households are not affected similarly. The well off have access to go to the better hospitals like the private ones while the poor go to the public ones. Secondly, there is additional cost for funeral when a person with AIDS dies. The costs related with death of a family member are very high particularly in Ethiopia because the cost is not only for funerals but also for feeding guests for a long period of time.

The additional expenditure for medical treatment and funerals combined with the already existing poverty in the HIV/AIDS affected households is aggravated. Therefore, HIV/AIDS affected households are more likely to be impoverished.

The other economic impact of the HIV/AIDS affected household is the income effect. The affected household will lose the income of the member died of AIDS. As a result of this, the surviving family members such as one of the partners, usually women, children and other dependents will be affected. Children especially girls will be forced to drop out of school; their nutritional status will decrease. In general because of shortage of income, they will face lack of access to health services, education, housing and the like. Thus, the living standard of the HIV/AIDS affected household will decline.

There are different strategies which affected households use to cope with HIV/AIDS. The major ones are withdrawing savings, selling household assets and searching assistance from NGOs, government and the extended family.

The impact of HIV/AIDS on households does not end with economic effects. The surviving family and the extended family will also be affected socially and psychologically. Firstly, they are affected psychologically because of stigma. Secondly, as soon as parents die, children will be orphaned which results in a burden for the extended family primarily and the community and the country as a whole. When children are not able to live alone because of the household's conditions, they will leave the house to join the extended family or if they do not have access to it, to an institution. However, in the Ethiopian case since there are not enough of such institutions, many of these kinds of orphans will be forced to become street children and prostitutes.

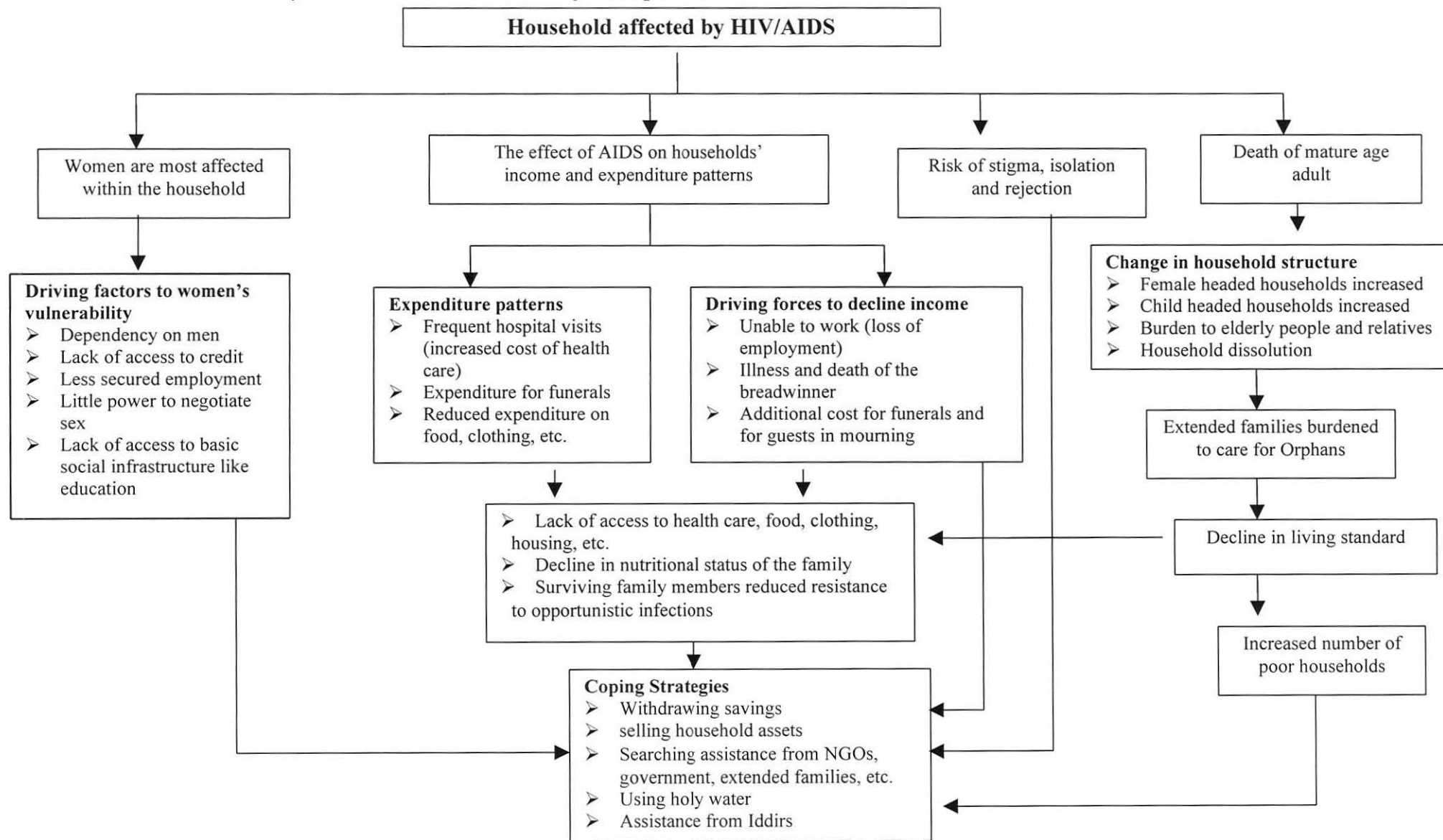
Furthermore, HIV/AIDS changes the household structure and family sizes after a specific household is affected. After the death of the mature age/breadwinner, different types of households originate such as female headed, child headed, grandparent headed and dissolved households. As a result the extended families will be burdened because they usually take in the orphans and other relatives who need support. This makes the extended family's living standard

decline as they share their resources with the new family members joining them, which in turn increases the number of poor households.

In most cases women are the surviving parent in the household. The problem is not only becoming heads of the household, but they also lack income. This is because they are dependent on their husbands primarily. When these surviving parents die, the family structure changes to be child headed, if they are grown-ups and capable of managing the house. However, if they are not capable to be self-reliant, extended families have to take care of them particularly the grand parents. As grand parents and close relatives take in the orphans, they share their resources as a result of which their living standard will decline. Then the number of poor households will be increased.

When families in affected households lack the access to be supported by extended families, they will be dissolved. This means that children and other family members will be dispersed in different households in order to survive. As a result of which extended families will again burden the problem and their family size will be increased.

Analytic Framework for the Study of Impact of HIV/AIDS on Households



Source: Formulated from the literature review (December 2004)

Chapter 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Description of the study area

The study area was selected after assessing various organizations that support people living with HIV/AIDS (PLWHA) in different areas. This was done to meet the study objective, which aimed at examining the impact of HIV/AIDS on poverty at household level and also to assess its impact on the extended family. Since the subject of the study was mainly to be households and individuals affected by HIV/AIDS, an extensive assessment was made in order to find these subjects.

Firstly, Christian Relief and Development Association (CRDA) was contacted in order to get the specific organizations from the members list of NGOs and GOs who work in different activities particularly HIV/AIDS. According to the data found from CRDA, there were 36 local and international NGOs involved in prevention and care of HIV/AIDS in Addis Ababa. Since it is difficult to communicate all these NGOs because of shortage of time, some were selected purposively after contacting most of the NGOs inquiring about their involvement in HIV and AIDS.

It was found that some NGOs were working only on awareness giving activities and on orphans, while others were involved in supporting PLWHA. Thus the one which specifically work to support HIV/AIDS affected individuals and households was selected purposively in order to meet the study objectives. Accordingly, organizations like Mekdim HIV Positive Persons and Orphans National Association, Christian Children Fund (CCF), National HIV/AIDS Prevention and Control Office (HAPCO), Addis Ababa HAPCO, were assessed. Most informants in different organization, particularly Dr. Meheretesellassie Menebere of the CCF acknowledged that it would be difficult to get the necessary information from affected households and individuals in Addis Ababa, because they were not found within specific area. The problem was not only to find enough number of households/individuals in a specific area, but also the difficulty to get the necessary information, as people are not willing to disclose themselves. The informants repeatedly recommended communicating with PLWHA through the charity organizations which

support them. According to the information collected from Mekdim HIV Positive Persons and Orphans National Association office, their members are found in different areas scattered in Addis Ababa. Only about 30 to 40 members lived in one sub-city. It was learnt from Ato Mengstu Zemene that these infected people would not easily give information about themselves. He confirmed that the affected individuals think that the organizations collect money by their name with no benefit for them.

Finally, based on the information from most informants, an NGO (Children Aid Ethiopia/CHAD-ET) that works in supporting HIV/AIDS patients and orphans and had relatively more clients in one of the Addis Ababa sub-city called 'Addis Ketema' was selected. Thus this sub-city was selected as a target population for the study as well. The researcher communicated with the project director, Ato Annania Admassu about the possibility of reaching the subjects. He suggested that it was possible to take all the samples from CHAD-ET because there were enough number of households and clients getting support. Therefore, the subjects for this study were selected from CHAD-ET's list of clients.

CHAD-ET was established in 1995 with the objectives to protect the rights and welfare of children and to deliver services to children living under difficult circumstances. However, it was realized that the work would not be fruitful with only supporting the children since their situation is related with their parents. Thus, it became clear that their parents also need support particularly with regard to HIV/AIDS, since its impact is seen more on children. Therefore, CHAD-ET started to support parents for the sake of the children. Accordingly, HIV/AIDS affected households or individuals who are ill and could not help themselves, as well as orphans are given different types of support such as financial, food items, and medical.

CHAD-ET has four main programs. Health program; alternative basic education; prevention and rehabilitation program for child abuse, neglect and exploitation; and community development and capacity building program. Under the health program, 'Community Based HIV/AIDS Prevention and Provision of Social Services' is one of the projects, which is the main focus of the study. This project has two main objectives, to reduce further spread of HIV and to increase/enhance the involvement of the community in the prevention of HIV/AIDS.

According to the project coordinator, there were 267 PLWHA, and 1047 orphans being supported by the project while in the sample area there were 140 PLWHA and 75 orphans. However, currently some clients have died. Thus, extracted data from the list of clients (exclusive of orphans) in CHAD-ET that depicts the number of clients based on their kebeles is shown in the following table.

Table 3.1. HIV/AIDS affected individuals supported by CHAD-ET

Kebele	Male	Female	Total
13/15	41	100	141
14/21	12	29	41
16/17	9	33	42
18	1	8	9
19/20	--	3	3
Total	63	173	236

Source: Extracted from CHAD-ET's List of Clients

As can be seen from the above table, in five Kebeles of the sub-city, 13/15, 14/21, 16/17, 18, and 19/20, there were 141, 41, 42, 9, 3 clients respectively which makes a total of 236 during the beginning of the data collection. Two kebeles with the identification number 13/15 and 14/21 were selected as a sample. These two kebeles were selected purposively because of two reasons. First, since the study focuses mainly on households and secondly on individuals, the two selected kebeles have more number of clients than the others, which contain households with a minimum family member of two and more. Second, there was a shortage of finance and adequate time in order to assess all the kebeles in the sub city.

The area is located in the country's largest market place 'Merkato'. The main bus terminal of the city is also located in this sub city in general and in the study area in particular. The study area is congested with a lot of destitute people.

Most of the people in the study area make their livings in the following ways. In Kebele 14/21 most respondents were civil servants, petty traders, daily laborers, and housewives. While in Kebele 13/15, the majority of the women sell local drinks such as Araki and Tela and most men work as daily laborers. There are also a significant numbers of sex workers. In a study conducted by Family Health International in 2002, it was found that from 8134 sex workers in the city, 655

(8.1%) were found to be in the study area. In addition to being involved in the above mentioned types of jobs many people particularly in kebele 13/15 rent beds on the daily basis.

These people do not only rent beds but they also rent their open floor in the house, as well as 'Kots'. There is a saying in the area that if someone has five beds to be rented, she is considered as owner of five taxis. Because of this, children, particularly girls, are vulnerable to HIV/AIDS. Forced by low standard of living and vulnerability, many children involve in sex work, they are mostly engaged with clients either who rent bed/floor or who drink local drinks in their house. The children in this area are not only vulnerable to HIV/AIDS but they also lack formal education at their normal age. According to the key informant from the project, 13000 school age children are not going to school because they cannot afford to do so.

3.2 Research Design

Since the objective of the study is to investigate the impacts of HIV/AIDS on poverty situation at household level, it is explanatory and descriptive. It is descriptive because the impacts of HIV/AIDS on poor households with regard to their income and expenditure, age group, and the like were established. And it is an explanatory study in which the socioeconomic statuses of affected households were examined. Therefore, the nature of the study led the researcher to use both qualitative and quantitative data collection techniques. The quantitative method used is simple statistics such as ratios, frequencies, and percentages in order to understand demographic and socioeconomic characteristics of the study subjects. Thus the study mainly employed qualitative and quantitative methodologies. The following methods of data collection were used: In-depth interviews using structured questionnaire (survey method) for the sample households, semi-structured interview for key informants, focus group discussions, case anecdotes and direct observation method.

Sampling techniques

Because of the nature of the research non-probability-sampling method was employed in this study to select the subjects of the study. Thus, the study subjects were purposively selected from an NGO working with the community in the selected Sub-City of Addis Ababa. And also key informants from the government agencies (Head of the HIV/AIDS Prevention and Control Office

of the sub-city, from the HIV Desk of the two selected kebeles), coordinator of the charity organization (Ato Ketema Abebe), and five home based caregivers from the community were selected purposively.

Study population

Different categories of respondents, which were the units from which information was collected, had participated in this study. The use of these different categories of study population is to triangulate the data and obtain more insight information gathered from the study subjects. The categories of the study population are described in the following section.

HIV/AIDS infected member of the households and Orphans

Primary data was collected using structured and semi-structured questionnaires. Therefore, a sample of 100 households and individuals as well as 50 orphans from different households were selected using purposive sampling method. The members in the affected households were either the surviving family member, head of the family (HIV/AIDS infected) or an individual who was member of the family.

Caregivers selected from the community

Five caregivers (two males and three females) were selected and answered the semi structured questionnaire to collect primary data.

Workers in the government institutions and the NGO

A purposive sampling method was applied in selecting the governmental agencies as source of data. Thus during the design of the study various governmental agencies were selected based on their relevance to objectives of the study. These were: Addis Ketema sub city HIV/AIDS Prevention and Control Office; Kebele administrations of 13/15 and 14/21 of the Addis Ketema sub city; and Children Aid Ethiopia (CHAD-ET).

Units of analysis

The units of analysis used are households affected by HIV/AIDS

Sample size

The total subjects of the study were 159. These were 100 households and 50 orphans, key informant from the NGO, representative from the Addis Ketema sub-city HIV/AIDS Prevention and Control Office, from the two kebeles where the study was conducted, and five randomly selected individuals from the community based caregivers were interviewed using structured and semi-structured questionnaire.

3.3 Data Collection Instruments

Triangulation method

The study employed triangulation method, to support and check up the reliability of data obtained. The methods used to collect the data include in-depth interview using structured and semi-structured questionnaire, key informant interviews, focus groups discussions, case stories, and observation methods. All categories of data collection were conducted in Amharic after translating the questions from English to Amharic. Then again the Amharic version responses were translated into English for analysis.

Instruments

Structured questionnaire for infected individual in the household

Structured questionnaire for 100 HIV/AIDS affected members of the households was developed in order to collect data using survey method. It had different parts and was developed to collect data on the socioeconomic status of the households. The questionnaire had four main sections. They were personal and demographic characteristics of the household; availability of basic facilities and services within the household; income and expenditure patterns; and coping strategies.

Unstructured questionnaire for the NGO (CHAD-ET) where the subjects were drawn

An unstructured questionnaire was developed for the key informant (coordinator of the CHAD-ET project). Questions raised were about the main activities of the project in the prevention, control, and support for PLWHA; kinds of support being given to the patient and orphans; the characteristics of the clients; and so on.

Semi-structured questionnaire for the Sub City's Head of HIV/AIDS Prevention and Control Office

The semi-structured questionnaire was developed in order to collect data from the sub city's HIV/AIDS Prevention and Control Office. The main part of this questionnaire comprises inquiring information about the following. The involvement of the office in the efforts to mitigate the spread of the epidemic; what should be the role of the government, NGOs, Religious institutions and the community; with regard to the main problems of households affected by the epidemic.

Semi-structured questionnaire for the selected kebele representatives

Semi structured questionnaire was developed to the sample kebeles representatives in order to collect data about the epidemic's impact in the study area, as well as the population's characteristics. For example questions such as about the involvement of the kebeles in the prevention and control of HIV/AIDS; the main livelihood strategy of the sample population; main problems of affected households as well as orphans and the like were posed in this questionnaire.

Unstructured questionnaire for community-based caregivers

Caregivers were also used as a source of data in the data collection process. The issues included in the questionnaire were about the age and sex of their clients; main problems of affected households and individuals, as well as orphans; and problems of caregivers themselves.

Structured questionnaire for orphans

AIDS orphan children were included in the study as a source of data. Similar to the households, orphans were selected from the same NGO's list (CHAD-ET) purposively. Structured questionnaire was developed to collect data from 50 orphans. The main parts included were about the custody of the orphans; educational situation; and access to basic needs.

Focus group discussion guide for infected household member and orphans

Focus group discussion guide was developed in order to support the data collected by survey method. The same discussion guide was used to female and male groups, while for orphan group

different discussion guide was developed. The guide was designed to gather qualitative data to various issues with regard to affected households and orphans. The main parts include about the link between HIV/AIDS and poverty; the impact of the epidemic on households and extended families, as well as orphans; its impact on female and girls, and coping strategies of the affected households and individuals.

The participants were drawn from the sample that participated in the survey data collection. They were grouped according to their gender so that they can feel free to talk about the issues raised.

Case anecdote

Among the informants who participated in the survey, 11 cases were selected purposively which were believed to be best representatives of the other informants. They were selected based on the information they gave in the survey as well as in the focus group discussions. The cases included four female-headed households, one female living with her husband and a child, one child headed household, one male-headed household, one man whose household was dissolved, two individuals living around holy water areas, and a widowed woman who returned back to her parents' home after death of her husband.

In this case the history of the households and individuals before and after they have been affected by HIV/AIDS were discussed. This includes their short life history, income before and after their infection, living condition, education, household structure, etc.

Direct observation

The researcher made observation in most of the households during the survey as well as during the time of data collection from the selected cases. Direct observation was made on the informants' housing condition, their access to different facilities such as water and toilet, and so on.

Data collection

Primary and secondary data were collected for this study. Secondary data was collected from literature and documents. While primary data was collected from households, orphans, government agencies, charity organization coordinator, and caregivers using the above indicated instruments (structured questionnaire, semi-structured questionnaire, focus group discussions, case story, and direct observation).

Data analysis

As indicated in the research design part, this study employed both qualitative and quantitative methods to collect the necessary data to meet the objectives of the study. Accordingly, the process of data entry began as soon as the fieldwork was completed. For the data collected using survey method, SPSS version 10.0 was used to enter the quantitative data for the questions related to demographic and socioeconomic situation of the subjects.

Then, the data collected from cases and focused group discussants were translated from Amharic into English in order to use them as additional/supportive information in a qualitative analysis.

Chapter 4: RESULTS OF THE STUDY

4.1 Socioeconomic status of HIV/AIDS affected households

4.1.1 Socioeconomic and Demographic Characteristics of the Sample Population

As indicated in the objectives of the study, the first characteristics of the households examined in the study were family size, sex, age, marital status, education, occupation, income, and housing conditions. The detailed information with regard to each variable is described as follows.

Sex and age of the respondents

The first and second characteristics examined were sex and age of the respondents. Eighty percent of the respondents were female while 20 percent were male. There are no men in the age group of 16-20, but five females were found in the same age group. The maximum number of respondents falls in the age group of 26-30, which is 7 and 25 for male and female respectively. The minimum number observed in the age group of 51-55, which is one for each sex. The detail information can be seen in the following table.

Table 4.1: Age and sex of the respondents

Age group	S E X				Total	
	Male		Female		No.	%
	No.	%	No.	%		
16-20			5	5	5	5
21-25	1	1	19	19	20	20
26-30	7	7	25	25	32	32
31-35	7	7	16	16	23	23
36-40	1	1	9	9	10	10
41-45			3	3	3	3
46-50	3	3	2	2	5	5
51-55	1	1	1	1	2	2
Total			20	80	100	100

Source: Field survey

The question why more women are clients for the support-giving project than men needs explanations. There may be many factors for this, some of the reasons were described by respondents. Both participants in the women and men's group agreed that women are more

vulnerable than men because of social, economic and cultural problems. One participant in the men's focus group discussion explained this in the following way.

Women have no much option like men as they are more likely housewives and have cultural influence to engage in various jobs like men, which has an impact on their socioeconomic status. When women get things to be beyond their capacity, they start working in bars which is likely to lead them to prostitution. Men could help themselves by working different kinds of work such as a daily laborer. But if a woman start working on street vending, she is seen as if she needs to be prostitute and become vulnerable to rape, which finally may lead to be like a bar lady.

Educational Level

Looking at the educational status of the respondents in the HIV/AIDS affected households, the largest number, 21 percent of the respondents (19 female and two males) did not have basic education. The second largest group, 19 percent (16 female and three male) had primary level education, while the same proportion (15 females and four males) had attended high schools. The smallest portion, five percent have completed 12th grade for both sexes. It is found that no one has attended higher education.

Occupation

Occupation of the respondents was the other variable through which the situation of affected households was investigated. The highest numbers, 43 percent of the respondents (35 percent of female and 8 percent of male) were unemployed. The second group, 23 percent (20 percent of women and three percent of male) have stopped working because of health problem/illness. The third group, 22 percent (16 females and 6 males) engages in various occupations such as selling local drinks (*Tela and Araki*), selling *Enjera*, *changing cents*, renting beds, etc. (Table 4.2).

Table 4.2. Occupational status of the respondents

Age group	S E X				Total	
	Male		Female		No.	%
	No.	%	No.	%		
Trader			1	1	1	1
Daily laborer	2	2	3	3	5	5
House work			2	2	2	2
Sex worker			1	1	1	1
Stop working because of illness	3	3	20	20	23	23
Unemployed	8	8	35	35	43	43
Other	6	6	16	16	22	22
Driver	1	1	1	1	2	2
Total	20	20	80	80	100	100

Source: Field survey

Most of the unemployed respondents revealed that the government is not supporting them in finding jobs. For example members who participated in focus group discussion of the male group declared that the charity organization (CHAD-ET) designed a project for them so that they can be involved in some kind of job. However, the Kebele prohibited the place given to them because an individual (investor) claimed it. And also a participant in the women's focus group discussion who was working in a bar said that she applied to a specific factory for a job for which she thinks she was qualified. She disclosed that the employer requested her to bring a result for HIV test. She put the situation in the following manner.

I applied for a work in a candy factory for a payment supposed to be 100 Birr on a weekly basis. But I was asked to get tested for HIV and bring the result. This shows that I am indirectly told that I could not work even if I am capable and healthy despite I am HIV positive. I was very angry and was thinking to give them the forged certificate, however I am not able to do it because of lack of money. Thus as I have not enough money for a living and found no choice, I do not sit idle and be died of hunger, rather I will go back to the Bar. In this situation the spread of HIV will not be decreased/stopped.

4.1.2 Availability of facilities for HIV/AIDS affected individuals

Under availability of facilities four main factors were considered. These were access to housing, availability of potable water, toilet, and access to health services.

Housing facilities and condition

Of the HIV/AIDS affected households, the majorities (38 percent) are living in rented houses from individuals who own private houses. The second largest (33 percent) live in houses rented from the Kebele. Only three percent of the respondents own houses privately. Seven percent of the respondents are dependent on some one like close relative or friends and six percent live around Tsebel (holy water) area.

Concerning the size of the households and number of rooms, the data shows that from 26 percent of respondents who live alone, 22 percent live in a single room while two percent each live in a two and four room house respectively. Among the households with family member of three, twenty five percent of all the respondents live in a single room, two percent in two room's house, and one percent has a four-room house. The following table depicts the detail information.

Table 4.3. Size and number of rooms of the households

Size of the household	Number of rooms in the house				Total
	one	two	three	four	
1	22	2		2	26
2	16				16
3	25	2		1	28
4	9	1	1		11
5	5	2	1		8
6	2	5			7
7	2	1			3
9			1		1
Total	81	13	3	3	100

Source: Field survey

In response to the major factors that aggravate their problems in the household, 38.4 percent of the respondents replied housing problem is one of the major factors that aggravate their problem. Not only those who responded about housing problem but there were also others who replied that they have housing problem in conjunction with other factors. Most of them have rented a single room with a minimum of 100 Birr that is beyond their capacity.

observed, and almost very poor. Most of the houses are single room, with the toilet far from the dwelling, and in most cases they also fetch water from nearby households.

Though the majority of the respondents described their income was only from the NGO, in reality this was not the case. Particularly in a specific area known as 'Kuchera sefer', in kebele 13/15 most of the houses are not only used for family members, but also rent for clients for overnight paying 50 cents to one Birr. In this area particularly in Kebele 13/15 in general, people do not only rent their bed, but also the open floor in the house. The researcher also saw an amazing thing in these households known as 'kot' in the local language, is a sleeping place prepared under the ceiling to solve problem of space, in which the people can go up by the ladder. It was observed in a specific single room house of a respondent that there were five beds arranged for sleeping under the ceiling and five beds on the floor. There is a saying in that area that if some one has five beds to be rented, is considered as equivalent to having five taxis.

Availability of Potable water

Easy access to clean water is a fundamental requirement for good public health. While most of the households surveyed had access to potable water, only 13 percent of the households have a tap water in their homes. The largest group of households (56 percent) gets water buying from the nearby resident. And 30 percent of the households get water from communal tap.

Most of the respondents of the survey as well as the participants of the focus group discussion explained that they have problem in getting water. For example one of the focus group participant said that her neighbors discriminate against her being HIV positive while she fetches water. She had to wait until every body gets water, it means she had to get it lastly because of her health status. She acknowledged that they were afraid of the disease as if the virus could transmit to them through the pipe she used.

Availability of toilet

The survey data shows that 87 percent of the households have access to toilets, while 13 percent do not have access to any kind of toilet. Most of the households (79 percent) have communal

toilet. Only two percent of the households have private flush toilet. Respondents who said they have no toilet use different places such as hotels, public toilet, open area, etc.

Access to health services

Most of the respondents (78 percent) use private clinics. They use a specific clinic arranged to them by the NGO (CHAD-ET). Twelve percent use government hospitals and clinics, and five percent uses traditional medicine, Tsebel (holy water).

They were asked whether they were satisfied with the service they get or not. The majority of the respondents replied that they were satisfied, while some said they were not satisfied. The non-satisfied respondents explained that the doctors did not treat them well when they knew that they are HIV positive. The doctors used to say that this happened because of the virus all the time and order the same type of medicine. They added that they could not change to any other clinic because the specific clinic they use is arranged by the charity organization. And if they need to change they had to have money, which is their major problem.

4.1.3 Income and expenditure of households before and after HIV infection

Income of households before and after HIV infection

Another main variable examined was income of the respondents before HIV infection. The data shows that six percent of the respondents who were all female were getting less than 100 Birr monthly. More households (22 percent) got a monthly income, which is between the range of 101 and 200 Birr. The next largest group (16 percent), which is all-female, used to get a monthly income between 201 and 300 Birr. The previous income of men is mostly between 301 and 800. The detail information about the households' income before they were infected is depicted in the following table.

Table 4.4. Monthly Income of the respondents before affected by HIV/AIDS

Income Category	S E X				Total	
	Male		Female		No.	%
	No.	%	No.	%		
<100			6	6	6	6
101-200	4	4	18	18	22	22
201-300			16	16	16	16
301-400	4	4	8	8	12	12
401-500	3	3	9	9	12	12
501-600	2	2	4	4	6	6
601-700	3	3	1	1	4	4
701-800	1	1	3	3	4	4
801-900			1	1	1	1
901-1000	1	1	5	5	6	6
>1000	1	1	2	2	3	3
Do not respond					8	8
Total	19	19	73	73	100	100
Average Income Before HIV = 437						

Source: Field survey

The data shows that the current income of affected households' ranges between less than 100 and 400 Birr (except one who gets between the ranges 601-700 Birr) unlike their previous income, which ranged between less than 100 and 1000 Birr. Most of the respondents (66 percent) get a monthly income between 101-200 Birr, of which 13 percent are male and 53 percent female. Twenty- percent of females get a monthly income below 100 Birr. As compared to their income before HIV infection, only six percent of females were earning less than 100 Birr. The detail information about the current income of households is depicted in the following table.

Table 4.5. Monthly Income of the respondents after HIV/AIDS

Income Category	S E X				Total	
	Male		Female		No.	%
	No.	%	No.	%		
<100	1	1	20	20	21	21
101-200	13	13	53	53	66	66
201-300	5	5	3	3	8	8
301-400	1	1			1	1
401-500	-	-	-	-	-	-
501-600	-	-	-	-	-	-
601-700	-	-	1	1	1	1
701-800	-	-	-	-	-	-
801-900	-	-	-	-	-	-
901-1000	-	-	-	-	-	-
>1000	-	-	-	-	-	-
Do not respond					3	3
Total	20	20	77	77	100	100
Average Income After HIV = 153						

Source: Field survey

As can be seen from the above table, there is a significant income difference between the income they used to earn before affected by HIV and current income. The survey data shows that the average income of households before HIV infection was 437 Birr, while after HIV infection it reduced to 153 Birr.

Expenditure patterns of households before and after HIV/AIDS

Expenditure during illness and death of the deceased family member

The data shows that among the 100 households surveyed, 45 percent said there was a deceased member in the family. While two did not respond about their expenditure for health services to the deceased member, 43 percent had responded. Accordingly, 23 percent (nine females and one male) respondents do not know the size of their expenditure. About 14 percent said they were using government hospitals free of charge, and the other 11 percent expend Birr 4001-6000. The detail information can be seen from the following table.

Table 4.6. Amount of expenditure for health treatment of the deceased Family member

Amount in Birr	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Free in government hospitals	1	1	5	5	6	13.95
101-300			1	1	1	2.33
301-500			2	2	2	4.65
501-700			3	3	3	6.98
701-900			1	1	1	2.33
901-1100			3	3	3	6.98
1101-2000			2	2	2	4.65
2001-4000			3	3	3	6.98
4001-6000			5	5	5	11.63
Other	-	-	-	-	-	-
>6000	2	2	3	3	5	11.63
Do not know because it was covered by parents	1	1	9	9	10	23.26
It was covered by NGO			2	2	2	4.65
Total	4	4	39	39	43	100.00

Source: Field survey

The other variable explored in the study was expenditure for funerals. The data shows that the largest number 37 percent (14 females and 2 males) do not know the amount because it was covered from parents and relatives. Sixteen percent who were all female spent an amount between Birr 501-700. About seven percent, all females spent Birr 4001-6000. The average expenditure for funeral constitutes a significant portion of annual income of a household. Detail information of the expenditure for funeral is shown in the following table.

Table 4.7. Amount of expenditure for funeral of the deceased Family member

Amount in Birr	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Free in government hospitals	-	-	-	-	-	-
101-300			2	2	4.65	4.65
301-500			3	3	6.98	6.98
501-700			7	7	16.28	16.28
701-900	1	1	2	2	6.98	6.98
901-1100	1	1	2	2	6.98	6.98
1101-2000			3	3	6.98	6.98
2001-4000			2	2	4.65	4.65
4001-6000			3	3	6.98	6.98
Other	-	-	1	1	2.33	2.33
>6000	-	-	-	-		
Do not know because it was covered by parents	2	2	14	14	37.21	37.21
It was covered by NGO	-	-	-	-	-	-
Total	4	4	39	39	100	100

Source: Field survey

Expenditure on food before and after HIV/AIDS infection

The monthly expense for food before they were affected by HIV/AIDS was another variable looked at in order to examine how the epidemic affects households and individuals by causing changes in food consumption. A significant number of respondents (29 percent), were spending Birr 101-200 monthly for food items before they were affected by HIV/AIDS, while 21 percent (6 male and 15 female), was spending Birr 201-300. Another 21 percent used to spend between Birr 301 and 400. The detail information about households' expenditure for food before they were affected is presented on the table below.

Table 4.9. Monthly expenditure for food after HIV infection

Amount in Birr	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	%
50-100	1	1	14	14	15	15
101-200	3	3	19	19	22	22
201-300	4	4	8	8	12	12
301-400	1	1	3	3	4	4
401-500			1	1	1	1
501-600			1	1	1	1
Do not know	11	11	34	34	45	45
Total	20	20	80	80	100	100
Average expenditure after HIV = 195						

Source: Field survey

Respondents answered the question as to how much they spent on food before and after infection. Accordingly, 88 percent responded on previous food consumption while only 55 percent responded to the question on current status. The significant portion of the respondents' expenditure falls between Birr 101 and 200 in both cases (previous and present), which was 29 percent before they were affected, and 22 percent after HIV infection. This shows that people in this area are not only poor because of the epidemic, but they were also poor before HIV infection. However, 21 percent of the respondents used to spend Birr 301-400 before their infection, while only four percent are spending the same amount after infection. In the case of the expenditure range between 401 and 500, 11 respondents used to spend this amount before their infection, while after HIV/AIDS, only one respondent spent Birr 401-500.

Most of the respondents of the in-depth interview, key informant of the NGO, focus group participants and the cases explained that they do not get adequate food at present mainly due to shortage of income. In supporting the above idea, key informants of the community based home caregivers said that the major problems of AIDS patients at present are lack of nutritious food, sanitation and inaccessibility of health services for opportunistic infections. Because of lack of

sanitation and nutritious food they are exposed to different kinds of bacteria and viruses such as Tuberculosis.

Source and size of current income

The other variable looked at was the source and size of current income of the respondents. More than half of the respondents (62 percent), get their income from NGO (CHAD-ET). Previously they were engaged in more than 18 activities to earn their income. The detail information on the source of current income of the households is depicted in the following table.

Table 4.10. Source and size of current income of the households

Current income	Source of income					Total	Percent (%)
	Self	Relatives	NGO	Self and NGO	Relatives and NGO		
<100	8	1	11		1	21	21
101-200	5	1	45	10	4	66	66
201-300	1		5	2		8	8
301-400				1		1	1
601-700				1		1	1
Do not respond						3	3
Total	14	2	61	14	5	100	100

Source: Field survey

The majority of the respondents who participated in the survey as well as in focus group discussions revealed that it was impossible for them to live if they were not getting the support from charity organization, though the support they get was not enough.

4.2 Changes in household and family structures and burden of dependency

4.2.1 Female headed households

Change in the household structure was another variable examined in the study. The survey data shows that in the two kebeles there were 31 households that are headed by female because of death of their husbands. Unlike the female respondents, only three males out of 20 lost their wives.

4.2.2 Child headed households

Death of the mature individual in the household results in increasing number of child headed households. The survey data shows that six children are responsible for themselves and managing the house. While nine orphans are cared for by their elder siblings that makes the child headed household 15 (30 percent of the respondents) out of 50 orphans.

4.2.3 Dissolved households

According to the survey data, there were 10 (10 percent of the respondents) households, which do not exist as normal households, the surviving member of those households had moved to different households for shelter as well as to find means of livelihood. Most of the members of the dissolved households went back to their parents' house, while some other were living around the Tsebel area. The latter group decided to live around Tsebel area mainly for two purposes. Firstly, they could find a house that is cheaper, and secondly psychologically they feel comfortable when using the holy water as means of healing.

One respondent who participated in the survey said that after death of her husband she returned to her parents' home with her three children. However, since her parents' house was not enough for the entire additional family members, she was forced to prepare a 'kot' and sleep there with her three children. Another respondent stated that after death of her husband, she dispersed her two children, one to her parents and the other to relatives in a rural area. Then, she started to live around Tsebel in order to get cheaper house and also use the holy water. There is also a man who lost his wife and a six-year-old son, who is now living around Tsebel in search of cheaper house.

4.2.4 Burden on extended families

The respondents revealed that they were supported by their extended families such as parents and relatives in different ways during illness/death of family member as well as in taking the orphans. For example when a family member was deceased, 16 percent of the respondents said that funeral and other related expenses were covered by their parents. And during illness, 28 percent of the respondents' caregivers were female relatives. A significant portion of respondents had dispersed their children to different relatives including to relatives in rural areas.

With regard to the burden the extended family bears, a 22 years old focus group discussion participant explained it as follows. Though she is HIV positive, she is healthy, but went to live around Tsebel. She further said that

I am a child in my family, and since I am living around Tsebel, my parents pay 100 Birr for house rent monthly for me. This has negative impact on their income, and their love for me since their income is affected due to my problem.

The survey data of orphans shows that extended families such as grand parents, particularly grandmothers, and aunts were responsible to take care of 50 percent of orphans selected as a sample. Among the respondents, one of the grandmothers stated that she was responsible not only for a double orphan child, but also a sick and widowed daughter and her child are living with her. Given a small size of income, the mentioned grandmother is highly overburdened and the problem is becoming beyond her capacity to afford to support the victims.

Moreover, extended families particularly parents and intimate relatives are burdened to share their income during illness and funeral of the family member of the affected households. As indicated above, parents and relatives covered 16 percent of the respondent's expenditure for funeral.

4.3 Status of AIDS orphan children

Fifty AIDS orphan children were surveyed in order to examine the following main variables. Type of custody of AIDS orphan; access to basic needs; Family income of AIDS orphan households; education of AIDS orphan; their involvement in income generating activities. Of the total respondents, twenty-four are females while 26 are males. All Children with the age of less than 10, and even some between 10 and 15 years old who could not respond properly were excluded from the survey, instead some grandparents and caregivers were interviewed.

With regard to age of the orphan children 16 percent of the respondents are between the ranges of less than 10, 42 percent between 10-14, and the same proportion are between 15-18 years of age. The majority of the respondents are under the age group of 10-18 years old.

4.3.1 Type of custody of AIDS orphan children

The study shows that among those who responded to the questionnaire, the majority (32 percent) lives with their grandmother. Sixteen percent live with their aunts (five females and 3 males). Twelve percent live with their elder sisters while the same proportion live alone caring for themselves. The following table gives the detail information on the custody of AIDS orphans in the study area.

Table 4.11. Type of custody of AIDS orphan

Type of custody	Sex				Total	
	Female		Male			
	No.	%	No.	%	No.	(%)
Mother	4	8	1	2	5	10
Self	3	6	3	6	6	12
Grandmother	6	12	10	20	16	32
Aunt	5	10	3	6	8	16
Uncle			1	2	1	2
Elder brother	3	6			3	6
Elder sister	2	4	4	8	6	12
Other	1	2	4	8	5	10
Total	24	48	26	52	50	100

Source: Field survey

4.3.2 Access to basic needs

The availability of basic needs mainly food and clothing for orphans was examined in the survey. Of the 50 orphan respondents, 50 percent (10 female and 15 male) said that they do not get enough food, while 46 percent (13 females and 10 males) responded that they are getting enough food at present.

Table 4.12. Availability of sufficient food for orphans

Availability of sufficient food	S E X				Total	
	Female		Male		No.	%
	No.	%	No.	%		
Yes	13	26	10	20	23	46
No	10	20	15	30	25	50
Other	1	2	1	2	2	4
Total	24	48	26	52	50	100

Source: Field survey

With regard to clothing, while only 18 percent responded positively, the majority (78 percent) responded that they do not get sufficient clothing. As compared to access to food more children lack access to clothing.

Table 4.13. Availability of sufficient cloth for orphans

Availability of sufficient cloth	S E X				Total	
	Female		Male		No.	%
	No.	%	No.	%		
Yes	5	10	4	8	9	18
No	18	36	21	42	39	78
Other	1	2	1	2	2	4
Total	24	48	26	52	50	100

Source: Field survey

4.3.3 Family income of AIDS orphan households

In order to analyze the living standard of orphan children, comparison of monthly income of their parents' and custodians was made and they were asked the monthly income of their parents. Accordingly, 22 percent had parents who were getting a monthly income between the ranges of Birr 201-600; while the same proportion answered they do not know because they were daily laborers. Six percent of the respondents parents' were earning below Birr 100, and the same proportion were getting more than Birr 1000. The detail information is shown in the table below.

Table 4.14. Parents income before HIV infection

Amount of Income (in Birr)	S E X				Total	
	Female		Male		No.	%
	No.	%	No.	%		
Below 100	2	4	1	2	3	6
101-200	3	6	5	10	8	16
201-600	3	6	8	16	11	22
601-1000	2	4			2	4
>1000	3	6			3	6
Daily laborer	7	14	4	8	11	22
Not known	4	8	8	16	12	24
Total	24	48	26	52	50	100

Source: Field survey

The current monthly incomes of the custodians were also examined. Most of the respondents (50 percent) do not know their custodians' incomes, while 32 percent responded that they get below 100 Birr monthly. The majority of the respondents fall under the income ranges of below 100 and 300 Birr, and only one household falls in the range between 301-500.

Table 4.15. Monthly income of the custodian

Amount in Birr	S E X				Total	
	Female		Male		No.	%
	No.	%	No.	%		
Below 100	9	18	7	14	16	32
100-300	4	8	4	8	8	16
301-500	1	2			1	2
Do not know	10	20	15	30	25	50
Total	24	48	26	52	50	100

Source: Field survey

4.3.4 Educational status of AIDS orphans

Education was the other variable to examine the situation of AIDS orphan children. The majority of the respondents (71 percent), attended education level of grades 1-8. Twenty six percent of orphan children, between the ages of 10-14 and 15-18, attended education level of 9-12. The detail information about educational level of orphan children is shown in the table below.

Table 4.19. Responses with regard to whether poverty expose one to HIV or not

Does poverty expose one to HIV?	S E X				Total	
	Female		Male		No.	%
	No.	%	No.	%		
Yes	37	37	2	2	39	39
No	42	42	18	18	60	60
Total	80	79	20	20	100	100

Source: Field survey

Focus group discussion participants were asked about how they perceive poverty. The women's groups reach on consensus and replied that "Poverty means the condition where someone has nothing. The ones who have are sitting in their home, while we are here because we are poor." Most of them explained that if they were not poor, they would have not come to get support from an NGO. And the men's group described poverty as living in low standard and lack of the basic necessities such as lack of education, because if someone has not awareness about the disease, s/he will be exposed to the disease. They also added that the major source of the disease could be poverty, since it means lack of medical services and nutritious food that incapacitates human body, and expose to the disease. Poverty exposes women to HIV than men because they are forced to work in Bars and as housemaids.

Furthermore, they explained that HIV/AIDS exacerbated their poverty. Some of the focus group participants said that before they were infected by HIV, they were living in rented houses where their privacy were maintained, but now they live either in a single room shared with three or four individuals or dependent on relatives or friends.

The participants in the survey, focus group discussion and case study also share the same idea about the change on food consumption pattern. Most of them described that they were getting food three times a day. However, at present, they said, "we eat only when we get something to eat, it could be once a day or there may be no single meal a day. There is nothing that we can do to get food."

4.5 Major findings from the cases

Eleven cases were selected from the sample population who had also participated in the survey. These cases were selected purposively so that they can represent the sample. Individuals were included from widowed persons (females and males), from dissolved households, orphans, individuals returned to their parents because of their economic problem, and individuals living around holy water area. Though they were different in their situation at the time of the study, they had many similarities in their background. Among others, some of them came to the city from different rural areas as migrants to live a better life, and most of the migrants did not succeed in the city life which was contrary to their anticipations.

According to the data from the cases about half of them (seven out of 11) were migrants from different parts of the country (five females and two males). Four of them were from Addis Ababa. The majority of the participants of the case study acknowledged that they came to Addis Ababa because they were informed that Addis Ababa was a wonderful city where people could be successful in life. As soon as they were arrived, most of them (particularly women) begun to work as a housemaid. After a while, some of them were married, some other were working in bars, involved in petty trade, became sex workers, and only two continued their education. The detail about the socioeconomic and demographic characteristics of the cases is shown in Annex 3.

However, the majority of the cases did not find the city as they had anticipated. Neither the married ones, neither those employed as housemaids nor those in the bars succeeded. For example a 23-year-old female from among the case studies revealed that she was married to a man who was much older than her, a marriage arranged by her sister. She explained her situation in the following manner.

"Six years passed but I was unable to conceive a child, I did not know the reason why I could not. My husband was nagging me now and then. He was highly degrading me for the reason that I was unable to give birth. I was spending most of my time in tears. There was no happiness in the house. He justified that it is because I always use a birth control medicine so that I could not conceive a child. Finally I left him and again was employed in a tearoom as a waitress."

Another person from among the case studies who came from Harar disclosed that he came to Addis without informing his parents because he was afraid they would stop him. He said, "I

thought Addis Ababa was a special place and convenient for living. I came to live with my brother. Unfortunately, I did not take his address and faced so many problems for four years until I met him. I used to sell newspapers and sleep in the street. "

Also a woman who came from Gondar who was employed as a housemaid for some time. But her first employer cast her out of the house because she suspected her of having an affair with her husband. Then she was employed in another house, and found the job difficult because she was supposed to bake 'Enjera' almost for 24 hours chewing chat so that she could not fall asleep. As she was doing this job she met a man who was a soldier and they started to live together and had two daughters. However, she was not living a good life with him not only because he did not support her economically but also he was disturbing her. She explained the situation as follows:

First of all slowly my husband's health deteriorated and finally he was diagnosed with TB. He was bedridden for two months and died without finishing his medicine. After his death I realized that he was taking credit monthly from an individual with interest and was not receiving his salary properly, because the creditor was waiting at a place where he received his salary, and taking all his money. He used his salary not only for himself, usually for drinking alcohol, but I also realized that he had another wife. When he was in clinic finally, he betrayed me telling everybody that he does not know me and I brought him to clinic to take his money. After his death, his friends contributed 220 Birr for his funeral. And I sold some valuable household furniture for his Teskar."

According to her, though she has the HIV virus, she is living a better life than she was with her husband, because she has peace and earns a better income than before. She sells 'Enjera' and also receives support from an NGO.

With regard to employment seven of them were not working at the time of the study. Four out of the 11 cases were unemployed, three of them had stopped working because of illness, three were working and one was an orphan student.

In addition to their employment situation, the cases' housing condition was also similar. All of them were living in a single room except one woman who has been living in a house with three rooms with her parents after her husband's death. Three cases were living renting private houses, while the same proportion rented Kebele houses. Two cases live around holy water because the

house rent is cheaper than the Addis Ketema sub city. A widowed woman with her two children was living in a shelter rather than a normal house.

The majority of the participants in the case study acknowledged that their major problem was housing. As compared to their income, the maximum share goes to house rent, particularly those who rent from private owners. For example a man who was separated from his family because of the virus described the problem of housing in the following manner.

"I have no brothers, sisters, or even distant relative to depend on. My main problem is shelter. I am living in one room shared with four others. I do not sleep on a bed, but on an open space on the floor paying 40 Birr per month. When I get sick, they do not allow me to sleep, I go to 'Michael'/church for a shelter, and when I get better they like me and allow me to sleep. The only income I have is the support I am getting from CHAD-ET, 75 Birr, of which 40 Birr goes to house rent. If I had enough income, I would have rented a room for myself."

Though the cases have similarities, they also have differences. Findings of the cases depicts that females who were not migrants but born and grew up in Addis Ababa were better off in their educational level. While most of the migrants drop out before they reach 6th grade, the ones from Addis Ababa proceeded at least up to grade 10. The other difference examined in the cases was that between men and women. Men migrants were involved in petty trade, contraband trade, and as daily laborers, while most of the female migrants were used to work as a housemaid at first and then married, or work in bars latter.

4.6 Coping Strategies

Coping mechanisms of HIV/AIDS affected households were explored. Affected households have different kinds of coping mechanisms among them the major ones are the following: Searching assistance from NGO, selling household assets and withdrawing savings, using two or three mechanisms at the same time, and so on. Accordingly, for 36 percent of the respondents (29 female and 7 male) searching support from an NGO is their coping strategy. The second largest group 21 percent (5 males and 16 females) use selling household assets and withdrawing savings as a coping mechanism. Though 13 percent responded 'doing nothing' as their coping mechanism, in reality they are already being supported by the NGO. The detail information about the coping mechanisms of affected households is depicted in the table below.

Table 4.20. Coping mechanisms of affected households

Coping mechanisms to solve problems	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	(%)
Do nothing	3	3	10	10	13	13
Selling household assets and withdrawing savings	5	5	16	16	21	21
Altering household composition (sibling dispersion)	3	3	1	1	4	4
Searching assistance from an NGO	7	7	29	29	36	36
All of the above except the first	1	1	10	10	11	11
Working	1	1	6	6	7	7
Selling household assets and searching support from an NGO			8	8	8	8
Total	20	20	80	80	100	100

Source: Field survey

Some of the respondents (all females) acknowledged that in order not to be dependent only on the NGO, they were given a credit to start something like a petty trade. The key informant from the NGO also shared this idea. The charity organization designed a project so that they could take credit and be self-reliant. However, most of them failed to be successful. They said that at present they are left with nothing because the support they were getting from the NGO was discontinued since they were given a credit with an agreement to be independent.

Role of the community, the government and NGOs

In order to examine the role of the above development partners in mitigating the spread of HIV/AIDS and in supporting the affected households and individuals, a semi-structured questionnaire was developed for the head/official of these organizations. And the affected members of the households were asked (in the survey) different questions with regard to their access to various social networks such as Iddirs that could be used as a coping strategy.

Concerning the role of the community, as the objective of the CHAD-ET project is to mitigate the effects of HIV/AIDS through community based approach, it uses different methods to involve the community in the prevention, care and support provision, capacity building and community empowerment. Accordingly, the project involves the community in the following ways. First, significant numbers of individuals were trained as a caregiver of HIV/AIDS patients. Second,

mobilizing the community for anti AIDS activities. Third, the community is requested for financial contribution, which could be used for orphans (education material and the like) and for patients (for food items and other basic necessities).

However, most of the respondents disclosed that the community in general and the extended family in particular are not capable of supporting affected households because they are also living in poverty. A focus group participant in the women's group described the situation in the following manner.

My parents, let alone supporting me, they do not have anything for themselves. I am supported by an NGO and I thank this organization very much, otherwise I would have been dead of hunger. My parents do not support me not because they are bad, but it is because they do not have capacity to do so.

Most of the respondents in the focus group discussion as well as in the case study pointed out that the government should help them. Respondents were asked if they get any kind of assistance from the government. Only one percent replied yes, while 97 percent confirmed they do not get any assistance from the government.

With regard to the role of NGOs, most respondents acknowledged that if they were not supported by the NGO, they would have been died. The survey data shows that 89 percent of the respondents get support from CHAD-ET while 11 percent do not get any. Most of the respondents who do not get support are new clients who applied to get support. And some other said that they do not need financial or other support but only need the social network with people living with HIV/AIDS.

Access to social networks

Respondents were asked if they have any social networks such as Iddir, Iqqub and Mahber (social relations) that could be used as a coping mechanism. As can be seen from the table below, only 28 percent of the respondents (6 male and 22 female) are member of the Iddir at present. The majority of the respondents (69 percent) replied that they do not have any kind of social networks currently. They were also asked if they were member of the Iddirs and received money for funeral and other purposes before being affected. One male and eight females (nine percent) responded that they were members before HIV affected them. They acknowledged that they

discontinued their membership since they could not pay the monthly payment because of shortage of income. The detail information about HIV/AIDS affected households' access to social networks can be seen in the following table.

Table 4.21. Access to social networks

Kind of social networks	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	(%)
Iddir	3	3	19	19	22	22
Eqqub			1	1	1	1
Maheber			2	2	2	2
No social networks	14	14	55	55	69	69
Iddir, Eqqub, and Mahiber	2	2	1	1	3	3
Iddir and microfinance			2	2	2	2
Iddir and mahiber	1	1			1	1
Total	20	20	80	80	100	100

Source: Field survey

Most of the respondents who were not member of the Iddir described that Iddir is not a priority for them because their basic needs were not yet fulfilled. Some respondents who participated in the survey as well as in the focus group discussion revealed that the Iddir allowed them to contribute their share in labor. A woman in a focus group discussion described that she had discontinued the monthly payment for Iddir for six months because of illness. Her neighbors said that she should stop the membership because she was a patient. However, the chairman of the Iddir who understands the problem well, allows her to continue without payment.

The monthly payment for Iddir varies from less than Birr five to and more than Birr 10. Fourteen respondents (13 female and 1 male) pay more than Birr 10 per month. While one male and three females do not pay but contribute by labor. The details can be seen in the following table.

Table 4.22. Monthly payment for Iddir

Monthly payment to Iddir (in Birr)	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	(%)
Below 5	1	3.57	-		1	3.57
5-8	2	7.14	2	7.14	4	14.29
9-10	1	3.57	4	14.29	5	17.86
More than 10	1	3.57	13	46.43	14	50.00
Do not pay/labor contribution	1	3.57	3	10.71	4	14.29
Total	6	21.43	22	78.57	28	100.00

Source: Field survey

Amount of money received from Iddir for funeral

The amount of money received from Iddir is chosen as a variable to see Iddir's contribution during death of members affected by HIV/AIDS. Seventeen respondents received money during funeral, of which 16 were female. The amount of money they received varied between 100 to more than 2000 Birr. Four female respondents received Birr 101-300, and three respondents received more than Birr 2000. The next table depicts the detail information about money received from Iddir for funeral.

Table 4.23. Amount of money received for funeral from Iddir

Amount received from Iddir to funeral (in Birr)	Sex				Total	(%)
	Male		Female			
	No.	%	No.	%	No.	
101-300			4	25.00	4	23.53
301-500			2	12.50	2	11.76
501-700			1	6.25	1	5.88
701-900			1	6.25	1	5.88
901-1100			3	18.75	3	17.65
1200-2000			2	12.50	2	11.76
More than 2000	1		3	18.75	4	23.53
Total	1			100.00	17	100.00

Source: Field survey

Since recently, the role of Iddir has been changed because of the epidemic. Some Iddirs such as 'Delbetegel' and 'Fregenet' in kebeles 13/15 do not give money only for funerals, but they also give financial support before people die. One woman who experienced death of husband and two children received money not only for the deceased persons funeral, but she said that the Iddir

gave her Birr 500 for herself so that she could use it for health treatment or for food items. The agreement was that if she feels well and work, she will pay back the money that she had received. But if she will not be cured and dies, 500 Birr would be deducted from 2000 Birr, the amount supposed to be given for funeral. Another woman also (sex worker) received Birr 500 in order to use it for food items.

With regard to other social networks, some of the focus group participants of the women's group explained that it is better not to have them. This is because if people or neighbors knew about their HIV status, they might face stigma and discrimination. A woman who faced similar problems where her children could not play with other children and could not dry her clothes together with neighbors because of her health status put it clearly in the following way. "It is better not to have the network because if one member knows, everybody will know. A person will be exposed to stigma. Thus it is better to be supported by other ones who have good understanding, or it is better to live by yourself."

Chapter 5: DISCUSSIONS OF THE MAJOR FINDINGS

In this study the impact of HIV/AIDS on households and individuals was explored. It was found that women were more vulnerable than men; income and expenditure patterns were changed dramatically, incomes were reduced and expenditures on health care and funerals were increased. Sales of assets and withdrawing financial savings as coping mechanisms with HIV/AIDS were observed. Also the epidemic had changed the household structure as a result different types such as female-headed, child-headed and dissolved households were increased significantly.

This study confirms that women are not only more exposed than men to be infected with HIV, but also tend to become infected at earlier ages. More than two thirds (80%) of the affected individuals surveyed were females. Five females were affected between 16-20 years of ages, while there were no males affected at the same age. Moreover, 19 females were affected on the age ranging 21-25 years, but only one man was affected at the same age group.

Moreover, it was found that women were more vulnerable than men because of economic problems. Many women migrated from the countryside with the hope of having a better life in the city. Due to their weak educational background, there is less likely that they get non-risky job to support themselves, as a result, when they arrived in the city, they either worked as a housemaid, a bar lady, or married someone. The study found that most of them were not successful, they were mistreated by their employers and husbands, and did not succeed in living a better life and end up to be AIDS patients. They could not even get the basic needs to the extent that they were forced to breast feed their children, as they could not afford to buy baby food.

The majority of households surveyed as well as cases studied did not have access to different facilities necessary to lead a normal life in general and helpful to patients and caregivers in particular. The respondents' accessibility of housing, water, toilet and the like was assessed in the study. It was found that the major problem of the affected individuals was housing in which 38.4 percent of the respondents were living renting houses from private owners, 33 percent rented from the kebele, and only three percent own houses privately which is very low as compared to the 48 percent of urban ownership of dwelling houses in the country (MoFED, 2002).

The problem was not only renting houses from private owners while they did not have enough income, but it was also found that most of them (81 percent) were living in a single room with an average family size of three. This is the worst situation as compared to Addis Ababa where the average room per household is two, while in the study area only 13 percent live in two room houses. The congestion of people in one room aggravates the health condition of the family members, and open ways for diseases such as tuberculosis to be easily transmitted. The poor housing conditions combined with lack of access to toilet and water within dwelling locations aggravated the situation.

This study found that 79 percent of the households had communal toilets outside their home. It was observed that most of the toilets were far from the respondents' home, and were constructed by some NGOs or the kebeles. Fifty six percent of the households had tap water in the immediate vicinity while only 13 percent had water in their dwellings. Some of the respondents were already AIDS patients during the study. Even under the best of circumstances, lack of control over bodily function is humiliating for the patient and unpleasant for the caregiver. When access to a toilet is difficult and where there are no proper facilities for the safe disposal of fecal matter as seen in the sample population, conditions are so much miserable, and there is a high risk of contamination and infection of others as well.

Some of the sick individuals had to have assistance walking even on level ground. This becomes a particular problem when toilet and washing facilities are not in the house, or are even not in the immediate vicinity of the dwelling. Chronic diarrhea becomes even more incapacitating when the sick person may have to struggle outside the house to relieve him or herself. Only two percent of households in this survey had access to a flush toilet, and substantial proportions of households still depend on pit latrines. Thirteen percent of the respondents did not have a toilet at all. It was found that they relieve themselves in different places such as hotels, public toilets, open areas etc. Particularly those who use open areas contaminate the surroundings which in turn transmits different kinds of diseases to the people living in the vicinities.

The majority of respondents revealed that opportunistic diseases were their major problems. Though most infected individuals had access to health services in private clinics, some of them were not satisfied with the treatment. They complain that, because of their health status (having

HIV virus), the physicians treat them differently, or they used to say, "it is just the characteristics of the virus" and prescribe the same medicine all the time. This has a negative psychological impact for the patient thinking that s/he is stigmatized because of the virus. Some of them stated that, when visiting a doctor, they do not tell their HIV status, but after finishing the treatment they tell the doctor their status so that he could prescribe the medicine, which does not, have side effects.

In addition to the mistreatment in the clinics and hospitals, the kebele officials deprived patients of the right to take antiretroviral treatment (ART) by denying letters to hospitals. Although it is confirmed by laboratory result, Kebele officials simply by seeing the physical condition of the patient allow or deny letters to hospitals, which is not their mandate. Thus these patients do not feel free to go to the Kebele in fear that they would not treat them well. As a result of lack of access to health services and lack of acceptance by different people in different organization, people living with HIV/AIDS will not be encouraged to disclose their status and care for others who are not infected. The situation if not improved, will have a negative impact on the ongoing effort to prevent and control the spread of the virus.

All the above mentioned problems of housing and lack of other basic facilities were the result of shortage of income. If they had enough income they could have rented a better houses and bought the facilities they needed. The study found that the monthly average income of the sample population before HIV affected them was 437 Birr, while after they were infected it dropped to 153 Birr, which shows that the income level was reduced by two-third.

This drop in income was worsening by the fact that most of the households studied were already very poor. Although the range of household income was very wide before their infection, from less than 100 Birr to more than 1000 Birr a month, 44 percent of households were surviving on less than 300 Birr a month. This is because the majority of them were working either as a daily laborer or petty trader and women in particular were dependent on their husbands' income, which they lost when they died. The study confirmed that HIV/AIDS exacerbated the problem of poor households by putting them into deeper poverty, it increased the size of households which were getting less than 300 Birr per month before they were affected from 44 percent to 95 percent after being affected by the epidemic.

In addition to the existing shortage of income, after being affected by HIV, the study showed that the problem was exacerbated by increased cost of livings. After the infection, 21 percent were getting less than 100 Birr while 66 percent were getting less than 200 Birr. The majority of the households' (62 percent) source of income was a non-government organization. Some of the major reasons for the loss of income are, some individual's being diverted from income generating activity or the inability of the AIDS-sick person to work, and because of unemployment. For example 23 percent of the respondents were not working because of their health problem and 43 percent were unemployed at the time of the study. As a result, households were coping with asset poverty as well as loss of income.

The HIV/AIDS affected households did not only face loss of income but their assets were also depleted. They used their savings for the expenditure on medicines and medical care, and the high cost of funerals were also contributing to the financial burden of affected households. Some households spend a significant amount of money for health treatment of the deceased person. For example 18 percent of the households, which had a deceased member, spent between the range of 2000 and 6000 Birr, while 24 percent spent from 300 to 2000 Birr, and 23 percent of the households received money from their parents and relatives, an amount, which they could not remember.

As households become more desperate, assets were also sold to raise funds. The majority of the respondents reported that they used incomes from selling assets as a coping mechanism. Some of the individuals sold valuable household equipment such as refrigerators, while others sold less valuable goods like beds. For instance a widowed woman revealed that she sold her bed when she exhausted her savings and begun sleeping on the floor. The survey data confirms this that the household expenditure was more than their income after HIV where the average monthly income is 153 Birr, their monthly expenditure for food is 195 Birr.

Following HIV/AIDS infection, loss of income, withdrawal of savings and selling of assets, and lack of any other means for survival, the affected households are forced to change their structures. It was found in this study that different types of households were created. Among them the major ones were the following. Female headed, child headed, grandparent-headed, and dissolved households.

As the breadwinner is infected with HIV, being ill and dies, women are primarily affected. Since most of them are dependent on their husbands, they are left with nothing economically as well as emotionally. According to MoFED (2002), women in urban area of Ethiopia head 41 percent of all households, and these households have been found to have higher poverty severity than their male counterparts. This study found that 31 percent of households were female-headed because of death of husbands. Since the majorities were not self-reliant, they were forced to search for a means for their livelihood anywhere they would find anything. The major source of livelihood they found was a charity organization, since some of them migrated from the countryside and they could not get support from relatives and extended families.

In this study 15 children out of 50 were found to care for themselves and siblings, and 32 percent were living with their grandmothers. Although the majority of these households are poor, the study confirmed that the extended family networks are still absorbing these children. That is why most of the caregivers (elder siblings and grandmothers) acknowledge that they did not want to give the orphans to institution, but wanted to keep them with them. Children do not only became head of the household, but also became responsible beyond their capacity since they were not matured enough to be responsible to become heads of the household. This has an impact on their education in general and for their future life in particular. Some of the orphans revealed that their grade dropped after their parents' death because they were stigmatized in school, responsible in caring for siblings, lacked access to basic needs and so on.

HIV/AIDS not only changes the household structure by creating child headed and grandmother headed households, but it also makes some households dissolve. This study found that 10 percent of the households were dissolved because they could not afford to sustain. Therefore, they were forced to join either their parents or started to live around the holy water in order to rent cheap houses as well as to use the holy water. Since the majority of the members in the dissolved households joined their parents, they have been a burden to extended family economically and in sharing the house, which is usually a single room. As a result of all these problems, the already poor households get into deeper poverty as they absorb orphans and members of the dissolved households.

Most of the affected households used different kinds of mechanisms to solve their financial and material problems. The major coping strategies which the affected individuals used as found in this study were the following: searching assistance from an NGO, selling assets and withdrawing savings, and altering household composition (sibling dispersion). It was also found that the majority (32 percent) of the households used to search support from NGOs as their coping strategy. However, these were not the only households looked for support from the NGO, but there are also other households (18 percent) which search assistance from an NGO in combination with other mechanism (such as selling assets). From this it can be seen that the role of the charity organization is important as was confirmed by most of the respondents who stated that they would not be alive if they would have not been supported by such organization.

However, it was also found that though the affected households were supported by the specific NGO, they acknowledged that it was not enough for a living since most of them were living in a house rented from individual owners which consumes the significant amount they received from the charity organization. Thus, they emphasized the need for additional support from other organizations particularly from the government. However, though it was not permanent, the community supports the affected households, particularly orphans, by contributing financially to cover school uniforms and educational materials. In the same situation the Iddir helps the patients financially in an agreement that they pay the money if they get well and if not it will be deducted from the amount supposed to be given during funeral. But this study showed that most of the households (69 percent) did not have social networks at all such as Iddir because they could not afford the monthly payment. Only 22 percent of them were members of an Iddir. Though households that are members of the Iddirs got support once in a while, they were not significant as compared to the number of households that were not members of Iddirs.

In general this study showed the impoverishing impact of HIV/AIDS on households. Though the epidemic affects all sectors of society, rich and poor, its impact is more severe among the poor. It also assessed the status of affected households' access to basic facilities and found that almost all households did not have basic facilities within the dwellings, but in the near by vicinities. With regard to their coping strategies, since they could not work for different reasons, most of them were reliant on searching for assistance from donors.

Chapter 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The study of the impact of HIV/AIDS on poverty conducted on 100 households and 50 orphans is believed to provide an important contribution to the limited literature on the impact of the epidemic on affected households. Of the total informants, 80 percent were females while 20 percent were males and almost all respondents were in the working age group. It was found that women were more vulnerable because of social, economic and cultural problems. Most of them had a low educational level and non-of them attended higher education. However, 43 percent were unemployed, while 23 percent has already stopped working due to health problems. As most of them were already poor before the infection, they did not have enough savings to cope with the epidemic.

The study found that shortage of income is the single major problem of the affected households since fulfillment of the basic necessities such as housing and health services is constrained by income size. The study also indicated that most of the households do not have access to facilities (housing, water, toilet and so on) that fulfill the normal standard. Most of them live in poor housing conditions (single rooms shared with upto five individuals), while some of them completely lack access to housing. It is observed that the real major problem of the informants is shelter and they are lacking appropriate place where they can rest when they feel sick. Moreover, the majority of them do not have access to water and toilet in their dwellings, but in the nearby vicinity and some have far from their dwellings; 13 percent do not have access to any kind of toilet at all. Though all the informants were getting health services in private clinic arranged by the NGO, some of them were not satisfied with the service, as they felt not treated properly like any other patients. While the virus need special attention they were told most of the time that their problem was related to the characteristics of the virus and they tended to be given the same type of medicine all the time. The study found that as some of the households do not have piped water in the dwellings, they were discriminated by the neighbors and forced to wait until others get the water.

The impact of HIV/AIDS on household is so complex, that it had brought a considerable change in income and expenditure patterns of the respondents. Before the infection, the average monthly income of the respondents was 437 Birr that ranges from less than 100 Birr up to more than 1000 Birr, while after the infection, the average monthly income reduced to 153 Birr, showed significant reduction. The effect of reduced income was seen to be severe on women as most of them were dependent on their husbands and became widowed. Similarly, as their income declined their expenditure mainly on food was also declined accordingly. Most households spent a significant amount of money for health care services and funerals of the deceased individual of the family member. The assistance received from Iddirs and extended families used to finance health care services and funerals.

Most of the respondent were not working, the major sources of their income is an NGO. The majority of them confessed that it was impossible for them to live if they were not supported by the charity organization, though the supports they got were not enough.

As a result of death of one of the breadwinner, and/or both parents, the family structure changes and the extended family such as grand parents and other relatives will be burdened. The epidemic generated four types of family structures: female headed, child headed, grandmother headed and dissolved households. Thirty one percent of female became heads of the family after the death of their husbands, 30 percent of orphans became responsible for themselves, and 10 percent of households were dissolved because they could not afford to survive and they either returned to their parents home or rent a single room around the holy water shared with three or four others.

HIV/AIDS had also burdened the extended families emotionally as well as economically. Since they were caregivers for the ill and orphans, some of them were stigmatized due to their ill/dead family member. They shared their resources to the surviving family members and covered the expense for health care services and funerals. Sixteen percent of the households' parents covered the expenses for funeral and other related things. And most of the dissolved households returned to their parents as a result of which they share the parents' resources including the houses. The same is true with the conditions of orphans since 32 percent of orphans were living with their grandmothers and 16 percent living with their aunts.

The major findings of this study indicated that as one or both parents' die, children not only lose parents love but also their income. Some of the orphans revealed that their grade declined after the death of parents. They also reported they do not get enough food and clothing. Some children dropped out of school to care for the young siblings some of whom were HIV positive, and some were engaged in income generating activities. Most of the orphans' educational level was found to be less as compared to their age. The majority of the caregivers for orphans feared about what they would do if the support from the NGO discontinued, as they have no other means of livelihood.

It was observed that the epidemic exposed households who were relatively well off to poverty and aggravated poverty of the already poor households. The study indicated that before HIV infection the households were living in a relatively better condition. They were at least renting houses from private owners for themselves, eating nutritious food at least three times a day, and so on. However, it was found that after HIV affected them, they even could not pay house rent let alone eating three times a day. Thus, the study clearly confirms that HIV/AIDS intensifies poverty. However, there were some households whose living standard did not change at all, and a few households revealed that they were living in a better condition after being affected by HIV/AIDS.

Households used various types of strategies for coping with the impact of HIV/AIDS. The major ones include searching for assistance from the charity organizations; selling household assets and withdrawing savings; dispersing siblings; returning to parents' home mostly as a result of death of husbands, and using holy water. Most of the households (50 percent) used searching assistance from the NGO as their main coping mechanism. It was also found that the affected individuals indicated that the government is not playing its role in the care and support of PLWHA and emphasized that it should do something about the problem of shelter they are facing.

The study found that the majority of the households do not have any kind of social networks such as Iddir, Eqqub, and so on. It was indicated that they could not afford to have these kinds even Iddir, which requires less monthly payment. While some were members of the Iddir by labor contribution, a significant number of households were member of the Iddir before they were

affected but discontinued after infection because of shortage of income. However, Iddirs had important roles, and this study found two Iddirs giving 500 Birr to their member who became patients of HIV/AIDS while they are alive so that they can use it to buy food items and medicine.

In summary, the Impact of HIV/AIDS on poverty at a household level is multifaceted as identified in this study. As the breadwinner is infected and dies, the household faces many challenges. First, their income and expenditure declined, second, women are left alone with nothing as they are mostly dependent on their husbands; third; children will be orphaned, and finally the extended families are burdened with care for the surviving family members.

6.2 Recommendations

According to the findings of this study various problems of HIV/AIDS affected households and individuals are identified. Based on these findings, the following recommendations are suggested that can be adopted by the concerned bodies to strengthen their ongoing activities in supporting the affected households, individuals and orphans in the efforts of prevention and control of the epidemic.

1. The amount of assistance being given to affected households has been inadequate. There is a need for the charity organizations/the government agencies supporting these people to give them assistance at least so that they can fulfill the basic needs. Due to shortage of income some people living with HIV/AIDS, particularly women, were returning to their previous work such as to bars, which impedes the effort to prevent the spread of the epidemic.
2. The major problem of HIV/AIDS affected households is housing among other things. They sell the wheat they received from the NGO in order to pay house rent to private owners. As they do not eat sufficient food, their health status deteriorates in a short time. Thus the government should facilitate a condition so that they could get shelter at a reasonable price and use the rest of their income for other basic necessities such as food.
3. The impact of HIV/AIDS is burdening the extended families since they take in the orphans when both parents die, as some of the surviving families returned to their parents' home. These families should be supported like other people living with HIV/AIDS are being

supported since they are depleting their resources to share with the incoming family members and are becoming impoverished, as a result of which the number of poor households will increase.

4. Households affected by HIV/AIDS need access not only to care and support but also to the means to maintain an income and pursue alternative livelihoods when traditional employment is no longer an option. Funding agencies and micro finance institutions can assist people living with HIV/AIDS and their families in diversifying and protection of their assets. Thus, there is a need that the funds from different Bilateral and multilateral organizations, which flow in the name of HIV/AIDS, should properly reach to the affected and infected households and individuals.
5. Community based organizations (CBO) such as Iddirs have started to play a significant role in the prevention and control of the epidemic. The funding agencies and the government should support these organizations in enhancing their human and financial capacities.
6. Most households particularly of the kebele 13/15 use renting beds as a source of income, which exposes children specifically girls as well as mothers, to HIV as most of the clients are men sleeping in a single room. Involving these households in other income generating activities will minimize the spread of HIV as well as the number of poor households created by the epidemic in the community.
7. Access to antiretroviral drugs is found to be another problem for patients. Because the responsible kebele administration officials should not deny the infected people a letter that enable them to get opportunity for the requisite drug. Thus, it is better if these officials are given training.
8. People living with HIV/AIDS come to the charity organization when they exhaust their assets and savings, and those who are well off do not come as they have adequate resource to cope with the virus. Though they manage to cope with the virus, they need support emotionally, so there is a need to encourage the well off to associate with people living with HIV/AIDS in order to reduce the stress and share feelings and experience. This can be done

through the various social networks such as community based organizations like Iddir, Eqqub, and religious institutions.

9. Finally, this study is based on only on two kebeles of the Addis Ababa sub city, which is difficult to take as representative of the city of Addis Ababa. Thus, it leads us to suggest a further in-depth study to investigate adequate information about the impact of HIV/AIDS on poverty at household level with regard to socioeconomic status and coping strategies of the affected households.

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APPENDICES

Annex 1: Case anecdotes

Case one

She is a widow and has two daughters, six and one years old. She described her short life history in the following manner.

"I was born in Dessie Gerado where my parents lived. They were farmers and I learned there up to grade 6th. When my age reached 18, I heard that one of my friends was getting ready to come to Addis Ababa. As soon as I heard this news, I decided to come with her. I was informed that Addis Ababa is wonderful city where people could be successful in their life. However, when I arrived in Addis, the reality and the information were very much far apart. My sister was living in Addis. After some time I decided to find job with my capacity and started to work as a housemaid. I worked for nine months and assessed everything. The job was very difficult to me. After some time my sister was very much fretful about me and she suspected something would happen in the future. So she didn't want to be responsible decided to return me back to my parents. I stayed there for three months, however I couldn't tolerate to stay there and came back to Addis without informing my parents and relatives."

I asked her why she wanted to come back to Addis. She said that she was not comfortable with the life style in rural areas after practicing the life style of Addis.

She continued the story. "Coming back I started working in a Tea Room as a waitress. After some time, my sister arranged a marriage with a man who was much elder than me and I was married. To be frank it was an ill-assorted marriage. Six years passed but I was unable to conceive a child, I did not know the reason why I could not. My husband was nagging me now and then. He was highly degrading me for the reason that I was unable to give birth. I was most often spending my time in tears. There was no domestic happiness in the house. He justified that it is because I take a medicine for birth control so that I could not conceive a child. Finally I left him and again employed in Tea Room as a waitress.

While I was working there very many men were offering me the chance to be their friend. Finally I settled with one person who was accompanying me when I came back to my home. He was working as an assistant for a truck driver. I stopped my job and started to live with him. As we were living together just about two months, I found a paper in his pocket, which reveals that he was diagnosed with Tuberculosis (TB). I was shocked and asked him why he concealed the truth. He told me his fear that if I knew about it I might leave him. At that time I could not run away because I was already pregnant with my first daughter."

I asked her if she had the knowledge about HIV/AIDS by then and why she did not have a test with her second husband.

She replied that by then the main concern was not HIV but it was TB. "My husband was looking so well when we met. However after some time, his health was not in a promising situation and he changed his job from assistant to driver to milling shop. I gave birth to my first daughter 'Rahmet' while he was ill."

I asked her why she became pregnant for the second time while her husband was diagnosed with TB, which is most likely related with HIV.

She told me that she didn't want to have second child at all. Besides she suspected her husband was ill because of HIV. However, she said that he was bothering her almost all the time that he does not want their child to be alone and she needs a sibling. He used to say every time "I do not want to die leaving my child alone". I asked her if he knew about his status by that time. She replied "Of course, he knew he had HIV, and we were getting assistance from an NGO because of him. Because of this we were always quarreling day and night. One day he threatened me very much I could not shout or do something. Thus he raped me. By that moment I conceived my second child. Beginning from the next day he was again very ill and admitted to Tuberculosis Hospital and was bedridden there for three months."

She continued, "since then he did not get well. Therefore, he insisted to be discharged from the hospital and come back home. By then I was also sick of diarrhea, did not get peace with him

because he was disturbing me saying he wanted to kill me. So I went out of the house to my sisters' home. He was again admitted to the hospital and died there a year and a half ago. Soon after, I came back here.

her house was not as such a standard house because it was built just to get shelter from cold and other dangers things. It is like a plastic shelter made by street person. The only difference is it is made by the material, which is used to roofing. The house is not more than three-square meter. I asked her where they were living before. She replied that they were renting a house from private owners.

Then she said she knew about her status while she was getting treatment in the clinic. "The Doctors asked me to get tested of HIV because I was not healthy when I was eight month's pregnant. Then I was willing and diagnosed with HIV and was shocked with the result, but what can I do about it? I am sure I get the disease from my second husband, not from the first, because my first husband is well and healthy at this time".

I asked her about her parents, whether they know about her status, and if they are helping her. She said her sister treated her for two days when she delivered her second child. But her parents who are in Dessie send her a message to come to their place so that they can bury her because when they saw her in the television as one of the HIV positive women, they felt as if she was dead. She told me that she does not need to go there because her father is very old. She felt that it is bad to be a burden to parents while it was supposed that she should help them.

Finally, I asked what are her main problems and coping mechanisms. She responded, "Currently my problem is primarily shelter. This is not dependable because the kebeles are giving me warning to leave because it is illegal. Secondly, it is a shortage of income. If I had enough income, I could rent a house. Because of lack of income I am breast feeding my child taking the risk of transmitting the virus to her. I have no other choice because I cannot afford to buy her baby foods. The doctors gave her a medicine for one year. But now after testing her blood quarterly for one year, before two days they told me that she is free of the virus, and they finish the treatment for my child and me. I am very happy about this and could not believe it.

However, I am still breast feeding her. The assistance I am getting from an NGO is not enough for us. That is why I am living in the street. I need my children to live a normal life and to be raised like any other children "

Case two

She was born in Gojam from farmers. Until she became 14 she lived with them and learned upto 5th grade. She said "after my mother died, my father influenced me to stop my school because he does not believe in learning. He was saying your brother has learned but nothing especial had happened to him." At last she migrated to Addis Ababa with her friend to live a better life in the city. After arrival in Addis, both employed as a housemaid. She said, "I changed a work place to Oromya region a place called 'Jeda' and work for two years. After that I got married and have one child, now he is 16. My husband died shortly because of poisonous food".

She again married to another person, a soldier. She has two children from her second husband, By now they are 13 and 11 years old. She lived for a short period of time with her husband because he was a soldier and died in 1991 E.C. Soon after he died her life became miserable with her two children. The first one was not living with her because grandparents was taking care of him. She had tried many things to make her improve her family life such as petty trading, namely, contraband trade, baking Enjera (Ethiopian bread) for sale. Despite her great effort, she was not satisfied with all these and was forced to join prostitution life since 1993 E.C.

"Presently I am HIV positive because of the risky work I had in the past. I thought to live a better life when I started the prostitution but what happened to me is the reverse. I have faced very many problems difficult to estimate. To mention some of them; health, economic problems, family dispersion, lack of shelter, and so on. I sent the 13 years old son to the non relative in the rural area, Presently he doesn't go to school and he is serving them. What bothers me for the future about my last son is that what will happen to him after my death. Now I am receiving 150 Birr per month. Out of this I pay 90 Birr for house rent. Since I am sick I could not work at anything, life is very difficult for me. I don't have any property, I sold my furniture like my bed when I fell ill. I could not get the pension of my second husband because I am not able to follow

the necessary processes, and have no money for transportation. I am just sitting and waiting for the grant from an NGO".

Case three

She said she was born in Gojam and her father died when she was a little girl. At the same time her mother died when she was 3rd grade. Her mother requested one of her sisters to take care of her shortly before her death. But her aunt found it difficult to raise her and brought her to Addis Ababa to one of her sisters. Her sister found a job for her and was employed as a housemaid. She said, "since it became difficult to work as a house servant, she started to work in Tej Bet" (a house where a local drink is sold). She learned in the extension division up to grade eight and working during the day. She could not continue because of financial problem and lack of settlement in one place. She said her sister needed her to be a sex worker rather than working as a housemaid. She said she had six sisters, but all of them have died. All of them were sex workers. "I am left only with one of my sister's daughter.

Thus, I left the 'Tej bet' because it was risky and got married. I was pregnant when we were married. Since he was a daily laborer, whose income is not enough to live, I was also working like washing clothes, making 'Enjera', collecting wastes from the street, and so on". She said while working she got ill, she had herpes which is called 'almaz balchera' in the local language, on her face and her eyes were affected. She was getting treatment in Ras Desta Hospital and they consulted her to get test of her blood. She was willing and her result became positive.

I asked her what she felt when she heard her result. She said, "I was shocked because I did not expect this to happen. I thought my relation with my husband was sincere and was highly innocent to him. My son was tested and is free of the virus. But my husband refused to be tested at that time. Let alone to be tested he wanted to kill me as if I brought the virus to the family".

I asked her in what way she thinks the virus could be transmitted to her. She replied that it might be while she was working in garbage collection. There are many types of wastes such as used condoms in the area. One day while cleaning, her hand was cut by something sharp and she thinks that may be the reason for her infection.

She said that because of the disagreement between herself and her husband about the test of his blood, she stopped to sleep with him. They used to sleep for one year and four months separately. He works as a daily laborer and is addicted to alcohol. She said that he always disturbs her asking why she was not sleeping with him. He used to say, "Am I a priest?" She finds it difficult to cope with the economic problem because he was not supporting her. Thus, she talks to some elders about her situation. Finally they reached to an agreement to be tested. His result turned out to be positive in September 1997 E.C. However, according to her he does not stop to disturb and drink alcohol when he gets some money.

She told me that currently she is five months pregnant. I asked her how she decided to have a child knowing she has the virus. She replied that after sleeping separately for one year and four months one day something happened. "He forced me to have sex. I refused. But he threatened me with something sharp, which he uses to cut a bag saying, choose either your life or having sex. By then I could not do anything. Then I started to use a birth control medicine, which was in the house for two months. But after three months I realized that the medicine did not work and went to the clinic. I told them my situation. However, they said that other than having the child the time is over to make abortion." She was worried for the first child, now another child is coming.

I asked her what would she do about the new child. She replied that she needs her first child to be raised like any normal children as far as her capacity is allowed. Her child has got one individual to support him giving 30 Birr per month, and also an NGO called 'Hope for all' which pays him tuition fee for school. With regard to the second child she also needs to keep it with her if she is capable; however, if not she will find an institution to take care of the new child.

About her coping mechanism she said that at present her health is on and off. She is getting assistance from an NGO and trying to work, but she has been absent for three days because of her health problem. She is receiving wheat and oil from CHAD-ET but not money. She used to receive money before but after taking credit of 2000 Birr for starting petty trade and failed to be successful, they are not now giving her any money. She said she gets 80 Birr monthly by

collecting wastes in the street. Her main problem at this time, according to her is shelter. The one she is living in is a single room Kebele's house, very old which she herself repaired. But they are giving her warnings to leave the house.

I asked the difference of her income now and before being affected. She replied that "Before it was better, we were living renting private houses for four years, I had women's Iddir and weekly Eqqub, I used to wash clothes in two houses daily. I earned at least 300 Birr monthly. Now I cannot work because I am not well enough. My husband also is not working like before, he is idle most of the time. I have no relative if I feel ill, only neighbors help. A woman in front of my house brings me some sort of food while I am sick."

Case four

She is an orphan and is 14 years of age. Her mother died six years ago leaving a child of one month. The new child and her father are different persons. Her father died when she was child. He was a driver frequently working in the field. Her mother was a housewife. She does not remember about her father's death. She said, "I was in grade three when my mother died, bedridden for one month. I dropped out of school to give care for her. My elder brother was with my uncle. After my mother's death, I could not continue my school to raise my younger brother. Then I started again. Now I am in grade six".

I asked her how they are managing to live economically. She replied that they do not get her father's pension, which her mother was earning. She was not able to process going from one office to the other and there was no one to help them get it. She said, "All our relatives did not come to our home after my mother's funeral". She told me that even her brother has come back from their uncle's house because he quarreled with him. She has been living in a single room with her other two brothers, which is kebele's house. Regarding their income she said CCF provide them 100 Birr, CHAD-ET 75 Birr, wheat and oil monthly.

One of the neighbors used to help her to raise her younger brother and to manage the house as well. But, at present their caregiver is another neighbor. According to her, the first caregiver stopped her help after she took her younger brother to clinic and made him test his blood without consulting her for he is always ill. In addition to this, she also told every body that he has the

virus. My six years old brother could not play with children because they insult him saying 'edsam' meaning you have AIDS. He then came back and asked me "Do I have AIDS?" This is a saddening event for me. her eyes were filled with tears as she remembered the event and the tears began to flow on her cheeks. Besides she explained the conditions of her brother with a broken heart. He is sick all the time. He is getting medical treatment from CHAD-ET. She used to be absent from school to take him to clinic and take care of him as well. She also said that some times she get very tired when she came back from school at 5:00 O'clock to perform domestic work let alone study.

I asked her what her brother is sick of and what her mother's disease was if she knows. She replied that she did not know her mother's disease before but now she realized that it was AIDS after her younger brother was diagnosed with HIV. I asked her also what if she gets an institution which can take care of her brother. She replied, "no, I will not give him to anybody. I will miss him and also he does not want to be separated from me. He cannot sleep at night if I am not with him." Unfortunately her brother died after two months of the discussion made with her.

To get some information I communicated to one of the neighbors, W/ro Mimi who was helping this family. She said that her father died seven years ago. He was very ill, especially his skin was full of sores. According to her, a woman who was sharing the same room in this family was giving care to this man and she also feel ill and died after one year of his death.

Regarding the little baby's father she said that he was a client in their room to spend the night, not actually in bed but sleep on the floor paying 50 cents per day. This is the habit of most households in this area, which is one of source of their income. Then, she gets pregnant from this person. He looked well at that time and was visiting his child for sometime. However, for the last six months he did not shown up.

Though she said they changed a caregiver because she get her younger brother tested of the virus without consulting them, W/ro Mimi does not agree with this. She said "the other neighbor misinformed them that I am getting support from an NGO because of them and I am using them

to get money and other material. But now, they are being spoiled. Many boys are passing the night in this family which is dangerous for the girl. her brother is chewing chat on Wednesdays and Saturdays, he also smokes shisha." According to her, the other neighbor wants to merge their house with her own room when the little boy dies. Even now they are using their room to keep their buffet. She also added that she is afraid that Tigest might get infected because she was not taking care of herself while giving care to her mother and to the child as well.

Case five

He was born in Harar. At the age of 15 and 6th grade education he came to Addis Ababa. He came to Addis without the knowledge of his family because he was afraid they would stop him. He said he thought Addis Ababa as a special place and convenient for a living. He came to live with his brother. Unfortunately, he did not take his address and face so many problems before he met him. He used to live on the street, selling journals and the like. He met his brother after four years and stayed with him for sometime.

In 1970s he was involved in a political party known as Ethiopian People Revolutionary Party (EPRP) and imprisoned for four years. He said he was tortured very much to the extent that he could not walk to the toilet by himself for eight months. After his release from prison he started to work as assistant for driver for a short time. Then he found a job in Addis Ababa Bus terminal and continued his education in extension class upto 12th grade. He also went to get training of soldier for the National service and came back because of health problem (he had hemorrhoids).

He got married in 1979 E.C. and he had four children with his wife. However, two of them have died. The first is died before 14 years when he was four months, and the second before two years at the age of 11. His daughter who is 19 years of age is now attending her education in Harar College. While the last one, seven years of age is with him. His wife passed away two years ago after being ill bedridden for three years. She has been tested her blood and diagnosed with HIV. He also has been tested before four years and diagnosed with HIV.

I asked him how the virus came into their family. He replied, "I have no idea how it enter in our family, I did not have any affair other than my wife. After five years of our marriage my wife was ill, at that time HIV was not well known in the country. She was tested and diagnosed negative. I do not know what has happened after that time. I am also diagnosed with diabetic since the last ten years. But I have managed to control it by avoiding alcohol and the like."

His brothers and other families do not know about his health status. He said he does not want them to know about it because it is useless. It is better if they do not know. The main problem was that loneliness. Thus, he brought his mother because she is dependent on him. And also he brought two female relatives so that they can help him in domestic work, which makes their family size five. One of them is in school.

With regard to economic situation, he said their living standard was much better before they have been infected with HIV. His wife was working with her sister in her own shop. When she became ill they finished their savings. He also sold some of their household furniture like their Refrigerator. But He has bought it again at present. He said his income does not have any change, he gets about 400-500 Birr monthly.

Case six

Unlike the above cases, she was born in Addis Ababa. She has finished her primary and junior secondary school. However, she did not finish her high school because of the education system. She said that she was admitted to Home economics class where she could not pass the first year. There was a policy, which says that Home economics students could not repeat class and then she was forced to drop out. Her family could not afford to pay her in private school.

She said that after three years she got married and became a housewife. Her husband was a civil servant. They had four children, but one of them died three days after delivery. And the last one, two years old, is in a Norwegian institution. Her two daughters 14 and 11 years of age are with her. She said her husband was ill diagnosed with TB. His health was on and off most of the time. Finally his blood was tested and diagnosed with HIV. When it became difficult economically, she brought him to her parent's house and he died in 1996 E.C. She was pregnant

when he died. Accordingly, while she attends anti natal service she was asked to get her blood tested and was diagnosed with HIV.

Then she continued to live with her parents again because she could not afford to rent a private house of her own like before. She said, "We were living renting private house for nine years. When he became very ill, I brought him to my parent's house, what can I do? We did not left with any money to pay for house rent or other necessary things such as food. Now I am a burden to my parents with my two children. My father is pensioned. Since his pension is not enough for us, he is now working as a guardian. This is because of us, instead of this he should have get rest. her father does not know about her health status. She said she does not want him to know because she is afraid of stigma. She said, "He always says that someone is becoming thin, the other is ill of this and that disease, it must be AIDS. Do not make any relationship with them." But my mother knows about me because she is understandable. She tells him not to talk like that."

She said that her main problems at present are: she does not feel at home because it is not her own house. She said, "Firstly, I could not cook any thing I like to eat, it is my mother who cook what she likes. Sometimes the food is not good for my stomach, I ask her not to cook such type of food. But I do not know why, she does the same thing every time. I have no choice. Before I used to order to my servant, but now I could not even cook myself and eat what I like to. Secondly, we are bothering about shelter. Though my parents privately own the house, we are afraid that we will be displaced and removed. We do not have money to buy a house, which is under construction by the city government. I worry about this."

She finally said she needs to work and get some money. The government or NGOs should facilitate a condition where we, who are capable to work could get jobs and be independent of our parents and other organizations.

Case seven

She came to Addis at the age of 25 from Gondar. She said she was living in a very remote area from the city with her parents and get married at the early age. When her first son was three

months, she left him with her mother and went to Gondar city which is said to be better. She said she decided to go because she saw one of her friends, who came from the small city, wear a good type of cloth and looked beautiful. Then while she was working as a house servant in Gondar, a woman who came from Addis asked her to work for her daughter who was pregnant. Then she came and started to work in Addis Ababa. After three months she stopped working because, according to her, the lady was suspecting her of having an affair with her husband because he was ordering her now and then. Then late at night they cast her out of the house and she became a street woman for sometime around Teklehaimanot.

While she was on the street, she met a man and they started to live together renting a house. He was a soldier and getting pension. She said he did not help her financially, but she herself was working. She used to bake Enjera. She said, “the owner give me Chat to chew so that I could not fell asleep. I bake for almost 24 hours. Therefore, when I started to feel sick, I stopped working and started to work as a daily laborer.”

She said that slowly her husband's health deteriorated and finally he was diagnosed with TB. He was bedridden for two months and died without finishing his medicine. After his death she realized that he was taking credit monthly from individual by interest and was not receiving his salary properly, because the creditor was waiting at a place where he received his salary, and taking all his money. He not only used his salary only for himself, usually for drinking alcohol, but she also realized that he had another wife. When he was in clinic lastly, he betrayed her telling everybody that he does not know her and she only brought him to clinic to take his money. She said, “He died at 12:00 p.m. His friends contributed 220 Birr for his funeral. And I sold some valuable household furniture for his Teskar” (which is cultural and religious events to invite people and feed who attended the funeral after 40 days of funeral).

After her husband's death, she decided to be tested because she said that since he had TB, he might also had AIDS. When the NGO asked them in the kebele to get tested of HIV if they need to get assistance she decided to be tested and was diagnosed with HIV. They had three children. One of them died when he was one month. The others 10 and 7 years old are grown up. But the last one does not start school because she is sick of her eyes all the time. She said that she is

afraid to take her daughter to hospital and get tested because she suspects that the virus might have transmitted to her. And she said hopefully, the other one must be free of the virus because she is healthy.

Concerning her parents and relatives, she said that her father heard about her situation and came to see her before one month. He said that he thinks about her as if she is dead. Saying, "I came here to mourn for you, because you are like a dead one."

She said her economic condition is much better than before. When her husband was alive, she said that let alone to give her money, he did not give her peace. He was always drinking alcohol and disturbing. Even her daughter said that we are doing better than the time when our father was with us. She gets some money, wheat and oil from CHAD-ET, and she also sale enjera. However, she said that people are afraid to buy enjera from her. They think the virus will transmit to them through it. Most of the time only those who are like me buy. She said that she rented her bed for one year. (which is common in this area. The majority not only rent the bed but the open space on the floor is rented on 50 cents or one Birr per night).

I asked her how risky it is to rent the bed in a single room for her and the children's future life. She answered that it is risky, that is why she stopped renting. Most of their neighbor's girls begin an affair with clients. She continued to tell about one of her neighbor, Tigst (who is an informant of the main survey). Tigst has six children and now she is pregnant again. Her children are from four different husbands, and four of them have died. Now she is pregnant from one of her clients who rent her bed or floor in the house.

Case eight

She is living around the Kedanemeheret Tsebel area. Tsebel is a Holy water traditionally believed to heal a person even if the disease is not supposed to be healed by scientific medicine. I have found some informants of the survey other than this case who said they live around Tsebel. According to them they live there mainly for two purposes. The first one is that the house rent in that area is cheaper than the Addis Ketema. They could not afford to pay 100 Birr and above monthly, even for very small and poor quality house. There around the Tsebel, being two or

above they share a single room. The second reason is the belief that they could be healed if they take shower by the Tsebel daily and most of them said they get a relief when they are around that very specific area.

She said she was born in Oromia Region in a place called Ginchi where her parents lived leading the life of farmers. When she was five years old an extended female relative brought her to Addis Ababa in order to educate her. She was learned upto grade 10 and drop out. She said she faced so many problems, which she did not want to disclose. Her relative was having a bar, but she was living in the living house doing domestic chores. After she drop out of school she went to Dire Dawa and start to work as a house servant for one year. Then she got a job in Cafe/Bar as cashier and worked for one year. She left the job and again started another one, which is petty trade from Addis to Dire Dawa, and failed to be successful and finally stop.

Then she met a man who was her friend's brother and a displaced person from Eritrea. They started to live together and she got pregnant. He did not like her pregnancy and left her alone. Thus, she went back to Dire Dawa and lived with a non-relative family who allowed her to live in their house for one year after she delivered a boy. The owner told her that she wanted to sale her house and came to Addis, asking her to go first. She came and waited her in her aunts house for a while. After this woman came they were living together for some years. However, as the woman had many health problems, she died.

She then again began to work in bar to support herself and her child as well. She said, "I found it very difficult to live in such a way and forced to find someone who can support me. Thus, I met a man who is the father of my seven years old daughter. He had a wife in Italy and was processing to go there. His work was driving truck of his own in the field. When I told him I was pregnant, he did not like it and leave me. He only came after 20 days of the birth of the child to see the child. He was giving me some money, but he discontinued the assistance when he stops his work. Because his parents also did not want him to have a child with other woman, they arranged him to go to Italy to his wife. However, I heard that they were divorced."

Her hardship did not stop, rather it continued. Her aunt advised her to go to Dubai in order to make her life better promising that she would take care of her daughter. Her first son was already living with his aunt who has no child. It was at this time her life changed completely. She had to get tested of HIV to go to Dubai and was diagnosed with HIV. She said, "I have been ill of haemorrhoid before five years. I am sure it was then the virus transmitted to me either by the injection needle or some other material they used. Traditional healer treated me. My daughter's father has sent me a lot of money from Italy during that times and was also treated in good hospital."

She continued, "now I have no close relatives who can support my daughter and me. Her father has stopped to send money after I told him my current health situation. We are supported only by CHAD-ET. They give us 150 Birr, 45kg wheat, and 3 litters oil monthly. She also has the virus. She saw me tearing while she gives her blood to be tested. I was telling her it was to another purpose. But she asked, "Do I have the virus?"

Case nine

This case like case eight is also living around the holy water. He said he wanted the holy water but more than that he had the interest to rent a house there because of the cheaper price. He is sharing one room with other person paying 60 Birr monthly.

He was born in Southern Ethiopia from farmer family and learned there upto grade 8th. Then his sisters who came first to Addis brought him so that he could continue his school. After completion of grade 12, he started to work with his brothers-in-law who had a business of their own. They had shop and also bus used for public transport, and the like. After working for some time, he stopped working with them and began his own business, which is contraband from Moyale to Shashemene. He said it was very risky, you cannot be always successful. Sometimes, you may lose all your property.

"Four years ago my parents wanted me to get married, I had a girl friend. Her father is one of the well offs. He has passenger Bus. We did not have sex relationship with her. According to our culture (Guragie), it has been a custom to be tested of HIV/AIDS before marriage. Then we were

tested and my result turned to be positive while hers was negative. I did not expect this result, it was a shocking incident. But later I began to adjust myself to accept the situation. Before I was addicted to different things such as chewing chat and drinking alcohol, but after I learned that I have the virus, I stopped all these."

He said that for some time after the knowledge of his status, he continued to work again with his relatives. But he said, "They began to avoid me from time to time." Then he stopped working totally. He said, "now I am not working anything, even if I am healthy and capable of working. We need the government, instead of supporting us with money, to facilitate something that we can work with our own initiative. We were given promise that to get credit and place to work. But the place is given to an investor not to us. The government is not helping us.

With regard to his income, he said that there is much difference before his knowledge of having the virus and now. "I was working and supporting myself and my father, as well as my little brothers in rural area. I used to send them learning materials, cloths, and money. I was supporting my father as he depended on me. But now let alone supporting them I need a support for myself. I am wearing clothes I bought years before, for how long can you be dependent of this type of organizations? Other than the virus I am also worried about my livelihood.

Case ten

The father of this case was a soldier and died in the war when he was seven months. His mother was a petty trader and died when he was 17 years of age. He said he was born in Addis Ababa and grown up but he could not proceed his learning beyond 3rd grade. This is because his mother was not settled in one place. She always went out to bring butter to be sold, thus he could not get someone who can support and follow him to go to school.

He said, "Because of the problems I faced, with my own interest I recruited in the army forces during the Derg regime. After four years service, the new government was established and we were displaced to the Sudan. I stayed eight months in the Sudan and came back through Red Cross to Addis Ababa in 1984 E.C. Then I began to work as a daily laborer in Merkato. I was

earning about 300-400 Birr per month. However, after the 'Shaebya' means (the Eritreans) were displaced to their country our income also dropped."

He was married in 1984 E.C. and has a daughter. He said, "I wanted to improve the life of myself and my family. Therefore, I went to 'Dima' to work as a daily laborer in gold mining. I was earning about 1000 Birr monthly. And I was sending money each month to my family. In 1991 I became ill and diagnosed with HIV. Since then I did not feel well, my health was on and off. Then the organization sent me to Jimma for blood test. I have been told that the virus was found in my blood. Then I did not return to my work place, instead I came back to Addis Ababa."

When he came to his home and tell his situation to his wife, she refused to accept him and he went out of the house. She was tested and her result turned to be negative. I asked him how he thinks the virus was transmitted to him. He said, " When I was working in Dima gold mining project I met a woman two years ago and have been friends, she was a business woman buying and selling gold. She was looking very well at that time and, I passed only one night with her. I did not have an affair with other woman before that other than my wife. It is her who transmitted the virus to me. Two months later she died.

Regarding his current condition, he said that he needs to work but he is not in a position to do work properly because of health problem. He said, "I have no brothers, sisters, or any even far relative because my mother was concentrating on her daily work which was the base of our subsistence. My main problem is shelter. I am living in one room shared for four. I do not sleep on bed, but on open space on the floor/soil paying 40 Birr per month. When I get sick, they do not allow me to sleep, I go to 'Mechael'/church for a shelter, and when I get better they like me and allow me to sleep. The only income I have is the support I am getting form CHAD-ET, 75 Birr. of which 40 Birr goes to house rent. I eat out, I do not get enough food because of the shortage of income."

He needs the government to do something for them especially concerning a serious problem of shelter. And also since he is not capable to work as a laborer, he needs the government to give

him some credit and open a shop. He said, "even though we are patients, we should be supported by the government, the main thing which bothers us is a place/shelter to sleep when we became ill. I always worry about a place where I can take rest.

Case eleven

This case has passed many hardships in her life beginning from her birth. Her mother was a house servant in Addis Ababa. While she was working in bachelor as a housemaid, she got pregnant from her employer. When she told him she was pregnant, he did not like her pregnancy. Thus he cast her out of the house.

She said, "Then, my mother was baking Enjera for many households and I was grown up in a kitchen with her. My mother used to give birth to twins, she had twins five times, but all of them have died. I am the only one who was borne alone. I have only one sister whose twin was died."

She told me that while she was in school, eighth grade, her mother became ill. Therefore, she had to find something since their livelihood was depended on her. In 1983 E.C. she drop out of school and started to wash clothes to generate income. When the job became beyond her capacity, one of her friend found her a job as a cashier in a Bar. She became a Bar lady. She said, "When I was a bar lady, I was getting a minimum of 30 Birr a day. I treated my mother without problem at that time. She was first diagnosed with TB and later with hepatitis. After two and half years, she died."

Eight years ago she was sick. She recalled it and said, "From the Bar men asked me to go to their place. I agreed if they give me 100 Birr, and they said money was not a problem and gave me the 100 Birr before I go, their car was very special. As soon as we arrived, I was left with one of them. He removed his fingers just like a ring, pick a cup with blood and forced me to drink it, I could not stop him. Then after I do not remember how he cast me out of his house. Finally, I was found insane on the street." I asked her how this thing could happen, because it is difficult to believe. She replied many women like her who was working in different Bars had faced similar problems. For example one lady had been cut her ear and different parts of her body when she came back who went in the same situation. She continued "Since then I did not go back to work

as a bar lady. I stayed more than one year in 'Tsebel'. When I get a little better I go to my house because I was bothering my only sister."

Since she was idle at home after returning from Tsebel, she needed somebody to support her and was met with a person who was working as a carpenter. After they lived as partners for about two months, he became ill and was diagnosed with TB. She said he was healthy and looked very well when they met at first. They lived together for two years, she said the second year was hard to her for she became a caregiver. When he died she was five months pregnant. After he died she got her blood tested and was diagnosed with HIV. I asked her why she wanted to be tested. She replied that there was a rumor from neighbors, they were saying that he died of AIDS but she is still very fat. her daughter is now five. She said that since her daughter sometimes is ill, she gets her blood tested and was diagnosed with HIV. But she is not sick, but instead she is healthy. She said, "For me, I deserve it, but I am very sorry for my innocent child for it is not her sin, now I am not worried about myself but about her." I asked her that what if she gets an institution for her daughter to take care? She replied, "No I will not give her to anybody."

Regarding her current situation she is washing cloths as a means of livelihood in her house to support herself and her daughter, gets 75 Birr from CHAD-ET as a support. She pays 90 Birr for house rent, her sister also works as a daily laborer. She is also attending extension class in 9th grade. She said her main problem currently is shelter. She said that the kebeles do not give them even if there is extra house and emphasized that the government is not doing any thing to them. She said that before two/three months there was announcement for a job in one factory. Since she was fulfilling the criteria, she applied and was called by the employer. However, he gave her 50 Birr and asks her to bring a blood test result from a given clinic. She said, "I am capable of working and healthy, but they could not allow us to work. I was very angry, I wanted to use a forged one and give him but I do not have money to do so."

Annex 2: Questionnaire

Addis Ababa University Regional and Local Development Studies

I. Questionnaire for households affected by HIV/AIDS

Date _____

Kebele and House Number _____

Interviewers name _____

Part I. 1. Personal and family situation

No.	Name of members in the household	Sex	Age	Relationship with head of the household	Level of education	Marital status	Type Occupation	Housing condition	No. of rooms in the house
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									

Sex:- (1) Male (2) Female

Relationship:- (1) Head (2) Husband/wife (3) Child (4) Brother (5) Sister (6) Grand Child (7) Doughtier in law /son in law (8) Other relative (9) Dependent (10) Other non relative

Level of Education:- (1) Do not have basic education (2) Read and write (3) Primary level (4) Junior secondary level (5) High school (6) 12 complete (7) Withdrawn because of shortage of finance (8) withdrawn to give care for the sick member of the family (9) other

Marital status:- (1) Married (2) unmarried (3) Separated (4) Divorced (5) Widowed

Occupation:- (1) Civil servant (2) Trader (3) Daily laborer (4) House work (5) Student (6) Sex worker (7) Stop working because of illness (8) Stop working to give care for the sick member of the family (9) Unemployed (10) Dependent (11) Other

Housing condition:- (1) Private (2) Rented from kebele (3) Rented from private (4) The same house rented shared with other person (5) Dependent (6) Other

Number of rooms of the house:- (1) one (2) two (3) three (4) four (5) more than four

2. When did you become ill of AIDS/knew you are positive of HIV/AIDS?
Below six months = 1; >6 months but < one year = 2; >one year but <two years =3; 2-3 year = 4; >3 years but <4 years =5; 4-5 years =6; >5 years but <6 years =7; 6-7 years =8; 7-8 years =9; more than 9 years = 10;
3. Is there any one who care for you in the house?
Yes = 1; No = 2; No need = 3
4. If the response for the above question is yes, who?
Husband =1; wife = 2; daughter = 3; son =4; sister =5; brother =6; female relative =7; male relative =8; volunteer from the community =9; there is no one =10; parents and siblings =11; mother & children =12
5. If the response for question 3 is no, why?
Because my parents are not near = 1; I have no relative =2; Because of stigma =3; Myself =4; I am not sick/not need care giver = 5; they did not know my status =6
6. Was there a deceased person in the family?
Yes = 1, No = 2; Other =3
7. If the response to the above question is yes, when was the person deceased?
Before 6 months = 1; Before one year = 2; Before one and half year = 3; Before two years = 4; Before two and half years = 5; Before 3 years = 6; Before more than 3 and half years = 7;
8. Who was deceased?
Husband=1, Wife=2, Child = 3 Sister = 4, Brother = 5; 1 and 3 =6; mother and father =7; Boy friend = 8; Girl friend = 9
9. In question number 8, (other than husband and wife) deceased member of the family?
one child = 1; two children =2; three children =3; two sisters = 4
10. What did you lose because of his/her death?
Loss of income = 1, loss of social acceptance and stigma =2, social services like education and health = 3, All = 4, affected emotionally =5; 1 and 2 =6; nothing =7; household dissolved =8; 1,2, & 8 =9; 1&8 =10
11. For how long had the deceased person been sick?
<One month = 1, 1-3months = 2, >3months and <1year = 3; 1-2 years = 4, >2 years = 5; Do not know =6; Other = 7

Part II. Household income and expenditure

12. How much did you spend for health services for the deceased person?
Free in government hospital = 1; 101-300 =2; 301-500 =3; 501-700 =4; 701-900 =5; 901-1100 =6;
1200-2000= 7; 2001-4000 =8; 4001-6000 =9; more than 6000 = 10; do not know =11; it was from NGO
=12
13. How much did you spend for funeral?
Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; 701-900 =5; 901-1100 =6; 1200-2000= 7;
2001-4000 =8; 4001-6000 =9; more than 6000 = 10; It is parents =11; Other =12
14. Are you member of the Iddir?
Yes =1; No =2; yes, before being affected by HIV =3
15. If the response for question no. 14 is yes, how many Iddir do you have?
One =1; two =2; three =3; four =4; more than four =5;
16. Did you receive assistance from Iddir for funeral?
Yes = 1; No = 2
17. If the response for the above question is yes, how much did you receive?
Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; 701-900 =5; 901-1100 =6; 1200-2000= 7;
More than 2000 =8
18. How much do you pay to Iddir monthly?
<5 Birr = 1; 5-8 = 2; 9-10 = 3; >10 = 4; contribute by labor =5
19. Have you received any other assistance from your Iddir?
Yes = 1; No = 2
20. If the response for the above question is yes, what kind of assistance have you received?
Money to purchase food items = 1; money for health services = 2; Learning materials and uniforms for
children = 3; For payment of house rent = 4; Clothing = 5;
21. How much was your monthly expenditure for food before affected by HIV/AIDS?
Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; more than 701 =5; it is the amount I receive
from NGO =6; I am living with my parents =7
22. How much is your monthly expenditure for food at present?
Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; more than 701 =5; it is the amount I receive
from NGO =6; I am living with my parents =7
23. How much is your monthly expenditure for health services?
Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; more than 701 =5; From NGO =6; From
government =7; never been sick =8; I go to Tsebel =9; not known =10; from parents =11
24. What is the source of this expenditure?
Self = 1, Idir = 2, Relatives = 3, NGO = 4, Government=5, 1 and 4 =6; 3&4 =7
25. Before being affected by HIV/AIDS what did you do/source of your income in the household?

Civil servant =1; business person = 2; employed in private organization =3; truck driver =4; assistance for truck driver =5; soldier =6; house maid =7; sex worker =8; Tela/Enjera/Araki trader =9; income from renting bed =10; 5 and 10 = 11; daily laborer =12; student =13; 8&10 =14; housewife =15; Other =16

26 What was the monthly income of the household before being affected by HIV/AIDS?

Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; 701-1000 =5; 1001-1500 =6; 1501-2000 =7; more than 2000 =8; not known =9; Did not have job =10

27 What is the monthly income of the household at present?

Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; 701-1000 =5; 1001-1500 =6; 1501-2000 =7; more than 2000 =8; not known =9; nothing =10

Part III. Availability of facilities and services

28 What is your source of access to water?

Tap water in the dwelling = 1, Public/communal tap = 2, Tap water in immediate vicinity = 3, Other =4

29 Do you have toilet?

Yes =1; No =2

30 If the response for question 28 is yes, what type of toilet do you use?

Flush toilet private =1, Flush toilet, communal =2, Pit latrine private =3, Pit latrine communal =4

31 If your response to question 28 is no, how do you use toilet?

Public toilet in different places =1; in hotels around =2; open area =3; use festal/plastic and through it some where =4

32 Where do you get health services?

From government hospitals/clinics = 1, From private = 2, From traditional healers = 3; 1&2 =4

33 Are you satisfied with the health services you are getting?

Yes = 1, No = 2

34 If the answer for question 32 is no, why?

It is unaffordable = 1, It is Poor quality =2, Doctors do not treat properly = 3, all = 4; the queue is boring =5

35 Do you have electric power in the dwelling?

Yes = 1, No = 2; Other =3

36 What do you use for cooking?

Electricity = 1, wood = 2, Charcoal = 3, Kerosene = 4, 2 and 4 =5; 3 and 4 =6; do not cook =7

37 What are the major factors aggravating your problems in the household?

Shortage of income =1; Stigma =2; Housing problem =3; Inadequate care and support from the community=4; Inadequate care and support provided by NGOs=5; Inadequate support from the government=6; All =7; 1,3,&5 =8; 1,2 &3 =9; I have no problem =10; 1,3 &6 =11; 1,5,&6=12

Part IV. Coping mechanisms

- 38 What are your coping mechanisms with the above problems?
Do nothing=1; Selling household assets=2; Withdrawing savings=3; Altering household composition (Sibling dispersion)=4; Searching for assistance from NGOs=5; 2,3,4 & 5 =6; 2 & 3 =7; 2,3, & 5 =8; working =9; renting bed =10; 5&10 =11; I refrain to disclose my status =12; 2&5 = 13; Other = 14
- 39 Do you get any assistance from the government?
Yes =1; No =2; Sometimes = 3
- 40 If your answer for question 38 is yes, what kind of assistance do you get?
Home based care=1; Medical assistance=2; Financial assistance =3; Assistance in kind (such as food and clothing)=4; All kinds =5
- 41 Do you get any assistance from NGOs?
Yes =1; No =2
- 42 If your response for question 40 is yes, what kind of assistance?
Home based care=1; Medical assistance=2; Financial assistance =3; Assistance in kind (such as food and clothing)=4; All in the above =5; 2 & 3 =6; 1&2 =7; 1,2.&4 =8; 2,3&4 =9; 3&4 =10
- 43 Do you think poverty exposed you to HIV/AIDS?
Yes = 1, No = 2; Do not know =3
- 44 If your answer for the above question is yes, how?
Lack of awareness about HIV/AIDS = 1, Lack of access to medical care =2, Working in high risk area =3; get married not tested of HIV =4; an affair with many to get financial support =5
- 45 What kind of social networks do you have that can be used as coping mechanism?
Idir = 1, Eqqub = 2, Microfinance =3; Maheber = 4, No social networks =5; 1,3&4 =6; 1,2,3,&4 = 7; 1&3 =8; 1&4 = 9
- 46 If your answer for the above question is no social networks, why?
Lack of financial resources = 1, Because I am not able to work = 2; Fear of stigma = 3, Due to the existence of stigma =4; not settled =5; 2,3,&4 = 6; 1,2,&4 =7

II. Questions posed for orphans

1. Age
5-9 = 1; 10-14 = 2; 15-18 =3
2. Sex
Male = 1, Female = 2
3. Level of education
No formal education =1, 1-8=2, 9-12=3, 12+=4; Other/specify _____
4. Are you in school currently?
Yes = 1, No = 2; Other/specify _____
5. If your answer for the above question is no, why?

Drop out because could not pay school fees = 1, Could not afford to buy uniforms and learning materials = 2, To care for the sick family member =3,
 To care for younger siblings = 4, Fear of stigma in school = 5,
 Other/specify = 6 _____

6. Your housing condition?

Privately owned=1, Rented from Kebele=2, Rented from private individual =3, Shared house with others =4; Other/specify =5 _____

7. Who is responsible to care for you now?

Father=1, mother=2, Self=3, grandmother=4, Grandfather=5, aunt=6, uncle =7, elder brother=8, elder sister=9, Neighbors=10, Parent's friends=11,
 other/specify=12 _____

8. What is source of income/what do your caregiver do for a living?

Civil servant =2; sale Tela/Enjera/Araki/rent bed etc. =2; house maid =3; driver =4; assistant for driver =5; daily laborer =6; sex worker =7; waitress in Bar/hotel, etc. =8; Pensioned = 9; No job = 10; Other =11

-- How much is your monthly income?

Below 100 Birr =1; 100-300 =2; 301-500 =3; 501-700 =4; 701-900 =5; 901-1000 =6; Greater than 1000 Birr =7; Do not know = 8

9. Who was deceased in the household?

Mother=1, Father=2, Both=3, Brother =4, Sister =5, 2 & 5 = 6; 2&4 = 7; 1&4 =8; 3&5 = 9

10. If your response for the above question is mother, when did she die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5, Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9; before more than 10 years =10

--- What was her health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3; Gastric =4; other =5 do not know =6; hemeroid = 7; Herpes = 8

11. If your response for question No. 10 is father, when did he die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5, Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9; before more than 10 years =10

--- What was his health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3; Gastric =4; other =5; do not know =6

12. If your response for question 10 is brother, how old was he?

below 5 =1; 5-10 = 2; 11-14 =3; 15-19 =4; 20-24 =5; older than 24 =6

-- when did he die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5,

Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9; before more than 10 years =10

-- what was his health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3; Gastric =4; other =5; do not know =6

13. If your response for question 10 is sister, how old was she?

below 5 =1; 5-10 = 2; 11-14 =3; 15-19 =4; 20-24 =5; older than 24 =6

-- when did she die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5, Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9; before more than 10 years =10

-- what was her health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3; Gastric =4; other =5; do not know =6

14. What is the gender composition, age structure, and size of members in the household?

Age structure	Sex		Total
	Male	Female	
Below 5			
5-10			
11-15			
15-18			
Above 18 years			
Total			

15. What are the major problems you are facing at present?

Financial = 1, Lack of family love =2, Housing = 3, stigma and discrimination = 4, 1 &3 = 5; no problem =6; 2&4 =7; 1&2 =8; 1,2&3= 9

16. What was your parent's income before being affected by HIV/AIDS?

Less than Birr 100= 1, Birr 101-200 = 2, Birr 201-600 = 3, Birr 601-1000 = 4; Birr >1000 = 5, Daily laborer =6; not known = 7

17. Do you get sufficient food?

Yes = 1, No. =2;

-- As compared with before death of parent/s, does the supply of food decrease, increase or has not changed?

Decreased =1; Increased =2; Not changed = 3

-- If it is decreased, how?

By quantity = 1, By quality = 2, 1&2 = 3

Do you get sufficient clothing?

Yes = 1, No. =2;

-- As compared with before death of parent/s, does the supply of clothing decrease, increase or has

not changed?

Decreased =1; Increased =2; Not changed = 3

If it is decreased, how?

By quantity = 1, By quality = 2, 1&2 = 3

Do you get sufficient health care?

Yes = 1, No. =2;

-- As compared with before death of parent/s, does the health care decrease, increase or has not changed?

Decreased =1; Increased =2; Not changed = 3

20. Are you engaged in income generating activities?

Yes =1, No = 2

21. If your answer for the above question is yes, why?

There is no income after parents death = 1, Income is not enough to cope with = 2, Caregiver needed me to work = 3, Responsibility for siblings = 4, 1, 2, and 4 = 5

22. Do you get assistance from government?

Yes =1, No = 2

23. If your response to question no. 25 is yes, what kind of assistance do you get?

Financial =1; Home base care =2; Medical assistance =3; Assistance in kind (such as food and clothing) =4; Other, specify =5

24. If you get financial assistance from government, how much is it?

50 Birr =1; 75 Birr =2; 100 Birr =3; 150 Birr =4; 200 Birr =5; more than 200=6

25. Do you get assistance from NGO?

Yes =1, No = 2

26. If your response to question no. 29 is yes, what kind of assistance do you get?

Financial =1; Home base care =2; Medical assistance =3; Assistance in kind (such as food and clothing) =4; Other, specify =5; 1 & 4 =6

27. If you get financial assistance from NGO, how much do you get?

50 Birr =1; 75 Birr =2; 100 Birr =3; 150 Birr =4; 200 Birr =5; more than 200=6

28. Do you get assistance from neighbors?

Yes =1, No = 2

29. If your response for question 28 is yes, what kind of assistance do you get?

Financial =1; Home base care =2; Medical assistance =3; Assistance in kind (such as food and clothing) =4; Other, specify =5

30. Is your family member of Iddir?

Yes =1, No = 2

31. If your response for the above question is yes, do you get assistance from Iddir?
Yes = 1; No = 2
32. If your response to the above question is yes, what kind of assistance?
Financial assistance = 1; Assistance in kind such as food and clothing = 2; Payment for housing = 3;
For medical =4; Other/specify = 5
33. If your response for the above question is financial assistance, how much do you get?
Less than 100 Birr = 1; 101-200 = 2; 201-300 = 3; 301-400 = 4; 401-500= 5
>500 =6 ; Other/specify
34. AIDS orphans are said more likely to be abused and engaged in deviant acts and behaviors, is it true?
Yes = 1, No. =2
35. If your answer for the above question is yes, what is the reason?
Due to lack of income as a coping mechanism/means of survival = 1
Due to lack of parents care = 2
Due to social exclusion and discrimination = 3
Due to lack of social welfare system in the country = 4
All = 5; 1 & 2 = 6

III. Questions posed to key informant selected from NGO working with AIDS patients and orphans,

Background of the key informant

Sex _____

Position _____

Profession _____

Service in the organization _____

1. When did your organization begin to work with AIDS patients and orphans? _____
2. What are the major objectives and strategies of your organization to address the problems of AIDS patients and orphans?
3. How did your organization identify these AIDS patients and orphans?
4. What were the major problems faced during the identification of these patients and orphans?
5. Do you think new emergencies like that of AIDS patients and orphans affected the objectives and activities of NGOs like yours? (Yes =1, No = 2)
6. If your response to above question is yes, describe how it hinder your activities?
7. If your response to question No. 5 is no, what do you think some of the possible reasons?
8. What is the size, age category, gender and status of the AIDS patients and orphans getting support from your organization?

Age category	Patients		Orphans		Total
	Male	Female	Male	Female	
Less than 5					
5-8					
9-14					
15-20					
21-25					
26-30					
31-35					
36-40					
41-45					
46-50					
51 and above					
Total					

9. What are the size, age category and gender of caregivers getting support for seriously ill AIDS patients and orphans?

Age category	Sex		Total
	Male	Female	
Below 15			
16 – 30			
31 – 50			
51 and above			
Total			

10. How do you assess the overall adequacy of care and support provided to AIDS affected households and orphans?
11. Who is the most vulnerable to various kinds of problems?
Male = 1, Female = 2
12. Based on your response for question No. 11, what are some of the possible reasons for the vulnerability?
13. After parent/s death, what are the major problems of the households? Please indicate by ranking from the most (give 1) to the least problems.

Sharp drop in income	
Children are forced to move out of their original home	
Children are forced to drop out of school	
Health status, nutritional status and the like of the household is decreased	
Women are forced to be head of the household	
Girls are more affected because of the burden of domestic work	
Elders are forced to shoulder the burden of care and support for the orphaned children	
Extended families are affected by taking in orphans	
Other/specify	

14. What are the major needs/problems of AIDS affected households?

15. What are the major problems faced by caregivers?
16. How does the rise in number of AIDS patients and orphans increased dependency and burden on the extended family and the community at large?
17. How are the extended families and local community coping with the problem and how traditional support mechanism is affected?
18. In poor countries like Ethiopia, how can be possible to provide adequate care and support to AIDS patients, orphans and caregivers?
 - What should be the role of the government?
 - What should be the role of the community organizations like Iddirs?
 - What should be the role of NGOs?
 - What should be the role of religious institutions?

IV. Questionnaire forwarded for community based caregivers

1. Age _
1. Sex
Male = 1, Female = 2
2. Level of education
(No formal education =1, 1-8=2, 9-12=3, 12+=4)
3. Type of occupation, if any _____
4. Did you get training to serve as a caregiver for AIDS patient?
Yes = 1, No = 2
5. If your response for the above question is yes, what type of training did you take?
Counseling = 1, Nursing care = 2, Sanitation = 3, Nutrition = 4, All = 5, Other/specify = 6
6. What are the major problems home based caregivers facing?
An increased demand for services = 1, Stigma = 2, Inadequate funding and supplies = 3,
Lack of training = 4, transport problems =5, Other/specify = 6
7. What is the age structure and gender distribution of patients receiving home based care?

Age group	Number of patients	
	Male	Female
15-20		
21-30		
31-40		
41-50		
>51		

8. Do you have home based care kits?
Yes = 1, No = 2

9. If your response for the above question is no, why?

Lack of funds = 1, Lack of awareness =2, Other/specify = 3

V. Checklist for focus group discussion of both male and female groups

1. How do you describe poverty?
2. Does poverty expose some one to HIV? If yes How?
3. Does HIV aggravate poverty? How?
4. When a breadwinner or other family member gets infected, what are the major problems the household face?
5. Do you think households who have different social networks /such as Iddir and Iqqub/ have better coping mechanisms than the one that have not social networks? If they have/have not, How?
6. Do HIV/AIDS affected households get social services such as health and housing?
7. When a specific household is affected with HIV/AIDS, what influenced does it have on extended families and neighbors?
8. Who is the most vulnerable to poverty because of HIV, women or men? Who can cope with the problem? If women are more vulnerable, why?
9. Do women get access to social services such as education, employment, housing and the like equally with men?
10. What are the major problems of AIDS orphans and children whose parents are patients of AIDS?
11. Do children drop out of school because of death of parents? Which are most likely to drop out, girls or boys?
12. Do AIDS orphan engage in income generating activities? If yes why do you think?

Is there any other comment?

VI. Questions posed to the Addis Ketema sub-city HIV/AIDS Prevention and Control Desk

1. What is the role of the office in the prevention and control of the epidemic?
2. When did the office begin its work?
3. Does the office give any support to HIV/AIDS affected households, individuals, and orphans?
4. If the answer for the above question is yes, what kind of support do you give?
5. Are there HIV/AIDS affected individuals who applied to receive support from you or other organizations?
6. If the answer for the above question is yes, how many applied?
7. If the answer for question 5 is no, why?
8. What should be the role of the government in prevention and control of HIV/AIDS?
9. What should be the role of the religious institutions in prevention and control of HIV/AIDS?
10. What should be the role of NGOs in prevention and control of HIV/AIDS?

11. What should be the role of the community based institutions such as Iddirs and Eqqubs in prevention and control of HIV/AIDS?
12. What are the major problems of the office, which hinders its activities?

Additional comment if any?

VII. Questions posed to Kebele 13/15 and 14/21 HIV/AIDS Desk officials

1. What is the size of the population in the kebele?
2. What are the major means of livelihood of the people in this area?
3. How many sex workers are there in the kebele?
4. What is the role of the kebele in the prevention and control of HIV/AIDS?
5. When did it start working on HIV/AIDS?
6. Does the kebele give assistance to HIV/AIDS affected households, individuals and orphans?
7. If the answer for the above question is yes, what kind of support do you give?
8. Are there HIV/AIDS affected individuals who disclose themselves and request assistance in the kebele?
9. If the answer for the above question is yes, how many applied?
13. What should be the role of the government in prevention and control of HIV/AIDS?
14. What should be the role of the religious institutions in prevention and control of HIV/AIDS?
15. What should be the role of the community based organizations such as Iddirs and Eqqubs in prevention and control of HIV/AIDS?
16. What should be the role of NGOs in prevention and control of HIV/AIDS?
17. What are the major problems of the Kebele, which hinders its activities?

Additional Comment if any?

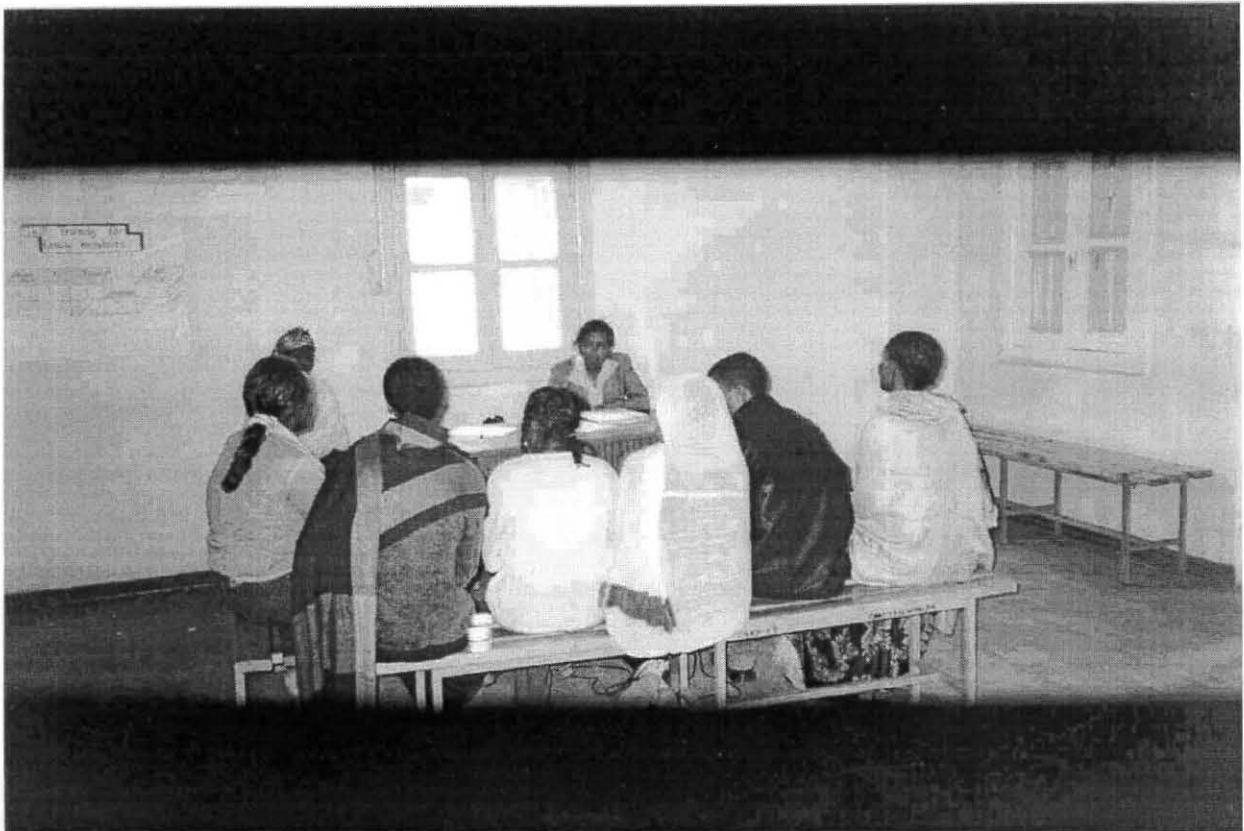
Annex 3: Socioeconomic and demographic characteristics of the cases

	Sex		Education (in grade)			Occupation
	Female	Male	1-5	6-8	9-12	
Age						
16-20	1			✓		Student (orphan)
21-25	1			✓		Stopped working because of the disease
26-30	1	1	✓		✓	The female is working as waste collector, and the male is unemployed
31-35	4	1	✓		4✓	Among the females two are unemployed, one is ill, and the other sales 'Enjera'. The male is unemployed.
36-40	1	1	✓		✓	The female has stopped working because of illness, while the male is working in bus terminal
Total	8	3				

Source: Own survey and case study



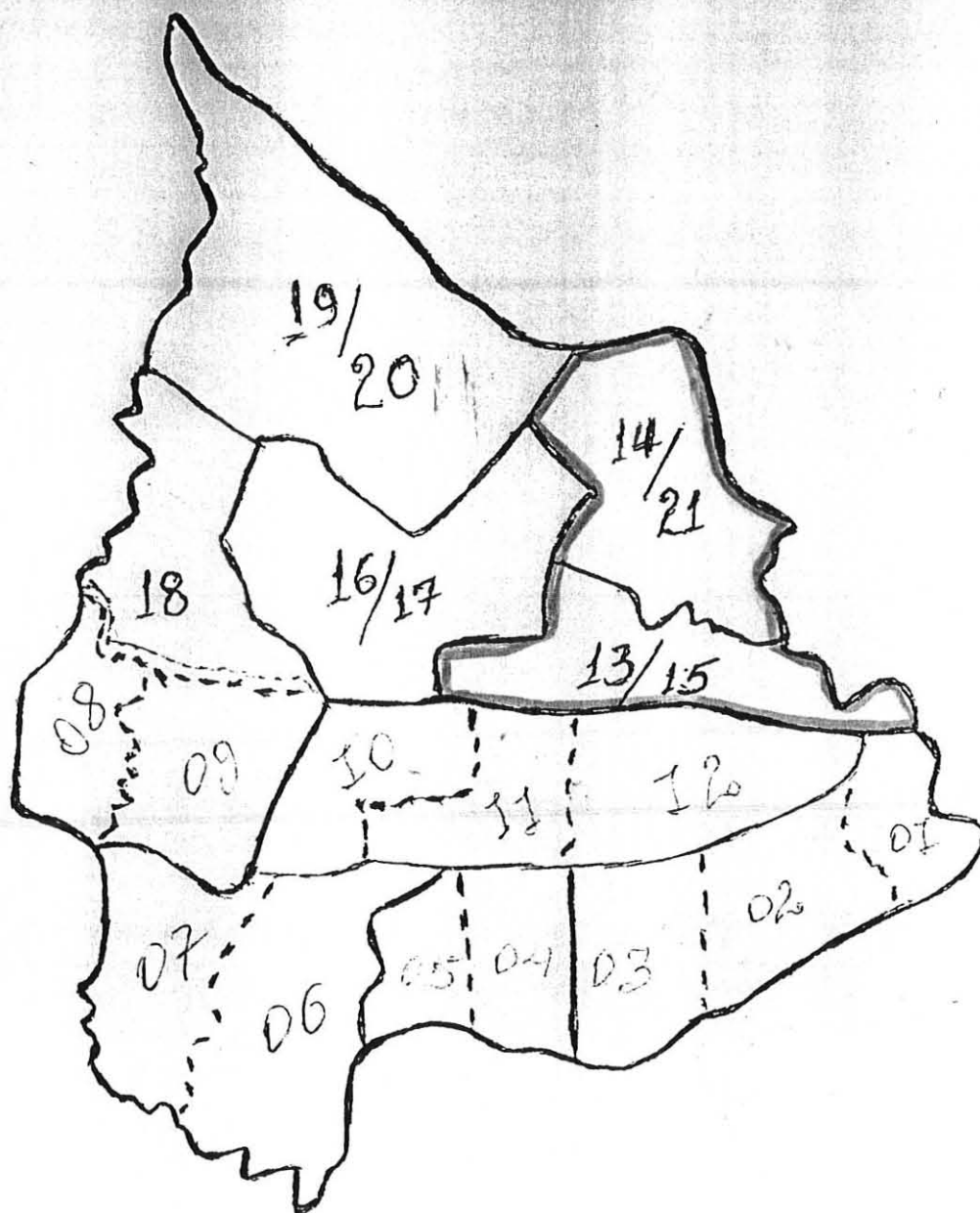
Focus Group Discussion conducted on March 23/2005



Focus Group discussion conducted on March 24/2005

Annex 5

Map of the Addis Ketema sub-city



— The study area

Declaration

This thesis is my original work and has not been presented for a degree in any other university, and that all sources of material used for the thesis have been duly acknowledged.



Aster Tadege

I confirm that this thesis has been submitted with my approval as a supervisor of the same.

Alula Pankhurst (PH.D)



Signature

12-07-05

Date