

**Impact of HIV and AIDS Related Stigma and Discrimination
on Income at Household Level: The Case of Babile District,
ETHIOPIA**

Masters of Professional Thesis

By

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
BIRDP	Babile Integrated Rural Development program
CHGA	Commission on HIV/AIDS and Governance in Africa
CHH	Child Headed Household
FGD	Focus Group Discussions
FHH	Female Headed Household
GO	Government Organizations
GHH	Grandparent Headed Household
HAPCO	HIV/AIDS Prevention and Control office
IBCC	Improved Behavioral Change Communication
HIV	Human Immunodeficiency Virus
ICRW	International Center for Research on Women
IGA	Income Generating Activities
Km	Kilometer
MHH	Male Headed Household
MfM	Menschen für Menschen
NGO	Non-Government Organization
No.	Number
PLWHA	People Living with HIV and AIDS
USAID	United Nations Program on HIV/AIDS
UNESCO	United Nations Education, Scientific and Cultural Organization
VCT	Voluntary counseling and Testing

DEFINITION OF LOCAL TERMS

Birr: Refers to Ethiopian Currency Unit equivalent to 100 cents denominations

Birr: Ethiopian currency 1Euro = 21Birr

Kebele: The smallest administrative unit under district

Idir: Community based organization established by interested group of people for the purpose of helping each other.

Khat: Popular stimulant chewed across Horn Africa

Injera: Ethiopian staple bread

ABSTRACT

HIV and AIDS is one of the key challenges for overall development. Currently Ethiopia has a generalized HIV epidemic mostly affecting the productive age group of the community. A hidden and unspoken issue of stigma and discrimination is contributing a lot to the rapid spread of Human Immunodeficiency Virus (HIV) infection in Ethiopia. Addressing consequences of stigma and discrimination, therefore, plays a major role in curbing the spread of HIV and reducing vulnerability of households to the impact of AIDS.

This study investigates the impacts of stigma and discrimination on income of petty trader households affected by HIV and Acquired Immune Deficiency Syndrome (AIDS) in Babile District regarding the challenges faced by those households when one of household member became infected. A household survey was conducted using semi- structured interview questionnaire with 30 petty traders People Living with HIV and AIDS (PLWHA) in Babile District. Survey finding was complemented by 2 Focus Group Discussions (FGD) conducted with 4 female and 4 male petty traders PLWHA. In the study emphasis was given in assessing the nature of challenges faced by households when the petty trader's HIV positive status is identified. Thus, manifestation of stigma and discrimination, change in income and expenditure pattern of households after known HIV positive status, coping strategies and access to facilities was examined.

The findings indicate that loss of income due to stigma and discrimination was the major challenge faced by households affected by HIV and AIDS. Women are the most who suffered from stigma and discrimination and its consequences. Both internal and enacted stigma and discrimination play a role for the decline or loss of income of the households included in the study. Some of the respondents lost their jobs due to their HIV positive status. Majority of the respondents especially females change their means of income after they had known their HIV positive status. All respondents have access to health facilities. Majority of respondents have no access to social network and micro credit scheme. This implies HIV and AIDS affected households need access not only to health facilities but also a means to maintain their income.

Different types of coping strategies were implemented by households affected by HIV and AIDS. Accordingly, seeking help from Government Organizations (GO), Non-Government Organization (NGO) and/or individuals are the most commonly used coping strategies. The other types of coping strategies were; selling household assets , consuming previous savings, sending siblings to relatives and involving children in income generating activities. In addition some female respondents indicated that commercial sex is also used as their coping strategy.

The major problem of HIV and AIDS affected households was lack or shortage of income to fulfill their basic needs as a result of stigma and discrimination. Considering this, equitable financial assistance with training on profitable Income Generating Activities (IGA) for all HIV and AIDS affected households and improved education and behavioral change communication for PLWHA and other community member in Babile District are recommended.

CHAPTER 1: INTRODUCTION

This chapter consists of four sections. The first one is background of the study, the second and third explain respectively problem statement and research objective and the last presents the research questions.

1.1 General background

Ethiopia has a generalized HIV epidemic, with some concentration among population groups that are engaged in high-risk behavior in specific regions. The current National HIV prevalence rate is estimated at 2.1% and ranges from 7.7% in urban areas and 0.9% in rural areas. Women and men at their productive age of 15-49 years take the highest rate of HIV prevalence 2.6% and 1.7% of the national prevalence rate respectively. In addition the prevalence is significantly higher among women (2.6%) than among men (1.7%) (Poate et al 2008). In 2005, there were a total of 137,500 new AIDS cases, 128,900 new HIV infections (353 per day) and 134,500 AIDS deaths (368 per day, including 20,900 children [<15 years]). Official reports show that currently there are a total of 1,320,000 people living with HIV/AIDS (Merso 2008).

Poverty, gender inequality, misunderstanding about the mode of transmission and prevention of HIV, underestimating the extent of problem, harmful traditional practices (Female genital mutilation, abduction etc...), rape, and taboo attached to talking about sexuality within the family and the community is considered to be the drivers of the epidemic. Furthermore a concealed and less understood issue of stigma and discrimination is contributing a lot to the rapid spread of HIV infection in Ethiopia. Ethiopian community, which is very much traditional in its socio cultural make up, has belief systems, power relations and psychological pre-dispositions that are conducive to the practice of stigma (Banteyirga et al 2004).

HIV and AIDS related stigma and discrimination has been identified as a complex, diverse and deeply rooted phenomenon that is dynamic in different cultural settings. As a collective social process rather than a mere reflection of an individual's subjective behavior, it operates by producing and reproducing social structures of power, hierarchy, class and exclusion and by transforming difference (class, race, ethnicity, health status, sexual orientation and gender) into inequality (Brown et al 2001).

Fear of stigmatization and discrimination discourages people from seeking information on HIV and AIDS, coming forward for counseling and testing, disclosing their status or accessing AIDS services. Living with or being associated with HIV and AIDS significantly discredits the individual in the eyes of others. The Actions, that harms or denies services or entitlements to stigmatized individuals consequently increases the risk of becoming HIV infected and less control over the impact of AIDS on their lives (Banteyirga et al 2004).

HIV epidemic coupled with stigma and discrimination worsen the already existing poverty situation among Babile District community, so the aim of this study is to assess the impact HIV and AIDS related stigma and discrimination on the income of petty trading HIV and AIDS affected households in Babile District, Ethiopia. Therefore, the findings will help to give recommendation on the appropriate response to mitigate the impact of stigma and discrimination in Babile District.

1.2 Problem statement

Stigma and discrimination is a daily reality for PLWHA and their family, operating at multiple levels and evoked individuals, communities, and nation level reactions ranging from sympathy and caring to silence, denial, fear, anger, and violence. HIV positive status can be socially and economically devastating. Worldwide, HIV positive people or people associated with HIV and AIDS are subjected to stigma and discrimination. They may lose their employment and livelihoods, property, social status, children and friends. In addition it result to get substandard care or even refused care for AIDS patients at health facilities (Carr & Nyblande 2007).

A survey done in Zambia shows that the prevalence of HIV and AIDS related stigma and discrimination is 56% (Carr & Nyblande 2007). Reports from developing and developed countries confirm that people are denied of employment and access to resources for example a survey done in South Africa on PLWHA found that 27% of men and 18% of women reported that, their HIV sero status cause loss of job or housing. Health professionals also have a perception that caring for PLWHA is worthless because of the incurable nature of the disease. Denied care and treatment by health professionals decreases the productivity of PLWHA, ultimately leading to premature death. Children with HIV and AIDS and associated with HIV through infected family member have been stigmatized and discriminated in education setting, varying from prohibiting from communal action to exclusion from school, this type practices at school compromise the future livelihood options of children's (Parker et al 2001) .

In order to undertake effective intervention on HIV and AIDS related stigma and discrimination, information on the extent of its impact on HIV and AIDS affected household income is important. However, although the impact seems same with other African Countries mentioned in above paragraph, there is no documented information with regards to the impact of Stigma and discrimination on household income of Ethiopia in general, Babile district in particular. Thus, this study aims to examine the impact of Stigma and discrimination on the income level of petty trading HIV and AIDS affected households' in Babile district, Ethiopia.

1.3 Objective of the research

To explore the impact of HIV and AIDS related stigma and discrimination on income of petty trading households affected by HIV and AIDS.

1.4 Research questions

Main question: What is the impact of stigma and discrimination on the income of petty trading households affected by HIV and AIDS?

Sub questions

How stigma and discrimination manifest on petty trading households?

1.5 Research methodology

In this chapter the researcher discussed methodology used to investigate the impact of HIV and AIDS related stigma and discrimination. Emphasis was given on the selection of the data collection methods, study population and the tool used for data collection and method of data analysis.

1.5.1 Description of the study area

Babile District is one of the districts in East Hararghe Zone Oromiya Region, Ethiopia. It is a trade center for many districts and a temporary staying place for heavy truck drivers and for those who go out of Ethiopia through Somali and who came in to Ethiopia. The district covers 202,217.37 hector and has 22 small kebeles (2 town and 20 rural).The total population of the district is 93,674 out of this male accounts 47,153 and female 64,521.The majority of the population depend on Agriculture and trade. In the district there are a total of 265 people living with HIV and AIDS, 169 female and 96 male which is considered very high from bordering districts (Menschen für Menschen Babile Integrated Rural Development Project (MfM BIRDP¹) 2009). Illiteracy, unemployment, migration, stigma and discrimination, harmful societal practices like female genital mutilation and early marriage are contributing factors for the high HIV prevalence in the district. All these factors arouse intellectual interest to study the social factors related to HIV and AIDS and its effect on income of HIV and AIDS affected households.

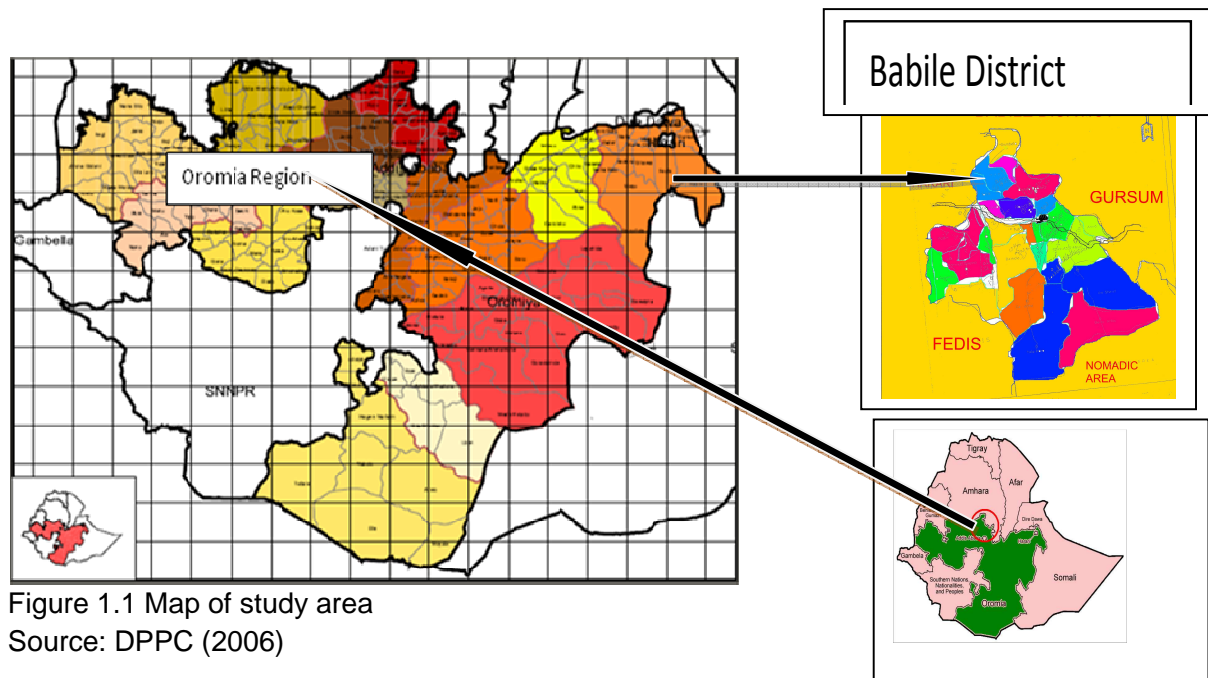


Figure 1.1 Map of study area

Source: DPPC (2006)

According to Babile district health office, there are two NGOs, one PLWHA association and government organizations² including the district health office that are working in HIV and AIDS prevention care and support program.

¹ MfM BIRDP is NGO working on HIV/AIDS prevention and care program in Babile District.

² Governmental organizations are hospital, health center and health posts in Babile district that are under district health bureau.

1.5.2 Scope of the study

The scope of the study is on the assessment of the impact of HIV and AIDS related stigma and discrimination on the income of households affected by HIV and AIDS. The study restricts its focus on HIV and AIDS affected households in Babile district only. The study limits its scope due to the limited time the researcher had for field work and production of the study result.

1.5.3 Research framework

Based on the objective of the study the researcher conducted a descriptive study to investigate the impact of stigma and discrimination on the income of HIV and AIDS affected households. The study mainly uses both quantitative and qualitative methods. The qualitative method helps the researcher to find an in-depth explanation on the relationship of HIV and AIDS stigma and discrimination on income level and on means of income of households affected by HIV and AIDS. Qualitative method also gives better understanding about the research issue since the nature of the study infers mainly on social issues. The quantitative method used is simple statistics such as frequencies, and percentage to understand demographic and socioeconomic characteristics of the study subjects. The researcher uses different literatures from different sources as secondary data. Survey method through interview, focus group discussion and observation were employed as a source of primary data. After the data was collected, the output of interview and focus group discussion was organized and analyzed.

1.5.4 Data collection

Pertinent literatures (secondary sources) such as books, journals and different publications were reviewed at the primary stage of the study from July 1 to 11. This helped the researcher to come across on the general overview of HIV and AIDS, stigma and discrimination related to HIV and AIDS and its impact on different community groups and countries.

Primary data were collected in the course of field work in Ethiopia for four weeks. In-depth interview and focus group discussion were the techniques implemented to collect primary data. The mentioned methods helped the researcher to have a clear understanding on the impact of stigma and discrimination on income of HIV and AIDS affected households in Babile district. In depth interview method facilitates free discussion between the researcher and the interviewee about sensitive issues like HIV and AIDS and income and it helped the researcher to gain extensive relevant information about the research issue. Moreover, since focus group discussion facilitates interaction among groups, the method also allows flow of different opinions and gave a wide range of views about the research issue. All the above mentioned methods of primary and secondary data collection techniques helped the researcher for triangulation and reliability of the information obtained.

1.5.5 Interview

Interview was conducted with 30 PLWHA, those who depend on petty trading for their subsistence. Lottery method was employed to select 30 respondents from the list 60 petty trading PLWHA found in Babile District Tesfa Goh³ PLWHA association. Initially it was planned to take both male and female respondents with equal proportion, however, since culturally female tend to involve in petty trading than male, the number of female respondents became greater than male respondents. The interview was conducted at the respective home or place of work of the interviewee by the researcher with the help of guide. A semi-structured survey questionnaire intended to answer the research question was developed by the researcher to undertake the interview. The survey questionnaire has got three parts that help to find out information on stigma and discrimination and its impact on income in different groups of the community (Annex1). The first part of the questionnaire consisted of demographic information of the respondent, the second part talked about HIV status and disclosure and the third part of the questionnaire was about income and expenditure and means of income before and after the respondents' knew their HIV status. Since HIV and AIDS and income is very sensitive issue, to ease the medium for interview and to find reliable information from the respondent the researcher explain the aim of the research and found oral consent from each respondent before starting the interview.

1.5.6 Focus Group Discussion

To enrich and validate the information obtained from interview and literature the researcher carried out two focus group discussions. Purposive selection of participants was done. The FGD comprised of 8 informants (4 male and 4 female). In the area culturally female feel shy to speak in front of male so to facilitate free discussion, participants were grouped in to male and female separately. The same guide line) was used for both FGDs (Annex 2). The guide line was developed to gather qualitative data and consists of information on the impact of stigma and discrimination on the income of HIV and AIDS affected households.

The semi structured questionnaires for the interview and the guideline the focus group discussion were first prepared in English then translated into Amharic to conduct the interview and retranslated to English for analysis.

1.5.7 Observation

The researcher made direct observation throughout the survey. The direct observation helped to understand the means of income, housing condition and the way the households live and interact with the community.

1.5.8 Data processing and analysis

All returned questionnaires were checked for completeness and consistency of responses manually. The information were entered in to excel Microsoft office program .Basic socio demographic characteristics, information on respondents to be tested for HIV and their concern about disclosure, experience of stigma and discrimination, income and expenditure of

³ Tesfa Goh is the name of PLWHA association working on HIV prevention and care in Babile District.

households, access to social network and information on the challenge faced by PLWHA were tabulated and presented with tables.

The data were analyzed based on the objective of the study and rising themes from the collected information. Basic quantitative methods were used to review and organize the information from survey questionnaire. Qualitative findings from the survey were also analyzed to supplement the quantitative data of the survey. The findings of FGD were qualitative and used to validate the survey finding in this study. Finally to make the findings more explanatory, the direct quotes of the respondents were incorporated.

5.8.9 Limitations

Due to the limited time the researcher has for field work, the study was conducted only in one district with limited number of sample, thus it is difficult to generalize the findings of the research. Secondly, since both income and HIV and AIDS are sensitive issues to discuss freely with in the community. Therefore, it was very difficult to find enough and reliable information from the respondent moreover it took longer time than the researcher had planned for the survey. Concerning the study population it was very difficult to find PLWHA who are not the member of Tesfa Goh association, due to this the number of PLWHA who are not included in the study was limited. During survey interview, there was also difficulty of getting accurate data about issues like income and expenditure of the households. In some cases the expenditure exceeds their income. This made the analysis and interpretation of the data difficult.

1.5.10 Organization of the thesis

The thesis consists of four chapters. The first chapter dealt with introduction including research problem, objective of the study, research questions and the research methodology researcher implemented to undertake the study. The second chapter deals with literature review about the general overview of HIV and AIDS, stigma and discrimination and its impact. Results and discussion of findings of the study are dealt in chapter three and finally, on chapter four conclusion and recommendations of the researcher are presented.

CHAPTER 2: HIV AND AIDS: STIGMA AND DISCRIMINATION

This section of the thesis presents on the relevant desk study done based on the title of the research. It consists of themes on the general overview about HIV epidemic, stigma and discrimination attached to HIV and AIDS at different level, consequences of stigma and discrimination, stigma and discrimination and human right violation, community coping strategies against stigma and discrimination and available anti stigma and discrimination strategies will be discussed.

2.1 An overview of HIV and AIDS

HIV is a virus that affects the body defense mechanism. It is transmitted from one person to another through exchange of body fluids mainly during sexual intercourse and during child birth. AIDS is a lethal disease caused by HIV infection and it arises when a person immune system is destabilized. The incurable nature, life threatening situation, being associated with behavior (promiscuity, prostitution), the myths and beliefs attached to HIV and AIDS and its mode of transmission build unique character in the society (Gillespie & Kadiyala 2005 cited in Drimie et al 2006).

HIV and AIDS is one of the greatest challenges of humankind. In the past two decades 65 million people are infected by HIV worldwide. Out of this, 22 million people have died from AIDS related illnesses and 17 million of them have been from Africa. Africa remains the hardest hit continent: with less than eleven percent of the total global population, the continent has more than 70 percent of all HIV and AIDS related cases in the world (Table 2:1). As well as a harrowing catalogue of lives lost, the implications of this human tragedy reach into the structure of economies, the capacity of institutions, the integrity of communities and the viability of families. In the extreme, the survival of some states may even be called into question. By now, communities across large parts of the continent are facing a day-to-day reality of declining standards of living, reduced capacities for personal and social achievement, and an increasingly uncertain future. This in turn profoundly constrains what can be achieved today. Meanwhile, HIV and AIDS is also diminishing the capacity of African states to maintain what has been secured over past decades in terms of social and economic development (Skinner 2004, p.158-61). At household level HIV and AIDS changes household composition and family size HIV and AIDS affected households. Adult death secondary to HIV and AIDS increases the number of orphans and dependency ratio. Child and grandparents headed households are also the newly emerged households in the era of HIV and AIDS following adult death (Nizi & Zirimenya 1999).

Table 2:1 HIV/AIDS: Global and African Situations

Glob	Global	Africa
People Living with HIV/AIDS(in millions)	32.2	22.5
New infection	2.5 (6,800/day)	1.7 (4,700/day)
Death due to HIV/AIDS	2.1 (5,700/day)	1.6 (4,400/day)

UNAIDS(2007)

HIV and AIDS is also a systemic condition because of its impacts (Skinner 2004, p.158-61). Since the beginning of HIV epidemic, three stages have been recognized: HIV epidemic, AIDS epidemic and epidemic of stigma, discrimination and denial (UNESCO 2002 cited in Bekele & Ali 2008). Stigma and discrimination also fuels HIV epidemic and build a great challenge to prevent further infection, minimize impact and provide appropriate support, care and treatment to the PLWHA.

2.2 HIV and AIDS related Stigma and discrimination

From the start of HIV epidemic, stigma and discrimination has accompanied and fuelled the transmission of HIV. Besides, stigma and discrimination greatly increase the negative impact associated with the epidemic. HIV related stigma and discrimination continue to be manifested in every country and region of the world. It is a major barrier in preventing further infection, alleviating impact and providing adequate care, support, treatment and has silenced open discussion about HIV and AIDS (Aggleton 2005). As Goffman (1963 cited in Nybland et al 2003) effect of stigma is the reduction of the life chances of the stigmatized through discriminatory actions.

Stigma is a quality that demarcates affected individuals or community from unaffected social order. It can be explained as a value that “significantly discredits” an individual or group in the eyes of others. Discrimination is the eventual consequence of stigma, so stigma and discrimination are issues that cannot be seen separately however discrimination is the end result of the process of stigmatization. Stigma and discrimination is a socially constructed and reinforced by social inequality. (Liu et al 2006, p. 134) This can be made worsen when individual or a group of people are a group of already undermined value in the community such as injecting drug users, men who have sex with men, and sex workers, poor and migrants (Aggleton 2005). It also affect both those infected or suspected of being infected by HIV and those who are AIDS affected by association, such as orphans or the children and families of people living with HIV. People living with HIV and AIDS, Sex workers, injecting drug users, and other marginalized groups are seen as responsible for HIV infection (Poku et al 2005, P. 234-248).

2.3 Types of stigma

Stigma can be evidenced in two ways with different effects. The first is enacted (external) stigma which leads to actual experience of discrimination (UNAIDS 2000). This include the experience of domination, oppression, the exercise of power or control, harassment, categorizing, accusation, punishment, blame, exclusion, ridicule, or resentment. This type of stigmatizing reactions is practiced on PLWHA and their families. The second one is felt (internal) stigma; it is an individual fear of anticipated social attitude towards being HIV positive. Stigmatized individuals experience depression, diminished self-esteem, withdrawal from the community and decreased performance in whatever the carrier they engaged (Siya’Kela 2002).

2.4 Causes of stigma and discrimination

HIV and AIDS is a condition closely attached to sex and death. Stigma and discrimination attached to HIV and AIDS persist so tenaciously because it is deeply entangled with social and personal views, beliefs, fears and taboos around sex and death (Odimegwu 2003). Lack of in depth knowledge on the mode of transmission, prevention and misconceptions about the disease are the main causes of stigma and discrimination. Religious believes which consider

HIV infection as a punishment for the sinners is also one factor that induces stigma and discrimination among the community (Aggleton 2005).

Attitudes like HIV as a disease of unfaithful wife, gays, prostitute, poor and women play a role for stigmatizing and discriminatory behavior of the community towards PLWHA. In addition combining some incorrect with some correct knowledge about transmission fuels these beliefs. For instance, people combine their knowledge of the sexual transmission of HIV with the incorrect belief that a condom used by someone with HIV can transmit the infection through even casual contact (Aggleton 2005).

PLWHA experience stigma and discrimination not only because they are perceived to be worthless and facing imminent death, but also due to incorrect knowledge and beliefs regarding casual transmission. Thus, because of limited knowledge fears surrounding HIV and social norms related to the nature of transmission of the disease create stigmatizing and discriminatory behaviors against PLWHA. Regardless of this people often do not recognize when their words, actions, or beliefs are stigmatizing or discriminatory towards PLWHA. Even when people are aware of their stigmatizing behavior, they may defend this simply as being self-protective (Nyblade 2003).

2.5 Manifestations of stigma and discrimination

Consequences of stigma and discrimination are quite similar across the world except variation in severity and prevalence. The manifestations of stigma and discrimination range from physical violence and death to depression. Stigma and discrimination against people living with HIV and AIDS; internalized stigma of people with HIV and AIDS; and stigma and discrimination against those related to or associated with PLWHA (secondary stigma) are the three broad forms of stigma and discrimination (Aggleton 2005).

Stigma and discrimination towards people infected with HIV can be demonstrated in different ways; differential treatment, gossip, loss of identity or role and loss of resources and livelihoods. The commonest types of differential treatment are; rejection from the family and community, deprived care and support from family member and so on (Family Health International-Ethiopia 2002). One of the most common and feared manifestations of stigma is gossip, voyeurism and taunting. As explained by a community leader in urban Zambia, "It is not sometimes the disease that kills these patients, it is the bad words and remarks from people" (Nyblade 2003).

People living with HIV and AIDS are viewed by the community as having no future or hope and are no longer considered as productive members of society, at the same time, people with HIV appear to acquire a new role and responsibility towards the community: to disclose their status publicly and "teach" others how they "got it" so that people can learn from their "mistakes." People with HIV and AIDS who do not fulfill this responsibility to "teach" are considered irresponsible and selfish (Nyblade 2003).

Loss of access to resources is one of the manifestations of stigma and discrimination, which increases individual susceptibility to HIV infection and vulnerability to the impact of AIDS. For example housing, people report being evicted by landlords who suspected them of having HIV, regardless of knowing their HIV status. Thus, fear of loss of access to resources, loss of livelihood options and negative community reaction hinders disclosure about HIV infection in addition to hampering free discussion and counseling (Nyblade 2003).

Loss of employment is the other devastating manifestation of stigma and discrimination attached to HIV and AIDS. Loss of job can occur when the employee develops overt signs and symptoms of the disease and/or due to repeated absenteeism or sick leave and/or when the employer learns HIV positive status of the employee and/or when the employee discloses his/her HIV positive status. The other manifestation is denying employment unless the employees have evidence showing HIV negative status (Nyblade 2003).

A study done in Nigeria revealed that 48% PLWHA lost their jobs and 16% threatened with dismissal. Job duties were changed for 26%. About 10% lost prospects for promotion and 40% were excluded from insurance schemes. Mandatory HIV tests and testing without specific and informed consent affected 5%. More women than men experienced these stigmatizing and discriminating acts (Chinwe 2005). Another study done in Ethiopia depicts that almost two-thirds (61%) of the respondents stated that they would not buy food from a food vendor with HIV or AIDS. This leads to loss of livelihood options of PLWHAs whose means of income is from selling food items (Nyblade 2003). From this we can conclude that stigma and discrimination is a biggest challenge to respond to the epidemic of HIV and AIDS. Furthermore stigma and discrimination is one of the causes that increase individual susceptibility to HIV infection and vulnerability to the impact of AIDS.

Blame and disgrace concerning HIV was notably widespread amongst people who attach religiously-based guilt to PLWHA. Zou et al (2009, P. 1-12) found that, religious beliefs and religious organizations can play a very important role to alleviate or aggravate shame-related stigma and discrimination. The present findings show that religion can also be a significant source of negative perceptions about HIV and PLWHA.

2.6 Gender, stigma and discrimination

The already existing gender inequality worsens HIV related stigma and discrimination on women than men. Family is the primary site for inequality that is manifested by violence, sexual abuse, stigma and discrimination against women and children especially AIDS orphans and HIV positive women. Always women are considered to be a source of HIV infection in the family. Impact of stigma and discrimination is severe in women than men; this makes them more vulnerable to the impact of AIDS. In consequence, women and girls are victims of discrimination in the economic, social and political life of the community which factors may directly or indirectly contribute to their exposure to HIV and AIDS (Commission on HIV/AIDS and Governance in Africa (CHGA) 2004).

2.7 Stigma and discrimination and human right violation

Stigma and discrimination are human rights issues that should be seen critically. People living with HIV and AIDS have equal rights as other people do. In contrast PLWHA are denied of the rights as human beings. PLWHA are denied of education, the right to be healthy, employment, health care services, and freedom of movement and so on. This is due to some discriminatory policies ratified at national and institutional level. Thus, this hampers physiological and psychological health of PLWHA. People living with HIV and AIDS should be supported within their society, capable to live, work and move freely and openly. In addition avoiding stigma and discrimination play a great role in prevention, care and treatment of HIV and AIDS (Aggleton 2005).

Even though different policies on human right are in place, they are not effective to address stigma and discrimination issues related to HIV and AIDS. There is no proper sanction against violence and gender inequality. Thus, legal frame work needs to be amended and ratified (Human Right watch 2003) Children and orphans right to education, inheritance, respectable life and right to health should be guaranteed. Policies against violence, stigma and discrimination attached to HIV and AIDS especially for the destitute; HIV positive women and AIDS orphans should be enacted. Addressing stigma and discrimination must be the central part in responding to the epidemic. The conventions ratified by African government to protect the rights of women must be synchronized with the national law and executed (CHGA 2004).

2.8 Community coping strategies against stigma and discrimination

Coping refers to the processes that people use to handle stigma and discrimination (Banteyerga 2006).study done in Zimbabwe showed that 60%of PLWHA cope with stigma through withdrawal from the community and this is most practiced by men.83.3% cope with joining HIV support group, 95% cope with looking for counseling. Joining support group and looking for counseling are mostly practiced by older women.83.7% cope with prayer and 98.3% believe that counseling, knowing HIV status and disclosure are the best way to cope with stigma and discrimination (Tarwireyi 2005).

2.9 Household response for the change in income level

HIV and AIDS affected households practice different type strategies to cope with decline in income level. According to World Bank as cited by Topouzis (1999) households cope using three major strategies; altering household composition, by sending one or more family member to stay with relatives. Second one is withdrawing from saving or selling household assets and the third one is getting help from other households or informal organization.

Haile & Gezahegne (2002) stated that involving children in income generating activities due to declining household income after the death or illness breadwinner is considered as one strategy to guarantee access to essential needs for affected households. Reducing household expenditure is also another widely used strategy to deal with loss of income. Withdrawing children from school, minimizing household expenditure on food, housing and break off from some social networks like Idir are the most affected areas by this mechanism.

2.10 Empirical literature

Nybland et al (2003) showed that, people with HIV and AIDS face stigma and discrimination in multiple arenas of their lives: in the home, in the community, in the school or workplace, and in the health care setting. However, in most cases the causes and ultimate consequences are unchanged .Fear of infection through casual contact, presumed behavior that lead to HIV infection, misconception about the mode of transmission, considering HIV infection is due to immoral action, sine and punishment from God or Allah are the commonest causes of stigma and discrimination. The striking effects of stigma and discrimination are loss of livelihood option and income, premature death, poverty, involvement in risky livelihood option that can finally forming a vicious circle leading to HIV infection (Dlamini et al 2007, P.339-399).

Individual level stigma and discrimination can be manifested by; rejection of PLWHA from communal activities such as eating together, sharing glass, bed, towel and other recreational

activities that allow direct contact (ICRW 2006). Labeling PLWHA with different terms; walking skeleton, ghost, victim of AIDS are other manifestation stigma and discrimination at individual level.

Individuals in various countries of Asia have reported that, they were forced to move from their homes by landlords and refusal of service at food and other business establishments (Human Rights Watch 2003). PLWHA also reported being referred to by derogatory terminology (Ickovics et al 2007). Magrath & Tesfu (2006) in a study done Addis Ababa found out that most of the problems faced by PLWHA are related to stigma and discrimination. PLWHA suffer with a multifaceted nature stigma and discrimination affecting accommodations like housing, water & sanitation, social interaction child care, loss of job & employment and access to health care.

According to Banteyerga (2006) a rural man in Ethiopia elaborates how people avoid physical contact with PLWHA as follows:

Box 2:1 Stigma and discrimination at family level

If the family knows that he/she has AIDS, they separate their commodities from him/her and they let him/her sleep in a separate room and let him/her eat alone with his/her own plate. No one will come close to him/her, they will isolate him/her from the society...The family tells him/her to use his/her own things for himself/herself without mixing with their materials.

Moreover, perceived stigma can hinder from seeking medical care, social and financial support. It can also cause withdrawal from the community, hasten disease process loss of job and death (Poku et al 2005, P. 234-248).

Having PLWHA in a family member can stigmatize and discriminate the family as a whole and it can happen both during episode of sickness and following bereavement of a family member due to AIDS. Negative reaction from the community, rejecting from social services like Idir, and gossip are some of the manifestations. In some cases relatives refuse supporting children whose parents died of AIDS, even though they are sure that the child is free of HIV (Ickovics et al 2007).

Stigma and discrimination can also be seen at institutional level. A study done one in Asian countries reported that 45% PLWHA experienced low quality health care, denied of delivery services by health professionals. Studies done in India, Indonesia and Thailand shows that & % of PLWHA were dismissed from their job. 10% occurrence of demotion from their position. It is also observed that some organizations have discriminatory employment policies that require obligatory HIV test for job claimant.

As Family Health International - Ethiopia (2002) directly quote the experience of stigma and discrimination:

Box 2:2 HIV infection and social network

I was on the leadership committee for the Idir. Upon realizing my HIV/AIDS status and my role in Mekdim Ethiopia, fellow committee members began to subtly ostracize me. They stopped notifying me of committee and general meetings, as well as charging me membership contributions. Thus, by withdrawing all previous forms of social interaction, they dismembered me in the end.

Reference made to Family Health International – Ethiopia (2002) stated that a female informant in a study done in Addis Ababa express her experience of stigma and discrimination at health institution like this;

Box 2:3 Stigma and discrimination at health institution

Medical professionals at health institutions do not give you due respect when they realize that you are HIV positive. This is so because they know that it is a terminal illness. I had a problem with my ear. Seeking medical treatment, I went to Zewditu Hospital. I was referred to a specialist at Yekatit 12 Hospital. It took me two whole days to see the specialist. When I met the specialist, I told him that I live with the HIV virus. He said, 'You should have protected yourself from HIV/AIDS.' We [PLWHA] badly need love, I said. 'I know very well that is your usual mantra', he replied. 'Death means nothing', he continued. When he was examining my ear, he was very careful not to touch it.

According to Family Health International - Ethiopia (2002) a female informant in a study done in Addis Ababa express her experience of stigma and work place like this;

Box 2:4 Stigma and discrimination causing premature death

The woman started by explaining that her husband was a cook at the Hilton International Hotel in Addis Ababa: As painful rashes on his skin persisted, he went to the Hilton clinic for treatment. HIV/AIDS test was recommended for him. He tested positive. Upon learning of the test result, the management suspended him from his job. Within months of his suspension, he applied to be reassigned to a different job, like timekeeping or gardening. The management declined his petitions. Worse still, I also lost my temporary employment at the hotel only because of being my husband. As a result, he took to heavy drinking, which eventually led him to the loss of sanity. Things deteriorated so rapidly that he finally left home, withdrew all his savings from the bank and squandered it all on drinks. He ended up yelling around at the pubs that he was HIV/AIDS positive. At last, he committed suicide. Many people said, as I do myself, that the immediate cause for my husband's painful death and the resulting family breakdown lies with the management of the company where my husband and I both used to work.

At national level some countries have got discriminatory HIV and AIDS policies. Policies that extend from health care sector to immigration and migration law. Physicians in Thailand and India have an obligation to disclose the name and address of a person who is tested for HIV positive. So many countries access to immigrants to enter to their country enforced HIV testing before entering to the country demanding a statement showing HIV negative status before offering work permit. Countries like China deport immigrant workers who were HIV positive (Aggleton 2005). Additionally; there is a mandatory testing policy for drug users, sex workers, and residents who have lived outside China for more than one year (Ickovics et al 2007).

2.11 Consequences of stigma and discrimination on development

Table 2:2 Influences of stigma and discrimination on development at different level

	Individual	Family
Individual	Perceived stigma limit individuals capacity to generating income and education Fasten disease progress and premature death due to stress	Withdrawal from school (other member of family) to generate income and to give care for the sick Failure to seek medical care causes loss of family capital
Family	Hammer family income leading to poverty Distress sell of asset Orphan	Removal from socioeconomic activity Resettlement or movement from place to place to avoid stigma and discrimination
Institution	Denied right to facilities like school job etc. compulsory testing/notification Expulsion from job, school once HIV positive status in identified	HIV and AIDS affected families deprived of social support, microcredit and so on
Structure/Society	Affect people economic opportunities Involvement in risky livelihood options	Restriction of free movement among countries Loss of remittance Involvement in risky livelihood option Loss of savings

Source: Adapted from Ickovics (2007).

Chapter 3: RESULT AND DISCUSSION

This section presents findings from the survey and focus group discussion. First, the description of socio demographic data of the study population was presented and then the impact of HIV related stigma and discrimination on income of HIV and AIDS affected households was explained. Finally the results were presented by grouping the study population in to male and female. This helps to explore the impact of stigma and discrimination on this group of affected household and socio cultural factors that have influence on income of households affected HIV and AIDS.

3.1 Basic information about study population

From 30 respondents 63.3% were females and 36.7% were male. The most frequent age groups were 30-34 for male and 35-39 for female and least frequent age groups were 40-44 and 50-55 for female and male respectively. There was no male respondent within the age range of 20- 24. The average age for female was 31 while for male was 39 years of old. The findings of the study substantiates the result of UNAIDS second independence evaluation report Poate et al (2008) which revealed that higher HIV prevalence rate of females than men ,higher infection rate of women and men at their productive age group and higher infection rate of female at early age than men.

Most of the respondents were PLWHA who disclose themselves to Tesfa Goh association and as it is accounted by the chairperson of the association majority of their members are females. Besides that culturally females tend to involve themselves in petty trading than men. The detail information can be seen in the figure below.

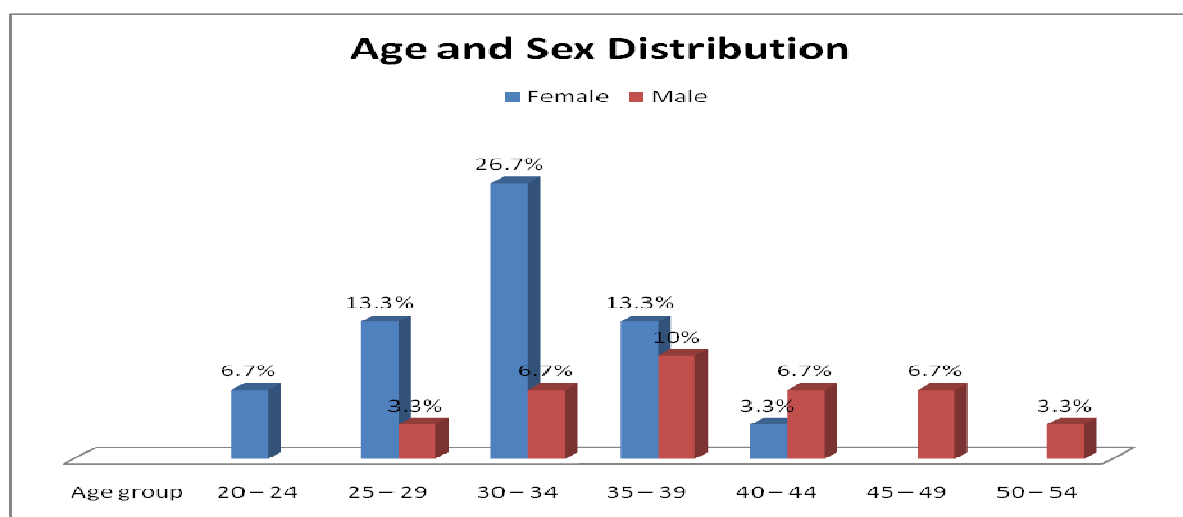


Figure 3:1 Age and sex distribution of the study population.

Source: Field survey

Looking on the urban and rural distribution of the respondents, majority are from urban than rural area. The finding is in line with a finding of UNAIDS second independence evaluation report Poate et al (2008) which revealed the prevalence of HIV infection is higher in urban than

rural places. Concerning religion of the respondents, the dominant religion was Orthodox followed by Protestant and Muslim. Majority of the respondent's ethnicity was Amhara followed by Oromo and Gurage. From the survey finding on educational status, majority of the respondents attended primary education and no respondent attended college/university. The detail information can be seen in the table below.

Table 3:1 Basic socio demographic characteristics of the study population

Characteristics	Category	No.	%
Residence	Urban	28	93.3
	Rural	2	6.7
Religion	Muslim	8	26.7
	Orthodox	12	40
	Protestant	9	30
	Johova witness	1	3.3
Ethnicity	Oromo	9	30
	Amhara	15	50
	Gurage	3	10
	Others	3	10
Educational Status	Unable to read & write	7	23.3
	First & second cycle	17	56.7
	Secondary education	5	16.7
	Preparatory	1	3.3

Source: Field survey

Considering marital status of the respondent, majority were married with equal proportion of female and male. The finding was in line with the finding which depicts that HIV infection is higher among married than any other categories (Seifu 2004).The striking finding on marital status of households affected by HIV and AIDS was 13.3% female were separated from their spouse either due to the discordant HIV test result they have with their spouse or their husband leave them without any legal agreement when the female spouse became sick. The detail about marital status of the respondent is presented on the table below.

Supporting the survey finding, FGD informants described that male tend to separate⁴ from their spouse when their HIV positive status does not match with his spouse (when wife became HIV positive and husband HIV negative).Respondent from female FGD explained that usually female are economically dependent on their husband so they have no any other option than staying with their husband. From this we can conclude that economic dependency of female on their husband aggravates the already existing stigma and discrimination attached to HIV and AIDS mean while increase vulnerability of female to the impact of AIDS. The finding compares favorably with CHGA (2004) which discovered that woman and girls are victims of discrimination in the economic, social and political life of the community which factors may directly or indirectly contribute to the exposure of HIV infection and vulnerability to the impact of AIDS. The table below shows the detail on the marital status of the respondents.

⁴ Separated -spouses living apart without legal procedure.

Table 3:2 Respondents by marital status

Sex	Marital Status									
	Single		Married		Widowed		Divorced		Separated	
	No.	%	No.	%	No.	%	No.	%	No.	%
Male	2	6.7	7	23.3	-	-	1	3.3	1	3.3
Female	1	3.3	7	23.3	5	16.7	2	6.7	4	13.3
Total	3	10	14	46.7	5	16.7	3	10	5	16.7

Source: Field survey

According to the survey finding the majority of respondents were Male Headed Household (MHH). It was also observed that there was no Child Headed Household (CHH) and Grandparent Headed Household (GHH). The finding was not in line with the findings which discovered new type of households like CHH and GHH in era of HIV and AIDS (Nizi & Zirimenya 1999). Informal discussion held with the head of Babile district health bureau revealed that AIDS related deaths have been decreased due to free and accessible ART service in the district. From this we can conclude that labor was not a constraint among PLWHA.

Table 3:3 Distribution of respondent by type of HH

Type of HH	Sex			
	MHH		FHH	
	No.	%	No.	%
Male	11	36.7	-	-
Female	9	30	10	33.3
Total	20	66.7	10	33.3

Source: Field survey

3.2 Concerns of HIV testing

According to the survey finding majority (76.7 %) of the respondents were tested for HIV when they themselves fall ill or due to death/illness of their spouses. The details are presented in the table below.

Informal discussion held with the head of district health office and the responsible person in Voluntary Counseling and Testing (VCT) department of Babile health center revealed that despite the repeated free HIV voluntary counseling and testing campaigns conducted in the district, most people were diagnosed at their terminal stage of the illness which is very difficult for effective treatment and care of the sick. As explained by the above mentioned persons, fear of stigma and discrimination and its consequences after positive test result was the main reason for this problem. Respondents in FGD were also asked the reason why people wait till they were sick to undertake HIV test. Both female and male participants replied that among the different factors that hinder an individual to be tested; incurable nature of the disease, and fear of negative community reaction were the leading ones. The findings corroborate the results of Aggleton (2005) which discovered stigma and discrimination attached to HIV is a major barrier in preventing further infection; alleviate impact and providing adequate care and treatment of HIV and AIDS.

Table 3:4 Reasons to be tested for HIV

Reason to be tested	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Illness	6	20	11	36.7	17	56.7
Death/illness of spouse	2	6.7	4	13.3	6	20
Self-initiated	3	10	4	13.3	7	23.3
Total	11	36.6	19	63.3	30	100

Source: Field survey

3.3 Concerns of disclosure

The survey finding showed that 76.7% (53.3 % female and 23.3 % male) of the respondents disclose their HIV positive status to others and the rest 23.3 % (10% female and 13.3 % male) did not tell to anyone about their HIV positive status. Out of the 76.7%, 48% disclose their HIV positive status for those who are very intimate (friend, family member or a neighbor) and support organizations (Tesfa Goh and Menscen für Menscen).The rationale behind disclosing their status was to get emotional and financial supports followed by acquiring knowledge about the disease by discussing with other Tsfa Goh members.

The other 21% of the respondent disclose their HIV positive status only to those they confide in and keep their HIV positive status confidential. Mostly explained reason to disclose themselves to the trusted ones is to get psychological support and help while they get sick. Financial support was their only reason for those (17.4%) who disclose themselves to the institute only.

Box 3:1 Disclosure for survival

One respondent: I am a very poor person to the extent that I cannot eat two times a day; imagine what could happen when illness and poverty join forces. No matter how scary it is my only option was to disclose myself and get some aid just for survival.

Box 3:2 Disclosure aggravate stigma and discrimination

One of the respondent explained: even though one hide his/her HIV positive status people talk and gossip by looking appearance of the body .One way or another we are victims of stigma and discrimination but it is not sever like those who disclose their HIV status.

The rest 13% disclose and teach about HIV and AIDS to the public. The slogan that says “save generation” and they tend to do this by teaching people how to prevent HIV infection by presenting themselves as a live example and explain how they get infected and how people could expose themselves to HIV through ignorance and lack of knowledge. The rationale behind hiding HIV positive test result for those who never disclose their status was fear of family and community negative reaction.

Information from female FGD; no PLWHA needs to disclose his/her HIV positive status unless they need to get financial or emotional support. The need to hide HIV positive status is due to fear of humiliation, rejection, gossip, loss of social interaction and income were frequently explained. The finding was in agreement with the finding which confirms fear of loss of access to resources, loss of livelihood options, loss of income and negative community reaction hinders disclosure about HIV infection in addition to hampering free discussion and counseling (Nyblade 2003).

Box 3:3 Lack of confidentiality

The other female respondent: I disclosed my HIV positive status to Tesfa Goh to get financial and emotional support but what happened was the reverse, now everybody knows that I am HIV positive due to information leakage from the organization, in addition I did not get the support I expected to get from the organization. Now my business is almost to be closed due to gradual loss of customers. I am really regretting of disclosing myself to Tesfa Goh.

The other 9% was due to loss of job and one respondent explained it like this:

Box 3:4 Loss of job due to stigma and discrimination

I was a guard in one of private drug stores and I was getting sick on and off for a long time. My employer suspected that I could have HIV in my blood and he requested me to be tested. Since he is my employer I did not hesitate to do so even though it was a head ache for me. Finally I have come to know that I am HIV positive. My employer was expecting my result, so I told him the truth, but his decision was to fire me and I ended up jobless.

Information from male FGD showed that PLWHA disclose their status because they are poor. They disclose themselves to get services for free like ART, financial support and so on. Male FGD respondent explained that in Babile district there are more than 100 PLWHA that did not disclose their status. They always receive their Antiretroviral Therapy (ART) and medical assistant from other nearby districts hospitals because they can afford to go get the service. They also add that it was the same if we were rich.

Box 3:5 Loss of asset due to fear stigma and discrimination

One member of Tesfa Goh remind that "I know one PLWHA who was rich before and took his ART drug from Gigiga (a district 65 km away from Babile district) hospital but now he is poor like us and become a member of our association to get financial support. He run out of money because of the fear of stigma and discrimination he may face around his neighborhood.

Informal discussion the researcher held with Tesfa Goh association head and MfM BIRDP HIV department head pointed out that, all their clients are those who are poor PLWHA. Even through financial support is given for those who are poor there are also support groups that help PLWHA with providing emotional and psychological support but the rich people in the district do not come for this service. Fear of community reaction can explain the problem with disclosure of HIV positive. Head of ART clinic also confirmed that there are so many well to do PLWHA who were not registered in Babile health center ART clinic instead they travel 35- 100km despite the free and same quality service that provided in the clinic for PLWHA.

The findings of the study showed that most PLWHA disclose their HIV positive status to get financial support. From this we can conclude that most of the respondents were having low income level before they knew their status that was aggravated by stigma and discrimination following HIV infection. In addition stigma and discrimination is a barrier to practice preventive measures. The finding corresponds with the finding of Dlamini et al (2007 P.339-399) which showed that loss of livelihood option, loss of income, premature death, poverty, involvement in risky livelihood option are effects of stigma and discrimination that can finally lead to HIV infection.

3.4 Stigma and discrimination

Survey respondents were asked whether they experience stigma and discrimination after they knew their HIV positive status. Majority of the respondent with higher percentage of females experience stigma and discrimination ranging from gossip to loss of livelihoods. From those who experience stigma 20 % was internal stigma and the rest 50 % was enacted stigma. According to the researcher observation internal stigma was seen as a problem for some of the respondent who revealed that they did not experience stigma and discrimination. Feeling of shame, disgraces and worthlessness were not considered as stigma and discrimination by the respondents. Table 4.6 presented the detail on the respondent experience of stigma and discrimination.

Most of the respondent of both male and female FGD explained that, all PLWHA experience stigma and discrimination one way or another, either other people stigmatize and discriminate PLWHA or they stigmatize themselves due to fear of negative community reaction.

Box 3:6 Self- stigma

One male respondent explained his experience as follows;

I was tested for HIV before three years because of sickness of my girl friend. After knowing that I am HIV positive I started to isolate myself, stopped to go to work. I fear that people can easily identify my status due to the disfiguring nature of the disease, so I prefer to hide.

Box 3:7 Community level stigma and discrimination

I was living in a rental house, I don't know how my land lord heard that I'm HIV positive, their behavior started to change from time to time, they even started locking the only toilet we used to share, they put soil bin a place where I wash my cloth and dispose water. They also forbid me to hang my cloths in the rope we normally Hang our clothes to dry .Their reaction was unbearable and I was forced to leave their house.

Box 3:8 Stigma by labeling derogatory terminology

The other female respondent whose 5 years old son was HIV positive shared her experience as follows:

One day my 5 years old baby came crying, because his friend didn't want to play with him anymore and he told me that his friend was calling him names like, " you are a poisons snake" so I had to approach him and ask him why would he say such things to my son and he told me that his mom told him not to play with my son that he is a poisons snack. I couldn't believe what I just heard .That day I wished I die and I hated the community I'm living in .

Looking on the manifestation of stigma and discrimination, the findings of this study was in line with the finding of UNAIDS (2000) and Siya'kela (2002) which revealed the two types of (enacted and internal) stigma and discrimination. In addition the finding was in harmony with Magrath & Tesfu (2006) which revealed the multifaceted nature stigma and discrimination.

According to survey, FGD and informal discussions report, females experience stigma and discrimination more than men, this increase the vulnerability of female to the impact of AIDS. The finding substantiates the finding of CHGA (2004) which revealed that, the already existing gender inequality worsens HIV related stigma and discrimination on women than men. In addition both male and female FGD respondents enlightened that; it is not only PLWHA who are victims by the community stigmatizing and discriminatory action but also families or any other person who is intimate with PLWHA is always mistreated. Negative community reaction is also very painful when it comes to the innocent children.

Box 3:9 Stigma and discrimination by association

One of female participant explained it as follows:

My intimate friend living in my neighborhood prohibited her child not to play with mine.

The finding was in line with the finding which revealed stigma and discrimination can affect member of a family who is not HIV positive (Ickovics et al 2007).

Table3:5 Respondents base on the experience of stigma and discrimination

Sex	Experience of stigma and discrimination			
	Yes		No	
	No.	%	No.	%
Male	7	23.3	4	13.3
Female	14	46.7	5	16.7
Total	21	70	9	30

Source: Sefield survey

3.5 Change in place of residence

From the survey data it was observed that 36.7% (26.7% female and 10% male) of the respondent changes their place of residence after they learned their HIV positive status. The most frequently explained reason to change in place of residence was due to fear of stigma and discrimination by family and/or by the community members. Out of the 36 % who change their place of residence 45.5% was due to internal stigma and the rest 54.5% was enacted stigma.

Box 3:10 Culture inducing stigma and discrimination

One of female respondent put it:

I am not married and I am living with my families, you know that for a female sexual intercourse before marriage is considered as a sin let alone being HIV positive ,so you will be out casted once your family found out that you are not virgin and on top of that HIV positive. I acquired this disease from my boyfriend through sex, so it was very hard for me to accept the positive test result besides it was very hard to let my family know about it, though I am not going to have anything to support myself with, I decided to leave the place where I was born and raised and head for a place where nobody knows my history.

18% of the respondents change their place of residence due to fear of loss of income.

Box 3:11 Fear of loss of income due to internal stigma

One of female respondent says:

I make a living by selling “Khat”, if my customers knew that I am HIV positive they will stop buying from me, so I decided to leave the place I use to live.

The rest 27.3% were for looking financial support and to be taken care of by their families because of their sickness.

Informal discussion with MfM BIRDP HIV/AIDS prevention and care program department head and Tesfa Goh association head pointed out that there are so many PLWHA came to Babile district from the nearby districts to look for financial support.

Male and female FGD participants explained that the main reason most PLWHA change their place of residence after knowing their status was due to fear of negative community reaction, loss of job and income.

From the findings it was observed that stigma and discrimination was the reason for PLWHA to migrate. Thus, this increases individual susceptibility to HIV infection and vulnerability to the impact of AIDS following displacement, loss of asset and income while moving from place to place.

3.6 Impact of stigma and discrimination on income

To assess the impact of stigma and discrimination on income of households affected by HIV and AIDS the researcher uses the following indicators;

- Change in household income
- Change in household means of income
- Change in household expenditure
- Change in the number of customer
- Change in saving practice and
- Household access to different services and social network

3.6.1 Change in household income

From the survey result it was observed that 33.3 % of the respondents use to earn a monthly income ranging from 801 - 1000. The previous income of majority of female informant (33.3%) and male informant (20 %) lay between 601 to more than 1000 Birr/month. There was no respondent earning less than 100 Birr per month before they knew their HIV positive status. The average monthly income of female respondents was 751 Birr and for male 735 Birr. This signifies that both male and female were earning almost equal amount of average income per month.

Table 3:6 Monthly incomes before they knew their HIV positive status

Monthly Income/Birr	Sex				Total	
	Male		Female		No.	%
	No.	%	No.	%		
100 – 200	1	3.3	2	6.7	3	10
201 – 300	1	3.3	2	6.7	3	10
301 – 400	1	3.3	1	3.3	2	6.7
401 – 500	1	3.3	3	10	4	13.3
501 – 600						
601 – 700	2	6.7	3	10	5	16.7
701 – 800			1	3.3	1	3.3
801 – 900	2	6.7	3	10	5	16.7
901 – 1000						
>1000	2	6.7	3	10	5	16.7
I do not know	1	3.3	1	3.3	2	6.7
Average monthly income 745						

Source: Field survey

The survey result showed that, the current income of majority of female respondent (46.7 %) and male respondent (16.6 %) falls between 100 – 400 and 301 - 600 Birr/month respectively. On average female earn 315 Birr per month and male earn 449 Birr per month. The average monthly income of HIV and AIDS affected households after known HIV positive status was 365 Birr per month. The table below shows the detail information on income of households affected by HIV and AIDS after known HIV positive status.

Table 3:7 Monthly incomes after they knew their HIV positive status

Monthly Income/Birr	Sex				Total	
	Male		Female		No.	%
	No.	%	No.	%		
< 100	1	3.3	1	3.3	2	6.7
100 – 200	1	3.3	4	13.4	5	16.7
201 – 300	1	3.3	7	23.3	8	26.7
301 – 400	2	6.7	3	10	5	16.7
401 – 500	1	3.3			1	3.3
501 – 600	2	6.7			2	6.7
601 – 700			1	3.3	1	3.3
701 – 800			1	3.3	1	3.3
801 – 900			1	3.3	1	3.3
901 – 1000	1				1	3.3
>1000						
I do not know	2	6.7	1	3.3	3	10
Average monthly income 365						

Source: Field survey

From the above two tables (Table 4:6 & 4:7) it is observed that, there is considerable distinction on the income of HIV and AIDS affected households before and after the respondents knew their HIV positive status. The average monthly income before they knew their HIV positive

status was 745 Birr and 365 Birr after they knew their HIV positive status. From the data 73.3% (50% of female and 13.3% of male) were getting an income of 400 and /or less Birr per month after they know their HIV positive status, but there were only 36.7 % (16.7% female and 10% male) of respondents were in the same range before they know their HIV status. The survey finding also depict that the declining on income level was more sever on females than male. The finding was in consistent with CHGA (2004) which revealed that the impact of stigma and discrimination is severe in women than men.

Respondents were asked the opinion about the income they had before and after they learnt their HIV status. 66% of the respondent reported that their income before they learn their HIV status was enough to cover their expenses. 33% of respondent reported that their pervious income was not enough but it was better than their current income. Thus, 100% of the respondent reported that their current income is not enough to fulfill their basic need especially food and shelter. When they explain their current income it is like between 'life and death'. They added that the support they got from NGO is not regular at least to cover their food expense. Both male and female FGD participants explained that, their income is declining from time to time. According to the view of both survey and FGD respondents stigma and discrimination was not only affecting their social life but it affect their income to the extent that they cannot fulfill their basic need. The finding confirms the finding of Dlamini et al (2007 P.339-399) which revealed that loss of income is one of the striking effects of stigma and discrimination.

3.6.2 Change in means of income

The study also explored the means of income of HIV and AIDS affected households before and after known HIV positive status.

Based on the survey finding majority of the respondents with higher proportion of female means of income was selling food items before they had known their HIV positive status. The table below shows the detail of the means of income of HIV and AIDS affected households before known HIV status.

Table 3:8 Means of income before they know their HIV positive status

Means income of	Sex		Sex		Total	
	No.	%	No.	%	No.	%
Selling food item	3	10	14	46.7	17	56.7
Handcraft	1	3.3	1	3.3	2	6.7
Hair dressing	1	3.3			1	3.3
Playing musical instruments	1	3.3			1	3.3
Daily laborer	2	6.7			2	6.7
Guard	1	3.3			1	3.3
Selling second hand clothes	2	6.7			2	6.7
Housemaid			1	3.3	1	3.3
Cook in restaurant			1	3.3	1	3.3
Dependent on husband			2	6.7	2	6.7
Total	11	36.7	19	63.3	30	100

Source: Field survey

The survey finding presented that, the means of income of majority households affected by HIV and AIDS after they knew their HIV status was depend on selling food items. Comparing the means of income more female (46.7%) respondents depend on selling food item before they knew their HIV status than after they knew their status (36.7%). while Male respondents who were selling food remain to be 10% before and after they learn their HIV positive status. 53.3% of the respondent change their means of income after they learned their HIV positive status. The detail information can be seen from the following table.

Box 3:12 Stigma and discrimination by husband

Female respondent whose husband was HIV negative share her experience:
Previously I used to own a very nice restaurant that generates a very good income for our subsistence, one day people heard while my husband insulting me by telling my HIV status and he left me without any support. Starting from that moment my clients decline from time to time and I started to dispose what I prepared, finally I decided to stop working on restaurant. Now I depended on only renting the shower room I have before.

Box 4:13 Denied of right due to HIV positive status

The same respondent also explained that: I presented the act of my husband in front of the court before three years but I couldn't find any solution except finishing my money. She also added that, this world is a world for men and healthy ones.

The finding was in line with Aggleton (2005) which confirm PLWHA are denied of the rights as human being.

Table 3:9 Means of income after known HIV positive status

Means of Income	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Selling food item	3	10	11	36.7	14	46
Handcraft	3	10	2	6.7	5	16.7
Hair dressing	1	3.3	2	6.7	3	10
Renting DVD&CD	1	3.3			1	3.3
Selling second hand clothes	2	6.7	3	10	5	16.7
Renting shower room			1	3.3	1	3.3
Selling livestock	1	3.3			1	3.3
Total	11	36.6	19	63.3	30	99.9

Source: Field survey

Comparing the above two tables (4:9 & 4:10) it was observed that more females were involved in selling food items than men because culturally female tend to involve in dealing with food than men. The most affected means of income by stigma and discrimination was selling food item and more female were affected while men remain the same before and after known HIV positive status. Supporting this female FGD respondents explain that most PLWHA change their means of income after they knew their HIV positive status due to loss customer and income. Mostly people do not want to buy food items and if they think that the item they buy have direct contact with food. More clear picture and impact of stigma and discrimination also seen on food vendors. The finding was in line with the finding of (2003) which demonstrates loss of livelihoods after known HIV positive status among food vendors. In addition the finding was in line with the finding of Chinwe (2005) showing more women than men experienced stigmatizing and discriminating acts.

According to the survey finding 40% (23.3% female & 16.6% male) respondents change their means of income due to stigma and discrimination related issue. The finding was supported by both male and female FGD participants. The table below shows the details on respondents' reason to change of means of income after known their means of income. In the same manner both male and female FGD participants supported the survey finding.

Table 3:10 Reasons to change their mean of income

Reason to change means of income	Sex				Total	
	Male		Female		No.	%
	No.	%	No.	%		
Sickness	2	6.7			2	6.7
To increase income level	1	3.3	1	3.3	2	6.7
Fear of loss of income	3	10	3	10	5	20
Loss of job due to HIV Positive status	1	3.3	1	3.3	2	6.7
Loss of customer due to HIV positive status	1	3.3	3	10	3	13.3

Source: Field survey

3.6.3 Change in household expenditure

The other variable explored was respondents' monthly expenditure for food before and after they learned their HIV positive status.

Looking on the survey result on food expenditure before they knew their HIV positive test result, 20% of the participants were spending 201 to 300 Birr per month, of which 3.3% male and 16.7% female. The average food expenditure of female respondent was 442 Birr/month. In the same manner the average food expenditure of male respondents were 525 Birr/month. The average monthly expenditure on food when it is computed from the total study population was 470 Birr. The table below shows the details on food expenditure.

Table 3:11 Monthly expenditure on food before known HIV positive status

Amount in Birr	Sex				Total	
	Male		Female		No.	%
	No.	%	No.	%		
101- 200	1	3.3	1	3.3	2	6.7
201- 300	1	3.3	5	16.7	6	20
301- 400	1	3.3	2	6.7	3	10
401- 500	1	3.3	3	10	4	13.3
501 – 600	2	6.7	3	10	5	16.7
601 – 700	2	6.7	3	10	5	16.7
>700	1	3.3			1	3.3
Covered by employer	1	3.3	2	6.7	3	10
Do not know	1	3.3			1	3.3
Average household food expenditure 470 Birr						

Source: Field survey

According to the survey result on food expenditure of respondents before they knew their HIV positive test result, majority of respondents food expenditure falls between 101-200. The average expenditure on food for both male and female respondents was almost the same. The average monthly expenditure on food when it is computed from the total study population was

342 birr per month with an average 2 and 3 household member for male and female respectively. The detail information can be seen in the table below.

Comparing household expenditure on food before and after known HIV positive status: before known HIV positive status 33.3% % of female and 46.65 % of male respondents fall within the range of 501 to 700 and 201 to 400 Birr per month respectively. 50 % of female and 26.7 % of male respondents expenditure on food fall between > 100 to 400 and 101 to 400 respectively after they knew their HIV positive status. Participants from the FGD explained that their expenditure on food decrease when their income decreases. Their income was affected to the extent that they cannot eat the lowest quality and quantity of food. The finding was in line with the study finding which revealed minimizing house hold expenditure food as household coping mechanism to the decline in household income level (Haile & Gezahegne 2002).

Table 3:12 Monthly expenditure on food after known HIV positive status

	Sex					
	Male		Female		Total	
	No.	%	No.	%	No.	%
<100	2	6.7			2	6.7
101- 200	1	3.3	5	16.7	6	20
201- 300	2	6.7	5	16.7	7	23.3
301- 400	2	6.7	5	16.7	7	23.3
401- 500			3	10	3	10
501 – 600	4	13.3			4	13.3
601 – 700			1	3.3	1	3.3
>700						
Covered by employer						
Do not know			1	3.3	1	3.3
Average household food expenditure 342						

Source: Field survey

Looking on the respondent's household expenditure for house rent, the average expenditure before and after they learned their HIV positive status was 70 Birr/month and 50 Birr/month respectively. Great disparity was observed in their expenditure for housing ,this was due to shift of expenditure to more important basic needs in response to declining income level after they learned their HIV positive status. Participants from FGD explained that when household income decrease they normally change their rented house to lower quality so that they can afford to pay based on their income and or use the money for other purpose. The finding was in line with the study finding which revealed minimizing house hold expenditure housing in response to declining in household income level (Haile & Gezahegne 2002).The detail information can be seen in the figure bellow.

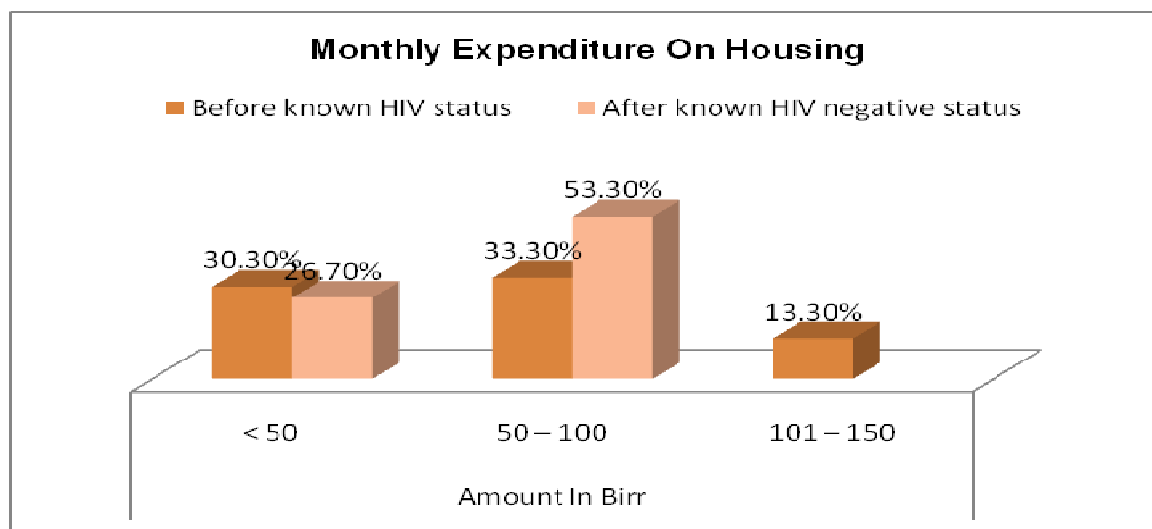


Figure 3:2 Expenditure for housing before and after they knew their HIV positive status

Source: Field survey

Survey result showed majority 70 % (26.7% male & 46.7%female) of the respondents reported that stigma and discrimination can cause decrease in their income level. One of the respondent explained that stigma and discrimination can lead to loss of livelihood option especially if one is earning his/her income through selling cooked food or if there is any contact with sharp items like shoe repairing. 26% of the respondent said stigma and discrimination cannot lead to low income level. Most of the respondents elaborated that loss of income is not from negative community reaction, it is because that PLWHA themselves feel worthless and demoralized to continue their normal productive life. The detail information can be seen in the table below.

Table 3:13 Acknowledgments of stigma and discrimination impact on income

Stigma causes lower income level	Sex					Total
	Male		Female		No.	
	No.	%	No.	%		
Yes	8	26.7	13	43.3	21	70
No	3	10	5	16.7	8	26.7
I don't know			1	3.3	1	3.3
Total	11	36.7	19	63.3	30	100

Source: Field survey

3.7 Change in the number of customer

The other variable looked at was change in the number of customers after knowing their HIV positive status .66.7% of petty traders realize that their number of customers started to drop after their HIV positive status is revealed , of which 43.3% female and 23.3% male. 26.7 % (13.3%female & 13.3 Male) respondent did not report a change in the number of customers. The remaining 6.7 % female respondents do not know whether there was change in the number of customers or not.

Participants were also asked the reason why they lost their customers. 40% of respondents reported that it was because people unwillingness to buy from them due to fear of HIV transmission through contact 23.3% female and 16.7% male. The second most frequent reason that accounts 16% (10% female and 6.7%) of the respondents was due to the expensive living condition their customers themselves were facing. The remaining 6.7% of female respondents do not know the reason and 3.3% of female respondents reported that they lost interest in doing their job after they knew their HIV positive status. Participants in the FGD had also substantiated the above explained reasons. Reduction in the number of client after known HIV positive status was mostly observed on those who are food vendors, they also added that they know food vendor PLWHA who were rich but now they change their means of income due to loss of customer. This is because of lack of knowledge on the means of transmission of HIV.

One of the male FGD participant said that *“generally speaking people are not comfortable to buy from PLWHA unless they have no other option”* According to the view of majority of the respondents’ stigma and discrimination following HIV positive status was the reason in the decline of their customers. The finding substantiates a study done in Ethiopia that depicts 61% of the study population have no willingness to buy food from PLWHA food vendors (Nyblade 2003).

3.8 Change in saving practice

According to the survey finding, majority of the respondents with higher proportion of female use to save money before they knew their HIV status. In general saving practice decline after known HIV positive status for both female and male respondents but higher percentage of female quit from saving. Information from both male and female FGD, some of them use to save money before they knew their HIV positive status but now it very difficult to save money because of decline in income level. The other who was having saving consumed it when they fail to fulfill their expenses with the existing decline in income level and they cannot save any more. The study finding was in harmony with the study done in Nigeria showing that withdrawing from saving as one of household coping mechanism for households affected HIV and AIDS (Topouzis 1999).The details on saving practice are presented on the table below.

Table 3:14 Households change in saving practice

Sex	Before				After			
	Yes		No		Yes		No	
	No.	%	No.	%	No.	%	No.	%
Male	7	23.3	4	13.3	2	6.7	9	30
Female	10	33.3	9	30	1	3.3	18	60
Total	17	56.6	13	43.3	3	10	27	90

Source: Field survey

As it is shown on the table above 7 male and 10 female respondents use to save money before they had known their HIV positive status, but after they learned their status only 2 men and 1 female respondent reported that they have save money.

3.9 Challenges of HIV posetive status

According to the survey data, 83.3% of the respondents faced a problem on income and loss of job since they had known their HIV positive status. Stress/bad feeling about their Hiv positive status due to different reasons were fount to be the second biggest (46.7%) problem PLWHA face in the district. 26.7 % of the respondent were concerned about loss of families ,friends,and/or spouse. 20% of the respondents were concerned about illness and displacement or migration from their place of residence to a new place due to negative community and family reaction. The rest 2.6% losst their asset due to illness and or due to stigma and discrimination.

Majority of FGD respondents were also explaining that illness due to HIV is not a problem of current PLWHA. Stigma and discrimination and its consequences were enlightened as a major problem. They said that PLWHA loss their job or income due to the bad attitude of the community about HIV infection and lack of knowledge on the mode of transmission of HIV. Even though the communities have good understanding on the mode of transmission of the disease, their stigmatizing and discriminating behavior was not changed. They also added that, they cannot deny that there is big change from the previous.

Box 3:15 Problem in employment

One respondent explained it:

Thanks for ART now a day there is nob

ody who suffers from illness as previous days. I have a lot of energy to do whatever I can get that can help me to earn money but the problem is the society do not want to employ me when they know that I am HIV positive. They think that HIV is transmitted easily through our day to day contacts like working together, sharing same utensils, eating and drinking together even though much was done and much is known about this issue the attitude of the community is not yet changed. I was working a private food store keeper as soon as my boss hear that am HIV positive from others he started to insult me indirectly about my HIV positive status, I could not tolerate this even though did not tell me to stop the job, so I left and.

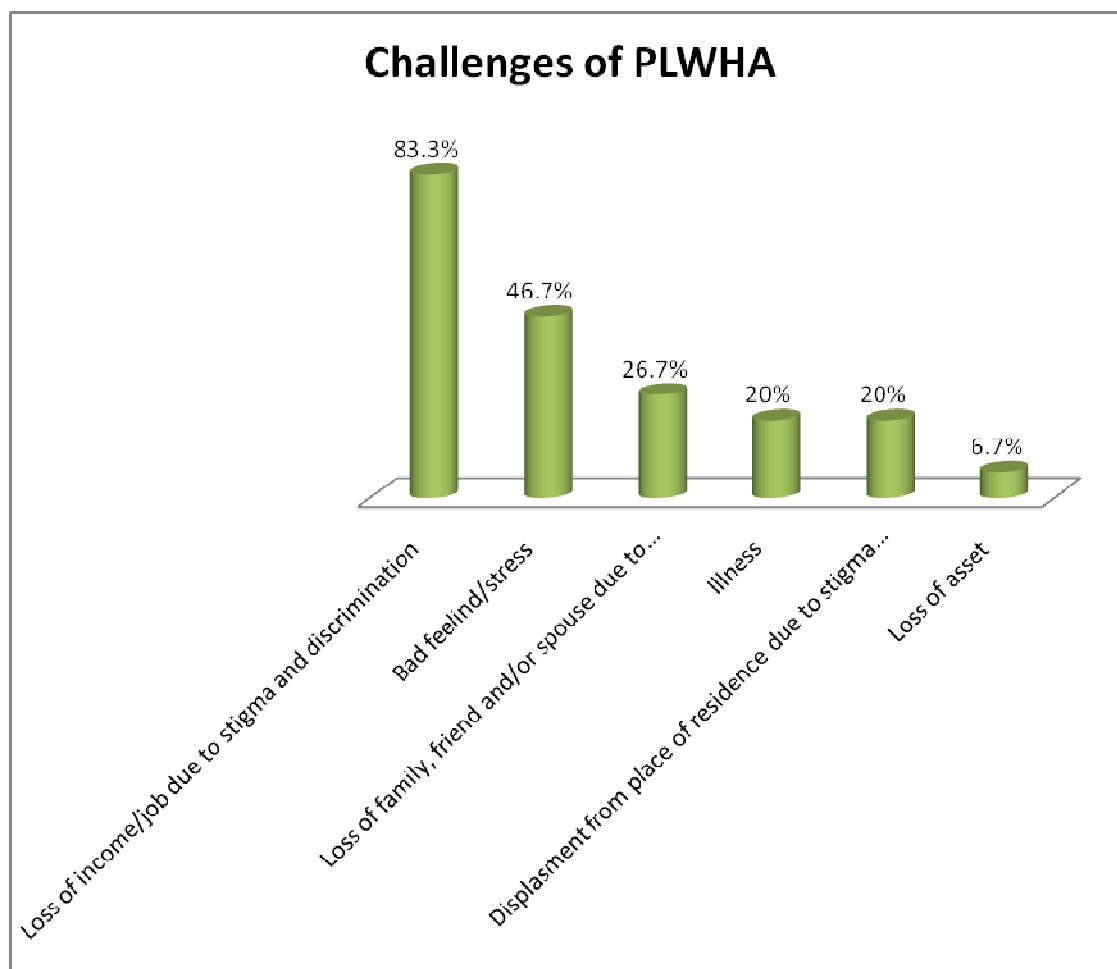


Figure 3:3 Challenges of households affected by HIV and AIDS.

Source: Field survey

3.10 Household response

The other variable explored during survey was coping mechanisms practiced by HIV and AIDS affected households.

According to the survey finding different coping mechanisms were used by affected households and Majority of the respondents have got more than one coping mechanism. Among the coping mechanisms withdrawing from saving, selling household assets and looking financial support from NGO, GO and other relatives were frequently explained by the respondents. Change in place of residence, low budgeting for some aspects of basic needs like food and sending their small children for work were also carried out as house hold coping strategies. From the survey risky livelihood option like commercializing sex was also explained as coping mechanism. The detail information can be seen from the table below.

The finding was in line with the finding that showed decreasing expenditure and participating child in income generation activities as coping mechanism (Haile & Gezahegne (2002).The

finding is also in line with the finding that showed households coping mechanisms by changing household composition, withdrawing savings and finding help from NGO(Topouzis 1999).

Box 3:14 Stigma and discrimination leading to risky livelihood option

One of female respondent: previously I was selling “Injera”, after some time I realize that my customers are decreasing from day to day due to my HIV positive status, then I decided to change my means of income and tried to be hired as a house made more than three places, but I couldn’t make it, people refuse to hire me again because I am HIV positive. Finally I was forced to go to another place where people do not know me and I was doing commercial sex work

Table 3:15 Households coping mechanism

Coping mechanism	Sex					
	Male		Female		No.	%
	No.	%	No.	%		
Withdrawing from saving and selling household asset	4	13.3	3	10	7	23.3
Change in place of residence	4	13.3	6	20	10	33.3
Working	1	3.3			1	3.3
Changing means of income			3	10	3	10
Looking for support from NGO,GO, individuals	5	16.7	14	46.7	19	63.3
Commercializing sex			1	3.3	1	3.3
Low budgeting for food, housing and other basic needs	4	13.3	1	3.3	5	16.7
Sending Children to other relatives or work	1	3.3	6	20	7	23.3
Nothing	1	3.3	3	10	4	13.3
Total	20	66.7	37	70	57	189.5

Source: Field survey

3.11 Access to services

From the survey finding all respondents have access to private or government health facilities.83.3% and 16.7% of the respondents used free government hospitals and private hospitals respectively before they knew their HIV positive status. After they knew their HIV status 100% of the respondents were using government hospital for free.

Looking on the respondents access to school, 46.7 % and 13.3% of the respondents send their children to government school for free and private school respectively before they knew their HIV positive status. On the other hand 66.7% send their children to government school and no child was sent to private school after known HIV positive status.

FGD informants explained that in the district both government school and hospitals are free and accessible so they use government schools for their children and government hospitals for free. Even though they believe that the service provided in government schools and government hospitals are not standard as the private ones due to the problem they have to fulfill other priority need they do not want to spend money on private schools or hospitals.

Respondents were also asked whether there is organization that supports them or not. More than 95% said that there is no organizations that support them except the support given for those critically ill from MfM BIRDP. Tesfa Goh association also supports some basic items such as food and clothes with a very long interval. Looking on access to credit and support scheme 20 %(10 % female & 10% male) got some startup money but it was not enough to be benefited from it. The rest 80% did not get any support from Tesfa Goh.

Participants from female focus group discussion explained that both male and female respondents have got equal access to credit scheme but the problem was while they are given the money they did not took any training how to use it profitably. The other male FGD participant explained the selection was beneficiary was not fair the money was given repeatedly for those who are intimate or relatives of the staffs of the association. According to the researcher observation during house to house survey interview those who get the chance for the credit schema were relatively in a better situation that the rest .

3.12 Access to social network

Participation in social network was the other variables explored during the study.76.7% of the participant are not a member of any social network currently, of which 53.3% female and 23.3% male. The rest 23.3 % (10% female & 13.3% male) were member of social network especially Idir. 36.7%(30% female 76.7% male) were member before they knew their HIV positive test result and discontinued due to several reasons given bellow. Majority 23.3% of females and 6.7 of males' reason was lack of money to pay monthly contribution. The other 16.7% of the female and 6.7% of male respondents didn't feel it necessary to be a member of social network. 10% of female and 6.7% of male respondents didn't want to be a member due to the wide spread stigma and discrimination against PLWHA in this places.6.7% of male and female respondents said that this places needs a great deal of social interaction but their HIV status do not allow them to participate in such place. In the same manner almost all FGD participants were not a member of social network due to the above explained reasons.

Box 3:15 Stigma and discrimination in social network

Female FGD informant:

Last time commemorative ceremony for the lost ones was being held in my neighborhood , as you know it is customary for a member of social network to get together and prepare enough food and drink for the attendant of the ceremony ,so as a member I went there and started peeling some onions, most of the people there told me that I should go home and rest and the onions will irritate my eyes, but I know as well as everybody else that this was not the reason why they did not want me to peel the onions, in fact the only reason was because I am HIV positive ,so at that time I felt terrible and decided to leave the social network.

CHAPTER 4: CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the main findings of the research and the recommendations given to different concerned bodies. In section 4.1 Conclusion are presented and in section 4.2 consists of recommendations given by the researcher based on the study findings.

4.1 Conclusion

The study was conducted to assess the impact of stigma and discrimination on income of households affected by HIV and AIDS. Out of 30 PLWHA 63.3 % were female and 36.7% were male at their productive age group. Women get infected at earlier age than male. It was found that women are more vulnerable than men due to cultural and economic problems. Women play a great role in household income generation than men counterparts. Concerning type of HH, more MHH were observed than FHH. Other type of HH (CHH & GHH) emerged on the era of HIV and AIDS were not observed due to the free and accessible ART which minimizes AIDS related death. HIV prevalence was higher in married ones. Most of the study population had low educational status and no respondent was found attended higher education. As most of them were already poor before the infection, they did not have enough savings to cope with the epidemic. 13.3 % of females were separated from their spouses due to their HIV positive status

The study found out that stigma and discrimination attached to HIV and AIDS was a big challenge for HIV and AIDS prevention and care program. People prefer not to be tested unless they are sick. Thus, decrease the chance of quicker recovery and causing premature death due to AIDS related illness. In case of breadwinner, stigma and discrimination become a reason for loss of income indirectly. Concerning disclosure of HIV positive status, majority of the respondent disclose their status to get financial support. Fear of disclosure of HIV positive status was due to negative community reaction, fear of abandonment and loss of income. The prevalence of stigma and discrimination is 70 % of which 20 % internal stigma by which PLWHA feel disgrace and worthlessness about themselves and 50 % was enacted stigma by which the community stigmatizes and discriminate PLWHA. Majority of the respondents also change their place of residence after they knew their HIV positive status. The rationale behind was loss of job and income due to stigma and discrimination.

According to the findings loss of income due to stigma and discrimination was the single major problem of households affected by HIV and AIDS. All PLWHA were on good health condition and there was no labor constraint due to death or illness. The change on means of income and the level of income due to stigma and discrimination was the major issues looked to investigate the impact on income.

Regarding the change in income before and after they learn their HIV positive status shows a great difference. The average income after they knew their HIV status decline from 745Birr to 365 Birr/month /household. In addition, majority of female respondents who earn their income by selling food items changed their means of income after they knew their HIV positive. Decreased motivation to work (Internal stigma) and negative community reaction (Enacted stigma & discrimination) was the major causes for the declining in income level of households

affected by HIV and AIDS. It was also clearly seen that the effect of stigma and discrimination was sever in female than male. In addition majority (70 %) of respondents were also explaining that stigma and discrimination had a contribution on declined income level. Household average expenditure on food declines from 470 Birr/month/household to 342 Birr/month/household after they learned their HIV positive status. In the same manner average expenditure on housing reduced incredibly as income of household decrease after respondents learned their HIV positive status.

The study also showed that all respondents have free access to health facility and schooling from the government. It was also observed that 76.6 % of the respondents were not a member of social network after they knew their HIV positive status, majority of them quite their membership after they learn their HIV positive status. Lack of money for monthly contribution and stigma and discrimination were majorly explained reasons.

4.2 Recommendations

According to the finding of the study problems associated with stigma and discrimination on HIV and AIDS affected households were identified. Based on the finding, short term and long term recommendations are suggested that can be implemented by the relevant concerned bodies(MfM BIRDP, Tesfa Goh, district HAPCO) to build up the activities in supporting the affected households, individuals and in their response to the epidemic of HIV in the district.

Short term Recommendations

Further studies: To design appropriate intervention for addressing stigma and discrimination in Babile district; socio-cultural factors associated with stigma and discrimination, manifestations and consequences of stigma and discrimination, and community attitude towards HIV infection should be investigated by Babile district health bureau, MfM BIRDP and Babile district HAPCO.

Supporting livelihood options: To address the loss of income among PLWHA, MfM BIRDP, district HAPCO should study, identify and provide appropriate IGA to insure sustainable livelihood among PLWHA.

Equity in distribution of supports: Financial assistance run in the name of vulnerable households should properly reach to the intended beneficiaries. Thus; Tesfa Goh should develop beneficiary selection criteria to address the most vulnerable households. More over monitoring and evaluation tool should be developed and applied.

Improved Behavioral Change Communication (IBCC): Targeted IBCC should be implemented by AIDS MfM BIRDP, district HAPCO and health bureau. This can be better achieved through involving community social networks and culturally and socially influential peoples.

Active participation of PLWHA; MfM BIRDP, district health bureau ,district HAPCO should participate PLWHA in the planning, implementing, monitoring and evaluation of HIV and AIDS prevention, care and support programs.

Legal protection: District administrative institutions and the court should take the responsibility in reinforcing laws to protect the rights of people living with HIV and AIDS to be free from discrimination. Laws that protect people living with HIV and AIDS at the family, community, and legally established institutions need to be formulated specifically addressing discriminatory acts enacted explicitly and/or implicitly.

Advocacy: District health bureau and PLWHA association, needs to advocate on the rights of PLWHA gender equality to legal institutions in the district.

Long term recommendation

Policy revision: At national level policies related to HIV and AIDS should be revised and explicit identification of specific laws targeting stigma and discrimination should be in place.

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Annexes

Annex 1. Survey Questionnaire

Introduction

My name is seble mamo. I am a master student in Management of Development at VanHall Larenstein University of Applied Science in the Netherlands. I am interviewing PLWHA to examine the impact of stigma and discrimination on AIDS afflicted petty trading household's .Your willingness and indisputable participation on the interview could help in clear identification of the problem and in designing appropriate response. Your name will not be explained in the study and your information's will not be disclosed to others. There is no any obligation to participate on this study, and also if you are not willing to answer some of questions you are freely requested to stop at any time in the interview. However your frank participation has a great value for the study. I would greatly appreciate your contribution for the study.

Are you willing to participate in this study? _____

I. Socio demographic data

1. Village (Kebele) of the respondent _____
2. Sex Male _____ Female _____
3. Age _____
4. What _____ is your relationship in the household head _____ Husband _____ wife _____ child _____ brother _____ sister _____ Grand mother or father _____ Other (specify) _____
5. Marital status Single _____ Married _____ Divorced _____ Widowed _____ Separated _____
6. No of household member _____ Male _____ Female _____
7. Educational status Not able to read and write _____ read and write _____ 1-4 grade _____ 5-8 _____ 9-10 _____ Preparatory _____ Collage/ University _____
8. Religion Muslim _____ Orthodox _____ Protestant _____ Catholic _____ other (specify) _____
9. Ethnicity _____ Oromo _____ Somali _____ Ahmhara _____ urage _____ Others specify _____
10. Have you ever changed your place of resident? yes _____ No _____
11. If yes since when? _____ why you changed _____

II HIV Status

12. When did you know your HIV status? _____
13. What was your reason to be tested for HIV? Health provider _____ initiated(illness) _____ Self initiated _____ other (specify) _____
14. Have you tell your HIV status to another person and/or institution? Yes _____ No _____
15. If yes to whom? _____
16. Why you choose that person or institution? _____

17. What was your reason to tell your HIV status?
 for financial support _____ for psychological support _____
 other (specify) _____
18. If no to Q no17 what was our reason not to tell to others? _____

III. Income and expenditure before the respondent know his/her HIV positive sero status.

19. What was your source of income three years before you know your HIV status?

20. How much was your monthly income? _____
21. What is your monthly household expenditure?
 House rent _____ Food _____
 other (specify) _____
22. Do you use to save money? Yes _____ No _____
23. If yes how money per month? _____
24. How do you explain your income in terms of your need or expenditure before you new
 your HIV positive
 status? _____
25. Was there any other source of income? Yes _____ No _____
26. If yes from whom ?other family members _____relatives _____NGO _____
 GO _____ other (specify) _____
27. How much? _____
28. Do you participate in social net work? yes _____ No _____
29. If no hy? _____

V. Income and expenditure after the respondent learned his/her HIV positive sero status.

30. Is there any change in your source of income after you know your HIV status?
 Yes _____ No _____
31. If _____ yes _____ ,
 why _____
32. What is your current source of income?

33. When did you change your source of income? Immediately after I learned my HIV
 positive status _____ after I disclose myself to another person _____
 after I become sick _____ other specify _____
34. How much is your monthly income from the petty trading? _____

35. How is your income when you compare it with your previous (before you knew your sero status) amount of income?

36. What is your monthly household expenditure after known HIV positive status?

House rent _____ Food _____

other (specify) _____

37. Is there any other source of income? Yes _____ No _____

38. If yes, from whom? other family members _____ relatives _____ NGO _____ GO

39. Other (specify) _____

40. If yes how much? _____

41. Do you save money Yes _____ No _____

If yes how much? _____

42. Do you have access to facilities? Health _____ School _____ Microcredit _____

43. (how is the trend before and after you knew your HIV status

44. Is there any change in your income level from other sources after known your HIV status

Yes _____ No _____

45. If yes for above question, why? _____

46. Is there any change in your number of customers after known your status?

Yes _____ No _____

47. If yes for above question, why? _____

48. In general what problem did you face after you know your HIV status?

49. Do you think that stigma and discrimination can cause loss of income among PLWHA?

Yes _____ No _____

50. How? _____

Part IV. Coping strategies

49. What mechanism do you use to solve your problem was your cope up mechanism to tackle this problem? _____

50. What social networks do you have that can help in problems? _____

57. If you don't have any social networks, why? _____

Annex 2. Guide lines for focus group discussion

1. When did you know your HIV positive status?
2. What was your reason to be tested?
3. What is your opinion about HIV testing?
4. What is your opinion about HIV positive status disclosure?
5. What are the challenges faced by PLWHA?
6. What is the effect of stigma and discrimination at household level?
7. What do you think is the cause for stigma and discrimination?
8. Do you think stigma and discrimination have an impact on income?
9. How stigma and discrimination affect income?
10. What coping strategies did you use to overcome the change in your income level?
11. Does men and women affected equally?
12. Do you participate in social network?
13. Do you have access to services like health service, school, and credit schemes?

Annex 3. Study sample profile

Interviewees	No.	Remarks
Informants in the community	30	19 female and 11 male
PLWHA involved in petty trading, Babile District		
Focus Group Discussions	2	4 participants in each FGD
Male focus group	1	
Female focus group	1	
The informal discussion		3 men and 1 female
MfM HIV and AIDS Prevention and care program head		1 man
Tesfa Goh head	1	1man
Head of district health bureau and health centre ART and VCT head	2	1man and 1 female