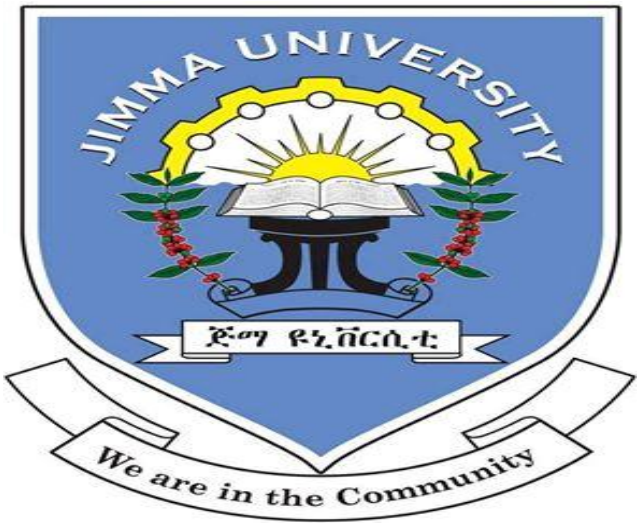
Socio-Economic Impact of World Food Programmes Urban HIV/AIDS Project: the Case of Jimma Town

A Thesis Submitted to the School of Graduate Studies of Jimma University in Partial Fulfillment of the Requirements for the Award of the Degree of Master of Science (MSc) in Economy Policy Analysis

By:

MUKTAR JEBEL



JIMMA UNIVERSITY

COLLEGE OF BUSINESS AND ECONOMICS

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June, 2016

JIMMA, ETHIOPIA

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Certificate

This is to certify that the thesis entitles *"Socio-Economic Impact of World Food Programme's Urban HIV/AIDS Project: The Case of Jimma Town"*, submitted to Jimma University for the award of the degree of masters of science in Economics (MSc) and is a record of bonafide research work carried out by Mr. Muktar Jebel Ababulgu, under our guidance and supervision.

Therefore, we hereby declare that no part of this thesis has been submitted to any other university or institutions for the award of any degree or diploma.

Wondaferahu Mulugeta (PhD) _____ _____
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Endeg Tekalegn (MSc) _____ _____
(Co-advisor)Date Signature

Declaration

I hereby declare that this thesis entitled *"Socio-Economic Impact of WFP's Urban HIV/AIDS Nutrition & Food Security Project: The Case of Jimma Town",* has been carried out by me under the guidance of Wondaferahu Mulugeta (PhD) and Endeg Tekalegn (MSc).

The thesis is original and has not been submitted for the award of any degree or diploma to any university or institutions.

Muktar Jebel _____ _____

Date Signature

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Treatment
BMI	Body Mass Index
CHG	Commission on HIV/AIDS and Governance in Africa
CSA	Central Statistical Agency
CSO	Civil Society Organizations
DRMFSS	Disaster Risk Management and Food Security sector
ES	Economic Strengthening
ESPs	Economic Strengthening Participants
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
NACS	Nutritional Assessment, Counseling and Support
NACS	Nutritional assessment, counseling, and support
NGO	Non-Governmental Organization
OSSA	Organization for Social Service for AIDS
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PSNP	Productive Safety Net Program
SNNPR	Southern Nations, Nationalities and Peoples Region
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAIDS	United States Agency for International Development
WFP	World Food Programme

Abstract

This study set out to examine the social and economic Impact of World Food Programmes (WFP) aided project in Jimma town, Oromiya region of Ethiopia. This was a case study research based on World Food Programmes Urban HIV/AIDS Project implementation in stated town. In this thesis quantitative and qualitative methods and techniques were used to gather and analyze data. The techniques that were employed includes project beneficiaries individual interviews , key local government stakeholders interviews, observations of projects intervention outcomes, interviews of other NGOs working on HIV/AIDS. These deliberations were also guided by different secondary sources of data found from the local governments and WFP itself. Random sampling methods were used for the respondents that were participated in this study. In the findings of the research, encouraging social and economic effects had accumulated to WFP Urban HIV/AIDS project beneficiaries in Jimma town. Concerning social impacts of WFP Urban HIV/AIDS project, this research established that 58 out of 62 children of beneficiaries dropped out school before were become the reverse status. Further, the support was clearly effective in making to cover the children's school fee, solved food shortage as well as improved the health status of the beneficiaries. In analyzing the economic impact, the share WFP's support on economic impact have also identified and its direct support have an impact of 20.8%, other things being constant, for income of the beneficiaries to improve. It was identified from interview with local governments officers that the working space were given with the prerequisite of WFP supports and those who were agreed to work cooperatively. Finally, this research among others recommends that the concept of involving people living with HIV in programmes addressing HIV/AIDS issues needs to be implemented in reality from both WFP and the local government. WFP should change the strategy from financial grant provision to loans to be returned in some time period without interest. The local governments and their leaders have an important role to play in combating HIV/AIDS, and they need to increase their efforts to recognize and support the proper implementation of projects.

Key Words**: **WFP, HIV/AIDS, NGOs, Socio-Economic Impact

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

HIV/AIDS is more than a health concern as the socio-economic consequence of the epidemic can seriously destabilize the development achievements of achievable policies and programmes. The epidemic becomes a major disaster to the life of people especially in the so called developing countries. The poverty that prevails among developing nations makes the epidemic more challenging. Resources exhausted in HIV/AIDS treatment and control from the beginning of its pandemic was clearly impeded global development multi-directionally, especially in sub-Saharan African countries. Unfortunately, it is keep going to spoil the development in future unless remedial interventions in use.

In Ethiopia, the AIDS epidemic is having a shocking impact on both rural and urban parts of its society. The syndrome has affected millions of people and continues to have a hurtful effect on a wide range of societal features including incomes, augmented risk for health care employees, production and productivity, life expectancy, infrastructures as well as the shape, size, and structure of Ethiopian families. Ethiopia is home to approximately 730,100 patients with HIV/AIDS (WHO Country Office for Ethiopia, 2015) and of which the adults population aged 15 to 49 HIV prevalence rate is 1.2% (UNAIDS, 2014). Worldwide Orphan (WWO) was the first NGO to bring HIV/AIDS medication in to Ethiopia specifically for orphans in 2003. The free antiretroviral therapy (ART) programme in Ethiopia, introduced in 2005, has decreased mortality and morbidity and improved the quality of life of patients (Woldesellassie et al, 2013).

In developing countries and specifically in sub-Saharan African countries, most of the resource (mostly financial) with which HIV/AIDS prevention and control as well as care and treatment undertaken comes in the form aid from societies, organizations and governments in developed countries. Ethiopia is the top 10 largest recipient of foreign aid for HIV/AIDS prevention and other socio-economic problems (Nathan and Nancy (2011), Frederic and Melissa (2013) and Statistical Report on Canadian International Assistance (2013-2014)).

The WFP was established 1961 under resolution A/RES/1/61 as a three-year trial programme by corresponding declarations of the Food and Agricultural Organization (FAO) and the General Assembly (GA) passed. The WFP was programmed to go into function in 1963, two years after programme endorsement by the GA and FAO. In 2003, the WFP received an official authorization to provide services of air transports for humanitarian operations UN-wide (Elena and et al, 2016). According to the 2013 annual report of WFP (2013), more than 80 million people in 75 countries are benefited from the programme. The programme has a vision of the world in with every man, woman and child has access to the food required for an active and healthy life of them.

WFP started its operations in Ethiopia in 1965 (WFP Profile Design, 2014). The guiding code of WFP in Ethiopia is to maintain government programmes by addressing hunger through direct food assistance for the needy where it adds significant value and build government's capacity. WFP's Food and nutrition support project to people infected and affected by HIV/AIDS directed through the urban HIV/AIDS project and has been under implementation since 2003 in Ethiopia. With the new and innovative ideas, the project has been modified in captivating the strengths and opportunities in the time of implementation. Recently, *Urban HIV and AIDS Nutrition and Food Security Project* has introduced major changes in its blueprint with more focus on economic strengthening (ES).

Economic strengthening is the collection of strategies and interventions that supply, protect, and/or raise physical, natural and financial as well as human and social possessions (United States Agency for International Development (USAID), 2008). The center of attention on (ES) is because it has been verified that any food and nutrition assistance is a short term therapy to food insecurity of PLHIV that over again exposing them to food insecurity as the assistance congested. According to UNAIDS (2008), lack of food security and poor nutritional status may accelerate succession to AIDS-related illnesses and weaken devotion and response to antiretroviral therapy (ART). Results of previous studies illustrated that feasible ES activities that assist malnourished people living with HIV (PLHIV) address their nutritional needs must be practical to stop reappearance at health institutions as malnourished and with poor response to ART treatment (WFP Ethiopia's ES Strategic document, 2012).

The Urban HIV/AIDS programme was established in 2003 in three major towns: Addis Ababa, Dire Dawa and Adama. It has since grown to include 23 towns, where Jimma town was among, in 2009. Recently, these implementation areas have grown to 85 town / cities (WFP Ethiopia, 2015). Project sites are jointly selected by regional HIV/AIDS Prevention and Control Offices (HAPCOs), WFP and other partners based on food security status, population size and HIV prevalence (WFP Ethiopia, 2010).

Individual PLHIV participated in ES intervention are called ES Participants (ESPs) and they are targeted accordingly with WFP targeting criterion primed together with Jimma Town Health Office. About 800 ESPs were targeted year after year and have been benefitted from the project since 2012. The implementation this project being realistic, many people that have been suffering from and dying of HIV/AIDS would become to the unknot status. Thus, the health and nutritional security of people have a great impact on the social and economic life of PLHIV and their household members of Jimma town. In spite of the fact that the impacts can be expressed at different levels, this paper was focused on the social and economic impact of WFP's *Urban HIV and AIDS Project* in Jimma town.

1.2. Statement of the Problem

There is no cure or effective vaccine for HIV infection and is a serious menace that had been claiming millions of lives worldwide. According to UNAIDS (2014), Sub-Saharan Africa (SSA) is home to 24.7 million of the nearly 36.9 million people living with HIV/AIDS globally, making it the worst affected region. HIV/AIDS threatens economic development, social solidity, political stability, food security and life expectancy. So, HIV/AIDS is treated as unfinished business as well as a global development issue with huge socioeconomic implications, rather than an isolated health issue.

A significant macroeconomic impact is also to be predictable, with HIV/AIDS affecting the size of the labor force, the availability of skills and productivity. Despite its effect on the labor force, HIV/AIDS causes resources to be diverted that would otherwise be used to finance investment. Hence, the impact of HIV/AIDS on macroeconomic variables such as economic growth, per capita incomes, savings, investment and employment is likely to be notable. For governments

like Ethiopia, HIV/AIDS has an adverse fiscal impact, as expenditures rise with higher spending on health care and social support, and revenues are affected by slower economic growth.

In Jimma town, high prevalence of HIV/AIDS is expected due to the reality that HIV prevalence in urban areas is more as compared to the rural areas in one way and the town is the midpoint and corridor for south-west part of Ethiopia as well as renowned for its coffee production area (Dharmendra, Hiranmai and Dube, 2014).

The participation of aid organizations in fighting HIV/AIDS in developing countries is well recognized by both the government and the international donor community. The contribution of NGO's/Aid organizations/ in combating HIV/AIDS worldwide in general and in Africa in particular is huge. Otherwise, coupled with extreme poverty, the quandary HIV/AIDS making in the lives of developing nations would have been hazardous.

According to Jimma Town Economic and Development Office annual report (2010), WFP's urban HIV/AIDS project is under implementation since 2009 in Jimma Town. During these periods, millions of money was expensed by WFP through the project in helping peoples infected and affected by HIV/AIDS. Despite the evaluations done regarding the outcome/impacts of the project for report purposes by WFP and local government sectors, the social and economic impacts of the project was not yet deliberated.

In some cases, the impact of an aid is positive in changing/improving the lifestyle features of the beneficiaries. But, sometimes and unfortunately, we may not get the result or outcome we wished-for. The dependency syndrome on aid may arise. In this case, the positive impacts of the project will definitely going to fall.

Non-governmental organizations have been instrumental in different types support to PLHIV in Jimma town in the past decades. However, most households in such areas have remained dependent and cannot sustain their life easily. This study intends to examine the contribution of WFP's intervention to these PLHIV life stability and security.

1.3. Objectives of the Study

The principal objective of this paper is to investigate the socio-economic Impact of World Food Programmes *Urban HIV/AIDS Project:* the case of Jimma town.

The specific objectives of the study are:-

- To assess the socio-economic impacts of the project on the target group.
- To evaluate the effectiveness of WFP's HIV/AIDS project against its strategies and objectives.
- To find out the role played by local government in terms of insuring a cordial relationship between the community and WFP.

1.4. Research Questions

In this research, the following questions are identified as a phenomenon to be studied.

- To what extent does WFP's urban HIV/AIDS project contributed to the social and economic development of the beneficiaries Jimma town?
- How successful and sustainable were the strategies and objectives employed by WFP in combating HIV/AIDS in Jimma town?
- What types of activities were made by local government and/or WFP interventions that mediate the impact of WFP on the livelihoods strategies of the target group and the community?

1.5. Significance of the Study

Researches on the impact of NGO on social and economic and other features are infrequent. Though both local governments and donors conduct monitoring and evaluation on few NGOs or aid organizations (such as World Vision Ethiopia, Organization for Social Service for AIDS (OSSA) in Jimma, Mekdim Ethiopia, Plan Ethiopia, PSI Ethiopia and the like), they focus on hollow out the impact from their angle of view only. Thus, this study is differing from the previous studies for it assessed and examined the impact of WFP's Urban HIV/AIDS project from the target groups' angle principally and also the local government and donor/WFP perspective. Moreover, though the project interventions aimed at making the target groups

economically stable, were the beneficiaries felt independent and were they ready to challenge any problems in future after the project is another area that was examined in the study.

From the WFP's strategy document (2012), its indicated that the main goal/objectives of the project is to mitigate the impacts HIV/AIDS by improving the nutritional status and health of malnourished PLHIV and securing food security status of PLHIV, PMTCT clients and OVC. So, this study helps to expand the vision of the donor in incorporating the social and economic components as a target in future project implementation. In addition, for WFP, the results and recommendations of this research will be valuable as it can be practical for other similar project intervention areas.

The study shall also motivate and stimulate other researchers; hence, they will have the intellectual vigor to continuously advance learning into this seemingly grey area. In particular the research will sensitize the people of Jimma town to the negative or positive implications of donor aid so that they deal with donor aid carefully. This conscience will help them avoid dependency syndromes and to indigenize projects including those that are donor-funded. In a sense they will own their development programs. Finally, the motivation of this study to the future researchers, it will reanimate them in depth with the new approaches about the foreign aid and will add more knowledge to the existing intellectual studies.

Finally, this study is the first research document that may tend to immensely benefit the local government, donor and the beneficiaries at large.

1.6. Scope of the Study

In terms of peripheral guides, the study was confined to the Jimma town, Oromiya regional state. Mainly, WFP's urban HIV/AIDS projects Economic Strengthening (ES) activities were explored. Majority of the respondents were PLHIV in this particular study. The study in context of socio-economic impact of any project is broad. Conceptually, this study was restrained in to the study of HIV/AIDS, social and economic structures.

1.7. Organization of the Paper

This thesis is organized as follows. A detailed review of relevant theoretical and empirical literatures is presented in the next chapter.

Chapter three deals with the methodology and research approaches by outlining the opportunities provided by conducting, either qualitative or quantitative work. The research instruments, research setting and sample size and sampling techniques are also dealt in detail.

Chapter 4 presents the findings of the research is described, analyzed and collated.

Chapter 5 provides a summary of the findings as well as of the thesis. The main findings of the thesis will be summarized and the potential contribution of the study to knowledge will also be discussed. Finally, priority areas and recommendations for both further and future research are suggested in relation to a careful evaluation of the methodology, study limitations and coverage of the present study

CHAPTER TWO

REVIW OF RELATED LITERATURE

2.1. Theoretical Framework

2.1.1. HIV/ AIDS: Background and Its Impact

The human immunodeficiency virus (HIV) is a lentivirus (a subgroup of retrovirus) that causes HIV infection and acquired immunodeficiency syndrome (AIDS). AIDS is a state in humans in which progressive malfunction of the immune system allows life-threatening opportunistic diseases and cancers to bloom. Without treatment, average survival time after infection with HIV is estimated to be 9 to 11 years, depending on the HIV subtype. Infection with HIV occurs by the transfer of blood, semen, vaginal fluid, pre-ejaculate, or breast milk. HIV infects vital cells in the human immune system such as helper T cells (specifically $CD4^+$ T cells), macrophages, and dendritic cells which leads to low levels of $CD4^+$ T cells. When $CD4^+$ T cell numbers turn down beneath a critical level, cell-mediated resistance is lost, and the body turns into increasingly more at risk to opportunistic infections.[1]

The main way of spread of HIV worldwide is heterosexual intercourse with an infected individual; the virus immediately enters the body through the lining of the vagina, penis, rectum, or mouth. HIV also frequently spread among intravenous drug users who share needles or syringes. The pathology of HIV infection involves three stages: (1) primary HIV infection, (2) the asymptomatic phase, and (3) AIDS. In Primary HIV infection, the virus transmition replicates rapidly. Someone may experience acute flu-like symptoms for one to two weeks and standard HIV tests measuring antibodies are initially negative. The asymptomatic period lasts an average of 10 years and the virus continues to replicate concurrent to a gradual decline in the CD^4 count. AIDS is the final stage where patients can have dementia and develop cancers, with Kaposi's sarcoma and lymphomas. At the end, death may be expected to happen from the permanent growth of opportunistic diseases or the body's stoppage to fight off malignancies (Hormazd N. Sethna, 2003).

[1] Wikipedia, the free encyclopedia

2.1.2. HIV/AIDS in Africa

HIV is the most sexually-transmitted disease in Africa and livelihood protection and economic condition are vital determinants of its prevalence and spread. These factors also contour AIDS' impact and the outcomes of care and treatment. Livelihood protection is a consequence and a cause of HIV/AIDS and both are vibrant, growing as the social and economic background changes (Michael et al. 2012).There are two very vital uniqueness of the HIV epidemic in Africa, which needs to be acknowledged and understood, either they affected the existing response strategies or will influence and determine the coming generation of interference approach on the continent (CHG, 2012)

HIV/AIDS is a major public health concern and cause of death in many parts of Africa. Sub-Saharan Africa has the most serious HIV/AIDS epidemic region universally. In 2013, probably 35 million people were living with HIV worldwide, of which is 71% of them are Sub-Saharan Africa. In this year, there were an estimated 1.5 million new HIV infections and 1.1 million AIDS-related deaths (HIV and AIDS in sub-Saharan Africa regional overview, 2013). Nations in Northern Africa and the Horn of Africa have considerably lower prevalence rates due to their populations normally engage in fewer high-risk cultural models that have been implicated in the virus's spread in SSA. Southern Africa is the most horrible affected region on the continent.[2]

UNAIDS (2013) indicates that the number of HIV positive people in Africa receiving anti-retroviral treatment (ART) in 2012 was over seven fold the number receiving treatment in 2005, "with nearly 1 million added in the last year alone". The figure of AIDS-related deaths in Sub-Saharan Africa in 2011 was 33% less than the 2005. The number of new HIV infections in SSA in 2011 was 25% less than the number in 2001.

HIV has caused enormous human beings suffering in the Africa. The most apparent effect has been illness and death, but the impact has not been restricted only to the health sector; families, education sector, and socio-economic features have also been greatly affected. In sub-Saharan Africa, more than half of all hospital beds were occupied by HIV related problems. In many cases, AIDS causes the household to dissolve, as parents die and children are sent to relatives for care and upbringing. The epidemic ads to food insecurity in many areas, as agricultural work is

[2] HIV/AIDS in Africa-Wikipedia, the free encyclopedia

neglected or abandoned due to household illness. In the time they would have been treated by the young generation, older populations are heavily challenged by the epidemic; they have to care and look after for their grand children orphaned by HIV. There are several children orphaned by AIDS in Africa than anywhere in the world (Ann May, 2003)

2.1.3. Overview of the AIDS Epidemic in Ethiopia

As of May 2016, based on the latest United Nations estimates, Ethiopian current population is 101,583,412 which is 1.35% of the total world population (worldometers, 2016). One of the world's oldest civilizations, Ethiopia is also one of the world's poorest nation with per capita income of $550 is considerably worse than the regional average. Recently, encouraging improvement in gender parity, in primary education, HIV/AIDS, and malaria has been achieved. (World Bank Ethiopia, 2015)

HIV/AIDS epidemic were first found in Ethiopia in 1984, one to two years later than in most other Sub-Saharan countries but its major features look like those elsewhere in Eastern Africa: the relatively virulent HIV-1 is the major strain of the virus in Ethiopia, transmission is mostly by heterosexual contact and to a lesser extent to mother-to-child transmission, and the prevalence is higher among the 20-39 age group, with females higher rates than males in this younger age groups (Helmut Kloos, 2001).

The HIV/AIDS position in Ethiopia is characterized by a low intensity mixed epidemic defined by independent self sustaining HIV transmission streams within key populations with significant heterogeneity across geographic areas, urban vs. rural, and population groups (PEPFAR, 2014). In 2013 there were an estimated 793,700 people living with HIV where 200,300 of them children's. There were around 45,200 AIDS associated deaths in 2013 and about 898,400 AIDS orphans in the same year. Nationally, HIV adult prevalence is estimated at 1.5% in 2011 with substantial variation by region (from 6.5% in Gambella to 0.9% in SNNP), residence (4.2% urban vs. 0.6% rural) and gender (1.9% female vs. 1.0% male). (Country progress report on the HIV response, 2014)

Due to labor movement to large urban areas and large scale construction projects s well as a growing service industry, high prevalence in Addis Ababa and large towns are expected.

Moreover HIV prevalence is four times greater among populations that reside within 5km from a main asphalt road compared to those further away. Gambella region and the urban administrations of Addis Ababa and Dire Dawa have the highest prevalence while Southern Nations, Nationalities and Peoples Region (SNNPR) and Oromiya region the lowest. Regionally, Oromiya, Amhara and SNNPR regions, have the leading PLHIV population due to their population size (Central Statistical Agency (Ethiopia) and ICF International (2012).

2.1.4. Socio-Economic Impacts of HIV/AIDS

HIV/AIDS uniqueness and its means of transmission are the chief determinants of its impact on society. According to UNAIDS (2001), it is a central health issue and has evolved into a multipart social and economic emergency. HIV principally affects the young generation, hurting a broad path through society's most productive deposit and demolishing a generation of parents, leaving behind many orphans, dissocializing the young and child-headed households. The stigma attributed to HIV/AIDS magnifies to the impediment encountered in mounting a response to AIDS, in addition to the discrimination normally faced by infected individuals and their families.

Kara Greenblott (2007) explained common socio-economic impacts of HIV. Among them HIV reduce household labor productivity, it divert income from investment, it reduces or eliminate savings which is used for medical expenses, funerals and related costs; it cooked the time and effort devoted for production or income due to caring of household; Intergenerational skills and knowledge are also not inherited due to the fact that parents are ill or dying; children quiet school; it increased the number of orphans. We will see all these impacts in the following three areas of division.

Demographic Consequences: HIV/AIDS affects the population structure in a number of ways. There will be more morbidity and most of these people are women's and at their reproductive years which could reduce fertility rates. This doesn't mean that the epidemic will not stop population growth or populations to fall. So, the idea that "AIDS is the way out to the population dilemma" is groundless (Rene and Alan, 1997).

Social Impacts: Lives lost, critically robs the family of the only "social security" system; productive members or breadwinner are taken out, are the major costs associated with HIV/AIDS epidemic worldwide. Distress of families, extreme socio-economic and emotional loads on orphans left behind and caregivers, reduction in productivity/production and food insecurity, and the incredible costs and irresistible demands on health sectors are a few. Children marry at their earlier age, drop out of school to support the family, and take on informal labor system (Ann May, 2003).

HIV affected families are also subject to stigma and discrimination and the gender dynamics of the disease are broad due to women's inability to bargain safe sex and inferior social and economic position. More women than men are infected and surprisingly they are caretakers of PLHIV which may encumber them with the triple burden: caring for children, the elderly and people living with HIV/AIDS as well as economic liability for the whole family. The pandemic also reduced the quality of education by eroding the supply of teachers and as a result, this forces the students to drop out of school and shrink the amount of income/revenue available from school fees (UNAIDS, 2001).

Economic Impacts: According to Markus Haacker (2006) of economic perspective, the most immediate impact of HIV/AIDS is mortality and consequent decline in life expectancy. The worst-affected countries like Ethiopia, it is estimated that HIV/AIDS has condensed life expectancy by about 15-20 years. At the household level, HIV/AIDS is associated with income losses (as household head become ill and working time devoted declines) and increased expense of medication. Largely sub-Saharan Africans experience an adverse impact of HIV/AIDS on incomes, consumption, and wealth of the affected household (Ibid).

Lack of money from the illness or death of the main source of income, cutback of saving, offensive utilization of money due to lack of hope are main confrontations that PLHIV were facing (Dereje, 2013). Alterations in the age structure, additional orphaned children in line with school dropout; survival strategies leading to wearing away of the household economic foundation (due to sale of irreplaceable assets); increasing discrimination and marginalization of people living with HIV/AIDS; and mounting numbers of female-headed households (widows and grandmothers) are going to happen (Ann May, 2003).

2.1.5. The Role Non-Governmental Organizations (NGOs)

The notion of NGO came into exercised in 1945 subsequent to the establishment of the United Nations organization which acknowledged the need to provide a consultative function to organizations which were not classified as government or states (Lekorwe and Mpabanga, 2007).

The name "non-governmental organization (NGO)" has no settled authorized definition and these are termed as "civil society organizations (CSO)" in numerous influences though not every civil society organizations are NGO's. NGO is any non-profit, voluntary citizens' group which is organized on a local, national or international level.[3]

As cited by NGOs are organizations that are not governments or not created by governments. They are officially organized, private and not belongs government (but entertain government support), not-for-profit in nature (but generate profits for organizational development purpose), and are self-governed and founded on voluntary partaking (Jørgen, 2008).

The functions of NGOs may include developing individual ability, educational and health functions, awareness building and mobilizing and empowering women and the like. NGO stress on the core matter related to human origin like sustainable development, developmental aid and other humanitarian questions.[4]

NGO Vs Government: There is escalating demands on the state by the people and there is no doubt that the state is not the only source growth and development. According to Lekorwe and Mpabanga (2007), NGOs also have grown as a result of the malfunction of some sectors by governments to deliver goods and services. Therefore, the governments and NGOs require each other. Their interaction may have three options; they can complement, reform, and/or oppose the state. Nerfin's prominent words, "neither prince nor merchant: citizen" are often quoted in order to demonstrate how one can visualize of civil society as a separate subject, dissimilar from the political and economic spheres. NGOs are portrayed as non-profit stimulus and on the contrary, the private sector is profit oriented. Actuality, these subjects are not trouble-free to discriminate (Inger, 2009).

[3] www.ngo.org/ngoinfo/define.html
[4] www.ngo.in/

2.1.6. World Food Programme and HIV/AIDS

The World Food Programme (WFP) is the major programme of the UN structure focused on supplying food and endorsing food security, making it the biggest food-focused charitable organization in the globe. WFP constantly have the intention of exterminating hunger and poverty with the ultimate goal of eradication the need for food aid (United Nations (UN), 2015). WFP's HIV and tuberculosis (TB) programmes reached approximately 700,000 beneficiaries in 29 countries in 2014 worldwide. The objective of these initiative, as outlined in the policy paper "Programming in the Era of AIDS: WFP's Response to HIV/AIDS" (2003), is to supply food and nutritional for those individuals and households affected by HIV/AIDS. Main activities include: the nutritional provision programmes, orphans and children affected by HIV/AIDS support and school feeding programmes at schools and relief operations.

From Update on WFP's Response to HIV and AIDS (2015), HIV-focused funding is declining, as a result WFP approved the following sustainable holistic approach to HIV program:

- ≈ food support was linked to economic activities to promote long-term sustainability;
- ≈ work on HIV and TB was integrated with nutrition programmes in advance.
- ≈ support for HIV-sensitive social safety nets was enlarged;
- ≈ cash and voucher designs for HIV programmes were augmented; and
- ≈ Partnerships were recognized well with the United Nations Population Fund and the United Nations Children's Fund to reach women and girls.

WFP Food Assistance Policy Regarding HIV: WFP gives food and nutrition to individuals and households affected by HIV/AIDS and food insecurity. The center of attention of WFP's HIV involvements is to provide food support to treatment and care programs, maintain orphans and children affected by HIV and school feeding programs and relief operations. European commission, on their Aid Annual Work Programme (2006), HIV policies outlined below were made official by WFP board in 2003:

- WFP include HIV/AIDS agendas in all of its programming categories.
- WFP work with local and international associates to make sure that food is integrated into HIV/AIDS activities.
- WFP adjusts programming apparatus for the plan of rations and other related activities.

Food Assistance in the context of HIV: There is a two-way and synergistic correlation between food security and HIV/AIDS. In past three decades, a multifaceted, bi-directional affiliation between food security and HIV were experienced. Illness and death due to HIV/AIDS have an immediate and disgusting crash on food security in restraining income and food production of the household. Furthermore, food insecurity and poverty fuel the spread of the disease. Access to sufficient nutrition is impossible to the infected persons. At the end, the joint impacts of food insecurity and HIV/AIDS put extra damage on the existing limited resources (Mutangadura, 2000).

Against the usual shocks, the convergence of food insecurity with HIV/AIDS frequently leads to the establishment of progressively vicious cycle, with food insecurity amplifying vulnerability to the disease and HIV in turn again heightening exposure to food insecurity (Loevinsohn and Gillespie, 2003).

Food Security: A food-secure family is one in which each member in the family are well-nourished. It occurs when "all people, at all times, have physically as well as economically access to adequate, protected and healthful food to meet their nutritional needs and food preference for their well functioning of the body" (Sseguya, 2009).

According to the publication of Food and Nutrition Technical Assistance (FANTA) Project and World Food Programme (WFP), (2007), food security embraces on the following three essential elements: *adequate food availability*, *access to it* and *proper food utilization*. In the HIV perspective, food availability have a tendency to be harmed by production malfunctions arise from low productivity due to loss of useful assets needed to maintain family food production. Food access is the situation in which the household's are able to get food in the market or other sources. This access may determined mostly by household purchasing power. Here HIV affected families may be ill or burdened to have income and buy food. Food utilization refers to how much one eats and how well he changed food to energy, all of which influence appropriate biological use of the food (Ibid).

2.1.7. World Food Programme in Ethiopia

Ethiopia is positioned 173 from 186 nations on the 2014 United Nations Development Programme (UNDP) Human Development Report. However, the country has made improvement in education, extended the health structure and made outstanding accomplishments in fighting against HIV.(WFP Ethiopia Report, 2015). On yearly average, WFP supplies cash and food support to 7 million persistently food-insecure peoples. The subject of graduation, which refers to the status people reaches when they are no longer in need of food or cash support, has gained distinction due to remaining concerns of dependency syndrome. Although there is insufficient proof that safety nets can create negative cost, more verification is desirable to comprehend how to promote the beneficiaries' continuous graduation (Ibid).

Urban HIV/AIDS Programme*:* In 2014, WFP's Access to HIV Care, Treatment and Support in Urban Areas of the country and the programme targeted nearly 100,000 beneficiaries. The objectives of the Urban HIV and AIDS project are to advance the dietary status of malnourished PLHIV; to improve the food and livelihood safety HIV/AIDS affected families; to encourage the school enrollment and attendance of orphans and vulnerable children (OVC); to maintain the compliance of HIV-positive pregnant and lactating mothers to PMTCT services; and to reinforce the health system competence. The assistance was provided through food distributions, vouchers, and cash transfers. cash and voucher modality, implemented in 85 towns/cities throughout the country. For the Economic Strengthening (ES) beneficiaries, a variety of trainings and thorough technical maintenances are provided (WFP Ethiopia situation Report, 2015).

From WFP Ethiopia of "The Humanitarian Requirements Document for 2015" that World Food Programme intervened by the following three projects beneficiary breakdown nationally:

1) Protracted Relief and Recovery Operation (4.37 million total beneficiaries which include Relief Assistance (2.14 million), Productive Safety Net (1.21 million), and Targeted Supplementary Feeding (1.02 million).
2) Country Programme (909,800 total beneficiaries including School Feeding (672,600), MERET (143,500), and HIV and AIDS (93,700).
3) Refugee Operation (650,000).

From WFP Ethiopia annual report (2015), in 2015, 6,593 new food insecure PLHIV and 19,101 PLHIV carried over from the previous years are being reached through economic Strengthening Intervention (ES) that helped them to engage in group and/ or individual microenterprises. Proportion of PLHIV engaged in ES intervention experienced severe hunger dropped from 69 percent at baseline to 19 percent at the last follow-up survey in December 2014.Using the international poverty line of US$1.25 PPP a day, some 70% of the ES participants were deemed poor in 2012 and this proportion dropped to some 32.6 percent after 24 months, a reduction of 37.3% point.

2.2. Empirical Review of Related Literatures

2.2.1. Status of HIV/AIDS Worldwide

It gives the impression of being; the world is about to bring to a standstill and invalidate the overall impact of HIV/AIDS. The epidemic has been forced into decline. New HIV infections and AIDS-related deaths have fallen since the peak of the epidemic.

As of UNAIDS (2015), "AIDS by the Numbers", the following figures are in fact authorizing the above statements globally:

- 35% decrease in new HIV infections since 2000
- 42% decrease in AIDS-related deaths since the peak in 2004
- 58% decrease in new HIV infections among children since 2000
- 84% increase in access to antiretroviral therapy since 2010

In sub-Saharan Africa, there were an estimated 1.4 million new HIV infections in 2014, a drop of 41% since 2000. In 2000, there were 2.3 million infections. There were an estimated 34% fewer AIDS-related deaths in sub-Saharan Africa in 2014 (790,000) than in 2000 (1.2 million) (UNAIDS, 2015).

2.2.2. The Impacts of HIV/AIDS in Ethiopia

HIV/AIDS epidemic in Ethiopian shares many features to that elsewhere in Northeast and East Africa. The Socio-economic, demographic, cultural and political factors have extensively affected HIV transmission and spread. These dynamics function interactively at the individual

level by rising high-risk sexual behavior and at the community level in the course of population displacements and instability, unemployment, poverty, construction and urbanization and prostitution (Kloos et al. 2007).

Results from household survey in Ethiopia by Alemtsehay & Tsegazeab (2008), their study pointed to that HIV/AIDS have instant impact on human capital, household structures and greatly created dependency. In their findings, 16% of households have experienced death of their family member and of which, 89% are HIV/AIDS affected households. Therefore, mortality among affected families is higher which restrain human capital and consequently impacts on household structure. The divorce/separation rate is also high among HIV affected households. Prominent disparity is observed between orphans from both group of families in terms of absenteeism from class and dropout from school. Some 30% and 8% of the children from affected households and non-affected families reported the absenteeism, and of 20% or above of the classes and dropped out in the previous school year, respectively. The study also established that affected families have much less labor and mostly, those ill are men implying more exposure to labor shortage and, as a result, direct financial impact. To the worst, from 441 affected families chronically ill, 40% households of them sold assets and from 44 not-affected and chronically ill, 12 (29.5%) of them sold assets. 82% of the households sold assets were affected households(Ibid).

2.2.3. Donors and Impact of the NGOs

The inspiration underlying aid distribution of donors has so far considered only bilateral and multilateral aid streams. Most NGO's works as per the orders given from their particular head offices that might be a challenge in community interventions and may occasionally result in mislaid priorities. Therefore, the effectiveness and impact of the NGOs development initiatives will set out to shrink.

According to Gilles and Boriana (2012) findings, most of the time NGOs intervene in poor nations with low life expectancy and they emerge rather resistant to strategic concerns, as the pressure of the donor that funds is very fragile, and they don't actually reply to the business contact between the recipient nation and their original region. In this case, undemocratic and extremely militarized nations are less likely to gain from NGO aid.

The number of the beneficiaries had experienced improvement in their incomes and productivity levels as compared to the circumstances prior to the interventions of the NGOs significantly. There was a strong and significantly positive relationship between health, education, water and community involvement on one hand, and households' efficiency/profits and living environment on the other hand. They conclude that there was a significant correlation between NGOs interventions and enhanced socio-economic position of beneficiaries (Osei-Wusu et al. 2012).

On the other surface, NGOs have negatively impacted the beneficiaries they helping and the surrounding communities to some extent. This may be due to varied causes occurring from both the beneficiaries and the community in one hand and NGOs/donor intervention system in other side. As most of funds of NGOs were almost totally externally supported and determined by it, the sustainability concern will be critical and without doubt the majority of these NGOs and their structures will be closed. Busiinge (2010) has found out that NGO projects are a imitation of the donors' strategy objectives and do not involve the beneficiaries and the community in their plan. Further, the power disparity originated by the economic muscle of the donor, NGOs are improbable to put into practice the schema of the beneficiaries and their communities. Majority of NGO's have no prospect lacking donor support and their project donations had created dependency syndrome in the community(Ibid, 2010).

2.2.4. The Role NGOs VS Government in HIV/AIDS

Non-governmental organizations (NGOs) and states relationship has never been trouble-free particularly in Africa. Development NGOs have guaranteed that HIV/AIDS is an essential part of their programme center as sustainable development can only be recognized after the limiting the adverse impact of this pandemic. From Zungura (2012) findings, NGOs has supported a number of orphans due to HIV/AIDS who might have dropped out of school because of their failure to pay school fee. NGOs intentionally put themselves even in rural areas to attain all societies and cultures Therefore, NGOs are better positioned to move ahead HIV/AIDS government programmes.

In another angle of view, there may be imperfect harmonization between NGOs and government due to sometimes the donor's choice to channel funds and directives through NGOs and not

government has crippled the connection. Sometimes, the community may face two or more NGOs providing similar services even at the same time period which hinders the improved strategy in response to HIV/AIDS and finally shrinking the intended goal. Although occasionally, some NGO's involve in political movements by omitting the development assignment they have to accomplish. In the study of Zungura (2012) in Zimbabwe, PLHIV have revealed that NGOs in their daily visits of the patients, they were intensely concerned in complementing government efforts in the health system programmes. Sometimes beneficiaries were sent back without a ration that would be provided because of those beneficiaries suspected to support government. Consequently, the government will be against NGOs and at any time they are suspected in political involvement and against the government policies, immediately forced to stop any interventions throughout the country.

2.2.5. Outputs of Food Security in HIV/AIDS

There are different hypothetical justifications on the impact of HIV/AIDS on food security Alemtsehay & Tsegazeab (2008), in their logistic regression model study findings, HIV affected households had a probability of 27.8% lower than those unaffected by the disease in terms of falling into "better" nutritional class. Concerning food access, households with food from own production were less in the affected than not affected implying the HIV affected households produced a smaller amount of food (Ibid). Therefore, the HIV/AIDS affected households had inferior consumption than non-affected households.

The evidence from Dipankar and James (2009), PLHIV families previously had been used to get food rations from AIDS support association, not only harvested sufficient for their needs but had supplementary for the market to sell so as to meet other financial needs. Definitely, these families were able to feed themselves contrast to relying on safety nets which consequently brought back their status in the community as productive, and thus decreased stigma and discrimination. There was also an optimism considerably developed among the clients.

CHAPTER THREE

METHODOLOGY OF THE STUDY

This chapter is vital for the study to demonstrate the details of research design, methodology, research approach and sampling methods as well as the source and manner in which the data were collected and analyzed for the study.

3.1. Site Description

The study was conducted in Jimma town, Oromiya Regional State, Ethiopia. Jimma town is located in south west part of Ethiopia at 347 Km from Addis Ababa. The town has a total of 17 kebele administrations with 13 urban kebeles and 4 rural kebeles. Currently, the town has a total population of 189,733 (projected Central Statistical Agency (CSA), 2015). Jimma town as has a high prevalence of HIV/AIDS due to being urban area and the town is a midpoint and corridor of south west part of Ethiopia.

3.2. Research Design

In this specific study, analytical and descriptive types of research designs were used. These methods are used because various activities were performed in identifying the socio-economic impacts of the WFP's Urban HIV/AIDS project operating in Jimma town. In this study also, a mixed method research approach was used. This is an approach to investigation concerning collecting both quantitative and qualitative data; combine the two forms of data, and using separate designs that may involve theoretical suppositions and frameworks where these two approaches provided more inclusive perception of a research problem than either approach alone. The qualitative research attempts to review experiences and events appropriately and with their character setting and attempts to analyze historically. The quantitative research design uses statistical processes in describing representation of behaviors and comprehensive findings from sample to population of interest. Soundly deliberated and implemented quantitative research has the merit of being able to make overview for a wider population on the findings from the sample. Therefore, the utilization of both methods made possible the researcher to acquire sufficient, pertinent and consistent data to the issue under the study.

3.3. Method of Data Collection

Verifications of facts, events and incidents are acquired through the data collection. This study used both the primary and secondary data's. The quality and reliability of the research findings fundamentally stand on the quality and reliability of appropriately accessible data from any sources. The primary data was collected from direct WFPs beneficiaries, local government sectors and NGOs working on HIV/AIDS through written questionnaires and observation. The secondary sources of data were obtained from the reports and different strategic documents concerning the issue from different organization, including WFP, local government offices, and different health institutions.

During the field work, each of the data collectors was in charge of their respective kebeles. The researcher and programme coordinator from WFP Jimma Office, as a leader, roles were to oversee the work in all the kebeles (provinces). 6 data collectors (with pertinent experience in the HIV/AIDS activities) were recruited and oriented to undertake the data collection exercise in the selected kebeles. Stakeholders in each of the sampled areas were informed of the aims and objectives, and permission was obtained from all for the interview.

The gathering of data for each local government sectors involved the use of a variety of methods. The main methods included are: Review of reports, Personal interviews and Physical observation/checks.

The instrument that was used to collect information relating to the various indicators included is questionnaires for personal interviews and there were 3 types of questionnaires: individual beneficiaries (ESPs), local government sectors and NGOs working on HIV/AIDS.

3.4. Sources of Secondary Data/Information

Relevant review of literature was done to determine both the comprehensiveness of the accessible data and development of the hypotheses that formed the setting for the field study. The secondary data/documents were sourced from:

- Jimma town Health Office quarterly and annual progress reports of HIV/AIDS activities

- Jimma town Finance and Economic Development Office quarterly and annual financial reports.
- World Food Programmes HIV/AIDS intervention in Jimma Town and country level

3.5. Population and Sampling Techniques

3.5.1. The Population Size

World Food Programme is one of the Non-governmental organizations acting in co-operation with the government towards supporting and enabling the HIV/AIDS victims as a target group through its urban HIV/AIDS projects operating in Jimma town. Since the particular project of the of the program is ensuring the nutrition and food security to the target group so as to enable them socially and economically productive, it is currently acting towards achieving this goal.

It emerged from this research that the case study organization implemented "**Urban HIV and AIDS Nutrition and Food Security Project"** uniformly in more than 50 towns throughout Ethiopia where Jimma town was among the project intervention area. From Jimma town Health Office, it was found that World Food Programme has three beneficiary categories: PLHIV (People Living with HIV) support, OVC (the Orphan Vulnerable Children) Support and PMTCT (Prevention of Mother to Child Transmission) support groups. The researcher purposely confined himself only on PLHIV category of Economic Strengthening Participants (ESPs) sub group. This is because of two reasons: firstly all these ESPs were targeted from those under PLHIV and PMTCT support groups and most of OVC support groups are their children's and grandchildren's. The second reason is that from all support groups unlike the rest ESPs have a comprehensive support with food, cash, trainings with continuous follow up from both local governments and donor side that made significant to see the impact of the project well. Therefore, the total number of ESPs was 800 up to end of 2015 taken as a population size in the study.

The study was also employed other external (including private and government agencies) sources of data from within the town in order to analyze the social as well economic impacts of the organization to the town and the country in general. For this purpose, the data were gathered from local governmental sectors (particularly Jimma town Health office, Education Office, Women and Children affair office and the office of Labor and Social affairs) as well as other

NGOs functioning on HIV/AIDS in Jimma town. In each organization, the questionnaires were distributed to the HIV focal persons working as a distinct department.

3.5.2. The Sampling Technique

The sampling strategy was a two stage process. The first stage involved selection of kebeles (province) for study. As recommended by Jimma Town Health Office based on HIV/AIDS prevalence and taking into account the socio-ecological diversity, 8 kebeles were included to ensure a fully representative sample. The second stage involved selection of individuals of study within the selected kebeles. These individuals were mainly PLHIVs included in WFP support programme. Finally, these individuals were selected using the simple random sampling method.

As stated in the above section, the total size of the target groups was 800. There are four governmental agencies and 12 NGOs acting on HIV in the town from which the data was proposed to be collected. The respondents were divided in to three strata based on their homogeneity (type of formation): being, governmental organizations, NGOs and the target groups. Since governmental organizations are small in number, all will be included in the study. On the rest target group, simple random selection technique will be applied.

The (Kothari, 2004) method is to be used in sample size determination. The formula commonly used in determining the sample size is given by:

$$n_0 = \frac{N}{1 + N(e^2)}$$

Where n_o – the Sample size N - The population size & e - the sampling error (e=5%)
Accordingly,

$$n_0 = \frac{800}{1 + 800((0.05)^2)}$$

$$n_0 = \frac{800}{3}$$

$$n_0 \approx 267$$

Following the above approach, a sample size of 267 individuals was determined to provide reliable estimates for the chosen kebeles and the town as a general.

3.6. Methods of Data Analysis

In order to deal with the full terms of reference and thereby provide the necessary information for assessing the socio-economic impact of World Food Programmes Urban HIV/AIDS Project on Jimma Town, there was need to analyze and reduce the masses of data generated by the field exercise to get meaningful parameters/statistics. Both primary and secondary data were analyzed and presented quantitatively. This was accomplished through the use of various statistical and econometric packages for handling both quantitative and qualitative analysis. The researcher analyzed two areas: the social and economic impact of the project, from the PLHIV engaged in Economic Strengthening activities. The data collected from all beneficiaries, the organization, display and analysis of data, was based on a combination of descriptive statistics tools likes mean, percentages and statistical software SPSS version 20 was used to facilitate the interpretation of the results of the data.

To analyze the economic impact of the project the researcher selected the change in change in yearly income of beneficiaries as dependent variables and multiple linear regression analysis was done to determine the independent influences.

The dependent variable is the average annual income or profit which is given by:

$\Delta \mathbf{Y} = \left(\frac{\mathbf{Y_t} - \mathbf{Y_{t-1}}}{\mathbf{Y_{t-1}}}\right) \mathbf{100},$ Where $\mathbf{Y_t}$ is annual income at period $\mathbf{t}$ and $\mathbf{Y_{t-1}}$ represents previous annual income of the beneficiaries.

The explanatory variables that were entered in the adopted model are:

1. Different supports provided by WFP like food, cash and trainings supports (WS)
2. Different supports provided by local government administrations like work space, finance, free health service and moral (LS)
3. Previous business experience (EX) in the area of their business intervention in year
4. Types of business (BT) beneficiaries engaged in like trade, production, agriculture, service and etc
5. Business formation (BF) is whether beneficiaries worked in cooperative or individually (sole proprietorship)
6. Educational level of the beneficiaries (ED)

7. Sex (SE) of the beneficiaries.
8. Business training (TR) taken by the beneficiaries (trained or not trained)
9. Consumer attitudes towards their products/services (AT)
10. Family size of the beneficiaries(FS)
11. Regular technical follow up (TF) from WFP or local government on their business.
12. Seasonal Factors (SF) (winter or summer season)

Then, we can develop the single equation model considering our dependent and independent variables. The regression model takes the following form:

That *is* $\Delta Y = f(WS, LS, EX, BT, BF, ED, TR, SE, FS, CA, TF, SF) \cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots (1)$

The researcher developed the following model to test the impact of independent variables on average yearly profit change.

$$\Delta Y = \beta_0 + \beta_1 WS + \beta_2 LS + \beta_3 EX + \beta_4 BT + \beta_5 BF + \beta_6 ED + \beta_7 TR + \beta_8 SE + \beta_9 FS + \beta_{10} CA + \beta_{11} TF + \beta_{12} SF + u \cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots\cdots (2)$$

Where β_0=Constant, β_1, β_2…… $\beta_{11}$and β_{12}= coefficient to estimate the relationship between change in average yearly income and the independent variables and u - Random error term. Therefore, change in income is the function of all the above variables:

It was established that after the data were analyzed, variables like business sector, business formation, business trainings, sex and seasonal factors were not significantly affecting the dependent variable at 5% significant level and removed from the model. In other hand, two variables were identified and they significantly affected the dependent variable at 5% significant level and included in the model. These variables were marital status of the respondents (MS) and business area location of their respective business. Accordingly, the revised model is

$$\Delta Y = \beta_0 + \beta_1 AG + \beta_2 ED + \beta_3 MS + \beta_4 FS + \beta_5 WS + \beta_6 LS + \beta_7 EX + \beta_8 BA + \beta_9 AT + u \ldots.. (3)$$

3.7. Expected Impacts of Independent Variables

Supports provided by WFP (WS): this includes supports like food, cash and trainings. Food and cash (financial) supports are expected to affect the income of the beneficiaries directly and

positively. Trainings on business and other life skill trainings also contributes for the improvements and strengthening of the business efficiency.

Local government Supports (LS): here also the local governments especially the kebele (province) provides free working spaces for PLHIV that would increases the cost of rent or buying this places. Sometimes, there are also other supports provided by LG like financial and free health service for those who are PLHV and very poor. So, other things being stable, this variable has direct impact on the income of these beneficiaries.

Business experience (EX): in any area of one's business intervention, business experience has always had a credit on the profitability of respective businesses. So, having an experience in any businesses make someone to be in a better position in gaining profit than otherwise. Therefore, other variables being stagnant, this variable have directly related with income.

Types of business (BT): in this variable, the study tries to identify the engagement of beneficiaries in business type like trade, production, agriculture and service. The sign of this variable is indeterminate since which of business types have positive or negative impact on income PLHIV in this study.

Business formation (BF): in this variable whether beneficiaries worked in cooperative or individually (sole proprietorship) are seen. Since both of these formations have their own merits and demerits, it's challenging to forecast their sign in affecting income. So, this variable is indeterminate.

Educational level (ED): education is a key for effective and efficient accomplishment of any currier. So, other things being constant, education has a positive impact on income.

Sex (SE): this is also another variable that is impossible to identify the expected sign. Therefore, sex is indeterminate.

Training (TR): different trainings taken by the beneficiaries have a credit for to be effective in business activities. So, other things being constant, being trained has a positive impact on income than not trained.

Consumer attitudes (AT): concerning HIV, most of the time the issue of stigma and discrimination arise in many ways. In this variable, consumer's attitude towards the products and services provided by PLHIV is seen as a great challenge for not only to be profitable but also in business existence. So, if consumers have a good/positive attitude on PLHIV products/services, other things being stable, this variable have positively related to income and if not negatively related. So, this variable is indeterminate.

Family size (FS): the impact of family size on income depends on the nature of dependency of family member's status. If there are dependent family members in a household, the family size have negative impact on income and if not, positive impact on income. So, the sign of this variable is indeterminate.

Technical follow up (TF): technical follow up and support from WFP or local government on the businesses PLHIV running have sound impact on the effective business progress. So, other things being constant, this variable has a positive impact on income

Seasonal Factors (SF): seasonal variability is also seen as a factor for any business profitability. In this study, if the season is winter, there are a favorable marketing and differenet business activities can be done so that positive income progresses. In contrast, if the season is summer, it's difficult to have alternative business activities so that negative income-season relationship will happen.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1. Introduction

This chapter presents the key findings of this research according to research objectives and the research questions. The findings in this chapter have been arranged accordingly with the following topics: nature of projects by the case study organization, the socio-demographic features of the informants and the social and economic impact of these projects onto their intended primary beneficiaries and the surrounding community. The study investigated a sample of 267 people living with HIV (PLHIV) receiving different kinds of supports like food, financial and trainings by World Food Programme targeted with the help of Jimma Town Health Office in Jimma town.

4.1.1. Socio-Demographic Characteristics

Sex of the Respondents

Women are predominantly important in any approach to HIV/AIDS prevention. Women's disadvantaged biological, economic, social and reproductive position in most societies is a major factor influencing the spread of HIV. In general, women face greater risk of rejection, ostracism and neglect when they are infected. It was emerged that most of the respondents (74.4%) were females and 26.6% of them were males and the programme should be appreciated for that in empowering women's more. The general perception was that women needed to be economically independent.

Age of the Respondents

The socio-demographic characteristics of study are listed in Table 2 below. It was established that most (66.3%) of the respondents were between 31-45 years of age. About a one fifth (20.6%) are young with less than 30 years of age and 13% of the are at old age group above 46 years of age. Traditionally we know that an increases in earnings in the early years, a peak around middle age, and a decline thereafter. Age is an important aspect as it determines one's

knowledge and experience in income generation activities. As people age and gain work experience, their earnings might be expected to continue to rise or at least remain stable until retirement (Luong and Hébert, 2009). However, this appears not to be the case with this study that we find that almost all the respondents were HIV positive who actually needs an attention regardless of their age. In this study, being around 79.4% of the respondents were above 30 years of age, we find that as the age variable is significant in affecting the annual income. As age increased, the average annual income is going down by 0.188%.

Educational level

Illiteracy, male gender, no perceptible source of income, and being widowed, divorced or separated are associated with poor quality of life among PLHIV (Banandur et al, 2011). The low educational attainment level may be attributed to low levels of income. In this study, as educational level increases it was found that there is an increase in average yearly income too. About 7.5% of respondents were did not attend school at all while a relatively low proportion (1.9 %) advanced beyond secondary school level. Most of the respondents were in educational category of 1 - 4 and 5 - 8 grades with about 40.4% and 41.2% respectively. Around 9% of them are found with educational level of 9-12 grades.

Marital status

Family status and stability as well as family formation may matter even more than incomes. A further analysis of the marital status of the household head was also done. The findings from this study indicate that the majority of the respondents (42.7%) were divorced or separated while 10.5% were widowed (Table 2 below). The rest of respondents were single and married with 22.5% and 24.3% respectively. From the study, we found that being married and then being single is having more positive impact on the yearly average income than being divorced or widowed.

Household size

The results of the study are presented in Table 2 below again. It was established that the majority of households (49.4%) and (42.3%) had household members between 4-6 and less than 3 household members respectively. Minority respondents (8.2%) had more than seven household

members. The study results clearly show that family size significantly affected yearly average income negatively.

Table 1: Socio-Demographic Characteristics of the Respondents

Characteristics	Frequency	Percent
Age in years		
Less than 30 years	55	20.6
Between 31-45 years	177	66.3
Above 46 years	35	13.1
Sex of informants		
Male	71	26.6
Female	196	74.4
Educational Levels		
Illiterate	20	7.5
Grade 1-4	108	40.4
Grade 5-8	110	41.2
Grade 9-12	24	9
Above 12 grade	5	1.9
Marital Status		
Married	65	24.3
Single	60	22.5
Divorced	114	42.7
Widowed	28	10.5
Household Size		
Less than 3	113	42.3
Between 4-6	132	49.4
More than 7	22	8.2

***Source**: SPSS Output based on survey data.*

4.1.2. Nature and Strategy of World Food Programme

This section presents findings according to research objective two, that is, to evaluate the effectiveness of WFP's HIV/AIDS project against its strategies and objectives in Jimma Town. The key research question that was asked under this objective was what key strategies and objectives were employed by WFP in tackling HIV/AIDS; and how successful and sustainable were the strategies in combating HIV/AIDS in Jimma town? What follows in table 1 below is a discussion and analysis of key findings to this question.

Table 2: WFP's support types and its contribution for beneficiaries

Variables	Frequency	Percent
Support type from WFP		
Food support & Training service	44	16.5
Trainings & Financial support	51	19.1
Food & Financial supports	17	6.4
All (Trainings, Food & Financial)	155	58
WFP Creation Opportunity to live		
Low	19	7.1
Moderate	74	27.7
High	174	65.2
WFP Contribution for Work ability		
Small	28	10.5
Medium	82	30.7
Large	157	58.8
WFP Contribution for Health		
Nothing	11	4.1
Little	39	14.6
Medium	101	37.8
Great	116	43.4

***Source**: SPSS Output based on survey data.*

It was found that the programme incorporated different types of support type components. From table 1 above, it was established that 58% of the respondents have got all the support type components (Trainings, Food & Financial). The rest of them were supported with one or two types of the components. It was established that this support has a significant effect on the income of the beneficiaries. This is also described in another way that from the table 1 that 58.8% and 30.7% of beneficiaries work ability were increased largely and moderately in respective which also implies an improvement in income earnings. Additionally, the informants felt that 43.4% and 37.8% of them witnessed that their health status were improved greatly and moderately in respectively due to WFP support. Generally, the support highly benefited PLHIV incorporated in the project multidirectional. This is also confirmed in table 1 above that the project created an opportunity to live for beneficiaries of 65.2% (highly) and 27.7% (moderately).

4.1.3. Business and Business Related Characteristics

Type of business formation

From table 3 below, majority (76.8%) of the respondent's business formation is sole proprietorship and 21% of them were involved in cooperatives business. Although both the business formations have their own merits and demerits, in this study it was found insignificant in influencing the yearly average income. About 6(2.2%) of the beneficiaries were not engaged in either of the two business forms due to lag of financial support release and other personal problems (behavior) they have accordingly the information from the WFP programme coordinator at Jimma branch.

Respondents Business Experience

It's obvious that any experience in any intervention have a credit for the well accomplishments of any movement. Likewise in this study, business experiences in the respondents' area of business activity have highly significant in affecting their respective yearly average income positively more than any other variables with coefficient 0.881. From table 3 below, we can find that 73% of them have an experience on their respective business activity.

Business Sector

The business sector is also one variable that might be the reason for the success in any business activity. In this study it was found that most of (68.2%) of respondents were engaged in the so called trade business sector. Also insignificant at 5%, the study result shows those business sectors other than trade were more impact on yearly average income.

Table 3: Characteristics about business and business related issues

Characteristics	Frequency	Percent
Type of business formation		
Sole proprietorship	205	76.8
Cooperative	56	21.0
Respondents Business Experience		
Yes	195	73.0
No	72	27.0
Business Sector		
Trade	182	68.2
Service	29	10.9
Manufacturing	19	7.1
Agriculture	26	9.7
Business trainings		
Yes	246	92.1
No	21	7.9
Business area location		
At commercial area	128	47.9
Far from commercial area	139	52.1

***Source**: SPSS Output based on survey data.*

Business trainings taken

Another business related variable that significantly have an impact on yearly average income is business trainings (both long and short period) given by the local governments and World Food

Programme itself. The result of the study from table 3 above shows that almost all (92.1%) of the beneficiaries were provided with business trainings. Although the trainings was given by both by the local governments and World Food Programme, it was found that World Food Programme delivered consecutive business trainings more formally to all the beneficiaries as mandatory.

Business area location

In any business activity, the areal position of that specific business has an acknowledgment in any business success. For more retail business, foot traffic is more important that they shouldn't be tucked away in a corner where shoppers are likely to bypass. In our study, the position where these businesses were located has a great significant impact on yearly average income of the respondents. It was established from table 3 above that 47.2% of the businesses owned by these beneficiaries were found at commercial places. The rest 52.8% of the businesses owned by these beneficiaries were far from the commercial places that related to their respective business types.

4.2. The Social and Economic Impact

This section presents a discussion of the key findings under general objective of this research that sought to examine the social and economic impacts of World Food Programme on their intended beneficiaries and the community around.

4.2.1. The Social Impact

The social impact of HIV/AIDS has been noticeable in various ways. Stigma and discrimination, lack of confidence to interact with other people, increasing rate of orphans and dropouts from school were problems that had been related with HIV/AIDS epidemic. The key research question investigated under this research objective was what are the socio-economic problems facing the PLHIV individual per household; and to what extent does WFP's urban HIV/AIDS project contributed to the social and economic development of the beneficiaries in Jimma town? With the intervention of World Food Programme, this study found that there were improvements in the following social variables of the beneficiaries.

Children and Schooling

Education is broadly seen as critical to social mobility, equality of opportunity, the development process, and poverty alleviation. Children in families affected by AIDS in sure face reduced opportunities to enjoy the benefits of education. According to the information from the informants, the number of school drop outs increased from time to time because of HIV/AIDS in general. It was mentioned by the informants that the children of HIV positive parents faced problems to attend school regularly. From table 4 below, we can find the results that previously before the support a total of 62 (23.2%) households out of 267 respondent's children dropped out school due to food shortage, school fee and health problem of the head of the households.

Table 4: Children Dropped School, Reasons for Dropping School Before WFP Support and School Improvement after WFP Support Cross Tabulation

Variables/Characteristics	Children dropped school before		
	Yes	**No**	**Total**
Reasons for dropping school before WFP			
Food shortage	5	0	5
Lack of school fee	30	0	30
Health problem	23	0	23
Total	**58**	**0**	**58**
School improvement after WFP			
Yes	58	174	232
No	4	31	35
Total	**62**	**205**	**267**

***Source**: SPSS Output based on survey data.*

Following World food Programme involvement, a total of 232 (86.9% of 267) informants' children's school status was improved. Of which 58 out of 62 respondent's children dropped out school, their schooling occurred and become improved that was unrealistic before. Furthermore, the support was clearly effective in making to cover the children's school fee, to solve food

shortage as well as improving health status of the beneficiaries. This implies that the qualities of life of these households were improved and then their respective social status upgrading was recognized.

Social Relation

The second social impact that was mentioned by the informants was fear of interactions with other members of the society. People with HIV/AIDS were not frequently seen interacting with people freely. They preferred to be alone due to the attitudes that the people in their society had about the epidemic. Therefore, they separated themselves. To see the change after WFP project intervention, the informants were asked about their social interaction with the WFP staffs, with other PLHIV and the community around themselves as shown in table 5 below. Accordingly, 53.9% of the respondents have well and 36% have moderate in relation with other PLHIV. Only 10.1% of them are poor status in their relation. Regarding interaction with the community around 43.4% and 52.1% of them were good and moderate relation respectively.

Table 5: Social Relationship among the Respondents and Community around them

Type of Relation	Status	Frequency	Percent
With other PLHIV	Poor	27	10.1
	Medium	96	36
	Good	144	53.9
With all the community	Poor	12	4.5
	Medium	139	52.1
	Good	116	43.4
WFP contribution for this relations	Small	22	8.2
	Medium	128	47.9
	Large	117	43.8

***Source**: SPSS Output based on survey data.*

The implication of the above findings is that members of these organizations were not isolated, but were in close contact with other people. These interactions are a source of knowledge, as well as of financial, psychological and emotional support, which may, in turn, improve the health and welfare of interacting individuals. Interactions also result in people getting to know each other and provide a basis for collective action. To all these interactions, the contribution of WFP was great and contributed at large and moderately for 43.8% and 47.9% respondents respectively.

Individual Status

Table 6 below shows the informants feeling happiness and confidence in living with HIV. Accordingly, 94.4% of the respondents were feeling happy with all what they have and who they are and 80.5% of respondents have much confidence to sustain life with HIV and its all confronts. The implication is that these people were become strong background socially and economically that WFP have a lion share in building the strength.

Table 6: General Feeling and Confidence of Respondents

Variable/Characteristics	Frequency	Valid %
Feeling happy		
Yes	252	94.4
No	15	5.6
Confident living with HIV		
Less confident	9	3.4
Same as before	43	16.1
Much confident	215	80.5

***Source**: SPSS Output based on survey data.*

4.2.2. The Economic impact

The unpleasant impact of HIV/AIDS can also be exposed in the consequence it has on the economic status of PLHIV. One of the most commonly observed ways in which HIV/AIDS affects households and individuals is through the unexpected loss of income and economic security as household earnings decline and medical expenses increase. In the interview with the informants, the researcher came across a lot of factors that had influenced economically their life before WFP support. Lack of money due to the sickness or death of the breadwinner, reduction of saving, improper utilization of money because of lose of hope and lack of labor force in the household were the major challenges that PLHIV were suffering from. According to the Jimma Town Health Office, there were families that reached at a complete poverty due to sickness and death of household heads.

To analyze whether WFP support actually changed the economic life of these beneficiaries or not, the researcher took their annual income progress as a dependent variables and exhaustively identified all explanatory variables that may have an effect on income. The following coefficient table was found from linear regression of SPSS tool. From table 7 below, the adjusted R-squared for this model is 0.563 or 56.3% of the variation in annual income progress of the beneficiaries can be explained by this set of variables. The F-statistic also indicates that the overall model is statistically significant and different than zero.

Table 7 below shows that age of the informants and family size variables were negatively related to the annual income whereas the rest variables were positively related to income. As described in section 4.1.2 earlier age is the major factor in affecting one's earnings. What made the things worst were the informants being PLHIV that added for the variable to be more sensitive even earlier age than we expect. The other variable that affected our model negatively was the size of the family in a household. This shows that there are more dependent family members in those households with more family members.

Education and income have a positive relationship in this study affecting the income by 18.3%, other variables being stable, as educational level of the respondents increased. In the above equation, the variable that has a greater impact of all on the income is business experience that the informants had before. Other variables being constant, 44% of increment in income is due to

the reason that these PLHIV to have an experience on business activity. From descriptive statistics, 195 (73%) of informants have an experience on business which makes fertile for World Food Programme ES activities and success to some extent.

Table 7: Impact of Explanatory Variables on Annual Business Profit of the informants

Independent Variables	***Unstandardized Coefficients***		***Standardized Coefficients***	***t-value***	***Sig.***
	B	*Std.Error*	*Beta*		
(Constant)	0.523	0.429		1.220	0.224
Sex	-0.225	0.088	-0.113	-2.546	0.012
Age	-0.285	0.067	-0.188	-4.226	0.000**
Educational Level	0.195	0.047	0.183	4.172	0.000**
Marital Status	0.111	0.041	0.122	2.694	0.008*
Family Size	-0.344	0.062	-0.243	-5.523	0.000**
Support from WFP	0.154	0.033	0.208	4.722	0.000**
Support from LG	0.069	0.024	0.132	2.898	0.004*
Type of business formation	-0.087	0.097	-0.041	-0.895	0.372
Business Experience	0.894	0.092	0.440	9.686	0.000**
Business Sector	0.060	0.080	0.033	0.750	0.454
Business trainings taken	0.241	0.145	0.074	1.664	0.097
Business area location	0.437	0.077	0.250	5.677	0.000**
Business age in year	0.004	0.052	0.003	0.069	0.945
Follow-up of LG or WFP	-0.070	0.080	-0.039	-0.873	0.384
Impact of season	0.026	0.107	0.011	0.247	0.805
Other financial sources	-0.121	0.084	-0.067	-1.443	0.150
Attitude towards products	0.303	0.052	0.259	5.865	0.000**
Community support type	-0.018	0.046	-0.017	-0.402	0.688
Adjusted R^2 =0.563					
F statistic= 18.788 (***P***-value = 0.000)					

No of studies=267 **Significant at 5%* ***Significant at 1%*

Source*: SPSS Output based on survey data.*

The issues of stigma and discrimination are always arising wherever HIV issues considered. Stigma and discrimination have taken their toll in Ethiopia not only at the work place, in housing, health facilities, schools, and in family and personal relationships but also in the medical services, discouraging people from being tested for HIV (Lindtjørn, 2001). In this study, the attitude towards the goods and services sold by PLHIV was taken as a variable. So, attitude towards their product was significant variable for income to increase. Most of PLHIV informants also gave their words that previously it's impossible to be successful in any type of business activities due to negative attitude towards on our goods and services. In this study, other things being constant, attitude of the consumers have 25.9% contribution for income to change from past years.

Every business owner must figure out how location will or won't contribute to the success of the business and choose the spot accordingly. For more retail businesses like most of PLHIV in this research do have, foot traffic is more important that they shouldn't be tucked away in a corner where shoppers are likely to bypass. In our study, other variables being constant, the position where these businesses were located has a great significant impact with 25% on yearly average income of the respondents. It was established that 126 (47.2%) of the businesses owned by these beneficiaries were found at commercial places in an opinion given by themselves.

WFP's economic impact also identified and its direct support have an impact in 1% significant level. Other things being constant, 20.8% of income change was confirmed that it's owed to WFP support. The indirect support that the researcher wants to explain is the local governments working area provision. It was identified from interview with local governments officers that the working space were given with the precondition of WFP supports and those who were agreed to work cooperatively. It was also identified that 46.2% (67) of beneficiaries were provided with working space from a total of 145 beneficiaries supported by different types of support by local government. This space provision, added with other types of supports the local government given, other things being constant, have an impact of 13.2% on income the beneficiaries to rise.

From table 7 above, age of businesses was insignificant to affect the income of the beneficiaries that was supposed to affect positively. It was also identified from local governments administrators that most of the time, these peoples businesses deteriorated as the age of businesses increased unless strong technical support were by near. From the town health

department, the officers experienced that some beneficiaries used to benefit from two or more NGO's working on HIV by having different names for registration. Therefore, unless what discussed above critically considered, the so called "dependency syndrome" will affect the community widely.

4.3. The Role of Local Government and Community

It's obvious that NGOs are operating in an environment where external resources are necessary for success and where there are a large number and variety of actors. Families need support, they need incomes and medicine for the sick and they need information. Therefore, their roles require external connections and linkages with other actors. Here in our case the local government has a particularly crucial role to play, not only in providing with the necessary resources locally existing but also in linking the marginalized community to the civil society and even to the donor community. Furthermore, PLHIV acquire ART (therapy drugs) totally from government health institutions and HIV/AIDS organizations also refer their clients to for treatment to these institutions. Therefore, the local government and its institutions are critically important in the way NGOs operate and their success onward.

In this section, the research question number three which says what type of activities were made by local government that mediate the impact of WFP on the strategies will be answered. Here we found four types of support (Working space provision, financial support, free health service and Psycho-Social services) that the local government with its sectors like Jimma Town Health Office, Jimma Town Women's and Children Affairs Office and Jimma Town Social and Labor Affairs Office. Table 7 below shows that about 54.3% of the beneficiaries out of 267 samples were supported with working space provision (25.1%), financial support (5.2%) free health service (19.9%) and psycho-social support (4.5%). It was also recognized that these supports significantly had an impact on the yearly average profit of beneficiaries with a coefficient of 13.2%.

Community Support

It was found that the community side by side with local government and different NGOs intervened in HIV activities have a great role in treating and capacitating PLHIV around them

with all resources what they have as much as they can. From table 7 above, it was established that moral support (71.2%) covers the leading among what the community did hold in. the others include in-kind (16.5%) and financial (8.6%) support.

Table 8: Support from the Community and Local Governments.

Types of supports	Frequency	Percent
Support from Community		
In kind	44	16.5
Financial	23	8.6
Moral	190	71.2
In-kind & Financial	4	1.5
All types	6	2.2
Support from local governments		
Working space provision	67	25.1
Financial support	14	5.2
Free health service	52	19.5
Psycho-Social support	12	4.5

***Source**: SPSS Output based on survey data.*

Trust on Personal Cases

Interactions between the community and state agents were similarly varied with findings of improved relations as well as disaffection and hostility. Government is an important element in the protection and promotion of PLHIV in their overall life activities. This activity starts with interacting smoothly to these people personally. Unlike that, the result we got from the responses of respondents was, they don't trust government officials that much in discussing their personal issues. From table 8 below, we can see that 64.4% of respondents were not trust government officials in discussing their personal cases. To the reverse they prefer to share the same issues to NGO officers including WFP. The following table shows the degree of trust PLHIV have on both government officials and NGO officers.

Table 9: Trust in personal case with government and NGO/WFP Officials

Variables/Characteristics	Frequency	Valid %
WFP & other NGO trust in any personal case		
Yes	182	68.2
No	85	31.8
Government offices trust in any personal case		
Yes	95	35.6
No	172	64.4
Confidence in Gov't authority in PLHIV right protection		
Not confident	45	16.9
50-50	132	49.4
Very confident	90	33.7

***Source**: SPSS Output based on survey data.*

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

HIV/AIDS is the main developmental challenge crosswise the world. Partnerships between the governments and civil society organizations/ NGOs were revealed to be the most necessary strategy for not only bringing down the HIV/AIDS prevalence rates, but also helping those already infected and affected by it to live a long and healthy life.

Findings demonstrate that WFP resulted in significant gains for individuals, households and the community socio-economic factors, helping to not only improve their material wellbeing, but also contributed to enhancing the dignity of beneficiaries. Positive effects were found across key programme objectives in Jimma town. Programme beneficiaries consistently reported the following:

- Improved social interaction and communication between themselves and the surrounding community
- Better health status, ability to work and a sense of hope to live and confident to change their future life
- The programme also fostered solidarity and cohesion and empowered individuals and groups in the community
- Simultaneous with the empowering impacts, there were adverse outcomes for social relations, engendering tensions and divisions that threatened cohesion and solidarity.

The key strategies employed by WFP have been very instrumental in guarding against new infections through sensitization, encouraging disclosure and promoting PMTCT. While care and support for PLHIV has been mainly done through treatment, provision of food, monitoring adherence and most importantly through financial support. The study suggests that while NGOs, in our case WFP, are becoming very influential and popular among the community, the role of the government cannot be overlooked. Government with its line departments and structures has

the power to originate the guidelines that NGOs use and still develops appropriate structures that allows for NGOs-state coordination of activities, sharing and exchange of ideas.
Pleasant dealings between community members and PLHIV is the way forward for fighting HIV/AIDS. Interviews with PLHIV in the community emphasized the positive role of NGOs in creating social harmony that NGOs bring together and unite people, especially those affected by HIV/AIDS. They give such people confidence and a positive attitude towards life.

This study can also conclude that, there are uncoordinated NGOs working on similar interventions on the existing beneficiaries that may open the way for peoples to deal deficiently among these organizations and created a dependency syndrome among target beneficiaries and accelerated it to surrounding community.

As a wrapping up in this thesis, projects and NGOs including Community based organizations are unlikely to function and survive without external aid from international development organizations. More than 95% of the NGO projects on HIV/AIDS, including the case study organization, and on other socio-economic related issues were completely externally supported and determined by the donor resources and imagine the consequence if one day the donors blocked to finance on the nasty and multifaceted social, economic and political problems we are in to work-out.

5.2. Recommendations

The purpose of recommendations is to make sure that lessons learned from this research are implemented in the future. The main actions that are required are that further research is performed, successful components of the programme continued and weaknesses addressed. Broadly speaking, our findings suggest that the policy instruments and programme approaches adopted by WFP in Jimma Town were successful in their intended objectives and there would be value in scaling-up, replicating and sharing the lessons from the programme more widely. Six critical recommendations emerge from the programme as a whole:

- A wide-ranging advance is important, working at and across different levels, including with the PLHIV themselves , and also with different sectors including health and labor and social and women and children affairs. Not only few sectors of government and NGO's commitment vital to deal with the vulnerabilities of

HIV/AIDS, but all sectors actions are also necessary in order to support increased dialogue and coordination on HIV issues

- ≈ Joint collaborations between governments at different levels and non-government health service providers like WFP are important to improve cooperation and enhance the comparative advantages of each.
- ≈ The concept of involving people living with HIV in programmes addressing HIV/AIDS issues needs to be implemented in reality.
- ≈ Awareness-creation is needed at all levels and for all kinds of actors about the discrimination, stigma and harassment faced by PLHIV, their rights and privileges as well as their potential risks and vulnerabilities.
- ≈ NGO's in our case WFP, once PLHIV became food secured with the food assistance should change the strategy from financial grant provision to loans to be returned in some time period without interest. The government also should not encourage or accept such interventions, it may finally a great challenge of dependency syndrome will happen community wide.
- ≈ Finally, the local governments and their leaders have an important role to play in combating HIV/AIDS. While as WFP in Jimma town have played a great role to mitigate the impact of HIV/AIDS by not only supporting the beneficiaries, but also strengthen even local governments capacity, they need to increase their efforts to recognize and support the proper implementation of projects.

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APPENDIXES

Appendix 1: Questionnaires on "The Socio-Economic Impact of WFP's *Urban HIV/AIDS Project: the* Case of Jimma Town"

Section I: Questionnaire for ES Participants

Part one: Personal Information

1. Gender: Male ☐ Female ☐

   For cooperative business; the total number of: Male _____ Female _____.
2. Age of the beneficiary (in years): _____
3. Educational level:

   A. Elementary; Grades 1-4 Grades 5-8

   B. High school D. Vocational Training

   C. Any other _____.
4. Marital Status: A =single B =married C =separated D =divorced E =widowed
5. Household size _____
6. Number of children at school:

   a) Primary school _____b) Secondary school_____ C)Higher institution _____
7. Are there any children who have dropped out of school before WFP aid?

   A) Yes B) No
8. If yes to question 8, state the number and give reasons _____

   A) Due to shortage of food B) Due to lack in expensing school fee

   C) Due to health problems in following my children's attentively

Part Two: Business Related Factors.

1. What type of support did you got from WFP? A) Food support B) Financial aid

   C) Psycho-Social support D) Training E) All F) Other: _____
2. If your response is financial support, how much money did you supported with (in birr)?

   _____
3. How is the way the money provided? A) All at once B) Depending on business plan

   C) Not clear
4. What type of support did you got from kebele/Jimma town administrations?

A) Financial aid B) Working space/house C) Free health service D) Psycho-Social support E) Nothing

5. Currently, what is your business formation? A) Sole proprietorship B) Cooperative
6. What type of assets do you own?

Ser.No	Type of assets	Current value in birr	Remark
1			
2			
3			
4			
5			

7. Currently, the amount of cash balance belonging to your business totals;
   A. At hand _____ B) At Bank _____ C) Cash receivables (Credit sale, lent to friends, relatives & others) _____ D) Total Cash balance _____
8. Do you have any business working experience prior to your current operation?
   A) Yes B) No
9. In which of the following business sector are you currently engaged?
   A. Trade B. Service C. Manufacturing D) Agriculture E) Other _____
10. Have you taken any business Training? A)Yes B) No
11. Who delivered the trainings? A) WFP B) Kebele administration C) Other NGO's D) All of them
12. If your response to your question 10 is yes, how much the training helped you in your life in general? A) A little B) Medium C) High
13. Where is your business located? A) At commercial area B) Far from commercial center
    Currently which location do you recommend? _____
14. What is the age of your business/firm? (In Years) A) Below a Year B) 1-2 year C) 2-3 years D. Above 3 years
15. Are there any hired laborers in your business?
    A. Yes B. No
16. If yes to 15, how many? _____

17. Is there any follow up and business supervision on business progress from WFP and other local government bodies? A) Yes B) No
18. If yes to 17, how much the follow up and supervision benefited you in your work?
    A) Nothing B) Partly C) Greatly
19. Does seasonal variability impact your business operation?
    A. Yes B. No
20. Which season performs your business better?
    A. Winter B. Summer C. Other
21. What is your justification for the co-movement between your business performance and the season you preferred? _____
    _____
    _____.
22. Was there another source of finance (other than WFP) to start your business?
    A) Yes B) No
23. If Yes, Please specify the source and the amount guaranteed. _____.
24. What is your average annual profit/net income during the life of your business? Please specify it in birr _____.
25. What is the current net value of your business asset (i.e. exclusive of others claim). To be stated also in birr _____.
26. Please compare it to the initial level of your wealth and still compute the difference.
    A) No change this much B) There is an improvement C) The previous one is better
27. Demand discrimination: How do you rate the attitude of others towards your products and services?
    A. Consumers prefer yours more so that Excellent preference
    B. Consumers prefer less yours so that negative preference
    C. Consumers preference is irrespective of your health consideration but rather it depends on Price, quality and other market considerations so that preference is neutral
    D. Difficult to identify
28. What other measure do you think will improve your business performance? _____

_____

_____.

Part Three: Social Relation

1. Is there any improvement in school attendance to your children's since you receiving food aid? 1= yes 2 = no
2. If no to question 11, what is the reason? _____

   _____
3. How many organization(s) do you know dealing with HIV/AIDS? _____
4. What is status of the assistance now? A) Stopped B) Running
5. If your answer for question 16 is number 1, what is reason you think? _____

   _____

   _____
6. About how many close friends do you have these days? These are people you feel at ease with, can talk to about private matters, or call on for help? _____
7. Are these friends of the same: A) Organization you belong B) Ethnic background

C) Have the same HIV/AIDS status D) Gender E) Employment F)All

---

8. How would you describe your relationship with other PLHIV members supported by WFP? A) poor B) Neither good nor poor C) Good
9. How would you define your link with staff of WFP? A) poor B) Neither good nor poor C) Good
10. How often you do participate in the following activities?

	Each week	Once a month	Twice month	Above month
	1	2	3	4
Spending time with close family or other relatives				
Spending time with friends and neighbors				
Spending time with co workers and professional colleagues				
Other PLHIV members of WFP (if any)				
Persons met in other organizations or Volunteer or service organizations				

11. How would you define your relationship with the persons and groups mentioned in the preceding question?

	Poor	Medium	good
Close family or other relatives			
Friends and neighbors			
co workers and professional colleagues			
Other PLHIV members of WFP (if any)			
Persons met in other organizations or Volunteer or service organizations			

12. Using a 3-point scale from 1 to 3, where 1 represents to a small extent and 3 represents to large extent, determine the extent to which WFP assistance has contributed to your relationship with different people in which you belong and the community.

	Small	Medium	Large
Close family or other relatives			
Friends and neighbors			
co workers and professional colleagues			
Other PLHIV members of WFP (if any)			
Persons met in other organizations or Volunteer or service organizations			

13. In your opinion how WFP assistance does increased your working ability?

A) No impact B) Less impact C) Medium D) Large

14. I am going to name organizations that are involved in HIV/AIDS activities, please mention in order (1, 2, 3) of their contribution to the status you have acquired.

Government programmes ☐ WFP ☐ Other NGO's ☐

15. In your opinion, justify WFP interventions have any benefit to your community?

_____

_____

_____

16. To what extent has your neighborhood/community benefited from the activities of WFP?

A) Nothing B) To a small extent (c) Medium D) To a large extent

17. Using a 3-point scale, how would you rate the contribution of WFP in creating opportunities to live? A) low B) 50-50 C) High

Part Four: Self-confidence and Satisfaction

1. Generally speaking, would you say you are happy, with the intervention of WFP in handling HIV/AIDS (Probe)? *Are you proud to be a member of the WFP's support programme?
   A) Yes B) No
2. If your answer is no, what are the things you are not comfortable with WFP in handling HIV/AIDS? _____
   _____
3. Since you joined the WFP, would you say that your health has improved? Do you feel that life is worth living? Does it change your lifestyle and living conditions?
   A) Yes B) No
4. How has belonging to WFP's support helped you? A) Nothing B) Little C) Medium D) Good
5. You know that the existence of the Government's or other NGO's HIV/AIDS programmes including WFP. How would you describe these programmes compared to the WFP's programmes in HIV/AIDS? A) Negligible B) Fair C) Better
6. How confident would you say that you are more prepared to live with HIV compared to years ago? A) Less confident B) Same C) Much Confident
7. Determine the extent to which WFP assistance has contributed to your confidence above?
   A) Small B) 50-50 C) Large

Part Five: Social Support and Trust in people and institutions of government

1. On a scale of 1 to 3 where 1 is very little support and 3 is a lot of support, how would you rate the support you are getting from

	little support	50-50	A lot of support
Family members			
Friends			
Community and neighbors.			

2. What is the nature of support do you get from

	Non-financial services	Financial Services	Psychological	Other
Family members				
Friends and Relatives				
Community and neighbors.				

3. Using a 3-point scale determine the level of competence or efficiency of the institutions I am going to name.

	Inefficient	Average	Efficient
Jimma town administration / Municipality			
Kebele administration			
Government Hospitals and health centers			
WFP			
Other NGOs dealing with HIV/AIDS			

4. In your opinion, how honest are the officials and staff of the following agencies? Please rate them on a 1 to 5 scale, where 1 is very dishonest and 5 is very honest

	Mostly honest	Neither honest nor dishonest	Mostly dishonest
Jimma town administration / Municipality officials			
Kebele administration officials			
Doctors and nurses in government Hospitals and health centers			
WFP staffs			
Other NGOs dealing with HIV/AIDS staffs			

5. If you had HIV/AIDS how much confidence do you have that government authority, like courts of law and police can protect you and people like you from harassment, exclusion and or unlawful dismissal from your employment if you have one?

   A) Not confident at all B) 50-50 C) Very confident

6. Other than HIV/AIDS related issues, would you trust WFP or other NGO officials with some other information e.g. family problem, financial difficulties, any other? A) Yes B) No

7. Would you do the same with the government official? A) Yes B) No

Section II: Questionnaire for local Government Officials

A. General Information and HIV/AIDS

1. What is the name of your organization? _____
2. What is your position in the office? _____
3. Do you think HIV/AIDS is a problem to Jimma town? Yes ☐ No ☐
   *How? Please describe? _____
   _____
4. Do you know any government-aided programmes dealing with HIV/AIDS? Yes ☐ No ☐
   *What is the nature of the programmes?
   _____
   _____
   _____.
5. To what extent have the programmes benefited the PLHIV and Jimma town community in general? Yes ☐ No ☐
   *Probe for any voluntary testimonies._____
   _____
   _____
6. There are often problems, which are faced by PLHIV, apart from the general sickness. In your opinion, what are the BIGGEST problems facing these people?
   _____
   _____
7. Do you think the local government has tried to fix these problems? Yes ☐ ☐
   *Please justify? _____
   _____
   _____
8. If you had HIV/AIDS, how much confidence do you have that local government authority can protect you and people like you from harassment, exclusion and or unlawful dismissal from your employment if you have one? _____
   _____
   _____

9. Would you say that the local government is an important element in the protection & promotion of PLHIV? Yes ☐ No ☐

10. How? Please describe? _____

_____

_____

B. Government & WFP Relationship

1. Do you know WFP and any other NGOs dealing with HIV/AIDS? Yes ☐ o ☐
2. How do you perceive them? _____

_____

_____

3. How do you perceive its activities in respect to handling HIV/AIDS problems? _____

_____

_____

4. Do you have any activities done by WFP supported (funded by the government).
   Yes ☐ No ☐
5. If yes to question 4, please describe? _____

_____

_____

6. Do you have any support you offer to WFP and other NGO's fighting HIV/AIDS or any joint activities? Yes ☐ No ☐
7. If yes to question 6, please describe? _____

_____

8. How would you compare the effectiveness of WFP programmes to that of NGOs in dealing with HIV/AIDS, like reaching the people, influencing voluntary testimonies etc?

_____

_____

9. In your opinion what benefit (economic benefit, social benefit or others?) WFP provided to PLHIV specifically and other community in Jimma town? Please justify?

_____

_____

_____

Section III: Questionnaire for Non-Government Officials

C. General Information and HIV/AIDS

11. What is the name of your organization? _____
12. What is your position in the organization? _____
13. How do you describe HIV/AIDS is a problem to Jimma town? _____

    _____

    _____
14. Do you know any government-aided programmes dealing with HIV/AIDS? Yes ☐ No ☐

    *What is the nature of the programmes?

    _____

    _____

    _____.
15. What activity did and is doing your organization regarding HIV/AIDS? _____

    _____

    _____
16. To what extent these programmes benefited the PLHIV and Jimma town community in general? _____

    .____

    _____
17. There are often problems, which are faced by PLHIV, apart from the general sickness. In your opinion, what are the BIGGEST problems facing these people?

    _____

    _____
18. What mobilization did your organization tried to fix these problems? _____

    _____

    _____

    _____
19. How do you perceive WFP and its activities in respect to handling HIV/AIDS problems in Jimma town? _____

_____

_____

20. Do you have any activities done by your organization in collaboration with WFP supported (funded by the government). Yes ☐ No ☐
21. If yes to question 10, please describe? _____

_____

_____

22. In your opinion what benefit (economic benefit, social benefit or others?) WFP provided to PLHIV specifically and other community in Jimma town? Please justify?

_____

_____

_____

Appendix 2: Multiple Regression Model Summaries

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.771[a]	.594	.563	.578	.594	18.788	18	231	.000	2.066

a. Predictors: (Constant), Community support type, Attitude towards products, Sex of the informants, Business area location, Age, Type of business formation, Impact of season on business, Other financial sources, Business trainings taken, Family Size, Educational Level, Business Sector, Support type from WFP, Business age in year, Follwup from gov't or WFP, Support from local governments, Business Experience, Marital Status

b. Dependent Variable: Average yearly business profit

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	113.127	18	6.285	18.788	.000[b]
	Residual	77.273	231	.335		
	Total	190.400	249			

a. Dependent Variable: Average yearly business profit

b. Predictors: (Constant), Community support type, Attitude towards products, Sex of the informants, Business area location, Age, Type of business formation, Impact of season on business, Other financial sources, Business trainings taken, Family Size, Educational Level, Business Sector, Support type from WFP, Business age in year, Follwup from gov't or WFP, Support from local governments, Business Experience, Marital Status

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	.523	.429		1.220	.224	-.322	1.367
	Sex of the informants	-.225	.088	-.113	-2.546	.012	-.399	-.051
	Age	-.285	.067	-.188	-4.226	.000	-.418	-.152
	Educational Level	.195	.047	.183	4.172	.000	.103	.287
	Marital Status	.111	.041	.122	2.694	.008	.030	.193
	Family Size	-.344	.062	-.243	-5.523	.000	-.467	-.221
	Support type from WFP	.154	.033	.208	4.722	.000	.090	.218
	Support from local governments	.069	.024	.132	2.898	.004	.022	.116
	Type of business formation	-.087	.097	-.041	-.895	.372	-.277	.104
	Business Experience	.894	.092	.440	9.686	.000	.712	1.075
	Business Sector	.060	.080	.033	.750	.454	-.098	.218
	Business trainings taken	.241	.145	.074	1.664	.097	-.044	.527
	Business area location	.437	.077	.250	5.677	.000	.285	.588
	Business age in year	.004	.052	.003	.069	.945	-.098	.105
	Follwup from gov't or WFP	-.070	.080	-.039	-.873	.384	-.227	.088
	Impact of season on business	.026	.107	.011	.247	.805	-.184	.237
	Other financial sources	-.121	.084	-.067	-1.443	.150	-.285	.044
	Attitude towards products	.303	.052	.259	5.865	.000	.201	.404
	Community support type	-.018	.046	-.017	-.402	.688	-.109	.072

a. Dependent Variable: Average yearly business profit

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	.56	4.16	2.68	.674	250
Residual	-1.485	2.107	.000	.557	250
Std. Predicted Value	-3.151	2.197	.000	1.000	250
Std. Residual	-2.568	3.642	.000	.963	250

a. Dependent Variable: Average yearly business profit

Appendix 3: Descriptive Statistics from SPSS Frequency Tables

Sex of the informants

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	71	26.6	26.6	26.6
	Female	196	73.4	73.4	100.0
	Total	267	100.0	100.0	

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than 30 years	55	20.6	20.6	20.6
	Between 31-45	177	66.3	66.3	86.9
	more than 46	35	13.1	13.1	100.0
	Total	267	100.0	100.0	

Educational Level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Illeterate	20	7.5	7.5	7.5
	Grade 1-4	108	40.4	40.4	47.9
	Grade 5-8	110	41.2	41.2	89.1
	Grade 9-12	24	9.0	9.0	98.1
	Above 12 grade	5	1.9	1.9	100.0
	Total	267	100.0	100.0	

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Widowed	28	10.5	10.5	10.5
	Divorced	114	42.7	42.7	53.2
	Single	60	22.5	22.5	75.7
	Married	65	24.3	24.3	100.0
	Total	267	100.0	100.0	

Family Size

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 3	113	42.3	42.3	42.3
	Between 4-6	132	49.4	49.4	91.8
	More than 7	22	8.2	8.2	100.0
	Total	267	100.0	100.0	

Children dropped school befaore WFP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	62	23.2	23.2	23.2
	No	205	76.8	76.8	100.0
	Total	267	100.0	100.0	

Reasons for dropping school

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Food shortage	5	1.9	8.6	8.6
	Lack of school fee	30	11.2	51.7	60.3
	Health problem	23	8.6	39.7	100.0
	Total	58	21.7	100.0	
Missing	System	209	78.3		
Total		267	100.0		

Support type from WFP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Food & Trainings	44	16.5	16.5	16.5
	Trainings & Fianancial	51	19.1	19.1	35.6
	Food & Financial	17	6.4	6.4	41.9
	All	155	58.1	58.1	100.0
	Total	267	100.0	100.0	

Support from local governments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nothing	122	45.7	45.7	45.7
	Phycho-Social	12	4.5	4.5	50.2
	Free health service	52	19.5	19.5	69.7
	Financial	14	5.2	5.2	74.9
	Working space	67	25.1	25.1	100.0
	Total	267	100.0	100.0	

Type of business formation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sole proprietorship	205	76.8	78.5	78.5
	Cooperative	56	21.0	21.5	100.0
	Total	261	97.8	100.0	
Missing	System	6	2.2		
Total		267	100.0		

Business Experience

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	72	27.0	27.0	27.0
	Yes	195	73.0	73.0	100.0
	Total	267	100.0	100.0	

Business Sector

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Trade	182	68.2	71.1	71.1
	Others	73	27.3	28.5	99.6
	4	1	.4	.4	100.0
	Total	256	95.9	100.0	
Missing	System	11	4.1		
Total		267	100.0		

Business trainings taken

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	20	7.5	7.5	7.5
	Yes	246	92.1	92.1	99.6
	2	1	.4	.4	100.0
	Total	267	100.0	100.0	

Business age in year

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below a year	56	21.0	21.0	21.0
	Between 1-2 year	75	28.1	28.1	49.1
	Above 3 year	136	50.9	50.9	100.0
	Total	267	100.0	100.0	

Follwup from gov't or WFP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	155	58.1	58.1	58.1
	No	112	41.9	41.9	100.0
	Total	267	100.0	100.0	

Impact of season on business

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	224	83.9	85.2	85.2
	No	39	14.6	14.8	100.0
	Total	263	98.5	100.0	
Missing	System	4	1.5		
Total		267	100.0		

Other financial sources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	99	37.1	37.1	37.1
	No	168	62.9	62.9	100.0
	Total	267	100.0	100.0	

Average yearly business profit

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 1800 birr	28	10.5	10.5	10.5
	Between 1800-3600 birr	82	30.7	30.7	41.2
	Between 3600-5400 birr	110	41.2	41.2	82.4
	Above 5400 birr	47	17.6	17.6	100.0
	Total	267	100.0	100.0	

Attitude towards products

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Negative	39	14.6	14.6	14.6
	Difficul to identify	39	14.6	14.6	29.2
	Price, quality and market issues	189	70.8	70.8	100.0
	Total	267	100.0	100.0	

School improvemnet after WFP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	232	86.9	86.9	86.9
	No	35	13.1	13.1	100.0
	Total	267	100.0	100.0	

Relation with other PLHIV supported by WFP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor	27	10.1	10.1	10.1
	Medium	96	36.0	36.0	46.1
	Good	144	53.9	53.9	100.0
	Total	267	100.0	100.0	

Relation with WFP staffs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor	19	7.1	7.1	7.1
	Medium	69	25.8	25.8	33.0
	Good	179	67.0	67.0	100.0
	Total	267	100.0	100.0	

Relation with all the community around

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor	12	4.5	4.5	4.5
	Medium	139	52.1	52.1	56.6
	Good	116	43.4	43.4	100.0
	Total	267	100.0	100.0	

WFP contribution for this relations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Small	22	8.2	8.2	8.2
	Medium	128	47.9	47.9	56.2
	Large	117	43.8	43.8	100.0
	Total	267	100.0	100.0	

WFP contribution for work ability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Small	28	10.5	10.5	10.5
	Medium	82	30.7	30.7	41.2
	Large	157	58.8	58.8	100.0
	Total	267	100.0	100.0	

WFP contribution for the community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nothing	5	1.9	1.9	1.9
	Small	25	9.4	9.4	11.2
	Medium	68	25.5	25.5	36.7
	Large	168	62.9	62.9	99.6
	7	1	.4	.4	100.0
	Total	267	100.0	100.0	

WFP opportunity for live

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	19	7.1	7.1	7.1
	50-50	74	27.7	27.7	34.8
	Higgh	174	65.2	65.2	100.0
	Total	267	100.0	100.0	

Health improvement after WFP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	232	86.9	88.2	88.2
	No	31	11.6	11.8	100.0
	Total	263	98.5	100.0	
Missing	System	4	1.5		
Total		267	100.0		

Confident living with HIV

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less confident	9	3.4	3.4	3.4
	Same as before	43	16.1	16.1	19.5
	Much confident	215	80.5	80.5	100.0
	Total	267	100.0	100.0	

WFP confidence creation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Small	16	6.0	6.0	6.0
	50-50	71	26.6	26.8	32.8
	Large	178	66.7	67.2	100.0
	Total	265	99.3	100.0	
Missing	System	2	.7		
Total		267	100.0		

Community support type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In kind	44	16.5	16.5	16.5
	Financial	23	8.6	8.6	25.1
	Phcycological	190	71.2	71.2	96.3
	Inkind & Financial	4	1.5	1.5	97.8
	All	6	2.2	2.2	100.0
	Total	267	100.0	100.0	

WFP & other NGO trust in any case

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	182	68.2	68.2	68.2
	No	85	31.8	31.8	100.0
	Total	267	100.0	100.0	

Government trust in any case

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	95	35.6	35.6	35.6
	No	172	64.4	64.4	100.0
	Total	267	100.0	100.0	

Appendix 4: Correlation Coefficients **Correlations**

		Average yearly profit	Sex of the informants	Age	Educational Level	Marital Status	Family Size	Support type from WFP	Support of local gov'ts	Business Experience	Business Sector	Business trainings taken	Business area location	Business age in year	Follwup from gov't or WFP	Impact of season on	Other financial sources	Attitude towards products
Average yearly business profit	Pearson Correlation	1	-.145*	-.263**	.271**	.193**	-.190**	.291**	.155*	-.414**	.001	-.233**	.313**	.145*	-.084	.075	-.234**	.237**
	Sig. (2-tailed)		.018	.000	.000	.002	.002	.000	.011	.000	.985	.000	.000	.018	.171	.227	.000	.000
	Sum of Squares and Cross-products	209.985	-15.199	-35.816	53.146	44.213	-28.015	82.453	61.191	-43.461	.125	-14.843	36.944	27.266	-9.828	6.198	-26.742	41.124
Sex of the informants	Pearson Correlation	-.145*	1	-.034	-.106	-.175**	.065	-.019	.047	-.055	-.205**	-.013	.009	.014	.013	-.019	-.023	.010
	Sig. (2-tailed)	.018		.579	.085	.004	.288	.751	.441	.375	.001	.831	.889	.825	.827	.763	.705	.868
	Sum of Squares and Cross-products	-15.199	52.120	-2.318	-10.315	-19.921	4.801	-2.745	9.281	-2.854	-11.109	-.416	.506	1.273	.783	-.768	-1.326	.888
Age	Pearson Correlation	-.263**	-.034	1	-.114	-.140*	.127*	-.032	-.051	-.053	-.023	-.059	-.033	.041	.097	-.072	.075	-.016
	Sig. (2-tailed)	.000	.579		.063	.022	.038	.607	.405	.390	.710	.340	.587	.505	.112	.244	.221	.799
	Sum of Squares and Cross-products	-35.816	-2.318	88.502	-14.539	-20.865	12.184	-5.801	-13.090	-3.607	-1.656	-2.427	-2.562	4.993	7.390	-3.886	5.584	-1.764
Educational Level	Pearson Correlation	.271**	-.106	-.114	1	.127*	.001	.022	.008	.069	.055	-.101	.062	-.033	.044	.099	.082	.148*
	Sig. (2-tailed)	.000	.085	.063		.038	.986	.720	.898	.264	.381	.099	.316	.588	.473	.110	.183	.015
	Sum of Squares and Cross-products	53.146	-10.315	-14.539	183.326	27.169	.146	5.831	2.888	6.742	5.547	-6.034	6.798	-5.843	4.820	7.608	8.730	24.045
Marital	Pearson Correlation	.193**	-.175**	-.140*	.127*	1	.163**	-.022	-.092	.038	.006	-.054	.144*	-.086	.040	.051	.065	.090

Status	Sig. (2-tailed)	.002	.004	.022	.038		.008	.724	.134	.540	.918	.381	.019	.163	.519	.413	.292	.144
	Sum of Squares and Cross-products	44.213	-19.921	-20.865	27.169	249.708	26.213	-6.708	-39.472	4.315	.766	-3.742	18.551	-17.539	5.045	4.570	8.067	16.989
Family Size	Pearson Correlation	-.190**	.065	.127*	.001	.163**	1	-.028	-.003	-.101	-.060	-.019	.035	.055	-.047	-.045	-.022	.034
	Sig. (2-tailed)	.002	.288	.038	.986	.008		.650	.962	.100	.339	.760	.565	.371	.449	.464	.725	.583
	Sum of Squares and Cross-products	-28.015	4.801	12.184	.146	26.213	103.985018726591	-5.547	-.809	-7.461	-4.578	-.843	2.944	7.266	-3.828	-2.654	-1.742	4.124
Support type from WFP	Pearson Correlation	.291**	-.019	-.032	.022	-.022	-.028	1	.042	-.059	-.019	-.015	.154*	.021	-.125*	.115	-.156*	-.077
	Sig. (2-tailed)	.000	.751	.607	.720	.724	.650		.491	.339	.765	.812	.012	.738	.041	.063	.011	.211
	Sum of Squares and Cross-products	82.453	-2.745	-5.801	5.831	-6.708	-5.547	381.041	22.472	-8.315	-2.750	-1.258	24.449	5.206	-19.712	12.776	-24.067	-17.989
Support from local governments	Pearson Correlation	.155*	.047	-.051	.008	-.092	-.003	.042	1	-.030	-.014	-.105	-.054	.120*	-.172**	-.028	-.163**	-.041
	Sig. (2-tailed)	.011	.441	.405	.898	.134	.962	.491		.628	.819	.088	.377	.050	.005	.646	.007	.506
	Sum of Squares and Cross-products	61.191	9.281	-13.090	2.888	-39.472	-.809	22.472	738.315	-5.876	-2.938	-12.506	-12.034	42.360	-37.697	-4.392	-35.045	-13.326
Business Experience	Pearson Correlation	-.414**	-.055	-.053	.069	.038	-.101	-.059	-.030	1	.125*	.073	-.067	-.251**	.031	.063	.292**	.052
	Sig. (2-tailed)	.000	.375	.390	.264	.540	.100	.339	.628		.046	.233	.274	.000	.617	.306	.000	.394
	Sum of Squares and Cross-products	-43.461	-2.854	-3.607	6.742	4.315	-7.461	-8.315	-5.876	52.584	6.703	2.337	-3.978	-23.573	1.798	2.620	16.697	4.551
Business	Pearson Correlation	.001	-.205**	-.023	.055	.006	-.060	-.019	-.014	.125*	1	-.059	-.122	-.068	-.095	-.005	.080	.057

Sector	Sig. (2-tailed)	.985	.001	.710	.381	.918	.339	.765	.819	.046		.351	.051	.275	.130	.936	.201	.361
	Sum of Squares and Cross-products	.125	-11.109	-1.656	5.547	.766	-4.578	-2.750	-2.938	6.703	59.438	-1.938	-7.516	-6.531	-5.766	-.220	4.797	5.250
Business trainings taken	Pearson Correlation	-.233**	-.013	-.059	-.101	-.054	-.019	-.015	-.105	.073	-.059	1	-.053	-.110	.034	-.005	-.006	-.205**
	Sig. (2-tailed)	.000	.831	.340	.099	.381	.760	.812	.088	.233	.351		.386	.072	.585	.942	.920	.001
	Sum of Squares and Cross-products	-14.843	-.416	-2.427	-6.034	-3.742	-.843	-1.258	-12.506	2.337	-1.938	19.348	-1.910	-6.292	1.191	-.114	-.213	-10.798
Business area location	Pearson Correlation	.313**	.009	-.033	.062	.144*	.035	.154*	-.054	-.067	-.122	-.053	1	.125*	-.089	.028	-.004	-.008
	Sig. (2-tailed)	.000	.889	.587	.316	.019	.565	.012	.377	.274	.051	.386		.041	.147	.649	.943	.896
	Sum of Squares and Cross-products	36.944	.506	-2.562	6.798	18.551	2.944	24.449	-12.034	-3.978	-7.516	-1.910	66.539	13.247	-5.854	1.316	-.281	-.787
Business age in year	Pearson Correlation	.145*	.014	.041	-.033	-.086	.055	.021	.120*	-.251**	-.068	-.110	.125*	1	-.072	.037	-.257**	.123*
	Sig. (2-tailed)	.018	.825	.505	.588	.163	.371	.738	.050	.000	.275	.072	.041		.239	.554	.000	.045
	Sum of Squares and Cross-products	27.266	1.273	4.993	-5.843	-17.539	7.266	5.206	42.360	-23.573	-6.531	-6.292	13.247	168.030	-7.558	2.692	-26.337	19.056
Follwup from gov't or WFP	Pearson Correlation	-.084	.013	.097	.044	.040	-.047	-.125*	-.172**	.031	-.095	.034	-.089	-.072	1	.145*	.134*	.104
	Sig. (2-tailed)	.171	.827	.112	.473	.519	.449	.041	.005	.617	.130	.585	.147	.239		.019	.029	.089
	Sum of Squares and Cross-products	-9.828	.783	7.390	4.820	5.045	-3.828	-19.712	-37.697	1.798	-5.766	1.191	-5.854	-7.558	65.019	6.688	8.528	10.079
Impact of	Pearson Correlation	.075	-.019	-.072	.099	.051	-.045	.115	-.028	.063	-.005	-.005	.028	.037	.145*	1	.037	.069

season on business	Sig. (2-tailed)	.227	.763	.244	.110	.413	.464	.063	.646	.306	.936	.942	.649	.554	.019		.549	.264
	Sum of Squares and Cross-products	6.198	-.768	-3.886	7.608	4.570	-2.654	12.776	-4.392	2.620	-.220	-.114	1.316	2.692	6.688	33.217	1.681	4.757
Other financial sources	Pearson Correlation	-.234**	-.023	.075	.082	.065	-.022	-.156*	-.163**	.292**	.080	-.006	-.004	-.257**	.134*	.037	1	-.025
	Sig. (2-tailed)	.000	.705	.221	.183	.292	.725	.011	.007	.000	.201	.920	.943	.000	.029	.549		.682
	Sum of Squares and Cross-products	-26.742	-1.326	5.584	8.730	8.067	-1.742	-24.067	-35.045	16.697	4.797	-.213	-.281	-26.337	8.528	1.681	62.292	-2.382
Attitude towards products	Pearson Correlation	.237**	.010	-.016	.148*	.090	.034	-.077	-.041	.052	.057	-.205**	-.008	.123*	.104	.069	-.025	1
	Sig. (2-tailed)	.000	.868	.799	.015	.144	.583	.211	.506	.394	.361	.001	.896	.045	.089	.264	.682	
	Sum of Squares and Cross-products	41.124	.888	-1.764	24.045	16.989	4.124	-17.989	-13.326	4.551	5.250	-10.798	-.787	19.056	10.079	4.757	-2.382	143.730

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).