

“Poverty and HIV/AIDS”: Are they Related? An Ecological Issue

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ABSTRACT This paper looks at the theoretical relationship between HIV/AIDS and poverty. The paper makes reference to various research conducted by various HIV/AIDS Centers. The paper tries to evaluate the impact of the studies conducted and draw from their work. It is true that there is a relationship between HIV/AIDS and poverty. However the study did embrace service poverty as a focus. It can be concluded that poverty has a huge impact in accelerating the epidemic. Such inference can be made with regard to financial means to survive. It was also established that women are more likely to be exposed to HIV/AIDS risk as they don't negotiate safe sex because of their dependence on men. The results showed that there should be more emphasis on sex education; community members should be knowledgeable about HIV/ AIDS and the use of condoms. The usage of means to promote sex safe behavior should be encouraged among community members; this will require the need to reflect more on cultural, economic and moral issues.

I. INTRODUCTION

There is a relationship between Human Immuno-Deficiency Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS) and poverty and this has been widely accepted by literature on the subject. AIDS deepens poverty and increases inequalities at every level, households and community. It is a fact that the epidemic undermines the effort of the South African government of reducing poverty and improving productivity and the economic growth. There is a huge disgraceful lacuna in what we know about HIV and poverty, both the ways in which poverty exacerbates poverty and vice versa. According to Barnett and Whiteside (2002), very little is known about poverty and infectious diseases.

- 1) HIV/AIDS leads to financial, resource and income impoverishment. Households become poorer as a result of the illness and death of members; in many cases it is the earning adults who are lost. However, impoverishment is more than financial. Illness and death lead to an erosion of social capital and social characteristics of the system rather than the solely commonly identified social and economic units (Reddy 2005:15).

- 2) Death and illness means that the buying of foods, clothes and taking care of the family members will no longer be possible or will be done less effectively. According to Barnett and Whiteside (2002), poverty is also about more than income and economics. There are many types of poverty: Service poverty, where people are unable to access or are not provided with services such as health and education; Resource poverty, where though they have sufficient income people are unable to access resources because they may be poor in terms of their rights, representations and governance.
- 3) The purpose of this paper is to explore HIV/AIDS and to study service poverty as a concern, with particular focus on the link between HIV/AIDS and poverty. As such, this paper intends to demonstrate that HIV/AIDS is not merely a health concern, but in essence a development issue.

II. THEORETICAL RATIONALE: POVERTY AND HIV/AIDS

It should be taken into consideration that there is a relationship between poverty and the

development of communicable diseases and at the same time epidemic diseases-like any illness-have the potential to increase poverty. Reddy (2005:16), further mentions that the link between poverty and HIV/AIDS highlighted ways in which poverty increases the risk of HIV infection. But poverty does not only increase vulnerability to HIV infection, it also reduces the capacity of people living with and affected by HIV/AIDS to cope with the consequences of infection, so say Heather and Rosalind (2002). HIV/AIDS is associated with repeated bouts of illness, which tend to last longer as the immune system gets more and more eroded. The lack of adequate nutrition significantly reduces resistance and accelerates ill health and death. Moreover, poor households are less able to access appropriate health care services, either because the available services lack the resources (including medicines and human resources) to provide effective health care, or because a household contribution is required, or because public transport to these services is inadequate or unaffordable for poor households (Marce and Lessing 2004: 110).

In context of a sexually transmitted epidemic, gender inequality clearly is a core factor determining vulnerability. Like poverty, gender relations not only influence people's ability to choose responsible sexual behaviour and decide on the appropriate risk prevention method, gender imbalances also influence their capacity to cope with the consequences of HIV infection. Women often prioritise the well-being of other family members at the expense of their own health and well-being. Thus, male members of a poor household tend to be the first to receive food, with what is leftover shared between women and children. This compromises the nutritional intake of women, thereby leaving them more susceptible to ill health and death as a result of HIV/AIDS (Van Donk 2002).

Poverty is likely to deepen as the aids epidemic takes its course, with households being caught up in a vicious cycle of poverty and HIV/AIDS. The number was estimated to be 800, 000 by 2005, rising to more than 1.95 million by 2010 (Visser 2005: 205-216). These infected individuals and affected children all belong to individual households and their deaths will have significant impact on their families. Poverty, moreover, is likely to deepen as the epidemic takes its course.

The social-economic impact of HIV/AIDS combines to create a vicious cycle of poverty and HIV/AIDS in which affected households are caught up. If the breadwinners or parents at home become ill and are forced to give up their jobs, household income will fall (UNAIDS 2001: 6). To cope with the change in income and the need to spend more on health care, children are often kept from school to take care of the sick or to work so as to contribute to household income. Due to the fact that expenditure on food comes under pressure, malnutrition often results, while access to other basic needs such as health care, housing and sanitation also comes under threat. Consequently the opportunities for children for their physical and mental development are impaired (Bonnell 2000: 5; Wekesa 2000: 118).

Households that are affected and infected by HIV/AIDS become the victim of poverty or faced with the challenge of poverty. Affected households and poorer than non-affected households are measured per capita or adult equivalent level with regard to their poverty level. These incidences, death and poverty are worse among affected households, particularly amongst the ones that have experienced illness (Bonnell 2000:4). Today families may find it difficult to cope with the large numbers of children who need care and orphans experiences a similar problem (Department of Education 2004: 44). Their loss and enforced silent grieving can have a detrimental emotional effect on them for the rest of their lives. One way of helping community to grieve, is to talk to them about death related to HIV/AIDS, so that they can come to terms with their situation (DoE 2004: 45).

According to Rosen and Simons (2002: 163), households headed by AIDS widows are also particularly vulnerable, because women have limited economic opportunities and traditional arms and customs may see them severed from their extended family and demand access to inherited firms. In fact, Desmond (2001: 146) emphasizes how complex the relationship between poverty and HIV/AIDS actually is and how many facets it has. For example, How labour migration induced by horary poverty and contribute to the spread of the disease and how poor, single mothers may be forced to become accessional sex in order to survive, to maintain the children, to pay schools, buy food and clothes because learners are forced by poverty (Desmond 2001:156; Poku 2001: 195).

III. DISCUSSION

Globally, inequality is generally greater both with respect to income and in terms of the quality of life. This suggests that if one is not successful in accessing job opportunities and public services, there is a significant risk of social and economic exclusion. Current realities in South Africa attest to this dichotomy between the prospects of a better life and the ability to benefit from these prospects. It is widely recognised that HIV/AIDS follows social divisions and patterns of inequality, with factors like gender and socio-economic status having particular relevance in the South African context (Hunter and Williamson 2000).

In the context of HIV/AIDS, gender inequality implies that it is difficult for African women to negotiating safe sex with their partners or for that matter prevent their partner from having additional sexual contacts. It was also highlighted that women are most engaged in these unprotected sex because of their economic background. Women participated in unsafe sex because of the financial benefit which leads to risky sexual behavior.

Poverty is also a significant factor in the spread of HIV/AIDS. International evidence suggests that there is a close correlation between poverty and HIV/AIDS, with the poor constituting the absolute majority of those living with HIV/AIDS. However, the relationship between poverty and HIV/AIDS is not simplistic. Although the majority of people living with HIV/AIDS are poor, not all poor people are HIV-positive and a significant number of middle class people are infected with HIV. In the study conducted by Jeff and Chris (2002), they mention that although the two are not related, poverty should be seen as a co-factor among others.

There are various ways in which poverty facilitates the transmission of HIV/AIDS. For example, evidence suggests that there is a correlation between levels of education, fertility and condom use. This shows that those with higher levels of education are more able to prevent risk of HIV transmission. Poverty, particularly income poverty, also forces people to engage in survival strategies that put them at risk of HIV infection. The two most significant strategies in this respect are migration and sexual networking, which have been discussed already. Poverty at community level also enhances the risk of HIV

infection. For example, the treatment of sexually transmitted infections can significantly reduce the risk of HIV infection. Yet, in many poor communities, basic health services are lacking or inadequate and such preventative treatment is not accessible. Similarly, condoms may not be freely available, which puts prevention beyond the means of poor urban households. As highlighted before, in contexts where immediate survival needs are more pressing than the long term threat of ill health and death caused by an invisible virus, there is little incentive to practice safe sex.

Clearly, the overlap between factors like age, gender and socio-economic status creates a context of compounded vulnerability, with poor black young women being most at risk of HIV infection. The exact nature of vulnerability depends on the local context, which points to the need for local data that is disaggregated according to age, gender, socio-economic status and population group and for a proper analysis of relevant local trends. One of the challenges in accessing and interpreting local data is to prevent equating risk with responsibility. In other words, as the preceding discussion has sought to highlight, many so-called ‘risk groups’ have limited power and resources to prevent HIV infection. Without recognising the broader socio-political context in which people live, act and behave sexually, there is a danger of perpetuating the stigma associated with HIV/AIDS.

Poverty does not only increase vulnerability to HIV infection, it also reduces the capacity of people living with and affected by HIV/AIDS to cope with the consequences of infection. HIV/AIDS is associated with repeated bouts of illness, which tend to last longer as the immune system gets more and more eroded. The lack of adequate nutrition significantly reduces resistance and accelerates ill health and death. Moreover, poor urban households are less able to access appropriate health care services, either because the available services lack the resources (including medicines and human resources) to provide effective health care, or because a household contribution is required, or because public transport to these services is inadequate or unaffordable for poor households.

Minister of Health, Dr Motsoaledi, has on several occasions mentioned the fight against HIV/AIDS as adoption of practising safe sex. It is a fact that using a condom as a protective

measure is the most effective means of avoiding the HIV infection. It is quite difficult for individuals to abstain, in that regard the encouragement of the use of condoms becomes relevant. However, the problem becomes the availability of condoms in a poverty stricken community and also as part of improving the sexual behavior.

The immediate impact is felt at household level, where medical costs and funeral costs add a significant burden to the household budget. At the same time, because HIV/AIDS generally affects young adults and productive members of the household, repeated periods of ill health and death of these providers reduces household income. HIV/AIDS changes the structure of the population; it is distinct from other diseases because it strikes prime-aged adults, in particular the most productive segment of the economy. Thus, the bread-winners fall ill and die, destroy the much-needed skills and deprive children from being raised under good parental care. The principal economic impacts experienced by the affected household are loss of available income, as working adults are ill or dying or have indeed stop working, and the other cost is the funeral preparation.

Other effects include the depletion of the household, lower productivity of subsistence labour and reduced availability of food. School enrollment may also decrease, as children are forced to dedicate time to labour that is earning a living and care-giving.

IV. CONCLUSION

Poverty and its associated factors, such as the education level and more importantly access to health care is the main indicator in accelerating the epidemic. The poor economic status of most women drives them to the process of engaging in unprotected sex. This poor economic status robs the economically challenged community the knowledge to practice safe sex. Poverty and its related factors, such as low education level and financial dependence on the partners are the contributing factors for the acceleration of the epidemic. Poor individuals often sacrifice their future just to have a meal on their table. The lack of condoms usage is perceived as another risk of accelerating the growth of the disease.

There should be new ways of encouraging the community to practice safe sex, Minister of

Health, Dr Motsoaledi has introduced a free testing approach to encourage any member of the community to know his/her status. This testing is conducted free of charge at the different health care centers. This is part of the renewal strategies introduced by the South African Government.

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