The Real Price of Poverty

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When HIV strikes a household the financial and psychological stress is often overwhelming. In the majority of cases, in places like sub-Saharan Africa, HIV often strikes more than one parent or household member; household reserves erode quickly as the earners become ill or are forced to remain at home and become caregivers. This frequent clustering of illness and death pushes households into a downward spiral of impoverishment, which culminates in reduced quantity and quality of available food, withdrawing children from school and forgoing vital healthcare access. This is primarily because in most African countries free access to health care is reserved for employees of the public and private sectors; there is no national health system for the often poorer and more vulnerable workers of the informal sector and rural areas, who account for over 90% of the workforce in Africa. As such they must rely on themselves to provide social and financial protection responding to their medical needs.[1]

In many cases a chronic illness, such as HIV doesn't cause poverty it just exacerbates it, initiating a vicious circle between impoverishment and long-term illness or death of the core-earner. Multiple medical expenses in combination with a curtailed income means productive assets such as land, animals, or fixed capital have to be sold. This leaves the household in a state of intense vulnerability as they have limited means, or labour remaining with which to earn money. Remaining family members can become increasingly susceptible to future HIV infection when they are forced into high-risk situations to raise money towards household expenditure.[2] Women and girls, who understand the risk of AIDS, may, through economic desperation resign themselves to sex without condoms if there is a greater return in money, food or other elements of survival. A recent Human Rights Watch (December 2003) report entitled, "Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa" quoted a Kenyan girl as saying, "I may have to go into prostitution, and then I know I will get HIV and die; I would rather have a real business, but it is not easy."[3] Moreover males may be forced to migrate to the city or enter high-risk employment, such as trucking or mining, where loneliness and workplace hazards instil normality behind risky sexual behaviour. Worsening poverty throughout a community can also affect social structure cohesion, weakening traditional restraints regarding promiscuity.

Over the past 5 years there have been significant decreases in the cost of anti-retroviral therapy (ART) and an increase in international commitment to make this more widely accessible in

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1 http://www.ilo.org/public/english/region/afpro/abidjan/publ/ilo8/social7.pdf

2 Donahue, Jill. 1998. Community-Based Economic Support for Households Affected by HIV/AIDS, Discussion Paper on HIV/AIDS Care and Support No. 6. Arlington, VA: Health Technical Services (HTS) Project for USAID.

3 http://www.hrw.org/reports/2003/africa1203/1.htm

developing countries. This has lead to a significant increase in ART availability in many African countries. However it is notable that poverty and limited health services prevent many HIV-positive people from maintaining the high levels of ART adherence (at least 95%) needed to avert drug resistance and enable a positive treatment outcome.[4] Although many countries in sub-Saharan Africa now provide ART free of charge it is the multiple costs and obstacles involved with accessing treatment, such as lost wages due to frequent clinic visits, transport costs, user fees, and hunger that undermine the intentions of patients who are highly motivated to take ART as prescribed.[5] This strong correlation between HIV and poverty is further supported by the vicious circle between malnutrition and HIV. An insufficient diet leads to immune impairment, which worsens the effects of HIV and increases progression to AIDS, even whilst on ART, whereas HIV infection causes changed metabolism and reduced nutrient absorption; an asymptomatic HIV patient requires 10% more energy than a non-HIV healthy person of same age, sex, physical activity level whereas an HIV symptomatic requires 20-30% more.[6] Three-quarters of participants in a Rwandan study declared that the biggest obstacle to treatment adherence was the fear that they would develop too much of an appetite as a result of taking the drugs, but would not be able to afford enough to eat.[7]

As more young adults and parents fall sick and die of HIV-related diseases the number of orphans and vulnerable children multiplies. The high HIV-seroprevalance of pregnant women in countries of sub-Saharan Africa, such as Kenya (16%) and Zambia's (24%), means that in the absence of HIV chemotherapy, against mother to child transmission, roughly one in ten delivered infants will be infected themselves. According to a recent study by the United Nations Children's Fund (UNICEF), about 15 to 20 percent of infant HIV infections occur during pregnancy, 50 percent during labour and delivery, while breastfeeding accounts for a further 10 to 30 percent.[8]

National Prevention of Mother-To-Child Treatment (PMTCT) programmes, that largely focus on the roll out of Nevirapine, an anti-retroviral drug that can lower the chances of a mother infecting her baby by up to 40 percent, are now in place in many countries across Africa. Access to these simple interventions is increasing significantly but UNAIDS reported that the total number of pregnant women in Malawi who accessed PMTCT services in 2006 was still only 3 percent of those who needed it; in Malawi an estimated 30,000 babies are born HIV positive every year.[9] Moreover very poor families generally have low self esteem and little recognition within their community, they therefore have less negotiating power and organizational advantages for leveraging care and accessing these limited PMTCT services.

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[4] *AIDS care programme in rural Uganda Home based ART programme overcomes economic barriers to accessing treatment and care Weidle, P.; Wamai, N.; Solberb, P.; Liechty, C.; et al / The Lancet , 2006*

[5] Hardon, A.; Davey, S.; Gerrits, T.; Hodgkin, C.; et al **From access to adherence: the challenges of antiretroviral treatment. Antiretroviral treatment failure due to lack of patient support**. World Health Organization (WHO) , 2006 Qualitative findings from three WHO- supported country studies (Botswana, Tanzania, and Uganda)

[6] FAO/WHO. **Living well with HIV/AIDS:** A manual on nutritional care and support for people living with HIV and AIDS. FAO/WHO, Rome, 2002.

[7] Samuels, F.; Simon, S. **Food, nutrition and HIV: what's next?** Food and nutrition security are essential components of an HIV/AIDS prevention and treatment strategy. Overseas Development Institute (ODI) , 2006

[8] ETHIOPIA: **Poverty threatens efforts to stop mother-to-child HIV transmission**. ADDIS ABABA, 28 Apr 2006. Integrated Regional Information Networks PlusNews The HIV/AIDS News Service. http://www.plusnews.org/pnprint.asp?ReportID=5907

[9] MALAWI: **Limping PMTCT programme failing infants**. Integrated Regional Information Networks PlusNews The HIV/AIDS News Service. http://www.plusnews.org/aidsreport.asp?reportid=6564 21st November 2006.

PMTCT programmes advise mothers, who are HIV positive, to find replacements for breast milk in order to reduce the risk of passing on HIV to their children through breastfeeding. However, in many African countries, like Ethiopia, where parts suffer from chronic food shortages, alternative food sources are often unavailable.[10] Additionally even where clean water is accessible, the cost of locally available formula normally exceeds the average household's income.

The poverty exacerbated by HIV-infection within a large number of sub-Saharan African households, by lost employment and necessary raised expenditures, means that children, be they themselves HIV-infected or otherwise, are at risk of numerous social and economic issues, such as homelessness, restricted education, lack of healthcare access and increased susceptibility to malnutrition. As they reach adulthood these children are vulnerable to a range of consequences such as HIV infection, illiteracy, child labour, exploitation and unemployment. Possibly the most concerning long term matter is that children, particularly girls, are forced to drop out of school to replace lost adult labour and to care for their remaining family; research has shown that drops in female educational levels correlate with increased infant and maternal mortality. Girls may also abandon school and enter sexual relationships with older men, known as 'sugar-daddies' who generally have a high turn-over rate of sexual partners and a significant risk of HIV infection, so as to finance 'beauty' costs (for hair-styling and clothes) and keep up an expected and respectable appearance. Orphans and vulnerable children, living in weakened households, having minimal finances for the material items they desire, may feel a greater incentive to enter these relationships.

In summary, HIV-positive people face huge economic and social costs throughout their lifetime. Accessing the multitude of vital treatments for HIV (ART), TB and opportunistic infections are not only a monetary concern but also primarily a threat to job security; ART users have reported that after disclosing their HIV-positive status they have been made redundant. Furthermore the immense barriers that prevent adequate adherence to ART, for those who can access it, can culminate in drug resistance and ART failure. To combat this drug resistance expensive, more complex regimes of anti-retroviral medication are required, which have increased side effects and reduced efficacy. As more and more of sub-Saharan African's population become infected with HIV (a recent estimate placing the figure at 25.8 million people[11]) the greater the economic and developmental destruction of a country there will be. The immense political and financial strain on governments of sub-Saharan Africa to provide ART free of charge, to all those in need, culminates in a heavily curtailed annual budget. Ultimately this is preventing government revenue being utilised for essential country development such as for infrastructure, business development, health and education; in numerous African countries these factors are affecting national stability and causing economic recession.[12] This problem is further exacerbated as the illness and death of many skilled and educated adults is occurring alongside the loss of schooling in the next generation; this will lead to a significant dearth of qualified adults who can rebuild the country and will facilitate the ever-continuing viscous cycle between poverty and HIV.

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[10] ETHIOPIA: **Poverty threatens efforts to stop mother-to-child HIV transmission**. ADDIS ABABA, 28 Apr 2006. Integrated Regional Information Networks PlusNews The HIV/AIDS News Service. http://www.plusnews.org/pnprint.asp?ReportID=5907

[11] http://www.aids.net.au/aids-statistics-dec05.htm

[12] The Nexus of Microfinance and the HIV/AIDS epidemic: the 14th CGAP/UNCDF Donor Brief. UNITED NATIONS CAPITAL DEVELOPMENT FUND Microfinance http://www.uncdf.org/english/microfinance/newsletter/pages/dec_2003/news_hiv.php