

Development of a Conceptual Framework to Help Understand The Interactions Between Poverty and HIV/AIDS at the Household Level



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Introduction

Poverty can be a risk factor for and a consequence of HIV infection. The poor frequently live in high-risk social environments and HIV-infected persons experience adverse economic impacts. Typically, poor people have less access to the services they need most, e.g. health care, welfare support, education, and agricultural extension services. The problem is compounded by indirect costs of access, such as transport and time, and lack of knowledge about services. Worst hit are communities that are already poor, with inadequate infrastructure and limited access to basic services.

HIV infection can result in:

- Direct economic impacts (loss of income, increased health care expenditure)
- Indirect economic impacts (social exclusion/stigma)
- New responsibilities and work for children (caring and provider roles)
- Impacts on Child Rights (orphans may lose their inheritance)
- Declining food security, nutrition and health (loss of productive labour and buying power)

Overall Aim:

The overall aim of the SAHARA poverty research is to address the role of HIV in reducing the possibility of attaining the poverty reduction Millennium Development Goal.

Specific objective:

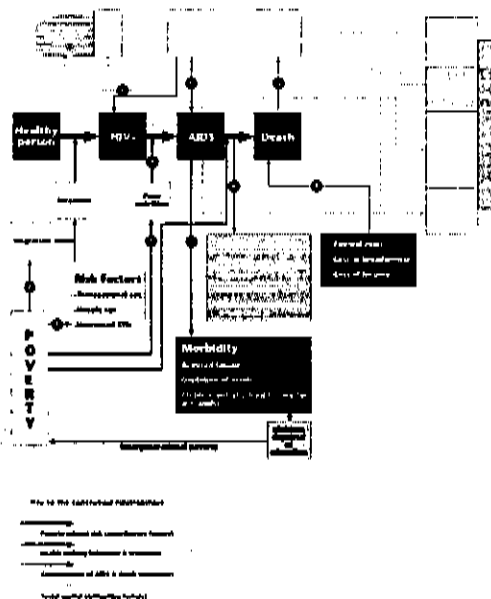
To provide empirical evidence on the role of poverty as an added risk factor for HIV transmission.

Methodology

- A literature review on 'Poverty and HIV/AIDS interactions and their impacts on households'
- Developing a conceptual framework on interactions between poverty & HIV/AIDS (THIS POSTER)
- A study of Poverty & HIV/AIDS in six African countries (Botswana, Burkina Faso, Kenya, Rwanda, Senegal, South Africa) using qualitative and quantitative methods

Explanatory Notes

The interactions between poverty and HIV/AIDS are many and multidirectional. The conceptual framework encourages thinking about these relationships and helps to identify points where intervention is possible. The table below provides explanations of the nature of the relationships (shown by arrows in the diagram) and the intervention options are classified according to their 'level' (i.e. individual, household/community or policy levels).



Conclusions

- There is a huge volume of literature on poverty and on HIV/AIDS. However, literature explaining the interactions between the two is almost non-existent.
- Examining these interactions, and their direction, is useful for informing interventions.
- Interventions are required at individual, Family/Community and Policy levels.
- Empirical evidence is needed to establish the relative importance of the identified relationships.
- Gathering this evidence will require both qualitative and quantitative approaches because poverty has much broader implications than mere income. For example, understanding people's 'connectedness', or social capital, is a crucial part of understanding HIV risk and response.
- The next step is to empirically examine the interactions between poverty and HIV/AIDS in the field.

Theoretical pathway	Intervention Level		
	Individual	Household/Community	Policy
1. Poor people are more likely to have risky behaviours, e.g. unprotected or inconsistent sex, unsafe sex, infected sexually transmitted infections (STIs). ➔ Increased risk HIV exposure	***	+	
2. Household members migrate from poor rural areas to the cities seeking work that they may not find. Migrants may engage in transactional/commercial sex as a means of survival. ➔ Increased risk HIV exposure	**	+	***
3. Poor nutrition is associated with poverty ➔ Increased risk of opportunistic infections and more rapid progression to AIDS	+	**	***
4. A combination of poor nutrition and transactional/commercial sex increases the risk of HIV to AIDS (overriding treatment (ART)). The ART slows down the progression and prolongs life. However, there is a need for good nutrition for the drugs to be sustained and effective. Without food, treatment default is more likely, increasing the chance for rapid progression of the illness. ➔ more rapid progression of AIDS	+	**	***
5. Opportunistic infections (e.g. TB) further contribute to the progression of the illness.	**	**	***
6. The symptomatic phase is when people seek medical assistance. The health system is less accessible, and sometimes less responsive, to the poor. ➔ more exposure for opportunistic infections and more rapid progression of the illness from HIV to AIDS, for the poor.	***	**	+
7. Progression from HIV to AIDS usually leads to reduced labour, loss of income, and sale of property to pay for medical care etc. Children may be taken out of school to care for sick adults or because there is no money for schooling. ➔ being deprived of education may promote intergenerational poverty.	+	**	***
8. As the illness reaches full-blown AIDS, it increases the demand for care. Traditionally, women and children carry a disproportionate burden of care (unpaid labour). As more women and children care for the sick, households experience a reduction in labour and decreased agricultural production. The often high impact acute aid to the household burden, livelihoods are therefore severely affected. ➔ household risk further into poverty.		***	***
9. Losing a breadwinner can cause a critical loss of income for the household. The household may also lose knowledge and skills, especially in the agricultural sector, that are essential for the household's continued existence. If this knowledge and skill is not transferred to the younger generation, the vulnerability of the household to poverty is increased especially HIV/AIDS increases further. ➔ potential for intergenerational poverty.		***	**
10. The death of adult members increases dependency ratios and demand for support from other family members, government and organisations working with children. ➔ increasing numbers of orphans and demand for care.		***	***

Key: Focus of intervention: + some, ** moderate, *** high.

HSRC RESEARCH OUTPUTS

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