# Struggling for Survival: The Intricate Relationship between Poverty & Hiv/Aids In District Dir Lower, Khyber Pakhtunkhwa

S. Ullah (Sana Ullah)[1], A. Naz (Arab Naz)[2], W. Khan (Waseem Khan)[3], B. Ali (Basit Ali)[4], A. Hakim (Aziz -ul- Hakim)[5]

Original Article

[1] Lecturer in Sociology, University of Malakand, Khyber Pakhtunkhwa, Pakistan
[2] Dean Social Sciences, University of Malakand, Khyber Pakhtunkhwa, Pakistan
[3] Lecturer in Sociology, University of Malakand,Khber Pakhtunkhwa, Pakistan
[4] PhD Scholar Abdul Wali Khan University Mardan, Khyber Pakhtunkhwa, Pakistan
[5] Lecturer in Sociology, University of Malakand, Pakistan

**E-mail address:**

sana_871@yahoo.com

**Reprint address:**

Sana Ullah
University of Malakand
Khyber Pakhtunkhwa
Pakistan

*Source: Clinical Social Work and Health Intervention* *Volume: 10* *Issue: 2*
*Pages: 101 – 109* *Cited references: 18*

**Reviewers:**

Juraj Benca
St. Elisabeth University of Health and Social Work, Bratislava, Slovakia
Andrea Shahum
University of North Carolina at Chapel Hill School of Medicine, USA

**Key words:**

HIV/AIDS. Poverty. Infection. Spread.

**Publisher:**

International Society of Applied Preventive Medicine i-gap

CSWHI 2019; 10(2): 101 – 109; DOI 10.22359/cswhi_10_2_13 © 2019 Clinical Social Work and Health Intervention

**Abstract:**

Poverty a multifaceted phenomenon has been defined as hunger, deprivation, constrained choices and other interrelated features that impact upon the standard of living and quality of life of people. Poverty not only consists in the absence of financial capital but also includes an inability to access education, a doctor, information, social assets and skills. There has been a close association between poverty and HIV infection. HIV/AIDS is widely known around the world where the disease is destroying the lives and livelihood of tens of thousands of people. A major portion of infected people are found in developing countries like Pakistan The issue calls for the immediate attention of the research community because of its rapid spread in Pakistan. The current research was conducted with the objectives to identify the relationship between poverty and the spread of HIV/AIDS. The study applying a qualitative research approach was conducted in District Dir Lower, Khyber Pakhtunkhwa. Primary data was collected from fifteen (15) respondents through in-depth interview (using an interview guide) while the selection of the sample was made through non-probability sampling using a purposive sampling technique. Further, the research was analyzed qualitatively and a thematic discussion was made to clarify the issue under study. Research concluded that poverty and the spread of HIV/AIDS have close association and some remedies were also suggested in order to control the spread of the disease.

## Introduction

Health is a valuable and crucial asset for people and ill health is often associated with many factors including poverty (WHO, 2003). Poverty exposes people to various health hazards and infectious diseases such as malaria, diarrhea, tuberculosis, HIV and other risks through malnutrition, and lack of basic services of life (Pattanayak & Paff, 2009). The Human Immune-deficiency Virus (HIV) is principally a sexually transmitted disease, and most of medical scientists agree that HIV cause the syndrome (AIDS). The transmission routes of HIV i.e. unprotected sexual intercourse, blood transfusion, sharing of HIV contaminated needles, breastfeeding, blood products and artificial insemination show that HIV transmission is caused by many interrelated factors (Karewa, 2000). It was during early 1980s that HIV/ AIDS was first clinically identified in the USA, however, currently the disease is more prevalent in the developing countries including Pakistan (Okeregbe, 2000). In the developing countries the higher prevalence rate of the disease is because of poverty, poor knowledge of hygiene and poor availability of disease preventive measures. The combination of low level of knowledge and poverty further lead to: poor environmental situations; adverse sanitation; malnutrition; overcrowded dwellings, limited availability of portable water increase the risks of HIV.

Poverty is a multifaceted phenomenon that includes hunger; having no shelter; an inability to see a doctor during sickness to maintain a minimum standard of living (World Bank, 2008). Deleck, *et al* (1992)

defined poverty as a relative term that includes several multi-dimensional and dynamic aspects including social, economic and psychological. There have been close links between poverty and HIV/AIDS; poverty contributing not only in the spread epidemic but also producing poverty in its turn. Similarly, HIV/AIDS strongly interacts with poverty and such interaction has increased the intensity of vulnerability of those households who were already vulnerable to the shocks of poverty (Gaanyaza & Segeer, 2005). The strong association between HIV/AIDS and poverty is also evident from the fact that the disease exists more in resource poor countries and communities (UN, 2004).

At the same time, poverty is perceived as both a cause and an outcome of HIV/AIDS because HIV/AIDS impact households and families when income earning adults in poor households become ill and require treatment, care and thus household expenditures increase due to medical treatment and care costs (Heiland & Lexow, 1999). Similarly, poor households, most of the time exhaust their savings losing their economic resources to pay for the medical care of sick members; their productivity becomes severely reduced. In poverty stricken and least developed countries poor people are further exposed to greater risks including contracting the HIV infection (Barnett, Whiteside & Desmond, 2001). Poverty then promotes negative and fatalistic attitudes. Many poor people consider it less important to protect themselves from risky sexual and other behaviors, so individuals in such conditions are poorly motivated to take the necessary measures to protect themselves from HIV (Bachmann & Booysen, 2004). HIV is not only a medical disease but many other factors including poverty is at the core of spreading the disease. Being a developing country in Pakistan the risks of HIV spread is further intensified by: lack of awareness; poverty; lack of HIV related education; lesser or no access to HIV treatment centers.

## Statement of the Problem

Poverty and HIV/AIDS are closely related with each other and could result in having the ability to reverse the economic development in many countries including Pakistan. In Pakistan, there is a rapid increase in HIV patients (World Bank, 2003). In the absence of a comprehensive poverty reduction and growth strategies in Pakistan, currently there is little chances to control or eradicate the disease in the near future (UNDP, 2012). Although, there have been certain health sector interventions, these are not sufficient at providing support to those deprived and susceptible to HIV. In recent years, no significant improvement has been observed in understanding of the consequences of HIV/AIDS. Similarly, those socio-economic factors that drive the HIV epidemic in Pakistan are not well understood, which further deteriorates the situation and thus resulted in the increase number of untreated HIV population (Barnett *et al.*, 2002). Poverty increases the vulnerability of an individual and decreases the capability of a person to avoid the infection. These may include limited knowledge, information and skills required to protect from HIV; inability to access health care services; no affordability of treatment costs (UNAIDS, 2008). The relationship between HIV/AIDS and poverty is complex. HIV is both an outcome and cause of poverty as it results in depletion of income resources; reduces the ability of assets accumulations; intensifies the process of economic exclusion (Collins & Rau, 2000). Similarly, poor people are unable to meet their basic needs and are vulnerable to engage in risky behavior such as use of contaminated needles; unprotected sexual intercourse; poor hygiene practices

including commercial sex (Iceland, 2005, (Dibua, 2010, Yekaterina *et al.,* 2012). It was emphasized that poor people including young female labor, migrant workers, and other economically disadvantaged people are more exposed to HIV infection. Thus, the current study was conducted in District Dir Lower of Khyber Pakhtunkhwa, with the objectives to find out the relation between poverty and the spread of HIV/AIDS.

## Methodology

A qualitative study design was adopted for conducting the study. A study sample was taken from the total registered HIV infected patients from District Dir Lower. In this regard, the primary field research was collected from fifteen (15) respondents through in-depth interviews (using an interview guide) while the selection of the samples was made through non-probability sampling (using purposive sampling technique). For maintaining the anonymity of the respondent's first alphabet of their names was used as a code and number of their interview was used as a serial number. Further, data was collected from married and unmarried respondents of the age group between 25-50 years. In order to analyze the phenomenon of HIV/AIDS and its close association with poverty detailed primary information were collected from the selected respondents using secondary information as a base. As the study was qualitative in nature therefore the collected information were elaborated, interpreted and thematically discussed in detail and conclusions were drawn on its basis for clarification and understanding of the issue under study.

## Results & Discussion

### General & Demographic Characteristics of the Respondents

**Table 1:** General & Demographic Characteristics of the Respondents

| **Age Group** | **Frequency** | **Percentage** | **Total** |
|---|---|---|---|
| 25-30 | 03 | 20 | 03 |
| 31-35 | 05 | 33.3 | 05 |
| 36-40 | 05 | 33.3 | 05 |
| 41-50 | 02 | 13.3 | 02 |
| **Total** | **15** | **100** | **15** |
| **Family Types** | **Frequency** | **Percentage** | **Total** |
| Joint Family | 10 | 66.6 | 10 |
| Nuclear Family | 02 | 13.3 | 02 |
| Extended Family | 03 | 20 | 03 |
| **Total** | **15** | **100** | **15** |
| **Education** | **Frequency** | **Percentage** | **Total** |
| Illiterate | 9 | 60 | 10 |
| Primary | 03 | 20 | 03 |
| Middle | 01 | 6.66 | 01 |
| Matric & above | 02 | 13.3 | 01 |
| **Total** | **15** | **15** | **15** |
| **Marital Status** | **Frequency** | **Percentage** | **Total** |
| Married | 13 | 86.6 | 13 |
| Unmarried | 02 | 13.3 | 02 |
| **Total** | **15** | **100** | **15** |

The demographic information shows that respondents who were interviewed belong to different age groups. In this regard, the interviewed respondents were between the ages of 25-50 years. Out of the total respondents 3 (20%) were between the ages

of 25-30; 5 (33.3%) each were in the age category from 31-35; 36-40; while the remaining 2 (13.3%) were in the age group from 41 to 50. The research also reveals that most of the respondents: 10 (66.6%) belong to a joint family; 2 (13.3%) were from a nuclear family; the remaining 3 (20%) were in an extended family systems. Further, regarding education: 9 (60%) respondents were illiterate; 3 (20%) were having primary education; while 1 (6.6%) middle education; 2 (13.3%) metric and above level of education. Similarly, on the basis of marital status, respondents were distributed into married and unmarried categories: married 13 (86.6%): 2 (13.3%) were unmarried.

## Poverty & HIV/AIDS in the Area

World Bank (2008) defines poverty as hunger, lack of shelter; poverty is also being sick and not able to see a doctor; having no access to doctor or job. Historically, there have been strong linkages found between HIV/AIDS, and poverty conditions and poverty is regarded as both a cause and an outcome of HIV/AIDS (UN, 2004). HIV/AIDS impoverishes families when working adults in poor households become ill; need treatment and care; household expenditures increase due to medical care costs (Heiland & Lexow, 1999). Similarly, poor households often spend their savings and lose their assets in order to purchase medical care for sick members; their productivity becomes severely curtailed. Primary research and observations reflect similar results as compared to the secondary information where a majority of respondents explain that poverty and HIV/AIDS have close relationship and the disease affect the poor worsely. According to a respondent:

"*..We, the poor are badly affected by many diseases including HIV/AIDS. HIV/AIDS intensify our poverty, as we spend most of our saving and medical care..*" *(4-S-1).*

Various research studies show that HIV/AIDS slows economic growth and expose the poor to a greater risk of contracting HIV/AIDS (Barnett, Whiteside & Desmond, 2001). Poverty then fosters a fatalistic attitude that manifests in indifference to high-risk sexual and other behaviors; individuals in such situations are poorly motivated to take necessary steps to protect themselves from HIV (Bachmann & Booysen, 2004). In this regard a respondent affirmed that:

*"..Because of poor economic condition also both men and women are compelled to involve in risky sexual and other behaviors that cause the contracting of the disease…" (5-T-4.).*

Similarly, poor households may find it even more difficult to exonerate themselves from dire poverty due to HIV infection. Rather they are further exposed to HIV because of their risky behaviors. While HIV intensifies poverty and generates a culture of poverty this circle of poverty is likely to repeat itself and so be felt over generations (Cohen, 1998). A majority of the partici-pants believe that HIV/AIDS long term consequences are not only limited to us but will be felt by our children as well. It was substantiated by respondent during interview that:

*"..Our children will also bear the long-lasting consequences of HIV/AIDS as in absence of adequate economic resources they will remain vulnerable to the infection. …" (2-G-5).*

HIV/AIDS appears to have strong interaction with poverty and the depth of vulnerability, intensified on the disadvantaged and poor households and communities.

## Poverty, Risky Sexual Behavior & HIV/AIDS

In patriarchal societies men hinder women access to achieve elevated socio-economic status and control the social system, resources, family and opportunities (Mason, 1986 & 2001). Kabeer (2000) asserts that in patriarchal societies men make the decisions regarding health, education, family planning and residence. As men are expected to be the primary breadwinner for their families, women often experience poverty; have lesser control over economic resources; make productive and reproductive decisions which lead to the poor socio-economic position of women in society (Folbre & Bruce, 1988). During interviews a respondent was of the opinion that:

*"...In our society men control economic resources and make major decisions regarding family affairs, while women have little or no say in decisions and are deprived of exercising economic powers…" (3-M-7).*

Studies indicate that many rural men who work outside their homes often replace their rural wives with town women (Cohen, 1993). Similarly, in the absence of proper opportunities to earn livelihood millions of women throughout the world are engaged in commercial sex work on a regular basis, and many other exchange sex for money or goods on an occasional basis (USAID, 2007). Poverty stricken women are at high risks of unwanted pregnancies and of contracting HIV/AIDS and other sexually transmitted diseases (Cohen, 1993). The field data also confirms the same because a respondent argues that:

*"...Both men and women both are responsible for illegal sexuality in society. Many men and women are involved in unprotected sexual relations, and women in particular are exposed to the infection ..." (8-W-18).*

Due to a persistent increase in economic insecurity women become vulnerable to sexual harassment, exploitation, and ultimately to HIV/AIDS. While commercial sex workers do not use condoms as men will make the decision regarding the use of condom because it is he who pays for the sex (Tobias, 2001). It is evident that both poverty and excess in money contribute in spreading the disease (HIV), while a respondent argues that:

"…*Both poverty and abundance in wealth promote commercial sexual practices in society. The poor sell their bodies, and the rich pay for sex and both are responsible for transmitting HIV in our society…."(11-Y-19).*

Conclusively, people both men and women are engaged in risky health behavior for their social and economic survival which results in their exploitation, and also promotes sex without condom use and contribute to the spread of HIV/AIDS.

## Poverty, Polygamy & HIV/AIDS

The practice of polygamy allows a husband to have more than one wife. The risks of direct sexual transmission of HIV can occur in these sexual relationships because of the presence of multiple cross infections (Tumwine, 2005). In developing countries like Pakistan, inequality between women and men exist, and this gender bias has limited the value, opportunities, rights and economic resources for women (Kabeer & Subrahmanian, 1996). In spite of their high contribution in rural agriculture production, they are not being benefited properly and equally; are economically dependent on their men; are in the clutches of poverty throughout their life. A respondent during a field interview also shares that:

*"..Women are working in the agriculture fields, and also perform other domestic tasks levels, but their jobs are unpaid and their economic contribution is not recognized...." (17-J-9).*

Further, research shows that in poverty stricken societies polygamy is practiced in order to sustain equity of resources (Gazdar, 2001). There is a strong relationship between polygamous relationships and HIV, and in Africa 42% of HIV positive were in those who have practiced polygamy (Cohen, 1993). Therefore, the spread of HIV/AIDS within polygamous relationships are regarded as higher risks than in monogamous marriages because of the presence and spread of multiple cross infection (Tobias, 2001). Moreover, polygamous women while tired of waiting for their husbands, indulge into extra marital affairs and expose themselves to HIV, so if one woman contracts the virus eventually everyone would be infected (Adow, 2007). An extract from an interview is:

"*..Women's poverty makes them voiceless and they are compelled for polygamous marriages. Infection in one wife or husband will expose all the others to the disease…." (18-S-23).*

Similarly, poverty also played an important role in perpetuating teenage marriage in order to ensure financial security; daughters are considered an economic burden in the family (WHO, 2006). Poor parents think that feeding, clothing, and especially educating girls is costly, and the family can recover its investment in a daughter by having her married in exchange for a dowry as soon as possible. Conclusively, polygamy and teenage marriages are practiced in poor patriarchal societies, and risks of HIV within these marriages are more than in monogamous relationships.

## Poverty, Livelihood, Nutrition & HIV/AIDS

Livelihood includes assets such as natural, physical, financial and social capital and access to institutions and social relations (Ellis, 2004). HIV infected and poverty stricken households may find it difficult to maintain their livelihood and nutrition, and thus exert tremendous pressure on the household's ability to provide for their basic needs of food and nutrition (Samatebele, 2005). Such circumstances also compel infected households to spend their savings for medical costs of the ill person and the huge cost of treatment and care will never allow them to live a better life. Most of the field information and information validate the literature and an extract from a field interview explain that:

"*...HIV/AIDS has impacted our livelihood and nutrition. Also due to high costs of treatment the inability of the infected person to work thus badly impacts our livelihood and nutrition....."(13-F-11).*

Relevant literature also suggests that HIV is a hurdle to household's well-being reducing their income and productivity. Waal & Whiteside (2003) argue that decline in agricultural production is attributable to the effects of HIV/AIDS. They further assert that households with a chronically ill person see an income reduction of between 30% to 35% affecting the food security of the household with an infected person. As a result these families will adopt alternate strategies for their economic survival that may also include engaging in commercial sex that puts them in general, and women in particular danger of acquiring HIV infection (Rosegrant, 2001). Field information also shows similar findings and an extract from an interview shows that:

*"…HIV/AIDS ruined me and my family economically. I could not maintain my business and am unable to work long hours and hardly bear food expenses of my family…." (16-Z-16).*

Poor nutrition is also linked with adverse outcomes of HIV/AIDS, which increase the vulnerability from HIV infection to mortality (Bates *et al,* 2004). Poor nutrition weakens the body's defenses against infections; infections in turn weaken the efficiency of absorption of nutrients, thus contributing to further HIV vulnerability and infection (Nattrass, 2004). Moreover, HIV progress fast in households with poor nutritional status, affect immune system further, and cause the death of ill persons. Regarding, the association of HIV livelihood and nutrition, the respondents explained that HIV/AIDS badly affected the quality of the food and thus we face multiple diseases:

*"...I am unable to fulfill food requirement of my children and two of my children are declared as malnourished by the doctor."(9-A-20).*

The majority of the informants were of the opinion that that HIV adversely impact income, livelihood, productivity of the infected individuals and families, and there was both direct and indirect economic impacts of HIV/AIDS on the infected people.

## Conclusion

HIV/AIDS is one amongst the most devastating public health issues affecting thousands of people in Pakistan. In Pakistan, the disease is rapidly expanding and has tragic consequences on individuals, families, communities and on the entire population both at national and provincial levels. The infection has close association with poverty and exclusively affects the poor and vulnerable people and communities. Economic factors such as poverty; individual and household income; lack of access to productive resources; livelihood; nutrition; economic dependency have made the people vulnerable to HIV/AIDS. This study also concluded that in order to provide treatment for HIV/AIDS patients, households and families' health care expenditures increased, and further intensify their poor economic position. It also will reduce the size of the working-age population at household levels; reduce the working capacity of the infected individuals; have negative consequences upon social networks; effect family integration and recognition.

## Recommendations

On the basis of the findings of the research, the study suggests investment in human resources development; food security; youth employment; gender equality in order to alleviate poverty and contribute toward addressing HIV/AIDS. Further, lack of health education and HIV related information have been significant contributors to HIV/AIDS. Thus there is a need to improve people's knowledge and information regarding the causes, consequences and control measures of HIV/AIDS. Moreover, formulation and implementation of a comprehensive HIV treatment and prevention strategy is necessary, keeping in consideration all the economic factors of the infection in the society. Moreover, jobs opportunities must be created in local areas in order to focus the key drivers of the disease in poor communities and reduce the import and import of the disease.

## References

1. ALLAIN J P (2000) *Emerging Viruses in Blood Transfusion.* Vox Sang. Vol (78):243-848.
2. ALLISON, E.H., SEELEY, J.A. (2004). *HIV and AIDS among Fisher Folk: a Threat to Responsible Fisheries'?'* Fish Fisheries. Vol (3) p. 215–234.
3. ANDERSON DJ, et al. (1992) *Effects of Disease Stage and Zidovudine Therapy on the Detection of Human Immunodeficiency Virus Type 1 in Semen.* JAMA. Vol (267) p: 2769-2774.

4. ARANETA MRG, MASCOLA L, ELLER A, *et al.* (1995) *HIV Transmission Through Donor Artificial Insemination.* JAMA. Vol (273) p: 854-858.
5. BACCHETTI P, MOSS AR (1989) "Incubation Period of AIDS in San Francisco." Nature. Vol (338) p: 251-253.
6. BARNETT T, WHITESIDE A, DESMOND C (2001) *The social and economic impact of HIV/AIDS in poor countries: a review of studies and lessons.* Progress in Development Studies. Vol (2) pp: 151-170.
7. BARNETT T, WHITESIDE A, DESMOND C (2001) *The Social and Economic Impact of HIV/AIDS in Poor Countries: A Review of Studies and Lessons*. Progress in Development Studies 1 (2): 151-170.
8. BATES I, FENTON C, GRUBER J, LALLOO D, LARA A M, SQUIRE SB, THEOBALD S, THOMSON , TOLHURST R (2004) *Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part 1: determinants operating at individual and household level*. THE LANCET Infectious Diseases Vol. 4, May.
9. COHEN D (1993) *Socio-Economic Causes and Consequences of the HIV Epidemic in Southern Africa: The case of Namibia.* New York (NY): UNDP.
10. COHEN O J, *et al*. (1995) *Pathogenic Insights from Studies of Lymphoid tissue from HIV-nfected Individuals*. J Acquir Immune Defic Syndr Human Retrovirol. Vol (10) p: S6-S14.
11. DALLABETTA G (1999) *Treating sexually transmitted diseases to control HIV transmission.* Current Option in Infectious Diseases, 10:22-25.
12. DIBUA U (2009) *Socio-economic and socio-cultural predisposing risk factors to HIV/AIDS: case study of some locations in Eastern Nigeria.* Internet Journal of Tropical Medicine, 6 (2).
13. DORRINGTON R, BOURNE R, BRADSHAW D, LAUBSCHER R, TIMAEUS I M (2001) *The impact of HIV/AIDS on adult mortality in South Africa*. So. African Medical Research Council, Cape Town.
14. JOOMA B M (2005) *Southern Africa Assessment: Food Security and HIV/AIDS.* African Security Review. 14 (1).
15. LUGALLA J P L, EMMELIN M A C, MUTEMBEI A K, COMORO C J, KILLEWO J Z J, KWESIGABO G, SANDSTROM A I M, DAHLGREN L G (1999) *The Social and Cultural Contexts of HIV/AIDS Transmission in the Kagera Region, Tanzania.* Koninklijke Brill NV, Leiden. p: 377-402.
16. NATTRASS N (2004) The *Moral Economy of AIDS in South Africa.* United Kingdom: Cambridge University Press.
17. STEWART J (2003) *Moving Food: The World Food Programme's Response to the Southern African Humanitarian Crisis.* African Security Review, 12(1) 17-27.
18. WORLD HEALTH ORGANIZATION (WHO) (2003) *The World Health Report, Chapter 1: Global Health: today's challenges.*