DEBT RELIEF INITIATIVES AND POVERTY ALLEVIATION

Lessons from Africa

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Poverty and HIV/AIDS Patient Management in Swaziland: A case study of known HIV/AIDS patients

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Over the years, poverty has been described as a disease. This disease transgresses all boundaries and could include unimaginable consequences. Its impact can only be better appreciated when an examination of the vicissitudes which humans face in their quest for survival in an unpredictable environment is undertaken. Jacobson has this to say of the ailment:

> Two out of three women in the world presently suffer from the most debilitating disease known to humanity. Common symptoms of this fast-spreading ailment include chronic anaemia, malnutrition, and severe fatigue. Sufferers exhibit an increased susceptibility to infections of the respiratory and reproductive tracts. And premature death is a frequent outcome. In the absence of direct intervention the disease is often communicated from mother to child with markedly high transmission rates among females than males. Yet while studies confirm the efficacy of numerous prevention and treatment strategies, to date few have been vigorously pursued. The disease is poverty.[1]

Illuminating as the above would seem, it should also be noted that the gender emphasis of Jacobson is also not only appropriate in the present dispensation but highly germane in the sense that women's susceptibility to HIVAIDS is greater than men's.[2] By the same token, the recognition of HIV/AIDS in poverty reduction strategy papers (PRSPs), the heavily indebted poor countries (HIPC) strategy, and the conception of poverty as bi-directional, is a function of the pivotal influence of this causative factor.[3]

Needless to emphasise at this point the utility of poverty in the present study. Instead, we note that in 1993 the government of Swaziland declared HIV/AIDS as a national priority and today HIV/AIDS has emerged as a national crisis.[4] Today, the country is an

HIV/AIDS endemic society with about 34% of the population HIV positive. The government's health statistics reveal that, of admission and case fatality rates by disease and condition, AIDS ranked second with 30.6% in 1999. The significance of this figure can only be appreciated when it is noted that the state of vital statistics (deaths) is dismal in developing societies. The implications of the emergent morbidity and mortality rates for socio-economic development are enormous.

Apart from the fact that the above reveals how threatening the HIV/AIDS pandemic appears, it also indicates the stress it has imposed on the economy. It is within this context of the problems posed that this chapter attempts to study HIV/AIDS patients and their socio-economic conditions and the extent to which their background has inhibited or otherwise managing effectively their health status. The chapter essentially focuses on identified HIV/AIDS patients and examines their socio-economic status with a view to establishing its impact on health maintenance.

The available source(s) of funding to patients and the healing context will also be examined in accordance with the basic framework of the study.

Setting and Methodology

Swaziland is a small landlocked country with an estimated population of about 1 018 000 people and an area of 17 364 km^2.[5] South Africa encircles the country in the north, west, and south while the eastern part is bounded by Mozambique.[6] It is a mono-ethic group and largely not urbanised. The majority of the population is poor and rural based.[7] Swaziland is a society with strong cultural values and traditions, which is due partly to the patrimonial monarchical system of government that is in operation.

The country's health care system is heavily dependent on government and missionaries, with small private support. The health care system is not highly developed owing largely to the small size of the population, which does not permit highly sophisticated facilities as these are not cost effective. Swaziland is therefore dependent on South Africa for health care that requires specialised attention. The population from which the study benefits is drawn from the largest government hospital, which is located at the seat of government (Mbabane). This hospital is highly accessible except for the remote rural areas of the country.

Methodology

The information on which this study depends was generated through interviews and observation. The adoption of these methods was due to the ethos of the respondents involved in the study. A 53-item questionnaire was used to elicit information from the sample of twenty respondents. These were all interviewed in their hospital beds, as they were patients being treated for HIV/AIDS. It is vital to note that we could not reach 'healthy' carriers of the virus who commute between their homes and the hospital for counselling services due to their sensitivity and reluctance to be identified as carriers. It is vital to note that their non-cooperation is responsible for their non-inclusion in this study. The sample size and choice is based partly on availability and also the special character of the studied group. This was supplemented by the observation of the hospital milieu and the infirm patients who could not be interviewed largely due to their impaired state of health.

Brief Literature Review

The literature on the relationship between HIV/AIDS and poverty is enormous and diverse as to the direction of impact. In a recent UNRISD/UNAIDS report, it is observed that since the beginning of the pandemic, over 50 million people have become infected with HIV, while about 34 million are living with and over 18 million have died from AIDS.[8] About 95% of these live in developing countries. The report further states that the proportion of women being infected is becoming more and more significant, with 55% of the infections in sub-Saharan Africa in 1999 occurring among women. The global and gender dichotomy of the affliction speaks for itself.

By the same token, a UNAIDS/World Bank report suggests two possible directions for the links between HIV/AIDS and poverty.[9] First, it observed that AIDS is a cause of poverty or that AIDS deepens poverty, and second, the combined effects of poverty and income inequalities on social transactions including sex, patterns of vulnerability and risky behaviour in relation to HIV infections and AIDS have been implicated in the spread of the pandemic. In their view, evidence abounds of both strong and weak demonstrable relationships of the direction of association. They observe that at the inception of the HIV/AIDS pandemic, persons of higher socio-economic status were more likely than others to become infected with HIV. As

HIV/AIDS becomes endemic in most African countries, the positive correlation between socio-economic status and HIV infection could be expected to disappear. Poverty and illiteracy, they observe, might be expected to raise the possibility of infection from sexually transmitted diseases, including HIV/AIDS, since people with low incomes may be less able to afford condoms. Those with low levels of education may have less access to information about the dangers of high-risk behaviour or may be less able to understand prevention messages.

Poverty and the resultant malnutrition also make children more susceptible to infections and impair the body's immune system, resulting in higher mortality rates from infections.[10] Diseases that are major causes of morbidity and mortality in Southern Africa, such as diarrhoeal diseases, respiratory infections and tuberculosis, are thus sustained by poverty. Thus, the belief is rife that HIV/AIDS is likely to gravitate more and more to the poor for reasons of low education and poor social conditions. While this line of argument is sound, recent findings show that poor people infected with HIV are considerably more likely to become sick and die faster since they are likely to be malnourished, in poor health and lacking health attention and medication. This ethos would therefore not only inhibit the prevention of mucus but also slow the healing process and depress the immune system.[11]

The Concept of Poverty

The term poverty is so focal to human existence that its influence cannot be over-emphasised in an analysis of contemporary social issues. The concept not only determines the social divide but also demonstrates how members of society are differentially located and how they are allocated societal goods, which invariably dictate longevity and wellbeing. For instance, Vella has observed that poverty appears to be associated with adverse health conditions.[12] He concludes that the very poor are more satisfied with their health and are more frequently hospitalised than the non-poor. It is within this basic framework that we intend to conceive the concept without being drawn into existing disputations on the effectiveness of the yardstick chosen.

Essentially, the concept of poverty can be examined from two perspectives: absolute poverty and relative poverty. Absolute poverty

rests on the evaluation of the required amount of income to provide the basic needs of existence. The value of this basic 'basket of goods', when compared with people's earnings, marks the threshold which determines which side of the divide one belongs: poor or not.[13] This is also known as the poverty line.[14] It should be noted, however, that in strict economic terms, most typical measures of wellbeing are made in terms of income or consumption or both. For instance, the poverty line in Swaziland is estimated at E448 (US $72) for an average family of 6.3 persons per day – which puts the poverty rate of the country at 66% of the entire population.[15] This statistic suggests that a very large proportion of the population lives below the poverty line and is, therefore, vulnerable to ill health.

Relative poverty, on the other hand, defines households or persons with income or expenditure below a certain percentage of the national mean of the country as poor.[16] In this wise, the standards used in measuring the poor and non-poor vary from one country to the next, to the extent that the poor in the United States may not be regarded as poor in the developing world.[17] The measure is therefore country or region specific.

In general terms, therefore, being poor in the context of this chapter would imply an inability to access nutritious food, education, or health facilities, and consequently a higher degree of vulnerability to infirmity.

Findings and Discussions

The government hospital in Mbabane is the biggest of the three government-owned hospitals in the country. The structures are well laid out and designed to cater for the disabled and specialised conditions of patients. While it would be out of place to say that the hospital is not well equipped, some of the facilities are consumable and may run short of supplies. The physical facilities and space are at the moment inadequate due to the patient load and admissions. The plight of the HIV/AIDS patients examined is terrible. Apart from the debilitating condition under which they live due to the ailment, 42% of the observed cases had no hospital beds and, therefore, had to provide themselves with bedding, which was laid under other beds, while some occupied any available space within the wards. The sight of small children, which is against hospital regulations, is a common phenomenon.

The results emanating from the study indicate that 70% of the respondents were women, a finding that backs up other recent findings, which show that the infection rates of HIV/AIDS are higher for women than men.[18] Vital as this fact may appear, the demographic data of Swaziland also shows a higher proportion of women as compared to men, a fact that is further exacerbated by male labour migration, which has further compounded women's plight.[19] All the respondents, with the exception of two, were children aged between 12 and 14 years, the others were adults between 25 and 40 years. The youthfulness of this population and its implications for national development are tremendous, especially in terms of the loss of manpower and scarce resources.

All the respondents, with the exception of the children, belong to a low socio-economic bracket, due partly to unemployment and illness. As a result of their poor state of health, most of them lost their jobs and so had to depend on relatives and government subsidies for medical support. This became apparent when we observed that, apart from 10% of the respondents who had visited private hospitals before being admitted to the government hospital in Mbabane, the rest came straight to this hospital, due mainly to the cost of services. It is within this context that the implications of poverty can be fully appreciated. Apart from being unable to provide for their medical needs, their ailment has further drained the resources of their families and the government. The pandemic, therefore, impoverishes the individual, the family and the government.

Moreover, there is a need for the government to improve the existing facilities. The mere announcement that free treatment at the clinics (primary health care) will soon commence will not in itself improve the poor state of health in the country.[20] The government must therefore move beyond an awareness campaign to providing functional services.

The educational background of the respondents is quite high. Over 60% of the sample had secondary education and above. It is germane in this regard to note that the literacy level is as high as 78% among Swazis.[21] Only 10% of the sample had no formal education. The high literacy and educational levels have led to a high level of awareness of HIV/AIDS in this society. Moreover, the de-stigmatisation of the ailment has led to a positive attitude of patients towards their status (that of acceptance of their condition), as revealed by the support they received from their relatives. In fact, the recent marriage

of an HIV-positive patient is testimony to this fact.[22] One wonders if this social acceptance may not lead to a situation where HIV/AIDS will be treated as just another common ailment, with the danger that the caution required might be thrown overboard. For instance, one of our respondents had this to say: "Everyone will die so why should I be afraid? It is even better that I am aware so that I can prepare myself."

Conclusion

The study reveals that the majority of the afflicted are young (in a highly productive age group) and, therefore, a major drain on resources for their families and the government. The study also shows that the social stigma associated with HIV/AIDS is waning, perhaps due to the high literacy level in the society. This development, although generally positive, could have negative consequences if not properly managed, as it may lead to a fatalistic attitude.

With all its ramifications, it is obvious that HIV/AIDS is a resource-sapping problem for the individual, family, and government, and is therefore an impediment to national development. In addition, it is observed that the poor socio-economic status of the respondents has a good deal of bearing on their health status. It is therefore our belief that HIV/AIDS and poverty are inextricably intertwined and, therefore, deserve a tandem approach to solving them.

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