Editorial

Poverty and HIV/AIDS

HIV/AIDS is not simply a health issue and cannot be addressed through the health sector alone. Globally, an estimated 35.3 million people were living with HIV in 2012. HIV epidemic in SAARC region is continued to be a major public health problem. All eight Member States of the SAARC region are designated as low prevalence countries. However, as per latest available information this region is home for an estimated number of 2.24 million HIV infected people.

In SAARC Region the first HIV infected persons were diagnosed in 1986 in India and Pakistan. By 1993, all the SAARC Member States had reported the existence of HIV infection in their countries. After more than 25 years of struggle against HIV, the SAARC Region is witnessing unprecedented returns from its investment in HIV prevention, treatment and care. The annual number of new HIV infection has declined. Effective ART has been demonstrated by significant reduction in the rate of ongoing HIV transmission. Despite this progress in global and regional response, economic inequality, social marginalization and other structural factors continue to fuel the HIV epidemic with estimated 1.56 lakh dying from AIDS in year 2012 in SAARC region. In the region HIV/AIDS is increasingly concentrated among persons marginalized by poverty, inequities and stigma. Social, economic and legal disadvantages increase vulnerability to HIV.

The impact of infection is already evident on health care systems e.g. decreasing life expectancy figures. The economic negative impact of HIV is immense, particularly among poor individuals and households. While all chronic diseases take their toll on human productivity, HIV is markedly worse because it affects people in their prime productive years of 15-49 years of age.

Many studies have documented the impact on families and communities, particularly due to the loss of income from both the infected persons and those who care for them, expenditures on health care and funerals, loss of future earnings and investment as children drop out of school to earn money or help caretakers, decreased agricultural production due to lack of labor, lost savings, lost homes, land sold to cover health costs and increased indebtedness.

Many developing countries are focusing on poverty reduction as a key component of their overall development. Poverty reduction strategies are now a key to all government in SAARC region. HIV/AIDS clearly has an impact on the prospects of poor people who become infected with the virus and, as such, it needs to be given careful consideration in any poverty reduction strategy.

Data on the extent of this problem proves elusive. However, the most striking figure is simple to understand. The 95 percent of those infected with HIV live in developing countries, home to around 85 per cent of the world's population. There is a strong positive association between HIV globally and the absolute poverty rate (at both $1 and $2 a day levels).

Some research suggest that investment in ART for maintaining 3.5 million people on treatment would save 18.5 million life-years and return US$ 12-34 billion mainly through increased labour productivity and averted orphan care over 2011-30. A recent systematic review of the literature on economic and quality of life outcomes of ART for HIV/AIDS in developing countries concluded that ending AIDS would lead to better skilled, productive workforce and stronger economies. Special commission on health convened by The Lancet concluded that additional life years due to health improvements were responsible for 24% of the growth in income in low and middle income countries from 2000-2011.

So it is high time to re-think about the control and prevention of HIV, which cannot be addressed solely through medical and clinical approaches, but through combined efforts to work across sectors to avoid working in isolation. The region needs to leverage capacity to build a new movement to achieve common goals to end AIDS and to end extreme poverty by 2030.