

Poverty reduction strategies in a public health perspective

Social grants, AIDS and the role-out of HAART in South Africa



“It is about my life”

AIDS, social grants and the ARV roll-out in South Africa: Is there a tension between health, economy and welfare?

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Background

AIDS is a serious problem in South Africa. HIV prevalence is highest among South Africa's majority black African population, which also has the highest rate of unemployment and the lowest per capita income of all the racial groups (UNAIDS/WHO, 2005 ; Seekings and Nattrass, 2006). Despite high unemployment, South Africa's welfare system is premised on full employment, with no support system for the unemployed.

Prior to the roll-out of Anti-retrovirals (ARVs), many people living with HIV (PLWH) accessed disability grants. Once on ARVs, many stand to lose the grant as a result of their improved health. The principal objective of the research was to explore tensions between health and welfare among PLWH in the context of high unemployment.

Methods

A triangulation of methods was applied: (1) In-depth interviews with 29 PLWH and 8 public health doctors, (2) three focus groups with program managers/stake holders, (3) a panel survey (KSPS) of 216 PLWH accessing ARVs, and (4) a control panel-survey of 517 people. The study was conducted in peri-urban townships in the Cape Flats, Cape Town, in 2007.

Key Findings

50% of the KSPS-sample was currently unemployed, and 46% of the control group. 78% of households in the KSPS-survey were receiving some kind of grant as a part of their income.

- 1 98% of those receiving disability grants used the grant to cover general (household) living expenses. This put PLWH under pressure.

“The problem is that we have over-crowded families with huge numbers of children who are depending on one person who is ‘granting’. Our parents are both ‘granting’, and it is the same situation. My mother is retired, but it is not easy for her to support because there are other people she lives with.”

HIV-infected man, 35 years

- 2 The qualitative interviews clearly revealed that the loss of disability grants as a result of improved health had a significant impact on physical and emotional health and

also led to high levels of stress.

42% of the KSPS respondents had experienced losing their disability grant. 90% of the PS respondents who had their disability grant terminated reported that it had a large impact on the household economy, while 8% reported that it had moderate impact.

"So you know, you become sick once you loose your grant. Mmm, because you become depressed and after that your CD4 count drops because you don't know what you're going to eat. People become sick all the time, because you need to take your medication. But, if you don't have food, it's difficult, and you cannot go back to your family. No one will help you. If you are unemployed, you will experience problems, because you have to buy food and clothing and pay for funerals with that grant."

HIV-infected woman, 28 years

3 Discontinuation of ARVs in order to maintain and in some cases requalify for the disability grant was not a common strategy. 3% of the KSPS respondents had stopped taking ARVs for other reasons than to extend the disability grant period. 99% of the PS-respondents would not stop taking ARVs in order to keep or renew the disability grant. However, 38% agreed that it is a common strategy among PLWH to stop taking ARVs in order to get the disability grant back. The qualitative data confirmed that PLWH would give priority to their health and risk losing the grant. However, sometimes patients complained that it was difficult to take the drugs on an empty stomach.

Some doctors were of the opinion that low adherence was a strategy to prolong the eligibility for the disability grant period.

"Oh no, I take my drugs every day, because I do care about my health and all that since I started to take my treatment. It is about my life."

HIV-infected man, 44 years

"I just tell them [doctors], sometimes, when I am hungry, I just leave the ARV treatment, I don't take the drugs, I just leave it lying there... and then I'll see [if I have any food to eat] the following/next day."

HIV-infected woman, 30 years

4 Doctors' criteria for assessing disability eligibility were obscure, resulting in an ad hoc distribution of grants. The recommended duration of the grant also varied from doctor to doctor. Some patients with high CD4 counts and who were employed were still receiving disability grants, while others who were unemployed and with CD4 counts that made them eligible for the grant were struggling to get it. In the KSPS survey 51% of those who had lost the disability grant stated that the reason was that their doctor indicated that they no longer qualified for it, while 29% stated that their application was refused. So, the doctor's assessment emerges as the most important reason for terminating the grant."

"First of all, nationally there are no clear guidelines. It varies from province to province, and even in this province, it varies

from doctor to doctor. Some doctors are hesitant to write a disability grant while others give just about anyone a disability grant. Some doctors still prescribe permanent disability grants (duration five years), while other doctors never do it. Locally, there has been some sort of agreement, if your CD4 count is less than 200 then you qualify for a grant; however, some doctors will give it to you for six months and other doctors will give you a 12-months grant."

HIV-doctor, 38 years

5 Patients classified doctors as 'good' or 'bad' in relation to their attitudes towards and practices of making disability grants which is both an interesting and useful finding. This also puts doctors under pressure to balance the biomedical criteria for grant eligibility against other forms of knowledge such as the individual's circumstances, unemployment and poverty in which most HIV-positive South Africans live.

"It depends of the heart of the doctor sometimes ... [talking about extension of the original disability grant time period]. If the doctor has got your sympathy then he can do that."

HIV-infected woman, 28 years

"The most difficult thing about being a doctor, is that you have to write disability grants. It is like you are God; you just have to look at the person's face and decide about whether they qualify or not."

HIV doctor, 29 years

Conclusions

The disability grant plays a critical role in supporting PLWH who are unable to access employment opportunities. However, there seems to be some unfairness and unevenness in the social grant system; a disability grant assistant may facilitate the process of assisting those eligible and in need, as well as of ensuring that people who are ineligible do not receive the grant. However, we did not find evidence that PLWH stop taking ARVs in order to qualify or requalify for a disability grant. However, the disability grant is crucial for many PLWH in that it ensures a degree of economic stability, as they have few other means for buying what they need without it. However, given the importance of the public sector ARV roll-out, it is crucial for the state to provide these resources. Alternatives to disability grants could be a chronic illness grant or a basic income grant, in order make 'positive living' a reality among PLWH. Furthermore, incentives to create employment are pivotal. Due to the fact that unemployment is a central problem for many people with HIV, an unemployment grant could also be an important improvement. A more-predictable economy for the individual and the household is also crucial for treatment and support for PLWH.

UNAIDS/WHO. *AIDS epidemic update. December 2005.* Geneva: UNAIDS/WHO, 2005.

Seekings, J & Natrass, N. *Class, Race, and Inequality in South Africa*, University of KwaZulu-Natal Press, Pietermaritzburg, 2006.

"They call me Mr HIV"

Creating an AIDS enabling environment among people living with HIV in South Africa

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Background

The 2007 - 2011 HIV/AIDS and STI National Strategic Plan (NSP) stipulates the creation of an AIDS enabling environment as a central component for HIV prevention, treatment and care in South Africa. As part of a qualitative and quantitative research study conducted in Cape Town from 2006 - 2008, the researchers explored the hypothesis that there is a disjuncture between this policy directive and state and community-based resources available for people living with HIV (PLWH) in South Africa.

Research Methods

- 1 Key informant interviews were conducted with 29 PLWH and with 8 public health doctors;
- 2 Three focus group discussions with women and men affected by HIV living in informal settlements in Cape Town, and with a group of community health workers from this area.
- 3 A panel survey was conducted in Khayelitsha with 216 respondents on antiretrovirals (KSPS survey);
- 4 The control survey was conducted in Khayelitsha with 517 respondents from a matched sub-sample (KPS survey).

Main Findings

1. Unemployment

"Workplace education and awareness raising is a crucial determinant in an effective response to challenging stigma within the workplace."
NGO focus group, 2007

The qualitative findings indicate that fear of stigma and/or denial of employment opportunities following the disclosure of one's HIV-positive status to actual or potential employers respectively. In particular, informants reported negative implications, including stigma and delayed work output, when taking a day off each month to receive their ARV treatment.

50% unemployment was reported in the KSPS survey and 33% of the KSPS respondents indicated that disability had negatively affected their ability to work, study, look for a job or work around the house.

2. Poverty

"Last month we did not pay our bills. Problems will come up next month because we are going to pay [our

bills], but we do not know what we are going to eat."
HIV-infected male, 2007

The qualitative findings indicate that adherence to medication is undermined by endemic poverty, particularly a lack of money to buy nutritious food.

In 2007, 79% of the households in KSPS survey received a state grant as part of their income; in particular, 41% of respondents in the KSPS survey received a disability grant compared to 6% from the KPS survey. 5% of the KSPS respondents agreed or strongly agreed that the disability grant had a positive and significant impact on helping PLWH receive support and acceptance from their families. Therefore, there is a significant correlation between the respondents' HIV-positive status and their ability to access disability grants, which in turn ameliorates the negative impact of poverty and unemployment on PLWH.

3. Gender Disparity

"Men won't go for VCT [HIV testing]. They want to make their partners pregnant. Then if the partner comes back from the clinic and says that 'I'm negative', he will be happy because he thinks he is negative. But if the partner says 'I'm HIV-positive', that will create domestic violence. He will say, 'You are the one who came with this thing. You were sleeping around.'"
Men's focus group, 2007

The qualitative findings indicate men were reluctant to test for HIV compared to women especially after they had learnt of their partner's HIV-positive test result. A related finding may account for men's reluctance to test: clinics and hospitals were perceived to be 'women's spaces', which raises the importance of engaging with men, through male-support groups for example, to address this disparity and encourage testing and treatment of HIV.

Pernicious structural limitations to improving education and employment opportunities continue to hamper the advance of gender equality and reinforce women's vulnerability to HIV infection. Among the KSPS respondents, men have the highest level of education: 39% of the men completed secondary-level education compared to 28% of the women. However, the KSPS survey also indicates that a higher proportion of women (16%) compared to men (7%) attend courses with the aim of getting a qualification.

4. Depression and Self-destructive Behaviour

"We need to have more awareness... When people tested [HIV] positive they thought this is the end and they went to alcohol and to drugs."
NGO focus group, 2007

Initial despair and association of HIV with death compelled some respondents to resort to self-destructive behaviour. However, commencement on ARVs, support groups and treatment literacy prompted significant behavioural change; informants reduced or terminated alcohol consumption and unprotected sex with multiple-concurrent partners.

Higher levels of depression and anxiety were reported in the KPS (control) survey than in the KSPS survey: 15% of

the KPS respondents compared to 7% of the KSPS respondents reported that they 'often or all the time' felt that problems were piling up so high that they could not overcome them. Given that both survey cohorts live in Khayelitsha, a poverty-stricken peri-urban area, these findings indicate that that the support systems for PLWH are relatively effective in this area.

5. Stigma and Support

"Your support group must start where you live."

HIV-infected male, 2007

The quantitative and qualitative findings indicate that families are the most critical site for community interventions to reduce stigma and facilitate support for PLWH. The KPS survey reports higher levels of trust among family members than among the KSPS respondents.

This finding also emerged in the focus groups discussions:

"In some families, when a child is ... HIV [positive] she will be treated so badly that the child can't even use a spoon or cup. There should be more awareness and we are working very hard in our communities to make [families] aware of the disease."

NGO focus group, 2007

6. Sustainable State-Community Collaboration

"The NGOs - they are the ones who see the needs of the people in the community. So the NGOs played a huge role in the community because they do home visits and take care of the people."

HIV-infected male, 2007

A number of examples of close collaboration between state and community emerged through analysis of the qualitative data. In particular, infrastructural support provided by the state (through grants and biomedical health care resources for example) complimented the psycho-social and educational role that many community organisations were reported to fill. Community organisations, however, struggle to access state funding, which limits the services they are able to provide in resource-constrained communities. Access to state support for PLWH is also fraught with bureaucratic bottlenecks, and the respondents perceived slow government response as an indication of the state's failure to prioritise the implementation of HIV/AIDS policy in South Africa.

Conclusion

Promoting acceptance of one's HIV-positive status, to the point where one respondent said, "They call me Mr HIV", is a central component of an effective personal and community strategy for challenging stigma and providing support to PLWH. This strategy, however, also requires significant state and community collaboration in which structural factors (like unemployment and poverty) and psycho-social factors (like gender-inequality, depression and stigma) are challenged, thus creating an AIDS enabling environment in which all people affected by HIV are able to thrive in South Africa.

Characteristics of participants (n = 29)

Characteristic	Profile	No
Gender	Male	14
	Female	15
Age	20 - 29	4
	30 - 39	15
	40 - 49	9
	Older than 50	1
Civil status	Married	8
	Widowed/Divorced	3
	Cohabiting	3
	Single	15
Number of children (<18 years)	0	3
	1	14
	2	10
	3 or more	2
Disability grant (DG)	Currently receives DG	15
	Previously received DG	8
	Never received DG	6
Employment	Full employment	6
	Casual or part time work	8
	Unemployed	15
Education	Grade 9 and below	8
	Grade 10 - 11	16
	Matriculated	4
	No Information	1
On ARVs	Yes	27
	No	2

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