

**AN INVESTIGATION OF HIV/AIDS INFECTIONS AND POVERTY AMONG
HOUSEHOLDS IN TEGERES PARISH, KAPCHORWA DISTRICT UGANDA**

BY

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DECLARATION

I Kiptoek Levi do declare that this piece of work is as result of my own effort and that has never been presented before to any institution of learning for any award

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APPROVAL

This is to certify that the research report submitted with my approval as the University Supervisor.

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Date. 14/10/2016

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DEDICATION

This work is dedicated to my parents, guardians and friends not forgetting Mr. Cherotwo Patrick, Everlyne Chemutai, Chelangat Eunice, Chebet joy, Chemutai Rabbecca Chekwemboi Ruth, my brother Chemonges Ivan , My friends Ogema Deogratius, Aleper Denis, Chemutai Habert and others. And above all to the almighty God for his grateful wisdom and strength while I was carrying out my research.

MAY THE ALMIGHTY GOD BLESS YOU ABUNDANTLY

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I would like to express my dearly appreciations to my beloved brothers and sisters for all their precious support both financial and spiritually and also extent my gratitude to my cousin brothers and uncles, and the rest.

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MAY ALMIGHTY GOD BLESS YOU ALL

ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral Therapy
HIV	Human immune deficiency syndrome
MOH	Ministry of health
UNAIDS	Joint United Nations programs on HIV/AIDS
UNICEF	United Nations children's fund
WHO	World Health Organization
PLWA	People Living With HIV/AIDS.

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ABSTRACT

The research entitled “An investigation on HIV/AIDS infections and Poverty among selected households in Tegeres Parish, Kapchorwa District” was conducted to determine relationship between HIV/AIDS infections and poverty, It was guided by the following objectives; to investigate on the factors contributing to increase HIV/AIDS infection and Poverty in selected households; to find out how HIV/AIDS affect individual’s productive work and to investigate the state and different forms of poverty among selected households in Tegeres Parish, Kapchorwa district. The research methods used include study designs which were categorized under qualitative and some quantitative sampling design and data collection among others. Data was collected from a sample of 40 respondents so as to get in-depth information, whereby the researcher used various methods of data collection like observation, interview guide and questionnaire. The data collected passed through various data processing methods like editing, coding tabulation and others during the study and the limitation of the study were highlighted as well as solutions. The study establish that HIV/AIDS impacts on children especially after the death of their parents and this leads them with no choice since most of the family members are not employed having much time being spend on looking after their relatives increasing number of dependents that are all their responsibility. To manage with a challenge of HIV/AIDS amidst poverty situation, household individual have try to earn salary ,selling and buying good ,do work for food , participating in social networks, reviving money from family members. The study recommends that health experts sensitize the members of community about the disease to create awareness, care and support to given households in preventive measures such as condom use should be emphasized.

CHAPTER ONE

INTRODUCTION

1.0. Introduction

This chapter consists of background to the study. It includes the problem statement, the goal and objectives of the study, research questions, scope, and lastly the significance of the study.

1.1. Background to the Study

The background of this study is divided into four parts; historical perspective, theoretical perspective, conceptual perspective, and contextual perspective.

1.2. Historical Perspective

Globally, Inter-Action, (2005) put forward that HIV/AIDs is a global pandemic that affects individual families and entire communities around the world and profound social and economic implications. In 2004, the pandemic killed an estimated 3 million people and additional 40 million were infected. The epidemic primarily affects the world's poverty people in countries with the greatest gender inequalities disparities in income and access to productive resource HIV/AIDs is primarily a heterosexual epidemic in developing countries, yet sex between men remain crucial aspect of the epidemic in middle and high income counties .UNAIDS 2005 however , estimated 1/3 of new infections or occur by heterosexual contact in these countries) often caregivers, families and friends encounter the same stigma and prejudice as those they care for endure. The everyday psychosocial issues for persons living with or affected by HIV/AIDs are compound by poverty, homelessness and in addition, unsanitary living conditions has been the trauma discrimination and societal in differences.

WHO (2005), each day 8000 people die of AIDs related conditions, in part due to a lack of awareness of their health status / limited access to the antiretroviral therapies (ARTS) available to delay disease progression. In fact a significant factor in the spread of this disease is that most people worldwide living with HIV/AIDs were not aware of their health status.

The World Bank's (1997) report confronting AIDs explained the wide spread poverty and unequal distribution of income that typify under development appears to stimulates the spread of HIV. United Nation joint Program on HIV/AIDs (UNAIDS) stated in 2001 that poverty, underdevelopment, the lack of choice and the inability to determine one's own destiny fuels the HIV epidemic. Fenton (2004) also reviewed evidence on how poverty leads to people to high

risk behavior and concludes that reducing poverty may be the only viable long term response to the epidemic.

In Africa, South Africa is believed that, at least one adult in five is living with virus and there is also growing epidemic in Africa as the 2004. William et al (2002) echoed that, Botswana and Southern African migration project (SAMP) explains the reason why the highest rates of infection in the world occur in South Africa and other African counties are unclear. Although the countries of the SADC region have much in common their histories over the last 20 years have been very different. With the highest rate of infection, has experienced stable democratic government and a strong economy since independence in 1986, Mozambique with the lowest rate of infection experienced 16 years of devastating civil war from which it only emerged in 1992.

In sub-Saharan Africa, a number of varying factors have been advanced to explain the rapid spread, high prevalence and uneven distribution on HIV/AIDs in Sub-Saharan Africa. They include poverty and economic marginalization, poor nutrition, opportunistic infection, migration, sexual networking and patterns of sexual contact armed conflict and gender inequality. Whereby Collins and Rail (2001), asserted that, HIV/AIDs like all communicable diseases is linked to poverty. The complex relationship between poverty and HIV/AIDs is central to an understanding of the impact of the epidemic on rural livelihood. The relationship is directional in that poverty is a key factor in transmission and HIV/AIDs can impoverish people in such a way as to intensify the epidemic itself. Thus the relation between poverty and HIV transmission is not simplistic.

HSRC, 2001 also put further that, although these are some powerful critiques of the poverty, AIDs argument, which claims that many of the worse affected African countries such as Zimbabwe and South Africa are among the most economically developed in the region. Poverty does seem to be crucial factors in the spread of HIV/AIDs. (Ibid) it should be emphasized that poor people infected with HIV are considerably more likely to become sick and die faster than the non-poor since they are likely to be malnourished in poor health and lacking health attention and medications. In effects, all factors, which predispose people to HIV infections, are aggravated by poverty, which creates an environmental risk.

Food agricultural organization (FAO) (2001), illustrated that, the experience of HIV/AIDs by poor individuals household and communities are like to lead to an intensification of poverty, push some non-poor into poverty and some of the very poor into destitution in turn, poverty can accelerate the onset of HIV/AIDs and tends to accelerate the impact of epidemic. As a result of the effect on mortality, morbidity life expectancy and population growth, HIV/AIDs is having a direct negative impact on poverty especially as experienced by poor rural household. In the (2001) Report on the special session of the General Assembly on HIV/AIDs the United Nation secretary warned that, HIV/AIDs was reversing decades of development in hardest hit region of the world. UNDP (2013), roughly 70% of all people living with HIV/Aids live in Sub-Saharan Africa, despite accounting for just 13% of the world's population.

UNAID (2013) also explained that epidemic had a number of impacts on this region with the most obvious effect being ill health and the number of lives lost in 2012 there were 1.6 million new HIV infections and 1.2million new related death as well as health care and Household, HIV/AIDs have impacted significantly upon the education sector labor and productivity and the wide economy. In 2010, 48.5 percent of people living in sub-Saharan Africa were living below the poverty line (\$1.25) a day. (World Bank: 2012). In 1997 the World Bank reported that wide spread poverty and unequal distribution of income that typify under development appears to stimulate the spread of HIV.

Foxm and Thomson (2012) coined that, Poverty can force people to leave home in order to find work for woman in particular, this can make them vulnerable to exploitation including early marriage & forced some into sexual work (UNAIDs, 2012) poverty alleviation odes have a role to play in preventing the spread of HIV/AIDs in Sub-Saharan Africa. However, the relationship between HIV prevalence and wealth is not direct and is influenced by a number of underlying social and cultural factors. The HIV/AIDs epidemic has had severe and wide ranging impact upon households in Sub-Saharan Africa many families have lost their chief income earners, who have died are too sick to work. This put a heavy financial burden on families who have to pay ever increasing medical cost, forcing many into poverty. As a result many families have to provide home based care further reducing their earning capacity and placing more demands on

their resources. In many cases, households simply dissolve because parents die and children are sent to relatives for care & upbringing.

The HIV/AIDs epidemics in Sub-Saharan Africa can serious impact upon household ability to generate income. The loss of income in addition to rising medical cost, reduces their ability of people giving care to work themselves pushing HIV affected households deeper into poverty. WHO (2009) poverty and health care, blight of malaria and HIV/AIDs explained that an estimated 1.2 million children has lost either one / both parents to HIV/AIDs.

In Uganda, Health and Social Issues significantly affected rural population as well. The population of about 3 million is growing at an annual rate of 3.4%. Although the country had dramatically reduced the incidence of HIV/AIDs since the 1990s prevalence rates have begun rising again in a recent.(WHO(2004) The pandemic has caused the death of large number of young adults and orphaned up to 1.2million children (IFAD, Uganda 2010). The lack of health care and other social services puts rural women at a particular disadvantage. They work for long hours than men, have limited access to resources and lack control over what they produce. Among many other tasks, they also bear the double burden of ensuring that households are adequately fed and caring for the sick, elderly and for orphaned children.

UNAIDs/ WHO AIDs, 2001 analyzed that Uganda is among the African countries with generalized HIV epidemics that have registered in a significant decline in overall prevalence of HIV/AIDs in the last decades. Although there is new evidence of an increase in HIV infection in some parts of Uganda. Sexually Transmitted Diseases (STDs) Aids surveillance report (2003) by the Uganda Ministry of Health the most predominate factor living the HIV epidemic in most communities in Uganda were sexual behavior at risk (multiple sexual partners, extra marital sex, early age sex, unprotected casual sex) infection (STIS) such as syphilis and helpers simplex virus type 2 (HSV-2), and social cultural and economic factors (Poverty alcoholism prostitution drug abuse, lack of male circumcision, domestic violence conflict and civil strife MDH; 2004/5).nm

AIDS is a chronic, potentially life-threatening condition caused by the human immune virus (HIV) which damages a person's body ability to fight the organisms that cause the disease. HIV is a virus that attacks the immune system, the body's natural defense system. Uganda National survey 2004/ 2015 explained that, HIV prevalence rate in Eastern Uganda is 5.9% and since it

has continuously affected household participation in economic activities rendering them poor and helpless. The report on the situation of children and women in the Republic of Uganda (Oct; 2005) estimate that there are more than 70,000 new infections every year in Uganda with children according for 16,000 of total 85% of those new infection are estimated to be people aged 15-49 years, families have been devastated as large number of children have lost one or both parents due to the epidemic creating an estimate 900,000 orphans who are left in the care of grand parents or other siblings. Many AIDs affected families have had to withdraw children from education system. To compensate for labor losses, increased care activities and additional expenses incurred by chronic morbidity and mortality. Productivity has declined and entire households have been impoverished while attempting to meet AIDs related costs. The government health services have been severely challenged by ever increasing need for HIV/AIDs.

1.3. Contextual Perspective.

The study was conducted in Tegeres Parish, Kapchorwa district in the eastern part of Uganda. This study was also take place in my home region because it shelter's the less costs since it is my area of residence and so it was easy for me to get information from home ground people and even saves me in terms of cost. World Health Organizations (WHO) notes that the access to ART has improved over the years in 2009 a total of 141,416 patients (43%) was receiving ART out of about 33,000 PLWA who needed treatment. There has also been increased access to HIV/AIDs related information, condoms and social support. Having observed and analyzed the trend of poverty among households that are affected and infected by HIV/AIDs. According to Kapchorwa Municipal Council 5 year's development plan 2010/11 – 2014/2015 cited that 25% of the household are affected by poverty as a result of HIV/AIDs infection. This is how by inability of the affected families to send their children for studies in higher institutions of learning, unable to sustain treatment or acquiring proper medication, stigma still exists among households and among others in Kapchorwa District.

1.4. Conceptual Perspective

Poverty is lack of freedom, enslaved by crushing daily burden, by depression and fear of what the future will bring.

Poverty also is defined by poor people who have inadequate food and housing as well as having to rely upon charity.

In terms of material well-being, poverty is defined in terms of cost of living, low salaries and lack of jobs. In addition, poverty is a state of not having medicine, food and clothes.

According to Encyclopedia Britain (2008), poverty is the state of one who lacks a usual or socially acceptable amount of money or material possessions.

According to Business Dictionary, poverty is a condition where people's basic needs for food, clothing and shelter are not being met.

In addition Business Dictionary goes ahead to categorized poverty in to two types that is,

1. Absolute poverty is synonymous with destitution and occurs when people cannot obtain adequate resources measured in terms of calories or nutrition to support a minimum level of physical health.
2. Relative poverty is a state when people do not enjoy a certain minimum level of living standards as determined by a government and enjoyed by the bulk of the population that vary from country to country, sometimes within the same country .

HIV/AIDS is a state of a symptomatic or being associated with features of an acute retroviral syndrome of variable severity (16-21) and usually presents as an acute febrile illness of 2-4 weeks post-exposure, often with lymphadenopathy, pharyngitis, maculo popular rash, Orogenitaluclers and meningoenocephalitis .AIDS (Acquired Immune Deficiency Syndrome) is an infectious disease caused by the human immunodeficiency virus (HIV) and there are two variants of the HIV Virus that is; HIV-1 and HIV-2, both of which ultimately cause AIDS (Medical Dictionary).

AIDS is the final stage of infection that occurs when an individual's immune system is badly damaged thus becoming vulnerable to opportunistic infections.

A household is a group of persons who live in the same dwelling and eat meals together.

1.5. Statement of the Problem

World Health Organizations (WHO) notes that the access to ART has improved over the years in 2009 a total of 141,416 patients (43%) was receiving ART out of about 33,000 PLWA who needed treatment. There has also been increased access to HIV/AIDs related preventive measures and awareness Programs such as information, condoms and social support from a number of donors and facilitators such as NGOs, World Food Organizations among others. Having observed and analyzed the trend of poverty among households that were affected and infected by HIV/AIDs. According to Kapchorwa Municipal Council 5 year's development plan 2010/11 – 2014/2015 cited that 25% of the household are affected by poverty as a result of HIV/AIDs infection. This is how by inability of the affected families to send their children for studies in higher institutions of learning, unable to sustain treatment or acquiring proper medication, stigma still exists among households and others. Despite the above development inform of free testing and counseling offered, support from Non-government organizations, provision of free antiretroviral drugs provided by government among others, HIV/AIDs epidemic in Uganda remains a major development challenge. The social impact of HIV/AIDs is still alarming and in December; 2005, a total of 19154 people were living with HIV/AIDs of whom 530,932 were women and 109,000 were children under 15 years. The impact is greater in rural areas where poverty rises by 1.6 percentage point compared to 0.9 in urban areas, HIV/AIDs also undermine the sector's ability to deliver services (AIC; 2004). That is why having observed the above scenario will stimulate the researcher to examine the HIV/AIDs infection and Poverty among households in Tegeres parish, Kapchorwa District.

1.6. Objectives of the Study

1.6.1. General objective

To investigate on the factors contributing to increase HIV/AIDS infection and Poverty in selected households.

1.6.2. Specific objectives

- I. To establish how HIV/AIDS has led to poverty among the selected households in Tegeres Parish, Kapchorwa district.
- II. To find out how HIV/AIDs has affected individual's productive work.

- III. To investigate the state and different forms of poverty among selected households in Tegeres Parish, Kapchorwa district.

1.7. Research Questions

- I. What are the factors contributing to increased HIV/AIDS infection and poverty among selected households?
- II. How has HIV/AIDS led to poverty among selected households?
- III. What was the state and different forms of poverty among selected households?
- IV. How has HIV/AIDS affected individual's productivity?

1.8. Significance of the Study

The study aimed at causing a social change making it easy for households to work hard and improve on their quality of life and solving the daily household's problems. This was possible through eliminating tendencies of unproved beliefs, cultures and taboos and to advise policy makers and implementers substantively.

The study also helped the researcher to acquire experience on poverty reduction strategies among HIV/AIDS infected households and determine copying mechanism for such individuals.

Similarly, it was envisaged that the findings will be useful to AIDS advocates at the grass root levels such as Community Development Officers (CDOs), district leaders, Local councilors and NGOs in sensitizing and mobilizing the victims and then one on how to reduce the risks of contracting HIV/AIDS.

The main output of this study was the research report which helped the researcher to obtain the award of a Bachelor's Degree in Development Studies at Kampala International University.

1.9. Scope of the Study

The scope of the study involved taking analysis on factors contributing to increased HIV/AIDS infections and Poverty among households between Jun – August 2016 through simple random sampling to HIV/AIDS infection and Poverty among households in Tegeres parish, Kapchorwa District. Kapchorwa district lies along Mountain Elgon region in Eastern Uganda. Data by the researcher was collected using, interviews, focus group discussion and documentary review. The study specifically seeks to determine and explain reasons for the high HIV/AIDS infection and Poverty among selected households in Tegeres sub county, Kapchorwa District. Data will be collected by the student with the help of a research assistant.

1.9.1. Geographical scope

The research on HIV/AIDs infection and Poverty among selected households was carried out in Tegeres parish, Kapchorwa District Uganda.

1.9.2. Time scope

The research study was carried out in a period of three month starting from June to August 2016 on HIV/AIDs and Poverty among households among Tegeres parish, Kapchorwa District Uganda.

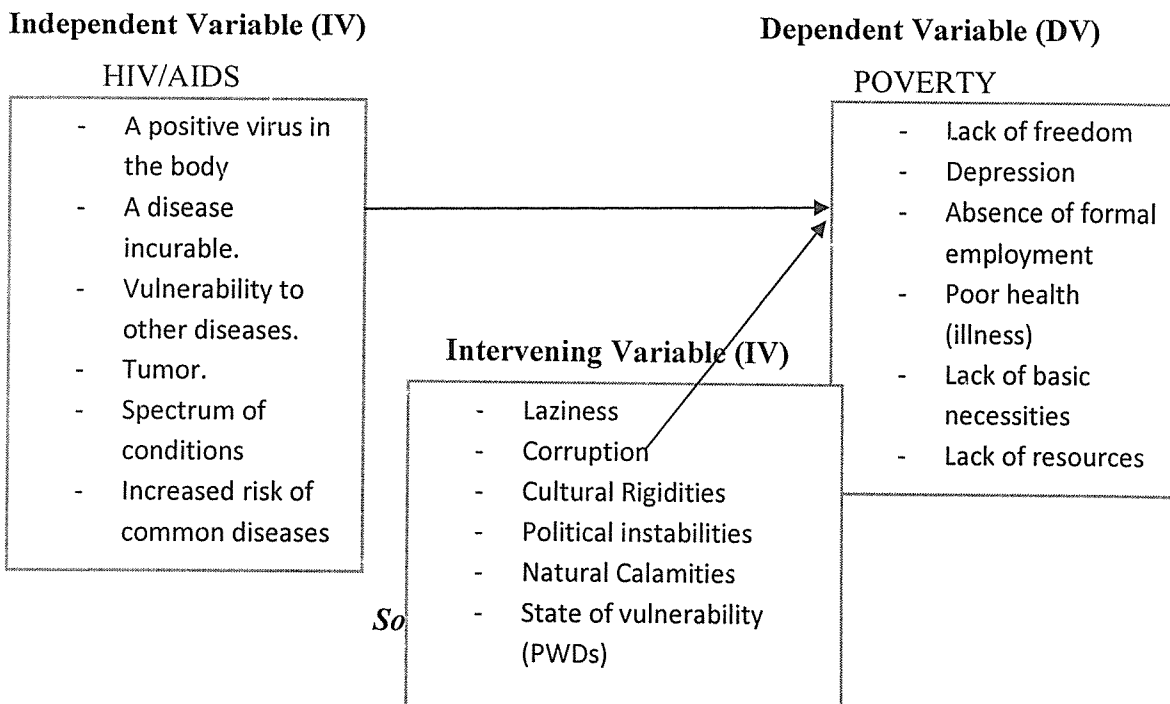
CHAPTER TWO

LITERATURE REVIE

2.0. Introduction

This chapter consists of the conceptual framework of an investigation of HIV/AIDS infections and Poverty, the related literature review, the factors contributing to increase HIV/AIDS, impact of HIV/AIDS to individual's productive work and to poverty and the state and different forms of poverty in Tegeres parish, Kapchorwa District.

2.1. Figure.1: Conceptual Framework Showing An investigation of HIV/AIDS infections and Poverty among households in Tegeres Parish, Kapchorwa District in Eastern Uganda.



The diagram above is the conceptual framework showing HIV/ AIDS infection and Poverty among selected households in Tegeres parish, Kapchorwa district Uganda. It reveals that the independent variable on this study is HIV/AIDS while the dependent variable is poverty. Where HIV/AIDS is operationally defined as; a positive virus in the body, disease which is incurable and vulnerability to other diseases such as tuberculosis, malaria mentioned but a few.

While Poverty is operationally defined as lack of freedom, depression, absence of formal employment, poor health (illness), lack of basic needs, fear of the future like being, and lack of resources.

The figure further shows that apart from HIV/AIDS, other factors such as Laziness, Corruption, Political instabilities, Cultural rigidities, Natural Calamities like drought, landslides among others, High population growth rate, Other epidemic diseases and the state of vulnerability for example People with Disabilities (PWDs).

2.2. The factors contributing to increased HIV/AIDS infections and poverty among households.

Singh AR & Singh SA (2008), for many environmental and social reasons, including crowded living and working conditions, inadequate sanitation and disproportionate occupation as sex workers, the poor are more likely to be exposed to infectious diseases, malnutrition, stress, over work, and inadequate inaccessible, or non-existent health care on hinder recovery and exacerbate the disease malnutrition is associated with 54% of children death from disease of poverty and lack of skilled attendants during child birth is primary responsible for the high maternal and infant death rates among the poor. ([Http/www.unicef.usa.org/work/wakr](http://www.unicef.usa.org/work/wakr)) many communicable diseases and many of poverty related diseases spread as a result of inadequate access to clean drinking water. UNICEF (2005) explained that, 3,000 children die every day, worldwide due to contaminated water and sanitation. In India sub-Saharan Africa, and parts of Latin America women are required to travel long distances in order to access clean water and this significantly affects girls educational attainments and these are related and cause disease malaria parasitic diseases and schistosomiasis. This infection acts as a co-factor that increases the risk HIV transmission.

Adam Wagstaff (2002) put forward that, poor population of both the developed and developing world faces the challenges of limited access to care, information about health care options and living conditions that predispose them to many poverty related diseases. In all part of the world including industrialized nations the group gap in health inequalities is growing rather than narrowing. (ibid) Poverty and disease are light closely together with each factor aiding the other many that primary affect the poor serve to deepen poverty and worsen conditions. Poverty significantly reduce people's capabilities making it more difficult to avoid poverty related diseases (WHO) the majority of diseases and related mortality in poor countries is due to preventable treatable diseases for which medicine and treatment regimes are ready available poverty is in many case single dominant factors in higher rates of prevalence of this diseases, poor hygiene,

ignorance in health related education, non-availability of safe drinking water, inadequate nutrition and indoor pollutions are factors exacerbated by poverty.

Phillip (Nov, 2004), ascertained that, just the big three preventable diseases that is to say. T.B Malaria and HIV/Aids account for 18% of diseases in high mortality, poor countries is 5.2% in terms of disability adjust life year but just 0.2% in case of advanced countries. In addition, Adsel and Bour (2012) suggested that, infant mortality maternal mortality are year more prevalent among the poor examples 98% of 11600 daily maternal new natal deaths occur in developing countries. At a global level, the three primary related diseases are AIDs, malaria, Tuberculosis, developing countries account for 95% of the global AIDs Prevalence and 98% of activity Tuberculosis infection (World Health/ Disease of poverty further, more 90% of malaria death occur in sub-Saharan Africa to together with those three disease account for 10% of the global mortality.

Hotez .PS. (2008), the combined number of total death due to HIV/AIDS is dwarfed by enormous number of patients affected by poverty related diseases such reporting infections of HIV/AIDs, diarrhea and Tuberculosis, beside many other similarly the spread of tropical neglected diseases in developing nations and those infections disproportionally affects poor and minority population in United States. Woodward (1998), and Asthina facts (2007), therefore disease of poverty reflects the dynamic relationship between poverty and poor health, while such disease result directly from poverty or causes poverty, they also perpetuate and disproportionately impoverished by sapping personal and national health and financial resources, GDP growth by up-to 1.3% in some developing countries and by killing tens of millions in Sub-Saharan Africa, AIDs alone threatens “the economics, social structures and political stability of entire societies (Roll Black malaria partnership: economic costs of malaria” Rbm.who.int.retrieved.29th April 2015.

The characteristics of poor working relationship are some of the causal factors of work which contribute to a culture of poverty. The fact that the children of the poor often become the poor of succeeding generation. Poverty is associated with weak endowment of human and financial resources such as low levels of education with associated low levels of literacy and few marketable skills, generally poor health status & low labor productivity as a result. An aspect of the poor health status of the poor is the existence amongst many African of undiagnosed untreated STDs which is now recognized as a very significant co-factor in the transmission of

HIV. (UNAIDS) Desmondcohen (Issue paper No. 27. Poverty and HIV/AIDs in Sub-Saharan Africa DemondCohevi).

WHO (2015) chronic diseases and Poverty are interconnected in a vicious cycle. The chronic disease burden is concentrated among the poor. Poor people as more vulnerable for several reasons including increased exposure to risks and decreased access to health services by HIV infected individuals. Chronic diseases cause poverty in families, draw them into a downward spiral of worsening diseases and poverty: (WHO, 2015) poverty and Worsening of already existing poverty are also caused by chronic diseases on its people and families who are already poor who are most likely to suffer, because chronic diseases are likely to ruin a family's economic prospects (ibid) inadequate access to good quality health services, including diagnostic and clinical prevention services, is a significant cause of the social and economic inequalities in the burden of chronic diseases. The poor face several health care barriers including financial constraints, lack of proximity and availability of transport to health care centers and poor responsiveness from the health care system. Financial considerations can Act as barriers to health care access some people are unable to afford out of pocket charges for healthcare and might forfeit their wages by missing work. Even though health services are subsidized by the government or provided for free in low and middle income countries, it is the weather who gain more from such services findings from south Africa showed that among people with high blood pressure, the wealthiest 30% of the population was more than twice as likely to have received treatment as the poorest 40% (WHO, 2015) Chronic diseases and health promotion.

Furthermore, WHO (2015) put forward that, from Chronic disease to poverty an important cause of poverty in low and middle income countries is the death or server illness of family's primary income earner out of 125 case studies summarized in the World Bank's publication voices of the poor crying out for change, illness, injury or death was the most common trigger household impoverishment. In Bangladesh, for example of those households that moved into the status "Always poor," all reported death or severe disabling diseases as one of the main causes chronic disease inflict on enormous direct and indirect economic burden on the poor and push many people and their families into poverty. Existing knowledge underestimates the implications of chronic diseases for poverty and the potential that chronic disease prevention and health promotion have for alleviating poverty in low & middle countries. (Ibid) in Jamaica 59% people with chronic diseases experienced financial difficulties because of their illness and a high

proportion of people admitting such difficulties avoided some medical treatment as a result; people in India, the poorest people. Those who can least afford cost spend the greatest proportion of that income on medical care.

On average, they spend 25% of their annual income on private care, compared with 4% in high income group.

In addition, WHO (2008) ascertained that, those with poor health tend to fall into poverty and the poor tend to have poor health. According to WHO, within countries those of lower, socio-economic strata have the worst health outcomes. Health also appears to have a strong social component linking it to education and access to Adjai and Buor (2012 in terms of health, poverty includes low income, low education, social exclusion and environmental decay. They poor within most countries are trapped in a cycle in which poverty breeds ill health and ill health breeds poverty Adam Wagstaff (2002). Adjai and Buor (2012), in rural communities of Ghana for example poverty has become the largest determinant of poor health and life expectancy. In the case of Ghana and other developing countries, poverty causes more death and illness than plague, famine.

WHO (2015) asserted that, Neglected diseases in Uganda like in most developing countries; the health status of the people of Uganda is poor. This is mainly due to infectious and parasite diseases, most of which are preventable and or treatable, illiteracy and perpetual poverty. Most infectious and parasitic diseases fall into the category of neglected diseases and those affected are exclusively poor and marginalized population with limited geographical access to health care. David Lawson (2004) from a qualitative perspective in particular, ill health has been identified as a major cause of poverty. For instance Uganda's participatory poverty assessment process indicates that over 37% communities thought ill health was a major cause of moving into poverty (Republic of Uganda, 2002).

Mack et al (2009) also explained that, the poorest of the poor are found in the developing countries with high disease prevalence, high infant mortality rates, high national death, and low literacy rates, malnutrition and stunted growth of children. The two regions are southern Asia and Asia and sub-Saharan Africa and children are the innocent victims of this enduring moral dilemma (<http://www.worldbank.org>).

2.3. HIV/AIDs affect individual's productive work

HIV/AIDs affects economic growth by reducing the availability of human capital (Greiner .R. 2002) without proper prevention, nutrition, health care and medicine that is available in developing countries, large numbers of people are falling victim to AIDs.

People living with HIV/AIDs will not only be unable to work, but will also require significant medical care. The forecast is that this will probably cause a collapse of economies and societies in countries with a significant AID population. In some heavily infected areas, the epidemic has left behind many orphans cared for by elderly grandparents (Risley C.L. et al, 2012).

The increase mortality in this region will result in a smaller skilled population & labor force. This will be predominantly young people, with reduced knowledge and work experience leading to reduced productivity. An increase in workers time off to look after sick family members or for sick leave will also lower productivity. Increased mortality will also weaken the mechanisms that generate human capital & investment in people, though loss of income & the death of parents (Risley .C.L. et al, 2012). As the epidemic progresses the age profile of these infected will increase, though the peak is expected to stay within the working age population. However, this disproportionately impact on women, so those sectors employing large number of women for example education, may be disproportionately economically impacted by HIV (Over .M, 1992). By killing of mainly young adult, AIDs seriously weakens the taxable population reducing resources available for public expenditure such as education and health care not related to AIDs resulting in increasing pressure for state families and slow growth of the economy. This result in a slower growth of tax base, an effect that will be reinforced if they are growing expenditures on treating the sick, training, (Replace sick workers), sick pay and caring for Aids orphans this is especially true if they shape increase in adult mortality shifts the responsibility & blame from the family to the government in caring for those orphans (Risley et al; 2012). On the level of households, AIDs results into both losses of income & increased spending on health care by those households. The income effects of this it leads to spending reduction as well as substitution effects away from education and towards health care and funeral spending. A study from cote-d'ivoire shows that households with HIV/AIDs patients spend twice as much as medical expenses as other households (Bonne,2000) with economic stimulus from the government, however, HIV/AIDs can be fought thus the economy with some money HIV/AIDs patients will have worry

less about getting enough food & shelter and more about fighting their diseases. However, if economic conditions are not good, a person with HIV/AIDs may decide to become a sex trade worker to earn more money, as a result more people become infected with HIV.

UNAIDS, WHO and United Nation Development Program have documented a correlation between decreasing life expectancy & the lowering National product. In many African countries with prevalence rate of 10% or more indeed since 1992 prediction that Aids will slow economic growth in these countries have been published the degree of impacts depended on assumptions about the extent to which illness would be funded by saving & who will be infected. (Bonnell, 2000).

Conclusions reached from models of the growth trajectory of 30 Sub-Saharan Economies of the period of 1990-2025 were that; the economic growth rate of these countries will be between 0.56% and 1.47% lower. The impact on GDP per capita income was less conclusive. However, in 2000, the rate of growth of African per capita GDP was in fact reduced by 0.7% per year from 1990 to 1997 with further 0.3 per year lower in countries affected by malaria (Goetzel et al; 2005). The focus now is the growth of GDP of these countries will undergo a further reduction of between 0.5 and 2.6% per annum (Risley CL et al; 2012).

2.4. How HIV/AIDS lead to poverty?

The Micro Level: HIV/AIDS, poverty and inequality.

The greatest impact of the epidemic is felt at a household level, where socio-economic factors combine with socio-cultural and epidemiological variables to influence prevalence (SSRC, 2004). It is the household unit that carries the greatest burden. Since socio-economic indicators, such as poverty and inequality, are both consequences and determinants of HIV/AIDS, they can interact with the epidemic at a household level to perpetuate a vicious downward cycle towards greater indigence.

Socio-economic determinants and impacts of HIV/AIDS.

Some of the ways in which poverty increases susceptibility to contracting the disease are through: increased migration to urban areas; limited access to health care, nutrition and other basic services; limited access to education and information, sexual exploitation and gender inequality. There is little recent research exploring the influence of socio-economic variables on the risk of contracting the HIV virus. Bloom's (2002) analysis of Cambodian and Vietnamese households is one of the exceptions.

This study suggests that there are strong correlations between wealth and education on the one hand, and reduced risk for HIV on the other. Wealth and education both appear positively correlated with better knowledge and behavior.

A number of International Food Policy Research Institute (IFPRI) publications investigate the causal relationship between good nutrition and HIV prevalence. For example, Gillespie and Kadiyala (2005) affirm that food insecurity and malnutrition may accelerate the spread of HIV, both by increasing people's exposure to the virus and by increasing the risk of infection following exposure. They draw on a number of previous studies to support this theory, including work carried out by Stillwaggon (2002), which finds falling calorie and protein consumption and increasing inequality to be strongly correlated with HIV prevalence in 44 Sub-Saharan African countries. Moreover, the authors cite a number of medical studies suggesting that improved maternal micronutrient status may reduce vertical transmission of HIV; they conclude that one of the main factors determining the risk of mother-to-child transmission of HIV is the health and nutritional status of the mother.

A large amount of work has concentrated on socio-economic variables as consequences, or rather the epidemic's influence on household living conditions. This influence derives in great part from the virus's specific demographic effects. HIV/AIDS changes the structure of the population; it is distinct from other diseases because it strikes prime-aged adults, the most productive segment of the economy (Barnett and Whiteside, 2002). Thus the breadwinners are falling ill and dying, destroying much-needed skills and depriving children of their parents. Barnett and Clement (2005) point out that the key to the social and economic importance of HIV/AIDS is that it is a slow moving virus: as a result it has demographic effects and the individual disease process in one body can affect three human generations.

The principal types of economic impacts experienced by affected households are: loss of available income, as a result of working adults falling ill or dying or having to stop work to look after children and/or the ill; additional expenditure on health care and funerals (UNAIDS, 2004). Other effects on the household include depletion of household assets (as a result of increased health expenditure and other consumption needs and labor losses), lower productivity of subsistence labor and reduced availability

of food. School enrolment may also decrease, as children are forced to dedicate time to labor and caregiving.

In a survey of 771 AIDS-affected households throughout South Africa, Steinberg et al (2002) document the impoverishment and burden of care for family members. They find that poor people in South Africa are the most adversely affected by HIV/AIDS, and that those households worst hit by the epidemic are also those underserved by basic public services such as sanitation and piped water. Furthermore, the epidemic deepens poverty among the already poor through loss of income and medical care costs, which absorb up to 1/3 of household income. Children's schooling is also disrupted, especially among girls, and increasing early childhood malnutrition can be observed. This study also reveals a growing strain on the extended family networks: more than 12% of households have sent their children to live elsewhere, most often with relatives.

Similar dynamics are described in Bachmann and Booysen's (2002/2004) 18-month longitudinal study of rural and urban households in South Africa's Free State Province. Some findings of the baseline study (2001-2002) are that affected households are poorer than non-affected households, regardless of the poverty measure used. Compared to unaffected households, affected households had lower monthly incomes (mean \$130 vs \$215) and expenditures (\$90 vs \$119) and lower proportions of members in employment (11% vs 20%). The incidence, depth and severity of poverty were worse among affected households, particularly among those that had experienced illness or death. Some new findings of the follow-up studies are the insignificant differences in the impact on rural and urban households (even though the income and expenditure levels of rural households are lower) and the decline in income of unaffected households. The latter phenomenon suggests that the effects of the epidemic are not limited to "infected" households, but are giving rise to deepening poverty in the wider community.

In a paper published in 2004, Wyss et al attempt to ascribe a value to the household level economic costs of HIV/AIDS described above. Their fieldwork is based in Chad, one of the poorest countries in the world. The data collected confirms "for most households, especially in the low-income settings, the consequences of AIDS are disastrous." Specifically, costs attributable to the epidemic during the period of illness up to death represent more than four times the annual GNP per head in Chad. Costs related to productivity losses make up 28% of total costs, while 56% of costs are on health related expenditure and 16% on funeral expenses.

In a study carried out in rural Malawi, Mtika (2003) explores a slightly different but related concept to human capital, denoted “embodied capital investment”. Embodied capital investment is described as the allocation of resources to “current and future biological, social and economic reproduction, for purposes of ensuring dynastic fitness and continuity”. This refers to the channeling of time, money, general assistance and other resources to activities such as reproduction, growth, skill development, health and security, in a way that sustains lineages. It includes investment in children (‘offspring-embodied capital’) to ensure the continuity and future welfare of families. Mtika concludes that prime-age adults are central to resource exchanges or transfers, be they vertical (between parents and offspring) or generational (between siblings). Moreover, through reciprocal transfers among themselves, young adults are better able to support their children and the elderly. The health status of adults is an important factor in their involvement in these exchanges. Since AIDS mostly strikes young adults, it is therefore striking the core of the resource flow system in subsistence economies. The inability of these adults to fulfil their role in embodied capital investment, will lead to a huge demand for public intervention to sustain social and economic reproductive activities.

Mtika’s study thus also touches the issue of dependency. In the developed world people generally are able to save and social welfare and public assistance programs support the needy (children, poor and the elderly). This is not the case in subsistence economies of the developing world, where children and the elderly are heavily dependent on the ‘productive middle generation’ and their transfers (Mtika, 2003; Barnett and Clement, 2005). By striking the middle generation, the HIV/AIDS epidemic is disrupting and eroding intergenerational dependency structures. Once again the poor are disproportionately affected, in that they are less likely to have alternative sources of income, accumulated wealth (assets to sell) and access to health and other welfare services (e.g. pension funds). When young adults fall ill and die, the children and the elderly – who are the most vulnerable household members - have no choice but to find ways of taking care of them.

HIV/AIDS and Macroeconomic Growth.

Since the 1990s, many economists have been concerned with assessing the impact of AIDS on economic performance and, more specifically, on national GDP growth. One may question why so much attention has been afforded to this aggregate, representing the annual rate of increase in the total output of a country. The answer is that high and sustained growth – although not in itself sufficient - is

associated with job creation and higher living standards, as well as a greater amount of resources that could be utilized for government spending. Economic growth can therefore influence the capacity of countries to deal with social injustice and to respond effectively to the epidemic itself. In the developing world, it is part of a promise of improved living standards, human development¹⁰ and quality of life.

There are many channels through which HIV/AIDS can influence macroeconomic growth. The most obvious and direct is the effect on productivity and size of the labor force, as a result of prime age adult illness and death (Greener, 2004). One of the things that distinguish the HIV/AIDS pandemic from other global diseases is that it predominantly affects young adults, stripping families, communities and nations of those who are also the main contributors to income-generating activities (Barnett and Whiteside, 2002).

The epidemic can also influence macroeconomic growth by changing resource allocation between consumption and savings. Increased costs (such as health expenditure and funerals), shortened life expectancy and less available disposable income are all potential contributors to higher consumption/savings ratios of households. However, despite increasing evidence at a household level, the information available does not allow us to generalize to the national level. As pointed out originally by ING Barings (2000) and repeated by Nattrass (2002), these known dynamics at the level of affected households do not give us a full enough picture to determine the aggregate effect on macroeconomic variables, in that they are also a function of the allocation of income between households.

Furthermore, the large number of children orphaned as a result of HIV/AIDS may also have significant economic implications (Corrigan et al, 2005). This may be through a government response to higher demand for social services (and thus public spending) and/or the greater challenges that orphans pose in terms of human capital accumulation.

HIV/AIDS also influences macroeconomic aggregates through 'second-order effects' (Nattrass, 2002) or rather through the impacts of the way firms and governments respond to the first-order impacts of AIDS. For example, potentially large public health costs could divert government resources from other productivity enhancing expenditure (e.g. education and infrastructure investments). Firms may be

reluctant to invest in the economy in general and, more specifically, in training of workers, as a result of larger production costs and a higher likelihood of workers dying because of AIDS. Second-order effects depend on the specific decisions taken by private and public sector economic actors, and are therefore very difficult to predict and assess. The foreseeable danger here is that this chain of causal effects may transform itself into a downward economic spiral: lower growth could discourage investment, which could, in turn, hinder economic growth potential by reducing the availability of capital as a production factor (Barnett and Whiteside, 2002). This dire possibility has been one of the rationales behind the development of scenarios, such as those published by UNAIDS¹², which explore how the HIV/AIDS epidemic and our responses to it may shape the future.

Literature on the Impact of HIV/AIDS on GDP growth

Up till now, studies which attempt to estimate the impact of HIV/AIDS on macroeconomic growth have focused – as could be expected – on the most affected regions, namely Southern and Eastern Africa. A relatively large amount of work has been done using the South African Bureau of Economic Research, 2001; ING Barings, 2000; Arndt and Lewis, 2001 economy as a case study, because of greater data availability and capacity to carry out such analyses. Despite their usefulness, it is important to point out the limitations of these studies, which also explain their often diverging results. Macroeconomic modeling necessitates using a theoretical framework to project forward in time. Methodologies are inevitably dependent on underlying assumptions and forecasts regarding factors such as the evolution of the epidemic and the behavior of various economic actors. This explains the frequent lack of consensus among authors regarding some of the exact mechanisms through which the epidemic will impact on the macro economy, as well as the relative weight of these mechanisms. Another constraint, especially for earlier studies, has been the limited availability of empirical data, since the epidemic has still not peaked in many affected areas, and countries in which prevalence is highest often do not have reliable data. To complicate matters further, the comparison of models with actual economic performance means overcoming what Booysen (2003) describes as the “difficulty of entangling the simultaneous effect of HIV/AIDS and a myriad of other economic forces on these macroeconomic parameters.” Lastly, models are, in the end, a simplification of reality and will never be able to fully reflect the complexity of a ‘real’ economy.

Earlier quantitative economic analysis on the macroeconomic impact of the HIV/AIDS epidemic came to the conclusion that the epidemic would have an insignificant effect on GDP growth rates (authors include: Bloom and Mahal, 1997, World Bank, 2000). These studies focused on the way in which HIV/AIDS influences investment and productivity, through a reduction in the size and productivity of the labor force. On the other hand, theoretical studies that considered the potential cumulative long-run impact predicted larger macroeconomic costs (e.g. Cuddington and Hancock, 1994, Arndt and Lewis, 2000, 2001). Nevertheless, projected differences in annual GDP growth rates in relation to the no-aids scenario were generally low. The epidemic was treated, in a conventional economic framework, as an exogenous influence, which would not shift long-run equilibrium growth levels. For example, various simulations carried out in 2000 and 2001¹³, using South Africa as a case study, estimated reductions in annual GDP growth rates as a result of the epidemic in the order of 0.1% to 2.6%.

More recent studies have, instead, moved beyond this focus on the immediate effects on investment and labor productivity, to take into account other factors relating to social development and social welfare, as well as the indirect and intergenerational effects of the epidemic on these indicators. There has been a movement towards analyzing welfare and human development indicators such as human capital formation, in order to obtain a fuller picture of the impact on affected households and communities (Barnett and Clement, 2005).

Some criticisms of the use of traditional macroeconomic analysis to measure impact are advanced by MacPherson (2000), and later by Drouhin et al (2003). While the former did not develop a complete or alternative model, his conclusions were innovative for the time at which they were published and served as an incentive for the development of subsequent models. MacPherson argues that previous studies underestimate the complexity and impact of HIV and AIDS on the economy and questions their assumptions with regard to labor productivity, demographic shifts and prediction of trends in HIV prevalence. He concludes that the epidemic can no longer be considered an 'exogenous' influence, which presumes that the workforce is HIV-free, but that rather we must take into account the endogeneity of the social and economic impact of HIV/AIDS. Three years later Drouhin et al (2003) published a paper with the results of a model constructed to synthesize the different approaches of macroeconomic impact studies, in an attempt to compare the means of forecasting the impact of AIDS in a developing economy. The result of this work is that endogenous growth models produce

more valuable and precise assessments of an epidemiological crisis such as AIDS in developing countries, by considering a multiplicity of productivity variables as potential engines of development (such as human capital, public spending, etc.). Economic behavior, incorporating the shift of the long-term equilibrium, is already altered due to the crisis.

Arguably the most significant modeling work produced over the past two years, at least from a theoretical perspective, is contained in a paper published by the World Bank in 2003 (Bell et al). The authors develop an endogenous Overlapping Generations Model (OLG) and apply it to the South African economy. The result is that the projected long-run economic costs of AIDS are much higher than predicted in previous studies. In the extreme case - in the absence of appropriate and efficient measures – the authors maintain that we could witness economic collapse. An element that distinguishes the model used from previous work, is that it incorporates the long-run human capital loss caused by HIV and AIDS. According to Bell et al, human capital is destroyed in a number of ways: through sickness and death of young adults, by weakening or destroying the mechanisms that generate human capital formation (i.e. the transmission of knowledge and potential productive capacity from parents to children, lower school attendance and less investment in children's education) and by continuing the vicious cycle across generations, as children with less education and knowledge received from their parents will, in turn, be less able to raise their own children and invest in their education. The authors conclude that economic disaster can be averted, but only with an aggressive set of policies aimed at protecting these mechanisms of human capital transmission between generations (e.g. prevention, support and education of children, prolonging the life of the sick). There has been much controversy around the results of this paper, including criticism of the assumptions' appropriateness to South Africa. It can, however, be useful, if not as a forecast, to identify dynamics and cause-effect relationships.

In recent years, other authors have explored the concepts of human capital accumulation and intergenerational effects, to estimate macroeconomic impact. Corrigan, Glomm and Mendez (2003), for example, construct and fully study an OLG model that predicts the effects of HIV/AIDS on growth, mainly through the detrimental impact of lower life expectancy on investment combined with a sizable number of orphans created by the pandemic. They study how intra-family allocations regarding school and work time of children are adjusted within affected families and how, in turn,

these adjustments influence accumulation of physical and human capital. Their conclusion – substantial negative growth effects - confirms findings of prior general equilibrium models and simulation exercises.

Also with a focus on human capital development, Ferreira and Pessoa (2003) propose an OLG model in which AIDS impacts negatively on income by affecting the incentives for school attainment due to shorter expected longevity. They predict that the most affected countries in Specific years or time periods are not indicated.

Sub-Saharan Africa will, in the long run¹⁴, become 25% poorer than they would be without AIDS, due only to the direct (human capital reduction) and indirect (decline in savings and investment) effects of life expectancy reductions.

Hamoudi & Birdsall (2004) use human capital to describe the links between health, education and growth. This paper outlines the likely effects of the AIDS pandemic on the African continent's ability to produce education – one of the greatest challenges to development - and use it effectively for growth and poverty reduction. It explores four channels, through which HIV/AIDS impacts on education (through supply and demand side factors) and ultimately on human capital accumulation and growth. These are: 1) supply effect: death of millions of adults will increase the difficulty of finding and retaining enough teachers 2) demand effect: reduction in lifetime private returns to education 3) factor productivity: the loss of a large share of the skilled work force may reduce the social returns to skill among educated people who survive, reducing the contribution of education to overall growth (related to positive externalities associated with a larger stock of human capital) and 4) factor complementary effect: the loss of physical capital assets may reduce the ability of skilled workers to contribute to overall economic production, to the extent that physical and human capital are complementary inputs. These channels add up to the qualitative conclusion that, without offsetting policies and programs, Africa's dearth of human capital – and thus its capacity for growth and redistribution - will deteriorate.

Furthermore, various studies that draw conclusions from the analysis of empirical data have also been produced over the last few years, as this data becomes more readily available. One such study, which uses cross-country empirical evidence and panel data methods, is that of McDonald and Roberts

(2004). Results point to alarming past and potential future macroeconomic effects of the epidemic. This is especially true for Africa, where the average marginal negative impact on income per capita of a one percent increase in HIV prevalence is estimated to be 0.59 %. The authors believe that in African countries where HIV and malaria are health problems on a large scale, apparently poor economic performance over the past 10 to 20 years is, to a large degree, attributable to the epidemic. Moreover, the marginal effects appear sufficient to threaten macroeconomic stability, which is generally more fragile in poorer countries most prone to escalation of the epidemic. This paper is based on a model that recognizes that human capital is not only education and productive skills, but a complex input which includes health capital.

The originality of the empirical analysis conducted by Papageorgiou and Stoytcheva (2005) is that it investigates the impact of AIDS on cross-country income levels, as opposed to GDP growth. Using data for 89 countries spanning the period 1979 to 2000, the authors find that AIDS has a negative and significant effect on income per worker. This relationship appears to be valid only for the 16 – 34 age group and only for non OECD countries. The main quantitative result is that an increase in AIDS incidence by 1 in 100,000 people is associated with a 0.003% - 0.004% reduction in income per worker (across both full and non OECD samples). What the results also show, however, is that the impact of AIDS can differ considerably across countries. The authors conclude that the epidemic can have “devastating effects” especially in countries with high incidence and low per capita income.

Referring to historical data for the period 1992 – 2002, the International Labor Organization’s 2004 report (HIV/AIDS and Work: Global Estimates, Impact and Response 2004) presents a table illustrating the economic impact of HIV/AIDS – in terms of GDP growth and per capita GDP growth – in 12 Southern African countries, for the period 1992 - 2002. The estimated average annual rate of GDP growth loss attributable to HIV/AIDS ranges from 0.6% in Angola to 2.8% in Botswana and Swaziland. As far as per capita GDP growth is concerned, losses range from 0.4% in Angola to 1.4% in Zimbabwe. We cannot but reflect that, in the context of acute poverty and AIDS, the amounts these percentages translate into could contribute to a family’s ability to pay for food, medicines or other basic needs, or to a governments’ ability to provide social services.

As previously mentioned, most macroeconomic studies have focused on SSA, with the exception of a few, which have been concerned with the possible impact of the disease in other developing countries where prevalence is rising. Robalino et al (2002), for example, develop a model of optimal growth to assess the risks of an HIV/AIDS epidemic and quantify expected economic impacts in nine countries in the Middle East and North Africa region¹⁵. They conclude that GDP losses over the next 25 years could equate to 35% of today's GDP. Interventions that expand condom use and access to clean needles could act as insurance policies, reducing GDP losses across the nine countries by an average of 19% of today's GDP. On the other hand, delaying action for five years can cost, on average, the equivalent of six percentage points of today's GDP.

Looking more generally at the relationship between the health of a population and economic growth, in a recent IMF Health and Development Report, Bloom et al (2004) present evidence from various studies that suggest sizeable economic returns to better health: an extra year of life expectancy is estimated to raise a country's per capita GDP by about 4%, for example. This paper also highlights the shortcomings of GDP and GDP per capita as a measure of national economic wellbeing. Measures of full income – that capture the value of changes in life expectancy by including them in the assessment of economic welfare – are deemed to convey a more accurate picture of the economic effect of AIDS. This suggests that a focus on national and per capita GDP may have underestimated the impact that AIDS is having on economies in Africa.

The impact of HIV/AIDS on per capita GDP

Most of the studies cited up to now focus specifically on the effect of the AIDS epidemic on GDP growth. However, the predicted trend of this macroeconomic indicator does not, in itself, tell us what will happen to per capita GDP. Average wealth per head is an outcome not only of the level of aggregate national output growth, but also of population trends. Some authors predict that the HIV/AIDS epidemic will cause per capita GDP to increase as a result of greater productivity of capital (decreasing population and increasing capital/labor ratio).

In their study on the effect of AIDS on the Cote d'Ivoire economy, Grimm and Cogneau (2004) illustrate that a reduction in the size of the economy as a result of HIV/AIDS does not necessarily lead to lower per capita income and worsened poverty and inequality. The authors develop an innovative approach¹⁶: a “micro-simulation” model able to simulate, over a fifteen-year period, the impact of AIDS on household and individual incomes. This approach allows the authors to take into account individual heterogeneity (which is not possible with most macro models), in particular with regard to the risk of AIDS infection and income earning capacity. Unlike aggregated models, it allows for the analysis of policy outcomes in terms of inequality and poverty, and not only in terms of growth. When focusing on the labor supply effects of mortality, the main outcome is a shrinking of the size of the economy by around 6% after 15 years, leaving average income per capita, income inequality, and poverty roughly unchanged. Young (2004) comes to similar conclusions in his simulation of the impact of the AIDS epidemic on future living standards in South Africa. The model utilized considers two competing effects, that is the detrimental impact on the human capital accumulation of orphaned children and 2) lower fertility, resulting from a reduction in willingness to engage in unprotected sexual activity and an increase in the value of a woman's time (scarcity of labor). The author finds that, even under the most pessimistic assumptions concerning reductions in educational attainment, the fertility effect dominates. Thus the net effect of the AIDS epidemic is that of enhancing the future per capita consumption possibilities of the South African economy, in fact endowing it with additional resources which can be channeled to care-giving and to providing higher living standards for future generations.

Meso Level: Effects on For Profit Enterprises.

The sectorial analysis of the effects of HIV/AIDS on business, as well as business responses, links micro level behavior and outcomes to macro aggregates. One example of this is how responses at a household level can affect the labor supply, which influences the response of firms, which, in turn, produces macro level consequences (SSRC, 2004). Decisions at a business level can sift through to the macro economy, translating into changes in national investment, demand for goods and services, employment and economic structure.

The key linkage between business and macroeconomic growth is investment, both in production and in knowledge building (ILO, 2004). Increasing operating costs can make investment in the long run less attractive. The International Monetary Fund's Regional Economic Outlook for Sub-Saharan Africa

report (2005) warns that the HIV/AIDS epidemic is jeopardizing the sustainability of growth in several Sub-Saharan African countries, by taking a serious toll on societies and economies in the region. An important concern of the business communities is that an uncertain and deteriorating outlook could deter domestic and foreign investment. In addition, in the longer term, HIV/AIDS could discourage individuals and companies from investing in human capital, given significantly lower expected returns.

The epidemic can affect individual firms both on the supply side (efficiency losses and subsequent higher production costs) and on the demand side (change in the demand for goods and services produced). There are both direct costs – provident fund contributions, absenteeism, additional recruitment and training costs, death and funeral benefits, in-firm medical services – as well as indirect costs, which are more difficult to quantify, such as lower productivity of ill workers, disruptions and lower staff morale (Simon, Rosen et al, 2003; Nattrass, 2002). The degree to which AIDS increases costs for companies depends on the type of benefits provided as well as the status of employees. Often semiskilled or unskilled workers are not employed with permanent or long-term contracts and therefore do not receive benefits and training, nor a commitment to continuity in their employment (Nattrass, 2002).

Despite the acknowledgement that AIDS will impact on businesses in the developing countries affected by the epidemic, research on the subject is not extensive. An interesting study carried out in Kenya (Fox, Rosen et al, 2004) aims to measure the impact of HIV/AIDS on labor productivity by focusing on an economic activity in which output is more easily measurable, since workers are paid on the basis of their performance. The authors monitor individual output and work attendance during disease progression of HIV positive tea estate workers in Western Kenya. They find that as many as three years before death, farm workers with HIV/AIDS are absent from the job more often, produce less on the job and are more often given less strenuous tasks. From three years before death, productivity suffers (daily output of cases is on average 91% of that of controls), to decline sharply and steadily during the last year, until death (on average cases' daily output is 82% of controls' in the last year and 77% in the last 3 months).

Moving from a country specific to a regional outlook, in a paper published in 2004, Rosen et al estimate the cost of HIV/AIDS to businesses in Africa¹⁷. The main quantitative finding is that HIV/AIDS adds 0.4 – 5.9% to the companies' annual salaries and wage bills; the present value of an incident HIV infection ranges from 0.5 to 3.6 times the annual salary of the affected worker. Moreover, the authors specify that these results should be regarded as conservative since some costs are not considered due to unavailability of data. The implication is that AIDS is causing labor costs for businesses in Southern Africa to rise and further threaten the global competitiveness of African industry, jeopardizing its ability to attract investment and expand.

A 2004 survey conducted for SABCOHA (South African Business Coalition on HIV and AIDS), in which 1008 companies participated¹⁸, constitutes the largest survey on the impact of HIV/AIDS on business in South Africa. One of the main findings is that the epidemic is impacting on profits of all firms and particularly of those in specific sectors (between 40% and 50% of firms in the financial services and manufacturing sectors and between 25% and 35% of other respondents indicate that company profits have been negatively affected). Furthermore, all sectors expect the impact of HIV/AIDS on their operations to escalate. What also emerges from the survey is that labor productivity and worker absenteeism have been most affected, followed by employee benefit costs. Some companies are, however, experiencing higher labor turnover rates, lost experience and skills and higher training and recruitment costs. Thus far the impact on the demand side (i.e. sales) appears to have been much lower than the impact on the production side.

In general, the dimension of losses to firms and its effect on national production also depends on how the private sector deals with the epidemic. In many cases firms have realized that, from an economic point of view, it is in their interest to provide testing, counseling and treatment, rather than bear the cost of morbidity and mortality in the workforce. If HIV/AIDS policies are effectively put into place and antiretroviral drugs (ARVs) distributed the impact of HIV/AIDS on a business's activities can be significantly lowered. This is the conclusion that Rosen et al (2003) come to: if the companies studied in South Africa and Botswana had provided ARVs at no cost to HIV positive employees, they would have earned positive returns on their investment and reduced the additional costs due to HIV/AIDS by as much as 40%.

As far as responses are concerned, results of the SABCOHA survey show that larger companies and the financial, manufacturing and mining sectors seem to be taking the lead in implementing HIV/AIDS work policies¹⁹. However, very few companies have attempted to quantify the impact of the epidemic on their operations. Some coping strategies revealed in the survey are the appointment of extra employees (larger companies) and shifting to more capital-intensive operations (with obvious implications for employment). The epidemic already appears to be affecting investment decisions: 10% or less of respondents in all sectors indicated that HIV and AIDS have had a negative effect on their decision to invest in South Africa.

Lastly, employment status may worsen inequality. Since the formally employed and mainly skilled workers will have greater access to health care and ARVs through their firms, the divide between formal and informal, skilled and unskilled employment could dictate availability of treatment and job security, exacerbating the disparities which they may already reflect. Antiretroviral drugs, for example, are currently out of reach of the average household in the developing world, and will only be available to the small minority that can afford them (Barnett and Whiteside, 2002). A UNAIDS report (2005) estimates that treatment is available to only 8%, or 310,000 of the 4 million Africans estimated to require it.

CHAPTER THREE

METHODOLOGY

3.0. Introduction

This chapter includes the research Methodology, research design, the area of study, target population, sampling procedure, sample size, data collection methods and instruments, validity and reliability of procedure, data analysis and presentation and limitations of the study. There after plan for dissertation of results will be made.

3.1. Research Methodology

Research methodology is defined by Leedy & Ormrod (2001) as “the general approach the researcher takes in carrying out the research project” (p. 14). Quantitative research involves the collection of data so that information can be quantified and subjected to statistical treatment in order to support or refute “alternate knowledge claims” (Creswell, 2003, p. 153).

According to Creswell, (2002) asserts that quantitative research originated in the physical sciences, particularly in chemistry and physics. The researcher uses mathematical models as the methodology of data analysis. Three historical trends pertaining to quantitative research include research design, test and measurement procedures, and statistical analysis. Quantitative research also involves data collection that is typically numeric and the researcher tends to use mathematical models as the methodology of data analysis. Additionally, the researcher uses the inquiry methods to ensure alignment with statistical data collection methodology.

3.2. Qualitative Research Methodology

There are several different methods for conducting a qualitative research; however, Leedy and Ormrod (2001) recommend the following five: Case studies, grounded theory, ethnography, content analysis, and phenomenological.

According to Creswell (2003), she describes how these methods meet different needs. For instance, case studies and the grounded theory research explore processes, activities, and events while ethnographic research analyses broad cultural-sharing behaviors of individuals or groups. Case studies as well as phenomenology can be used to study individuals such as;

3.2.1. Case Study

Creswell (2003) defined case study as “researcher explores in depth a program, an event, an activity, a process, or one or more individuals” (p. 15). Leedy and Ormrod (2001) further require a case study to have a defined time frame. The case study can be either a single case or a case bounded by time and place (Creswell, 1998).

3.2.2. Ethnography Study

The ethnography differs from a case study. The case study studies a person, program, or event while ethnography studies an entire group that shares a common culture (Leedy & Ormrod, 2001). Creswell (2003) defines “ethnographies, in which the researcher studies an intact cultural group in a natural setting over a prolonged period of time by collecting, primarily, observational data” (p. 14). The focus is on everyday behaviors to identify norms, beliefs, social structures, and other factors. Ethnography studies usually try to understand the changes in the groups’ culture over time. As a result, findings may be limited to generalization in other topics or theories.

In the ethnography methodology, the researcher must become immersed in the daily lives of the participants in order to observe their behavior then interpret the culture or social group and systems (Creswell, 1998). The initial step in the ethnography process is to gain access to a site. Second, the researcher must establish rapport with the participants and build trust. Third, the researcher starts using the big net approach by intermingling with everyone in order to identify the key informants in the culture (Leedy & Ormrod, 2001). The data is collected from participant observations and from interviewing several key informants. If the interviews are lengthy, the researcher gathers documentation by using audiotapes or videotapes media. The aspects included in ethnography are: the justification for the study, the description of the group and method of study, the evidence to support the researchers’ claims, and the findings to the research question. The report must provide evidence of the groups’ shared culture that developed over time.

3.2.3. Grounded Theory Study

Creswell (2003) defines grounded theory research as the “researcher attempts to derive a general, abstract theory of a process, action, or interaction grounded in the views of participants in a study” (p. 14).

3.2.4. Phenomenological Study

The purpose of this study is “to understand an experience from the participants’ point of view” (Leedy & Ormrod, 2001, p. 157). The focus is on the participants’ perceptions of the event or situation and the study tries to answer the question of the experience. Creswell (1998) points out that the essence of this study is the search for “the central underlying meaning of the experience and emphasize the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on the memory, image, and meaning” (p. 52).

3.2.5. Content Analysis Study

Leedy and Ormrod (2001) define this method as “a detailed and systematic examination of the contents of a particular body of materials for the purpose of identifying patterns, themes, or biases” (p. 155). Content analysis review forms of human communication including books, newspapers, and films as well as other forms in order to identify patterns, themes, or biases. The method is designed to identify specific characteristics from the content in the human communications. The researcher is exploring verbal, visual, behavioral patterns, themes, or biases.

The procedural process for the content analysis study is designed to achieve the highest objective analysis possible and involves identifying the body of material to be studied and defining the characteristics or qualities to be examined (Leedy & Ormrod, 2001). The collection of data is a two-step process. First, the researcher must analyze the materials and put them in a frequency table as each characteristic or quality is mentioned. Second, the researcher must conduct a statistical analysis so that the results are reported in a quantitative format. The research report has five sections: the description of the materials studied, the characteristics and qualities studied, a description of the methodology, the statistical analysis showing the frequency table, and drawing conclusions about the patterns, themes, or biases found in the human communications and data collection.

3.3.0. Research Design

Synbdon, et al (2005), defined research design as plan or blue print of how one intends to conduct research. It focuses on the end product, formulates a research problem as point of departure and focuses on logic of research. In selecting appropriate research design for this study, qualitative approach was employed. With qualitative approach there was possibility of using various instruments such as descriptive and exploratory research designs.

3.4. Study Area

Tegeres parish is located in Kapchorwa municipal council, Kapchorwa District in Eastern Uganda where the research will be carried out.

3.5. Study Population

The researcher carried out the study on the targeted respondent from the Tegeres Parish population 2,200 persons according to 2014 population census. This was because of the knowledge about the topic of study due to the constant interactions the researcher had with HIV/AIDS infections and poverty in selected households.

3.6. Sample Size

The sample consisted of 50 individuals with knowledge on the topic of study. The population also consisted of 10 infected and 10 affected individuals of households, 5 medical experts, 2 member from NGOs dealing with poverty and HIV issues, community leaders like 5 LCs, 5 religious leaders, 7 students and pupils and 6 teachers.

Among these were the infected and affected members constituted of children, mothers, fathers and the elderly in selected households, chairpersons, religious leaders, students, pupils and teachers who had interactions with members form NGOs dealing in poverty and HIV medical worker who offer treatment to these individuals and members of these households. These members of 50 individuals were chosen according to the knowledge of topic of study, the interactions they had with members of the affected and infected households and their personal experiences as members of the affected households.

3.7. Sample Techniques

a) Simple random sampling

The researcher listed households and community members from who he will be in position to obtain information from. The method was only applied to households on whom an interview schedule was used. Because it favors the randomness and selection of individual by chance thus all individuals were included in the study.

b) Judgmental / purposive sampling method

Here a sample was drawn depending on the researcher's knowledge and preference and of the knowledge of the respondents about the subject matter wider study. This was because those who were knowledgeable provided necessary information like the LC3, students and NGOs.

3.8. Data Collection

1) Interview

This was a person to person verbal communication in which the researcher asked questions with an intention to elicit information. This method was used because it will assist the researcher in collecting information that cannot be directly observed, historical information and gain control over the line of questioning.

2) Observation

These required the use of checklists as instruments. Checklists will contain a list of all items to be observed in a particular situation.

The checklist also contains all the possible states of each item to be observed and these include physical appearance of household members, performance in class, and nature of business done by household members. This method was used because the student believed that, he was in position to collect first-hand information, record information as it occurs, and also notice unusual aspect.

3) Questionnaire method

Mbaaga (1990) defined questionnaire as a predetermined written list of questions which may be answered by a subject or respondent without supervision or explanations by the interviewer. This was used for those who were able to read and write due to the fact that it was cheap and saved

time which reduced the workload on the researcher over direct interview, since the questionnaire guides were sent to the respondents in advance with the absence of the researcher.

3.9. Data Processing

3.9.1. Data organization and processing

This was the first step that the researcher undertook on existing the field. Moser and Kalton (1979) stressed that questions had to be checked, details reduced to manageable preparations and material summarized by tables to show salient features. Data was recorded systematically made its reading easy through.

3.9.2. Data sorting and coding

Coding involved assigning of numbers, symbols or words to classify response. This helped in summarizing all the detailed data.

3.9.3. Data analysis

At this level data collected was examined and deductions were made from it. Data analysis was made with reference to the study objectives and questions. This began way back before the field activities were performed inform of literature review.

3.9.4. Data presentation

Data was presented in table. This was because tables present a good summary of sample data and make interpretation of data easy.

3.9.5. Data processing and analysis

The data collected by the researcher underwent through various processes ranging from editing, coding, tabulation and the later analyze and interpreted into statements for easy analysis by the respective officials as illustrated below.

3.9.6. Editing;

The researcher examined the raw data to detect errors and omissions. The editing process involved careful scrutiny of completed interview schedule and documentary review in order to

be sure of the data that was accurate, consistent with other facts gathered and uniformly entered. Reviewing and reading of whole work or section of the data collected required whereby omitted sentences, phrases, words and others included into the context before presenting it for interpretation that was done by the researcher.

3.9.7. Coding;

This was the process of categorizing the data into meaningful sequences by the use of open-ended questions. The researcher used this data processing and analysis procedures in order to give the respondent free choice to give whatever answers they choose or exhaust all what they wanted to say.

3.9.8. Tabulation;

The researcher used tabulation data processing and analysis technique because it facilitated the process of comparison and summation of items and detection of errors and omission. The researcher summarized the data collected from the respondents into tables to determine the frequencies of the variables and the respondents by use of percentage and numbers

3.10. Ethical Consideration.

Informed consent

Respondents decided on participation in the study basing on the adequate knowledge of the study and they were therefore provided with; purpose of the research, expected duration of participation, benefits and extent of confidentiality and privacy was assured to select members of community who had prior knowledge about the topic under study because the information they had, was in line with the study topic.

Anonymity

Individual identities were a salient feature in the study.

Researcher's responsibility

The researcher was sensitive to human dignity and well-meaning in his intention.

3.11. Limitations.

The researcher encountered the following challenges in the process of collecting data on contributing factors to HIV/AIDS infections and Poverty in the selected households in Tegeres parish Kapchorwa municipal council Kapchorwa district.

The study was sensitive that it explored people's personal life styles, the researcher faced resistance from household members especially the infected to give information about their status.

The researcher identified that some respondents lack knowledge about the topic of study and others because they simply felt not being interrupted especially in their private activities.

The researcher was also challenged with language barrier during the time of interviewing.

The researcher experienced shortage of funds while carrying the research, compiling the data.

The researcher will be was challenged by respondents who provided varying information hence sorting the required information was challenging and time consuming.

There was also a challenge of poor turn up by the respondents that delay the process of obtaining data compilation and analyzing of data collected by the researcher.

CHAPTER FOUR

PRESENTATION, INTERPRETATION AND DISCUSION OF FINDINGS

4.0. Introduction

This chapter presents the findings of the study according to the key objectives and research questions on contributing factors to poverty increase among HIV/AIDS infected and affected households in Tegeres Parish, Kapchorwa District, how HIV/AIDS has affected individual's Productivity and the state and different forms of poverty among households . It gives full explanation of both qualitative information which the researcher has collected from the field research depending on the researcher problem and this can below basing on each objective.

4.1. Factors contributing to increased HIV/AIDS infections and Poverty among households in Tegeres Parish, Kapchorwa District in Eastern Uganda.

Table I: Factors contributing to increased HIV/AIDS infections and Poverty among households in Tegeres Parish, Kapchorwa District in Eastern Uganda.

Factors	Frequency	Percentage (%)
Inequality and social instability	2.5	6.25
Low status of women	6	15
High levels of Illiteracy	7	17.5
High mobility (particularly migrant labor)	3	7.5
Limited and uneven access to quality medical care	10	25
Sexual Violence	3.5	8.75
History of poor leadership in response to the epidemic	1.5	3.75
High levels of Ignorance about the causes of the identified calamities	6.5	16.25
Total	40	100

Source: Primary data, 2016.

Basing on the figures illustrated obtained primary data (2016) above, the researcher collected data from 40 respondents of which, it reveals that the sole cause of the identified calamities is; limited and uneven access to quality medical care facilities as evidenced with only one health center in the whole Parish and its proportion stands at 25%, followed by high levels of illiteracy with a percentage of 17.5 due to the facts that there are no improved education facilities in Tegeres Parish coupled up with low turn up rates of on-going pupils and students, high levels of ignorance about the likely causes of the identified calamities like; having unprotected sex with unfaithful partners, sharing sharp items such as; needles, razor blades, among others, laziness among productive labor force especially the youth, mother to child infections, mentioned but a few, low status of women in Tegeres Parish with a percentage of 15% associated with little support given to women by their husbands, sex violence with a percentage of 8.75% evidenced with a couple of sexual harassments and forceful sex, high mobility particularly migrant labor with a percentage of 7.5% , last but not least, by inequality and social instability at 6.25% and lastly, by the history of poor leadership underlying the response the epidemic like the increase prevalence of HIV/AIDS and high levels of poverty in Tegeres Parish without strategic interventions about the likely measures to the problems

Therefore basing on the data captured from the respondents the situations where the communities were the critical observation was done by the researcher. The findings were to a greater extent reveal that limited and uneven access to quality medical care facilities coupled up with high levels of illiteracy and ignorance were responsible for contributing to increased HIV/AIDS infections and Poverty in Tegeres parish, Kapchorwa district. Thus the research hypothesis was achieved of 60%.

4.2. How HIV/AIDS affect Individual's productive work

Through the researchers' interview which suited the respondents who could not read and write as well as interpretation of questions with the respondents whereby a question was probed which stated that 'how HIV/AIDS does affects individual's productive work? Therefore, the findings were collected. The researcher's findings where that the community put forward that HIV/AIDS weakness their immune system they are unable to work thus failing to provide themselves with basic necessities. They also added that individuals who are HIV/AIDS affected and infected cannot engage in community productive work due to their stigmatization by the community thus

cannot be in position to work. As a result, they are driven to poverty due to; inability to provide themselves with income and food to sustain their welfare, negative attitude towards individuals who are HIV/AIDS affected, fear about public opinion, inadequate sensitization about the vice and so forth.

All in all this has contributed to poverty as a result of HIV/AIDS and affects their participation in productive work of the community and triggers the researcher to determine whether the research/hypothesis is true or false whereby 40 respondents were interviewed and questioned as illustrated in the table below;

Table II: “Does HIV/AIDS affect individual’s productivity contributing to factors to poverty increase among HIV/AIDS infected and affected households in Tegeres parish?”

Category	Frequency of respondent		Percentage	
	Agreed	Disagree	Agree	Disagree
Local council leaders	1	3	2.5	7.5
municipal council officials	8	2	20	5
Community members	20	6	50	15
Total	29	11	72.5%	27.5%

Source: Primary data, 2016

According to the results from the table above, the researcher collected data from 40 respondents where 72.5% of respondent agreed that HIV/AIDS affect individual’s work while on other hand 27.5% of the respondents disagreed on above factor. Therefore the research question was greatly achieved whereby 72.5% agreed. This implied that HIV/AIDS affects individuals work has greatly contributing factors to poverty increase among HIV/AIDS in Tegeres Parish Kapchorwa municipal council, Kapchorwa district.

4.3. The state and different forms of Poverty among households in Tegeres Parish, Kapchorwa District in Eastern Uganda.

Table III: Showing the state and different forms of Poverty among households in Tegeres Parish, Kapchorwa District Eastern Uganda.

Forms of Poverty	Frequency	Percentage (%)
Absolute Poverty	3.5	8.75
Relative Poverty	6	15
Spiritual Poverty	1	2.5
Intellectual Poverty	5	12.5
Poverty of Affection	2.5	6.25
Poverty of the Will	2.5	6.25
Physical Poverty	7	17.5
Poverty of solidarity	2	5
Poverty of Civic Involvement	2.5	6.25
Economic Poverty	8	20
Total	40	100

Source: Primary data, 2016

Basing on the data collected through the instrument used that is to say, questionnaire, interview guide and others. The respondents gave varying arguments and views that channeled or conclusive and this is what the researcher found out that; the highest proportion of form of poverty in Tegeres Parish economic poverty rated at 20% which is simply as a result of lack of resources such as land, Livestock, finances among others, followed by physical poverty rated at 17.5% which results from the lack of health facilities such as quality medical care and presence of poor infrastructures coupled up with inadequate infrastructures like there is a prevalent shortage of referral hospitals and well-structured and equipped health centers as evidenced with only one health center at the Parish promises, relative poverty rated at 15% which is a result of high levels of unemployment, low income, lack of education mentioned but a few, intellectual poverty also is another form of poverty that has hit the people of Tegeres Parish and it is rated at 12.5% which is result of lack of knowledge, Absolute poverty rated at 8.75% which is the inability to meet all basic needs of live such as lack of clothing, shelter, safe drinking water, and

medicine among others, poverty of Affection , poverty of the will plus poverty of civic involvement all rated at 6.25% each, last but not least is poverty of solidarity which is the lack of support network for example biological family support rated at 5%, and lastly by Spiritual poverty rated at 2.5%. This is a result of lack of relationship with God. All these are the listed identified forms of different forms of poverty in Tegeres Parish, Kapchorwa District in Eastern Uganda.

CHAPTER FIVE

SUMMARY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0. Introduction

This chapter consists of the conclusion of the study and the policy recommendation for further improvement by the government and the stakeholders on contributing factors to poverty increase among HIV/AIDs infected and affected household in Tegeres parish, Kapchorwa municipal council, Kapchorwa District.

5.2.0. Summary Findings.

This part presented the summarized results and interpretations (findings) based on the study objectives as established at the beginning of the study.

5.2.1. Factors contributing to increased HIV/AIDS infections and poverty among households in Tegeres Parish, Kapchorwa District, in Eastern Uganda.

According to study findings, the researcher revealed that there were three macro factors with the highest proportions that contributed to the increased HIV/AIDS infections and poverty and these were; limited and uneven access to quality medical care facilities with a percentage of 25%, followed by high levels of illiteracy rated at 17.5% and as well high levels of ignorance about the likely causes of these problems rated at 16.25% while rest of the other factors parked up in influencing the persistence of these calamities and these included; sexual violence with a proportion of 8.75%, high mobility particularly migrant labor with a proportion of 7.5%, high levels of inequality and social instability with a percentage of 6.25% and lastly by the history of poor leadership in the response to the epidemic with a proportion of 3.75%.

5.2.2. How HIV/AIDs affect Individual's productive work.

According to the researcher's findings it was revealed that the community put forward that HIV/AIDs weakness their immune system thus making them unable to work thus failing to provide themselves with basic necessities, to participate in any other productive work like digging or doing farm work. They also added that individuals who are HIV/AIDs affected and infected cannot engage in community productive work due to their stigmatization by the

community thus cannot be in position to work. As a result, they are driven to poverty due to; inability to provide themselves with income and food to sustain their welfare, negative attitude towards individuals who are HIV/AIDs affected, fear about public opinion, inadequate sensitization about the vice and so forth.

5.2.3. The state and different forms of Poverty among households in Tegeres Parish, Kapchorwa District in Eastern Uganda.

According to the study research findings, the researcher revealed that the most common forms of poverty include; economic poverty with the highest proportion of 20%, and physical poverty with a percentage of 17.5% were the most leading forms of poverty affecting the people of Tegeres Parish in particular, followed by intellectual poverty with a percentage of 12.5%, poverty of civic involvement, poverty of the will and poverty of affection all rated at 6.25% each, followed by poverty of solidarity with a proportion of 5% and lastly by spiritual poverty with a lowest proportion of 2.5%. The researcher conducted research basing on the very findings as the existing different forms of poverty in Tegeres Parish, Kapchorwa district in Eastern Uganda.

5.3. Conclusions

According to the findings, the following remarks and observations were drawn and can be illustrated below:

Based on chronic sickness as a cause of poverty, HIV/AIDs affected and infected individuals, it was found out that 60% of the respondents agreed that chronic sickness was a major cause and other factors were involved like absence of support from family members for instance if individual is a female and a bread winner as well; cultural rigidity among others.

In addition it was found out that HIV/AIDs affects individual's productivity by the bigger percentage of 72.5%. Despite this argument, 27.5% disagreed citing other factors like negative attitude towards individuals who are affected at workplace, perception by the client about public opinion, limited access to credit and asserts like land and others.

Furthermore, the researcher concluded that the leading forms of poverty present in Tegeres Parish were; economic poverty rated at 20%, physical poverty rated at 17.5% and relative poverty respectively rated at 15% and the minor form of poverty as spiritual poverty rated at

2.5%. And this therefore, calls for stakeholders to intervene so as to address the situation before it becomes worse by providing the victims with financial support for their betterment so that they become change and agents of change in the bid to improve their welfare in Tegeres Parish, Kapchorwa district and the nation at large.

5.4. Recommendations

The researcher recommends that preventive measures like condom use should be emphasized especially in health centers by health workers. This is vital in minimizing the rate at which HIV would spread without this measure.

The researcher recommends to the ministry of education through the functional adult education in the districts that emphasis should be made on educating infected and affected members of the households throughout giving them scholarships since their household's income cannot meet the educational standards rendering them illiterate.

The researcher further recommends that sensitization by the health experts such as nurses and community health offices about the disease should be done so as to create awareness since this will help to reduce the levels of infection because the strategies to minimize the spread are known to member of community.

The government through community leaders like local councilors, reverent and priests should come into provide care and support like giving treatment such as ART, provision of safe clean water and extending VCT service nearer to people that may need it through making contributions inform of money and other resources to support the program.

The researcher recommends the government officials review its policies especially the HIV work place policy in various government officers and also in the coming up non-governmental institution to enable infected household members earn an income that may create a difference in their status socially and economically.

The researcher recommends that facilitators to be sensitive to age and the implications of aging on the psychological and physical health of clients provide trainees with experience with clients who are living with HIV/AIDs.

5.5. Areas for further research.

There is need for academia to research on the prevalence rate of HIV/AIDS infections and poverty.

There is need for academia to look forward for elastic strategic measures to curb the high persistent cases of HIV/AIDS infections and Poverty.

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APPENDICIES

APPENDIX I

INTERVIEW GUIDE FOR LOCAL COUNCILORS

TOPIC: AN INVESTIGATION OF HIV/AIDS INFECTIONS AND POVERTY AMONG HOUSEHOLDS IN TEGERES PARISH, KAPCHORWA DISTRICT UGANDA.

Questions

1. Why do you think poverty is increasing in HIV/AIDS infected and affected households?
2. How HIV/AIDS does affects individual's productive work?
3. How are the members of the household doing to overcome poverty situation?
4. How are you helping the infected and affected individuals out of the poverty situation?
5. Which other leaders have joined hands with you to help households of infected and affected individuals especially if they are not working?
6. Are infected and affected household individuals engaging in any activities in this community?
7. What forms of activities are they engaging in?
8. How do they benefit from these activities?
9. What is the state and different forms of poverty in your local community?

APPENDIX. II

INTERVIEW GUIDE FOR LOCAL LEADERS

TOPIC: AN INVESTIGATION OF HIV/AIDS INFECTIONS AND POVERTY AMONG HOUSEHOLDS IN TEGERES PARISH, KAPCHORWA DISTRICT UGANDA.

Questions

1. How HIV/AIDS infections lead to poverty among household individuals living in your community?
2. What activities do they participate into earning a living?
3. Do the infected and affected household individual seem poor to your own observation?
4. What do you think keeps these households individual poor?
5. What have you done to assist the infected individual of the household in your community?
6. What other form of assistance is availed to be infected and affected individuals.
7. Do these infected and affected household individuals participate in any kind of relief activities?
8. What is the state and different forms of poverty in your local community?

APPENDIX. III

QUESTIONNAIRE FORM FOR COMMUNITY MEMBERS

I am a student of Kampala International University pursuing a Bachelor's Degree in Development Studies. I am conducting research entitled an "investigation of HIV/AIDS and poverty among households in Tegeres parish, Kapchorwa district Uganda". This information given by you will be treated with maximum confidentiality and it's for academic purpose only. Please fill in the boxes and questions provided below;

NAME OF RESPONDENT:

SEX

--

AGE

--

RELIGION

MARITAL STATUS

LEVEL OF EDUCATION

VILLAGE / ZONE

TOPIC: A study examining the contributing factors to poverty increase among HIV/ AIDS infected and affected and households in Tegeres parish, Kapchorwa district.

Objective 1: To establish how HIV/AIDS lead to poverty among the selected households in Tegeres Parish, Kapchorwa district.

- a. How chronic sickness leads to increased poverty among HIV/AIDSs does infected and affected household?

.....
.....

- b. What are the possible solutions to address the issue chronic sickness?

.....
.....

- c. What strategies should be put in place to address the above challenge?

.....
.....

Objective II: To find out how HIV/AIDs affects individuals productivity.

a. How HIV/AIDs do affect individual's productivity?

.....

.....

b. What are the possible solutions to address the above issue?

.....

.....

Objective III: To investigate the state and different forms of poverty among selected households in Tegeres Parish, Kapchorwa district.

a. What is the state of poverty at your household basis basing on the cost of living per day?

.....

.....

b. What do you think should be adopt to address this issue?

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.....

APPENDIX. IV
QUESTIONNAIRE FORM FOR LOCAL COUNCIL

I am a student of Kampala international University pursuing a Bachelor's Degree in Development studies. I am conducting research entitled "An investigation of HIV/AIDS infections and poverty among households in Tegeres parish, Kapchorwa district". This information given by you will be treated with maximum confidentiality and it's for academic purpose only. Please fill in the boxes and questions provided below;

NAME OF RESPONDENT:

SEX

AGE

RELIGION

MARITAL STATUS

LEVEL OF EDUCATION

VILLAGE / ZONE

TOPIC: AN INVESTIGATION OF HIV/AIDS INFECTIONS AND POVERTY AMONG HOUSEHOLDS IN TEGERES PARISH, KAPCHORWA DISTRICT UGANDA.

Objective 1: To investigate on the factors contributing to increase HIV/AIDS infections and poverty in selected households

a. What factors lead to high spread of HIV/AIDS in your community?

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.....

e. What can be done to address the issue of high HIV/AIDS infections and Poverty levels in your local community?

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.....

Objective II: To find out how HIV/AIDs affects individual's productivity.

c. How HIV/AIDs do affect individual's productivity?

.....
.....

d. What are the possible solutions to address the above issue?

.....
.....

Objective III: To investigate the state and different forms of poverty among selected households in Tegeres Parish, Kapchorwa district.

c. What is the state of poverty at your household basis basing on the cost of living per day?

.....
.....

d. What do you think should be adopt to address this issue?

.....
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APPENDIX. V

Observation checklist

1. Physical set up of the homestead and compound in particular.
2. The physical outlook of the individual households.
3. The assets the family possesses.
4. The level of sanitation at the households.

APPENDIX. VI
BUDGET

ITEMS	QUALITY	COST
Stationary	-	70,000/=
Equipment	-	50,000/=
Transport	-	30,000/=
Accommodation	-	20,000/=
Lunch & breakfast	-	40,000/=
Total		210,000/=