

Economics and Illness: the HIV/AIDS Link of Being Socioeconomically Disadvantaged

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Many U.S. Americans might argue it is impossible to be a news-savvy individual living in the United States in recent years and not be familiar with the term “fake news.” Those who identify with either side of the political aisle have hurled these two words each other when arguing particular information is inaccurate, when attempting to communicate accurate information and correct perceived misinformation communicated to the voting public that can alter political and governmental outcomes. For responsible global health organizations as well as for conscientious international faith-based ministries, the search for what is true, for what is accurate also reigns as a current priority, although for different reasons: the facts regarding these organizations’ beneficiaries’ daily existence drive (or should drive) the assistance given for these beneficiaries’ well-being as well as provide the impetus for the funding received with which to do the work. For nongovernmental organizations seeking specifically to benefit HIV/AIDS patients and their local communities, proper understanding of the multi-faceted realities in which HIV/AIDS patients acquire and live with HIV can save the beneficiaries’ lives or empower them to move forward to live productive, meaningful lives as defined by the beneficiaries themselves. Having-and communicating accurate information regarding the beneficiaries’ realities related to their HIV-positive status can determine whether the organization is granted necessary funding as well as how the organization utilizes its the resources to bring benefit to this population.

However, the data the nongovernmental organizations utilize regarding the contexts in which HIV patients acquire and live with HIV has differed significantly from the data the general public has access to, until at least recently, regarding whether the socioeconomically disadvantaged are at increased risk of HIV. This discrepancy commanded my attention a number of years ago, when I first started working in Central America with AIDS patients. All of the patients with whom I worked in inland Costa Rica were socioeconomically disadvantaged. I had already done volunteer work at Bailey Boushay House, part of Virginia Mason Hospital in Seattle, Washington, for nine months, whose HIV-positive beneficiaries at the time were strictly socioeconomically disadvantaged individuals. But I had always

assumed there were just as many HIV-positive individuals in the Seattle area who were *not* socioeconomically disadvantaged. After my first few months working in inland Costa Rica, during which I had numerous conversations with Costa Rican nationals about the plight of the HIV-positive individual in the country, I started regarding socioeconomic disadvantage as the norm for those who were at greater risk of HIV infection. I needed to know – is this true? I know what I see in the field, but what do global health researchers say? Are the socioeconomically disadvantaged at greater risk for HIV? If this was true, this would need to inform LoveAIDS' strategy in how and why we did things. This would also be something Christians need to put our focus on, because our focus has not been there.

The World Health Organization, UNAIDS, and other large organizations have mounted large campaigns funded by the United States and other countries to help low- and middle-income countries respond to the HIV epidemic. But while there are Christian organizations which have done effective, ethical work, for example working with orphans internationally, building schools and providing schooling for children in impoverished regions across the world, and building hospitals, I had never heard of (or been able to find other) U.S. based Christian organizations sending long-term workers to provide health care to HIV and AIDS patients. But I had received messages that Christians were not welcome in global health.

I had personally interacted face-to-face with global health specialists who communicated verbally a bias against Christians and accused people of faith of wasting funds, doing ineffective work, and wanting only to “impose a white-man’s colonial agenda.” Being an international ministry worker and having numerous college peers currently in the field overseas in long-term ministry, I already had access to data which contradicts what these contrary global health specialists claim, data which documents the long-term benefit which my college peers and Christians in general have brought about through their selfless actions over the years in their long-term global work. It was because of this that I was able to stand my ground as a premedical student and communicate very respectfully to these

competent medical anthropologists whom I respect for their work that I believe there is a place for people of faith in global health. The global HIV/AIDS epidemic deals with brain drain (a shortage of doctors, nurses and other specialists available to work with HIV/AIDS patients) (Kirby and Siplon 154), funds mismanagement by nongovernmental organizations, and tremendous HIV/AIDS stigma towards patients. (“The Joint Learning Initiative (JLI), a group of more than 100 health care leaders, estimates that there is a shortage of more than four million workers” (Kirby and Siplon 154).) Trained medical and global health professionals are needed, professionals who carry out patient care responsibilities ethically and at the highest professional standards, who want to work and live long-term among the people in middle- and low-income countries to serve them, who believe that every life has value, and who strategically and deliberately come alongside local health workers to help strengthen existing in-country systems. Why would people of faith not be worthy workers? What matters is to save lives. The argument that people of faith should not be involved in helping save lives is a political argument or a personal argument or both, depending on who is making the argument. But it cannot be argued credibly from a medical standpoint that competent, ethical, and effective medical and global health workers who are also people of faith should not be involved in low- and middle-income countries, especially when there is so much need and so much work to be done.

I naturally then wanted to find out whether the socioeconomically disadvantaged are at greater risk of HIV infection. Did researchers agree with what I witnessed personally in the field? I first needed to ask myself if I had just been ignoring blindly what was in front of me. Was the general public in the United States, where I lived most of my life before starting to work with HIV and AIDS patients, being exposed to the message all along that the socioeconomically disadvantaged are at greater risk of HIV infection? So over four years ago, I started researching. My recent online search finds that the National Institute on Drug Abuse reports as of 2012 that men who have sex with men, injection drug users, and women who have heterosexual relationships with men (yes, women who have heterosexual

relationships with men – I would not have thought of this as a “high-risk” group), including women who are trauma victims, have the highest risk of acquiring HIV. It also reports that across these groups, ethnic minorities, youth, individuals over fifty, and those imprisoned within the United States’ criminal justice system have even higher odds of HIV infection (Who, Drug). While this data provides its audience with specific groups at risk, it does not use the words “socioeconomic disadvantage,” “economic disadvantage,” “poverty” or similar words which would communicate where these groups might fit within society to help the reader recognize larger patterns. A current reading of the website for the Eunice Kennedy Shriver National Institute of Child Health and Human Development, part of the United States National Institutes of Health, similarly leaves these types of words out also (Who, Eunice).

Four years ago, when I started searching the internet to find what the differing United States governmental organizations were providing to the general public, I came across the similar results. Government website after government website provided these categories as higher-risk groups but excluded the words “socioeconomically disadvantaged” and similar words. I regret now that I did not document systematically at the time how many and which government websites neglected to include the words “socioeconomically disadvantaged” or similar words. I know I did not find one U.S governmental website that did include this group. I wondered at the time why U.S government websites were excluded the fact that socioeconomically disadvantaged people are at higher risk of HIV infection. The Henry J. Kaiser Family Foundation’s lengthy thirty-four-page report covers a twenty-five-year time span of HIV/AIDS media coverage in the United States through 2006 and documents similarly the exclusion of the category “socioeconomically disadvantaged” [or a similar category] in the United States’ mass media’s communication of groups at increased risk of HIV infection (Evolution, 1-34). But the United States was not alone in this. Globally, the mass media of other countries also excluded the category “socioeconomically disadvantaged” [or a similar category] as a high-risk group for HIV. The mass media of these countries occupied themselves with educating the public regarding safe sex

practices and about not sharing intravenous needles, for example, but not helping the public to understand the larger contexts within which individuals acquire or live with HIV (Bekalu and Eggermont 739-40).

So, I am surprised to find, during my recent investigation, an exception: as of 2017, the Center for Disease Control (abbreviated CDC) reports that the socioeconomically disadvantaged are at higher risk of HIV infection. The CDC was not reporting this on their website for the general public four years ago, in December of 2014, when I had started my research trying to find HIV risk data for the socioeconomically disadvantaged. The Center for Disease Control in the United States now reports that poverty is the single most important demographic factor for increased HIV infection risk for heterosexuals (Currie.) And on their website under “HIV/AIDS”, they now have a page where they list high at-risk HIV groups and include “Economically Disadvantaged” in this list(HIV). This category did not exist on their website four years ago. The CDC defines a poverty area in the United States as an area where twenty percent or more of residents have household incomes below the US. poverty level and reports that these poverty areas have a 2.1% HIV prevalence rate, meaning that these poverty areas have generalized HIV epidemics within them. The CDC even goes so far to communicate that this 2.1% HIV prevalence rate is similar to that found in a number of low-income countries with generalized HIV epidemics such as Ethiopia, Burundi, and Haiti (Denning and DiNenno).

In contrast to governmental organizations’ mass media communications in the United States, the United Nations and the World Health Organization have been reporting for years on the social determinants of illness (The Solid Facts). Social determinants of health are defined as “the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness (Davis and Tucker-Brown 274). The World Health Organization reports that the poor have twice the likelihood of experiencing premature death and severe illness as the wealthy, and naturally this carries over into who is at higher risk of HIV infection (*The Solid Facts* 10). The United Nations, in their

UNAIDS Gap Report, list the socioeconomically disadvantaged as: 1) people with disabilities, 2) adolescent girls and young women, 3) prisoners, 4) migrants, 5) intravenous drug users, 6) displaced persons, 7) children and pregnant women living with HIV, 8) people living with HIV, 9) sex workers, 10) gay men who have sex with men, 11) people who are 50 years and older, and 12) prisoners (UNAIDS 11).

Journal articles produced by global health researchers abound in support of these associations between poverty and increased risk of HIV infection. Researchers Rajeev Kumar, Damodar Suar, and Sanjay Kumar Singh, investigating populations in India, list off various HIV high-risk factors which are associated with socioeconomic disadvantage: “poverty, social inequality, migration, low literacy, inadequate access to health services, high population density, vulnerable ethnic minorities, and less per capita spending on health” (Kumar, et al. 204). Nyovani J. Madise, together with eight other global health researchers, provide documentation drawn from a sample of 3,000 people that shows that the HIV prevalence among urban slum dwellers in two Nairobi slums is twice (12%) that of Kenyan non-slum urban dwellers (6%) (Madise, et al. 1144).

Suneeta Krishnan along with five other researchers working collaboratively through the Women’s Global Health Imperative and Global Health Sciences at the University of California, San Francisco, California, the University of California, Berkeley, California, and the Center for Public Policy at the Indian Institute of Management in Bangalore, India argue that both economic inequality and gender inequality are at the root of the growing global HIV epidemic for women. Women’s lack of access to health services, the gender-based violence against them, their low education levels, and necessary migration due to their lack of economic resources increases their likelihoods of engaging in risky sexual behaviors. As a result, these disadvantaged women are more likely to start having sex at an early age, engaging in frequent and risky types of sexual activity, having concurrent or multiple partners and participating in transactional sex (Krishnan, et al. 101).

Asseffa Tolera Sori presents individual cases as she argues that socioeconomically disadvantaged women in Addis Ababa, Ethiopia are more likely to participate in risky sexual behaviors even when educated about HIV risks because they feel they have no other options. “Poor uneducated women in poor neighborhoods are more likely to engage in risky sexual encounters despite awareness about the risk of HIV infection as they operate in an environment that provides the path of least resistance,” writes Sori (677). This includes their likelihood to marry before the age of fifteen, their likelihood to engage in transactional sex to obtain food, early sexual debut, and not using a condom when engaging in sex. For young women born in poverty, Sori argues, HIV/AIDS is just another life-threatening condition among the other serious health conditions they face in their existence. The determinants of HIV infection skip the possibility of individual choice as high-risk behaviors become an automatic way of life as a means of survival for young women born in poverty (Sori 667-701).

Feliz M. Muchomba, Julia Shu-Huah Wang, and Laura Maria Agosta report indeed that, using a sample of 5511 women in Kenya, “land ownership was...associated with reduced HIV-infection among women most likely to engage in survival sex,” but not for women who need to negotiate for safe sex with casual partners or with husbands (97). The increased HIV infection rate amongst the Kenyan women who need to negotiate for safe sex reflects the gender inequality between men and women and how difficult it is for women to protect themselves against sexually transmitted infections when they do not share equal power status with men in relationships. Alessandra S. Chacham and her research associates found similar results when a cross-sectional survey was carried out on a random sample of 356 women between 14 and 24 years old in an urban slum area of Belo Horizonte, Brazil. “Indicators of autonomy that relate to sexuality, mobility and freedom from threat by partners were significantly correlated with practices linked to HIV prevention” (S12). “Structural gender inequalities translate into unequal relationships and reduce autonomy, increasing women’s susceptibility to HIV” (S12).

Chacham and her associates define autonomy as the degree of access that an individual has to material and social resources. When there are unequal power relationships in intimate partner relationships between men and women, it makes it difficult for women's desires to be heard and respected. This power imbalance makes it challenging for women to control their own lives within the social spheres in which they live, including in their families and dating relationships. This includes negotiating for condom use during sex. Young girls are particularly vulnerable because of their economic vulnerability; teen pregnancy and early marriage are more common in urban slum areas and poor rural areas in Brazil. In a culture with a high gender imbalance, the request by young girls for condom use symbolizes multiple partners and lack of trust, putting them at a disadvantage in negotiating for the condom use (S12-13). 100% of the women surveyed understood that using a condom could protect them from HIV infection, but that knowledge alone did not lower their HIV infection risk (S20). Chacham and her associates observe that in Brazil, there are few empowerment programs focused on vocational training and job placement for young women compared to the volume of similar programs provided for men, so that although young women tend to be better educated than young men, they have far less job prospects. The result is that getting pregnant or marrying may seem like the only viable option young women have, further reinforcing the gender inequality which puts them at higher risk of HIV (S22).

Interestingly, though the U.S. government, except for the CDC since 2017, is not communicating about the relationship between socioeconomic disadvantage and increased HIV infection risk to the general public, the data that at least the CDC has been releasing for years is used by researchers to document this association between socioeconomic disadvantage and increased HIV infection risk within the United States. Sarita K. Davis and Aisha Tucker-Brown report how black women in the United States are "disproportionately affected by the human immunodeficiency virus (HIV) that causes AIDS" and use CDC data as part of the data provided to support their claims (273). They list the CDC's Center 2009 HIV

infection rates, explaining that 57% of all HIV infections among women in the United States were in Blacks, versus 21% in Whites and 16% in Hispanics. This means that the HIV infection rate for new infections is 15 almost times as high as the rate for White women and nearly 3 times that for Hispanic women. Davis and Tucker-Brown explain how social determinants such as a history of sexual oppression by mainstream U.S. society, poverty, racial segregation, and mass incarceration of Blacks put women at higher risk of acquiring HIV (275-283). Avert, a charity dedicated to HIV prevention through HIV education, provides additional data regarding the HIV prevalence among Black U.S. Americans: "In the USA, African American/Black people...[account] for 44% of all new HIV infections in 2014 despite only making up 12% of the population" (HIV, Avert).

Medical anthropologists agree with these findings as they seek solutions to help the socioeconomically disadvantaged. Dr. Paul Farmer of Harvard Medical School argues that public health measures have failed to "prevent AIDS from becoming...the leading cause of death for young women living in poverty". Gender inequality and poverty create situations of risk for poor women which more affluent women do not experience (Farmer, *Pathologies* 166). Structural violence, which Farmer describes as "offenses against human dignity," includes social inequality, the oppression of the poor by the rich, starvation due to poverty, denial of health care services, and the types of violence readily accepted as unacceptable abuses, such as torture, rape, and murder. It is this structural violence which predisposes the poor to lifetimes of suffering, including predisposing those who live in poverty to become HIV positive. Farmer argues that the right to survive is a basic human right that is violated by those in power, including those with financial resources, who, in contrast, believe that the right to survive is something only for those with resources (Farmer, *Pathologies* 6-9). In other words, if one is wealthy or at least is lives in a region of the world where they can access resources (food, hospital systems,) then they have a right to life. The wealthier they are, the more they deserve to thrive in their life. But if they are born in poverty, they are neglected this right. This is structural violence: that the rich

have a right to survive, but the poor do not, that the rich have the right not to acquire HIV, or to receive quality HIV treatment, but that the poor do not. As systems are put – or left – in place which deny the rights of the poor to receive medical care, to receive an education, to succeed in a career, to have a political voice and rights, structural violence is committed against these poor. They are not given a choice to not be high-risk for HIV infection. By being poor, in a system of structural violence, those born into poverty automatically inherit these increased odds of infection.

Janet Seeley and her five research partners help us understand this context in which structural violence thrives further with her use – and definition – of another term that some argue can be used interchangeably with the term structural violence. Seeley *et al.* defines structural drivers – also named social drivers – as “core social processes and arrangements , reflective of social and cultural norms, values, networks, structures and institutions, that operate in concert with individuals’ behaviors and practices to influence HIV epidemics in particular settings” (Seeley *et al.* 1). Seeley *et al.* explains it and provides an example:

“These structural forces undermine the effectiveness of proven HIV interventions. A recent trial in Malawi, for example, showed that a programme that provided a stipend to girls and their households had a significant impact on HIV...prevalence among young girls who stayed in school, even though the intervention did not directly target sexual behavior change. The reductions in prevalence were likely to be the result of reductions in the levels of transactional sex, with girls reporting fewer sexual partners and less sex with much older men. This finding underscores the importance of structural interventions that explicitly address the social and economic forces that shape much HIV vulnerability” (Seeley *et al.* 1).

The element that drives the behavior here is need: In an environment in which certain behavioral responses are normalized in the face of need, a young girl, out of desperation might resort to

transactional sex, an informal cultural norm of earning income through available networks, to help pay for her school expenses or compensate for the food shortage at home, especially if she sees that her peers in the school resort to transactional sex also or if a parent encourages her to do so.

Medical anthropologist James Pfeiffer, from the University of Washington Department of Global Health, believes that the strengthening of public systems needs to occur in areas of extreme poverty to address the contexts that lead to increased HIV infection risk and AIDS-related deaths.

Nongovernmental organizations which have a vertical approach, only providing one service, for example providing HIV medications, and, for example which are built next to existing, crumbling hospitals, run parallel operations dependent on funds coming from outside of the country but do not strengthen the existing in-country health systems. (Pfeiffer 173-5). He also criticizes the innovation-seeking approaches of the Gates Foundation and other nongovernmental organizations, writing, “the basic strengthening of public institutions, services, and safety nets requires a reinvestment in well-known fundamentals, not necessarily new innovations in programs” (Pfeiffer 179). If these basic systems, to address food insecurity in a country or region, to provide quality health care and medicines, to train health care workers so that there are workers available to provide health care to the poor, to create strong public school systems, and to strengthen social safety nets, aren’t built, or if they are built in a way that still relies on a wealthy outside source, then the poor are still victims trapped in a system of structural violence. To change the existing landscape in which the socioeconomically disadvantaged are at increased risk of HIV infection means to dissolve the present structural violence, so that the poor have access to resources, no longer trapped in a system of powerlessness and suffering which includes increased likelihood of HIV infection.

Farmer agrees with Pfeiffer about the need to strengthen existing health systems as well as other basic systems within the community, writing, “Money designated for AIDS, when used as a means of strengthening health systems...can indeed have a salutary and rapid impact on, for example, the

provision of women's health care or vaccinations" (Farmer, Marvelous 158). He also explains, "It is simply not possible to have vertical programs in poor, rural areas, because people in those areas typically suffer from more than one disease at a time" (Farmer, Marvelous 158). For example, one must also treat tuberculosis, as half of his patients in Haiti and African countries have tuberculosis. More African children die from malaria than from AIDS, so malaria must be treated. (If malaria is not treated, its prevalence can threaten the health of those with HIV.) Family planning and modern obstetrics need to be provided for in order HIV prevention to be both ethical and effective (Marvelous 158) Clean water needs to be provided in order for pediatric HIV infections to be stamped out (Marvelous 159).

In the midst of the flood of data and literature that argue that the poor are at increased risk of HIV infection because of the context of structural violence in which they live, I did find some data which at first glance provides contradicting evidence. Examining 5,155 women aged 15-49 in Cameroon, Joyce N. Mumah and Douglas Jackson-Smith find that wealthier women in Cameroon are at greater risk of HIV infection than their poor counterparts. Although wealthier women have "greater access to and use of health care facilities, higher levels of condom use, more HIV knowledge, and command higher power within their relationships," they also have higher HIV infection rates (Mumah and Jackson-Smith 1). This is because these wealthier women engage in higher-risk sexual practices that were recorded in their study: more years of premarital sexual activity, sexual acts outside of relationship, and multiple partners in the previous twelve months (Mumah and Jackson-Smith 1).

A study by Ashley M. Fox examining 133,568 respondents in 170 regions across 16 sub-Saharan African countries, including Cameroon, sheds more light on what is really going on with increased HIV infection rates among the wealthy in Cameroon and reveals the complexity regarding what affects the HIV infection rate. Using the presence of extramarital partners as the dependent variable, she finds that HIV infection risk indeed increases with an increase in wealth within the countries examined, with the Ivory Coast, Zimbabwe, Cameroon and Swaziland reflecting higher infection rates than other countries in

the region (465). However, this is not the full picture. Fox explains that HIV infection rates increase in a country or region as the wealth inequality among the population increases, and she demonstrates how, as wealth inequality increases within the 170 regions and 16 being examined, HIV prevalence rates also increase. Her research also supports a paradox just starting to be understood regarding HIV infection rates: “In wealthier regions/countries, individuals with less wealth were more likely to be infected with HIV, whereas in poorer regions/countries, individuals with more wealth were more likely to be infected with HIV (459).

How does this work, that the poorer are more likely to be infected with HIV in wealthier regions and countries with significant wealth inequality, and the richer are more likely to be infected with HIV in poorer regions and countries with significant wealth inequality? Fox found that in urban settings, HIV infection mainly decreases with wealth, and in rural settings, HIV infection mainly increases with wealth, (470). Overall, though, the odds of HIV infection still were significantly higher in the regions and countries with greater wealth inequality (470-1). Fox also found that “the likelihood of being in an extramarital partnership was higher in regions with more wealth inequality” (473). The likelihood of being in an extramarital relationship increased as an individual’s wealth increased, specifically that “in rural areas, the odds of being in an extramarital partnership increased with an individual’s wealth” but not in urban areas (473). So, although “in urban areas, there was no significant association between extramarital partnerships and individual wealth,” the likelihood of that being the case in rural areas was so high that overall, across all regions where there was greater wealth inequality, the likelihood of being in an extramarital relationship increased as an individual’s wealth increased (473).

Fox suggests that economic migration of individuals from poorer rural areas to wealthier urban areas “fuels HIV disparities” (474). As families send family members to urban areas to work, those family members send wages earned back home to the rural areas, increasing the wealth, comparatively with others in the rural area, of the family members back home. Research shows that in economic migration,

male migrants take on long-term non-marital partners as well as “both women who migrate to urban centers and women who remain behind while their partners migrate take on informal, long-term partners” (462). The migrating partners who now live in urban centers are not considered wealthy, comparatively, to others in the urban center, but their spouses back home in the rural centers, who receive the remittances, are considered wealthy, comparatively, to others in the rural areas. As the migrating partners, classified among the poor in the urban centers, have extramarital relations and then occasionally travel back home, having sexual relations with their spouse back home, HIV is transmitted. As the spouse back home in the rural center, who is now considered wealthy comparatively to others in the rural area and who potentially has received HIV from the migrating spouse, has extramarital relations with a long-term extramarital partner, HIV is transmitted to that extra-marital partner.

This data deepens the understanding in how socioeconomic status relates to HIV infection risk in African countries and draws attention to the nuances affecting this risk. Fox clarifies that most studies either address the relationship between how individual wealth influences HIV infection risk (as done in the study examining women in Cameroon) or address the combined relationship between economic development and HIV prevalence. By using multi-level analysis and examining both relationships, she is able to address a number of gaps in the academic literature to come to these results (462). But there is still much work to be done in understanding these gaps and these results, as there still is a shortage of research data to fill in these knowledge gaps.

The question remains, from Fox’s research, regarding why the wealthy in the urban centers in African countries examined are at decreased risk of HIV infection. Fox suggests that “wealthier individuals [in urban centers,] because of their greater knowledge, prestige, and power, are better able to adapt to new health threats, reproducing social inequalities in health” (476). She then concludes that HIV prevention efforts should be altered to “avoid reproducing social gradients that disadvantage people who are poor” (477). This brings us back to the structural violence which Farmer writes about:

wealth inequalities create environments in which the poor migrate to urban centers for higher wages. After migrating, these workers lack their sexual partners, as so do the spouses left back home, and so they seek extra-marital sexual partners, resulting in concurrent relationships for the spouses who have migrated, the spouses left back home, and often, both.

The research is still young regarding the association between wealth inequalities and increased HIV infection rate. The only other study I found producing empirical evidence regarding this association which also uses multiple countries and regions across sub-Saharan Africa is done by Paul Henry Brodish, consisting of 43,091 participants in 2,641 regions across 6 sub-Saharan African countries and builds on Fox's work (Brodish 317). He documents similar results from his analysis that HIV prevalence is higher when there is higher wealth inequality (317) and that the likelihood of having extramarital partners increases in regions with higher wealth inequality (325). Brodish also reports that for women, having only a primary education is associated with increased risk of HIV infection and that the inverse is true for men; the higher the level of education men obtain, the higher their risk of HIV infection becomes (325).

Brodish observes a considerable number of other factors associated with increased HIV risk (325), but in his study he does not distinguish between rural and urban dwellers in the six African countries he examines. As a result, it is not possible to identify migratory patterns in his study, particularly economically-motivated migratory patterns that can help us further understand why increased HIV risk is found in contexts of greater wealth inequalities. For example, the relationships between a limited education with increased HIV risk for women and between an increase in education with increased HIV risk for men can result from poor women in urban areas wanting to move up the social ladder or provide for their children and thus engaging in extramarital relationships or transactional sex with educated men who come from rural centers. Alternatively, these women with limited education who are show a higher risk of HIV infection may be back home living in a rural center, and their more educated husbands may be living in urban centers having extramarital sex and then

returning home to the rural center occasionally and passing HIV to their spouses. There are numerous other options, of course, but without distinguishing between rural and urban dwellers, it is difficult to begin to identify these nuances further.

We lack research on the migratory and economic patterns that focuses on understanding the relationship between increased wealth inequalities and increased HIV infection rates. It is reasonable to suspect this so-far observed association regarding HIV infection risk exists on all continents. Global health is still such a young field, with much research that still needs to be done to understand these and other associations between wealth inequality and increased HIV infection risk. To remove the structural violence that fuels this predisposition for the socioeconomically disadvantaged to be at higher risk of HIV infection, we need to understand these relationships as well as other factors which make up a complex ecosystem in which increased HIV infection prevalence occurs in order to know how to respond. "A comprehensive HIV response...[including] meaningful responses to the social, political, economic and environmental factors that affect HIV risk and vulnerability" is needed, argues Seeley *et al.* (1). In contrast, we cannot address what we do not understand. "The failure to contemplate [these] social and economic aspects of epidemics," writes Farmer, "stunts our understanding of them," and if we do not understand this HIV epidemic, we cannot eliminate it (Farmer, Partner 151).

In conclusion, the question I found myself confronted with when I started my work with AIDS patients in Central America, regarding whether the socioeconomically disadvantaged are at higher risk of HIV infection is answered in the affirmative. But this answer is complex, multi-faceted as to how and why the socioeconomically disadvantaged are at higher risk. Because of structural violence, in which lack of finances, gender inequality, lack of education, lack of job opportunities, physical violence and emotional abuse, as well as cultural normalization of transactional sex are included, socioeconomically disadvantaged populations are more likely to become infected with HIV. Wealth inequalities also relate to increased HIV infection rate, but the research is still completely new regarding these nuances. The

fact that this has not been previously disclosed (before 2017) to the public through the media channels in the United States or in other countries can be seen as reinforcing this structural violence, as what is not recognized cannot be fixed. The public cannot be moved to help with something they do not know about. The question still remains as to why the CDC is the only government organization within the United States sharing this with the public and still not in any mass media format.

For LoveAIDS, the research-based confirmation that socioeconomic disadvantage is associated with increased HIV infection rates serves as fuel in our work and will inform and guide our fieldwork strategies and approaches. Those of us who are Christ-followers know that God holds those who are suffering in a special place in His heart. When Jesus sees that Lazarus has died, He cries. He then is moved to action and brings Lazarus back to life (*New International Version Bilingual Bible*, John 11:33-44). Witnessing suffering and loss of life, Jesus is moved to action. The Apostle Paul explains in a simple phrase the driving force beneath Christian action, “The love of Christ compels us” (2 Cor. 5:14). Jesus’ love compels us to move and serve effectively, strategically, intelligently, and compassionately where there is a need.

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