Research Update

Research indicates that poverty can significantly contribute to poor health, and sustained economic hardship tends to result in reduced physical, psychological, and cognitive functioning. Poverty contributes to poor nutrition, chronic stress, and substance use, which increase susceptibility to a variety of infections, including HIV.

A lack of social support, unemployment, and the prevalence of poor health and psychological distress may contribute to the vulnerability of people living in poverty to engage in behaviors that put them at risk for HIV infection. One study found that communities located in zip codes with high rates of poverty were four times more likely to have high rates of HIV infection—defined as 3 percent or greater—than communities located in high-income zip codes.

People who live in poverty tend to have limited access to education and typically receive less schooling throughout their lives than people with greater financial resources, and, as a result, have fewer opportunities to improve their economic status.

Defining Poverty

According to federal guidelines, individuals with an annual income of $8,050 or lower and families of four with an annual income of $16,450 or lower live in poverty. Between 1994 and 1996, 17 percent of California’s population lived below the federal poverty level. This compares to a national average of 14 percent during this period.

Of the 37 million people living in poverty nationally in 1996, 10 million worked at some time during the year. These low-income wage earners, often referred to as “the working poor,” comprised 7 percent of the total labor force in 1996. Forty-three percent of poor people lived in inner cities, which tend to have high rates of unemployment, poverty, homelessness, residential overcrowding, environmental toxins, and related health risks, and substandard nutrition.

Poverty rates are typically higher in rural areas than in cities. In 1996, the poverty rate was 16 percent in rural areas and 13 percent in metropolitan areas. Rural areas accounted for 7.2 percent of all U.S. AIDS cases in 1997, an increase from 6.7 percent in 1996.

Poor women are at especially high risk for infection with HIV and other sexually transmitted diseases (STDs). For this reason, a majority of researchers studying...
Related Issue: Living with HIV and Poverty

Survival times of HIV-infected people living in poverty are generally shorter than for other people with HIV. A study examining the association between socioeconomic status and survival in HIV-infected gay men found that low-income men died earlier despite adjustment for age at infection, CD4+ cell count, use of HIV medications, and length of time since infection. The reasons for this were not entirely clear.27

Poor people often have limited or no access to health care and, therefore, many who are infected do not receive HIV treatments. In 1997, fewer than 20 percent of HIV-infected people in the United States had private health insurance, and roughly 29 percent had no insurance at all. About half were insured by Medicaid, Medi-Cal, or other government program, but Medicaid and Medi-Cal cover treatments only for people who are disabled by AIDS, a policy that does little to help people in earlier stages of infection from progressing to more critical conditions.28

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Treatment for HIV may not be a high priority for poor people because of other concerns that may have more immediate implications.29 Although combination drug therapies are too expensive for many people to afford, California residents may be eligible to receive payment for treatments through the AIDS Drug Assistance Program (ADAP), administered by the state’s Office of AIDS. The state also operates the Early Intervention Program (EIP), a free or low-cost program at 27 sites across California that offer services such as health care, case management, and education for people living with HIV.

Limited Access

Many poor people lack health insurance or are underinsured, and they are less likely than others to receive medical treatment. According to a San Francisco study of urban poor people living with HIV, only 28 percent of the sample received any antiviral drugs, compared to almost 90 percent of HIV-infected middle-class people. Furthermore, only 8 percent of the urban poor received protease inhibitors.29

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untreated, the presence of other afflictions, especially STDs, increases susceptibility to HIV infection. One study found that people without health insurance are more than twice as likely to be infected with HIV as those with private health insurance, and those who receive Medicaid, Medi-Cal, or other public assistance are more than three times as likely to be infected.5

In rural areas, access to resources such as health care and support services is often limited, especially for people living in poverty. To obtain these services, people in rural areas often must travel long distances, and many of the rural poor lack dependable transportation.16 In addition, residents of rural areas may not consider HIV to be a significant threat because of the relative scarcity of visible HIV prevention campaigns in these environments.9

Most HIV prevention education is inaccessible to poor people, and people who face multiple daily crises as a result of poverty, victimization, and physical and emotional distress are less likely to be receptive to prevention messages.17 HIV education programs, which generally draw heavily on middle-class values, often do not reach poor people or are incomprehensible to them. Homeless people are especially unlikely to hear prevention messages because of unstable conditions in their lives, unemployment, physical and mental illness, and low self-esteem.18

Research suggests that poor people are more likely than others to have misconceptions about HIV. One study found that many inner-city women do not know that natural-skin condoms are an inadequate barrier against HIV transmission, that many people with HIV look and feel healthy, and that there should be some space left at the tip of a condom when applying it. Many of these women also incorrectly believe that oil-based lotions are good lubricants for condoms and that condom use is painful for men.19 In a study of women living in low-income housing developments, 32 percent incorrectly believed that most people with HIV know of their infection, 41 percent believed that bathing after sex is an effective risk reduction measure, and 54 percent did not know that injection drug users are often infected with HIV.11

Lack of financial resources may also prevent people from acquiring condoms, lubricant, or clean injection drug using equipment, all of which can help prevent the transmission of HIV. In some areas, publicly funded programs provide free condoms, but the selection is often limited. If, for instance, the only available free condoms are not the type a person prefers or if lubricants are not available, he or she may forego condom use. Similarly, free condoms may not be available in different sizes, or they may come with lubricants to which a person is allergic.

Some injection drug users cannot afford to purchase new needles from pharmacies or on the “black market.” In areas with needle exchange programs, a person must first acquire a needle from some other source, and then exchange it. Some injection drug users may have a small number of needles and may, therefore, use and reuse these before they are able to exchange them. Research indicates that the main reason injection drug users share needles is not the symbolic significance of sharing, as once had been supposed, but the lack of access to clean needles.20

Other Priorities

People living in poverty tend to place a higher priority on issues related to daily survival than on long-term threats, including HIV. The risk of HIV infection is just one of many risks poor people face on a daily basis. Compared to the general population, poor women have higher rates of heart disease, diabetes, cancer, and infant mortality, and poor women in urban areas are especially susceptible to unplanned pregnancies and STDs.1

Women living in poverty may engage in unprotected sex because the consequences of not doing so, such as verbal or physical abuse, the loss of a partner, or childlessness, may be more immediate than the risk of HIV infection. In addition, these consequences often result in lowered self-esteem.21 Similarly, some poor people may find that the economic benefits of sex work or “survival sex”—the exchange of sex for anything needed—outweigh the risks of infection.22 In one study of homeless
people, 25 percent of men and 19 percent of women reported engaging in survival sex during the prior three months.\textsuperscript{13}

Some poor people are economically dependent on their sex partners. This dependence can affect a person’s ability to negotiate to engage only in safer sex, and, for those who inject drugs, to implement safer injection practices.\textsuperscript{3} This is true even in situations in which a partner’s economic contribution is not the recipient’s primary financial support. The benefit of engaging in unprotected sex and the immediate financial support that accompanies it is often more compelling than the long-term risk of HIV infection and the conflicts that may result from attempting to negotiate safer sex.\textsuperscript{22}

People who are financially dependent on partners often agree to engage in unprotected sex when, in fact, they would rather use condoms. They may consider such an agreement to be “mutual” as a way to protect themselves from confronting their own emotional and economic dependence on a partner as well as the feelings of powerless this might involve.\textsuperscript{21}

**Substance Use**

HIV prevention can be a low priority for people who abuse substances, many of whom live in poverty. Because of the many factors causing stress in their lives, poor people are susceptible to substance use. In addition, research indicates that poor people are more likely than others to have injection drug users as sex partners.\textsuperscript{23}

The combination of poverty and drug addiction can lead people to exchange sex for money or drugs. People who trade sex for drugs are often homeless and desperate,\textsuperscript{24} and because they have little power to negotiate condom use, these sexual encounters may be unprotected.

Injection drug users who are homeless are more likely than those with homes to use drugs with greater frequency and to have sex with multiple partners, and they are less likely to use new needles or to clean needles.\textsuperscript{18} Because some people who inject drugs consider sharing injection equipment to be an important activity for emotional bonding, sharing needles can establish a sense of security for people with limited financial resources by helping them maintain relationships with sex partners or other people who can provide support.\textsuperscript{3}

In a study of impoverished female injection drug users and partners of injection drug users, more than half reported sharing drug-injection equipment, and only about half of these women attempted to clean needles they shared. Virtually all participants in the study were sexually active, and more than 80 percent engaged in unprotected sex.\textsuperscript{18} In a series of interviews with sexual partners of male injection drug users—many of whom also abused substances—82 percent said they experienced depression and anxiety about lack of control over aspects of their lives such as locating a place to live, providing a better life for their children, and finding employment.\textsuperscript{23}

In one study, impoverished women whose partners were injection drug users or who were uncertain about their partner’s drug use reported lower levels of support than women who believed their partners did not inject drugs.\textsuperscript{3}

**Unstable Social Support Networks**

Positive social support can help people utilize their psychological resources and manage their emotional burdens while providing the money, materials, skills, and guidance they may need to handle a variety of challenging situations.\textsuperscript{4} Establishing and maintaining social support networks can be difficult—or sometimes impossible—in areas with high rates of poverty, especially in urban settings.\textsuperscript{25}

Families may become displaced or be forced to move because of redevelopment projects or financial difficulties, and urban decay may fragment communities.\textsuperscript{25} Low vacancy rates and competitive housing markets in some parts of California contribute to residential transience, further contributing to feelings of instability.\textsuperscript{26} These types of disruptions within a community often weaken formal and informal mechanisms of social support and limit economic opportunities. Environments devoid of social support tend to encourage substance abuse, increase the likelihood of sexual contacts with multiple partners, and lead to decreased access to services and increased social discrimination, all of which may contribute to HIV transmission.\textsuperscript{25}

Lack of positive social support can also cause depression and lead to feelings of low self-esteem, both of which can increase the likelihood of engaging in high-risk behavior. Researchers have found that availability, use, and effectiveness of social support tends to raise self-esteem among impoverished women while the lack of adequate social support increases the potential for distress and depression.\textsuperscript{4}

People who face multiple daily crises as a result of poverty are less likely to be receptive to prevention messages.
Implications for Counseling

A client’s economic status can have a variety of effects on the counseling session. It can diminish the sense of control a client has in maintaining or changing his or her life, determine the number and kinds of options for behavioral change a client perceives, and undermine priorities related to HIV prevention.

Because definitions and perceptions of poverty vary widely among people, it is important for counselors to avoid projecting their values and beliefs onto clients. Counselors must also be careful not to apply generalizations about experiences of being poor to any particular client. The effects of poverty on someone whose family has lived with it for generations may be very different from its effects on a person who has recently become poor.

During an HIV test counseling session, it is important to assess how the client perceives the effects of economic issues on his or her life, particularly related to HIV infection risks. For instance, a client may say that to obtain money or drugs, he or she must engage in sex with partners who refuse to use condoms. Clients may describe less obvious, but still important, ways that financial issues affect risk behaviors.

Having Control and Seeing Options

Poverty can involve complex and overwhelming challenges. In addition to the fact that a client may not be able to afford to see a health care provider, he or she may risk losing a job by missing work because of an appointment. A counselor can explore the extent of the challenges a client perceives, acknowledge the significance of each, and then help develop ways to respond to them.

Overcoming challenges may require time and patience, and it may cause a client to feel overwhelmed. For example, a poor person may be unable to imagine making changes in or ending an economically dependent relationship in which he or she is verbally abused and feels forced to engage in unprotected sex. Helping this client become aware of steps to reduce harm can lead him or her to recognize—perhaps for the first time—further actions that might eventually lead to ending the verbal abuse and unprotected sex or to helping him or her leave the relationship.

When a client expresses having little control as a result of poverty and feels dependent on others, such as the government, an employer, or “the system,” ask the client to identify times when he or she has taken control of a situation and how this has worked. Reflect this success back to the client. If the client can accept that he or she has done something well, it may signal a shift in his or her attitude about the possibility of making further positive changes.

As a result of receiving economic support from a partner, clients may feel their choices are limited or non-existent. Validate such feelings while helping to objectively examine the benefits and drawbacks of continuing to accept financial support from someone who, for example, demands unsafe sex. Assess the client’s history of relationships and economic dependence, how the client feels about economic independence and dependence, and the value the client places upon the relationship.

Many Needs

Clients with limited economic resources often have many needs, but within the limited role of the HIV counseling session, it is important to focus on helping clients reduce HIV risk. Both counselors and clients need to know that the test counseling session is not an environment for resolving all of a client’s challenges related to being poor; it is a place where clients may get help in dealing with HIV infection risks, receiving test results and related support, and acquiring referrals for further services related to HIV infection and other areas of a client’s life.

If the client’s focus during a session is on issues other than HIV risk, the counselor can provide appropriate linkage. Resources outside the test counseling session are better places to discuss a broad range of concerns, but be aware that other priorities in a poor person’s life may take precedence over HIV risk reduction and following up on referrals. Acknowledge the challenges these dilemmas may pose, and explore ways the client might address HIV risks while also addressing other concerns. It may be useful to help clients prioritize their personal needs while stressing that they have control over these decisions.

A case manager may be a good source of information about services, how to access such services, and how to prioritize needs. Case management may be available at local public health or mental health clinics as well as at community-based agencies. Contact such agencies and speak to case managers to learn more about the services they provide and their availability.

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A Counselor’s Perspective

“When I counsel clients who are poor, I can’t help wanting to solve their financial problems, but the best thing to do remain focused on HIV risk and provide referrals for linkage for their other needs.”
Some people living in poverty are eligible for social service assistance such as Medi-Cal; others have incomes that are too high to qualify for Medi-Cal but cannot afford private health insurance. As a result, people without health insurance or those who are underinsured may not seek preventative care and health education.

When clients describe obstacles to keeping appointments, such as lack of transportation or childcare services, help identify specific and concrete solutions to these problems. At the same time, empathize with and validate challenges that may be the result of unstable living situations and related anxiety, powerlessness, lowered self-esteem, or other issues.

Poverty and Addiction

The limited options that result from the combination of poverty and addiction can be particularly damaging to the individual and to his or her family. Clients who are family members of people with addictions face greater risk of adverse health in general and HIV risk in particular. When counseling someone who is a family member, sex partner, or close friend of someone with a drug addiction, keep the focus of the session on the client and ways he or she can gain support.

In addition to the consequences of addiction, the effects of alcohol and other drugs can lead to volatile emotions and behavior that can further fuel the cycle of using and abusing substances, sex, people, and power. The counselor should assess how the client—whether this is the substance user or his or her partner, family member, or friend—views the emotional and behavioral effects of substance use and its relevance to HIV risk. A counselor can serve as a mirror to help clients assess how addiction prevents people from meeting basic needs. Counselors can point out the contradiction that may emerge between what the client “gets” and what he or she “loses” in continuing a pattern of substance abuse.

Internalized Shame

In addition to its tangible disadvantages, poverty is widely stigmatized by society. People living in

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poverty often internalize society’s expectations and negative judgments as shame. Poor people may view themselves as inferior rather than as honorably struggling to survive. Internalized shame may cause people to feel unworthy of protecting themselves, which in turn may lead them to engage in risk behaviors and to feel hopeless about the future.

It can be important for counselors to assess if a client who is poor has internalized shame. Explore areas of life in which the client finds or has found value in him or herself. Reinforce the client’s ability to take care of him or herself, and assess the extent to which the client might imagine the possibility of changing self-perceptions. Point out that, while societal messages can have an enormous impact on how a person regards him or herself, people can—often with support—deal with destructive societal messages. In addition, evaluate the client’s sense of hopefulness about the future. Referrals that can help a client alleviate current life stress or create a basis for optimism about the future can be especially important.

Internalized feelings of shame can erode self-confidence, and a client may not recognize his or her ability to take steps to reduce risks. Regardless of whether or not a client knows how to use a condom, for instance, this person may not feel capable of doing so.

Testing Positive
For clients who test positive, provide referrals to a local site of the state’s Early Intervention Program (EIP), a free or low-cost service. For more information, call (916) 327-6784.

A person with HIV who has limited financial resources may be eligible for other free or low-cost services. Such services, often in public clinics, may have drawbacks, such as the possibility of having to wait extended periods to see a physician. When providing referrals to resources, it is important to know if a client has used similar services in the past and what these experiences were like. Be aware that clients who live in poverty may be reluctant to seek services not only because of prior negative experiences, but also because of the challenges involved in accessing services. Validate a client’s feelings, and explore factors that might prevent the client from utilizing resources following the counseling session.

While emphasizing the importance of seeking services, do not insist that a client accept or use a resource, even in the face of possible adverse health effects. Also, be careful not to present resources as something the client is “lucky to have.” The client may feel otherwise.
Test Yourself

Review Questions

1. True or False: Research indicates that symbolic significance is the main reason injection drug users share equipment.
2. Poverty contributes to which of the following? a) poor nutrition; b) chronic stress; c) substance use; d) all of the above.
3. What percentage of people in California lived in below the federal poverty level between 1994 and 1996? a) 5 percent; b) 17 percent; c) 35 percent; d) 70 percent.
4. True or False: Poor people are as likely to be receptive to traditional prevention education as other people.
5. True or False: Research indicates that people without health insurance are more than twice as likely to be infected with HIV than people with private health insurance.
6. True or False: HIV prevention is a high priority for all people regardless of their financial standing.
7. True or False: Urban poverty rates are generally much higher than rural poverty rates in the United States.
8. Impoverished environments devoid of social support tend to increase the likelihood of which of the following HIV risk factors? a) substance use; b) sexual contacts with multiple partners; c) limited access to services; d) all of the above.

Discussion Questions

1. How can counselors respond when clients say they are not interested in receiving services from publicly funded agencies because they have been treated poorly by such agencies in the past?
2. How can a counselor assess if avoiding HIV infection is a relatively low priority given economic and other challenges a person faces? In such cases, how can counselors help clients recognize that reducing HIV risks is important?
3. How can counselors respond to clients who say they will not be able to follow-up on referral resources because they lack transportation or cannot afford to take time off from a job to receive services?
4. Preconceived notions about poverty and about clients who are economically disadvantaged might interfere with a counselor’s ability to be effective. How can counselors assess the extent to which they may have such judgments? How can counselors address these issues if they exist?

Answers to Test Yourself

1. False. The main reason for sharing is the lack of access to clean needles.
2. d.
3. b.
4. False. HIV education programs, which generally draw heavily on middle-class values, often do not reach poor people or fail to address issues unique to their plight.
5. True.
6. False. For poor people, priorities relating to daily survival often take precedence over long-term threats such as HIV infection.
7. False. In 1996, the rural poverty rate in the United States was 16 percent, and the urban poverty rate was 13 percent.
8. d.
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