Socio-economic Impact of HIV/AIDS Deaths on Households in India and Coping Strategies: A Study of Well Being of Children

By

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Importance of the problem and objectives: Over the years, there has been growing concern about the HIV epidemic in India and its impact on individuals, families and society as a whole. It has been argued that the impact of epidemic so far has not been serious enough to make any significant dent in the socio-economic and demographic scenario of the country. Various estimates of AIDS related mortality however seem to suggest that the situation is more serious than what meets the eye. At the micro level, a few recent studies have shown a noticeable drop in household income, an increase in debt and mortgaging, the continued presence of older household members in the labour market, effects on the form and patterns of employment of care givers, significant hardship especially in treatment seeking, and also widespread discrimination. However, there is a dearth of studies to examine the role of the family in mitigating the negative impact on children. Very little is known about the role of the extended family in relation to addressing the health and educational needs of children. It is not known how relatives would react to adopting orphans and meeting their needs as if they were their own children. Therefore, this study makes an attempt to assess the socio-economic impact of adult deaths due to AIDS on households and their coping strategies, especially for the well being of children.

Data and Study Design: The basic data used in this paper has been taken from Sangli district (Maharashtra), which has been recognized as one of the three most HIV affected districts in India. Among various reasons assumed to be responsible for the growing epidemic in Sangli, one prominent reason is the rapid social and economic growth that the district has witnessed in recent years, where commercial production of sugarcane has generated a large amount of money in a short period of time. Coupled with this is the fact that very close to the boundaries of Sangli district is the area in Karnataka where the 'Devdasi' system is highly prevalent. The system, which, in some form legitimizes young girls getting initiated into the sex trade. A major highway also cut across the district and is considered to be one of the major contributors towards the spread of the epidemic.

The data for this study comes from interviews that were carried out in the households that were affected by HIV/AIDS related deaths that had occurred during the reference period of two years (during July 2000 to June 2002). This information, was also compared with the interviews that were carried out in households where there had been deaths but not due to AIDS. The overall sample for the survey included 300 households. For the comparability of results, all households were sampled from rural and urban areas according to the distribution of total registered cases of AIDS deaths. The sample was subdivided into three sub-samples of 100 households, each drawn from populations with broadly similar socio-economic characteristics but differing in terms of the presence/absence of HIV/AIDS or deaths related to HIV/AIDS. Concretely, the first sub sample of 100 households, had an active adult member(s) diagnosed to have experienced an AIDS death, the second sub sample of 100 households had adult

member(s) diagnosed to have experienced a non-AIDS death (due to an illness, not an accident) and the third sub sample of 100 households, had not experienced any death of an active adult member. In addition, information was also collected from a number of stakeholders in order to assess their perception about the impact of AIDS and the efforts that are needed to mitigate the impact at different levels. The stakeholders, who were interviewed in Sangli included local political leaders, medical practitioners, teachers, and out reach workers and counselors involved in educational and rural developmental efforts. Adequate care was taken to maintain the confidentiality at all levels of data collection.

Findings on Well-Being of children: Seven indicators were used to assess the well-being of children(up to the age of 15 years) across the three types of death status households (HIV/AIDS death, non-HIV/AIDS death and no-death) in the study. There were a total of 700 children among surveyed households, of which 256 children were in the HIV/AIDS death households, 214 children were in the non-HIV/AIDS death households and 230 children were in the households, which did not experience any adult death during the reference period. However, the proportion of orphans (the children of age 15 or less who lost their mothers or both parents) was extremely high in HIV/AIDS households. Although, there was no difference in the extent of morbidity among children from the three types of households, the relative risk of child deprivation was higher in households with HIV/AIDS related deaths. More than a quarter of the children in HIV/AIDS death households reportedly could not be taken to a health center when in need of essential health care services. A much larger proportion of children from illiterate households, low

income households and households with no assets could not be taken to a health center in case of need. This was true in all the three types of death status households. The differences however, across social and economic status and the ability to reach the health care center were sharper in case of HIV/AIDS death households than in other types. Overall, the percentage of children who had to work did not vary much in three types of the death status households. However, within the HIV/AIDS death households, a higher proportion of children from illiterate and low-income households were reported to be working during the period of observation. The low proportion of children being withdrawn from schools in the case of all three types of households cannot be attributed to HIV/AIDS death status of an adult. A much higher proportion of HIV/AIDS death households reported of one or the other kinds of discrimination against children of their households than the other types of death households.

Findings on Coping Strategies: Twelve indicators were used to assess the coping strategies adopted by the households to mitigate the impact of an adult death. Among the HIV/AIDS death households the percentage of the households, which reported to have reduced investments was 88 percent among high-income group, followed by 57 percent in middle-income group and 41 percent in low-income group. On the other hand, a higher proportion of low-income HIV/AIDS death households reported to have reduced expenditure on consumer durables. It was found that a larger proportion of HIV/AIDS death households had reportedly allocated a large proportion of daily time (34 percent) to child care compared to no-death households (17percent) and non-HIV/AIDS death households (25 percent). More than three-quarters of the HIV/AIDS death households

had increased the average daily time for productive activities. Average daily time spent on productive activities was more among the higher educated households in the HIV/AIDS deaths category. At the same time, a larger proportion of higher educated households among HIV/AIDS death category had reportedly reduced average daily time on non-productive family activities.

Conclusions and Recommendations :A significant negative impact on the economy of households where an active adult had died due to HIV/AIDS is clearly evident from the present comparative analysis. Households with HIV/AIDS deaths had reported reduced savings during the reference period of, reduced expenditures on consumer durables, and had sold assets in order to raise or supplement income. On the social front, they had experienced discriminations and a few of them have had to send their children away to distant relatives, and withdraw children from school.

Adult deaths due to HIV/AIDS has also impacted negatively on children's access both health and education. Discrimination against children in schools and in the community was clearly articulated. While the members of the extended families provide orphans with shelter, it is obvious that several of these children do not receive continued education and health care when needed. In fact a larger number of these children had joined the labour force.

Yet, another finding that comes out clearly from the present analysis is that the impact on both households and children is much more negative in case of those households which are socially and economically disadvantaged. A much larger proportion of children from illiterate households, low income households and households with no assets could not be taken to a health center in case of need. This was true in all the three types of death status households. The differences however, across social and economic status and the ability to reach the health care center were sharper in case of HIV/AIDS death households than in other types. A higher proportion of better educated households however reported perceived discrimination against children.

This study clearly points out towards a need of a comprehensive response to HIV/AIDS which includes efforts to reduce stigma and discrimination at all levels; developing a supportive network system for women and orphans; and more specifically preparing families to provide for children in the eventuality of death of both the parents or one parent.

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