International Journal of Research (IJR)

e-ISSN: 2348-6848
p-ISSN: 2348-795X
Vol. 10 Issue 03
March 2023

Changes in Household Structure and Consumption Patterns among Households with HIV-positive members in Uttar Dinajpur district, West Bengal

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Abstract: The HIV/AIDS epidemic threatens the social structure of the most affected countries. Of all the units affected by the HIV/AIDS epidemic, individuals, households and families are the most affected. Evidence shows that the AIDS epidemic has serious effects on households. In addition to the social and psychological consequences, HIV infection poses a serious threat to the household economy. The HIV/AIDS epidemic can lead to a change in the composition of households, with the gradual disappearance of the parental generation and children cared for by grandparents and other relatives. In some cases, older children may act as surrogate parents for their younger siblings, leading to an increase in single-generation households headed by older children. The composition of many households is complex and changes over time. It is even more complicated when the head of the household, usually a man, becomes infected with HIV, becomes ill and in many cases dies. This also leads to shifting dynamics within households. There are a number of ways in which HIV and AIDS can affect the level and pattern of household consumption and ultimately have a detrimental impact on individual sectors. The analysis shows that households with HIV members spend a large part of their monthly consumption expenditure on medicines. Almost 12.53 percent of the total consumption expenditure of households with HIV is devoted to medical expenses in the post-symptomatic stage which is much higher than the expenditure on Education. This confirms the general idea in the literature that HIV and AIDS can affect children's education. As nutritious and balanced foods are important to ensure longer and healthier lives for people living with HIV/AIDS (PLHA), it is important to determine whether these households spend less on food, or not, even in absolute terms, in the post-symptomatic stage. The policy response must include an appropriate balance between targeted health insurance interventions and social security systems to protect households with HIV+ members from impoverishment due to HIV-related illnesses.

Keywords: HIV/AIDS, consumption pattern, HIV-infected families, economic impoverishment

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Received: *22 Feb. 2023*
Revised: *13 March 2023*
Final Accepted for publication: *23 March 2023*
 DOI : https://doi.org/ 10.5281/zenodo.7823818

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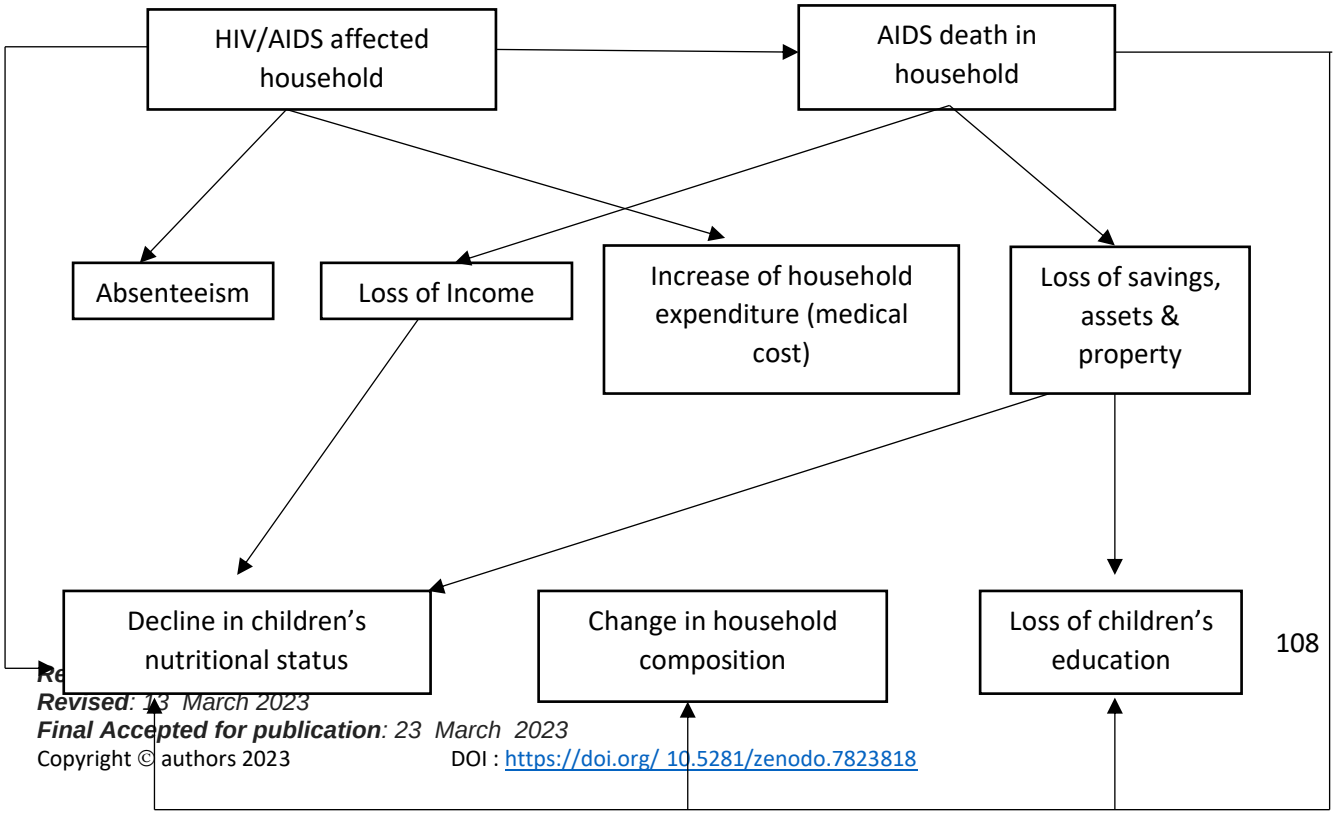
1. Introduction:

According to the latest available estimates, about 2.5 million people are currently living with HIV or AIDS in India, corresponding to an HIV prevalence rate of 0.36 percent in the population aged 15–49 years (IIPS 2007). The HIV/AIDS epidemic threatens the social structure of the most affected countries. Of all the units affected by the HIV/AIDS epidemic, individuals, households, and families are the most affected. Evidence shows that the AIDS epidemic has serious effects on households. The impact on the household begins as soon as a member suffers from HIV-related illnesses. In addition to social and psychological consequences, three types of economic impacts can be distinguished. The first is the loss of income of a family member, especially if he is the breadwinner. The second impact is an increase in household expenditure to cover the cost of treatment. A third impact is the indirect costs resulting from family members being absent from work or school to care for an AIDS patient.

Figure 1 illustrates the processes by which HIV-related illness or the death of one of its members from AIDS affects the household economically and socially:

Fig: 1 Conceptual Framework of the Socio-Economic Impact of the HIV/AIDS epidemic on households



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Source: "Impact of AIDS", United Nations Secretariat, Population Division

In addition to the economic impact that the HIV/AIDS epidemic can have on households and families, it can also have social impacts. The household is the first unit of socialization and can undergo enormous changes. The death of an adult may lead to dislocation or dissolution of the household, and children may be sent to live with relatives. Some children may drop out of school not only because of financial constraints but also because no one is there to look after them. The number of female-headed impoverished households increases when the male breadwinner either suffers or dies of AIDS.

Several studies have been conducted to find out the impacts of people living with HIV, but no studies have been reported in the Uttar Dinajpur district of West Bengal. The household impact study below was conducted to examine changes in household composition and the social consequences.

2. Sample size, sampling process, and data collection

This is a study that used a quantitative approach to collect information. A personal interview was conducted to obtain information from respondents. A questionnaire was used to collect data from the respondents. A total of 93 respondents were approached to participate in the survey (which included about 50 households from different blocks of the district). The source of information for the survey was people living with HIV/AIDS (PLHA) aged 18 and above who had been diagnosed as HIV positive more than a month or year before the survey. A purposive sampling method was used to select participants for easy recruitment and active participation of respondents in the research.

3. Results and discussion

3.1. Profile of the respondents:

Out of the total 93 respondents, 47 percent were men and 53 percent were women. Of these, 69 percent were between the ages of 25 and 40. About 60.2 percent of respondents were Muslim. Almost 37 percent of women and 32 percent of men were illiterate respondents. 72 percent of respondents used Anti-Retroviral Therapy (ART).

Received: *22 Feb. 2023*
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Table-1: socio-economic characteristics of the respondent

Characteristics	No. of Respondents
Gender	
Male	44 (47)
Female	49 (53)
Age Group of Respondent	
18-25	29 (31)
26-40	64 (69)
Educational Status	
Illiterate	32 (34)
Primary	33 (36)
Secondary	21 (23)
Higher-Secondary	7 (8)
Main Occupation	
Non-Agricultural wage Labour	23 (25)
Truck driver	7 (7)
Agricultural Wage Labour	13 (14)
Business	8 (9)
Cultivator	1 (1)
Local Driver	7 (8)
Housewife	19 (20)
Housemaid	8 (9)
Service	2 (2)
Not able to work	5 (5)
Having ART or NOT	
Having ART	67 (72)
Not Having ART	26 (28)

Source: Field data (figure in parenthesis indicates percentage)

Income of Households (Annual Income): Total respondent HHs- 50	
Up to Rs. 24000	19 (38)
Rs. 24001-Rs. 48000	19 (38)
Rs. 48001- Rs. 72000	7 (14)
Rs. 72000 and above	5 (10)

Source: Field data (figure in parenthesis indicates percentage)

3.2 Change in the composition and structure of households as a result of the disease:

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The purpose of this section is to analyze whether the composition of the household has changed after one or more household members became ill. It compares household composition in two phases: pre- and post-symptomatic.

The "pre-symptomatic" phase refers to the period when all members of a given household are from medically free health problems and are therefore able to function well. The "post symptomatic" phase can be divided into two: pre-and post-diagnosis, in each of which one or more household members experienced HIV-related symptoms, although they were unaware of their positive status until properly diagnosed. The loss of a breadwinner obviously tends to reduce the economic viability of the household that remains, and some households faced with this situation may disintegrate, with members dispersing to the households of relatives.

Table 2(A): HIV and AIDS affected households' socio-demographic characteristics:

Household Composition	**Pre-Symptomatic (%)**		**Post-Symptomatic (%)**	
	Male	**Female**	**Male**	**Female**
Live with Parents/in-laws	36 (82)	41(84)	2(5)	4(8)
Nuclear	8(18)	8(16)	42(95)	45(92)

Source: Field Data (figure in parenthesis indicates percentage)

Table 2(B): Composition of Households

Pre-Symptomatic Phase	
Composition of Nuclear family	composed of one to three children, ranging in age from 6 to 14 years.
Composition of Parental family	composed of one or two children under 12

Post Symptomatic Phase	
Composition	The number of single-parent households had increased from **one to four**

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	Four (4) women reported that their husbands had died from HIV/AIDS-related illnesses or that they had separated, leaving them with at least one or two dependents who had gone to live in parental households.

Based on data from all 93 participants, during the pre-symptomatic phase, 16 lived in nuclear households (one or two parents with children), almost composed of two adults with one to three children aged 6 to 14 years. Of these 16 nuclear households, 14 had children under the age of 14 who were dependent on their parents, while another five contained at least one child aged 14+ who worked part-time (more common for sons) or did housework. and acted as caregivers to their parents (more common in daughters).

During the post-diagnosis phase (at the time of the interviews), the majority of respondents who had previously lived with their parents/in-laws had moved into a nuclear family (87 out of 93). However, the number of single-parent households increased from one to four, with four women reporting that their husbands had died of HIV/AIDS-related illnesses or had separated, leaving at least one dependent aged 12 or younger.

In addition, four participants who lived with their in-laws during the pre-symptomatic phase returned to their own parents after their husbands died of an HIV-related illness. Only 2 (two) men continued to live there with their parents after being diagnosed with HIV, and a total of 6 respondents reported living with their paternal families at the post-diagnosis stage, four women and two men.

During the post-diagnosis phase, 10 women reported becoming head of their household, with four becoming single parents, four heading a household in which their husband was still alive but very ill, and two continuing to live with their parents after their death. Their spouse, but not as a dependent. In addition, two women who became single parents went to live in paternal households where their mothers were already head of households, the women became heads of their changed households, either because they were widowed or separated from their husbands and chose to live alone or only with their children under 14 years of age. (See Fig. 2(a) and (b)).

Fig: 2(a) and (b): Household Composition (pre- and post-diagnosis phase)

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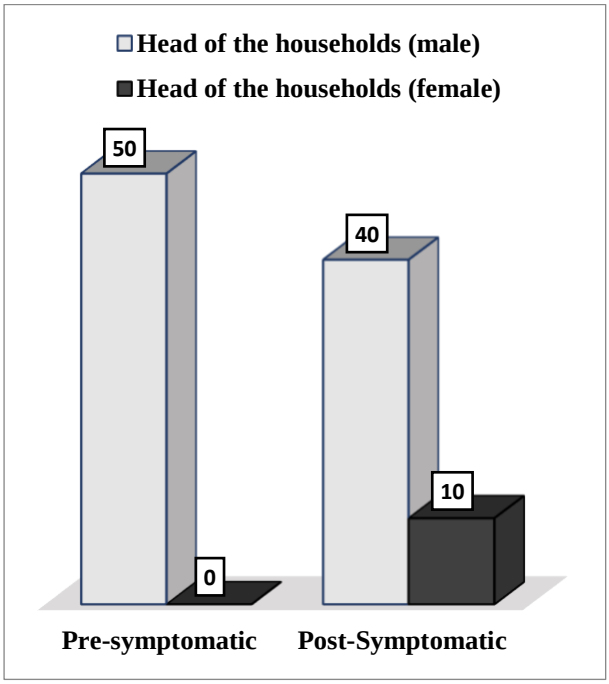

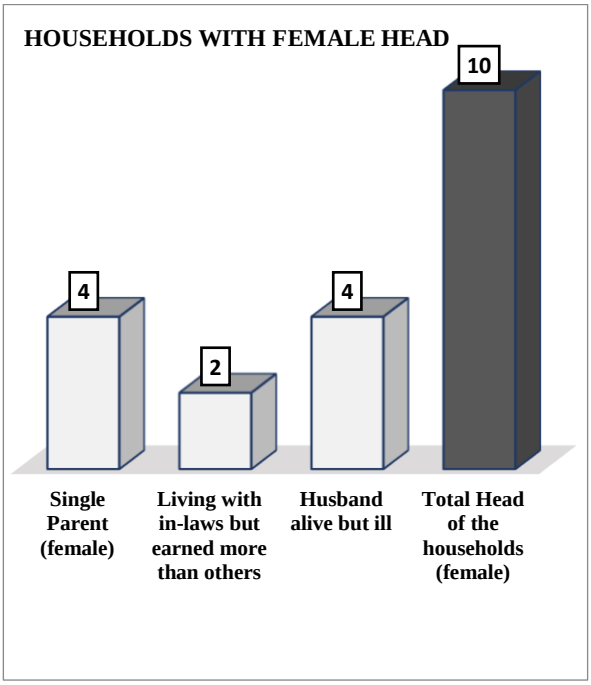

The composition of many households is complex and changes over time. It is even more complicated when the head of the household, usually a man, becomes infected with HIV, becomes ill and in many cases dies. This also leads to shifting dynamics within households.

The power to mobilize resources usually rests in the hands of the head of the household. In this research, it was found that the identity of the "household head" varied. Participants generally considered themselves head of their household when they were the sole earner or earned more than any other household member. Some (especially women) became the head of their household when their husbands left them after being diagnosed with HIV. However, in some cases, the participant had a dominant presence in the household, leading other members to view them as the head. Examples of each are given below:

A 39-year-old Hindu married man diagnosed in 2007 lived with his wife, daughter, mother, and younger brother in a house given to his mother after his father died. His mother and younger brother lived off his father's pension. When asked who, he considers to be the head of his household, he replied, "…my wife works as a field worker in UDP+ and earns Rs. 5000 per month. The Money I earn Rs.1200, is not enough to keep our household running. My wife is the head of the household, she earns more than me and supports us. ..." thus, he considered his wife as the head of the household because she was the main earner, even though he earned some money and his mother received a pension.

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Overall, changing household power dynamics, manifested among other things in the identity of the head, would be expected to influence the mobilization and use of material and social resources, but little additional information is available because family members other than the research respondents were not interviewed. This chapter will therefore be based on an analysis of the ways in which livelihoods have changed based on the statements of the interviewed participants – all of whom were HIV positive but had different positions in their households.

3.3 Change in household consumption pattern due to illness:

There are a number of ways in which HIV and AIDS can affect the level and pattern of household consumption and ultimately have a detrimental impact on individual sectors. The analysis shows that households with HIV members spend a large part of their monthly consumption expenditure on medicines. Children's education expenses make up a smaller part of the total monthly expenses. A high share of medical expenses affects the economic situation of households with HIV members.

Table 3: Share of expenditure on some major items:

Items	Pre-Symptomatic phase (%)	Post-Symptomatic phase (%)
Cereals	15.35	12.66
Pulses	2.62	2.43
Other Food	31.77	29.66
Total Food	***49.74***	***44.75***
Fuel and Light	8.15	7.76
House Rent	1.34	2.63
Clothing	5.69	4.84
Education for Children	3.86	3.05
Medical	3.58	12.53
Durables	2.22	1.32
Other Non-Food	25.42	23.12
Total Non-Food	***50.26***	***55.25***

Source: Field data

In the sample, almost 12.53 percent of the total consumption expenditure of households with HIV is devoted to medical expenses in the post-symptomatic stage. Regarding children's education, it can be seen that HIV households spend a smaller part of their total consumption expenditure on education

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in the post-symptomatic stage. This confirms the general idea in the literature that HIV and AIDS can affect children's education. As nutritious and balanced foods are important to ensure longer and healthier lives for people living with HIV/AIDS (PLHA), it is important to determine whether these households spend less on food, even in absolute terms, in the post-symptomatic stage.

For example, the average direct cost to an HIV-affected household at the last visit to a treatment center was found to be Rs 609, which was 20.3% of the average household income (Rs 3,000). The average treatment cost (cost of drugs in case of opportunistic infection) for HIV/AIDS at the last visit was Rs 372, which was 61% of the average direct cost at the last visit. Transportation costs accounted for 17% of average direct costs. Patient food costs were close to about 10% of average direct costs. Thus, the total cost of treatment and access of PLHIV at the last visit was Rs 535, which is 87.8% of the average direct cost of the last visit. The cost of accompanying persons was 12.2% of the average direct cost (Rs. 74).

The study found that households with HIV+ members spent a large proportion of their total expenditure on food and medical care. It highlights their economic situation and draws attention to impoverishment due to health expenditure. Children's education accounts for an inadequate share of total consumption expenditure in households with HIV+ members, indicating how HIV/AIDS affects children's education and hinders the formation of future human capital (Pradhan et al., 2006).

4. Conclusion:

The economic burden of HIV-related diseases at the household level is embodied in health expenditure, leading to increased poverty among households with HIV+ members. Illness-related healthcare costs disproportionately affect households below the poverty line (Kamolratanakul et al., 1999). The most severe impact of HIV/AIDS was felt at the household level. The illness or death of a household member means a reduction or loss of household income, a drop in productivity, and a huge loss of household savings due to medical, care, and funeral costs. The impact of HIV/AIDS is usually great on poor households, which are least prepared to deal with such problems. By its very nature, AIDS can kill more than one family member, as spouses or partners and children can also be infected, adding to the financial and psychological burden on households. The overall well-being of surviving household members declines due to economic hardship, illness, and grief over the loss of a relative. In some cases, the family breakdowns.

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Thus, the economic burden of disease associated with HIV infection is a serious concern for health policymakers. In the absence of social support programs and health insurance for people living with HIV, this is enough to push some households below the poverty line. Households with HIV+ members need much more support from the government in terms of access and affordability of health care to avoid economic disaster. The policy response must include an appropriate balance between targeted health insurance interventions and social security systems to protect households with HIV+ members from impoverishment due to HIV-related illnesses.

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Received: *22 Feb. 2023*
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