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Socio-Economic aspects of HIV/AIDS in Kashmir Valley

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ABSTRACT

This research uses an economic model of risky sexual behaviour to investigate the correlation between different socio-economic attributes and HIV prevalence at district-level in Kashmir. The empirical findings show that district HIV prevalence is positively correlated to expenditure, education and the proportion of female headed households and negatively correlated to the proportion of women and their fertility. This state level HIV prevention proposes attempts to change the norms, attitudes, collective self-efficacy and risk behaviour practices in populations vulnerable to AIDS are essential for various reasons. People contract HIV as a result of sexual and drug abuse activities that take place in their day-to-day lives in the state. According to the empirical literature little attention has been given to the socio-economic context in which people live when it comes to understanding the disease. This will be preceded by a discussion of the various state engagement theories and frameworks in the context of HIV and AIDS prevention, care and support, and impact mitigation. A subsequent section will focus on the socio-economic context in relation to cultural movements and gender dynamics. The research paper will conclude with a comparison of the state engagement and socio- economic attributes and their suitability to the HIV and AIDS response among the Kashmiri people.

Keywords: *HIV-AIDS, Attitude, Stigma, Kashmir, Socio-Economic Factors.*

HIV/AIDS is one of the largest obstacles to development in many countries and is destroying the lives and livelihoods of millions of people around the world. Nearly 95 percent of all infected individuals are found in developing countries and the situation is especially problematic in Asia. India has the third largest number of people living with HIV in the world — 2.1 million at the end of 2013 — and accounts for about 4 out of 10 people living with HIV in the region. HIV is a sociocultural and socioeconomic disease in India, and the paradigm of its infection and spread particularly within the states is a reflection of the sociocultural and socioeconomic profile of the people. The factors have overlapping or interconnected relationships – none excludes the other in importance or in enhancing HIV spread and progression. These factors are further explained in the preceding discusses on the sociocultural studies. The population became aware of HIV/AIDS

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either from the mass media (particularly radio and television) or as usual, rumours and peer group conversations.

The presence, in the communities, of known cases of those infected with HIV/AIDS was source of information with gossips aiding in the dissemination. That none of the respondents or discussants in the BSS indicated knowledge of any HIV/AIDS victim that had been cured underscored their concept of incurability of the disease. Despite the apparent incurability of the disease, for about 70% of the single women getting pregnant was still the major concern in unprotected sex rather than HIV infection. In fact, this attitude of "one must die of something someday" is reminiscent of one caught between "the devil and the blue sea", death by hunger and death by HIV/AIDS. It further shows the societal concern regarding extramarital pregnancy – the stigma of getting an illegitimate child is paramount to the concern of contracting an infectious disease.

OBJECTIVE

The objective of this study is to assess the socio-economic consequences of HIV/AIDS within the family.

METHODOLOGY

Different studies employ different methods to work out of the trials to get the desired objectives, but when it comes the turn of some stigmatized issues like prostitution, white slavery, lesbianism or gaiety, there always arise some ubiquitous issues. The reason behind may be that the things are linked with unethical or immoral or sometimes non-religious constructs. Same is the case with HIV/AIDS, but the difference lies in the fact that after all AIDS is a disease which has to be understood, tackled and exterminated from the life of a liver. The AIDS epidemic has posed unique challenges to the medical sciences and also for the analysis of data new statistical methods have been employed to handle such problems as the tracking and prediction of number of AIDS cases and the assessments to reach out the HIV patients and the analysis and monitoring of clinical trials with censored and missing data. So, the work will mostly base on the primary data collected from the field *plus* the quantitative and empirical techniques will be used to analyze the data. Further the work shall stand on the qualitative design as well. The historical analysis is necessary at the same time to understand the differences in the magnitude of ostracism over the last three decades. Research methodology in this changing and ever more complex environment presents great methodological changes. And so is my study depending upon.

Procedure & source of data:

Most of the estimates presented in this research are made on the basis of original analysis of available survey data. I have sought datasets from nationally representative population-based surveys in Kashmir undertaken during the 21st century. Values have been aggregated at district-level from these household surveys. The dependent variable, HIV prevalence, and the

independent variables fertility and major trunk roads were already aggregated values. The empirical analysis of this thesis is mainly based on data from the Living Conditions Monitoring Survey field study and census of India (2011). This survey has a nationwide coverage on a sample basis and covers both rural and urban areas. The survey was designed to provide data on the various aspects of the living conditions of households for each and every district in Kashmir. District-level HIV prevalence are estimated figures from the Epidemiological report published in 2011, which contains epidemiological projections for the period 1985 to 2010,as I could not find proxies for mobility anywhere else. Data on adjusted total fertility rates comes from the Census of Population and Housing in 2011. Unfortunately, data on fertility rates for later years did not exist at district-level. Developing countries have a hard time gathering and updating a good database because of high costs and organization problems. High quality data is therefore a luxury article in countries like India. However, good quality data can be enhanced by using well designed questionnaires and well trained interviewers – more common when dealing with large surveys such as LCMS.

RESULTS AND DISCUSSION:

Table 1, District wise Distribution of PLWHA in Kashmir Division

Name of districts	Population 2011 census	Area [km^2]	No. of HIV patients
Kupwara	875,564	2,379	17
Anantnag	1,069,749	3,984	21
Kulgam	423,181		21
Pulwama	570,060	1,398	16
Shopian	265,960		23
Budgam	755,331	1,371	11
Srinagar	1,250,173	2,228	43
Ganderbal	297,003		9
Bandipora	385,099		5
Baramulla	1,015,503	4,588	30
Total	6,907,623	15,948	196

Source*: Field Study and Census of India 2011*.

The above table shows that maximum 22 percent of HIV patients are residing in Srinagar followed by 15 percent in Baramulla. Then comes District Shopian with 12 percent followed by District Anantnag and Kulgam both with 11 percent of HIV patients. Two more Districts Pulwama and Kupwara share a common percentile of 8 each. Three more Districts Budgam, Ganderbal, and Bandipora are having 6, 5, and 2 percent of HIV patients respectively.

J&K State is a low prevalence state where the mean prevalence rate of HIV infection among high risk groups (STD) is 0.3% and among low risk groups (ANC) is 0.04 %, as per various Sentinel

Surveillance rounds conducted during last eight years. There are 2102 confirmed HIV positive cases in the State. 799 full-blown AIDS cases have been registered out of which 133 AIDS deaths have taken place so far. 518 AIDS patients including 35 children are receiving free Anti-retroviral treatment (ART) in two ART centers functioning in the State. Jammu division has highest number of HIV positive with 90% of these cases, while Kashmir with only 13% of HIV positive cases are detected so far.

CONCLUSION

The socio-economic impact of HIV/AIDS was considerably grave, and certainly more among the sicker patients with increased severity and duration of the disease. Intensive education for PLWHAs, their family members, and other stakeholders is urgently required for the reduction of AIDS-related stigma and discrimination, as also the need for care and support. More research to get a better insight into the problem of socio-economic impact at household and community levels, and for mainstreaming of PLWHAs is the need of the hour. Services to support those affected as well as a legal framework to protect their rights is also important.

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