Socio-economic impact of HIV at the individual and household levels in Indonesia: a seven province study

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Outline

- Background
- Methodology
- Limitations
- Main findings
- Key recommendations
Background

• **Status of epidemic**
  - Low prevalence, concentrated epidemic
  - About 314,500 PLHIV (0.22%); projected to rise to 0.37% by 2014
  - 2010-2014: about 23,000 projected annual deaths

• **Objective**
  - Assess SE impact in wide range of areas (income and employment; consumption, assets and savings; coping mechanism; stigma; health; education; gender etc)
  - Inform impact mitigation policies and programmes

• **Partners**
  
  UNDP, BPS, ILO, UNV, NAC, UNAIDS, Jothi
Methodology

- **Quantitative and qualitative:** questionnaire survey, FGDs, in-depth interviews, case studies

- **5 high prevalence provinces** (Jakarta, West Java, East Java, Bali & Papua) & **2 low prevalence provinces** (NTB, NTT)

- **Purposive, quota sampling:** 1019 PLHIV-households & 1019 control households (non-PLHIV households)

- **Control households** from same socio-economic background in the neighbourhood
Limitations

- No sampling frame available and accessing PLHIV-households difficult
- No equal probability for all PLHIV households to be selected
- Selection bias because of access through PLHIV-network
- Recall errors, approximation by respondents etc
- Inhibition in disclosing intimate details, money matters
### Sample distribution

Number of samples proportional to the number of reported AIDS cases

<table>
<thead>
<tr>
<th>PROVINCES</th>
<th>Number of Reported AIDS cases</th>
<th>Number of Deaths</th>
<th>Sample Households</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
<tr>
<td>Jakarta</td>
<td>2,781</td>
<td>419</td>
<td>280</td>
<td>280</td>
</tr>
<tr>
<td>West Java</td>
<td>2,888</td>
<td>544</td>
<td>197</td>
<td>197</td>
</tr>
<tr>
<td>East Java</td>
<td>2,591</td>
<td>584</td>
<td>211</td>
<td>211</td>
</tr>
<tr>
<td>Bali</td>
<td>1,177</td>
<td>228</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>West NT</td>
<td>80</td>
<td>47</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>East NT</td>
<td>110</td>
<td>23</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Papua</td>
<td>2,382</td>
<td>351</td>
<td>225</td>
<td>225</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,019</strong></td>
<td><strong>1,019</strong></td>
<td><strong>2,038</strong></td>
<td></td>
</tr>
</tbody>
</table>

Number of samples proportional to the number of reported AIDS cases.
## PLHIV Profile (%)

### Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20</td>
<td>2.2</td>
<td>10.1</td>
</tr>
<tr>
<td>20 - 30</td>
<td>58.4</td>
<td>55.5</td>
</tr>
<tr>
<td>31 - 40</td>
<td>33.2</td>
<td>26.9</td>
</tr>
<tr>
<td>41 - 50</td>
<td>4.7</td>
<td>6.3</td>
</tr>
<tr>
<td>51 - 60</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>0.5</td>
<td>0</td>
</tr>
</tbody>
</table>

### PLHIV Categories

<table>
<thead>
<tr>
<th>PLHIV Categories</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDU</td>
<td>73.4</td>
<td>20.9</td>
</tr>
<tr>
<td>Transgender</td>
<td>7.0</td>
<td>0.3</td>
</tr>
<tr>
<td>CSW</td>
<td>5.6</td>
<td>14.3</td>
</tr>
<tr>
<td>MSM</td>
<td>2.1</td>
<td>0</td>
</tr>
<tr>
<td>Spousal transmission</td>
<td>4.3</td>
<td>48.4</td>
</tr>
<tr>
<td>Mother-to-infant transmission</td>
<td>1.3</td>
<td>6.3</td>
</tr>
<tr>
<td>Blood transmission</td>
<td>0.4</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Do not know</td>
<td>4.9</td>
<td>8.4</td>
</tr>
</tbody>
</table>
Main findings
Impact on income, consumption, assets & savings; coping mechanisms
Formal employment is considerably lower among HIV-households.

More PLHIV-households are self-employed (own business).

Free workers more in PLHIV-households.

**Percentage of household members by occupation**

- PLHIV Household members
- non-PLHIV household members
Income-loss

Caring for the sick cost 55% more income-loss in PLHIV-households than regular households.

Loss of income more pronounced for men.
Income Vs expenses & social support

- Big gap between income and expenses in PLHIV households
- Expenses higher than income
- Social support bridges the gap to some level
- Without social support, high risk of impoverishment

**Income Vs expenses with and without social support (last one month)**

- Income: Transfer in (social support) not included
- Income: Transfer in included
- Expenses per capita
Coping mechanisms

- 74% said HIV has led to additional expenses
- 63.56% used up savings
- 60.32% PLHIV borrowed from families and friends
- Significant liquidation of assets
- Social support great relief
Stigma & discrimination
Time for disclosure

- 18% still not informed families
- 9% live in isolation
- 5% took 1-2 years
- Level of disclosure among female PLHIV is lower: 21.25% still haven’t informed families
- 13% live in isolation
- 41% informed the family immediately after the diagnosis.
Discrimination in residential settings

- 17% households said they experienced discrimination
- Most common (59%) was avoidance by others.
- 53% were subjected to verbal abuse
- 38% reported children were not allowed to play with the children of the neighborhood.
- 12% experienced physical violence
- Loss of friends and customers in business, rejection by community & social boycott were common

Percentage of PLHIV households undergoing discriminatory treatment in residential settings by types of discrimination
Discrimination in healthcare settings

- > 50% PLHIV felt discrimination

- Worst form (70.23%) was that they were publicly marked as HIV+ in hospitals.

- 10% PLHIV-households also felt discrimination
health
Health expenses

- PLHIV-households spent 5 times more than non-PLHIV households on medical expenses.

- Average medical expenses of PLHIV alone are 3 times higher than the total medical expenses of non-PLHIV households.

![Graph showing average health expenses by household types and share of PLHIV (in IDR)](image)
Medical expenses - provincial variation

- Medical expenses 17 times higher in Surabaya-Malang
- 9.5 times higher in Mataram
ARV consumption

- 53.7% of the respondents said they use ARV, mostly supported by the Government.

- Incidence of opportunistic infections fallen to 35.4%, commensurate with increasing ARV coverage as well as increased access to treatment.
OIs and places of treatment

Most PLHIV access treatment in government hospitals and community health centres - need for health and community systems strengthening.
Education and gender
Education expenses

- HIV households spend 36% less on education compared to the non-HIV households.

- Non-HIV households spend 3.46% of household income on education, for HIV households, it is only 1.78%.
School drop out

- School drop-out among PLHIV-households significantly higher

- Drop-out higher among higher classes compromising higher education

- Twice as many girls drop out compared to non-PLHIV households

- Considerable absenteeism – twice compared to non-PLHIV households
Women-headed households 10% higher in the HIV-affected families.
Chronic OIs by gender

- HIV-related illnesses and morbidity are higher among women – lack of attention and medical care

- 20.6% women had chronic OIs during last 3 months as against 17.25% men
Gender disparity in treatment

• Twice as many women as men reported difficult access to healthcare facilities (20.83% Vs 10.31%) as the major reason for accessing treatment.

• Higher number of women (23.6% against 16.03% men) also cited fear of disclosure to the healthcare provider as a reason for not accessing treatment.

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot afford medical cost</td>
<td>48.47</td>
<td>37.50</td>
<td>47.68</td>
</tr>
<tr>
<td>Health facility difficult to reach</td>
<td>10.31</td>
<td>20.83</td>
<td>13.00</td>
</tr>
<tr>
<td>Afraid of being known his/her HIV status by health provider</td>
<td>16.03</td>
<td>23.61</td>
<td>18.27</td>
</tr>
<tr>
<td>Afraid of discrimination</td>
<td>10.31</td>
<td>8.33</td>
<td>10.22</td>
</tr>
<tr>
<td>Other</td>
<td>14.89</td>
<td>9.72</td>
<td>14.24</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>103.41</td>
</tr>
</tbody>
</table>
Decision making roles: women living with HIV

AIDS widows receiving husband’s property

- Yes: 29.31%
- No: 70.69%

Percentage of women living with HIV by decision making roles:

- Buying household asset (land, house): 20.38%
- To choose caregiver for herself: 29.94%
- To choose health service provider for children: 25.48%
- To have child: 28.03%
Summary

- Significant impact on income, employment, assets and savings
- Compounding deficit in family budgets leading to impoverisation
- Borrowing and liquidation of assets high
- Education, particularly in higher classes and of girls badly compromised
- Serious impact on women: education-health-care burden-household burden etc
- Health expenses crippling; compromises other expenses
- Stigma in residential and healthcare settings high; low self esteem
- Social protection considerable relief
- Increasing ARV coverage and reduction of OIs
- Government major source of support
Recommendations (1)

- Impact mitigation efforts should be an integral part of the national and provincial AIDS strategies – should be budgeted
- Impact mitigation efforts should be aimed at the household levels
- Local socio-economic variations of the impact may be seriously considered while designing and implementing impact mitigation steps
- HIV should be strategically integrated into social protection schemes, and specific social protection schemes may be designed to address PLHIV-households
- Steps are needed to address stigma and discrimination, in both community and public services settings. A combination of legal empowerment and awareness creation may be strategically implemented.
Recommendations (2)

- Time-bound plans required to address discrimination in the hospital settings
- Special attention on the multiple burden of women, spousal transmission and low access to information and services, including treatment should be prioritised
- Considerable efforts required to increase coverage of treatment, including for OI and ARV. Particular attention should be paid to bring more women into the treatment coverage.
- Treatment drop-out also should be seriously addressed.
- Specific efforts should be made to ensure that children from PLHIV-households are not pulled out, particularly in higher classes
THANK YOU

For PDF copy of advance summary please write to

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