Summary and Conclusions
The history of HIV/AIDS is hardly 25 years but the damage it has inflicted on the mankind has been appalling and overwhelming. The countries allover the world now know from bitter experience that the deadly AIDS is caused by the virus HIV, and that it can devastate families, communities, countries and whole continents. The countries have seen the epidemic knock decades off national development, widen the gulf between rich and poor nations and push already stigmatized groups closer to the margins of society. HIV/AIDS has become the first truly 'international' epidemic, easily crossing oceans and borders. At the moment, there is neither a fully preventive vaccine of HIV nor cure for AIDS. As such, a person inflicted with HIV typically dies of AIDS in course of time.

HIV/AIDS is not only a health problem but an overall development problem in developing and poor countries. Lack of awareness and resources for prevention of HIV infection and poor health care systems are the main reasons the spread of the virus in the developing countries. Africa has been the epicenter of HIV/AIDS. In the country’s most heavily affected, HIV has reduced life expectancy by more than 20 years, slowed economic growth, deepened household poverty and dramatically skewed the natural age distribution. According to the United Nations Development Programme (UNDP), HIV has inflicted the “single greatest reversal in human development” in modern history. In Asia HIV infection rates are much lower than in Africa.

It has been noted that a country with a very high HIV prevalence rate will often see this rate eventually stabilize, and even decline. In some cases this indicates, among other things, that people are beginning to change risky behavior patterns, because they have seen and known people who have been killed by AIDS. Fear is the worst and last way of changing people's
behavior and by the time this happens it is usually too late to save a huge number of that country's population.

Apart from inadequate funding, major obstacles in tackling the global AIDS epidemic include weak infrastructure and shortages of health workers in the worst affected countries. Political or cultural attitudes are also significant: for example some authorities are opposed to condom promotion, while others refuse to support needle exchanges for injecting drug users. Many are reluctant to provide young people with adequate education about sex and sexual health. Another very serious issue is stigma and discrimination. People known to be living with HIV are often shunned or abused by community members, employers and even health workers. As well as causing much personal suffering, this sort of prejudice discourages people from seeking HIV testing, treatment and care.

Based on recent trends it is likely that AIDS around the world will keep getting worse for many years to come. Millions more will become infected with HIV and millions will die of AIDS. The only way to turn things around is to rapidly scale up the measures we already know are effective. In 2005 the world's leaders pledged to try to achieve universal access to HIV prevention, treatment and care worldwide by 2010. This would be one of the greatest health achievements in history - saving millions of lives and giving new hope to suffering nations. But meeting this challenge will take bold leadership and a massive increase in effort; otherwise the promise is sure to be broken.

HIV emerged later in India than it did in many other countries. At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had no reported cases of HIV or AIDS. India's first cases of HIV were diagnosed in the year 1986 among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had played a role in initial infections among sex workers. This would not be the case for long, and concerns were raised about how India would cope once HIV/AIDS cases started to emerge as India is one of the largest of most populated countries.
in the world. Population of India has crossed one billion. There are so many people living in India that a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million.

UNAIDS estimated that in the year 2006 there were 5.6 million people living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world. However, NACO disputed this estimate, and claimed that the actual and revised figure was lower. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate - between 2 million and 3.6 million people living with HIV. The figure was confirmed to be 2.47 million in 2008 and that adult national HIV prevalence was 0.36%. This puts India behind South Africa and Nigeria in numbers living with HIV. Overall, around 0.3% of India’s population is living with HIV and it is greater among males (0.44%) than among females (0.23%). While this may seem a low rate, India’s population is vast, so the actual number of people living with HIV is remarkably high.

The epidemic in India is very heterogeneous with diverse modes of infection, particularly in southern and western states, namely, Tami Nadu, Karnataka, Andhra Pradesh, Maharashtra and two north eastern states, namely, Nagaland and Manipur. Even within states, there is a wide variance in HIV prevalence between and within districts as evidenced by data from HIV sentinel surveillance centres and ICTCs. The epidemic in India is largely driven by sub epidemics among sex workers, injecting drug users and men who have sex with men. India continues to be in the category of concentrated epidemic. Higher HIV prevalence among IDU is an important feature of North Eastern States.

There is decline in the HIV Prevalence among ANC clinic attendees in most of the high burden states, reflecting the impact of interventions. Similar trends are seen in Female Sex Workers also. Rising HIV prevalence among different population groups in North Indian states is an alarming
signal for focused attention. The epidemic is greater in urban areas than rural areas, greater among males than females, decreases with increasing education level, and is found to be highest among women whose spouses work in transport industry. There are 156 A category districts and 39 B category districts in the country. Thus, HIV epidemic in India is a dual epidemic driven by sexual and IDU routes of transmission, concentrated in nature with high HIV prevalence among high risk groups and heterogeneous in spread with pockets of infection found in various districts of the country.

Andhra Pradesh tops the list of States in India, where HIV is generalized epidemic. Andhra Pradesh is facing a serious HIV epidemic. The State has high prevalence rate of HIV in country (1.26 in Antenatal Clinic cases (ANC) and 24.4% among Sexually Transmitted Disease (STD) clinic attendees. About 22% of all HIV positive people in India estimated as more than half a million PLHAs are in Andhra Pradesh alone. All the 23 districts of Andhra Pradesh figure in the AIDS ‘hot zone’. HIV/AIDS is no longer confined to groups with high-risk behaviour and has penetrated the general population of State and has assumed proportions of a generalized epidemic.

The NACO Director General noticed that high prevalence of HIV in Andhra Pradesh is because of ‘one in every five men in Andhra Pradesh has multi partner sex’ and of them only 25 % use condoms. She also said that the surveys conducted by APSACS showed that of the youngsters who have been surveyed, 20-30% had premarital sex. The first HIV/AIDS case in Andhra Pradesh was reported in the year 1986, only twenty years ago. But the rate and speed at which the HIV infections are increasing in Andhra Pradesh is astonishing, incredible and mind-boggling.

As more than 80% of HIV infections are through sexual route, mother to children infection and Children living with HIV/AIDS (CLHA) is a neglected facet of HIV/AIDS. HIV/AIDS is redefining the very meaning of childhood for millions, depriving children of many of their human rights - of the care, love and affection of their parents; of their teachers; of education and options for the future; of protection against exploitation and abuse. Hundreds of
thousands of children across the world become infected with HIV every year and, without treatment, die as a result of AIDS. In addition, millions more children who are not infected with HIV are indirectly affected by the epidemic, as a result of the death and suffering that AIDS causes in their families and their communities.

Mother-to-child-transmission of HIV accounts for the vast majority of children who are infected with HIV. An HIV positive woman can transmit the virus to her baby during pregnancy, labour and delivery, and through breastfeeding. If she takes no preventive drugs and breastfeeds then the chance of her baby becoming infected is around 20-45%. Aside from mother-to-child transmission, some children are exposed to HIV in medical settings; for instance, through needles that has not been sterilized or blood transfusions where infected blood is used. In wealthier countries this problem has virtually been eliminated, but in resource-poor communities it is still an issue. For older children, sexual activity and drug use present a risk. Sexual transmission does not account for a high proportion of child infections but in some countries children are becoming sexually active at an early age. This is potentially conducive to the sexual spread of HIV among children especially in areas where condom use is low.

HIV infection in children affects their immature immune system at a very early stage in prenatally acquired infection. These children experience rapid progression to severe symptomatic disease. As a consequence of HIV infection, severe nutritional and immune deficiencies occur in children leading to higher mortality in children less than five years old. 40 percent of HIV-positive children fewer than 18 months in clinics experience developmental delays. Cumulative mortality is 33% in first 12 months, 50% by 24 months and 60% by 36 months.

The HIV infected children suffer from different problems that are peculiar to them. UNAIDS, UNICEF and other agencies that are working with infected children have noticed with concern the social exclusion, neglect, discrimination, stigma and ill-treatment of the HIV infected Children.
Shunned by their families and communities, they are often placed in situations that only increase their risk. The challenges include stigma, discrimination, opportunistic infections, economic uncertainty, denial of property and inheritance rights, illiteracy, malnutrition, illness and physical and sexual abuse.

Anantapur district which is the locale for the study has been identified by NACO as one of the vulnerable districts in the state. The RCH situation in the district indicates relatively low institutional deliveries, high IMR and low condom use. The sentinel surveillance data 2006 indicates that the prevalence is more than 1% among the ANC's, with urban areas crossing the threshold of 2%. The VCTC data suggest that about 11.54% of the persons tested were positive, while the positivity rates indicate by PPTCTs was 1.03%. About 81% of the positive ANC partners were reported to be positive. On the average, about 5.70% of the total tested was found to be positive. The estimate of PLHAs varied between 7,480(RDT) and 11,643(ADM & HO).

The prevalence rates (as percent of tested cases) among children below 19 years was 6.3%, with under14 accounting for a substantially higher rate. The estimates of CLHAs varied between 392(ADM & HO) and 1444 (NGOs). The number of Children affected by AIDS is estimated to be around 6,200 (largely based on the data of children not testing positive).

The intra-district scenario clearly reveals that PLHAs and CLHAs are concentrated in the urban agglomerations of presence of sex workers, victims of trafficking, migrants and other bridge groups such as truckers. MSMs and IDUs. However, with the expansion of testing facilities, the intra-district situation could become more visible. In July 2007, 82 CLHAs and 1,171 adults were on ART, although the number registered for ART is much higher, indicating the potential for increase in these numbers. The number of CLHAs is likely to rise further in the near future, with serious consequences to the well being of the children in the shout run and to the quality of human resource in the long run.
In November 2006, the National AIDS Control Organization (NACO), in partnership with the Clinton HIV/AIDS Initiative (CHAI), the United Nations Children's Fund (UNICEF), and the Indian Academy of Pediatrics (IAP), launched the National Pediatric HIV/AIDS Initiative with the aim of ensuring that each child living with HIV/AIDS (CLHA) receives high-quality care, treatment, and support. The Initiative sought to bring the level of access to treatment on par with that of adults and to address a large, unmet need of CLHAs requiring ART with the introduction of Pediatric-specific anti-retroviral treatment (ART) formulations, a key improvement in the quality of care.

While providing ART to an HIV-positive child is the first step towards improving their wellbeing, it is not sufficient to ensure that each CLHA will have the chance of living a happy, vigorous life. With this in mind to ensure optimal health outcomes for CLHA, NACO requested CHAI to initiate an extensive Care and Support Program to complement the rapid scale-up of children into the ART Program.

When the Initiative launched, 2,635 CLHAs were registered for care at 36 government ART Centres, of whom 1,403 CLHAs were receiving ART. By the end of December 2007, due to large-scale mobilization efforts and testing camps conducted by CHAI, UNICEF, and the SACS, the number of children on ART increased six-fold to 8,706, comprising 30% of the approximately 29,000 HIV-positive children registered at 132 ART Centers.

Vasavya Mahila Mandali (VMM) located in Andhra Pradesh is a non governmental organization registered in 1975 is working with a network of 25 NGOs besides 23 positive networks. Ananta Net work of Positives (ANP+) is an implementing partner for VMM in Anantapur district for the National Pediatric HIV/AIDS Initiative with the aim of ensuring care to each child living with HIV/AIDS (CLHA). The 156 children who are with VMM and ANP+ as part of National Pediatric HIV/AIDS Initiative are the population for the present study.
The overall aim of the present research topic is to make a study on impact of HIV/AIDS on CLHA. The above being the general objective; following specific objectives were set for the present study:

- To trace the history and prevalence of HIV/AIDS—Global and Indian scenario in general and Andhra Pradesh in particular;
- To trace the history and prevalence of HIV/AIDS with special reference to HIV/AIDS infected children;
- To examine the profile of Andhra Pradesh and Anantapur district in terms of HIV/AIDS;
- To examine the profile of VMM and ANP+ as Lead Partner and Implementing Partner in implementing National Pediatric HIV/AIDS Initiative;
- To probe into socio economic background of the infected children and their family;
- To ascertain problems that are specific for the infected children and family; and
- To assess the care and support available to the infected children.

The present study adapted descriptive research design. It describes the sociological issues pertaining to impact of HIV/AIDS on the lives of children. The study describes the issues related to impact of HIV/AIDS on CLHA. The present study is conceived and designed to be a district wide study and Anantapur, the largest district in the state of Andhra Pradesh is area of the study.

Anantapur district was purposively selected for conduct of the present study. The VMM and ANP+ are the Lead Partner and Implementing Partner in implementing National Pediatric HIV/AIDS Initiative in Anantapur considered as universe for the study. There are 156 CLHA attached to the VMM and ANP+ and half of these children numbering to 78 were randomly selected for detailed study.

The data pertaining to the study was collected from both from primary and secondary sources; more from primary source. In the present research study interview schedule was used to collect primary data.
and standardization of the schedule was done after the pilot study. Every care was taken to collect and record only reliable data. Personal observations were also recorded.

Collected quantitative as well as qualitative data were analysed by using the appropriate statistical and non statistical tools. Frequency and cross tables were generated and the results were interpreted through percentage analysis. While frequency tables were used to examine the profile and socio economic particulars of the CLHA, cross tables were used to analyse other pertinent variables in the study.

The important findings of the study are as follows:

- The study reveals that about 56% of the children are boys and the rest are girls. The study also reveals that almost all the respondents in the study were infected through their parents only. HIV/AIDS do not shown any gender bias and the gender-wise figures in the study almost match the district and State wise sex distribution of CLHA;

- The study reveals that majority of the children affected by HIV/AIDS were in between 4-12 years and their percentage comes to around 89;

- 72 (92.3%) respondents belong to Hindu religion and the remaining were Muslim;

- More than 70% of the respondents in the study belong to backward castes, Scheduled Castes and Scheduled Tribes. Less than thirty percent of the respondents belong to forward castes;

- The collected data reveals that more than 80% of the respondents are from the urban areas and this is more than the district, state and national average;

- More than 70% of the respondents went to school. Around 58 percent of the respondents were pursuing primary education and about 22 percent of the respondents were pursuing secondary education. Nearly 14 percent of the respondents never went to school or dropped out of the school due to various reasons such as poverty, health and discrimination at school;
More than forty percent of respondents are living with both the parents. Less than forty percent of the infected respondents are living with one parent and of a predominant number with mothers. A little more than ten percent of the respondents are being supported by aged grandparents and another six percent by the relatives. None of the respondents are staying in the shelter homes the data reveals that about eighty percent of the respondents are living with at least one parent. More than 50% are Double orphan, Semi orphan or dependent on grand parents;

HIV infection coupled with malnutrition adversely affects the normal growth of the infected children and may result in stunted growth. However, it was found that more than 84 percent of the infected respondents were normal in their heights;

Data pertaining to weight of respondents reveals that seventy percent of the children in different age groups weigh less than twenty Kilograms. As per the records of the medical doctor in ANC+ almost 78% of the infected children are under weight for their age. The respondents also looked weak compared to normal children;

The total number of members in the families of the 78 respondents comes to 288. Majority of the family members are siblings of the respondents. Of the 78 respondents 31 respondents have lost their fathers to HIV/AIDS and 16 have lost their mothers and as such there are only 47 fathers and 62 mothers among the family members. Twelve members in the family are the grandparents and five are other relatives, besides parents and siblings;

In the sample selected for study the infection to both the parents were total. There were 78 infected children in the sample of the study and each one of the father and mother of the respondents were infected. The respondents have 73 brothers and 89 sisters. Of the 73 brothers of the respondents 13 were infected and of the infected one were dead. Of the 89 respondents sisters 18 were infected and all of them were alive. Thus in the total 318 family members of the respondents 188 were HIV infected. Out of 318 family members 48 were already dead and the death toll due to HIV/AIDS works out to 15%;
The data reveals that overwhelming percentage, more than 90%, of the families of the respondents were Joint Families and less than ten percent of families were nuclear families;

The ownership of house of the respondents indicate that majority of the respondents (61.5%) were residing in own houses and about 39% of respondents were residing in rented houses. Most of the respondents were from the social categories of Scheduled Caste and Scheduled Tribes and as such were provided own houses under different housing schemes by the government as part of welfare schemes to the BPLs in weaker sections;

Data reveals that only five respondents are in the thatched houses and as many as 73 respondents are living in tiled and terraced houses. The economic position of the families of the respondents' makes it amply clear that majority of them were in BPL category, and general perception is that they live in thatched houses. However, as said earlier majority of the respondents were from weaker sections and also BPL, the terraced houses they live were constructed by government under various schemes;

Data reveals that four respondents families only , which is about five percent of respondents' families, own land and the remaining 74 (95%) were landless labour. Each of the respondents whose families have land has inherited their land. Though the respondents families own land the land holding are small and it ranged from one to three acres and the income that the families are deriving is also small and it ranged from Rs.20,000 to 35,000;

In the study, each of the 78 fathers of the respondents is infected and 31 of them have died. Similarly each of the 78 mothers of the respondents was infected of which 16 have died. Of the surviving 47 fathers only 32 are working and the remaining 15 fathers are unable to work due to HIV/AIDS. In such cases it is the mother or grand parents who are taking care of the family and ultimately the breadwinners in the family. Almost 60% of the cases the father is not breadwinner in the family. The study also reveals the importance of the aged grand parents in supporting HIV/AIDS infected families, as in as many as 20 (26%) families they were completely or partially supporting the respondents’ families. In five percents of cases the relatives had also been the breadwinners in the family;
➢ The Nevirapine (NVP) treatment and delivery through caesarean section to prevent mother to child transmission. Data clearly indicate that overwhelming majority of respondents did not make use of the latest developments in the prevention of mother to child HIV transmission. More than 95% of the respondents mothers’ did not use nevirapine treatment and the delivery was not by caesarean section;

➢ 69 children were tested for HIV after the HIV status of their parents was known to the ANP. Thus, in about 88% of respondents the ANP+ through their staff initiated HIV test in the PPTCT/ICTC located in the Government hospital, Anantapur. In case of the remaining nine children, at some point or other they had health problems and the attending doctors suspected them to be the cases of HIV/AIDS and advised them to go for HIV test. Even in that nine cases four were tested for HIV in the Government hospital and only five respondents have undergone HIV test in other than government facility that was private lab;

➢ More than 85% of the respondents’ parents were advised by ANP+ to go for HIV tests of their children. As said earlier in case of nine respondents the doctors have advised the parents of the respondents to take the child to HIV test after they suspected HIV in the children. In case of two respondents the parents themselves suspected that their children could be HIV positive as they have frequently taken ill and as such approached the test centres;

➢ The CLHA face stigma and discrimination. The discrimination is widespread and as explained by the respondents could be seen in the family, neighbors, friends, relatives and community at large. The fear of stigma and discrimination is making the respondents not to disclose their HIV status to others. All the respondents have said that all their family members know about the HIV status of them. Friends, neighbors, relatives and community in that order know less about the HIV status of the respondents. It is also significant to know from the data that the majority of the respondents did not reveal about their HIV status to their relatives for they fear stigma and discrimination from their relatives;

➢ There is still no way to cure AIDS, and at the moment the only way to remain safe is not to become infected. There is antiretroviral medication which slows the progression from HIV to AIDS, and which can keep some people healthy for many years and live with HIV for a very long time. To judge whether an HIV-positive person requires treatment, a CD4 test is usually carried out. A falling CD4 count is a
sign that HIV is progressing, and that the immune system is becoming weaker. Two out of 78 respondents have less 100 CD4 count and they were said to be in critical condition. 18 respondents CD4 count is in between 100-200 and their health condition was said to be risky with opportunistic infections. 37 respondents, that is the majority (47.4%) CD4 count in between 500-1000 and these respondents will have occasional opportunistic infections.

- HIV infection is not the end of life. People can lead healthy life for a long time with appropriate medical care. Anti-retroviral therapy (ART) effectively suppresses replication of virus, if taken at the right time. Successful viral suppression restores the immune system and halts onset and progression of disease as well as reduces chances of getting opportunistic infections. ART thus enhances both quality of life and longevity. PLHA with less than 200 CD4 (while blood cells/mm3) require treatment irrespective of the clinical stage. For PLHA with 200-350 CD4, ART is offered to symptomatic patients. Among those with CD4 of more than 350, treatment is deferred for asymptomatic persons. It is clear from the table that 19 respondents, who almost account for one fourth of the respondents, are on ART. About 59% are not on ART, for certain. Three respondents had said they do not know whether they are on ART or not. However, it can be safely assumed that they are not on ART, for on ART means taking medicine everyday with strict adherence and a person with out this knowledge will not be on ART;

- Opportunistic infections occur when HIV has weakened the body’s defenses against disease. For young children and people with weak immune systems, drugs such as cotrimoxazole may be recommended to prevent opportunistic infections occurring. It is evident from the data almost 70% of the respondents suffered from candidacies, pneumonia and diarrhea, the common opportunistic infections found in PLHA. Tuberculosis in another common co-infection found among the PLHA and about 8 % of the respondents had this opportunistic infection. Head ache, pain in the joints and anemia can be named as common ailments and need not be necessarily considered opportunistic infections as reported by the respondents;

- The respondents who were CLHA were vulnerable to opportunistic infections, time to time. As the CD4 count comes down the immune system fails the respondents paving way for opportunistic infections. Data was collected as to how many time the respondent visited hospital for various health problems in the last year. Data makes it is
clear that about 92% of the respondents went to hospital with some or other medical problem. Of the respondents who visited hospital, majority went only once and their number worked out to 48. Those who are on ART went to hospital three times on an average and some of them even joined as inpatients in the hospital;

- Data reveals that there was discrimination of PLHA at health care facilities, be it government or private. At the same time the PLHA do not go all hospitals for the fear of exposure and visit only certain hospitals where confidentiality is maintained and specialized doctors were present. There are two such facilities in Anantapur district. One is Government Hospital, where ART centre is also located. The second and most popular is the Community Care Centre run by Rural Development Trust located at Bathalapalli, 25 kilo meters to the district head quarters. 68 respondents who were hospitalized last year went to medical help. Majority of the respondents went to Community Care Centre, Bathalapalli run by RDT and it was also revealed by the respondents that they went to CCC, Bathalapalli because they received quality medical service. About one third of the respondents went to Government General Hospital Anantapur. Less than five percent of the respondents went locally available medical doctor, registered medical practitioner (RMP) and quack;

- Five out of 78 respondents in the study were not in the school going age group and the rest i.e. 73 respondents are in school going age group. Of the school going respondents about 85% were attending school. While 5 respondents have permanently dropped out of school for about two years; 6 respondents did not attend school though they were on rolls for problems such as health, poor economic condition and discrimination. Out of eleven respondents who were not going to school and school drop outs, five had said they had been working on regular basis for a salary. Of these five respondents three are working as helping hands/cleaners in the hotels, two respondents were engaged as helping hands in other business. Four respondents had been running errands or helping their parents in the occupations;

- Information about regularity of the school going respondents, numbering to 62 were collected in the study reveals that of the 62 respondents, 48 students had reported attending school regularly. The remaining 14 respondents were not regular to school. The 14 respondents who were irregular had stated that there deteriorating health; general weakness and opportunistic infections time to time are some of the reason for not attending school regularly;
The performance grading arrived at taking into consideration their examination performance based on the marks reveal that about 65% of the respondents were average in their educational performance. While around twenty percent of the respondents were poor in educational performance, thirteen percent have performed well in their examinations;

Data reveals that more than 60% of the students did not face any discrimination in the school. Severe discrimination in the school setting was shown against one respondent in the form of throwing him out because of his HIV status. The other forms of discrimination in the class room, in play ground and from parents of the other children. Name calling, not allowing near to them by other students and teacher and not allowing them to play with others were the common complaints by the respondents;

Besides discrimination in school, the respondents have also faced discrimination in work place, neighbourhood and also in the health setting. Collecting data from the HIV infected children the researcher had noticed with concern the social exclusion, neglect, discrimination, stigma and ill-treatment. Other students are reluctant to sit next to the respondent not only in the school but also in public places. Some actions may be subtle and covert, but some actions may be obvious and overt. In more extreme cases, it has taken the form of beating up the respondents for no reason;

The respondents said they faced discrimination in health care settings also. The discrimination manifested by denying access to health care and treatment. Stigma and discrimination in hospitals range from condescending attitudes to denial of treatment. The discrimination varied between private hospitals and the public and state run hospitals. One of the important reasons for discrimination of CLHA in health care was due to fear of exposure to infection by doctors and healthcare workers in course of treatment. There have been complaints from the respondents about the Government Hospital and other doctors of breaching of confidentiality, denial of treatment and care cessation of ongoing treatment, condescending and judgmental remarks, unwarranted referrals to other facilities, segregation and labeling of patients, revealing serostatus to relatives without prior consent to be problems in some health care settings;
Many international players and donor agencies, directly or indirectly entered into HIV/AIDS rehabilitation arena by providing different forms of support. It was found out from the study as to who was helping the PLHA in different needs, be it financial, medical, nutrition support, psychological support or life saving skills. It quite a few cases it was found out that the respondents are taking help from different quarters. If they have taken medical and financial help from the VMM they have taken nutrition support from RDT and availed government schemes provided by different departments on priority basis to them. Majority of help to the respondents was from the NGOs only. Two NGOs viz. VMM and RDT put together have taken care of the needs of almost 85% of the respondents in the district;

Each one of the respondent is receiving some or other help from different organizations. The respondents received different types of help from different organizations. However, important help was in the form of ration and nutrition. The parents of the respondents are also PLHA and as such they also received help from the organizations. Ration in the form of rice, dal and oil for a month was provided to PLHA who were BPL. Nutrition in the form of food supplements such as Horlicks etc. was provided to children who were orphans or semi orphans and belonging to BPL families. Free medical help was received by respondents in two forms viz. ART treatment and treatment for OI s. Psychological support and life skill training was also provided to the needy and deserving cases. Majority of the respondents received rations and nutrition and the percentage of the respondents receiving such help works out to 80% and 30% respectively. Medical treatment is another major form of help received by the respondents and this works out almost 25% and 75% towards ART and OI treatment. More than 10% of the respondents also received psychological counseling and life skill support;

HIV/AIDS is a life threatening disease. The disease takes heavy toll on the finances of the family, and if the family is BPL the problem still worsens. Each one of the respondent has said that the help they received is not sufficient to cope with the disease. They wanted more help from government as well as non governmental organizations. More than 80% of the respondents are asking for financial help; a fixed amount per month to cope with the disease. Some of the respondents wanted financial help to cope with their inability to work because of disease; some others wanted financial help for medical expenditure. Less than 20% of the respondents asked for counseling and life skills training.
To conclude the study it can be said that children living with HIV/AIDS (CLHA) are a sad and unexplored facet of HIV ravaged modern society. CLHA stand against the daunting task of facing health problems, economic problems, psychological problems and stigma and discrimination in the community. More than the government organizations the non-government organizations are active in providing life saving support to them. Compared to the magnitude of the problem faced by the CLHA the quantum of support, service and relief they receive is marginal. There is an urgent need for scaled up rehabilitation of the CLHA in a comprehensive and sustainable way by government agencies and donor agencies. Confronted with dwindling health and uncertain future as a result of HIV infection, the CLHA need all the support and help to lead the rest of insecure life with self respect and dignity.