CHAPTER - II

HIV/AIDS and Children
Introduction

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. The world must act now, urgently and decisively, to ensure the next generation of children is AIDS-free. (A Call to Action: Children, the missing face of AIDS. UNICEF, UNAIDS 2005)

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. (Report on the global AIDS epidemic; UNAIDS, 2008)

How do children contract HIV/AIDS?

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. In Sub-Saharan Africa 16% of young females (aged 15-19) and 12% of young males report having sex before they were 15. In Lesotho, these figures are 16% and 30%, respectively; in Kenya, 15% and 31%.8 Studies have thrown up the alarming fact that India is no exception and quite a few infections among children are obviously related to indulging in unsafe sex. The more important of them of listed below.

- More adolescents are sexually active before marriage and at times this is as early as twelve years.
- Due to earlier experimentation with sex, the prevalence of sexually transmitted infections (STIs) and reproductive tract infections (RTIs) are quite high.
- Sex education and HIV related awareness is not freely available to children in India. Girls have next to no information. Misinformation is rampant among boys.
- Children seldom use healthcare services for conditions like STIs and RTIs and the existing healthcare services do not cater for such problems in adolescents.
- Trafficking young girls in country is very high. Street children and child workers are vulnerable to sexual exploitation. Some have sex for mere companionship.
- Often, young girls are in the sex trade to support their poor families; few others are introduced to drugs and then forced into prostitution to feed their habit.

In some cases children have become infected with HIV through sexual abuse and rape. This is a significant problem in many areas. For instance, in parts of Africa, the myth that HIV can be cured through sex with a virgin has led to a large number of rapes - sometimes of very young children - by infected men.9 In some cases, young children are coerced into sex work, which can put them at a very high risk of becoming infected with HIV.
Prevention of HIV infection among children

Males who engage in high-risk behavior and subsequently HIV infected are said to act as a “bridge” population who may transmit HIV to their wives. Children account for 5-10% of HIV infection world-wide. 90% of children with HIV are infected by their mothers. Without interventions, there is a chance that a baby born to an HIV-infected mother will become infected (MTCT is (30% (21-43%))

At the end of 2007, there were 2 million children living with HIV around the world, mainly through mother-to-child transmission. Almost all of these infections occur in developing countries and about 90% of them occurred in Africa. India has its own share of the MTCT.

Most of the MTCT infections could be averted. The most effective way to prevent mother-to-child transmission of HIV involves a long course of antiretroviral drugs and avoidance of breastfeeding, which reduces the risk to below 2%. Since 1999, it has been known that much simpler, inexpensive courses of drugs can also cut mother-to-child transmission rates by at least a half. The most basic of these comprises just two doses of a drug called Nevirapine - one given to the mother during labour and the other given to her baby soon after birth. These short-course treatments, combined with safer infant feeding, have the potential to save many tens of thousands of children from HIV infection each year. Recognising this potential, the member states of the United Nations set targets for preventing mother-to-child transmission in 2001, as part of a landmark agreement called the UNGASS declaration.

‘Prevention of Mother-to-Child Transmission’ (PMTCT) is a three-fold strategy and is practiced in almost all countries.

- Preventing HIV infection among prospective mothers
- Avoiding unwanted pregnancies among HIV positive women
- Preventing the transmission of HIV from HIV positive mothers to their infants during pregnancy, labour, delivery and breastfeeding.
The problem with MTCT is that very few of the world's pregnant women are being reached by PMTCT services. In developed countries MTCT has been virtually eliminated thanks to effective voluntary testing and counseling, access to antiretroviral therapy, safe delivery practices, and the widespread availability and safe use of breast-milk substitutes. Despite the UNGASS target, in 2005, only 9% of all pregnant women were offered services to prevent HIV transmission to their newborns. Among pregnant women with HIV, just 9% received preventive drugs - barely making a dent in the number of infant infections. (Report on the Global AIDS Epidemic, UNAIDS/WHO May 2006)

Unfortunately, prevention of mother-to-child-transmission (PMTCT) services fail to reach most women in resource-poor countries. In 2007, only 33% of HIV-infected pregnant women in low- and middle-income countries received drugs to protect their babies from infection. Reasons for this lack of coverage are discussed in our PMTCT worldwide page, while our Stop AIDS in Children campaign calls for rapid improvement.

The use of sterile medical equipment and screened blood products can help to prevent children becoming infected through medical transmission. Where children are becoming infected through non-MTCT routes, abstaining from sex or injecting drug use is the most effective means of preventing HIV transmission. However, it is inevitable that there will be some children engaging in risky behaviors, through having unprotected sex or needle sharing. Promoting abstinence could be ineffective if complementary HIV education, including the promotion of safer sex and learning how HIV is transmitted through drug use, is not also provided.

HIV and breastfeeding: For most babies, breastfeeding is without question the best way to be fed, but unfortunately breastfeeding can also transmit HIV. When a mother has HIV, the dangers of not breastfeeding must be balanced against the risk of HIV transmission. This result in a painful dilemma for millions of women in developing countries, for whom there are no easy options.
AIDS orphans

Important dimension related to HIV/AIDS is not only Children living with HIV/AIDS but also AIDS orphans. If the children lose at least one of their parents due to AIDS related reasons they are called AIDS orphans.

With an estimated 33 million adults living with HIV around the world, large numbers of children have family members that are living with HIV, or who have died from AIDS. One of the harshest effects of the global AIDS epidemic is the number of orphans it has created, and continues to create. By the end of 2007, it is estimated that more than 15 million children had lost one or both of their parents as a result of AIDS, a significant increase on the estimated 8 million in 2001.22 Some AIDS orphans are adopted by grandparents or other extended family-members, but many are left without any support. Child-headed households as a result of AIDS are common in some areas, with older children fending for their siblings and themselves.

Worldwide, it is estimated that more than 15 million children under 18 have been orphaned as a result of AIDS. Around 11.6 million of these children live in sub-Saharan Africa. In countries badly affected by the epidemic such as Zambia and Botswana, it is estimated that 20 percent of children under 17 are orphans - most of whom have lost one or both parents to AIDS.

AIDS is responsible for leaving vast numbers of children across Africa without one or both parents. In some countries, a larger proportion of orphans have lost their parents to AIDS than to any other cause of death - meaning that, were it not for the AIDS epidemic, these children would not have been orphaned. Even with the expansion of antiretroviral treatment access, it is estimated that by 2015, the number of orphaned children will still be overwhelmingly high.

Most of the AIDS orphans who live outside of Africa live in Asia, where the total number of orphans - orphaned for all reasons - exceeds 73 million. There is, however, insufficient information available to provide figures for the number of AIDS orphans in individual Asian countries. The rest of this page concentrates on AIDS orphans in Africa, although the issues described here are present to some extent in many countries around the world.
Life of a HIV infected Child

HIV disease 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.

Early diagnosis for confirmation of infection in children less than 18 months exposed to HIV through vertical transmission is the cornerstone of treatment, care and support interventions. Providing adequate nutrition and micronutrients at early stages improves immune status, delaying disease progression and mortality. Simultaneously children should be followed up with regular CD4 estimations and clinical evaluations to establish eligibility for antiretroviral therapy. Children on ART combined with appropriate nutritional supplementation respond rapidly, ensuring normal development.

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 list of challenges is indeed daunting: economic uncertainty, denial of property and inheritance rights, illiteracy, malnutrition, illness and physical and sexual abuse. More specifically the segregation/ problem are:

A. In family, neighborhood and social setting:
   - Restriction on entry into own and others houses
   - Restriction on social intercourse with other children
   - Restriction in participation in social get-together
   - Restriction on use of civic amenities especially the water sources
   - Facing derision, abhorrence, avoidance and ridicule of others in social milieu
B. In school setting:
- Discrimination by teachers and fellow students in the classroom, library, school premises and playgrounds
- Forced dropping out from school due to personal and financial reasons;

C. In Health care setting:
- Non Availability of medical facilities
- Avoidance by Medical Staff
- Avoidance by paramedical and auxiliary medical staff
- Non availability of medicine for OIs
- Availability and adherence of ART
- Being referred to a different health care setting to avoid them

D. Other Problems:
- Deteriorating family
- Isolation, trauma, distress and other psychological problems
- Malnutrition
- Financial constraints

The effect of HIV infection has proved to be devastating for the children as well as their parents. 90% of children got the infection from their mother and as such in a majority of the cases both the parents are already infected. Few of the HIV infected children are already double orphaned (both parents dead) and semi orphaned (one parent dead). In case, if both the parents are alive, they are usually infected and are fighting for their life. In a few cases the infected children are bread winners of the family. Being rejected by relatives if parents are dead; malnutrition, failing health, opportunistic infections; dwindling chances of continuing education, struggle for survival, being homeless, distress migration, on the streets, seeking employment (usually physically draining) to avoid starvation and delinquency are the usual ingredients of the life of an HIV infected child.

HIV & AIDS Treatment for Children

HIV develops very rapidly among infants and children, and, without treatment, a third of infected children will die of AIDS before their first birthday, with half dying before they are two. In 2007, there were 270,000 deaths attributed to HIV in under-15s, most of which could have been prevented through early diagnosis and effective treatment. Though the
number of children receiving antiretroviral therapy (ART) has increased significantly in recent years, at the end of 2007 just 200,000 of the 690,000 children needing ART was receiving it. According to non-governmental sources reporting to UNAIDS, it is estimated just 9% of countries with generalized epidemics provide pediatric HIV treatment in the areas where it is needed. Newell, M. et al (2004),

How effective is antiretroviral treatment in children: The most effective treatment for HIV-positive children is antiretroviral therapy. This requires several antiretroviral drugs (ARVs) be taken every day. Antiretroviral treatment reduces illness and mortality among children living with HIV in much the same way that it does among adults. In one study in Brazil, three-quarters of HIV-positive children receiving ART, also known as HAART (highly active antiretroviral therapy), were alive after a four-year follow-up period. A study released in 2007, which monitored 586 HIV-positive children receiving antiretroviral treatment in 14 countries in Africa and Asia, found that 82% were still alive after two years. Some of the most compelling evidence that treatment works in children does not come from studies or statistics, but rather the stories of those who have witnessed HIV-positive children returning to health after starting treatment. UNAIDS (2008)

Starting antiretroviral treatment in children: As with adult treatment, there is ongoing debate about when it is best to start antiretroviral treatment in HIV-positive children. There is a complex balance between the immediate benefits of providing treatment to children who are not showing any symptoms of AIDS-related illness, and concerns about long-term resistance and antiretroviral drug side effects if treatment is started too early. UNAIDS/UNICEF/WHO (2007, April),

To judge whether an HIV-positive person requires treatment, a CD4 test is usually carried out. This measures the number of T-helper cells - white blood cells that are attacked by HIV - in an individual’s blood. It can either measure the absolute number of CD4 cells, or the percentage of white blood cells that are CD4 cells, in a sample of blood. A falling CD4 count is a sign that HIV is progressing, and that the immune system is becoming weaker. In healthy, uninfected adults, absolute CD4 count is usually between 400 and 1600 cells per cubic millimeter of blood. When an HIV-positive adult’s CD4 count falls below 350, it is usually recommended that they start receiving antiretroviral treatment.
For children below the age of six, though, these adult guidelines are generally irrelevant. Children below this age generally have a much higher CD4 level than is usually present in adults, unless their immune system has been damaged by AIDS. The CD4 levels found in children therefore need to be judged in the context of their age, making it difficult to know exactly when treatment should be started. Since percentage CD4 count generally varies less with age, this type of test is generally recommended in children under the age of five. In some cases, viral load testing (which measures the amount of HIV in an individual's blood) is used alongside CD4 testing to guide decisions about treatment.

**When to start treatment:** Until recently it was generally agreed across guidelines that a child aged less than one year to 18 months with a percentage CD4 count below 20-25% should be started on treatment, whether symptomatic or not. However, the findings of one study prompted WHO to revise their guidelines and it now recommends that all diagnosed children under 12-months should begin antiretroviral therapy regardless of the infant's clinical or immunological stage. The Children with HIV Early Antiretroviral Therapy (CHER) study of infants (aged six-to-twelve weeks) in South Africa compared the outcomes of those starting limited treatment immediately with those deferring treatment until CD4 percentage dropped below certain levels or if symptomatic and severe disease occurred. (The criteria for deferred treatment were only slightly different from South African or WHO guidelines.) It found the risk of death for infants who began treatment immediately was 76% lower than the deferred treatment group.

**Adherence:** Children on HAART need to take three or more types of ARVs every day for the rest of their lives. If drugs are not taken routinely, at around the same time every day, HIV may become resistant to the therapy, causing it to stop working.

There is evidence that adherence problems are common in children. In one US study, for instance, 43% of people caring for a child receiving treatment reported at least one missed dose in the past week. In less
developed countries, adherence is an even greater challenge. There are a number of factors that commonly cause adherence problems: inadequate dosing; high pill burden; reluctance among young infants to take syrups and powders due to their unpleasant taste; dietary restrictions; and toxic side effects of drugs. Adherence issues can put an enormous strain on the daily lives of parents and caregivers, who are usually responsible for administering treatment. Some ARVs need to be taken with food, so carers may have to perform the often difficult task of providing a meal and administering drugs simultaneously. This is assuming that an adequate supply of food is actually available. If fixed-dose combinations appropriate for use in children became more widely available, it is likely that adherence would generally improve, since it is much easier to take a single dose every day rather than multiple doses. The Paediatric Infectious Disease Journal, 19:12(1148)

HIV/AIDS and opportunistic infections among children:
Opportunistic infections, which take advantage of weak immune systems, are a serious threat to children living with HIV. Tuberculosis and PCP (a form of pneumonia) in particular are major causes of illness and death among infected infants. Children are at particular risk of tuberculosis (TB), particularly if they are suffering from a weak immune system due to HIV infection. Co-infection with HIV and tuberculosis in children is increasingly common in many areas. While the basic principles of TB treatment are the same in HIV-positive children and uninfected children, the situation is complicated by drug interactions between ARVs and drugs that are used to treat TB. The drug rifampicin, which is commonly used to treat TB, can react negatively with NNRTIs such as nevirapine, as well as with protease inhibitors. Such interactions can lead to sub-therapeutic drug levels and an increased risk of toxic side effects. For HIV-positive children who are not yet receiving ARVs, it is recommended that treatment for TB should ideally be initiated some weeks before ARV treatment, allowing the child to stabilise on this therapy. For children who are diagnosed with TB while already receiving treatment, ARV regimens need to be carefully reviewed, and may
need to be adjusted in accordance with official guidelines. In order to avoid late diagnosis of HIV, it has been suggested that all TB-infected children should be considered for an HIV test.

Problems with adherence: As well as the unavailability of appropriate drugs, stigma surrounding HIV can also lead to adherence problems if parents and caregivers are unwilling to make it publicly known that the child in their care is HIV-positive. For instance, carers may be reluctant to fill out prescriptions in their local community, or may not make a child's school aware of their condition, which can lead to them missing out on drug doses during the school day. They may also hesitate to administer ARVs if other people are present when a child is due to receive them. For children who are old enough to administer their own ARVs, it can be hard to fit their treatment routine in with their increasingly active social lives. World Health Organisation (2006),

The Community Response

Affronted with the naïve problem of HIV infection among the children the response of government and different international players has been swift. They started working with them, more often than not, by involving civil society organizations and community based organizations. These players have been working with a goal to provide comprehensive medical, nutritional, educational and socio psychological care and support for children infected by HIV/AIDS and also their families and thereby improving the quality of life of the infected. While a few players work on their own the others do that by strengthening community based services. The essential areas of support could be:

- **Medical support**
  - Clinical care
  - Pre ART services
  - ART support
  - ART follow up
  - Palliative care
Different players involved working with HIV infected children is in the process to evolve an effective strategy for intervention. Many trials are on and different policies and programmes are already in vogue. Seminars, workshops and brain storming sessions have been organized to seek direction and path breaking. The efficacy of different programmes of the Government and Non Government Organizations will be assessed in course of time.

HIV infected children around the world:

The figures below show the number of children (defined by UNAIDS as under-15s) directly affected by HIV and AIDS:

- At the end of 2007, there were 2 million children living with HIV around the world.
- Of the 2 million people who died of AIDS during 2007, more than one in seven was children. Every hour, around 31 children die as a result of AIDS.

Most children living with HIV, around 9 out of 10, live in Sub-Saharan Africa, the region of the world where AIDS has taken its greatest toll. Large numbers of children with HIV also live in the Caribbean, Latin America and South/South East Asia. Around 90% of all children living with HIV acquired the infection from their mothers during pregnancy, birth or breastfeeding.

Many countries that had previously seen child-survival rates rise, as a result of improved healthcare, are now seeing these rates fall again. It has been estimated that without AIDS, Botswana's under-5 mortality rate would have been 31 per 100,000 in 2002 compared to 107 with AIDS. By 2010, the country's under-5 mortality is expected to have increased by 100 deaths per 100,000 as a result of AIDS. Most regions of the world, including African...
regions, have seen a decline in child mortality but in Southern Africa, the area most affected by HIV, under-5 mortality has increased.

In Africa, studies suggest that one in three newborns infected with HIV die before the age of one, over half die before reaching their second birthday, and most are dead before they are five years old. Conversely, in developed countries, preventive measures ensure that the transmission of HIV from mother to child is relatively rare, and in those cases where it does occur, a range of treatment options means that the child can survive - often into adulthood. This shows that with funding, trained staff and resources, the infections and deaths of many children in lower-income countries might easily be avoided.

**HIV infected children in India:**

Women and children are increasingly becoming vulnerable to HIV/AIDS. The new findings conclude that 39% of the infected persons in India are women. This indicates the increasing feminization of HIV/AIDS in India. This alarming trend is being observed closely as more HIV positive mothers will unknowingly pass the virus on to their children.

The number of people living with HIV/AIDS in India is estimated to be 2.0 - 3.1 million, giving a national adult prevalence of 0.36 percent. In 2006, HIV surveillance was carried out among pregnant women attending antenatal clinics in 453 districts. A total of 118 districts had HIV prevalence >1% among antenatal attendees and in 16 sites the HIV prevalence >3%. Without treatment an estimated 30% of these women will transmit HIV to their newborns during pregnancy, labor or through breastfeeding after six months. There is effective treatment available, but this is not reaching all women and children who need it.

It is estimated that 70,000 children below the age of 15 are infected with HIV in India and 21,000 children are infected every year through mother to child transmission. A small proportion is also infected by unsafe
injections and infected blood transfusions, a preventable cause which continues in resource limited countries.

**International Commitments made by India for children and HIV/AIDS:** India along with other member states adopted a Declaration of Commitment for HIV/AIDS in the United Nations General Assembly Special Session on HIV/AIDS in 2001. It reflected a global consensus on a framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV epidemic by 2015. The core indicators agreed upon by the Member states including India in 2001 were:

- By 2005, ensure that 90%, and, by 2010, 95% of youth aged 15-24 have information, education, services and life-skills to enable them to reduce vulnerability to HIV infection.
- By 2005, reduce HIV prevalence among young people (aged 15 to 24) by 25% in the most affected countries, and by 2010, reduce it by 25% globally.
- By 2005, reduce by 20% and, by 2010, by 50%, the number of babies infected by HIV by ensuring that: 80% of pregnant women in antenatal care receive HIV information, counseling and other prevention services; HIV-infected women and babies receive treatment, including antiretroviral drugs and breast-milk substitutes.
- By 2005 implement national policies and strategies to build and strengthen government, family, and community capacities to provide a supportive environment for orphans and children infected and affected by HIV/ AIDS including by providing appropriate counseling and psycho-social support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

India is a signatory of the International Child Rights Convention since 1992. The Government has been proactive in developing legislations and
policies to address all form of violation of rights of the children. The fight against HIV/AIDS must include efforts to prevent child protection abuses, which make children particularly vulnerable to the disease. For children orphaned or otherwise made vulnerable by HIV/AIDS, protection of their rights is a key priority. General comment of the Committee on the Rights of the Child, 2003 in relation to children affected by HIV/AIDS provides an authoritative guidance to states parties to the CRC in relation to specific rights or specific situations of children. The committee recommends that there is a need to identify measures and good practices to increase the level of implementation by the States of the rights related to prevention of HIV/AIDS and the support, care and protection of children infected and affected by HIV and AIDS. All the efforts of Government of India culminated in formulation of a policy framework on of 31st July, 2007 to combat the problem of HIV/AIDS among children.

![Table 2.1](image-url)

**The challenges - Children in the context of HIV/AIDS in India**

<table>
<thead>
<tr>
<th>Target population</th>
<th>Adolescents vulnerable to infection</th>
<th>HIV-positive pregnant women</th>
<th>HIV-positive children</th>
<th>Children orphaned or affected by HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Biologically and behaviourally most at risk of infection</td>
<td>Can infect new born children before, during or after birth</td>
<td>Likely to die within two years unless diagnosed &amp; treated</td>
<td>Parental illness often leads to poverty and disintegration of family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social impacts as for affected children</td>
<td>Stigma often leads to exclusion from family and community support, and from public services and entitlements</td>
</tr>
<tr>
<td>Actions</td>
<td>Life-skills education in schools</td>
<td>Diagnose (VCT and ANC) PPTCT</td>
<td>Paediatric ART Early diagnosis and treatment</td>
<td>Diagnose and treat parents</td>
</tr>
<tr>
<td></td>
<td>Targeted interventions with high risk groups and out of school adolescents</td>
<td></td>
<td>Help parents and children cope with medical and psychosocial issues</td>
<td>Ensure access to standard services and entitlements for all children – including those affected by HIV/AIDS</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Address social impacts</td>
<td>Redress the rights of those excluded, and refer for additional services where required.</td>
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</table>
Policy Framework for Children and AIDS' - India 2007

Overall Goal

India will provide a sustainable and integrated system of HIV prevention, counseling, testing, treatment, care and support to ensure that children who are vulnerable to HIV-infection or who are HIV-positive or otherwise affected by HIV/AIDS enjoy the same benefits and opportunities as all other children to develop their full potential.

Children affected by HIV/AIDS include a relatively small number of children who are HIV-positive and a far larger number who are not infected but whose parents are living with, or have died of AIDS. In addition, there is an even larger group of adolescents who are at a heightened risk of HIV infection because they engage in unsafe behaviour or live in communities which are vulnerable to HIV.

The Government of India is committed to preventing HIV-infections and mitigating the medical impact of the virus on the lives of those already infected. It has already provided a detailed vision of how it proposes to do so in the National AIDS Control Programme 2007-2012 (NACP III). The Policy Framework adopts a rights based approach. It takes into account recent changes in the global understanding of the adverse impacts of HIV/AIDS on children, and of the best ways to address them. It is cognizant of advances in medical science.

The first priority of this Policy is to prevent HIV infection, in order to ensure an AIDS-free generation. In addition to prompt diagnosis, the focus will also be to ensure access to treatment to prolong life. Treatment of parents is vital to maintain family cohesion and protect the best interests of children. And where families are affected by HIV/AIDS, the imperative is to ensure they are not excluded from the same services and opportunities as others. For families affected by HIV/AIDS the Policy will seek to ensure their inclusion and access to social services and opportunities.
Policy framework:

- provides rights-based programming guidance to MOHFW (NACO & NRHM), MWCD, MHRD and MSJE to develop and implement programmes for children and AIDS in a coordinated manner;
- forms the basis of implementation by all donor agencies, international NGOs and civil society organizations, private foundations, and other like stakeholders/partners, working in the area of children and AIDS under the leadership of Government;
- Complement Policy guidance in NACP III and the GOI 11th Five Year Plan on issues concerned with children.

The Policy Framework will focus on

- Pregnant HIV infected women.
- Children including adolescents who are vulnerable to HIV infection.
- Children who are HIV infected.
- Children who have a parent (or two) who has died from AIDS related conditions.
- Children who have a parent (or two) who is HIV infected.

Strategies to implement this Policy must employ a life-cycle approach while keeping elimination of stigma and discrimination central to the formulation, implementation and monitoring of all policies, programmes and activities. Evidence based strategies based on the Global Campaign are as follows:

- Primary prevention - to reduce and eliminate HIV infection among adolescents by encouraging behaviour change and linking to services.
- Prevention of parent to child transmission - to reduce vertical transmission of HIV from mother to child before, during or after birth, ensuring access for care and treatment of mothers and follow up care of mothers and infants;
- Pediatric AIDS treatment - to diagnose and treat new-born children, ensure drug adherence and provide assessment based nutritional supplementation;

Protection and care of children and families affected by AIDS - to ensure that children who have been orphaned by AIDS, have a parent who is HIV-positive, or are HIV positive themselves, have equal access to family and alternate care and services without discrimination and on par with other children in their communities. While the framework focuses on children, it does recognize that
children grow up in families and communities and interventions need to take place in that context. This subsection is drawn from the SAARC Regional Framework for programming for children affected by HIV/AIDS, and will evolve in line with that document. SAARC Regional

Key actions include

- Strengthen existing public health infrastructure to scale up access to youth-friendly health services;
- Integrate prevention, care, support and treatment with NRHM initiatives through RCH;
- Expanding access to institutional deliveries for increasing uptake of ARV prophylaxis as part of PPTCT services, family planning and abortion services, STD treatment, health education such as nutrition, breast feeding, alcohol, drug abuse etc.;
- Treatment of TB and opportunistic infections through TB control programmes.
- Treatment of opportunistic infections through public health infrastructure located as close to the community as possible;
- Institute procedures to prevent stigma and redress discrimination in healthcare settings by raising awareness, knowledge and empathy, and by enforcing hospital infection control and disciplinary action;
- Leverage utilization of existing schemes and programmes to remove financial barriers and ensure social security in order to remove financial barriers and provide social security to children affected by HIV/AIDS;
- Ensure supply of and access to condoms to young people at high risk through innovative distribution systems and promote dual use of condoms;
- Ensure access to safe blood;
- Train all health care providers in public health facilities at all levels on HIV prevention and against stigma and discrimination;
- Strengthen data management and review performance at state and district levels;
- Strengthen district health societies to oversee the implementation by DAPCU
- Expedite the processing of the HIV/AIDS Bill and utilize existing policies and laws to protect children against stigma and discrimination.
The key interventions for operationalizing the above are capacity building of service providers, building of an enabling environment, and the implementation of monitoring systems. The monitoring system will incorporate HIV data such as the use of condoms during last sex among 15-19 year old, and the proportion of young people aged 10-19 who are HIV positive.

**Strategic Objectives**

- To create a non stigmatizing environment, enabling access by children and young people to prevention services including complete information and skills to protect themselves from and reduce their vulnerability to HIV infection;
- To identify HIV-infected parents and children early, and to provide high quality treatment and support to prolong and maintain the quality of life, and to ensure they are able to fulfill their potential and responsibilities;
- To ensure that affected children - whether HIV positive or not - are not excluded from or treated differentially by service providers in the public and private sector;
- To eliminate stigma and discrimination by overcoming myths and misconceptions in relation to HIV/AIDS, and by implementing regulatory and legal measures to address discrimination wherever it occurs.
- To ensure social protection measures are in place to prevent and redress violations of their rights and entitlements

**Strategic Responses**

The concepts of universal and targeted interventions; mainstream or HIV/AIDS-specific interventions and supply - or demand-driven services are the strategic responses proposed in the policy.

**Targeted vs. universal (or systemic) interventions:** Targeted interventions identify a specific group of people as the recipients of a service, while universal or systemic interventions aim to provide that service to everybody. Many medical interventions are targeted - attempting to locate and treat people who need that treatment - while public awareness interventions are generally universal, attempting to get a message to all people in a given area.
Mainstream vs. HIV/AIDS specific: A school or anganwadi centre is “mainstream”, while an ART or VCT centre is HIV/AIDS specific. However, it is possible to have HIV/AIDS specific services within a mainstream institution - for example voluntary testing in an antenatal clinic, or preventive (life-skills) education in a school. It is also possible (although nearly always undesirable) to have mainstream services within an HIV/AIDS specific institution - for example offering regular school classes in an institution for children orphaned by AIDS.

Supply-driven vs. demand-driven services: Supply driven services attempt to locate beneficiaries to “deliver” a particular service, and are measured by how many services are supplied (e.g.: as a proportion of the number estimated to need that service). Demand-driven services attempt to persuade people to come forward and “demand” a service, and are measured by the number of people who ask for the service.

The following table categorizes the indicated actions according to service type and classification.

Table 2.2

<table>
<thead>
<tr>
<th>Objective for the child</th>
<th>Method</th>
<th>Service type</th>
<th>HIV/AIDS specific?</th>
<th>Supply-or demand-driven?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention</td>
<td>Behaviour development and modification</td>
<td>Universal, information</td>
<td>Yes</td>
<td>Supply</td>
</tr>
<tr>
<td>Overcome stigma</td>
<td>Overcome myths &amp; misconceptions</td>
<td>Universal, information</td>
<td>Yes</td>
<td>Supply</td>
</tr>
<tr>
<td>Overcome discrimination</td>
<td>Awareness of children’s rights &amp; entitlements</td>
<td>Universal, information</td>
<td>No</td>
<td>Supply</td>
</tr>
<tr>
<td>Screening &amp; referral</td>
<td>VCT</td>
<td>Targeted service</td>
<td>Yes</td>
<td>Demand</td>
</tr>
<tr>
<td>Family support - medical</td>
<td>Parental ART, PPTCT</td>
<td>Targeted service</td>
<td>Yes</td>
<td>Supply</td>
</tr>
<tr>
<td>Family support - social/medical</td>
<td>Counselling</td>
<td>Targeted service</td>
<td>No</td>
<td>Demand</td>
</tr>
<tr>
<td>Diagnosis and Treatment of AIDS</td>
<td>Paediatric ART</td>
<td>Targeted service</td>
<td>Yes</td>
<td>Supply</td>
</tr>
<tr>
<td>Family support - social</td>
<td>Facilitate access to services</td>
<td>Universal access</td>
<td>No</td>
<td>Demand</td>
</tr>
<tr>
<td>Alternative care</td>
<td>Family based care and Institutional care</td>
<td>Universal access</td>
<td>No</td>
<td>Demand</td>
</tr>
<tr>
<td>Enforce rights</td>
<td>Legal intervention</td>
<td>Universal access</td>
<td>No</td>
<td>Demand</td>
</tr>
<tr>
<td>Address discrimination</td>
<td>Redressal mechanism</td>
<td>Universal access</td>
<td>No</td>
<td>Demand</td>
</tr>
</tbody>
</table>
HIV/AIDS Bill, a comprehensive policy: Under the NACP II programme efforts were made to enforce the rights of people living with HIV/AIDS and people vulnerable to infection. A bill to this effect was developed and placed before the parliament; this is yet to become an Act of Parliament. The bill proposes to prevent and address any form of discrimination, which may result due to HIV for all affected people. It states that the National AIDS authority is responsible for making available counseling protocols for HIV testing and stresses on more elaborate ones for children which includes details on informed consent from children and disclosure. The bill proposes that every person below the age of 18yrs should have access to HIV related IEC. Under the clause (d) related to education it proposes age appropriate information on HIV, prevention, treatment care and support and on stigma and discrimination. The HIV/AIDS bill also provides specific provision to ensure that children affected by HIV/AIDS are not deprived of their right to health, education and right to property & inheritance. The new Government strategy NACP III plans advocate for adoption of this bill, the process towards this needs to be taken up in a more systematic manner so that it becomes law.