" A study of orphan children infected and affected by HIV/AIDS"

-Dr.Irudayasamy.Ph.D

INTRODUCTION

This chapter discusses the definition of the terms Orphan, scope of Orphan and incidence and prevalence details as an introduction to the study.

Definition of Orphans: [1] In order to develop effective and non-discriminatory interventions, allocate resources equitably, and minimize subjectivity in research, agreed-upon definitions are needed. Orphan means either both the parents lost or died, nor single parent died or lost is defined as orphans. Two important examples are definitions of "orphan" and the maximum age of orphan designation. The age of orphans discussed in the subsequent pages.

Orphan Incidence and Prevalence: It is difficult to determine the existing number of orphans, or to make future projections, because of problems of both under-enumeration and over-enumeration. Improved enumeration methodologies can arm policy Planners to be more proactive in developing appropriate community-based responses to anticipated needs. Knowing the age at which orphan-hood occurs is also crucial to planning. Incidence studies of orphans over time are needed to assess the impact on children more fully and to provide insight into migration patterns.

Psychosocial consequences: The psychosocial implications of orphan-hood and the utility of such mitigating practices as youth counseling and should community education, would be examined. it will also be important to understand the impact on all children of growing up in an environment where so many adults and children are ill and dying.

Care Giving: There is an urgent need to understand the circumstances of those who care for children who have been orphaned by HIV/AIDs, to document the availability and limitations of financial and material support to caregivers, and to understand the nature and extent of caregiver burnout and the need for emotional support.

Research is also needed to analyze the cultural, ethnic, and socio-economic variations in families affected by HIV/AIDS and to identify the strength of family support systems, communications networks, and patterns of closeness and partnerships.

Sibling Dispersal: Despite a consensus that surviving children should remain together after a parent's death, orphaned siblings are very commonly separated, often with resulting emotional problems. The nature of this suffering, in both the short term and long term, should be better understood.

Research into the appropriate role that siblings can play in the economic and emotional support of their families, and the informal education of younger siblings, is a related area of exploration. Research would focus on the appropriate balance between recognizing children's value in the household economy and protecting them from exploitation.

Research in the Developed World : In addition to the research described above, knowledge in the developed world is particularly weak in several other areas. These include the economic impact of HIV/AIDS on children and families once the parent has died, or in communities where the disease is entrenched; the impact on school attendance and performance; and the extent to which orphaned adolescents enter the criminal justice system.

In summary, what is ultimately needed is a global strategy that embraces specific local responses, that recognizes interconnections but facilitates local ingenuity and strengthens communities and families to provide environments in which children are protected, nurtured, and given opportunities to thrive. This begins with greater information sharing across national boundaries, encouraging research collaborations and bringing greater visibility to children's issues.

1.1 GLOBAL STATISTICS ON HIV/AIDS

According to UNAIDS* estimates, by December-2005, nearly 42-45 million people including over 2.5 million children - had been infected with HIV since the start of the epidemic. (* UNAIDS/WHO AIDS epidemic update: December 2005)

GLOBAL SUMMARY OF THE AIDS EPIDEMIC DECEMBER 2005

Number of people living with HIV in 2005	Total	40.3 million (36.7–45.3 million)
	Adults	38.0 million (34.5–42.6 million)
	Women	17.5 million (16.2–19.3 million)
	Children under 15 years	2.3 million (2.1–2.8 million)
People newly infected with HIV in 2005	Total	4.9 million (4.3–6.6 million)
	Adults	4.2 million (3.6–5.8 million)
	Children under 15 years	700 000 (630 000–820 000)
AIDS deaths in 2005	Total	3.1 million (2.8–3.6 million)
	Adults	2.6 million (2.3–2.9 million)
	Children under 15 years	570 000 (510 000–670 000)

- Figures taken from www.unaids.org [2]
- The ranges around the estimates in this table defines the boundaries within which the actual numbers lie, based on the best available information.

- Number of people living with HIV/AIDS Total 40 million (42 – 48 million)
- Adults 37 million (31 – 43 million)
- Children under 15 years 2.5 million (2.1 – 2.9 million)
- People newly infected with HIV in 2003 Total 5 million (4.2 – 5.8 million)
- 4.2 million (3.6 – 4.8 million)
- Children under 15 years 700 000 (590 000 – 810 000)

AIDS DEATHS:

- AIDS deaths in 2003 Total 3 million (2.5 – 3.5 million)
- Adults 2.5 million (2.1 – 2.9 million)
- Children under 15 years 500 000 (420 000 – 580 000)

UNAIDS/WHO 2004 Report on the global AIDS epidemic www.unaids.org

1.2 INDIA STATISTICS ON HIV/AIDS:

While the overall prevalence of HIV in India is below 1%, with its huge population size, the country faces an epidemic of large numbers. The spread of HIV in India has increased from an estimated 1.75 million adults in 1994 to over 5 million by 2005. Nearly 80% of these cases are in the six states of Tamil Nadu, Andhra Pradesh, Maharashtra, Karnataka, Manipur and Nagaland.

There are indicators that epidemic may have stabilized in the high prevalence states. This is based on data that HIV occurrence among pregnant women remained constant for three years until 2004. At the same time, surveillance data reveals new indicators of the epidemic. It is moving from urban areas to rural districts and towards women and young people.

Migration among the economically productive sections of society is common. Over 250 million Indians move from one location to another. India also has a large number of truck-drivers and their helpers, ranging from estimates of two to five million people. These mobile groups, who traverse across one of the largest road networks in the world, are considered high-risk carriers of HIV / AIDS infection.

The alarming increase of HIV infection in Manipur City from around 60% to nearly 85% in just three years is largely linked to injecting drug use. Metropolitan cities of Mumbai, Kolkata, Delhi and Chennai also face a major problem of injecting drug use.

The situations and behavior patterns in such groups increases the vulnerability and risk of HIV / AIDS. Until now, AIDS remains an incurable disease, although medical advances have enabled it to be a manageable chronic illness. All those who are infected or are potentially at risk of infection, face this harsh reality.

Of Course, today, if a person is well cared for, HIV / AIDS patients can live with a fair quality of life for a number of years and even work. Equally, a person may live for years after infection without any symptoms or sickness, while they unknowingly transmit the disease to others.

In this context, we cannot forget that the maximum infections are in the continents of Africa and Asia, and in groups that have limited or no access to dependable health care systems.

The epidemic now well into the second decade is marked by its growing heterogeneity. It is primarily driven through the heterosexual transmission mode. The epidemic has moved beyond the high-risk groups and has established a firm foothold in the general population. However the epidemic in the high-risk groups can not be ignored as it

continues to play a critical role in the larger epidemic and therefore requires to be continually monitored and addressed.

Conservative estimates of HIV infection currently stands at 5.2 million.[3] The epidemic is highly concentrated in the southern states (Tamilnadu, Karantaka, Andhra Predesh and Kerala) of the country as well as in Maharashtra and in the northeast. The difference in the prevalence rates across the states is seen to be only a matter of time.

The disconcerting trends of the epidemic include a continuing shift toward women and youth. The implications for the future are in vertical transmission and pediatric HIV. Gender discrimination, the inability to negotiate safe sex and the cultural difficulties in communicating on matters of sex and sexuality remain areas to be addressed. There is also a need for more information through systematic research on risk behaviors, especially in adolescent groups.

The burden of full-blown AIDS cases is now being felt in high prevalence Tamilandu in some districts like Namakkal, Salem, Villupuram , response has been typically delayed and inadequate. Lower cost solutions such as home based and day care are still to be established.

The momentum of awareness programs has tapered off giving rise for concern that intervention programs especially for new adolescents is at present insufficient. The visibility and awareness of HIV has brought its own dimensions. Generally the positive have been poorly received and discriminated against. An area of immediate concern is the issue of stigma surrounding the disease, there is a need to address unnecessary fears and misconceptions of the disease among the general population.

Response to the epidemic has been marked by denial and an unwillingness by even professionals to be involved in the care of positive people. The impact of awareness programs in reducing high-risk behavior has to be documented, this will provide valuable feed back to intervention programs. Policy implementation at the grassroots level and at the first point of contact of positive people and the health care delivery system needs to be critically examined and rectified.

At present there are very few specific programs for the vulnerable and marginalized groups of sex workers and Transgender people, the effect of increasing awareness of HIV/AIDS in these groups has been inadequate, let alone effecting behavioral changes. There are plans by the Government to include initiation of support groups, thrift and savings, livelihood skills training.

1.3 WOMEN SITUATION IN HIV/AIDS

India has the second largest HIV/AIDs infection, and according to the United Nations report AIDS is the fourth largest killer after heart attacks, stroke and respiratory infection. 3.1 million have died due to AIDS since the start of the epidemic. Presently India has 5.2 million HIV Positive cases(2003). children are 0.04%. 50% of them were women.

More than often men are infected first and pass on the disease to their wives. The women are then widowed, disowned by both families and being generally unskilled find themselves with no public or social support systems to seek out, this along with the burden of caring for children in the face of a hostile society. Number of children are became orphan. There is no social support to these children. They were distress, lonely

feelings, no proper food, clothing, and educational support. They forced as a child labor for their survival and to care the next children in the house. There the researcher would like to find out the situation of orphan children infected and affected by HIV/ AIDS

1.4 CHILDREN & ADOLESCENTS IN HIV/AIDS

HIV/AIDS is having a devastating impact on the world's children and adolescents:

Children and adolescents infected:

Child deaths due to AIDS in 2004:	510,000
New HIV infections among children in 2004	640,000
Children living with HIV:	2.2 million

Children affected:

Children orphaned by AIDS:	15 million
Children made vulnerable by HIV/AIDS:	???

Systems affected the health, education, etc., all have direct impact on the wider group of children affected by HIV/AIDS. At present there are very few specific programs for the vulnerable and marginalized groups of sex workers and Transgender people, the effect of increasing awareness of HIV/AIDS in these groups has been inadequate, let alone effecting behavioral changes.

These realities endanger house hold food security both in short term and long term. This has implications in the sustainability of the farming system in terms of loss of labor, changes in the labor availability of both men & women affect the selection of crop species and food production. These leads to low social-economic condition force the children into laborers. Naturally drop outs, discontinued their studies and start earning in cycle shops, provision stores, Hotels, etc. as assisting jobs to the owners.

To authenticate the problems, the researcher would like to study and understand the current situation and quality of life of children, with HIV & their families. The medical, Psychological and social support of children with HIV/AIDS in Puduchathiram Block, Namakkal District, Tamilnadu. The researcher already working in these areas through few social and economical welfare programs for Orphan children infected and affected by HIV/AIDS.

1.5 DEFINITIONS OF KEY TERMS

UNAIDS –United Nations AIDS organization
NACO- National AIDS control organization
TANSACS- Tamilnadu State AIDS control society

According to NACO:

AIDS definition:
Acquired (must do something to contact)
Immune (ability to fight off infections agent)
Deficiency (lack of)
Syndrome (cluster of symptoms that are characteristic for a disease)

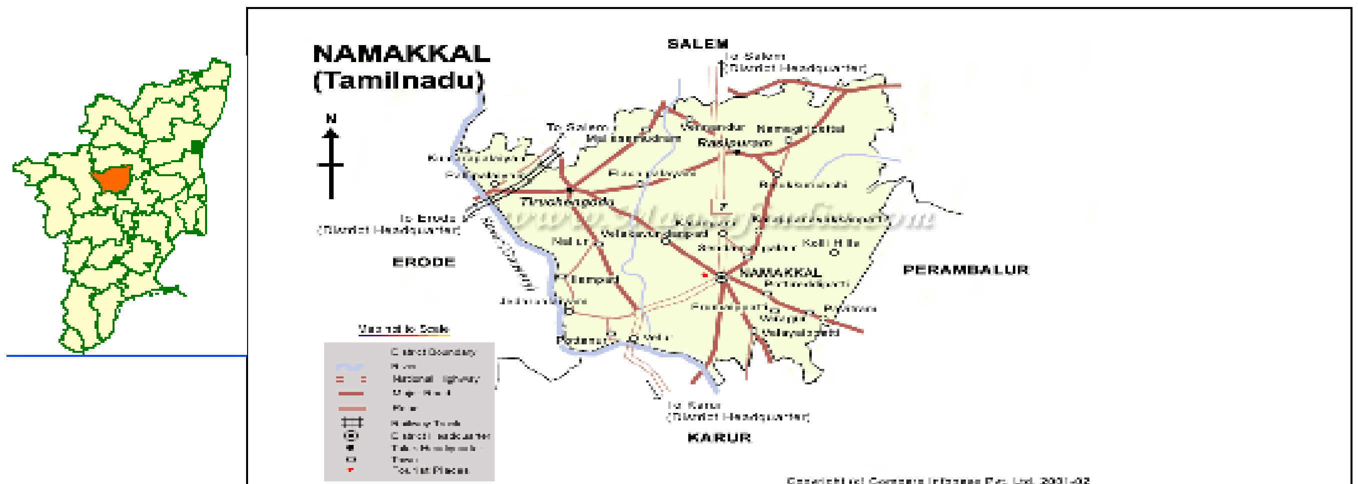
HIV Definition:

Human (Isolated to the human species)
Immuno-Deficiency (lacking the ability to fight off infections agents)
Virus – (a disease causing agent)

1.6 BRIEF HISTORY OF NAMAKKAL

Namakkal District was bifurcated from Salem District with Head Quarters as Namakkal with an Order issued by the Government on 25-07-1996. Namakkal District started functioning as a separate district with effect from 01-01-1997. It has two Revenue Divisions, viz., Namakkal and Tiruchengode and four Taluks viz., Namakkal, Rasipuram, Tiruchengode and Paramathi-Velur.

In Namakkal, Kottai (Fort) area is on the west and the Pettai (Business) area is on the east and at the centre is the rock Namagiri, which is the source for the town's name. The fort covers an area of one and a half acres of flat surface and is accessible from the southwest by a flight of narrow steps. The namam (mark) is the white and red graphic symbol of Vishnu. The symbol is depicted with two white and one red vertical lines.



AREA AND POPULATION – (2001 CENSUS)

The Namakkal district covers 3363 sq.km. Total population is 14,95,661 among these Male population is 7,60,409 and female population is 7,35,252 . The important statistics available below :-

Rural Population	:	9,45,956
Urban Population	:	5,49,705
Density / Sq.Km	:	444
Literates	:	67.66%

Main Workers : 1991 Census

a. Total Workers : 614989

b. Male Workers : 368011

c. Female Workers : 246978

d. Rural Workers : 567879

e. Urban Workers : 47110

f. Cultivators : 168025

g. Agricultural Labourers : 228897

h. Household Industry: 140200

i. Other Workers : 42952

j. Marginal Workers : 34915

Non-Workers : 707726

3. TEMPERATURE (in Degree Centigrade)

Plains

i. Maximum : 44.2

ii. Minimum : 20.1

4. RAINFALL (IN mm)

a. Normal

i. North East Monsoon : 290.7

ii. South West Monsoon : 316.2

b. Actual

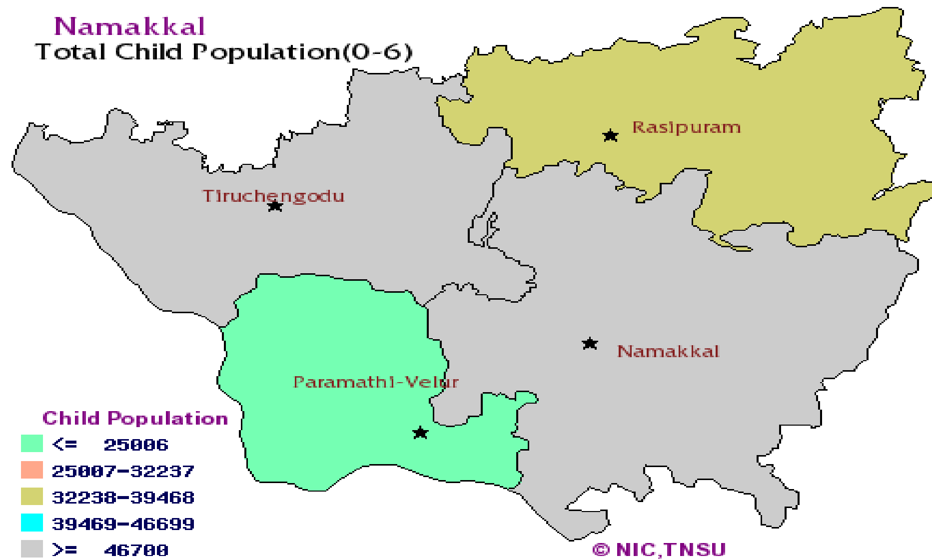
i. North East Monsoon : 164.7

ii. South West Monsoon : 259.8

c. Number of Raining days : 49 days

Namakkal District Child population:

The proposed study area of Puduchathiram block comes under Rasipuram Taluk where the child population is between 32,238 - 39,468. Therefore the selected area is highly child populated area, Refer the underneath the District child population map.



1.7 STATEMENT OF THE PROBLEM AND HYPOTHESIS

PROBLEM:

The present study of orphan children infected and affected by HIV/AIDS aims to find out the problems of orphans in a systematic scientific study to reveal the situation and improve the well being of HIV/AIDS infected and affected children provision of comprehensive care and relevant programs within an enabling environment by the Government and NGOs.

HYPOTHESIS

1. There is increasing problem of orphan children infected and affected by HIV/AIDs in India,
2. Namakkal District in Tamilnadu is very high prevalence of HIV/AIDS and increasing number of HIV/AIDS orphan children.
3. Many affected & infected children are in the adolescent age group where they need support to help them to develop values of life.
4. Life skill education needs to be imparted.
5. Children are discriminated in the society and forbidden to play with other children.

6. Children are not able to continue their studies because of children lost the both parents or the bread winner in the families. This increases the drop out rate in the villages.

7. Children are forced to be a Child laborer.

8. Children are denied in school enrolment school.

9. Lack of access to shelter, good nutrition, health and social services on an equal basis with other children;

1. 8 WHY THE RESEARCHER HAS CHOSEN THE STUDY

" HIV/AIDS is a serious and urgent problem. Without children there can be no nation, there can be no future leaders of our country. - Nelson Mandela

The situation in Africa threatens everybody to thing of their own country. As India develops second largest HIV/AIDS cases, we need to study the situation of Africa and learn few models how they are caring HIV/AIDS orphans and what best we can do for the increasing orphans. Africa is at the crossroads of multiple issues such as poor governance, underdevelopment, conflicts, environmental disasters, economic exploitation, and grinding poverty. However, the HIV/AIDS epidemic is by far the biggest challenge of modern day Africa. With more than 30 million individuals, mostly men and women in the prime of their lives, living with HIV/AIDS in Africa, and less than 5% of these individuals having access to lifesaving medicines, the future is not very promising.

African children infected and affected by HIV/AIDS are the ultimate development nightmare for a continent grappling with major socio-economic problems. According to the UNAIDS, every day, two thousand infants contract HIV through their mothers throughout the world.

Every day, in the entire world, six thousand children lose one or both parents to AIDS. More than 90% of these children are Africans. Every day, sixteen hundred children die of AIDS worldwide. At least 90% of these dead children are Africans. Remaining 10% from developing world (Asia) .Today, every child in Southern Africa is 50% most likely to die of AIDS in his/her lifetime

The worse is yet to come. According to the UNAIDS, UNICEF and USAID, by 2010, at least 20 million AIDS orphans will live in Africa. This is in a continent where children face the deadly combination of high rates of infant deaths, vaccine preventable deaths, under-five mortality, diarrhea-related deaths, and death from malaria. It is also a continent where children face major challenges of going to school, staying in school, eating nutritious meals, and having access to adequate sanitation.

This blueprint, while recognizing distinct local and national issues, will set guidelines and parameters for scaled up continent and international remedial efforts. This blueprint should also set guidelines for regional initiatives, for sharing expertise across national boundaries, and, for creating opportunities for communities to share lessons learned.

To recognize the unique needs of children infected and/or affected by HIV/AIDS, local, national, continent and international remedial efforts should focus on outcome indicators for an index child. Did this infected child receive his/her lifesaving medicines? Did this affected child complete age-appropriate grade school? Did this infected child meet his/her nutritional needs (for example, through age-appropriate weight gain)? Did this affected child leave the streets and move into decent housing? To meet the challenges of these children, each unique need must be met or considered.

Every year, successive cohorts of AIDS orphans will become young adults, the economic and social fulcrum of their societies. No matter what our actions or inaction are these children will assume their natural role as the engine room of their societies. Whether these children are socialized, educated, clothed or fed, they will assume their role in the society. The question is what kind of role we expect these children to play in the future. We have to make ourselves ready to face the epidemic with suitable answers. Therefore this study will help to plan few answers to the questions raised here.

1.9 OBJECTIVES OF THE RESEARCH

- To study the profile of orphan Children infected and affected HIV/AIDs in Puduchathiram Block of Namakkal District , since it is a very high prevalence area.
- To study the effect of HIV/AIDS epidemic among the rural population
- To study the attitude and reactions of neighbors, relatives and communities towards HIV/AIDS infected and affected children.
- To identify the support system existed in the community for proper growth of these children.

References:

1. www.avert.org *" study of orphan report in Africa..*
2. www.unaids.org *UNAIDS/ WHO 2004 Report on the global AIDS epidemic.*
3. www.tnsacs.nic.in The report of HIV/AIDS in Tamilnadu, basic information of HIV/AIDS
4. www.naco.nic.in

RESEARCH METHODS

INTRODUCTION

Methodology is an important aspect of any kind of research work. Each research study has its objectives. The procedure adopted by the Research works for the realization of these objectives is known as methodology.

"Methodology is the science of methods or principles of procedures" (Good, 1945, p.259) the methodology adopted enables the investigation to look at the amorphous data in a meaningful way.

METHODOLOGY:

A detailed interview schedule was developed and the same was interviewed with orphan children infected and affected by HIV/AIDS, relatives, and communities. The Interview schedule included personal details of children (age, sex, caste, education and future ambition etc.,) parents occupation. income and , their HIV/AIDs status.

Second schedule of interview had been collected from the communities and neighbors regarding attitude of communities, Stigma and discrimination , opinion about HIV/AIDS.

SAMPLING AND DATA COLLECTION

Sampling followed through Snow Ball Sampling which means finding out the HIV/AIDS infected and affected adults through person to person. Researcher found out the 50 orphan children through referral from the respondent.

SAMPLE

A study of orphan children infected and affected by HIV/AIDS was done through Snow Ball Sampling which means finding out the HIV/AIDS infected and affected children through person to person. A sample size of 50 orphan children were selected through referral from the respondent. Secondary Data collected from the positive networks, NGOS who are working in these areas, Government Hospital Counselors, Maternity Hospitals, and Orphanage homes.

Most of the children were under age group of 6-13 years. As per the directive principles of Indian constitution the child is referred to less than 14 years of age is considered as child under Indian constitutional law. Therefore the study used the definition of child under 14 years of age.

Since the researcher has been working in this area with verities programs related to HIV/AIDS. One of the program is also on care and support project to orphan children infected and affected by HIV/AIDS. Therefore he established personal rapport with all these children and neighbors. It made him to collect the data easily the targeted samples.

Secondary Data will be collected from the positive networks, NGOS who are working in these areas, Government Hospital Counselors, Maternity Hospitals, and Orphanage homes.

RESEARCH DESIGN

This study is an exploratory study to asses plight and situation of orphan children infected and affected by HIV/AIDS.

TOOLS USED FOR THE STUDY

A structured interview schedule was used to interview all the orphan children. The Tools had consisted of six part and each part was attempted to gather necessary information related to orphans.

Part A Background information about name, sex, religion, caste, age & family
Part B Diseases identification of parents.
Part C Social support system in the community.
Part D Health care system
Part E Access to adequate daily nutrition
Part F Future ambition of child.

DESCRIPTION OF THE TOOL

The tool was simply designed, easy to understand. The researcher have been working in these areas with HIV/AIDS prevention, control programs. The researcher could understand the child's psychology and capabilities. Therefore the researcher designed questions in a very simple way and easy to answer by the children. Some of the questions have scales too.

PROCEDURE

The respondents were identified and explained the purpose of the study, stating that it was only on academic nature. Therefore the children felt free and expressed their answers without any hesitations. The respondent was seated comfortably and relaxed mannered. Then the Researcher asked all the questions one by one to the child and recorded the answers very carefully. Later he also enquired the neighbors and relatives about the discrimination and stigma prevailing in the society.

DATA COLLECTION

The sample size was 50 orphan children. The data was collected in 30 villages of Puduchathiram block, Namakkal District. The orphans may be lost their either both parents or single parents treated as orphans in the study. This was the recent definition given in UNAIDS global assembly. In the process of Data collection the Researcher approached the target group easily since he was working in these areas for the past 3 years by HIV/AIDS intervention programs. Therefore it was easy for him to develop rapport with the children and community. He also co-ordinated with other NGOs and Positive networks working in the target communities.

An interview schedule was taken to know about each respondent personally but the details were not noted in front of the respondent and in other words confidentiality was being maintained at every stage of sharing their problems. The duration of each respondent was for more than 1 hour to 2 hours. In some cases Researcher established a rapport with the respondent took much more time to study the situation. Respondents were ensured that none of their names or village they belong would be published in this research study. A complete confidentiality was maintained.

STATISTICAL ANALYSIS

The data collected from the respondents were analyzed and interpretations were analyzed and showed in tables and graphs in the following chapter.

CONCLUSION

The tools of the study above mentioned were administered to the sample of 50 orphan children infected and affected by HIV/AIDS. Details of the analysis of the data were given in the next chapter.

ANALYSIS AND INTERPRETATION

INTRODUCTION

This Chapter deals with the presentation of analyzed data by using different techniques. Different diagrammatic presentation and tables were used. Methods by which the particulars of the orphan children infected and affected by HIV/AIDS and scoring procedure were adopted. For the purpose of testing the hypothesis sound statistical principles were employed.

ANALYSIS

The study has analyzed the age of the children, the sex of the children, Educational level of children, occupation of parents, Parents' life situation and diagnosis of HIV/AIDS patients diagnosed.

Table No. 1 Age of the children

Age of the children in years	No. of children	Percentage
0-3	8	16
3-6	12	24
6-9	18	36
9-12	5	10
12-15	7	14
Total	50	100

Table No. 1 shows the age of the children. According to this study analysis, 36 percent of the children are in the age group of 6-9 years and 24 percent of the children are in the age group of 3-6 years. This shows that many parents die due to infection of HIV when the child is in the early adolescent age or when they are entering the adolescent period. Hypothesis 3 proves that most of the children affected & infected are in the early adolescent age group , where they need support to help them to develop values of life. Usually adolescent children need more support from the parents to help them to judge the value of life. But due to this they face more turmoil in life and could not develop the right values in life.

Mean of the Age group

Age of the children in years	Mid value – x	No of children or frequency –f	xf
0-3	1.5	8	12.0
3-6	4.5	12	54.0
6-9	7.5	18	135.0

9-12	11.5	5	57.5
12-15	13.5	7	94.5
		50	353.0

N= 50 $\Sigma xf = 353$

$$m = \frac{\Sigma xf}{N} = \frac{353}{50} = 7.06 \text{ years}$$

Mean age of the children is 7.06

Figure No.1 Simple Bar diagram of Age of the children.

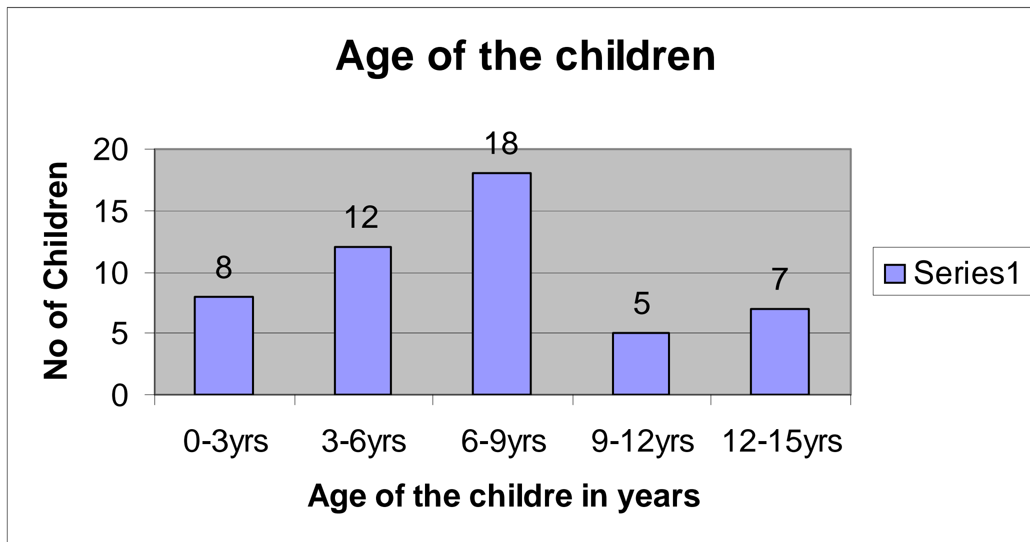


Table No. 2 Sex of the children

Sex of the children	No. of children	Percentage
Males	22	54
Females	28	56
Total	50	100

The above table analyses the sex of the children. According to the table 56 percent of the children are Females and 54 per cent of the children are males. Girl children are high in percentage which means the family need to find very difficult to manage the future of the girl specially the marriage and setting up life of them. Already the society has the discrimination and stigmatization of HIV/AIDS in the community. These girls would find very difficult to get brides for them in future.

Table No. 3 Religion of the children

Religion	No. of persons	Percentage

Hindus	44	88%
Christians	-	-
Muslims	6	12
Total	50	100

Table No. 3 shows that 88 per cent of them children are belongs to Hindus religion and 12 per cent of them are representing Muslims. There is no evidence of Christian children infected and affected by HIV/AIDS in the society particularly in my study.

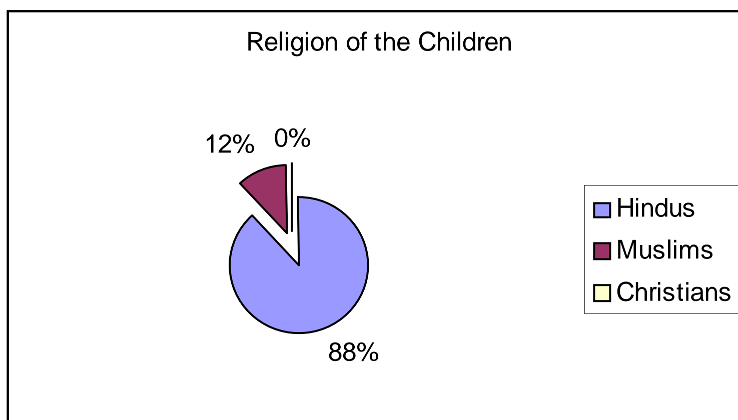


Figure No.2 Pie- Diagram – Religion of the children
The Figure No 2 . shows the religion of the Children.

Table No. 4 Caste of the children

Caste	No of children	Percentage
Schedule caste	34	78
Schedule Tribe	6	12
Backward caste	10	20
Total	50	100

Table No.4 shows that 78 percent of the children belongs to Schedule caste and 12 percent of them are schedule Tribe. There are 20 percent of Backward communities. It correlates with the income and poverty in the particular caste groups.

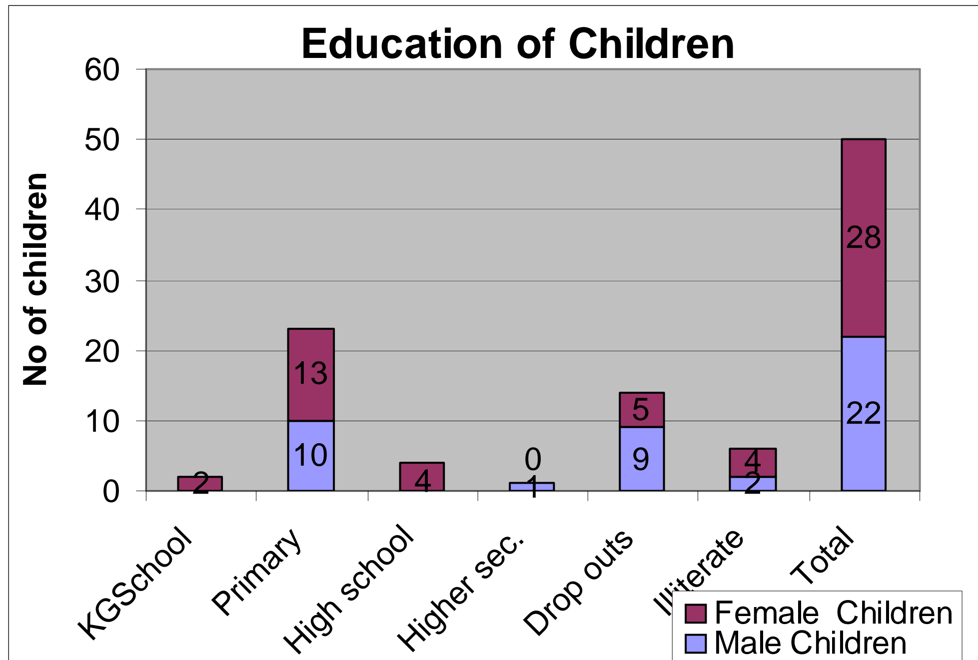
Table No. 5 Education of children

Education of children	No of children		Percentage		Grand Total
	Boys	Girls	Boys	Girls	
Kindergarten KGs school		2		4	
Primary school (1- 5 std)	10	13	20	26	
High school (6 – 10)		4		8	
Higher secondary (11- 12)	1	-	2		
Drop outs from school	9	5	18	10	

Illiterate	2	4	4	8	
Total	22	28	**44**	**56**	**100%**

Table No.5 shows about the education of the children. 20 percent of male children and 26 percent of female children are continuing their primary education. 8 percent of girl children are studying in High school and only 2 percent of male children only studies in Higher Secondary school. 96 percent of children are studying only in Government school. 4 percent of children studying in private school , Its only a kindergarten school.

Figure No: 3 Education status of the children



Above Diagram No :3 Sub-Divided Bar Diagram shows the educational status of the children. There are 18 percent of male children and 10 percent of girl children were drop out their studies. This is due to discrimination and stigmatization in the schools. Some schools didn't allow the children in school. Hypothesis 5 & 6 prove that the 28 percent of children were discontinued their studies and forced to be child labor involved in works. Among these 68 percent of the children works in cycle shops, mechanic shops and hotels 32 percent of the children (specially girls) helping their parents in agricultural works.

Table No.6 Occupation of parents

Occupation of the parents	No. of persons	Percentage
Agriculture / coolie	28	56
Truck driver	18	36
Private sector	2	4
Jobless	2	4
Total	50	100

According to Above Table No 6. shows that 56 percent of the children' parents are Agricultural Laborers. 36 percent of children's parents are Truck drivers who runs the heavy vehicle for loading of chickens and other materials to national level loading. They are away from the house more than 15-20 days in a month. There is high chance of contacting sexual partners in roadsides , due to not of control of sexual feelings.

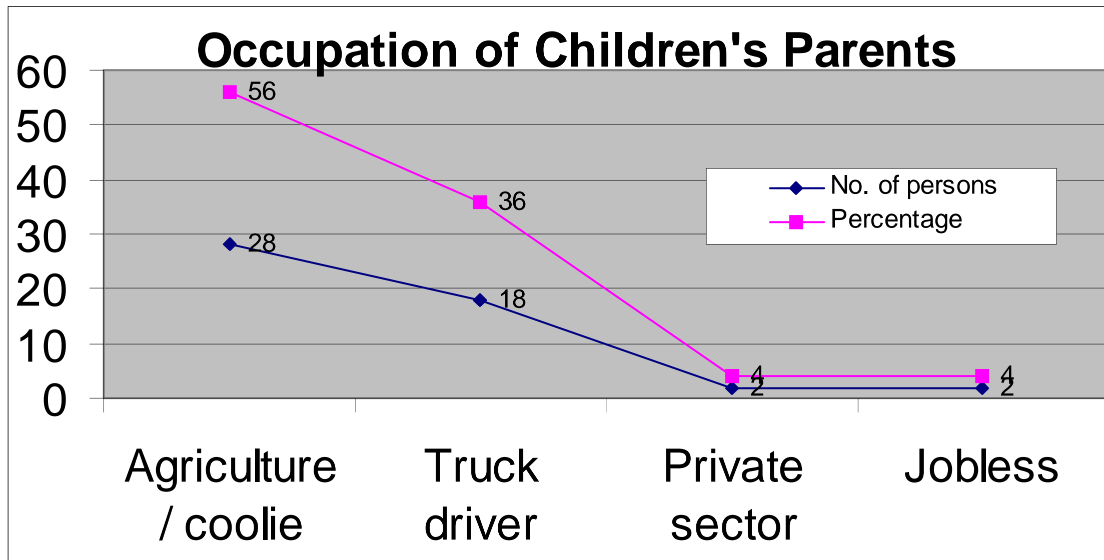


Fig. No. 4 Occupation of Children's Parents

There are only 4 percent of the parents are private sector and other 4 percent are jobless, who can't work due to poor health status.

Table No. 7 Parent's Monthly Income

Monthly income of Parents	No of children's parents	Percentage
Rs.1000- 1500	28	56
Rs.1500- 2000	12	24
Rs.2000- 2500	4	8
Rs.2500- 3000	4	8
Rs.3000- 3500	2	4
	50	100

The above Table No.7 shows that 56 percent of children's parents are under Rs.1000 – 1500 monthly income group. There are 24 percent of children's parents receives Rs.1500-Rs.2000. There are 8 percent of children's parents receives Rs.2000-2500 and another 8 percent of parents receives Rs.2500-3000. Only 4 percent of children's parents receives Rs.3000-3500 as monthly income.

Table No. 8 Life status of Parent

Parents status	No. of persons	Percentage
Father died	22	44
Mother died	13	26

Both died	15	30
Total	50	100

According to the table no. (8) 44 per cent of the children father are not alive. They would have died due to HIV infection. Since father is the breadwinner of our Indian families, the families would definitely face economic problems. So it is very essential to organize some income generation program for women. The table also shows that 30 percent of the children have lost both their parents.

Table No. 9 Number of Children in Families

No of children in a family (x)	**Frequency of Number of families (f)**	**Xf**
0	-	-
1	2	2
2	32	64
3	13	39
4	3	12
Total	**50**	**117**

Σxf 117

Here N= 50 Σxf = 117 $m = \frac{\Sigma xf}{N} = \frac{117}{50} = 2.34$

The mean number of children in a family , m = 2 children

Table No. 10 Number of children working in a family

No of children working in a family (x)	**Frequency of Number of families (f)**	**xf**
0	-	-
1	9	9
2	2	4
3	-	-
Total	11	13

N = 11 Σ xf = 13

Σxf 13

Mean = ----- = --- = 1.18
N 11

Mean = 1.18

The mean number of children working in a family = 1 children

TABLE N0.10 STIGMA AND DISCRIMINATION

DETAILS	Number of children	Percentage
Infected and affected Children not to play with other children	21	42
Infected and affected Children play with other children	29	58
Total	50	100

The above Table No.11 shows that 42 percent of HIV/AIDS infected and affected orphan children were not allowed to play with other children in the villages. There is a village restriction and rules not to play with HIV/AIDS infected and affected children.

Table No. 11 Diagnosis of HIV/AIDS

Diagnosed at	No. of persons	Percentage
Government hospital	32	64
Private hospital	16	32
Not known	2	4
Total	50	100

This table shows that 64 per cent of the children parents were diagnosed as AIDS patients in Government hospitals and 32 per cent were diagnosed as AIDS patients in private hospitals. 4 percentage of children could not identify where the parents got diagnosed.

Table No 12 Food habits of children

Meal	No.of children taking	No.of children not taking meal	Grand total
Breakfast	42 **(84%)**	8 **(16 %)**	50 **(100%)**
Lunch	34 **(68%)**	16 **(32 %)**	50 **(100%)**
Dinner	50 **(100%)**	-	50 **(100%)**

Above table No.12 shows that 84 percent of children taking only Breakfast and 32 percent of children not taking Lunch. 100 percent of children taking night dinner. It's a positive sign that at least all children taking night dinner.

Table No.13 Children taking Vegetarian food

Vegetarian food	No. of children taking daily	No. of children taking Alternative days	No. of children taking Weekly once	Rarely	Grand Total
Carrot	-	13 (26%)	28 (56%)	9 (18%)	50(100%)
Beet root		13 (26%)	28 (56%)	9 (18%)	50(100%)
Brinjal	39 (78%)	11 (22%)	-	-	50(100%)
Greens		33 (66%)	13 (26%)	4 (8%)	50(100%)
Potatoes	39 (78%)	11 (22%)	-	-	50(100%)
Pulses and peas		43 (86%)	2(4%)	5(10%)	50(100%)

Table No.13 shows that 56 percent of children weekly once taking carrots and beet root in their food. 78 percent of children taking Brinjal and Potatoes as chief vegetables in the food. 66 percent of children taking greens in their alternative foods. 86 percent of children taking pulses and peas alternative once in their food. The above table reveals that children are taking inadequate nutritious value foods daily in their food. It develops malnutrition among the children specially the girl children loses their physical strength.

Table No.14 Children taking Non-Vegetarian foods

Food Pattern	No. of children taking daily	No. of children taking Alternative days	No. of children taking Weekly once	Rarely	Grand Total
Egg	-	-	34 (68%)	16 (32%)	50(100%)
Fish	-	-	34 (68%)	16 (32%)	50(100%)
Meat	-	-	-	50 (100%)	50 (100%)
Any other Beef/pork			39 (78%)	11 (22%)	50(100%)

The above table.14 shows that only 68 percent of children takes egg and fish along with their food weekly once and 32 percent of the children taking them rarely. Beef and pork 78 percent of children taking weekly once. Meat 100 of the children rarely consume. Since the cost of meat is very high, they could not buy and prepare it.

Table No. 15 Fruits taking habit of children

Fruits	No. of children taking daily	No. of children taking Alternative days	No. of children taking Weekly once	Rarely	Grand Total
Orange	-	-	34 (68%)	16 (32%)	50(100%)
Papaya	-	-	34 (68%)	16 (32%)	50(100%)
Banana	-	26 (52%)	18 (36%)	6 (12%)	50(100%)
Guava	-	26 (52%)	18 (36%)	6 (12%)	50(100%)
Apple	-	-	18 (36%)	32 (64%)	50(100%)

Table No16. Fruits taking habits of children – reveals that Banana and Guava 52 percent of children alternative days once. Papaya and Orange weekly 68 percent of children taking them and 64 percent of the children rarely taking apple.

Table No.16 Future Ambition of children

Choice of children	No. of children	Percentage
Teacher	23	46
Doctor	5	10
Engineer	3	6
Other works	11	22
Not decided	8	16
	50	**100**

Above table No.16 shows that 46% of children are aiming to become as Teachers and 10% of children planning for Doctor. There are 22 percentage of are working as child laborers and 16% not yet decided their future.

FINDINGS AND RECEOMMENDATION

1. The Study urges the Government and NGOS both National and International agencies should focus the issue of orphan children infected and affected by HIV/AIDS, because its increasing number in villages. In each villages there are about 10-15 children are living as orphans, Global statistics reveals that Millions of children have already lost at least one parent as a result of the AIDS epidemic, and millions more are likely to over the next few years. There is an urgent need to help, care and protect these children, as well as preventing more children from becoming orphans in the future.

2. In many countries a variety of initiatives are now taking place to help AIDS orphans, but in India it is very slow in responding to children infected and affected by HIV/AIDS. The number of children is increasing rapidly, and in many instances the increase in response is not keeping up with the increase in need. There is an urgent need to scale up responses and this is going to need both increased financial resources and commitment over the next few years.

3. The study found that 28% of the children were discontinued their studies due to stigmatize in the school and children could not afford to the pay the school feed and clothing. There is no steps by the government to identify such children and encourage to continue their studies and no legal action against the children. There is no legislation to protect the children infected and affected by HIV/AIDS. In other countries like Africa and Malawi there is an effort to keep children in school, communities have developed three types of response.

4. The first is to lobby local school management committees to not claim fees from the most vulnerable children. A second community strategy is to raise money for orphans' school fees. A third way is the Open Community Schools program - community run schools without fees or dress codes using volunteer teachers, donated space and a curriculum that compresses the first six years into three. Like wise India also should develop some strategy to reduce the school fees or scholarship arrangements to children specially affected and infected by HIV/AIDS, then only the drop out rate would be reduced.

5. Keeping orphans at school is crucial for their future. It can provide education that can work as a safety net in the child's life. Schooling can also help to break the cycle of poverty. But orphans may be the first to be denied education when extended families cannot afford to educate all the children of the household.

6. Government should bring out a policy to take necessary action against the school management committee who denies the school admission for the cause of HIV/AIDS infection whether they are infected and affected by HIV/AIDS.

7. Government should develop a comprehensive National Orphan Policy, based on the Convention on the Rights of the Child. Protection for the Legal & Human Rights of Orphans. Much can be done to ensure the legal and human rights of AIDS orphans. Many communities are now writing wills to protect the inheritance rights of children and to prevent land and property grabbing (an adult attempting to rob orphans of their property once the children have no parents to protect their rights). This should be done to protect the rights of children in properties.

8. Government should initiate an grass root level workers, like Tamilnadu state AIDS Control Society recently announced village counseling centers would help to promote community volunteers and local extension staff - government paid employees, including social workers and family welfare educators. The members could identify and register orphans in the district, and through home visits, schools and churches, screen orphans using established criteria to identify the type of assistance they need. They also initiate community-placed foster placement, and identify local groups who purchase food and clothing and distribute them to orphans.

9. 48% of children are under malnourished condition. Taking inadequate food and vegetables. Only 12% of the children take nutritious food. Therefore the needy orphans should be assisted with food, clothing, blankets, counseling, etc., those children who are going school need to be supported with books, bus fares to and from school, school uniforms and other educational needs.

10. Impoverished and without parents to educate and protect them, orphans and affected children face every kind of abuse and risk, including HIV infection. 22% of children were forced into exploitative and dangerous work – including cheap labors in house work, Hotels, and other causal works.

11. Community discrimination and isolation were practiced in the rural villages. Children were not allowed to play with normal children. Therefore the community needs to be supportive of children when they are orphaned. Orphans need to be accepted as part of the community and to have access to essential services such as health care and education. This means improving existing services and reducing the stigma surrounding children affected by AIDS so they are not stigmatized and denied the services they need.

12. In the early days of the AIDS orphan crisis, there was a rush by well meaning Non-Governmental organizations to build orphanages. But this response was unsustainable given the scale of the problem, as the cost of maintaining a child in such an institution is many times that of other forms of care. Most people now believe that orphans should be cared for in family units through extended family networks, foster families and adoption, and that siblings should not be separated.

13. Children grieving for dying or dead parents are often stigmatized by society through association with HIV/AIDS. The distress and social isolation experienced by these children, both before and after the death of their parent(s), is strongly exacerbated by the shame, fear, and rejection that often surrounds people affected by HIV/AIDS. Because of this stigma and often-irrational fear surrounding AIDS, children may be denied access to schooling and health care. And once a parent dies, children may also be denied their inheritance and property. Often children who have lost their parents to AIDS are assumed to be infected with HIV them. This further stigmatizes the children, reduces their opportunities in the future, and they may also not receive the health care they need, and sometimes this is because it is assumed they are infected with HIV and their illnesses are untreatable.

14. The vulnerability of AIDS orphans starts well before the death of a parent. Children living with caregivers who have HIV/AIDS will often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before the death of the parent or caregiver. Therefore there should be a role of community counselors to provide psychological and social support to children and caregivers.

15. The economic impact of HIV/AIDS illness and death has serious consequences for an orphan's access to basic necessities such as shelter, food, clothing, health and education. Orphans run greater risks of being malnourished than children who have parents to look after them. **Malnutrition and illness –48 percentage of** Orphans and other affected children are more likely to be malnourished or to fall ill – and less likely to get the medical care they need. Poverty is the root cause, but neglect and discrimination by adults in whose care they have been left are also important factors for it.

16. In addition there is the emotional suffering of the children which usually begins with their parents' distress and progressive illness. Eventually, the children suffer the death of their parent(s) and the emotional trauma that results. They then may

have to adjust to a new situation, with little or no support, and they may suffer exploitation and abuse.

17. Since HIV can spread sexually between father and mother, once AIDS has claimed the mother or father, children are far more likely to lose the remaining parent. With parents unable to work and savings spent on care, children are forced to take on the frightening adult responsibility of supporting the family. Children often then find themselves taking the role of mother or father or both - doing the housework, looking after siblings and caring for ill or dying parent(s). This is an additional pardon to the children specially the girl children.

18. To stop HIV transmission, aggressive information, education and communication campaigns must continue. Pregnant women should have access to anti-retroviral therapy that can cut maternal transmission in half. Children and adults living with HIV/AIDS should have access to antiretroviral drugs.

The Researcher therefore concludes that the Governments and Non Governmental Organizations (NGOs) should ensure non-discrimination and equal enjoyment of all human rights through actively promoting the de-stigmatization of children orphaned and made vulnerable by HIV/AIDS. I also urge all sectors of the international community to support program for children orphaned or made vulnerable in affected regions, particularly in Asia.

In my working with orphan children experiencing in working with orphans and other affected children has shown that following strategies are needed to best protect and care for them:

Strengthen the capacity of families to protect and care for their children – by providing free basic education and expanding social welfare and income-generating programs

Mobilize and strengthen community-based mechanisms – by establishing community-level orphan monitoring committees and community day-care centers.

Strengthen the capacity of children and young people to meet their basic needs and fulfill their rights – by providing educational materials, life-skills education and vocational training.

- Strengthen the capacity of families to cope with their problems.
- Stimulate and strengthen community-based resources.
- Ensure that Governments protect the most vulnerable children and provide essential services.

- Build the capacities of children to support them.
- Create an enabling environment for affected children and families. Monitor the impact of HIV/AIDS on children and families.

CONCLUSION:

The Research study produced more highlights related the problems of children infected and affected by HIV/IDS. They need to be focused for their development. We knew that Children are the Future of our Nation but those children should not denied of their basic rights like – education, decent life and protection of their life. Therefore these children are also part of our community. Government and NGOs should initiate lot of research studies and improve the situation. My study is a drop of water in an ocean but more things has to be done to improve the children infected and affected by HIV/AIDS.