SOCIO-ECONOMIC IMPACT ON CHILDREN LIVING WITH HIV

A Case Study of Rupandehi District, Nepal

A Thesis Submitted to
Central Department of Rural Development
Tribhuvan University

In partial fulfilment of the requirements for the
Degree of the Master of Arts (M.A.)
In
Rural Development

Submitted by
BIPIN KUMAR MISHRA
Central Department of Rural Development

Tribhuvan University, Kathmandu
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TRIBHUVAN UNIVERSITY
त्रिभुवन विश्वविद्यालय
CENTRAL DEPARTMENT OF RURAL DEVELOPMENT
ग्रामीण विकास केन्द्रीय विभाग

विभागीय प्रमुखको कार्यालय
कीर्तिपुर, काठमाडौं, नेपाल ।
Office of the Head of Department
Kirtipur, Kathmandu, Nepal.

f. No. :.....

Date मिति.....

Approval Letter

The thesis entitled "**SOCIO-ECONOMIC IMPACT ON CHILDREN LIVING WITH HIV" A Case Study of Rupandehi District, Nepal** submitted by **Mr.Bipin Kumar Mishra** In partial fulfilment of the requirements for the Master's Degree (M.A.) in Rural Development has been approved by the evaluation committee.

Evaluation Committee

.....

Prof. Dr. Prem Sharma
Department Head

.....

Mr. Umesh Acharya
External Examiner

.....

Mr.Prajwal Man Pradhan
Date: 11-30-2073 (B.S.)
03-13-11-27 (A.D.)

Tel.: 977-1- 4333581, 977-1- 4331383, Website: www.cdrd.edu.np, E-mail : contact@cdrd.edu.np

RECOMMENDATION LETTER

This is to recommend that the thesis entitled **Socio-Economic Impact on Children Living with HIV: A Case Study of Rupandehi District, Nepal** has been prepared by **Bipin Kumar Mishra** under my guidance and supervision in partial fulfilment of requirements for Master Degree of Arts in Rural Development. To the best of my knowledge, this thesis work has not been submitted for any degree in any institution. I hereby forward this thesis to the evaluation committee for final evaluation and approval.

……..

Prajwal Man Pradhan

Supervisor

DECLARATION

I hereby declare that the thesis entitled **Socio-Economic Impact on Children Living with HIV: A Case Study of Rupandehi District, Nepal** submitted to the Central Department of Rural Development, Tribhuwan University, is entirely my original work prepared under the guidance and supervision of my supervisor. I have made due acknowledgements to all ideas and information borrowed from different sources in the course of preparing this thesis. The results of this thesis have not been presented or submitted anywhere else for the award of any degree or for any other purposes. I assure that no part of the content of this thesis has been published in any form before.

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Bipin Kumar Mishra

T.U. Registration No: 6-2-52-156-2007

Date: 30/11/2073(B.S.)

13/32017(A.D.)

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ABSTRACT

HIV, an immune deficiency virus is a viral disease which has no treatment till this date. In Nepal there are many reported cases of HIV infected people, the children being the vulnerable case since 1988. At the end of 2014, more than 39,000 people have been infected with HIV in Nepal with 0.2 percent infected young group. In Ruapandehi District more than 1000 people have been living with HIV and 88 children living with HIV. To know about the socio-economic impact on children living with HIV a study was carried out in Rupandehi District to analyze the status of Children living with HIV and the role of existing health facilities of concerned agencies.

The main objective of the study is to find out the socio-economic impact on children living with HIV. This research tries to analyze the current status of Children living with HIV; analyze the socio-economic impact of social security fund on the life of the children living with HIV; analyze the role of existing health facilities of concerned agencies to strengthen and sustain their life to live a better life in upcoming days.

Literature Review was conducted through various sources such as previous studies report, different articles about FMIS, previous thesis and internet to identify the gap. The research was conducted under descriptive and exploratory research design. Both primary and secondary information were collected during the course of study. Primary data were collected through structured questionnaire survey from the farmers. Key informant interview, field visit, observation and focus group discussion were also carried out while secondary data were collected from various published & unpublished information sources i.e. relevant literatures, books, journals, reports, annual reports and other official sources.

In Rupandehi District, the children living with HIV are from different ethnic group and they have at least obtained primary level of education. In most of the cases, children living with HIV have been deprived from their biological parents care as most of children have lost their biological parents. 25 percentage Children Living with HIV have found lost their both biological, 37 percentage Children Living with HIV have found lost their father only and 14 percentage Children Living with HIV have found their mother only. Though 100 percentage

Children living with HIV found having two times meal however 55 percentage Children living with HIV only found having nutritional balanced food in their day to day food. Children living with HIV.77 percentage Children living with HIV have enrolled in school and mostly have been found continuously attending school whereas 67 percentage Children living with HIV have found have rejoined school who once were school drop-out but because of several factors those drop-out Children living with HIV students again have found been enrolled in school.

83 percentage Children living with HIV have been found enrolled in Anti-Retro Viral therapy which improves health status of Children living with HIV from Lumbini Zonal Hospital in regular mode. Children living with HIV have not their health check-up in fixed routine however they have been found having their health check-up in need basis however 71 percentage children living with HIV found having regular health check-up from their nearest health post, district hospital, zonal hospital or community based health care or community care centre. 91 percentage Children living with HIV have got Cluster of differentiation (CD4) check-up whereas remained 9 percentage due to several reasons yet not found have got CD4 check-up. 83 percentage Children living with HIV agree on being some discriminated from society in community in different manners. 66 Children living with HIV have been got enrolled and receiving health facilities run and governed governmental agencies through different phases and different forums. Due to their HIV status Children living with HIV have been facing mixed behaviours from community person in their day to day life. High number of Children living with HIV found not having participated development activities exercised by government in different forums and have not got their equitable participation as well.

All Children living with HIV have been enrolled in Children Affected By AIDS (CABA) Cash Transfer Program and are being benefited from program through monthly Rs.1000 cash support to them to have educational, nutritional and health support which have been found in different lives of Children living with HIV as CABA Cash Transfer program found have been supported to Children living with HIV to have school enrolment or re-join their school, to have ART start-up and continuity, CD4 check-up, regular health check-up, linkages in different types of health related services by government or social organization, provide regular counselling and positive way of living. Care and Support services in Rupandehi district have been found providing health services in home of each Children living with HIV in regular and need basis which has found beneficial for children living with HIV to enhance their quality of life living which has been clearly found in their day to day life.

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ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CABA	Children Affected By AIDS
CBS	Central Bureau of Statistics
CDC	Centres for Disease Control & Prevention
CLHA	Children Living with HIV/AIDS
CLHIV	Children Living with HIV
CHBC	Community Home Based Care
CCC	Community Care Centre
DPHOs	District Public Health Offices
EU	European Union
et al	and others (from Latin *et alii*)
etc	and so forth (from the Latin *et cetera*)
FHI	Family Health International
FSWs	Female Sex Workers
GMHC	Gay Men's Health Crisis
GON	Government of Nepal
GRID	Gay- Related Immune Deficiency
HH	Household
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction & Development
IDU	Injecting Drug User
INGOs	International Non-Governmental Organizations
MDG	Millennium Development Goal
MSM	Male having Sex with Male
MTCT	Mother-to-Child Transmission
NCASC	Nepal Centre for AIDS and SD Control
NGOs	Non Government Organizations
No.	Number
PACTG	Paediatric AIDS Clinical Trials Group
PCP	Pneumocystis Carinii Pneumonia
PLHA	Parents Living with HIV/AIDS

PLHIVs	People Living with HIV
PMTCT	Parents to Mother to C
SADC	Support Activities for Poor Producers of Nepal
S & D	Sex and Disease
S.N	Symbol Number
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TG	Target Group
TU	Tribhuwan University
UN	United Nation
UNAIDS	United Nation Programme on HIV and AIDS
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nation Development Programme
UNESCO	United Nation Educational Scientific & Cultural Organization
UNICEF	United Nation International Children's Emergency Fund
UNGASS	United Nation General Assembly Special Session
USA	United States of America
VSO	Voluntary Service Overseas
WB	World Bank
WHO	World Health Organizations
%	Percentage

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ANNEXES

ANNEX 1: Questionnaire for Household Survey

Name of Interviewer: ……. Date:…….

VDC/Ward:…….. House No:……..

I. General Information:

Name:…….(only if agree)

Sex: Male ☐ Female ☐ Third Gender ☐ Age: ……

Head of Family:……..

Family Occupation:…….

Family Source of Income:…….....

Family Size: Single ☐ Joint ☐

II. Social Status Information:

1. Are you HIV positive? Yes ☐ No ☐

2. Are you living with you parents? Yes ☐ No ☐

✓ With whom you are living?..... (If not living with parents in Q.2)

3. Are your parents alive? Yes ☐ No ☐

✓ If not alive only?

a. Single Orphan

b. Double Orphan (only if No in Q.3)

✓ Who does take care of you?.....(Only if Both parents not alive)

III. Balanced Diet Information

1. How many times you eat your food in a day? Morning ☐ Evening ☐ Both ☐

✓ Why only in morning/evening?.....
(if Only in Morning or Evening in Q.1)

2. What do you eat as your food?.....
3. From where does your family get food and vegetable and other things? Market ☐ Own Kitchen Garden ☐ other sources ☐

✓ What are those other sources?
…… ……(Only if from Other in Q.6?)

4. Are you Vegetarian or Non-Vegetarian?
   a.Vegetarian
   b.Nonvegetarian

5. How frequent you eat meat and eggs?
   a. Daily
   b. In every two days
   c. Once in a week
   d. Once in a month
   e. not have fixed routine
   f. very often (Only if non-vegetarian)

6. How frequent you eat fruits and drink milk?
   a.Daily
   b.In every two days
   c.Once in a week
   d.Not have fixed routine
   e.Often

IV. School Enrollment Status

1. Do you go to school? Yes ☐ No ☐

   - ✓ Do you regularly go to school Yes ☐ No ☐ (Only if Yes in Q.1)
   - ✓ Why do not you go school?.....(If No in Q.8)

2. Were you drop-out from school? Yes ☐ No ☐

✓ If yes than who motivated to rejoin the school?

a. Parents

b. Target group person

c. CABA Cash Transfer Program

d. Above all

3. Who pays your schooling expenses?

   a. Parents

   b. Other source

✓ What is other source?.....(only if Other in Q.2)

4. Who does know your HIV status in school?

   a. Friends

   b. Teachers

   c. No one

5. Do your friends and teachers behave little extra good or bad with you than your other friend because of HIV status? Yes ☐ No ☐
6. Do your school friends play with you in school as like with others? Yes ☐ No ☐
7. Do you like to study and get good marks in school? Yes ☐ No ☐

V. Health Status

1. Are you enrolled in A.R.V? Yes ☐ No ☐

✓ Why are not you enrolled in A.R.V.?.....
(Only if No in Q.1)

✓ From how many months/year are you taking ARV? ……..

2. Where do you go to get ARV?.....
3. Have you fallen serious ill? Yes ☐ No ☐

- ✓ How often you become ill?
  a. Weekly
  b. Monthly
  c. In every two months
  d. Not fixed

4. Do you get regular health check-up? Yes ☐ No ☐

- ✓ How often you get check? (Only if Yes in Q.3)
  a. Weekly
  b. Monthly
  c. In every two months
  d. Not fixed routine

5. Why do not you get frequent health check-up?(Only if No in Q.4)
   a. Health post is far from my home
   b. Do not have sufficient money
   c. Transportation problem
   d. Unknown about health related service center
6. Do you have your CD4 checked? Yes ☐ No ☐

- ✓ Why do not yet you have checked your CD4 status? (Only if No in Q.6)
  a. Distance Problem
  b. Unknown about service center
  c. Do not feel so important
  d. Other (Please specify……)

7. Where do you go for CD4 check? ……
8. From where you get your needed health facilities?
   a. Health post
   b. District/Zonal hospital
   c. Community Home Based Center
   d. Other (Please specify…….)
9. Does any government or nongovernmental organization provide you health related services to you in your home? Yes ☐ No ☐

- ✓ How frequent they visit you to provide health related services?
  a. Weekly
  b. Monthly

c. In every two months
d. Need basis by phonic contact
e. Not have any fixed routine

10. Does any institution provide you health related counseling and suggestion to you at your home visit? Yes ☐ No ☐

If yes, can you point some institution's name who visits you to provide health related counseling and suggestion?.....

……

11. How do you manage health related expenses?
    a. By Self
    b. By family support
    c. By help of some social organization and some other
    d. By other(Please specify……)
12. Does any governmental or nongovernmental organization provide you any support to get your health check-up accessibility? Yes ☐ No ☐

✓ If yes, can you point some institution's name who supports to get your health check-up accessibility?.....

VI. Social Stigma and Discrimination status

1. Do you feel discriminated at anywhere by your belonged persons and other people who know your status? Yes ☐ No ☐
2. Does community person behave with you in discriminated manner at any matter at any point of time and situation? Yes ☐ No ☐

✓ If yes than do they ?a. Exclude your family in community matter
b. Do not keep any relation
c. Avoids in day to day matter
d. Do not care to my family

3. Do you feel discriminated in your school by your teachers and friends because of your HIV status? Yes ☐ No ☐

4. Are you being deprived from any governmental or non-governmental facilities because of you HIV status? Yes ☐ No ☐

✓ Please specify if your being deprived from any facilities of governmental and non-governmental?.....
…….

5. Have you ever felt discriminated in hospitals/health post by health person? Yes ☐ No ☐

✓ If yes than, do they: a. Do not serve in common way
b. Do not make frequent contact for check-up
c. Shows extra self protect in unwanted manner
d. Avoids

6. How does community behaves with you after being informed or known about your HIV status?
   a. Pity
   b. Avoid
   c. Sympathize
   d. Mixed
7. How does your relative behave with you comparatively with other non positive?
   a. Avoid
   b. Sympathize
   c. Do not care
8. What challenges do you face in your day to day life from community?
   a. Community person avoid to me and my family
   b. Do not involve us for any common activities
   c. Non HIV positive friends do not play with me
   d. To step for any assistance
   e. Do not keep any contact

VII. Status of Participation in Development and Social Protection

1. Are you and family participated in any governmental and nongovernmental program? Yes ☐ No ☐

2. Does any institution 'person visit to you and your family to look after you in any manner? Yes ☐ No ☐

- ✓ If yes than are they? a. Governmental Agencies
  b. Non-Governmental Organization
  c. Community Based Organization
  d. Target group

3. Are you being benefited by governmental or nongovernmental organization? Yes ☐ No ☐

- ✓ If yes than: a. Governmental Organization only
  b. Nongovernmental Organization only
  c. Both

4. Which facilities are you receiving from governmental and nongovernmental agencies? Please specify

   ……..

   ……...

5. Are you being enrolled in CABA Cash Transfer service? Yes ☐ No ☐

- ✓ If yes than how do you use this service in your day to day life? Please specify

  ……

  ……

  …….

- ✓ If not enrolled than what are the reasons not being enrolled in CABA Cash Transfer Program? Please specify …….

  ……

6. Are you being benefited by any other programs by District Development Committee/Municipality/Village Development Committee or NGOs under children living with HIV care and support? Yes ☐ No ☐

7. Is any organization specifically working for your care and support and other support? Yes ☐ No ☐

- ✓ If yes please specify:……

  …….

  ……..

8. How social security fund is being beneficial to you?
    a. Assist in regular health check
    b. Get school enrollment
    c. Get some balance food diet
    d. Above all

9. In what aspect CABA Cash Transfer Program helped you?
    a. Helped for my schooling
    b. Helped for balanced food(nutrition)
    c. Helped for frequent health check up
    d. Help for ARV start-up
    e. Above all

VIII. Respondents Comments: ……
……
……...

ANNEX 2: Questionnaire for Key Informant Interview

1. What is your name? (only if you feel free to tell and which will not be disclosed anywhere)
2. What do you do for your living expense?
3. Is your any child being HIV affected?
4. How is community behaving with you and your children when they come to know your HIV status?
5. Are you and your children getting regular health check? And how did you manage your children' health check expanses?
6. What does your family eat in food?
7. Is your family enrolled in ARV and have CD4 check up?
8. Do you feel separated from you community?
9. Have you ever felt stigma and discrimination from your relatives and friends?
10. From where you receive health related facilities and how frequent you go for regular check up?
11. Are your children enrolled in school?
12. How do you manage your children' schooling expenses?
13. Have you ever received any positive beneficial support from any agencies (governmental and nongovernmental) for you an your HIV positive children?
14. Are you involved any programs implemented by any agencies in your community?
15. Does any organization come to your home to give you, your health, psycho-social and counseling along with informative services?
16. Are your children is being benefited by CABA cash transfer program?
17. How do you use the support under CABA cash transfer program for the betterment of your HIV positive children?
18. What problems your children are facing in day to day life? Can you explain it in brief?
19. I heard that some governmental and nongovernmental have been providing some service for HIV positive children and other; could you explain me what services are you receiving from them?
20. What change you found in your children after being benefited by CABA Cash Transfer program?

21. I have heard and known that through CABA Cash Transfer Program and Care and Support program some organization is providing various services to HIV positive children and adult. Can you explain in brief what this type of service these organization providing to you and you HIV positive children?
22. Do you have some word to say……
    …….
    …….

CHAPTER-I
INTRODUCTION

1.1 Background of the Study

HIV in Nepal is characterized as concentrated epidemic. More than 80 percent HIV infections spread through heterosexual transmission. People who inject drugs, female sex workers (FSWs) and men having sex with other men (MSM) are the key populations at higher risk spreading the epidemic. Male labour migrants (particularly to HIV prevalence areas in India, where labour migrants often visit female sex workers) and clients of female sex workers in Nepal are acting as bridging populations that transmit infections from higher risk groups to lower risk general population. As the epidemic is maturing (after the first HIV case reported in 1988), increased number of infections are being recorded among low risk general men and women. However, the epidemic has never maintained through heterosexual transmission in the general population in Nepal, rather driven by the infections among higher risk populations and their sexual partners.

It is estimated that about 55,626 people are living with HIV in Nepal in2010. Majority of infections are occurred among adult (15-49) male (58%) women of reproductive age group (28%) populations, while 8% of infections are occurred among children under 15 years of age. The key populations at higher risk (IDUs, FSWs, MSM, male labour migrants and clients of FSWs) shared 58% of all adult HIV infections. Highest number of infections is estimated is in the age group of 25-49 years who are economically productive and sexually active. The younger stratum of population below the age of 15 has lowest number of infections and most are due to mother to child transmission.

Recent results of reduced new HIV infections are attributed to effective prevention interventions, particularly among key high risk population groups such as IDUs, FSWs and their clients. However, the rate of new infections has increased among MSM/TG in Nepal. In overall, the adult (15-49) HIV prevalence has started declining slowly, while the prevalence has been

declining more rapidly among young populations (15-24). This demands for a continued effective prevention efforts to be sustained among key populations at higher risk, especially among young and new entrants into the risk behaviours. There were significant achievements in the last 5 years. The HIV prevalence is moving to a downward trend and it is at 0.33% in 2011.

Followings are key-population is at most risk stage in HIV transmission:

I. Injecting Drug User (IDU): Those people who inject drugs and mostly who shares needle syringe in the course of injecting drug fall in this category.
II. Female Sex Worker (Female Sex Worker): Those women who establish sexual relationship with multiple partners for any matter fall in this category.
III. Male Having Sex with male (MSM): Those male who establish sexual relationship with other male comes under this category.
IV. Clients of Female Sex Workers: Those male personalities who establish sexual relationship with multiple female partners come under this category.

Children Living With HIV/AIDS (CLHIV)

CLHIV comprised of those children who are HIV positive and have age under 15 years old. As of Nepal Centre for AIDs and STD Control (NCASC, 2013) there were 1900 found HIV infected. These children have directly being affected by HIV as they got HIV virus in their body by born from their parents. They have been facing multiple of problems in their life. Their life is moving in measurable way. They have been deprived to various facilities from state and local level. They have been facing various problems in local and national level. Government of Nepal (GoN) has not played a single role to enhance the quality life of those children who are directly infected by HIV. CLHIVs have very low excess in following areas which are important for growth and development of every single person in their childhood to grow-up as a better person in their life:

i) School enrolment and continuity

ii) Family Capacity and Food Intake (Nutrition Food)
iii) Access to health facility
iv) Participation in development
v) Stigma and Discrimination
vi) Psycho-Social Issues
vii) Social Protection System

There are lots of studies and assessments/research done for different groups including several groups of children; for example Street-Children, Homeless Children, Child Sex Worker, Slum Children and many more. But not much institutions and personalities have done any paper work about the children living with HIV (CLHIV) or Children Affected by AIDs (CABA). UNAID UNICEF, Save the Children, Nepal Center for AIDS and STD Control (NCASC). Since 1988 the 1st HIV case found in Nepal People Living with HIV (PLHIVs) have been facing multiple problem as it is earlier mentioned. As it is also clearly mentioned in Millennium Development Goal that none of children should deprived from School enrollment and continuity; children should have proper food with balance diet; none of any personalities face stigma and discrimination from any aspect at any corner of universe; all personalities should be engaged in decision making and should get their active partnership and so on. Though Nepal has been running several project from People Living with HIV with support of multiple donor agencies in Nepal but Government of Nepal fails to support the Children Living with HIV (CLHIVs) or Children Affected by AIDs (CABA) to strengthen their life.

However Government of Nepal (GoN) through Ministry of Health and Population in February-14, 2014 declared a booklet of rules and regulation to execute "Social Security Fund for Children Living with HIV" for all over country with the partnership of Save the children under Global Fund. Under this Fund those HIV positive Nepalese children get Rs. 1,000 per month as a social security fund under District Health Office by partner organization of save the children. They also do not have proper access in health facilities. As they do not have proper earning they do not afford regular health check and care themselves. They become bound to be unhealthy which may cause their earlier death or to be caught by another health problem.

1.2 Statement of Problem

Children Living With HIV daily face many challenges in society. As they have virus in their body, mainly they face “Stigma and Discrimination”. Though it is very much known about that HIV virus is not communicable virus. It does not transfer from one person to another just by interacting, passing day’s together, using same toilet, shower, etc. It transfers only from blood and sexual activities with one HIV positive person. But those HIV positive children are mainly facing “Stigma and Discrimination” which shows that there is still need of awareness about HIV and AIDs in society.

They have been deprived from School enrollment. As their parents do not have source of income, they do not get chance to have school enrollment and to fulfill the schooling necessity. As per positive discrimination state does not seem to provide any incentive to those families for schooling facilities to their children who were born being HIV positive. Hence they do not become able to get education and further more higher education to strengthen and sustain their life in upcoming days. Children Living With HIV do not get chance to develop their selves and turn their life in new horizon as education turn everyone’s life into new horizon.

As HIV positive families are usually poor and have being neglected from society, they become incapable to earn enough money by which they get well balanced food for themselves and for their affected and infected children.HIV affected children very rarely get two time food intake in nutritional manner as well. Thus they become week and poor by the sense of health manner and also fall weak.

In Rupandehi district, it is found that more than 1000 people have been living with HIV and 88 children have been living with HIV as per District Public Health Office, Rupandehi from all parts of districts. As per discussion with local support groups who have been working in HIV and AIDS, maximum households are from lower economic status ‘background and their children are bound to pass life in miserable way. They did not had proper access on health facilities, school enrollment, proper food intake and did not have psycho-social support and had face stigma and discrimination. However their life have changed in positive manner as some NGOs has been providing health facilities to them in their own house-setting with close coordination of District Public Health Office, Rupandehi and have been bridging to them with district health

agencies. As they have been receiving Rs.1000 per month by save the children under global fund with the close coordination of District Public Health Office, Rupandehi has changed their life as they have been expanding their life in new horizon.

In different studies by UNAID, UNICEF, Save the Children, Nepal Center For AIDS an STD Control (NCASC), Local NGOs and District Health Office shows that these HIV positive spouse along with their affected children have been facing many problem but Government of Nepal has been raising any voice to support their life. Though some of donor agencies have been running care and support program to strengthen their quality of life and support their health facilities but this is not being enough to retain and sustain their life. Though various projects are under execution in many districts by foreign donor agencies for care and support of People Living with HIV including Children Living with HIV.

Thesis Questions

This study aims to find the current status of Children Living with HIV focusing "Health, Education, Nutrition, Stigma and Discrimination and Psycho-social" and the gap between CLHIV and present facilities. Therefore following questions will be integral part of this study:

I. What are the major problems People Living with HIV and Children Living with HIV are facing in their day to day life?
II. What is the current status of Children Living with HIV in School Enrollment, Food Intake (Nutrition), Access of Health Facilities?
III. How does society behave with People Living with HIV and their children (both infected and affected)?
IV. What are the factors that motivate and de-motivate them to live a life? And how do the concerned agencies correlate health services, social phenomena with them?

1.3 Objectives of the Study

The prime objective of this study is to find the current status of Children Living with HIV in the sense of School enrollment (education), Food Intake (Nutrition), Accessibility of Health Facility, Stigma and Discrimination, Psycho-social support towards them in society, and make analysis of their status in the sense fulfillment of the goal of Millennium Development Goal.

Followings are specific objective of this study:

I. To examine the current status of Children Living with HIV
II. To evaluate the socio-economic impact of social security fund on the life of Children Living with HIV
III. To analyze the role of existing health facilities of concerned agencies to strengthen and sustain their life to live a better life in upcoming days.

1.4 Significance of the Study

Since, the study is primarily concerned with the accessibility of Health, Education, Nutrition to Children Affected By AIDs/Children Living with HIV to analyze the fulfillment of the goal of Millennium Development Goal "Combat with HIV/AIDS" which directly supports for the development of humanity and the nation which covers the aspect of Rural Development.The rationale of the study lies in the fact obtained from the analysis of the respondent view over the accessibilities of human right which are cleared by international Global submit and covered by MDG. This study supports the theory of development including rural development and goal of MDG which can be achieved only by having equal access of every person of Rural and Urban on government facilities such as education and health and also have proper food intake (nutrition) and do not have any stigma and discrimination towards any member of society.

Children Living with HIV are dominant in this society in every aspects of their life. They are humiliated and exploited by the society and are also excluded from every economic aspects prevailing in the society. They are actually unaware from the fact that they are being affected with HIV but still they have to face the hurdle in their day to day life. Hence, this study will focus on the socio-economic impact on children living with HIV so, the study is of great valued from both socio-economic as well as academic point of view.

1.5 Scope and Limitation of the Study

The study is mainly confined to Children Living with HIV' pocket areas of Rupandehi District of Nepal. The study will be very specific like that of case studies. So, the conclusion drawn from the study might not be conclusive. The study will represent the whole geographical area and

socio-economic settings. The sample selected was 40% of 200 household i.e. 80 household. As the study area was near to Kathmandu valley the total cost was effective. The time dimension was important limitation factor as the research was conducted for short period of time. The relevancy of the information lies on the assumption that the respondents have given true information and the phenomenon was studied for the one time field visit and analysis was done accordingly.

1.6 Organization of the Study

Chapter I is the introductory section, which includes the background of the study which sheds light on the HIV and Children Living with HIV, national overview on HIV, statement of problem, objectives, significance of the study and assumptions and limitations of the study.

Chapter II is the review of the literature concerned with the present study which includes review of concepts ad theories, review of previous studies, summary of the review and gaps in existing literature.

Chapter III covers the details of the methodology adopted for the research. It includes research survey design, nature and sources of the data and methods of the data analysis.

Chapter IV presents the finding of the study. In this section the results are presented according to the specific objectives. Charts, graphs and diagrams are drawn to illustrate the result.

Chapter V presents the conclusions of the study based on the findings and discussions. Some recommendations are also mentioned in this chapter.

CHAPTER-II
LITERATURE REVIEW

2.1 Definition HIV/AIDS

The human immunodeficiency Virus (HIV) is a retrovirus that infects the body's cells, and destroys or damages their function. The virus weakens the immune system, and makes the body more vulnerable to other infections. Acquired immunodeficiency Syndrome (AIDS) is the most advanced stage of HIV-associated disease. HIV is acquired in different ways including through unprotected sexual intercourse, through transfusion of contaminated blood, through sharing of contaminated needles, and through mother-to-child transmission (WHO 2010a).

Many people have no symptoms after initial HIV infection and may not suspect that they are infected. For some patients, flu-like symptoms appear weeks or days after the initial infection. These symptoms tend to disappear within a few weeks, however. After the first phase, some people can be free of symptoms for years. The disease develops over a period of time, varying from a few months to several years. During this period, the virus continues to kill and destroy the patient's white blood cells of type CD4. These cells are vital in protecting the body against infections. The HIV infections will eventually reach the stage of AIDS when the CD4 count has dropped to a low level. At this point the immune system's ability to fight infection is severely weakened, and the patient is more likely to develop diseases such as cancers, pneumonia, brain infections, and yeast infections (Emedicinehealth, 2010).

2.1.1 Mother-to-Child Transmission

When HIV transmits from a mother to a child during pregnancy, labor, or breastfeeding, this is referred to as Mother-to-Child Transmission (MTCT). The risk of MTCT is 25-45% without intervention. There is a 5-10% risk of being infected during pregnancy, 10-15% risk of being infected during labor and delivery, and 5-20% risk of being infected during breastfeeding (Ministry of Health and Social Welfare, 2007, 3). A majority of infants and young children infected by HIV are infected through MTCT. In 2009, 370,000 children were newly infected with HIV (UNAIDS 2010, 9). A number of factors increase the risk of MTCT. These include

low CD4 count of the mother and high maternal viral load, which is often a reality in newly infected people and in people with advanced stages of HIV; placental infection, such as malaria; ruptures of membranes before delivery; increased contact with the mother's blood or body fluids during delivery, deliveries that are complicated; how long the mother breastfeeds; mixed feeding before the baby is six months; oral disease such as mouth sores or thrush of the infant, breast abscesses, nipple fissures, and mastitis of the mother (Ministry of Health and Social Welfare 2007,3-4).

2.1.2 Preventing Mother-to-Child Transmission

Preventing Mother-to-Child Transmission (PMTCT) is an attempt to decrease the rate of MTCT (WHO 2007, 3). With comprehensive PMTCT interventions, the risk of infection through MTCT can effectively be reduced to 2% for women who do not breastfeed, and to 5% in breastfeeding populations (WHO 2010b, 6).

There are four elements in comprehensive PMTCT program. The first is the element of primary prevention of HIV. Primary prevention includes the following prevention of HIV infection in women of childbearing age, prevention of spread of HIV in health facilities (for instance through blood transfusion with contaminated blood); prevention and treatment of sexual transmitted infections as this increase HIV acquisition; and the dissemination of information regarding HIV. Secondly, the program seeks to prevent unintended pregnancies among women with HIV through family planning and the provision of contraception. Thirdly, prevention of HIV from mother to child for women who are already infected with HIV includes health education, HIV testing of the women and the partners, counselling, antiretroviral treatment and prophylaxis, safe delivery practice, and counselling on infant feeding. Fourthly, PMTCT programs should ensure adequate treatment; care and support for HIV infected women and their partners, children and families (Ministry of Health and Social Welfare 2007, 4-7).

2.1.3 Overview of HIV diagnosis disclosure in Children

As early as 1999, the American Academy of Paediatrics Committee recommended that social aged children and adolescents with HIV be informed about their diagnosis (Committee on Paediatric AIDS, 1999). According to Mialky, et.al, (2001) at the time the recommendations

were made, children who were parentally infected with HIV in the early 1990s were attending public schools in the USA in larger numbers than ever before. However, caregivers in well developed and less developed settings remain reluctant to discuss a child's HIV infection with the child (Mellins, et.al, 2002). One of the major difficulties when the person being disclosed to is a child is that one is dealing with many layers of disclosure of HIV diagnosis to the child; the concomitant disclosure of HIV diagnosis of the parent/s and other siblings or other family members, and having to anticipate the child's own disclosure to his/her friends, extended family and community (Naeem-Sheik and Gray, 2005). The other thing that makes disclosure to children complex is the social stigma and life-threatening nature of HIV infection, parental guilt over parental transmission, or loss of another family member to AIDS makes disclosure difficult for many parents and caregivers (Instone, 2000; Lesch, et.al, 2007).

2.2 History of HIV/AIDS

Although Africa is generally considered as the origin of HIV and AIDS, first reports appeared in various publications in the United States of America (Nicholas and Frederic, 2010; Centres for Disease Control and Prevention (CDC), 1982a). At the beginning of the 1980s various reports began to emerge in California and New York of a small number of men who had been diagnosed with rare forms of cancer and/or pneumonia (Centre for Disease Control and Prevention (CDC), 1981). The cancer, Kaposi's sarcoma, had previously only affected elderly men of Mediterranean or Jewish heritage and young adult African men (Black, 1986; CDC, 1982b), while pneumonia, Pneumocystis Carinii Pneumonia (PCP), was generally only found in individuals with seriously compromised immune systems (Shepard, 1997). However, these men were young and had previously been in relatively good health (Shepard, 1997; Black, 1986) and the only other characteristic that connected them was that they were all gay (Black, 1986).

The first official documentation of the condition was published by the US Centre for Disease Control and Prevention (CDC) on 5th June 1981 (CDC, 1981a). Entitled *"Pneumocystis Pneumonia-Los Angeles*", the report detailed the cases of five young gay men hospitalized with serious PCP, cytomegalovirus, and disseminated candida infections (CDC, 1982c). By 1982 the condition had acquired a number of names-GRID (gay-related immune deficiency),'gay cancer', community-acquired immune dysfunction' and 'gay compromise syndrome'(Oswald, et.al ,

1982). It was not until July in 1982 at a meeting in Washington, D.C., that the acronym AIDS (Acquired Immune Deficiency Syndrome) was suggested (Grmek, 1990). The CDC used the term for the first time in September 1982, when it reported that on average of one to two cases of AIDS were being diagnosed in America every day (Grmek, 1990). At that time within the popular press, AIDS had become a disease of the "four H club"-homosexuals, heroin addicts, haemophiliacs and Haitians-even though there had been cases among non-drug users, non-Haitian women and children (Grmek, 1990). The absence of HIV discovery had led to rapid and silent spread of this epidemic (UNDP, 2009), which coupled with the lack of HIV testing brought untold suffering to the patient populations (WHO, 2006).

Initially the mode of transmission appeared to be restricted to injections and men who had sex with men (CDC, 1982a). However, by 1985, HIV and AIDS cases started to e reported in different countries affecting not only men having sex with men but heterosexual group (WHO, 2006). During that time, various potential causes were considered, including lifestyle factors, chronic drug abuse and many other infections agents (Nicholas and Frederic, 2010). HIV was not identified until two years later in 1983 (Nicholas and Frederic, 2010).

Countries in Africa started reporting more and more cases of HIV and AIDS more than any other continent in the world (UNDP, 2009; WHO, 2006). Sub-Saharan Africa, reported more than the rest of Africa by the end of 1990s (WHO, 2006). Currently, countries in Sub-Saharan Africa still report more cases of HIV and AIDS than any other continent in the world (WHO, 2009; WHO, 2006). Among HIV and AIDS issues that are reported in countries (particularly in Sub-Saharan African countries) include but not limited to stigma, discrimination, increased rates of HIV infection (prevalence rates) and political inaction to combat the HIV and AIDS (UNAIDS, 2009; WHO, 2006). The first published reports on HIV and AIDS have shown the Americans were the first to do so in its early stage but there was political inactivity and lack of commitment by politicians at all levels.

Stigma, Discrimination and increasing prevalence of HIV and AIDS

From the outset, a diagnosis of HIV and AIDS was associated with a high level of discrimination and stigma (Altman, 1983). This prejudice arouse in part because HIV and AIDS was linked to

groups, such as gay men and intravenous drug users, that were already highly stigmatized, but also because evidence-based information about what was causing AIDS, and how it might be passed on, was inadequate(Simons, 1983; Altman, 1983). While most of the scientists investigating AIDS already strongly suspected that it was related to sexual contact and the transfer of contaminated blood, there was no definitive evidence at the time to prove these were the only routes of transmission (Black, 1986). Jacobs (2004) further contends that for a while the American government completely ignored the emerging AIDS epidemic. In a press briefing at the White House in 1982, a journalist asked a spokesperson for President Reagan

"*...does the President have any reaction to the announcement-the Centre for Disease Control in Atlanta, that AIDS is now an epidemic and have over 600 cases?"*

The spokesperson responded- "What is AIDS?"To a question about whether the President, or anybody in the White House knew about the epidemic, the spokesperson replied, *"I don't think so"*(Jacobs, 2004).

Centres for Disease Control and Prevention (CDC, 1988) further acknowledge that while the United States of American federal government failed to respond to the epidemic, a number of non-governmental organizations (within USA) were founded in most affected areas of America, such non-governmental organizations as The Kaposi's Sarcoma Research and Education Foundation in San Fransisco (later renamed the San Fransisco AIDS Foundation) and, in New York, Gay Men's Health Crisis (GMHC). In 1982 GMHC distributed 50,000 free copies of its first newsletter about the syndrome in hospitals, doctors, clinics and the Library of Congress (CDC, 1988). By 1985 the US government had given five pharmaceutical companies licenses to develop a test, and in March in 1986, the first blood test for identifying antibodies to HIV was made commercially available (Abbott, 2008). The test was produced by Abbott Laboratories, and soon began to be used in a number of blood transfusion centres (Grmek, 1990; Abbott, 2008). At that time 73 cases of haemophilia-associated AIDS had been reported (Grmek, 1990; Abbott, 2008). It is estimated that by 1986 (when a heat treatment was introduced to kill HIV in blood products), more than half of all haemophiliacs in America had become infected with the virus (Grmek, 1990).

Mother to Child transmission of HIV

One of the key health problems in relation to HIV infection is the transmission of HIV from the mother to the child (UNAIDS, 2009). In 2002, an estimated 800,000 children were infected with HIV -1 through mother to child transmission and more than 90% were in resource poor countries such as Malawi, Uganda and Zimbabwe (Jackson et al., 2003). In 2005, it was estimated that 280,000 to 360,000 infants were newly infected through breastfeeding alone worldwide and majority of these were in resource poor countries (Coovadia et al. 2007). In contrast, in more developed countries, the transmission from mother to child of HIV-1 has been drastically lowered because of the use of Paediatric AIDS Clinical trials Group (PACTG) 076 zidovudine regime that is given to mothers during pregnancy (Jackson et al., 2003).

Mother-to-child transmission of HIV-1 infection can take place during pregnancy, the intrapatrtum period, or postnatally (Leroy et al., 1998). Unborn children to HIV-1 infected mother have a high risk of acquiring HIV-1 while in the uterus or during breastfeeding (Newell and Bryson, 1997). HIV-1 transmission from infected mother to her child is estimated to be responsible for more than half of all the transmission occurring in late pregnancy (Gray, et al., 1999). This is because as the placenta becomes mature its polarity makes it easier for the HIV-1 to cross over to the child from the mother (Leroy et al., 1998). To minimise or prevent these infection scenarios, research has shown that administering antiretroviral medicines such as zidovudine or nevirapine to the pregnant mother has proved to be a success (Gray et al., 1999) and reduces mother to child transmission by at least 37 to 38 percent (Jackson et al., 2003). Coutoudis et al. (1999) states that the provision of antiretroviral treatment such as zidovudine or nevirapine to women during pregnancy, neonatal, and breastfeeding periods, is an important strategy and offers a less complex and more affordable approach in less developed countries. Once clinical features of HIV and AIDS are manifested and the women is diagnosed HIV positive, then antiretroviral medicines must be commenced so that the risk of mother to child transmission is minimised (Jackson et al., 2003).

According to Avert, (2010) more than 15 million children have been orphaned by AIDS. About 11.6 million are found in Sub-Saharan Africa. This is confirmed by UNAIDS, (2009) Children across the world are infected every year and without treatment they die of AIDS. Millions of

children not infected by HIV/AIDS are affected indirectly by the epidemic, as a result of death and suffering brought about by AIDS in their families and communities. This suffering is part of the HIV/AIDS related S&D. S&D means that children will continue to suffer the consequences of the epidemic.

In addition, Avert, (2010) stated that AIDS orphan suffer emotional problems. Often AIDS orphan experience negative changes in their lives like neglect and emotional distress long before the death of their parent(s). They suffer the death of their parent(s) and the emotional trauma that follows. AIDS orphans have to adjust to a new situation with little or no support and they suffer from exploitation and abuse. Research by Avert, (2010) indicates that the plight of AIDS orphans which include psychological distress, anxiety, depression and anger are evident among AIDS orphans. It is worse when the child is separated from other siblings.

Avert, (2010) confirmed child -headed households among AIDS orphans. To access basic needs, AIDS orphans are forced to engage in child labour which is an infringement of a child's right to protection against economic, exploitation as stated by UNCRC (1991). Consequently, AIDS orphans miss out enrolment in school or are interrupted or perform poorly as a result of their situation. They are unable to meet school expenses such as books, uniforms, shoes and pens. In addition, they fail to attend school because they are caring for their ailing family members or siblings infringing on their right to education.

Avert, (2010) ascertained that AIDS orphans face stigma from the society through association with AIDS. The distress and social isolation experienced by CLHA, both before and after the death of their parent(s) is strongly exacerbated by shame, fear and rejection that often surround PLHA. Because of this Avert (2010) asserts that CLHA are denied access to schooling and health care. In addition CLHA are denied their inheritance and property leaving AIDS orphans poor.

In a study done by UNAIDS (2007) it was established that CLHA suffer social rejection, financial insecurity, shame/guilt, low self esteem, depression and other psychological problem. Children who feel rejected, insecure financially, have low self esteem and depressed are likely

not to participate adequately in the learning process. To this extent the rights of the child are infringed.

It is evident from research carried out by SADC-EU Corporation in UNICEF (1999), that HIV/AIDS induces anxiety through trauma, discrimination and stigma, which affect children's concentration in class during the learning exercise. Aggleton and Warwick (1999) echoes these sentiments of orphans being isolated by stigma and sickness, reflected in schools leading to in access to education. Children affected by AIDS face risks to their education, health and well being stipulated by UNICEF (2006a). Children are forced to forgo schooling, there may be less food or clothing, suffer from anxiety and abuse. Alarmingly UNICEF (2006a) asserts that orphans and vulnerable children have higher risk of exposure than non affected children.

Study done by UNESCO, (2005) indicated that teachers expressed their concern or worries about the risks of HIV being transmitted to other children during interactions in the learning process. In addition other parent's complaint about the presence of CLHA in the pre-school. This amounts to S&D towards CLHA and in turn on the right to education. Other studies done by Strode and Grant (2010) showed that CLHA are denied access to pre-schools on the basis of their HIV status. CLHA attend school irregularly because in case of minor ailments the teacher asks the child to stay at home to avoid infecting other children. When at school the teacher handles the child with lot of care, the teachers distance themselves from the child and gossip about the child's HIV status. Such acts make CLHA uncomfortable at school and prefer to stay at home, infringing on the right to education.

UNICEF (1999) indicated that HIV makes it likely that a substantial number of children are not able to enrol in Pre-school. According to UNICEF (1999) HIV/AIDS orphan stand high risks of being denied access to education. From the study, HIV/AIDS orphans enrolment is low as compared to un-orphaned children. UNICEF (1999) found out that CLHA attendance in school was low and irregular. Poor participation of pre-school children is associated with anxiety caused by trauma, stigma and discrimination that CLHA go through. Rejection, isolation and abandonment of CLHA are an impediment to child's participation in school as stipulated by Cao

and Sullivan (2006). According to Mayer (1996) and Hetherigton (1999) children need love and care to be able to develop well and hence participate in learning activities.

HIV/AIDS causes trauma and hardships to CLHA. The epidemic not only causes children to lose their parents or guardians, but lose their childhood as well. Studies by Avert (2010) showed that as parents and family members become ill, children take more responsibility to earn income, produce food and care for the family. As a result children have entered labour market early in age leading to economic exploitation and engagement in hard work. UN, CRC (1991) safeguards children against economic exploitation. Children working to earn income to meet the basic needs are an infringement of the rights of the child as stipulated by the UN, CRC (1991) article 32.

Studies by Lyons (1998) established that children between ages 5-14 years work in conditions that are hazardous to healthy growth and development. In addition the study showed that poverty level as a result of parents exhausting family resources due to ailment had landed CLHA into labour market. Poverty pushes families, unaware of the risk, to send children into work force or to hand to recruiters promising jobs in distant place where unprotected, might be forced into childhood harsh labour. As a result, the pressures and pain of poverty increases. Consequently, the right to protection from economic exploitation and hazardous work harmful to health and development of CLHA is infringed. The illness or death of parents or guardians caused by AIDS robs the child of the emotional and physical support that defines and sustains childhood. It leaves a void where parents and guardians once provided love, protection, care and support. The resulting effect is children entering labour force at an early age to earn income to meet basic needs.

Lyons (1998) further explained that in the absence of parents and guardians the children take up the responsibilities of the parents for survival of the family and home. The child's contribution towards the family survival is necessary and highly needed. In addition to working the children have assumed decision making and responsibilities that transform roles within the family and households. Further analysis of the findings indicated that CLHA assume adult roles as heads of the household because there are no alternatives. They work long hours doing household tasks, supervising younger children and engaging in income generating work in order to support the

family. Many quit the school and jeopardize their own health and development needs to take on the roles as parents or guardians, nurse and provider.

2.3 HIV/AIDS in Nepal

National policy on HIV and STI (2011) stated that as HIV in Nepal is characterized as concentrated epidemic and multiple groups of people have been affected and infected by this virus in all over world and Nepal has also been in vulnerable stage as more that 24,000 person have been found as HIV positive and among these groups children are being in measurable condition. Though there is not found various study done on children living with HIV in Nepal but the study which is being done shows that those children has been facing various problems in their day to day life. They have not found in good schooling, proper food intake (nutrition), accessibility of health facilities, facing stigma and discrimination in society from society member, not having psycho-social support. Nepal Centre For AIDS and STD Control, Teku , VSO Nepal, Save the children, UNICEF,UNAIDS,FHI, Local NGOs, DPHOs, Municipalities have published in their reports that Children affected by HIV/AIDS has passing their life in measurable way and have not equal amount of access in Food, Education, Health and so on.

VSO Nepal stated in its Advocacy case study: Nepal:- Changing attitudes on inclusion of HIV positive children in schools that in September 2009 two HIV positive children and one HIV affected child were expelled from a private school in Kaski, Western Nepal, due to pressure from other parents. The children were 'Dalits' (formerly called 'untouchables') latter on those children had been given scholarships to attend the school by an NGO. This shows that HIV affected children do not have an equal accessibility of schooling and continuity due various reason VSO (2009).

Similarly "A Situation Assessment of Children Affected by AIDS in Nepal" by save the children in 2009 recommends that the "Sensitization programs focusing on the rights of CABA to education in discrimination free environment should be conducted to reduce existing discriminatory practices against CABA students in schools. School children, guardians and teachers should been courage to play more pro-active roles to reduce the feeling of isolation and neglect in school environment; since most CABA families live in worse economic deprivation,

children of such families are found to be extremely malnourished and need supplementary diet and health attention. To ameliorate the condition of CABA families, at least one of the caregivers in a family be provided with skills and seed funds for income generation such as goat and pig rearing, poultry farming, commercial vegetable farming, etc. which have proved to be commercially viable than the conventional skill development training programs; a coordinated effort from the government and civil society organizations working in HIV/AIDS sectors is needed to establish psycho-social counselling and support services in the place PLHIV community and CABA live and work every day; Provisions should be made for greater involvement of local community leaders and PLHIV community to reduce vulnerability, stigma and discrimination and strengthen the capacities of the communities to respond to HIV/AIDS and other human rights priorities."

UN Millennium Development Goals as stated to combat HIV/AIDS, malaria and other disease-halt and begin to reverse the spread of HIV/AIDS by 2015 and Deceleration of commitment on children affected by HIV/AIDS UNGASS on HIV/AIDS 2001 : Save the children (2009).

Save the Children (2009) further explained that by 2003,develop and by 2005, implement national policies and strategies to build and strengthen government, family and community capacities to provide a supportive environment for orphan, girls and boy infected and affected by HIV/AIDS, including by providing appropriate counselling and psychological support, ensuring their enrolment in school 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.

UNICEF in November 2002 in its assessment "The increasing vulnerability of children in Nepal; an assessment of children affected by HIV/AIDS and the response at family, community, district and national level" stated in the timeline planning for effective responses that "To be effective, planning for community-based programmes for families and children affected by HIV/AIDS must be included in the current planning process at all levels, and intervention for care and support implemented immediately in the most affected areas such as Far West, West and Terai. Plans for families and children affected by HIV/AIDS must include consideration of the expanding view of the epidemic that has developed in Nepal over the past few years, and the

growing body of data that suggests that Nepal already has a much bigger problem than anticipated even two years ago." Same assessment has cleared that;

Special Needs of HIV/AIDS-Affected Children and Families in Nepal:- At the same time that international guidelines promote programming to address the need of HIV/AIDS and other vulnerable children simultaneously, they recognize that children affected by HIV/AIDS have special needs not experienced by other vulnerable children.

HIV Positive children: - diagnosis, treatment, full care if they are abandoned by Mothers or other caregivers.

Children with HIV positive parents:- assistance with care giving responsibilities for adults, loss of parental protection and love, isolation from the community due to stigma and fear of infection, trauma of watching parents and other relatives die and caring for them through that process; increased risk of infection, largely due to loss of parental protection.

HIV/AIDS is no longer only a public health challenge. Poverty, lack of adequate medical facilities, inadequate education, cultural/social barriers and political inertia are but the few of the complex factors that facilitate the spread of this disease which is undermining the hard won economic and social gains IBRD/WB (2000). The impact of HIV/AIDS is pervasive and far-reaching, affecting individuals and communities not only psychologically but also economically and socially. Families lost their most productive members to this disease, leaving elderly people and children without means of support. The high cost of disease wreaks havoc within communities where the already fragile structures are not capable of absorbing further strain.

Initially, the focus of HIV/AIDS interventions was on specific traditionally risk-laden population groups, such as sex workers, truck drivers, and pregnant women. More recently, this approach has shifted to include prevention efforts targeted at lager community groups (Verma, Sureender Guruswamy, 1997), and in particular at children between the ages of 5-14, the so called "window of hope"(IBRD/World Bank, 2002) for the countries in Southern Africa that have been so severely affected by HIV/AIDS. These children have escaped infection at birth and are assumed not yet to be sexually active. In addition, at this stage children are still developing attitudes and behavioural patterns and are therefore more easily compared to adults (UNAIDS, 1997).

The absence of HIV prevention interventions in the care of the HIV positive mothers during pregnancy, labour. delivery and post delivery as in the case in most African countries or developing countries is blamed for the high rate of HIV infection in children. Data shows that without any intervention, the risk of MTCT of HIV is common and it is estimated that 15 to 30% of HIV positive mothers will transmit the infection to their infants during pregnancy and delivery, with an additional 10 to 20% transmission occurring through breastfeeding (Ferrand, et.al, 2010; Rosenberg, 2007). It is important to note that this high population of HIV-infected children will not decrease anytime soon as more children born HIV positive are now being able to survive up to adolescence and beyond (WHO, 2010). This is largely due to the advert of antiretroviral therapy (ART) which was introduced in the late 1990's in most Africa states source. Data shows that the clinical benefits of effective use of ART is that children with HIV experience fewer opportunistic infections and lower risk of disease progression (Biadgilign, et.al, 2009; Ferris, et.al, 2007). Furthermore access to ART resulted in many HIV infected children who were not expected to survive childhood entering adolescence and young adulthood, increasing the population of children living with HIV as a chronic illness (Butler, et.al, 2009; Wiener et.al, 2007b). The availability of ART has remarkably improved the life expectancy of HIV-infected children from low rates of below 8 years to encouraging ages of 13 years and above thus giving rise to a demand in their management as they grow and mature (Lesch ,et.al, 2007).

Children with HIV can now live longer, certain issues that were not present when the life expectancy of children with HIV was very low have now came up and need serious attention (Lesch, et.al, 2007). One of these issues is the disclosure of the child's HIV diagnosis by their caregivers or health care providers. There is a general consensus among researchers in paediatric disclosure that as the population of HIV infected children on ART matures the issue of disclosure of diagnosis becomes more significant (Myer, et.al, 2006, Oberdorfer, et.al, 2006, Rujumba, et.al, 2010). In this context, HIV diagnosis disclosure in children refers to the caregiver's perception of having told the children about their HIV diagnosis regardless of whether they told the child specific information that the child is HIV-infected or has AIDS.

With increased survival, paediatric disclosure has come up as one of the greatest psychological challenges that parents and caregivers of prenatally HIV-infected children face as HIV diagnosis disclosure entails communication about a potentially life threatening stigmatized and transmissible illness hence many caregivers fear that such communication may create distress for the child or even potentially damage caregiver-child relationship (Ostrom, et.al, 2006). Certainly as HIV-infected children grow their caregivers are faced with this challenging task of making the child aware of HIV diagnosis and this has now come up as an important issue in the care of HIV-infected children which has for a long time been ignored by both caregivers and health care providers (Nehring, et.al, 2000).

The global epidemiology of paediatric HIV has changed in recent years with the prevalence of children living with HIV reaching a steady rise coupled with a significant decline in HIV related morbidity and mortality rates among HIV-infected children. In fact, this development has also been observed in most developing countries as well, as there is a growing availability of ART in many resource limited countries found in Africa and Asia hence more children infected through MTCT are surviving to middle childhood and some to adolescence (Peralta, et.al, 2007). These positive achievements are however accompanied by numerous challenge which if left unattended to have a potential of reversing the gains made in the management of children with HIV (Mialky, et.al, 2001). Among the pressing challenges which need attention is the issue of paediatric HIV disclosure? As more and more children live into adolescence and beyond as highlighted above, the questions of when, how and what to disclose to the child about their HIV positive diagnosis has proved to be a complex issue to be addressed by most caregivers and health care providers (Ledlie, 1999). However in this third decade of HIV/AIDS, questions related to paediatric HIV disclosure and the management of sensitive disease-related information have become salient within the paediatric population (Ledlie, 1999).

UNAIDS (2015) stated that 15.8 million people are accessing antiretroviral therapy as of June 2015 while 36.9 million people globally were living with HIV, 2 million people became newly infected with HIV and 1.2 million people died from AIDS-related illness till the end of 2014. As of June 2015, 15.8 million people living with HIV were accessing antiretroviral therapy, up from 13.6 million in June 2014. 41% of all adults living with HIV were accessing treatment in 2014,

up from 23% in 2010. 32% of all children living with HIV were accessing treatment in 2014, up from 14% in 2010. 73% of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their babies in 2014; new HIV infections among children were reduced by 58% from 2000 to 2014.

UNAIDS (2015) further stated that in 2014, there were 36.9 million people living with HIV and since 2000, around 38.1 million people have become infected with HIV and 25.3 million people have died of AIDS related illnesses. New HIV infections have fallen by 35% since 2000. Worldwide, 2 million people became newly infected with HIV in 2014, down from 3.1 million in 2000. New HIV infections among children have declined by 58% since 2000. Worldwide, 220,000 children became newly infected with HIV in 2014, down from 520,000 in 2000. AIDS-related deaths have fallen by 42% since the peak in 2004. In 2014, 1.2 million people died from AIDS-related causes worldwide compared to 2 million in 2005. Tuberculosis-related deaths in people living with HIV have fallen by 32% since 2004. Tuberculosis remains the leading cause of death among people living with HIV, accounting for around one in three AIDS-related deaths. In 2014, the percentage of identified HIV-positive tuberculosis patients who started or continued on antiretroviral treatment reached 77%. The world appears to be within reach of achieving the investment target in the 2011. Political Declaration on HIV/AIDS which called on the global community to mobilize between US$22 billion and US$24 billion in low-and middle-income countries for the AIDS response by 2015. At the end of 2014, US$ 20.2 billion was invested in the AIDS response in low-and middle-income countries. Domestic resource constituted 57% of the total resource available for AIDS in low-and middle-income countries in 2014. Between 2009 and 2014, 84 out of 121 low-and middle income countries increased their domestic spending on AIDS. Of these countries, 46 reported an increase of more than 50% including 35 countries which reported an increase in domestic spending of more than 100 %. 44 low-and middle income countries looked to international donors for 75% or more of their AIDS financing needs. UNAIDS estimates that US$ 31.1 billion will be required for the AIDS response in 2020, with US$ 29.3 billion will be required in 2030.

CHAPTER-III
RESEARCH METHODOLOGY

3.1 Research Design

The research was conducted under descriptive and exploratory research design. It is because the characteristics intended to study the current statuses of those HIV affected children by which they are being in such a miserable condition in multiple senses. It also studied and described that how and in what respect those HIV affected children' accessibility of schooling, proper food intake (nutrition), health facilities, mitigation of stigma and discrimination helped to enhance their quality of living life and in what respect the social security fund from global fund has assisted to gain all these matter in their life to develop the quality of life.

3.2 Nature and Sources of Data

To fulfil the objective of the study, both primary and secondary data were collected.

3.2.1 Primary Data

This study aimed to explore the socio-economic impact of HIV on children and the accessibility of schooling, proper food intake (nutrition), health facilities, end of stigma and discrimination to enhance their life. Thus to find the specific household of specific geographical area the primary data were collected from the district health office and local NGOs working in similar field in the study area. In the due course of my investigation/research, primary data were collected viz. observation, focus group discussion, interview and questionnaire as per the convenience to aid to my study.

3.2.2 Secondary Data

Since, this research has been composed up of the base of description and analysis, secondary data was must. Therefore, secondary data played the role of corner stone for this research. The various internal and external sources were used for acquiring the secondary data. The various sources consisted of Ministry of Irrigation, Central Bureau of Statistics, District Irrigation Office, Google, Bulletins/Reports, and NGOs/INGOs etc.

3.3 Sample Size and Sampling Procedure

In this study all the demographic population of Rupandehi District implicitly or explicitly one who is living with HIV came under the universe or population frame. Primarily the investigation was targeted to HIV infected and affected children household followed by observations at various household in respect to their level of accessibility in schooling, health, nutrition, stigma and discrimination. Since, according to the motive of my research, probabilistic sampling method was used. The sample size was selected on the basis of cluster sampling method. Under this method the sample selected was 40% households out of 88 HIV affected households of Rupandehi district. All together a sample size of 35 HIV affected children households was taken under my inquiry. Similarly, simple random sampling was applied to take HIV affected children household survey.

3.4 Data Collection Methods and Tools

To collect reliable and authentic data various research tools and techniques were used, based on the nature of the study. The following tools and techniques were adopted to obtain primary data and information. The structure/ questionnaire or unstructured interviews and observation methods were applied to generate the primary data.

3.4.1 Household survey (HH)

The Household survey was used to collect data related to socio-economic aspects of children living with HIV such as school enrolment, health, nutrition, stigma and discrimination. Questionnaire survey was conducted randomly in the study area. Two different types of questionnaire were developed for local people and key informants. To generate the accurate data structured questionnaire were carried out to draw the current status and socio-economic information of the children living with HIV, the role of health facilities to strengthen and sustain their life in the coming days. The respondents were requested to fill up the questionnaire. In case of the respondents who couldn't fill up the questionnaire, the questions were asked to the respondent and answers were filled up to collect the required information. Present status of the children living with HIV, the role of health facilities and socio-economic impacts on children

living with HIV in the study area helped to visualize the scenario of HIV affected children in Rupandehi District.

3.4.2 Key Informant Interview

The numbers of key informants were interacted on socio impact of HIV on Children living with HIV. The interaction programs were conducted with the target group of people, households of people living with HIV and working organisation and service providers. Structured interviews were taken with school teachers, health personnel, community health service providers and social mobilizors working for children living with HIV. For this, interview schedule was prepared to obtain accurate and reliable information from the respondents. Target group of people, family of children living with HIV who are HIV affected, health workers, volunteers and school teachers were the key informants.

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3.5 Data Analysis

The data obtained from the field survey were coded and categorized according to requirement. Then the coded data were converted into tables with numbers, average and percentage through computer office program as MS Word and MS Excel. Simple statistical tools like tables, graphs were used in presenting the data. They were categorized and analyzed according to the objective of the study.

All the information of household questionnaire collected from the field was edited and coded prior to entering it into computer. The data was entered into the computer using the data entry format developed into Microsoft Access software for easy data entry work. The validity of data entry work was assured by checking all the information of the randomly selected questionnaires. The data was analyzed through the computer using the data processing software. Simple statistical tools like average and percentage have been calculated for different groups and sub groups considering the nature of the study. The open-ended questions of the questionnaire have been coded manually and later it was processed through computer.

CHAPTER -IV
SETTING OF THE STUDY AREA

4.1 Description of Study Area

a) Location

Rupandehi District lies on the southern and western part of Nepal. The total area of the district is 1,360 km^2 with 16.1% in Churia Range and rest in the Terai region.

Figure 1: Map of Nepal Showing Rupandehi District

On the East it shares border with Nawalparasi District, on West with Kapilvastu District, on North with Palpa District and on South with India. The elevation of the district lies

between 100m to 1229m from sea level. The survey was conducted in Rupandehi District to analyze the current status of children living with HIV.

4.2 Rupandehi District

Rupandehi District is a part of Province Number 5 as per the new drafted constitution 2072 is one of the 75 district of Nepal. The district headquarter is Siddharthanagar. Rupandehi is named after Rupadevi, the queen of king Suddhodhana. Lumbini, the birthplace of Lord Gautam Buddha lies in Rupandehi District. Devdaha, the birthplace of Mayadevi also lies in Rupandehi District.

Figure 2: Map of Rupandehi District

The total population of the district is 880,196 (432,193 Males and 448,003 Females) as per the national census 2011. The total households were 163,916 as on census 2011 (CBS,

2011). The ethnic composition in this district varies which comprises Brahmin, Chhetri, Tharu, Dalit and Janajatis. The literacy rate of the district is 72% where male literacy rate is 89% and female literacy rate is 62% as per national census 2011. The person of this district is mainly engaged in agriculture, business and services. A largely plain and flat area, the district is quite populated.

4.3 Livelihood Status

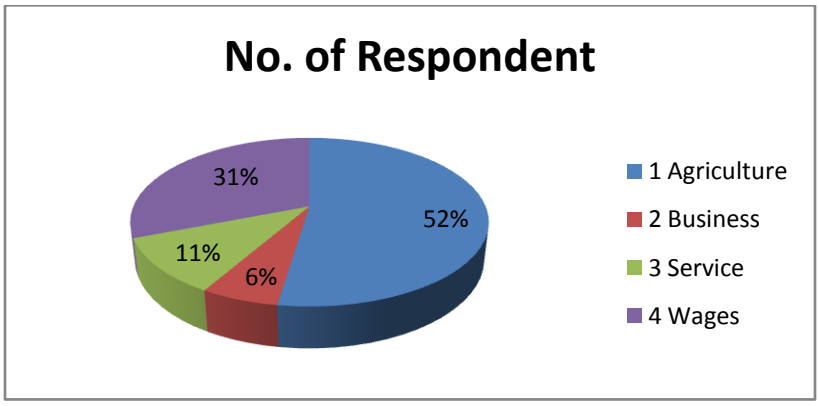
The local people predominantly depend on agriculture and animal husbandry whereas many others are also engaged in business and service sectors. The livelihood status of the study area is represented by table 4.1 and Figure 3 respectively.

Table 4.1: Major Occupation of Local Respondents

S. N.	Major Occupation	No. of Respondent	Percentage
1	Agriculture	44	52
2	Business	05	06
3	Service	09	11
4	Wages	26	31

Source: Field Survey 2015

Figure 3: Livelihood Status in Study Area



Source: Field Survey 2016

The average family size of the household surveyed was 4 persons per family. The family income source of the household was particularly agriculture because of the plain, fertile and irrigated land which was accounted 52 percent whereas business, service and wages contributed 6 percent, 11 percent and 31 percent respectively.

4.4 Livestock Herding

Being located in the plain areas and agriculture being the primary source of income livestock herding comes along with agriculture. Cattle, buffaloes and goat are the main livestock reared in the study area. From the survey 90 percent of the household were found to be rearing at least one kind of livestock and 10 percent of the household were not rearing single livestock. Of the total household 10 percent were rearing cattle and goat, 60 percent were rearing buffaloes, 20 percent were rearing goat only and 10 percent were rearing goat and buffaloes.

4.5 Climate

The climate pattern of the study area is mostly dominated by hot weather which reaches up to 45 degree Celsius as 89.3% area lies below 300 meters above the sea level. The weather is also relatively cold in winter season with cloudy fog.

4.6 Population Size

The total no of household and the population of the study area are tabulated as follows:

Table 4.2: Population Settlement in Study Area

Name of District	Population			
	Male	Female	Total	Total Households
Rupandehi	432,193	448,003	880,196	163,196

Source: Field Survey, 2011

The population size in the study area is increasing with the infrastructure development and the migration of people from the hilly areas to plain areas. Being the border between Nepal and India the district is converting into one of the economic centres of the country providing greater opportunities to the people living there. Many leading industrial centres of the country are also located in this district. Rupandehi District being close to India is the leading reason to spread HIV among the people and their children.

CHAPTER- IV
DATA ANALYSIS AND INTERPRETATION

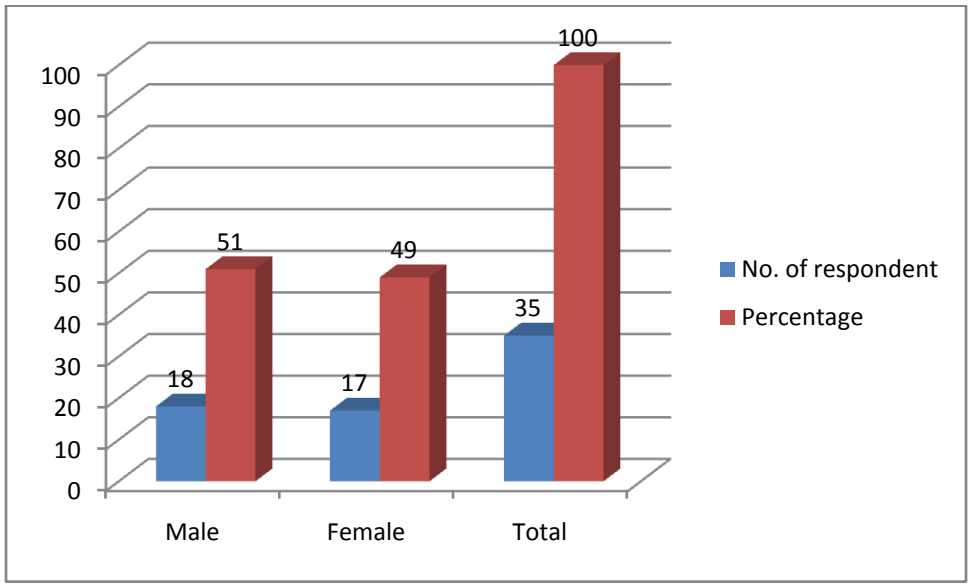
5.1 General Information of respondent

This research has been targeted to investigate some questions and answers with HIV positive people of Rupanedhi district at where respondent indicates to those HIV affected people and children from whom information has been gathered and presented here the actual data and analysis of those data based on one to one question and answers based on pre-exercised and set questionnaire.

5.1.1 Sex of respondent of study area

Sex at here in this study defines the composition of male and female along with third gender with whom research questionnaire are asked and detailed information are presented herewith in field study area. Altogether 35 children living with HIV were interviewed in the study area. The composition of sex of the respondents are represented by Figure 1

Figure 1: Sex distribution of children living with HIV(CLHIV)



Source: Field Survey, 2016

Among the all selected 35 Children living with HIV in study area and was interviewed in field survey found that 51 percentage CLHIV were male and 49% were female.

5.1.2 Demographic and Socioeconomic Information of Children with HIV

This study was set to study socio economic status of children living with HIV and this section also describes the age group of children living with HIV. Altogether 35 children living with HIV were interviewed in the study area. The age distribution of the respondents is represented by table 1 respectively.

Table 1: Age distribution of Children living with HIV (CLHIV)

Age Group	Age of respondent	Percentage
0-6	10	28
7-12	16	46
13-18	9	26
Total	35	100

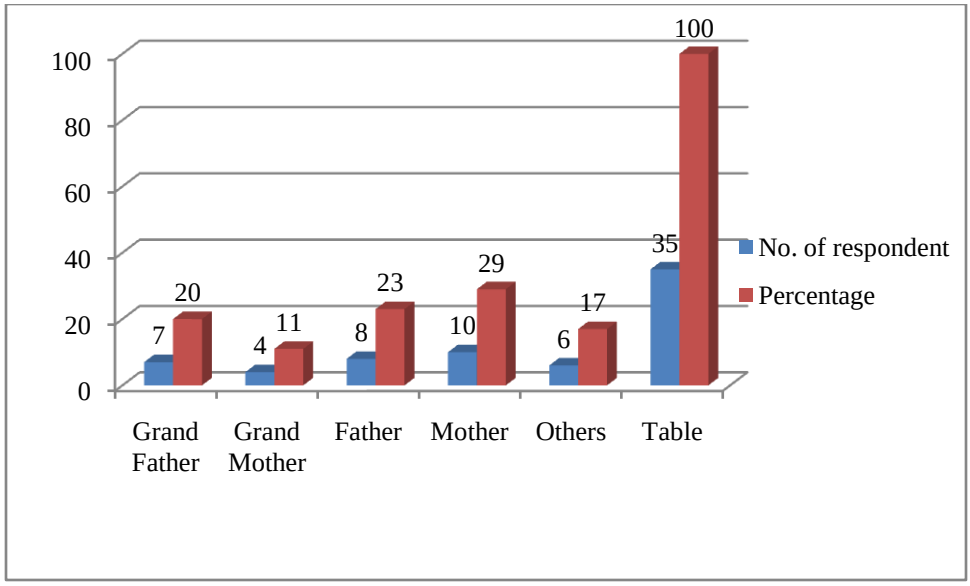
Source: Field survey 2016

Among 35 Children living with HIV interviewed 28 percentage children were from 0-6 age group, 46 percentage children were from 7-12 and 26 children were from 13-18 age groups. The age of the children living with HIV varied from 6 years to 18 years and the average age was 12 years. The age limit of children was considered below 18 years and the data were collected accordingly

5.1.3. Head of family

This section sets to describe about the leadership of family who runs the family in every up and down and look after his/her family. Here head of family represents that the head of the family of children living with HIV and the head of the family is the responsible of security of his/her family. Father, Mother, Grandfather, Grandmother and other person who look after children living with HIV ought to be the head of family. The segmentation of family head among all 35 children living with HIV is represented by Figure 2:

Figure 2: Head of CLHIV family' respondents



Source: Field survey, 2016

Study on Head of Family among all 35 children living with HIV respondent, the study shows that 20 percentage Grandfather, 4 percentage Grandmother, 8 percentage Father, 10 percentage mother and 6 percentages others are head of family of the respected children living with HIV in respected research setting. Here other indicates current guardian of children living with HIV who has lost his/her biological parents and living with siblings or in relatives who look after Children living with HIV.

5.1.4 Family Occupation

Occupation indicates the core mode of income any family by which family earns money for day to day living and bear expenses of his/her family. Family occupation is varies from family to family. Mainly Agriculture, Business, government service, daily wage or foreign employment can be occupation of family to earn money for survival of any family. Major oc

Table 2: Major occupation of CLHIV' Family

S. N.	Major Occupation	No. of Respondent	Percentage
1	Agriculture	12	34
2	Business	6	17

3	Service	2	6
4	Wages	10	29
5	Others	5	14

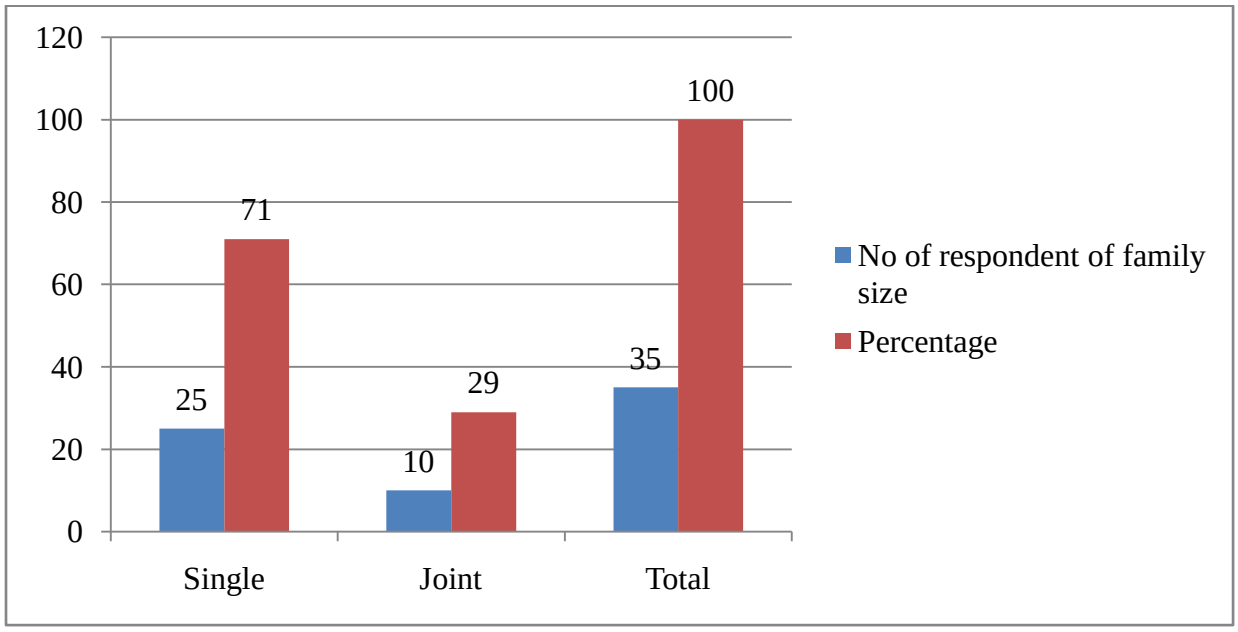
Source: Field Survey, 2016

Above table on family occupation shows that among 35 respondent 34 percentage children living HIV' family occupation is agriculture likewise 17 percentage children living with HIV' family main occupation is business, 6 percentage children living with HIV' family main occupation is government service, 29 percentage children living with HIV' family main occupation is daily wages and 14 percentage children living with HIV' family main occupation is others where others indicates season India employment sources of family Income(Explain). This table clears about the source of income of family of children living with HIV for day to day living and health care management.

5.1.5 Family Size

Every family has its own composition in living modality at where Single and joint family' classification can easily be seen. Family have less than 5 members defines single family and more than members in family defines joint family

Figure 3: Family size distribution of Children living with HIV (CLHIV)



Source: Field Survey, 2016

Above figure on family size shows that 71 percentage Children living with HIV respondents have single family whereas 29 percentage Children living with HIV respondents have joint family. Single family' Children living with HIV respondents found living with either with father only or mother only along with one or two brothers and sisters whereas Joint family' Children living with HIV respondents found living altogether with rest of his/her family members in separated mode but not have officially and have joint property (low manner of property) among 35 children living with HIV in study area.

5.2 Social Status Information of respondent of Study area

Social Status information of respondent in study area shows the clear condition of children living with HIV in study area which also presents the living standard, child right and accessibility of development on their life.

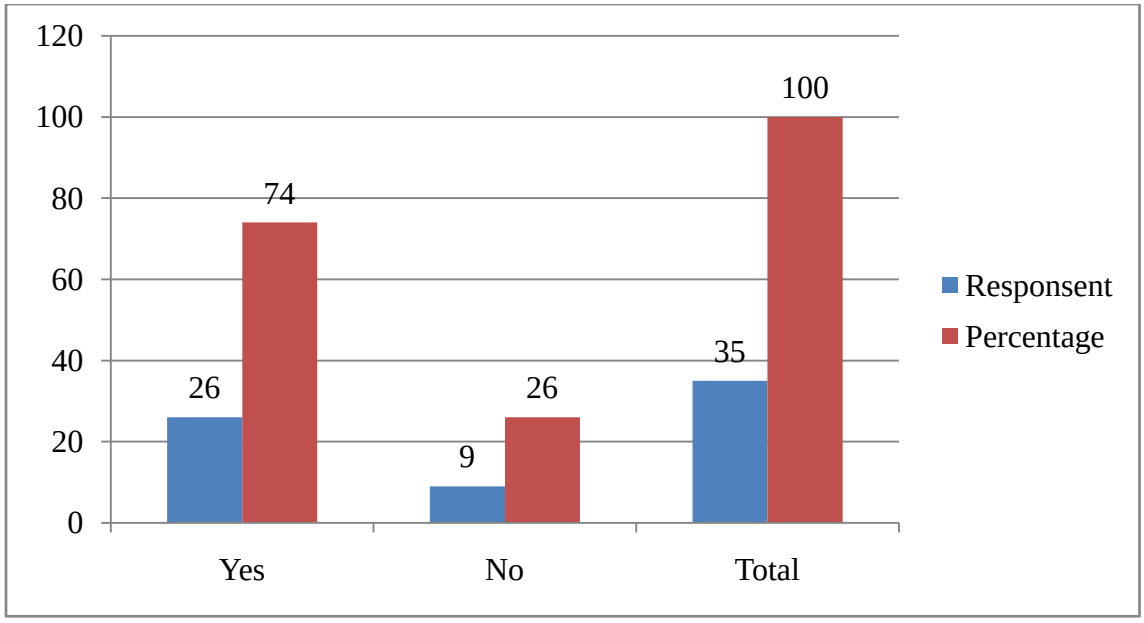
5.2.1 HIV Status of CLHIV' respondent

This study area has been set to study socio economic status of children living with HIV which clarifies that all selected 35 Children living with HIV respondents represents that all respondents are HIV positive and are under 18 years old.

5.2.2 Living with parents

Children living with HIV have got HIV infected from their biological parents and some of their biological parents alive and some are deceased and some of children are semi orphan. This head indicates that Children living with HIV have been passing their life without of their biological parents and some are without parental care as well. This heading in study tries to endeavor about the condition of children, either living with their biological parents or living with guardian who are not their biological parents but looking after them. Here figure 4 explains that the total number of CLHIV respondent living with their parents and living with their care takers:

Figure: 4 living with Biological parents or with guardian



Source: Field Survey, 2016

Study among all 35 selected children living with HIV, the above graph show that 74 percentage children living with HIV respondents have been living with their biological parents and 26 percentage children living with HIV respondents are not living with their biological parents. Here 74 percentages CLHIV living with their biological parents also clears that there are semi orphan CLHIVs are as well among which 50 percentage CLHIV responders are living only with their mother and 19 percentage CLHIV respondents are living only with their father however 31 percentage CLHIV respondents are living with both father and mother respectively. However as per above figure 26 percentage CHLIV respondents found living with their care takers. This care taker can be his/her grandfather or grandmother or uncle or aunt (both paternal and maternal)

5.2.3 Parents living status

Figure 4 taught that 74 percentage Children living with HIV (CLHIV) have been living with their biological which showed that they are semi orphan CLHIV however 26 CLHIV respondents are found to be double orphan and they are got to live without their biological parental care and living with care takers.

5.3 Balanced diet Information

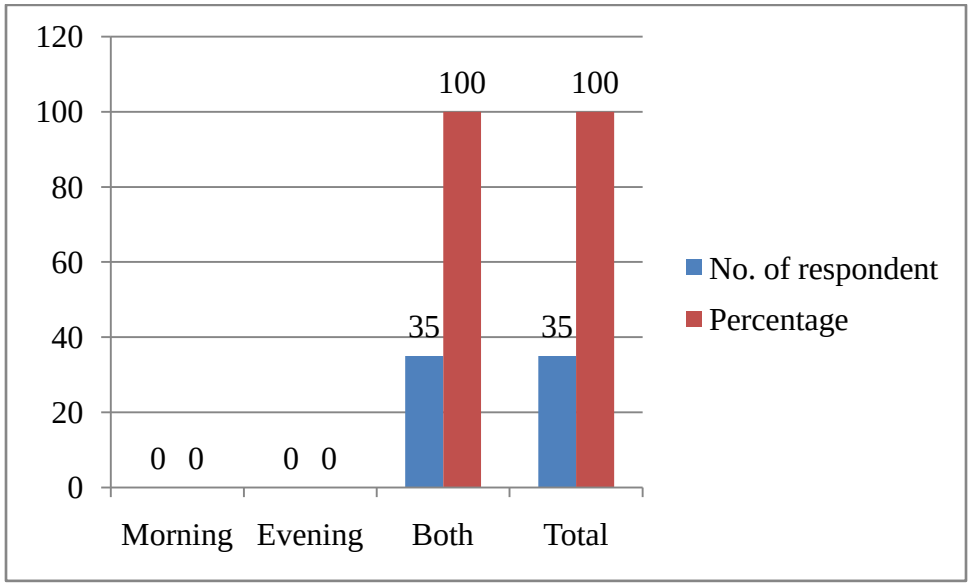
Food is essential for every human being to live on and to gain balanced nutrition to coop in day to day life. Nutrition or balanced food at here resembles food with composition of nominal

calories that human body needs to live on and to coop with their day to day life. Hence in this regard Children living with HIV(CLHIV) need balanced food to coop with their day to day life to live on happy and healthy life

5.3.1 Food frequency of a day

Balanced food composition of nominal nutrition that human body need to live on and to coop with their day to day life is needed for healthy and happy life; Children living with HIV compulsory need two time food of a day to gain nutrition to coop with their day to day life. Food frequency here resembles that times of food CLHIV has a day in their day to day life. At here figure 5 shows times of food in a day 35 CLHIVs have in their day to day life:

Figure 5: Frequency of food Children living with HIV have in a day



Source: Field Survey 2016

Presented figure 5 here shows that all 100 percentage CLHIV respondents do have two time food in a day. All respondents found to have two times food in a day to live on and gain nutrition to coop with their day to day life. Though CLHIV do have two times food in a day but balanced diet remains question at here to have nutrition in their day to day food as only 55 percentage CLHIVs have found to have nutrition food in their daily food.

5.3.2 Source of food materials availability

Most to CLHIV respondent's family lies under poverty and have very minimal land to work on and also have lack of source of income to invest in their own farm. They do have tough situation to get food materials to prepare for day to day food as a basic need to get nutrition to coop in their life however somehow 35 CLHIV' respondents family manage. Below table 2 describes the

full information of all 35 CLHIV' respondent's family on source of food availability that from where they get their food materials:

Table 2: Source of Food materials of CLHIV' Family

Source of food availability	No. of respondent	Percentage
Market	23	66
Own Kitchen garden	10	28
Others	2	6
Total	35	100

Source: Field survey 2016

All together 35 Children living with HIV respondents' family answered on from where they get their food items in which 66 percentage stated that they purchase those food materials from market as they do not have either sufficient land or finance to invest in agriculture whereas 28 percentage stated that somehow they did invest in agriculture so they mostly get most of food items from their kitchen garden and farms. But 6 percentage CLHIV' families' respondents said they have different condition as they has very low income therefore they it all food item from other sources. Here other refers relative and friend's support or beg from somewhere.

5.3.3 Frequency of meat and eggs in food

Meat and eggs along with other food items are major ways to get nutrition as of food or something else to gain nutrition. In different mode or ways meat and eggs get balanced nutrition to CLHIV to strengthen their inner heeling power. All 35 CLHIV respondents found non-vegetarian who were questioned on their frequency of having meat and eggs in their daily life which results have been presented here by table 3

Table 3: Frequency of Children living with HIV having meat and eggs

Frequency of eating meat and eggs	No. of respondent	Percentage
Daily	0	0
In every two days	5	14
Once in a week	20	57
Once in a month	0	0
Not have fix routine	8	23
Very often	2	6
Total	35	100

Source: Field Survey 2016

In interview with 35 Children living with HIV, none of CLHIV have been found having daily meat and eggs in their food as most of CLHIV have been found living their life in nominal ways of living whereas 14 percentage CLHIV found to have meat and eggs in every two days in their

food in which maximum respondents have some support from relatives. But 57 percentages CLHIV have been found to have meat and eggs only once in a week which seems not very best practice for nutritional food for CLHIV. 23 percentage CLHIV said that they have not any fix routine to have meat and egg and 6 percentage CLHIV even answers that they very often have egg and meat in their food as they have been passing very vulnerable life which hardly support them to have egg and meat in their food which is very much needed for balanced diet.

5.3.4 Frequency of fruits and milk in day to day life

Fruits and milk is major source of nutrition that gives comprehensive nutrition to human body to coop with day to day life. Children living with HIV need fruits and milk as well along with meat and egg for balanced nutritional diet. All 35 CLHIV were asked that how frequent they do have fruits and milk in their day to day life to gain nutrition which has been cleared by table 3

Table No 3: Times of milk and fruit in a day of Children living with HIV

Frequency of eating milk and fruit	No. of respondent	Percentage
Daily	6	17
In every two days	10	29
Once in a week	10	29
Once in a month	0	0
Not have fix routine	9	25
Very often	0	0
Total	35	100

Source: Field survey 2016

Among all 35 CLHIV respondent, 17 percentage respondents answered that they daily have milk and fruit to have balanced diet however 29,29 and 25 percentage respondents answered that they have in every two days and once in a week respectively get milk and fruit in their day to day life whereas 25 percentage CLHIV respondent answered that they do not have fixed routine to get milk and fruit in their day to day life due to poverty which halts them to main nutrition balanced diet in their daily life.

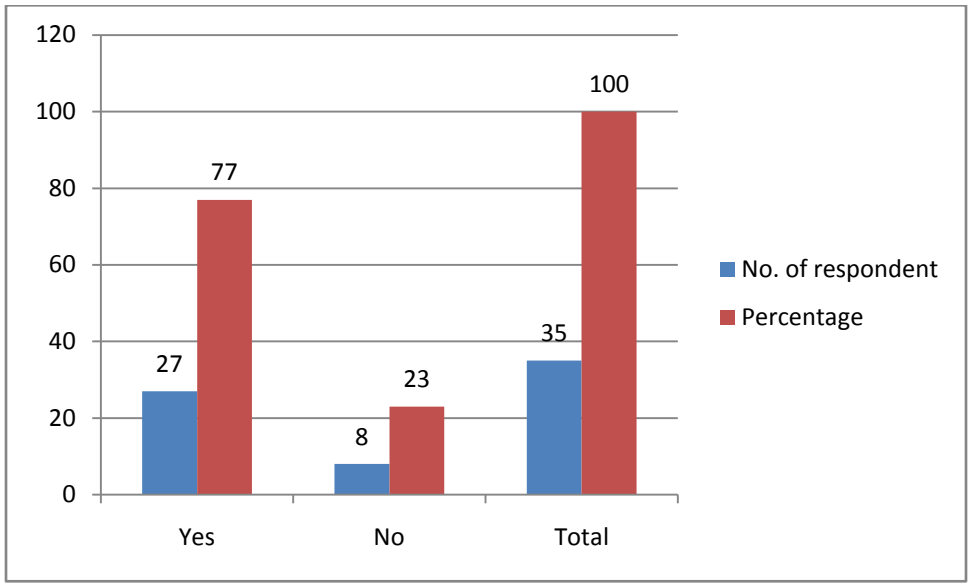
5.4 School Enrollment

To share bright future for any children school enrollment is very much essential factor, which drives them to new horizon and provides quality in human life to coop in this competitive time. School enrollment is vital elements of child right and should every child have proper accessibility of education. School enrollment here describes the status of education' follow in Children living with HIV and their accessibility in education that can shape their future to new horizon.

5.4.1 Schooling status

All together 35 Children living with HIV were asked about their accessibility on education; how many among of all CLHIV respondents have school enrollment and how many among of all CLHIV respondents have been drop out from school or not have enrolled in school. Figure 6 describe all 35 CLHIV respondents' words on their accessibility on education in mode of school enrollment herewith:

Figure 6: School enrollment status of Children living with HIV



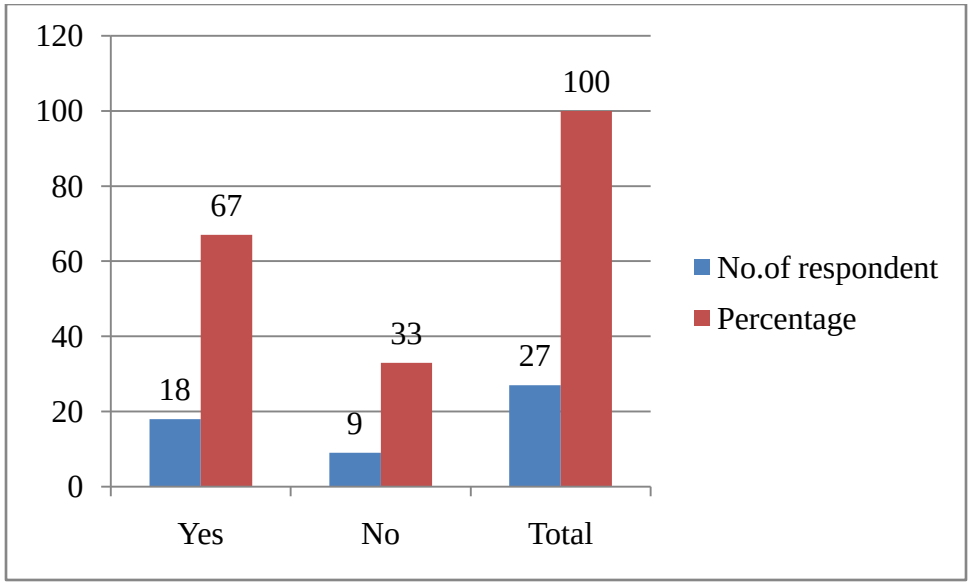
Source: Field Survey 2016

In response of school enrollment study, 77 percentage Children living with HIV respondents were found to have been enrolled in governmental school whereas 23 percentage found not have been enrolled in school yet due to their weak status which halted them to be enrolled in school and deprived them from education. 23 percentage children showed their problem that their families are financially poor to bear education expenses though they do have high interest to go school.

5.4.2 School Drop-out ration

All 27 Children living with HIV who were found going school were asked that whether they were school dropout and due to some motivation factor they rejoined their school; figure 7 presents the clear study on school dropout ration of all 27 CLHIV found going school in regular mode at the study time of this research:

Figure7: School dropout status of Children living with HIV



Source: Field survey 2016

As per above response from CLHIV, 67 percentage CHLIV respondents stated that they were school dropout and some positive factors motivated them to rejoin school and now they have been regularly going to school however 33 percentage CLHIV found not have been school drop as they have regularly been going school since their enrollment.

5.4.3 Motivation to rejoin School

Through this study, among 35 CLHIV respondents 77 percentage respondents were found having school enrollment and amongst 77 percentage CLHIV respondents 67 percentage CLHIV respondents found that they were school dropout due to several reasons as they were bound to leave their school however because of some motivational factors they rejoined their school and regularly going school in present days. Table 4 elaborates the motivational factors along with the number of CLHIV respondents were motivated by respective factors:

Table 4: Motivation to rejoin school for CLHIV

Motivate to rejoin the school	No. of respondent	Percentage
Parents	3	17
Target group person	5	28
CABA Cash Transfer Program	8	44
Above all	2	11
Total	18	100

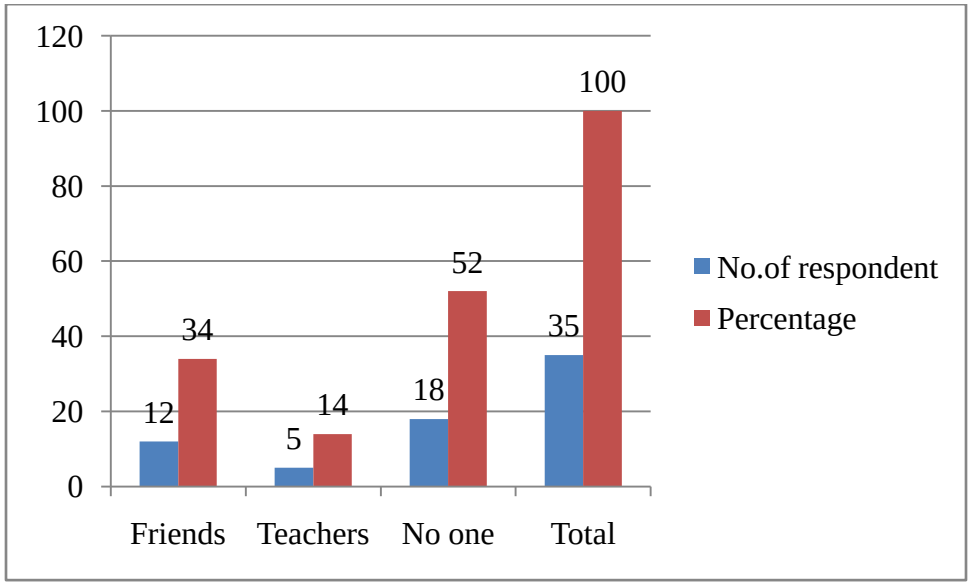
Source: Field Survey 2016

Amongst 18 CLHIV respondents who were found once school dropout but due to several motivational factor they rejoined school; in this regard 17 percentage respondents agreed on that their parents motivated them to rejoin school but 28 CLHIV respondents stated that target group of person motivated them to rejoin school . 44 percentage respondents said that CABA Cash Transfer Program motivated them to rejoin their school by providing several support through program however 11 percentage CLHIV respondents said above all factors motivated them to rejoin school and continue it in regular mode without any distraction.

5.4.4 HIV Status disclosure among

Identification play a key factor to get good or bad response from belonging person. It depends upon types of identification, at here HIV status' identification play vital role to get positive or negative support from respondents belonging. All 35 CLHIV respondents were inquired in period of study that with whom their identification has been disclosed. Figure 8 describe the groups with whom targeted respondents identification has been disclosed:

Figure 8: HIV Status disclosure among belonging group



Source: Field Survey 2016

Among all 35 CLHIV respondents, 34 CLHIV percentage respondents stated that their friends are well known about their HIV status however only 14 percentage respondent's teachers are known about their HIV status. But 52 percentage CLHIV respondents stated that no one know about their identification as it has been hidden from everyone except their biological parents and some close relatives in afraid of discrimination they might get from them.

5.4.5 Positive or negative or different behavior by disclosures about HIV Status

All 17 CLHIV respondents whose HIV status has been disclosed to their day to day belonging shows mixed emotions as their friends yet does not have much understanding about HIV however they get some sympathetic behavior from their teacher.

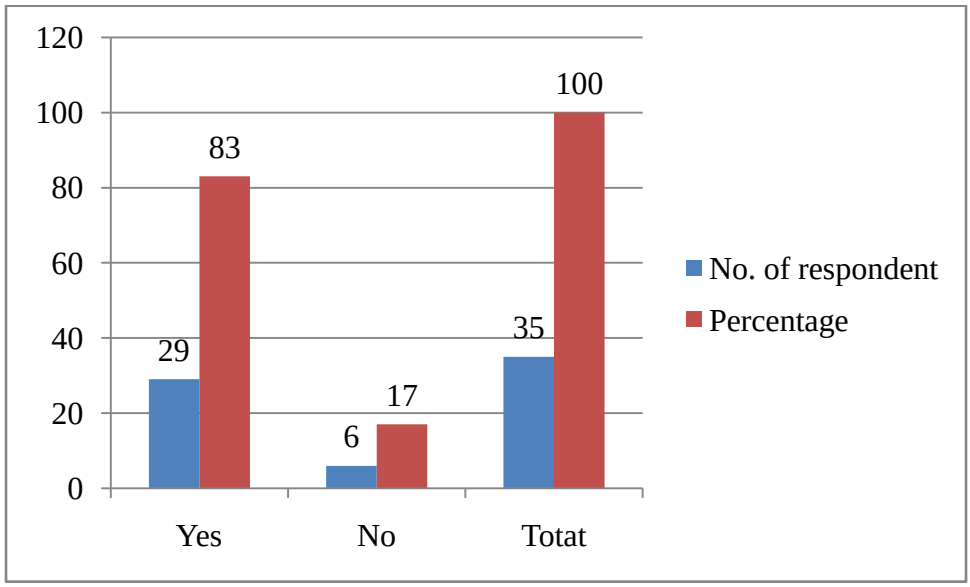
5.5 Health Status

Good health is very important aspect for all people to live on in graceful way. Good health denotes that not have fallen ill in periodic ways. Health status defines how much good cooping power does respondent has in him/herself with. In the context of CLHIV, health status shows that how much they have been in positive behavior and having good life. Regular health check-up for them is very much important to maintain good health status. Anti-Retro Viral therapy is core and vital medicine for HIV positive person to enhance their resist capacity to coop with day to day life and to main good health status.

5.5.1 Status of CLHIV Enrollment in A.R.V.

Anti-Retro Viral therapy is core and vital medicine for HIV positive person to enhance their resist capacity to coop with day to day life and to main good health status. Figure 8 describes the enrollment status of Children living with HIV in Anti-Retro Viral therapy herewith:

Figure 8: Status of CLHIV enrollment in A.R.V.



Source: Field Survey 2016

Amongst all 35 CLHIV, 83 percentage children found having regular AVR to maintain good health status since their enrollment in ARV however yet 17 percentages yet not enrolled in ARV as they have their CD4 more than 1000 and some of have not yet checked their CD4 so remaining 6 percentage CLHIV respondents could not have been enrolled in ARV.

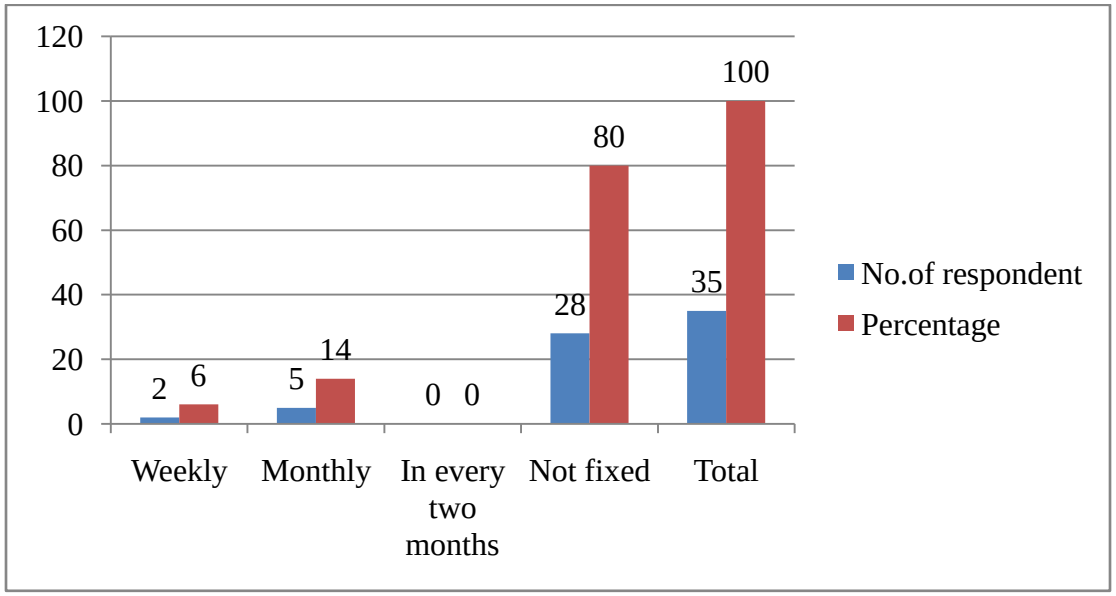
5.5.2 ARV service talking station

Anti-Retro Viral therapy is medicine for HIV positive person to enhance resist power of HIV positive person which is need to have continuously in regular basis in twice of day system. ARV medicine that is being under government custody therefore this cannot be either purchased or sold by private firms as it is found free of cost from government agencies. ARV in Rupandehi district is to be distributed from Lumbini Zonal hospital. Children living with HIV' family get ARV for them zonal hospital.

5.5.3 Frequency of illness

If health status is not strong of people living with HIV, than they do get frequent ill therefore in this regard it is very much important for Children living with HIV to maintain good health and should be enrolled in ARV. Frequent illness points that CLHIVs have not been taking ARV and have not getting balanced diet in their food. Figure 9 describes how frequent all 35 CLHIV respondents get illness in their day to day life:

Figure 9: Frequency of illness amongst Children living with HIV(CLHIV)



Source: Field Survey, 2016

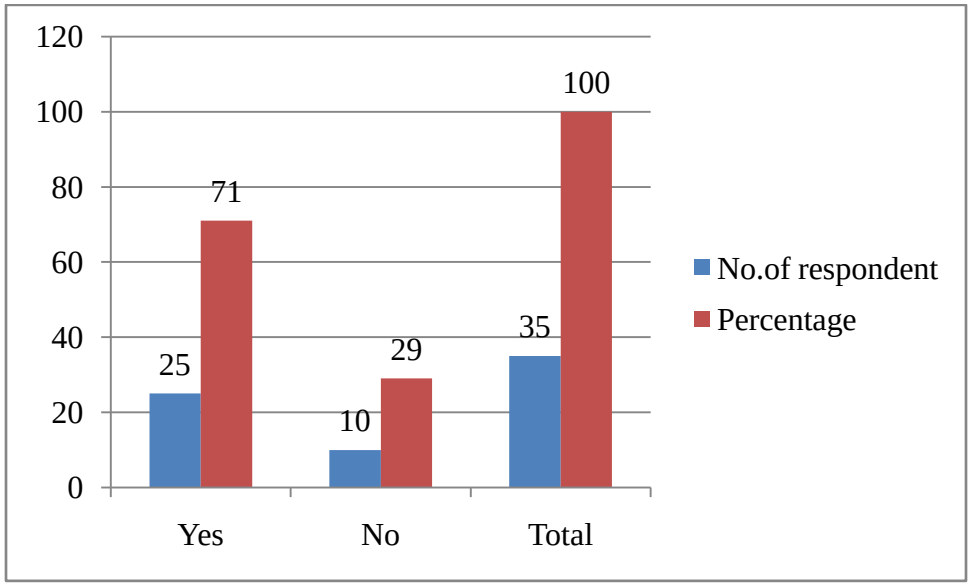
Amongst all 35 CLHIV respondents 6 an 14 percentage children found to be fallen ill weekly and monthly respectively however 80 percentage CLHIV respondents have not fixed when they

get ill. This figure shows that maximum children do not frequent get ill therefore there is not any fixed ration about this which show that they do get frequent health check-up.

5.5.4 Regular Health check-up status

Regular health check is very much needed for Children living with HIV for their good health which would guide them for positive behavior which will turn them for bright life. Regular health can be got either in health post or district hospital or zonal hospital. CLHIV respondent also get regular health check community based working health institution as well. CLHIV respondents responded positively in query over how regular they do get health check-up. Figure 10 represents here the regular or irregular health check-up status of health check-up of CLHIV

Figure 10: Regular health check-up status of CLHIV



Source: Field Survey 2016

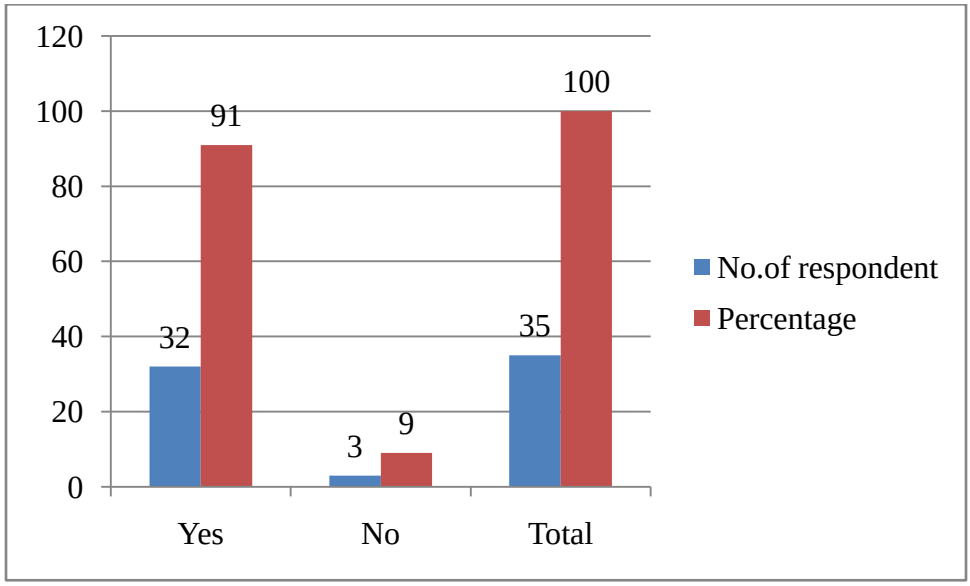
Amongst 35 CLHIV respondents 71 percentage shares that they do get regular health check-up but 29 percentages do not have fixed health check-up routine. They check-up when they get ill despite illness 29 percentage CLHIV respondent do not get regular check-up. All together only 5 percentage CLHIV respondents get weekly health check-up from health person from community based organization whereas 85 percentage CLHIV respondents get their health check-up in monthly basis. But 10 percentage CLHIV respondents do get health check-up in every two months when they come in contact with community based health person and visit health center.

5.5.5 CD4 Check-up

Cluster of differentiation (CD4) is a test that count how many T-cells have been left in blood which also calculates that immune system of boy which help health person to treat with patient.

CD4 test should be done of each and every HIV positive person. Figure 11 shows that how many respondents among all 35 CLHIV respondents have CD4 test done herewith:

Figure 11: CD4 Check-up status of Children living with HIV



Source: Field Survey 2016

Figure 11 on CD4 check status among all 35 CLHIV respondents, 91 respondents found to have CD4 check once and have updated it in every six months however 9 percentages CLHIV found not yet have checked up the CD4. 80 percentages of CLHIV not yet have checked their CD4 showed distance problem as due to not have proper accessibility of CD4 check in district they feel uncomfortable to go other district for CD4 and 20 percentages respondents have been found that not giving importance to CD4 check for their better healthy life.

5.5.6 CD4 check-up location

Cluster of differentiation (CD4) is very much vital test of HIV positive person as it count the T cell in blood which show the effectiveness of immune power of HIV positive person. As this test can only be done herein only government agencies therefore in Rupandehi' district context this test only can be done Lumbini Zonal hospital.

5.5.7 Health facilities

Health check-up is very much need aspect of every human life however regular health check-up is much needed to HIV positive person and children living with children. In district lots of institution can be found that provides health facilities. CLHIV visits as per their easy access to health providing center for health services and some social organization gives health services in

their home visit. Table 5 shows the response of CLHIV' respondents that from where they get health facilities in their day to day life:

Table 5: Health facilities form CLHIV receives health facilities

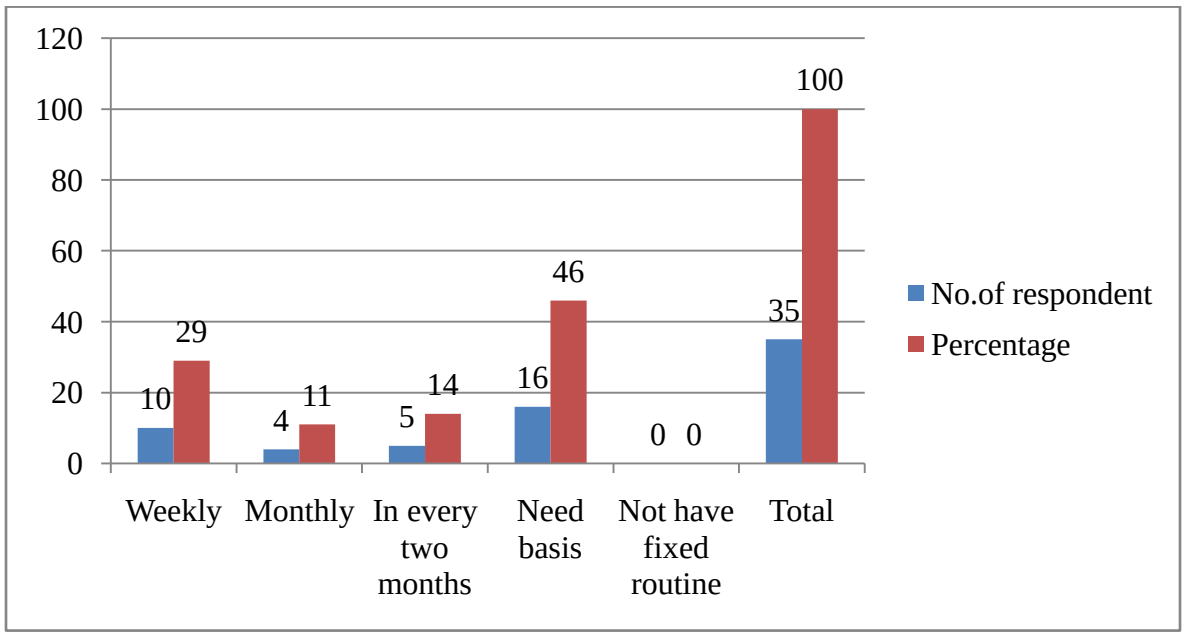
Health Facilities' Location	No. of respondent	Percentage
Health Post	2	6
District Zonal Hospital	15	43
Community Home Based Centre	13	37
Other	5	14
Total	35	100

Source: Field Survey 2016

6 percentage CLHIV' respondent stated that they do get health services from health post due to distance easiness as it is beside their residence however 43,37 and 14 percentage CLHIV respondents stated that they receive health services respectively from District Zonal Hospital, Community Home Based Center and Other. Here other refers private hospitals and some helping institution.

5.5.8 Frequency of health related services

Figure 12: Frequency of health related services



Source: Field Survey, 2016

In study of how frequent CLHIV receives health services as table 5 show that they do receive health services from different institutions as per their accessibility; amongst all 35 CLHIV respondents, 29 percentage CLHIV respondents agreed that they receive health services in every week however 11 percentage and 14 percentages CLHIV respondents that they receives health services respectively monthly and in every two months. 46 percentages CLHIV respondents said that they receive health services as per their need from access health service providing center. 100 percentage CLHIV respondents stated that they receive health related and other positive behavior counseling and suggestions from respective health and community mobilizor of United Nepal Foundation Lumbini(UNFL) NGO working in field of HIV and AIDs in their home visit.

5.5.9 Health expenses management

Every health and other services cost some expenditure and without financial management CLHIV' respondents' family could not access the health services to their children. It's very important to manage health expenses from any sources. In question to CLHIV from where their parents manage their health expenses they shares their view which can be cleared by below table 6

Table 6: Health expenses management of CLHIV

Health expenses management	No. of respondent	Percentage
Self	0	0
Family Support	10	29
Government and Social Organization	20	57
Other	5	14
Total	35	100

Source: Field Survey, 2016

Amongst all 35 CLHIV respondents, 29 percentages stated that their family manages expenses for their health check-up however 57 and 14 CLHIV respondents stated that Government and Social organization and other respectively manage the health expenses. Here other refers support and management from relatives, community and some helpful individuals.

5.6 Social Stigma and Discrimination

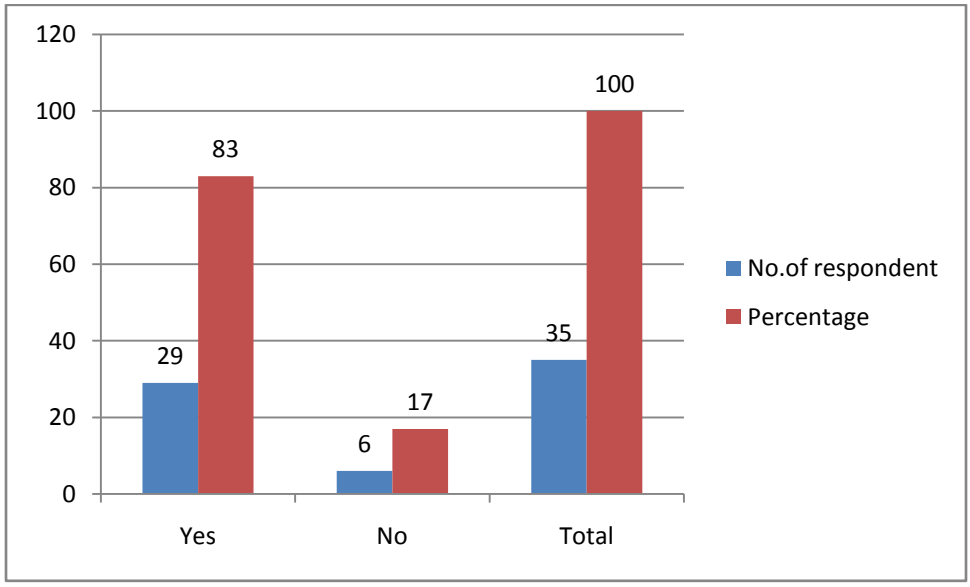
Social stigma and discrimination has been splashed all over in community due to several factors. People living with HIV (PLHIV) face social stigma and discrimination is society due to their HIV status that's why they are bound to hide their HIV status. Children living with HIV (CLHIV) face discrimination in community by different actors and sectors that's why they

hesitate to disclose their HIV identification. Due to stigma and discrimination in community, we may find that HIV positive person do not get their identification disclosed in public place in fear of social disrespect and fear of opportunity loss.

5.6.1 Discrimination because of HIV status

In discussion with target group of HIV, it came out that there is still existence of discrimination in every sector because of HIV status of HIV positive people. HIV positive people have been deprived from the human right and the children living with HIV has been separated from child right which is most needed for comprehensive development of children. For holistic development of children living with HIV, social stigma and discrimination should be completely halted from community. Amongst all 35 CLHIV respondents a common question asked about the discrimination they have been facing since their birth has asked and the result on discrimination is figured by figure 13 below herewith:

Figure 13: Discrimination in community because of HIV status with CLHIV



Source: Field Survey 2016

On the basis of study on existing discrimination in community to CLHIV from 35 CLHIV respondents 83 percentages respondents said that they have directly faced discrimination from community in their day to day life in multiple sectors of community however 17 percentage CLHIV respondent stated that they do not have yet directly faced any discrimination from society however they also have face indirect discrimination from society. This statements shows that there is still the strong existence of discrimination towards HIV positive person and children living with HIV.

5.6.2 Discrimination in Community by community person

People living with HIV and their children living with HIV found facing discrimination in community by community person in day to day life. Though there is not found condition like in previous days which was un bearable but still found strong emergence of discrimination toward children living with HIV' family in multiple ways. Some discrimination' mode can be measure but some discrimination in community cannot be measure and also get mental and emotional discrimination as well toward children living with HIV and their family. Below table 7 shows the modes of discrimination HIV positive people facing in their day to day life in community by community people:

Table 7: Discrimination in community by community person towards CLHIV

Modes/Ways of discrimination	No. of respondent	Percentage
Exclude CLHIV family	5	14
Do not keep any relation	9	26
Avoids in day to day matter	10	29
Do not care to CLHIV infected family	11	31
Total	35	100

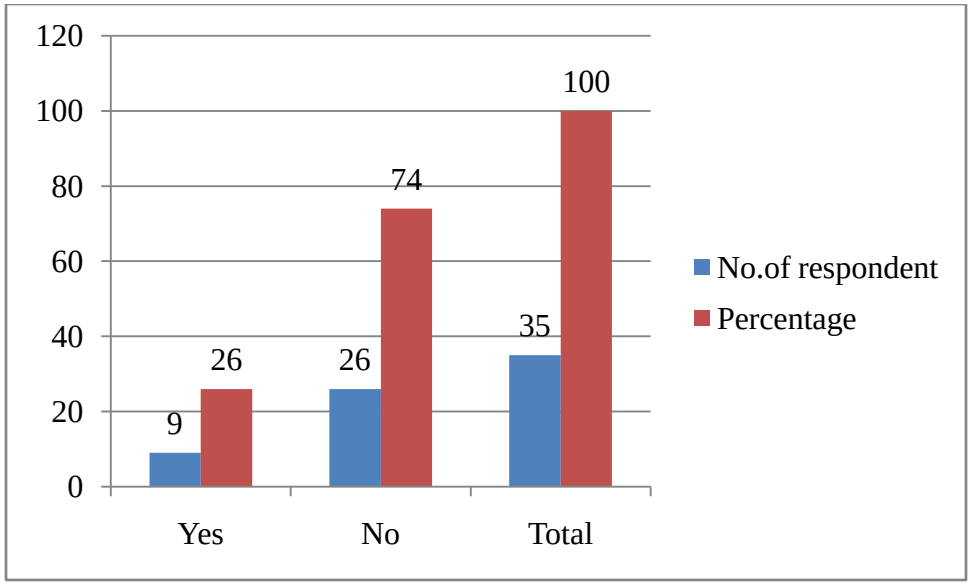
Source: Field Survey 2016

Above table 7 shows that 14 and 26 percentages of children living with HIV' family face discrimination respective in way of family exclusion from community program and do not keep any relation with family.29 and 31 percentages CLHIV' family stated that their family respectively found facing discrimination in society that community people avoid their family in day to day manner and community people do not care any to CLHIV infected family. At here all gathered information throughout study explains that CLHIV' family have been found that their family have yet been facing discrimination in community by community people.

5.6.3 Discrimination in school

Children living with HIV (CLHIV) found facing indirect discrimination in their day to day schooling life. Target groups stated that CLHIV did feel discrimination in their school by teachers somehow and parents along with senior students in both way emotional and mental which halt them to be frank and open in development of their carrier. Figure 14 explores the number of respondents who faced and who did not face among all 35 respondents herewith:

Figure 14: Discrimination with CLHIV in school



Source: Field Survey 2016

As the figure 14 explores that 26 percentage Children living with HIV respondents explained that they felt emotional, mental and social discrimination in school by their seniors, teachers and friends parent in parental visit whereas 74 percentages Children living with HIV respondents did not feel much discrimination in their day to day schooling life which could halt carrier development because most of them are not disclosed among schooling teachers, friends and their parents however they also feel nominal discrimination in school because of their HIV status among whom they are disclosed.

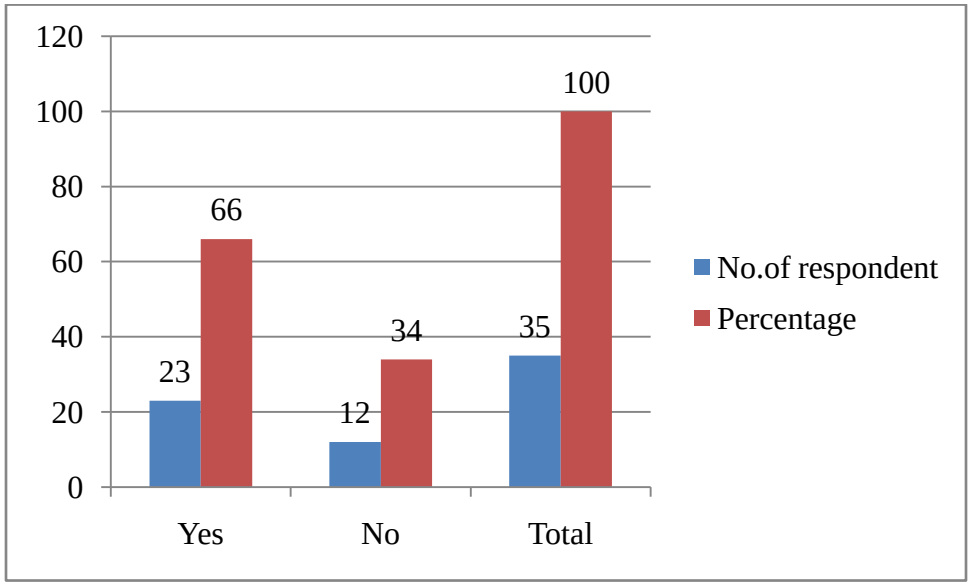
5.6.4 Government facilities

Government facilities have been developed for every person of nation in equal amount of manner without any discrimination among citizen but the follow of government facilities only seem to those groups of people who are educated and have accessibility of those sectors which are linked with government facilities. So in all these races, those groups who are out of race of accessibility of these government services could not get their accessibility in government facilities which are promoted by government for them as well like others. People living with HIV and Children living with HIV most have been out of accessibility of those types of government services due to discrimination because of their HIV status. 35 CLHIV respondents found not to be benefited by certain level of facilities which have been single handed by government of Nepal. However all 35 respondents have been found to be benefited by those type of facilities which have been jointly provided by other development partners; for example non-governmental organizations and community based organization along with International non-governmental organizations.

5.6.5 Governmental Health facilities

Through District Public Health Office (DPHO), District Hospital, Zonal Hospital and Local Health posts government have been benefiting people by providing multiples of health facilities. Here in context of Children living with HIV (CLHIV) in target group discussion found to be sidelined from benefited by governmental health facilities. All 35 CLHIV respondents were inquired about their accessibility in governmental health facilities whose result has been explored by figure 15 herewith:

Figure 15: Accessibility of CLHIV on Governmental Health Facilities



Source: Field Survey 2016

66 percentage CLHIV respondents explored that they have not much deprived from governmental health services and actively and regularly taking health facilities from local health posts, district and zonal hospital and district public health office however 34 percentage CLHIV respondents somehow found to be sidelined from governmental health facilities due to their HIV status as they need to face lots of difficulties to be enrolled in governmental health facilities.

5.6.6 Community Behaves with CLHIV after disclosure about his/her HIV status

Children living with HIV (CLHIV) gets some little extra or minimal or misbehave from community due to disclosure of their HIV status came in light in discussion with target group of person. All 35 CLHIV respondents were asked over community behave with them because of their HIV status and their response are explored by table 8 herewith:

Table 8: Community behaves with CLHIV

Community behave with CLHIV	No. of respondent	Percentage
Pity	5	14
Avoid	2	6
Sympathy	10	29
Mixed	18	51
Total	35	100

Source: Field Survey 2016

In response all 35 CLHIV respondents stated that they feel different behavior from community due to their HIV status disclosure in community. 14 and 6 percentage CLHIV respondents explored that they respectively feel pity and avoid type of behave from community people where 29 and 51 percentages CLHIV respondents stated respectively faced sympathy and mixed type of behavior from community in their day to day life which get them to be exposed and emotionally drives them into next level which drives them path of under development.

All 35 CLHIV respondents stated that they face mixed behavior from their relatives and friends due to their HIV status disclosure among them.

5.6.7 Challenges in day to day life from community

All 35 CLHIV respondents face following challenges from community in their day to day life:

a. Community person avoid to me and my family

   30 percentages CLHIV respondents stated that community person somehow avoid to them and their in community level activities and program which emotionally halts CLHIV to deal in day to day life.

b. Do not involve us for any common activities

   45 percentages CLHIV respondents explored that community people do not engage to them and their family in any common community level activities due to their HIV status.

c. Non HIV positive friends do not play with me

   20 percentage CLHIV respondents opened that their friend's families have restricted to their children to play with them in common play ground after schools and holidays which create emptiness in their day to day life.

d. To step for any assistance: NA

e. Do not keep any contact

5 percentage CLHIV stated community people do not keep any contact with them and their family due to their HIV status which create loneliness environment in their family life.

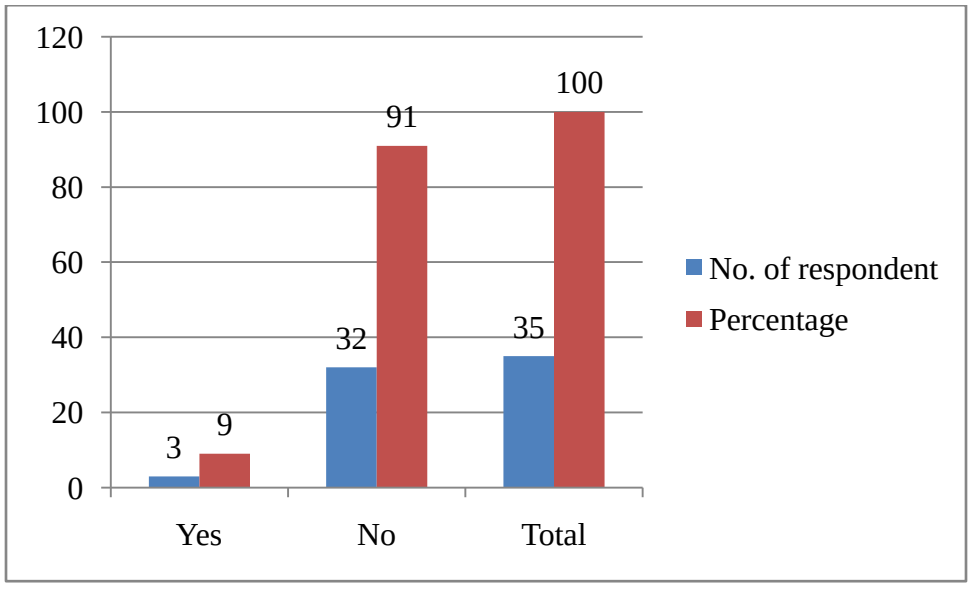
5.7 CLHIV' Participation in development and Social Protection

Every child's basic right should be fulfilled and should be enrolled in development as key actors. Children living with HIV (CLHIV) needs to be groomed as like other children and should be participated in development activities as the child right advocates for active participation of children in development programs. Special children who have been fallen in some serious health problems and have been living vulnerable life should be given social protection. Hence, in this regards CLHIV needs to be groomed under social protection program initiated by government and other development partners.

5.7.1 Participation in Governmental and Non-Governmental Program

All 35 CLHIV respondents who were inquired on whether they are participated in governmental and non-governmental programs either as key actors or beneficiaries, their answers were being figured by figure 16:

Figure 16: CLHIV' participation in governmental and non-governmental program



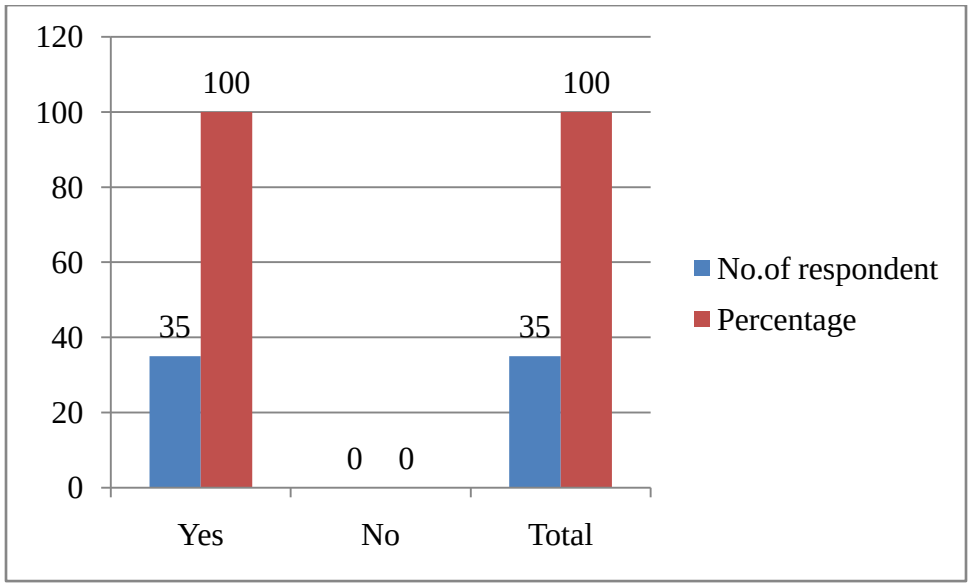
Source: Field Survey 2016

9 percentage CLHIV respondents amongst all 35 CLHIV respondent stated that they are enrolled and have been participated in development activities organized by either governmental or non-governmental activities whereas 91 percentages CLHIV respondents stated that they have not been participated either as key actor or participants in development activities of governmental or non-governmental program.

5.7.2 Benefited by Governmental or Non-Governmental Organization

Some development activities have been initiated for Children living with HIV (CLHIV) by governmental and non-governmental activities as keeping them as a key actor. Target group people stated that most of CLHIVs have been found as enrolled in development programs which is presented herewith by figure 17 as following information have been explored on the basis of answer provided by CLHIV:

Figure 17: CLHIV benefited by Governmental or Non-Governmental programs



Source: Field Survey 2016

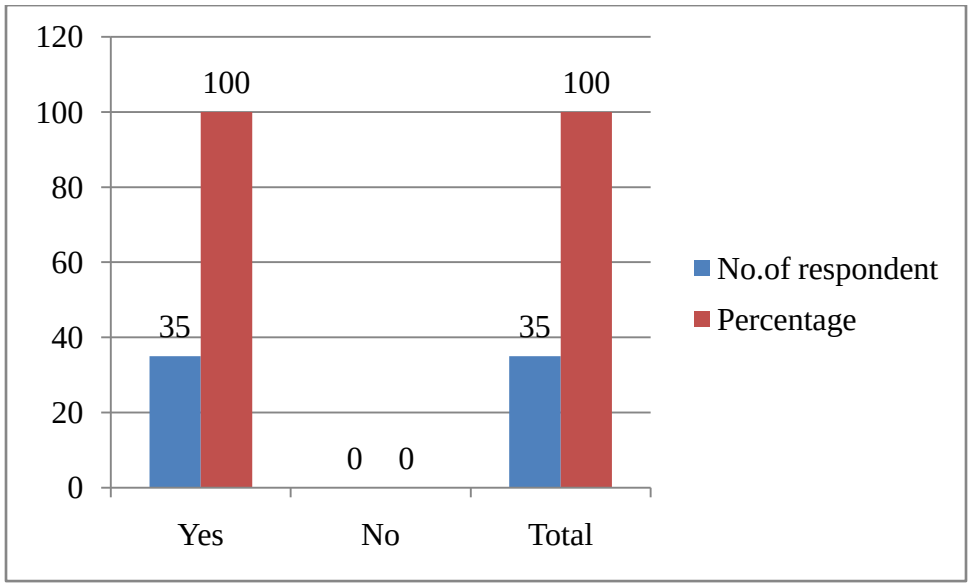
On study of CLHIV whether being benefited by any programs of government or non-government, it has been found that 100 CLHIV respondents amongst 35 CLHIV directly being benefited by Children Affected by AIDs (CABA) Cash Transfer Program implemented by

United Nepal Foundation Lumbini (UNFL) named non-governmental organization in partnership with Save the children under Global Fund. Under CABA Cash Transfer Program CLHIV children found as receiving Rs.1000 per month to support in their Education, Nutrition and Health care management in day to day life.

5.7.3 Status of CLHIV enrollment in CABA Cash Transfer Program

Children Affected by AIDs is a global fund funded program being implemented in Nepal in as Permanent partnership with Save the children by Global Fund to support HIV affected children under 18 years by providing cash Rs.1000 per month to support in their education, nutrition and health. In context of Rupandehi district United Nepal Foundation Lumbini(UNFL) found as implementing partner of CABA Cash Transfer Program. All 35 CLHIV were asked their status in enrollment of program and their answers is being figured through figure 18 herewith:

Figure 18: Status of CLHIV enrollment in CABA CASH Transfer Program



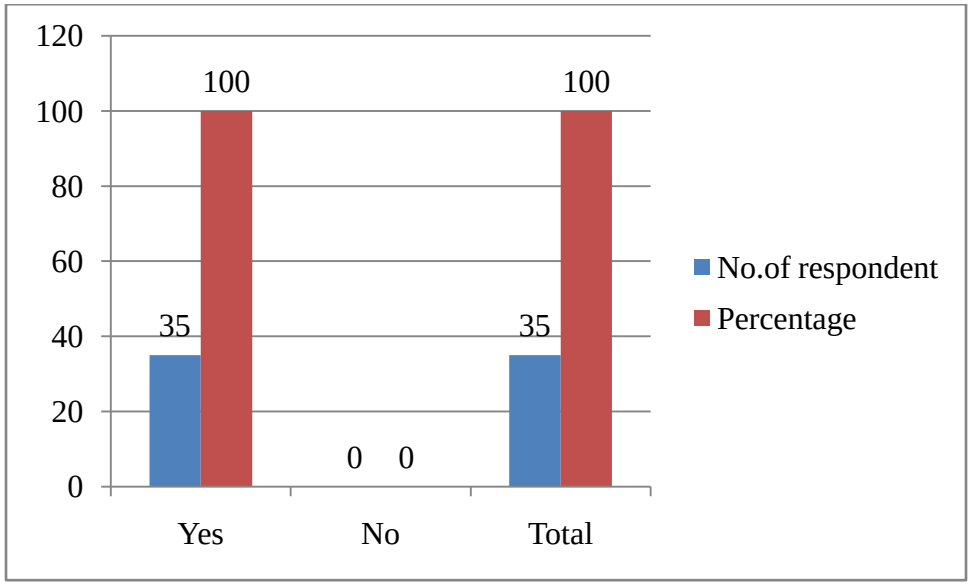
Source: Field Survey 2016

100 percentages respondents among 35 CLHIV respondents found to be enrolled in CABA CASH Transfer to have supportive factor in their education, nutrition and primary health care management which has been clarified by above figure 18.

5.7.4 CLHIV benefited by other programs

Children living with HIV have been integrated in different programs in districts under collaboration of governmental and non-governmental agencies in different time of zone and period.

Figure 19: CLHIV benefited by other programs



Source: Field Survey 2016

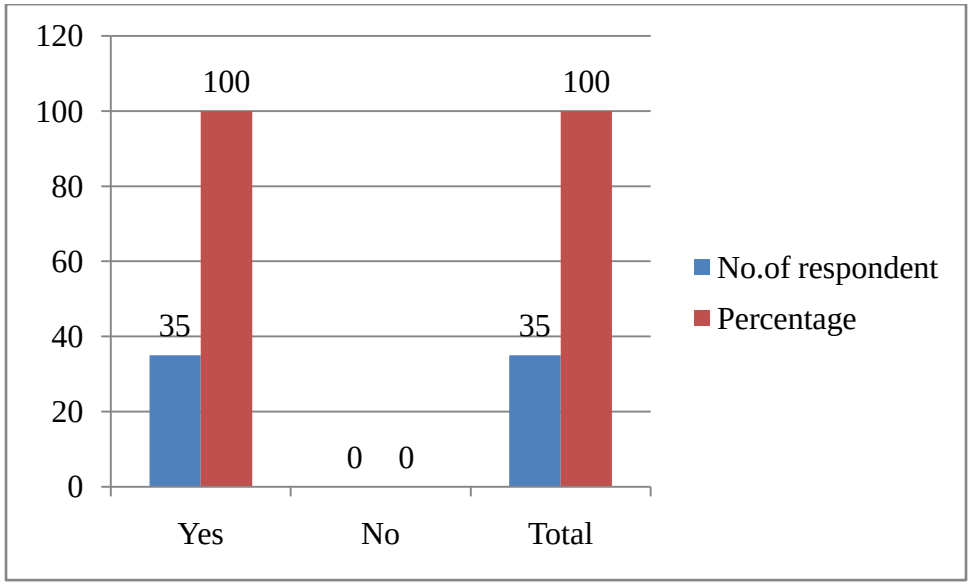
All 100 percentages CLHIV amongst 35 CLHIV found to be enrolled in other programs implemented in collaboration with governmental and non-governmental agencies in different time of period and zone. Here other program refers programs like Stationary materials distribution to CLHIV, warm clothes distribution to CLHIV in cold season, nutritional food materials distribution to CLHIV and so on to CLHIV.

5.7.5 Care and Support services

Care and support is what we all need is universal acceptance which is much applicable for Children living with HIV. Care and Support services give comprehensive care to CLHIV in different ways. Health check-up, proper counseling, nutritional support, positive behavior classes

types of services are being provided to Children living with HIV. In question how many respondents have been receiving Care and Support services in study area below figure 20 shows the clear picture of research on care and support services' beneficiaries:

Figure 20: Status of CLHIV receiving Care and Support services



Source: Field Survey 2016

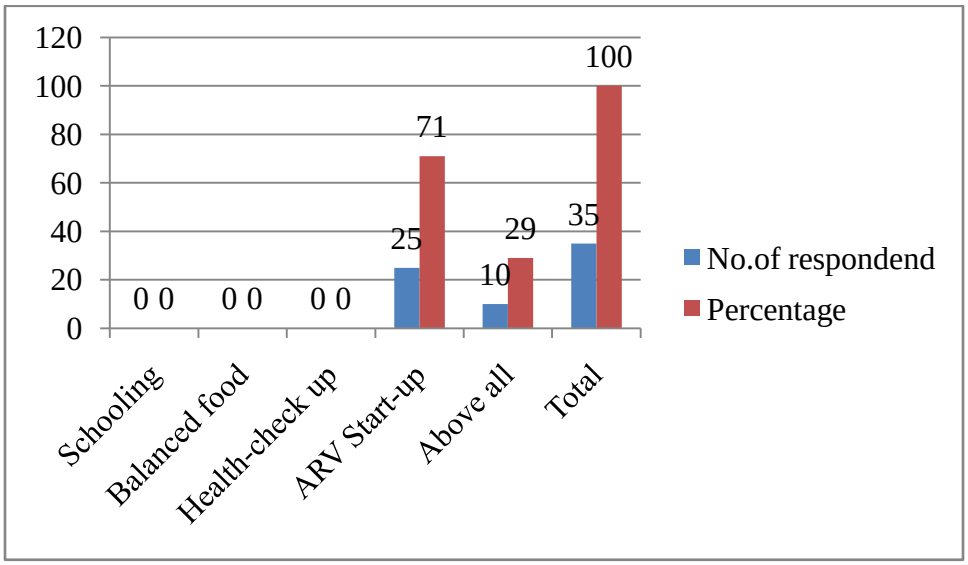
Above figure 20 describes that 100 percentages amongst 35 CLHIVs have been benefiting care and support services implemented by non-governmental organization in Rupandehi district. Through care and support services all 35 CLHIVs have been found receiving regular health check-up by community home based center and community care center implemented by non-governmental organization in Rupandehi district and also receiving other services through Lumbini Zonal hospital.

5.7.7 CABA Cash Transfer Program' benefit to CLHIV

Children Affected by AIDs is a global fund funded program being implemented in Nepal in as Permanent partnership with Save the children by Global Fund to support HIV affected children under 18 years by providing cash Rs.1000 per month to support in their education, nutrition and health. In context of Rupandehi district United Nepal Foundation

Lumbini(UNFL) found as implementing partner of CABA Cash Transfer Program. All 35 CLHIV were asked about area of support of program and their answers are being figured through figure 21 herewith:

Figure 21: CABA Cash Transfer Program' benefit to CLHIV



Source: Field Survey 2016

Amongst 35 CLHIV respondents on in what ways CABA Cash Transfer Program did benefit to CLHIV, 71 percentages CLHIV respondent stated that CABA Cash Transfer program did improve their health as it helped them to be enrolled in ARV which much has benefited them where 29 percentages CLHIV respondents stated that CABA Cash Transfer Program did benefit them in overall manner as this program helped them to re-join their school, get balanced diet food, motivated to have regular health check-up, assisted to have ARV start-up along with CD4 check-up as well. 35 CLHIV respondents explored that CABA Cash Transfer Program turned their life into new horizon as it turned their life in educational lamp of life, motivate and counseled to have regular health check-up and also have mere or more assistance in nutritional food in their day to day life.

CHAPTER -VI
SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

HIV is a lent virus that causes HIV infection and over time acquired immunodeficiency syndrome AIDS. Without treatment, average survival time after infection with HIV is estimated to be 9 to 11 years, depending on the HIV subtype. Infection with HIV occurs by the transfer of blood, semen, vaginal fluid, pre-ejaculate, or breast milk. Within these bodily fluids, HIV is present as both free virus particles and virus within infected immune cells. The majority of children living with HIV are infected via mother –to-child transmission, during pregnancy, childbirth or breastfeeding. In Nepal as of 2015, there are 1600 children with age group 0-14 living with HIV which increases from 1300 in 2004.

- In Rupandehi District 88 children are living with HIV as per District Public Health Office. Most of them are from poor families so they are facing different problems. Besides, most of the children with HIV had schooling which is a positive aspect of the district.
- Children living with HIV are from the different ethnic groups such as Tharu, Muslim, Janajati, Dalits, Brahmin/Chhetri and others.
- Most of the children living with HIV have already lost their fathers. This represent HIV have been transmitted from father-mother-children.
- Most of children living with HIV are from poor background and their family's major occupation seems as agriculture and daily wages to earn money and this enhance poverty in their life which creates difficult situation to them to live on.
- Most of Children living with HIV have found to have with biological parents which yet gives them an opportunity to groom in their life with parental care which is much needed for children' holistic development.
- Due to poverty most of children do not get balanced diet in their meal however it is positive factor all children living with HIV are having two time meal in their day to day life.

- Most of Children living with HIV' family purchase food materials from market. Despite their poverty they are somehow seem managing to purchase food materials from market. This represents that they do not own farm or finance to invest in their own kitchen garden so that that they can get most of food materials in their own farm or kitchen garden which could save their money and get them fresh food which could be good for health of children living with HIV.
- Most of Children living with HIV seem to have nutritional food in continuous mode for their good health. Here nutritional food means meat, eggs, fruit and milk which are much needed for them to maintain good health.
- Some positive factors seem had diverted to school dropout students to rejoin the school and found Children living with HIV continuing their schooling which resembles accessibility of education in their life as a once most important factor for their carrier development.
- Due to discrimination' fear Children living with HIV found not to disclosed among community person which shows the existence of discrimination in community for people living with HIV as a major social challenge for holistic development of community as those children are also major actor of development.
- Its seems that Children living with HIV' families have been educated towards good health' importance in their life which has caused most of children living with HIV enrolled in Anti-Retro viral therapy and also found anxious towards CD4 check-up.
- Children living with HIV seem having sound accessibility on regular health check-up through different health service providers in district through different existing mechanism from government and non-governmental organization.
- Though there is not yet existence of earlier type of barrier in community but yet there is found the existence of huge amount of discrimination in community towards children living with HIV which is not found as favourable for community development as Children living with HIV are also core partner of community development.
- Children living with HIV seem to have discriminated in governmental health providing agencies in indirect manner which halts them to have equal amount of accessibility in health services as like other people.

- Children living with HIV and their families feel day to day discrimination from community as they and their family found to be exclude from community programs, non-positive children do not interact and play in common ways and do not keep any contact which create lonely space in heart and life of children living with HIV
- In sense of equal participation of children in development activities of governmental program, children living with HIV found to have very low participation in development activities run by government which shows very low participation in development activities of Children living with HIV. This resembles that they have been deprived from their child right as well along with facilities.
- CABA Cash Transfer Program (CABA) seem to have a major program implemented by International Non-Governmental organization through local Non-governmental organization in district as all children living with HIV under 18 years old seem to enrolled in program as this program found to have been investing in education, health and nutrition balanced diet for children living with HIV as prime factor of development in support of Global fund.
- Children living with HIV seem to have been benefiting by other different types of seasonal program implemented by multiples of organizations in joint collaboration with governmental organization in district.
- Local organizations seem to have been providing care and support services to Children living with HIV by which they have been receiving regular health check-up, counselling and positive message in their own house through house hold visit of development partners in regular period of time.
- CABA Cash Transfer Program found to have been benefiting children through Rs.1000 per month pay to support in their education, nutrition and health which resembles good changes in life of Children living with HIV as they have been maintaining good health through enrolment in Anti-Retro Viral Therapy, re-school joining to dropout students, regular health check-up and have nutritional balanced diet.

6.2 Conclusion

Children living with HIV seem to have been facing discrimination in community in their day to day life though not in direct way but indirect way which shows vulnerability in society. Children living with HIV feel indirect discrimination which hits to their emotion, confidence and heart indirect ways as well which reduce their confidence to live in community in comprehensive manner.

Through different motivational factor mainly because of CABA Cash Transfer Program Children living with HIV have been found properly enrolled in community level school who were previously drop-out from school.

Children living with HIV and their families feel being isolated as they do not get information on development program and not found to be involved in development programs implemented by governmental agencies in different time frame of development calendars.

Children living with HIV seem to have been enrolled in health services and programs either run by governmental or non-governmental organization however they feel uncomfortable in governmental health posts and hospitals as they feel that they are being treated differently by health staff in different manner. Through Care and Support services program Children living with HIV receive different types of health services and major and important positive counselling in their household in house hold visit by development partner non-governmental agencies in regular basis.

CABA Cash Transfer Program through Rs.1000 per month support to Children living with HIV for their Education, Health and Nutrition support to enhance their carrier. This program seem to have benefited to Children living with HIV as Children living with HIV found to have been re-schooling, regular health check-up, enrolment in Anti-Retro Viral Therapy, CD4 check, Positive behaviour, Balanced diet and so on .

6.3 Recommendations

- Children should be given age-appropriate, culturally relevant, scientifically accurate and non-judgmental education and information about sex, HIV, AIDS and relationships.
- Children living with HIV' HIV affected family should be given strengthened so they could properly look after their children and themselves as well which could secure the parental care of children living with HIV.
- Supporting a family holistically can be the best way to ensure a good quality of life for the child. This should include social protection schemes that provide external assistance to poorer families in areas where HIV prevalence is high. Such schemes are now seen as a valuable part of improving the lives of children affected by HIV.
- By reducing a household's economic vulnerability, children benefit from better nutrition, the opportunity to go to school instead of work and better access to healthcare.
- Governmental clinical staffs at hospital need to be well sensitized on emotional and mental aspect about children living with HIV as their harsh behaviour could halt the emotional heart of children and could reduce their regular health check-up which would damage health of children living with HIV. Therefore governmental clinical staffs need to be sensitized on these serious issues.
- Ministry of Health, District Health Office and District Hospital along with District Development Committee should be more focused on Children living with HIV to advocate for them to develop Children living with HIV friendly program to upgrade their life.