Educational Problems of Children Orphaned by AIDS: A Study in Krishna, YSR Kadapa and Karimnagar Districts of Andhra Pradesh

–Mutluri Abraham*, A.B.S.V. Ranga Rao**

Abstract

HIV/AIDS is one of the major social problems in developing countries like India. In 1986, the first HIV case was diagnosed by Dr. Suniti Salmon in a female sex worker from Tamil Nadu, India. Then gradually the HIV has been transmitted and diagnosed in all states of India. More than 6 million people in India are living with HIV/AIDS. The impact of HIV/AIDS is more on children, women and aged people. According to NACO, more than 2.1 million children, below age of 18 years have been orphaned as a result of AIDS. NACO defined "AIDS orphan is a child who is less than 18 years of age whose mother or father or both have died of HIV/AIDS".

This study makes an attempt to analyse the situation of AIDS orphans in three high prevalent districts of united Andhra Pradesh i.e. Krishna, YSR Kadapa, and Karimnagar. India. The study analysed socio-economic demographic profile of the AIDS orphans, perceived stigma and discrimination, educational and psychological problems faced by AIDS orphans and suggested the better interventions to promote the quality of life among AIDS orphans. The study collected data from 316 AIDS orphans and also conducted 6 focus group discussions. The study found that there are many challenges facing by AIDS orphans to access the basic education.

Keywords: *AIDS Orphans, Situation, Education, Stigma, Government Support*

* Guest Faculty, Department of Social Work, Andhra University, Visakhapatnam, Andhra Pradesh, Email: vijjyabhi@gmail.com

** Professor, Department of Social Work, Andhra University, Visakhapatnam, Andhra Pradesh, India. Email: Rangarao_ausw@yahoo.co.in

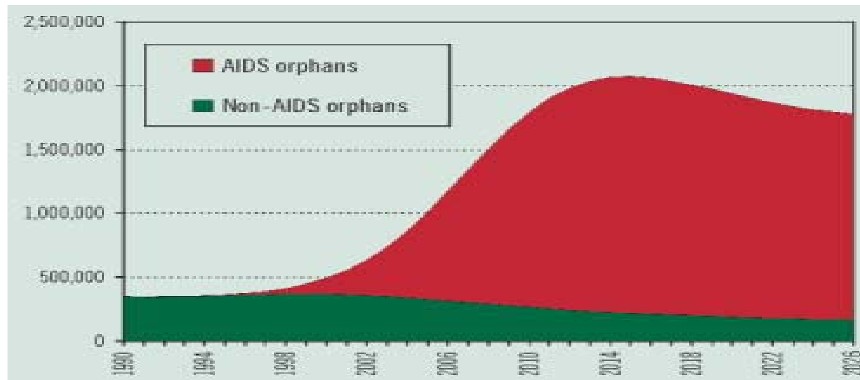
INTRODUCTION

Health is a fundamental human right for every human being. As per the Indian constitution “everyone has the right to have a standard of living adequate for the health, including food, clothing, housing and medical care and necessary social services”. This statement needs a serious attention because HIV/AIDS has created lot of alertness in health sector. HIV/AIDS is one of the major social problems in developing countries like India. In 1986, the first HIV case was diagnosed by Dr. Suniti Salmon in a female sex worker from Tamil Nadu. Then gradually the HIV has been transformed and diagnosed in all states of India. More than 6 million people in India are living with HIV/AIDS. The impact of HIV/AIDS is more on children, women and aged people. According to NACO, more than 2.1 million children, below age of 18 years have been orphaned as a result of AIDS and the number is expected to double by end of 2017. This study makes an attempt to analyse the situation of AIDS orphans in three high prevalent districts of India.

CHILDREN ORPHANED BY AIDS

One of the most tragic consequences of HIV/AIDS epidemic is that a huge number of children get orphaned as a result of parents dying of AIDS. It has a devastating impact on the emotional and physical health and well-being of children orphaned by AIDS. Some of these children are HIV-positive themselves having been infected through their mothers either at birth or by breast milk. It is estimated that 27 million children have been orphaned by AIDS in the world, among them 2.1 million are from India. This number is expected to double in the next five years (WHO, NACO 2011). According to Andhra Pradesh State AIDS Control Society (APSACS), there are 1, 50,000 children orphaned by AIDS living in Andhra Pradesh (APSACS, 2012).

Fig. 1 shows that morbidity of the AIDS orphans is high during 2013-2020. Due to the 10-year time between HIV infection and death, officials predict that orphan populations will continue to rise for a similar period, even after the HIV rate begins to decline. Experts say only massive spending to prolong the lives of parents could be expected to change this trend (UNAIDS, 2007).



Source: UNAIDS, and the Global Partners Forum (2004)

Fig. 1: Trend Analysis of the AIDS Orphans from 1990 to 2026

PURPOSE OF THE RESEARCH

HIV/AIDS epidemic has created many orphaned and vulnerable children affected directly or indirectly, because their family members were infected and died. Often the changes in family structures make the children orphans or sometimes they have to take up the responsibilities to take care of infected elders in the family. National AIDS Control Organisation (NACO) defined "AIDS orphan is a child who is less than 18 years of age whose mother or father or both have died of HIV/AIDS".

OBJECTIVES OF THE STUDY

1. To study the socio economic demographic profile of the AIDS orphans.
2. To study the perceived stigma and discrimination, educational, and psychological problems faced by AIDS orphans.
3. To suggest to initiate better interventions to promote the quality of life among AIDS orphans.

RESEARCH METHODOLOGY

The research study was conducted in three high prevalence districts from three regions of united Andhra Pradesh i.e., Krishna (coastal region), YSR Kadapa (Rayalaseema region), and Karimnagar (Telangana region)

districts. Descriptive research design was formulated for the present study with a view to describe, compare, and analyse the perceptions of the children orphaned by AIDS towards the issues and problems of the children orphaned by AIDS.

Universe and Sample

As the universe for the study is not known, the researcher has undertaken a baseline survey and collected the list of 5146 AIDS orphans ranging from the age of 01 - 18 years from 21 NGOs and ART centres working in the field of HIV/AIDS. Then the researcher excluded the children below the age of 8 years as they are too young and innocent to express or reflect on different aspects of their health status and other things. Hence the study is confined to the children between the ages of 8-18 years only. After elimination process the number of children falling within the sampling frame was 3160. The researcher decided to take 10 percent of the universe as the respondents for the study. The researcher collected information from the 316 children through systematic random sampling method.

Data Collection Tools

The data collection tools are interview schedule and focus group discussion. The researcher followed the ethical guidelines of National AIDS Control Organisation. Data collected through interview schedules were analysed by using the software of Statistical Package for Social Scientists (SPSS) and generated tables.

Data Analysis and Interpretation

The researcher made an attempt to make the study more broad based covering a large sample of the AIDS orphans and conducted focus group discussions for caregivers. For the purpose of this study the orphans are classified into two groups.

Orphans Affected by HIV/ AIDS (OAA) means, an orphan is a child between the ages of 8 - 18 years who has lost his/her single or both parents due to AIDS.

Orphans Living with HIV/AIDS (OLHA) means, an orphan is a child between the ages of 8 - 18 years who has been infected with HIV and also lost his/her single or both parents due to AIDS.

Table 1: Distribution of Respondents by Their Category or HIV Status

Respondent Category	*Frequency*	*Percent*
OAA	169	53.5
OLHA	147	46.5
Total	316	100.0

The data in Table 1 show that majority (53.5 percent) of the respondents are children affected by AIDS (OAA), while 46.5 percent of the respondents are children living with HIV/AIDS (OLHA).

Table 2: Distribution of the Respondents by Their Age

Age	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
8- 10 years	32 (46.0) [19.0]	38 (54.0) [26.0]	70 (100.0) [22.0]
11 – 15 years	98 (47.0) [58.0]	101 (53.0) [69.0]	199 (100.0) [63.0]
16-18 years	39 (83.0) [23.0]	8 (17.0) [5.0]	47 (100.0) [15.0]
Total	169(53.5) [100.0]	147(46.5) [100.0]	316(100.0) [100.0]
Mean age of OAA Mean age of OLHA		13.22 11.84	

Table 2 presents the age wise brake up of the respondents of the study. The data show that the majority (63 percent) of the respondents is in 11-15 years age group, followed by 08-10 years age group which accounted for 22.0 percent of the sample and the remaining respondents are between 16-18 years of age. The data further show that out of the total orphans in the age group of 16-18, the percentage of orphan's livings with HIV/AIDS accounted for only 15 percent while orphans affected with HIV/AIDS is around 83 percent. The low percentage of orphans living with HIV/AIDS in the age group of 16-18 years may be due to the fact that the mortality levels may be high because of severe opportunistic infections that inflict the OLHA. The mean ages of OAA and OLHA are 13.2 and 11.84 respectively.

Table 3: Distribution of the Respondents by Their Sex

Sex	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Boys	86 (49.0) [51.0]	89 (51.0) [61.0]	175 (100.0) [55.0]
Girls	83 (59.0) [49.0]	58 (41.0) [39.0]	141 (100.0) [45.0]
Total	169(53.5) [100.0]	147(46.5) [100.0]	316(100.0) [100.0]

The sex wise analysis of the data show that boys constituted 55 percent of the sample while girls formed 45 percent of the respondnets. The data show that in the category of OAA, boys accounted for 49 percent while girls formed 51 percent. In OLHA category, boys out numbered girls, constituting 61 percent while girls formed only 39 percent. The low percentage of girls in OLHA category may be due to the fact that mortality levels may be high among girls because of neglect and discrimination shown by the caregivers.

Table 4: Distribution of Respondents by Education Levels

Education	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Illiterate	19 (70.0) [11.0]	8 (30.0) [5.0]	27 (100.0) [9.0]
Below 5th standard	87 (48.0) [52.0]	96 (52.0) [65.0]	183 (100.0) [58.0]
6th- 7th Standard	26 (54.0) [15.0]	24 (46.0) [16.0]	50 (100.0) [15.0]
8th - 10th Standard	21 (62.0) [12.0]	13 (38.0) [9.0]	34 (100.0) [11.0]
Above 10th	16 (73.0) [10.0]	6 (27.0) [5.0]	22 (100.0) [7.0]
Total	169(53.5) [100.0]	147(46.5) [100.0]	316(100.0) [100.0]

The educational attainments of the respondents are presented in Table 4. The data show that the majority (58 percent) of the respondents have not completed the primary education while 26 percent of the respondents

have education qualification ranging from 6th class to below 10th class. The data show that among the OLHA, 65 percent have not completed the primary education and only 30 percent have above 5th class to 10th class qualification. There is no much difference in the educational qualification of the respondents and the percentage of the respondents having primary education and above show a declining trend in the sample. This may be due to the fact that in many villages, only primary schools are available and for obtaining education beyond primary level one has to go to other villages. Lack of upper primary and secondary schools may deter the respondents and caregivers to pursue education.

Table 5: Distribution of Respondents by Their Place of Residence/ Origin

Residence /Origin	***OAA***	***OLHA***	***Total***
	Frequency	***Frequency***	***Frequency***
Rural	101 (51.0) [60.0]	99 (49.0) [67.0]	200 100.0) [63.0]
Urban	68 (34.0) [40.0]	43 (66.0) [29.0]	111 (100.0) [35.0]
Tribal	0 (0.0) [0.0]	5 (100.0) [4.0]	5 (100.0) [2.0]
Total	169(53.5) [100.0]	147(46.5) [100.0]	316(100.0) [100.0]

Table 5 presents the information about the area/place of residence (rural, urban and tribal) of the respondents. The data in the table show that majority (63 percent) of the respondents are from rural areas while 35 percent are from urban areas and the remaining 2 percent of the respondents are from the tribal areas.

Fig. 2 presents details of head of the households of the respondents. The common form of household or family is the male or father headed families but the HIV/AIDS changed the situation and increased the woman headed families. The data show that 36.0 percent of the respondents reported that their families are women headed (mother) and 24.0 percent of the respondents families are grandparents headed households, and 13.0 percent are child headed families. The epidemic of HIV is more likely to cause changes in the family structure of the society and it is evident from the data, that 83.0 percent of the families are other than male (parental) headed. The child headed families are also emerging and they

are more among OAA respondents than OLHA respondents. In many households older siblings (18 years or older) who have been caring for younger brothers and sisters during their parents' illness may carry on as the head of household. Some of these households are only temporary until it is decided which relative should take responsibility for the orphaned children (UNICEF, 2012).

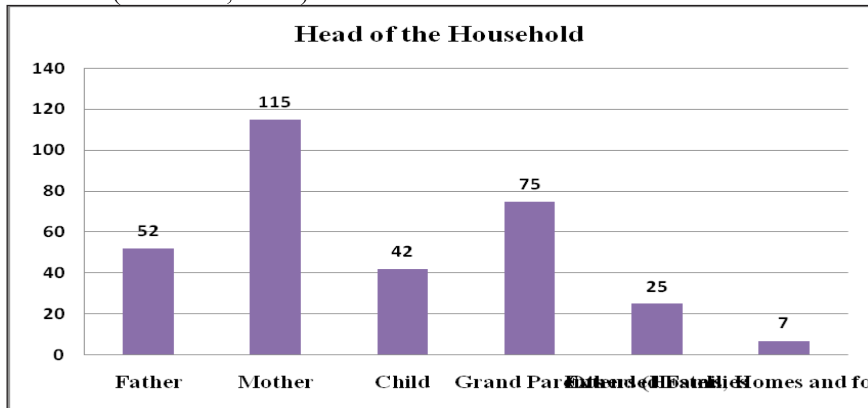


Fig. 2: Head of the Household

One of the respondents who is heading the family and taking care of the grannies reported, *'I am Nageswara Rao, 6th class drop out. Both of my parents have died with AIDS. I have stopped my education at 6th class and started vending the plastic material along with my 78 years old grandfather. Now my grandmother and grandfather are aged. Now I am only one person who can do some work and taking all the care of the older.'*

During the FGDs conducted as a part of study with caregivers, one of the woman participants who is heading the family reported, *'I am Sitamaha Lakshmi, 28 years. I have two children. My husband died 6 years back. My mother-in-law family did not support me. I left the village along with my two children. Now I am vending the dry-fish and earning Rs. 100-150 per day. The elder girl child got married and my son is studying 7th class in Government School. I am taking ART medicine.*

Table 6 presents the data on the current attendance of AIDS orphans to school or college. The data show that majority (64.9 percent) of the respondents attending school/college and remaining 35.1 percent of the children are not attending school/college. It has been observed in the data

that school attendance is more likely among OAAs than among OLHAs. The plausible reason for majority of the AIDS orphaned children attending the school may be due to social pressure on the host family not to deprive the orphan in obvious ways (Satish, 2009).

Table 6: Distribution of Respondents by Attending to School/College at Present

Attending school/College	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Yes	115 (56.0) [68.0]	90 (44.0) [61.2]	205 (100.0) [64.9]
No	54 (48.6) [32.0]	57 (51.4) [38.8]	111 (100.0) [35.1]
Total	169(53.5) [100.0]	147(46.5) [100.0]	316(100.0) [100.0]

The reasons for children dropping out of the school are of denial of accessing admission to school or of the stigma and discrimination within communities or the common misconception that they also will be HIV positive. But often children affected by HIV/AIDS drop out of school in order to support the family economically, while at the same time caring for their sick parent and managing the household (Deeksha, 2008). These children work at their homes and few work for the daily wage in agriculture, automobile shops, hotels, and house made works.

Age and Attending Status of School

The data relating to current school or college attendance and ages of respondents are cross tabulated and presented in Table 7 to know whether there is an association between two variables.

Table 7: Distribution of Respondents by Age and School / College Attendance

Age	*Current school / college attendance*		*Total*
	Yes	*No*	
Below 10 Years	63 (90.0)	7 (10.0)	70 (100.0)
11 - 15 Years	127 (63.5)	73 (36.5)	200 (100)
Above 15 Years	15 (32.6)	31 (67.4)	46 (100)

Total	205 (64.8) [100.0]	111 (35.2) [100.0]	316 (100.0) [100.0]

Chi- Square: 40.573 (a) df: 2 Significance Value: 0.000

Analysis of the data on the present school attendance and age of the respondents show that there is an association between two variables as it is evident from the data that children above 15 years of age are less likely to continue their education. Orphaned and vulnerable children may be at greater risk of dropping out of school. This can happen for many reasons, such as the inability to pay school fees, the need to help with household labor, or to stay at home to care for sick parents or younger siblings. After death of the parents children have stopped education and are working for the livelihoods.

Table 8: Distribution of Respondents by Reasons for Not Attending the School/College

Reasons for not attending the school/college	***OAA***	***OLHA***	***Total***
	Frequency	***Frequency***	***Frequency***
Non-cooperation from the family members	9 (39.1) [16.3]	14 (60.9) [24.6]	23 (100.0) [20.7]
Economic problems	17 (54.8) [32.1]	14 (45.2) [24.6]	31 (100.0) [27.9]
Stigma in schools	18 (69.2) [33.3]	8 (30.8) [14.0]	26 (100.0) [23.4]
Personal disinterest to do Job	10 (76.9) [18.3]	3 (23.1) [5.2]	13 (100.0) [11.7]
Health problems	0 0	18 (100) [31.6]	18 (100.0) [16.3]
Total	54 (48.6) [100.0]	57 (51.4) [100.0]	111 (100.0) [100.0]

The data in Table 8 show that 27.9 percent of the respondents are not attending school/college due to the economic problems while 23.4 percent of the respondents due to the stigma in the schools and 20.7 percent respondents due to non-cooperation from their family members to attend school/college. The data show that in OLHA 31.6 percent respondents are not attending school/college due to health problems. HIV affected respondents revealed that they are made to sit separately, gets less

attention than their classmates, and mentioned that their parents' illness is a reason for humiliation. Their classmates are told by their parents not to have any contact with affected children, and some schools bow to public pressure to refuse admission to affected children. Some children spoke of being withdrawn from school to care for sick parents, or to supplement household income, although this was listed as a priority concern in only one state, Andhra Pradesh (UNICEF, 2008).

Another important reason for dropout of children belonging to the HIV households turns out to be inability to afford schooling. This indicates that many of the HIV households are not able to afford education due to reduced household income or increasing expenditure on medical treatment. Even if the schooling is free, the households have to bear some costs like purchase of textbooks, exercise books, uniforms, etc. The various incentives provided by the government have influenced their decision to enroll the children in school. The most popular scheme seems to be the 'Mid-day Meals Scheme' and the other incentives mentioned include free books, hostel accommodation, and free school uniform supplied by the government to children belonging to economically weaker sections of society (Basanta, 2010).

Table 9: Distribution of the Respondents by Distance of their School

School distance	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Below 1 Kilometer	42 (65.7) [37.5]	22 (34.3) [22.9]	64 (100.0) [30.7]
2-5 Kilometers	44 (43.3) [39.3]	58 (56.7) [60.4]	102 (100.0) [49.2]
5-10 Kilometers	24 (63.2) [21,4]	14 (36.8) [14.6]	38 (100.0) [18.2]
Above 10 Kilometers	2 (50.0) [1.8]	2 (50.0) [2.1]	4 (100.0) [1.9]
Total	112(53.8) [100.0]	96(46.2) [100.0]	208(100.0) [100.0]

Table 9 provides the information about the distance of schools from their place of residence. The data show that 49.2 percent of the respondents reported that their school is 2-5 kilometers away from the place of residence. For 30.7 percent it is less than 1 kilometer. It is noticed that 18.2 percent children have to travel more than 5 -10 kilometers to

attend the school. The study is in line with the study of Directorate School Education Andhra Pradesh (2008) which stated that the school facility for 6-14 years is available in every *mandal* of Andhra Pradesh. For primary education the distance of the schools are within one kilometer for each habitation. For the upper primary education the distance of the school is within three kilometers from each habitation and for the high schools within five kilometers from each habitation.

Table 10: Distribution of Respondents by Mode of Travel to Reach Schools Regularly

Mode of the travel to reach the school	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Walk	63 (57.8) [56.3]	46 (42.2) [47.9]	109 (100) [52.4]
Cycle	29 (65.9) [25.9]	15 (34.1) [15.6]	44 (100) [21.1]
Bus	18 (37.5) [16.1]	30 (62.5) [31.2]	48 (100) [23.1]
Others	2 (28.6) [1.8]	5 (71.4) [5.2]	7 (100) [3.4]
Total	112 (53.8) [100.0]	96 (46.2) [100.0]	208 (100.0) [100.0]

Table 10 provides the information about the mode of transport to attend the school. The data show that majority (52.4 percent) of the children go to school on foot, while 23.1 percent of the children go to school by bus and the remaining respondents go to the schools by cycle, auto rickshaw and are being dropped by the someone in the family. The data show that 31.2 percent of the OLHA are going school by bus. The OLHA respondents have stated that they are unable to walk along with the other school going children. If they walk a few minutes they get tired.

The data show that 35.4 percent of the respondents are getting the educational support from the government and non-governmental organisations while (64.6 percent) of the respondents are not getting the educational support. During the interviews with respondents of the remote villages they stated that children orphaned by AIDS require more services from Government like uniforms, note books, issue based scholarships, and Income Generation Programmes to their parents to afford the expenses of the children to continue their education.

Table 11: Distribution of Respondents by Getting Educational Support Regularly

Getting education support	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Yes	63 (56.3) [36.6]	49 (43.7) [43]	112 (100.0) [35.4]
No	109 (53.4) [63.4]	95 (46.6) [66.6]	204 (100.0) [64.6]
Total	172(54.4) [100.0]	144(45.6) [100.0]	316(100.0) [100.0]

During the interaction with one of the NGOs staff Mr. Jagadeesh, Kadapa Net Work of Positive People, has stated that *"there is no focused programme or activities to promote the education of children affected by AIDS. The funding of the previous programmes like Children Health and Happy Programme (CHAHA), Balasahayoga Programme and Children Affected by AIDS (CABA) has been closed by donor agencies. Now we do not have the budget to provide the education support to the AIDS affected Children"*

SCHOOL SUPPORT GROUPS

The concept of School Support Group was started by NGOs to promote the enabling environment in the schools for children affected by AIDS. Children (10-15) will be formed into group and sensitised by the teachers and other children on the issues of AIDS affected children. The groups create an enabling environment to children affected by AIDS in the schools and address the issues of OAA in the schools by sensitising teachers and other children. Table 12 provides the information about the membership in school support groups.

Table 12: Distribution of Respondents by their Membership in School Support Group

Member in support group	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Yes	29 (55.8) [17.2]	23 (44.2) [15.6]	52 (100.0) [16.5]

No	140 (42.6) [82.8]	124 (47.4) [84.4]	264 (100.0) [83.5]
Total	169(53.5) [100.0]	147(46.5) [100.0]	316(100.0) [100.0]

The data show that only (16.5 percent) respondents were involved in school support groups while the majority (83.5 percent) was not involved in the school support groups, as there was no existence of support groups in schools they attend. NGOs in those areas did not promote support groups in the schools. It is observed that in some schools of Vijayawada, Krishna District the NGOs like VMM, Deepthi Socio Educational Society (DSES), and Reeds India have formed school support groups. It is observed that the model of school support groups are not replicated in YSR Kadapa and Karimnagar Districts of Andhra Pradesh but the red ribbon clubs are available for the college students.

School support groups started to create conducive environment in the school by reducing stigma and discrimination. There are many benefits with school support groups; mutual support groups reduce the sense of loneliness, offering a new community of peers that can be supportive both during and between group meetings. In addition to receiving emotional support and empathic understanding, members acquire practical advice and information from individuals in similar predicaments or life circumstances. Mutual school support groups also provide the opportunity for optimistic peer comparisons, as members realise with relief that their problems really are not so extraordinary and that others with similar problems are working toward their resolution (VMM, 2007). Table 13 provides information about the type of benefits respondents received as a member of school support group.

Table 13: Distribution of Respondents by the Type of Benefits Received As A Member of the Support Group

Type of benefits received from school support group	*OAA*	*OLHA*	*Total*
	Frequency	*Frequency*	*Frequency*
Knowledge about HIV and AIDS	1 (10.0) [3.4]	9 (90.0) [39.1]	10 (100.0) [19.2]
Reduction of loneliness and increased interest to attend the school	8 (72.7) [27.6]	3 (27.3) [13.0]	11 (100.0) [21.1]

Psychological support and 'we feeling'	9 (69.2) [31.0]	4 (30.8) [17.4]	13 (100.0) [25.2]
Referral services	6 (60) [20.7]	4 (40) [17.4]	10 (100.0) [19.2]
Confidence	4 (66.7) [13.8]	2 (33.3) [8.7]	6 (100.0) [11.5]
Others	1 (50.0) [3.5]	1 (50.0) [4.4]	2 (100.0) [3.8]
Total	29(55.8) [100.0]	23(44.2) [100.0]	52(100.0) [100.0]

The data show that 25.2 percent of the respondents have benefited by psychological support and 'we feeling' among them whereas 21.1 percent of the respondents have stated that school support groups helped them reducing their loneliness and increasing interest to attend the school. 19.2 percent of respondents stated that they got the knowledge on HIV/AIDS and 11.5 percent of the respondents stated that their confidence levels have gone up after participating in the school support group.

SUGGESTIONS AND RECOMMENDATIONS

1. In women headed families children orphaned by AIDS are taking the emotional decisions and going for work to lead the family. They think if they go for the work it will be helpful to the family. Regular follow up counselling is most important for them to build their life in positive manner. The health workers, AASHA workers, Anganwadi teachers, and NGOs who work in grassroots should provide the immediate counselling to promote the education among children orphaned by AIDS
2. Government organisations and non-governmental Organisations should work for the development of children orphaned by AIDS by introducing the focused interventions. Government has to accord the highest priority in responding to the urgent needs of these children with appropriate and immediate actions on the ground.
3. The Government should provide bicycles for children orphaned by AIDS to go to schools, which are far from the villages.
4. Children orphaned by AIDS drop out from the schools with the different problems. It happens mostly after their primary school is

completed. Non-governmental organisations, charitable trusts have to encourage all the children to go to school. NGOs and Government should provide issue based scholarships and give priority to children orphaned by AIDS.

5. Child headed families need vocational trainings to lead a dignified life. Government, NGOs, donors, and individuals have to come forward to impart different vocational training programmes which provide immediate livelihood to children orphaned by AIDS. Children orphaned by AIDS should be given stipend based vocational trainings to help their families during the training.
6. The teachers in schools are also discriminating the children orphaned by AIDS. NGOs and GOs have to promote the children support groups in the schools to decrease the discrimination and increase the mutual support among children. Parents or caregivers have to disclose the HIV status of the children with the school teachers and request them for special care.

Role of Social Workers

Social work is a professional and academic discipline that seeks to improve the quality of life and well-being of individuals, groups, or communities by intervening through case work, group work, community organisation, social research, social welfare administration, and social action. There is a greater scope for a professional social worker to work in the field of HIV/AIDS. The professional social workers can work with PLHA, OAA, and OLHA to fight for their rights.

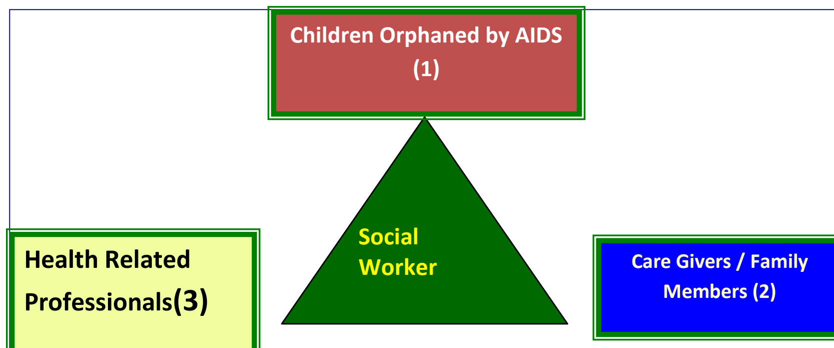


Fig. 3: Working Strategy of Social Workers with Children Orphaned by AIDS

The social worker play different roles and so she/he can be a community mobiliser, educator, counsellor, referral officer, facilitator, case worker, group worker, family therapist, liaison officer or play many other roles in working with orphans affected by AIDS (OAA) and orphans living with HIV/AIDS (OLHA). They are to be trained in working with their families where one or more members face a chronic or life threatening illness and also other professionals working in the same communities. Fig. 3 explains the working strategy of the professional social workers with the children Orphaned by AIDS.

The professional social workers have to work with the children orphaned by AIDS as well as the family members of the children and other professionals working to promote the support to the concerned children in same geographical area. The strategy helps sensitise the family members and community key persons on the issues of children orphaned by AIDS thereby increase the community participation.

REFERENCES

Andhra Pradesh State AIDS Control Society & Department of health. (2012). *HIV/AIDS Surveillance data of Andhra Pradesh.* Hyderabad, Andhra Pradesh, India.

Deeksha P. (2008). *Six Years of Home and Community Based HIV/AIDS Care and Support Programme Report*. Vijayawada, Andhra Pradesh, India: Vasavya Mahila Mandali (VMM).

Government of India. (2011). *India Censes: Ministry of Statistics and Programme Implementation.* New Delhi, India. Retrieved from website: (www.mospi.nic.in).

National AIDS Control Organisation. (2008). *HIV Sentinel Surveillance and HIV Estimation in India 2007 [Brochure]*. New Delhi: Ministry of Health and Family Welfare Government of India.

Pradhan, B. K., Sundar, R., Singh, S. K. *et. al* .(2010). *Socio-Economic IMPACT of HIV and AIDS in Andhra Pradesh and India*. New Delhi, India: National AIDS Control Organization.

Satish, R. (2010). *Impact of HIV/AIDS on Children's Education*. Tarnaka, Hyderabad, India: Institute of Foreign Languages.

UNAIDS. (1999). *A Review of Household and Community Responses to the HIV/AIDS Epidemic in the Rural Areas of Sub-Sahara Africa.* South Africa.

UNICEF. (2002). Supporting community efforts to assist orphans in Africa. *New England Journal of Medicine,* 6(3), 125-129.

World Health Organization. (1948). *Health and Society*, Geneva.

Yosef, S. (2009). *Impact of HIV/AIDS on AIDS orphans with Special emphasis on social capital*, Addis Ababa University, South Africa.