



सत्यमेव जयते



NATIONAL COMMISSION FOR PROTECTION OF CHILD RIGHTS

Rights and Entitlements of Children Affected and Infected by HIV/AIDS

Proposed Policy of NCPCR

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5th floor, Chanderlok Building, 36, Janpath, New Delhi-110001

Ph: 011-23724027, Fax: 23724026,

E-mail: ncpcr.india@gmail.com, Web: www.ncpcr.gov.in

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Foreword

In efforts to addressing the issues of children in HIV/AIDS context, six public hearings have been held by NCPCR for orphan and vulnerable children infected/affected by HIV/AIDS from September 2008 to February 2010 in Tamil Nadu (Chennai), Karnataka (Bangalore), Maharashtra (Mumbai), Andhra Pradesh (Hyderabad), Manipur (Imphal), and Delhi (where West Bengal, Orissa, Gujarat, Nagaland and Uttar Pradesh also participated), involving the participation of ten states. The hearings in six high prevalence States in India have shown the challenges faced by children to live a life with dignity vis a vis the responses of various State governments in provisioning of services. It is estimated that there are 100,000 children in need of treatment for HIV and AIDS. They continue to live precariously in many parts of the country where they lack access to health care, adequate treatment of HIV and AIDS and face discrimination, exclusion and isolation. Orphans, children without security, and many other children are in need of counseling.

Considering the rapid strides that are being made in the field of medicine and science and the available knowledge on public health systems for preventive and curative care, such neglect cannot be allowed. There is an urgent need for State provisioning of health and allied services for all such children. Likewise there has to be a comprehensive child health policy to address all health related aspects of children.

A complete package of access to nutrition, safe drinking water, holistic health care through a network of informed functionaries from village to district and the State level must be provided. Combating malnourishment must be central to any health policy and health programmes must converge with the ICDS. Supporting and building the capacity of village level health care functionaries such as the ANMs and ASHAs must be a priority. The midday meal programme must develop indicators to monitor the nutritional status of children and go beyond measuring the efficacy of the programme in terms of enrolment and attendance of children in schools. There have been attempts to develop a school health programme, but this has not been implemented in a systematic fashion. This needs to be strengthened. Health care must also include institution building processes that reach out to the community. It is ultimately a statement of care for each and every child, her life and dignity regardless of her location and socio-economic status. In operationalizing services for children it is essential to abide by the principle of non-discrimination and equality.

The child health policy should encompass primary care, immunization, prevention of diseases and nutrition with special attention to the physically and mentally disabled and the most

vulnerable communities. The PHCs must have a child centred perspective and the hospitals strong pediatric capability.

Good health is a fundamental right of every child and measures to protect it have to be taken up immediately by different ministries and departments in coordination with each other.

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(Shantha Sinha)

1. INTRODUCTION

1.1. Role of the State:

- 1.1.1. Child policies in India are guided by the role of the State as articulated in the Constitution of India (COI) that provides for right to life, education, health, nutrition, food, and protection from exploitation. As a signatory to the United Nations Convention on the Rights of the Child (UNCRC), India has affirmed its commitment to recognizing and protecting children's rights including the fundamental right of all children to be heard and taken seriously. Any deficit in programs and policies of the State to reach out to children in fulfilling their childhood rights to survival, development, dignity and protection would represent a violation of India's constitutional and treaty obligations.
- 1.1.2. Children affected and infected by HIV and AIDS, and all other chronic ailments such as tuberculosis, cancer, cardio vascular diseases and respiratory ailments therefore require the fulfilment of a core minimum of health care services as well as a broad range of protections by the State. This policy document is focused on the needs of children infected and affected by HIV and AIDS. It lays emphasis on the principle of 'best interest of the child' and on the fact that a child be given preference under all circumstances. There cannot be one uniform policy for all children, given the diversity of background of each child, and therefore this document only suggests ways and means for the States to support a programme which is sustainable, on a case to case basis.
- 1.1.3. Addressing the issue of children and HIV and AIDS is multi-sectoral in nature and involves simultaneous efforts by organizations and institutions working at different levels of governance. The role of State becomes integral in coordinating such efforts both at national as well as state level. While at the national level, the State needs to bring together knowledge, resource and technical expertise to devise umbrella policies which ensure a minimum standard of care, support, protection and treatment, at the State level it must ensure systemic implementation and outreach of these policies and development of schemes and programs, which are responsive to the specific needs of its people. Further in the context of care and protection the government has an obligation to protect and ensure appropriate care for children deprived of parental care.
- 1.1.4. The Government of India has adopted a rights based approach to deal with the issue of child rights and entitlements in the context of HIV and AIDS. However, at present, different States have formulated differing policy responses to the issue and there are huge gaps between these policies and their on-ground implementation. There is an urgent need for a comprehensive national policy embracing both the clinical and non-clinical aspects of health care as it affects children.

1.2 Role of Policy for Children in HIV and AIDS context

- 1.2.1 The policy for children in the context of HIV and AIDS must be informed by field reality and the powerful testimonies of young children who, whether infected or affected, brave the bodily pain as well as other insults, whether at home, school or hospital. It must address the issue of gross denial of fundamental rights and entitlements of orphan and vulnerable children (OVC), infected or affected by HIV and AIDS – the very right to survive and develop with dignity.
- 1.2.2 These children must grapple with multiple, inter-linked deprivations, challenges and violations of their rights. They are denied admission in school due to their or their parents' HIV status; do not get access to adequate nutrition, leisure and a safe and secure environment; are thrown out of their house and dispossessed of their property rights; and often are unable to access quality treatment, whether it is their pediatric dosage, Anti-Retroviral Therapy (ART) treatment or treatment for opportunistic infections. Young children, at a tender age, are forced to assume the role of adults in face of sick and dying parents, and the issue of child-headed households becomes a major challenge.
- 1.2.3 The policy must support a resilient continuum of care and support within a rights based framework to address all the issues faced by each child affected by **chronic ailments** such as HIV and AIDS. It must also address the needs of single parents, especially the single mother, as well as other caregivers especially with regard to their difficult and compromised circumstances in ensuring the care and protection of orphan and vulnerable children.

1.3 Profile of Children

- 1.3.1. India has the third largest population living with HIV/AIDS¹, and amongst them, children have emerged as a significant group. The latest estimate of number of people living with HIV in India is 2.27 million in 2008². While there are no current official estimates of children living with HIV in India, we are to accept that approximately 100,000 children in India are HIV-positive³. However, these figures do not reveal that the number of children affected by HIV/AIDS is far larger than those infected. For every child who is infected there are apparently another fifty who are affected – have an HIV positive parent or have been orphaned by AIDS⁴. Some of the HIV high prevalence states in India

¹ Source: Department of AIDS Control (Ministry of Health and Family Welfare), Annual Report 2009-10

² Source: Department of AIDS Control (Ministry of Health and Family Welfare), Annual Report 2009-10

³ Barriers to services for children with HIV positive parents', UNICEF, July 2007, Pg 1

⁴ Ibid, pg 1.

Also refer to, Anant Kumar and Toni Schofield, 'Orphan and Vulnerable Children: Health Policy Interventions in India', Journal of Health and Development, 2008, Vol. 4, No. 1 – 4

such as Karnataka, Tamil Nadu, Andhra Pradesh, Maharashtra, Manipur and Nagaland are grappling with increased numbers of children infected and affected by HIV and AIDS.

- 1.3.2. There is thus a need to examine the status as well as needs of orphan and vulnerable children both infected and affected by HIV and AIDS. There are a large number of children who are often left to fend for themselves in this context. They first lose one, or both, parent(s) to the illness and are later confused due to their stigmatization. The children who are neither infected nor 'double orphans' are often excluded from the purview of policy and law. In paradigmatic cases, these children, considered single orphans, live with their widowed mother after having lost their father to the infection. These children are forced to give up their property rights after the death of their father and sometimes their education in order to care for their ailing mother. Their circumstances are worsened when both parents are positive and they live under the constant fear of losing both parents. The only alternatives left for their care and protection in such a context is often either hostels or grandparents faced with significant strains on their capacity to care for these children.
- 1.3.3. Children who have lost both parents to the infection and live with their grandparents are often not cared for adequately. Although the grandparents nurture the children to the best of their abilities, their own health is often an impediment. An alarming consequence of this is a child-headed household where "the very young end up looking after the very old"⁵. Children drop out or are pulled out of school and assume the role of adults to provide for the family. HIV is a stigmatized infection and after the loss of both parents these children suffer from considerable stigma and discrimination, and even if negative, are often thought of being HIV-positive by others. Extended family, such as aunts and uncles, also sometimes assume the role of care givers for these children but there are no tangible provisions for them in such circumstances. Provisioning of some form of livelihood (for instance pensions) and other family strengthening measures become essential in these circumstances. The demands of caring for additional children can also undermine the food security and nutritional development of the children.
- 1.3.4. In the absence of primary and family caregivers, children are cared for in shelter and care homes, since non-institutional alternatives such as adoption and community foster care models still lack a definite backing and are constantly being experimented with. Institutional facilities have to adhere to a large number of qualifying regulations in order to be recognized and registered and obtain a license or 'fit institution' status. While a number of such rules help to provide governance mechanisms to combat practices such as illegal adoptions in shelter homes, some of the over broad procedural requirements have the unintended consequence of excluding care facilities with otherwise good

⁵ Ibid, pg 26.

performance records from obtaining a 'fit institution' status. The lack of tailored procedural requirements results in an increased number of unlicensed facilities and adversely affects their funding and functioning.

- 1.3.5. For children who are infected, whether single or double orphans, there are numerous problems, involving also the ones mentioned above. For them the fight is at two levels – combating bodily insults and those from their surroundings, be it in family, school or hospital. There is difficulty in accessing their basic and most fundamental rights of survival and development, whether in the form of dignity, education, medical, health and nutritional care, property rights and legal aid, or shelter, care and protection.
- 1.3.6. By differentiating between infected and affected children and selecting and prioritizing only a few of their needs, rights and entitlements, the definition of children living with HIV/AIDS becomes narrow and excludes large numbers of children who are affected one way or the other by the epidemic. The compulsion to exclude children (for instance, single orphan and affected) arises out of the narrowed commitment and intention to have a comprehensive law and policy for all the OVC infected and affected by HIV/AIDS. Thus if a child is not infected or a double orphan, she can always be ignored.
- 1.3.7. A broad consensus which has emerged from all the public hearings held by the Commission as well as from all the consultations held with different stakeholders is that the definition of children living with HIV/AIDS should be inclusive and have a rights-based perspective. It must consider all the OVC infected and affected and all their needs, rights and entitlements must be acknowledged, easily available as well as accessible.
- 1.3.8. The Commission recognises every such child, infected and affected by HIV and AIDS, and recommends comprehensive policy development which encompasses all the issues faced by these children and access to their fundamental rights and entitlements for survival, dignity and development – nutrition, health, care, treatment and medication, education, housing, property rights, shelter and legal aid, and thereby freedom from stigma and discrimination. While most of the legislations for children in our country state that they are entitled to free services – education, nutrition, treatment or legal aid – it is not always possible for the children to avail these services due to numerous reasons such as lack of sensitivity of delivery mechanisms; thus the services must be accessible and the service providers must proactively reach out to these children, especially those orphan and vulnerable children who either have a widowed mother or frail grandparents fighting for their basic rights and entitlements.

1.4 National Policy for Children in HIV and AIDS context – Fundamental Principles

- 1.4.1. The National Policy must be founded on appreciation of following ground realities – (i) lack of comprehensive preventive and curative health care program focusing on maternal and child health, that includes transmission of virus from father to mother, in other words Parent to Child Transmission of infection; (ii) lack of accessible services in the form of entitlements for treatment, education, nutrition, shelter and protection, legal aid etc for OVC infected and affected by HIV/AIDS; (iii) lack of support to children being discriminated against at home, school and hospital; (iv) lack of sensitivity as well as knowledge of programs among the service providers; (v) tolerance of children orphaned by the infection who live with their grandparents and assume the role of caregivers but are often themselves frail; (vi) child-headed households who are dispossessed of their basic right to childhood – right to be protected, provided opportunities for development – in many instances have perpetuated child labour.
- 1.4.2. Children living with HIV/AIDS can and do attend school and access other services similarly as children otherwise. However, more than paying attention to their bodily insults and overcoming them they are compelled to pay attention to issues at social and family level – for dignity, survival, food, nutrition and unaffordable health care. All health care therefore must be comprehensive and fit into a rights based perspective.

2. CURRENT POLICY AND LEGAL INSTRUMENTS TO ADDRESS ISSUES OF RIGHTS AND ENTITLEMENTS OF OVC IN HIV AND AIDS CONTEXT

- 2.1. Indian State is signatory to International Human Rights Treaties and especially the UN Convention on the Rights of the Child.** The Government of India is committed to protecting and ensuring children's rights by ratification of various international human rights documents and its own national protection framework. The Convention on the Rights of the Child (CRC) holds significance amongst the human rights document India has been signatory to regarding children's rights, and the only international instrument that incorporates the full range of human rights – civil, political, social, economic and cultural, for children⁶.
- 2.2. Constitution of India provides for rights to: education, food, protection from harm, health, nutrition, non-discrimination.** As per Article 21 of the Constitution, no citizen can be denied her life and liberty except by law - protection of a child's life and liberty thus becomes extremely essential in this regard. This also implies that the child's right to survival – right to be alive, to enough food, good health, and to have a home and family is indispensable. Under the Article 21 A, the State has been entrusted with the task of providing free and compulsory education to all children in the age group of 6-14 years. The State is bound to ensure free and compulsory education to children in the context of OVC infected and affected by HIV/AIDS. State has to remove all the barriers that any child faces in accessing education, including social and financial barriers, with no discrimination involved. Protection against exploitation is entailed in Article 23 and 24, providing for the abolition of trafficking and forced labour, and abolition of employment of children below the age of 14 years in any factory, mine or hazardous employment. Likewise the Directive Principles of State policy provide for right to early childhood care, education; health and nutrition.
- 2.3. The Juvenile Justice (Care and Protection of Children) Act, 2000** is by and large the comprehensive legislation that deals with issues of children who are in need of care and protection. Foster care, sponsorship and institutional care feature amongst key support that can be accessed by OVC.
- 2.4. Programs and Institutional Mechanisms:**
- 2.4.1. National AIDS Control Organization (NACO), a semi-autonomous body under the Ministry of Health and Family Welfare (MoHFW),** was set up for the implementation of National AIDS Control Programme (NACP)⁷. The first phase of NACP, 1992-1999, focused

⁶ The four core principles of the UNCRC are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child.

⁷ HIV/AIDS in India, World Bank, August 2007, Available at <http://siteresources.worldbank.org/INTSAREGTOPHIVAIDS/Resources/HIV-AIDS-brief-Aug07-IN.pdf>

on increasing awareness among the masses, prevention among the high risk population and blood safety⁸. The second phase of NACP began in 1999 and ended in 2006⁹. It focused on targeted interventions among the high risk groups, increasing awareness about prevention among general population, and involvement of NGOs and other concerned organization/institutions/departments. NACP III, 2006-2011, is the current phase which aims to halt and reverse the epidemic over a stipulated period of time (by 2011) through a four pronged strategy involving¹⁰: (a) prevention of new infections in high risk groups and in general population; (b) provision of better care, support and treatment to People Living with HIV/AIDS; (c) strengthening the infrastructure at district, state and national level; (d) strengthening the nationwide Strategic Information Management System.

- 2.4.2. **ART Centres, Prevention of Parent to Child Transmission (PPTCT) Centres, and Integrated Counselling and Testing Centres (ICTC) at block and district levels** form the essence of the prevention and treatment programme initiated by NACO. National Rural Health Mission (NRHM; 2005-12), also administered by the MoHFW, provides ('effective') healthcare to rural population throughout the country, with the primary aims of reduction in Infant Mortality Rate and Maternal Mortality Ratio, universal access to public health services and integrated comprehensive primary healthcare, and prevention and control of communicable and non-communicable diseases¹¹.
- 2.4.3. **Operational guidelines for 'Children Affected By AIDS' (CABA)** have recently been formulated and are currently being piloted in 10 districts in the country, through adoption of multi-sectoral mainstreaming approach for its implementation. CABA Scheme is being implemented at the District level to ensure that all children, exposed to and affected by HIV/AIDS, are identified and linked to early diagnosis and treatment services, along with development, protection and welfare services on need basis¹².
- 2.4.4. **The Integrated Child Development Services (ICDS)** Scheme administered by the Ministry of Women and Child Development (MWCD) aims to achieve the State's pre-school education, health and nutrition related goals, with an emphasis on women and children¹³. The Integrated Child Protection Scheme (ICPS) under the MWCD aims to

⁸ *Id.*

⁹ *Id.*

¹⁰ National AIDS Control Programme, Phase III (2006-2011), Strategy and Implementation Plan, 30 November 2006, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, Available at: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_117311.pdf

¹¹ National Rural Health Mission, 2005-12, Mission Document.

http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf. Accessed on 03/12/10.

¹² Operational Guidelines for Children Affected by HIV/AIDS, Ministry of Women and Child Development (MWCD); National AIDS Control Organisation (NACO), May 2010, pg 3.

¹³ Integrated Child Development Services (ICDS) Scheme, <http://wcd.nic.in/icds.htm>. Accessed on 03/12/10.

provide care and protection for children especially in need. It also sets out proactive measures by the State to reach out to children in distress.

- 2.4.5. **Sarva Shiksha Abhiyan (SSA)** is a flagship program of the Ministry of Human Resource Development and aims to bring all children into the fold of schooling through Universalization of Elementary Education (UEE) in a time-bound manner¹⁴. Similarly, Rashtriya Madhyamik Shiksha Abhiyan (RMSA) aims at providing secondary school education to children above 14 years. The Mid Day Meal Scheme is the world's largest feeding programme serving primary and upper primary school children in the country¹⁵.
- 2.4.6. **As per the Legal Services Authority Act, 1987**, children are entitled to free legal services. In every State and District, State and District Legal Services Authority is constituted respectively to give effect to the policies and directions of the Central Authority (National Legal Services Authority) and to give legal services to the people¹⁶. Legal Aid in India is a Constitutional imperative and is arising from Articles 14(2), 21 (3), 22 [4] (1), 39-A (5) of COI.
- 2.4.7. **Children Affected by AIDS (CABA)**, the pilot project being implemented by MWCD and NACO in 10 districts in the country, is by far the comprehensive scheme which deals with a majority of issues faced by OVC – health/medical care, nutrition support, psychosocial support, education support, social protection/economic strengthening, alternative care, and legal and redressal support. The scheme aims to strengthen 'access', instead of supplies, to the existing services for OVC and their families through district level mechanisms.

¹⁴ Sarva Shiksha Abhiyan, <http://ssa.nic.in/>. Accessed on 09/12/10.

¹⁵ Ministry of Human Resource Development, Department of School Education and Literacy, Government of India, Mid Day Meal Scheme, <http://education.nic.in/Elementary/mdm/index.htm>. Accessed on 09/12/10.

¹⁶ National Legal Services Authority, <http://causelists.nic.in/nalsa/>. Accessed on 03/12/10.

3. LIMITATIONS OF POLICIES

- 3.1 The primary thrust of the National AIDS Control Programme, Phase III [2006-2011], in its implementation, initially was 'prevention' among high risk groups of sex workers, men who have sex with men etc. and highly vulnerable populations of truckers and migrants¹⁷. It has now however shifted from a targeted approach to cover all those who are infected as well as affected by HIV/AIDS.
- 3.2 Although prevention remains the core focus of the Programme, the access to and availability of preventive measures remains inadequate. While CD4 count method is of prime importance in establishing the stage of HIV infection and making treatment decisions, those who are HIV infected but do not fall under the prescribed category of "low CD4 cell count" the treatment has to wait and this can often become a delayed response to the infection. This does not allow for 'prevention' at all.
- 3.3 Also, care, support and treatment do not assume an equal significance as prevention, as evident through the budget allocation in the Programme¹⁸. While NACP III seeks to implement the principle of continuum of care, it has not fully translated it in to implementation. There is an increased emphasis on home, family and community based care whereas institutional care is not viewed as a long term alternative. The children orphaned by the epidemic and abandoned by the extended family and community face a serious challenge in this context. There is no mention of enhanced number and facilities in government shelters and hostels to provide care required for OVC. This is where the continuum of care is broken.
- 3.4 The availability of treatment remains restricted to first line ART and first line ARV drugs. The provision of second and alternative ART still remains a challenge and so does availability of drugs beyond fixed dose combinations. Similarly, the availability of diagnosis and treatment of all opportunistic infections (OIs) is problematic. There are places where only major OIs such as TB and Hepatitis are treated free of cost and not other minor OIs. Children and their caregivers often have to pay for tests for OIs and not being able to afford leads to late diagnosis and treatment. Link ART centres, though in existence, are either not well-staffed or not well-stocked. Community Care Centres (CCCs) are temporary and clinical solution to the issue and there are no long term care alternatives available.
- 3.5 Even in a clinical setting there have been gaps and other deficits when children are concerned. Some PPTCT centres lack PPTCT kits as well as Nevirapine stocks. Early Infant Diagnosis (EID) is yet to spread to whole of the country. There is no mention of providing child friendly health settings. For those affected and vulnerable, especially children, and

¹⁷ National AIDS Control Programme, Phase III [2006-2011], Strategy and Implementation Plan, National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, November 30, 2006, pg iii.

¹⁸ Ibid, pg iii.

living in remote districts and villages accessing these services becomes a major issue as transportation is sometimes neither free nor subsidized for their relief, and although there is a provision for Link centres, they are not well-equipped to cater to all the needs.

- 3.6 OVC infected or affected by HIV/AIDS require adequate nutrition to improve the efficacy of their treatment and medication as well as build immunity against AIDS. Children, up to 14 years, are entitled to the mid-day meal at school under Sarva Shiksha Abhiyan (SSA) programme. However, HIV-positive children suffer opportunistic infections and often have to miss school, also for their ART treatment and medication. In light of this, children tend to miss their mid-day meals and are prone to malnutrition. At present, double ration is provided to children suffering from severe and acute malnutrition and not to children with mild to moderate malnutrition. The children who do not correspond to the criteria of AWC, NRC and PHC, which is not standard, regarding malnutrition do not receive a timely intervention. Such a practice again combats the issue at a very late stage. There is no provision of double or dry ration for all OVC infected and affected by HIV/AIDS based on their need and nutrition assessment to avert the onset of malnutrition in them.
- 3.7 CABA, the project being implemented in 10 districts in the country, is still in pilot phase, with no universal coverage, and whether children are able to access the services under this scheme as well as other referral services effectively will have to be assessed. Also, mechanisms for nutritional support require further strengthening, as indicated in the limitations above.
- 3.8 NACP, thus, is not a comprehensive programme when it comes to relevant and critical issues such as nutrition, education, livelihood, and protection from exploitation, legal aid, shelter and property rights, confidentiality and disclosure, and other welfare services. Children, to a significant extent, are beneficiaries of adult-focussed programmes and prevention of paediatric HIV and availability of paediatric care and dosage still remain a challenge.

4. CONTRADICTING COMMITMENTS: DEMANDS OF CHILDREN VS. RESPONSE OF THE STATE

4.1. Children demand dignity and a rights based approach to provisioning of health, nutrition, education, shelter and care

4.1.1. The six public hearings held by the Commission for orphan and vulnerable children infected/affected by HIV/AIDS in six high prevalence states in India have shown the challenges faced by children to live a life with dignity vis a vis the responses of various State governments in provisioning of services – in terms of health care, psycho-social support, nutritional support through ICDS, mid day meal schemes, PDS and other programs, education facilities, free transportation, legal aid, access to institutional as well as non-institutional support and so on. Further, efforts of the State have been focused largely on prevention of HIV/AIDS amongst adults and minimal on prevention of paediatric HIV and adequate provisioning of care and protection to those children affected and infected by HIV/AIDS¹⁹.

4.2. Children demand comprehensive health care

4.2.1. Health care is largely confined to providing ART for children whose CD4 count is below the minimum level of threshold. There is no provision for children who do not fall under the CD4-count criterion. There is a need for a prevention strategy and especially ensure children's right to food and nutrition. Children both infected and affected need free health care including medicines to address their health issues, especially for opportunistic infections for the infected children. Likewise deficiencies are found in other health care services such as availability of paediatric dosage, PPTCT kits, medicines, easy checkups, diagnosis, counselling and sensitivity.

4.2.2. Children and caregivers run from pillar to post in accessing health services and cannot afford it most of the time. State provides ART free of cost, but easy and free access to other important services, even Second Line ART, is still a major challenge.

4.3. There is an explosive demand for food and nutritional security

4.3.1. Nutrition and food security is the key to improve the efficacy of treatment and medication in children infected by HIV and AIDS. State services through ICDS, midday meals and public distribution system suffer from inherent limitations to fulfil adequate

¹⁹ In efforts to addressing the issues of children in HIV/AIDS context, six public hearings have been held by NCPDR for orphan and vulnerable children infected/affected by HIV/AIDS from September 2008 to February 2010 in Tamil Nadu (Chennai), Karnataka (Bangalore), Maharashtra (Mumbai), Andhra Pradesh (Hyderabad), Manipur (Imphal), and Delhi (where West Bengal, Orissa, Gujarat, Nagaland and Uttar Pradesh also participated), involving the participation of ten states.

nutrition and food needs of children. A) A differential treatment in food and nutrition provisioning is needed for children on treatment – adequate and balanced nutrition is needed which most families cannot afford on their own and both ICDS and midday meal are not designed to address this issue. B) PDS does not meet food needs adequately (per person and not per unit i.e., family). There is a dire need for providing double ration to infected children. C) There are places where packaged pre-cooked meal is provided to children in *anganwadi* which does not take care of nutritional needs of children. D) Supplementary nutrition as well as double ration is provided to severely malnourished children. There is no provision for children with symptoms of malnutrition. Such a delayed intervention is ineffective.

4.3.2. HIV has struck India at a time when nearly 50% of our children suffer from malnutrition. The State should look at the comprehensive guidelines provided by WHO²⁰, and have a consultation on food for children and make it a part of public distribution system to ensuring Right to Food.

4.3.3. Powdered/package food is not a solution to the problem of food and nutrition in the context of children infected and affected by HIV/AIDS. Instead, children should be provided with a holistic diet of fish, rice, oil, eggs, nuts, etc. as well as with micro-nutrients, as enumerated in several expert studies²¹.

4.4. Education and freedom from stigma and discrimination

4.4.1. Education of children who assume the role of adults and head their respective households gets hampered one way or the other and they are unable to attend school for they have to work and school expenses are unaffordable²². Also there are few easily accessible institutions to address education and shelter needs of children whose single parent or grandparents cannot afford both health care and education of children.

4.4.2. Confidentiality and disclosure of their HIV status also forms a major barrier in accessing normal educational opportunities on an everyday basis. Children on ART have to miss classes at least once a month due to treatment and counselling and this hampers learning and also are subjected to punishment at school for procedural violation.

²⁰ WHO Technical Consultation on Nutrient Requirements for People Living with HIV/AIDS (2003:Geneva)

²¹ Bunn J, Thindwa M, Kerac M, "Features associated with underlying HIV infection in acute severe childhood malnutrition: A cross sectional study", *Malawi Medical J.* 2009, Sept; 21(3): 108-12

Also refer to, (i) HIV Nutrition & Health (July 2009) From Tufts University; (ii) Why Nutrition Matters to HIV-Positive People (2009) From The Momentum Project, Inc.; (iii) Food Insecurity, Malnutrition and HIV/AIDS Treatment: A Global Perspective (December 2008) To read PDF, In *GMHC Treatment Issues*, from Gay Men's Health Crisis; and (iv) A Practical Guide to Nutrition for People Living With HIV (October 2007) To read PDF, From Canadian AIDS Treatment Information Exchange.

²² During the Public hearing in Maharashtra, on 30th January 2010, many working children deposed before the panel of jurists. They work to supplement income of the family. Either old grandparents or a single parent living with HIV and AIDS are not able to provide sufficient care and protection and children are pushed to work.

- 4.4.3. Parents want to educate their children against all odds, want to give meaning to their life, and want them to live long, and sentiments of children resonate that of parents. Many parents stretch beyond their means to ensure right to education to their children; and the perception about quality of education in Government schools compels parents/caregivers to send children to private schools with nearly unaffordable tuition fee.
- 4.4.4. Child rights activists, parents and children feel on the contrary that their rights are and can be protected in Government schooling as education is the fundamental right. Children cannot be thrown out of school for want of fees, uniform and other materials. They feel the need to strengthen State education system including residential facilities and support for continuation of education through scholarships etc., so that they are able to access their fundamental right to education²³.

4.5. Need for care, shelter and protection

- 4.5.1. HIV and AIDS have led to a large number of children losing one or both parents. Children, along with their mother, have been thrown out of their house when the father has died. Availability of shelter and care facilities becomes essential in this context. Institutions run by the State are not equipped to accommodate all these children due to stigma and lack of protection mechanisms to address their needs, especially health needs.
- 4.5.2. Children infected by HIV are not accepted for adoption and foster care. Therefore voluntary organisations that run shelter homes for infected and affected children and provide care and support services to OVC, are few in number, need to be strengthened by the State in terms of resources/funds. Care for a child infected and affected by HIV/AIDS is lifelong and it is imperative to provide a committed/dedicated support to these children. The donor-centric approach must be rectified – it is unfair if support is withdrawn from certain projects and programmes due to lack of funds after children are given hope and aspirations of a better future.
- 4.5.3. Such a situation also poses questions of availability of accessible legal aid and other grievance redressal mechanisms for the protection of property and other rights of the child. If a child is denied of her basic rights such as healthcare or education – she is denied ART treatment or discriminated against in school due to her HIV status – there must be a provision for her to be heard. Children and their caregivers believe that availability of legal aid at ART and Link ART centres, complaint redressal mechanism at village/district level, involvement of *Gram Panchayat*, and strengthening of State and

²³ Milana, Bangalore based family support network of people living with HIV and AIDS.

District Legal Services Authority will protect and ensure access to their basic rights and entitlements. There is an urgent need for an institutionalized response to the issue.

- 4.6.** Thus there is a need for a comprehensive legal and policy framework to address all rights and entitlements of children who are facing a lonely battle – who want to live long, in dignity, and have support for health, nutrition, education, shelter, care and protection.

5. RECOMMENDATIONS

5.1. Legal Framework

- 5.1.1. The definition of a 'child' has to include all children up to 18 years of age in consonance with the Juvenile Justice (Care and Protection of Children) Act, 2000; the Indian Majority Act, 1875; the Indian Contract Act, 1872; the Guardians and Wards Act, 1890; the Persons with Disability Act, 1995; the Child Marriage Prevention Act 2006; the Domestic Violence Act, 2005 and the United Nations Convention on Rights of the Child (UNCRC), 1989 as ratified by Government of India on 11th December 1992.
- 5.1.2. The legal framework must have clarity on the definition of 'children living with HIV/AIDS'. It must be inclusive and cover all children infected and affected by HIV/AIDS.
- 5.1.3. From a rights based perspective, the definition of 'children living with HIV/AIDS' must include all OVC infected as well as affected by HIV/AIDS.
- 5.1.4. Adequate and effective legal provisions must be in place to ensure relief, compensation and reparation and restitution for abuse, torture, harassment (physical, mental, psychological).
- 5.1.5. Access to legal aid must be simplified for OVC and should be available at the district level ART centre, since property rights are one of the first to be violated when a child is orphaned by AIDS. There also must be an effective grievance redressal mechanism in place at the block, village or district level everywhere, whether in school or hospital, public and private sector both. This must include redressal of all issues related to food, healthcare, nutrition, treatment, education, stigma, discrimination, and rehabilitation.
- 5.1.6. The provision for access to all services - treatment, tests, treatment of opportunistic infections etc – must be in place in the legal framework.
- 5.1.7. In cases where children live with their frail grandparents or extended family, with aunt and uncle, provisions must be made for de facto guardianship.

5.2. Policy Framework

- 5.2.1. A national policy on chronic ailments, especially on HIV/AIDS and children, must move away from the selective approach and address the universe of children, infected and affected and forced out of school and/or engaged in some form of work or other. Such a policy must insist on a rights based perspective and must address clinical and non-clinical rights and entitlements of each child.
- 5.2.2. Children must be prevented from joining the workforce through counselling of parents, grandparents, employers and children. In cases where children live with their frail grandparents or extended family, with aunt and uncle, provisions must be made for pension and BPL card to ensure minimum food security, nutritional support and to prevent child labour. With regard to single mothers, widowed by AIDS, livelihood

programmes must be available and accessible such that the child is not forced in to labour.

- 5.2.3. There is an indispensable role for local bodies. A record of all children, infected and affected, must be maintained and even tracked and it must be ensured that they have access to their basic rights and entitlements²⁴. District Collectors should also play a part in such implementation.

5.3. Systemic Framework

- 5.3.1 Children affected and infected by HIV/AIDS come from diverse contexts with a multiplicity of needs and requirements. In anticipation of this diversity of children, provisions have to be made at every level, both in the context of institutions and processes, where each child can be followed up on a regular basis through a case worker with a case plan. Therefore any policy and support services for the children are to be designed on a case to case basis. These decisions are to be taken by a mechanism that is built-in at the district/local level.

- 5.3.2 The focus of the policy for children in the context of HIV/AIDS and other chronic ailments must be on (i) strict enforcement of all the relevant laws; and (ii) institutionalising inter-departmental (such as NRHM and NACO) and inter-ministerial (MWCD, MHFW, MHRD, MSJE etc) coordination mechanisms for effective implementation of all the existing Government policies, schemes and programmes [clinical and non-clinical]. The scope of convergence and systemic framework in the context of HIV/AIDS is highlighted in Figure 1.

5.4. General

- 5.4.1. Data regarding OVC must be available in every State and nationally to ensure delivery of services to the children. Such a database must include – child headed households, old headed households, school dropouts etc. – and such cases may be prioritized.
- 5.4.2. Capacity building of doctors at government hospitals, especially relating to paediatric HIV, such that it leads to constant monitoring and mentoring. Doctors should be able to diagnose opportunistic infections and differentiate them from other infections and the concept of admitting and treating paediatric HIV cases needs to be strengthened. With regard to Prevention of Parent to Child Transmission (PPTCT), the private sector

²⁴ In the State of Karnataka an OVC Fund, initially of Rs 1 crore, has been constituted and is being implemented through the Village Health and Sanitation Committee (VHSC) at the Panchayat level, where a list of all children and their families is available and their issues and needs are assessed in detail. The focus of the project is to retain the child in her village, with her family or extended family, where she was born and the Community Care Centers (CCCs) will be the last resort for her. The families (immediate or extended) are encouraged to retain an orphan or vulnerable child infected/affected by HIV/AIDS within the community and in return the child is provided monetary support in 6 areas – (a) education; (b) sponsorship; (c) foster care; (d) travel; (e) nutrition; and (f) medical. The Fund is being utilized with the help of ASHA workers who are being trained to follow up with every HIV positive person in a village and ensure institutional deliveries alongside HIV testing.

(hospitals) needs to be tapped properly such that all the institutional deliveries are safe for both the mother and the child.

- 5.4.3. Free access to quality prevention, treatment, care and support services must be ensured – availability of paediatric dosage, Early Infant Diagnosis (EID), 2nd and 3rd Line ART treatment, PPTCT kits, medicines for Opportunistic Infections, well-stocked treatment and care centres, especially government-run ones, must translate in to accessibility. There is an urgent need for sensitization of staff as well as child friendly services – doctors and counsellors. The country must be saturated with well-stocked and well-staffed Link ART Centres, and transportation to these centres must be made free (its concessional in certain States at present).
- 5.4.4. In the same spirit, availability of good quality of supplementary nutrition, in the form of micro-nutrients and double or dry ration to OVC must be ensured, since one mid-day meal a day is not sufficient. Also, OVC who are not enrolled in school, miss school due to treatment, or during vacations require supplementary nutritional support. Due to poor infrastructure ICDS scheme is unable to reach all children and the quality of education and nutrition provided is questionable; children are provided with objectionable quality of packaged/powdered food which is often rejected by them. In the best interest of the child, a hot-cooked and wholesome meal must be provided. Also BPL cards must be provided to families of OVC to ensure nutritional support.
- 5.4.5. No child can be denied admission to school on the basis of her (or her parents') HIV status and strict action must be taken against educational institutions which discriminate on the said basis. Every child must attend full time formal school up to 18 years of age and such a policy must be recognized as non-negotiable and as a goal which is possible to achieve. In addition, OVC must be provided with scholarships, especially with regard to (a) child/old headed households, and (b) as an incentive to attend school. Certain special provisions for OVC such as getting relaxation in attendance, retests etc will help them realize their right to education.
- 5.4.6. For children who have dropped out of school, there has to be a policy of integrating them into an appropriate education programme that will enhance their capabilities and also give them a second chance to pursue formal education. The State must ensure that the child studies until she completes 18 years of age, up to class 10 and even beyond. Courses of good quality are to be provided for such children who wish to opt for other educational streams after completing class 10. Vocational as well as life skills training facilities must be developed and strengthened.
- 5.4.7. A comprehensive school health programme should be established across the country wherein all children with chronic ailments can be identified and thereafter taken care

of²⁵. Similarly, a comprehensive child health policy must cover every child infected as well as affected and address all issues faced by her.

5.4.8. There is a need to establish a “continuum of care” – shelter, institutional and community-based – to address the basic needs of OVC. Many NGOs provide shelter, care and support services to OVC and have to rely on external funding. When the funding is stopped, or an NGO is derecognized for lack of transparency, children have nowhere to go and it negatively impacts their well-being. The government has a responsibility towards ensuring the continuum of care without any disruption and it must extend full support to NGOs in order to do so. Those NGOs providing good quality shelter care services shouldn’t be denied license or ‘fit institution’ status. Services at the government run Community Care Centres (CCCs) must also be strengthened.

5.4.9. While confidentiality of one’s HIV status must be respected, the focus of all policy must be empowering individuals, especially children, to enable them to ‘disclose’ their HIV status and breaking stigma and discrimination associated with it. The public hearings held by the Commission have shown that disclosure can be empowering, and in this context children are to be counselled in a manner that they exercise agency to disclose their status and overcome being stigmatized further²⁶. The government should evolve Standard Operating Procedures (SOPs) in this context.

5.4.10. To invoke public interest and large-scale awareness on this issue, there is a need for an extensive awareness generation campaign launched over a period of time at the Centre and State on a sustained basis. Children must be able to access all the services and live with dignity.

²⁵ The Government of Gujarat started a comprehensive school health programme in 1997 and has further scaled it up since 2007. It includes all – anganwadi centres, govt. and private primary, secondary and higher secondary schools, ashram shalas, govt. children’s homes, voluntary observation homes and informal schools run by FBOs such as madrasas. The objectives of the programme include promotion of positive health, prevention of diseases among children, and early diagnosis and treatment, among others. Children are provided with health check up, spot treatment, referral services, and free super specialty treatment, amongst other health care services.

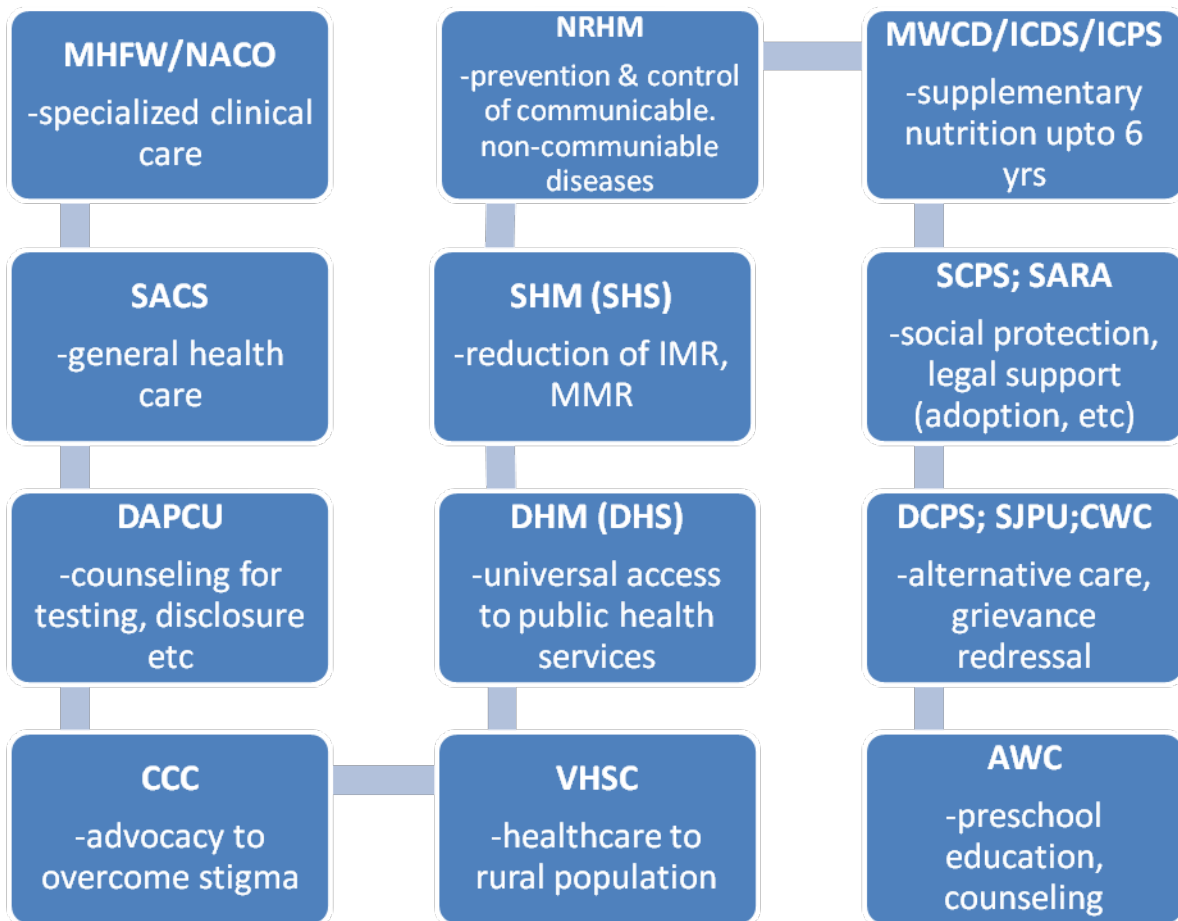
²⁶ The Commission is conscious of the following principles – (i) the child’s right to age appropriate information under the CRC; (ii) the child’s right to participation and (iii) the right to confidentiality.

6. Conclusion

There are anywhere between 3 to 4 lakh children infected by HIV and majority of them are in Tamil Nadu, Maharashtra, Andhra Pradesh, Karnataka,. There are five to six times the infected children who are facing parentless, shelter-less situation without any care and protection. Thus when we speak of HIV in the context of children it's not only those infected but also those affected who are battling with the aftermath of this chronic and fatal infection. These children, at a very tender age, are confused, first, due to the loss of one or both parent(s) and second due to the bodily insults they have to combat on an everyday basis. Despite such clinical repercussions of the ailment we do not let the issue be confined to its medical connotations – it's made out to be a social issue and beyond.

It is bad enough that the child has to worry about her medicines, treatment, ailing caregivers that we also burden her with anxiety of school fee, property rights, pension etc. The child must be freed from such encumbrances and instead the system should take care of them. **Children should be made to live like children and not adults**, not in the least with the burden of things even we as adults don't live with!

Figure 1 – Systemic Framework and Scope of Inter-Ministerial and Inter-Departmental Convergence in the context of HIV and AIDS



Abbreviations used:

AWC – Anganwadi Centre

CCC – Community Care Centre

CWC – Child Welfare Committee

DAPCU – District AIDS Prevention and Control Society

DCPS – District Child Protection Society

DHM – District Health Mission

DHS – District Health Society

ICDS – Integrated Child Development Services

ICPS – Integrated Child Protection Scheme

IMR – Infant Mortality Rate

MMR – Maternal Mortality Rate

NACO – National AIDS Control Organization

NRHM – National Rural Health Mission

SACS – State AIDS Prevention and Control Society

SARA – State Adoption Regulatory Authority

SCPS – State Child Protection Society

SHM – State Health Mission

SHS – State Health Society

SJPU – Special Juvenile Police Unit

VHSC – Village Health and Sanitation Committee

Annexure-I

Issues highlighted during the Public Hearings

States	Total no. Of cases ²⁷	Health & Nutrition	Education	Shelter care & Housing	Property Rights & Legal Aid	Stigma & Discrimination	Livelihood
1. Andhra Pradesh	27	25	20	9	6	10	13
2. Tamil Nadu	44	5	15	7	9	5	13
3. Karnataka	23	5	3	5	13	3	8
4. Maharashtra	19	9	5	6	3	5	4
5. Delhi	5	4	1	0	0	0	2
6. Orissa	7	6	3	1	1	0	5
7. Gujarat	6	3	3	1	0	3	4
8. West Bengal	3	3	2	0	1	2	2
9. Uttar Pradesh	2	2	1	0	2	0	2
10. Nagaland	1	1	1	0	0	0	1

²⁷ Each case involved more than one issue during the public hearings

II

Issue-wise Recommendations made by NCPCR during the Public Hearings

ISSUES	NCPCR's RECOMMENDATIONS
1. Health and Nutrition	<ul style="list-style-type: none">- The child should be admitted at a certain hospital which is equipped with a paediatric centre of excellence- The child to be provided with a therapeutic diet.- Mid-day meal scheme to be extended to the child.- Dry ration to be provided on holidays and weekends- Provision of Antyodaya cards- To enable the whole family to access ART facilities at one go, the Centre should provide harmonious dates to them.- The Sarva Shiksha Abhiyan to provide eggs to the family at their residence so that the child can avail the nutrition facilities with ease.- The child to be hospitalised for extending therapeutic nutrition.- Nutritional inputs from anganwadi centre as well as the mid-day meal scheme.- Health progress report to be submitted to the jury on a regular basis.- If an affected child is not on ART yet, she should be given a balanced and fortified diet that would reduce her chances of being put on ART, to a considerable extent.- Immediate paediatric care and treatment to be given to the child.- Health insurance to be provided.- Explore options for easy accessibility of clinical investigation, CD4 test and referral treatment at the nearest clinical centre.- Detailed report of eating habit of victim – ActionAid to document- Treatment procedures followed up at hospital during check-up- Put up posters at hospital premises with contact information for registering complaints- Discrimination at hospital will be enquired and necessary action will be taken- follow up on the health of pregnant mother(s)- a child need not drop out of school for epilepsy because it can be easily solved

<p>2. Education</p>	<ul style="list-style-type: none"> - The child should be re-admitted in school without discrimination - Compensatory tutorial support to be provided. - Explore good schools with hostels that can take care of the child's special needs - Adequate orientation to ICDS teachers/staff so as to eliminate chances of discrimination etc. - Educational scholarship to be provided. - Free textbooks and uniform to be supplied through the Sarva Shiksha Abhiyan. - All schools must have a board saying that "We welcome all Children without any Discrimination". - Easy accessibility of getting admission in a school should be explored - Suggested to provide education to child in English medium
<p>3. Property rights/legal aid</p>	<ul style="list-style-type: none"> - The child has full legal claim over the property of her father. - The patta has to be transferred in the child's name even though he is a minor. - The District Collector has to ensure that the child and his family are not evicted from their residence. Further, criminal proceedings have to be initiated against the concerned parties who are trying to dupe and cheat a vulnerable family in the form of usurping their property. - Legal support to be extended to expeditiously determine the affected child's right to property. - Deputation of officer to settle the land and property title deeds of the child. - Lawyers at legal aid centers have to be trained to handle issues related to gender and children more sensitively
<p>4. Housing/shelter</p>	<ul style="list-style-type: none"> - Housing rights to be extended to the child - Explore possibility to provide permanent shelter for a certain shelter home - Special consideration has to be given to quickly process housing for those who are under ART due to lesser longevity of life - Directed the family to the District Collector to provide a proper place to stay
<p>5. Stigma and Discrimination</p>	<ul style="list-style-type: none"> - Institutional mechanism to tackle the stigma and discrimination in educational institutions
<p>6. Transportation</p>	<ul style="list-style-type: none"> - Travel costs from home to school and return to be reimbursed - Child has to be picked up and dropped back to her residence from the ICDS Centre

	<ul style="list-style-type: none"> - Enquire about transport facilities like provision of free bus pass for treatment
7. Livelihood	<ul style="list-style-type: none"> - Disability pension to be given to the aunt - Financial support through self help group scheme or any other government scheme - Pension for the grandmother - Family to be covered under Andhyodhaya scheme - Make arrangement to avail widow pension and all other benefit schemes - Possibility of vocational training should be explored - Make arrangements to avail a certain loan - Link the mother with another livelihood project - Jury asked to submit details to Dist Admin for ration card - Delay pertaining to issue of ration card & birth certificate has to be resolved soon
8. Miscellaneous	<ul style="list-style-type: none"> - Instead of NCPCR, it is the State that has to take action - Place the child back in ICDS, and take this matter further with the Ministry of Women and Child Welfare Department, as readmission to the ICDS centre is not the final solution. - Ensuring child and guardian's right to protection and to live a life with dignity. - Take measures to ensure that no harm is done to the child's dignity while extending support - Psychosocial counselling for mother and child - Linking the child with Community Care Centre - A thorough review of NRHM (National Rural Health Mission) required, as reach of the same is constricted to certain regions of the country. - Legal support to be extended through the District Legal Services Authority - Girls to be covered under the 'Girl Protection Scheme'. - Protection from emotional turmoil. - Action taken/follow up report has to be submitted to the Commission by the concerned departments. - Encouraged to live boldly and set an example for such women. - Government should reassure the family that it has taken cognizance of the grievance. - Send all petition/ copies of submitted papers to NCPCR

	<ul style="list-style-type: none">- Report on action taken has to be submitted to the Commission- Government should take up the case for appropriate intervention- Dist Admin to follow up the case & submit a report- A comprehensive plan for the family has to be submitted- The details have to be submitted to ActionAid & through them approach the Dist Collector- Safety of the family has to be ensured
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MODEL GRID**State Interventions (compiled) for Children living with HIV/AIDS**

Issue	Programme/Scheme/Intervention	State(s)
Prevention, Testing, Treatment, Counseling, Care and Psycho-social support	1. National AIDS Control Programme (NACP) [PPTCT Centres, ART & Link ART Centres/LAC, ICTCs, CCCs, Drop-in Centres, State & District Level Positive Networks]	National -All States and UTs
	2. CABA (Children Affected by AIDS) Pilot Project	AP, Delhi, Karnataka, Maharashtra, Manipur, TN
Comprehensive care and support programme	3. Balasahyoga Programme	AP (linking child to clinical care including ART, educational & nutritional support, income generating activities for parents, and housing support); also issuance of SAHARA cards to access services.
Health and Nutrition	4. Provision of milk for newly born children of HIV infected mothers	Chandigarh (Rs 600/- per infant per month to 10 infants); Himachal Pradesh (milk powder to infants of HIV +ve mothers for 1 year)
	5. Nutritional Assistance	Gujarat (Medical Aid Help Scheme of Rs 500/- per month as nutritional support); Tamil Nadu (through trust fund); Karnataka (provision of micronutrients at ART centres); Jharkhand (Hazaribagh district); Kerala (provision of Nutrimix & multi vitamin iron folic acid tablets through ART/LAC Centres); National (provision of double ration to malnourished children)
	6. Antyodaya Anna Yojna (AAY Scheme)	National Scheme-All States and UTs
Education	7. Adolescent Education Programme (AEP)	Chandigarh, Jharkhand,
	8. Adolescent Reproductive Health Project (sex education)	Jharkhand

	9. State policy for children affected by HIV/AIDS in educational sector (to reduce stigma and discrimination & provide info on HIV/AIDS)	Kerala
Education, vocational training	10. School-cum-Trade Learning Centre-cum-Hostel	Chandigarh, Jharkhand (residential & non-residential services/bridge courses only in Hazaribagh district)
Support	11. Trust/Fund	Karnataka; Tamil Nadu (also District Collector Discretionary Fund in Nagapattinam district)
	12. Scholarship to children affected/infected by HIV/AIDS	AP, Chandigarh, Gujarat, Himachal Pradesh, Tamil Nadu, Jharkhand (linkage under Balika Samridhi Yojna, only in Hazaribagh district); Karnataka (minority & girl-child scholarship)
	13. Palak Mata Pita Scheme (Rs 1000/- per month for people who adopt orphans)	Gujarat
	14. Widow Pension	National Scheme-All States and UTs
	15. Social Security Pension Scheme/ Child & Old headed Households	Old Age Pension Scheme- National Karnataka & Maharashtra (Special Pension for Old caregivers/grandparents); Orissa (Madhubabu Pension Yojana, Rs 200/- per month)
	16. Livelihood programme	Maharashtra
Housing	17. Indira Awas Yojana (IAY)	National Scheme Karnataka (special housing scheme); TN (houses constructed TN Slum Clearance Board & IAY)
Shelter and Care	18. Shelter and Care Homes	National eg., Gujarat (orphanage homes)
	19. Foster Care	Maharashtra (Bal Sangopan Scheme);
Travel & transportation	20. Travel assistance to reach ART centres for children and accompanying adults	Gujarat (Project Jatan); Himachal Pradesh (bus fare is reimbursed for child & 1 attendant); Maharashtra (75% concession);

Care and Protection Mechanisms	21. Child Protection Unit	National
	22. Special Juvenile Police Unit	National
	23. Child Welfare Committee	National
Legal aid	24. Free and competent legal service (through State and District Legal Services Authority)	National
Stigma and Discrimination	25. State wise campaign against stigma (through planning meetings, awareness seminars, media workshops, street plays etc)	Kerala
Grievance Redressal	26. Drop boxes for complaints	Tamil Nadu (drop boxes at ART centres & State Grievance Redressal Committee convened by Principal Secy, Health);
Girl Child	27. Protection & Benefits	AP (Girl Child Protection Scheme to fight discrimination); Maharashtra (access to all entitlements such as bicycle, shelter, food, RTE etc); Karnataka (girl-child scholarships)