Report on the Problems of Children in Kerala who are Infected and Affected by HIV/AIDS

March 2016
Thiruvananthapuram
Preface

Much has been done by the National and State AIDS Control societies over the years to address the problems of persons (including children) infected and affected by HIV/AIDS, especially in respect of ensuring treatment. Much effort has also gone into creating awareness about the disease so that the stigma associated with the illness is mitigated and persons affected by this disease can live a life of dignity. However, such stigma continues to exist, and it affects the old and young alike, as is evident from the sporadic tales of discrimination that emerge in the media. In the case of children, such discrimination, targeted not only against those who have tested positive for HIV/AIDS, but even those who may not have tested positive, but hail from families which have, results in gross violation of their rights to survival, development, protection and participation - the four cardinal rights that are to be ensured for all children as enshrined in the United Nations Charter for the Rights of Children.

It is in this context that the Kerala State Commission for Protection of Child Rights undertook this study on the impact of HIV/AIDS on children who are infected or affected by it. The study examines the medical facilities available, the convenience of access to such facilities for testing and support, the reliability in the supply of medicines, the availability of nutrition for all those who have tested positive, as it plays a major role in ensuring that children enjoy a decent quality of life, the shelters available for children who tested positive without families, the support being given to them and rehabilitation measures, if any. The Commission has made some recommendations to fill in the gaps noted during the study so that children can live and develop their talents and capabilities optimally. There are also serious challenges that children continue to face to train themselves to lead independent lives.

The Commission would like to thank all those who helped us in the course of this study, including the officers of Kerala State Aids Control Society (KSACS), especially Shri Sunil Kumar, G, Joint Director, IEC and Dr. B.B. Rewari, National Programme Officer, ART-NACO, Ministry of Health and Family Welfare, Govt. of India, all of whom spared the time from their busy schedules to peruse the manuscript and offer valuable feedback. The Commission hopes that these recommendations will find favour with the competent authorities and measures will be put in place to improve the conditions in which children infected or affected by HIV/AIDS live in society.
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1. Introduction

A State level workshop was held with experts and stakeholders on 29.1.2015 at the Government Guest House, Thycaud, Thiruvananthapuram, to discuss the status of children affected by HIV/AIDS, identify the action to be taken to mitigate the problems and alienation that they suffer, and suggest to Government some practical measures to rehabilitate them. This was followed up with a meeting with the stakeholders on 10.9.2015 at Thiruvananthapuram to identify the priority areas of action and the way forward. The list of participants at the Workshop and the Consultation are given as Annex I and Annex II respectively. This report seeks to make an assessment of the issues that came up for consideration in relation to the status and concerns of children infected or affected by HIV in Kerala, and to suggest some measures to address them.

2. Data on children infected or affected with HIV/AIDS

2.1 The state of Kerala is categorized as a low prevalent state in the matter of persons infected with HIV. Against the figures of estimated 20.9 lakh people living with HIV (PLHIV) in the country (0.26%), Kerala has only 25,000 (0.12%). However, Kerala is situated in the vicinity of states like Tamil Nadu, Karnataka and Andhra Pradesh, all of which are high prevalent states. This also highlights the need to be ever vigilant about creating awareness and promoting preventive measures.

2.2 The statistics of People Living with HIV (PLHIV) is normally obtained from the information collected through the Strategic Information Management System (SIMS) of the National AIDS Control Organisation (NACO) and its state based units; in Kerala it is the Kerala State AIDS Control Society (KSACS) that performs this responsibility. Their data on children is based on the number of children who enroll in the Anti Retroviral Treatment (ART) centres across the country/ state, and the number of infected children who are being provided social support through these centres supported by the Kerala State AIDS Control Society (KSACS). Only persons up to the age of 15 are unfortunately classified as children for the purposes of this data base. According to such data from SIMS, there are 884 children at present in Kerala who are infected with HIV, as against 1.5 lakh children infected across the country. Of the 884 infected children, 553 are undergoing regular treatment based on CD 4 count, while around 697 children require treatment and check up every six months.
2.3 It is estimated that there are over 2000 children affected by HIV in the State; but it is very difficult to give an accurate figure for children affected by HIV because these children do not need to access the treatment centers, and so the figures are those based only on information about their families who may be taking treatment available in the ART centres. However, this figure will not be comprehensive because children whose parents who discontinue treatment or whose parents have passed away will not come under this group as the ART centres can give the figures of only those who are currently undergoing treatment. There is a need to create this database so that we have a better understanding of the magnitude of the problems faced by children affected by HIV.

2.4 It was also learnt that it is difficult to explain the gap between those who were registered for treatment and those actually taking regular treatment; the gap could be due to deaths that have not been reported, or because the patient has gone abroad or away from the place of treatment without intimation, or simply because the patient has stopped taking treatment. It is evident that there is room for improvement in the existing system for following up on those undergoing treatment.

2.5 A related as well as significant issue regarding children infected by HIV is that these figures do not include data for children between 15 and 18. The data on children available with the National and State AIDS Control (NACO) societies is limited to that of children below 15. And this data is based on the figures available of children under 15 undergoing treatment in the ART centres. So, when planning strategies for children infected with HIV, it needs to be recognized that the data available is not comprehensive, especially when planning strategies for children in the late adolescent stage. This is a very serious issue because it is during the late teen years that children normally become more sexually curious, and more vulnerable, especially if there are issues about their sexuality. In the case of the children infected with HIV, if they are not given proper counseling and handholding, it can lead to life-long tragic consequences for themselves and for others. Therefore, it is critically important to identify these children at this stage, and provide them the counseling support they need.

2.5 Another related issue is that although all hospitals are required to give data about their patients who are HIV infected, only Government hospitals, Medical colleges etc have a stable reporting system. It is still to be established in private hospitals, where this system has not even been initialized in many cases; though reporting is a mandatory requirement. This is apparently a problem that plagues the reporting system not only in Kerala but across the country. This matter assumes importance because 72% of all deliveries occur in the private sector.

2.6 Most smaller nursing homes send patients with HIV to Government Hospitals once the patient is diagnosed; but treatment is being provided in some private institutions, which continue to remain outside the reporting network. It is important to help upgrade the skills of the doctors handling HIV and Opportunistic Infections (OIs) in all hospitals, especially pediatricians, so that they take up the treatment of these patients, and the related monitoring, with the seriousness it deserves. It is also important to give better awareness of this disease to all health personnel so that they take due precautions and also
treat the patients, particularly children, with the consideration they deserve.

2.7 From the programme data available, 88% of patients in the state have contracted this disease through the sexual route, a figure that is on par with the national figures, 1% from infected syringes, which is again on par with the national average, and 3% through transmission from mother to child. The data on mother to child transmission in the state of Kerala over the last 4 years is given below:

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of new born children found positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>6</td>
</tr>
<tr>
<td>2012</td>
<td>5</td>
</tr>
<tr>
<td>2013</td>
<td>3</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
</tr>
</tbody>
</table>

In Kerala, since we reportedly have almost full coverage for registration at birth, it is consequently presumed that these figures reflect the total picture of children infected at birth via the parent.

3. Infrastructure facilities available for testing

3.1 Testing for HIV is mandatory in the case of all pregnant women. This is an important prevention measure prescribed by Government to stop the spread of infection. The treatment for HIV is required to be started as early as possible in the pregnancy, because early treatment definitely helps bring down the HIV viral load in the mother. This reduces risk of HIV transmission to the baby not only during pregnancy and delivery but also through breast feeding. This is the reason why the lack of reporting by hospitals of persons who test positive for HIV becomes a problem in the fight against HIV/AIDS. Since 72% of the patients go to private hospitals, their failure to explain to the patients the critical need to take medicines from the earliest possible stage of pregnancy, and the practice of merely referring them to ART centres delays the whole process of starting treatment, mainly because patients try to avoid such identification as long as possible to avoid the stigma both in society and in their own families.

3.2 NACO recommends initiation of ART in all HIV pregnant women as soon as possible, irrespective of status of their immune suppression. This helps in reducing HIV plasma viral load of the mother and in turn reduces the risk of HIV transmission to the babies. But, even in Government hospitals, the required emphasis is not being given to the need to get the testing done early, so as to reduce the infection load sufficiently to protect the baby and to ensure that it is breast fed, which is now possible as per WHO guidelines in this regard; on the contrary, it is insisted upon normally in the last trimester, more as a precautionary measure for the safety of the health personnel who attend to the childbirth. Little do doctors and other health personnel realize that reduction of the infection load to the lowest possible level is beneficial to them too. Therefore, there appears to be a need to address this lack of awareness on the part of doctors and patients alike. Details of mothers who tested positive in the last 3 years during antenatal check ups are given below:
### Table

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of ANC tested</th>
<th>No. of positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>133078</td>
<td>71</td>
</tr>
<tr>
<td>2013</td>
<td>149723</td>
<td>38</td>
</tr>
<tr>
<td>2014</td>
<td>159300</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>442101</td>
<td>171</td>
</tr>
</tbody>
</table>

3.3 Testing facilities are available across Kerala in the network of 165 Integrated Counselling and Testing Centres (ICTCs), 263 Facility Integrated Counselling and Testing Centres (FICTCs) and 41 PPP ICTCs in private hospitals. ICTCs are available in all Medical Colleges, General hospitals, District Hospitals, Taluk Hospitals and selected Community Health centres (CHCs), and they constitute the first point in HIV care. In these units KSACS provides one or two counselors and a lab technician. These counselors provide the pre testing and post testing counseling to those who come for the testing. FICTCs are available in CHCs, Primary Health Centres (PHCs) and even some private hospitals; in these centres the existing lab technician and staff nurse have been trained to do the testing and counseling respectively. The FICTCs do only the preliminary screening test by a highly sensitive test. If the result is positive, the patient is then referred to the nearest ICTC to do two more tests before the patient is declared as positive. Testing kits are supplied by NACO and it was learnt that the supplies of testing kits are fairly regular and that gaps in supply have occurred only on extremely rare occasions.

3.4 Testing is done for antibodies which are the outcome of infection; but one has to wait for the window period of three months to get over. Testing for antigen can be done as early as twelve days from any risky episode, but it is expensive and also has its own variable window period. Therefore, across India, the decision has been taken to continue with the testing for antibodies. Ideally, such testing to detect infection, if any, needs to be done after any instance of risky behavior, within the window period, because infection can occur from any such episode at any time. Testing, as well as facility for diagnosis, including scanning for Opportunistic Infections (OIs), are all being given totally free in Government hospitals. Diagnosis of HIV in Infants, termed as Early Infant Diagnosis, can be got done as early as six weeks from the infant’s birth.

3.5 Testing for HIV is considered a sensitive issue and so it requires parental consent in the case of children. In case of children who are brought to Child care institutions, or an orphaned child, it requires permission of the child’s guardians. This has raised an issue that merits attention. Because parental consent is mandatory for testing for HIV, a problem arises in the case of adolescents who have been sexually active and may have contracted HIV but do not wish to divulge the matter to their parents or guardians. They are denied the benefit of treatment since treatment can only follow testing, for which guardian’s/ parental consent is mandatory. This is an issue that underlines the importance of counseling support, especially during adolescent years, because only through good counseling support to both the child and the parents/guardian can this matter be handled effectively and timely treatment made possible, if at all.

3.6. Once the testing is completed, HIV positive infants and children are provided
medicines through the Anti Retroviral Treatment (ART) centres. ART is supplied to them in appropriate paediatric dosages, by the National AIDS Control Organisation (NACO). There are ten ART centres in the state and two more have recently been approved by NACO. These centres, besides undertaking the supply of medicines, also have three to four counselors and community care coordinators who do the important task of peer counseling; together they provide the counseling support that any PLHIV needs. The four districts that are still to be provided ART centres, for want of the requisite quantum of patient load, are Idukki, Wayanad, Malappuram and Pathanamthitta.

3.7 Since the treatment has to be continued without a break, 13 Link ART centres (LAC) are understood to have been set up to cover districts that do not have an ART centre, or where the distance to the nearest ART centre is very vast. These Link ART centres are equipped to disburse medicines while counseling is being provided by ICTC counselors at the same facility, who are also designated as LAC counselors. Both the ART and Link ART centres provide medicines for Opportunistic Infections (OI) too. To ensure the uninterrupted supply of medicines, in case the supply through NACO is interrupted, there is provision to transfer the stocks from available points, or even to purchase medicines locally and maintain supplies. Therefore, provisions are available to ensure availability of medicines to patients at all times.

3.8 While studying this issue, an area of concern came to notice regarding the lack of link centres in certain vulnerable and remote areas in tribal belts. Experience of handling nutrition related issues with people in the tribal belts shows a singular lack of interest among most of them in following a prescribed treatment regimen. Even in the case of Immunisation, only when there is proactive action on the part of the health personnel can the desirable coverage be achieved. In such a scenario, there is a real challenge to ensure that these people follow up on their treatment regimen for HIV treatment systematically, even though free transportation is being arranged to take them to the ART centres to collect their supplies of medicine. In such areas, it makes greater sense to have the source of supply closer to their place of residence so that monitoring can be done more effectively. There also appears to be a case for looking beyond patient load for providing a Link ART centre in tribal areas for the reasons that they are mostly on the borders of Tamil Nadu and Karnataka, which are states with high prevalence of HIV, and there are genuine difficulties in making them follow the discipline of adhering to a treatment regimen. There are also challenges in monitoring these patients as, the terrain is difficult to negotiate, the nutritional status in such pockets is very poor, lifestyles are not conducive, with alcoholism being very prevalent among all households, and they are vulnerable to abuse. In tribal belts of Idukki and Palakkad, there is a tendency to move to areas in Tamil Nadu frequently, which also makes the monitoring of the intake of medicines even more difficult because the patients are not under the scanner of any one ART centre at all times. This issue needs to be addressed by exploring the possibility of providing additional link centres closer to such areas. All essential medicines needed for the treatment of HIV and OI are given free of cost by the Government. The treatment given in ART centres is the first line of treatment;
second line of treatment is also available, but only from a single point located at Thrissur. It is learnt that at present there are only 14 children undergoing second level of treatment for HIV in the state.

3.9 Drug resistance is mostly a result of irregular intake of medicines. It is an expensive treatment but that too is being given free of cost by Government. For diagnosis, the Prevention of Parent to Child Transmission (PPCT) kits are being supplied by NACO and given free of cost to all patients as a preventive measure against the disease passing on to children. The numbers of pregnant mothers-to-be who are users of this kit in the last five years are given below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>113</td>
</tr>
<tr>
<td>2011</td>
<td>61</td>
</tr>
<tr>
<td>2012</td>
<td>62</td>
</tr>
<tr>
<td>2013</td>
<td>56</td>
</tr>
<tr>
<td>2014</td>
<td>41</td>
</tr>
</tbody>
</table>

3.10 With so much emphasis being given to control the transmission of this disease and also to ensure treatment at the earliest possible time, it has been possible for the state to reduce deaths among children very substantially. Though a year-wise break up is not readily available, it is understood that the number of deaths among children in the last 5 years is 97. Similarly, the occurrence of this disease among children up to the age of fifteen in the last five years is also given below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>113</td>
</tr>
<tr>
<td>2011</td>
<td>61</td>
</tr>
<tr>
<td>2012</td>
<td>62</td>
</tr>
<tr>
<td>2013</td>
<td>56</td>
</tr>
<tr>
<td>2014</td>
<td>41</td>
</tr>
</tbody>
</table>

4. Treatment regimen for those infected or at risk of being infected with HIV.

4.1 At present the treatment regimen is started when a patient’s CD 4 count goes below 350, a recent increase from the earlier cut off level of 250; however the level of the CD 4 count is not taken into account if the client is a pregnant woman or for Opportunistic Infections (OI) like TB. As per the WHO guidelines, CD 4 count is defined as normal if it ranges from 500 to 1600/ cubic milliliter of blood. Some of the factors that contribute towards bringing down the CD 4 count in HIV infected persons are one’s lifestyle, quality of nutrition intake and the general quality of health. It takes about 7 to 10 years for a PLHIV to reach the level when he or she needs to take treatment; however, once started, the person has to continue to take treatment in perpetuity to keep down the infection load. This highlights the reason why the AIDS control programme gives as much importance to preventive aspects like positive prevention, ensuring mental and physical well being, nutritious food, exercise etc and the need to avoid beverages like alcohol, soft drinks etc as to adherence to ART,
4.2 The treatment regimen for HIV comprises a single pill that is a combination of three drugs which has to be taken on a daily basis without a break. The ART centre initially gives drugs only for a month at a time and monitors side effects, if any. There is a pediatric dosage schedule of drugs for children. Children need to be given treatment immediately after birth as prophylaxis, as diagnosis can be done only within six months of birth. This will help curb the rate of infection to below 5%, giving these children a chance to enjoy a better quality of life. A child infected by HIV carries the virus within his or her body throughout his or her lifetime. This weakens the child’s immune system and makes him or her liable to opportunistic infections throughout his or her lifetime, which in turn restricts the quality of the child’s life. This situation also calls for access to good, nutritious food, in addition to ART at the required frequency and dosage and medicines to tackle susceptibility to opportunistic infections.

4.3 The challenge of providing good nutritious food continues to be an area of concern because it is an acknowledged fact that the intake of food by children infected by HIV is inadequate. Previously, iron and folic acid tablets were being given by the Department of Social Justice as part of the treatment regimen. But this has been done away with. At present pregnant women, PLHIVs whose CD4 count is less than 350, children below the age of 6 and persons above the age of 65 are eligible to receive nutritional support from the panchayats to the extent of Rs 250 per month, provided they are not receiving such support for nutrition from any other source in Government. A nutri mix powder made by Kudumbasree, called Amritham powder, was also being supplied to children, which was discontinued as its taste was not favoured by the children.

4.4 Today, these children are dependent only on midday meals and the food and nutrition support programme of Panchayats, under which some of them supply rice, pulses etc to HIV positives. While a hot meal is any day a better way to provide nutrition to a child, the child may not benefit fully from the Panchayat scheme for providing nutrition, as there is no uniformity in the frequency of supply, with the supply sometimes happening once in six months. During the interim months, the children are denied nutrition, which defeats the very purpose of this scheme. When supply is made at one go, there is the problem of safe storage of the food items. Since the beneficiaries are unable to ensure the safe storage of such large quantities, the food often gets spoilt and therefore unfit for use. Lack of a stable supply chain prevents these children from being given fruits, vegetables etc which are actually very beneficial to them. The quantum and range of items supplied are also not consistent; in fact while some supply even items like dates, others supply just the basic requirements. With an allocation of Rs 1.7 crores for this activity, the scheme caters only to approximately, 3700 persons whereas there are 4500 registered cases with Care Support Centers. Therefore, it is clear that there are issues yet to be sorted out in terms of coverage, quality and assuredness of supply in the matter of providing regular, nutritious food to children infected and affected by HIV.

4.5 In the case of midday meals, there is also the issue of providing the beneficiary children support during vacations or when children infected with HIV remain absent from school due to poor health. Here the problem is that
while everyone unanimously agrees that children need to be given nutrition, there are numerous challenges in ensuring its effective delivery; it has also to be acknowledged that nutrimixes are not really an answer to the problem except as a stop gap arrangement. This is an issue that needs to be studied in depth as it appears that there is scope to further streamline the present efforts being made at the local level so that adequate nutritional intake is assured. There is also a need to sensitize the panchayats about the importance of this measure towards improving the quality of life of their children who are infected with HIV and to educate them about the items of food that need to be given to them.

5. Economic Consequences of the disease

5.1 Those infected by the disease have the burden of coping with the consequences of this debilitating disease, its economic consequences and its impact on the quality of life not only on themselves but even on their children. This is because their physical debilitation prevents them from taking up many normal avenues available to earn a livelihood; in addition, their families have to cope with the social stigma attached to the disease. These children who are affected by HIV i.e those who are not infected but have parents or family members who are infected by the disease, are also victims of these economic consequences. The economic burden is substantial, and certainly beyond the means of a family already blighted by the existence of this disease in their midst.

5.2 There are also cases where a child heads the household after the demise of his or her parents, and others where an elderly grandparent or grandparents head the household; in all such cases the ability to generate resources are limited. Such situations can even lead to drop out issues for children who have to shoulder the responsibility of the family; circumstances may compel them to join the work force before they complete their education, and this needs to be prevented with timely intervention. These children are also mostly deprived of the care and protection that parents can give, since one or both of them may also be a patient of the disease, or are no longer alive. Some of these children may also be the victims of exploitation and abuse, with no one to protect and take care of them, especially in the matter of securing their property rights and such other benefits due to them. In some cases they lose out because of ignorance of the facilities and schemes available or lack of knowledge about how to access them. Others lose out due to the lack of sensitivity or ignorance of service providers. It is noted that at present the state does not have the details of such Orphans and Vulnerable Children (OVCs) in the state. This is a key requirement if the needs of children from 0 to 18, who are infected or affected by HIV, are to be comprehensively addressed. Such data should also yield information about child headed families, old headed families, and school drop outs, so that targeted interventions can be put in place to address these concerns.

5.3 In the context of the various problems faced by children infected or affected by HIV, social protection measures play a very significant role. By definition, social protection measures include public and private initiatives that provide income or consumption transfers to the needy, protect the vulnerable against livelihood risks, and enhance the social status and
rights of the marginalized with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups. The facilities extended by the Kerala state Government to persons infected with HIV are all contained in the Government Order (GO) issued by the Local Self Government Department on 15.3.2013 (Annexure III). This order is comprehensive and covers measures relating to prevention of the spread of the disease, for identification of persons with HIV, for treatment, care, provision of nutrition, for providing for psychosocial needs, welfare programmes and basic needs, for improving their financial condition, facilities at the testing and treatment centres, and those related to service providers; it also contains some general instructions and even provides for a system to monitor the provision of all these facilities.

5.4 Based on this GO, as well as the GO issued by the Health Department, the order of the Kerala Social Security Mission (KSSM), and as part of the advocacy measures of KSACS, today children infected with HIV in the State are entitled to many important benefits over and above the free facilities that they receive towards treatment, diagnosis and medicines. Some of these are discussed below, along with the current status of implementation:

i) Financial support to the extent of Rs 1000 per month is distributed through KSACS for all PLHIV, including children. The only difficulty is that this amount is normally distributed as per the availability of funds. Since the monthly allowance was recently enhanced to Rs 1000 from the earlier sum of Rs 400, there are arrears also to be cleared. Against a total arrears of Rs 10 crores due to be given, the annual provision made in the current year for this support is only Rs 2 crores. Even the existing support is not given on a monthly basis, as a result of which the beneficiaries do not get the intended benefit from this scheme. This is a matter of concern, especially since other safety net measures, like insurance for example, are not available to this segment of the population. (GO of the Department of Health.)

ii) From 2012, all families which have members who are infected or affected by HIV have been declared as Below Poverty Line (BPL), whether they are BPL or otherwise, so that they can avail of all the benefits due to BPL families. This includes the provision of house, toilets, electricity etc to such families through the Local Self Government Institutions. (Order of Department of LSG)

iii) The Snehapoorvam scheme of the Kerala Social Security Mission (KSSM), which provides education scholarships ranging from Rs 350-Rs 700 per month to children of single parents, has been extended to all children from families with HIV, irrespective of whether they are single parent families. (Order of KSSM).

iv) For those who require home care to manage their daily life, there is provision to provide them palliative care, in line with the existing guidelines for providing such care, and also to train them to manage their lives better. There is also provision to use the services of
Voluntary agencies to transport these patients for treatment and also to provide them care. Such patients who need support and daily care to manage their lives have been covered under the Aaswasakiranam project, and such support will be forthcoming for one member of the family who takes care of the patient.

v) The food and nutrition support scheme of the panchayats has already been referred to earlier. This scheme can play a critical role in ensuring that these patients get adequate nutrition; however, its uneven implementation across panchayats is an issue that needs to be addressed, particularly in tribal areas where the nutritional levels are normally very poor.

vi) The KSSM has also provided a scheme to address the problem that many PLHIV who have lost family members face when they are hospitalized, viz the lack of a bystander. KSSM has a Treatment Care Team Support initiative under which persons already infected are trained to provide such support for a fee of Rs 300 for 12 hours, thus giving them an employment opportunity, while the patient gets skilled assistance with empathy from these care givers. (Order of KSSM)

vii) Free transport is being provided to all patients of HIV to collect their medicines from the ART or Link centres regularly, and since it is not possible for children to travel on their own, there is provision for a person to accompany them and each will be paid Rs 100 to meet their expenses along the way. If it is not possible for them to travel by bus or train, based on the certification from the doctor in charge of the ART centre or the District Medical Officer (DMO) they can even be given Ambulance facility. Convenient dates are given for check-ups of all members of a family infected with HIV so that they can travel together avoiding unnecessary wastage of days.

viii) Some livelihood programmes are being extended to persons infected with HIV. They include the opportunity to become trained bystanders as well as to serve as peer counselors or Community care coordinators in ART centres or to manage helpdesks. At present there are 8 ART centres having such care and support centres and another 6 which have help desks.

ix) LSGIs are also required to help the persons infected with HIV and those in the High risk group as well as their family members to obtain Voter’s ID cards, ration cards etc so that they can access the services (house construction, health and other welfare schemes) that require such documents to be produced.

x) Persons infected with HIV are also eligible for support from the Chief Minister’s Disaster Relief Fund, the Aashraya Project etc if their condition warrants such support. The panchayats are expected to play a major role in helping them access such services.

xi) Legal support is being provided with the assistance of the Kerala State Legal services Authority (KELSA). One of the chief obstacles that
children face when they become orphans is the difficulty to obtain death certificates, proof of residence, inability to establish property rights etc. Legal assistance is at present made available to these children with the assistance of KELSA who through their district units help to arrange adalats for linking the children with the concerned authorities; para legal volunteers help follow up on the cases They are being paid a small remuneration for this service. Although the advocates of DELSA are willing to provide their legal services to HIV patients once or twice a month at the ART centres, if need be, this system is yet to stabilize or be optimally made use of (Part of the advocacy programme of KSACS)

xii) To ensure the effective implementation of the facilities to be extended to persons infected and affected by HIV, a multi sectoral approach is ideal, and to ensure this, so that all beneficiaries are included in the related schemes, be it widow's pension, Old Age Pension, provision of BPL cards etc, the Government Order (GO) at Annex III provides for the effective intervention of the panchayat. This intervention is expected to bring about the much needed coordination between Government departments. Redressal mechanisms at the grass root level have also been prescribed at the level of the panchayats to ensure support for these patients. To implement all these provisions, ideally, every panchayat must have a list of all persons infected with HIV, including Orphans and Vulnerable children (OVCs). However, herein lies the problem. For fear of stigma, hardly anyone is willing to reveal at the local level that they are infected with HIV; as a result many of these benefits and support services remain inaccessible to PLHIV, even though they need it and are eligible for it. It is understood that an online system to track the socio economic conditions of persons, including children who are infected with HIV, is being prepared to assess the extent to which such beneficiaries have availed the benefits that they are eligible for. This needs to be completed at the earliest.

5.6. Similarly, it may be seen that almost all these services and benefits remain inaccessible to children who are “double” orphaned due to HIV, but are themselves not infected with HIV. Such children appear to fall outside the ambit of all the benefits that were available to these families when at least any one parent who was infected with HIV was alive. In fact, hardly any facility exists today for children affected by HIV, except the provision of scholarship, even though, when their parents are infected by HIV, they are unable to provide them the care and protection they require. The only areas in which support is extended to them are in the matter of being given shelter in Mahila Mandirams and orphanages, for redressing their grievances through the mechanism available at the panchayat level, for providing counseling through school counselors, and support to help start their own businesses. These children are often denied property...
rights by their families, they are often forced to earn their own livelihood to support their families, disrupting their education (if there is a family to support) as such children are the only persons in the family who can earn an income. This problem exists even when children are looked after by their old grandparents after the demise of their parents. There is a need to identify all such categories of children to assess their needs and support them. The possibility of providing them support available for sponsorship under the Integrated Child Protection Programme (ICPS) so that the children can continue to stay with their families, with the help and intervention of the Child Welfare Committee (CWC) for example merits consideration. The main challenges in this regard are about creating awareness about the scheme and also to encourage the eligible families to apply with the assurance that their details will be kept completely confidential.

5.7 There are a large number of children infected with HIV who are abandoned by families once their parents are no more. They are left to fend for themselves or are taken into orphanages and child care Homes. If the Home is registered under the Juvenile Justice (Care and Protection Act) 2000, then these children can be kept in these Homes only up to the age of eighteen. However by that age, hardly any child infected with HIV would have completed his or her education up to a level where they can earn on their own, and be economically independent. Once these children can no longer be kept in the Child care Home after they complete 18 years of age, the question arises as to how they will fend for themselves if they leave the Home, and who will support their medical, shelter and educational needs once they leave the orphanage/Home. Further, not all children infected with HIV can undertake higher studies to an extent that will enable them to acquire a job that will support them. Therefore, they will have to be trained to become self-employed, which is also not possible by the time they are 18. This problem of economic sustainability is a major issue for children infected and affected by HIV during their late adolescent years and requires to be addressed. It is also the period the children are currently receiving no handholding or support. Therefore, the need to have a data base of children already infected and affected by HIV is reiterated once again and there is a need to address this issue. Whether the age of support to be given to such children can be enhanced so that they are given assured support till they become more independent, or have the opportunity to be so, is another issue for consideration.

5.8 At present some of the facilities due to these patients are being provided through specialized agencies where their identity can be kept confidential. That social stigma exists becomes painfully clear from the incidents of rejection and denial that such children face which are reported in the media from time to time. Till social stigma related to HIV/AIDS reduces with greater awareness, the only practical solution appears
to be to provide such support, and more sustained legal assistance through the help desks at the ART centres, as the number of patients handled by them may not be very high. The feasibility of implementing this suggestion either by providing separate resources or by expanding the capacity of existing personnel and augmented with external legal support on a more regular basis than is now available, needs to be examined through a study. For assessing the need, every ART centre must prepare a list of OVCs in their jurisdiction. This will help make it possible to make a proper assessment. Where the need for separate resources is established, qualified persons who are infected with HIV may be employed as they will be able to provide such service with empathy. However, the final solution for ensuring that all the needy avail the benefits due to them lies only in breaking the social stigma attached to this disease.

6. Issues relating to stigma and the need for counseling

6.1 One of the most critical issues that need to be addressed in respect of children infected or affected by HIV is the issue of stigma because it has many spinoffs that have far reaching consequences on other aspects of their lives and which affect the quality of their lives significantly. Stigma itself can be further categorized into two, viz the stigma from society and self-imposed stigma. It is seen that such stigma affects not merely those who are infected with HIV but even those affected by it, ie those who are not themselves infected with the disease but who suffer the stigma and discrimination merely because some member of their family suffers from it. Over the years much has been done to reduce the first type of stigma that impacts those infected and affected by HIV equally. It is understood that no formal complaints against discrimination have been received by KSACS from any quarter since 2010. However, this does not mean in any way that discrimination in society has been completely eliminated or that such issues have been eliminated, as is clear from incidents that are reported from time to time; at best it indicates that the frequency of such occurrences have reduced.

6.2 Therefore, efforts need to continue for creating greater awareness about this disease among all persons with whom children have to normally interact, especially in schools. These efforts should include introducing modules at the High school and Higher secondary school levels to create awareness among the students, and teachers at this level need to be capacitated to handle these issues through exposure to the subject in their B.Ed training module as well as in the trainings organized by the Sarva Shiksha Abhiyan(SSA). It is also necessary to start sensitizing children early at the Upper Primary/Lower primary (UP/LP) levels through cluster training modules given through the SSA. Awareness programmes need to be conducted through the School Health Programme to students and to Parent Teacher Associations.
(PTA) to reduce discrimination based on stigma. Training of trainers (TOT) should be done for the Police Department; the services of DELSAs and KELSA should also be used for providing this training. Awareness about HIV can also be included in the Anganwadi Mothers meets and in the Adolescent Children’s meetings. Such sensitization is very essential to create an enabling environment in schools for these children for ensuring their all-round development. In the case of children infected with HIV it will also help if their teachers have an idea of this ailment, the adverse impact of their illness on regular attendance in school, the need for relaxation in attendance, opportunities for doing retests on certain occasions, and also some support in participating in extracurricular activities. It is only such attempts at creating widespread awareness about HIV at every level in society that will help combat the stigma against adults and children infected or affected by HIV.

6.3 One aspect that needs to be addressed at the earliest when creating awareness about HIV is the issue of how this disease has to be handled by care givers who could be in schools, households, child care institutions, hospitals and nursing homes. Today, the lack of such awareness is one of the main causes for the difficulty in integrating such children with their peers. Two years ago KSACS is understood to have given training to all the care givers under the Department of Social justice. However, this needs to be given more regularly as part of the regular training given to them. Therefore, a plan has to be developed for this purpose; such training should also cover the question of how to address the health risks involved when the HIV status of children are not known to the care givers in these institutions or when such children have to be handled in situations where they are in close proximity to many other children for whose health and safety they are accountable. Equally important are the measures to be followed by them to protect themselves, and also the preventive actions to be taken when they are unwittingly exposed to the disease when handling such children whose HIV status was not known to them.

6.4 The problem of “self stigma” experienced by children infected or affected by HIV is an even graver issue. Almost all HIV positive people, including children or those affected by the disease suffer from this problem; it is in many ways a byproduct of the stigma about this disease in society. It is the biggest challenge that has to be overcome to ensure proper rehabilitation of these children in society. The problems of children infected by the disease and those only affected by it are strangely similar in many respects; they both suffer from lack of self esteem and they have very serious problems in socializing, both due to their own inhibitions and also due to a lack of acceptance of such persons on the part of society at large. That is why confidentiality forms a very important part of handling children with HIV or those
affected by it. Yet, it is equally important that they be encouraged to develop the confidence to “disclose” their condition so that they do not have to bear the burden of having to perpetually conceal their identity. This is especially so in the case of children affected by HIV who do not suffer from the disease and have the capacity to participate in any activity without any restriction. Availability of adequate facilities for counseling is an important requisite to help tackle this problem.

6.5 At present the following counseling facilities are available where counselors have been specially trained to handle such issues:

i) in the ICTCs where there are facilities for both pre and post testing counseling facilities. It is also available to some extent in FICTCs, where the staff nurse in the testing facility has been trained to provide some basic counseling to patients.

ii) in ICTCs where there are professionally trained counselors to provide counseling support. They were being given training for 12 days through the School for Behavioural Studies of the MG University under a programme funded by the Global Fund for Aids, TB and Malaria (GFATM). However, since this funding has ceased, this training programme is not being continued. This is an issue that needs to be addressed.

iii) ART centres also have peer counseling support provided through 8 Counseling centres and 6 Help Desks now being managed through persons infected by HIV who have been trained to handle this work. This project is also supported by the GFATM through the project VIHAAN managed by Alliance, an NGO, across the country. Their presence in Kerala is through Council for Positive Persons in Kerala (CPK+). Besides counseling support, they also follow up on patients in the treatment regimen, to prevent dropouts from the treatment. There is still room for improvement in the present follow up regimen, as can be seen from the figures of children registered for the second line of treatment. Selected children are, at present, understood to be brought to the ART centres once a year for training, life skill training etc. This provides an opportunity to assess their nutritional status, and the general experience is that these children do not have good appetites and that their Body to Mass Index is less than the required minimum. In the matter of nutrition intake, diet plans have to be often drawn up on a case by case basis, to help overcome the normal aversion that children infected with HIV have for food intake. However, it needs to be noted that not all children come up for such evaluation, and that this assessment is therefore limited to a few children who display leadership qualities among those infected by HIV and are under treatment in the ART centres. Therefore, there is need for a better system to gauge the nutrition intake of all children registered with ART centres.
6.6 The above mentioned counselling facilities address the needs of both children and adults alike. Therefore, these resources need to be augmented, particularly in the school environment, so that children in need of counseling can access them easily as and when the need arises; such availability will also help to guide other children in the school environment who have to interact with these children. A serious, emerging problem is the lack of adequate facilities for adolescent counseling. At present the facilities available for this purpose is not sufficient and the number of children requiring this facility are increasing; therefore, there is a need to increase such facilities. It is also necessary to bear in mind the fact that only the programme data of children up to the age of 15 is being maintained by KSACs at present and that the data for adolescents between 15-18 years is crucial in this context, and needs to be specifically obtained for making a proper assessment of the demand for such services. It would be possible for the ART centres to make a consolidation of the data regarding children being treated by them who are/were 15 years over the last 3 years and make a list of adolescents who need to be supported through counseling etc. This data will need to be maintained on a year-wise basis so that there is some basis for providing counseling support to children who are between 15 and 18.

6.7 Children infected with HIV have to face the challenges caused by HIV all their lives, none more so than the issues that they have to grapple with in terms of physical urges natural to them in their adolescent years, and the life-long choices they have to make in their personal lives. For this, they need strong counseling support from a very early age. The prevention of unacceptable sexual contact by those infected by HIV has very serious implications for society as a whole; therefore, these children need to be given appropriate support even as a measure against the spread of the disease. Recognising the importance of this problem, KSACS undertook such training for 120 children infected by HIV under a training programme funded under Annual Plan. However, this is woefully inadequate vis a vis the actual need. Funding needs to be provided adequately and on a continuous basis for such a preventive measure.

6.8 A review of the counseling facilities available for children in the State under various schemes reveal the existence of the following facilities under various schemes in the health and education sectors:

i) 500 odd counselors appointed by the Department of Social Justice (DSJ)

ii) the counselors under the Our Responsibility to Children (ORC) programme,

iii) in 23 centres available for handling Sexually Transmitted Diseases in Medical Colleges, District Hospitals and some Government Hospitals;
iv) counseling centres for Adolescent Reproductive and Sexual Health centres set up under the National Rural Health Mission (NRHM) in District Hospitals,
v) the Bhoomika one stop crisis centres in District Hospitals, and
vi) the Family Counselling centres set up under the Central Social Welfare Board.

A very convenient option is to empower all these counselors with adequate training so that they are in a position to provide appropriate counseling support on this subject, particularly for adolescent children.

7. Challenges in providing care

7.1 Just as there are challenges in providing counseling to this vulnerable group of children, there are very many challenges in providing them care. There could be problems due to the fact that it is one or both of the parents who are infected by HIV and are unable to give the child the necessary care; it could also be that the child has lost one or both of his or her parents and hence have either none to look after him or her or has been given to the care of elderly relatives who do not have the capacity to look after them. If there are none to look after such children, they need to be given care and protection, which will include the opportunity to study without disruptions and not become dropouts. If so, the Child Welfare Committees (CWCs) have an important role to play in the matter, and they need to be given an orientation to handle such cases. The problem gets worse if one or more of the children are also infected. We are yet to have structured systems in India like those available in Sweden and the USA, for providing foster care and adoption for persons infected with HIV, nor are we equipped as yet to handle such children along with other children in our Child Care Homes. In this scenario, the siblings are likely to be separated because often Care Homes are not trained to handle children with HIV. Such children need counseling support and opportunities to continue their bonds with their siblings.

7.2 There are hardly any Homes in the state which handle children infected with HIV. St John’s at Venjarammodu is one such institution. They provide these children, who are either orphans or those who have no one to look after them, with facilities for education, special diets, the medical support, counseling etc. Efforts are in progress to provide them support under the Integrated Child Protection Scheme (ICPS) programme. However, more such institutions than presently available are needed to manage the requirements of the state as a whole because an institution like St John’s for example, can cater at best for about 30 to 40 children. The possibility of creating such institutions with the support of ICPS needs to be explored. In developed countries, community has become more involved in providing support and care for children infected with HIV, but it is yet to become a reality in India. We have some distance to travel before we can ensure that level of participation in provision of care. Therefore, support through Homes set up with the help of the voluntary sector remains the best the option, and needs to be encouraged.
7.3 Even as we provide them care and protection, in the case of these children, the question arises as to how the continuum of care that they require in some cases will be provided after they turn 18 and are no longer categorised as children. Many of them suffer interruptions in their studies and so they may not have finished their elementary education by the time they turn 18. It needs to be considered how this aspect can be addressed and how they can be supported till they at least complete their education or learn a skill that will help them to be self-supportive. Unless they learn a trade or acquire a skill, it will be challenging for them to earn a living which is compatible with their health problems. At present there are no facilities available, except the ASAP, for providing them skills to become self-supportive at least in terms of earning a livelihood. But the opportunities available under ASAP like hospitality industry, automobile or electronic repair etc are not deemed suitable to those infected with HIV. It is therefore necessary to identify areas in which those infected with HIV can be gainfully employed, taking into account the limitations they may have in the matter of their health, while yet leveraging on their capabilities. It is also necessary to figure out how to maintain the continuum of care beyond 18 years to those who are not in a position to do so or have no one to depend on for such support.

7.4 For becoming more independent and to live in society on their own terms, besides the imparting of skills, they also need the ability to interact with the community at large. Because of the stigma they suffer, it becomes necessary to create opportunities for them to do so, be it in school or in other social fora. This is an area where organizations with tremendous strength at the local level, like Kudumbasree could play an important role. This aspect has been acknowledged in the Government Order marked as Annex III. However, the problem in leveraging them is the issue of confidentiality. Most parents or children are unwilling to come forward to declare their health status and enroll, for fear of being socially ostracized. Therefore, there is need to encourage organizations like CPK+ to provide platforms where these children can start the process of socializing, and then be encouraged to participate in mainstream activities. At present they do not have the funds to expand their operations. If support is provided, it will be possible for them to provide the children avenues for life skill training including leadership development, for career counseling, and for imparting job skills, taking into account the nature of their health and capabilities. It will also be possible to provide opportunities for recreational activities like indoor and outdoor games, quizzes, painting competitions, meditation programmes etc. Competitions could also be held in such activities for them at regular intervals in order to encourage them. Through these efforts the aim must be to empower these children to break the self-stigma that they have imposed on themselves, especially those children who are affected by HIV, and they should be encouraged to face the world without any inhibition. Initiatives like the Student Police cadets (SPC), the NCC and the NSS can also be encouraged to involve such children in their activities, thus providing opportunities for peer group interaction. The possibility of tapping
funds for such purposes under CSR from the corporate sector, as has been done in Tamil Nadu to the extent of Rs 10 crores, is an option that needs to be examined.

Recommendations

Keeping the above aspects in view, the following recommendations are being made to improve the conditions of children infected or affected with HIV:

1. In order to have a fully comprehensive data base about children who are affected and infected by HIV, the following issues need to be addressed:

   i) The state must ensure that every Hospital that treats children or pregnant mothers with HIV, especially the private hospitals, report their information on such patients without fail to KSACS under shared confidentiality. For this, appropriate awareness classes should be taken to reach all medical practitioners in the Government and private sectors, using the training opportunities available in the Government system and also with the Indian Medical Association (IMA) (Action: KSACS, DHS, DME)

   ii) The data of children between the ages 15 to 18, who were/are under treatment, and which would be readily available with the ART centres and KSACS needs to be carved out to create a state based data base of these children. This will facilitate the State to take action to address their specific issues. This needs to be done at the earliest. (ACTION: KSACS)

2. To address the crucial needs of adolescents between 12 and 18, especially in respect of counseling, resources have to be made available to KSACS. Their present efforts to do so using the funds available to them are too meager when measured against the actual need. (ACTION: KSACS)

3. There is currently no database of children affected by HIV. This needs to be started by collecting the information about the families of all patients who are currently availing treatment in ART centres. (ACTION: KSACS)

4. The medical practitioners in private and Government hospitals need to be sensitized so that pregnant women get the testing done for HIV in their first trimester itself, and start the treatment immediately thereafter if they test positive for HIV. Similarly doctors, especially paediatricians, need to be trained to distinguish between Opportunistic Infections like TB and similar infections that occur not as part of HIV. The Director of Health Services, the Director of Medical Education and the IMA must take necessary action to reach out to all health personnel and create the necessary awareness in this regard. (ACTION: DHS, DME, Department of Health, KSACS)

5. KSACS needs to consider setting up Link ART centres in tribal belts in the border areas of the state, irrespective of patient load, due to the special circumstances prevailing there, as there is genuine difficulty in ensuring follow up without direct supervision, despite the free transport facility being provided up to the nearest ART centre. (ACTION: KSACS)

6. The nutrition intake of children infected with HIV is a matter of concern, given the loss of appetite that is a natural consequence of this illness, the lack of access to midday meals during holidays, vacations and on days the child falls sick, and also the lack of nourishment in the
diet of many families who are below the poverty line. There has to be a mechanism to ensure steady availability of nutritious food. The adverse impact of fast foods, soft drinks etc are also a factor that children and their families need to be made aware of so that they can maintain their quality of life. (ACTION: DSJ, Dept. Of Health)

7. The elected representatives of LSGIs need to be sensitized about the serious impact of malnutrition so that they can review the situation in each of their wards to see how effective the available arrangements are for providing nutritious and clean food in an uninterrupted manner, to the targeted beneficiaries, and take corrective measures, wherever needed. This aspect must form a part of the training being given to the newly elected representatives of LSGIs. (ACTION: LSGD)

8. The supply of nutritious food by the LSGIs varies from one to another with some supplying a more comprehensive diet than another. KSACS should ideally try to bring in some level of uniformity in the diet that needs to be given to any child infected with HIV, taking into account the nutrition status and dietary habits in different areas so that the children get optimum benefit from this programme. (ACTION: LSGD, KSACS)

9. The state must take action to prepare a list of old headed and child headed families as well as list of drop out children who constitute the Orphans and Vulnerable Children (OVC) segment. Due to the stigma in society and the need to protect their identity, arrangements should be made to have such lists, which should ideally be with LSGIs, initially prepared by Community Care Centres or Help desks linked to ART centres, from the data available with them. Targeted action must be taken for supporting them so that children get the care and protection that they deserve, and they do not become drop outs or join the workforce at the cost of their studies. Special attention also needs to be given to children who have lost both their parents and are therefore currently outside the framework of benefits given to the families of persons infected with HIV. (ACTION: KSACS, LSGD)

10. Today the Government's Integrated Child Protection Scheme (ICPS) has many provisions to support children in need of care and protection, including sponsorship schemes for supporting economically and adverse children in family circumstances. It is a necessary to ensure that the benefit of these schemes is extended to all eligible children infected/affected by HIV. Since District Child Protection Units (DCPUs) are now available in every district, KSACS must establish a link with them and the ICPS to ensure that the benefits of this scheme are extended to these categories of children who are very much in need of care and protection (KSACS, DSJ)

11. There is an urgent need for a support centre at the level of the ART centre to provide the OVCs guidance and support to access the benefits due to them and also access the grievance redressal machinery, if any, available at the grass root level so that these issues can be sorted out at the earliest. Simultaneously, service providers in panchayats need to be sensitized about the special needs of this group of people and the importance of privacy and sensitivity in dealing with their needs. Additional manpower resources needed for supporting children infected with HIV through ART centres can be made available by employing persons infected by HIV, as is already being done in these centres for providing other services. A feasibility study needs to be
got done and sustainable options identified to extend such services to the needy. (ACTION: KSACS)

12. OVCs need easy access to legal aid. KSACS needs to examine whether the legal support made available through DELSA in the form of occasional legal aid clinics is adequate or whether there is need to provide them more support that is easy to access and will help them to redress their problems more effectively. (ACTION: KSACS, KELSA)

13. All persons infected or affected by HIV in the state are to be given Rs 1000 per month as family support. The arrears of Rs 10 crores pending for paying the balance of the enhanced amount from the date the revised amount came into effect, and also the amount now due to be given to them, need to be cleared at the earliest by the state Government as the current year’s allocation is only Rs 2 crores and an allocation of Rs 8 crores is still pending settlement. (ACTION: DSJ, Dept of Finance)

14. Counseling needs of children infected and affected with HIV are varied, and they would have to even include the need to counsel the parents and the child, in case the child contracts HIV on his or her own, and needs to be tested and treated. In order to meet these counseling needs of children infected and affected by HIV, it is felt necessary to train and sensitize all counseling resources available in the state, in all institutions and mechanisms that interact with children. KSACS will provide the necessary support for this initiative. (ACTION: DSJ, KSACS, Dept of Health)

15. Awareness training, on how to handle children who are infected and affected by HIV and also for dealing with any emergency situations, needs to be given to all care givers, be they in hospitals, Child care institutions and schools. Teachers must be sensitized about their enforced absence at times due to poor health, the need for special consideration at times due to poor health etc. Awareness training must also be given to the CWCs who will have to provide care and protection to children infected and affected by HIV. KSACS needs to take action in this matter in conjunction with the concerned authorities who will lend full support to this initiative. (ACTION: KSACS)

16. In order to overcome the stigma that prevents children affected or infected with HIV from actively participating in normal socializing avenues available to children, special opportunities need to be created by providing adequate resources to organizations like CPK+ which can provide them the avenues to do so among themselves, if suitably supported. This initiative must be two pronged—one to ensure that children affected by HIV are given the necessary handholding to participate in mainstream activities, and the other, to provide opportunities to those infected with HIV to socialise by supporting activities where they can participate without the fear of stigma. (ACTION: KSACS, General Education Dept)

17. To encourage children infected and affected by HIV to lead as normal a life as possible, it is necessary to provide them life skill training, opportunities for skill development (in the case of children infected with HIV, it needs to be ensured that such vocations take into account their health needs), avenues for career guidance and exposure to the opportunities available to them to pursue a career. These aspects should become an important part of the activities that will be taken up by the Community care centres.
or help desks once their scope is expanded. (ACTION: KSACS)

18. Children who are only affected by HIV need to be encouraged to break free from the self stigma that inhibits them from taking part in activities along with their peers. For this, special efforts need to be made to involve them in activities like the SPC, NCC etc as well as in other mainstream activities. (ACTION: Gen Education Department, Police, KSACS)

19. Given the present stage of evolution regarding the care being given to children infected with HIV, while institutionalized care will continue to be the last option, there is a need to actively encourage more voluntary agencies to provide such support to children in need, with support from ICPS. While care within the family is the best option, there has to be provision for institution based care. Since there are very few institutions providing care to children infected and affected by HIV in the State, the possibility of setting up more such institutions, on a need basis, even in the PPP mode, needs to be considered. (ACTION: DSJ)

20. To address the challenge of ensuring the continuum of care required by children infected with HIV once they turn 18, life skill and vocational training has to be given to those who are not in a position to continue their studies, so that they can stand on their own feet and become economically stable. This places a double strain on children infected by HIV because, in addition to the burden faced by normal children when tackling their studies at the higher levels in schools, they have to cope with the twin burdens of having to do the same with the additional burden of the limitations faced as a consequence to their ill health, and also the concern about their future once the turn 18 and can no longer be supported in a Home registered under the JJ Act. This is an area that needs to be studied in depth if the objective of proper rehabilitation of these children is to be achieved. (ACTION: KSACS, DSJ)

21. Since no child can be retained in a Home registered under the JJ Act 2000 after he or she completes 18 years, and many of these children would not have completed their basic education by then due to their health issues, and given the stigma and rejection they face in society, there is a need to consider the possibility of providing them support beyond 18 years till they reach a stage where they can fend for themselves after securing a suitable level of education or skill, depending on individual capabilities. In some countries like the United Kingdom, for example, the age limit has been extended for children with vulnerabilities. (ACTION: KSACS, DSJ)

22. The possibility of seeking CSR support for projects to ensure the quality of life to children infected and affected by HIV and to provide them the necessary support to break free of the self stigma imposed upon themselves due to the attitude in society towards them, need to be explored. (ACTION: KSACS, DSJ)
Annexure - 1

Participants in the Workshop on the Status of HIV - AIDS affected Children on September 17, 2015 at Mascot Hotel, Thiruvananthapuram

1. Smt Shoba Koshy, Chairperson, KeSCPCR
2. Shri K. Nazeer, Member, KeSCPCR
3. Fr Philip Parakkatt PV, Member, KeSCPCR
4. Smt Meena C.U, Member, KeSCPCR
5. Shri Babu.N, Member, KeSCPCR
6. Smt J. Sandhya, Member, KeSCPCR
7. Smt Glory George, Member, KeSCPCR
8. Dr Bindu G.S, Pediatrician, SAT Hospital, Thiruvananthapuram
9. Shri Sunil Kumar G, Joint Director (IEC), KSACS, Thiruvananthapuram
10. Dr T.V. Velayudhan, Joint Director (Care & Support), KSACS, Thiruvananthapuram
11. Smt Anjana.G, Assistant Director, GIPA, KSACS, Thiruvananthapuram
12. Smt Sandhya Sarath, Secretary, CPK+, Ernakulam
13. Shri B. Prathapa Chandra, Law Officer, Social Justice Department
14. Shri P.S. Mathew, ASPD, RMSA, Thiruvananthapuram
15. Smt Sangeetha.S, APO, SSA, Thiruvananthapuram
16. Dr T.P. Asharaf, Executive Director, Kerala Social Security Mission
17. Shri Aseef Reju.M.I, Directorate of Higher Secondary Education
18. Fr Alexander Valiyaveettil, St Johns Health Centre
19. Shri Ubaidulla.M, Research Assistant, DVHSE, Thiruvananthapuram
### Participants in the One Day Workshop on the Status of HIV - AIDS affected Children on January 1, 2015 at Government Guest House, Thiruvananthapuram

1. Shri Madhusoodanan T.K, Joint Secretary, CDNP+, Kannur
2. Shri Muhammed, Joint Secretary, KDNP+, Kasaragod
3. Shri C.M. Radhakrishnan, President, IDNP+, Idukki
4. Shri Sugith, Member, IDNP+, Idukki
5. Smt Sumathi.A, PDNP+, Palakkad
6. Shri Pious.C.F, General Secretary, TNP+, Thrissur
7. Shri Mathew.K, President, KNP+, Kozhikkode
8. Shri Zakkir Hussain P.B, Programme Officer, SSA, Alappuzha
9. Smt Sreeja,S, Protection Officer (NIC), DCPU, Thiruvananthapuram
10. Smt Nimmimol.G, Protection Officer (IC), DCPU, Thiruvananthapuram
11. Smt Gayathri.J, Legal cum Probation Officer, DCPU, Thiruvananthapuram
12. Smt Vidya.S.S, Social Worker, DCPU, Thiruvananthapuram
13. Shri Abraham.C, Nodal Coordinator, Childline, Kollam
14. Shri Josepther. K.O, AO, CPK+, Kochi
15. Smt Anitha Rajan, Block Programme Officer, SSA, Kaniyapuram BRC
16. Smt Shaniba, Project Officer, Nirbhaya
17. Sr Chaithanya, Chavara Inspire Charitable Society, Ernakulam
18. Sr Little Theresa, Chavara Inspire Charitable Society, Ernakulam
19. Smt Thresia.E.M, WNP+, Wayanad
20. Smt Mini Ashokan, ADNP+, Alappuzha
21. Shri Nidhish M. George, Nodal Coordinator, Childline, Kasaragod
22. Dr V.R. Mohanan Nair, Member, CWC, Pathanamthitta
23. Shri V. Chandramohan, Member, CWC, Kozhikkode
24. Smt Thara.I, CRCC, Thiruvananthapuram
25. Smt Lilly Bai.K.J, SPO, SSA, Thiruvananthapuram
26. Smt Sobhana Kumari.P, State Programme Officer, SSA, Thiruvananthapuram
27. Smt Boby Joseph, State Consultant, Kerala Mahila Samakhya Society, Thiruvananthapuram
28. Fr Thomas P.D, Director, Childline, Thiruvananthapuram
<table>
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<th>No.</th>
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<td>Anil Kumar K.N. Pillai</td>
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<td>45</td>
<td>Dr T.V. Velayudhan</td>
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<td>Shri Victor Johnson</td>
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<td>Smt Alice George</td>
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<td>Dr Usha Kumari B</td>
<td>APD, KSACS</td>
<td>KSACS</td>
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<td>61</td>
<td>Dr Anjana S.</td>
<td>Assistant Director, GIPA, KSACS</td>
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62. Fr Alexander Valiyaveettil, St John’s, Pirappancode
63. Shri R.S. Shibu, Chief Planning Officer, DPI, Thiruvananthapuram
64. Thasneem P.S, Programme Officer, Social Justice Directorate
65. Smt Bindhu S, J.S, Directorate of Vocational Higher Secondary
66. Smt Maya Devi.M, Directorate of Vocational Higher Secondary
67. Shri Ashok Nair, NNP+, Thiruvananthapuram
68. Shri K. Surendran Pillai, Block Programme Officer, SSA, Alappuzha
69. Dr M. Prasanna Kumar
70. Dr Ajay Rajan, KSACS
71. Smt Bindu Gopinath, Programme Officer
72. Shri M. Sideekhul Kabeer, Programme Officer, DVHSE
73. Shri Brijithlal.V, KTDNP+, Kottayam
74. Shri Rajan, KDNP+, Kasaragod
75. Smt Maheswari, CDNP+, Kannur
76. Raji, KND+, Kozhikkode
77. Smt Syamala.L, TNP+, Thrissur
78. Shri Balan, PDNP+, Pathanamthitta
Annexure III

ക്ഷeso (ആണ്‌) സാംഗീതം

ബ്രഹ്മപ്രദേശത്തെ ക്ഷesoയ്ക്കുള്ള പ്രവൃത്തികലേക്കിലെപ്പെടുന്ന പ്രവൃത്തികലാണല്ലോ പോലെ മറ്റും വിവരണം കൊടുക്കാനാണ്‌. എന്നാലാണ്‌ പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌.

(ആൾ സാംഗീതം)

(1) 11.01.2011, 25.08.2012 അതോതെ വിവരണം കൊടുക്കാൻ അല്ലെങ്കിൽ 87/09-10 സമയം കൊടുക്കാൻ
(2) 21/06/2012 അതോതെ (ആൾ) 124/2012 വിവരണം
(3) 18.01.2012, 25.09.2012, 3.3 10.01.2013 അതോതെ 3.2 അതോതെ വിവരണം

ഇതാണ്‌ പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌.

ഇതാണ്‌ പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌. പ്രവൃത്തികലാണ്‌.

(ആൾ) സാംഗീതം

1. പ്രവൃത്തികലാണ്‌
2. പ്രവൃത്തികലാണ്‌
3. പ്രവൃത്തികലാണ്‌
4. വരദമുഖപ്പാത കുടിക്കാനാണ്, തുടർന്നുകൊണ്ടു
5. അതായിട്ടുള്ള പാദത്തില്‍, അതുതുടരുന്ന്
6. അവസാനം പാദത്തില്‍, കൊടും അടിവൃത്തിൽ അന്തരിക്കുന്നത്രേയും ഉണ്ടാക്കുന്നു
7. പോക്കള്‍ക്ക്, അറിയാനും അവസാനം വീട്
8. ശക്തിയും മാനം
9. അവസാനംപരിപാലന (പ്രബുദ്ധ) മാനം (U.O. No. 667/DAI/13/സ്ഥാപന (ബാലാം))
10. അവസാനം പ്രബുധ/ബാലാം എന്നു

ഡോ.കോളേബ്രി (പ്രബുദ്ധ)

ബാലാം എന്നരുവി
മലയാളം

1. മലയാളം നാമവാരക്കൃതി
2. പ്രായമാരകം നാമവാരക്കൃതി
3. പ്രീട്ടോ നാമവാരക്കൃതി
4. വിവിധകൃതി
5. കലനാട്ടം-ചെറുന്നു നാമവാരക്കൃതി
6. സാധമാണവാരക്കൃതി
7. അർജ്ജേതാം നാമവാരക്കൃതി
8. പ്രായമാരകം 
9. പ്രീട്ടോ നാമവാരക്കൃതി
10. വിവിധകൃതി
11. സാധമാണവാരക്കൃതി
12. അർജ്ജേതാം
പ്രതിവാarda എബഹയവാനം പ്രകാശിക്ഷാ (2012-2017) :
കാസ്സൽക്കാലാചാരാധ്യവാഴിന്റെ കോഴിക്കുട്ട
ഓള്ളുകര പി./ അദ്ധ്യാപനനിർദ്ദേശം

2008 ൽ കെട്ടിയിട്ട് പലപ്പോഴും ഒരു ശേഖരിക്കാവുന്ന അസീനികളുടെ ആയോധണത്തിന് 0.36 കേസുകൾക്ക് എല്ലാം പ്രായോഗിക ഉപയോഗത്തിന്റെ ലക്ഷ്യം ഉണ്ടാക്കുന്നതിനു കാരണമായി അനുമാനപ്പെട്ടു. നിരീക്ഷണഹൃദയ എന്നാണ് കാസ്സൽക്കാലാചാരത്തിലെ കാരണമായി ഉവേചാനലുകൾ ഉദ്ദേശ്യത്തിന്റെ ലക്ഷ്യം ഉണ്ടാക്കുന്നതിനു കാരണമായി അനുമാനപ്പെട്ടു. നിരീക്ഷണഹൃദയ എന്നാണ് കാസ്സൽക്കാലാചാരത്തിലെ കാരണമായി ഉവേചാനലുകൾ ഉദ്ദേശ്യത്തിന്റെ ലക്ഷ്യം ഉണ്ടാക്കുന്നതിനു കാരണമായി അനുമാനപ്പെട്ടു. 

2008 ലെ കെട്ടിയിട്ട് പലപ്പോഴും ഒരു ശേഖരിക്കാവുന്ന അസീനികളുടെ ആയോധണത്തിന് 0.36 കേസുകൾക്ക് എല്ലാം പ്രായോഗിക ഉപയോഗത്തിന്റെ ലക്ഷ്യം ഉണ്ടാക്കുന്നതിനു കാരണമായി അനുമാനപ്പെട്ടു. നിരീക്ഷണഹൃദയ എന്നാണ് കാസ്സൽ�്കാലാചാരത്തിലെ കാരണമായി ഉവേചാനലുകൾ ഉദ്ദേശ്യത്തിന്റെ ലക്ഷ്യം ഉണ്ടാക്കുന്നതിനു കാരണമായി അനുമാനപ്പെട്ടു.

2008 ലെ കെട്ടിയിട്ട് പലപ്പോഴും ഒരു ശേഖരിക്കാവുന്ന അസീനികളുടെ ആയോധണത്തിന് 0.36 കേസുകൾക്ക് എല്ലാം പ്രായോഗിക ഉപയോഗത്തിന്റെ ലക്ഷ്യം ഉണ്ടാക്കുന്നതിനു കാരണമായി അനുമാനപ്പെട്ടു. നിരീക്ഷണഹൃദയ എന്നാണ് കാസ്സൽക്കാലാചാരത്തിലെ കാരണമായി ഉവേചാനലുകൾ ഉദ്ദേശ്യത്തിന്റെ ലക്ഷ്യം ഉണ്ടാക്കുന്നതിനു കാരണമായി അനുമാനപ്പെട്ടു.
7. സാധ്യതയുള്ള സാധ്യതയുള്ള
8. വായക്കെടുക്ക വായിക്കെടുക്ക
9. മിശ്രമിശ്ര ഗ്രാമവും ഗ്രാമവും
10. സമൂഹത്തിന്റെ സാധ്യതയുള്ള സാധ്യതയുള്ള
11. സാധ്യതയുള്ള സാധ്യതയുള്ള

സ്ഥാപനത്തിന്റെ പ്രാധാന്യം

(a) അനുഭവമയുള്ള പ്രാധാന്യം എതിരകേന്ദ്രം എതിരകേന്ദ്രം എതിരകേന്ദ്രം എതിരകേന്ദ്രം, ഭരണകോമ്പനി ഭരണകോമ്പനി ഭരണകോമ്പനി ഭരണകോമ്പനി, എന്ന ഭരണകോമ്പനി ഭരണകോമ്പനി.

(b) സ്ഥാപനത്തിന്റെ പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം.

(c) സ്ഥാപനത്തിന്റെ പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം.

(d) സ്ഥാപനത്തിന്റെ പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം.

(e) സ്ഥാപനത്തിന്റെ പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം.

(f) സ്ഥാപനത്തിന്റെ പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം.

(g) സ്ഥാപനത്തിന്റെ പ്രാധാന്യം എന്ന പ്രാധാന്യം എന്ന പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം, എന്ന് പ്രാധാന്യം പ്രാധാന്യം.
(h) ഫുട്ട്.എ ബ്യൂറോ. സ്വദേശിക്കാ നിരൂപണ രേഖകൾ സൃഷ്ടിക്കുന്നതും നൂറ്റാണ്ടുകളിലെ ലോകത്തിലെ ഒരു അലങ്കാരമേഖലയാണ്.

(i) നമുക്കുതന്നെ അതീവ ശ്വെസ്റ്റ്റു ഇത്തരം ഒരു പ്രസ്താവന അത്യുക്തിയായിരിക്കാം ഫുട്ട്.എ ബ്യൂറോ. / അനുഭവം സ്വദേശിക്കാ നിരൂപണം

(j) ഫുട്ട്.എ വിഷയാനന്തര അഖാരം സ്വദേശിക്കാ നിരൂപണം ഒരു പ്രസ്താവന നിരൂപണമാണ് ന്യൂസ് ലോകത്തിലെ ഒരു അലങ്കാരമേഖലയാണ് ഫുട്ട്.എ ബ്യൂറോ.

2. ഫുട്ട്.എ ബ്യൂറോ. സ്വദേശിക്കാ നിരൂപണം

(i) സ്വദേശിക്കാ നിരൂപണം ഒരു പ്രസ്താവന നിരൂപണമാണ് സ്വദേശിക്കാ നിരൂപണം അദ്ദേഹം നിരൂപണം അദ്ദേഹം നിരൂപണം അദ്ദേഹം നിരൂപണം അദ്ദേഹം നിരൂപണം അദ്ദേഹം നിരൂപണം അദ്ദേഹം നിരൂപണം

3. എബ്ലോൻ, പ്രോസിസം

(i) മലയാളം സ്വദേശിക്കാ നിരൂപണം, സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം, മലയാളം സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം മലയാളം സ്വദേശിക്കാ നിരൂപണം
ഇവിടെ വസ്തുവിന്റെ നിരക്കുകളിൽ അലേഖിപ്പിക്കപ്പെട്ട ഒരു ക്ലാസിഫിക്കേഷനാണ് ആധാരമാക്കിയിരിക്കുന്നത്. പിന്നീട് വസ്തുവിന്റെ അംശങ്ങളെ വിഭജിച്ച് ഉള്ളതിനെയാണ് ഇതിന്റെ പ്രധാന വിഭജനം. ഒരു വസ്തുവിന്റെ ഒരു അംശം തന്നെ ഉൾപ്പെടുന്ന ഒരു വസ്തുവിന്റെ പ്രധാന വിഭജനം എന്നാണ് ഇതിന്റെ പ്രധാന വിഭജനം. 

ii) സിയർവിസിന്റെ വിഭജിച്ചുകൊണ്ടിരിക്കുന്ന ഒരു വസ്തുവിന്റെ പ്രധാന വിഭജനം (Opportunistic Infections) വസ്തുവിന്റെ ഒരു അംശം ഉൾപ്പെടുന്ന ഒരു വസ്തുവിന്റെ പ്രധാന വിഭജനം എന്നാണ് ഇതിന്റെ പ്രധാന വിഭജനം. പിന്നീട് വസ്തുവിന്റെ ഒരു അംശം ഉൾപ്പെടുന്ന ഒരു വസ്തുവിന്റെ പ്രധാന വിഭജനം എന്നാണ് ഇതിന്റെ പ്രധാന വിഭജനം. 

iii) സിയർവിസിന്റെ വിഭജിച്ചുകൊണ്ടിരിക്കുന്ന ഒരു വസ്തുവിന്റെ ഒരു അംശം ഉൾപ്പെടുന്ന ഒരു വസ്തുവിന്റെ പ്രധാന വിഭജനം (Infected and Affected) എന്നാണ് ഇതിന്റെ പ്രധാന വിഭജനം. 

iv) സിയർവിസിന്റെ വിഭജിച്ചുകൊണ്ടിരിക്കുന്ന ഒരു വസ്തുവിന്റെ ഒരു അംശം ഉൾപ്പെടുന്ന ഒരു വസ്തുവിന്റെ പ്രധാന വിഭജനം (Infected and Affected) എന്നാണ് ഇതിന്റെ പ്രധാന വിഭജനം. 

v) സിയർവിസിന്റെ വിഭജിച്ചുകൊണ്ടിരിക്കുന്ന ഒരു വസ്തുവിന്റെ ഒരു അംശം ഉൾപ്പെടുന്ന ഒരു വസ്തുവിന്റെ പ്രധാന വിഭജനം (Infected and Affected) എന്നാണ് ഇതിന്റെ പ്രധാന വിഭജനം. 

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4. മെയ്റ്റ്‌വ്യത്യരണം

i) മെയ്റ്റ്‌. അഗ്നി ശാസ്ത്രജ്ഞന്റെ ഭാവനക്കുറിപ്പുകളുടെയേറെയും ഉപയോഗങ്ങളുടെയേറെയും മുൻപുറം കൊണ്ടുപെട്ടിയാണ്‌ അവിടെ. അന്ന് മെയ്റ്റ്‌വ്യത്യരണം വിവിധ അധികാരങ്ങളുടെ അങ്കങ്ങളുടെയേറെയും മുതിർന്നതും അതിനുള്ള സമയം എന്നിവയുടെയേറെയും പ്രയോജനമാക്കിയാണ്‌. 

ii) കിഴക്കൻ സ്വാഭാവിക സാമ്പത്തിക കാർഷിക വികസന കേന്ദ്രത്തിൽ നടത്തിയ പ്രവർത്തനങ്ങൾ ഉൾപ്പെടുന്നു. പ്രധാനമായും മാണ്ഡ്റ്‌ സ്വാഭാവിക സാമ്പത്തിക കാർഷിക വികസന കേന്ദ്രത്തിന്റെ മുൻപുറം കൊണ്ടുപെട്ടിയാണ്‌. 

iii) മെയ്റ്റ്‌ ജനറൽ സ്വാഭാവിക സാമ്പത്തിക കാർഷിക വികസന ചെയ്യുന്നതിന്റെ പങ്കു എന്നിവയുടെയേറെയും പ്രയോജനമാക്കിയാണ്‌. 

5. തടാകുകര എന്നിവയുടെ മെയ്റ്റ്‌വ്യത്യരണം

ജെ. ജി. ആൻഡ്‌ ജെ. വി. എണ്ണാകെഞ്ഞലുകൾ (PLHIV) ആദ്യം കൃത്യമായാണ്‌ മെയ്റ്റ്‌വ്യത്യരണം പൂർത്തിയാക്കാൻ സാധ്യമായതു. ഇവയുടെയേറെയും മുൻപുറം കൊണ്ടുപെട്ടിയാണ്‌. 

i) സ്വാഭാവിക കൃഷി വർദ്ധനം അനുസരിച്ചും പ്രവർത്തനങ്ങൾ നടത്തുന്നു. 

ii) സ്വാഭാവിക കൃഷി വർദ്ധനം അനുസരിച്ചും പ്രവർത്തനങ്ങൾ നടത്തുന്നു.
iii) ക്രമീകരണം പ്രകാരം താൾ പരാമർശിക്കുന്ന മൂല്യാകൃതികൾ ക്രമീകരിക്കുന്ന എണ്ണത്തിലും സംവിധാനത്തിലും പഠനത്തിലും കാര്യത്തിൽ പ്രകാരം ഇടയ്ക്കുകയും വേദിയുപയോഗിക്കുകയും

iv) ക്രമീകരണം പ്രകാരം മൂല്യാകൃതികൾ ക്രമീകരിക്കുന്ന എണ്ണത്തിലും സംവിധാനത്തിലും പഠനത്തിലും കാര്യത്തിൽ പാതലാണെന്ന് താളിന്റെ പരാമർശം 

<table>
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<th>ക്കണക്ക്</th>
<th>മൂല്യാകൃതി/ഭാഗ്</th>
<th>പിനകംവിവരണം (എണ്ണ)</th>
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<td>1.</td>
<td>മിക്ക 1-4</td>
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<td>5.</td>
<td>മൂല്യാകൃതിയും</td>
<td>750</td>
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ഇവ ക്കണക്കുകളാണെന്ന് മൂല്യാകൃതികൾ/സംവിധാനം സ്ഥാപിക്കാൻ ലഭ്യമാണെന്ന് പരാമർശം ചെയ്യുന്നു. പഠനത്തിൽ പ്രകാരം മൂല്യാകൃതികൾ നൽകുന്നതിനു പകരം അത്യുക്തികൾ പ്രകാരം മൂല്യാകൃതികൾ പൊരുതാൻ പ്രട്ടിപ്പെട്ടുപോലെ പ്രത്യേകിച്ച് കോഴികളുടെ പ്രത്യേകിച്ച കോഴികളുടെ പ്രത്യേകിച്ച കോഴികളുടെ.

ക്രമീകരണം പ്രകാരം മൂല്യാകൃതികൾ മൂല്യാകൃതി പൊരുതാൻ മൂല്യാകൃതികളുടെ എണ്ണത്തിൽ കോഴികളുടെ പ്രത്യേകിച്ച കോഴികളുടെ.

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<td>4.</td>
<td>മൂല്യാകൃതിയും</td>
<td>500</td>
</tr>
<tr>
<td>5.</td>
<td>മൂല്യാകൃതിയും</td>
<td>750</td>
</tr>
</tbody>
</table>

v) ക്രമീകരണം പ്രകാരം മൂല്യാകൃതികൾ പൊരുതാൻ മൂല്യാകൃതികളുടെ എണ്ണത്തിൽ കോഴികളുടെ പ്രത്യേകിച്ച കോഴികളുടെ

vi) ക്രമീകരണം പ്രകാരം മൂല്യാകൃതികളുടെ എണ്ണത്തിൽ കോഴികളുടെ പ്രത്യേകിച്ച കോഴികളുടെ

6. പ്രഭാവസ്വഭാവികൾ

i) ക്രമീകരണം പ്രകാരം മൂല്യാകൃതികൾ പൊരുതാൻ മൂല്യാകൃതികൾ (ക്രമീകരണം/ഭാഗ്, പഠനത്തിലും സംവിധാനത്തിലും പ്രത്യേകിച്ച് കോഴികളുടെ.
13
v) സ്വീകാരത്തിലില്ല അരികേട്ടത്തിൽ അധീനതയിലെ നിരുപാധിക്കോഴികൾ മുതിരിക്കുന്നതിന്

9. മൂലദേശത്തിലെ പിന്നിൻറെ സമയവശ്രമാവശ്യം

ലോകാനുസരണമായ അരികേട്ടത്തിലെ അവസ്ഥയില്ല (മാന്യാവശ്യമായ ദേശാംഗങ്ങൾ, മണ്ഡലങ്ങൾ, മേഖലകൾ എന്നിവയിലേക്ക് സമയവശ്രമാവശ്യം അവസ്ഥയിലെ നിരുപാധിക്കോഴിക്കാനുള്ള പ്രവൃത്തികൾക്കും മുതിരിക്കുന്നതിന്)

10. കഴിക്കുന്നതിന്റെ വാക്യം സമയവശ്രമാവശ്യം

ക്കടുത്തിനകത്തിലെ (KSCAS) 53 വക്താ സ്വകാരന്റെ സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം (കേരളഗണം വെള്ളം, മണ്ഡലങ്ങൾ വായനാധിനിവുക്കുന്ന സമയവശ്രമാവശ്യം) സ്വകാരന്റെ വാക്യത്തിലേക്ക്/സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യത്തിലേക്ക് മുന്നിൽ.

11. വസ്ത്രം സ്വാധീനം

i) അടുത്തായി സ്വാധീനം സ്വകാരന്റെ സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം

ii) അടുത്തായി സ്വാധീനം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം

iii) മാതൃകാഭിവിധികളും സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം (കേരളത്തിന്റെ വാക്യം സമയവശ്രമാവശ്യം) സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം

iv) അടുത്തായി സ്വാധീനം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം (High Risk Behaviour Groups) സ്വാധീനം സ്വകാരന്റെ അവസ്ഥയിലെ വാക്യം സമയവശ്രമാവശ്യം, കേരളത്തിന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം, കേരളത്തിന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം. സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം

v) സ്വാധീനം സമയവശ്രമാവശ്യം സ്വകാരന്റെ അവസ്ഥയിലെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം

vi) അടുത്തായി സ്വാധീനം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം സ്വകാരന്റെ വാക്യം സമയവശ്രമാവശ്യം.
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</tr>
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<td>ഇത് മനുഷ്യത്തിന്റെ സ്വാഭാവികം പെരുംകായം മനുഷ്യായാണ്</td>
<td>ഭാഗവത്മാക്യമായ പെരുംകായം മനുഷ്യായാണ്</td>
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</tr>
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12. പ്രക്രിയാഭ്യാസം

i) മൂന്ന് മാർച്ച് 30 വരെ പുലർത്തുന്ന പ്രസിദ്ധീകരണം അടക്കം മനുഷ്യായാണ് പ്രവാചകനായാണ് | പ്രവാചകനായാണ് മനുഷ്യായാണ് |

ii) മൂന്ന് മാർച്ച് 30 വരെ പുലർത്തുന്ന പ്രസിദ്ധീകരണം അടക്കം പ്രവാചകനായാണ് | പ്രവാചകനായാണ് മനുഷ്യായാണ് |

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