# CARE AND SUPPORT OF CHILDREN AFFECTED BY HIV AND AIDS: A STUDY AMONG THE KUKI CHILDREN OF SADAR HILLS IN MANIPUR

*Dissertation submitted to Jawaharlal Nehru University*
*in partial fulfilment of the requirements for*
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**MASTER OF PHILOSOPHY**

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## CERTIFICATE

This dissertation entitled **"CARE AND SUPPORT OF CHILDREN AFFECTED BY HIV AND AIDS: A STUDY AMONG THE KUKI CHILDREN OF SADAR HILLS IN MANIPUR"** is submitted in partial fulfilment of the requirement for the award of the degree of **Master of Philosophy** of this university. This work is original and has not been submitted so far, in part or full, for any degree or diploma of this university or any other university.

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We recommend that this dissertation be placed before the examiners for evaluation.

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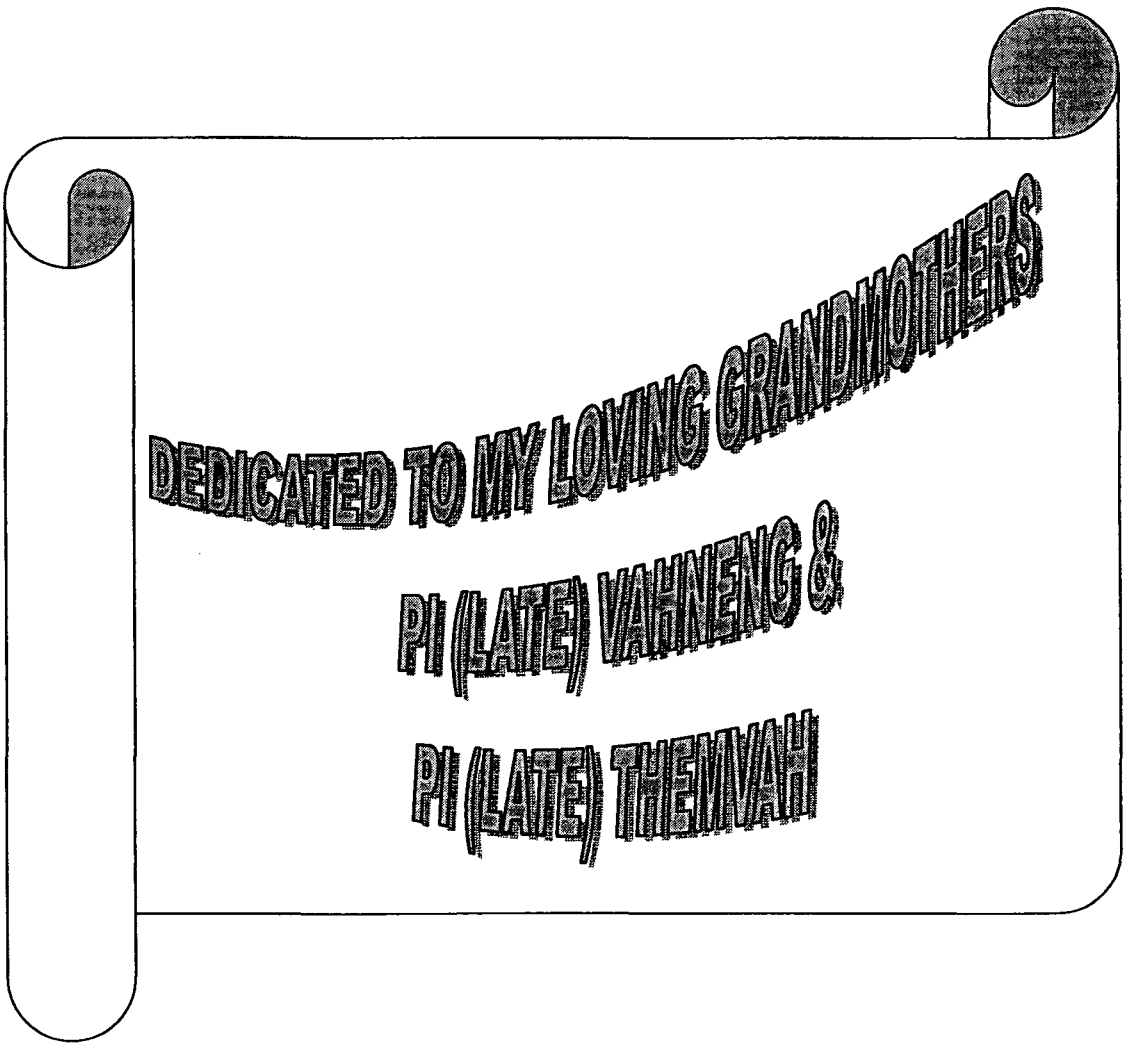
DEDICATED TO MY LOVING GRANDMOTHERS
PI (LATE) VAHNENG &
PI (LATE) THEMVAH

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*Ruth Nengneilhing*

# ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AFSPA | Armed Forces Special Powers Act |
| CARA | Central Adoption Resource Agency |
| CBCS | Community Based Care and Support |
| CRC | Convention on the Rights of the Child |
| HIV | Human Immunodeficiency Virus |
| IDUs | Injecting Drug Users |
| IWCD | Integrated Women and Child Development Centre |
| ISS | International Social Service |
| LEWS | Leprosy Patients Welfare Society |
| MACS | Manipur State Aids Control Society |
| MLSS | Meetei Leimarol Sinai Sang |
| MSJE | Ministry of Social Justice and Empowerment |
| NACP | National Aids Control Programme |
| NGO | Non Governmental Organisation |
| SOS | Save Our Soul |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNICEF | United Nations Children's Fund |
| USA | United States of America |
| WHO | World Health Organisation |

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# VOICES...

"Care for us and accept us- we are all human beings. We are normal. We have hands. We have feet. We can walk, we can talk, we have needs just like everyone else- don't be afraid of us- we are all the same!"

___ The late Nkosi Johnson from his speech for the opening ceremony of the 13th International AIDS conference in Durban.

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Listen to my heart speak...
please look at me and see
I am just a child
trying to live with aids/hiv

Listen to my heart speak...
to those who are afraid
showing kindness touching
and hugging me will not
give you hiv/aids

I know what it feels like to live
with pain when people I love
are sick and go away
smiling and laughing
sometimes can be strain

Listen to my heart speak...
please, please hear what I say let us love one another for I, like you
maybe here just for today

Stephanie Ray

Phoenix, AZ 8/29/96

# CHAPTER 1
# INTRODUCTION

## *Statement of Problem*

Ever since its recognition in the year 1981 in USA, HIV and AIDS has been spreading rapidly and widely in the human race. While the HIV infects young adults most, and social and economic status influences the vulnerability to it, no age group or social group is left untouched. Young and old, rich and poor are struck and victimized by this deadly disease. Not only is the disease a medical issue but it also shakes the root of family and social relationships. While HIV and AIDS deeply affect life expectancy and health and has economic and societal impact, children of affected families emerge as the worst sufferers as their lives become shattered at a very young age. When HIV and AIDS intrude into a household, it quakes the entire structure of the family and affects the economic and social interaction and obligations of family relations. In the process, the children affected by HIV and AIDS are denied proper care and support for survival and development which poses a serious challenge to the wellbeing of children and their growing up into responsible adults (Levine 1994).

Children orphaned by HIV and AIDS are found in almost every country (UNAIDS 2004). The numbers, magnitude of problems associated with the phenomenon, and the point and mode of intervention differ from country to country. Sub-Saharan Africa remains the area worst hit by the orphan crisis with an estimated 12 million children already orphaned by the disease (UNAIDS, 2004).

'Children affected by HIV and AIDS' can be those whose one or both parents are alive but living with HIV infection, or those whose one or both parents have died of AIDS. In both these categories, the children may be uninfected themselves or the children are also infected. The nature of problems and support structures required for these different situations is somewhat different.

An AIDS orphan is defined as a child under the age of fifteen who has had at least one parent die of AIDS. The AIDS report (UNAIDS, 2004), defines three categories of orphans due to AIDS: (1) maternal (2) paternal (3) double orphans. A maternal orphan is one who has lost the mother to the disease, a paternal orphan has lost the father, and a double orphan has lost both parents to the disease. Orphans are defined as children who have lost either of the parents.

According to the global reports of UNAIDS and WHO it has been estimated that by the beginning of 1998, over 30.6 million people of the world were infected with HIV. From among them, 29.4 millions are adults, 12.2 millions were women and 1.1 million were children less than 15 years of age. The total number of deaths since the beginning of the epidemic to 1998 was estimated to be 11.7 million in which 9 million were children while the total number of orphans was estimated to be 8.2 millions in 1998(UNAIDS/WHO, 1998). In India, according to the UNICEF give full reference estimation to provide the general sense of the proportion of children affected by HIV and AIDS, the following guesstimates have been made:

1. Infected by HIV----55,000-220,000
2. Orphaned by AIDS ----1,500,000-2,500,000
3. Living with HIV positive parent----6,000,000-10,000,000

Taking this global estimate of 1998 and the global summary of the AIDS epidemic December 2006 (UNAIDS 2006), considerable increase in the number of people affected by HIV and AIDS is clearly indicated. The number of **people living with HIV in 2006** is 39.5-47.1 million (34.1-47.1 million) which comprise of the following distributions:

Adults----------37.2 million (32.1-44.5 million)

Women----------17.7 million (15.1-20.9 million)

Children under 15 years------2.3million (1.7-3.5 million)

**People newly infected with HIV in 2006**

Total ----------4.3 million (3.6-6.6 million)

Adults ---------3.8 million (3.2-5.7 million)

Children under 15 years -----530 000 (410 000 – 660 000)

**AIDS death in 2006**

Total ---------2.9 million (2.5-3.5 million)

Adults-------2.6 million (2.2-3.0 million)

Children under 15 years----380 000 (290 000-500 000)

The new method for estimation of HIV prevalence adopted by UNAIDS in 2007 has halved the estimates for many countries including India. However, this does not mean that there is a declining trend, only that estimation methodology has improved, and the problem remains large enough and the effects just as important to understand and minimise.

Promising developments have been seen in recent years in global efforts to address the AIDS epidemic, including increased access to effective treatment and prevention programmes. However, the number of people living with HIV continues to grow, as does the number of deaths due to AIDS and the increasing number of affected children by HIV.

The problems that children and families face as a result of HIV and AIDS are many. Williamson (2000) gives a summary of some of the psychosocial problems orphans may face. Children who have lost their parents to the disease are not only deprived of love, support, and care of parents, but worse still; they face the problem of having lost their parents to a shameful and stigmatized disease. The cumulative effect of these problems on an orphan in childhood and adulthood cannot be underestimated. As parents become increasingly ill, there is the possibility that children, especially girls, may become caregivers to both their parents and their siblings. As caregivers, children bear the brunt of hardships for providing for themselves, their sick parents and their siblings as well. Children may drop out of school to take care of their sick parents, or to look for jobs to earn income to support the family. The protracted nature of HIV and AIDS is likely to create economic problems due to loss of jobs and the depletion of savings or other resources leaving little or nothing to care for orphans. Thus at death, victims may not leave enough for the care of their children (orphans) or dependents. In addition, the stigma of shame attached to death caused by the HIV and AIDS may serve as a disincentive toward the adoption or fostering of AIDS orphans. Failure to address these problems may result in children growing up with experiences that might have traumatic effects in adulthood (Ansah-koi 2006).

**Common problems for children affected by HIV and AIDS:**

**Education:**

-children, particularly girls withdrawn from school to care for siblings, for the sick or for economic reasons.

-reduced parental or adult responsibility.

-increased truancy

-fewer vocational opportunities.

-traditional knowledge and practices not passed down.

**Health:**

-Lower nutritional status of orphans.

-less attention to sick orphans.

-less likely to be immunised.

-increased vulnerability to HIV and AIDS.

-higher child morality.

-higher exposure to opportunistic infections, especially tuberculosis and pneumonia.

**Livelihoods, social welfare and protection:**

-Increased poverty.

-stigma and social isolation of orphans.

-loss of property and inheritance.

-discrimination based on HIV status.

-loss of food security particularly in rural areas.

- Abandonment.

-institutionalisation.

-harsh treatment of orphans.

-increased sexual abuse of unprotected children.

(Source: UNICEF/CEDC 1998 a and b; Hunter and Williamson 1998b; authors)

Growing up in the midst of all these problems, these children affected by HIV and AIDS ultimately become the most vulnerable group that requires the utmost care and support. However, they are found to be denied even the basic provisions for life. There is an urgent need therefore to explore various possible options for care and support that can be provided and are available and their accessibility to these children.

Thus, care for children affected by HIV and AIDS, including orphans, is one of the major concerns emanating from HIV and AIDS epidemic (UNAIDS 2004). This is more so in countries where there are no formal governmental welfare policies for care of orphans and vulnerable children. This situation is aggravated when customary caregivers in the family and community also die or where stigma of AIDS is high.

However there is little information available on the problem in India. All that is available are news reports about the children who are discriminated against because of their identification as HIV and AIDS affected. The response of NACP has given no special attention to the HIV and AIDS affected children right up to phase II of the World Bank project that ended in 2007. It is important to know the nature of social response to their problems and the existing care and support they are getting so as to identify the needs that must get urgent attention to decrease the impact of the epidemic on them. This study is therefore being undertaken to examine the nature of care and support presently being received by children affected by HIV and AIDS. Given the limitations of this being a preliminary one person study, it is being conducted for only one of the highly endemic states, Manipur.

In Manipur, according to the epidemiological estimates of HIV and AIDS in Manipur, from 1986 to 2006, the total numbers of HIV positive cases among children in the age-group of 0- 10 years are 1009 while in the age group of 11-20 years are 1149 (see table 1.1)

**Table-1.1**

**Epidemiological analysis of HIV and AIDS in Manipur**

**(September 1986-September2006)**

| age-group | males | females | total | %of total positives |
|---|---|---|---|---|
| 0-10 years | 548 | 461 | 1009 | 5.39 |
| 11-20years | 849 | 300 | 1149 | 6.14 |
| 21-30years | 6118 | 2613 | 8731 | 46.67 |
| 31-40years | 4690 | 1703 | 6393 | 34.17 |
| 41&above | 1012 | 414 | 1426 | 7.62 |
| TOTAL | 13217 | 5491 | 18708 | 100.00 |

(Source: Manipur state AIDS control society)

The increasing number of orphans resulting from AIDS calls for a review of the support and care systems available for them. Their childhood which forms the basis of their lives begins with a shaky foundation of social and emotional instability. They are attended to either by single parents, relatives or left in orphanages. Thereby, the care and support accorded to these children by the caretakers, be it near or far relatives, institutions and the community, plays a great role in the overall upbringing of these children and determines the child's development outcomes. Thus, the present study is an attempt to explore the care and support extended to the children affected by HIV and AIDS by various possible caretakers such as the family, community and orphanages.

## Conceptualization of Problem

The Convention on the Rights of the Child (CRC) lays down the principles of non discrimination in the best interest of the child along with the common standards for the various rights of children. It takes into account the different cultural, social, economic and political realities in which children live. In 1989 the convention was formed for children wherein it was felt that the children needed a special convention to cater to the need for special care and protection. The convention spells out the basic rights that children everywhere have; the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation and to participate fully in family, cultural and social life. The convention protects children's rights by setting standards in health care, education and legal, civil and social services. The UN convention on the rights of the child affirms and describes the fundamental human rights of all children below 18 years and the governments that have ratified it have legally agreed to fulfil its promises. India ratified the Convention on the 11th of December, 1992.

Children ought to receive the best possible start in life. Their survival, protection, growth and development in good health and with proper nutrition are the essential foundation of human development. Children need to be cared upon and nurture in a safe environment that enables them to be physically healthy, mentally alert, emotionally secure and socially competent.

Therefore the needs of children are more than mere physical care. They need the affection, attention, security and social connections that families and communities can

provide and respond. All children yearn for acceptance and love from their families and friends. They need someone who is there to cater them not just the physical provisions but also equally important is the unconditional love which forms an important aspect of their growth and development. Thus in the present study the nature of care and support is studied in the light of 'cared for' and 'cared about'.

The first is to do with the tasks of tending another person; the second is to do with feelings for another person (Parker, 1981; Graham, 1983). 'Cared for' relates to meeting the physical necessities while 'cared about' involves more of human values which consider the emotional and psychological needs by the 'care providers'. The integration of these two aspects of care and support is said to be fitted into "motherhood". While "cared for" may vary based on various social and economic background, however "cared about" stems from the heart of the mother to cater to the emotional needs and care of the child. The two facets form an integral and unitary part in the upbringing of children, where both are equally significant.

While these rights and needs of children are universally recognised, societies have diverse ways of ensuring their provision and dealing with social situations that need a large contribution of human feeling and individual support for them to be given concrete form. The social institutions, economic and cultural conditions, prevailing social values and the social perception of HIV and AIDS could generate diverse responses to the problems of HIV and AIDS affected children. Thus, as brought out by Alice Ansah-koi (2006), one of the devastating social problems associated with HIV and AIDS is the increasing number of children who are orphaned within relatively short periods of time and the nature of the burden of care and support for such orphans calls for individual, community, societal, and even global efforts. However, the response will have to be suited to the local societal and community milieu.

Children who are affected with HIV and AIDS could face diverse situations depending on whether they are infected with HIV, they are orphaned by AIDS or they are living with an HIV positive parent. Children affected by HIV and AIDS are most affected by lack of parental care. With the disease intruding their families, the prerequisites of satisfactory and healthy childhood development vanishes into thin air. At an early age, they lose their safety net of survival and development. Not only are they denied of physical and emotional care and support, they are traumatized by the

stigma of HIV and AIDS and face a great chance of social discrimination. They may end up being mistreated by their foster household or may have to endure separation from their siblings as well as the loss of their parents.

Edelstein, Burge and waterman have pointed out that attachments between foster parents and the children in their care are encouraged as a means of nurturing the child's ability to develop and sustain future relationships (Edelstein, Burge & Waterman, J 2001).

In traditional societies, all the adult members of the family, and some of the younger ones have a hand in child care and child rearing. The task or the responsibility of child rearing is not entirely held by the parents but covers a wide network of kinship relations like the aunts, uncles, grandparents and older siblings. Communities also play the role of care and support givers where there is a collective responsibility for the child. Community care often acts as the answer for people who cannot fully care for themselves. Orphanages have also been set up to answer orphan crisis to provide care and support to children without any means. Thus the family, community and institutions are held to be the three networks of care providers for the upbringing of children.

The nature of care and support to children is being studied on the basis of the three levels of care providers- the family, the community and orphanages. Safety, permanence, and child well-being are considered the primary goals of the child welfare system. Placement stability is a critical factor for children. Research literature suggests that children develop best when they live in safe, stable, and nurturing families (Bass, Shields, & Behrman 2004). Foster care has the potential to provide this stable foundation when children are able to experience a sense of family membership in a variety of alternative/substitute care giving arrangements (Bronferbrenner, U 1994). Attachments between the foster parents and the children in their care are encouraged as a means of nurturing the child's ability to develop and sustain future relationships (Edelstein S.B., Burge.D & Waterman. J 2001). A child's developmental needs are best met when their substitute families are able to 'nurture and commit to these children over the long term.' (Jones 2004). All these literatures bring out the importance of a safe and stable family which provides proper care and support to the children to develop and have a secure future. However, the larger kin

network and community also play an important role, both directly through the child's interaction and indirectly by support to the primary family unit and its members. When this basic support is disrupted, the other institutions play an even greater role in the care and support of a child. What the nature of this support is in 'normal' times and does it continue to be given in the case of HIV and AIDS affected children to the same extent as others is an issue that needs to be studied.

## ***Role of the Family***

Understanding the nature of the institution of family is important as it brings out the picture of the pattern of the nature of care and support of its members in the family. Many sociologists have regarded the family as the cornerstone of society. It forms the basic unit of social organization. The unit is expected to be the primary focus of the member's interests and loyalties (Haralambos & Head 1980). Carol Levine (Levine 1994) clearly defines the bond that a family shares among its members: family members are individuals who by birth, adoption, marriage or declared commitment share deep, personal connections and are mutually entitled to receive and obligated to provide support of various kinds to the extent possible, especially in times of need. The Webster's dictionary defines family as the basic unit in society which have as its nucleus two or more adults living together and cooperating in the care and rearing of their own or adopted children.

Some of the distinguishing features of family as a social group include (Klein &White 1996):

- ***Families are intergenerational***: - Generally families include people who are related as parents and children. If elders live long enough, there are ties to grandparents. At some point, there are living members of both older and younger generation, eventually the presence of grandparents or great-grandparents.

  The fact that the human infant at birth is a virtually helpless creature and cannot approach self-sufficiency during their initial years means that the intergenerational bond is particularly crucial to human survival.

- Families contain biological and affinal relationships between members such as relationships like cousins, or aunts and nephews who eventually step in times of crisis or need within the family circle.

There are various types of families that sociologists have distinguished. According to the widely accepted distinction made by George Murdock (1949), families are of three types. There is the nuclear family, composed of husband, wife and children. The extended family is another type of family which is a merger of several nuclear families. A particular type of extended family is the joint family. It is characterized by the co-residence, commensality, and joint family property, unit of common worship, authority and decision-making generally vested in the eldest male except in matrilineal joint families where laws of descent, residence, property and authority follow the female line.

Family performs various roles for the members especially in regard to childcare. As for nuclear family, where there is only the mother, father and children, it is the sole responsibility of the parents to care and bring up the children. But this is not so in all societies and not necessarily the most desirable form of family or child care. Parents, grandparents, uncles and aunts, older siblings and even other members of the community can all be legitimate care givers in societies with a high prevalence of joint families and community cohesion. The extended family comes in the forefront for such time of crisis to assist the ailing members or in the rearing of the younger members when the primary caretakers are absent. The presence of the older folks such as the grandparents in the family matters a lot in the care and support for children without proper parental care.

The family, being at the root of society, performs some basic functions. Whatever definition may be drawn about family, some socially ascribed functions of the family unit are economic production, care of the children and aged, protecting its member's interests against outsiders. Different scholars such as Kingsley Davis, MacIver and Talcott Parsons (Haralambos & Mead 1980) have drawn out various functions carried out by the family as a basic institution. The various irreducible and basic functions which are performed by the family include the following:

1. The regulation of sexual behaviour and reproduction
2. Care and rearing of children

3. Cooperation and division of labour
4. Primary group satisfaction of basic needs, material and emotional
5. Primary socialization of children.

Family is an institution that cannot be replaced when it comes to child rearing. Human beings need intimate human response as much as they need food and water. Psychologists hold that probably the greatest single cause of emotional difficulties and behaviour problems is lack of love, that is, lack of warm, affectionate relationship within a small circle of intimate associate. Most societies rely almost entirely upon the family for such affectionate response.

The discussion brings to the understanding that family performs the basic functions of not only reproduction but also rearing and caring of children or the younger members. In fact, family carries out the primary socialization of children. Primary socialization refers to socialization during the early years of childhood which takes place mainly within the family. Parsons argues that families are "factories" which produce human personalities. He believes they are essential for this purpose since primary socialization requires a context which provides warmth, security and mutual support. He can conceive of no institution other than the family which could provide such a context (Haralambos & Mead 1980). The family prepares a child to interact with the society at large. When a child is born into a family he or she is a social blank. The family prepares the ground work upon which the agencies coming afterwards build. No other single group satisfies the needs of the child as much as the family does. Family is therefore seen to play the foremost role in the formation of personality. The emotional basis of the family where love, sharing and solidarity are the main drives behind the adult's role as the teacher and the preceptor spares the learning child all unnecessary strains and anxieties, thereby laying solid foundations for fully integrated and secure personality structures. The secure, emotional-laden atmosphere of the home has no substitute whatever.

## ***Kinship***

Kinship group also plays an important role in forming social bonds and relationships in the life of the nuclear family and an individual. Individuals in all societies have certain rights and obligations based on their positions in their kin-group. Thus, kinship constitutes a system of blood group relationships or relationships through marriage.

Kins are persons related by real, putative or fictive consanguinity (Fox 1967). As Radcliffe Brown (1950) pointed out that, "When we speak of kinship systems an assumption is made that there is a complex relation of interdependence between the members". Thus kinship institution is the principal factor in which the individuals acquire certain rights and obligations and thereby receive aid and protection.

In the study, a line is drawn on the terms 'kin' and 'family', on the basis that family consists of the primary social group consisting of parents, children and the presence of older generation such as grandparents while kin refers to one's distant relatives which could be from both the maternal as well as the paternal lines of relations. Family are the ones who take immediate needs and concerns of its members in the institution. The kins make their presence felt in the absence of the primary caregivers and avail themselves to those who slip through the safety net of the family. D'Cruz's (2004) and Campbell's (1999) review show that kinship caregivers play a key role in families where mothers can no longer care for their children.

## ***Role of Community in Care of Children with Family Crisis***

At times, families fail to provide care and support to children due to loss of parents, poor economic conditions or absence of any adult members such as child-headed households. In such cases where the care and support to children is found to be lacking in the family level, the community steps in as the next level of providers of primary care.

The social life people lead is affected by the kind of community in which they live. A community, in general sense, can be defined either as a human group (town, city, and village) or as a body of sentiment (sense of commitment, loyalty), but there is no uniformity in the use of the term. Defined in greater detail a community includes a grouping of people:

1. within a geographic area
2. with a division of labour into specialized and interdependent functions
3. with common culture and a social system which organizes their activities
4. whose members are conscious of their unity and of belonging and
5. whose members can act collectively in an organized manner

Community forms a wider network of human relationships. Generally, a community is a group of people living in the same geographical location or administrative boundary such as a village or a sub-district. Rather than the physical boundaries or the territorial area, what matters most is the sense of commitment and loyalty among its members. Bogardus defines community as a social group with some degree of 'we-feeling' and 'living in a given area.' MacIver (1970) also points to locality and community sentiment as the bases of community. Community sentiment is also a major prerequisite for the existence of any community. MacIver (1970) draws the elements of community sentiment:

1. ***We-Feeling***: This feeling of 'we-sentiment' is found wherever men have common interest. It leads men to identify themselves with others in the community.
2. ***Role-Feeling*** In this each person feels that he has a role to play, his own function to fulfil in the reciprocal exchanges of the social scene.
3. ***Dependency-Feeling:*** This refers to the individual sense of dependence upon the community as a necessary condition of his own. This involves both a physical dependence, since his material wants are satisfied within it, and a psychological dependence, since the community is the greater 'home' that sustains him, embodying all that is at least familiar, if not wholly congenial to his life.

Aristotle, the father of western social theory, observed: 'Man is a political (i.e. a social) animal'. He was the first western thinker to stress the pragmatism of the human animal achieving his humanness due to his life in the polis. When Rousseau declared, 'Man is born free but is found everywhere in chains', he on the contrary exaggerated the animal disposition of man as the bond of human community and completely disregarded the dynamic reciprocity or interchange between human impulses and human institutions. Selfhood is moulded, stimulated, and fulfilled by the human community as the human community is rooted in the individual's positive self-identification, empathy, and appreciation which unite the individual with others in a group. Neither the Hobbesian view of the community based on constraint nor consent or contract does justice to the communion, interchange, interfusion between self and the other that underlie normal human growth and self-actualization and to the positive sharing of fellowship, inseparable from the community, whether primitive or civilized. Every man is a part of the single, unlimited community of cosmos and is concerned

with the absolute good of fulfilment of the cosmic values and possibilities of himself and of all his fellowmen as parts of a single, forward oriented purpose of cosmos. The human personality's supreme moral commitment is for the fulfilment of the absolute good for all fellowmen who exist in the community of communities (Dalley 1988).

Aristotle has rightly pointed out that man is a social animal. A basic requirement of existence has been the social bonds that unite each man to others, the most intimate being those of the family and close kin groups. But other wider social bonds have also been needed to link man to more extensive social arrangements. The structures developed from these more public ties have been called 'communities'. Recently, there has been a great deal of thoughtful discussion about the apparent loss of community, and man's alienation from his fellow. However communities have always existed and will continue to do so because man is basically a social creature, unable to live independently. The essence of the communal form is a shared association of fellow human beings. Etzioni (1964) expresses it thus:

"*Man is not unless he is social. What he is depends on his social being, and what he makes of his social being is irrevocably bound to what he makes of himself.*"

One of the practical components of collectivism is to do with responsibility. There are a number of levels at which collective responsibility operates. At its broadest, collectivism is about a societal responsibility for all members of that society- a moral responsibility which at the same time is translated into a practical responsibility in relation to all citizens. At the narrower level, responsibility may be held by the local community- the municipality, the neighbourhood, the commune- or by a function/interest group (women's organizations, trades unions, professionals, friendly societies, and so on) and that responsibility is concerned with ensuring the welfare of all members of the collectivity or particular specified categories within it. Provision of care and support for those who are in any way dependent is clearly part of that responsibility. Along with responsibility for welfare, is a responsibility for the production, distribution and consumption of particular goods, resources and services for the benefit of the collectivity as a whole or for certain mutually agreed member groups.

A conceptual analysis is offered that differentiates four types of motivation for community involvement: egoism, altruism, collectivism, and principalism. For

egoism, the ultimate goal is to increase one's own welfare; for altruism to increase the welfare of another individual or individuals; for collectivism to increase the welfare of a group; and for principalism, to uphold one or more principles (Batson, Daniel, & Tsang 2002). However it needs to consider not only the existence of all four but also their interplay. For a given individual in a given situation, more than one of these motives may be present at once. When this is the case, the motives may either conflict or cooperate with one another. In any society, it will be the degree of interplay between these that will determine the extent of community support available to orphaned children.

Care and support of orphaned children is provided either by arrangements for foster care in existing families or by creating special institutions for the purpose such as orphanages. Fostering is possible where family, kin or community is cohesive enough for its members to take on such a responsibility. Orphanages are set up as an alternative for children without families and home or dysfunctional families. Poverty-stricken parents and relatives may abandon their children to an institution if they believe that the immediate needs of their child will be better served, or because they think the children are a burden for them. Here we will discuss both provisions.

## ***Fostering***

Childhood is not only a sensitive and vulnerable period of life, but crucial from the standpoint of development. The foundations for the future are laid at this time. Among the needs of the young child for satisfactory and healthy development are adequate health care and nutrition, the presence of a safe, healthy and supportive environment and other ingredients such as psychological prerequisites. These include the intellectual stimulation and guidance necessary for optimal mental growth and development of cognitive abilities, the warmth, affection and loving care necessary for emotional security, the bedrock on which personality development, social adjustment and emotional maturity are founded. In these earliest periods of life the basis for learning and development is contained in a combination of nurturing qualities which can be summed up in the concept of "mothering" or the close bond and interaction with a primary caretaker. Usually, the one who provides "mothering" in the first few years of life is the biological mother. However, it need not necessarily be so in every case.

Children who have lost both parents are more likely to be fostered than those with a surviving parent. This is because a surviving parent is expected to provide the first line of care for orphans. Primary care by relatives, community members or institutions is considered only when care by a surviving parent is not provided or is inadequate.

Fostering as a system of care has been used extensively in caring for most orphans in most parts of the world. As a system of care, it has been used in situations such as illness and death of biological parents. Foster care is considered a substitute care of children outside their own homes by people other than the biological parents, to bring up or nurture the orphan children by providing parental care or nurture to these children who are related through legal or blood ties. Fostering as a system of care has also been resorted to when assistance from biological parents is either nonexistent or inadequate, or when biological parents are simply incapable. Under such circumstances, fostering is resorted to as a means of rearing the children. Fostering systems are culturally very diverse and differ by conditions, rules and regulations. In most western countries, fostering systems are guided by rules and regulations. This is different from most African countries where fostering is closely tied up to customs kinship obligation and family ties rather than to public intervention systems (Philon 2003). This is similar to the Indian context, the pattern of obligations for care varying depending on local community structure and practices.

In North America, foster care is a system by which a certified stand-in "parent(s)" cares for minor children or young people who have been removed from their biological parents or other custodial adults by state authority. There can be voluntary placements by a parent of a child into foster care. Voluntary foster care may be utilized in circumstances where there is a temporary or permanent inability to care for the child or children. Involuntary foster care may be implemented when a child is removed from their caregiver for his/her own safety (Wikepedia.org 2007).

Holman (2002) identifies two types of fostering: private and public fostering. Private fostering involves parents or guardians placing their children in the homes of non-relatives while public fostering involves placing of children with foster parents by public agencies which select and supervise such foster parents. Private fostering involves some form of voluntary decision making on the part of biological parents to

put up their children to be fostered by others. Several factors may motivate parents to give up their children into fosterage. These include crisis situations such as financial difficulties, violence, travel or migration.

Public fostering does not necessarily mean that parents voluntarily give up their children into fosterage. If for some reason parental care is lacking or inadequate (e.g. abuse, abandonment and endangerment to children), public agencies reserve the right to protect children by removing them from their biological parents and placing them with foster parents.

Fostering systems also differ by context. For example, in a study of 1,528 foster caregivers, Sinclair, Gibbs and Wilson (2004), identified five main contexts in which fostering may occur:

1. ***Long-term fostering***: here foster parents take care of children over a long period of time usually leading to adoption.
2. ***Short-term fostering***: this usually spans over short periods of time( e.g. during a crisis situation until the situations returns to normal)
3. ***Task-centred fostering***: this is used to achieve specially purpose or as an intervention with special group of people (e.g. children with emotional problems may be fostered in institutional setting for a period of time.
4. ***Relative fostering:*** this is fostering undertaken by a close blood relation.
5. ***Respite fostering***: this is used for children needing special care e.g. physically or emotionally challenged children.

According to Goody (1982), voluntary fostering occurs when parents decide to put their own children into fosterage [similar to Holman's (2002) definition of private fostering that suggests that parents willingly place their children in the homes of fostered parents]. Usually, it involves parents who are willing to give their children into fosterage and individuals or families willing to foster them. Due to factors such as ethnic violence, the intrusion of HIV and AIDS in the family, and other social, political and economic conditions, the role of the family is not fulfilled in terms of child care. As such in cases where the family or the surviving parent is absent or inadequate, the community takes up the next level of care and support. The community members may or may not be related to the orphans but they choose to foster them out of sympathy or altruism and/or religious reasons as a moral obligation.

## ***Role of Orphanages***

An orphanage is considered as an institution dedicated to caring for orphans who consist of children who have lost their parents and children who are abused, abandoned and neglected children. Orphanages may be privately or publicly funded, and many are run by religious organizations.

The first orphanages in Europe, called 'Orphanotrophia' were founded in the 1st century BC and various alternative means of orphan support. Jewish law, for instance, prescribed care for the widow and orphan, and Athenian law supported all orphans of those killed in military service until the age of eighteen. The care of orphans was particularly commended to Bishops and, during the middle ages, to monasteries (Wikepedia 2007).

Today, the orphanage remains common and necessary in most parts of the world, even if the term has given way to such softer language as 'group home', 'children's home', or 'rehabilitation center'. In many works of fiction (notably Oliver Twist and Annie) the administrators of orphanages are depicted as cruel monsters.

In this case of providing care and support, the institution mostly caters to the 'caring for' to meet the basic requirements of the children. Dana E.Johnson (Hunter 2005) reflects the view that a child raised in an institution has virtually zero chance of developing normally. The aspect of 'cared about' finds less room in the institutions .The disappearance of the primary care taker in the family pervades every aspect of a child's life: their emotional well-being, physical security, mental development and overall health. It deprives the child of the right to live in a family environment.

Thus, if a policy approach is to be evolved for ensuring care and support for children affected by HIV and AIDS, information about the prevailing conditions of the large numbers is required so as to plan appropriately for promoting the social support networks and developing institutional capacities for those who have high deficits of care. The normal social and cultural practices and relationships can breakdown or get transformed by high profile and high impact events, such as an epidemic of a fatal disease. It is therefore important to explore the possible changes that the AIDS epidemic has brought about in the social support networks and their response to AIDS

orphans as against the nature of support made available to orphans before this. Since orphanages are generally known to be less than kind to the inmates, it is necessary to compare the conditions of orphans whose parents died due to AIDS and due to other causes.

## ***African Experiences:***

The case study based on years of experiences in Zimbabwe and the United Republic of Tanzania where the problems faced by the children affected by HIV and AIDS are regularly confronted, describes efforts to address the tough questions related to the rights and needs of children affected by HIV and AIDS, with a focus on the psychological needs.

When considering the basic needs of a child one is inclined to think in terms of food, shelter, clothing, love and security, a combination of the material and psychological needs. Children infected and affected by HIV and AIDS have similar needs, except the fulfilment of these needs is potentially in jeopardy when a parent or caregiver becomes ill and eventually dies. In addition they need greater nutritional support if infected themselves and psychosocial support in either case, whether infected or not. Meeting these needs is important for the growth and ability of a child to succeed through life.

Organisations in Sub-Saharan Africa have addressed the rights and needs of children affected by HIV and AIDS. Many of them deal solely with material aid, such as school fees and food supplied. The White Oak Report (2000) reports, "Although a family member's death from AIDS may be a catalyst that propels children into escalating the psychosocial needs of children, are far too often perceived as somehow less important than their economic necessities. If children are to develop the resilience to deal with the challenge in their lives, their psychosocial needs must receive proper and prompt attention."

In the article "Care of Orphans: Fostering interventions for children whose parents die of aids in Ghana", Alice Ansah Koi (2006) brought out the significance of the kinship ties and the family in their role as caregivers. In the US and most western countries, foster care systems are guided by rules and regulations. This is different from most African countries where fostering is closely tied to social customs such as kinship

obligation and family ties rather than to public intervention systems. This article depicts the familial, social and economic factors in the current nature and status of family foster care of orphans in Ghana. The AIDS epidemic has left 132,000 children orphaned and it is projected that by 2015 the number will increase to 291,000. Children who have lost their parents to the disease not only face lack of love, support, and the care parents offer, but worse still, they face the problem of having lost their parents to a shameful and stigmatised disease. In light of the immense challenge of the AIDS epidemic, the article advocates for governmental and international study and support to strengthen study and support to strengthen the situation of these children in care.

In the study by UNICEF and ISS (2004) on improving protection for children without parental care, they have sailed for urgent need for international standards especially for children affected by HIV and AIDS. An additional large group of children live in families or communities where adult illness and death, as well as the stigma surrounding HIV and AIDS have brought additional hardships. Family coping mechanisms include placing children with relatives, foster families or in residential institutions in the belief that their material institutions will be met.

Infants from affected families are at increased risk of abandonment. In Thailand for example, the probability of being abandoned by an HIV positive mother was to be five times that of non-infected mothers in the early stages of the epidemic. There are between two and three million children under 15 years currently living with HIV and AIDS. Such children are often placed in foster or residential care, because of a perceived need for care, or due to abandonment.

Increasing problems in their original families as well as difficulties encountered in new living arrangements with extended family members or others may also contribute to children leaving home and migrating on their own, and/or living and working on the street.

The Africa, HIV/AIDS pandemic poses unprecedented long-term dilemmas for those taking responsibility for organising out-of-home care for children. On the one hand the traditional response of kinship care is becoming increasingly overwhelmed. There are fewer and fewer adult family members available to look after an ever-increasing

member of affected children. As a result, some relatives often elderly widowed grandmothers are attempting to take care of a dozen or more children, usually in dire material circumstances that may be unsustainable in the medium term.

In the great majority of severely affected countries, formal family-based care situations are virtually unknown and would take both considerable time and resources including financial support to develop in any significant manner. Even existing residential facilities are often unwilling to take in children whose parents are living with or have died of AIDS and all the more so if the children themselves are HIV positive.

Informal fostering and kinship care, already a common response to temporary or permanent incapacity of parents to care for their children, has become increasingly common. In sub-Saharan Africa, where HIV is a major and after the most significant cause of orphaning, over 90% of orphans live with relative. These arrangements are generally preferably to other alternatives, since children maintain a sense of original community. There is also evidence from Sub-Saharan Africa to suggest that close relatives are likely to provide better care than more distant ones or the non-related foster carers, at least with respect to access to education, food provision and domestic chore allocation. While kinship care is thus often the best option, there are several ways in which HIV may have an impact on the care children receive in their extended family. In highly affected communities, fewer adults are available to care for an increasing number of orphaned children, and many of them are older and beyond their most economically productive years. For example in many of the most affected countries in eastern and southern Africa, over 50% of all orphaned children are cared for by their grandparents. Similar findings have been reported in Thailand. Due to poor financial resources available, the caregivers struggle to make ends meet. In an effort to distribute the burden of care, orphaned siblings may be separated in different households, further compounding their sense of loss. Furthermore, the stigma associated with HIV may have a negative impact on the perception of the child taken in by the extended family and contribute to poorer treatment or lesser integration into the household. Indeed, exploitation abuse and neglect are not uncommon in informal kinship care situations.

Informal foster care by unrelated families is a less common, but not insignificant form of response to children orphaned by AIDS, especially in sub-Saharan Africa. In Cameroon, Nigeria, Ethiopia and Kenya for example over 50% of orphans are not related to the head of the household in which they live, and an equal or larger number are furthermore described as foster children (who may or may not be related). However the pressures on these informal foster families are much the same as those described for the extended family above. In addition, in some societies informal fostering is already a common practice, but often "based on the tradition of exchange between families" and not necessarily on "perceptions of the child's best interests." Concerns over exploitation of the children (as domestic workers for example) sexual abuse and unfavourable treatment or neglect in comparison to the caregiver's biological children are frequently reported.

The use of institutional care is increasing in some high HIV prevalence countries. Even in countries where the use of institutions is not a traditional response, growing concern about the HIV orphaning crisis and the availability of external support is leading to their proliferation. Institutional care although is rarely the undesirable response; and should not be regarded as a permanent measure, rather a means of working towards reunification or family placement. Institutional care is also expensive, and thus concentrates funds available for the care of orphans and other at-risk children on a small group. In Tanzania, for example, it has been documented that the cost per child in conditions of residential care institutions such as poor health and hygiene standards, lack of attention to the needs of individual children, lack of review placements, as well as violence and abuse are common in many settings.

Recognition of these concerns has led to decreasing rise of institutional care throughout the industrialised world. Significant efforts are underway to develop alternatives in many countries of the former Soviet Union and Eastern Europe where residential placements had previously been use as a first line social welfare response as well as in several Sub-Saharan African countries. In most HIV-affected countries, however, the trend now appears to be reversing.

As resources grow even scarcer in poverty and HIV-stressed families and communities, institutions serve as magnets when other care and family support options are unavailable. Indeed this tendency may explain why the majority of

children in residential care in many countries do, in fact, have a living parent or other relatives.

## *Research questions*

The main research questions in the study are:

- How does the community deal with family crisis such as long term illness, death of family members, and major financial crisis historically?
- How does the community both in the past and in the present context deal with orphans in general and provide care to them?
- Why are the children sent to the orphanages and which group of children (based on economic background, gender and HIV affected status) are sent to the orphanages?
- What is the nature of care and support in the orphanages as compared to that of the community?
- How does the community deal with children affected by HIV and AIDS children?
- How is the nature of care and support different for HIV and AIDS affected children and those orphaned otherwise?

## *Methodology*

This was designed as an exploratory study of the sources and nature of care and support for the children affected by HIV and AIDS among the Kukis of Sadar Hills in Manipur. A quantitative estimation of the number of orphans based on NGO records and reported cases, source of care for orphans who are HIV infected and not infected as against other orphans, all reflect the situation but do not allow for a quantitative analysis. Case studies of the children, perceptions of family and community members, care providers in the orphanages and the children themselves, helped to gain insights into the nature of care received from different sources and the problem faced.

## *Area of study*

While examining the situation of children affected by HIV and AIDS in Manipur it was found that little data was available and what was available showed a distribution that could as well be due to the biases of data collection as of the real prevalence (see Map I). Manipuri society is composed of three major groups—the Meitei, the Kuki

and the Naga. Since the three have somewhat different social customs and practices, the nature of support to children affected by HIV and AIDS may also be different. Therefore a study in only one region of Manipur and of only one tribal community within that was selected for the present study, focusing on the HIV affected children among the Kukis of Sadar Hills in Manipur.

According to an assessment of hill households for the year 1990 by the Sadar Hills Council, the district has 497 villages with a population of 1,47,500 including Nagas, Nepalese and other communities. Out of these, approximately 400 villages belong to the Kuki group whereas the remaining 97 villages belong to the other tribal groups and the rest comprise of other ethnic groups. Thus, as this area proves to be the most concentrated Kuki inhabited area, it is selected to be the area of study. The area has been witnessing a number of social and political problems which are causing a threat to the harmony and solidarity of the society. Mention may be made of poverty, unemployment, gun-culture, insurgency; draconian laws such as the Armed Forces Special Powers Act (AFSPA), drug abuse and alcoholism are some of the main social problems. Northeast India which comprises of the seven sisters states consisting of Assam, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura has experienced sustained conflicts. This has mostly been along ethnic lines and has led to sustained violence and breakdown of peace and public order. Of these, Manipur has been particularly a demonstrative example. Manipur with the political instability experiences various kinds of violence among the different communities in the state.

Agriculture remains the main source of livelihood of the people. Unemployment is one of main problems faced by the Kuki community. There are a large number of unemployed youths, which may be held as one of the reasons for the increasing insurgents in the area. Resorting to the practice of gun-culture by the insurgents has greatly disrupted the tranquillity of the region. Since the early 1980's drug abuse and alcoholism have taken ground and is widely devastating the society, and in particular the youth. Another factor of social instability in the community was the inter-ethnic violence which resulted in the loss of many lives and properties. A number of children also experienced the loss of their parents. Along with all these social problems, the Kuki community is witnessing an increasing trend of HIV and AIDS which is leading to disintegration of families in particular and the society in general.

Sadar hills has been divided into five blocks for convenience of study Dr. P.C.Tuboi (Tuboi 2005):-

1. Gunhom Block
2. Tuilang Block
3. Zilhom Block
4. Kangchup Block
5. Bungpi Block

The present study focuses upon the Kukis of Sadar hills residing in Gunhom Block (see map III). The reasons for this selection are:

- The block covers the major settlements of the Kukis. Also, with the national highway crossing through it, the bigger settlements areas are confined in this block. There are health centres, mission hospital, educational centres and administrative centres which are the major pull factors for many villages from other blocks.
- The area covers the largest number of orphanages in the Sadar hills district. There are seven orphanages in the area.

## ***Study Population***

In this Gunhom area six villages are selected on the basis of their settlement year whereby these villages are believed to be some of the oldest established villages in the area. Traditionally the Kukis would select the hilly slopes as their village sites depending upon the subsistence economy based mainly upon shifting cultivation and partly upon wet cultivation. However of the six villages in the present study, four reside by the national highway 39 while two villages are few kilometres away from the main road. Thus these villages comprise of the Kuki settlements which are considered as urbanized or at the outskirts of the growing towns within the district. It is seen that the former four villages get a better facility of communications and other advantages. The population size of the villages ranges from six hundred to ten thousand approximately. Among the villages Kangpokpi constitute the highest population while Haijang is the least populated village.

It is seen that the various economic, political, social and religious institutions of the Kukis are undergoing transition with the introduction of modern education system and spread of Christianity. Though urbanization is a part of the inevitable result of

civilization and planned development requiring bringing in of all facilities of up to-date living at the door step of rural population, and despite changes in the matter of administration with the introduction of village authority act, 1956 coupled with negation of the authority of the Kuki chiefs, the traditional system of administration continues to hold centre stage.

The Kukis are largely an agrarian community living in rural areas engaging in agricultural activities and farming. Thus, a greater number of people who die of AIDS are likely to leave their children to families whose income is confined to unreliable sources of income such as farming. As such, caregivers may not only endure the loss of loved ones but also incur debt incurred for expenditure on the treatment and funeral of those who have died of AIDS.

These six villages comprise of mainly the Kuki community except in two of the settlement areas namely –Motbung and Kangpokpi. In these two places, the population ranges from different ethnic backgrounds mainly the Kukis, Meiteis and the Nepalese. Of these, the Kukis are in majority in all the villages. The data taken under the study comprised of only the Kuki population as the study is concentrated on the Kuki community.

In the Kuki society, the socio-economic class is drawn on the basis of the level of education, placement in government jobs, property in terms of house, land, paddy-fields, vehicles, gadgets etc. The socioeconomic differences of the families as per the study may be described as belonging to three strata:-

- The higher-income group with a monthly income within the range of Rupees7000 or more, enjoying the highest layer in the society.

- The middle-income group with a monthly income ranging from 3000 to Rupees 7000, which can manage and meet daily needs reasonably well.

- The lowest rung in the society is held by the low-income group of people in the society comprising of those who live by daily wages, cultivators or menial workers earning monthly income of less than Rupees 3000 who can manage to meet the bare necessities of life, thereby living in the firm grip of poverty. They are not only poor financially but poorly educated as well. Poverty and ignorance couple up to worsen and endanger their survival.

Among the Kukis, fostering of children, including orphans, has been in practice since olden days. Fostering may occur among kinsmen or people who may or may not know one another, and it may involve private and voluntary arrangements between biological parents or their relations and the foster parents. The most common type of fostering found among the Kukis is the relative fostering (Sinclair 2004) or the kinship fostering (Goody 1981) which involves fostering by close relatives. Kinship-fostered children are raised in households of maternal or paternal relatives. In some cases, children are also given out into fosterage in situations where the child has to live with other families for schooling or other vocational purposes since most of the villages are in the remote areas with no proper educational institutions.

## ***The Children in the study***

According to the study in these six villages, the total numbers of Kuki orphan children affected by HIV and AIDS as well as those orphaned otherwise are altogether two hundred sixteen in number. Among these, the children may be further categorized according to their HIV affected status and present source of primary care.

**Table 1.2**

**Categories of children and their caregivers**

| Category of orphans | Number of children | Caregivers | | |
|---|---|---|---|---|
| | | Family | Community | Institutional |
| HIV infected | 33 | 21 | 21 | 12 |
| HIV negative AIDS orphans | 48 | 23 | 23 | 25 |
| Other orphans | 135 | 32 | 32 | 103 |
| Total | 216 | 76 | 76 | 140 |

Based on the above categories, sixty children (ten children from each category) were purposively chosen for more detailed study.

The villages are selected on the basis of their year of establishment; these villages are believed to be some of the earliest settlement areas in the block. The estimated demographic profile of the villages that has been compiled from the field interview with the village chiefs has also been taken into account –the total population, sex-wise distribution, number of children, the total number of orphans and children with HIV and AIDS in the area of study have been tabulated as follows in table-1.3

**Table 1.3**

**Demographic profile of Kuki villages under study:**

| | Name of village | Est. year | No. of houses | Total popln. | Male popln. | Female popln. | Total no. of children | Total no. of orphans | Identified HIVand AIDS affected children |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Kangpokpi | 1917 | 1440 | 11638 | 4044 | 4094 | 3500 | 150 | 2 |
| 2 | Keithelmanbi | 1942 | 540 | 6562 | 2117 | 2445 | 2000 | 25 | 9 |
| 3 | Motbung | 1921 | 523 | 5085 | 1795 | 1790 | 1500 | 20 | 9 |
| 4 | Bongmol | 1947 | 67 | 770 | 272 | 298 | 200 | 6 | 1 |
| 5 | Khengjang | 1948 | 82 | 370 | 350 | 250 | 250 | 10 | NA |
| 6 | Haijang | 1870 | 70 | 670 | 240 | 260 | 170 | 5 | NA |
| | TOTAL | | 2722 | 25095 | 8818 | 9137 | 7620 | 216 | 21 |

*NA= not available *Source: field interview

To capture a picture of care and support in the orphanages, all the seven orphanages in the area of study have been visited. Through Manipur State Aids Control Society different NGOs in Imphal dealing with children have been contacted. Several NGOs such as Wide Angle, Shnia Bhavan, LEWS, Tera Keithel, Mission orphanage and Meetei Leimarol Sinai Sang (MLSS) have been visited. Among these includes the first orphanage in the state which was established in 1947 by a Kuki lady named Mrs. Ngahhoikim. The orphanage is still functional although poorly maintained due to inadequate financial assistance. There is also a particular orphanage that caters care and support to children who have lost their parents during the ethnic conflict.

However, among these, only two, Mission orphanage and MLSS, were found to meet the requirements of the study since the recipients of care and support from these two institutions comprise children of the Kuki community from Sadar hills district. Total number of children interacted from these two institutions are seven and nine respectively. The latter is an orphanage for children infected with HIV and AIDS while the former consists of children orphaned otherwise.

Meetei Leimarol Sinai Sang also extends its networks in the Sadar hills district. This NGO provides homecare to the children affected with HIV and AIDS. MLSS is a non-profitable community based women's organization. It was established in 1983 and has been working for the progress and development of the people giving special concern for women and children since its inception. One of its objectives is to create awareness, promote, prevent and provide healthcare to people particularly women and children. MLSS has been in the service of the people particularly backward schedule tribes/castes and rural people of the state giving concern for women and children. MLSS has been found to be the most intervening NGO in the Sadar Hills district. Along with the active participation of several Kuki women as staff in the organization, more Kuki people are found to come out openly with the disease to get treatment. It has been roughly estimated by the local working staff that there would be more than five hundred infected children among the Kuki children in the area.

The study of orphanages was carried out on three bases:

1. Orphanages where infected are kept.
2. Orphanages which looked after children who are orphaned otherwise.
3. Orphanages who keep both types of children.

Meetei Leimarol Sinai Sang fits into the first type of orphanage where about nine Kuki children are taken care of in this institution. There are a number of orphanages which fit into the second type of orphanages. They are:-Mission orphanages in Imphal, Kanglatombi children home, Logos, Grace boarding, and Mercy children home which are all in Sadar hills district. The numbers of Kuki children in these institutions are about sixty four. The second type of orphanage is the most widely institutionalized set-up in the area. Mentioned may also be made of one such orphanage in Sapermaina which gives emphasis and supports children who became orphaned due to the communal conflict in the 90s between the Kukis and the Nagas. The third type of

orphanage is the scarcest one. There was a strong inhibition on the part of the care providers in this institution to shed light into the presence of HIV positive children in the institution. They fear that the admittance of HIV children would create fear and disrupt the institutional functioning. As such the confidentiality was assured at the time that the study was conducted. This institution has twenty-seven children of which three of them are HIV positive children.

## ***Tools of data collection***

The care providers in the family, community as well as in the institutions were interviewed with the help of an interview schedule with open-ended questions related to the care and support catered to the children affected by HIV and AIDS. The elderly members were also interviewed in the same process to gather information on the traditional system of care and support in the Kuki community. There was an interaction with children in the orphanages as well as outside the orphanages. Children who are willing to talk and share were encouraged to do so. During interaction with the children, they were encouraged to share what they enjoyed and loved doing, their likes, dislikes and what they wish to acquire or possess as a child. The process of interaction with the various respondents among the children and the care providers was carried out to find out their perception of the problems and opinion of the care given to the children affected by HIV and AIDS. The data was analysed for sources of care and support parallel to conceptual framework of "caring for" and "caring about".

## ***Limitations***

1. The study is a very preliminary exploration that points to the need for more in depth and intensive study on the subject to get better estimates of affected children and some objective indicators of the many dimensions of care and support.
2. The ethics of research for consent and confidentiality requires much greater interaction in the villages in order to identify the affected children, along with some means of amelioration of their urgent needs when they are identified.

## ***Chapterisation***

**The first chapter** introduces the whole study with the issue of HIV affected children and its importance in Manipur. A literature review leads to the statement and

conceptualisation of the problem, various definitions of HIV affected children, HIV infected children, AIDS orphans and fostering. The role of family, kin, community and orphanages is discussed in general. In its second half, the chapter then discusses the methodology adopted for the study along with information about the selected study area and group.

**Chapter 2** discusses the role of family as care giver for AIDS affected children among the Kukis. The care and support provided within the family and the kinship structure traditionally by different care givers and the present context is also taken into consideration. The socio economic status of the care givers is very significant in determining the kind of care and support accorded to the children. As such, differences are being observed and studied as regard to the care and support based on the socio economic status. Other issues covered in this chapter consist of the difference in the care and support among the three categories of orphans, children's perceptions and preferences of care-givers, children's problems of all the orphans specially the problems of HIV affected and HIV infected orphans, various problems faced by the care givers along the line of the socio-economic status.

**Chapter 3** discusses the various forms of community care in the Kuki community, the traditional worldview and the forms of community support existing and its effectiveness in the present day, the impact of socio-economic status and the effects on the various categories of orphans.

**Chapter 4** discusses the institutional care being provided by orphanages for AIDS affected children among the Kukis. Differences are being considered on the various categories of children affected by HIV and children orphaned otherwise. The experiences shared by the children based on the different socio economic background and the shortcomings faced by the NGOs and the orphanages are observed and taken into study.

**The last chapter** discusses the sources of care and support being given to HIV and AIDS affected children in Manipur and the associated problems as reflected in the previous chapters.

# CHAPTER: 2

## ROLE OF THE FAMILY IN CARE OF ORPHANED CHILDREN

The institution of Tucha-Sunggao is very significant to a Kuki family, in as much as to the whole social system. Perhaps, this can be said as one of the excellent arrangements of division of labour, responsibility and an extension of public relation in an egalitarian society where the golden rule of the olden days is still prevailing. For the study of any aspect of life of the Kukis, this institution is inevitable, be it their social life, or political life, or economic life or religious life.

The life-style of a Kuki, beginning from birth, is nothing but a manifestation of the social structure. The alternate generation naming system is basic and conspicuous in its singular system in all the societies of the world. This system has greatly helped the Kukis maintain their tradition and in reckoning their genealogy (Gangte 1993).

The system of naming among the Kukis is peculiar-unique in system, singularly conspicuous in its reflection to their social structure and manifestly structured social relationships through kinship and marriage. The naming system is so strong that even after generations it still holds sway in the Kuki society. Of all the social systems among the Kukis that withstands the onslaught of changes brought about by the various agencies, such as Christianity, modern education, developmental schemes etc is the naming system of the Kukis. The system is such that the first born son of a family is necessarily named after his paternal grandfather. Conversely, the first born daughter of the family is given the name after her grandmother. From the second child to the remaining children they go after the names of the maternal grandparents of the child, or they may be named after some other person close to the family. But such naming other than the maternal grandparents should have sufficiently good reason in dong so. Otherwise, the relationship with maternal side is likely to be strained. When a child is named, the last syllable of the grandfather or the grandmother or any other person's name the child is supposed to take after, is taken as the first syllable of the name of the child or the grandchild, as the case may be. The person whose name has been given to the child is called by the latter as '*hepu*' or '*hepi*', i.e., grandpa or

grandma. Likewise, a person whose name has been given to a child other than the child's own grandfather or grandmother addresses the child as '*katu*' meaning, my grandchild; even if their relationship would have been otherwise. As such, this practice of naming system serves as a strong incentive in building up the tie among the grandparents and the children thereby strengthening the bond between the two generations. The peculiar joint family system of the Kukis is also another revealing singular aspect in the study of social life of the numerous communities and tribes all over the world (Gangte 1993).

The family of the eldest son of the Kuki parents called '*UPA*', which must necessarily have a joint family comprising his parents, unmarried brothers and sisters, and sometimes with married brothers, who have yet to establish themselves, is called 'inherent joint family', consisting of vertical generations. The other joint family system is that of the youngest brother of the '*UPA*', which is known as the family of '*NAOPA*'. He forms a nuclear family of his own. This family ultimately becomes a joint family of '*UPA*' when his first son is married and lives with him. This kind of joint family is called 'earned joint family' (Gangte 1993).

The Kuki community being patrilineal, it is seen that the paternal relatives are taken to be the core care providers. In paternal kinship the role of the eldest son is found to be very significant as he takes up the role of a father figure for all the other members in the family after the death of the father or head of the family. He is like a big tree around whom all the members come for refuge and shelter. As regards kinship relations, the '*Tucha- Sunggao*' relative involving the relationship with the maternal relatives forms an imperative part of the care and support of children who lack proper parental care.

The Kukis follow the patriarchal system of family structure. As a result, the line of descent, law of inheritance and law of residence is appointed to the male line only and the children follow the clan name of the father. Therefore a male child is always preferred to a female child to continue the line of descent. Only the eldest son remains in the '*Inpi*' meaning the parental house, to look after his parents. However, the permanent type of family system and the accepted one is one in which the eldest son of a family called '*Upa*' lives with his parents along with his unmarried younger brothers called '*Naopa*' and unmarried sisters. When the younger brothers get married

they move away from their parental house. Similarly, the women folk also move to the house of their husbands at the time of marriage. In the case of '*Chapagam*' (barren fatherhood), the law of inheritance is passed on through the next closest or nearest male relative of the family, which is the reason that a male child is preferred. The inheritance of property by the eldest brother does not necessarily mean that other sons are fully denied of any share. It only means that the lion share goes to the eldest son who is the legitimate heir as per the custom.

## ***Kinship Group***

Individuals in every society have certain rights and obligations based on their positions in his/her kin-group. Thus, kinship constitutes a system of blood group relationships or relationships through marriage. As Radcliffe Brown (1950) pointed out that, "when we speak of kinship systems an assumption is made that there is a complex relation of interdependence between the members." The study of kinship is the study of these basic facts of life- mating, gestation, parenthood, socialization, siblingship etc (Fox 1967).

The Kuki society like any other tribal society is bound together in groups by various kinds of ties from time immemorial. The most universal and basic of this bond is based on reproduction and inheritance through affinal and consanguinal kin grouping where members of these kin groups both enjoy or restrict their relationship rights. It is the "*Tucha-Sunggao*" (mother's brother's children and ego's children) relationship and the "*pute and neite*" (ego's children and aunt's children) relationship, through which one can obtain certain privileges and understand the individual rights and obligations. When an ego marries the daughter or sister or aunt of a man he earns the relationship of his children and becomes the '*Tute*' or '*Tuchas*' of his-in-laws, i.e., their '*Pute*' becomes automatically the '*Sunggao*' relatives to the ego and his children. There are certain specific duties and obligation assigned to the '*Tucha*' relatives which are implied, if a person is in a position of *'Tucha'* relation to an ego. If an ego has to perform a social, economic, religious or political duty, the '*Tucha*' stands by his side called to do all the essential services. Thereby, there is a strong tie between this set of relations which is seems to be indispensable in the social life of the Kukis.

In olden days, the '*Sunggao*' (maternal uncle and his sons) were not permitted to eat or drink in the hearth of their '*tutes*' (nephews). It is a custom for the '*Sunggao*' to dine only outside the corridor at the back of the house called '*intom-kem-chung*' made of a bamboo plank. This is practiced to show that the '*Sunggao*' or the '*putes*' are the providers of all the necessary requirements for the '*tute*'. The '*Tucha- Sunggao'* relationship is considered to be much closer than that of the parallel cousins relationships (father's brother's children). It is the structure in which one is obliged to perform his rights and duties. This bond of close tie between the kinship structures is still found to be practiced.

The '*Tucha-Sunggao'* set of relationship among the Kuki community stands through thick and thin which is found to be very supportive especially in times of need. The children who do not receive proper care in most cases are taken care of by the '*Sunggao'*. In the study conducted, out of thirty orphan children which includes children affected by HIV and AIDS and children orphaned otherwise receiving care and support in the family, eleven of them are found to be cared by the '*Sunggao'*. This kind of '*Sunggao'* care and support is also evident from the elderly respondents who are narrating how children who lacked parental care were taken care of traditionally.

However, the study reflects the major role of paternal kins in the caring of orphan children in the family. The role of paternal aunt termed as '*Heni'* is also widely recognized. Especially in the case of male child being heirs of the property and the recipients of descent; care is mostly accorded to the child by the paternal kins.

**Table 1.4**

**Care givers of Kuki orphaned children within the family level in Sadar Hills:**

| Care providers | HIV positive Children | | | HIV negative Children | | | Orphaned otherwise | | |
|---|---|---|---|---|---|---|---|---|---|
| | M | F | T | M | F | T | M | F | T |
| Single parent | 1 | - | 1 | 1 | - | 1 | 1 | - | 1 |
| Paternal grandparents | 3 | 1 | 4 | 2 | 1 | 3 | 2 | 1 | 3 |
| Paternal uncle | 1 | - | 1 | - | - | - | - | - | - |
| Paternal aunty | 1 | 1 | 2 | - | - | - | 1 | 1 | 2 |
| Paternal kins | - | - | - | - | 1 | 1 | - | - | - |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Sub-total*** | *6* | *2* | *8* | *3* | *2* | *5* | *4* | *2* | *6* |
| Maternal grandparents | 1 | - | 1 | 2 | 1 | 3 | - | 1 | 1 |
| Maternal uncle | 1 | - | 1 | - | - | - | 1 | - | 1 |
| Maternal aunty | - | - | - | - | 1 | 1 | - | - | - |
| Maternal kins | - | - | - | 1 | - | 1 | 2 | - | 2 |
| ***Sub-total*** | *2* | *-* | *2* | *3* | *2* | *5* | *2* | *2* | *4* |
| TOTAL | 8 | 2 | 10 | 6 | 4 | 10 | 6 | 4 | 10 |

In the study a line is drawn between paternal/maternal uncle/aunty and paternal/maternal. This is made on the basis that the uncles/aunties are the immediate relations while kins consist of distant relatives either from the paternal or the maternal line.

The present study shows the various caregivers comprising of single parent, maternal and paternal grandparents, maternal and paternal uncles/aunties and kins from both maternal and paternal sides. In case where parents are no longer there to provide care and support for the children, either the grandparents or the nearest kin who is competent as well as willing to fill the gap of the lost parents take up the role of care giver for the child.

## ***Difference of caregivers between the three categories of orphans***

On analysing the differences between the caregivers among the three categories of children, it is observed that certain amount of variations appear as regard to the providers of care and support to these different categories of children.

## ***Single parent alive***

Out of the thirty children taken for the study, it is seen that among children receiving homecare, three of them are under the care of their single parent where in these three cases the parent alive is the mother. In cases where the father is alive, care providers usually consist of the grandparents as per the study conducted. When the biological parents are unable or are absent to bring up the child, grandparents come into the picture to take up the role of care givers to the orphan child.

## ***Double orphans under the care of relatives***

According to the study, paternal grandparents stand out as the care givers in most cases where out of the thirty children ten are under their care. Next in line among the caregivers are the maternal grandparents with five children in their care. The remaining children are under the care and support of maternal uncle, maternal aunt, paternal uncle or aunt, and maternal kins or paternal kins. The latter group of care providers usually step in only when the grandparents are unable to provide for the orphaned children due to ill health or financial constraints. Otherwise, it is seen that grandparents take up the role of caregivers in most cases.

The Relative or kinship-fostered children in the Kuki community are found to be raised in households of maternal or paternal relatives. It is held that children are to be reared by their paternal kins as it is a patriarchal society. However, the concept of '*Tucha-Sunggao*' holds strong ground in the rearing and support of the children. A woman respondent who is now eighty years narrates how she was brought up by her maternal grandparents till her marriageable age as she became an orphaned at the age of about ten years old.

"*I became an orphan at a young age of five years. It was my maternal grandmother who took pity of my state and took me to my maternal house and brought me up there till my marriage. My paternal relatives care for me but I was more attached to my maternal kins and felt more secured in their bosom.*"

## ***HIV and AIDS Affected Children***

The majority of children affected by HIV and AIDS are looked after by family and kin. However there is often a difference in response if the children are not infected themselves or if they are. One grandparent who is taking care of an AIDS orphan child of his son says that at the initial phase after the death of the child's parents, other members of the family showed love and affection to the boy who is now seven years old. However, now with the child's status of being HIV infected, relatives show signs of reluctance to give care and support to the child and those who had earlier wanted to bring up the child have stepped back and declined. The child is now under the care of his paternal grandparents along with some unmarried family members in the family.

There is also an HIV infected orphaned boy of eight years who has been looked after by his maternal uncle. The child has been growing up with his maternal kins who have taken complete responsibility for the boy. Even the child feels so attached to them. His parents had passed away due to HIV and AIDS.

There is an HIV infected orphan boy of seven years whose parents died of HIV and AIDS. He is under the care of his paternal uncle for sometime, who is later taken care of by his maternal aunty, a government employee. She says:
"*It may not necessarily be my responsibility to look after the boy but the condition he is in, at such a young age; it is unbearable for me to give a blind eye. So, taking the consent of his paternal uncle, I have brought him up under my care.*"

Some orphaned children are also adopted by their kins without children of their own and make these orphans as their own children. There is an AIDS orphan boy of ten years who is non-infected but his parents left him as an orphan. In spite of the other caretakers in the family, his maternal uncle wanted to raise him as his son as he has no other children. He is a government employee and well established. However as he does not have any children of his own to inherit his property, he adopted this child as his own to be his heir.

Therefore, except in few cases like this where relatives or kins come up to care and support the orphaned child, it is widely assumed to be the responsibility of the grandparents to take up the role of caregiver. The next levels of care givers such as the community and the orphanages therefore come into being when the providers at this level fail or are unable to fulfil this function of care and support to the orphaned child.

**Table 1.5**

**Profile of Kuki children infected by HIV in Sadar Hills receiving homecare:**

| J | 7 | Male | Parents dead | Paternal aunty | Higher income group |
|---|---|---|---|---|---|
| ***Children*** | ***Age*** | ***Sex*** | ***Status of parents*** | ***Care providers*** | ***SES*** |
| A | 3 | Male | Mother alive | Maternal grandparents | Higher income group |
| B | 10 | Male | Mother alive | Single parent | Low income group |
| C | 8 | Male | Mother alive | Paternal grandparents | Low income group |
| D | 6 | female | Mother alive | Paternal grandparents | Higher income group |
| E | 10 | Male | dead | Maternal uncle | High income group |
| F | 4 | Male | Mother alive | Paternal uncle | Low income group |
| G | 12 | Female | Parents dead | Paternal aunty | Higher income group |
| H | 7 | Male | Parents dead | Paternal grandparents | Higher income group |
| I | 5 | Male | Parents dead | Parental grandparents | Low income group |

**Table 1.6**

**Profile of HIV negative Kuki children of HIV and AIDS infected parents in Sadar Hills**

| *Children* | *SEX* | *Age* | *Status of parents* | *Care providers* | *SES* |
|---|---|---|---|---|---|
| AA | female | 5 | dead | Maternal grandparents | Higher income group |
| BB | male | 6 | Father alive | Paternal grandparents | Middle income group |
| CC | female | 14 | dead | Paternal grandparents | Low income group |
| DD | male | 10 | dead | Maternal kins | Higher income group |
| EE | male | 11 | Mother alive | Single parent | Low income group |
| FF | female | 10 | dead | Paternal kins | Higher income group |
| GG | female | 14 | Mother alive | Paternal grandparents | Low income group |
| HH | male | 10 | dead | Maternal grandparents | Middle income group |
| II | male | 12 | dead | Maternal grandparents | Low income group |
| JJ | male | 4 | Father alive | Paternal grandparents | Middle income group |

## *Impact of socio-economic Status on Care and Support*

Economic constraints may make it difficult for people to foster or adopt orphans. When people struggle to meet the basic needs of their own children, it is very difficult for them to take upon themselves the additional burden of taking care of other people's children. As such, there arises a difference in the care and support of the orphans depending on the socio-economic status of the caregivers.

Parents are considered to be the primary caretakers of children. However, AIDS has brought in a scenario where parents are no longer in a state to provide care and support to their children leaving them in the hands of others. At times where there is a surviving HIV parent, the parent is in a poor state thereby incapable to assist in the upbringing of the child.

As per the study, due to poor socio economic conditions of the family, many orphaned children are unable to receive care and support of their close ones like their grandparents to whom they feel a kind of strong attachment. In such cases, any other kinship relations who are in a better financial position to support the child steps in to take up the role of caregiver to the orphan child.

The study shows that the socioeconomic status of the caregivers greatly determines the care and support of their infected family member. Majority of the children come from the low-income group of the society. The children are taken care of by any relative who can and is willing to provide care and support, be it maternal or paternal kins. Else they are sent to an orphanage. It is seen that out of the thirty children receiving care and support in the family level, fifteen of the caregivers belonged to the higher income group while six of them belonged to the middle income section and the remaining nine are from the low income group. The reason for the biggest number of the higher income group is that the paternal and maternal kins, uncles and aunts who have taken up the role of caregivers are mostly from the higher income group. They have come forward to take up the role as they are financially better placed and are in a position to cater to the needs of the orphaned children, when the grandparents are absent or unable to do so due to ill health or financial constraints.

There is a great variation in the nature of care and support given to the children based on the economic status of the care givers. The low income groups were often unable

to even meet the basic requirements of the children, as such even though there is strong emotional bonding among the members in the family. Children are deprived of schooling thereby their future is more at stake. It is in such circumstances that putting them in an orphanage is thought of. A caregiver of three HIV infected orphaned children laments:

*"Even before HIV and AIDS struck our family we have been living hand to mouth. Now, the intrusion of this disease into our family has greatly degraded our family. I have lost my son and my daughter-in-law, leaving behind three of their children. I am also becoming old; my husband is in no state of health to care for children. They will someday get married and leave the house. I am really disturbed and saddened with the thought of my grandchildren. The staff of NGOs would visit us with medicines and food for the children. However, I have to think of either sending them to the orphanage for their survival as I am not able to provide them with the meagre income I get and how long will I live at this age. There is no other earning member in the family. I am really sorry for their lives as I cannot even afford them schooling."*

The high income group of caretakers are in a much better state of providing care and support. In this type of families, there is at least one government employee in the family who is capable to look after the needs of the orphaned children. The study shows that children coming from such families attend schools and are more secure in terms of their placements. A twelve year old HIV infected girl who is taken care of by her paternal aunty who is from a high income family narrates:

*"My paternal aunty is very loving to me. My father left me when I was eight years old, the next year my mother left me again. I cried a lot and even now I really miss them. My younger brother is with my grandparents while my aunty who is working in the town came and took me to her place after a few months because they live in the town and there are good schools in the town. My aunty has two sons and a daughter. She treats me like one of them. We all have the same toys. During holidays we go to the village to visit our grandparents and my brother."*

In such cases where the caretakers are placed in a better economic position, the care and support of children is also found to take better shape. The aspect of 'cared for' is found to take good ground in high income groups. However, it is also equally important to take into account the aspect of 'cared about' as well. There are instances

where children faced the grim of rejection and lack the aspect of 'cared about' even when placed under a fine and economically sound 'care givers'. One infected HIV boy of ten years was placed in his maternal uncle's house after his parents passed away says:

"*When I first reached the house, everyone was so nice to me; however, they started avoiding me and rejecting me on the fact that my parents died of AIDS. Of course, my uncle was always nice to me but the other inmates in the house treated me indifferently in the absence of my uncle. They were scared to sleep with me and treated me so badly. I could not bear it any longer, so I blurted out to my uncle and cried like anything. I asked him why I should be treated in this manner and pleaded him to take me to my grandparents. So, after staying there for one and a half year, I returned to my village. My grandparents are poor but they love me. And they make me happy.*"

There are also some children from high income group. There was a HIV negative girl of five years whose maternal grandparents were from high income group. When the child became an orphan, her maternal grandparents came forward to claim the child and undertake to look after her. Her paternal grandparents were no longer alive and there was no other member capable of caring the child. The child is fondly cared and supported by them. The child is now five years and is provided with proper medication and healthy diet. As such, it is seen that the nature of care and support received by children undergoes variations related to social and economic class.

## ***Children's perceptions and preferences of caregivers- of all orphans, special problems of HIV affected, of HIV infected- difference across socio-economic sections***

The family is found to be a safe abode for the members even in times of crisis and unpleasant situations. One male respondent who is now eighty years recalls his childhood days of being under the care of his paternal aunty.

"*I am one fortunate orphaned person who does not know what it is to be an orphan. Because to me, even though both my parents left me at young age, my grandparents, uncles, aunts and everyone in the family were my parents. They never let me be deprived of anything. My uncle who stays in the town arranged and supported my*

*schooling. During holidays, I would go to the village and spent time with my grandparents, uncles and aunts and cousins who lived in the same village. With the care and support of my loved and dear ones in the family, I got proper education and then got a government job. I am a stable man with a family of my own."*

Family care is considered to be a self-evident activity that involves providing the needs of the members, assisting ill and infirm relatives who are unable to perform such activities themselves. The managing and meeting of these needs goes beyond mere physical assistance. It also encompasses the emotional aspect of managing feelings and establishing and maintaining relationships which need to be fulfilled by the caregivers in the family. One female child respondent of twelve years who lost her parents due to ethnic violence says:

*"My parents died when I was about six years old. I have one elder sister and a younger brother. Even though our parents left us, there is grandmother who is like a mother to us. My Uncle and aunty who stay in the city would buy lots of good clothes for us which would be an eye of envy for our friends in the village. We study in a government school, now I am in class five. I want to become to become a big officer someday."*

The positive attitude that reflects from this girl even after she lost her parents shows the role of the other family members who were there for her to provide not only her basic requirements of food and clothing but more importantly meeting the needs of emotional satisfaction and love, which the child needs most in this stage of her life, thereby her confidence and self-esteem was also built up.

Children have expressed their keen desire and their strong attachment to their family and preferred to be within their familiar environment. They show great reluctance when they are to leave their parental house and adapt to new family settings apart from the one they have been brought up in. A boy of ten years whose parents have died of AIDS felt very saddened when he was joined to his maternal kin's family after the death of his parents. However, he is now enjoying living with them and maintaining a healthy relationship where he says he receives all he wanted. He says:

*"My uncle and aunt love me a lot, they have sent me to school and get equal share of all the toys and things other children in the family possess. When I first came to live*

*with them, I missed my parental home, my sister and my grandparents. However, the love and the care I get here make me feel at home now."*

However, these arrangements are not always smooth and the children who have lost their parents to the disease not only face lack of love, support, and care parents offer, but worse still, they face the problem of having lost their parents to a shameful and stigmatized disease if they are left neglected without proper care ad support. The cumulative effect of these problems on an orphan in childhood and adulthood cannot be underestimated.

Among the various caregivers where positive parents are unavailable to provide care to HIV infected or affected children, it is usually grandparents who take the responsibility. In spite of their old age, they are the ones who can take up the role of "caring about" even though they may not be smoothly carrying out the role of "caring for". The present study shows that out of the thirty children affected by HIV and AIDS receiving homecare, fifteen of them stay with their grandparents, while the rest are either with single parent or their aunts or uncles. A point in favour of grandparent caregivers is that by and large, as compared to other relatives who may provide care reluctantly, exploit the children or deprive them of their rights and assets, grandparents usually work single-mindedly and selflessly for their grandchildren's well-being. A non-infected girl of fourteen years who has lost her parents due to AIDS recounts her story with her grandparents. She has grown so attached to them and says she cannot imagine her life without them.

*"I was so scared when my parents died one after the other. People said that they died of AIDS. I did not know what that was, but later I came to know it was a disease which was dreaded and feared. I was ashamed of the fact that my parents died of that disease. I did not want to go school any more but my paternal grandparents were always by my side to give me hope and sunshine to my life. I wish they never grow old and die. In school I hang around only with my closest friends who have sympathy and concern for me."*

A child's developmental needs are best met when their substitute families are able to "nurture and commit to these children over the long term". A twelve year old boy orphaned otherwise under the care of his maternal uncle strongly feels that it is the

feeling of being at home wherever you may be placed after your parents' death. He says:

*"We are a sibling of three, of whom my eldest sister has got married a year back. We used to really miss her as she was married to a far off village, while I and my younger brother were under the care of my grandparents, however due to family's poor financial condition; we were made placed to an orphanage. It was really hard for us to go through all this being shifted from one place to another. We felt very much unwanted. We wanted a place where we would feel at home and discard the feeling of being shifted from one place to the other. Our prayers were answered when our maternal uncle and his wife took us home. It is their house where we feel homely and safe because they love us equally with our cousins."*

**Table 1.7**

**Profile of children orphaned otherwise and their care providers:**

| *Children* | *Sex* | *Age* | *Status of parents* | *Care Providers* | *SES of care providers* |
|---|---|---|---|---|---|
| A1 | female | 5 | Father alive | Paternal grandparents | Middle-income group |
| B1 | male | 7 | dead | Paternal grandparents | Middle income group |
| C1 | female | 12 | dead | Maternal kins | Higher income group |
| D1 | male | 14 | Mother alive | Single parent | Low income group |
| E1 | Male | 10 | Father alive | Maternal kins | Higher income group |
| F1 | female | 9 | dead | Paternal aunty | Higher income group |
| G1 | female | 11 | dead | Maternal uncle | Middle income group |
| H1 | female | 6 | Father alive | Maternal grandparents | Higher income group |
| I1 | male | 7 | dead | Paternal aunty | Higher income group |
| J1 | male | 12 | dead | Paternal grandparents | Higher income group |

## ***Children's problems- of all orphans, special problems of HIV affected and of HIV infected orphans***

A female orphaned respondent who is now eighty two years recalls her moving childhood days when she became an orphan when her parents left her one after the other by the age of five years. She was under the foster care of relatives who reluctantly reared her up. Living with her cousins was not a pleasant experience for her as she faced step motherly treatment from her caretakers. She reflects back on her childhood memories which she had to cope with much struggle mentally and physically.

*"I was deprived of proper food and made to do a lot of work beyond my capacity. I would go to the forest to fetch water to get a morsel of food. There were times when I would come across wild animals. However, I would return unharmed by the animals."* From her experience, she strongly feels that orphans should be given proper care and support especially emotional bonding which is most needed at such primary stage of life. Else it creates a long term impact and leaves a mark of hurt and resentment towards others throughout their lifelong. Children in the family should be cared upon without any favouritism or preferential treatment. She further suggests:

*"All children need stability, unconditional love and nurturing...they need acceptance from family and friends. Especially for children who are facing the grim reality of HIV and AIDS the absence of these aspects of life creates a lot of insecurities in them. There should always be someone to fill the gap that has been left with the loss of parental care. It is not just physical necessities that promote the growth of children but the satisfaction of being loved and accepted."*

Among the low income groups, a girl child who has been orphaned otherwise and is being fostered by her maternal kins tends to get more work load and is under stress to meet the demands of the foster family. Unlike the male child she is expected to help out in attending to the household chores whereby she has less time for her studies. Wherever a girl is placed, she is expected to perform all the needful household chores. The economic constraint of family may cause a lasting impact on the physical and psychological trait of the children especially the girl child. Girls are more likely to contribute to the menial work to run the household. As such they are found to be seen helping out either in relatives house or other homes where they perform various jobs

such as baby sitting, and other household chores. Boys are mostly raised and supported in the care of their close kins or relatives in the absence of the biological parents. Even among the male child, the eldest male child who will be the heir of the father to carry on the lineage is taken proper care to be the successor of the father.

An eleven year old girl orphaned otherwise who is in her uncle's house after her parent's death says that she helps our her uncle's family by performing household chores like fetching water from the nearby spring, cleaning the house and other menial work. While she has been sent to her uncle's house, her brothers are in their natal house with their grandparents. Her brothers go to school while she is unable to attend school due to financial problems as well as time constraints. She says,

*"After few months from my parent's death, my maternal uncle and aunt came to take me to their house. They have three children, the eldest a year older to me while the youngest is still an infant, and since the eldest daughter goes to school, I have to do the baby sitting in the absence of my aunt. I could not attend school as I have to attend to the household chores while my brothers who are with my grandparents go to school."*

A boy of ten years who has been orphaned otherwise whose mother passed away during the ethnic violence laments over his life as he shares how he feels about playing around and spending time with his friends. He says:

"*When my mother passed away, my father got married for the second time. Then, the decision whether I was to be with my father or my grandparents became a big issue in the family. I felt very unwanted as shifted from one place to the other. Sometimes, I was put in the boarding, then with my father and later to my grandparents. I feel that no one loves me. I feel even my friends do not enjoy my company and nobody loves me.*" Such family responses make the child feel unloved and lonely.

## ***Children's concerns***

Conversations with the children brought out that they are most concerned about the health and tensions in the family, stigma, discrimination, their friendships and their studies. Although few children were not accustomed to being asked about their opinions and were not ready to talk about their experiences, there was a good rapport build with most of the children who shared about their likes, dislikes and their

concerns. An HIV infected boy of ten years who is living with her infected mother with low income barely meeting their basic needs shares:

*"I am envious of other children who are not sick and could go to school. As for me, I tend to fall sick often and as we are poor, mother cannot afford to send me to school. I fear my mother would die and who would look after us. My relatives pay us a visit sometimes and asked me to be with them. But I love my mother and my sisters and I want to be with them."*

A girl of twelve years whose parents died due to other causes other than AIDS lives with her maternal kins belonging to a higher income group. She articulates her experiences:

*"My father died during the communal conflict when I was very young. My mother died very recently after undergoing treatment and medication for a long time. My elder sister is married while my younger brother stays with my grandparents. As for me, I am living with my mother's distant cousin sister along with their family. I am provided with good food, clothes and I get to attend school. However, there are other children in the family where I undergo many experiences of being left neglected and getting different treatment being an orphan and from a different family. I long for the kind of unconditional love and attention I get from my mother. Sometimes, I feel very lonely and feel isolated from the other children."*

It is therefore important to take these into account to meet the needs of the children in areas of their concern and provide the necessary support and security while catering both the aspects of 'cared for' and 'cared about'. Children who slip from the safety net of their primary caregivers like their natural parents tend to experience lack of 'cared for' more when placed in different family set up.

## ***Problems faced by care givers –difference across socio-economic sections***

Respondents expressed the importance of meeting the child's needs; provision of family environment; and supporting the caregivers in the family to support the child.

In the case of a surviving parent, the first line of care is expected to be provided by the parent. However, as per the study, most single parents being unable to handle the situation alone take assistance from their parental house. In most cases, when the surviving parent is the mother, she along with her children moves to her natal house. However there were also cases where she continues to abide with her in-laws but with a feeling of rejection and negative response. An HIV infected lady with two children says:

"*After my husband passed away, I feel so rejected by my in-laws being an HIV patient. My children were also in the same state. So, I decided to leave my in-laws and returned to my natal home. At least there I would be accepted as I am. I know I am creating a great burden to my parents but I have no other option. I am getting sick and the thought of my children worries me a lot. But I am assured of the unconditional love of their grandparents which relieves me of my fears and insecurities. When I interact with my children I try my best to convey love and happiness at all times so that in such a situation of distress, they feel comforted and stable.*"

There is a family where a HIV infected single parent lives with five of her children who are also infected. She laments over her life and the fate of her children. She narrates:

*"My husband was an IDU who would spend money recklessly. We had no source of income, so we resorted to selling local wine. When there was a ban from the authorities, being helpless we continued selling the liquor surreptitiously. My husband was caught and shot at in his leg. We could not afford his treatment; as such he succumbed to death after few months. Now, my HIV status is known to my in-laws who are unwilling to even care for my children. I have no option but to send my two eldest children to an orphanage while I am struggling to rear the other three. I can barely meet their basic needs. I cannot even afford to send them to school. I am so thankful to the local NGO staffs who are helping out with medicines and diet after every fifteen days. Above all, I greatly appreciate and value the time they spent with me to listen to my tales. What worries me is the destiny of my children after my death."*

Thus among the three categories of orphans which includes children infected by HIV, non –infected orphans of HIV and AIDS and those orphaned otherwise, grandparents comprise of the greatest number of caregivers. About 50% of the orphans were under the care and support of the grandparents of which 33.3% are under the paternal grandparents while 16.7% are under the maternal grandparents. Studies also shows that children affected by HIV are less preferred and face unequal treatment from the caregivers to those orphaned otherwise, more so if they are themselves infected.

The families providing homecare are divided into three socio-economic sections based on the amount of monthly income earned by the members in the family. On this basis, it is seen that about 50% of the caregiver belong to the higher income group; while 20% belong to the middle income group and the remaining 30% belong to the low income group. It is thereby seen that among the kin, the responsibility of homecare is generally taken over by kin who are financially relatively better off. Parents and caregivers in the low income group are seen to raise children in an environment of stress. However, the orphaned children across all the categories which include the infected, non-infected and the orphan otherwise conceive the family which provides the natural environment and the familiar surroundings with an atmosphere of happiness, love and understanding as a good alternative to grow up in the absence of their biological parents.

The problems that caregivers and the orphans face are many. With the death of their parents, children face the grim of lack of parental care and support, thereby miss out the love and care from their parents at a young age when they need it the most. Another complexity which orphan children have to face is that they have to adapt and adjust to their new environments under their substitute care providers when they are taken away from their parental home.

Among the caregivers, the care and support varies on the basis of the socio economic sections of the various caregivers. The low income groups are found to struggle in the rearing and support of the children with bare minimal income. In some cases, they cannot afford to send the children to school. Worst still, when the surrogate caregivers are not able to meet the basic needs of the family, these children are deprived as well. A single parent who has been supporting her children after the death of her husband due to ethnic violence says that she cannot afford to send her children to school as she

struggles to bring them up. She has sent one of her children to the orphanage thinking at least he would be provided the basic schooling in the orphanage.

Although family is considered to be the basic unit for the formation and upbringing of a child, in cases like this where the caregivers fail to provide adequate care and support to the orphan children, the next level of caregivers which comprise of the various community care providers step in to take the role of care providers.

# CHAPTER: 3

## COMMUNITY AS CARE PROVIDERS

### *Kin and Friendship Network*

It is interesting to note that among the Kukis each household is intricately bound up with others in "*Tucha-Becha-Sunggao'* relationship. A Kuki family has no real existence apart from the village, clan and tribe to which it belongs. The whole village is inter-connected via this system. The first priority for a person having separated from the parent's household is to have his '*Tucha Becha'* instituted with the initiation of his elder brother in his father's absence as he represents the parent family. In fact, the life of the Kukis veers round these three sets of relatives. He is essentially guided by a set-pattern of etiquettes of institutionalized mechanism of social control which manifests itself in a structure from which he cannot deviate. One set of relatives as mentioned earlier in the previous chapter is the *'Tucha-Sunggao'* relationship which is purely the by-product of marriage.

There is another set of relatives which is known as '*Becha'* relatives. This set of relatives of an ego may be termed as representative in nature who have been vested with full power and authority of an ego. Customarily, there are two kinds of '*Bechas'* who represent the whole '*Becha*' relatives of an ego. Of these two, one is senior, named '*Becha Bul*' or '*Bebul*' and the other is junior called '*Becha*' (Gangte 1993). The '*Bebul*' holds the right of every family matters in the ego's family. As such, when there is an orphan in the family, the '*Bebul'* makes the rightful decision as to who should care and support the child. If there is no capable caregiver for the child, then the '*Bebul*' either makes arrangements for the child to be in orphan care or he himself becomes the care provider of the orphaned child.

Therefore, the *'Becha'* relative stands at a very commanding position of authority, being the spokesman of the ego, and is considered to be the ego himself. The Becha relatives are basically exogamous or collateral male relatives of an ego.

The range of being a '*Becha'* relative is very elastic. A person whom an ego considers good and who can go along with him and can stand by him in times of joy and sorrow,

may be chosen as a *'Becha'* relative. Secondly, a man of wisdom, well versed in customary laws and traditions, and also expert in interpreting culture and social values, may be so selected. He is the spokesman of the ego on a self-reciprocal basis and is the administrator with his full authority to exercise discretion on behalf of the ego. He is a person who can efficiently shoulder the responsibilities associated with the *'Becha'* relatives to act on behalf of the ego. These are, in a nutshell, his duties and powers. Thus, these three sets of relatives known as *'Tucha, Sunggao* and *Becha'* have come to stay in the Kuki society as an indispensable part of their social life in an institutionalized form.

As stated above, in a man's life these three sets of relatives are so intertwined that without them a Kuki is unable to face the reality of life. A man can use anyone on whom he has confidence and close personal relationship, by the mechanism of extension of the classificatory terminology of *'Becha'* which literally stands for any collateral male relatives within the fold of exogamous group.

This bond of relationships among the Kukis is very significant in wielding the feeling of togetherness and community feeling wherever Kukis reside. These sets of relatives of *'Tucha, Sunggao* and *Becha'* act as the backbone of gaining security and support at all times. In times of crisis or any happy occasions in the family, all these relationships come together to share and carry about the necessary arrangements as required.

## ***Village as care providers***

In the larger arena of community life in the Kuki community, beyond the kin and friendship network, it is the village chief known as *'Haosa'* who bears responsibility for and exercises the immediate command over the villagers. The system of chieftainship is being institutionalized in the Kuki villages where the village head known as the *'Haosa'* and his council of ministers called *'Semang Upa* or *Pachong'* exercise their political powers. A village is an independent political unit among the Kukis, and the chief of the village and his Council of Ministers are the political leaders. Administrations of justice, enforcement of executive function, maintenance of social practices and customary law, including religious performances are the areas of the village administration under the Chieftainship and his Council of Ministers. Thus, a Kuki village is an important administrative unit (Gangte 1993).

The office of Chieftainship called '*Haosa'* is vested with much power and authority. It is not elective but hereditary, passing from father to the eldest son. The '*Haosa'* has the absolute right of ownership over the entire land of the village. The villagers have to pay the Haosa in return for such privilege in the shape of tributes called '*changseo'* which even includes part of hunted games called '*saleng'*. '*Changseo'* is payable annually after harvest. The Haosa is also entitled to free labour of each villager once a year caked '*khuotha'*.

Together with such rights, the '*Haosa'* has certain obligations over the villagers. In return for the services rendered by the villager, free of cost and the tributes paid as a token of loyalty, recognition, obedience and solidarity, the '*Haosa'* has to protect their interest by providing security socially, politically and economically. It is also the duty of the '*Haosa*' to see that every villager is protected from external aggression and danger. He is to protect the lives of the villagers in times of war; he is the defender of justice and looks into the welfare of his people along with the assistance of his ministers and secretary called '*Semang*' and '*Pachong*'.

In case of family crisis such as long term illness, death of family members, major financial crisis, the village chief would call upon the villagers for assistance to be catered to the family concerned. The chief exempts the payment of various taxes such as the above mentioned ones as well as another tax known as '*khasana'* from these people. The whole villagers join hands to render services to those in need. There exists a strong sense of social obligations among its members. There is a strong sense of community. As cited by S.Doliand (Capvung 1995) there exists a system of community and social obligations termed as '*Tawmngaihna*' and '*Kihutuana*' which means the service rendered to others in times of need, i.e. in times of joy, sorrow or calamity. It is expected on the part of everyone to contribute his or her good-will and free-will offerings to the poor and the needy. There are voluntary services towards the neighbours for the unity and betterment of the society, where no one expects to receive a reward or a profit or gain in return for rendering such services.

Apart from the family care and support, it is the village under the initiative of the village chief known as '*Haosa'* who acts as a strong supporter for the inmates of the village, especially the orphans and the widows. He exempts them from tributes to be paid to the village chief during harvest time and other occasions. In earlier days there were instances where the village chief adopted orphan children known as '*chengcha*'

whom he kept under his care before any claim is made on the child. In case no such claim comes forward, then the child continues to grow up under the guardianship of the village chief in which case the male child becomes the clan member of his guardian, while in the case of the female, she is borne into another family after her marriage. This type of guardianship is believed to be still prevalent in some villages although there is no such evidence from the six villages under study.

However, during family crisis or when cases arise where there is a need to support a meagre family; the chief does still initiate help and assistance for the family. The chief calls upon the whole village to render services to the concerned family. The whole village would then jointly come together to offer services. There exists a strong sense of social obligations among its members. The chief of Khengjang village responds to such cases by calling upon all his villagers to contribute in cash or in kind to give the household the necessary provisions. They also build houses for those who are unable to build for themselves or those without proper shelter.

Similarly in Haijang village, the village chief provides support to those in crisis with the support and cooperation of the villagers. There was a case of a child-headed family who lived by daily wages they earned in the nearby town. According to their own capability, the villagers would donate food, clothes or money and render services. The family was given some assistance in times of illness and was provided help in cash or kind as required till they were able to stand on their own and support themselves.

It is also interesting to note that among the Kukis, community preventive ritual known as '*khojeh*' was observed to prevent epidemics like cholera, diarrhoea or other diseases which break out from the neighbouring areas. This ritual was performed by the '*Thempu*' who was the traditional priest in the presence of the '*Semang-Pachong*' or the council of ministers in the village cemetery called '*Kho-moul*'. When this ritual was performed in the village, it was strictly observed that no visitors were allowed to enter the village nor were the villagers allowed to go out of the village for two to seven days depending on the severity of the diseases. However, all these rituals and practices are no longer found to be practiced among the Kukis.

In the cases where care by surviving parents has been absent or inadequate and families are overwhelmed by the number of orphans they have to take care of, it is

reported that some of orphans are being cared for by sympathizers or individuals within communities out of sympathy or altruism and/or religious reasons. There are cases where orphans are adopted and made a part of the family till their marriageable age. A couple who already had six children of their own, still adopted a girl child because the child had lost her parents due to ethnic violence. She was adopted at the age of about twelve years. Recently, she was married and the foster family carried out all the necessary arrangements for the ceremony.

## *Children affected by HV/AIDS*

The sense of community feeling and social obligation remain unaltered even with the advent of HIV and AIDS among the Kukis. In the study undertaken in six villages in Sadar Hills, there was evidence of the role of the community in the care and support of children. Along with this, emphasis was laid on the care and support of children affected by HIV and AIDS.

**Table-1.8**

**List of the Kuki settlement areas visited in Sadar Hills District:**

| | Name of the area | Estb. year | No. of houses | Total popln. | Male popln. | Female popln. | No. of children | orphans | HIVand AIDS infected children |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Kangpokpi | 1917 | 1440 | 11638 | 4044 | 4094 | 3500 | 150 | 2 |
| 2. | Keithelmanbi | 1942 | 540 | 6562 | 2117 | 2445 | 2000 | 25 | 9 |
| 3. | Motbung | 1921 | 523 | 5085 | 1795 | 1790 | 1500 | 20 | 9 |
| 4. | Bongmoul | 1947 | 67 | 770 | 272 | 298 | 200 | 6 | 1 |
| 5. | Khenjang | 1948 | 82 | 370 | 350 | 250 | 250 | 10 | NA* |
| 6. | Haijang | 1870 | 70 | 670 | 240 | 170 | 170 | 5 | NA* |

*NA- not available (Children population comprises of children below 15 years.)

* Compiled from the field data

In the study on the children affected by HIV and AIDS among the Kukis in Sadar Hills, it was found that a number of children affected by the disease are receiving care

and support in the community, supported or facilitated by NGOs. In the course of this study, it was found that there is an active involvement of an NGO called Meetei Leimarol Sinai Sang which is reaching out to those affected by HIV and AIDS persons. They also provide care and support to the children affected by the disease, with the strong support of the local people within the community as staff workers.

In Motbung village, being aware of the rise of HIV and AIDS affected people, the village authority along with the NGO jointly carries out various prevention and awareness programmes. This NGO has opened a community care centre in this village and is carrying out various programmes among people with HIV and AIDS infected people. They also provide home-care through the local Kuki women who are working as staff members in the NGO. In fact, the participation of these local women as staff members opens the barriers for persons affected by the disease. The children who receive home-care from this organization receives medical care, along with a diet delivered every fifteen days which consists of eggs, bananas, milk powder and some other foodstuff. There seems to be a wide recognition of emerging problems and increasing trend of the disease. The active staff members in the NGO believe that the best way to combat the disease would be to join hands and create awareness and support for the persons affected by HIV and AIDS, especially children who emerge as the worst sufferers. One of the elders pointed out that the Kuki society is witnessing a degeneration of many families with no heirs to prolong or continue the lineage of the families. Thereby, it has become an emerging social issue which must be given serious thought by the community in general and the social workers in particular. There is a great need for more involvement of the Kuki community in this regard and to take up measures to curb the problem.

A lady staff member from Keithelmanbi village who has been working with an NGO says that:

"*Children affected by HIV and AIDS must be cared for without any discrimination. They must be given proper upbringing and not deprived of their right to live. Their lives are already devastated with the loss of their parents and therefore they must be encouraged to grow into young responsible adults and given positive outlook to life.*"

A lady caregiver, who is supporting her HIV infected nephew, says:

*"No matter what disease they bear, they are human beings who should not be denied the right to live. Rather than institutionalizing them, orphans should be cared for in the family in their young age. Because, it is felt that in most cases, a child in the institution tends to grow with a rigid mindset and this greatly affects his or her life in the long run."*

A local staff worker of an NGO, (Meetei Leimarol Sinai Sang) states,

*"Children affected by HIV and AIDS need more care and support than the other orphan children because while they have to cope with the death of their parents, with their poor health conditions and lack of care, they have a negative picture of themselves due to the stigma attached to people with HIV and AIDS. As such care providers in the family along with the community workers must take proper measures to cater to the needs of children affected by HIV and AIDS as they are denied an untroubled childhood. We are providing them with medical care but the community also holds a big responsibility in providing care and support to these orphans by eliminating any kind of discrimination, without any barrier."*

However, in spite of the strong desire to provide care and support to the children within the community rather than institutionalizing them, due to lack of financial resources and inadequate income, sometimes there is no other option than to send children to orphanages. One grandmother of an HIV infected child says,

*"I want my grand-daughter to be under the care of my bosom, and to bring her up with all the possible love and care after her parents left her as an infant. However, the child is becoming very sickly and tends to fall sick very often. Everyone in the village who knows about the fate of this child comes and renders help to us in every way. However, how long will I continue to provide care and support to my grand-daughter? I want her to grow up as a healthy child. So, no matter how hard and painful it was to part with her, when I heard about the NGO who keeps and supports children with this kind of disease, I have given my grand-daughter to be kept under their care. I visit her once in a while. I wish to take her home when she is fit and strong enough."*

Community has a great role to play in providing care and support to children especially the orphans. Next to family, it is the community that has a great influence

upon the socialization of the child. It is where the child gets exposure to the outside world and thereby greatly determines the personality development of the child. If the child feels accepted and loved within the community, it results in positive upbringing and growth of the child. However, if the child faces discrimination or prejudices within the community, it will build and develop contempt and repulsive attitude in the child. It can be said that the community is like a mirror in which the child sees its reflections and reacts accordingly.

A girl of twelve years narrates her story of how she grew up as an orphan in the care of her grandparents and the love she receives from people around her in the community. She says:

*"Life taught me so much when my parents left us. Now, me along with my four younger siblings are growing up under the care of my grandparents and paternal kins. Being the eldest it was hard to cope with the death of my parents. However, till now we do not lack anything. Everyone in the family loves us. In the church, the people show us much love and concern. We feel everyone loves us. We get free school facilities. Though I miss my parents, I feel warm with the people around me, especially my grandparents and my best friends."*

While this girl feels accepted and is positive about her life due to the strong support she receives around her, cases where children feel unloved and rejected are no exception. Worse is the case of children affected by HIV and AIDS as compared to children who are orphaned otherwise. Not only do they have to face the death of their parents, if they themselves are infected, then they have to cope with the disease. Above all, they face the trauma of being rejected and discriminated by others. An infected boy of ten years lost his parents due to AIDS. Even as he survived, he is crippled on his left leg due to polio. After his parents died, he was kept in the orphanage. Later, his maternal grandparents took him out of the orphanage and since then he has been with them and has been receiving home-care from MLSS. He is a child who is much withdrawn from the outside world. As he plays with his friends, he is always left out as he cannot run around and do what his friends are enjoying. While in the orphanage, he came to know about the kind of disease he is suffering from. At such a young age, he is burdened with the triple loss of being an AIDS orphan, being HIV infected and facing the stigma of disability. When a staff from the NGO comes for medical aid and diet, he would ask her to bring the best medicines to heal his leg

so that he can run around like his friends. Otherwise he says that he feels very rejected and cast off from others.

Among the various caregivers in the community, the '*Becha*' relatives extend great support. Also, the '*Becha*' relative acts as the backbone of the family when it comes to making decisions. Mentioned may be made of an HIV infected orphan girl of six years old who was left with no capable care provider whose parents died in a consecutive manner. Her grandparents were too old to care for an infant and no near or distant relative was available to support the child. Thereby a decision was taken by the '*Bebul*' that it would be best for the child to be in the orphan care in the orphanage.

All the villages in the study are found to be supportive to orphaned children, although not adequately. Community care is found to be lacking for children especially those affected by HIV and AIDS. As such, there is a great need to increase the awareness for more response from people to understand and support the people living with HIV and AIDS and the children affected by the disease. Economic constraint stands out as the main reason for the lack of proper care and support. Many children fail to receive proper caring on the aspects of both 'caring for' which regards to meeting their physical needs. Most of the children in the study belonged to the low income group, who depend on daily wages for livelihood. As such, the family fails to support them with adequate basic provisions. While in the case of the high income and middle income group, their physical requirements are adequately met, in some cases, the aspect of 'caring about', where the child's emotional needs are significant due to the loss of parents, tends to be neglected and may be found missing in the aspects of care and support accorded to the orphan children.

Thus in the Kuki community traditional kinship ties like '*Becha*' and the responsibility shouldered by the village chief have traditionally come into play to provide for the care of children in general and especially when the immediate family is found to be lacking or unable to do the same. Although from this study in the field it has emerged that these networks seem to have been eroded to some extent in the present day, relations like grandparents, paternal and maternal relations continue to play a vital role in providing much needed care for children who have been orphaned and this is evident in the case of HIV and AIDS affected children as well. In fact, in spite of the attendant stigma attached to this disease, this study has encountered a number of cases where community networks have effectively provided care and

support for children who have lost their parents to this much dreaded disease. However, there remains a significant number of HIV and AIDS affected children who slip through this safety net of family and community care and support, who due to economic or other reasons do not have care and support from their kinship network and community. There is no option for these children other than institutional care although it is least preferred. The following chapter probes the care and support provided to orphans in institutions like orphanages.

# CHAPTER: 4

## THE ROLE OF ORPHANAGES

The Ministry of Social Justice and Empowerment at the national level and corresponding state government departments are responsible for children in conflict with the law and children in need of care and protection, which include street children and orphans. The ministry also licenses adoption agencies, and, through the Central Adoption Resource Agency, monitors and regulates them. The state is also responsible for "review of the quality of care and treatment provided to the child who has been placed in institutions for care and protection."

### *Orphan care in Manipur*

Department of social welfare, government of Manipur has implemented welfare programmes for children, destitute children and orphans of the hills and the plain in Manipur. Following schemes have been implemented for child welfare:

#### *Running of children's home*

Under the welfare scheme for the welfare of children in need of care and protection, the government has been extending 90% of grant in aid to children of eight destitute children's homes run by voluntary organizations. At present, a sum of rupees 270/- per child per annum is provided of care, maintenance, food, education etc. as per record, there are altogether around 320 children in these orphanages. Another scheme which is implemented is the government of India initiated, 90% centrally sponsored scheme of assistance to homes called Sishu Greeha which has been implemented in Manipur for in-country adoption of the unfortunate children. Objectives of the scheme are:

- To regulate adoption within the country to ensure minimum standards in care of children.
- To provide support for institutional care within the country for care and protection of infants and children up to six years of age who are either

abandoned or orphaned/destitute and their rehabilitation through in-country adoption.

- To provide in-country adoptions.

The following NGOS have been recognised by the state government and approved by Central Adoption Resource Agency (CARA), ministry of social justice and empowerment, government of India to run Sishu Greeha.

- Integrated Women and Child Development Centre (IWCD), Thangmeiband Yumnam Leikai, Imphal district.
- Tearfund India Committee on Relief and Rehabilitation Service, Churachandpur district.
- Community Development Programme Centre, Thoubal district.

Also, a financial aid of rupees 60/- is provided to 288 school going children who are living below the poverty line.

Among these three NGOs, the first one i.e., Integrated Women and Child Development Centre, Imphal district carried out a project called CBCS-Community Based Care and Support for children affected and infected by HIV and AIDS. Working with intravenous drug users (IDUs), HIV and AIDS issues for a long time, it felt the need to work for their children who were suffering. IWCD thus started reaching out to them and started addressing their needs. A situation assessment of the children of IDUs was carried out in the organisation project area of Imphal East and West. Addressing the findings of this situation assessment the project proposal to implement a similar programme with 103 children was proposed to the Ministry of Social Justice and Empowerment (MSJE), Government of India. The project was sanctioned for the period December 2005 to March 2006. This project is the first of its kind which addresses the needs of children infected and affected by HIV and AIDS in the state.

Under this project, a total number of one hundred children were selected which includes:

- Orphans whose parents have died of AIDS

- Children of HIV positive mothers

- Children who are HIV positive
- Children of single parents whose parents have died of AIDS
- Children in age group of 4-15(below 4 years are also covered as per the need arises)

The objectives of this project were:

- To improve the health condition and instil health seeking behaviour to the HIV infected/affected children.
- To provide services to improve their quality in education so that the HIV infected/affected do not drop out of school.
- To create enabling environment to sustain support to the children.

This project was implemented in the Imphal east and west district alone. It is felt that there is great urgency to call for such projects which identify and address the needs of the children affected by HIV and AIDS in other parts of the state as well. The state has established eight orphanages which are tabled as below:

**Table 1.9**

**State Orphanages in Manipur:**

| Sl. No. | Name of homes (orphanages and addresses) | No. of inmates |
|---|---|---|
| 1. | Destitute Children Home<br>Kanglatombi, PO Motbung<br>Senapati District. | 60 |
| 2. | Destitute Children Home<br>Manipur Mahila Samiti<br>Deulahland, Imphal east | 50 |

| | | |
|---|---|---|
| 3. | Destitute Children Home<br>Salvation Army, SA Road,<br>Malvaiphei Churachandpur. | 50 |
| 4. | Destitute Children Home<br>Liwachanning, Chandel. | 25 |
| 5. | Destitute Children Home<br>Tera Keithel, Sagolband, Imphal. | 50 |
| 6. | Destitute Children Home<br>C/o Ningrin Club, Ukhrul. | 25 |
| 7. | Destitute Children Home<br>Lei-ingkhol,Chingmeirong, Imphal. | 25 |
| 8. | Destitute Children Home<br>C/o Lower Lamka Women Society, SA Road,<br>Churachandpur. | 35 |
| | Total | 320 |

(Source: Social Welfare Department, Government of Manipur)

Institutional fostering appears to be the last resort when family and community efforts fail to adequately care for orphans. Orphans are then taken care of in institutional settings known as foster homes or orphanages. In Sadar hills, the area of study, there are seven orphanages of which only one of these is a state recognized or funded by the state while the rest are run by donations from the communities, missions or churches. The state funded orphanage is called 'Kanglatombi Children Home' while the others are George Muller School cum boarding, Logos, Grace Boarding, Mercy Children Home, Lighthouse School and Disabled Children Home. Apart from these the other orphanages visited are Mission Orphanage and an orphanage run by an NGO called Meetei Leimarol Sinai Sang, both of which are in the capital city of Imphal. Among the various orphanages in Imphal, these are the two institutions which have children

belonging to the Kuki community mainly from Sadar Hills. Among all these orphanages, three orphanages were taken for in-depth studies, which are the Kanglatombi Children Home, the Mission orphanage and the Meetei Leimarol Sinai Sang.

- ***Kanglatombi Children Home***: This is one of the destitute children home which runs with the help of the state's assistance. In fact, it is the first orphanage in the state which was set up in 1947 by Mrs. Ngahhoikim. It is one of the state funded orphanages in Manipur. Presently, it is run by Mr. Chungson Kilong and his wife Adaphro who have also grown up from this orphanage. The children hail from different ethnic backgrounds- Naga, Meitei, Nepali, Bihari and Kuki. At present, there are about forty children, of which thirty eight are boys and three girls. According to the rules laid down by the government, the children should not remain in the orphanage beyond fifteen years. However, many children are unwilling to move out of the orphanage which they regard as their home. As such, there are also college going students who are attending classes in the nearby college. In case of sickness, the children are taken to nearby health centres. The state also sends a medical team occasionally for health check-up. However, the orphanage faces lack of financial assistance and also shortage of staff to assist in managing the orphanage.

- ***Mission Orphanage:*** This orphanage was started in 1992 by Rev.Thangkholal Singson. It is jointly run with various churches who form a ministry for orphans around the world called 'Reach an orphan ministry'.

There are about twenty six children in the age group of fourteen and twenty-one years. There are twelve females and fourteen males from different communities such as Nepali, Meetei, Naga and Kuki. Most of them are from the rural areas while few are from the urban Imphal area. The children receive health care from the Regional Institute of Medical Science. At times, they also receive medical aid from the army personnel. The children are imparted training in various artwork and other vocations. They attend schools in the neighbourhood of the home while a college level boy attends a good reputed college in Imphal. There are also cases of young boys who have been selected in the army recruitment and are now joining the armed forces. Most of the children do not have frequent visitors and some children are not visited

even once since their arrival to the orphanage. As such, they are made to feel at home and provided every possible care and support.

- ***Meetei Leimarol Sinai Sang:*** The MLSS is a non-profitable community based women's voluntary organization. It was established in 1983 and has been working for the progress and development of the people with a special focus on women and children since its inception. Its vision is an establishment of a healthy, peaceful and developed Manipur. The mission is to work within the community giving special care for women and children, with the participation and support of the people, NGOs, government and other concerns for making a healthy, peaceful and developed Manipur.

  ***Some of its objectives are:***

  1. To cultivate and harness the resources of the people, giving special importance to women and children for their progress and development.
  2. To create awareness, promote, prevent and care for the health of people, particularly women and children.
  3. To make our society free from drugs, HIV/AIDS and other vulnerable diseases.
  4. To take up drug-addiction centre, rehabilitation centre, orphanage, health care centre and other related institutions.

The MLSS through the constant support and active participation of the people has been in the service of the people particularly backward Schedule Tribes/Castes and rural people of the state with a focus on women and children. It provides home care to infected children at several Kuki villages in Sadar Hills. Apart from these, they also provide a shelter home for the female infected children at Koirengei in Imphal.

MLSS is found to be the most functional NGO in providing services to the HIV and AIDS infected persons and their families. Along with the active participation of the Kuki women as staff, more people are found to come out for treatment from the NGO. The involvement of the Kuki ladies plays a positive role in the Kuki community as it encourages and enables the infected persons to shed their inhibitions and share their problems. They feel more comfortable and open to discuss the matters to their own group due to many factors such as language problem, no travel expense and easy

of positive/infected women who have joined the NGO as volunteers to reach out to more people in the community with the same cause.

In the orphanage which the NGO operates at Koirengei, it provides care and support to these children by giving the children medical treatment, schooling, vocational training such as making bags, weaving, tailoring etc. the children could go and spent time with their families during Christmas seasons.

The total number of orphan children in the orphanages amounts to about one hundred forty in all as seen in table-1.10. From this total number of children the following tables are being provided to present the profile of the children taken for more detailed study.

**Table – 1.10**

**Profile of HIV positive orphans in the orphanages:**

| Sl no. | Age | Sex | Economic status | Status of parents |
|---|---|---|---|---|
| 1 | 6 | f | Low income group | Dead |
| 2 | 9 | m | Low income group | Dead |
| 3 | 11 | m | Middle income group | Dead |
| 4 | 14 | f | Low income group | Mother alive |
| 5 | 7 | f | Middle income group | Father alive |
| 6 | 12 | f | Low income group | Dead |
| 7 | 10 | f | Low income group | Dead |
| 8 | 8 | f | Middle income group | Dead |
| 9 | 11 | f | Low income group | Dead |
| 10 | 9 | f | Low income group | Dead |

**Table –1.11**

**Profile of non-infected HIV/AIDS orphans in the orphanages:**

| SL.No. | Age | Sex | Economic status | Status of parents |
|---|---|---|---|---|
| 11 | 9 | F | Low economic group | dead |
| 12 | 12 | F | Low economic group | dead |
| 13 | 14 | M | Low economic group | dead |
| 14 | 6 | M | Low income group | dead |
| 15 | 10 | M | Low income group | Mother alive |
| 16 | 7 | M | Low income group | dead |
| 17 | 9 | F | Middle income group | dead |
| 18 | 8 | F | Low income group | dead |
| 19 | 5 | M | Middle income group | dead |
| 20 | 11 | F | Low income group | Mother alive |

**Table -1.12**

**Profile of children orphaned otherwise in the orphanages:**

| Sl.no. | Age | Sex | Economic status | Status of parents |
|---|---|---|---|---|
| 21 | 7 | F | Low income group | dead |
| 22 | 5 | M | Low income group | dead |
| 23 | 3 | M | Low income group | dead |
| 24 | 9 | F | Low income group | dead |
| 25 | 8 | F | Low income group | Mother alive |
| 26 | 12 | M | Low income group | dead |
| 27 | 10 | M | Low income group | dead |
| 28 | 14 | M | Low income group | Father alive |
| 29 | 5 | F | Low income group | dead |
| 30 | 4 | F | Middle income group | dead |

While interacting with the children in the orphanages, it was found that they missed their family and friends but being confined in the orphanages they cannot go out according to their own free will. They feel sorry for themselves as they are deprived of the right to live in a family environment. Carol Levine (1994) has clearly pointed out the significance of family in the life of children and when deprived of the opportunity to grow up in a supportive family environment, children are found to receive less stimulation, individual attention and love and are ill prepared for life and healthy social interaction. By and large, the aspect of 'care about' is found to be greatly lacking in some of the orphanages. However, the responses of the children vary in terms of the care and support they receive in the orphanages. While some children missed the homely or the natural environment they had left behind, some children feel there is no place like the institution they are placed in.

There were different responses from the children in the orphanages. Each child who was interacted with shared different experiences. The pattern of experience varies from one child to the other. Some children feel very comfortable in the orphanage, while there are some who do not feel comfortable. There are some children who feel

the orphanages are better than their previous stay, while some do not feel at home in the same. There were some children who could not afford to eat proper food and clothes before they were placed in the orphanage. These children said they enjoyed the life in the institutions as they no longer have to go hungry. There are also children who have built strong bonds with the other peer groups who share similar experiences. As such, there is a strong attachment among these children.

A ten year old child who has been orphaned as he lost his parents during the communal conflict says:

*"I used to stay with my uncle and his family, however as they could no longer support me, I was sent to an orphanage. Initially, I was missing home, however I began to feel more at home than my previous family. I meet a lot of children like me who are in the same situation like me. We all feel the same way about life without parental care. I began to grow very close to the children in the orphanage. There are children younger than me. Rather than pitying my life, I began to gain a family here in the orphanage. I have become so attached to everyone here that I do not have a heart to leave it anymore. We get proper food and schooling. I want to study well and become a big officer someday."*

A non-infected HIV girl of twelve years who lost her parents due to AIDS staying in the orphanage also says:

*"When I stayed with my grandparents, although they loved me a lot, they could not afford my schooling, so I was sent to my aunt's house. However, it was hard to get along with the other siblings. I felt much neglected although I was cared for with proper food, clothes and schooling. A year later, I was admitted to an orphanage. I cried a lot when I was sent there. However, after a month or so, I began to have lots of friends who were like me without parents. Although I used to miss my parents and my grandparents, I enjoy the company of my friends here in the orphanage. When I go for Christmas celebration, I could get to meet my old friends in the village."*

As regard to the differences between boys and girls, girls have less complains in the orphanages. They feel here they share equal work load, while girls carry out the kitchen chores, the boys are also engaged in other jobs. Everyone is given a share of things to be done. No one is spared on the basis of age, sex or class. A non-infected girl of eleven years old in the orphanage shares:

*"Back at home I was the only one who would do all the household work, the younger boys would just play around and come home at lunch time or dinner time, while I hardly had time to meet my friends and play. However, here in the orphanage, all the children eat, drink, play and work together. There is no segregation of work. As such I prefer the live here in the orphanage where I enjoy doing things with my friends who have also lost their parents."*

The experiences of these children in the orphanages vary. There is a boy of fourteen years who has been orphaned otherwise and has been in the orphanage for the past two years. He longs to run around the fields chasing birds, swim in the river and enjoy the wild fruits that grow in the forest which he had enjoyed before he was brought into the orphanage. After coming to the orphanage, he has been denied of all these experiences and fun. He says:

*"I miss my village where I could run around anywhere, and do anything I want to. But here in the orphanage I have to follow many rules, follow a routine for everything which is very tedious."*

Children orphaned by HIV and AIDS face different experiences due to the fact that they are attached with the disease which carries stigmatisation along with it. Even though they may not be themselves infected, they are regarded as children whose parents have died of a disease which is regarded as frightening and fearful. For some of these children, orphanage seems a safe refuge to hide from social discrimination. However, even inside the orphanage, they feel that they are treated differently from the other children. Except in orphanages specially meant for the infected children of HIV and AIDS, in other orphanages where all children are kept together, they feel the difference in the treatment catered to them. There were children who were aware about the death of their parents. They knew that their parents died of a disease which was socially regarded as undesirable. There was a non-infected girl in one of the orphanage whose parents have died of the disease. She shares her experiences saying that people around would feel hesitant to be friendly with her. Sometimes, she would be left without any friends as parents would not allow their children to play with her. As there was no proper care taker for her and her sister, they were sent to an orphanage. Even in the orphanage, they feel very distant from the other children as they feel the difference in the treatment as compared to other children. The elder sister says:

*"We are at least safe from the gossips that we faced before we came to the orphanage. However, even in the orphanage, people who know about our parent's death seem to treat us differently with some reservations."* Children whose parents have died of HIV and AIDS are found to share similar experiences. They feel they are being denied equal treatment.

On the other hand, children who are themselves infected face more disappointment and frustration. Children in the orphanage which is meant only for the infected children are seen to be the worst sufferers of HIV and AIDS. They are denied the carefree and fun filled life of childhood. There is an HIV infected girl of ten years in the orphanage who says:

*"I wish I am not sick like this. I want to grow up and enjoy like other children. I terribly missed my family and friends. I am confined to this place and I'm told that if I want to get well, I have to stay here and take proper medication. They give us proper food but I want to be with my family and friends in the village. Sometimes, during Christmas season when I go for holidays, I cry a lot when I have to come back. I want to get well soon and stay in the village permanently."*

In most cases the infected children need proper care and support which the family is unable to cope with due to lack of enough resources. Even though they care about their children, due to lack of proper medication for their treatment, they are left with no option but to send their children to the orphanages where they provide proper medical aid to children of HIV and AIDS. However, these children feel sorry for their lives as they are deprived of the right to live in a family environment which is crucial for the development of a positive self-identity and self-esteem. The loss of parents implies more than just the disappearance of a caregiver. It pervades every aspect of a child's life; their emotional well-being, physical security, mental development and overall health. It deprives them of the right to live in a family environment when the family is unable to cope with all the expenses it has to incur for the treatment. Thereby, there is no option but to send the child to the orphanages for better medical treatment. However, the child's perspective of care and support does not rest only in the medical aid, proper food and the material needs, but more importantly, the meeting or the satisfaction of their emotional and psychological needs. As such, the facet of care and support lies not only in catering to the need for

being 'cared for' which meets their physical needs but also more importantly to cater to their emotional satisfaction of being 'cared about' wherever they may be placed.

These orphanages were overall maintained satisfactorily, however it was felt that the quality of care can be enhanced and organized with more adequate financial and social support. The feedback during the study was that sometimes the resources available are not sufficient to meet the requirements of the children. As such they usually fail to accommodate more children who come and seek a refuge in the orphanages. The supply accorded to the orphanages thereby fails to meet the increasing demands.

The NGOs who are working in this area of study face problems while carrying out the various programmes. One main reason pointed out by the staff is the lack of awareness and the people's lack of enthusiasm in participating in the various programmes initiated by the organisation. People are still reluctant to come out with the disease of HIV and AIDS due to fear of discrimination. They point out to the emerging need of greater care and support for the children who are affected by HIV and AIDS as increasing number of children are found to be affected by the disease and lack proper care and support.

A staff working in one of the village opines:
"*I have been working with people living with HIV and AIDS in this village and in the course of my involvement, I find there is still a great need to sensitize the public to the specific needs and problems of children in families affected by the disease as well as to promote a sense of responsibility for responding to the emerging needs faced especially by the orphan children of HIV.*"

Another lady staff from the NGO MLSS says:
"*Apart from the community participation, the government, private organisations, and faith communities can all help create an environment that will facilitate appropriate responses to the families and the children affected by HIV and AIDS, which is still found to be lacking.*"

The NGOs and the caregivers have identified and pointed out certain suggestive measures to improve the nature and the quality of care and support provided to the orphans of all the three categories. Firstly, they point out that there should be more

effective provision of, and greater advocacy for, the services the children need; secondly, imparting more training and information to the personnel to be able to provide care and support to the orphans of all categories with special emphasis on the children affected by HIV and AIDS. Thirdly, adequate and ample resources to meet the needs of these children and fourthly, to have strong support and cooperation from the community in carrying out various programmes related to the welfare of the children. The strain of stigma and discrimination related to HIV and AIDS within the families and community is still a major burden. They also suggest that policy areas could include measures to protect the rights and prevent discrimination against affected children and their families; the availability of affordable voluntary counselling and testing which ensures the accessibility and affordability of the basic medicines needed to treat opportunistic infections; non-discriminatory personnel polices which enable infected person to continue to work, the rights of affected families to medical benefits and insurance.

There is no simple solution. There is not a government, NGO or 'childcare model' that alone can solve the problem of how to prop up all the over-extended families and catch all the children who fall through existing safety nets. But governments, donors, NGOs and community leaders can learn to confront the crisis and try to exorcise the stigma that still surrounds AIDS. More effective planning and co-operation would follow (Guest 2001).

# CHAPTER: 5

## DISCUSSION AND CONCLUSION

The main objective of this exploratory study was to look into the care and support availability for the children affected by HIV and AIDS in Sadar hills in Manipur. As such, the various levels of care and support from the family, community and orphanages were taken into consideration. The findings reveal a mixed picture, where there is potential within the community that needs to be nurtured so that the children can be adequately nurtured. At the same time institutional care is necessary for the very poor, those with no social support and those needing special medical attention. The state has a role to play in promoting both these forms of care for the children affected by HIV and AIDS.

Every child needs some sort of caregiver, whether it is a biological parent, an adoptive or a foster parent, or somebody else who takes the responsibility for providing nurture during the early years of life. Families are not just small groups of closely related individuals who live together or interact on a frequent basis. Families extend outward to include anybody sufficiently related by blood, marriage or adoption forming a larger network of relations called kinship. As such, it was evident, even without having identified all the affected children according to the requirements of a quantitative analysis, that the major proportion of care and support came from the family and kin. The children too prefer the home and community based living rather than in the orphanage. In fact cases came to light that show the community actively supporting such children while they fend for themselves. In all there were 216 orphaned children in the six villages while in all of Manipur there are only 320 children who are under the care of the state funded orphanages. Obviously the large majority of them are being looked after by the family and community.

These findings also point to the need to re-examine the nature of discrimination and stigma experienced by children affected by HIV and AIDS which seem to be more in the orphanages than among the family and community members. As our data shows, the proportion of HIV affected children is much higher in the community than in the orphanages (**Table 1.2**).

## ***Family and Kin as Caregivers***

In the family and kin, the paternal kin are the primary support as expected in a patrilineal social system. The Tucha-Sunggao relationship which relates to the maternal relatives is also significant and the major support outside the immediate family. The care providers providing care and support to children affected by HIV and AIDS in Sadar hills as per the study consist of single parent, maternal grandparents, paternal grandparents, maternal kins, paternal kins, maternal aunty, paternal aunty, paternal uncle and maternal uncle. The grandparents on both sides are the major care givers.

The study shows that the socio-economic status of the care providers greatly determines the nature of the care and support of the children under care. Majority of the respondents come from the low-income group of the society, as such many children cannot be adequately supported by their family due to poverty. In spite of the strong bonds of relationship that exists in the various network of relations in the Kuki community, the determining factor that hinders this level of family care and support is mainly the economic constraint which crippled the family from performing its role of care and support to the children especially the ones affected by HIV and AIDS who needs both adequate medical as well as emotional care and support. The economic status of the foster care givers was found to be better, indicating that, within the family and kin network, the responsibility of caring for the orphaned children is taken by those who are relatively better off.

As per the study, it is found that in both the family and community levels of care, an economic constraint stands out as the main reason for the lack of proper care and support. Children belonging to low income group who depend on daily wages find it difficult and struggled to meet the needs and requirements in the family. While in the case of the high income and middle income group, their physical requirements are adequately met, however in some cases, where children are placed the aspect of 'caring about' where the child's emotional need tend to be neglected. The care and support accorded to the orphaned children is thereby considered insufficient due to the lack in one aspect.

According to the study among the thirty orphan children receiving homecare, 50% of the children belonged to the higher income group, 23.3% in the middle income group

and the remaining 26.7% belonged to the low income group. There is greater number of the higher income group in the family level of care and support, the reason being that these orphan children are within the safety net of caregivers in the family and the kinship relations who are capable and financially better. While in the orphanage, 80% of the orphans hail from the low income group while the remaining 20% comes from the middle income group. Due to economic constraint orphanage remains as the only possible resort to avail care and support for the orphans from these low economic sections. As such, many orphans in the orphanage come from the low economic sections in the society. The economic distribution of the various caregivers in all the levels of care providers according to the study may be seen as 25%, 21.7% and 53% from the higher, middle and lower income respectively. Orphans from the lower income group are found to received care and support mostly from the orphanages. And those orphans in the homecare are mostly under the care and support of caregivers from the higher income group

It appears that boys are more likely to the orphanage, may be to ensure education for them by the poorer families. The girls are most often looked after by the grandparents and aunts/uncles. They are also put to do household tasks that the boys are not. Among the low income group, a girl child tends to be more work loaded and thereby has to contribute much to run the household chores. The economic constraint as such cause a great impact on the girl child especially as she in most cases has to leave school to meet the demands at home.

It is also found that in spite of the preference to nurture orphans in the care of the family and the community, families from low income group are crippled by financial resources and inadequate income, and therefore they are left with no option but send the orphaned children to orphanages. There is an instance of a girl where she has to leave school when she was at her fifth standard. She lost her parents during the communal violence in the 90s. She is now fourteen years old living with her grandparents who are from the low income section. While she is helping out her grandparents in the agricultural field to maintain the family, her younger brothers are in the orphanage.

## *Community Care and Support*

The study of the role of the family in the care and support of children brings to the understanding that family performs the basic functions of not only reproductive but also to rear and care children in the family. However, it is important to note that not every family smoothly carries out its primary functions of nurturing and carrying out the process of socialization of children. As such the care and support of children is also observed in the next level, where the community steps in as the next level of care providers. In the study, there is an evidence of a child-headed household where the community comes forward to provide assistance. The various care takers in the community level are instituted in the roles of the Becha, the village headman and others as well as religious establishments.

The village was seen in the study to be supportive, however not adequately. Community care is found to be lacking to the children especially the children affected by HIV and AIDS. Community members other than kin are not taking primary responsibility of the children even though they do play a supportive role when others do so. A great need is felt by the NGOs working in this area of study to increase the awareness of HIV and AIDS and urge for more response from the people to understand and support the people living with HIV and AIDS and the children affected by the disease.

Orphanages are set up as an alternative for children without families and home without proper parental care, although institutionalization is not considered a satisfactory alternative to homes where children belong to their natural environment. Poverty-stricken parents and relatives may abandon their children to an institution if they believe that the immediate needs of their child will be better served. This is supported by the study made by Jean Marie Anglade, on "How poverty separates children and parents- A challenge to family continuity and human rights" (Anglade 2005). In the study it is seen that there are cases of children where the mother is alive but due to financial constraints, the child is sent to the orphanage so that at least the various basic necessities along with fundamental schooling which the primary caregiver cannot afford can be met. In the study, there are six cases of such children who are sent to the orphanages in spite of having single parent alive.

Study has also been made as to whether the aspect of cared about finds less room in the orphanages. As orphan children lack consistent caregivers, during the study when orphans are asked about their problems, the first one most children mention is that they miss the love of their parents and family. Denied the proximity to family life, most children in the orphanage are found to be lacking in love, attention and affection which are actually the most fundamental assets at this stage of their childhood. However there are also cases where children have found strong attachment in the orphanages. No matter where the child is reared, safety, permanence and child well-being are to be regarded as the primary goals (Bass, Shields & Behrman 2004).

As such a child's developmental needs are best met when their substitute caregivers - be it in the family level, community level or in the orphanages- are able to provide these criteria to nurture and commit to the orphan children over the long term. The disappearance of the primary caretaker in the family pervades every aspect of a child's life: their emotional well-being, physical security, mental development and overall health. It deprives the child of the right to live in a family environment (Guest 2001). Similarly, the experiences of the orphans in the study show that it is not just 'caring for' and seeing their physical needs that is essential but more so of 'caring about' that the child craves and yearns for.

Reflecting on the nature of the care and support to the different categories of children in the study, various themes such as long-term trusting relationships, premised on respect and caring, and built over time, are found to be crucial to meeting the needs of the orphans in care, to providing a family environment, and to supporting substitute caregivers to effectively parent the child in care. This finding is similarly supported in the studies by Renwick, Schormans and Zechovic (2003) where they have mentioned that relationship facilitates an understanding of the child as a person, of their individual needs and personality, and the development of emotional attachments which reinforce placement stability. A caregiver in one of the orphanage points out that what is highly important for these orphans is the stability of caregivers in the various levels where they have someone who listens and cares for them genuinely.

Study shows that there is also variation between children orphaned by HIV and AIDS and those orphaned otherwise. Children orphaned by HIV and AIDS face different experiences due to the fact that they are attached with the disease which carries stigmatization along with it. Even though they may not be themselves infected, they

are regarded a children whose parents have died of a disease which is looked upon as frightening and fearful. As such these children feel different and alienated from the other orphan children. The participating caregivers have also pointed out the difference in the needs of the children affected by HIV and those orphaned otherwise. They feel there is a need to show the former children that they are loved and accepted as they are even though they are affected by HIV. Caregivers opined that these children are more likely to become solitary, appear distressed and be fearful of new situations as compared to ordinary children.

On the other hand, children who are themselves infected are faced with much more disappointments and frustrations. Even though the family care about their children, due to lack of proper medication for their treatment, they are left with no option but to send their children to the orphanages where they provide better medical aid.

The main findings from the study on the care and support of children in all the three levels of care and support relate to children's experiences and potential for exclusion, loneliness, isolation, uncertainties and their fears and worries. They not only undergo the trauma of not only losing their parents at such a young age, but they also face the denial of the aspect of 'cared about' when children do not receive proper care and support from their respective caregivers. In most cases, children do not want to leave their villages or their natural home. Children long for a familiar identifiable community with the people around them maintaining family relationships which would reduce the strong weight of stigma and discrimination but rather strengthen and provide social activities and build up community networks. Thus, there is a need to recognize children's participation in decision making in a safe environment wherever they are placed without the worries of prejudice, stigma and neglect and where both the aspects of 'cared for' and cared about' are felt and recognized.

Most of the caregivers in the various levels opined that even though all children need proper care and support when they lost their biological parents or their primary caretakers, the children affected by HIV and AIDS needs to be given more emphasis considering the trauma of experiencing the death of their parents dying of a dreadful and alarming disease. While some caregivers articulated that the needs of all the orphans are more or less similar. One caregiver in the orphanage says:

*"All children crave for love, attention and care. So, I feel they all require the same needs. Every kid needs acceptance and they need to have friends and family. Considering all, I feel they all have the same requirements."*

Another universal need as stated by the caregivers is the placement stability. Irrespective of the type of their placement, what children need is stability. They need nurturing; they need unconditional love and care. They need someone who is readily available for them. The study divulges that when children are deprived of the right to live in a family environment, children are found to receive less stimulation, individual attention and love and are ill prepared for life and healthy social interaction. One non-infected girl of 14 years says:

*"When my father passed away, my mother could not afford my schooling and basic needs with other siblings in the family. So, she sent me to an orphanage in Imphal. After a year, I pleaded my mother to take me home because I missed my family so much. Although I was properly fed and taken care of, I terribly missed the love and affection from the home environment. So, I am now united with my family and helping out my mother in the household chores and care of the younger siblings. I am not enjoying good food and proper education any longer but I am happy to be with my family no matter what the situation is."*

Another non-infected orphaned boy of twelve years says: *"Even though my parents have died, my grandparents are like my parents. I use to miss my parents but my grandparents would buy me whatever I like. I have many toys. I also have a new bicycle. My cousins would come over to my place to play with me. I really enjoy playing with them."* The child is made to feel at his best by the surviving family members and as such they try to fill the gap that is left by his parents.

Thus the aspect of "caring about" is very much significant to curb the painful experiences of the children who are affected by HIV and AIDS. While the findings are limited in their generalization by sample size and the nature of qualitative research, the information provided by participants in this study reinforces the importance of the feeling of acceptance and also the importance of placement stability to all orphans in care in various levels of caregivers. "Positive and consistent caregivers has the potential to compensate for factors that have a deleterious impact on children." (Jones 2004)

As the study shows, the socio-economic status of the caregivers is a great determinant of the nature of the care and support of the orphans. The areas of priority that are identified includes ensuring food and nutrition, increasing access to education, ensuring child protection and socio economic security and monitoring of the caregivers, advocacy and community mobilization.

## *Role of state agencies*

The Convention on the Rights of the Child in article 19 requires states parties to take all appropriate measures to protect children from "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardians(s) or any other person who has the care of the child." Article 20(1) provides that "a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State."

However, it is evident from this study that the state cannot ensure it through the conventional institutional care of orphanages alone. Neither the quantum nor the quality can meet the needs of these children in the present times. Ways of promoting existing social support systems and supplementing them with innovative means of institutional care have to be evolved. Some examples are available from the global experience of orphan care, such as the SOS villages, and from African countries in promoting community support.

## *Conceptualising Strengthening of Community Care*

### *Evidence of collective care of children*

In pre-industrial England two immediate responses were made for the provision of care and support for the infirm elderly, the young children and the chronically disabled: first was the church and secondly was that extended group of kin who may not necessarily live under the same roof (Dalley 1998).

Gillian Dalley (1998) has pointed out that extended families, supported by neighbourhoods and/or religious and caste networks, carry out such fostering and

generally keep the state and various other formal organizations at arms' length. If these families are to continue to foster those whom they perceive as their 'own' (and if the circle of perceived responsibility is not to shrink drastically) they will need new sources of support for instance when the number of orphans increase dramatically at the same time that family, neighbourhood, caste and religious networks weaken and wither under the onslaught of AIDS.

Families and communities are seen as the first to respond to the need of children in affected families. Consequently, governmental and the agency policies and programmes to benefit these children will need to focus primarily on how they can support families and communities to provide for their needs. The emphasis will be on supporting, and where government policies and programmes include the full range of children's psychological, social, material, legal and spiritual needs (Miriam 1998).

Certainly, the picture of young children being cared for by a number of people-both adults and older children, both kin and non-kin – is a familiar image across the world. The following passage from the classic anthropological text by Radcliffe-Brown (1964), *The Andaman Islanders,* originally written almost eighty years ago, is typical of many other ethnographic accounts written subsequently:

Children are such favourites with the Andamanese that a child is played with and petted and nursed not only by his own father and mother but by everyone in the village. A woman with an unweaned child will often give suck to the children of other women. Before the children can walk they are carried about by the mother and sometimes by the father or other persons.

In the case of Andaman islanders, it was commonplace for children to be fostered into the families of friends and neighbours. Once children reached the age of six or seven, they frequently moved to live with other families and their own parents took in children from elsewhere. There was no apparent economic reason for doing this; it was simply a means of fulfilling friendship obligations. And it did not mean that their parental or filial feelings were diminished; these ties were maintained by frequent visiting.

Fostering has been commonplace too in many other parts of the world- that is, fostering in the sense that parents do not regard themselves as having exclusive rights over the rearing of their children, and therefore perceive a variety of benefits to stem

from the 'sharing' of these with other people. Goody's (1982) study of fostering practices in West Africa demonstrates that it is widespread there, and relates its different forms to the structures of the particular societies involved. Gillian Dalley (1988) in her book "ideologies of caring" points out that the non-centralized and segmentary societies are less inclined to adopt the practice, or even if they do, only amongst close kin. On the other hand, more differentiated, centralized societies have adopted elaborate forms of the practice. In some cases it may be to strengthen alliances and friendships, in others it may be to offer informal training and learning opportunities, or to enable children concerned to be better placed economically and socially in their future lives. The Kuki society is seen more in the light of a centralised and a close-knit homogenous community. Among the Kukis, although the parental roles are regarded as most appropriately filled by the biological parents within the nuclear family, in the absence of the biological parents, these roles are available for sharing not only among the kins but even with un-related neighbours and friends which is also an effective way of spreading the task of caring for deprived children.

Alice A. Ansah Koi (2006) in her study on the care of children in Ghana finds that commitment to care for orphans extends beyond kinship ties. Obligation of communities, sympathy, altruism or religious beliefs may also make it possible for children to have continuity of care if there is nobody in the immediate or extended family to care for them after the death of their parents. The assumption is that children belong to the community and the community is responsible for providing care and nurturing them. In fact, the only time a child is said to belong to one person (i.e., the mother) is the period of pregnancy. Once a child is born, he or she is assumed to belong to the whole community; members of the community are equally responsible for providing care and support and nurturing the child. Members of the community who may not in any way be related to the orphans may take it upon themselves to foster them. It is also possible that some sympathizers may not foster children but may offer financial and material support for orphans while these orphans live with other families. In some of the villages, there are schools where there tuition fees are waived or concessions are offered to orphan children who cannot afford to pay their fees.

Another form of community care is where community leaders are expected to assume key roles in offering support and care for needy and vulnerable children especially

those in situations where biological parents are unable to care for them. In such cases, traditional leaders such as chiefs and leaders within the communities may spearhead such initiatives. Such an instance is found to be practiced in the Manya Krobo District of Ghana where queen mothers are fostering children whose parents have died of AIDS (UNDP & Ghana AIDS Commission, 2003). Queen mothers are generally regarded as mothers to all members of the community. As mothers they are responsible for ensuring the welfare of members of the community especially women and children. For example, through the Queen Mothers Orphans Care Initiative, the Queen Mothers in the Manya Krobo district help to take care of orphans and vulnerable children in their various communities. It is reported that each queen mother fosters at least six orphans in her home (UNDP & Ghana AIDS Commission, 2003). This is not the same as institutional care as in this case the orphans are taken care of in a traditional home setting.

It is written that this is the first time in the history of Ghana that queen mothers have taken it upon themselves to foster orphans on such a large scale. Fostering by the queen mothers is unique in the care services systems for orphans and is a commendable thing because queen mothers are traditional political figures who have taken the initiatives to take care for orphans in their own homes thereby setting an example for members of the community and other queen mothers. As the orphans are taken care of in a home setting, they are integrated into the families of the queen mother. This seems similar to the traditional Kuki practice of the village chieftain taking orphaned children into his own family. While this practice is now dying, can it be revived is an option to consider.

With regard to the care and support catered by the community, Shanti George has written about the term 'community fostering' which has come into use in southern Africa in the context of children orphaned by HIV/AIDS. It appears to be used as a contrast to institutional care, and indeed it often emerges in the context of the make over of conventional orphanages or hospital units for abandoned children-i.e., 'fostering in the community' denotes not holding children in institutions, especially given that the AIDS pandemic has engendered a large number of orphans with which no rushed huge programme of orphanage building could hope to keep up. The term denotes that a middle level should emerge that comprises the amorphous social groupings that have 'traditionally' supported those who foster children and that constitutes what we call civil society. Local non-governmental organizations

encourage and support capacities within these amorphous social groupings, and simultaneously bring them into contact with the state agencies that can provide material aid in a context where AIDS eats away at the economic underpinnings of society. 'Community child care volunteers' in Zimbabwe may be cited as an example. They are known as foot soldiers wearing green uniforms numbering some twenty or so in number. Their homes have become safe houses for children in exigencies. They support sibling-headed households and grandparent-headed households, with advice and help and sometimes material aid despite their limited means.

Although no exact pictures of such volunteers exist in the area of study in Sadar Hills, there are a number of institutions or orphanages which mushroomed due to the emerging needs. There is also a school in Kangpokpi which provides free education to the orphaned children. Some of these institutions run with funds from the government while some are managed by donations from missions or churches. However, the common picture seen is that there is also strong sense of community support to these institutions in terms of cash or kind.

## ***Improving Institutional Care***

### ***SOS Villages***

SOS village stands out as an institution where a child is brought up in a family environment and can be considered as a model institute for bringing up children without proper parental care. SOS children's village is independent non-governmental and social development organization which has been active in the field of children's needs, concerns and rights since 1949. Its activities focus on neglected and abandoned children and orphans as well as disadvantaged families.

Even if a child cannot stay with his/her biological family, the right to care, protection and equal opportunities should still be guaranteed. This is the basic principle according to which SOS children's villages carries out its activities in 132 countries. SOS villages make it possible for children to be part of a family once again by providing family-based care.

In addition to this, there are various "family –strengthening" programmes and facilities which offer targeted promotion and advice for socially and economically disadvantaged families at risk of living in poverty. SOS also recognizes the

importance of preparing them thoroughly for independence apart from providing physical and emotional stability. They also provide people's basic health care and cater other preventive progammes as regards to the fight against AIDS and to teach people how best to care for their children and their children's health.

The first SOS children's village was founded by Hermann Gmeiner in 1949 in Imst, Austria. He was committed to helping children who had lost their homes, their security and their families as result of the Second World War. The organization provided a family approach to the long term care of orphaned and abandonment children. This concept is based on four principles:

1. ***The mother***- Each child has a caring parent. The SOS mother builds a close relationship with every child entrusted to her, she provides the security, love and stability that each child needs. As a child care professional she lives together with the children guides their development she recognizes and respects each child's family background, cultural roots and religion.
2. ***Brothers and sisters***: family ties grow naturally. Girls and boys of different ages live together as brothers and sisters with natural brothers and sisters always staying together with the same SOS family. These children and their SOS mother build emotional ties that last a lifetime.
3. ***The house***: each family creates its own home. The house is the family's home with its feeling, rhythm and routine. Under its roofs, children enjoy a real sense of security and belonging. Children grow and learn together, sharing responsibilities and all the joys and sorrows of daily life.
4. ***Village:*** SOS families live together forming a supportive village environment where children enjoy a happy childhood. They also live as integrated and contributing members of the local community. Through his or her family village and community each child learns to participate actively in society.

Such institutions for the orphans provide a family-based care and support are a commendable example in setting up institutions for children without proper parental care and support. As institution is seen as the last resort for the orphans without proper parental care and support to seek refuge or place of safety, it is important that the various orphanages are equipped and consistent to meet the needs of the children

who come under its umbrella for care and support. The Convention on the Rights of Children in its article 3 states that state parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent super vision.

Against this background, there is obviously a need for innovative strategies—as well as resources to implement them—if children affected by HIV and AIDS are not to be treated in a manner that jeopardise their rights and contradicts accepted good practice in child care. Such strategies must include: countering the removal of a child from parental care solely for reasons directly linked to the parents HIV and AIDS status; provisions of sufficient resources (including treatment) and support to parents to enable them to continue to care for their children; provision of support to kin and others who could provide family based care when maintenance of children with their parents is impossible; information and other campaign to overcome stigma and affective promotion of policies restricting the establishment of residential units with the requirement that the potential resources involved be re-directed to family based schemes.

The UNICEF/ISS working paper provides a list of issues for which internationally-agreed guidelines or minimum standards do not exist and are needed, almost all of which are relevant in the context of HIV and AIDS. Those of particular importance in this regard include:

- Services to be provided for maintaining children in safety with their parents wherever possible.
- Conditions to be met when children are to be removed from parental care.
- Processes and mechanisms enabling the children (and, where applicable, their parents) concerned to have a real say in the care option chooser, and to be consulted regularly throughout the period in which out-of-home care is provided.
- Permanent planning.
- Protection in informal care situations.
- Selection, training, monitoring and support for faster caregivers.

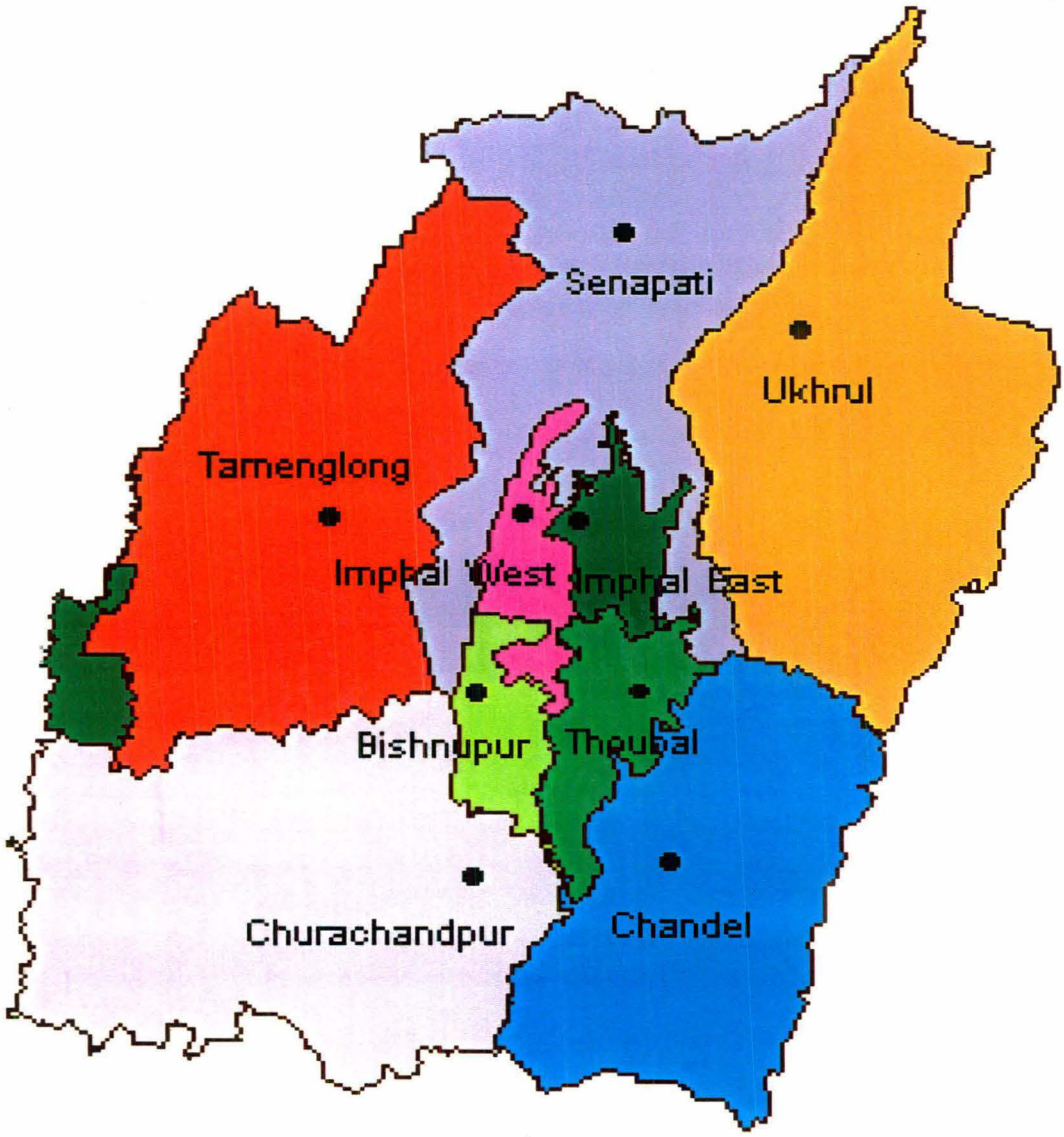
- Recourse to, conditions in residential care.
- Responses to child-headed households.

In order to respond to the specific concern raised on this paper, both international and national standards and guidelines should also explicitly address.

- The importance of provisions to prevent separation. In the case of parents or children living with HIV-and other chronic illness-access to health care and related services can prolong lives and make it possible for parents to remain with their children, and siblings to remain together.
- Mechanisms for supporting and monitoring kinship case as well as other forms of informal faster care which can be met by a majority of countries and which help ensure greater protection for children living in such care arrangements.
- Care options and legal mechanisms to ensure appropriate support for abandoned children, and prevent unneeded separation of children from their peers or other discriminatory treatment.
- Guidance on appropriate use of medical considerations in the determination to remove children from care or to isolate them within their care environment.
- Guidance on the appropriate use of different case options, including innovative options for older children, such as child headed households and other supported independent living arrangements, standards relating to inheritance and succession rights as an integral part of permanency planning.

## MAP I

**District wise distribution of HIV positive cases (sero-surveillance), September1986-April2003**

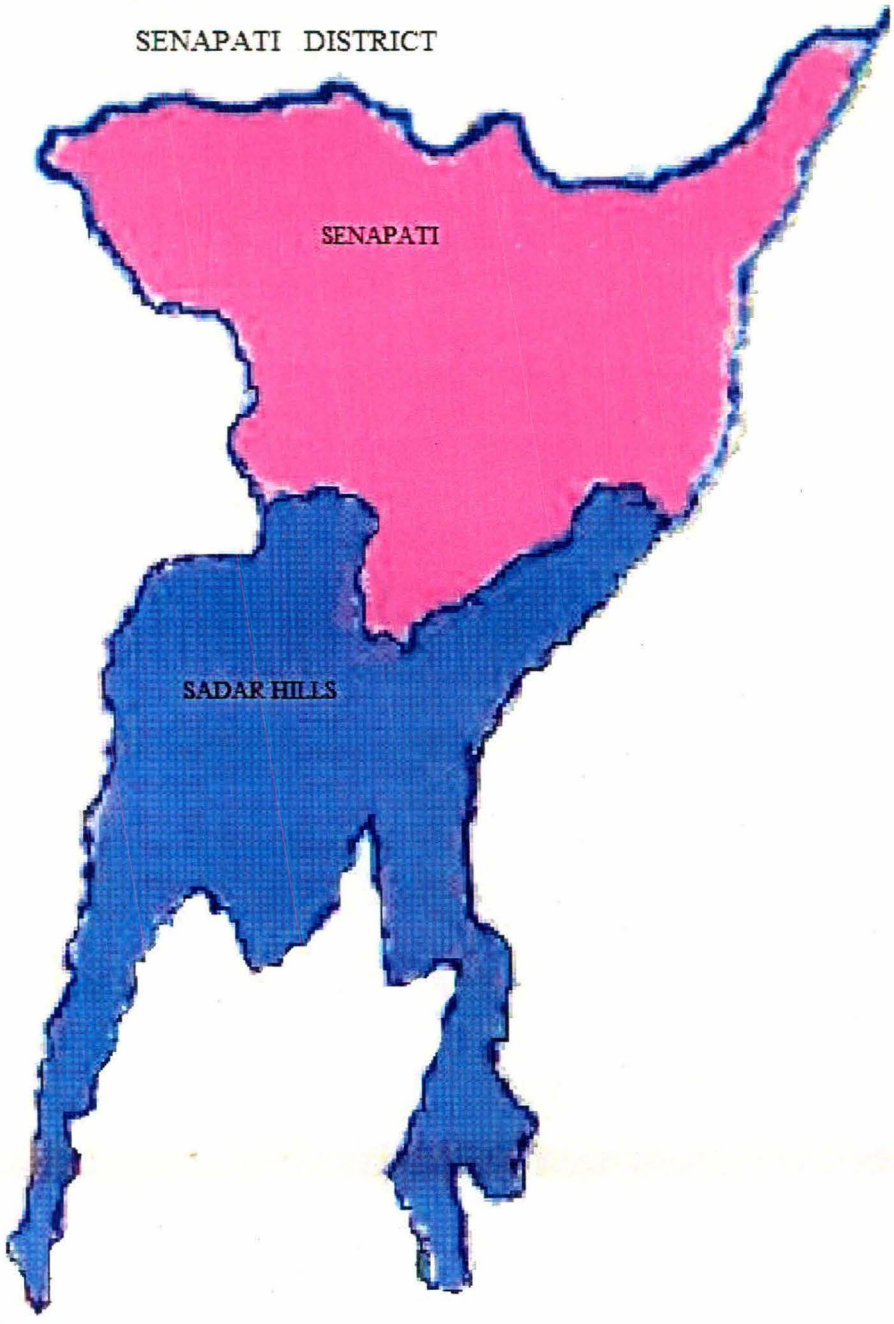



| *District* | *Percentage* |
|---|---|
| IMPHAL EAST & IMPHAL WEST | -------68.19 |
| THOUBAL | ------9.49 |
| CHURACHANPUR | -------5.68 |
| BISHNUPUR | ------4.97 |
| SENAPATI | ------3.90 |
| CHANDEL | ------3.85 |
| UKHRUL | ------3.65 |
| TAMENGLONG | ------0.26 |

(* Courtesy: Manipur State AIDS Control Society)

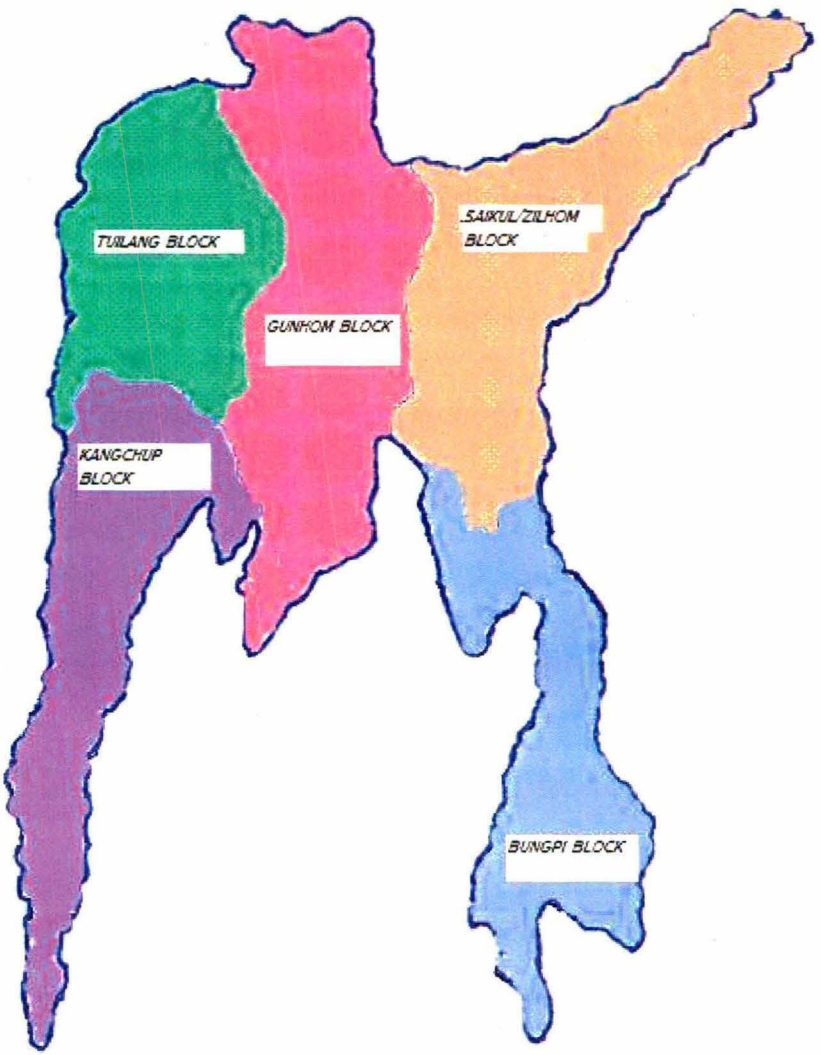
## MAP II

## SENAPATI DISTRICT:



## MAP III

## SADAR HILLS (AREA OF STUDY):




- Tuilang block
- Gunhom block
- Saikul/Zilhom block
- Kangchup block
- Bungpi block

# BIBLIOGRAPHY

## BOOKS


Bronferbrenner, U, 1994, "Ecological Models of Human Development" in Husen, T. and Postlethwaite, T. N. (Eds*), International Encyclopedia of Education (2nd edition, Vol. 3),* Oxford, Pergamon/Elsevier Science

Campbell, C. A., 1999, *Women, Families and HIV/AIDS*, New York, Cambridge University Press

Capvung Doliand S., 1995, The social institutions of the Vaipheis in Naorem Sanajaoba (Ed), *Manipur: Past and Present,* New Delhi, Mittal Publication

Dalley, Gillian, 1988, *Ideologies of Caring, Rethinking, Community and Collectivism*, London, Macmillan Education Ltd

D'Cruz, Premilla, 2004, *Family Care in HIV/AIDS: Exploring Lived Experience*, New Delhi, Sage Publications

Dena, Lal, 1991, *History of Modern Manipur (1826-1949),* New Delhi, Orbit Publishers-Distributors

Etzioni, A, 1964, *The Active Society: A Theory of Societal and Political Process,* London, Collier-Macmillan

Fox Robin, 1967, *Kinship and Marriage: An anthropological perspective*, Middlesex, England, Penguin Books

Gangte, Thangkhomang S., 1993, *The Kukis of Manipur: A Historical Analysis*, New Delhi, Gyan Publishing House

George, Shanti, 2001, Community fostering for children orphaned by HIV/AIDS in India: perspectives from southern Africa. IDPAD seminar on International Perspectives on AIDS Prevention and Care, Amsterdam, 27-29 June.

Goody, E. N., 1982, *Parenthood and Social Reproduction: Fostering and Social Roles in West Africa*, Cambridge: Cambridge University Press

Guest Emma, 2001, *Children of AIDS- Africa's Orphan Crisis*, London, Pluto press

Haralambos, M. and Head, R. M., 1980, *Sociology: Themes and Perspectives*, New Delhi, Oxford University Press

Holman, B, 2002, *The Unknown Fostering: A Study of Private Fostering,* England, Russell House Publishing

Hunter, Susan, 2005, *Aids in Asia: A Continent in Peril*, New York, Palgrave-Macmillan

Kabui, Gangumei, 1995, "Genesis of the Nagas and the Kukis" in Naorem Sanajaoba (Ed), *Manipur: Past and Present,* New Delhi, Mittal Publication

Klein, David M., and White, James M., 1996, *Family Theories: An Introduction*, New Delhi, Sage Publications.

Levine, Carol, 1994, "Aids and the Changing Concept of the Family" in Bor, Robert and Elford, Jonathan (Eds), *Impact of HIV/AIDS On the Family*, Great Britain, British Library Cataloguing-in-publication Data

Lyons, Miriam, 1998, *The Impact of HIV/AIDS on Children, Families and Communities: Risks and Realities of Childhood during the HIV Epidemic*, New York, United Nations Development Programme

MacIver R.M., 1970, *Community - a Sociological Study: Being an Attempt to Set Out the Nature and Fundamental Laws of Social Life*, London. Frank Cass and Co. Ltd.

Marmot, Michael and Wilkinson, Richard G., 1999, *Social Determinants of Health*, United States, Oxford University Press

Mukherjee, R. K., 1979, *Community and Society in India,* Ajmer, Sachin Publications

Murdock George Peter, 1949, *Social Structure*, New York, McMillan

Nelkim, Dorothy, Willis David P. and Parris, Scott V. (Eds), 1991, *A Disease of Society – Cultural Responses to AIDS,* Cambridge: Cambridge University Press.

Parker, R., 1981, "Tending and Social Policy", in Goldberg, E.M and Hatch, S., (Eds), *A New Look at The Personal Social Services, Discussion Paper 4,* London, Policy Studies Institute,

Radcliff-Brown, A. R. 1950, "Introduction", in A. R. Radcliff-Brown and D. Forde (eds), *African Systems of Kinship and Marriage*, London, Oxford University Press

Ramasubban, Radhika (Ed) 2005, *AIDS and Civil Society: India's Learning Curve*, Jaipur, Rawat Publications

Roy, Jyotirmoy, 1958, *History of Manipur*, Calcutta, Eastlight Book House.

Scherer, Jacqueline, 1972, *Contemporary Community: Sociological Illusion or Reality?* , London, Tavistock Publications Limited

Sinclair, I., Gibbs, I., and Wilson, K., 2004, *Foster Careers: Why They Stay and Why They Leave*, London, Jessica Kingsley Publishers

Williamson, John, 2000, *Finding a Way Forward: Principles and Strategies to Reduce the Impact of AIDS on Children and Families,* Washington, The Displaced Children and Orphans Fund and War Victims Fund

## JOURNALS AND ARTICLES


Ankrah, Maxine E, "The Impact of HIV/AIDS on the Family and Other Significant Relationships: The African Clan Revisited", *AIDS CARE*; Vol. 5, No. 1, pp 5-12, 1993

Ansah-koi, A. Alice, "Care of Orphans: Fostering Interventions for Children whose Parents Die of AIDS in Ghana" *Families in Societies*: *The Journal of Contemporary Social Services,* Vol. 87 (4): 555 – 564, 2006
Available online: http:// www.familiesinsociety.org.

Bass, S., M.K. Shields, and R.E. Behrman, "Children, Families, and Foster Care: Analysis and Recommendations", *The Future of Children,* 14, 5-29, 2004

Batson, Daniel C., and Tsang Jo-Ann Ahmad, "Four Motives for Community Involvement" *Journal of Social Sciences,* Vol. 58 (3): 429 – 445. 2002

Bernard Van Leer Foundation, "An interview with Emmanuel Sherwin: There is An Invisible Wall between Children in Care and the Community", *Early Childhood Matters*, No. 105: 32 – 36, December 2005

Cantwell, Nigel, "The Challenges of Out-of-Home Care" in Bernard Van Leer Foundation, 2005, 'Children without Parental Care: Qualitative Alternatives', *Early Childhood Matters*, No105, December 2005

Casas, Ferran, "Children's Rights and Children's Quality of Life: Conceptual and Practical Issues", Social *Indicators Research* 42: 283-298, 1997- Kluwer Academic Publishers, Netherlands

Corinne Grainger, Webb, Douglas, and Elliot, Lyn, 2001, *Children Affected by HIV/AIDS: Rights and Responses in the Developing World, Working* Paper Number 23, May 2001, *Save the Children UK-*

Drew R.S., Makufa C and Foster G., "Strategies for Providing Care and Support to Children Orphaned by AIDS", *AIDS Care*, Vol. 10, Supplement 1, pp.9-15 April 1998

Edelstein, S. B., D. Burge and J. Waterman, "Helping Foster Parents Cope with Separation, Loss and Grief", *Child Welfare* 80(1): 5 – 25. 2001

EFICOR, "HIV AND AIDS", *Drishtikone-Evangelical perspective on Mission and Ethics,* December 05- March 06

Foster, G., "Supporting Children in Need through a Community-Based Orphan Visiting Programme", *AIDS Care*, Vol. 8, No. 4.pp386-403, 1996

Gardner, H., "The Concept of Family: Perceptions of Children in Family Foster Care", *Child Welfare,* 75(2), 161-182, 1996

Gardner, William and Preator, Karleen, "Children of Seropositive Mothers in the U.S. AIDS Epidemic, *Journal of Social Issues*, Vol. 52, No 3, pp177-195, 1996
Jones, Harden B., "Safety and Stability for Foster Children: A Developmental Perspective" *The Future of Children,* 14: 31 - 47. 2004.

Renwick, R., Fudge Schormans, A., and Zekovic, B., "Quality of Life for Children with Developmental Disabilities: a new conceptual framework", *Journal on developmental disabilities*, 10,107-114, 2003.

Stukas, Arthur A. and Dunlap, Michelle R, Community Involvement: Theoretical Approaches and Educational Initiatives, *Journal of Social Issues*, Vol,58, No. 3,pp.41-427, 2002

Thomas, J. and M. Bandyopadhyay, Ethnic Minorities and Their Vulnerability to AIDS in a Border State of India, *AIDS Care* 11, 1:45-60 1999

The White Oak Report, Orphan Project, New York, 2000

**INTERNET SOURCES:**

Anglade Jean Marie, "How poverty separates children and parents: a challenge to family continuity and human rights", Bernard van leer foundation, *Early childhood matters*, December 2005
http://www.bernardvanleer.org
Accessed on 3rd March 2007

Desmond M Tutu- Archbishop Emeritus, "A Matter of Belonging- How Faith –Based Organizations Can Strengthen Families and Communities to Support Orphans and Vulnerable Children", http://www.christianaid.org.uk
Accessed on 8th May 2007

Drew, R.S, Makufa, C and Foster, G, "Strategies for Providing Care and Support to Children Orphaned by AIDS", *AIDS CARE; Vol. 10, Supplement 1*, 1998
http://www.undp.org/hiv/publications/index.htm and
http://www-nceph.anu.edu.au/htc/html/htr.htm
Accessed on 5th February 2007

"Future Forsaken: Abuses against Children Affected by HIV/AIDS in India", *Human Rights Watch, USA*, 2004, http://www.hrw.org/reports/2004/india0704/index.htm
Accessed on 5th February 2007

Meier (2003, January-February), "The Growth of AIDS Orphans and Policy Solutions" May12, 2007, http://www.eurasiahealth.org/attaches/93/9385/1666.pdf
Accessed on 4th May 2007

Miriam Lyons, "The impact of HIV/AIDS on children, families and communities: Risks and realities of childhood during the HIV epidemic", *United Nations Development Programme-HIV and development programme*, New York, 1998 www.undp.org/hiv/issue 30E. html Accessed on 18th January 2007

Monk. N., "Children of the HIV/AIDS Pandemic: The Challenge for India", Orphan Alert 2, Association, Francois- Xavier Bagroud, http://www.albinasactionfororphans.org/hear/inform.html
Accessed on 22nd January 2007

"Orphanage", *Wikepedia, the Free Encyclopedia*,
http://www.en.wikepedia.org/wki/orphanage
Accessed on 9th April 2007

Philon, M. 2003. "Foster Care and Schooling in West Africa: The State of Knowledge.' *The UNESCO EFA Report Monitoring Report: IRD,* Institute de Recherché Pour le Development France, http:// www.unesco.org/education/gmr/download/summary.pdf
Accessed on 18th January 2007

Phiri, S and Webb, D, "The Impact of HIV/AIDS on Orphans and Programme and Policy Responses", *AIDS, Public Policy and Child Wellbeing,2002* http://www.unicef.icdc.org/research/ESP/aids/aids- index.html
Accessed on 9th April 2007

Teresa Moreno and Jan Van Dongen (Series Editors), "Children without Parental Care: Qualitative Alternatives" Bernard van Leer Foundation, Netherlands, *Early childhood matters*, 2005 http://www.bernardvanleer.org
Accessed on 3rd March 2007

USAID/Ghana (July, 2003). HIV/AIDS strategic plan (2004-2010)
www.dec.org/pdf_docs/pdaby445.pdf
Accessed on 12th April 2007

West, Andy and Zhang Hui, "A Strange Illness: Issues and Research on Children Affected by HIV/AIDS in Central China", Save the children, Beijing, 2005,
http://www.savethechildren.org.cn
Accessed on 3rd March 2007

Williamson, Johnson, 2000, "Finding a Way Forward: Principles and Strategies to Reduce the Impact of AIDS on Children and Families", http:// www.iaen.org/impact/williamson.pdf
Accessed on 20th January 2007

Worldwide AIDS and HIV statistics including deaths
www.avert.org/worldstats.htm
Accessed on 12th April 2007

Improving protection for children without parental care
Care for children affected by HIV/AIDS: the urgent need; UNICEF, International Social Services, November 2004
www.unicef.org/protection/files/HIV-note-final
Accessed on 12th July

http://www.aidsonline.com
http://www.unaids.org
http://www.unicef.org
http://www.orphans.fxb.org

**THESIS/DISSERTATION**

Tuboi P.C., (2005), *Socio-cultural life of the Kukis in Manipur*, PhD. Thesis, Sociology, North Eastern Hills University, Shillong (unpublished)

Irengbam Rajeev (2001), *Demographic and socio-economic scenario of HIV/AIDS infected persons in Imphal District*, M.Phil Dissertation, CSMCH, JNU (unpublished)