HIV/AIDS Risk among the Children of Bangladesh

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ABSTRACT

Everyday more than thousands of people are becoming infected with HIV/AIDs worldwide nearly half of them are women. According to the joint United Nations Program on HIV/AIDs (JNAIDs) "2010 Report on the Global Aids Epidemic", 2.5 million children around the world are living with HIV/AIDs. Most HIV infections are passed from mother to child during pregnancy. Bangladesh as a developing country, in spite of resource scarcity, has been operating some significant policy initiatives with the active role from both governmental and non-governmental bodies to prevent and mitigate the impact of the epidemic in the families. Though there is, no notable program running in Bangladesh especially for children developed awareness as well as preventing them from HIV and AIDS. This Study reviews current knowledge of mother-to-child HIV transmission in developing countries, summarizes key findings from the trials, outlines future research requirements, and implementing prenatal HIV prevention interventions in resource-poor settings. Successful implementation of available prenatal HIV interventions could substantially improve global child survival. As for this, to formulate a complete strategy and action plan in both national and local level for this alarming issue is an utmost necessity.

Key words: HIV infection, HIV/AIDS Targeted Intervention (HATI), Mother to Child Transmission (MTCT), HIV Epidemic, Peer education, Sexually Transmitted Disease (STD), Migrant workers, Pregnant Women, People living with HIV/AIDS (PLHIV)

INTRODUCTION

As a global issue, over twenty-five years into the AIDS (Acquired Immune Deficiency Syndrome) epidemic, like other groups the children in their path remain at grave risk. Basic statistics shows, at the end of 2010, an estimated 34 million people were living with HIV worldwide, up 17 percent from 2001. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years. Although Bangladesh continues to be a low prevalence area, it is surrounded by high prevalence countries (High prevalence of HIV/AIDs in neighboring India). We however must not adopt a complacent attitude in respect as our country has all the determinants for an explosive outbreak of HIV/AIDs epidemic. Curses of poverty, illiteracy, ignorance, proximity of Bangladesh to the so-called 'Golden Triangle' & high prevalence of STDs, make our country seriously vulnerable.

Moreover, the intravenous drug users (IDU) are the potential carriers of HIV/AIDs among the vulnerable groups in the country. Everyday a large number of people cross border movement take place both officially and illegally. Due to reason of that, great chance to spread out HIV/AIDs in Bangladesh.

AIDS is a chronic illness caused by infection with HIV (Human Immunodeficiency Virus). HIV is transmitted through exchange of certain bodily fluids such as blood, semen, vaginal secretions, and breast milk. To produce an infection, the virus must pass through the skin or mucous membranes into the body. HIV infection occurs in all age groups. Twenty-five percent of the babies born to untreated mothers infected with HIV develop HIV infection themselves. Many of these children die within one or two years, but some live for years, although their development is slowed and they can get many infections. Mothers-to-be with HIV must get special treatment to try to prevent transmission of the virus to their fetuses. New treatments for pregnant women may reduce the transmission of the virus to less than one in ten babies of HIV-positive mothers. Drug and/or alcohol abuse, premature and/or promiscuous sexual activity are serious risk behaviors. Evaluation by a child and adolescent psychiatrist can be the first important steps in helping a family respond effectively high-risk behaviors in their children and adolescents (Forsythe, Siegel, Nyamete, 1996).

Today adolescents of both sexes face a serious risk of HIV infection, which is the cause of AIDS in most developing countries. Despite growing understanding and awareness, HIV infection is a serious threat to both heterosexual and homosexual teens. When adolescents take certain risks, they are more prone to become infected with HIV and develop AIDS.

HIV AMONG CHILDREN

According to UNAIDS (The Joint United Nations Program on HIV/AIDS) at the end of 2010, an estimated 3.4 million children worldwide under age 15 years were living with HIV/AIDS. Approximately 1.8 million children under age 15 years had died from the virus or associated causes in that year alone (UNAIDS, 2011). As HIV infection rates rise in the general population, new infections are increasingly concentrating in younger age groups. About 1,000 babies were infected with HIV every day during pregnancy, birth or breastfeeding. (http://unicef.org)

CAUSES OF HIV/AIDS AMONG CHILDREN

HIV/AIDS infections in children are passed from mother to child during pregnancy, labor and delivery, or breastfeeding. In 2009, an estimated 370,000 children contracted HIV during the prenatal and breastfeeding period, down from 500,000 in 2001, according to the JNAIDS report. Beside this, blood transfusions using infected blood or injections with unsterilized needles can lead to HIV infection and AIDS among children.

Although sexual transmission is not a main cause of HIV/AIDS among children, it does occur in countries where children become sexually active at an early age. Children may become infected through sexual abuse.

MOTHER TO CHILD TRANSMISSION (MTCT) OF HIV/AIDS

If a pregnant woman is infected with HIV, she can transmit the virus to her baby during pregnancy. An intervention known as "prevention of mother-to-child transmission of HIV" (PMTCT) provides drugs, counseling and psychological support to help mothers safeguard their infants against the virus. Ensuring PMTCT is provided to all women that

need it is our most effective way to end mother-to-child HIV transmission by 2015, and reach the UN's Millennium Development Goal 6. Ensuring that no baby is born with HIV is an essential step towards achieving an AIDS-free generation. Too far a few pregnant women and their infants have access to this preventive treatment. In the United States, approximately 25 percent of pregnant HIV-infected women not receiving AZT therapies have passed on the virus to their babies (UNAIDS 2008a). The rate is significantly higher in developing countries. In many communities, countries and regions of the world, however, access to services to halt MTCT needs to be scaled up. In 2009, UNAIDS called for the virtual elimination of mother-to-child transmission of HIV by 2015.

"Globally, 45 percent of HIV-positive pregnant women are now receiving treatment to prevent them passing HIV on to their children, with an increasing rate since 2005," said Ann M. Veneman, UNICEF Executive Director. Children are adversely affected by the impact that HIV and AIDS has on country's essential services. One of the most important services that children need is healthcare. In areas heavily affected by AIDS, the large number of patients that they have to look after often overwhelms hospitals. In many cases, these hospitals have lost staff to AIDS, making it even more difficult for them to cope. Providing adequate care for sick children is made all the more difficult with a health system heavily burdened by the HIV epidemic in vulnerable countries like Bangladesh and other developing states.

PREVENTING MOTHER-TO-CHILD TRANSMISSION (MTCT) OF HIV

Women who have reached the advanced stages of HIV disease require a combination of antiretroviral drugs for their own health. This treatment, which must be taken every day for the rest of a woman's life, is also highly effective at preventing mother-to-child transmission (PMTCT). Women who require treatment will usually be advised to take it, beginning either immediately or after the first trimester. Their newborn babies will usually be given a course of treatment for the first few days or weeks of life, to lower the risk even further.

In 1994, a landmark study conducted by the Pediatric AIDS Clinical Trials Group (PACTG) demonstrated that AZT, given to HIV-infected women who had very little or no prior antiretroviral therapy and CD4+ T-cell counts above 200/mm3, reduced the risk of MTCT by two-thirds, from 25 percent to 8 percent. In the study, AZT(Ziduvudine) therapy was initiated in the second or third trimester and continued during born labor, and infant were treated for 6 weeks following birth. Later on according to Kisumu Breastfeeding Study and MITRA PLUS, study shows maternal triple drug therapy to decrease MTCT to further down to around 5 percent. Long-term follow up of the infants and mothers is ongoing.

A few years later, another PACTG study found that the risk of transmitting HIV from a HIV-positive mother to her newborn infant could be reduced to 1.5 percent in those women who received antiretroviral treatment and appropriate medical and obstetrical care during pregnancy. Combination therapies have been shown to be beneficial in treating HIV-infected adults, and current guidelines have been designed accordingly.

The AZT regimen is not available in much of the world because of its high cost and logistical requirements. The cost of a short-course AZT regimen is substantially lower, but is still prohibitive in many countries included Bangladesh, India, Nepal and Malaysia. International agencies are studying whether there may be innovative ways to provide AZT at lower cost, for example, through reductions in drug prices to developing countries or partnerships with industry. As a result, NIAID continues to evaluate other strategies

that may be simpler and less costly to prevent MTCT in various settings. In September 1999, one study demonstrated that short-course therapy nevirapine lowered the risk of HIV-1 transmission during the first 14 to16 weeks of life at nearly 50 percent compared to AZT in a breastfeeding population. As a follow up, NIAID released a final report on additional data showing that the results nevirapine were sustained after 18 months. These findings have significant implications because this simple, inexpensive regimen offers a potential cost-effective alternative for decreasing MTCT in developing countries.

Under the 2010 guidelines of WHO, all HIV positive mothers, identified during pregnancy, should receive an extensive course antiretroviral drugs to prevent mother to child transmission. If these extensive drugs are not available, then the WHO 2006 recommended course might be an option and a woman should begin taking AZT after 28 weeks of pregnancy (or as soon as possible thereafter). During labor, she should take AZT and 3TC, as well as a single dose nevirapine. Her baby should receive a single dose nevirapine immediately after birth, followed by a seven-day course of AZT. The mother should continue taking AZT and 3TC for seven days after delivery, to cut the risk of drug resistance still further.

WHO says that PMTCT programmes are "strongly encouraged" to implement the 2010 recommendations but acknowledges that this might not be possible for all countries. In this situation, there are previous regimens that have been used and might be implemented, these options are shown in the table below.

Table-01

WHO guidelines for PMTCT drug regimens in resource-limited settings

	Pregnancy	Labour	After birth: mother	After birth: infant
2010 Recommendations option A (WHO/UNAIDS/ UNICEF,2011)	Zidovudine (AZT) after 14 weeks	Single dose nevirapine (NVP) and lamivudine (3TC)	Zidovudine (AZT) and lamivudine (3TC) for seven days	(If mother breastfeeds) Daily nevirapine (NVP) syrup until 1 week after breastfeeding has finished. (If using replacement feeding) Daily NVP or AZT until 4-6 weeks of age.
2010 Recommendations option B (WHO/UNAIDS/ UNICEF, 2011)	Triple ARVs after 14 weeks	Triple ARVs	Triple ARVs until 1 week after breastfeeding has finished	4-6 weeks of daily nevirapine (NVP) syrup or daily zidovudine (AZT) syrup, regardless of feeding method.
2006 Recommendations	Zidovudine (AZT) after 28 weeks	Single dose nevirapine (NVP), zidovudine (AZT) and lamivudine (3TC)	zidovudine (AZT) and lamivudine (3TC) for seven days	single dose nevirapine (NVP) and zidovudine (AZT) for seven days
Alternative (higher risk of drug resistance)	Zidovudine (AZT) after 28 weeks	single dose nevirapine (NVP)	-	single dose nevirapine (NVP) and zidovudine (AZT) for seven days

Minimum (less effective)	-	Single dose nevirapine (NVP), zidovudine (AZT) and lamivudine (3TC)	zidovudine (AZT) and lamivudine (3TC) for seven days	single dose nevirapine (NVP)
Minimum (less effective; higher risk of drug resistance)	-	single dose nevirapine (NVP)	-	single dose nevirapine (NVP)

Source: http://.avert.org

Under the 2006 recommendations, if a woman receives at least four weeks of AZT during pregnancy, doctors may choose to omit her dose nevirapine from the recommended regimen. In this case she will not have to take 3TC during labour, or to take any drugs after birth. However, her baby must still receive nevirapine, and should also receive AZT for four weeks instead of one. If the woman receives less than four weeks of AZT during pregnancy then her baby should receive AZT for four weeks instead of one.

GROWING UP WITH THE HIV EPIDEMIC

Children and young adults currently between the ages of 15 to 24 years were born and grew up as the first generation to experience childhood during the HIV/AIDS epidemic (Bernard van Leer Foundation, 2006). Today it is among this same population of 15 - 24 years old that new HIV infections are concentrated. According to recent United Nations estimates, near about half of the 16,000 new HIV infections, which occur daily, are within this age group. An additional 10 percent of new infections occur among children under age 15 years. Since the virus was first identified in 1981, more than 3 million children have been born HIV positive and the mothers of over 8 million children have died from AIDS. The effects of HIV and AIDS on children who are orphaned, or in families where parents are living with the virus, not only include these calculable losses, but also the immeasurable effects of altered roles and relationships within families. Clearly, HIV infection has its greatest impact on the young. The proportion of women living with HIV has remained stable at 50 percent globally, although women are more affected in sub-Saharan Africa (59 percent of all people living with HIV) and the Caribbean (53 percent) (UNAIDS 2011).

Regionally we see that Sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68 percent of all people living with HIV resided in sub-Saharan Africa, a region with only 12 percent of the global population and the Caribbean has the second highest regional HIV prevalence after sub-Saharan Africa. However, the rate of HIV prevalence is substantially lower in Asia than in some other regions, the absolute size of the Asian population means it is the second largest grouping of people living with HIV. In Bangladesh, the overall prevalence of HIV in populations must at risk remains below 1 percent (NASP, 2011).

Table -02
Regional Statistics for HIV & AIDS, end of 2010

Region	Adults & children living with HIV/AIDS	Adults & children newly infected	Adult prevalence	Adult & child death due to AIDS	Young people (15–24) prevalence (%)	
					Male	Female
Sub-Saharan Africa	22.9 million	1.9million	5.o%	1.2 million	1.4	3.3
North Africa & Middle East	470,000	59,000	0.2%	35,000	0.1	0.2
South and South-East Asia	**4.2 million**	**270,000**	**0.3%**	**250,000**	**0.1**	**0.1**
East Asia	790,000	88,000	<0.1%	56,000	<0.1	<0.1
OCEANIA	54,000	3300	0.3	1600	0.1	0.2
Latin America	1.5 million	100,000	0.4%	67,000	0.2	0.2
Caribbean	200,000	12,000	0.9%	9,000	0.2	0.5
Eastern Europe & Central Asia	1.5 million	160,000	0.9%	90,000	0.6	0.5
North America	1.3 million	58,000	0.6%	20,000	0.3	0.2
Western & Central Europe	840,000	30,000	0.2	9900	0.1	0.1
Global Total	34.0 million	2.7 million	0.8%	1.8 million	0.3	0.6

Source: UNAIDS (2011).

During 2010 more than two and a half million adults and children became infected with HIV, the virus that causes AIDS. By the end of the year, an estimated 34.0 million people worldwide were living with HIV/AIDS. The year also saw 1.8 million deaths from AIDS, despite recent improvements in access to antiretroviral treatment.

HIV/AIDS SITUATION IN BANGLADESH

Bangladesh is one of the most densely populated countries in the world. Its population of over 150 million places a tremendous economic, social and environmental strain on the country's resources. In spite of development successes in the last three decades, with fertility declining from 6.3 to 2.5 children per women, Bangladesh's population is still projected to reach 200 million by 2050. (UNDP, 2008b) Bangladesh is at high risk to the spread of HIV/AIDS, despite its low prevalence among the general population; due to a concentrated epidemic among inject drug users. HIV prevalence is less than 1 percent among high-risk groups. According to the Bangladesh National AIDS and STD (Sexually Transmitted Disease) Program (NASP), the

number of HIV cases in the country is estimated at 7,500, although the number of cases officially reported is significantly lower (http://unaids.org/pub). By December 2011 there were 2533 reported cases of HIV and 1101 cases of AIDS, as well as 325 AIDS-related deaths (Table:03). UNAIDS estimates that the number of people living with HIV in the country may be around 12,000 (UNAIDS, 2008c).

Table: 03
National Summary of the HIV and AIDS Epidemic of Bangladesh

	As of 2009	2010	As of 2010	2011	As of 2011
New HIV		343		445	
Total HIV	1745		2088		2533
New AIDS		231		251	
Total AIDS	619		850		1101
New AIDS Death		37		84	
Total AIDS Death	204		241		325

Source: (NASP, 2011)

The first case of HIV in Bangladesh was detected in 1989; and the last surveillance (9th Round) conducted in 2009-10 found the national HIV prevalence at less than 1 percent, making Bangladesh a low-prevalence country. However, significant levels of risk behavior, such as the formal and informal commercial sex trade, low levels of condom use, and rising HIV-prevalence levels among inject drug users (IDUs) are of increasing concern. An estimated 2.2 to 3.9 million Bangladesh nationals are considered to be at higher risk of acquiring HIV, including drug users, female sex workers and their clients, men who have sex with men (MSM), and internal and cross border migrants (World Bank and UNAIDS, 2009). In addition, there is sufficient evidence of high rates of HIV transmission to wives from their migrant husbands after their return from abroad. More than 80 percent of the diagnosed HIV positive people are migrant Bangladeshi workers and their wives (Southasia, 2008). Other documented proofs, include unsafe practice in health service, unprotected sexual practices, increasing number of homosexuality and low patronage of condoms. According to a NASP study, most of the men in the study population do not use condom in their commercial sex encounters. Likewise, female sex workers report the lowest use of condom in the region [only 0 to 12 percent of the different groups of sex workers recorded that they use condom with new clients] (Daily Star, 2010).

NATIONAL RESPONSE TO HIV/AIDS IN BANGLADESH

The government of Bangladesh (GOB), from the very beginning, has taken an evidence-based approach towards HIV programming. Prevention programs have been scaled up among sex worker, IDUs, MSM and hijra. The government of Bangladesh responds to HIV and AIDS from the first case detected in 1989, GOB formed National AIDS Committee (NAC), Technical Advisory Committee (TAC), the AIDS policy and National AIDS/STD Program (NASP). The NASP is one of the wings of Directorate General of Health Services (DGHS) under the Ministry

of Health & Family Welfare (MOHFW) responsible for coordinating with all stakeholders and development partners involved in HIV/AIDS program activities throughout the country. There are several policy documents developed to guide the national HIV and AIDS program intervention. NAC comprises national experts from various disciplines, including parliamentarians, representatives from key ministries, and NGOs. NASP is responsible for coordinating with all stakeholders and development partners involved in HIV and AIDS programming. Based on the National Policy on HIV/AIDS, the five year (1997-2002) Strategic Plan for the National AIDS Program of Bangladesh focused on issues related to HIV/AIDS and sexually transmitted infections (STI), with emphasis on safe blood transfusion protocols.

The implementation of the third National Strategic Plan for HIV/AIDS Program (2011-2015) is currently underway. The goal of the third national strategic plan is, to minimize the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society. The GOB also developed the National Advocacy and Communication Strategy (2005-2010) in collaboration with all relevant government ministries, NGOs, the UN, and other development agencies. The policy identified priority groups for HIV intervention as sex workers, IDUs, MSM, mobile populations (immigrant, people regularly crossing borders, transport workers, factory and other mobile workers), prisoners, uniformed forces, and street children. The multi-sector response to HIV/AIDS in Bangladesh has broadened beyond the Health Ministry to include all sectors of government. Efforts have yielded a variety of strategic action plans for NASP, defined fundamental principles, and provided the framework for a national response. The national response is supported by specific guidelines on a range of issues, including testing, care, blood safety, and HIV prevention among youth, women, migrant workers, and commercial sex workers. The Ministry of Health, through the National AIDS Committee, conducts general mass HIV prevention campaigns using electronic and print media. Bangladesh is well positioned to avert an HIV epidemic through strategic, effective, and quick interventions among vulnerable groups engaging in high-risk behaviors as well as among the general population, including women and youth. Without strategic interventions, it is estimated that prevalence in the general adult population could be as high as 2 percent in 2012 and 8 percent by 2025 (Government of Bangladesh, 2008.), but in 9th Round serological report show that the overall prevalence of HIV in populations must at risk remains below 1 percent (NASP, 2011).

Table: 04
HIV Programs in Bangladesh

Programme Name	**Financed by**	**Funding**	**Focus Areas**
HIV/AIDS Targeted Intervention (HATI)	Credit of the International Development Association (IDA) and a grant from DFID	US$ 20M 2008 under Health, Nutrition and Population Strategic Plan (HNPSP)	High-risk group interventions: IDUs, sex workers, clients of sex workers ,MSM, Hijra*
HAPP HIV/AIDS Prevention Project	DFID and World Bank	US$ 26M	Harm reduction to prevent HIV transmission amongst high risk group: IDUs, sex workers and their clients, MSM, and Hijra
Global Fund	GFATM	US$ 80M	Youth HIV prevention

to Fight AIDS, Tuberculosis, and Malaria (GFATM)	Round 2 (2004-2009) Round 6 (2007-2012) Rolling Continuation Channel (RCC), Round 2 (2010-2015)		targeting interventions among high-risk groups: sex workers, IDUs, workplace programs
Bangladesh AIDS Program (BAP)	United States Agency for International Development (USAID) (2009-2013)	US$ 12.7M	Targeting the most-at-risk groups: IDUs, female sex workers, clients of sex workers, MSM, transgender and their sexual partners
--	United Nations and other donors	US$ 20M	Technical support, capacity building, and policy development

* Transgender Sex Workers
Source: World Bank and UNAIDS, (2009).

MIGRATION AND HIV/AIDS POSITIVE PARENTS IN BANGLADESH

The linkage between migration and HIV for migrant workers and their families is now of growing concern in Bangladesh. According to the International Centre for Diarrheal Disease Research, 47 of the 259 new HIV cases reported during the period 2002-2004 were migrants. Of these, 29 were returning males from abroad, 7 were wives of migrant workers, and 4 were children of HIV-positive migrant workers. Data from the NASP in 2004 showed 57 of 102 newly reported HIV cases were among returning migrants, and the National AIDS STI Program Report of 2006 states that approximately 67 percent of identified HIV-positive cases in the country are returnee migrant workers and their spouses. However, many migrant workers receive their HIV diagnosis from mandatory job-related testing, while the general population is not tested.

However, the HIV/AIDS Targeted Intervention (HATI) program includes a package of targeted interventions for external migrants, and migrant workers have been identified as a priority in the Bangladesh National Strategic Plan for HIV and AIDS, 2005-2010. Bureau of Manpower, Employment & Training (BMET) is the only agency that offers pre-departure briefings to migrants on a regular basis incorporating general information on health, including Sexual Transmitted Infections (STIs). However, BMET does not raise any awareness on HIV and AIDS issues, and no linkages between STIs and HIV are established. Private recruiting agencies and the medical centers do not conduct pre-departure briefings on HIV, and consequently migrants go abroad for employment without the necessary information to protect themselves from HIV infection. To reduce the vulnerability of migrants and their families throughout the migration cycle, reliable evidence base is needed that better informs the national response on targeted interventions (USAID-Bangladesh, 2009). Currently, integration of migration and HIV in national policies and programming is limited.

AWARENESS ABOUT HIV/AIDS ON YOUNG GENERATION

Human rights are no longer considered peripheral to the AIDS response. Today, the vast majority of countries explicitly acknowledges or addresses human rights in their national AIDS strategies, with 92 percent of countries reporting that they have programs in place to reduce HIV-related stigma and discrimination. Knowledge of the epidemic and how to prevent HIV infection has increased among young people aged 15–24 years—people frequently at the

highest risk for infection. Young people still lack of knowledge and importantly they need to practice HIV risk-reduction strategies, however. Many people still lack ready access to condoms and lubrication, and people who inject drugs lack sufficient access to sterile needles. From a study in the urban slum area of Dhaka city, found 22 percent boys and 18 percent girls saying that they came to know about HIV/AIDS from their parents, 25 percent boys know about this from their friends/peer group; among the girls, 21 percent know from their teachers. When they were asked whether they knew about the causes and consequences at that moment, they failed to answer so. (Table 05).

Table-05
Source of knowing about HIV/AIDS of the respondents

Source of knowing about AIDS/HIV	Child group (age 15-24)	
	Boys	Girls
From a friend/peer-group	17 (25%)	2 (4%)
From parents	15 (22%)	10 (18%)
From local people	9 (13%)	7 (12.5%)
From the relative (s)	5 (7.5%)	12 (21%)
From the teacher	9 (13%)	12 (21%)
From any senior vai/apa	8 (12%)	10 (18%)
Doesn't know	5 (7.5%)	3 (5.5%)
Total	68 (100%)	56 (100%)

Source: (Zahan, 2010)

Moreover, 26 percent boys said that one of the preventive measures is to avoid the strangers. A good number of boys (22 percent) and girls (32 percent) thought that Kabiraj/Hakim (Traditional Healer) is better for treatment, 2 percent of girls did not know how to safe from it. (Table 06)

Table -06
Opinion about their safety from HIV/AIDS

Opinion about their safety from HIV/AIDS	Child group	
	Boys	Girls
Need proper guidance	5 (7.5%)	11 (20%)
Go to local Kabiraj/Hakim	15 (22%)	18 (32%)
By following the health rules	14 (21%)	13 (23%)
Avoiding the strangers	18 (26%)	4 (7%)
Never mix with the bad guys/friends	2 (3%)	3 (5%)
Learn the direction from TV/Radio/mass media	14 (21%)	6 (11%)
Doesn't know/No Answer	-	1 (2%)
Total	68 (54.8%)	56 (45.2%)

Source: (Zahan, 2010)

Table 07 indicates that in January 2012 registered PLHIV of Ashar Alo Society (AAS) in total 1133, among these total 56 are children and in Sylhet region, the rate of children was 28. Moreover, the rate of male registered PLHIV was higher (721) than the rate of others in the table; and it is evident from the table that the PLHIV rate was highest in Sylhet area also.

Because of, many people of this region work abroad; and from these migrant/foreign living parents' children has affected by the HIV.

Table: 07
Registered PLHIV of Ashar Alo Society* (AAS) (as of January 2012) in Bangladesh

Area	Male	Female	Child	TG	Total
Dhaka	149	82	6	6	243
Sylhet	278	123	28	1	430
Chittagong	245	110	20	0	375
Khulna	15	18	1	0	34
Barisal	10	6	1	0	17
Rajshahi	16	5	0	2	23
Rangpur	4	2	0	1	7
other	4	0	0	0	4
Total	721	346	56	10	1133

* Ashar Alo Society is a community based non government registered organization working towards ensuring treatment, care, and support, establish rights, enhance empowerment and greater involvement of people living with or effected by HIV and AIDS (PLHIV) in Bangladesh. PLHIV of Barisal, Khulna, Rajshahi & Rangpur division receive service from Dhaka service centre.

In Bangladesh, Care and treatment Centre (CTC) of AAS has provide PMTCT service for HIV positive pregnant women. By January 2012, there are 33 HIV positive pregnant women received care treatment service. Those women were given birth 30 infants within this period. Among 18 of them 17 were identified as HIV negative and one (1) infant identified as HIV positive when they gone under laboratory test after 18 month of their born. The rest of 12 infants are not still complete their 18 month. Beside this, other three women were still waiting for labor and delivery. It is worth mentioning here that these infant were not given breastfeeding and their mothers were under treatment from the beginning of pregnancy.
From some case studies, most under aged People Living with HIV & AIDS (PLHA) had to face serious obstacles (i.e. harsh behavior, prohibiting mingling with close peoples and depriving from most normal rights). A limited number of the PLHAs received accurate information and knowledge on HIV & AIDS, positive living and public speaking. In some areas, a small number of organizations like AAS counselors counseled the relatives of the PLHAs through home visit; sensitize her neighbors on HIV and AIDS issue as well as rights of HIV positive people through courtyard meeting (Uthan Boithak). In addition, they received some grant money for alternative livelihood support. After receiving counseling and caregiver training, these relatives are now supportive and caring to the PLHAs. They realized their fault and committed to make sure proper care of the PLHAs.

CONCLUSION AND RECOMMENDATIONS

The development of children in any society is determined by the willingness and ability of family and community members to contribute to their successful survival and growth. In the most concrete ways, this includes the provision of food, shelter, clothing, health care, schools and recreational opportunities. It also includes emotional needs such as love, security, guidance, and encouragement. People living in countries where HIV is not widespread like Bangladesh, it can be hard to appreciate how severely some communities have been damaged by the epidemic.

HIV and AIDS policies and strategies specially designed for affected children need to be formulated and implemented with serious monitoring and evaluation at different levels, involving both public and private sectors. This will guide policymakers, researchers and practitioners, who are involved in HIV and AIDS activities to respond timely and efficiently in controlling the spread of the misconduct with these people of the community affected by this deadly disease. UNAIDS has declared the framework to mitigate the issue represents a radical departure from current approaches, and has four clear aims (UNAIDS, 2011):

1. Maximizing the benefits of the HIV response
2. Using country-specific epidemiology to ensure rational resource allocation
3. Effective programs based on local contexts
4. Increasing efficiency in HIV prevention, treatment, care and support

UNICEF also has declared a four-prolonged strategy to prevent HIV among infants and young children. This includes key interventions to be implemented as a component of overall maternal, newborn and child health services (http://.unicef.org)

Prong 1: Primary prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum/natal care, other health, and HIV service delivery points, including working with community structures.

Prong 2: Providing appropriate counseling and support to women living with HIV to enable them make an informed decision about their future reproductive life, with special attention to preventing unintended pregnancies.

Prong 3: For pregnant women living with HIV, ensure HIV testing and access to the antiretroviral drugs that will help mothers' own health and prevent infection being passed on to their babies during pregnancy, delivery and breastfeeding.

Prong 4: Better integration of HIV care, treatment and support for women found to be positive and their families.

According to the above framework, there are some recommendations in context of Bangladesh. First, arranging Community Support Groups for children and family members who are living with HIV (uninfected family members and affected others), which can provide:

- emotional support through a forum where family members, including children, can discuss concerns, sharing information and ask Questions
- a platform for speakers to discuss prevention, care and treatment
- a focus for educational activities
- a focus for mutual support and income generating projects
- a platform for community advocacy and activism.

Secondly, providing Services and Assistance to support families affected by HIV/AIDS in ways that enable them to stay together and maintain their home. Such services can be offered by a combination of formal and informal service providers, including government or privately supported agencies, and might include:

- child or day care by government institutions like, Government Orphanages
- health and nutritional support by home health care providers
- Income generating projects or direct financial support like, VGD/VGF, etc.

Training for those in the community who interact with HIV/AIDS affected families, offering support to dying parents and their children in future planning. It can reduce the fear and discrimination, which result from misunderstanding and misinformation.

Peer education programs involving children work with facilitators in learning about HIV/AIDS in more details form. They design projects, create educational materials, and educate through drama and talks in schools and community meeting places. It encourages

confidence and self-esteem in those children and young people. In addition, arranged alternative education strengthens efforts to remove and protect children and adolescents from high-risk situations.

Finally, consolidate a participatory holistic approach upon existing limited community efforts and assets towards preventing and mitigating HIV/AIDS and build a HIV/AIDS free society for next generation.

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