

Building Protection and Resilience: Synergies for child protection systems and children affected by HIV and AIDS

Submitted by:

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This document has not been endorsed by each individual IATT member and therefore does not necessarily reflect consensus by all members on its content.

ACRONYMS

ART	antiretroviral therapy
CABA	children affected by HIV and AIDS
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States
IATT	Inter-Agency Task Team
OVC	orphans and vulnerable children
PMTCT	prevention of mother-to-child transmission
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This paper presents findings from a study commissioned by the Inter Agency Task Team on Children affected by HIV and AIDS. The study aims to better understand the ways in which child protection systems can respond to the needs of children living with and affected by HIV and how those working on issues related to this specific group of children can give greater attention to child protection issues.

In recent years, growing attention has been paid to strengthening child protection systems, and there is recognition that while it is still a nascent agenda and continues to develop,ⁱ it is important that programming for children reliant on such systems, such as those affected by HIV and AIDS, is able to find a place within systems strengthening initiatives to bring about positive impacts. This shift in focus offers an opportunity for the sector on children and HIV to deliver sustained, tangible benefits over the long term, but more clarity is needed on how the two sectors can and should engage with each other. As a result of reduced funding, the HIV sector is being pressed to be more targeted about the specific areas of a child protection system agenda it should invest in, as strengthening the whole system is not feasible.

This paper presents findings from a global literature search and key informant interviews with leading actors representing the child protection systems strengthening and children and HIV sectors. The findings clearly demonstrate that protection violations negatively impact on HIV outcomes and that HIV and AIDS affects child protection outcomes in many different settings, which justifies the need for specific HIV and child protection interventions to be integrated into each other's responses. There is evidence on the impacts of protection violations compounded by HIV and AIDS and vice versa, in all settings, including high HIV prevalence

settings and concentrated settings across Africa, Asia, Central and Eastern Europe and the Commonwealth of Independent States, and Latin America. The results also show that children of all different ages and stages of life are affected, as are their caregivers.

Existing evidence and identified gaps in the system

The literature review and key informant interviews provided ample evidence highlighting the increased vulnerabilities of HIV-affected children to child protection violations, and also indicated where the child protection system needs to be strengthened to better prevent and respond to those vulnerabilities. Key findings include:

- Children orphaned by or living with HIV-positive caregivers face an increased risk of physical and emotional abuse as compared with other children in sub-Saharan Africa, including other orphans.
- Caregivers of AIDS-orphaned children have higher rates of depression than other caregivers in sub-Saharan Africa; this leads to increased mental health and behavioural problems in children.
- Children affected by HIV experience greater stigma, bullying and emotional abuse than their peers.
- Children who are orphaned or are caregivers to a person with AIDS have higher rates of transactional sex or increased (unsafe) sexual activity and/or sexual abuse.
- Households affected by HIV or other stigmatized households are more likely to be excluded from social networks and protective environments than many other households that are otherwise similar, in high HIV prevalence settings.
- Children who have HIV-positive mothers are at significantly higher risk of being abandoned or placed into residential care in concentrated HIV epidemics.

The evidence also shows that children who experience protection violations have a greater risk of acquiring HIV

ⁱ See, for example, "A Better Way to Protect All Children: The theory and practice of child protection systems," Global Conference, November 2012, available at <www.cpsconference.org>.

or worse outcomes if they are already affected by HIV. For example:

- For both women and men in high HIV prevalence areas, there is a direct link between childhood sexual, emotional and physical abuse and HIV infection later in life.
- Across all regions, childhood sexual abuse is linked to higher rates of sexual exploitation and other HIV risks, such as earlier initiation into injecting drug use, sex work and living on the streets.
- Children living in all forms of alternative care may experience greater protection risks because of exclusion from information or lack of access to such things as sexual reproductive health services, although all of the realities of children's lives in different forms of alternative care are not fully known.

The study also highlights areas where, anecdotally, children experience extreme protection and HIV rights violations and are at very high risk, yet there is little to no evidence to assist in designing effective responses. These gaps include the HIV experiences of children living in residential care and other alternative care settings, children living with disabilities and children who are not part of the formal 'system' or do not live within settled households.

In addition, the study underscores positive examples of resilience and protective factors. These programming approaches need to be documented, replicated and placed at the forefront of any child protection system.

It is not so much the individual acts of violence or abuse that harm, but the cumulative experience of risk that does the greatest harm. There are multiple pathways through which abuse, violence, exploitation and neglect link to HIV risk and poor outcomes for those living with HIV. The worsened outcomes for children from cumulative risk reveal how essential it is to have a systems response that is HIV sensitive and evidence-informed at all levels – individual, family, community and national – and that emphasizes the prevention of harm and supports strong families and social networks for vulnerable children.

Practical synergies: Action on HIV-sensitive child protection

The study identifies key areas for synergistic responses between the sectors that focus on HIV and children and child protection systems. These synergies outline significant entry points for both the child protection sector (case management, alternative care, development of a social welfare set of regulations, protocols and staffing) and the HIV sector (prevention of mother-to-child transmission, paediatric and adolescent care, community-based programming and adolescent HIV prevention). These synergies are identified and potential entry points are highlighted. Currently, this lack of synergy creates some of the most significant barriers in the system, yet many are relatively easy to introduce and rectify.

Recommendations

The following recommendations are made to actors at the national and global levels, with more detail on specific roles and responsibilities included in the main report:

Recommendations to the national body/ministry responsible for child protection:

1. Ensure that national child protection system strengthening initiatives (mapping, strategy and budget) include responses to HIV impact and subsequent child protection risks, and vice versa, based on evidence.
2. Advocate, educate and ensure that HIV-specific risks and inclusion of HIV-affected groups are clearly articulated and included within child protection laws, policies, guidance and standards, including a focus on HIV stigma.
3. Ensure that there is a baseline and on-going monitoring of how HIV affects children living in alternative care settings, especially residential care.
4. Ensure that services that are being delivered by the child protection and social welfare sector are adequately linked to HIV-specific prevention, care and support services being provided by other sectors, such as health where needed.
5. Prioritize interventions that are family focused

and include abuse/violence prevention, positive parenting techniques, early childhood development and economic strengthening initiatives as part of a standardized package of services available to vulnerable children and families. Ensure that the needs of the entire family – and not only one specific member – are considered.

6. Include HIV-specific indicators within child protection monitoring and evaluation frameworks.
7. Ensure that core HIV components are included in regulations, standards and operational guidelines for all child protection personnel.
8. Ensure that child protection and children's HIV vulnerabilities, such as reducing risk to sexual violence and provision of comprehensive post-rape care, are reflected in emergency preparedness and response plans, and that such plans are monitored.
9. Calculate the cost-effectiveness of delivering to children affected by AIDS through a child protection system as compared with stand-alone programmes.

Recommendations to national-level actors on children affected by HIV:

1. Ensure that national frameworks and strategies for child protection are inclusive of specific HIV interventions, and vice versa.
2. Make sure that HIV and AIDS monitoring systems are inclusive of child protection indicators where relevant.
3. Ensure that child-focused HIV regulations, standards and operational guidelines include child protection training for HIV staff, and provide a mandate for child protection referrals where necessary – for example, in cases of abuse and violence.
4. Ensure that HIV interventions at the household level are family focused and can identify and link household members to relevant child protection services such as abuse/violence prevention, positive parenting techniques, early childhood development and economic strengthening initiatives.

Recommendations to all agencies working on alternative care at the national level:

1. Improve means of collecting evidence around the different push factors causing children to leave home, resulting in their being in unsafe settings such as the street, exploitative labour situations or migration. Utilize the collected and analysed data to better inform responses that help prevent and/or mitigate the risks of protection violation and HIV infection that can occur in these settings.

Global-level recommendations

1. Ensure that any discussions on child protection systems consider the evidence that shows how HIV impacts on protection outcomes and subsequent documents and response integrate and/or link to HIV interventions.
2. Facilitate the development of global guidance that reflects the unique child protection needs of children affected by AIDS, and ensure that the respective HIV and child protection communities liaise with each other in developing this guidance.
3. Ensure that monitoring and evaluation frameworks incorporate both HIV-sensitive and child protection-related indicators, including a child focus within the global People Living with HIV Stigma Index and in liaison with the Joint United Nations Programme on HIV/AIDS, UNICEF and other global partners working on child protection systems strengthening.
4. Build on the emerging evidence base related to children and AIDS, stigma, resilience and cumulative risks, with a set of proposed research agenda considerations on abuse prevention in middle- and low-income countries, costing of significant HIV components of child protection systems, the links between stigma and child and family resilience, and incorporation of sexual abuse of boys into the broader agenda of violence against children.

INTRODUCTION AND RATIONALE

This report presents findings from a study commissioned by the Inter-Agency Task Team (IATT) on Children and HIV. The study aims to better understand the ways in which child protection systems can respond to the needs of children living with and affected by HIV and how those working on issues related to this group of children can give greater attention to child protection issues.

In 2009, the lives of more than 20 million children globally were impacted by HIV and AIDS – 3.4 million children under the age of 15 were living with HIV and more than 17.1 million children had lost one or both parents to AIDS.¹ In 2011, some 330,000 children were newly infected with HIV.² Despite the millions invested in programmes for HIV-affected children, many such children continue to face enormous economic, emotional and social challenges. While HIV infection rates and deaths are declining globally, most notably in East and Southern Africa, HIV infections among adolescents and young people continue to increase in many locations, including rapid increases in parts of Eastern Europe and Asia, where HIV is integrally linked with a range of protection threats faced by children.

Until recently, child protection efforts tended to concentrate on stand-alone programmes for specific groups of vulnerable children, such as children with disabilities, trafficked children, and children involved in hazardous labour or in institutional care. The protection and support of orphans and vulnerable children (OVC) was one such 'single issue' response. These programmes focused almost exclusively on a small group of beneficiaries, even though many of the risks faced and appropriate responses to such children are equally relevant to other poor or vulnerable children. As a result, many child protection responses were duplicative, costly and unsustainable. Child protection services and programmes have been significantly under-resourced relative to the scale and need globally, and to the potential benefits on health and other social, economic and developmental outcomes in the immediate and long term.³

Increased attention has been placed on child protection systems strengthening in recent years. Guided by the United Nations (UN) Convention on the Rights of the Child, the systems approach shifts attention to a larger systemic framework that can respond to abuse, violence, exploitation and neglect, and which comprises Legislation and policy, institutional capacity, community contexts, planning, budgeting, and monitoring and evaluation subsystems.⁴

The move towards strengthening child protection systems offers an opportunity for the children and HIV sector to situate child-focused HIV responses within a long-term, locally owned and sustainable approach. With reduced funding, the HIV sector is being pressed to be more specific about what areas of a child protection system it should invest in, as supporting the whole system would not be possible.

This paper seeks to identify which HIV-specific issues are of relevance to child protection programming, and vice versa. It then identifies practical ways in which both the child protection and HIV sectors can combine their comparative expertise and approach collectively, to build or strengthen child protection systems that meet the needs of all children at risk of abuse, violence, exploitation and neglect, while at the same time meeting the unique needs of HIV-affected children and those children who are at increased risk of both HIV infection and protection abuses – many of whom frequently or purposely turned away from the formal system, such as children on the move, sexually exploited children and children on the streets.

The paper is divided into four sections. The first section provides an overview of current trends in HIV and child protection systems strengthening. It highlights some of the key themes common to both child protection and child-focused HIV programming. Section 2 summarizes recent evidence on the linkages between HIV and child protection: (a) what HIV-specific and child protection-specific factors promote resilience or protect children

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from poor outcomes; and (b) where HIV increases child protection risks or child protection violations increase risk of HIV and worsened HIV outcomes for children. Section 3 suggests some practical entry points for the HIV and child protection sectors to promote greater synergies. Section 4 proposes recommendations for policymakers, practitioners and researchers working on child protection systems and focused on children affected by HIV at national and global levels. The recommendations aim to enhance synergies between child protection and HIV that should result in increased resilience, protection and well-being for children.

METHODOLOGY

The IATT on Children affected by HIV and AIDS posed four main questions for consideration:

1. What are the ways and extent to which children affected by HIV and AIDS are particularly prone to abuse, violence, exploitation and neglect?
2. What are the ways and extent to which children experiencing child protection violations are particularly prone to HIV infection or the negative impacts of HIV and AIDS?
3. Where are the key opportunities and synergies that practitioners and policymakers focused on child protection and children affected by HIVⁱⁱ should build upon in order to enhance HIV and child protection outcomes for vulnerable children?
4. To what extent do current policies, tools and guidance specify ways to respond to children living with and affected by HIV within the functions of a child protection systems?

The study is comprised of a literature review and key informant interviews. The literature review was global in scope, accessing documents primarily in

ii This report avoids the use of the acronym CABA (children affected by HIV and AIDS), other than in reference to organizations or resources that use the acronym. The acronyms OVC (orphans and vulnerable children) and MARA (most at risk adolescents) are also avoided. This is done primarily to avoid turning children into acronyms. Also, orphanhood, per se, does not predict vulnerability, and child vulnerability has multiple economic and social determinants. 'Key populations' of adolescents focus on contexts in which children and adolescents are facing extremely high risks of acquiring HIV because they lack access to mainstream HIV prevention interventions.

English, but also including some French, Spanish and Portuguese materials. It included peer-reviewed articles and grey literature, such as programme evaluations, tools and guidelines, National Plans of Action for OVC, and alternative care and related guidelines. Priority was given to documents published from 2009 to the present, and more than 120 documents were included in the review. A detailed review of the findings, with complete bibliography, is available separately.ⁱⁱⁱ A total of 31 key informants were interviewed (*see annex 2*), representing global and regional (Africa, Asia, Eastern Europe and Latin America) research, policy and programming expertise in children affected by HIV, child protection and children living with HIV. Informants provided inputs on the questions above and were also asked to recommend examples of promising practices or other key informants to be included.

Constraints and limitations to this report include the fact that it is global in scope and constrained by time. Therefore, this document is a snapshot of the current evidence, gaps and synergies that exist regarding child protection and HIV. It should be considered as a first step to help inform additional and larger evidence gathering, policy development and programmatic responses aimed at further fostering closer linkages between, coordination mechanisms and synergies between the two sectors.

iii The report, "Background Paper: Review of the evidence on HIV and child protection linkages," will be made available on the IATT website, at www.iattcaba.org.

SECTION 1: HIV AND CHILD PROTECTION CONTEXT

1.1 CHILD PROTECTION SYSTEMS STRENGTHENING

Prior to 2005, child protection was generally implemented through an issue-specific approach in lower- and middle-income countries.⁵ Funding tended to be donor-driven and priorities would regularly shift, limiting the possibility of long-term impact and sustainability. Recognizing the flaws in this, the systems approach was started in earnest with the introduction of UNICEF’s 2005 Protective Environment Framework.

The systems method requires key child protection actors to take a holistic approach, paying particular attention to the interconnectedness of the economic,

social, political, cultural, environmental and community factors that result in increased risks and vulnerabilities for children. Looking at the inter-related factors makes it easier to see what is required – at child, family, community and national levels – to provide a protective environment for children.⁶

Efforts to strengthen child protection systems have only taken off in force in the past eight years. The table below highlights the key events and frameworks that have informed this progress.

Table 1: Key moments in global child protection systems strengthening efforts

Document/Event	Summary of Content/Purpose
UN Secretary-General’s Study on Violence Against Children, 2006⁷	Proposed recommendations to develop and/or strengthen and expand protective mechanisms that should result in more holistic, comprehensive and long-term responses.
UNICEF’s Global Child Protection Strategy, 2008⁸	Provided guidance on the development or strengthening of community-based mechanisms within a national framework that protects children across the range of thematic areas.
Chapin Hall, proposed child protection systems approach, 2010⁹	Described key elements that every system – including a child protection system – should have, such as: <ul style="list-style-type: none"> ▪ Any system should involve a collection of components or parts that are organized around a common purpose or goal; this goal provides the glue that holds the system together. ▪ All systems should reflect a nested structure – in the case of child protection, children are embedded in families or kin, who live in communities that exist within a wider societal system. ▪ Given the nested nature of systems, specific attention must be paid to coordinating how these subsystems interact, so that each system mutually reinforces the purpose, goals and boundaries of related systems. ▪ All systems should accomplish their work through a specific set of functions, structures and capacities. These will be determined by the context in which the system operates. ▪ Every family, community and country has a child protection system in place that is contextually derived and defined.

Save the Children, 2010¹⁰	Developed organizational definition of child protection systems.
World Vision, 2011¹¹	Discussion paper on systems approach, including resilience and child participation.
U.S. President's Emergency Plan for AIDS Relief revised approach/ National Plan of Action for Children in Adversity, 2012¹²	Explicit focus on systems strengthening with investment in social welfare workforce.
Sub-Saharan (Dakar, May 2012) and global (Delhi, Dec 2012) child protection systems strengthening conferences¹³	<p>Aimed to reinforce, support and sustain national efforts to improve the impact of child protection systems on children. Learning exchange, dialogue, sharing of promising practices, stocktaking of current experiences, with the aim to build regional and country-level partnerships; exploring establishment of regional mechanisms to foster ongoing learning and exchange.</p> <p>The Delhi conference concluded that systems are dynamic and must protect all children, but be sensitive to the needs of especially vulnerable groups. Strong focus on prevention as a key function of a child protection system, and growing recognition of the need to collect information around the 'cost of inaction', which will help advocate for continued support for systems work.</p>
Development and application of a range of mapping tools¹⁴	Child protection systems mapping tools are helping to highlight the strengths and limitations of existing national child protection systems and facilitating informed planning, resourcing and implementation strategies to help strengthen the system. National-level mapping has been undertaken in Eastern, Southern, Central and West Africa and in a smaller number of Asian countries. Discussions are under way to develop tools to analyse 'systems bottlenecks' for child protection and social protection in Latin America.

There is general agreement on common principles and key components of a child protection system, although stakeholders use different terminologies or wording to describe them. The principles and components of three child protection systems frameworks developed by UNICEF, Save the Children and World Vision are summarized below.

Principles

- Child protection must promote a positive environment and prevent risk.
- Family and community are at the heart of a protective environment for children.
- Children's safety and interests are paramount.
- Child protection involves many actors.
- Children can only be protected from abuse,

violence, exploitation and neglect if basic needs are being met.

A systems strengthening approach, fundamentally, seeks to ensure that all components and all actors involved work together to protect the child and promote the resilience of the child and the family. The systems approach has to understand the child's own support structures, especially those of children who are not living within a formal, recognized family and other alternative care structures.¹⁵

Key components of a child protection system include:

- **Laws and policies:** reflective of international and regional rights conventions and instruments, but

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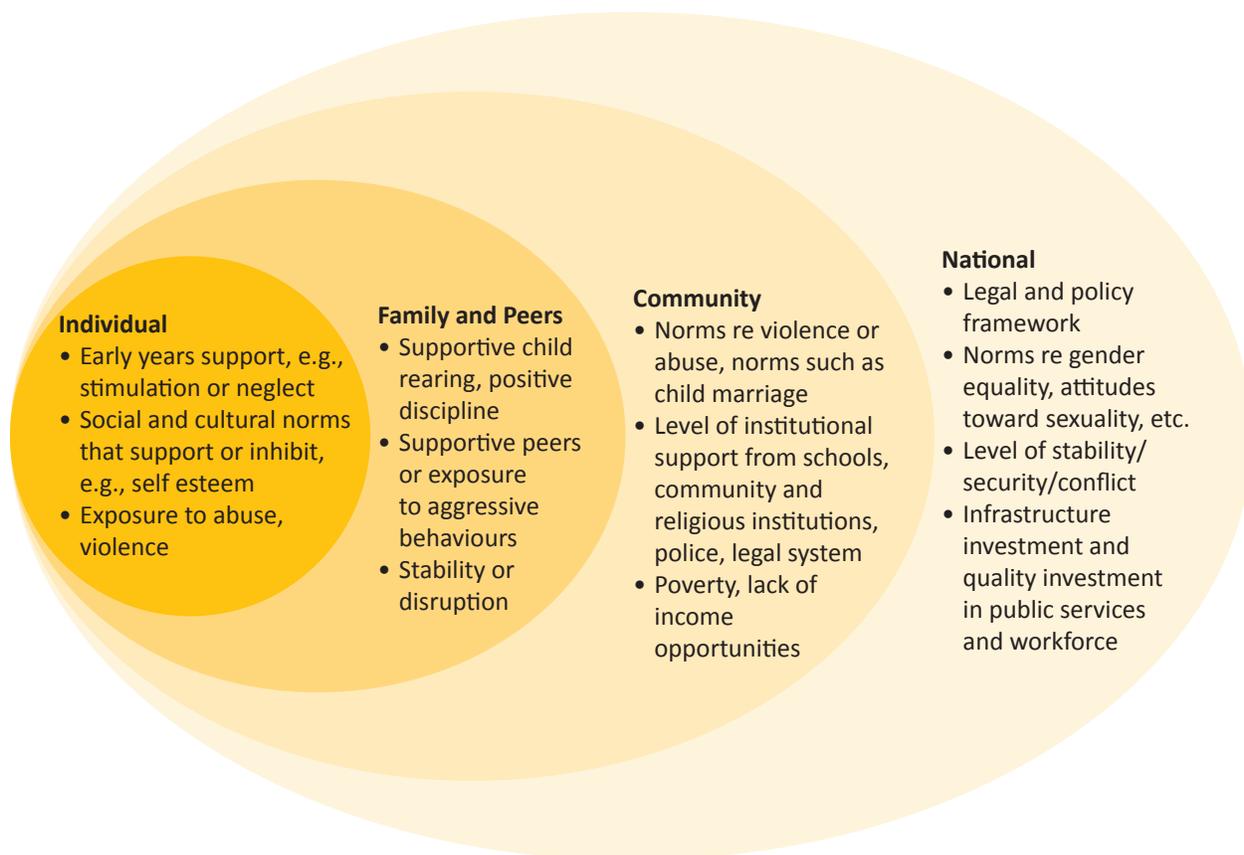
in ways that reflect national and sub-national circumstances;

- **Accountability:** including oversight, regulations and norms, and clear mandates for all actors, but most importantly, accountability mechanisms related to children and families;
- **Coordination:** should be bidirectional between the community and service provision levels, between and across statutory sectors and community mechanisms and information flows to track outcomes for children;
- **Preventive and responsive services (also referred to as continuum of care):** designed to be accessible by boys and girls of all ages, including those transitioning from childhood to young adulthood, and delivered through sustainable community-based mechanisms and government services;

- **Strong human and financial resources;**
- **Monitoring systems:** providing data and information that help inform evidence-based decisions and track outcomes for children; and
- **Child and family participation.**¹⁶

Children's development is affected by positive and negative influences around them, starting with their age and developmental stage and capacities, the nature of interactions with their family and peers, neighbourhood and community, and how larger national and global processes and policies influence their development and protection. The diagram below shows how 'systems' can provide support or increase risk at many different levels. This model recognizes the uniqueness of each actor, but also the interdependence of all of the levels.

Diagram 1: 'Systems' at all levels influence children's level of protection and risk¹⁷



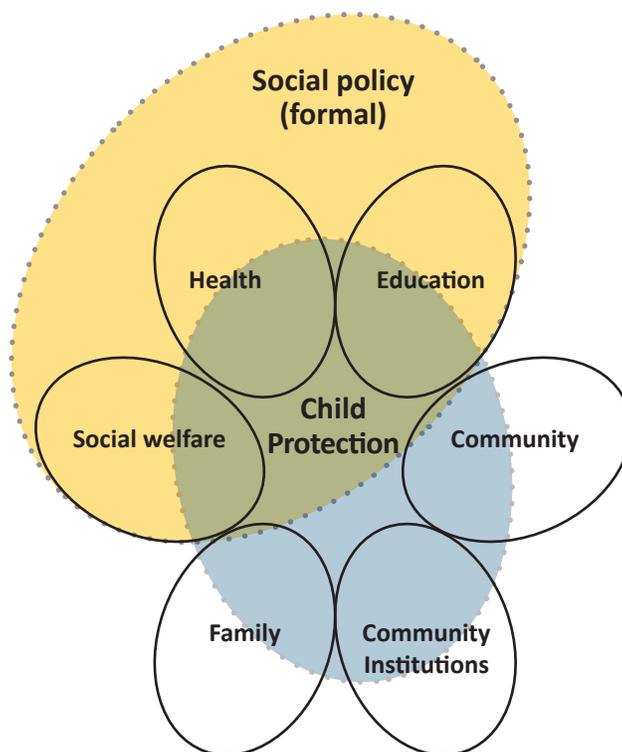
Source: Adapted from www.ctfalliance.org/images/initiatives/CDC_Ecological_Model.pdf.

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The emergence of a significantly different approach to child protection has generated a vibrant discussion about what constitutes a ‘system’ for children. A system generally implies a structure within which all children fit. One of the biggest challenges for the child protection system is to reach and ensure the rights of children who face abuse, violence, exploitation and neglect *because they are outside* commonly recognized ‘systems’ of family or formal care. Such children are often those at greatest risk of HIV infection – for example, migrant children and street-associated children. This is one key reason why a focus on children affected by HIV is so crucial to the development of a strong child protection systems approach.

A child protection system does not work in isolation. Rather, it involves, engages and intersects with other systems, including, health, education, social welfare and social protection, as illustrated above in diagram 4. One government ministry might typically be mandated with children’s issues and will have general oversight of child protection, but other sectors are significantly involved in the system. Staff working in all of the aforementioned sectors play a role in identification, reporting, referral, investigation, assessment and treatment of child protection violations. Similarly, a range of services should be provided within the continuum of care, including those focused on prevention, protection and promotion, and the provision of these falls under the auspices of the different sectors.¹⁸

Diagram 2: How child protection coordination covers many sectors



Source: World Vision. (2011) [A systems approach to child protection: A World Vision discussion paper.](#)

1.2 PROGRAMMING FOR CHILDREN AFFECTED BY HIV

Throughout the years, there has been growing recognition of the profound and serious impacts that HIV can have on children. It is now acknowledged, however, that interventions have, by and large, failed to deliver long-term impact or address underlying causes and drivers of vulnerability to the extent needed.

In 2010, UNICEF reported that only an estimated 11 per cent of households caring for OVC receive any form of external care and support and, in most instances, programmes have benefited the ‘easier to reach’ children – those who are living in conventional but poor households and who do not have significant developmental or protection challenges – children of primary school age who have received primarily material assistance.¹⁹ This has led to a focus more recently on the need for HIV-sensitive, not HIV-specific, programmes that address broader vulnerabilities and place more emphasis on linking to social protection systems and to child protection.

Changes in access to HIV treatment have generated enormous public health gains, with a 24 per cent decline in AIDS-related mortality between 2005 and 2011.²⁰ By 2011, 54 per cent of people who require HIV treatment in low- and middle-income countries had been enrolled on antiretroviral therapy (ART).²¹ Yet children fare worse than adults: Only 28 per cent of eligible children 0–14 years old globally were receiving ART.²² In one research and treatment programme in nine sub-Saharan African countries, 45 per cent of young people were lost to follow-up a year after enrolment, higher than adult and younger child drop-out rates (20–34 per cent).²³

A focus on the virtual elimination of mother-to-child transmission²⁴ reduced the number of children being born with HIV by 24 per cent since 2009 and increased the number of pregnant women and mothers on HIV treatment programmes. Yet child protection considerations remain. For example, are adolescent girls vulnerable to partner violence after HIV testing and disclosure?²⁵ Children of women from key populations are nearly 2.5 times more likely to acquire HIV as children of women in the general population.²⁶

Globally, the number of people becoming newly infected with HIV has declined, although this drop is not uniform.²⁷ In 2009, motivated by concern at the lack of progress and limited impact of programming, there was a call for greater attention to evidence-based approaches on prevention.²⁸ The focus now is on interventions that have demonstrated reductions in HIV infection, notably ‘treatment as prevention’ (the use of ART by a person living with HIV to reduce the risk of passing HIV to sexual partners) and medical male circumcision for adolescent boys and men. Despite an acknowledgement of their importance, the evidence about the effectiveness of structural interventions that address cultural norms, gender and economic inequalities, migrant labour and other factors underlying individual behaviour is still scant.²⁹

In 2011, UNAIDS developed an HIV Investment Framework,³⁰ which emphasizes three components: the scale-up of six high-impact, HIV-specific programmatic activities (prevention of mother-to-child transmission (PMTCT), condom promotion and distribution, targeted approaches for key populations, ART, voluntary male medical circumcision and behaviour change tailored to context); social and programmatic enablers; and synergies with broader development activities tailored to the specific context of the epidemic to reduce HIV risk, transmission, and morbidity and mortality. Implementation of this framework is predicted to avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020. Critiques of the investment framework point out that addressing structural drivers of the HIV epidemic, such as violence against girls and women or homophobia, is central to HIV prevention, and not merely a social determinant to be addressed by other development sectors.³¹ The Investment Framework lacks an impact mitigation outcome, and while child protection is included in the Framework’s ‘developmental synergies’, there are limited concrete recommendations about how to deliver effective HIV care and support to children. Further work to better unpack the critical enablers and development synergies elements of the Investment Framework, and in particular areas specific to child protection, will strengthen its value as a programming tool for the children and HIV sector.

SECTION 2: CHILD PROTECTION AND HIV: THE NEED TO WORK TOGETHER

2.1 HIV AND CHILD PROTECTION: SIGNIFICANT IMPACTS FOR BOYS AND GIRLS OF ALL AGES

Evidence presented in table 2 demonstrates that children living with or affected by HIV and AIDS have increased risk of being victims of protection violations, and that children who have been subject to violence, abuse, exploitation and neglect face increased risk of HIV infection.

It is the responsibility of every child protection actor to ensure that no child is needlessly exposed to the risk of acquiring HIV and that no child living with HIV is denied his or her right to HIV testing, treatment, care and the support necessary to live a healthy, independent life. It is also the responsibility of every person working on HIV prevention, care and support for children to prevent abuse, neglect, violence and exploitation and to support child survivors of these protection violations.

The limited but growing evidence shows *how* the impact of HIV can increase the risk of serious child protection violations. It also shows that experience of sexual or emotional abuse, violence and/or exploitation *can* expose children to increased risk of acquiring HIV as compared with their peers, through increased risk-taking or by being less supported and protected than their peers who have not experienced such problems.

The evidence is consistent across different contexts – areas of high HIV prevalence and those of low but concentrated epidemics, peri-urban and rural settings, extended family situations and children in more formal alternative care, such as foster care or residential care.

There is more limited evidence, but a strong indication, that children living with HIV who experience neglect, such as that found in residential care settings, or those who are excluded from health and other services because they are marginalized, socially isolated or in exploitative situations have a lower chance of living positively with HIV than their peers in other settings.

There is, however, a growing body of encouraging evidence demonstrating that these linkages are not inevitable – that children and their caregivers can not only survive but also thrive despite challenges such as HIV-related stigma, abusive homes, risky environments and more. This shows that action can and must be taken to enable children and families to ‘live lives well’.³² Examples of how to effectively maintain and promote child and family resilience are emerging.

This section focuses on the evidence that illustrates why there is such a compelling need for the two sectors to come together and form synergistic approaches and shared objectives. Table 2 on the following page, based on the global evidence, shows some of the most common linkages between HIV and child protection risks for children of all ages.

Table 2: Negative effects of HIV and child protection violations on children across childhood from 0–18 years

Pre-birth–2 years	3–6 years	7–10/11–14 years	15–18+ years
<ul style="list-style-type: none"> • Delayed cognitive development (due to HIV, maternal depression, alcohol or drug use, lack of social support) • Premature birth risk → developmental delays (HIV, adolescent mothers, marginalized pregnant women) • Post-natal depression/caregiver depression (HIV, marginalized) → neglect • Excluded from HIV testing/treatment/PMTCT = neglect either intentional by caregiver or neglect by state (children of marginalized caregivers, children in residential care) • HIV-related stigma → social isolation and reduced protective environment • Increased risk of abandonment/removal from family care due to stigma (in concentrated epidemics) 	<ul style="list-style-type: none"> • Exclusion from /HIV treatment/health services (where there is neglect or discrimination by caregiver or others) • Disability-related neglect (including HIV-specific) • Neglect, exclusion and abandonment (children of women from key populations, young mothers in coerced marriages/unplanned pregnancy/sexual violence) • Abuse/violence from unsafe environment (outside of family care – e.g., street-associated mother) • HIV-affected caregiver depression/stress → physical and emotional abuse, neglect • Denial of HIV testing and treatment by caregiver • Reduced care choices (e.g., adoption, foster care) and poor care for children with HIV in alternative care • HIV infection from sexual abuse • Exposure to domestic violence (long-term HIV risk) 	<ul style="list-style-type: none"> • Inconsistent/no education and social isolation (HIV+ children) • School dropout and possible earlier marriage (HIV-affected families in poverty) • Early sexual initiation, including transactional sex (especially AIDS-orphaned) • Early initiation into drug use/transition to injecting drug use • Stigma and bullying from peers (HIV-affected) • Exposure to violence/exploitation if not in school • HIV infection from sexual abuse 	<ul style="list-style-type: none"> • Unprotected sexual activity/coerced and transactional sex • Injecting drug use • Coerced marriage • Exploitative labour (boys and girls) • Early sexual initiation, including transactional sex (especially AIDS-orphaned) • Early initiation into drug use/transition to injecting drug use • Stigma and bullying from peers (HIV-affected) • Exposure to violence/exploitation if not in school • Leaving home (for economic or protection reasons), increasing violence and exploitation • Protection risks for HIV+ children exiting alternative care

2.2 EVIDENCE ON HIV AND CHILD PROTECTION LINKAGES

Table 3: Evidence on HIV and child protection linkages

FINDING	EVIDENCE	Source
Impact of HIV leading to worsened child protection outcomes		
Children orphaned by AIDS or living with HIV-positive caregivers face an increased risk of abuse (physical and emotional) compared with other children (including non AIDS-orphaned) and	<p><i>South Africa</i> – boys and girls experiencing AIDS orphanhood and caregiver AIDS sickness exposed to 3x higher levels of physical and emotional abuse than healthy or non-AIDS sickness/orphaned peers; 6x higher levels of involvement in transactional sex.</p> <p><i>United Republic of Tanzania</i> – orphaned girls have higher prevalence of sexual violence compared with those who have not lost a parent (36.2 per cent compared with 24.8 per cent, respectively).</p>	33
AIDS-orphaned children have higher levels of clinically measurable psychological problems than other children	<p><i>Kenya</i> – double orphans experience increased emotional violence compared with female single and non-orphans.</p> <p><i>Zimbabwe</i> – girls presenting with signs of sexual abuse 2x as likely to be orphans.</p> <p>Systematic review (12 studies, nearly 50,000 children) <i>Africa & Russia</i> – orphaned youth have increased levels of abuse and neglect compared with non-orphaned peers, nearly 2x greater odds of HIV infection.</p>	34 35, 36 37 38
Psychological distress in AIDS-orphaned children increases with compound and cumulative stress – compound stress generally greater for AIDS-orphaned than other-orphaned and non-orphaned	<p><i>South Africa</i> – Bullying and AIDS orphanhood status combined increased the likelihood of disorder from 12 per cent to 76 per cent, and food insecurity and stigma combined from 19 per cent to 83 per cent.</p> <p><i>China</i> – HIV-affected and AIDS-orphaned children who reported multiple changes of household/primary caregiver more likely to be depressed.</p>	39 40
AIDS-orphaned children have elevated levels of stigma, experienced as bullying and emotional abuse	<p><i>South Africa</i> – more than one third of surveyed children (orphans, AIDS-affected, street-associated, child household heads) bullied; risk factors = AIDS-related stigma, physical or sexual abuse, domestic violence. AIDS-affected children more likely to be bullied by peers.</p>	41
Caregivers of AIDS-orphaned children have higher rates of depression, leading to increased mental health and behavioural problems for children	<p><i>South Africa and Uganda</i> – caregivers of AIDS-orphaned children had greater risk of physical and mental health problems than caregivers of other-orphaned children; children of depressed caregivers have increased risks of mental health problems, poor educational outcomes, stigma and isolation from peers.</p> <p><i>South Africa</i> – caregivers of HIV-affected children have less social support and report greater stigma, leading to reduced ‘parenting’ (discipline, guidance, nurture).</p>	42, 43, 44 45
HIV-affected households or other stigmatized households are most likely to be excluded from social networks and protective environments	<p><i>Kenya</i> – review of HIV-affected and other households finds children least likely to develop or re-form positive social networks from highly stigmatized households; children who are totally powerless economically or whose movements outside the house are restricted.</p>	46

<p>HIV-negative and HIV-positive children of HIV-positive mothers more likely to be abandoned (in concentrated HIV epidemics) and subsequently placed in residential care facilities</p>	<p><i>Russia</i> – study found women living with HIV had rates of abandonment up to 20 per cent, compared with 1 per cent of births in the general population.</p> <p><i>Ukraine</i> – HIV status of mother increased risk of abandonment, influenced by mother’s lack of social networks, poverty, medical and family pressure to abandon, fear of birth defects and other HIV concerns from misinformation.</p>	<p>47</p> <p>48, 49, 50</p>
<p>Child protection violations leading to worsened HIV outcomes</p>		
<p>Childhood sexual, emotional and physical abuse directly linked to higher rates of HIV infection and herpes simplex virus type 2 for women and men</p>	<p><i>South Africa</i> – high levels of physical punishment, emotional abuse and sexual abuse linked to increased adult HIV and herpes (women); high levels of emotional and sexual abuse linked to problematic drug and alcohol use (men). Estimates that 1:7 new HIV infections could be prevented if young women not subjected to physical or sexual abuse; similar proportion could be prevented if they did not experience relationship power inequalities.</p> <p><i>South Africa</i> – meta-analysis of HIV testing data found significantly greater HIV sero-prevalence among orphaned (10.8 per cent) compared with non-orphaned youth (5.9 per cent).</p>	<p>51</p>
<p>Childhood sexual abuse linked to higher rates of sexual exploitation and other sexual behaviours associated with HIV risk in multiple settings</p>	<p><i>United States</i> – correlation in homeless young adults between childhood physical abuse and neglect and partner violence victimization, in turn associated with more HIV risk behaviours; those who suffered more types of neglect experienced more forms of sexual and physical victimization.</p> <p><i>Cambodia</i> – abuse and violence in the home were primary push factors for girls to enter brothels.</p>	<p>52</p>
<p>Childhood sexual abuse is a factor leading to initiation into injecting drug use, sex work and living on the streets</p>	<p><i>Ukraine, Canada, United States</i> – correlation between childhood sexual abuse and injecting drug use.</p> <p><i>United States</i> – childhood sexual abuse of homeless children linked to sexual victimization activities that positively associated with a greater number of HIV risk behaviours.</p> <p><i>Cambodia</i> – childhood sexual abuse associated with girls involved in brothel-based sex work.</p> <p><i>United States</i> – link between childhood sexual abuse and entry into foster care, which in turn has links into homelessness.</p>	<p>53</p> <p>54</p> <p>55</p> <p>56</p>
<p>Young age at entry to sexually exploitive work heightens vulnerability to physical and sexual violence</p>	<p><i>Canada, India, Nepal, Thailand</i> – younger sex workers had higher rates of violence and HIV infections; Thailand – 25 per cent of girls younger than age 18 in sex work reported violence, compared with 12 per cent of women older than age 30, had twofold to fourfold increase in HIV infection; Canada – more than two thirds of young female sex workers reported physical assault, and almost half reported sexual assault.</p> <p><i>India</i> – young age at entry into sex work associated with greater risk of being beaten and raped in the previous year, with the greatest risk among those younger than age 20.</p>	<p>57</p>
<p>Children of key populations face particular HIV-related risks</p>	<p><i>Ukraine, East Asia, Zambia and the Pacific</i> – children of female sex workers and injecting drug users face separation from parents, sexual abuse, early sexual debut, introduction to sex work as adolescents and low school enrolment. However, note that this evidence has not yet been fully measured against other children and more robust data are needed.</p> <p><i>Russian</i> study found that HIV+ women abandon babies at rates of 20 times that of their peers without HIV; and also found that 20 per cent of pregnant HIV+ women do not access prenatal increasing risk of vertical transmission.</p>	<p>58, 59, 60, 61</p> <p>62</p>

<p>AIDS-orphaned children and children who are caregivers to person suffering from AIDS have higher rates of transactional sex or increased (unsafe) sexual activity and/or sexual abuse</p>	<p><i>South Africa</i> – adolescent girls ‘dualy’ affected by AIDS orphanhood and sickness had sixfold chance of transactional sexual exploitation compared with their peers; transactional sex rose from 2.8 per cent in girls living within healthy families to 57 per cent. Combined effects of familial AIDS, food insecurity and exposure to abuse on girls resulted in little ability to insist on or negotiate safe sex practices when they are involved in exploitive, coerced or transactional sex.</p> <p><i>Zimbabwe</i> study found that girls presenting at the clinic were almost twice as likely to be orphaned compared with a representative sample of girls in Harare; suggests that orphans may be at higher risk of abuse than non-orphans – especially maternal orphans.</p>	<p>63, 64, 65</p> <p>66</p> <p>67</p>
<p>Physical, cognitive and emotional disability can increase a person’s risk of acquiring HIV</p>	<p><i>Global systematic review</i> – children with disabilities suffer abuse, neglect, exploitation and violence at higher rates than children without disabilities. Persons with disabilities are subject to all HIV risk factors, including increased rates of drug and alcohol abuse, sexual and physical abuse and transactional sex, but data are extremely limited, including few studies proving higher rates of physical and sexual abuse than able-bodied children.</p>	<p>68</p>
<p>Children living in residential care and other alternative care situations may be at heightened risk of HIV infection</p>	<p><i>Russia, United States</i> – higher levels of abuse and suicidal feelings/attempts in children leaving foster care.</p> <p><i>United States</i> – women with a history of being in foster care have early entry into sex work; 62 per cent before age 18, with independent correlation with positive HIV status.</p> <p><i>United States, East Asia</i> – children in foster/residential care lacked access to sexuality education and support.</p> <p>Note that not enough data are available on children’s exposure to HIV risk in residential care, and even less on the experience of HIV-positive children in residential care.^{iv}</p>	<p>69, 70</p> <p>71</p> <p>72, 73</p>
<p>Girls in early marriage and cross-generational sexual relationships have increased risk of HIV infection</p>	<p><i>South Africa, Uganda, Kenya, Zambia, Ethiopia</i> – high levels of HIV infection from cross-generational sex; although evidence that not forced and includes girls using own agency to achieve gains in economically constrained settings.</p> <p><i>Africa</i> – review of child marriages shows increased risk of HIV infection due to young age and forced sex and limited social networks; Uganda – married girls have higher rates of HIV than their non-married counterparts.</p>	<p>74, 75, 76, 77</p> <p>78, 79</p>
<p>Evidence showing protective linkages between HIV and child protection</p>		
<p>Factors that promote the resilience of HIV-affected children to poor child protection outcomes</p>		
<p>HIV-affected and HIV-positive children can and do develop strong social networks, mostly informal, in their neighbourhood, correlating with positive well-being and the ability to avoid abuse, neglect, violence and exploitation.</p>	<p><i>Kenya, United Republic of Tanzania, Rwanda</i> – studies of AIDS-orphaned and affected children show high levels of well-being despite adversity.</p> <p><i>Angola, Nigeria, Uganda, Zimbabwe</i> – child carers show resilience and positive self-image.</p> <p><i>South Africa, Kenya, Rwanda</i> – HIV-affected children report they are more able to cope with emotional shocks/make constructive decisions about their future when feel protected or supported by family or community.</p>	<p>80, 81, 82</p> <p>83</p> <p>84, 85, 86</p>

iv UNICEF is currently supporting a global study on HIV and residential care that will consolidate current evidence and gather more robust data in this area.

<p>Actively identifying and facilitating peer and social groups increases psychosocial well-being and enables children to survive alone</p> <p>Improved child-caregiver communication increases child resilience and reduces HIV-related risk</p> <p>Child abandonment and neglect can reduce when HIV care services are family centred and reach key populations</p> <p>Home visiting and parenting interventions show reductions in child maltreatment</p> <p>Support for parental HIV disclosure has longer-term effect on children's psychosocial well-being</p>	<p><i>Kenya, Rwanda, Namibia</i> – interventions that promote peer groups lead to enhanced resilience, leading directly and indirectly to greater safety (children managing social networks and enabling to live alone safely) and making more of available situations (such as school).</p> <p><i>Uganda</i> – perceived support from caregivers accounted for close to 20 per cent of postponed sexual activity/likelihood of condom use (80 per cent from increased economic support).</p> <p><i>Ukraine</i> – more than four out of five children living with a parent with HIV in poverty; women without a partner show fourfold increase of likelihood of infant abandonment; decrease in child abandonment by 88 per cent when HIV treatment and support are provided and used.</p> <p>Systematic review of child maltreatment programmes found home visiting (especially United States' Nurse Family Partnership Programme) and parenting support reduces risk.</p> <p>Review of global literature regarding disclosure of parental HIV infection to children found that disclosure rates were relatively low worldwide, and that unintentional and forced disclosures were common; disclosure tended to have long-term positive impacts on the well-being of children, parents and family in general.</p>	<p>87, 88, 89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p>
<p>Factors that reduce HIV risk for children who have experienced abuse, violence, exploitation and neglect</p>		
<p>Interventions for and contexts of children and families of especially at-risk populations such as injecting drug users and sex workers build resilience</p>	<p>Most research on protective factors from high income countries; some tentative findings in low to medium resource contexts found that sources of potential resilience for children of sex workers are also dependent on a complex combination of economic, environmental and social factors. <i>India</i> - maintaining connection to native village and extended family care giving role helped foster mother/child connection.</p>	<p>94</p>
<p>Early HIV testing and PMTCT provision correlates with decreased abandonment of newborns</p>	<p><i>Ukraine</i> - PMTCT services that include interventions to address stigma and discrimination resulted in significant decline in abandonment of newborns by HIV-positive mothers.</p>	<p>95</p>
<p>Family is the first pillar of support; open communication about sexuality and prevention of HIV appear to minimize risk taking.</p>	<p><i>Romania</i> – adolescents living with HIV in families had reduced risk behaviours. Open communication about HIV and sexuality had positive influence on decreasing risk taking, when supported by trained and supportive medical and social service personnel. <i>Rwanda</i> – enhanced psychosocial well-being of HIV- and genocide-affected children and adults when families showed unity or trust, positive parenting, self-esteem/confidence and community collective support.</p> <p><i>Uganda</i> – adolescents who felt that they had frequent and open carer-child communication, including discussions about sexuality, showed postponed sexual activity and higher likelihood of condom use.</p> <p><i>Global, both high and low-income settings</i> – overview of family based interventions, in high and low HIV-prevalence settings and concentrated and generalized epidemics, show improved health, education and other outcomes (with protection outcomes implicitly included) when family based HIV prevention and care interventions are implemented, including for key populations whose 'families' are often not recognized.</p>	<p>96</p> <p>97</p> <p>98</p> <p>99</p>

2.3 GAPS IN THE EVIDENCE

The gaps in evidence below were highlighted in the literature review and by informants as key areas of concern. They illustrate the shortcomings in the current ways of working – highlighting where links between different sources of support for the most vulnerable children are not being considered or where there are barriers to joined-up action. This could be enhanced with a more HIV-focused, systemic look at child protection.

- More data are needed on household-level resilience, social networks and protective factors for key populations in concentrated epidemics, areas of high mobility, post-conflict settings and from Asia, Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS), and Latin America and the Caribbean. There needs to be more evidence about family centred interventions for such settings and population groups.¹⁰⁰
- There is limited information about treatment neglect for children living with HIV. Anecdotally, some children are denied treatment, intentionally by caregivers or because of inability to provide care due to poverty or lack of information or service access¹⁰¹ More information is needed about the links between different alternative care arrangements and treatment outcomes for children living with HIV and how to scale up positive disclosure by adult caregivers of their own or a child's status.¹⁰²
- Children with disabilities are likely to face increased protection risks, but there are little or no data to show this. No data are available about the scope of HIV-specific cognitive or other impairments¹⁰³ and whether some children are at increased risk of abuse, abandonment or neglect because of their HIV status and/or related disabilities. Adults with disabilities are at risk of HIV because of power inequalities, non- acknowledgement of the sexuality of people with disabilities and lack of opportunity for their participation.¹⁰⁴ The same factors are likely to be exacerbated for children with disabilities.¹⁰⁵
- There are little data available on children who do not fall into some form of recognized 'system' of either family or alternative care, such as street-associated children, including those who inject drugs or sell sex – neither on the risks that they face, nor on their own forms of resilience.
- More evidence is needed about the extent and nature of abuse and violence experienced by children living with HIV. For example, HIV-positive pregnant adolescents may be in less permanent arrangements than older married women, or may be in more controlled marital arrangements in the case of child brides. In these cases, the introduction of provider-initiated testing and counselling carries the potential risk of violence if the male tests positive during his partners' pregnancy or if she tests positive and her partner is negative.¹⁰⁶ More information is needed about the experiences of children living with HIV in institutional care, including physical and sexual abuse.¹⁰⁷
- There were no data found during this study on the protection-related experiences of children living with HIV in emergency contexts, where HIV treatment and support may be disrupted and where there are high levels of conflict-related sexual violence.
- A child-specific definition of HIV stigma is needed. The global tool for measuring HIV stigma states that it is hard to obtain ethical consent and thus children younger than age 16 and people with disabilities who inhibit understanding or communication should not be interviewed.¹⁰⁸ There are, as yet, no data on the cost of delivering evidence-informed interventions with demonstrable HIV *and* child protection results.

2.4 CUMULATIVE RISK AND PROTECTIVE FACTORS

2.4.1 Cumulative risk factors

The evidence from studies across all continents, age groups, and HIV and protection contexts is that ***it is not so much the individual acts of violence or abuse that harm, but the cumulative risks experienced by children and families that do the greatest harm.***

Cumulative risk occurs when children face multiple stresses at the same time or when the risks continue over time. A child or a family recovers from one shock, but another follows shortly, and then another and so on. Each time a shock occurs, it can be harder to recover. Cumulative, multiple and chronic exposure all appear to lead to a quantum leap in reduced ability for a child, family or community to deal with trauma and shock, and this is very much the case for HIV and abuse, violence, exploitation and neglect, all issues that are often intertwined (as demonstrated in diagrams 3 and 4, below).¹⁰⁹

Multiple or chronic exposure to risks increases the damage done to children and can undermine resilience. Studies have examined how each shock influences the next step taken by that child or family – by influencing the reaction of the child, the decision taken by the child or by others, and the response from family, peers or services. For example, in South Africa, food insecurity, HIV stigma and bullying all independently increase the risk of psychosocial disorder, but when children experienced food insecurity *and* stigma together, the likelihood of disorder rose from 19 per cent to 83 per cent. When bullying *and* AIDS orphanhood status were combined, the likelihood of disorder rose from 12 per cent to 76 per cent.¹¹⁰ A systematic review of mental health resilience in HIV-affected children¹¹¹ found that it is the multiple stressors, including HIV, poverty, multiple displacements and living in violent communities, which have the most profound impact on reducing the ability of children to recover from severe shocks.

Diagram 3: The spiral of cumulative HIV and child protection risk



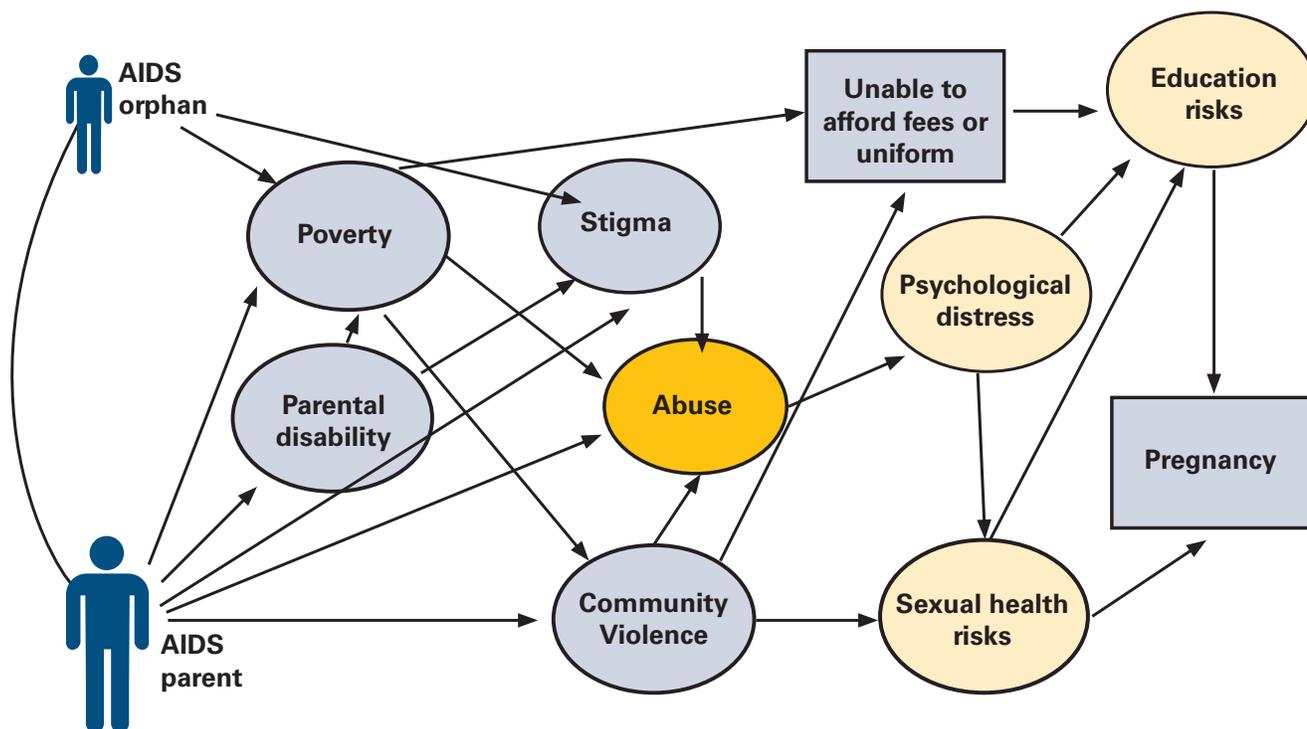
Building Protection and Resilience

The South African study¹¹² represented below maps the pathways from AIDS orphanhood and sickness, indicating how strong the likelihood is that one adverse event will lead to another negative outcome. The evidence suggests that the relationship from AIDS orphanhood or parental AIDS sickness to child psychological distress, educational or sexual health

risks happens *via* a set of factors: parental disability, poverty, community violence, HIV-related stigma and child abuse.

The priority for both HIV and child protection actors is to identify possible pathways and identify which factors increase risk and which factors promote resilience.

Diagram 4: Identifying and changing pathways of risk for an AIDS orphan



Source: Cluver, L., Orkin, M., Boyes, M. E., Sherr, L., Makasi, D., & Nikelo, J. (2013). Pathways from parental AIDS to child psychological, educational and sexual risk: Developing an empirically based interactive theoretical model. *Social Science and Medicine*, 87, 185-193.

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2.4.2 Protective factors

It is critically important that protective factors be identified, promoted and fostered to help minimize the negative impacts of cumulative risks. Helping children and caregivers develop and strengthen protective factors is an essential function of the child protection system and works as both a preventive measure and increases the ability of caregivers and children to positively deal with shocks when they do occur.

Both the child protection system and the children affected by HIV sectors endorse a family centred approach. A systems approach offers the benefit of linking with other sectors to meet the economic, social and emotional needs of children and families, thus reducing some of the drivers that render families fragile and make it harder for them to provide protective care for children.¹¹³ There is evidence that families that are able to communicate well with children and provide structure (discipline, boundaries) and nurturing care (love, stimulation, play) are more resilient when shocks occur and reduce the likelihood of risky sexual and other behaviour in children. Strengthening the family or household unit as the first point of entry, in whatever form that family takes – grandparents, gay couples, child-headed households, foster parents or others – is thus at the core of any HIV-sensitive child protection system.

This is especially true during adolescence, where evidence demonstrates that improved child/ adolescent-caregiver communication has resulted in increased resilience, positive sense of well-being and reduced HIV-related risk in children.¹¹⁴ In various cultural contexts, evidence shows that families that are able to communicate, especially about subjects related to sexuality and HIV, results in decreased risk taking by adolescents. Therefore, providing parents with training and the tools to be able to discuss these sensitive matters is a critical intervention that can and should be provided by the child protection system. A review of programmes on parental depression argues that family based, rather than individual, interventions to reduce family depression are an important piece of the HIV prevention and treatment response.¹¹⁵ At the same time, the children and HIV sector has expertise in the area of family based support and could provide important guidance, existing models and tools for this kind of

support – both sectors would be able to help each other to address some of the core child protective factors, such as addressing parental depression, in a family focused rather than individual way.

Studies of HIV- and genocide-affected Rwandan children and families identified five protective resources that appeared to make a difference in the psychosocial well-being of affected children and families.¹¹⁶ These included: perseverance; family unity or trust; positive parenting; strong self-esteem and self-confidence; and collective support within the community.¹¹⁷ The findings informed the development of a national Family Support Initiative aimed at strengthening vulnerable families and child-headed households and building resilience.¹¹⁸

Children and youth who are able to construct positive social identities and have strong peer groups or social networks – i.e., peer social capital – appear to be more resilient to shocks.¹¹⁹ Across many countries, studies on the resilience of children and youth affected by HIV illustrate that children affected by HIV and/or children in caregiving roles construct and foster supportive friendship groups as a coping strategy.¹²⁰ Research from Kenya found that friendships provided material support, such as lending necessary supplies for school, help with domestic chores, sharing of income-generating activities such as farming, in addition to emotional support, particularly during times of illness or other severe stress in the family.¹²¹ The research also highlighted the importance of school settings as being primary contexts for the formation and fostering of friendships and identified adult friendships within the community as positive factors in children's perception of peer support. Similar findings from Uganda and the United Republic of Tanzania found that strong peer relationships, healthy self-esteem and community mobilization were key factors in fostering children's agency and increased resiliency.¹²²

The children and AIDS sector already has a strong focus on community-centred and family strengthening approaches and, through social protection interventions, has generated some important lessons on the economic strengthening of families vulnerable to the impacts of HIV.

SECTION 3: EVIDENCE TO ACTION: MOVING FROM GAPS TO OPPORTUNITIES

3.1 CHILD PROTECTION AND HIV PROGRAMMING GUIDANCE

This study reviewed how far global and national tools and guidance reflect existing evidence and enable policymakers and practitioners to deliver HIV-sensitive child protection responses.

3.1.1 Global guidance and policies on child protection and child protection systems

The **2009 Guidelines for the Alternative Care of Children**¹²³ are core global guidelines, endorsed by all UN Member States, providing guidance on how governments should implement alternative care for children outside of parental care and for children in vulnerable families and at risk. The Guidelines stress the importance of preventing family separation¹²⁴ and emphasize the need to consider HIV and other ‘special needs’ of children in alternative care in the assessment and development of an individualized response for children requiring specific care and protection measures. Several countries have adapted the Guidelines^v to meet the nationally specific care options and populations of children in need of care. Ethiopia’s 2009 Alternative Care Guidelines¹²⁵ mention HIV as one of a number of issues affecting vulnerable child populations and highlight the health, HIV treatment and psychosocial care needs of children living with HIV in residential care. Kenya’s Alternative Care Guidelines do not specify specific groups of children with ‘special needs’, but do mention HIV support services within different care options.¹²⁶

Where countries develop national guidelines that build on an evidence base that considers the unique issues related to children affected by HIV, this should inform the development of standards of care that would include specifics related to protocols around testing, access to HIV treatment and care, potential effects of stigma and support needs related to caregiver sickness

and other HIV-sensitive concerns. The Guidelines offer a valuable opportunity to ensure that the unique care and protection needs of children with HIV are included in the development of national guidelines, standards and other tools related to alternative care. Alternative care can be a useful entry point into larger systems strengthening efforts¹²⁷ and are particularly relevant where HIV has contributed to a high number of orphaned children.

The **2013 Handbook for the Implementation of the Guidelines for the Alternative Care of Children**¹²⁸ offers clear implementing guidance to government and civil society and provides several examples of promising practice of alternative care programmes for children affected by HIV, including a foster care programme for children orphaned by AIDS in Zimbabwe and a child and youth care workers training programme for community-based social welfare workers in South Africa.¹²⁹ It does not cover children who are not in formally recognized ‘alternative care’ – that is, who are not currently within some recognized family or non-family institution. This might include street-associated children or children on the move. Such children are often at the greatest risk of acquiring HIV and least likely to be accessing any form of formal service, be it health, education or social welfare. The HIV sector should play an important role in ensuring that these children are taken into account when the Guidelines are translated into national policies, regulations and standards.

The **Alternative Care in Emergency Guidelines** give overarching, global child protection guidance for children in emergency contexts.¹³⁰ Emergency situations often put children, especially girls, at high risk of sexual abuse and measures need to be put in place to prevent and respond to this. The Guidelines also make reference to children with special needs, including children affected by HIV, and mention the importance of providing information related to HIV prevention as part

v For example, Ethiopia, Ghana, Namibia and Kenya.

of life skills for older adolescents and when planning reintegration and reunification. There is limited guidance or evidence on the links between HIV and child protection in emergency settings, yet the strongest linkages – sexual violence and lack of a protective family environment – are exacerbated in emergency settings. As such, this is a significant gap that both child protection and HIV sectors must address, advocating and supporting emergency responses to integrate HIV-sensitive protection.

Child protection systems stakeholders in sub-Saharan Africa are developing **a proposed framework of action** with core components and causal mechanisms to inform the development and implementation of future policy, practice and research efforts in the region.¹³¹ It is essential that this framework address the needs of children affected by HIV, given that the major burden of care is on children affected by HIV.

There has been a significant increase in the numbers of countries that have developed new Children’s Acts or Child Protection Bills, but few have yet spelled out detailed rules and regulations.¹³² These rules and regulations need to integrate HIV prevention and treatment, and support the needs of children to ensure that child protection responses spell out HIV-specific mandates and protocols and include core costs.

Data collection and child protection indicators

Existing child protection monitoring and evaluation frameworks include little or no specific indicators related to HIV. For example, the TransMONEE database used in CEE/CIS has 180 social and economic indicators related to child protection and well-being, but only one is HIV specific.¹³³ In concentrated epidemics, child protection indicators are needed that recognize the susceptibility of abused, exploited and neglected children to increased HIV risk; protect the right to children living with HIV and HIV-affected children from neglect, abuse and abandonment; and ensure that children in key populations have their HIV needs met within a protection response.

There are important child protection data collection tools, such as the Better Care Network/UNICEF *Manual for the Measurement of Indicators for Children in Formal Care*,¹³⁴ which provides important national and global indicators, but they address only one part of the system. As one study informant mentioned, “*the way that data is typically collected leads to fragmentation of the child,*” especially children who do not fit into the formal care sector.^{vi}

Data on a particular aspect of child protection can be used as an entry point to a broader HIV-sensitive response. The recent studies on violence and children have been helpful in illustrating the scale and scope of violence against children and offer an entry point for HIV-sensitive child protection (*see the box on page 28*).

vi Currently, there is no standard, globally agreed upon set of indicators for measuring whether the child protection system is doing what it should do. Global indicators for child protection tend to focus on issues-based outputs rather than the outcomes related to safety and well-being that should be the end goals of a child protection system.

3.1.2 Global guidance on children affected by HIV and AIDS

Child protection has been an integral part of children affected by AIDS policy and programming for the past 10 years, included within the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*,¹³⁵ a companion paper to the OVC Framework¹³⁶ and the 2011 *Taking Evidence to Action*, which highlights the importance of integrating responses into HIV-sensitive, rather than HIV-specific, development and child protection efforts. The key approaches are in line with child protection systems strengthening: HIV-sensitive and not HIV-specific programming with a more nuanced understanding of predictors of economic and social vulnerabilities¹³⁷ and a focus on delivering appropriate support equitably, fast-tracked to those most in need,¹³⁸ an increased focus on social protection that is child-sensitive and that addresses both poverty-related vulnerabilities but provides wrap-around protection and basic services,¹³⁹ and family centred approaches, working not just with individual children but the whole family and community.¹⁴⁰

While global HIV prevention guidance for adolescents¹⁴¹ recommends links with child protection systems, there is no detailed guidance on how to make such links effective. HIV testing and treatment guidance stresses the importance of, but offers no detail on, how to support children and adolescents who are at risk of or have experienced abuse or violence.¹⁴² Adolescent HIV treatment guidance is currently being developed.

Guidance on HIV prevention and care for key adolescent populations considers child protection, but there remain gaps such as considering issues around legal age of consent and reaching children who wish to stay under the radar for fear of being put into residential care or prison.¹⁴³ HIV guidance for sex workers does not consider the particular needs of those aged younger than 18 years old involved in sex work. The only mention of under-18s is referral to specialist trafficking services for exploited children, considering sex workers' children when offering alternatives to sex work (although not explaining what the consideration

Linking social and child protection for HIV-affected households, Zimbabwe

Zimbabwe's National Action Plan II for Orphans and Vulnerable Children aims for all children in Zimbabwe to live in a safe, secure and supportive environment that is conducive to child growth and development. The plan receives multi-donor support from a Child Protection Fund aiming to reduce household poverty and provide quality social protection and child protection services that are combined. The programme is HIV-sensitive but not HIV-targeted. HIV is one of the largest drivers of vulnerability in Zimbabwe – 1.5 million children have lost one or both parents to AIDS. But the programme recognizes that there are other vulnerabilities, such as sexual violence. A social services capacity audit found that there were only 96 social workers who could offer child protection services and only 17 child-centred courts with legal officers.

An evaluation of the previous National Action Plan noted that, despite offering material support, it lacked evidence of impact on overall poverty and had not addressed non-material risks, such as abuse. The new Plan both provides cash to the most vulnerable households and offers a core package of child protection services for all children, including access to justice and welfare services, immediate post-rape care, rehabilitation services for children with disabilities and alternative care such as reintegration for children in residential care. The programme is piloting a community-managed case management system. The Fund includes significant investment in capacity building for social workers and developing codes of conduct and minimum standards of training and support for volunteer community workers.

Sources: Informant interview; Ministry of Labour and Social Services and UNICEF Zimbabwe, "Proposal: Critical child protection interventions within the framework of a child-sensitive social protection framework – Supporting Government of Zimbabwe's National Action Plan II", 2011.

should be) and encouraging a focus on keeping girls in school.¹⁴⁴ HIV guidance for injecting drug users does not refer to adolescents, and only mentions children in the context of age of consent for testing.¹⁴⁵

There is a documented gap in translation from policy to action – a review of Southern African National Strategic Plans on HIV and AIDS found “a failure to recognise and meaningfully programme for gender-based violence as a cause and consequence of HIV transmission” and “failure to address strengthening care and support for women and girls and reducing their unpaid care burden.”¹⁴⁶

A rapid review of 23 National Plans of Action for Orphans and Vulnerable Children^{vii} found that plans generally refer to the need to “implement child protection guidance” or “refer to child protection services,” without considering financial or other implications and without locally developed and regulated mechanisms that meet the multiple needs of vulnerable children, especially those facing complex vulnerabilities.¹⁴⁷ Zimbabwe is an exception, with a national plan for children that invests in both child protection and social protection and a case management system that intentionally links child protection and HIV. Child protection systems advocates can work with the HIV prevention and treatment sector to highlight the need to consider abuse and violence as a direct cause of HIV infection and a possible outcome, sensitizing the HIV sector on age-appropriate child protection measures, while ensuring that children and adolescents have access to HIV-prevention information and tools. Child protection and HIV experts are needed to develop more age-appropriate guidance for working with children who are sexually exploited.

The child protection sector can work with the HIV community when developing national plans responding to HIV-affected children (either stand-alone ‘OVC plans’ or impact mitigation components of National HIV and AIDS Strategic Plans) to ensure a child protection-sensitive system.¹⁴⁸

vii Two from Latin America, 5 from Asia and 16 from sub-Saharan Africa. Child-care bills and related guidance were from 11 countries (1 from Latin America, 4 from Asia and 6 from Africa).

Data collection and indicators on children and HIV and AIDS

Most countries collect and report on global core HIV indicators. These do not include information on violence against children, although they do include one indicator on intimate partner violence. Demographic Households Surveys and Multiple Indicator Cluster Surveys provide useful data on household caring patterns, economic trends and household HIV impact. One significant gap is that these surveys do not automatically gather data on children that are especially vulnerable but are not based within households – children on the move or street associated, for example. Several study informants noted the absence of data on the linkages between children who have tested positive for HIV and possible linkages with sexual abuse.

HIV surveillance usually disaggregates into 0–14 years and 15–45 years, although some prevention data disaggregates into 15–24 years. It is critically important to have disaggregated data for adolescents, especially those outside of households/family structures. The example of adolescents who inject drugs illustrates this need. Most studies on drug use exclude children and adolescents who are most at risk, because data are generally collected via home- or school-based surveys. Rates of adolescent injecting drug use are significantly higher in street surveys. In many cases there is an age restriction on when participants can consent to take part in research, which limits inclusion of data on key adolescent populations such as sex workers and injecting drug users. The new World Health Organization/United Nations Office on Drugs and Crime/UNAIDS guide on HIV and injecting drug users calls for data disaggregation for under-18s, which is a positive development.

3.2 INTEGRATING HIV AND CHILD PROTECTION

HIV interventions must be adequately reflected in child protection response, and vice versa, in order to provide a comprehensive response to children affected by HIV and AIDS. The sections below illustrate some of the key

entry points where a combined HIV and child protection intervention can offer a preventive, sustained and integrated response.

3.2.1 Making child protection systems HIV-sensitive

Child protection component or intervention	HIV-sensitive entry points
National legal and regulatory framework for child protection	<ul style="list-style-type: none"> • Include response to HIV impacts (stigma, household economic vulnerability, adverse coping mechanisms, risk of HIV infection through abuse and violence) in child protection bills and policies. • Ensure that laws do not discriminate against vulnerable and excluded populations (men who have sex with men, sex workers, drug users, ethnic minorities, migrants, etc.), especially access to HIV support and services; may require development of child-specific ethical guidelines for harm minimization, safe sex and other services. • Include support to HIV-affected caregivers within domesticated Alternative Care Guidelines, to minimize impacts of HIV on households (e.g., depression and poverty) and ensure children living with HIV are accessing necessary services. • Ensure that provisions for the availability of medical services and post-exposure prophylaxis are included in national frameworks and strategies responding to abuse and violence. • Ensure that alternative care guidelines and regulations, especially for children in residential care, include relevant HIV and AIDS services – e.g., testing, treatment, disclosure support, family support/parenting.
Coordination mechanisms	<ul style="list-style-type: none"> • Transfer 'CABA/OVC' oversight responsibility to a statutory child protection body for all children in need of care and protection; and continue to require that this function has two-way referral and accountability with HIV prevention and treatment services.
Monitoring and evaluation	<ul style="list-style-type: none"> • Include children who are not routinely counted within national data collection systems – e.g., children who do not live in households and include data on HIV as part of situation analysis. • Generate and track data on the cost of delivering evidence-informed interventions with demonstrable HIV results (building on HIV expertise in this sector).^{viii} • Ensure that indicators around HIV and AIDS are integrated into child protection responses – e.g., availability of HIV services, testing protocols, sexual and reproductive health education. • Monitor the number of children living with HIV in residential and other forms of alternative care in both generalized and low and concentrated epidemic settings. • Monitor and track the extent to which sexual abuse leads to HIV infection; ensure access to post-exposure prophylaxis where necessary.
Informal approaches to community-based and family strengthening interventions	<ul style="list-style-type: none"> • Where available, work with HIV sector initiatives to challenge social and cultural customs that increase HIV infection, and work to enhance informal child protection responses. • Strengthen community-level workers who support households to link to HIV services and other essential services – e.g., economic support programmes or other schemes (e.g., utilize a family centred approach).

^{viii} UNICEF is currently developing a model to cost interventions, such as social work and community care work, that will address both HIV and child protection. Source: Informant interview.

<p>Informal approaches to community-based and family strengthening interventions (continued)</p>	<ul style="list-style-type: none"> • Partner with actors working on HIV-related ‘burden of care’, family strengthening male engagement¹⁴⁹ and psychosocial support to generate gender-sensitive, family care and parenting programmes.¹⁵⁰ • Use evidence from successful adolescent HIV prevention programming that has resulted in reduced HIV infections (e.g., reduction of multiple concurrent partners and age-disparate sex, links with social protection) to develop evidence-informed responses to violence against children. • Identify and monitor/refer access to HIV services for disabled children and their families. • Ensure that HIV-related stigma reduction is part of any child protection response and is included in training for social workers and other care professionals. • Integrate support for HIV disclosure (of adult and child HIV status) into family strengthening and parenting programmes. • Encourage and support families and communities to combat negative attitudes towards HIV, and ensure HIV stigma reduction policies in care and other institutions, including for children in detention and in conflict with the law. • Involve (HIV) key populations – adults and children – in design and delivery of child protection programmes, especially at community level. • Ensure that, where necessary, children identified as living with HIV (through paediatric testing or PMTCT programmes) are referred to appropriate care and support services, including parenting, early childhood development services, and access to social protection programmes.
<p>Statutory child protection services (case management)</p>	<ul style="list-style-type: none"> • Include HIV-specific guidance on confidentiality and treatment access, plus PMTCT, HIV prevention, testing and post-exposure prophylaxis referrals, within case management procedures and referral flow charts. • Involve networks regarding people living with HIV and AIDS in child protection coordinating bodies where relevant.
<p>Alternative care</p>	<ul style="list-style-type: none"> • Ensure that HIV and AIDS are not used as a justification for opening or maintaining residential care facilities – the evidence does not support this. • Ensure that caregivers of HIV-affected children in alternative care know how to care for children, including support on monitoring treatment, adherence, disclosure support, sexual and reproductive health for adolescents, and psychosocial support for children affected. • Actively engage children living with HIV and adolescents facing high HIV risk – including care leavers – in the adaptation of alternative care guidelines. • Address HIV-related health and psychosocial support needs of children living with HIV in residential care; focus on HIV support needs in transitional care for care leavers who are living with HIV. • Include HIV prevention, sexual and reproductive health and HIV care services in child labour and street-associated youth programmes. • Focus on reaching marginalized or excluded youth (including those with disabilities) who face high HIV risk because of their exclusion from information, support and services. This is particularly important in concentrated epidemics, but necessary in all settings. • Integrate HIV-related stigma reduction approaches. • Train alternative care workforce in and/or promote effective ongoing referrals to HIV-specific support for children in residential care. • Train alternative care workforce on HIV treatment adherence support for children in extended family/foster care. • Include HIV and AIDS protocols and guidelines in child protection contexts, including children in all forms of alternative care and juvenile detention centres.

3.2.2 Making HIV systems child protection sensitive

HIV sector component or intervention	Entry points for integrating child protection
National HIV strategies and legal frameworks	<ul style="list-style-type: none"> • Include child protection factors in situation analyses such as ‘Know your epidemic’ studies, to generate data on violence, abuse and neglect as social drivers of HIV infection. • Avoid punitive laws on HIV transmission; often linked to punitive laws on sexual behaviours that can drive key populations underground. • Include focus on sexual abuse against girls and boys within HIV strategic plans. • Align impact mitigation policies with the UN and related national alternative care policies and standards, to ensure that children living with HIV have appropriate family based care options and full access to HIV testing, treatment and support.
National and local coordination of child protection	<ul style="list-style-type: none"> • Where possible, transfer ‘CABA/OVC’ oversight responsibility to a statutory child protection body for all vulnerable children; continue to require that this function has two-way referral and accountability with HIV prevention and treatment services.
Monitoring and evaluation	<ul style="list-style-type: none"> • Include data on scale and scope of physical and sexual violence against boys and girls to inform national HIV and AIDS strategic plans. • Collect data and monitor children living with HIV in alternative care settings. • Monitor and track linkages between sexual abuse and HIV infection, through regulatory framework on violence against children.
Prevention of PMTCT of HIV and paediatric care	<ul style="list-style-type: none"> • Refer ‘at-risk’ mothers for child protection support – e.g., adolescent mothers and train staff (especially PMTCT and paediatric treatment) in importance of family based care, where placement of HIV-positive children is widespread. • Facilitate access to PMTCT services for key populations. • Link with child protection and disability services, to promote early identification of possible disabilities within HIV treatment services. • Ensure children born into HIV-affected families are linked to support services related to early childhood development. • Refer to community-based psychosocial support for HIV-positive/HIV-affected caregivers, where possible depression exists. • Ensure HIV and other health services in residential facilities are being monitored, including by the health sector where necessary.
Adolescent HIV treatment and support	<ul style="list-style-type: none"> • Include referral pathways for suspected HIV abuse, violence, exploitation or neglect in health-sector mandates and guidelines. • Include adolescent-specific gender-based violence within adolescent HIV care and support programmes. • Include abuse and violence prevention and referral for support within child/adolescent HIV testing and counselling and sexual and reproductive health. • Include care and support for HIV-positive adolescents living in alternative care settings, especially residential and other forms of institutional care.
Community-based family care support interventions	<ul style="list-style-type: none"> • Train community health/HIV and child-care workers on identification and referral of child protection issues, including gender-based violence and abuse.¹⁵¹ • Ensure psychosocial support for HIV-positive/HIV-affected caregivers where possible depression exists. • Ensure that alternative care for HIV-affected children in kinship or foster care is practiced and provided in accordance with Alternative Care Guidelines, standards of care, etc.
HIV prevention for children and adolescents	<ul style="list-style-type: none"> • Include child protection training for staff of all HIV prevention and care interventions, especially statutory processes and referrals around abuse and violence. • Ensure that abuse and violence factors are included in HIV prevention programmes, appropriate for both boys and girls. • Provide disability-specific/sensitive HIV prevention work for all children and adolescents, especially for HIV-positive children and adolescents. Ensure that materials are accessible for all learning types (e.g., non-literate or Braille). • Consider the age-specific child protection needs of legal minors, when delivering a harm minimization approach to injecting drug use and sex work.

3.3 ADDRESSING CHILD PROTECTION AND CHILDREN AFFECTED BY HIV WITHIN OTHER SECTORS

The response to children affected by HIV and AIDS and to child protection is not delivered only through the social welfare or protection sectors; it is also delivered through many other sectors, including education, health, early childhood and social protection (where it exists as a sector). The paper recognizes that a multi-sectoral approach is needed to contribute to improved

outcomes in protection and HIV for children. However, the details are not within the scope of this particular paper. It is recommended that actions to take forward work around protection and HIV are not done in isolation, but that consideration is given to where the links should be made to other sectors.

Adolescent girls, HIV and abuse, United Republic of Tanzania

In the United Republic of Tanzania, research on violence against children has proven to be a catalyst for significantly improved coordination and shared responsibility and accountability for both child protection and responses to children affected by HIV. In 2011, a study on violence against children found that almost one in three females and one in seven males experience at least one incident of sexual violence before the age of 18. Most children do not report sexual abuse, few seek services and even fewer receive services. Almost three quarters of girls and boys (72 per cent and 71 per cent, respectively) have been punched, whipped, kicked or threatened with a weapon by a family member, an authority figure or an intimate partner during their childhood. One quarter of all children are emotionally abused. The impact of this level of violence carries on beyond the abuse into adulthood.

Government and civil society HIV and child protection stakeholders announced commitments, sending a clear message that this was everyone's responsibility. This strong advocacy and accountability focus has helped to link HIV and child protection. The new National Costed Plan of Action for Most Vulnerable Children (originally primarily aimed at HIV-affected children) is now focused on ensuring an integrated approach to vulnerability, accountability and ownership of government and civil society.

In order to turn this evidence into practical results, stakeholders have developed a framework for action focusing on a population at the epicentre of HIV and child protection concerns – adolescent girls and their vulnerability to HIV, unwanted pregnancy and violence. The Plan of Action seeks to build adolescent girls' agency – recognizing that it is only when girls are at the centre of the response that these three interlinked imperatives will be addressed.

Source: Bangser, Maggie, "A Programming Framework for Working with Adolescent Girls in Tanzania, Tanzania Commission for AIDS and UNICEF Tanzania, Dar es Salaam, United Republic of Tanzania, June 2012.

SECTION 4: RECOMMENDATIONS

The recommendations below build on the synergies and practical entry points identified in Section 3. These recommendations highlight key systems strengthening entry points at national and global levels.

NATIONAL-LEVEL RECOMMENDATIONS

A. Recommendations to the national body/ ministry responsible for child protection

1. Ensure that the national child protection system (mapping, strategy and budget) articulates the specific linkages between HIV impact and subsequent child protection risks, and vice versa, based on national and comparative evidence.

If the evidence is lacking, liaise with the HIV and children sector to understand the specific nature of the gaps. If necessary, commission a rapid evidence review to identify priority entry points. At a minimum, consider the impact of HIV-related stigma and poverty, HIV-affected caregiver well-being and key population HIV and protection needs.

Where child protection system strengthening is under way, ensure involvement of the following key actors: national AIDS coordinating body (impact mitigation sector); key donors funding 'OVC' work; civil society working on children and HIV issues; child and adolescent representatives or organizations actively promoting their participation; and representatives of people living with HIV.

2. Advocate, educate and ensure that HIV-specific child protection risks and inclusion of HIV-affected groups are clearly articulated and included within child protection laws, policies, guidance and standards, including a focus on HIV stigma.

The national body for child protection must achieve this with input from health (including PMTCT,

paediatric HIV and HIV prevention expertise), education and justice ministries, technical agencies and civil society groups working with HIV-affected children. This can be accomplished through formation of technical working groups or similar review processes with a mandate to ensure that the unique care and protection needs of children with HIV are included.

Where HIV-specific child protection risks and responses are not known, commission a study to increase understanding of the evidence base about the protection risks children affected by HIV who might be outside of or purposefully turn away from the formal system.

3. Ensure that there is a baseline and means for ongoing monitoring on how HIV affects children living in alternative care settings.

This effort must be led by the lead child protection body and coordination mechanism working on alternative care policy and programming. It must involve technical partnerships with national-level paediatric and adolescent HIV experts and, ideally, children and caregivers involved in all types of alternative care.

Assess the extent to which HIV is used as a reason for placement in alternative care settings and identify barriers that might inhibit placement of children living with HIV in certain alternative care settings, when undertaking alternative care assessments, domesticating the UN Handbook guidelines or integrating HIV and AIDS into existing alternative policies, regulations and services.

4. Ensure that services that are being delivered by the child protection and social welfare sector include HIV-specific prevention, care and support components.

This must be coordinated by the government body mandated to lead on children's issues and involve active engagement by the Ministry of Health and other key HIV care sector personnel (coordinating and evaluation sectors and specialists from paediatric and adolescent care and HIV prevention sectors), representatives from civil society organizations involved in community-based HIV care and/or referrals for service delivery. At all stages, these efforts must involve civil society or other partners to ensure that HIV-positive and HIV-affected children and caregivers are included in design and monitoring.

If the social welfare and/or child protection sector are currently undertaking an assessment, capacity gap analysis, functional review or similar, include HIV-specific technical expertise from the design stage. If the country is considering an alternative care strategy, include HIV-specific technical expertise from the design stage.

5. Prioritize interventions that are family focused and include abuse/violence prevention, positive parenting techniques, early childhood development, and economic strengthening initiatives as part of a standardized package of services available to vulnerable children and families.

This must be integrated into national child protection budgets, requiring liaison with Ministries of Finance or equivalent. These should be done in collaboration with children and HIV actors, mobilizing resources from the HIV sector for the same end.

The child protection sector must first identify models of good practice and programming tools, which should be done jointly with those in the children and HIV sector who may have local examples. Selected interventions should incorporate HIV-related stigma.

Positive practice models need to be community-based and within the education sector, addressing the links between HIV and school-based bullying.

6. Include HIV-specific indicators within child protection monitoring and evaluation frameworks.

Government bodies, technical agencies and others responsible for developing national child protection plans and monitoring and evaluation frameworks should ensure that at least one core protection indicator is included that contributes to HIV outcomes.

Alternative care experts, building upon the momentum initiated by the launch of the Alternative Care Guidelines and subsequent Implementation Handbook must ensure that there is proper tracking and data collection around children with HIV in all types of alternative care settings.

Data collection should be age disaggregated for key populations, including injecting drug users with HIV status, sexually exploited children, etc.

7. Ensure that core HIV components are included in regulations, standards and operational guidelines for all child protection personnel.

The key ministries involved in the development of work-related regulations and standards, with engagement by technical agencies and key civil society organizations, should identify key topics to be included in guidance and training curricula for child protection, social welfare, education and social protection sectors (especially those working directly with children and families), including a focus on clear and accountable referral pathways.

8. Ensure that child protection and children's HIV vulnerabilities, including the synergies between these two, are reflected in emergency preparedness and response plans and are monitored.

This must be coordinated jointly with the emergency preparedness and coordination body/bodies

(government and multilateral), where there is already an HIV or a child protection component, to ensure synergies.

This may require advocacy from the national body responsible for child protection, national HIV and emergencies focal point and UN child protection emergency cluster.

9. Calculate the cost-effectiveness of delivering to children affected by AIDS through a child protection system as compared with stand-alone programmes.

This must be done within the overall child protection systems costing and budgeting exercise. The child protection ministry, jointly with HIV sector costing experts, must include HIV costs in child protection budgets where direct links are demonstrated, notably costs of post-rape HIV care and investment in community-based abuse and neglect prevention). Other areas for consideration include early childhood development support, psychosocial support for HIV-affected children and families, alternative care options in heavily HIV-affected contexts, HIV-specific care and support costs for priority groups of children in alternative and key populations.

B. Recommendations to national-level actors on children affected by HIV

1. Ensure strong coordination exists between National Plans of Action for Children with child protection systems strengthening efforts.

This must be led by the coordinating bodies mandated with developing the National Plan of Action for Children (or Most Vulnerable Children/ OVC) and with the impact mitigation components of National HIV and AIDS Strategic Plans. It may be necessary for civil society and government child protection advocates to sensitize HIV policymakers on this issue.

The evidence on cumulative risk can be used as a

strong justification for placing HIV resources within a multi-sectoral child protection system.

2. Include at least one child protection outcome in national HIV and AIDS indicators.^{ix}

This must be done by the national HIV coordinating body, in partnership with child protection ministries and civil society. One possible core indicator is sexual abuse prevalence and HIV outcomes.

3. Ensure that child-focused HIV regulations, standards and operational guidelines include child protection training for HIV staff and provide a mandate for child protection support and referrals.

The HIV sector must liaise with the child protection ministry, technical agencies and key civil society organizations in the development of key topics to be included in a training curriculum regarding child protection. These could include the following: including the skills to identify risk signs and provide clear and accountable referral pathways for suspected cases of violence, abuse, neglect and exploitation in children, women and families into guidance and training curricula for health, education and social protection sectors (especially those working directly with children and families). The training should be provided to all HIV and children staff working directly with children, including those in the formal and informal sector (e.g., governments, non-governmental organizations, faith-based organizations and community volunteers).

4. In HIV programming for children affected by HIV, prioritize interventions that are family focused and include abuse/violence prevention, positive parenting techniques, early childhood development and economic

ix United Nations Joint Programme for HIV and AIDS, [Global Aids Response Progress: Guidelines construction of core indicators for monitoring the 2011 Political Declaration on HIV/AIDS](#), UNAIDS, Geneva, 2011.

strengthening initiatives as part of a standardized package of services available to vulnerable children and families.

HIV-focused civil society organizations, especially those working in heavily HIV-affected settings, must ensure that HIV-affected children programmes have a strong emphasis on family strengthening, caregiver depression and stigma reduction, combined with economic support.

Civil society organizations working with key HIV-affected populations must coordinate an effective response that supports children and adolescents who do not form part of any formal health, education or social welfare system response.

If not already undertaken, ensure that indicators for key populations include age disaggregation, at a minimum to be able to identify adolescent versus adult status.

C. Recommendations to all agencies working on alternative care at national level

1. Improve means of collecting evidence around the different push factors causing children to leave home, resulting in their being in unsafe settings such as the street, exploitative labour situations or migration. Utilize the collected and analysed data to better inform responses that help prevent and/or mitigate the risks of protection violation and HIV infection that can occur in these settings.

RECOMMENDATIONS TO BE TAKEN FORWARD BY THE IATT WORKING GROUP

Recommendations being proposed within this paper should be taken forward by the IATT working group on children affected by HIV and AIDS. The working group should identify the relevant actors and organizations to engage, in addition to opportunities to build synergies between child protection and HIV and AIDS.

Ensure that emerging child protection systems frameworks explicitly reflect HIV.

The following recommendations should be taken forward by regional and global entities working on child protection systems strengthening:

- Ensure global and regional studies or evidence on child protection and child protection systems are inclusive of evidence around how HIV compounds child protection outcomes.
- Identify where child protection frameworks, evidence or guidance documents are being undertaken and engage with the relevant stakeholders to ensure integration of HIV interventions where relevant.
- Identify specific opportunities such as meetings, trainings and other global or regional-level events to present and discuss HIV and child protection synergies.

1. Facilitate the development of global guidance that reflects the unique child protection needs of children affected by AIDS.

- Together with entities working on young people and adolescents, such as the IATT on Young People, ensure that child protection evidence and responses are integrated into guidance around adolescents.
- Ensure that child protection interventions are built into guidance for specific vulnerable and excluded populations (key affected populations) – for example, enable service providers to make decisions in the best interests of the child, according to his or her age, developmental needs and evolving capacities, including harm minimization options, such as harm reduction relating to injecting drug use, access to condoms and related self-protection methods.

2. Ensure that monitoring and evaluation frameworks include both HIV-sensitive and

child protection-related indicators.

- Advocate for inclusion of child-specific indicators within the global People Living with Stigma Index.
- Encourage analysis to examine how interventions focused to child protection systems strengthening impact on HIV and AIDS outcomes, and how response to HIV and AIDS impacts on child protection outcomes.

violence initiatives on how to incorporate issues of boys' sexual abuse and exploitation within ongoing violence against children assessments and plans.

3. Build on the emerging evidence base related to children and AIDS, stigma, resilience and cumulative risks.

- Engage with relevant stakeholders in different sectors (health, education, child protection, social protection, etc.) to identify and improve evidence on what works for preventing child protection violations in all middle- and low-income countries in general and for HIV-affected children and adolescents in particular. Look at adaptability of early and regular home visiting programmes that have been identified as successful in high-income countries.
- Together with costing experts, assess to what extent a child protection systems approach is more cost-effective than delivering stand-alone programmes for the same outcomes for children affected by HIV and AIDS. This could be linked to the UNAIDS investment framework.
- Further explore with CABA IATT member organizations, academic partners and other experts in the area of stigma and resilience, evidence and gaps on how HIV-related and other child protection-related stigma affects child and family resilience. Stigma should form a priority research and action entry point for these actors through existing action research opportunities.
- Discuss with all actors involved in gender-based

SECTION 5: CONCLUSION

This study highlights the compelling evidence that children affected by HIV experience child protection violations and are at risk of them, although the pathways that lead to violations differ. Similarly, there is evidence that shows that children who experience abuse, violence, exploitation and neglect also face higher risks of HIV infection and are less able to overcome the negative aspects of HIV impact. The evidence clearly illustrates the need for specific HIV interventions to be built into child protection responses and vice versa.

This study also highlights how vulnerable and excluded populations – children and adolescents living with HIV and children and adolescents at high risk of HIV infection – are consistently overlooked by both child protection systems and CABA responses. An HIV-sensitive child protection response is a real opportunity for actors in both sectors to work together and coordinate approaches, interventions and responses for improved outcomes for these ‘overlooked’ populations of children.

The IATT CABA has focused on the HIV-child protection link at a timely moment. Global and regional child protection systems strengthening initiatives are in the early stages of defining what constitutes culturally sensitive, contextually appropriate, nationally owned and family focused child protection systems. There are some opportunities and key entry points where the expertise from the children and HIV sector can enhance the work of child protection systems strengthening.

There are some immediate opportunities for building synergies, and the recommendations contained within this report have sought to highlight these key opportunities. National strategies are being developed across Africa and Asia and are starting to be considered in Latin America – now is the time for the children and HIV sector to take a seat at the table and engage in this process. The recent launch of the Handbook for the implementation of Alternative Care Guidelines is an excellent opportunity to ensure that the unique care and protection needs of children with HIV are

incorporated into the larger strategies, standards of care and regulations for alternative care. Children affected by HIV are at high risk of losing family care – or are at high risk of HIV because they lack protective family support – and until now the HIV and children sector can improve responses utilizing the extensive expertise of child protection specialists.

The HIV sector has greatly contributed to the effort by focusing on measuring impact and generating the evidence to inform actions. It is only with such evidence that there will be significant investment, especially when children’s issues are often marginal to national budgets and development priorities. A huge opportunity exists to contribute to the current global efforts to develop monitoring and evaluation frameworks that are intended to measure the impact of a child protection system, as opposed to small-scale interventions, and to measure outcomes for children. Children and HIV actors should make sure that issues related to HIV are included within this global process and apply the emerging lessons into national monitoring systems. The existence of a strong HIV monitoring system is an opportunity to learn how interventions are impacting on children.

Working within a child protection *system* that has a strong focus on prevention and early intervention is an opportunity for the HIV sector to further develop and expand family focused initiatives. HIV actors can highlight and utilize their experience and expertise in this area to enhance efforts by the child protection systems strengthening actors. This paper focused on the interactions between HIV and child protection. It is hoped that such an approach might be useful as a way of considering how other groups of highly vulnerable children – for example, children with disabilities – can also incorporate their unique concerns, approaches and expertise into larger child protection systems strengthening efforts as a means of working towards building a system that prevents, protects and responds to all children.

ANNEX 1: GLOSSARY OF TERMS

Abuse: A deliberate act of ill treatment that can harm or is likely to cause harm to a child's safety, well-being, dignity and development. Abuse includes all forms of physical, sexual, psychological or emotional ill treatment.¹⁵²

Adolescent: Young people between 10 and 19 years old.¹⁵³

Age-disparate relationship: Relationships in which the age gap between sexual partners is five years or more.

Alternative care: A formal or informal arrangement whereby a child is looked after at least overnight outside the parental home, either by decision of a judicial or administrative authority or duly accredited body, or at the initiative of the child, his/her parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents. Alternative care may be provided within kinship care, foster care or other forms of family like placements, residential care, or supervised living arrangements for children.¹⁵⁴

Child associated with the street: A child (under 18 years of age) who spends most of his/her time on the streets. He/she may be engaged in some kind of economic activity ranging from begging to vending. He/she may go home at the end of the day and contribute his/her earnings to his/her family, or he/she may live on the street, with or without other family members. The term 'children living and working on the street' is preferred to 'street children'.¹⁵⁵

Child living with HIV: A child (under 18 years of age) who has been diagnosed as having the HIV virus, through a test for HIV antibodies (if older than 18 months) or a viral test.

Children affected by HIV and AIDS: Children living with HIV, as well as those whose well-being or development is threatened by HIV and AIDS in their families or communities.¹⁵⁶

Child protection system: A set of coordinated components that prevent and respond to violence, abuse, exploitation and neglect affecting children, including both formal and informal elements and a coordinated set of policies, accountability mechanisms, child-friendly preventive and responsive services and a social welfare workforce.

Child-sensitive social protection: Integrated social protection systems that: are responsive to the multiple and compounding vulnerabilities faced by children and their families; recognize the critical role of children's caregivers and the importance of addressing their broader vulnerabilities; and aim to maximize opportunities and developmental outcomes for children by considering different dimensions of children's well-being.¹⁵⁷

Children without parental care: All children not in the overnight care of at least one of their parents (or other stable primary caregiver – for example, grandmother), for whatever reason and under whatever circumstances.¹⁵⁸

Deinstitutionalisation: The process of providing alternative family based care for children in residential care institutions.

Exploitation: The use of children for someone else's advantage, gratification or profit, often resulting in unjust, cruel and harmful treatment of the child. These activities are to the detriment of the child's physical or mental health, education, moral or social-emotional development.¹⁵⁹

Family: A group of people related through kinship or marriage/regular partnership. The sense of membership is derived through family relationships with other members rather than necessarily shared residential or economic arrangements.¹⁶⁰

Family based care: The short-term or long-term placement of a child into a family environment with one

consistent caregiver and a nurturing family environment where the child is part of the supportive kin and community.

Family strengthening or support services: A range of measures to strengthen children and families, including but not limited to: parenting courses and sessions, the promotion of positive parent-child relationships, conflict resolution skills, opportunities for employment, income generation and, where required, social assistance, such as cash transfers.¹⁶¹

Family centred approach: A comprehensive coordinated care approach that addresses the needs of both adults and children in a family and attempts to meet their health and social care needs, either directly or indirectly, through strategic partnerships and/or linkages and referrals with other service providers.¹⁶²

Foster care: Situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the child's own family, which has been selected, qualified, approved and supervised for providing such care.¹⁶³

Harm reduction: Policies, programmes and approaches that seek to reduce the harmful health, social and economic consequences associated with the use of drugs without necessarily requiring cessation.¹⁶⁴

Inter-generational sex: Sex between a person and another person where there is a minimum of 10 years' age difference.¹⁶⁵

Kinship care: Family based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature.¹⁶⁶

Legal minor: Anyone under the age of legal majority within a particular judicial setting. In many countries, the age of legal majority is 18.

OVC: Orphans and vulnerable children. Developed in heavily HIV-affected contexts, in practice usually

includes single and double orphans or children in households with a chronically ill adult. National Plans of Action often extend OVC to include children in poor families, street children and children with disabilities, among others.¹⁶⁷

Most-at-risk adolescents: Adolescents at heightened risk of HIV infection associated with their risk behaviour.¹⁶⁸

Most vulnerable children: Definition applied in several countries to enhance the focus on broader vulnerability of *all* children.

Neglect: The failure of parents or carers to meet a child's physical and emotional needs when they have the means, knowledge and access to services to do so; or failure to protect him or her from exposure to danger.¹⁶⁹

Persons with disabilities: Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.¹⁷⁰

Physical abuse: Physical abuse involves the use of violent physical force so as to cause actual or likely physical injury or suffering (e.g., hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, female genital mutilation, torture). Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to, a child whom they are looking after. This situation is commonly described using such terms as fictitious illness by proxy or Munchausen Syndrome by proxy.¹⁷¹

Resilience: The process by which children are socially and emotionally adjusted – and are able to access individual, family and communal resources to assist them to thrive – despite facing risks.¹⁷²

Separated children: Children who have been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from

other relatives. These may, therefore, include children accompanied by other adult family members.¹⁷³

Sex work: The exchange of money or goods for sexual services, either regularly or occasionally, involving female, male and transgender adults, young people and children, where the sex worker may or may not consciously define such activity as income-generating.¹⁷⁴

Sexual abuse: All forms of sexual violence including incest, early and forced marriage, rape, involvement in child pornography and sexual slavery. Child sexual abuse may also include indecent touching or exposure, using sexually explicit language towards a child and showing children pornographic material.

Sexual and reproductive health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to sexuality and the reproductive system and to its functions and processes.¹⁷⁵

Sexual exploitation or commercial sexual exploitation of children: The abuse of a position of vulnerability, differential power, or trust for sexual purposes; this includes profiting monetarily, socially or politically from the exploitation of another as well as personal gratification – e.g., child prostitution, trafficking of children for sexual purpose, child pornography and sexual slavery.¹⁷⁶

Transactional sex: Transactional sex is the practice of exchanging sex for financial or lifestyle rewards. Distinct from formalized sex work, transactional sex is thought to be a fairly common form of sexual partnering in parts of sub-Saharan Africa. Young women may engage in transactional sex with older men to support their basic needs (e.g., food, clothing, school fees) or to obtain desirable consumer goods (e.g., cell phones, fashionable clothing, jewelry) and the social status that goes with them. Gifts for sex may be seen as symbolizing the love and respect a man feels for his partner and the importance he places on the relationship. In contrast, ‘giving away’ sex can stigmatize young women as ‘loose’

and lacking self-respect.

Unaccompanied minor: A child not cared for by another relative or an adult who by law or custom is responsible for doing so.¹⁷⁷

Young person/youth: Individual 15–24 years old.¹⁷⁸

ANNEX 2: LIST OF KEY INFORMANTS

Name	Title/Organization	Date
Miranda Armstrong	UNICEF WCARO	17 December 2013
Damon Barrett	Harm Reduction International	22 January 2013
Amy Bess	Coordinator, Global Social Service Workforce Alliance	11 January 2013
Andy Brooks	Chief of Child Protection, UNICEF Tanzania	16 January 2013
Mark Canavera	Child Protection in Crisis Network	13 January 2013
Severine Cheverel	Senior Coordinator, Better Care Network	10 January 2013
Dr. Lucie Cluver	Oxford University and University of Capetown	24 January 2013
Conraad de Beer	SOS Children's Villages	15 January 2013
Dr. Nina Ferencic	UNICEF CEE/CIS Senior Regional Adviser, HIV/AIDS and YPHDP	25 January 2013
Kendra Gregson	UNICEF NY, Senior Adviser, Social Welfare and Justice Systems	6 February 2013
Peter Beat Gross	UNICEF NY, Alternative Care Specialist	10 January 2013
Marie Eve Hammink	Save the Children, Regional Adviser for HIV and AIDS	9 January 2013
Tony Hodges	Oxford Policy Management	9 January 2013
Kate Iorpenda	International HIV/AIDS Alliance	28 January 2013
Sarah Karmin	Member of IATT HIV in Emergencies	30 January 2013
Susan Kasedde	UNICEF NY, Senior Adviser, HIV Prevention (Adolescents)	17 January 2013
Nankali Maksud	UNICEF ESARO	18 December 2012
Scott McGill	Save the Children, Regional Adviser on HIV and AIDS, South East Asia Region	23 January 2013
Franziska Meinck	D. Phil. Student, School of Social Policy and Intervention, University of Oxford/Young Carers Project South Africa	7 February 2013
Maury Mendenhall	Technical Adviser, Orphans and Vulnerable Children USAID, Office of HIV/AIDS	8 January 2013
Michelle Moloney- Kitts	Together for Girls	25 January 2013
Tapfuma Murove	REPSSI	22 January 2013
Claire O'Brien, Jo Baskott, and Jo Lucas,	Oxford Policy Management	24 January 2013
Rick Olson	UNICEF ESARO	23 January 2013
Nadine Perrault	UNICEF, Regional Child Protection Adviser, LAC	5 February 2013
Pierre Robert	Adolescent and Health Specialist, UNICEF NY	17 January 2013
Elayn Salmon	Child Protection Adviser, UNICEF Zimbabwe	17 January 2013
Dr. Lorraine Sherr	Head of Health Psychology Unit Research Department of Infection & Population Health Royal Free and UC Medical School, UCL	21 January 2013
Joachim Theis	UNICEF WCARO, Chief of Child Protection	17 December 2012
John Williamson	Displaced Children and Orphans Fund	8 January 2013
Dr. Rachel Yates	UNICEF NY, Senior Adviser, Children and HIV/AIDS	9 January 2013

Building Protection and Resilience

(Footnotes)

1 UNICEF is currently developing a model to cost interventions, such as social work and community care work, that will address both HIV and child protection. **Source:** Informant interview.

(Endnotes)

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