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Issues, priorities and responses in the region

IDS Institute of Development Studies

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The mother and child: Shehzad Noorani/UNICEF Myanmar/2006
Little girl and brother: Shehzad Noorani/UNICEF Myanmar/2006

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Acknowledgments

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (Drugs)
CABA	Children Affected by HIV/AIDS
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
EAPR	East Asia and Pacific Region
EPP	Estimation and Projection Package
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
EVA	Especially Vulnerable Adolescents
FBO	Faith Based Organisation
GHI	Global Hunger Index
HIV	Human Immunodeficiency Virus
IDS	Institute of Development Studies
ILO	International Labour Organisation
IOM	International Organisation for Migration
IPEC	International Programme for the Eradication of Child Labour
JLICA	Joint Learning Initiative on Children and AIDS
MARA	Most At Risk Adolescents
MDG	UN Millennium Development Goals
MOLSW	Ministry Of Labour and Social Welfare (Lao PDR)
MOSVY	Ministry Of Social Affairs, Veterans and Youth Rehabilitation (Cambodia)
MSM	Men who have Sex with Men
MTT	Mobile Task Team
NCCAB	National Committee for the Control of AIDS Bureau
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children/Orphans and Other Vulnerable Children

PLHA	People Living with HIV/AIDS
PMTCT	Preventing Mother-To-Child Transmission
PRSP	Poverty Reduction Strategy Paper
SCF	Save the Children Fund
TDRI	Thai Development Research Institute
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nation's General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

Executive Summary

The objective of this report to UNICEF is to provide decision makers, programme managers and advocates for children with evidence and guidance for setting priorities for the protection and care for children in the face of HIV and AIDS in East Asia and Pacific. Evidence on the situation of children and HIV in the region, and on the effectiveness of different solutions, remain limited. What counts as evidence in international policy ('gold standard' evidence-base for 'best practice') further restricts the development of effective national and regional solutions: What can be generalized across contexts is not necessarily the most significant epidemiological driver of the disease in local contexts. However, a regional perspective can provide an overview of local evidence and enable operational possibilities to be shared. Such a perspective can address the disparity between global guidance and local variation. It can also provide countries and stakeholders with opportunities to address cross-border aspects of the problem in ways which may include responding positively and collectively to issues such as migration *vis à vis* HIV, and building a shared pool of expertise and evidence that may be used to frame a cohesive regional approach.

An estimated 2.3 million people in East Asia and the Pacific were living with HIV in 2005. These figures are substantially lower than in higher prevalence regions such as sub-Saharan Africa or South Asia. The region is characterized by diverse, concentrated and emerging epidemics. For example, the highest recorded national HIV prevalence in the region are in Myanmar, Thailand and Cambodia. Nonetheless, those countries have shown declines in prevalence in recent years. In Indonesia and Viet Nam the epidemic is younger and swiftly expanding, while in China it is variegated and fragmented. In Papua New Guinea the epidemic is expanding and concentrated in rural areas. Although the region is home to an estimated 450,000 orphans resulting from AIDS, orphans comprise only a small minority of all children who have experienced the impacts of the epidemic and are relevant to this paper. Aside from those children infected or affected by HIV, many other vulnerable children need care and protection, for example street children, children in prostitution, or those exposed to drug use or commercial exploitation, including sexual exploitation.

The new millennium saw an increased understanding of the impacts of the HIV epidemic on children, leading to the increased incorporation of children into responses. Several partners endorsed the *"Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS"* in 2003. This document (a.k.a. "the Framework" or "the Global Framework") provides general directions for mounting a response to the needs of 'orphans and vulnerable children', which derive from a common framing of proximal to distal levels of action. A useful starting point, the Framework left many questions unanswered and so a companion paper on *Enhanced Protection and Care for Children Affected by AIDS* (hereafter referred to as the Companion Paper) was later developed. This Companion Paper stressed the need for governments to assume the lead and responsibility for children's rights, and to intensify measures in social protection, legal protection, as well as in alternative care and tackling stigma and discrimination – essentially defining the content of 'protection and care' more closely.

A further milestone in the global response to the problem of HIV and AIDS and children was the launch in 2005 of the *Unite for Children, Unite Against AIDS* campaign by UNICEF and UNAIDS, which recognized that children are vulnerable to infection as well as to the impacts of HIV and AIDS, and which placed prevention for children, as well as the needs of children infected with HIV, on the global agenda.

These frameworks have provoked debate regarding the conceptualization of vulnerability in relation to AIDS, resulting in a gradual evolution in our understanding of which children matter to the response. For example, while health perspectives prioritize prevention and treatment, the development community has focussed mainly on the social impacts of HIV and AIDS. Yet, children may be vulnerable in a variety of ways: they can be vulnerable 'to infection', vulnerable 'because they are infected' or 'because they are affected by the impacts of' HIV and AIDS. Understanding this differentiation is essential to targeting and appreciating which children may need care, protection and other support. A child's complex and overlapping sources of disadvantage can result in 'multiple vulnerabilities'. Additionally, various approaches have tended to construct passive notions of vulnerability. It is important to recognise that children's resilience is important in building solutions for them, and children, particularly as they grow older, may become central agents in their own care and protection. Definitions of vulnerable children have evolved from 'AIDS orphans' to 'orphans and other vulnerable children' (OVC), 'children affected by HIV and AIDS' (CABA) to our understanding of the relevant children as those *"vulnerable to, infected or affected by HIV or AIDS"*. Definitions are limited and

categories may overlap. Categorizing vulnerability risks compartmentalizing responses to needs and vulnerabilities which are complex and interwoven. Moreover, experience has shown how labelling can easily contribute to stigma and discrimination. It is crucial to target and reach real children to meet their actual needs – not categories. Recognizing multiple vulnerabilities means linking protection and care with prevention and treatment, particularly in a context of concentrated epidemics. In a region where the numbers of children concerned are still relatively manageable, doing so is likely to have greater synergistic effects in overall responses to the epidemic.

Moreover, the Global Framework 'strategies' and the Companion Paper's 'focus areas' need to be cross tabulated to help to clarify the issues at stake in addressing the needs of children vulnerable to, infected or affected by HIV in the different areas and levels. The three main focus areas for approaching the protection of children are social protection, alternative care, and legal protection. In addition, the cross-cutting areas of stigma reduction and strengthening the social welfare sector are highlighted. These component areas for 'enhanced protection of CABA' – unlike the Framework – take us in the direction of sectoral responsibilities, with their concomitant disciplinary foundations and limitations. In each area, the Global Framework is relevant. Moreover, it is notable that different sectors have different mandates, target different types of people/ beneficiaries, and thus apply different conceptual frameworks and theorized mechanisms to different dimensions or levels of aggregation.

Social protection fundamentally concerns poverty reduction, and needs to involve the broad-based, equitable targeting of children in poverty and exclusion rather than HIV per se. Where small proportions of all poor and vulnerable children are affected by HIV and AIDS, social protection can not easily claim resources closely earmarked for HIV and AIDS, unless a strong case can be made that significant proportions of other poor and marginalized children are vulnerable to infection. Social protection policies and programmes must enable and facilitate linkages between different services, for example between local authorities and community organizations.

Poor people who are not covered by existing social protection arrangements are a high priority (and often highly vulnerable to HIV) in East Asia and the Pacific. It is important to design solutions which can reach hard-to-access communities such as migrants, those outside of formal employment and those without current registration or citizenship claims. Additionally, solutions may benefit from regional, inter-governmental frameworks for equitable access for migrants across borders. Nesting social protection within more transformative, redistributive growth strategies would be highly appropriate in the region, as would strengthening and elevating social welfare sectors within the policy making process and architecture of governments.

The issue of alternative care broadly concerns children suffering inadequate care who are in need of support. While many vulnerable children may be in need of alternative care, children vulnerable to or affected by HIV and AIDS may be a minority of these children, even if they represent a particularly vulnerable minority. To overcome the specific obstacles for children associated with HIV, it is essential to provide support to caring families and to link responses to addressing stigma in services and communities. Firstly, solutions need to be evidence-based and family-based and, where actual families are not available, family-like options should be a next course of action. Secondly, solutions must be supported by social protection measures designed to help caring families to cope. The high cost and evidence for multiple problems associated with institutional care means that the tendency to opt for institutional care solutions needs to be redressed. Thirdly, targeting or focussing primarily on the most visible and obvious groups, such as 'orphans' or 'double orphans', fails to capture many of the most vulnerable children. Alternative care and support need to facilitate identification and 'case management' to meet real needs rather than being based on formulaic categorizations. Identification and support to vulnerable children needs to be strengthened through better linkages and co-ordination between social, health and education services at local level.

Legal protection essentially concerns ensuring that the universal rights of children affected by HIV and AIDS are respected, fulfilled and protected to the same degree as those of other children. While there has been progress in recent years, better registration and protection for all vulnerable children in the region is a high priority. Legal protection policies need better elaboration and linking with public health and educational objectives. Child protection interventions need to be more strongly evidence based and to be carefully balanced with welfare and economic rights. The voices of affected and vulnerable children and their carers' needs to be strengthened in the processes of protecting children's rights, and community-level mechanisms need to be developed to ensure rights are monitored.

Combating stigma and discrimination is an essential strategy in protection and care that specifically addresses children vulnerable to, infected by and affected by HIV. It also cuts across protection strategies at every level, as well as all other aspects of HIV and AIDS and responses. There is a critical need to address stigma and discrimination in all involved institutions, as well as in communities. It is also important to recognize that, while community-level action is essential to addressing stigma, stigma is also perpetuated and played out in communities. It is essential to ensure that community and faith-based organizations or leaders do not inadvertently contribute to discrimination or undermine the sensitive work of others in prevention with most-at-risk groups, including adolescents. It is important that programme strategies 'start at home' (with approaches such as staff training, equal opportunities policies and staff support to HIV positive employees). Increasing the visibility and meaningful participation of children and youth with HIV (while enlisting support from their families, teachers and health workers) in responses to advocate and tackle stigma is an important priority which may reduce stigmatizing attitudes related to HIV in general.

Progress in all areas of action under protection and care requires strengthening the social welfare sector. The sector must become a higher priority in national policy and planning processes, and demands stronger local level capacities, as well as better collaboration with the health and education sectors and law enforcement. Multi-sectoral engagement has been central in success stories in Thailand and Cambodia, but it requires strong and open leadership with transparent, inclusive, frequent and repeated processes of policy making and planning. International engagement can facilitate developing new strategies and exchanges of experiences and visions, as well as providing pressure to elevate issues on the national policy agenda, often bringing additional resources in the process. However, the influence of international partners can become disruptive and problematic, as can national governments' tendencies to fall back on business as usual. A culture of vertical management of the separate strategies remains an issue and a constraint. Furthermore, bureaucratic or political restrictions and conditions on resources by international partners may provoke clashes between programme guidance and donor requirements. The test of the quality and success of these processes will, in the end, lay in the ways countries implement agendas and allocate their own national resources.

Countries in East Asia and the Pacific face the challenge of mounting a unified, and comprehensive response to the needs of children vulnerable to, infected by and affected by HIV in the region's low-prevalence, dynamic settings. These countries have the opportunity to act in ways that contribute to the overall response to the epidemic, with greater cost-efficiency than those in high-prevalence settings. With their experience of integrating development objectives into social and economic planning, countries in the region are well-placed to design, update and integrate – or at least better link – social protection, care, legal protection, health and education in new, creative and sophisticated ways. In doing so, they will be well advised to engage and be guided by children, families and others who are vulnerable or affected by HIV and AIDS, and to position them at the centre of solutions.

Introduction

East Asia and the Pacific is one of the most diverse regions in the world. During the past few decades, many of its countries have experienced rapid social and economic development. Others have been left behind. Many countries in the region have made substantial gains in poverty reduction and child welfare. Others are still struggling with these issues. Policy makers' efforts to spur development by targeting social and economic policies and programmes at specific sectors and groups have led to impressive progress in some cases, and widening inequalities in others. Growing economic and social interconnectedness has increased population mobility, expanded contacts between peoples and, in some instances, heightened disparities. Increased mobility and contacts have also, in some settings, led to increased risk and vulnerability to infectious diseases.

It was within this context, during the 1980s and '90s, that the HIV epidemic took root in the region. Southeast Asia was its initial epicentre. Since then, HIV has spread in complex patterns and in various degrees to different countries. None have been left untouched. Efforts to respond to HIV have focused mainly on primary prevention targeted at groups considered drivers of the epidemic, such as sex workers, injecting drug users and men who have sex with men. Thailand and Cambodia have had notable success with this approach.

As HIV epidemics have matured and spread beyond core groups at particular risk, children have increasingly become infected and affected by the virus. Consequently, issues related to children and AIDS have emerged on the agenda of the global response. Experiences and lessons learned regarding children and AIDS have generally come from the highest prevalence parts of the world, particularly Africa. But these lessons and strategies may not always be easily transferable to the low-prevalence and concentrated epidemics typically found in East Asia and the Pacific. Those involved in the response face particular dilemmas in responding to a virus working through varied and complex dynamics – also involving children – within a highly diverse and dynamic region. These dilemmas are all the more difficult when research and global policy efforts continue to concentrate on the countries which are hardest hit and have different epidemic profiles than the countries of this region.

The objective of this report[1] is to provide decision makers, programme managers and advocates for children with guidance for framing and analysing available evidence and responses, and in setting priorities for the protection and care for children in the face of HIV and AIDS in East Asia and Pacific. The report does not provide a new framework or an exhaustive inventory of proven solutions for every context. Rather, it provides a critical review of existing frameworks, with reflections and regionally contextualised examples of evidence and experiences. Positions are taken on how these frameworks may be utilized, and recommendations are offered for future programming and policies. In essence, this work details selected and evaluated responses that policy makers may choose to adapt to their particular situations.

The broad diversity of East Asia and the Pacific – both in relation to development and HIV – means that a rigid framework of actions and interventions is unlikely to be useful. However, lessons and principles from broader evidence could facilitate the development of appropriate solutions and frameworks in different countries. The available evidence-base on the situation of children and HIV in the region and the effectiveness of different solutions remains limited. Solutions need to be based primarily on local research and information, although international evidence and lessons can suggest possible directions. However, in defining global best practices and formulating international policy 'what counts as evidence' often does not include the kinds of evidence actually needed to inform development of effective national and regional solutions. What can be generalized globally is not necessarily most appropriate regionally or locally.

This paper begins by setting the regional context on children and HIV, including a review of policy and framings of children and HIV and AIDS in international debates. This is followed by a review of issues, policies and current responses in the region for the protection and care of children linked to HIV. This review covers areas such as social protection, alternative care, legal protection, stigma reduction and strengthening the institutional environment. Gaps, constraints and suggested priorities are then summarised for each, followed by an overall concluding discussion.

Regional context

2a. Regional characteristics of the HIV epidemic

The HIV and AIDS situation in East Asia and the Pacific is in fact many epidemics. Strains of the virus, transmission patterns and groups affected can vary. UNAIDS estimates[2] that in 2007 some 4.9 million people across all of Asia were living with HIV, including 440,000 people newly infected that year. Some 300,000 people were estimated to have died from AIDS-related illnesses in Asia during 2007, and there were almost 20% more new HIV infections in East Asia than in 2001 (UNAIDS, 2007).

South Asia has the highest number of people estimated to be living with HIV. India, with its huge population, accounts for 2.5 million of these people, or more than half of all people (4 million) infected in South and Southeast Asia combined (UNAIDS 2007). Although estimates of the number of people living with HIV in India and other countries were recently revised downward, the numbers of people infected are still staggering.

Within Asia, HIV *prevalence* is highest in the Southeast Asian region, where there is wide variation in epidemic trends between different countries. Myanmar, Thailand and Cambodia have shown declines in prevalence while the epidemic is growing at a particularly high rate in Indonesia and in Viet Nam. Cambodia, Myanmar and Thailand have been epicentres for the epidemic in the region for well over a decade, and they share many characteristics.

The sheer size of the East Asia and Pacific region and the diversity of its epidemics have translated into a lower HIV prevalence than South Asia. Some 2.3 million people were estimated as living with HIV in 2005. (Table 1)

Table 1: Data on HIV prevalence and number of people living with HIV by Region, 2005

Regions	Estimated adult HIV prevalence (15+ years), end-2005	Estimated number of people (all ages) living with HIV, 2005 (1000's)		
		estimate	low estimate	high estimate
Sub-Saharan Africa	6.1	24,500	21,600	27,400
– Eastern and Southern Africa	8.6	17,500	15,800	19,200
– West and Central Africa	3.5	6,900	5,300	8,700
Middle East and North Africa	0.2	510	320	830
South Asia	0.7	5,900	3,600	9,700
East Asia and Pacific	0.2	2,300	1,800	3,200
Latin America and Caribbean	0.6	1,900	1,500	2,800
CEE/CIS	0.6	1,500	1,000	2,300
Industrialized countries§	0.4	2,000	1,400	3,000
Developing countries§	1.1	35,100	30,300	41,900
Least developed countries§	2.7	11,700	10,100	13,500
World	1.0	38,600	33,400	46,000

Source: Data from (UNICEF, 2007g) *State of the World Children 2008*, UNICEF, p. 137

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[2] UNAIDS, 2007, AIDS Epidemic update

Cambodia appears to have reversed a serious HIV epidemic that peaked during the late 1990s. This has been achieved through significant community mobilisation coupled with strong government action in well-focused and sustained prevention efforts. HIV prevalence has fallen to an estimated 0.9% among the adult (15-49 years) population nationally in 2006, which is down from a high of 2% in 1998 (National Centre for HIV/AIDS, Dermatology and STIs, 2007), as described in Figure 1, below.

Figure 1. Estimated prevalence of HIV infection among person aged 15-49 by urban or rural locations in Cambodia, 1995-2006
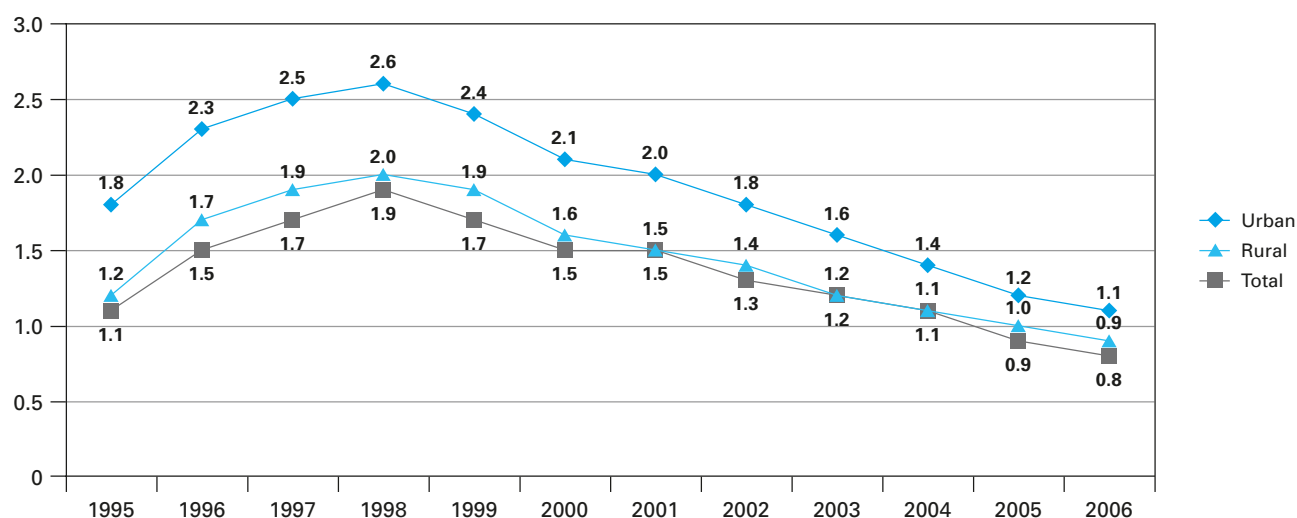
Source: National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

Myanmar is showing modest signs of a declining epidemic, with HIV prevalence among pregnant women attending antenatal clinics having dropped from 2.2% in 2000 to 1.5% in 2006 (National AIDS Programme Myanmar, 2006). Despite the overall decline in prevalence amongst pregnant women, the elevated prevalence of HIV among key populations at higher risk is of concern. A recent study found that 18% of young males (15-24 years) reported their first sexual partners as having been sex workers. In addition, approximately 5% of young males reported having sex with other males in the last 12 months. Out of a total of 78% of those males reporting to having been sexually active in the last 12 months, 7% reported having had multiple sexual partners (Myanmar National AIDS Programme and WHO, 2006).

Thailand continues to achieve a decline in the number of new HIV infections each year. While this decline has been sustained, it has also been slowing down in recent years, as prevention programmes with some of the most vulnerable groups remain under-developed and patterns of HIV transmission have changed over time. Among certain groups transmission has actually been increasing. Prevalence among injecting drug users has remained high for well over a decade, ranging between 30% and 50% (WHO, 2007). Furthermore, recent studies show rising HIV prevalence among men who have sex with men, for example, from 17% in 2003 to 28% in 2005 in Bangkok (van Griensven, 2006). The virus is also increasingly spreading to people considered at lower risk. More than four in ten (43%) new infections in 2005 were among women, many of whom likely acquired HIV from husbands or partners infected during unsafe commercial sex or through injecting drug use (WHO, 2007).

By contrast, Indonesia and Viet Nam are experiencing younger and escalating epidemics.

Indonesia has one of the fastest-growing HIV epidemics in Asia. Most infections are believed to occur through the use of shared and/or contaminated needles, unprotected commercial sex between women and men. Unprotected sex between men is a significant transmission pattern, though to a lesser extent than injecting drug use or commercial sex (Ministry of Health Indonesia & Statistics Indonesia, 2006). Sharing injection equipment is a major mode of transmission in the rest of the country. HIV prevalence among injecting drug users ranges from more than 40% HIV positive in Jakarta in 2005 (WHO & Ministry of Health Indonesia, 2007), to some 13% in West Java (Ministry of Health Indonesia, 2006). As elsewhere, many injecting drug users also engage in commercial sex (Ministry of Health Indonesia & Statistics Indonesia, 2006), and about one quarter of injecting drug users in Bandung, Jakarta and Medan reported having had unprotected commercial sex in the previous year (Ministry of Health Indonesia & Statistics Indonesia, 2006). The Indonesian epidemic is most serious in Papua province, where the transmission pattern differs from the rest of the country. Unprotected heterosexual sex is the main mode of transmission in Papua. A province-wide survey in 2006 suggested an overall adult HIV prevalence of 2.4%, with 3.2% in the remote highlands and 2.9% in some lowland areas. Among 15-24-year-olds, HIV prevalence was 3% (Ministry of Health Indonesia & Statistics Indonesia, 2007).

Viet Nam saw the estimated number of people living with HIV more than double in the five years, from 122,000 in 2000 to 263,000 in 2005 (Ministry of Health Viet Nam, 2007b), and projected to increase to 293,000 cases in 2007 (Ministry of Health Viet Nam, 2005). Major risk factors for HIV infection are the sharing of contaminated needles by injecting drug users and unprotected sex with non-regular partners, including sex workers (Tuan et al., 2007). HIV prevalence among injecting drug users rose from 9% in 1996 to about 34% in 2005 (Ministry of Health Viet Nam, 2006 & 2005). Increasing numbers of women are likely acquiring HIV from males who were infected during unsafe sex and injecting drug use. This evolution in the epidemic has been reflected in the increase in HIV prevalence among pregnant women attending antenatal clinics and by 2006 approximately one third of diagnosed HIV positive people were women (Viet Nam Commission for Population et al., 2006). It is difficult to know how many of those pregnant women were selling sex, but the majority of HIV infections are nevertheless directly or indirectly linked to injecting drug use.

China has a very diverse epidemic, reflecting its size and complexity. The highest concentrations of people living with HIV are believed to be in Guangdong, Guangxi, and Yunnan provinces in the South, Henan in Central China as well as Xinjiang in the North-west (Ministry of Health China, 2006). Approximately half of all people living with HIV in the country in 2006 contracted the virus through injecting drug use, while a similar proportion were infected during unprotected sex (Ministry of Health China, 2006; Lu et al., 2006). The combination of injecting drug use and sex work is a significant factor in the HIV epidemic in China, where growing numbers of women are injecting drugs (as many as half of those sell sex in some locations) and since male drug users commonly also buy sex (Hesketh et al., 2006). Recent data suggests an emerging epidemic among men who have sex with men (MSM) in major cities and some 7% of HIV infections are thought to be attributable to unsafe sex between men (Lu et al., 2006). Studies have found HIV prevalence among MSM between 1.5% and 3.1%-4.6% (Choi et al., 2003; Ma et al., 2006).

Papua New Guinea has an epidemic that is still expanding, though at slightly lower levels than previously estimated. Unsafe heterosexual intercourse is still thought to be the main mode of transmission. Most reported HIV infections have been from rural areas, where over 80% of the population lives (National AIDS Council Secretariat Papua New Guinea, 2007).

Box 1. HIV and AIDS in East Asia and Pacific

- Some 2.3 million people in East Asia and the Pacific were estimated to be living with HIV, in 2005.

- National HIV prevalence in the Asia region is highest in Southeast Asia.

- Wide variation in epidemic trends between different countries:
  - Myanmar, Thailand and Cambodia show declines in prevalence from earlier significant levels.
  - The epidemic is growing at a high rate in Indonesia and in Viet Nam.
  - China has very diverse epidemics, reflecting its size and complexity.
  - Papua New Guinea has a still expanding epidemic, and most reported HIV infections have been from rural areas.

2b. Regional context of children and AIDS

In terms of child health generally, East Asia and the Pacific compares favourably to most regions. The primary indicator of child health is the under-5 mortality rate. In East Asia and the Pacific this figure was 29 (out of 1,000 live births) in 2006, as compared with 72 in the world, 79 in developing countries and 142 in the group of least developed countries (UNICEF, 2007g).[3] The region has achieved sustained reductions in child mortality in recent decades, partly as a result of economic development and growth, expanding and improved health care systems and reduced total fertility rates for women. Reduced fertility rates are also changing family structures and the demographics of entire populations.

Children infected and affected by HIV

Gauging the situation of children and AIDS in the region is difficult because of the weakness of the evidence base. Data is scant. Definitions differ between organisations. Indicators are not always harmonized. Even defining children is problematic. The Convention on the Rights of the Child defines children as anyone under 18. But most data published by UNAIDS defines children as anyone under 15. The paucity of data has made it easier for policy makers to leave children off the agenda. But that is changing, and efforts are being made to improve the pool of data through a joint project of UNICEF, UNAIDS, ADB and WHO. Despite the current weakness of the evidence base it is estimated that the numbers of children in the region infected and affected by HIV are growing.

Estimating the number of children infected with HIV is easier than determining how many children are vulnerable to HIV infection or affected by the epidemic. Globally, the number of children (below the age of 15) living with HIV in 2007 was estimated at around 2.5 million, as compared to some 1.5 million in 2001. Almost 90% of all HIV-positive children live in sub-Saharan Africa. According to UNICEF, some 50,000 children (1-14 years) were living with HIV in East Asia and the Pacific in 2005 (Table 2). It is important to note that these figures (in all regions) exclude a large number of children infected in the age groups from 15 to 17 years, which significantly underestimates the true number of children infected.

Beyond the number of infections, there are indicators that can give some sense of the epidemic's impact on young people. For children affected by HIV and AIDS, a chief indicator is the number of orphans. Reliable data on the numbers of orphans, however, are hard to locate. When this data does exist or is found, it is not always disaggregated to provide figures on the numbers of children orphaned by AIDS. UNICEF (2007g) reported an estimated 132.7 million orphans (0-17 years) from all causes worldwide in 2005, of which some 15.2 million were thought to have lost one or both parents to AIDS, representing about 11% of all orphans. In sub-Saharan Africa this proportion exceeds 25%. Orphans from all causes in East Asia and the Pacific were estimated at 34.8 million for 2005, with approximately 450,000 children in East Asia and the Pacific having lost one or both parents to AIDS. This would represent some 1.3% of all orphans in the region. This is significantly lower than the global average, although the proportion varies substantially between countries in the region.

The figures in Table 2 must be treated with caution, however, as current estimation techniques do not provide accurate projections, particularly where the adult prevalence is below 5% and techniques are further compromised by a lack of size estimates of the sub-populations at high risk, their fertility rates, and age-specific child survival rates.

Children may also be affected by the epidemic even though they are not orphans. A parent infected with HIV may be ill and unable to work, possibly resulting in their child being sent to work to support the family instead of attending school. There are many scenarios in which the epidemic can affect children whose parents are still living, although they are not easy to measure or quantify.

Stigma and discrimination can also obscure how many children are affected by HIV. Being associated with HIV carries a fear of backlash ranging from isolation and rejection to violence, and so people avoid learning their status or hide it if they test positive. Also, affected children often live in poor communities where drug use and sex work can be common. Adults involved in illegal activities, such as drug use or sex work, tend to distrust government agencies and outsiders – even if these are health workers – and may block their children from contact with them. For these and other reasons, these populations are regarded as hard to reach, and therefore difficult to measure.

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[3] (UNICEF, 2007g), the State of the World's Children 2008

Table 2: Children Related Data on HIV, AIDS and Orphans by Region, 2005

Regions	Mother-to-child transmission		Paediatric infections	Orphans	
	Estimated number of women (15+) living with HIV, 2005 (1000's)	HIV prevalence in young pregnant women (15-24 years) in capital city	Estimated number of children (0-14 years) living with HIV, 2005 (1000's)	Children (0-17 years) orphaned by AIDS, 2005	Children (0-17 years) orphaned from all causes, 2005
		median		estimate (1000's)	estimate (1000's)
Sub-Saharan Africa	13,200	9.7	2,000	12,000	46,600
– Eastern and Southern Africa	9,400	13.5	1,400	8,700	24,300
– West and Central Africa	3,700	4.0	650	3,300	22,200
Middle East and North Africa	210	–	33	–	–
South Asia	1,600	–	130	–	37,500
East Asia and Pacific	750	–	50	–	34,800
Latin America and Caribbean	640	–	54	–	10,700
CEE/CIS	450	–	9	–	–
Industrialized countries§	530	–	13	–	–
Developing countries§	16,400	–	2,300	–	–
Least developed countries§	6,000	7.5	1,100	–	–
World	17,300	–	2,300	15,200	132,700

Source: Data from (UNICEF, 2007g) *State of the World's Children 2008,* UNICEF, p. 137

Official data on children affected by HIV and AIDS are available only from a small number of countries including; Cambodia, with some 60,000 children affected by HIV[4]; Thailand, where estimates include some 300,000 children[5] to 380,000 children[6] who have lost at least one parent to AIDS; and Viet Nam, where some 283,000 children were estimated to have been affected by HIV. Unofficial estimates have been circulated for China and Indonesia, but with both official and unofficial estimates, figures are fraught with inaccuracies and definitions of groups of children estimated also vary between orphans and a broader set of children affected.

Suffice to say that these country-reported figures illustrate the difficulties of getting a clear picture of the extent of the problem, with the likelihood that the 450,000 figure represents a significant under-estimate. Nevertheless, children orphaned by HIV and AIDS[7] comprise a minority of orphans in general in the region, and, the broader group of children affected by HIV and AIDS also likely comprise a minority of orphans and other vulnerable children, in general.

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[4] UNAIDS, the US Agency for International Development (USAID) and Policy Project

[5] Ministry of Public Health estimate

[6] UNAIDS, UNICEF and USAID, 2002. *Children on the Brink*

[7] These orphans are not only difficult to estimate because of low registration of children and low knowledge of HIV sero-status amongst adults, but also because HIV causes deaths from other diseases such as tuberculosis, which may not occur in the absence of HIV induced immunosupression

Most orphans and children needing alternative care[8] in the region are taken in by relatives. Extended family traditions are typically relied upon for support throughout East Asia, although urbanisation and demographic transitions have led to more nuclear family structures, which have been put under strain – a reality underscored by the social effects of the economic crisis in Asia during 1997-98, which saw increased levels of abandoned children and children put into institutional care (Cook and Kwon, 2006; TDRI, 2000). Quality of care varies in all settings, but institutional settings are generally regarded as the least likely to provide a positive environment for the child, as discussed in Chapter 5.

Other children made vulnerable to HIV

Injecting drug users are often young and face high HIV prevalence, as the behaviour is a key driver of transmission in a number of countries. Children of drug users and child drug users are not only at risk of HIV infection but also of increased vulnerabilities to poverty, dropping out of school, child labour or prostitution (Rau, 2002).

The sex industry in the region is driven primarily by domestic and intra-regional demand and it accounts for significant proportions of GDP in, for example, Indonesia, Malaysia, the Philippines, Thailand and Japan (WHO, 2000). Demand for children in prostitution is said to be high, but figures for child prostitution are largely unavailable (Pearson et al., 2006), although it is worth pointing out that growing up in a context of sex work can make children more easily vulnerable. Figures for trafficked people are very unreliable, but the IOM nevertheless provided a rough estimate of some 220,000 – 225,000 women and children possibly being trafficked for various purposes annually in Southeast Asia (IOM, 2001). However, along with a high uncertainty over numbers it is very common to see conflations of issues of migration, prostitution and trafficking in research as well as policy, thereby making it very difficult to estimate the relative magnitude of the problem.

The situation of these groups of children in the region is reviewed in Annex 2 of this report and box 2 draws together some key points on the context of child vulnerability in the face of HIV and AIDS in the region.

Box 2. Regional context of children and AIDS

- In terms of child health generally, East Asia and the Pacific compares favourably to most regions, but there are significant variations and groups of children with poor health.

- A figure of 450,000 orphans related to HIV and AIDS has been estimated for the EAP region, and orphans from all causes were estimated at almost 35 Mn in 2005.

- Figures for the region are substantially lower than in higher prevalence regions, such as Sub-Saharan Africa or South Asia, in both absolute (children orphaned by AIDS) and in relative terms (as a proportion of orphans from all causes).

- Aside from many more children living in families affected by HIV, and some children infected themselves, a greater number of vulnerable children are in need of care and protection, many being particularly vulnerable to HIV, such as street children, children in prostitution, or those growing up in contexts of drug use or exploitation.

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[8] "Alternative care" refers to care that places children under guardians who can meet their basic needs, and it includes formal (institutional) and informal solutions. The topic is discussed in chapter 5.

International policy context and framing of 'children and AIDS'

3

3a. The emergence of Children and AIDS on the international agenda

The turn of the millennium saw a significantly increased recognition of the impacts of the HIV epidemic on children and the need to address children in the response. The United Nations General Assembly 2001 Declaration of Commitment on HIV/AIDS and the Millennium Development Goals (MDGs) contain a range of targets and pledges of action agreed to by the governments of the world in responding to children affected by HIV and AIDS.

In 2003, the First Global Partners Forum endorsed the *"Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS."* The Forum, co-convened by the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the United Nations Children's Fund (UNICEF), was attended by a broad range of international agencies, governments and nongovernmental organisations. This Framework (variously referred to in short-hand as "the Framework" or "the Global Framework") provides directions for mounting an effective response and identifies five key strategies required to respond to the needs of 'orphans and vulnerable children', which relate to a common framing of areas – or 'levels' – of action, from proximal to distal to the child:
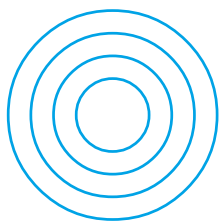
- strengthen the capacity of families
- mobilize and support community-based responses
- ensure access to essential services
- ensure protection of vulnerable children and
- create a supportive environment

The emphasis was on a need to reach and meet the needs of large numbers of vulnerable children in general, as opposed to strategies specific to HIV and AIDS. Although the evidence base underpinning specific recommended strategies under the Framework has been developed and drawn mainly in high prevalence countries (notably in Southern and Eastern Africa), the Framework has been adapted in various ways to guide the response in several regions, including East Asia and the Pacific. The Framework stresses that no government or organization is able to address all the issues identified alone and that solutions based in community responses are required, supported by partnership among governments, international and bilateral agencies and civil society groups.

The Global Framework provided a useful general direction, but left many questions unanswered. A companion paper entitled *Enhanced Protection and Care for Children Affected by AIDS* was later developed to assist governments in translating the Framework into action. It stressed the need for intensified measures in social protection, legal protection and justice, as well as alternative care (UNICEF, CIDA et al., 2006; UNICEF, 2007). A significant new emphasis in this was that governments must take the lead and carry responsibility for child rights being met, and particularly for those most vulnerable.

Another milestone in the global response was the launch in 2005 of the *Unite for Children, Unite Against AIDS* campaign, by UNICEF and UNAIDS (UNICEF, 2005). The signature message of the campaign was that for too long children have been "the missing face of AIDS.'' Its goal was to place children at the centre of the global, regional and national HIV and AIDS agendas. The campaign was a timely complement to the 2005 United Nation's General Assembly Special Session (UNGASS) for accelerating actions toward Universal Access (UA) to HIV prevention, treatment and care. What was particularly different and important in the UNICEF and UNAIDS campaign was the recognition of children as vulnerable to infection as well as to the impacts of AIDS. HIV prevention for children, as well as treatment, care and support for children already infected with HIV is now on the global agenda. The *Unite for Children, Unite Against AIDS* campaign focuses on access to services (one of the strategies of the Global Framework) in four strategies which were coined the **'4 Ps'**, namely:

- Preventing mother-to-child transmission (or PMTCT)
- Providing paediatric treatment (or Paediatric ART)
- Preventing infection among adolescents and young people (Primary prevention) and
- Protecting and supporting children affected by HIV/AIDS (or Protection and Care)

The call for accelerating actions toward Universal Access to HIV prevention, treatment and care for children led to the East Asia and Pacific Regional Consultation on Children and HIV/AIDS, held on 22-25 March 2006, in Hanoi, Vietnam.[9] This raised the profile of children and AIDS in the region and delegates adopted the *Hanoi Call to Action for Children and HIV and AIDS in the East Asia and Pacific Region* (UNICEF, 2006). The 'Hanoi Call to Action' outlined nine areas for action, which can be summarized as:

1. country level analysis and situation assessments of children and HIV;
2. assessment and update of existing legislation, policies and guidelines;
3. development of targets and local action plans for scaling up services under the four Ps;
4. increase in resource mobilization and improvement in resource allocation and utilization;
5. establishment of national multi-sectoral mechanisms on child welfare and development;
6. reduction of stigma and discrimination, financial and other obstacles to service access;
7. expansion of efforts to protect children and provide them with family-like care environment (ensuring that institutional care is used only as a temporary option of last resort);
8. national monitoring of the situation of children and of progress made in the response and;
9. strengthening of coordination in regional and international cooperation on networking, information sharing and research to scale up the response.

More information and knowledge on children's situations in various countries from around the region is gradually becoming available, as a result of increased studies and assessments over the last few years. It is also becoming clearer that the responses needed for children in relation to HIV are context specific: Inter-linked solutions need to be established nationally with local and international engagement.

By 2005 children and HIV has indeed become an issue increasingly beginning to be integrated into national policy frameworks.[10] Access to treatment has improved, including for children, and behaviour change has translated into declining HIV prevalence among young people in some countries. There remain major gaps between targets and outcomes, however. PMTCT roll-out is slow, for example. Prevention with adolescents is not always prioritized or well targeted and strategies and interventions under the four different areas (four Ps) are not often well integrated or linked. Perhaps most worryingly, the *protection and care* of children most vulnerable to, infected by and/or affected by HIV is not yet well developed in most low prevalence settings of East Asia and the Pacific, although some progress is being made.

Two years following the Hanoi consultation, a follow-up East Asia-Pacific Partnership Forum was convened in Bangkok on 31 March – 2 April 2008, in order to review progress on commitments since the Hanoi Consultation and to discuss future directions or areas of renewed emphasis required. The meeting sought to reaffirm and strengthen the commitments already made and propose new milestones in enhancing coverage of services as well as improve policy measures.

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[9] The consultation was co-organized by UNICEF East Asia and Pacific Regional Office in collaboration with UNAIDS, WHO, the United States President's Emergency Plan for AIDS Relief (PEPFAR) through United States Agency for International Development, Family Health International, Save the Children, and the Viet Nam National Committee for Population and Family Planning.

[10] In 2005, among 14 East Asia and Pacific (EAP) countries, eight (or 57%) conducted a national situation analysis on HIV and AIDS, children and young people which contributed to HIV and AIDS national strategy development (Cambodia, China, Lao PDR, Malaysia, Pacific Islands, Papua New Guinea, Philippines and Viet Nam).

3b. Framing vulnerability and vulnerable children relative to HIV and AIDS

Vulnerability is a key word in the lexicon of HIV for those working in health, development and child protection. It is often used in different senses by those working in different sectors. From a health perspective vulnerability is seen as relevant to prevention and treatment, while the development community has focused mainly on vulnerability as it relates to the impacts of HIV and AIDS. A crude over-simplification, this nevertheless highlights a basic reason for difficulties in finding common languages across health and development. Most definitions and theoretical constructions of vulnerability (on both sides) have tended to rely on passive notions of vulnerability as well as reduce it to linear models. As discussed in more detail in Annex 1, there are at least three dichotomies – or axes – inherent in vulnerability related to a health problem such as HIV and AIDS which are rarely brought together (Edström, 2007, Bloom et al., 2007).

- Before – after: vulnerability has different senses in relation to the causal path before, during and after the 'shock' or period of crises (i.e. HIV).

- Internal – external: vulnerability for specific children or adults arises in the *relation of embodied characteristics (of susceptibility and sensitivity) to contextual external factors* or sources of disadvantage, moderating their risk of exposure, their experience of ill health or further impacts, in complex ways.

- Vulnerability – resilience: these are *inter-related*, and vulnerable children are at the same time resilient actors in their own spheres.

It is important to underscore that general notions of vulnerability should not over-determine the relation of vulnerability to the actual risks and threats presented to individual children by HIV. Having peer groups involved in both drug taking and unprotected sex, can multiply (or, synergistically increase) a child's vulnerability to HIV infection (before the event, as it were). A combination of lack of social support and poverty can synergistically reduce their capacity to deal with crises brought by HIV in the home (after contact with the disease). A child whose (internal) sense of self-worth and happiness has been damaged by the death of a parent from AIDS may have a lower capacity to resist sexual advances of a peer, or adult, than an otherwise similar child, in a situation of similar contextual (external) disadvantages of lack of education or limited awareness of sexual risks.

This vulnerability may be minimized through the consistent and reliable care, empathy and support of significant adults. Children left vulnerable from experiencing traumatic shocks, and lack of care and supervision, can also develop resilient strategies for coping, such as begging, stealing, petty trade or other work, intimate relationships and/or stimulant use. While such strategies do display resilience and do reduce immediate challenges of hunger or boredom, for example, they can also make children vulnerable to other threats or risks, like violence or HIV. We should recognize how vulnerabilities play out differently and are experienced in relation to social and physical interactions, such as with parents, sexual partners, sex workers and drug users.

> **Box 3. Key points on 'vulnerability' in relation to HIV and Children**
> - HIV can make children be vulnerable in different senses: i) to infection ii) because they are infected or iii) to being negatively affected by the impacts of HIV and AIDS (e.g. in their family or social network). This is essential to targeting and appreciating which children may need care, protection, prevention and other support, and 'why?'
>
> - Vulnerability is embodied and relational to contexts, which involve complex and overlapping sources of disadvantage, sometimes referred to as 'multiple vulnerabilities'. Protecting children from such disadvantages can also support them in multiple ways.
>
> - Resilience coexists with vulnerability and may be as important to building enabling solutions with children. A child-developmental approach, sensitive to the maturation process, therefore challenges us to conceive of children as the central agents in solutions for their care and protection.

Targeting vulnerable children for care and protection because of HIV

'Children and HIV and AIDS' has only relatively recently received serious attention in the global response to the epidemic. One problem with early responses to the increasing numbers of orphans[11] from AIDS was the difficulty in discerning which orphans had become so as a result of AIDS. Another problem was that when faced with issues and needs of orphans in poor communities, there appeared to be little reason to treat one group differently from another, as all children have the same universal rights. Thirdly, the label "AIDS orphans", while effective for fund-raising, was soon recognized as potentially stigmatizing (Meintjes et al., 2003; UNICEF, 2004). Finally, the concept captures only a small sub-set of vulnerable children in relation to HIV.

In very high-prevalence countries, the proportion of children of adults dying of AIDS or severely ill from HIV is very large. On the other hand, people's knowledge of their HIV status has been very low. Classifying orphans or vulnerable children in relation to HIV is, therefore, viewed as unrealistic and inadvisable. For these and other reasons, the notion of *Orphans and Vulnerable Children* became a key category for attempting to reach children impacted by epidemic, by proxy, particularly in Sub-Saharan Africa. The concept was intended to include all orphans as well as children living with chronically ill parents, or carers, as well as those outside of family care – and none of it *necessarily* related to HIV.[12] The acronym "OVC" has often mistakenly been used, however, to refer solely to orphans, or children specifically affected by HIV and AIDS. These are different and more specific concepts, as discussed below.[13] Targeting and labelling have often been conflated in these debates.

To target or not?
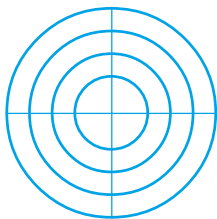
While arguing not to target on the basis of HIV may make sense in high prevalence countries, it is far less obvious for dealing with the challenges of HIV and AIDS for children in low prevalence settings, such as in East Asia and the Pacific. Here the category of orphans and vulnerable children is too broad to work as any proxy for children made vulnerable by the disease. The category also *does not* take account of those children infected with HIV themselves, or of children vulnerable to HIV infection. This is largely the result of the common conception of children as entirely asexual – despite the large overlap with adolescents and the fact that large proportions of infections occur in people under 18.

The argument that one should not seek to target children with reference to HIV or AIDS does not follow from the fact that there are also many other children vulnerable and in need, related to other problems. Furthermore, the argument sidesteps the inconvenient truth that many children associated with HIV do suffer from related discrimination regardless of targeting, although – granted – it correctly highlights the danger that 'crude' targeting and labelling easily compounds such stigma. Complex problems often do create special needs and, if not dedicated solutions, then at least they demand a specific and focused analysis (Edström, 2007). Furthermore, as in all areas of dealing with disadvantage, while too narrow targeting can indeed precipitate harmful stigmatization, too broad targeting tends to diffuse impact on the issue to which one is responding (Levine, 2001).

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[11] According to the UN Convention of the rights of the Child (1990), an orphan is a child under 18 years who has lost one or both parents, which in this case would be due to HIV or AIDS related mortality.

[12] UNICEF/UNAIDS (2005) Monitoring and Evaluation Guide defines **orphans and vulnerable children** in the following terms:

  ■ An orphan is a child below the age of 18 who has lost one or both parents,

  ■ A child made vulnerable by HIV/AIDS is below the age of 18 and:

    i)   has lost one or both parents, *or*

    ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child), *or*

    iii) lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, *or*

    iv) lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, *or*

    v)   lives outside of family care (i.e. lives in an institution or on the streets).

[13] The use of acronyms can be both misleading and dehumanizing (as in most programming categories for HIV), but in this report we use them for purposes of clarifying the issues and debates as well as to describe programmes and policy solutions having been developed in the region.

The concept of *children affected by HIV and AIDS* (or 'CABA') was introduced to be more specific to HIV and to redress the oversight on children infected with HIV. While there are a few slightly different definitions, the UNICEF definition includes children infected, as well as those children and adolescents whose "well-being or development is threatened … by HIV."[14] While slightly more sensitive to children's vulnerability in relation to HIV than the definition of orphans and vulnerable children, it is nevertheless problematic since it combines very specific characteristics with a third characteristic 'vulnerability', which are both highly complex and interpreted in different ways by different actors.

Most existing definitions of vulnerable children in relation to HIV overlap in terms of who they include. Neither the definition of orphans and vulnerable children nor most definitions of children affected by AIDS, *explicitly* or clearly capture vulnerability to HIV infection, which stems from a one-sided understanding of child vulnerability, as limited to the likelihood and costs of negative impacts. Children are seen as vulnerable victims without agency, gender, sexuality or any particular likelihood of engaging in sex, or other risk behaviours. When large proportions of new infections occur in adolescents (particularly girls) many children should be explicitly considered vulnerable to HIV and a more sophisticated understanding of vulnerability is needed, as suggested in the preceding section.

Definitions such as *especially vulnerable adolescents* (EVA) and *most at risk adolescents* (MARA) have also been developed and used for older children in the region. Most at risk adolescents include injecting drug users or those who have sex with others likely to be HIV positive (adolescent boys who have sex with men or other boys, or who sell sex, for example). Especially vulnerable adolescents are defined in broader terms of life context (rather than risk behaviours), as vulnerable to infection from living on the street, being out of school, or working in exploitative situations, such as some domestic worker situations.

In the end, the international community has so far failed to come up with or agreed on a conceptually helpful definition of which children are most important to identify and reach for protection and care. However, the recognition of the issue is reflected in the increasingly used phrase of *'children vulnerable to, infected by and affected by HIV and AIDS'* (UNICEF, 2008). This is important to underline the different senses of vulnerability in relation to HIV which are relevant for children and for their protection and care, a well as prevention.

However, any precise general definition or criteria to capture this group would likely be futile and/or operationally impracticable, given the contextually relative complex dynamics between overlapping vulnerabilities and disadvantages. For East Asia and the Pacific, it is crucial to also focus explicitly on the children most vulnerable to HIV infection and to those growing up affected by HIV in contexts of elevated risk.

List 1, below, relates existing defined categories of vulnerable children to prevention, care/treatment and impact mitigation. With most CABA and OVC also being in older age groups of children and definitions overlapping for many children, it is important to stress that different responses should not be fully segregated for different groups of children, but that they need to be linked. Different types of responses are needed for many children in all defined categories and, with many of the most vulnerable 'qualifying for multiple labels', programmes and policies need to combine to meet diverse real needs of individual children.

List 1. Categories of vulnerable children grouped in relation to HIV and AIDS		
Children vulnerable to HIV infection:	**Children infected with HIV:**	**Children affected by HIV and/or AIDS:**
■ Most at risk adolescents (MARA) ■ Especially Vulnerable Adolescents (EVA) ■ Many OVC & CABA, (but not 'by definition')	■ Peri-natally infected ■ Sexually, needle or blood infected ■ Some children affected by AIDS (CABA)	■ Children affected by AIDS (CABA) ■ Many orphans and vulnerable children (OVC) (but not 'by definition')
→ Relevant for **prevention** but many also need **protection and care**	→ Many need **paediatric ART**, but often also need **protection and care** and/or **prevention**	→ Need **protection and care** but may also be relevant for **prevention**

[14] In 'Child Protection and Children Affected by HIV/AIDS' UNICEF, CIDA et al. (2006) describe **Children Affected by HIV/AIDS** as children and adolescents under 18 years old who:

■ are living with HIV or AIDS,

■ orphans who have lost one or both parents due to AIDS

■ vulnerable children whose survival, well-being or development is threatened or negatively impacted by HIV and AIDS; and

■ children living in affected families and/or those families that have taken in children orphaned or displaced by HIV

Careful attention to gender, age and family relationships and living arrangements is needed to help us identify important gaps in current approaches to targeting. Orphan-hood is not the only or main problem, although it clearly matters to individual children orphaned and can have deep impacts throughout life.

In terms of orphans, those with one parent alive are for example often more vulnerable nutritionally than those having lost both parents, particularly when the latter are fostered in family settings. Sickness in the household (e.g. of a parent) is often more of a threat to child education and welfare, than is orphaning *per se*, since adults are too ill to work, medical bills become crippling and children often have to reduce or give up schooling to care for ill adults or work in order to replace some of the family's lost income. Gender differentiation in children is a neglected area and 'children' are often seen as a gender neutral category, with the same needs and vulnerabilities. Small children and older teens are often ignored in targeting responses, which misses out on important opportunities for addressing gendered intergenerational dynamics in the reproduction of disadvantage and HIV related vulnerability, as well as gender constructs, not to mention the challenge of actually recognizing and addressing child and adolescent sexuality.

Box 4. Key points on categories of vulnerable children in relation to HIV

- No generally agreed category: The international community has not agreed on a useful definition of all children relevant to HIV and AIDS, but there is increasing recognition that general categories can become restrictive for meeting complex needs.

- Labelling can feed stigma: Crude targeting and labelling children under definitions in programming and service provision can lead to further stigma and discrimination.

- Purpose should guide the identification of relevant children: Identification of vulnerable children for specific services should be related to HIV by the sense of their vulnerability in relation to HIV, or their:
  - vulnerability to HIV infection,
  - vulnerability from HIV infection and related disease and/or
  - vulnerability to being affected by HIV and AIDS

- Overlaps: Common categories of relevant vulnerable children overlap significantly, as many of the most vulnerable are also vulnerable in different senses. Such 'intersectionality' should be recognized as crucial for formulating effective complementary and linked solutions.

3c. Constraints and limitations of frameworks

Before going into more detail on the issues and strategies in the different focus areas of protection and care, it is necessary to consider some overlaps and potential apparent inconsistencies in different frameworks (the global framework, the companion paper, social protection, child protection, the 4Ps, etc.). At a minimum, a clearer sense of how they can be inter-related is needed, given some of the dilemmas around different definitions of relevant children, similar sounding (but not identical) headlines, terminologies and so on. Can these frameworks, strategies and focus areas help to clarify the issues at stake in addressing the needs of children vulnerable to, infected and/or affected by HIV? Can we guard against their becoming 'disabling' by their bewildering array of terminologies and concepts?

As mentioned above, the Global Framework – based on proximal-to-distal levels from the child – has as its target for concern primarily 'vulnerable children' (including orphans), but it stayed fairly silent on the 'how?' (other than starting with families and communities). The companion paper *Enhanced Protection for Children Affected by AIDS* (UNICEF, 2007) outlined focus areas needing particular attention from governments, in order to implement the Global Framework. In a sense, it was intended to help 'fill in the blanks'. In addition, the primary group of concern is now a little more explicitly 'children affected by AIDS'. The three main focus areas for approaching the protection of children are social protection, alternative care, and legal protection and justice. In addition, two more cross-cutting areas are highlighted: stigma reduction and strengthening the social welfare sector.

Subsequently, the global campaign to *Unite for Children and AIDS* took account of a broader set of senses of child vulnerability in relation to HIV and emphasized linked responses under the "four Ps". While the enhanced protection for CABA appears most closely related to the campaign's fourth P – "Protection and Care" – it is clear that this area is also highly relevant to prevention, education and access to health care (all central to the other three Ps – primary prevention, PMTCT and paediatric ARV treatment).

The component areas for 'enhanced protection of CABA' are – unlike the framework – moving in the direction of sectoral responsibilities, with their concomitant disciplinary foundations and limitations. In each area, the 'levels' of the global framework have relevance. However, it is also important to point out that:

(a) different sectors have different mandates and objectives and therefore

(b) target different types of people/units/beneficiaries, as well as

(c) apply different conceptual frameworks and theorized mechanisms intended to operate in different spheres, dimensions or levels of aggregation.

Social protection is fundamentally about reducing poverty and socio-economic disadvantage, for all poor and marginalized people – and in this case with an emphasis on children in such communities. The typical construction is that of households as consumers and producers in a context of better or less well functioning markets, applying economics as the over-riding hegemonic discipline.

Alternative care combines elements of sociology and psychology with an emphasis on inter-personal relations and dynamics in child development at the level of families and communities. The primary targets are children and their carers.

Legal protection of child rights is about equitable legal and regulatory frameworks – and its enforcement – based on universal rights of all people, and all children in this case.

The Global Framework recognizes stigma and discrimination as cross-cutting the proximal-to-distal levels, but it is important to point out that all the focus areas of the Companion Paper also cut across all levels. In addition, stigma and discrimination cut across all sectors and levels. In a sense, the same could be said for 'strengthening the welfare sector', since it would be a key sector charged with responsibilities for implementation, in most contexts.

Table 3, overleaf, attempts to illustrate how different strategies might fit along the Companion Paper's recommended focus areas, by level, in the Framework.

Several challenges make a unified, coordinated and comprehensive approach to children vulnerable to, infected and affected by HIV and AIDS slightly more difficult:

■ Different fields often aim at different criteria for the most relevant children:

   ■ 'poor and marginalized children' for social protection,

   ■ 'orphans and other vulnerable children' for alternative care, and

   ■ 'all children' – but particularly those suffering rights abuses – in legal protection

■ Actors in all fields have broader – potentially competing – objectives (poverty reduction, economic growth, disease management, security, justice, social welfare, etc.)

■ Operating within particular paradigms and disciplines, different policy makers and actors often find it hard to communicate clearly across sectors about realities, evidence (including 'what counts as evidence'), solutions and priorities.

Rather than forcing old concepts and strategies into new boxes, it is better to embrace the opportunities for cross-sectoral and inter-disciplinary debates and problem solving. The reality is that no one instance of government is in charge of all the levers necessary to combine the most strategic and optimal mix of policy solutions. The process is a political one and nested in bigger processes of priority setting and accountability and needs to be developed in that context, by actors bridging across sectors, pushing for influence and negotiating settlements. This is discussed in more detail in chapter 8.

Table 3. Mapping *illustrative examples* of strategies for protection and care, under focus areas by level in the global Framework

Global Framework levels →	*Strengthen families*	*Community responses*	*Access to services*	*Ensure protection of children by governments*	*Enabling environments, w/advocacy & mobilization*
Care and Protection					*(shaded=cross cutting)*
■ *Social protection*	Protective assistance transfers (Foster child grants, food rations, etc)	Preventive cost-sharing (nursery, funerals, etc) Promotive community livelihoods schemes	Public financing/subsidy (health, education), Social insurance (unemployment)	Pro-poor, child-friendly social and economic policies	Raising and advocating issue of child poverty and its links to HIV
■ *Alternative care*	Parenting, fostering and childhood development support, incl. home-based care	Community care, informal identification of foster care, monitoring	Day care, adoption, institutional care (as option of last resort), Psycho-social support	Strengthening child welfare services. Regulating institutional & foster care providers	Raising and advocating child rights to care and its links to HIV
■ *Legal protection and justice*	Promoting wills and birth registration. Legal aid for marginalized poor (incl. sex workers, IDU)	Dialogue on child rights and welfare norms with chiefs, traditional and religious leaders	Rights-based, clear access rules and recourse for claims	Legislating child rights, abuse and exploitation. Improving registration, law and enforcement	Anti-discrimination monitoring, advocacy and enforcement
■ *Stigma reduction*	Media child welfare & HIV campaigns, home-based care and support	Concerted community dialogue in awareness on HIV & child welfare, with child participation	Service standards and policy development. Services & public sector staff anti-stigma training	Strengthening multi-sectoral coordination: health, education, social and security services	Stigma awareness campaigns
■ *Strengthen social welfare sector*	Strong supportive and family-centred service orientation and philosophy	Strengthening local/district level social services	Co-ordinated line-ministry processes, with decentralized district planning, referrals, etc.	Increasing public sector spending priorities towards social service sector	Raising profile and engagement of social welfare sector in HIV and AIDS arenas

Social protection, child poverty and HIV in East Asia and the Pacific

4

Social protection is about reducing poverty and marginalization. HIV and AIDS can push people into poverty and certainly marginalize those affected or associated with the virus. Although the epidemic in East Asia and the Pacific has not noticeably affected countries' economic growth, the impact of HIV is felt most strongly at the household level and the epidemic is having an effect on the poverty reduction efforts in some countries. HIV pushes poor families further into poverty, which hampers governments' efforts to reach Millennium Development Goals and other poverty reduction targets. A study by the Asian Development Bank and UNAIDS (2004) estimated that, at trends current at that time, every year between 2003 and 2015 an average of 5.6 million people will be impoverished by HIV and AIDS in Cambodia, India, Thailand and Viet Nam. The same study reports that poverty reduction in Cambodia will be slowed by up to 60% in that same period.

Food security is often an issue for the poor. Links between HIV and weakened food security among the poor have not been established in poor communities in every country in the region, but have been documented in some. In China, children affected by HIV associate hunger with their experiences of HIV-related death or illness in the family (UNICEF, 2007c). In Cambodia, food and nutritional requirements are a fundamental priority in regard to HIV programming (Sussman, 2006). A study of children and adolescents affected by HIV and AIDS in Lao PDR (Niskanen, forthcoming) found that food or hunger were not priority issues. However, HIV affected households overall had lower income and higher expenses. A broad review of evidence by the Quality Assurance Project (QAP) and UNICEF (2008) found similar situations in other low prevalence settings. HIV-affected households, especially female headed ones, tend to be worse off than unaffected households. Furthermore, as a consequence of HIV in the household, children have increasing socioeconomic responsibilities, but effects on their lives are mixed.

Evidence exists of widespread educational deficits and disadvantages for CABA across the East Asia and Pacific region, as well as similar evidence for orphans more generally. HIV-affected households may experience a decline in wealth as a result of income losses from declining productivity and expenditure increases related to health care, and these families may become indebted or sell off assets (ibid). In Indonesia a UNICEF study found that free basic education was not provided for children of people living with HIV, and that they had poor access to insurance (UNICEF, 2007d). In Cambodia, D'Souza found that wealth status was strongly associated with school attendance, that paternal orphans were less likely to attend and that double orphans less likely than non-orphans to attend (2008), although this was not specific to orphaning due to HIV. In Thailand, D'Souza (2008b) found that until age 11, there is no difference in school attendance between orphans and non-orphans. However, from age 11 to 14, orphans have a slightly lower attendance rate than non-orphans and orphans live on average in poorer households than non-orphans (ibid). While these studies provide useful information on the linkages between household wealth, living arrangements and education, they do not account for children living in institutions or on the streets.

Box 5. Childhood poverty and impacts of HIV and AIDS

- Households affected with HIV do have lower incomes, and often experience lost productivity and economic decline related to increased expenditures, especially on health.

- Poverty is a major factor in reduced access to education in the region.

- Orphans are less likely to attend school than non-orphans.

- Paternal orphans have lower school attendance than non-orphans (Cambodia).

- Older than younger orphans appear more vulnerable to school drop out (Thailand).

4a. Social protection, children and HIV

The objective of social protection is broadly to reduce the economic and social vulnerability of all poor, vulnerable and marginalized groups (poor and marginalized children, in this case) and to enhance the social status and rights of the marginalized, by providing social transfers, which can take many forms. Older debates on *social welfare* and 'assistance' have focused mainly on welfare assistance to protect the poorest and most vulnerable from the welfare impacts of shocks and crises, as well as sometimes efforts to prevent crippling expenditures, such as on health care or funerals, through insurance and pooling of resources (i.e. usually to prevent economic impacts of such events or needs, rather than to actually prevent them).

While still about poverty-focused, predictable and equitable social transfers to poor and marginalized people, the idea of *social protection* takes on a broader perspective to also include promotive and transformative measures (Devereux and Sabates-Wheeler, 2004) and could lend itself better to building on a more balanced understanding of vulnerability, resilience and agency, which responds to the complex needs of people. A transformative social protection framework beyond welfare payments to the poor includes:

- Assistance with targeted *transfers* of e.g. food or cash to protect some minimum level of consumption for the poor and most vulnerable – referred to as 'protective measures'

- Spreading costs and economic risks through *social insurance, pooling of resources or public financing* for major costs like health care, education, pensions, unemployment, etc. to prevent major expenditures leading to deepening poverty – referred to as 'preventive measures'

- Securing access to *productive inputs, credit or training* for poor and marginalized people to promote productive livelihoods or income generation, allowing people to climb out of poverty and reduce vulnerabilities – referred to as 'promotive measures'

- Strategies transforming *structural*, regulatory, process or legal obstacles to empower the poor and marginalized to participate more fully in development, by e.g. addressing systemic discrimination – referred to as 'transformative measures'

There is no clear or definitive consensus on what types of interventions are covered by the concept of social protection. However, interventions appropriate to reduce vulnerability to HIV, improve and extend the lives of those infected and mitigate the impacts of HIV and AIDS include: transfers (such as cash or food); financial measures to ensure those poor and marginalized have access to essential services of health and education; and non-discriminatory access to financial resources (savings, insurance and credit). The interventions need to be tailored to specific contexts, individuals and stages of the epidemic.

Cash transfers (for example grants, such as child support, disability and foster care grants) can play an important role in mitigating the socio-economic impact of the HIV epidemic. Many of the most affected households remain beyond the grasp of existing social safety nets, so the introduction of a broad-based social security system offering minimal general benefits, or of specific targeted welfare programmes, may in the short and medium term be important in mitigating certain impacts of the epidemic (Booysen et al., 2004). It is important to qualify that, in a concentrated epidemic, only a small proportion of children benefiting from broad based poverty measures will be directly affected or infected by HIV, although such measures are worthwhile in their own right, and that many other poor and marginalized adolescent children will be vulnerable to infection. Limiting cash transfers specifically to families affected by HIV could also contribute to stigma as well as lead to limited uptake, since HIV testing uptake is limited and constrained by fear and discrimination.

Little research has been done on the comparative pros and cons of food vs. other forms of support relative to HIV and AIDS. It has been shown that food for education (FFE) can have a positive impact on absolute school enrolment, and universal access to primary education for boys and girls is a key human development objective in its own right and also supportive of HIV, AIDS and poverty reduction strategies. How education strategies prioritize investments and incentives, however, goes far beyond HIV and AIDS. Other priorities such as removing barriers to access (like school fees or uniforms), improving the relevance and quality of teaching and the curriculum (e.g. including sex and life skills education, which have been shown to have beneficial impacts) may be higher priorities.

In general, food transfers may be appropriate in some cases where markets are not working (e.g. in a disaster), where cash would be inflationary because of food shortages, or where inflation is out of control for other reasons. In a broader set of situations cash transfer is likely to be more appropriate since it can be more cost effective, can have lower transactions costs thus allowing for greater beneficiary choice and accountability due to awareness of entitlements, and can stimulate local markets (Slater, 2004; Harvey et al., 2005).

Many argue that innovation in microfinance to support HIV and AIDS-affected or other vulnerable households should be encouraged, accompanied by close scrutiny of the discrimination in communities that may result in exclusion of those affected by HIV and AIDS (Barnes, 2003; Slater, 2004; Pronyk et al., 2006). Few current programmes reach positive people or youth and some simply combine HIV awareness activities with microfinance projects, without deeper analysis.

There is a current major interest in cash transfers for assistance. However, the next generation of social protection programmes is likely to focus on, among other things, innovative approaches to social insurance, innovative partnerships between governments, donors, NGOs, civil society and the private sector. Furthermore, they will probably make more concerted efforts to reach vulnerable groups who are largely uncovered by existing social protection arrangements, such as migrants and poor people in informal sectors who are particularly marginalized and often most relevant to the dynamics of HIV and AIDS in the East Asia and Pacific region.

4b. Responses to strengthen social protection for children in the region

Social protection in East Asia and the Pacific has progressed further than in many other regions. Nonetheless, it remains variable and must be understood in the context of the complex history of social and economic development of the region. Several post-war East Asian developmental welfare state models, overseen by mainly authoritarian governments, prioritized social policy for sections of the populations in sectors identified for growth. These were combined with a reliance on traditional three-generation family structures, sometimes held up as ideals of 'Confucian family values' (Goodman and White, 1998). While rapid growth brought reductions in absolute numbers in poverty, the economic crises of the late 1990s showed up the weaknesses of these models. Inequalities in wealth, pressures on the traditional extended family, urbanization, mobility and demographic transitions had led to more nuclear families often unable to cope with crises at the lower end of widening income gaps. Trends in social policy responded to these economic patterns (Cook and Kwon, 2006).

It is important to recognize that the region is characterized by divergent and dynamic economies and different patterns of wealth distribution, poverty, as well as responses to the economic crisis of the late nineties. While Thailand followed the Korean and Taiwanese directions in response to the economic crisis with aspirations towards more universal benefits and social rights, the latter two moved in this direction out of economic necessity, in order to restructure their outdated economies, whereas Thailand did so more directly as a response to the crisis (Cook and Kwon, 2006). Some Thai responses included health and unemployment benefits, pensions and the development of effective community-based care and support models for children with HIV in conjunction with a significant scale-up of national advocacy on children (ibid). Malaysia, Hong Kong and Singapore responded to the economic crisis not by reforming the welfare system, but by retrenchment on expenditures on social programmes, although in Singapore this was done more selectively. Malaysia followed similar policies to Hong Kong and Taiwan, but since the 1970s also had a redistributive economic policy to reduce the relative disadvantages of the Malay population (ibid).

Social protection in countries undergoing economic transition

China and Vietnam took different paths out of the economic crisis than other countries in the region. Their process of rapid liberalization lifted significant numbers of people out of poverty. Yet in both countries poverty remains a serious challenge with widening income gaps and urban-rural exclusionary divides (Cook and Kwon, 2006).

The Chinese system of social protection is divided between urban and rural sectors through a system of registration, shaping patterns of access and exclusion. The system has negative consequences for migrants, who often have heightened vulnerabilities to HIV. The guiding issue in social welfare policy is recognition of the links between social and economic development, as well as a related concern with social stability. The dynamics of the latter have shifted towards rural populations in recent years and include the abolition of school fees, medical aid, a Minimal Living Guarantee Scheme, and agricultural taxes (Cook and Kwon, 2006). In China, social protection for CABA primarily focused on orphans, and 3,167 double orphans (93 percent of those of school-aged reported) received additional government support (UNICEF, 2008).

Indonesia had a prolonged economic crisis which was compounded by natural disaster (Tsunami), political unrest and internal conflict. Indonesia maintained subsidies on rice (renamed 'rice for the poor'), changed a scholarship programme to school block grants, re-centralized health insurance for the poor under one state company and launched a one-year unconditional means-tested cash transfer programme to counter the effects on the poor of raised domestic oil prices (Cook and Kwon, 2006).

A UNICEF sponsored national assessment of the socioeconomic impact on households affected by HIV and AIDS in 2007 revealed an increase in school dropout rate among children affected. Families experienced high funeral costs, high levels of discrimination and low access to government insurance schemes (UNICEF, 2007d). Consultation meetings were held at provincial level to discuss future strategies.

Social protection in low income countries

Lao PDR and Cambodia were not as directly affected by the recent economic crises as other countries more integrated into the global economy. Nevertheless, the social impacts were experienced by the poor through job losses and declining incomes compounded by inflation and increased health care costs, particularly in Cambodia (Edström et al., 2008). Poverty reduction is progressing slowly in both countries, while inequality is also increasing, with rapid migration, urbanization and reduction of arable land. Both countries have PRSP processes aimed at poverty reduction, and social investments are on the rise. A major response to poverty in Lao PDR and Cambodia is migration through which remittances play a major part. Migration, however, also poses a major challenge for social protection, as benefits tend to depend on citizenship and place of residence. Many poorer migrants – such as Khmer and Lao migrants in Thailand – can not easily access social services and benefits, and so lack protection and insurance against economic shocks, which may also limit their capacity to send remittances to struggling households in their communities of origin. While Cambodia lacks a broad-based social welfare scheme, numerous NGOs provide direct services to HIV affected families and their children, including transfers of food aid through home based care.

Papua New Guinea has no public social security for the poor (which comprises a large section of the population), whether unemployment insurance or other broader social safety nets. Social support falls to family and extended family networks, as well as the traditional "wantok" system, which is based on extended family, kin and clan. Extensive poverty, strains on families and HIV are, however, reducing the capacity of the wantok system to provide the required level of support. A pilot cash transfer programme is currently being designed with UNICEF support (Samson, 2008). There has also been other recent progress in terms of protection and care for children, including a Universal Basic Education Plan being finalized for submission to the Papua New Guinea National Executive Committee in the first quarter of 2008, ensuring access to primary education for all children, including orphans and other vulnerable children. Other advances include: the development of a Four-Year National Strategy for the Protection, Care and Support of Children Vulnerable to Violence, Abuse and Exploitation in Papua New Guinea and that the Lukautim Pikinini Act (Child Protection), was passed in April 2007, which prohibits institutional care and identifies orphans and other vulnerable children as requiring rights based care and support.

Aside from Papua New Guinea, child protection and care in relation to HIV has not yet begun to be developed on any significant scale in Timor-Leste or the rest of the Pacific sub-region.

Responses to improving educational access for the poor and marginalized

Commitments to support the protection and care of orphans and vulnerable children living in a world with HIV and AIDS and to ensure access for orphans and vulnerable children to free basic education have been articulated in the Global Framework (2004), the Companion Paper (2007), DFID et al (2006), UNESCO (2005) and the World Bank (2002), among others. In spite of these, however, governments have been slow to initiate progress. Education has been shown to be a powerful tool for slowing and reversing the trend of the epidemic (Kelly, 2006). The importance of access to education can not be over-stated for a transformative social protection agenda, for poor children in general as well as those affected by HIV/AIDS. While some studies have demonstrated the effectiveness of financial subsidies, few studies have examined or evaluated the impacts over time of educational interventions on children and families affected by HIV/AIDS (with longitudinal data-sets or analyses). One study by the World Bank found that education may provide some protection against HIV infection particularly in reducing girl's vulnerability to HIV by contributing to female economic empowerment, delayed marriage, increased use of family planning, and in bringing students, parents, teachers, and community members together (World Bank, 2002).

4c. Constraints and priorities in social protection and poverty reduction

Evidence indicates that children affected tend to experience more economic hardship than others and will often need social protection for that reason alone. However, current social protection arrangements for vulnerable children in relation to HIV are limited by gaps in research. For example, more and better socioeconomic research evidence would be useful for documenting better ways of targeting such as: impacts of HIV on children in different countries, particularly in terms of different stages of the disease as well as understanding differences in socioeconomic safety nets; the relative importance of economic barriers in access to health care, or what barriers to education operate, or; effective ways to reach and protect children most vulnerable to infection (QAP and UNICEF, 2007).

On the other hand, many situational assessments in different countries across the region, along with other existing social and economic data, lessons and pilot projects provide many countries with a reasonable base of information with which to set about planning better and more comprehensive strategies for social protection for poor and marginalized children. A broader range of children related to HIV are vulnerable in terms of economic hardship, than just orphans. Targeting on narrow and obvious criteria, such as orphan status, for social transfers misses many of the most relevant children and may also stigmatize children, as it has done in many countries already.

Even with more sophisticated and child-sensitive targeting, or case identification, children vulnerable to, infected and affected by HIV and AIDS are a small minority of poor and marginalized children in most countries in the region. Hence, social protection alone is not likely to meet the needs of the most vulnerable children in relation to HIV. In order to become accessible for some of the most vulnerable in relation to HIV, however, a range of creative approaches will be needed, such as solutions which do not require civic registration and/or linking it with referrals from other types of services and programmes, like schools, NGO/CBO outreach activities or home-based care. Such linkages are also likely to make social protection more transformative, in terms of contributing to responding to the dynamics of the epidemic.

Social protection is broadly about poverty reduction and protection of the marginalized and vulnerable against shocks or systemic disadvantages. There are strong arguments not to privilege specific groups of poor or marginalized children (or adults) on account of HIV, both in terms of equity and so as not to unwittingly cause division and feed stigma and discrimination against for example 'AIDS orphans', which can lead to further marginalization. It is important to recognize, that being essentially about equitable poverty reduction, social protection alone *will not* respond to all the needs for protection and care of children vulnerable to, infected and affected by HIV.

The units of analysis and 'beneficiaries' are rather abstracted households of individuals (including children), framed as economic agents (consumers and producers). The social protection framework *does not* cover alternative care or psycho-social support for children, and the primary focus of its transformative strategies is about transforming the economic situation and prospects of the poor, marginalized and disadvantaged (far broader than legal and structural transformations for child protection).

To the extent that the most relevant children for HIV and AIDS are also poor and marginalized (even if a minority of this group), the *availability* of and their access to social protection is clearly important. It becomes important that social protection measures aimed to create equitable access for all also take into account such particular complex vulnerabilities and the real-life situations of the most vulnerable in relation to HIV.

Given the contexts of many such children in the region, it becomes important that social protection policies and solutions reach people in informal sectors and people without strong documentation, or claims to residence or citizenship, such as internal or intra-regional migrants, etc. Furthermore, it is also relevant to take account of the extent that HIV appears to impoverish their families and lives in particular ways (such as through crippling health expenditures and exclusions from school etc.). The following considerations are central to making social protection sensitive to the needs of children vulnerable to, infected and affected by HIV in East Asia and the Pacific Region:

- The concentrated epidemics in the region mean that strategies must depend on the nature and phase of national and local epidemics and, particularly, how children figure in these.

- The relative costs and feasibility for specific protective transfers, preventive cost pooling, public financing of services or strategies to promote sustainable livelihoods of families and children vulnerable to, infected or affected by HIV need elaboration within larger poverty alleviation measures for all children and other health and social priorities.

- Children of parents with high risk behaviours have multiple HIV related vulnerabilities, as well as a range of needs for support and protection. The stigma, discrimination and social exclusion of such marginalized children and adults entail complex vulnerabilities far beyond poverty, which can only be addressed with linked or complementary responses.

- Social protection for the poor and marginalized must stand on a foundation of broad-based equitable measures targeted at poverty reduction, which has some history in the region, but specific solutions for children in relation to HIV need linked policies and responses devolved to local community settings, with the meaningful participation of relevant marginalized groups (incl. children) in developing solutions.

To become preventive in a deeper sense than insurance and cost-sharing measures preventing household destitution from catastrophic expenditures – i.e. in a sense of also contributing to HIV prevention – social protection programmes will need to treat families/households caring for vulnerable children in a holistic way, and link support to care and treatment, as well as HIV preventive measures, as appropriate.

To become 'transformative' social protection strategies need to become synchronized with transformative measures on child protection and HIV stigma, but also need to go beyond 'vulnerability' as the central issue to find ways of building on children's and carers' resilience and agency, not seeing them as mere passive victims. This involves linking social protection strategies and improved livelihoods and credit schemes, whilst tackling explicit or 'de facto' discrimination in access for PLHA or disadvantaged youth. It may also require ensuring support for access to good education for affected and disadvantaged children, or specific support to foster families caring for children.

Considerations for future and recommended priorities on social protection:

- Where small proportions of all poor and vulnerable children are actually affected by HIV and AIDS (CABA), social protection can not easily claim resources closely earmarked for HIV and AIDS, unless a strong case can be made that significant proportions of other poor and marginalized children are vulnerable to infection.

- Targeting of broad-based equitable social protection needs to be based on poverty and exclusion rather than HIV per se. For social protection to become accessible and relevant to children vulnerable to, infected and affected by HIV and AIDS, policies and programmes must enable and facilitate linkages between different services, for example, in collaboration between local authorities and community organizations.

- Poor people who are not covered by existing social protection arrangements are a particularly high priority (and often highly vulnerable to HIV) in East Asia and the Pacific. This involves solutions which extend support to marginalized migrants, those outside of formal employment and without current registration or citizenship claims.

- Nesting of social protection within more transformative redistributive growth strategies would be highly appropriate in the region, but this also requires strengthening and elevating social welfare sectors within the policy making process and architecture of governments.

Alternative care and psycho-social support in East Asia and the Pacific

<div style="text-align:right">5</div>

Living arrangements impact differently on children's vulnerability to HIV. Children may live in households where a parent or adult relative is infected, or have a relative or one or both parents who have died from AIDS, or be infected themselves. These circumstances can reinforce their vulnerability in different ways, by exacerbating poverty, thus propelling children into employment (child headed households, child labour for income generation), and by experiencing exclusion from school, psychological health problems and loss of homes. They may lead children, including orphans, to be cared for in alternative family environments (institutional care, foster care, adoption) or to runaway and live on the streets.

Families and children affected by HIV undergo psychological stress and discrimination. Some children, who have parents who are injecting drug users and/or sex workers, are themselves vulnerable to drug use, sexual abuse or exploitation, as are all children living on the street. These children also have a higher risk of HIV exposure (UNICEF, 2007).

Analyses of these children's family circumstances have given rise to a range of categories of children (orphans, CABA, children in alternative care, or street children). These categories are not mutually exclusive. Orphans are often in alternative care, street children can be orphans or may have families they return to and live with. Issues of choice and agency also feature, especially for older children who may choose to live on the street or with other children rather than in abusive or difficult family environments.

5a. Alternative care and psycho-social support for orphans and other vulnerable children

"Alternative care" refers to care that places children under guardians who can meet their basic needs. It is essentially about appropriate living arrangements of the most vulnerable children, including orphans, and those living in circumstances that have changed in ways which may threaten a child's well being. Such changed circumstances may include parental death/s, care-givers who have fallen ill and can not cope with arranging care for children, or violence, abuse or neglect. Formal alternative care typically involves a third party, such as the state, who arranges for a foster home, adoption or institutional care, whereas informal alternative care typically involves informal arrangements for placing the children with the extended family or a close neighbour (UNICEF, 2007). The approach should be family-centred and involving analysis of specific living arrangements. The focus is on inter-personal as well as extra-household relationships for support and protection, making kin and community networks central to finding solutions for children with inadequate care. In many settings in East Asia and the Pacific, the traditional safety net is the extended family. However, traditional family structures are changing with economic development and urbanization. Placement options vary by context and may include informal fostering by extended family, "community fostering", adoption, group homes and orphanages.

An important component of alternative care is psycho-social support, which is broadly under-developed in most countries. Psycho-social support for children is also about support to families which can be aided through home-based care outreach, as well as in various ways through community based organizations. Beyond supporting the family, psycho-social support may also – particularly for slightly older children and adolescents – need to involve issues of peer support and dealing with problems like bullying at school.

Children clearly do best in safe, supportive and supported families and extended families, while community networks are of crucial importance to carers' resilience and capacity. The starting point for care of children should always be to equip carers to prevent and avoid reaching a point of crises, and to help struggling families cope. This is not only about having a basic income, but also about getting help with parenting skills, understanding childhood development and so on, which can sometimes be strengthened through maternal health services, home-based care or other community-based solutions.

However, the reality is that for many children their current or original families are no longer able to cope, may have dispersed or parents having died. In the East Asia and Pacific region grandparents and extended families will often provide care for children when parents cannot cope, fall seriously ill or have to migrate

for making a livelihood. A key – and primary – recommendation of the companion paper is to *"find appropriate ways of supporting and monitoring informal care arrangements"*. These should be as close to the original family situation as possible, in terms of staying in the community, not splitting up siblings if possible, not imposing new cultural values such as new religions and so on.

When informal kin- and community-based solutions are not available for particular children, more formal solutions become necessary. There are many options available in theory, and we do have some evidence of drawbacks of certain solutions, such as orphanages, particularly if not managed and implemented with close attention to good practice and individual children's developmental needs. The second strong recommendation of the companion paper was for governments and partners to *"improve the formal care system"*. This involves investing seriously in better arrangements for foster care, ensuring that children are not placed in institutional care, unless absolutely necessary (an option of last resort), and ensuring that the primary function of alternative care is to support family reunification or another permanent option, such as adoption.

Alternative care in the region involves a bewildering array of informal and quasi-formal strategies and solutions (often by NGOs, CBOs and FBOs). A major challenge for alternative care is to ensure that better choices are made for and with children, and that good standards are established regulating both institutional and foster care providers. This ultimately requires strengthened child welfare services from local to central levels. The third recommendation in the companion paper is therefore for governments and partners to *"develop government and community-based protection and monitoring mechanisms"*.

5b. Strategies to improve alternative care and support for children in the region

The placement of children involves providing those lacking adequate adult care a safe and secure environment, including shelter and guardianship. *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (UNICEF, 2004) calls for the establishment of specific standards for alternative care for children without family support, including keeping siblings together, seeking family-based placements (using institutionalization as a last or temporary resort), and involving children in the decision-making processes regarding their placement.

In Lao PDR, increasing numbers of children were found to be abandoned, living on the street, involved with substance abuse and affected by HIV and AIDS (MOLSW, NCCAB and UNICEF, 2004). Existing care systems are fragile and that institutional options cater for less than one per cent of vulnerable children. Despite strong evidence and a growing international consensus that closed institutions are rarely in the best interests of the child, and can cause long term harm to the children they seek to protect, many government officials in Lao have promoted institutional care as a means to provide education, food and shelter for orphans. MOLSW found that orphans expressed a strong desire to remain within their community of origin, and caregivers of vulnerable children were committed to community based care options. Yet ineffective alternative care systems, combined with increasing youth problems such as children living and working on the streets, substance abuse and commercial sexual exploitation have resulted in many children, including orphans, ending up in endangered circumstances and/or in institutional care.

In China 277 institutions ('sunshine homes' and orphanages) were established, despite strong evidence and international recommendations against institutional care options. China reports having achieved its country target for care and support and 3,167 double orphans (93 percent of the total school-aged reported) received government support, while double orphans are not only a very small minority of all children vulnerable to, infected or affected by HIV and AIDS, but also only a sub-set of children affected.

There is extensive evidence to show that children placed in orphanages (whether HIV-infected or not) fare significantly worse than do children with their families or in foster settings (QAP and UNICEF, 2008; Tobias, 2000; UNICEF and SCF, 2007; Deininger et al., 2001). Moreover, young institutionalized children are especially vulnerable to infectious disease, impaired cognitive development, malnourishment, and physical and sexual

abuse (Frank et al., 1996). While orphanages and care institutions are also the most expensive option, they remain a first and often permanent "formal" response to orphans and vulnerable children, especially in Asia, as well as Central and Eastern Europe, and the former Soviet Union (Tobias, 2000; UNICEF 2006).

As an alternative to orphanages, *temporary placement homes* have been established in Thailand, China and elsewhere for children affected by HIV (Cook and Kwan, 2006). In China, foster care models have been developed to curb the costs of residential institutions, while in Cambodia, an Alternative Care Policy was adopted in 2006 seeking to set minimum standards on residential and community based care and highlighting residential care as a *least preferred option*. However, knowledge, use and ownership of the policy remains variable amongst the many civil society organizations involved in providing care (Edström et al., 2008).

Community and faith-based organizations have been key players in the delivery of alternative care as well as psycho-social support and in the tackling of stigma and discrimination (see chapter 7 for more detail on stigma and discrimination). Faith-based organizations (FBOs) are working on support of children and families affected by HIV in many countries. In Lao PDR, Buddhist monks have mobilized community support for affected families through the provision of healthcare and education (MOLSW, 2004). Myanmar and Cambodia are encouraging nongovernmental, community based and faith based organizations to play a major role in social support.

In Myanmar, NGOs working for HIV care and support respond to this need by including support to orphans in their projects (UNICEF, 2007). Health officers and people living with HIV reported that many of these infants and children are taken care of or rejected by members of the extended family; some are institutionalized by the Department of Social Welfare. Others are living in accommodation provided by Christian churches, Muslim and Hindu leaders and receiving care of NGOs/ charitable organizations and individuals. Over 15,000 orphans and vulnerable children including children affected by HIV and AIDS and their families received protection, care and support services in collaboration with local and international NGOs and FBOs during 2007.

An important aspect of community based and nongovernmental organizations being able to contribute to protection and care of children is the government's engagement with, and support of, such organizations in the process of developing guidelines and policies, as well as in assessing the situation and needs of children.

Cambodia has established a National Multi-sectoral Orphans and Vulnerable Children Task Force for developing a situation analysis of orphans, children affected by HIV and other vulnerable children. The Task Force includes key government and non-government organizations and has produced a costed Four-Year National Strategy for the Protection, Care and Support of Orphans and Other Vulnerable Children (Edström et al., 2008).

In Papua New Guinea, an Orphans and Other Vulnerable Children Task Force is co-chaired by the Department for Community Development with the National AIDS Council and a training manual has been developed to strengthen the capacity of faith based organizations to identify and respond to issues facing orphans and vulnerable children affected by HIV and AIDS (Samson, 2008). China has developed a national policy for the care of children orphaned by AIDS and Myanmar has developed a family and community-based care manual for women, children and families affected by AIDS, while Thailand has developed community-based care and support models for children with HIV in two provinces (UNICEF, 2008). Since there are no well researched large-scale models in the region for complementing access to paediatric ARVs with community-level support activities to address issues such as the psycho-social impacts, these pilots need to be developed and studied prior to national scale-up.

A number of countries have made concerted efforts to address gaps in knowledge on emerging concerns of children affected by AIDS in the last several years. Several countries have already conducted, are planning or conducting situational assessment of children affected by HIV and AIDS. These include Cambodia, China (Yunnan province), Indonesia, Lao PDR, Malaysia, Myanmar, Papua New Guinea and Viet Nam. In Malaysia, the Child Protection Act 2001 has been enforced. The provisions under this Act encompass the care of all children, including children affected by HIV and AIDS (Cook and Kwon, 2006).

In some countries with more concentrated and emerging epidemics, responses to care and protection for children in relation to HIV are more nascent. In Viet Nam, child protection and care programmes and activities include pilot programmes and small scale implementation of alternative care and comprehensive care for OVC and pilots on family-centred care (Bach and Duong, 2006). In Indonesia studies report that families affected by AIDS draw on extended family support systems to care for children or orphans within the family, but that official and non-governmental support for families is grossly neglected (UNICEF, 2007d).

5c. Constraints and priorities in alternative care and psycho-social support

There remains a lack of information on the current adequacy or inadequacy of caretaking arrangements in most countries of the region and maybe particularly on the problem of children living outside of family care. More information and research are needed on, for example: the situation with respect to orphans living with or separated from siblings; various psycho-social impacts on children affected by HIV or AIDS; effective strategies or the potential roles of different kinds of extra-familial support, or; which types of living environments support better psycho-social well-being.

Strong evidence exists that institutional care for children is not a good option for children's well-being and that 'family-like' options are preferable. We also know that placement solutions are not the only options, and we should also consider day care, such as in situations where street children are not likely to stay with foster carers, or are not likely to be successfully placed with a family. Other considerations and options for psycho-social support need to be explored and researched to unearth linkages with vulnerability to infection in adolescence as well as their effectiveness in providing support more generally.

Recommended priorities for the future include:

■ Solutions need to better follow evidence and good practice with family, or family-like, options as a first course of action, and be supported by social protection measures helping caring families to cope.

■ The tendency to continue or expand institutional care solutions needs to be checked and redressed.

■ Focusing primarily on the most visible and obvious groups of 'orphans' or 'double orphans' misses many of the most vulnerable children and are wholly inadequate.

■ Policies need to facilitate the identification and 'case management' to meet children's individual real needs rather than being based primarily on formulaic categorizations of different types of accommodation.

■ Identification and support to vulnerable children needs to be strengthened through better linkages and co-ordination between social, health and education services at local level.

Legal protection of children's rights in East Asia and the Pacific

6

The backdrop for considering legal protection of children in relation to HIV and AIDS is the legal context for vulnerable women and children. Legal systems in East Asia and the Pacific are often failing children in relation to access to important services such as health and education. Access has been exacerbated by association with HIV and AIDS, which has sometimes unfortunately been seen as a disease requiring social segregation, as for example in Nepal (UNICEF, 2002b). Women and children in many Asian countries are poorly protected by laws on inheritance rights, and may suffer from loss of inheritance, property grabbing or dispossession, as has been documented in Thailand and Bangladesh (UNICEF, 2005). Without adequate legislation to protect the economic security of vulnerable families and families affected by HIV, many children are forced to work and migrate (Reimer, 2006; ILO, 2006; Pearson et al., 2006). Several legal analyses indicate that legal protection for child labour is limited and/or poorly enforced (UNICEF, 2002). Some studies have found that young migrants in Thailand, vulnerable to exploitative forms of labour, are often not covered by local labour protection laws (Pearson et al., 2006) or that many workers in illegal and informal sectors have neither birth nor civil registration, lacking opportunities for redress if exploited (UNICEF, 2003). While these legal contexts appear particularly challenging for the children most vulnerable to HIV, or its personal and household impacts, most studies and analyses are rarely specific to children and AIDS.

6a. Legal protection of children's rights in relation to HIV

Legal protection covers several facets, such as inheritance, birth registration, civil registration, and legislation and enforcement policies on child labour, trafficking, sexual abuse, exploitation, and discrimination. All these aspects are important for vulnerable children, whether or not they are affected by HIV or AIDS. While normally referring to the obligations, policies and their implementation by the state, legal protection can also refer to the roles that other organizations and legal entities in society play to ensure the safety of children, such as local communities and families. The role of government in protecting all children, including those affected by HIV, includes:

- *respecting rights* – having laws that do not violate their rights;
- *protecting rights* – enforcing laws and policies; and
- *fulfilling rights* – creating mechanisms to realize rights (Gruskin and Tarantola, 2005).

The rights of children are defined in the *Convention on the Rights of the Child* (United Nations, 1989), now signed and ratified by almost every country. The Convention is an integral part of human rights discourse and the culmination of work that began in 1924 with the Declaration on the Rights of the Child. Various treaties, as well as the UN Convention on the Rights of the Child, recognize the fundamental rights connected to children's humanity.[15]

In setting the upper limit of childhood at 18 years, the Convention seeks to standardize an ideal of childhood and to secure the right of every child to a childhood that is free from the responsibilities of work and money. Additionally, article 34, which is one of the most heavily invoked and non-controversial articles of the Convention declares that *'States Parties to undertake to protect the child from all forms of sexual exploitation and sexual abuse.'*

Article 9 of the Convention specifically states that if it is in the best interests of the child, s/he can be removed from her/his parents. This approach has been advocated in Thailand by Dr Saisuree Chutikul, Secretary-General of the National Youth Bureau, who argued that parents whose children become involved in sex work should lose all their parental rights and even be actively discouraged from having children (Chutikul, 1992:5).

Although the Convention gives children rights to freedom from exploitation by mandating the steps necessary to reduce harm, even to the extent of splitting up families, the Convention makes no exceptions for cultural variations in the definition of childhood or for the ways the realities facing children may differ between countries and enforcement is difficult, particularly in Southeast Asia where there are enormous numbers of vulnerable children, including child sex workers who themselves may be the children of sex workers.

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[15] Over this period, children's rights were also enshrined in the 1948 Universal Declaration of Human Rights, the 1966 International Covenant on Economic, Social and Cultural Rights and the 1966 International Covenant on Civil and Political Rights.

Protection and Care for Children Faced with HIV and AIDS in East Asia and the Pacific

While any child may be vulnerable due to lack of adequate protection, children affected by HIV or AIDS are hypothesized to be at additional risk (UNICEF, 2007) because of the effects of HIV on their households, increased likelihood of leaving school early and/or seeking life on the street, and having to work for family income. The Companion paper to the global Framework (UNICEF, CIDA et al., 2006) urges governments to strengthen and/or develop:

- Legal support for the poor and marginalized (inheritance rights, and protection from abuse, exploitation and neglect)
- Civil registration systems, primarily birth registration
- Specialized child protective services (in police, justice and social welfare systems)
- Enforcement of legislation and policies on child labour, trafficking, sexual abuse and exploitation, and
- Support to community-based monitoring mechanisms.

6b. Strategies for child protection and strengthening legal frameworks in the region

Although increasing number of countries have reviewed legislation and polices to improve legal and social protection of children affected by HIV and AIDS, there is a need for all countries in the region to ensure adequate legal and social protection legislation are in place, to strengthen legal frameworks so that they guarantee compliance, to provide adequate protection for all children, including children affected by HIV or AIDS and to build advocacy to change the laws. As Heijnders & Van de Meij (2006) and Foreman et al (2003) found in their extensive literature reviews, there has been little or no evidence of the systematic evaluation of interventions that address the legal protection of children affected by HIV.

Yet, over the past two years, there has been substantive progress in legislation and policies that relate to the rights, protection, care and support of children in many countries of East Asia and the Pacific (UNICEF, 2008). In Papua New Guinea, the Lukautim Pikinini Act (Child Protection), which was passed in April 2007, prohibits institutional care and identifies orphans and other vulnerable children as requiring rights-based care and support. Additionally, the first national child protection policy is being developed and will provide the policy framework for improving the protection and care of orphans and other vulnerable children.

In Lao PDR, the National Assembly passed a law on children, which includes a provision for children affected and infected by AIDS. Lao also claims to have achieved the country target for care and support. It has passed a Law on the Protection of Rights and Interests of Children, which includes the care of children affected by HIV and AIDS (Article 17) and education for children affected by HIV and AIDS (Article 31).

In Thailand, a comprehensive Child Protection Law was passed by Parliament in 2004, which calls for decentralization of both management and resources to provinces and communities and requiring each province to establish appropriate systems for the child protection and welfare. UNICEF has provided support to selected provinces in preparing for implementation of the law, for the mapping of existing "welfare homes" across the country, as well as for providing training to child protection staff at central and provincial levels (Borthwick, 2003).

These and other examples are listed in table 4.

Table 4. Achievements in policy development

Country	Legislation/Policy
Cambodia	Alternative Care policy enacted in 2006 National Plan of Action for Orphans and Vulnerable Children (with costing) (2008).
China	National Policy for the care of children orphaned by AIDS Henan Province Policy for the care of children orphaned by AIDS (2007).
Indonesia	Development of National Strategic Plan 2007 – 2010 and a National Strategy for Children and Young People (2008 - 2010)
Lao PDR	National Assembly passed a law on children, which includes a provision for children affected and infected by AIDS. Article 17 is on the care of children affected by HIV and AIDS and Article 31 is on Education for Children affected (2007).
Malaysia	The Child Protection Act 2001 has been enforced, whereby the provisions under this act encompass all children including children affected by AIDS.
Papua New Guinea	The Lukautim Pikinini Act (Child Protection), passed in April 2007, prohibits institutional care and identifies orphans and other vulnerable children as requiring rights based care and support. The first national child protection policy is being developed. A community-based care and support policy has been developed for orphans and other vulnerable children.
Thailand	Thailand's Child Protection Law, passed in 2004, calls for decentralization of both management and resources to provinces and communities and requires each province to establish appropriate systems for the child protection and welfare.
Viet Nam	A legal review was undertaken on children affected by HIV and AIDS in Viet Nam in 2007, and a Law on Prevention and Control of HIV was also passed. Developing an outline for a National Plan of Action on Children and HIV/AIDS with costing (2008).

Source of data: (UNICEF, 2008). Background paper: East Asia and the Pacific Regional Partnership Forum on CHILDREN AND HIV & AIDS, 31 March – 2 April 2008 Bangkok, and (Borthwick, 2003).

Bach and Duong (2006) reported that in Viet Nam a national child protection strategy was under development and a guidance document on re-integration, community-based alternative care and increased social grants for vulnerable children has been issued.

Many recommendations have been made highlighting the range of issues to be addressed. Studies have highlighted the need for employment laws to protect migrant and informal sector workers. The Background Paper to the East Asia and Pacific Regional Consultation on Children and HIV/AIDS (2006) advocates enforcement of legislation protecting children vulnerable to, infected and affected regarding e.g. eliminating the worst forms of child labour, eliminating barriers to education and healthcare, protecting street children, encouraging family-based placements, providing guardianship, and tackling discrimination.

Beyond specific child protection laws, legal frameworks in areas such as employment and social benefits should have an impact on marginalized children who are vulnerable to HIV and AIDS. Without progress in these areas children may remain under-protected. In Thailand, for example, Pearson (2006) recommends the following: for the Thai government to provide adequate labour protection for informal sector workers; for the Ministry of Labour to facilitate the role of civil society, workers' and employers' organizations in protecting migrant workers in practice; and for the government to enforce a guideline informing employers of migrant workers' rights and informing law enforcement officials, including police and immigration officers, about those rights and their responsibilities when dealing with migrant workers. Furthermore, for the Ministry of Labour to: develop simple but effective complaint mechanisms for migrants to report exploitation in the workplace; educate employers about the rights of children and migrants; and monitor and evaluate the impact of policies and programmes on labour migration. These are important in themselves and would likely protect the rights of children in relation to HIV; however, their specific links to HIV are not well researched.

6c. Gaps and priorities in legal protection and eliminating discrimination

Knowledge is limited about specific vulnerabilities to lack of protection for children affected by HIV beyond those of vulnerable children in general. Even in terms of children vulnerable to HIV infection or vulnerable children in general, there is a lack of good evidence on the relative magnitudes of different types of protection problems, such as trafficking, sexual abuse or exploitative child labour. Little evaluation of the effects of birth registration on better protection is available and we don't have good evidence on which interventions are needed to remove barriers in the registration process nor on to ensure that rights (such as legal rights to inheritance and access to education) are protected as a result of registration. Strong evidence is lacking on interventions related to sexual abuse and exploitation among children affected by HIV or amongst children in general (The Quality Assurance Project and UNICEF, 2008).

Legal discrimination or the lack of enforcement of anti-discrimination legislation does appear to be specifically related to HIV and AIDS. However, we still know little about the magnitude of the problem of children without adequate protection, and few interventions have been evaluated for effectiveness in general. Links between improved legal frameworks and the protection or respect for actual rights has not been rigorously evaluated in the region, as evidence on protection failures or interventions has been limited and mostly qualitative.

Mechanisms for community support need to be put in place for child protection, including for birth registration. A high priority for action is raising the visibility and participation of people living with HIV through community initiatives, including HIV-positive and affected children. Providing opportunities for children affected by HIV to be with others who are similarly affected is likely to improve coping skills and serious efforts need to be made in building up health workers' openness to treat people living with HIV.

While some countries have made a certain amount of progress, the review of legal systems and changing implementation needs considerable work in most. Anti-discrimination work needs to become mainstreamed in particular in service areas for children, such as health, education and welfare sectors. Protection for children in contexts of sex work and drug use needs to be elaborated with the engagement and active participation of their parents/carers.

Some recommendations for the future include:

- Strengthen registration and protection for all vulnerable children

- Carefully balance interventions for child protection against abuse and exploitation with welfare and the complementary rights of children to economic security and to be listened to

- Strengthen the voice of affected and vulnerable children and carers in processes and solutions for protection of children's rights at local and national levels. Develop mechanisms for legal and advocacy support to vulnerable people

- Elaborate policies in legal protection in conjunction with public health and educational objectives

Stigma and discrimination of children linked to HIV in East Asia and the Pacific

7

Stigma and discrimination are cross-cutting issues that require strategic interventions at all levels. These range from legal protection and justice, to access to health services and education, non-discriminatory social protection policies and benefits, media training and community dialogue involving religious organizations. Yet it is clear that while anti-stigma and anti-discrimination are recognized as critical areas for interventions for people with HIV as well as for children affected, or otherwise associated with HIV, the evidence base is very limited.

Stigma and discrimination may represent one of the heaviest burdens on the well-being of persons affected by HIV or AIDS (Wijngaarden and Shaeffer, 2005). There are many instances where children are shunned by community members and actively discriminated against. Stigma and discrimination are usually based in myth or on misconceptions, such as the idea that the children of HIV positive parents may likely be infected themselves, or that ordinary contact with an HIV positive person can lead to infection. The depth and complexity of stigma and discrimination may also explain why there are no simple and compartmentalized 'fixes', or easily testable interventions, as well as why it cannot be easily relegated to a sub-strategy. It requires personal engagement, courage and leadership at all levels and in all aspects of HIV programmes and related policies, including on children.

A Save the Children Australia (2006) study of six countries found that discrimination and stigma were widespread in Asia and associated with emotional and psychological problems including stress and drug abuse. Further, there were few specific services designed to tackle stigma and discrimination for children. The Myanmar National AIDS programme reports that children are discriminated against by other children and their parents upon learning of the HIV-positive status of the child or their family members (WHO, 2006). In China, a UNICEF study reported that children affected by HIV and AIDS were negatively affected by their experiences of stigma and discrimination (West and Wedgewood, 2007). The study highlights issues of stigma and discrimination experienced by orphans and abandoned children in China. The Indonesia National Aids Programme found widespread stigmatization and discrimination experienced by people living with HIV (2007) and a UNICEF study of Indonesian households with at least one case of HIV found persistent psychological disturbance reflected in anxiety, in contrast with a low awareness and concern to address psychological problems (UNICEF, 2007d). Stigma and discrimination were shown to present considerable barriers to accessing services, yet local stakeholders hold that no discrimination exists in health, education and social services (ibid).

The Background Paper to the EAP Regional Partners Forum in Bangkok (UNICEF, 2008) notes that a key area where there has been progress in East Asia and the Pacific is in the work with faith based groups. Faith-based response to the protection and care of AIDS infected and affected children and their families has been a distinct part of national responses and is growing. In Lao PDR, UNICEF assisted monks, volunteers and hospitals to initiate comprehensive care for children infected, ensuring that 147 needy, hard to reach mothers and children had access to treatment and community-based care and 125 children received school supplies or small education grants. In Malaysia, pools of trainers involving religious leaders, marginalized communities and people living with HIV from Kedah were established and trained in care and addressing stigma and discrimination. Cambodia has reported that there has been a 16% increase (against a target of 5%) in the number of people living with HIV who received psychosocial support in the twelve provinces where the Buddhist Leadership Initiative programme was implemented. A recent regional inter-faith consultation in Bangkok (UNICEF 2008c) saw religious groups confirming a commitment to a comprehensive response to HIV and AIDS. However, while FBOs are providing important care to children and communities and do get involved in tackling the sources and effects of stigma and discrimination, strategies designed to tackle discrimination may sometimes inadvertently perpetuate the very stigma they are trying to reduce. In an evaluation of faith based interventions in South Asia, UNICEF found that religious leaders were often conservative, dogmatic and themselves sources that perpetuated stigma and discrimination (2003). It must also be underlined that the job of tackling stigma cannot be parcelled out primarily to one type of actor at the community: It is about all of us.

Recommended priorities for the future:

- National strategies for stigma and discrimination need to go beyond the remit of Protection and Care of Children and AIDS, as it also cuts across all other areas of HIV related interventions for children (the other three 'Ps' of the Global campaign).

- A classic feature of stigma and discrimination is denial and lack of awareness on the part of those involved. As every level and actor have important roles to play, any strategy on the issue under a programme or structure must *'start at home'* (with approaches like staff training, equal opportunities policies and staff support to HIV positive employees, etc).

- While community-level action is essential to addressing stigma, one must remember that it is maintained and rooted in communities. Attention must be paid to ensuring that community and faith-based organizations and leaders do not inadvertently contribute to discrimination or undermine sensitive work of others in, for example prevention with most-at-risk groups, including adolescents.

- Increasing the visibility and meaningful participation of children and youth with HIV (while enlisting support from their families, teachers and health workers) in responses to advocate and tackle stigma is an important priority, which may also be beneficial to changing deeper stigmatizing attitudes related to HIV more generally[16].

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[16] For example, stigma and discrimination against children affected by HIV in school and kindergarten settings is too often linked to local misconceptions of 'child-to-child transmission' of HIV in casual contact as being likely. This needs to be addressed through basic facts, but collecting experiences of children from different settings can also be useful and made available for teachers, children and parents.

Institutional environment for policy on protection and care of children: Strengthening processes for policy

8

There is a broad array of theories and frameworks for the analysis of the policy-making processes with some major differences, but also some clear commonalities. These analytical frameworks centre, broadly speaking, on power relations around three inter-locking domains: evidence and discourses underlying the policy narrative (i.e. values of the policy narrative itself and its construction and the ideas that trigger change); actors and their networks (including their political interests, incentives and capabilities) and; institutional context (which can be thought of as 'system imperatives', or the 'rules of the game').

8a. The role of discourse and evidence

In comparing three policy processes for children and AIDS in Cambodia, Edström, Roberts and Sumner found that the role of evidence, discourse and frameworks is limited as compared to the importance of the institutional processes, actors and networks engaged in the process (Edström et al., 2008). Nevertheless, the role of evidence, discourses and frameworks can be one of providing relevant actors (government, civil society and donors) with enabling concepts and language, providing this makes sense across sectors.

In Cambodia, it was found that evidence and discourses from international best practice have influenced policies differently in different areas. In the process of reviewing the impact mitigation chapter of NSPII, a number of assessments were carried out. A participatory situation analysis of orphans, children affected by HIV and other vulnerable children was carried out recently, including a secondary analysis of the 2005 Cambodian Demographic and Health Survey. A National Plan of Action for Orphans, Children Affected by HIV and other Vulnerable Children 2008-2010 has been developed and costed and the country has been successful in fund raising through Global Fund Round 7 (US$42 million, with US$6 million for OVC). National paediatric care and treatment guidelines and the national PMTCT training curriculum were developed. The Paediatric treatment operational policies (standard operating procedures) applied more iterative and local evidence than others, but overall the treatment discourse was nested in national commitments to Universal Access targets. The OVC impact mitigation discourse engaged a broader range of stakeholders across sectors/ perspectives, while the policy process for developing the Alternative Care policy was heavily influenced by international evidence and discourse on best practice. Gaps in evidence on children and differences in understandings of OVC and CABA became constraints in the process.

In China the national response has seen the development of a national policy for the care of children orphaned by AIDS. Important assessments have played a role in the process, including a household assessment of children affected by AIDS, as well as national advocacy and assessments on children orphaned and affected by AIDS. National paediatric care and treatment guidelines and life-skills training guidelines for children in and out of school have been developed, which build on earlier policy developments and continued implementation of the governments 'Four Frees and One Care' (free antiretroviral drugs, free prevention of mother-to-child transmission, free voluntary counselling and testing, free schooling for children orphaned by AIDS and care to people living with HIV/AIDS).

Indonesia's national response saw the development of the National Strategic Plan 2007-2010 and a National Strategy for Children and Young People 2008-2010. As part of the process a national assessment of children and family affected by HIV and AIDS was carried out with about 1,400 households in seven provinces to assess socioeconomic impact on households affected by HIV and AIDS as well as to assess the psycho-social impact on children affected by HIV and AIDS. Consultation meetings were held at provincial level to discuss future strategies. Guided by the assessment, the Ministry of Social Affairs will be initiating community and centre based pilot projects for support to families affected in seven provinces.

In Lao PDR, a national needs assessment on children and adolescents affected by HIV and AIDS was conducted, as well as a quantitative research into knowledge, attitudes and behaviours (KAP) among lower secondary pupils in relation to HIV/AIDS/STIs, reproductive health and drug use in eight provinces with 1,207 eighth grade pupils.

In Viet Nam, policies and a range of recent plans and guidelines were developed based on local evidence gathering, and the M&E framework for HIV and AIDS was approved in 2007. Aside from an impressive array of assessments for informing policy in primary prevention with youth[17], paediatric care and PMTCT[18], or HIV strategy more generally, policies for the protection and care of children in the context of HIV has also seen numerous studies and assessments guiding the process. A study on vulnerability of young people to HIV and AIDS focusing on children in institutions was conducted in 2006 and over 2006-2007 an assessment was carried out on Orphans and Vulnerable Children. A Situation Analysis on Children and HIV and AIDS in 2007 played a key role in preparations and the drafting of the National Plan of Action on Children and HIV and AIDS, which has been submitted to the Ministry of Justice for final review (prior to endorsement by the Prime Minister). An Estimation and Projection Package (EPP) was used to generate estimates on children infected and affected by HIV and child fora were held with HIV-affected children. A Community Home Based Care assessment is also in progress.

8b. Institutions and structured processes for developing policy on children

Clearly, attention to process and spaces for consultation and information do matter to the success of policies. Strategy development and implementation needs to include mapping of the actors and relevant networks, the logical leaders in different areas who are needed to drive the process forward. Social protection, for example, needs to be a part of a broader social and economic development strategy. Education is often seen as a driver in human capital development and therefore needs to take more of a lead on prevention for vulnerable adolescents, than is typically the case. Health has traditionally led in HIV, and in some countries leaders in health have increasingly encouraged others to lead on e.g. social policy, or child protection.

The overall national response in Cambodia included a review of the National HIV Strategic Plan 2006-2010 (NSP II) and the establishment of a National Multi-sectoral Taskforce on Orphans and Vulnerable Children, as well as the development of an Alternative Care Policy adopted in 2006, as mentioned. The policy process study in Cambodia found that the role of formal process varied between different policies – from simply establishing guidelines, which changed some ways of doing things, to taking leadership in creating a National OVC Task Force, broadening engagement with relevant stakeholders (Edström et al., 2008). It was found that instituting iterative processes for building consensus, agreeing priorities and setting targets were important drivers of success. Constraints, on the other hand, included institutional capacity, resources and leadership in some cases. In most processes children themselves are not well represented and they have limited voice in these arenas.

In Mongolia the Government has adopted the 'Three Ones' principle. The National AIDS Committee, chaired by the Deputy Prime-Minister, was re-established, showing increased political leadership on the issue. The National AIDS programme monitoring and evaluation indicators were set and the National AIDS strategy was revised in 2006. National PMTCT and voluntary counselling and testing guidelines were established.

The national response in Myanmar has seen the establishment of the first Technical Strategy Group on AIDS Sub-Working Group on Orphans and Vulnerable Children Affected by AIDS (contributing to higher-level advocacy for common strategies and appropriate responses), a national PMTCT training curriculum, the national paediatric care and treatment guidelines, as well as a family and community-based care manual for women, children and families affected by AIDS. A qualitative study on the situation and needs of children affected by AIDS, as well as a Joint PMTCT review assessment were carried out in the process.

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[17] A national policy on Harm reduction for 'most at risk populations', including youth was developed in 2007 and a research on street children and HIV is currently in progress, as are preparations for Survey Assessment of Vietnamese Youth 2 (in progress). A national policy on IEC and BCC (behaviour change communications), as well as a national policy for Reproductive Health and HIV/AIDS prevention education in secondary schools, were also developed in 2007. Meanwhile, preparation for a study on vulnerable children, including children affected by HIV and AIDS and for a Survey Assessment of Vietnamese Youth 2 are in progress.

[18] An end project assessment of the UNICEF supported PMTCT pilot programme was carried out and the national policy on PMTCT was developed in 2007, along with the policy on Care and Treatment, including specific targets on children. A national assessment on PMTCT, which was carried out in 2006, informed the drafting of the PMTCT guidelines. National guidelines were also developed on ART, palliative care, and OST.

In Papua New Guinea, an Orphans and Other Vulnerable Children Task Force was established and co-chaired by the Department for Community Development and the National AIDS Council, which comprises a mix of key government and nongovernmental organizations. Furthermore, provincial committees were established in 3 of the 6 focal provinces. A capacity assessment of faith based organizations in 4 provinces was also undertaken and an assessment of the feasibility of introducing a cash transfer programme to support orphans and other vulnerable children was conducted, with support from UNICEF. The Four-Year National Strategy for the Protection, Care and Support of Children Vulnerable to Violence, Abuse and Exploitation in Papua New Guinea was developed under the leadership of the Community Development Ministry. Also, a Universal Basic Education Plan is being finalized for submission to the Papua New Guinea National Executive Committee, ensuring access to primary education for all children, including orphans and other vulnerable children.

8c. Actors, stakeholders and networks in policy

In Cambodia, Edström and colleagues (2008) found several features relating to actors and networks as key to driving policy processes for children and AIDS, including: certain actors' commitment and proactive engagement (such as civil society networks and actors and international NGOs) were major drivers. Leadership from particular individuals in key positions and clear statements and backing from Ministries made a big difference, as did the establishment of networks and advisory groups by empowered actors as part of the process or in response was significant in driving policy. A constraint in impact mitigation was some tension emerging between those who focus on HIV-affected children versus those concerned with all vulnerable children.

The Philippines' response in protection and care of children has centred on strengthening the capacity of local governments to respond to HIV and AIDS with a particular focus on most-at-risk children. This has facilitated the formation of local AIDS Councils and Task Forces for AIDS and children, with 42 *Barangay* Councils for the Protection of Children having been reactivated. Barangays are the smallest unit of government in the Philippines. Another 30 structures are in the process of reactivation with HIV prevention mainstreamed into the structure.

In Thailand, more than 1,550 government officials and 7,400 community leaders from more than 20 provinces were involved in activities strengthening the capacity of local governments in HIV/AIDS planning for children and families affected by HIV/AIDS. National advocacy on children and HIV was scaled up significantly and effective community-based care and support models for children with HIV were developed in two regions (Chiang Rai and Khon Kaen). A study was initiated on HIV vulnerability among foreign migrant children in three provinces, and Children affected by HIV/AIDS were included in a review of institutional care.

In general, international partners can play a significant role in opening spaces for participation and pushing agendas forward, but local stakeholders feel international partners can also dominate agendas. There is a need to be as inclusive as possible and human resources capacities matter for participation, with the implication that financial as well as institutional support is often needed, particularly in strengthening actors in social welfare sectors. Incentives to participate in policy processes matter in particular and a strong incentive can be demonstrated that change is possible (e.g. through exposure to examples of successful processes in other places in the region). Overcoming bureaucratic resistances matters and political leadership is important, such as from charismatic leaders who can build consensus.

Conclusions

9

Strategies on Children and AIDS in East Asia and the Pacific must be closely adapted to context and for this we must better conceptualize vulnerability and resilience of children in relation to the epidemic, in order to better understand which children need what support as well as appreciate that many of the most vulnerable children are so in different senses, requiring complex or linked responses. A regional perspective helps us to cast the net wider for appropriate solutions and approaches across comparable contexts, particularly as much of the 'global evidence' for strategies come from different regional and epidemic contexts. In addition, both HIV and many vulnerable individuals (or families) cross borders and move around the region, implying specific challenges for national solutions.

Any strategy for Children and AIDS must be founded with a strong child-centred focus, which also implies a family-specific and childhood-developmental perspective, placed in relation to the dynamics of HIV for children and families. Taking initial direction of locating the starting point from the Global Framework, and delineating areas and responsibilities for Protection and Care, as per the Companion Paper to the Framework, countries can focus on strengthening social protection, care and legal protection for children vulnerable to, infected by or affected by HIV – and not just for orphans or children affected by AIDS. Nevertheless, it must be recognized that this is not one unified or easily identifiable category, but rather a broad set of children from various overlapping existing defined categories.

The development of 'the 4 Ps' (PMTCT, Primary prevention, Paediatric HIV treatment, and Protection and Care) under the Global Campaign to Unite for Children and AIDS, is particularly relevant because it gives us the "why" of different kinds of interventions or support to children, which also allows for identifying logical 'sector leaders' in different areas. While PMTCT and treatment needs a clear lead from the health sector, primary prevention needs stronger education sector engagement and leadership (than has typically been the case to date) and protection and care needs a strong lead from social welfare sector with the engagement and support of health, education and security sectors. The Global Campaign is also important because the objectives of the strategies speak to the different senses of vulnerability of children – *vulnerable to, infected by or affected by HIV or AIDS* –, often the same children (or the same children at different points in their development). Protection and Care is relevant to prevention and access to treatment as well as to other needs of poor and marginalized children. By separating out different kinds of children in different labelled boxes, one risks disjointed responses to complex and inter-woven needs and vulnerabilities.

Labelling children can easily contribute to stigma and discrimination, and all of the relevant children vulnerable to, infected by and affected by HIV or AIDS can not be easily captured under one practical definition or set of criteria for targeting. We must target real children to meet actual needs – not abstract categories. A recognition of the significant overlaps in terms of multiple vulnerabilities of children indicates a strong need to pull the 4 Ps together, particularly in a context of concentrated epidemics in the region, where the numbers of children of concern are still relatively manageable and where doing so is likely to have greater synergistic effects in overall responses to the epidemic.

There are compelling arguments for more effectively decentralizing authority and resources below province level for local solutions and decision making to allow for linking of strategies and case referrals. This is particularly important in large countries like China or Indonesia, but also relevant in countries like Cambodia or Thailand. Effective decentralization will entail concerted efforts in strengthening of local authority capacity, as well as careful harmonization of policy at national and provincial levels, while avoiding excessive disruptions to needed and effective existing systems.

Different programmes (such as social protection or alternative care) have different objectives and will aim for slightly different groups of children, while the same children may have different needs. We need to look for better ways of identifying vulnerable children on the basis of their real needs (be it by home-based care workers, prevention outreach volunteers, health workers, teachers, social workers or law enforcement officers) and ensuring better systems for referral and case management at local levels.

Social protection is fundamentally about poverty reduction and protection of the vulnerable and marginalized. It needs to be based on broad-based equitable targeting of children in poverty and exclusion rather than HIV per se. Where small proportions of all poor and vulnerable children are actually affected, social protection can not easily claim resources closely earmarked for HIV and AIDS, unless a strong case can be made that significant proportions of other poor and marginalized children are vulnerable to infection. For it to become accessible and relevant to children vulnerable to, infected and affected by HIV and AIDS, policies and programmes must enable and facilitate linkages between different services, for example in collaboration between local authorities and community organizations.

Poor people not covered by existing social protection arrangements are a particularly high priority (and often highly vulnerable to HIV) in the region. This involves solutions which extend support to marginalized migrants, those outside of formal employment and without current registration or citizenship claims. It may also benefit from regional level inter-governmental frameworks for equitable access for migrants across borders. Nesting of social protection within more transformative redistributive growth strategies would be highly appropriate in the region, but this also requires strengthening and elevating social welfare sectors within the policy making process and architecture of governments.

Alternative care is fundamentally about care to any children suffering inadequate care and in need of care and support and, while many children vulnerable to, infected by and affected by HIV and AIDS may be in need of such care, they may be a minority of these children (even if a particularly vulnerable minority). To overcome particular obstacles for children associated with HIV, it is essential to start with support to caring families as well as to link responses to addressing stigma in services and communities. Solutions in the region need to better follow evidence and good practice with family, or family-like, options as a first course of action, and be supported by social protection measures helping caring families to cope.

The tendency to opt for institutional care solutions needs to be checked and redressed, and targeting or focussing primarily on the most visible and obvious groups, such as 'orphans' or 'double orphans', misses many of the most vulnerable children and are wholly inadequate. Alternative care and support policies need to facilitate the identification and 'case management' to meet real children's individual needs rather than being based primarily on formulaic categorizations of different types of accommodation. Identification and support to vulnerable children needs to be strengthened through better linkages and co-ordination between social, health and education services at local level.

Legal protection for children associated with HIV is essentially about ensuring that their universal child rights are respected, fulfilled and protected to the same degree as those of all other children. While there has been some progress in recent years in the region, a high priority remains better registration and protection for all vulnerable children. Policies in legal protection need better elaboration in conjunction with public health and educational objectives. Interventions for child protection against abuse and exploitation need stronger evidence and need to be carefully balanced with welfare and complementary rights of children to economic security and to be listened to. The voice of affected and vulnerable children and carers need to be strengthened in processes and solutions for protection of children's rights at local and national levels and mechanisms need to be developed for community-level monitoring of rights and legal and advocacy support to vulnerable people.

Combating stigma and discrimination is an essential strategy in Protection and Care that is specifically about children (and adults) vulnerable to, infected and affected by HIV, but it also cuts across all other strategies at every level. Furthermore, strategies for stigma and discrimination need to go beyond the remit of Protection and Care of Children and AIDS, as it also cuts across all other approaches (the other 3 'Ps') of the Global campaign to unite for Children, as well as all areas of HIV related interventions generally. While community level action is essential to addressing stigma, one must remember that it is maintained and rooted in communities. Attention must be paid to ensuring that community and faith-based organizations, or leaders, do not inadvertently contribute to discrimination or undermine sensitive work of others in, for example, prevention with most at risk groups, including adolescents. A classic feature of stigma and discrimination is denial and lack of awareness on the part of those involved.

As every level and actor have important roles to play, any strategy on the issue under a programme or structure must 'start at home' (with approaches like staff training, equal opportunities policies and staff support to HIV positive employees, etc). Increasing the visibility and meaningful participation of children and youth with HIV in responses to advocate and tackle stigma is an important priority, which may also be beneficial to changing deeper stigmatizing attitudes related to HIV more generally.

Strengthening the social welfare sector is crucial for progress in all areas of action under Protection and Care. It demands a higher priority in national policy and planning processes, stronger local-level capacities, as well as better articulation with health, education and law enforcement. Leadership and positioning within government hierarchies are important here. Multi-sectoral engagement has been a key in success stories, but it requires strong and open leadership with transparent, inclusive and iterative processes of policy making and planning.

International engagement can facilitate developing new strategies and exchange of experience, as well as providing pressure to elevate issues on the national policy agenda, often bringing additional resources in the process. Such influence can also become disruptive and problematic in itself. Furthermore, bureaucratic and political restrictions and conditions on resources from international partners can lead to clashes between programme guidance and donor requirements. The test of the success of these processes over time will lie in how countries take charge of agendas and decide to allocate national resources.

To the extent that *it is not by virtue of association with HIV* that particular children deserve social protection (or legal protection or alternative care), we can also say *that it is not by virtue of HIV and AIDS that governments need to spend resources on social protection*. Clearly, HIV is only one out of many threats to families, livelihoods and children. Consequently, social protection generally holds no special a *priori* claim on resources for HIV and AIDS in most East Asian and Pacific contexts. Yet, better social protection, care and legal protection are required to meet the needs of many children vulnerable to, infected or affected by HIV and it will contribute to objectives in prevention and treatment as well as protection and care, if linked in the right ways for the right children. To the extent that it can be shown that HIV poses additional threats and economic impacts on children and families associated with HIV, additional resources should be defensible in the same way as for other crises.

Hence, AIDS specific resources may be better used in social service budgets:

  (a) to make human development and welfare services more sensitive to the special needs of these children, in order to ensure equitable access to social protection, alternative care, legal protection and other relevant HIV related services,

  (b) to provide for additional costs associated with impacts of HIV or problems raising vulnerabilities to infection and

  (c) to better link Care and Protection with other services at local levels for individual children and families and that those suffering poorer access are supported

Countries in East Asia and the Pacific have the challenge of designing and implementing a unified and comprehensive response to the needs of children vulnerable to, infected and affected by HIV. Such responses will be complex to mount and elaborate in low prevalence and dynamic settings. On the other hand, they have the opportunity to meet this challenge in ways that contribute to the overall response to the epidemic and at a cost far more manageable than would be required in a high prevalence setting. Furthermore, with histories of development orientations in social and economic planning, countries in the region are fairly well placed to design, update and integrate – or at least better link – social protection, care, legal protection heath and education in new, creative and sophisticated ways. In doing so, it will be important to engage and be guided by children, families and other individuals particularly vulnerable to and affected by HIV, but recognizing their resilience and seeing them as particularly resourceful and the key to solutions.

References

Alkenbrack S, Chettra T, Forsythe S. 2004. The social and economic impact of HIV/AIDS on families with adolescents and children in Cambodia. Ministry of Social Affairs and the POLICY Project

Asian Development Bank, 2003. At the margins: street children in Asia and the Pacific. Overview and best practice guide to assisting street children

Asian Development Bank, 2003b. Working with street children: exploring ways for ADB assistance

Asian Development Bank and UNAIDS, 2004. Asia Pacific's Opportunity: Investing to Avert and HIV/AIDS Crisis

Barnes C. 2003. Microfinance and Households Coping with HIV/AIDS in Zimbabwe: An Exploratory Study, Horizons, Population Council

Bauman L. J, Foster G, Silver E. J, et al. 2006. Children caring for their ill parents with HIV/AIDS. Vulnerable Children and Youth Studies 1(1):56-70

Bloom G, Edström J, Leach M, Lucas H, MacGregor H, Standing H and Waldman L (2007) "Health in a Dynamic World", STEPS Working Paper 5, STEPS Centre, IDS & SPRU

Booysen, F, M. Bachman, et al. 2004. The socio-economic impact of HIV/AIDS on households in South Africa: Pilot study of Welkom and Qwaqwa, Free State Province, University of the Free State and Centre for Health Systems Research & Development

Borthwick, P. 2003. 'Needs and responses: Children orphaned and made vulnerable by AIDS in the Mekong Subregion', in Lu, Y. and Essex, M. (eds.), AIDS in Asia, Springer

Brown L, Macintyre K, Trujillo, L. 2003. Interventions to reduce HIV/AIDS stigma: What have we learned? AIDS Education and Prevention 15(1):49-69

Busza J. 1999. Challenging HIV-related stigma and discrimination in Southeast Asia: Past successes and future priorities. Population Council/Horizons

Busza J., Castle, S. and Diarra, A. 2004. Trafficking and health. British Medical Journal

Carswell K, Ramage I, Richmond K. 2005. The psychosocial wellbeing of orphans and vulnerable children in the Thai/Cambodia border areas (Draft). CARE International

Choi K et al. 2003. Emerging HIV-1 epidemic in China in men who have sex with men. Lancet, 361(9375):2125-2126

Cluver, L. and Operario D. (Draft paper). Joint Learning Initiative on Children and HIV/AIDS. Learning Group 4: Social and Economic Policies

Cook S. and Kwon, H. J. 2006. Social Protection in East Asia: Economic Development and Social Protection in East Asia. Paper prepared by the East Asia Region Team for presentation at the launch workshop of the Centre for Social Protection, 23rd – 25th November 2006, Institute of Development Studies (IDS)

Deininger K, Garcia M, Subbarao K. 2001. AIDS-induced orphanhood as a systemic shock: Magnitude, impact, and program interventions in Africa (Draft). The World Bank

de Lind van Wijngaarden J. W. 2006. Literature review: Exploring factors and processes leading to HIV risk among the most vulnerable children and adolescents in Vietnam. UNICEF

de Lind van Wijngaarden J. W. 2007. Assessment of HIV/AIDS vulnerability, responses and STI/HIV prevention, care and support needs of institutionalized children aged 14 to 19 in selected labour and social education institutions and reform schools in Vietnam. UNICEF

Devereux, S. and Sabates-Wheeler, R. 2004. "Transformative Social Protection", IDS Working Paper 232, IDS

Devereux, S. and Sabates-Wheeler R. 2005. AIDS, Vulnerability and Social Protection, Institute of Development Studies, IDS

Devereux, S., Marshall, J., MacAskill, J. and Pelham, L. 2005. Making Cash Count: Lessons from cash transfer schemes in east and southern Africa for supporting the most vulnerable children and households, Save the Children UK, HelpAge International and Institute of Development Studies

DFID 2006. Using social transfers to improve human development. Social Protection Briefing Note Series, Number 3, DFID

D'Souza, C. 2008. Access to essential needs and services for orphans and children in poverty in Cambodia. Prepared for UNICEF East Asia and Pacific Regional Office (EAPRO)

D'Souza, C. 2008b. Orphans, Poverty and Access to Education in Thailand. Prepared for UNICEF East Asia and Pacific Regional Office (EAPRO)

D'Souza, C. 2008c. Access to essential needs and services for orphans and children in poverty in Vietnam. Prepared for UNICEF East Asia and Pacific Regional Office (EAPRO)

Dunn, A. 2004. HIV/AIDS: what about very young children?

East Asia and Pacific Regional Consultation on Children and HIV/AIDS, 2006. Background Paper. Scaling Up the Response for Children. Vietnam, 22-24 March

Edström, J., 2007. Rethinking 'Vulnerability' and Social Protection for Children Affected by AIDS. IDS Bulletin, 38:3; 101-105, Brighton: IDS

Edström, J., Roberts J. and Sumner, A. with Chamreun, C.S. 2008. Policy Process for Children and AIDS in Cambodia: Drivers and Obstacles, IDS Bulletin, 39: 5, Brighton: IDS

Edström, J. and Samuels, F. 2007. HIV, Nutrition, Food and Livelihoods in Sub-Saharan Africa: Evidence, debates and reflections for guidance. Report to DFID, June 2007, IDS/ODI

ESCAP, 2001. Sexually abused and sexually exploited children and youth in Pakistan: a qualitative assessment of their health needs and available services in selected provinces. United Nations Economic and Social Commission for Asia and the Pacific

Foreman M, Lyra P, Breinbauer C. 2003. Understanding and responding to HIV/AIDS-related stigma and stigma and discrimination in the health sector. Pan American Health Organization

Frank D. A, Klass P. E, Earls F, et al. 1996. Infants and young children in orphanages: One view from pediatrics and child psychiatry. Pediatrics 97(4): 569-578

Goodman R. and White, G. 1998. Welfare Orientalism and the Search for an East Asian Welfare Model in R. Goodman, G. White and H.J. Kwon (Eds.) The East Asian Welfare Model: Welfare Orientalism and the State. London: Routledge

Government of Vietnam. 2005. Plan on community-based caring for children with specially difficult circumstances, 2005-2010

Gruskin S, Tarantola D. 2005. Human rights and children affected by HIV/ AIDS. A Generation at Risk, Ch 5

Harvey, Paul; Slater R. and Farrington J. 2005. Cash Transfers – Mere 'Gadaffi Syndrome', or serious potential for rural rehabilitation and development? ODI NRP Perspective http://www.odi.org.uk/nrp/97.pdf

HEARD, 2005. Education Access and Retention for Educationally Marginalised Children: Innovations in Social Protection. Mobile Task Team (MTT) on the Impact of HIV/AIDS on Education, Health Economics & HIV and AIDS Research Division

Heijnders M, Van der Meij S. 2006. The fight against stigma: An overview of stigma reduction strategies and interventions. Psychology, Health & Medicine 11(3):353-363

Hesketh T et al. 2006. Risk behaviours in injecting drug users in Yunnan province, China: lessons for policy. Abstract CDD0591. XVI International AIDS Conference. 13-18 August. Toronto

Human Rights Watch, 2000. Owed justice: Thai women trafficked into debt bondage in Japan. Trafficking women into slavery and debt bondage: the case of Thailand and Japan

Institute of Development Studies, 2006. The importance of tackling childhood poverty

Institute of Development Studies, 2006. Social Assistance in Developing Countries (SADC)

Institute of Development Studies, 2006. Developing a Social Protection Index for Asia

International Federation of Journalists (n.d.). Telling Their Stories. Child rights, exploitation and the media International. Published by with support of the EC

International HIV/AIDS Alliance, 2006. Building blocks: Asia: briefing notes for communities working with orphans and vulnerable children

International Labour Organization, 2002. HIV/AIDS and Child Labour: Inequality Reinforces Child Labour and HIV Infection

International Labour Organization, 2006. Good practices in Asia: prevention and rehabilitation

International Organization for Migration, 2001. Combating trafficking in South-East Asia: a review of policy and programme responses

International Organization for Migration, 2007. Best practice in data collection on trafficking: learning from Cambodia, Indonesia, the Philippines and Thailand. International Organization for Migration

ILO-IPEC, 2000. Mekong Subregional Project to Combat Trafficking in Children and Women: Briefing note on trafficking in Greater Mekong Subregion. Bangkok

IPEC, 2002. Unbearable to the human heart. Trafficking in children and action to combat it. Programa Internacional para la Erradicación del Trabajo Infantil

Kacker L, Varadan S, Kumar P, et al. 2007. Study on child abuse: India 2007. Ministry of Women and Child Development, Government of India

Kelly M. J. 2006. The Response of the Educational System to the Needs of Orphans and Children Affected by HIV/ AIDS. Chap. 3. In: G. Foster, C. Levine, J. Williamson (eds.). A generation at risk: The global impact of HIV/AIDS on orphans and vulnerable children. Cambridge: Cambridge University Press

Levine, A. 2001. Orphans and other vulnerable children: what role for social protection? World Bank Human Development Network

Loudon M, Bhaskar M, Bhutia Y, et al. 2007. Barriers to service for children with HIV positive parents in 5 high prevalence states of India. UNICEF India, Government of India, Ministry of Women and Child Development, National HIV/AIDS Control Organization

Lu F et al. 2006. HIV/AIDS epidemic in China: Increasing or decreasing? Abstract MOPE0462. XVI International AIDS Conference. 13-18 August. Toronto

Lu L et al. 2005. Analysis of HIV/AIDS prevalence in Yunnan province. Journal of Chinese AIDS/STD Prevention and Control, 11(3):172-174

Lyytikainen, M., Jones, N., Huttly, S. and Abramsky, T. 2007. Childhood poverty, basic services and cumulative disadvantage: an international comparative analysis: Young Lives

Ma X et al. 2006. Possible rise in HIV prevalence among men who have sex with men (MSM) in Beijing. Abstract MOPE0526. XVI International AIDS Conference. 13-18 August. Toronto

Meintjes, H., Budlender, D. et al. 2003. Children 'in need of care' or in need of cash? Questioning social security provisions for orphans in the context of the South African AIDS pandemic, Children's Institute and Centre for Actuarial Research, University of Cape Town

Ministry of Health China, 2006. 2005 update on the HIV/AIDS epidemic and response in China. Beijing, Ministry of Health China, UNAIDS, WHO

Ministry of Health Indonesia, 2006. HIV/AIDS surveillance report. Jakarta

Ministry of Health Indonesia, Statistics Indonesia, 2006. Situation of risk behaviour for HIV in Indonesia. Results of BSS 2004-2005. Jakarta

Ministry of Health Indonesia, Statistics Indonesia, 2007. Risk behavior and HIV prevalence in Tanah Papua, 2006. Jakarta

Ministry of Health Viet Nam, 2005. HIV/AIDS estimates and projections 2005-2010. Hanoi, General Department of Preventive Medicine and HIV/AIDS Control, Ministry of Health

Ministry of Health Viet Nam, 2006. Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Viet Nam, 2005-2006. Hanoi

Ministry of Health Viet Nam 2007. HIV report. Hanoi

Ministry of Health Viet Nam 2007b. HIV/AIDS Country Profile. Hanoi

MOLSW and UNICEF, 2001. How I Got Here: The Commercial Sexual Exploitation of Children in Lao PDR

MOLSW, NCCAB and UNICEF, 2004. Orphans, Children Affected by HIV/AIDS and Other Vulnerable Children in Lao PDR

Monasch R, Stover J, Loudon M, et al. 2007. National response to OVCs in sub-Saharan Africa: The OVC Policy and Planning Effort Index 2004. Vulnerable Children and Youth Studies 2(1):40-59

National AIDS Programme Myanmar, 2006. Response to HIV & AIDS in Myanmar: progress report, 2005, Yangon. 2006

National Center for HIV/AIDS, Dermatology and STIs, 2007. HIV sentinel surveillance (HSS) 2006/2007: results, trends and estimates. NCHADS, Phnom Penh.

National Policy Forum Indonesia, 2005, Promotion of improved learning opportunities for street children in Indonesia. Education for street children in Indonesia

Niskanen, M. Draft Paper on Needs Assessment on Children and Adolescents Affected by HIV/AIDS in Lao PDR

Pearson, S. 2006. Underpaid, overworked and overlooked: the realities of young migrants in Thailand. Exploitation of young migrant workers in Thailand: Human Trafficking

Policy Project, 2004. Adolescent and youth reproductive health in the Asia and Near East Region: status, issues, policies, and programs: Policy Project, Futures Group, Washington

Policy Project, USAID, 2003. HIV/AIDS in the Mekong region: Cambodia, Lao PDR, Thailand, & Viet Nam: current situation, future projections, socioeconomic impacts, and recommendations

Pronyk, P. H. et al. 2006. 'Effect of a structural intervention for the prevention of intimate partner violence and HIV in rural South Africa: results of a cluster randomized trial.' The Lancet 368: 1973-1983

Rau, B. 2002. Intersecting risks: HIV/AIDS and child labour: Inequality reinforces child labour and HIV infection (International Labour Organization, 2002)

Reimer, K. 2006. At what price, honour?: research into domestic trafficking of Vietnamese (girl) children for sexual exploitation, from slums in Phnom Penh, Cambodia. Understanding trafficking and sexual exploitation of Vietnamese children in Cambodia: Human trafficking

Rivers, J, Silvestre E, Mason J. 2004. Nutritional and food security status of orphans and vulnerable children: Report of a research project supported by UNICEF, International Food Policy Research Institute, and World Food Programme

Sabrina, E. 2006. Sex trafficking in South Asia. International Journal of Gynecology & Obstetrics

Samson, M. 2008, Cash transfers for children in Papua New Guinea, DRAFT REPORT to UNICEF, Economic Policy Research Institute, Cape Town, 10 February 2008

Save The Children Australia, 2006. Small Also Have Something to Say. A Report onto the Effects of HIV/ AIDS on Children in Six Asian Countries. Save The Children, Australia

Save the Children UK, 2004. Children Affected By AIDS, Orphans and Impact Mitigation in China. Save the Children UK, China Programme, 2004

Save the Children, 2004. Food Security, Livelihoods & HIV/AIDS: Guide to the Linkages, Measurement and Programming Implications

Save the Children UK, 2003. A Last Resort: The Growing Concern about Children in Residential Care

Save the Children, 2001. Young people and HIV/AIDS: responding to the new Asian crisis. Collection of case studies from Asia describing child-focused HIV/AIDS projects

Scoones, I., Leach, M., Smith, A., Stagl, S., Stirling, A. and Thompson, J. 2007. Dynamic Systems and the Challenge of Sustainability, STEPS Working Paper 1, Brighton: STEPS Centre

Slater, R. 2004. The implications of HIV/AIDS for social protection, ODI for DFID

Solomon, C. 2004. Urban poverty, childhood poverty and social protection in China: critical issues. Childhood Poverty Research and Policy Centre

Sussman L. 2006. Providing support to children affected by HIV/AIDS and their families in the low prevalence countries of India and Cambodia: Programming issues. Policy Project/ USAID

Tanguay, P. 2007. The overlap between injecting drug use and sex work. Gender discrimination leaves women drug users in Asia at greater risk of HIV infection: Exchange

Thai Development Research Institute (TDRI), 2000. Social Impacts of the Asian Economic Crisis in Thailand, Indonesia, Malaysia and the Philippines, TDRI September 2000

The National HIV/AIDS Strategy 2007-2010 (Indonesia) National AIDS Commission 2007-2010 HIV and AIDS Response Strategies

The Quality Assurance Project and UNICEF, 2008. The Evidence Base for Programming for Children Affected by HIV/AIDS in Low Prevalence and Concentrated Epidemic Countries

Thomas de Benitez, S. 2007. State of the world's street children: Consortium for Street Children

Tobias D. 2000. Moving from residential institutions to community-based social services in Central and Eastern Europe and the Former Soviet Union. World Bank

Tolfree, D. 2005. Facing the Crisis: Supporting Children Through Positive Care Options

Tuan N. A et al. 2007. Human immunodeficiency virus (HIV) infection patterns and risk behaviours in different population groups and provinces in Viet Nam. Bulletin of the World Health Organization, 85(1):35-41

UN, 1989. Convention on the Rights of the Child. Geneva: United Nations

UNAIDS, 1999. Reducing Girls' Vulnerability to HIV/AIDS: The Thai approach: UNAIDS Best Practice

UNAIDS, 2004. The role of education in the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS

UNAIDS, 2006. 2006 report on the global AIDS epidemic. Geneva: UNAIDS, WHO 2006

UNAIDS, 2007. AIDS Epidemic Update 2007. Geneva: UNAIDS, WHO, 2007

"UNAIDS and UNICEF estimates 2006" (See UNICEF and UNAIDS. 2006)

UNAIDS, UNICEF and WHO. 2007. Children and AIDS: A stocktaking report. Actions and progress during the first year of Unite for Children, Unite against AIDS.

UNAIDS, UNICEF and USAID. 2002. Children on the Brink: A Joint Report on Orphan Estimates and Programme Strategies.

UN Asia-Pacific PMTCT Task Force, 2006. Consultation on Integrating Prevention and Management of STI/HIV into Reproductive Maternal and Newborn Health Services, Kuala Lumpur

UNDP, 2001. Population mobility and HIV/AIDS in Indonesia: UNDP South East Asia HIV and Development

UNDP, 2002. Mobile populations and HIV vulnerability: selected responses in South East Asia: United Nations Development Programme

UNESCAP, 2001. Sexually abused and sexually exploited children and youth in Pakistan: a qualitative assessment of their health needs and available services in selected provinces

UNESCO, 2003. Strengthening partnerships in education for children vulnerable to HIV/AIDS in the Mekong sub-region: Workshop for Government, UN, NGO, religious representatives and representatives of communities of HIV positive people providing education to children vulnerable to HIV/AIDS in Cambodia, Myanmar, Thailand and Viet Nam

UNESCO, 2003. For goodness sake!: Asia-Pacific faith-based organizations battle HIV/AIDS: How faith-based organizations are responding to HIV and AIDS: UNESCO for Asia and the Pacific

UNFPA. 2003. State of the world population. UNFPA

UNFPA. 2006. Investing when it counts. UNFPA

UNICEF, 2002. HIV/AIDS Education: A Gender Perspective

UNICEF, 2002b. The Increasing vulnerability of children in Nepal. UNICEF Nepal

UNICEF, 2003. Broken Promises Shattered Dreams

UNICEF, 2003b. Faith-Motivated Actions on HIV/AIDS Prevention and Care for Children and Young People in South Asia: A Regional Overview

UNICEF, 2004. The Framework for the Protection, Care and Support of Orphans and Vulnerable Children living in a world with HIV and AIDS. UNAIDS and UNICEF

UNICEF, 2004b. Children on the brink 2004: strategies to support children isolated by HIV/AIDS. Children orphaned by AIDS: response to a growing global crisis

UNICEF, 2005. A call to action: Children the missing face of AIDS. UNAIDS and UNICEF, New York, October 2005

UNICEF, 2006. Scaling up the response for children. East Asia and Pacific Regional Consultation on Children and HIV/AIDS, Hanoi, Viet Nam, 22-24 March 2006. UNICEF, 2006

UNICEF, 2006b. Children outside parental care in South Asian countries. UNICEF South Asia

UNICEF, 2007. Enhanced protection for children affected by AIDS. A companion paper to the framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS. New York: UNICEF, 2007

UNICEF, 2007b. Children affected by HIV/AIDS in South Asia: A synthesis of current global, regional and national thinking and research. UNICEF, South Asia Office

UNICEF, 2007c. Draft Paper on Policy Brief for Children Affected by AIDS: the Situation of HIV/AIDS in China

UNICEF, 2007d. Family and Children Affected by HIV and AIDS in Indonesia. Qualitative Study Report submitted to UNICEF. The Center for Health Research: University of Indonesia

UNICEF, 2007e. Family and Children Affected by HIV and AIDS in Indonesia. Executive Summary Report submitted to UNICEF. The Center for Health Research: University of Indonesia

UNICEF, 2007f. Regional Analysis Report: HIV and AIDS and Children

UNICEF, 2007g. State of the World's Children 2008 New York: UNICEF (December 2007)

UNICEF, 2008. Background paper: East Asia and the Pacific Regional Partnership Forum on CHILDREN AND HIV & AIDS, 31 March – 2 April 2008 Bangkok, Thailand, UNICEF East Asia and the Pacific Regional Office, March 2008

UNICEF, 2008b. East Asia and Pacific Regional Interfaith Consultation Meeting.Statement http://www.unicef.org/eapro/Statement_final.pdf

UNICEF, CIDA, et al. 2006. Child Protection and Children Affected by AIDS: A Companion Paper to The Framework

UNICEF, Ministry of Health Lao PDR. 2003. Street children and child beggars. UNICEF, Ministry of Labour and Social Welfare

UNICEF and SCF. 2007. Needs assessment on children and adolescents affected by HIV/AIDS in Lao PDR. UNICEF and Save the Children Fund (SCF)

USAID, POLICY Project. 2006. A closer look: The internalization of stigma related to HIV

USAID, Policy Project, 2003. HIV/AIDS in the Mekong region: Cambodia, Lao PDR, Thailand & Viet Nam: current situation, future projections, socioeconomic impacts, and recommendations. Policies to combat AIDS in the Mekong region

USAID, 2003. Trafficking of women and children in Indonesia. Literature review of trafficking in Indonesia

Van Griensven F et al. 2006. HIV prevalence among populations of men who have sex with men – Thailand, 2003

Viet Nam Commission for Population 2006. HIV/AIDS in Viet Nam. Ministry of Health, Population Reference Bureau

Vu Thuong N et al. 2007. Impact of a community sexually transmitted infection/HIV intervention project on female sex workers in five border provinces of Vietnam. Sexually Transmitted Infections, 83(5):376-382

Wattana S. and Suwanee, K. 2002. Long Term Socio-Economic Impact of HIV/AIDS on Children and Policy Response in Thailand. UNICEF: Thailand office

West, A. and Wedgwood, K. 2004. Save the Children UK, China Programme

WHO, 2000. Working with street children: understanding sexual and reproductive health including HIV/AIDS and STDs among street children. World Health Organization, WHO

WHO, 2006. Review of the Myanmar National AIDS Programme

WHO, 2007. HIV/AIDS in the South-East Asia region. March. New Delhi, WHO Regional Office for South-East Asia

WHO, 2007b. Ministry of Health Indonesia. Review of the health sector response to HIV and AIDS in Indonesia, 2007. Delhi

WHO, UNAIDS and UNICEF. 2007. Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector. WHO, UNAIDS, UNICEF

Wiesmann, D. 2006. Global Hunger Index: basis for cross country comparison. International Food Policy Research Institute, 2006

Wilson D, 2006. HIV Epidemiology: A Review of Recent Trends And Lessons. Global HIV/AIDS Program, World Bank

Wijngaarden, J. and Shaeffer, S. 2005. The impact of HIV/AIDS on children and young people: reviewing research conducted and distilling implications for the education sector in Asia. Asia and Pacific Regional Bureau for Education: UNESCO Bangkok

World Bank, 1999. Thailand Social Monitor: World Bank Office, Thailand, 1999

World Bank. 2002. Education and HIV/AIDS: A window of hope. World Bank

Worthington, R. 2007. Faith-Motivated Actions on HIV/AIDS Prevention and Care for Children and Young People in South Asia: A Regional Overview: UNICEF

Reconciling alternative framings of vulnerability

As discussed in chapter 3, there are at least three dichotomies – or axes – inherent in vulnerability related to a health problem like HIV and AIDS, which are rarely brought together (Edström, 2007, Bloom et al., 2007), namely:

- vulnerability has different senses in relation to the causal path before during and after the period of stress – before, during and after the 'event', as it were.

- vulnerability for specific children's or adults' (with susceptibilities and sensitivities) arises in their *relation to contextual factors* or sources of disadvantage, moderating their risk of exposure or experience of ill health or further impacts, in complex ways

- vulnerability and resilience are *inter-related* and vulnerable children are at the same time resilient actors (exhibiting resistance and responsiveness) in their own spheres

The sense vulnerability related to HIV is given by consideration of the causal pathway of HIV, with the implication that the two senses traditionally used by public health actors – vulnerability 'to being exposed' – versus the sense typically used by development actors and economist – vulnerability 'to the effects of' shocks, coexist despite the different sides seeing the problem in different ways. Both are in fact partial appreciations and both are missing the 'bit in the middle', by taking a one-sided perspective. As is becoming clearer with anti-retroviral (ARV) treatment extending the life-span of those infected over many years, the concept of a 'transient shock' underlying many definitions of vulnerability (in development and social protection in particular) has become less and less useful. Instead, we need to separate HIV infection from eventual health outcomes in relation to morbidity and mortality (outcomes impacting particularly on children affected). This is one strong reason to move away from earlier conflations of the issues and to not use short-hand terms like "HIV and AIDS", but instead being more specific of what we actually mean. As HIV is not a short-term transient event, vulnerability related to the virus has different senses in relation to the causal path 'before', 'during' and 'after', as it were. This then relates directly to approaches for (i) primary prevention, (ii) for treatment and (iii) for the protection and care of children and relations.

Vulnerability is a relational concept and its meaning refers to a person's (or unit's) relationship to various disabling factors or sources of disadvantage in a particular 'context'. Context is a treacherous concept in itself, however. Contexts are not only complex in terms of those factors interacting across different domains – such as inter-personal, economic, socio-cultural, political and institutional dimensions of the environment – but also because processes and dynamics operate across levels of aggregation and at more or less causal proximity to the individual. These different complexities easily get confused and models of proximal-to-distal levels of the context can readily suggest deterministic hierarchies of proximate-to-distal causes or effects, while knowledge of the realities of processes and interactions across spheres is limited by disciplinary boundaries and different ways of framing reality (Scoones et al., 2007). The model of levels of context can also easily lead to very passive as well as static understandings of vulnerable people. Levels can suggest 'protective layers', as on a growing onion or bark and fences around tree trunks, which may be appealing metaphors for child protection. While relatively more applicable to in-vitro foetuses, new-borns and infants, children have an uncanny ability to progressively interact with – and impact – their environments as they grow up. Situations and contexts also change (change being the only constant) and vulnerable people may respond by changing their context and migrate. Contexts change and people change contexts (in more ways than one): Vulnerabilities dynamically change in the process.

In the sense that something is defined not only in relation to what it is, but also to what it is not, vulnerability can only be understood properly by also referring to resilience. While in a sense opposites, the two coexist dynamically as in the example of migration being, on the one hand, a resilient response to threats or vulnerability, but also resulting in new vulnerabilities, such as to HIV infection. Some of the most vulnerable children, such as children on the street or those who migrate for work, are responding to threats and stress in resilient ways, and learn to become resourceful in the process, while their new contexts may make them vulnerable in multiple new ways. Solutions based purely on passive notions of child vulnerability fail to exploit the potential of their agency and resilience; solutions must be tailored to the specific needs as well as to the potentials of the child.

As the concept of vulnerability is somewhat complex in itself, it is not surprising that this has resulted in inconsistent usage. Figure A1, below, may help us retain the above three aspects of vulnerability in relation to HIV.

Figure A1: A model of vulnerability
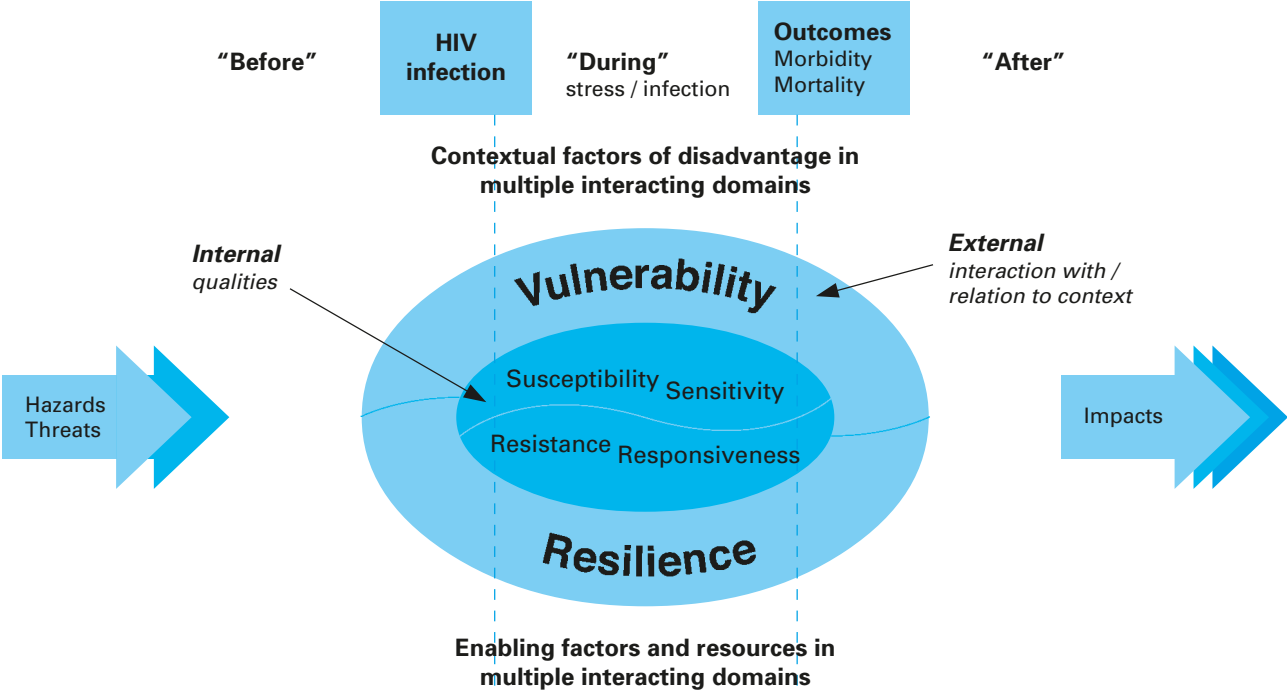
It is important to underscore that notions of vulnerability should not over-determine the relation of vulnerability to the risks and threats presented to children by HIV. We should recognize how vulnerabilities play out differently and are experienced in relation to social and physical interactions, such as for example with parents, sexual partners, sex workers, drug users.

Children made vulnerable by work

Analyses of the socioeconomic relationships between child labour and HIV risk can provide greater impetus to national and local responses to target factors that expose children to hazardous work which have, until now, been treated largely as separate and independent issues. Both responses to, and research into, children's vulnerability (to and by) HIV and AIDS are hindered by unregulated flows of migrants, which results in people who are frequently unregistered, working illegally in foreign countries, and difficult to reach and research. Urban development and rural unemployment results in significant rural-urban migration in Indonesia, for example (Indonesia NAC, 2007). Regional improvements to transport infrastructure have facilitated population mobility and transnational migration is common in Myanmar, Lao PDR and Cambodia which are source countries for migrant labour to Thailand (Pearson, 2006). Many migrants travel to work in the industrial and construction sectors which are dominated by male workers, while the domestic-help market is dominated by female workers. The gendered nature of these markets increases the likelihood of people engaging in high-risk behaviour. Although the sex industry is not the destination of many migrants, some others end up in it by intent, unwittingly or through coercion (IOM, 2007). In East Asia and the Pacific, internal and international migration has accelerated the spread of HIV and AIDS.

According to the World Health Organization (WHO, 2001) the sex industry (prostitution, pornography, sex tourism) in Asia accounts for up to 14 per cent of gross domestic product in Indonesia, Malaysia, the Philippines, Thailand and Japan. Wherever economies are liberalized the sex industry can flourish as a domestic market, leading to new waves of increased prostitution, for example as has recently been occurring in China, and Vietnam (EAPRC, 2006). Studies on child prostitution, for example in Lao PDR (MOLSW, 2001), Thailand (UNAIDS, 1999), the Philippines (IPEC, 2002), Indonesia (National Aids Commission, 2007), Vietnam (ref) and Cambodia (Reimer, 2006), have pointed to a range of health issues and other common problems associated with child sexual abuse and sexual exploitation, as well as to the high demand for children. According to Pearson et al., however, child prostitution is an extension of the adult sex trade and determining the age of child prostitutes is often very difficult (Pearson et al., 2006). The majority of clients are local men and the majority of sex tourism, which involves a greater proportion of foreign men, is intra-regional. Figures for child prostitution are largely unavailable and studies on the commercial sexual exploitation of children have neglected to analyse HIV perspectives or, where they have, focussed on children who are vulnerable to HIV infection rather than those infected or affected by HIV and AIDS. While research has charted pathways of risk to prostitution for girls (premature sexual relations, sexual coercion, rape, incest and domestic violence in the family) the evidence for boys is not equivalent, for example, by studies of boys' pathways to prostitution conducted on South Asia (ESCAP, 2001), South America or Europe.

Child migration and trafficking

Children migrate or are trafficked for a wide range of service, industrial and agricultural work, as well as to beg and hawk on the streets, or into the sex sector. As the IOM (2007) points out, it is important to distinguish between child migrants (children who migrate independently or accompanied, legally or illegally) and trafficked children (children who have either never consented to migrating for work or, if they did consent initially, that consent has become meaningless due to the deception and abuse they suffer). The International Labour Organization (ILO, 2006) estimates that children make up 40-50% of the 2.45 million persons trafficked for forms of exploitative labour including sex work and sex tourism globally. However, as the IOM has cautioned, figures for trafficked people are very difficult to estimate reliably (IOM, 2007). From Southeast Asia some 220,000 – 225,000 women and children may be trafficked annually (IOM, 2001). Most trafficking occurs *within* Southeast Asia, and only a minority of women from the region are trafficked to other parts of the world. UNICEF has built a profile of those most at risk of trafficking in Lao PDR in a report that found that an overwhelming majority of trafficked people surveyed (60%) were girls aged between 12-18 years of age and the largest group by occupation (35%) end up in prostitution (2003). Other forms of employment were domestic labour (32%), factory work (17%), and fishing boats (4%). Those that worked in agricultural labour tended not to be trafficked and exploited, while those working in domestic household situations experienced some of the most extreme cases of abuse and mistreatment. The majority of cross-border trafficking was found to occur into Thailand, although some cases were reported of trafficking into Myanmar and China for the purposes of buying and selling brides.

Ethnicity is also a factor that requires consideration as ethnic groups may be over-represented in prostitution. The Ministry of Labour and Social Welfare (2001) in Lao PDR found significant numbers of children working in places of prostitution. In terms of ethnicity, the majority of girls they surveyed were from the northern provinces; while their education levels were slightly lower than the national average, most girls had attained reasonable levels of education. While girls from this ethnic group are at high risk of HIV infection, the study provided no data on HIV or, despite the significance of gender, a discussion of boys. Similarly, in a study of families and children affected by HIV and AIDS in Indonesia, UNICEF urged the importance of analysing recruitment to prostitution by ethnicity, particularly in West Kalimantan (2007).

In one study of the sexual exploitation of Vietnamese girls in Cambodia, Reimer found that major risk factors, occurring within a context of general poverty and which induce families to sell their daughters for sexual exploitation include: crisis/extra-ordinary expenses, debt, the phenomenon of 'normalizing' child prostitution, materialism, family honour and cultural perceptions of women (2006). In China, children from Yunnan Province are trafficked into the sex sector in Thailand through Lao PDR and Myanmar (ILO-IPEC, 2000). Although much trafficking is domestic, exploitation may be progressive and children trafficked into one labour context can end up being abused sexually. IPEC found in the Philippines and in Indonesia that children who migrate to work in restaurants, bars, and cafés in the tourist industry or in cities ended up in commercial sexual exploitation (2002). They attribute much of the problem of trafficking in children for sexual purposes to the lack of law enforcement and a culture of impunity.

Children and drug use

Overall, there is very limited quantitative evidence on the intersection between children, HIV and drug use. Children of drug users and child drug users are at risk of HIV infection but also of increased vulnerabilities to poverty, dropping out of school, drug use and to hazardous form of child labour including prostitution. As Rau points out, in some instances, contextual factors run parallel; in others, they intersect, thereby putting working children at greater risk of HIV infection or of suffering the consequences of infection (2002). According to Rau, factors that contribute to greater incidence of child labour in many developing countries include increasing numbers of orphans, a lack of access to education, health and other welfare systems to care for them, as well as HIV caused illness and poverty in families. Additionally, orphans are more likely to be sold as sex workers, and poverty and child entry into sex work are linked; children forced into labour by poverty or the circumstances surrounding HIV infection are more vulnerable to sexual exploitation and to contracting HIV themselves.

In terms of the intersection between drug use and HIV, Tanquay (2007) argues that women drug users in Asia have a higher risk of HIV infection than their male counterparts. The article draws on research from a range of Asian countries which shows that while the number of women drug users is low, they are disproportionately at risk of HIV infection because many women drug users are also sex workers. Many poor women have fewer educational opportunities and are more vulnerable to discrimination, abuse and trafficking. Their dependence on male partners for the supply of drugs leaves women drug users vulnerable to unsafe sex and leads to greater use of shared needles. The study does not include statistics or information on the breakdown between age as well as gender.

The National AIDS Commission of Indonesia (2007) identifies injecting drug use as a significant issue for children and young people, and highlights concern over the increase in the numbers in Indonesia. The problem is exacerbated by a lack of concern about HIV and AIDS, as revealed by a 2002 behavioural survey, which found that two-thirds of injecting drug users who said they were not at risk of infection also said that they had used contaminated injecting equipment in the week prior to the survey. In Lao PDR, Niskanen (forthcoming) identified that children affected by HIV were more likely than other children to have a lack of information about HIV and AIDS, and to be smoking cigarettes and use alcohol more. There were also greater misunderstanding among girls than boys.

Orphans and children in alternative care

UNICEF (March 2008) estimates that in various countries across the East Asia and Pacific region, orphans represent between 5-10% of all children (for example, Cambodia 9%, China 6%, DPR Korea 10%, Indonesia 8%, Lao10%, Malaysia 5%, Mongolia 8%, Myanmar 9%, Pacific 10%, PNG 9%, Philippines 6%, Thailand 7% and Viet Nam 7%). There is a limited breakdown of figures on orphans and HIV exposure in low-prevalence countries, and controversies over classifications of vulnerability in relation to orphans. In terms of evidence, Niskanen (forthcoming) found that more than 50% of children in HIV families in Lao PDR were orphans. More than 50% complained of inadequate support regarding drug assistance, homecare services, food assistance, education assistance, vocational training assistance and access to medical treatment was a priority. Information about HIV was inadequate and girls displayed greater misunderstanding. Smoking cigarettes and alcohol use was also more common among AIDS orphans. UNICEF (2007) reports that the numbers of AIDS orphans is increasing in certain high prevalence townships in Myanmar. Although communities and individuals provide significant support to orphans and vulnerable children, and a range of religious institutions and clergy are involved, there remains a lack of attention and information about the numbers, location, situation and needs, and very few advocates for a largely hidden population.

There is substantial evidence across the region to show that the majority are being cared for by grandparents and extended families. In Cambodia Edström et al (2008) report an estimate of around 570,000 orphans, but they cite difficulty in obtaining estimates on how many children have lost one or both parents because of AIDS, or the total number of children affected by HIV and AIDS. However, the number of children displaced and orphaned is rising, as are the numbers of child-headed households. While extended families and local communities offer support and alternative care to the majority of children, many households are experiencing difficulty in meeting their basic needs and find it impossible to take in extra children. Much of the burden of caring for family members with HIV or AIDS falls on children or affects their access to protection, care and support. While other, more formal placement options exist at the community level, through nongovernmental fostering schemes and temporary group homes, as well as government-run orphanages, recourse to them for large numbers of orphans has been hampered by material, human resource, and logistical constraints. Adoption, although legally supported in most countries, has not benefited large numbers of orphans either, often because of cultural biases against adoption and legal or bureaucratic impediments. Furthermore, HIV-positive orphans are less willingly accepted in a variety of placement settings and may incur greater health care costs for their caretakers.

These findings for Cambodia are supported by a regional review of the situational findings on placement by the QAP and UNICEF (2008). This review found strong evidence that the majority of HIV and AIDS-affected children live with HIV-positive parents, that children orphaned by AIDS are largely and informally fostered by extended families, that grandparents are often caretakers of orphans from AIDS and that informal fostering can lead to household welfare loss. Furthermore, non-institutional placement options are less commonly used and mired by legal constraints; HIV-positive children face greater barriers to placement than other orphans and vulnerable children and fostered children may experience discrimination and abuse in non-kin households. Lastly, the review identified gaps in the information available on the adequacy of current caretaking situations, on youth living outside of adult care and on orphans living with siblings.

Street children

The ADB (2003) categorizes street children as children who "might transit to the street, live on the street, or children who previously lived on the street, with a variety of occupations, including beggar, rubbish picker, shoeshine boy or flower seller, sweat shop worker, sex worker, petty criminal, etc". While some major characteristics of street children include homelessness, separation from family, being out of school, of work and in poverty, not all street children possess these traits (ibid). Some problems facing street children include homelessness, exploitation, abuse, health difficulties, control by adult gangs, problems with the law, a lack of education and of identification papers (WHO, 2000). The experiences of street children overlap with other categories of children, such as those who are involved in exploitative work and sex work. Notwithstanding controversies over definition, *all* street children are vulnerable to sexual and reproductive health problems; their vulnerability in general as well as to HIV is increased by their lack of knowledge, skills and access to appropriate services (WHO, 2000).

The Asia and Pacific region has varied economies and political systems that provide different contexts for the reasons why children come to the streets, the problems they face on the street and their prospects for moving on from the street. The Asian economic crisis of the late 1990s for example, resulted in increased rates of suicides, orphans, divorce and crime. The World Bank (1999) reports that in Thailand the number of infants abandoned after birth increased during the crisis, as did the numbers of children placed in orphanages, becoming drug users and sellers or becoming street children. The migration of children creates different sets of formal and informal international linkages between countries. While the numbers of street children are not known, conservative figures indicate that there are millions of street children in the region (ADB, 2003). Through exploitation, street children are also at risk of drug or other substance abuse as well as HIV. In situations where children are affected by HIV and AIDS, extended family support systems are breaking down, with the result that children are left heading households, or orphaned, or homeless and left to fend for themselves on the streets (UNICEF, 2002). In Lao PDR, MOLSW and UNICEF found an association between difficult family situations and an increased risk of abandonment, runaways, orphans and children living with non parents and on the streets (2007). They report that girls in one-parent families or families with a stepfather were most vulnerable to commercial sex exploitation, although they reported no data for boys. Despite what we know about the increased vulnerability of children affected by HIV and AIDS to spiralling cycles of poverty and to disrupted family circumstances, there is little evidence for the linkage between HIV and street children in Asia.

The Asian Development Bank has reported that most street children across the region are boys and highlighted the immediate dangers facing them of sex abuse and violence from the public, the authorities, and other street children (ADB, 2003). This gender patterning is not replicated across individual countries, as in the Philippines 30% of street children are girls whose vulnerability centres (in similar ways to boys) around sexual abuse and exploitation, rape, unprotected sex, pregnancies and sexually transmitted diseases (CRB, 2003). The ADB report draws attention to the issue of children who are exploited through various forms of work across all parts of the region and argues that child sex work and the sex trafficking of children needs to be seen as, and linked to, the general question of child labour. Much of the work undertaken by street children falls under the purview of the ILO Convention on the Worst Forms of Child Labour and much of street children's lives is structured around work, and shifting to different means of survival or opportunity. A key issue for street children is their exclusion from much of everyday social life. Lacking identity papers, they are prevented from gaining access to education and health services and from subsequently registering the birth of their own children.

Evidence on psycho-social needs

Cluver (forthcoming) has expressed concern about the very limited evidence on pathways for increased HIV risk among children in families affected by AIDS. In terms of physical and psychological health Cluver suggests that risk is most likely occurring on multiple levels, rather than through one predominant factor. Risk factors relate to the impacts of poverty and HIV-related stigma and occur around the risk of infection through caring for AIDS-affected family members, malnutrition, reduced access to healthcare, reduced access to sex education and HIV education.

In a study of psycho-social well-being in Lao PDR, Niskanen (forthcoming) found that children and adolescents in general exhibited low prosocial behaviour problems, but high levels of emotional symptoms and problems in peer relations and, interestingly, there were no significant differences between the HIV-affected and the control group. Children's well-being overall was connected with their guardian's educational level, economic circumstances, domestic duties and gender, and with support from outside family. Of the nine knowingly HIV-infected children in the sample, all were at school. The report concludes that in Lao PDR, HIV and AIDS-affected children are affected primarily through economic difficulties and orphanhood, and that stigma and discrimination in Lao PDR were relatively low.

Being affected by HIV and AIDS carries with it a range of psycho-social impacts for children. These may be experienced in great severity or minimally. Cluver (forthcoming) has identified a risk to children affected or infected by HIV of contracting mental health problems, including clinical-level mental health problems through internalizing their problems, or through the use of drugs and alcohol. When caregivers or parents are stressed, this can also affect their capacity to parent and result in domestic violence and the physical abuse of children, all of which have been reported for households with HIV.

Loudon et al found substantial evidence that children affected by HIV and AIDS are more vulnerable to psychological problems than unaffected children (2007). The range of problems include "recent" anxiety disorders, "lifetime" anxiety disorders, post-traumatic stress disorders, feeling more worried, stressed, or disliked, getting into more trouble than usual, mental distress torment, increased sadness, despair, and loss of confidence, feelings of loneliness, depression, insecurity, and worthlessness, especially amongst those who had lost a parent, a lack of love and care from community elders, relatives, and friends, and shame and rejection. However, affected children may not always have greater needs than unaffected children. The QAP and UNICEF found that HIV and AIDS-affected children of different ages (pre-adolescent and adolescent) face different challenges, and that children living in HIV-affected households rate their quality of life as lower (Cambodia). However, the review identifies a number of gaps in the evidence from low prevalence and concentrated epidemic settings; on the psycho-social impact across stages of illness, caretaking situations, and social/cultural contexts and the role of extra-familial support.