Protection and resilience: A simple checklist for why, where and how to coordinate HIV and child protection policy and programming

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0. Introduction

This short checklist has been developed in response to the call from many practitioners, especially those working in HIV and AIDS affected countries, for practical guidance on *how* to link HIV and child protection policy and programming.

There is a strong, and growing, body of evidence showing that **achieving an AIDS-free generation requires protecting children and adolescents affected by or living with HIV from abuse, violence, exploitation and neglect and protecting child survivors of abuse, violence, exploitation and neglect from HIV**.

Global evidence on HIV and child protection linkages[1]

Children affected by HIV

- Children living with HIV have improved treatment outcomes when their psychosocial needs are met by caregivers or others. Stigma and neglect or abuse as a result of HIV can and does negatively impact the psychosocial wellbeing of children and make it harder to avoid or recover from abuse, violence or neglect.
- Children orphaned by AIDS or living with HIV-positive sick caregivers face an increased risk of physical and emotional abuse as compared to other children in sub-Saharan Africa, including other orphans.
- Children who are orphaned or are caregivers to an AIDS-sick person have higher rates of transactional sex or increased (unsafe) sexual activity and/or sexual abuse.
- Children orphaned by AIDS have around two times the likelihood of having HIV than their non-orphaned peers.

Children who experience protection violations

- In high HIV prevalence contexts, a high proportion of adults living with HIV experienced sexual, emotional or physical abuse in childhood, suggesting that early experience of abuse increases the risk of an adult getting HIV.
- Across all regions, childhood sexual abuse is linked to higher rates of sexual exploitation and other HIV risks, such as earlier initiation into injecting drug use, sex work and living on the streets.
- Children living in extended family care or outside of family care (e.g., in residential care or on the streets) disproportionately experience discrimination within the home or other environment as well as neglect, exploitation and psychological, sexual and physical abuse.

Caregivers affected by HIV or unable to protect children from abuse, violence, exploitation and neglect

- Caregivers of AIDS-orphaned children have higher rates of depression than other caregivers in sub-Saharan Africa; this leads to increased mental health and behavioural problems in children under their care.
- Adults living with HIV face unique challenges in providing a protective and caring environment for their children, especially where services are limited. HIV stigma hampers interventions to support parents and caregivers to have positive outcomes for the whole family.

Positive experiences in promoting resilience

- Interventions that focus on building up individual, family and community resilience and supporting existing protective factors show that it is possible to stop the vicious cycle of escalating risk and harm.
- The biggest impact on reducing risky sexual practices amongst adolescent girls in heavily HIV-impacted countries is a *combination* of economic support and social welfare support.

[1] Long, S and Bunkers K. (2013) Building protection and resilience: synergies for child protection systems and children affected by HIV and AIDS. For the IATT on children and HIV and AIDS; Long S & Bunkers K. (2015) Prevent and protect: linking the HIV and child protection response to keep children healthy, safe and resilient.

Below are some questions to ask during the development and refinement of policies, as well as the design and implementation of programmes. These questions seek to ensure that children's HIV and child protection needs are more closely and consistently coordinated, addressed and met. These questions can be used as a starting point for further dialogue and coordinated action. The questions are designed to help Identify key entry points where linkages are possible as well as gaps within existing policy and programming where creative and sustainable solutions can be developed.

1. Policy

HIV and child protection intersect along the whole continuum of HIV care from prevention through treatment to care and support of people living with HIV and their families and communities. It is the responsibility of all actors to ensure that a comprehensive policy framework addresses all vulnerabilities and that no children fall through the cracks. This can only be addressed when a multi-sectoral approach is taken, both within policy as well as in practice. Key sectors include, but are not limited to, health, education, social welfare and protection, gender and justice.

A comprehensive policy framework to address HIV and child protection outcomes can stimulate multi-sectoral collaboration (e.g., through a national OVC plan or a Children's Act) can maximise investment in a comprehensive child protection workforce. It identifies all relevant actors and holds them accountable. It further enables different sectors to coordinate and monitor and report within one framework and work towards mutually supportive objectives.

✓ **Questions: Is the development and oversight of national HIV policies handled through an effective coordination mechanism (such as a working group, committee or task force) engaging the key sectors mentioned above? Does the work of that coordination mechanism cover prevention, care and support? Are child protection actors included in that coordinating mechanism? Does policy seek to achieve objectives and outcomes in both HIV and child protection for the same group of children?**

2. Multi-sectoral planning and service design

Case management[2] and referral mechanisms are the 'glue' that binds populations affected by HIV and services, including child protection. Case management systems ensure that children are treated holistically, and recognize that they can be at risk of or experience multiple adversities.

✓ **Questions: Do national HIV and child protection strategies, budgets and planning procedures clearly articulate how to identify, support and refer children and adolescents to available programmes and services that address HIV and child protection concerns? Is there a related case management system in place? If so, does it include clear and appropriate regulations, guidelines and procedures, and are effective monitoring systems part of the system?**

[2] Case management can be understood as the process of identifying, assessing, planning, referring, monitoring and following up the delivery of services in a timely, context-sensitive, individualized and family-centered manner. It is conducted in a collaborative manner with the client unit—in this case the child and household. It is strengths-based, coordinated to reduce gaps in services and utilizes problem-solving and empowering approaches. Ideally, case management should build on the existing resources and strengths of the client, to help inform decisions about what interventions or services clients require, who can provide them, at what intensity, and for how long. It improves coordination and integration between and amongst different sectors, facilitating the delivery of multiple services.

3. Measuring and evaluating

The linkages between HIV and child protection can only be properly understood if monitoring and evaluation (M & E) systems include indicators for both HIV and child protection, including violence, exploitation, abuse and neglect of children. A robust case management system that makes linkages between HIV and child protection can be used to identify and document the synergies, as well as to enable integrated reporting. Key actors should also examine how evidence-building strategies can be developed on HIV and child protection that can support the goal of an AIDS-free generation in the country.

✓ **Questions: Does the national or project level M & E system collect and analyse data on both HIV and child protection? Are key child protection and HIV outcomes measured, e.g., reduction in forced or coerced sex for adolescents, increased support to HIV affected care givers, and HIV related support to children in alternative care? Are robust national studies underway or completed that can provide lessons on how to address HIV and child protection concerns, and in particular show how addressing each concurrently provides synergies that support objectives in each sector?**

4. Managing the workforce

The social service and health workforces, especially at the community level, are often the first point of contact for children and families affected by HIV and/or child protection concerns. However, HIV and child protection workers are often not based in the same place, do not report to the same managers and do not attend the same meetings. Proactively bringing health/HIV and social welfare workers together can increase identification of HIV-affected and/or abused/neglected/exploited children and improve service delivery and follow up care and support.

✓ **Questions: Do staff working directly with children and adolescents have basic training in child protection (if they are part of the HIV and health workforce) or training in basic HIV prevention, care and treatment (if they are part of the social welfare/child protection workforce)? Are there clear SOPs in place for both workforces in how to identify and refer children to child protection or health colleagues? Do community-based staff have opportunities to meet and are encouraged to do so by their respective supervisors? Do all staff have an understanding of how HIV-related stigma affects the children and families that they work with?**

5. Engaging children and youth

Engaging children and adolescents and youth, especially those directly affected by or living with HIV in all phases of programming provides critical understanding and empowerment that can reduce stigma and discrimination. This can improve both child protection and HIV outcomes. It is important that the workforce that is mandated to work with children and adolescents have the skills, tools and knowledge to proactively and safely engage children and are empowered by their supervisors to do so.

✓ **Questions: Are mechanisms in place for the meaningful involvement of children and youth affected by HIV and child protection issues during policy and program design, implementation and monitoring and evaluation? Are there means to support this effort in an ethical, child friendly and appropriate manner?**

6. Reaching children of different ages and facing different challenges

Children of different ages experience issues, shocks and vulnerabilities differently. Children living in different situations, or facing challenges such as disability, family separation or other factors, need different forms of support. For example, children who are abused or neglected at home are much less likely to be supported by their caregivers to get tested for HIV, receive treatment if they are HIV-positive, or be supported for treatment adherence and receive other needed care. Many challenges faced by children affected by HIV or child protection concerns are caused or made worse by stigma and discrimination, HIV-related or otherwise.

One of the challenges that vulnerable children mention most, and would most like to make better, is good communication between children and their caregivers. Talking with and listening to children – and helping their families to do so also – is essential for understanding the challenges and barriers that children face.

✓ **Questions: Do available programmes address in a comprehensive way the different needs of different vulnerable children, such as children with disabilities, children with all forms of gender identity and sexual orientation, children engaged in activities such as drug use or sex work? Are programs designed differently for different ages of children? Do programmatic interventions address and support caregiver-child communication including positive disclosure, bereavement, sexual health and stigma?**