



A report for UNICEF and World Vision International
Siân Long and Kelley Bunkers
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Prevent and protect: Linking the HIV and child protection response to keep children safe, healthy & resilient

Promising practices: Building on experience from Nigeria, Zambia and Zimbabwe

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Authors: Siân Long and Kelley Bunkers.

Other contributors: Patricia Lim Ah Ken, Stuart Kean, Denise Stuckenbruck and Amandine Bollinger.

Senior Editor: Heather Elliott. Production Management: Katie Fike, Daniel Mason.

Copyediting: Joan Laflamme. Proofreading: Audrey Dorsch. Design and Interior Layout: Alice Contreras.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
CABA	Children Affected by HIV and AIDS
CATS	Community Adolescent Treatment Supporter
CCABA	Coalition for Children Affected by HIV and AIDS
CCW	Case care worker
CHAMP	Comprehensive HIV/AIDS Management Programme
CMO	Case management officer
CRC	Convention on the Rights of the Child
CSO	Civil society organisation
DHS	Demographic Household Survey
ECD	Early childhood development
ESARO	Eastern and Southern Africa Regional Office (for UNICEF)
FGD	Focus-group discussion
GBV	Gender-based violence
HCT	HIV counselling and testing
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team
LGBTI	Lesbian, gay, bisexual, transgender, intersex people
MVC	Most-vulnerable children
MoH	Ministry of Health
MoPSLSW	Ministry of Public Service, Labour and Social Welfare
NAC	National AIDS Commission
NAP II	National Plan of Action for Orphans and Vulnerable Children II
NGO	Non-governmental organisation
NPA	National Plan of Action
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan For AIDS Relief
PLWHA	Person living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
PSS	Psychosocial care and support
SMS	Short message service
STI	Sexually transmitted infections
UNAIDS	United Nations Joint Programme for HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCARO	West and Central Africa Regional Office (for UNICEF)
WEI	World Education, Inc.

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Background

Child protection has been an integral part of programming for children affected by AIDS over the past 10 years, and this has been reflected in global guidance documents such as the OVC Framework in 2004 and Taking Evidence to Impact in 2011. Resources from HIV programmes have contributed to the strengthening of child protection systems, both formal and informal. The agenda for strengthening child protection systems has also pushed programmes for children affected by AIDS to move from a stand-alone HIV focus to programming that focuses on multiple vulnerabilities, including HIV.

With significant attention being placed on child protection systems strengthening comes a need to also show how this affects HIV results. This need is reflected in 'Protection, Care and Support for an AIDS-Free Generation: A call to action for all children',¹ issued at the 2014 Global Partners Forum in Melbourne. The policy and programming challenge is how to address the child protection issues that have a unique impact on children affected by HIV in a way that also strengthens sustainable systems.

In 2013 the Inter-Agency Task Team (IATT) on Children and HIV and AIDS undertook an analysis of evidence on how child protection systems and services affect HIV and AIDS, and vice versa, and provided recommendations on how the different sectors – child protection and HIV – could work closer together to improve each other's outcomes. The paper 'Building Protection and Resilience: Synergies for child protection systems and children affected by HIV and AIDS'² provided a first-step framework for cross-sectoral collaboration and a set of recommendations on building synergies.

The next step was to provide practitioners with actual lessons learnt and models of how synergies have been made in practice in specific countries. This report documents these models, case studies and lessons learnt in an effort to showcase practical ways in which child protection systems and services link to HIV services to benefit HIV and child protection outcomes for children. This report is a first step in documenting these lessons. It is not an exhaustive compilation of all interventions, nor does it document all evaluated programmes. The intention is that the report will stimulate policymakers and programmers to consider interventions that link across sectors and to support implementation and evaluation of these interventions.

¹ UNICEF, PEPFAR, UNAIDS, et al. (2014), *Protection, Care and Support for an AIDS-Free Generation: A call to action for all children*. [http://childrenandaids.org/css/GPF-2014-Call-to-Action\(1\).pdf](http://childrenandaids.org/css/GPF-2014-Call-to-Action(1).pdf).

² Long, S. and Bunkers, L. (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. <http://www.crin.org/docs/Building%20Protection.pdf>.

Executive summary

The potential to achieve an AIDS-free generation depends on protecting children from abuse, violence, exploitation and neglect. The reverse is also true: preventing HIV will help protect children from these violations. A review of evidence, commissioned by the Inter-Agency Task Team on Children Affected by HIV and AIDS in 2013,³ concluded that 'it is the responsibility of every child protection actor to ensure that no child be needlessly exposed to the risk of acquiring HIV and that no child living with HIV is denied his or her right to HIV testing, treatment, care and the support necessary to live a healthy, independent life. It is the responsibility of every person working on HIV prevention, care and support for children to prevent abuse, neglect, violence and exploitation and to support child survivors of these protection violations.'⁴

This report seeks to provide lessons about why making such synergies is important – what difference it makes for children and their families – and how this is being implemented in practice within three African countries. This report builds on the reflections and experiences collected from practitioners and policymakers at country level in order to provide practical recommendations on how to engage more effectively across the HIV and AIDS, health and child protection sectors.

The consultants undertook this study by first developing guiding questions to assess promising practices, reviewing key evidence that has emerged since February 2013, and then liaising with three countries selected by UNICEF. The consultants then conducted a brief field visit to each country, which included meetings with national stakeholders and visits to selected projects and services that highlight promising practices. The three countries highlighted in this report are Nigeria, Zambia and Zimbabwe. As the in-country work proceeded, it was obvious that programmes were coming to the realisation of the need to integrate responses but had not explicitly reflected on the process of doing so. Therefore, country visits involved documentation but also served as an interactive reflection between policymakers and practitioners and the global study team in order to build upon the interest and engagement of national stakeholders.

Key findings

Evidence published since February 2013 provides additional weight to the existing evidence that was highlighted in the original 2013 study. At policy level the children and AIDS community has started to focus on the need to identify and support protection, care and support interventions that contribute primarily to HIV prevention, treatment and mitigation results. Focusing on these interventions to deliver HIV outcomes remains a challenge, and the report findings reinforce the fact that HIV outcomes cannot be achieved without addressing child protection violations and other social and economic factors that increase HIV vulnerability and risk. The absence of clear reflection of this necessary linkage in HIV and in child protection guidelines is a significant challenge addressed in this report.

³ Ibid.

⁴ Ibid., 16.

The major lessons learnt from emerging models are as follows:

1. A comprehensive policy framework to address HIV and child protection outcomes should stimulate multi-sectoral collaboration. Such a framework holds all actors accountable and enables different sectors to report within one framework and work towards mutually supportive objectives.
2. The interventions that have intentionally brought together service providers and HIV-affected communities, especially children and young people living with HIV, have led to positive results.
3. Case management and referral mechanisms are the 'glue' that binds populations affected by HIV and services, including child protection.
4. Programmes working with children and young people, especially with the adolescent age group, are seeing that understanding and addressing child protection concerns lead to subsequent improvement in HIV treatment outcomes.
5. Engaging children and young people living with HIV in all phases of programming provides critical understanding and empowerment that can reduce stigma and discrimination, which improve both child protection and HIV outcomes. HIV-related stigma and discrimination are central to HIV-affected children's experience of abuse, violence, exploitation and neglect, and addressing stigma and discrimination must be a key component of any HIV programme targeting children.
6. Programmes should invest in improving communication between children and their caregivers from an early age in order to achieve HIV-related outcomes as children enter adolescence.

Key entry points

The 2013 study identified potential entry points where combined HIV and child protection intervention can offer a more preventative, sustained and integrated response:

1. Ensure that HIV and child protection are explicitly linked in one national policy, for example, using the development of the next national policy framework for children (e.g. the National Children's Plan, OVC or MVC Plan, Vulnerable Children's Strategy or Priority Agenda for Children, National AIDS Strategy) as a means to understand the interlinked economic, HIV and child protection vulnerabilities faced by children and families.
2. Include a focus on understanding and addressing HIV-related stigma and discrimination, as children and adolescents experience them, within HIV and child protection guidelines, standards and operating procedures.
3. Ensure that children, adolescents and young people, especially those living with HIV, are thoughtfully included throughout the various programming phases.
4. Involve child protection experts in national and subnational working groups on HIV prevention, treatment, care and support, as well as in OVC (orphans and vulnerable

children) or impact-mitigation groups, which could lead to improved HIV prevention and treatment outcomes that have been negatively affected in the past by child abuse, violence, exploitation and neglect.

5. Invest in a strong case management system that links HIV, health care, economic strengthening/social protection and child protection to improve paediatric HIV testing and treatment outcomes and support HIV-affected children and families who are at risk of harm.
6. Use the development of alternative care or family strengthening strategies and programmes as an opportunity to recognise, and respond to, neglect and abuse of children living with HIV in all forms of family and other alternative care, and to provide access for children living with HIV to appropriate testing, treatment and care.
7. Include one or more specific indicators on HIV and child protection synergies in national social workforce strengthening strategies.
8. Build on the global attention to violence against children and gender-based violence to link specialised services on sexuality or sexual abuse and violence with child protection case management and HIV prevention and treatment programmes.
9. Use the adoption of new PMTCT (prevention of mother-to-child transmission) and paediatric HIV treatment guidelines as an opportunity to include priority child protection information and referral protocols in staff job descriptions and standard operating procedures.
10. Include positive parenting to encourage communication and disclosure strategies between parents/caregivers and children and adolescents.

The report concludes that practical linkages are still emerging, many of them intuitively, within programmes. Policymakers must generate opportunities strategically and purposefully to establish linkages within policies and strategies. Globally, HIV and child protection actors must build on the evidence available to support the development of more integrated policies, strategies and guidelines.

I. Introduction

*'We can only achieve an AIDS-free generation by addressing the social and economic factors that continue to fuel and impact the HIV epidemic. Inequity, exclusion, poverty, violence, and stigma continue to increase risk, decrease resilience, and compound the impact of the epidemic.'*⁵

The potential to achieve an AIDS-free generation depends on protecting children from abuse, violence, exploitation and neglect. The reverse is also true: preventing HIV will help protect children from these violations. A review of evidence commissioned by the Inter-Agency Task Team (IATT) on Children Affected by HIV and AIDS in 2013⁶ concluded that interaction between HIV affectedness and child protection violations can lead to negative outcomes for children and adolescents. The study found that there are some unique and specific protection risks faced by children living with or affected by HIV, and there are increased risks of acquiring or being adversely affected by HIV faced by children who have survived or are experiencing child protection violations. The study concluded that

it is the responsibility of every child protection actor to ensure that no child be needlessly exposed to the risk of acquiring HIV and that no child living with HIV is denied his or her right to HIV testing, treatment, care and the support necessary to live a healthy, independent life. It is the responsibility of every person working on HIV prevention, care and support for children to prevent abuse, neglect, violence and exploitation and to support child survivors of these protection violations.⁷

Many policymakers and practitioners, especially those working in AIDS-affected contexts, appear to have an inherent understanding that living with or being affected by HIV makes a child more susceptible to violence and abuse and that children who face abuse are more susceptible to HIV. What has not happened, in most cases, is translating this understanding into concrete actions.

The evidence clearly shows that there are linkages that must be addressed. The next step is to understand how to translate this evidence into actual policy frameworks and practice. The 2013 study assessed global and national guidance within the child protection and HIV/health sectors and found that some priority synergies were not being recognised. Consequently, national strategies and programmes, which have drawn on this global guidance, have failed to address explicitly the protection-related vulnerabilities that lead to HIV infection in children and adolescents or that reduce the impact of HIV treatment, care and support programmes. In turn, the lack of targets or expected outcomes in national strategies reduces the opportunities to generate learning about the unique child protection issues related to children affected by HIV, and vice versa.

The 2013 IATT study identified key entry points where both issues could be addressed jointly, including within the legal and policy framework, the workforce, data collection and management. This report seeks to provide lessons about why making such synergies is

⁵ UNICEF, PEPFAR, UNAIDS, et al. (2014), *Protection, Care and Support for an AIDS-Free Generation: A call to action for all children*. [http://childrenandaids.org/css/GPF-2014-Call-to-Action\(1\).pdf](http://childrenandaids.org/css/GPF-2014-Call-to-Action(1).pdf).

⁶ Long and Bunkers, *Building Protection and Resilience*.

⁷ Ibid., 16.

important – what difference it makes for children and their families – and how this is being implemented in practice within three African countries. The study specifically looked for examples where policies and practices were addressing both HIV and child protection and were able to show tangible results. This report summarises these practical approaches and identifies key factors that have led to positive results for children at risk of and experiencing harm related to both HIV and child protection violations.

The promising practices within this report should be recognised as evolving. They are in varying stages of addressing the linkages between child protection and HIV. They are still being implemented on a small scale. Nevertheless, the different practices included herein provide useful insight into some of the benefits and the challenges involved in designing, implementing and measuring coordinated approaches to policy, programming and practice.

2. Methodology

The objective of this study was to document examples of approaches, interventions and tools that have effectively supported linkages between the child protection and HIV/health sectors. The focus of the study, and therefore of this report, is to use the reflections and experiences collected from practitioners and policymakers at country level to provide practical recommendations on how to engage more effectively across the child protection and the HIV/health sectors.

The consultants used a set of guiding questions to assess promising practices (see Box 1). They then undertook a very rapid scoping of key academic, policy and programming documents produced since February 2013, using an Internet search and contacting key practitioners working within both sectors, primarily those working in heavily AIDS-affected countries in Africa.

Box 1: What makes a practice promising?⁸

Promising practices should fit the following criteria, based on monitoring evidence, implementer perception and external assessment by consultants and other key stakeholders:

- can demonstrably meet an expressed need of key beneficiaries/participants
- are effective and relevant to the local context
- are ethically acceptable – for example, actively address issues of stigma, able to articulate and demonstrate a rights-based approach
- bear fruit in a reasonable time
- have a strong indication that they will be sustainable – for example, demonstration of local ownership and leadership, inclusion in national budgets or in local resource allocation
- are viewed by their initiators and core users as promising.

The three countries were selected by UNICEF from those that believed they had promising practices to share. Country visits ranged from six to ten days, preceded by a review of national documents and discussions with each UNICEF country office. The country visits entailed meetings with national stakeholders, visits to selected projects and services that highlight promising practices, and a debriefing meeting to review emerging findings. Each visit resulted in a country report with key findings and country-specific recommendations for child protection and HIV and AIDS actors.⁹

⁸ Adapted by the consultants from Family Health International (n.d.). *Selection Guide for STI/HIV/AIDS Promising and Best Practices*. The South African Development Community (SADC) has also defined best practices using similar criteria (see '[Overview of the SADC Best Practice Framework](#)').

⁹ All country reports are available from the respective UNICEF country offices.

Table 1: Emerging models of good practice included in this study

Country	Promising practices	Key informant interviews	Focus-group discussions (FGDs)
Nigeria	Two emerging potential opportunities for promoting synergies	Interviews with 60 stakeholders in individual or group interviews	Four FGDs with programme practitioners (1 × Abuja, 1 × Cross River State, 2 × Benue)
Zambia	Three promising practices	Interviews with 24 individuals or small groups	One FGD involving 15 adolescent girls
Zimbabwe	Three promising practices	Interviews with 23 individuals or small groups	Two FGDs in Epworth

The methodology was defined prior to the country visits, but it became clear during preparation for country visits that the approach would need to be adapted to country-specific realities. As the in-country work proceeded, it was obvious that programmes were coming to the realisation of the need to integrate responses but had not explicitly reflected on the process of doing so. Therefore, country visits involved documentation but also served as an interactive reflection between policymakers and practitioners and the global study team in order to build upon the interest and engagement of national stakeholders.

Table 2: Emerging models of good practice represented in this report

Emerging practice	Country	Description	Key HIV and child protection synergy being addressed
Child Protection Networks, Benue and Cross River States	Nigeria	Grassroots CSO (civil society organisation) supporting orphans and vulnerable children.	Child protection intervention that includes participation of CSOs currently providing range of HIV and other services (largely through PEPFAR), including HIV prevention and treatment services.
National Priority Agenda for Vulnerable Children in Nigeria (2013–20)	Nigeria	Strategic framework for vulnerable children that enables linkage of child poverty and child protection.	Developed by multiple ministries, under social welfare. Potentially enables a linked child protection and HIV agenda; actors hope to use new data on violence against children as advocacy entry point.
Childline Zambia, Lifeline	Zambia	National service offered by NGO. Telephone 'hotline' service providing information about child protection issues to children or those concerned about children.	Child protection intervention. Regularly identifies, counsels, refers and manages cases that combine issues of HIV prevention, testing and treatment, abuse, neglect, poverty, stigma and discrimination.
Kasisi Children's Home¹⁰	Zambia	Private, faith-based residential care facility: Residential care facility providing care for a large number of children living with HIV (around one-third of children in care). Individualised care plan address issues of treatment, stigma, reintegration back into family and/or independent living, self-care and relationships.	Child protection/alternative care sector. Developing lessons about how to integrate the care, treatment and support of children living with HIV within residential care, including promoting integration into community-based education facilities, and understanding how to ensure safe and successful transition into independent living.

Emerging practice	Country	Description	Key HIV and child protection synergy being addressed
URreport	Zambia	National service offered by NGO. Information exchange and referral mechanism, using informational technology and social media, offering gender/age-appropriate links to HIV, STI and child protection services.	Health and HIV prevention sector. Addresses HIV, child protection and combined concerns raised by children and adolescents. Reaching key target populations such as adolescents with HIV information using innovative, youth-friendly methods
National Action Plan for Orphans and Vulnerable Children (NAP II) (2011–15)	Zimbabwe	National policy – NAP for OVC; child protection and social protection combined with systems strengthening.	Developed by multiple ministries, under HIV strategy; child protection systems strengthening as major component; case management approach that can combine HIV and child protection.
National child protection case management system (component of NAP II, see above)	Zimbabwe	National system managed by national ministry responsible for social welfare and child protection, with NGO participation and support. Case management identification and referral system, based on community-based volunteers.	Child protection system. Involves both HIV and child protection actors at community and district levels to identify potential referrals; increasingly draws on HIV specialist actors, including young people living with HIV to work as case management workers.
Zvandiri, Africaid	Zimbabwe	NGO-led model, now being adopted by Ministry of Health, operating in five provinces: child- and youth-led model of clinical care, psychosocial support, training and advocacy for children, adolescents and young people living with HIV.	HIV-sector response, initially CSO, now national strategy. Addresses often hidden issues of treatment neglect and household abuse of children living with HIV. Trained adolescents living with HIV now participating in roll out of national child protection case management model.

¹⁰ A robust evidence base supports family-based care for children. Inclusion of Kasisi Home as an example should not be viewed as promoting residential care as a preferred care option for children, but as an example of an existing care option that promotes the sharing of appropriate child and youth friendly information and knowledge, and fosters the development of skills in children living with HIV in care. There is a dearth of information regarding children in residential care and care leavers (youth and young adults 18–30 years of age who have left residential care to return to a family environment or independent living and who are also living with HIV) and their experiences living with HIV.

3. HIV and child protection synergies: The latest evidence

3.1 The evidence of HIV and child protection linkages

There is ample evidence of increased vulnerability of HIV-affected children to child protection violations. The 2013 study documented key findings, highlighted in Box 2.

Box 2: Global evidence on the HIV and child protection linkages¹¹

Children affected by HIV

- Children orphaned by or living with HIV-positive sick caregivers face an increased risk of physical and emotional abuse compared to other children in sub-Saharan Africa, including other orphans.
- Caregivers of AIDS-orphaned children have higher rates of depression than other caregivers in sub-Saharan Africa; this leads to increased mental health and behavioural problems in children.
- HIV-affected children experience greater stigma, bullying and emotional abuse than their peers.
- 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 HIV are twice as likely as non-orphans to have HIV.

Children who experience protection violations

- There is a direct link between childhood sexual, emotional and physical abuse and HIV infection in later life for both women and men in high-HIV-prevalence areas.
- 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, across all regions.

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.

Evidence published since February 2013 provides additional weight to the existing evidence:

Adults living with HIV face unique challenges in providing a protective and caring environment for their children, especially where services are limited.

¹¹ Long and Bunkers, *Building Protection and Resilience*. See Annex 3 for a summary and bibliography of the global evidence.

HIV stigma hampers the ability of interventions that support parents and caregivers to have positive effects on the whole family.¹²

Children living in extended family care and children without family care, largely due to HIV, are not receiving the protection they need. A review of 15 studies in sub-Saharan Africa found that orphaned children consistently experienced discrimination within the home, material and educational neglect, excessive child labour, exploitation by family members and psychological, sexual and physical abuse.¹³

Psychosocial support for children living with HIV improves HIV treatment outcomes. In South Africa psychosocial support to HIV-positive children reduced paediatric mortality, improved viral load suppression and increased retention in HIV treatment services.¹⁴

Physical and sexual abuse in childhood is high and significantly increases the risk of HIV in adulthood for both men and women. In South Africa, Tanzania and Zimbabwe, reported childhood sexual and physical abuse was found to be high for men and women (between 6 per cent and 29 per cent of young adult men and women). Abuse was linked to higher risk of HIV infection through increased risk of early sexual debut, alcohol and drug use (from 1.5 to 3 times greater risks) and violence (2 to 3 times increased risk of recent forced sex or being hurt by a partner).¹⁵

Reducing risky sexual practices in boys and girls requires economic interventions but also 'care'. A review of South Africa's national child grant programme found that the biggest impact on reducing risky sexual practices occurred when social grants were provided in combination with social services.¹⁶ Cash alone had a reduced HIV risk for girls but not boys. Integrated cash plus care reduced HIV risk behaviour from 41 per cent to 15 per cent for girls and from 4 per cent to 17 per cent for boys.

12 Lachman, J. M., Cluver, L., Boyes, M. E. et al. (2014), 'Positive Parenting for Positive Parents: HIV/AIDS, poverty, caregiver depression, child behavior, and parenting in South Africa', *AIDS Care* 26(3):304–13. DOI: [10.1080/09540121.2013.825368](https://doi.org/10.1080/09540121.2013.825368); Sherr, L., Cluver, L., Betancourt, T. et al. (July 2014), 'Evidence of Impact: Health, psychological and social effects of adult HIV on children', *AIDS* 28: S251–S259. DOI: [10.1097/QAD.0000000000000327](https://doi.org/10.1097/QAD.0000000000000327).

13 Morantz, G., Cole, D., Vreeman, R. et al. (2014), 'Child Abuse and Neglect among Orphaned Children and Youth Living in Extended Families in Sub-Saharan Africa: What have we learned from qualitative inquiry?', *Vulnerable Children and Youth Studies* 38(2):304–16. DOI: [10.1080/17450128.2013.764476](https://doi.org/10.1080/17450128.2013.764476).

14 Fatti, G. et al. (2014), 'Improved Virological Suppression in Children on Antiretroviral Treatment Receiving Community-based Adherence Support: A multicentre cohort study from South Africa', *AIDS Care* 26(4): 448–53.

15 Richter, L., Komárek, A., Desmond, C. et al. (2014), 'Reported Physical and Sexual Abuse in Childhood and Adult HIV Risk Behaviour in Three African Countries: Findings from Project Accept (HPTN-043)', *AIDS Behavior* 18: 381–89. DOI: [10.1007/s10461-013-0439-7](https://doi.org/10.1007/s10461-013-0439-7).

16 Cluver, L., Orkin, M., Boyes, M. et al. (2014), 'Cash Plus Care: Social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa', *AIDS* 28: S389–S397, doi:10.1097/QAD.0000000000000340; Cluver, L., Boyes, M., Orkin, M. et al. (2013), 'Child-focused State Cash Transfers and Adolescent Risk of HIV Infection in South Africa: A propensity-score-matched case-control study', *The Lancet Global Health* 1:e362-70. DOI: [10.1016/S2214-109X\(13\)70115-3](https://doi.org/10.1016/S2214-109X(13)70115-3).

3.2 Policy progress

At policy level the children and AIDS community have started to focus on the need to ensure that child protection contributes to HIV prevention, treatment and mitigation targets. The 2014 Call to Action for Protection, Care and Support for an AIDS-Free Generation¹⁷ starkly highlights the fact that global targets to reduce vertical HIV transmission, increase HIV treatment and prevent new HIV infections cannot be achieved without addressing underlying factors of child abuse, violence, exploitation and neglect, along with other social and economic factors that increase HIV vulnerability. The Call to Action comes at a time of increasing focus, by children and AIDS actors, on the need to ensure that protection, care and support do not drop off the larger HIV agenda, as the global response increasingly focuses on biomedical prevention and treatment interventions. Whilst both treatment and prevention are essential, it is critical to ensure that the economic and psychosocial barriers to HIV treatment and prevention are also addressed.¹⁸

One notable gap on the policy front is support for children who are from or who have parents or caregivers who are from key populations – those most at risk of acquiring HIV, including men who have sex with men, transgender people, people who inject drugs and sex workers.¹⁹ There is a lack of guidance, and support for children in these populations is scant. Despite the growing evidence on HIV risks for men who have sex with men and transgender people, for example,²⁰ there remains limited attention paid to the needs of boys who have sex with men or boys, and to transgender children. The same is true of sex workers. Recent policy briefs – for example, UNICEF's position paper on lesbian, gay, bisexual, transgender and intersex (LGBTI) youth²¹ – highlights the necessity of supporting LGBTI children. A new toolkit on addressing ethical dilemmas for working with key populations addresses the particular issues that children face.²² The reluctance to address some of these complex issues was highlighted in all three countries, with some stakeholders emphasising the extreme difficulty of supporting vulnerable children in an oppressive legal context.

In parallel, global efforts to promote strengthened child protection and social welfare systems increasingly recognise that multiple child protection risks are often interlinked and therefore must be tackled holistically, engaging various sectors and actors, including children. As the child protection sector has moved forward in advancing its systems agenda, it has recognised that there is no need for ongoing debate about whether to focus on issues or systems; rather, a systems approach can and does effectively address specific issues, such as HIV (when the issues are explicitly taken into account and effort is paid to building effective linkages with

17 UNICEF, PEPFAR, UNAIDS et al. (2014), *Protection, Care and Support for an AIDS-Free Generation: A call to action for all children*. [http://childrenandaids.org/css/GPF-2014-Call-to-Action\(1\).pdf](http://childrenandaids.org/css/GPF-2014-Call-to-Action(1).pdf).

18 Cluver, L., Sherr, S., Grimwood, A. et al. (June 2014), 'Assembling an Effective Paediatric HIV Treatment and Prevention Toolkit: Correspondence', *Lancet Global Health* 7, [http://dx.doi.org/10.1016/S2214-109X\(14\)70267-0](http://dx.doi.org/10.1016/S2214-109X(14)70267-0).

19 World Health Organization (June 2013), 'HIV/AIDS: Definition of Key Terms'. www.who.int/hiv/pub/guidelines/arv2013/intro/keyterms/en/.

20 Baral, S., Poteat, T., Strömdahl, S. et al. (2013), 'Worldwide Burden of HIV in Transgender Women: A systematic review and meta-analysis', *Lancet Infectious Diseases* 13(3): 214–22. DOI: 10.1016/S1473-3099(12)70315-8.

21 UNICEF (November 2014), *Eliminating Discrimination against Children and Parents Based on Sexual Orientation and/or Gender Identity*. UNICEF Position Paper No. 9.

22 GNP Plus (2014), *Difficult Decisions: A tool for care workers managing ethical dilemmas when caring for children and families of Key Populations*.

key sectors), whilst also strengthening the larger system so that it prevents and responds to a wide range of issues and vulnerabilities.²³ Furthermore, the child protection sector increasingly acknowledges that child protection cannot exist in isolation. Rather, it is part of and explicitly linked to other sectors such as health, education, justice, social protection and social welfare.²⁴ Key entry points such as HIV, social protection and care reform must be seen as opportunities to support systems strengthening and to facilitate the integration of child protection and other related sectors. These entry points can be powerful catalysts for political action and public support of child protection systems strengthening.²⁵ The challenge is to make sure that the entry points are systematically included in child protection systems, which is a key issue that this report addresses.

In the high-HIV-prevalence contexts of the three countries featured in this study, it is not possible to consider child protection systems without placing them within and alongside the need for large-scale national HIV responses. Conversely, the HIV response, with its focus on scaling up prevention for adolescents and treatment access, must fully understand and respond to the comprehensive risks posed by endemic neglect, abuse, violence and exploitation to HIV infection and treatment access. 'Social experiences and behaviours can predispose adults to HIV infection, including migrancy and minority status, sexual behaviour and drug use, and are also independently associated with developmental challenges for children who are dependent on these adults.'²⁶ This means that children are already likely to face challenges, even without HIV. The response must address both HIV and other factors.

The rest of this report explores how practitioners and some policymakers are attempting to do this in three countries: Nigeria, Zambia and Zimbabwe.

23 Stuckenbruck, D. and Bunkers, K. (October 2014), 'A Systemic Approach to Child Protection', a presentation to a UNICEF regional meeting.

24 Ibid.

25 UNICEF, UNHCR, Save the Children and World Vision (2013), *A Better Way to Protect ALL Children: The Theory and Practice of Child Protection Systems*, Conference Report, 13–16 December 2013, New Delhi, India. http://www.crin.org/docs/C956_CPS_interior_5_130620web.pdf.

26 Sherr, Cluver, Betancourt et al., 'Evidence of Impact'.

4. Learning from the Field: Emerging promising practices in Nigeria, Zambia and Zimbabwe

The study sought to identify promising practices and highlight positive results. The examples included (see Table 2) are all emerging practices and, within their varying phases of implementation, offer important learning for both the HIV and child protection sectors. In the majority of cases the interventions did not start by intentionally creating linkages. The linkages emerged as implementers saw the need to create and reinforce synergies. Due to the fact that most of the models are relatively new, results that can be illustrated by robust data are limited. However, the models are informed by the real-life experiences of people responsible for designing and implementing programmes, or those who are benefitting from the interventions. As such, they provide a helpful reflection of how people in the field see priorities and where some of the most practical entry points can be found.

4.1 A comprehensive policy framework stimulates multi-sectoral collaboration

Integration of child protection and HIV responses for children requires a strong policy framework which articulates the specific linkages between HIV impact and subsequent child protection risks, and vice versa. These linkages should be based on national and comparative evidence. Having a supportive policy framework in place allows and facilitates the scaling up and resourcing of good practices with an appropriately qualified and trained social welfare and health workforce that has supporting guidance and protocols to implement.

In Zimbabwe the need to ensure that child protection and HIV were interlinked was embedded in a national strategic action plan. This plan provides a useful example of the benefits of transforming a traditional HIV-impact-mitigation plan for children into a more comprehensive HIV-sensitive plan addressing the needs of all vulnerable children, informed by evidence and reflective of the HIV, economic and protection vulnerabilities of all children. The new action plan is proving to be an instigator for developing integrated responses that address the multiple vulnerabilities of children, and there are some promising results from this approach that promote HIV and child protection synergies.

Box 3: The National Action Plan for Orphans and Vulnerable Children 2011–2015 (NAP II)

Zimbabwe's second National Action Plan for OVC (NAP II)²⁷ envisions that by 2020 all children in Zimbabwe will live in a safe, secure and supportive environment that is conducive to child growth and development. The NAP II is managed by a secretariat housed within the Department of Social Services in the Ministry of Public Service, Labour and Social Welfare (MoPSLSW).

²⁷ Ministry of Labour and Social Services (2011), *National Action Plan for Orphans and Vulnerable Children Phase II 2011–2015*.

The secretariat includes representatives from key ministries, such as health and education, and reports through a working party of officials to the National AIDS Commission (NAC), which then reports to the cabinet committee responsible for social services.

A review of the previous NAP found that, despite significant material inputs to vulnerable children, their nonmaterial HIV risks (for example, barriers to information access and abuse) had not been sufficiently addressed. The new NAP II combines social and child protection interventions within an HIV response framework, implemented through four pillars that collectively address material and nonmaterial elements. These include household economic strengthening; access to basic services (birth registration, basic education assistance through tuition waivers, grants for primary and secondary schools, and health-care vouchers); child protection; and strengthening child protection and social protection services and community-based family support. HIV is included as a crosscutting theme across all pillars and the related activities. The NAP II monitoring framework also includes key HIV considerations across all different pillars. For example, child protection services include HIV-specific activities, such as ensuring that HIV-affected children and families receive psychosocial support and are referred to HIV treatment and care, as well as other health-care services.

Three key factors helped strengthen effective linkages between HIV and child protection in the NAP II:

- The plan adopted a case-management approach (see section 4.3) ensuring that all partners who were working on the more traditional OVC response of the first NAP now contribute to a national child protection management and referral system. Both HIV actors from the Ministry of Health (MoH) and child protection actors attend NAP II coordination meetings and district coordination meetings. It was apparent in meeting with the staff of the lead ministry, the MoPSLSW, Department of Social Services, that child protection actors were aware of the impact of HIV on children's risk of harm.
- The plan is grounded in an analysis of childhood vulnerability that considers both economic and social risks, treating HIV and AIDS as a crosscutting factor across social protection and child protection activities in the implementation plan
- The plan includes an explicit focus on building capacity within government and civil society to deliver social protection resources and a core package of child protection services, including responses to abuse and violence, family tracing and reintegration, disability and a child-friendly justice system. The action plan not only spells out coordination responsibilities but calls for investment in capacity building to strengthen case management and referral.

There are still gaps and challenges. For example, there are no targets in the NAP II's monitoring and evaluation framework that explicitly demonstrate referrals and synergies between the HIV prevention and treatment components of the health sector and the social welfare/child protection sector. Having these would enable policymakers to see the impact of a combined response on HIV-sensitive child protection, as well as support the ways in which addressing abuse, violence or neglect can improve HIV prevention or treatment outcomes for children.

4.2 Fostering workforce collaboration

HIV and child protection policies have typically been developed in silos. Services tend to be delivered through, and staff report to, different ministries. Child protection and HIV service providers for children affected by HIV and AIDS typically work independently, often with different levels of training and salary scales. This is especially so where there is high donor investment in the HIV response and very limited investment in the child protection sector. Therefore, an approach that seeks to improve both HIV and child protection results must utilise mechanisms that intentionally bring together service providers who would not typically work together, even though in many instances they are working with the same child and family populations. The approach must promote coordination and establish common objectives.

Box 4: Enabling social welfare and health workforces to value and support each other's work to improve both HIV and child protection outcomes

In Zimbabwe, the Zvandiri model is a child- and youth-led approach to clinical care, psychosocial support, training and advocacy. Services are integrated within HIV treatment and care provided by government and private clinics and, increasingly, are linked to other social support programmes for vulnerable children. The Zvandiri approach is spearheaded by over 100 trained and mentored HIV-positive volunteer community adolescent treatment supporters (CATS). CATS volunteers conduct support groups for children living with HIV in clinic-based Zvandiri Centres and, increasingly, within communities. They also provide training and counselling to service providers and volunteers, including health workers, teachers, social welfare officers, church leaders and community members. The Ministry of Health's national training programme now includes HIV testing and counselling sessions that are jointly facilitated by CATS members and MoH trainers. Currently the MoH is considering making CATS volunteers part of the government health staff cadre on a similar footing to village health workers. Local service providers working on child protection and HIV treatment and care all work closely with the CATS volunteers.

In Zambia, the UReport²⁸ was developed as a response to the alarming increase of HIV infection amongst adolescents, especially girls. The programme was launched in 2012, designed to fill the knowledge gap around prevention and treatment of HIV and AIDS, male circumcision and sexually transmitted infections. UReport uses a combination of short message service (SMS) referrals and more interactive social media technologies for two-way communication with young people – providing information, facilitating access to counselling and referrals for support and services, and gathering inputs from young people. UReport has recruited youth ambassadors who are trained to promote UReport to friends, colleagues and other youth. They attend stakeholder meetings and provide useful insight into how to ensure that messaging reflects the language that youth are using. The youth ambassadors have also been closely involved in the Zambia UReport design phase to ensure that young opinions and voices are reflected in the project, particularly when it comes to the friendliness, effectiveness and impact of messaging and text polls designed for young people. UReport has used its platform to engage not only health and HIV facilities in its information dissemination and referral mechanism but also social service providers, police and the private sector. UReport recognises that HIV prevention and awareness is multifaceted and requires the engagement of both public and private sectors.

The community case management approach introduced under the Zimbabwe NAP II (see section 4.1) brings together government and civil society child protection and HIV service providers, both salaried and volunteers on stipends, at district level to act as a referral mechanism. At district level a qualified social worker promotes links to both HIV treatment and support services and other statutory service providers. With this regular forum at the nearest point of service delivery to the community, at which HIV and child protection actors participate on an equal basis, nurses and social workers are starting to find commonalities in terms of understanding both the HIV risks (treatment failure) and child protection risks (neglect, abuse, violence) faced by the same children and are starting to work together to understand who the priority populations are. In this model both sectors understand their own roles but respect the need for others and, based on this, the need to make room for each other to work together.

In the case of Zimbabwe's case management system, the fact that the new NAP II for children includes child protection activities and results as one of the plan's four pillars, and that the plan places investment in a comprehensive child protection workforce within this pillar, has brought recognition to a sector of the workforce that has traditionally lacked resources and investment (compared to the HIV sector). In the NAP II, child protection and HIV service providers are accorded equal status. This shared recognition of the roles they play means that child

28 Zambia National AIDS Council with UNICEF, Zambia UReport, www.zambiaureport.org/.

protection concerns, based on evidence and children's experiences, are increasingly being heard and addressed by HIV prevention and treatment actors in the MoH. For example, adolescents living with HIV have had the expertise that they have in understanding adolescents' HIV-related concerns 'legitimised' by the MoH through their inclusion in national health worker training, for example, and in their inclusion in local referral meetings for the national case management system. CATS volunteers, along with others, have successfully advocated to modify the national HIV testing guidelines to allow children under the age of 16 independently to seek an HIV test if the counsellor and nurse feel that the child is able to make this decision.²⁹ Young people living with HIV advocated for the change because of challenges faced in learning their positive HIV status when family members hide the diagnosis or refuse to test a child.

One challenge noted across all countries was that generally the HIV response is coordinated through three areas – prevention, treatment and impact mitigation, including OVC. Government and civil society partners responsible for child protection typically attend impact-mitigation meetings, but they are less likely to participate in HIV prevention or treatment discussions. Although there are examples in the field – for example, CATS volunteers addressing treatment adherence and youth ambassadors addressing prevention – representatives from these projects tend not to be present at national-level coordination meetings. Child protection should be recognised as a crosscutting issue and represented within all areas of HIV prevention, treatment care and support. Including child protection within prevention and treatment would reflect recognition of the evidence base that demonstrates that abuse and neglect can increase exposure to HIV and minimise treatment access and adherence.

4.3 Case management as the 'glue' that binds child protection and HIV

Child protection policymakers and programmers in Zimbabwe are exploring the best ways to ensure that HIV referrals are an integral part of a robust child protection case management system.

Box 5: Using a child protection case management approach to improve HIV outcomes

Zimbabwe's child protection case management system was developed in response to the growing realisation that children and families affected by HIV need access to child protection services and support. The model centres on community volunteers who are trained as case care workers (CCWs).

²⁹ Ministry of Health (May 2014), *Zimbabwe National Guidelines on HIV Testing and Counselling*, 2nd edition.

After training, CCWs follow up on informal referrals made to them within the community (neighbours mentioning worries about violence in the home, reports of abuse and often their own contacts with children and young people that they meet in the community) and make referrals to a government social worker who is a dedicated case management officer (CMO). There are discussions on how to integrate CCWs into the MoPSLSW workforce in the future, which would provide CCWs with formalised training and a career path. To date there has been little attrition from volunteers in the programme (CCWs), who report feeling satisfied that they are achieving results for children.

The CMO supervises CCWs and facilitates coordination meetings in order to promote links to both HIV treatment and support services and other statutory service providers, such as police, magistrates and specialist services for children with disabilities or children in conflict with the law. A large number of these actors are HIV specialists – for example, local government and NGO HIV testing, treatment and support services and Zvandiri support group members.

According to one implementing partner, around 15 per cent of all cases identified by CCWs involve HIV-specific interventions related to HIV treatment adherence for children and support for 'second-chance education' for children living with HIV (catch-up, fast-track education for children who have missed school due to sickness, caring for sick parents or simply having to leave school due to poverty or lack of caregiver support). The case management system is currently being implemented in 21 districts of a total of 59 in the country; it is aiming for coverage in all districts by the end of 2015.

As a result of the case management process in Zimbabwe, clinic nurses and counsellors are reportedly increasing referrals to social workers or others who can provide support or respond to concerns about violence, exploitation, abuse, or neglect by using the CCWs to refer to the district social worker, who can then link with other specialist services. Key factors that appeared to increase referrals between HIV care and child protection service providers included having a forum at the implementation level (district level, in Zimbabwe's case) where practitioners could see that regular information sharing improved their own 'targets' or desired results. HIV actors reported finding it useful to come to district case management coordination meetings because they learned of new cases being referred from others and received technical support. Informants believed this leads to better results, such as greater paediatric treatment adherence, for example. Child protection actors also found it useful to meet with HIV specialists because so many of their abuse and neglect cases require HIV technical support, through HIV counselling and testing, for example.

There is not yet enough data to measure HIV prevention and treatment outcomes through the case management process in Zimbabwe. It should be a priority to include HIV-specific outcomes in the referral tracking process and in a broader national monitoring and evaluation framework for the NAP II and for child protection that highlight the top priorities for

protecting children from HIV risk and from child protection violations. Currently, there is no Monitoring and Evaluation Unit in the Department of Social Services within the MoPSLSW. However, civil society partners who are participating in the process have started measuring outcomes. World Education, Inc., for example, is developing indicators that can measure the extent to which the case management process is improving HIV prevention outcomes by increasing access to HIV prevention information and services for adults or addressing issues such as gender-based violence, which is a known factor for increasing the risk of HIV transmission.

4.4 Understanding child protection concerns can improve HIV treatment outcomes

In all three case study countries the overriding message from key informants was that children's experiences of neglect and abuse within the home negatively affected their access to HIV testing, treatment and care. Treatment access for children is consistently lower than for adults.³⁰ Whilst there are many factors in this statistic, the three countries show that abuse and neglect at home are barriers that must be taken into account. In Nigeria, informants working both within HIV treatment facilities and with children in vulnerable homes in the Benue and Cross River States were clear that children living with HIV or those who have lost parents to HIV often face extremely harsh treatment within their home environments. In Benue State key informants reported high treatment dropout. Around one-third of the 7,000 children enrolled in one vulnerable child programme and around half of all children enrolled in another paediatric treatment programme were experiencing abuse and violence from family members or neglect and discrimination, such as being denied schooling or engaged in exploitative labour. In Zimbabwe, very similar challenges were noted, with families not feeling willing or able to access HIV testing and treatment.

This study shows how important it is that HIV counselling and testing and HIV treatment programmes understand that abuse, violence and neglect at home reduce children's ability to access HIV testing or adhere to treatment.

Box 6: Rapid referral for child protection concerns in an HIV information and support service

In Zambia, one element of the UReport initiative is an SMS counselling service through which young people text their questions or concerns to the UReport SMS number. A link was made between sexual abuse and violence and potential transmission of HIV at the design phase. The SMS platform can recognise key words that indicate if the user is in an especially vulnerable situation and needs immediate assistance. Words such as *rape*, *defilement*, *forced*, or *abuse* are

³⁰ In Nigeria, treatment access is an estimated 26% for adults and 7% for children (WHO 2011 data). In Zambia, it is 90% and 28.1% respectively, and in Zimbabwe, 76.9% and 46.12% respectively (Zambia and Zimbabwe Global Progress Reports 2014).

automatically recognised by the platform and the message flashes in red on the counsellor's computer screen and is automatically placed at the top of the list for an immediate response by the counsellor. At the same time, the platform sends an automated SMS to the person who sent the message asking him or her to immediately call the 990 hotline, free of charge, to speak to a counsellor in a language of their choice. The hotline counsellor provides immediate referral to a one-stop centre for access to post-rape prophylaxis, psychosocial and legal support. Examples of texts that would be immediately recognised by the platform include, 'If you are raped how can you know you are HIV positive and how can you treat it?' or 'Do you do other counselling apart from HIV, let's say sexual abuse?'

UReport works closely with Childline Zambia, another hotline service dedicated to child protection, implemented by the NGO Lifeline Zambia. Childline quickly found from children's calls that child protection issues, especially sexual abuse, were directly linked to HIV. For example, many calls or SMSs included questions related to sexual abuse and the possibility of HIV infection. Childline has also recognised that children with disabilities, especially those with hearing and speech challenges, could not access information through the hotline. Childline expanded services to include SMS and Facebook chat to create a forum that some children with disabilities could access, recognising that such children are especially vulnerable to child protection violations and HIV infection. A 2010 survey of children and young adults with disabilities found high levels of physical and sexual violence against children and young people with disabilities in Zambia.³¹ A recent Human Rights Report also recognised the increased vulnerability of women and girls with disabilities to sexual abuse, including a rise in the number of girls with disabilities reporting incidences of sexual abuse at One Stop Centres in Lusaka.³² Awareness-raising campaigns have specifically targeted teachers of children with disabilities and community members. To date, Childline receives 8 to 10 messages a month from children with disabilities. These calls have included questions related to abuse and HIV.

In Zimbabwe, the Zvandiri model seeks to increase children's treatment adherence and uptake. It has found that treatment neglect is often caused by child neglect, in terms of a caregiver not providing necessary health care, which can and does result in diminished well-being. The project approach is to involve children living with HIV in both outreach to children with poor adherence (CATS volunteers receive referrals from HIV clinics when children do not appear for treatment) and in peer-support-group activities and community outreach that explicitly addresses the stigma and exclusion faced by children and young people living with HIV.

31 The African Child Policy Forum (2011). Violence against Children with Disabilities in Africa: A compilation of the main findings of the various research projects conducted by the African Child Policy Forum (ACPF) since 2006, as referenced in Human Rights Watch (July 15, 2014), *'We Are Also Dying of AIDS': Barriers to HIV Services and Treatment for Persons with Disabilities in Zambia*.

32 Human Rights Watch, *'We Are Also Dying of AIDS'*.

In all cases the need to address child protection–related barriers to treatment access has not yet been explicitly integrated into programme design or implementation but has been identified as a critical issue. Even in Zvandiri, with a strong focus on treatment uptake and adherence, the programme is only starting to be able to document and track concerns related to violence, abuse and neglect. However, some interesting entry points, in addition to those highlighted in Box 5, are being actively explored. In Nigeria, key informants felt that an important entry point was HIV testing and counselling (HCT). OVC programmes already provide referral to HCT but more could be done to strengthen two-way referrals and to facilitate earlier identification and greater chance of support to children who are facing some form of violence, abuse, exploitation or neglect or who face a risk of violence if they test positive for HIV and disclose their status to family members or a partner.

4.5 Engaging children and young people living with HIV in all phases of programming

The study found that projects that are starting to address the child protection concerns unique to children living with HIV tended to have deliberately involved HIV-positive children, adolescents and young people in all phases of the programme, from design through implementation to monitoring and evaluation. This seemed to lead to better outcomes and a greater sense of ownership by target populations.

Box 7: Involvement of young people living with HIV improves outcomes

The UReport programme in Zambia has involved youth from the start. At the design phase and in implementation, youth ambassadors have been and continue to be actively engaged. Utilising the insight of adolescents from the beginning, UReport has been able to attract new users and reach more adolescents with critical information about HIV and sexually transmitted infections. They have done this by actively listening to youth and ensuring that messages and topics presented are user friendly and make sense for their target population. As a result of this deliberate engagement of youth in every step of the project, UReport has expanded from a pilot in two urban locations to more than 64,000 national users in less than two years. Furthermore, UReport will utilise its unique position with and trust amongst its youth users to address several areas where there are clear linkages between HIV and child protection, including gender-based violence, teen pregnancy and child marriage.

Young people drive the Zvandiri model in Zimbabwe. Actions by young people have demonstrated to others in the community that children and youth living with HIV can participate, take action and lead, as evidenced by the formal involvement of children and youth living with HIV in the national training of all HIV nurses and counsellors. As a consequence of this model the initiative is strongly grounded in local, child- and youth-defined definitions of children's

rights, especially within an HIV-affected context, such as the right to information and treatment access, protection and a safe home.

The main priority has to be protecting children from health workers who have negative views about children with HIV. I notice that individuals have changed when they have spoken to the Zvandiri youths.

—MoH official, Zimbabwe

In Zambia, Kasisi Children's Home utilises care leavers – youth and young adults 18–30 years of age who have left residential care to return to a family environment or independent living and who are also living with HIV – to act as mentors for HIV-positive children living in care. Sharing experiences of self-care as well as issues around stigma and discrimination and education, employment and relationships, provides a forum for children living in residential care to better understand and prepare for reintegration into a family environment or independent living. Utilising the real-life experiences of those youth who have once lived in residential care and are now living independently, children and adolescents are able to address concerns about their own HIV status, including issues of treatment and care.

Although there is still a lack of tangible evidence about outcomes in this area, as is the case in the other areas of emerging practice in Zimbabwe and Zambia, the idea of active child and youth involvement through Zvandiri's CATS volunteers and UReport's youth ambassadors has had significant buy-in from stakeholders in health and social welfare ministries, and UNICEF, suggesting that there is a firm belief in the value of adolescent involvement in programmes that have clear HIV-related and health outcomes (HIV prevention, HIV treatment, adolescent sexual and reproductive health).

4.6 Protecting children from HIV stigma and discrimination

Findings from all three countries highlight how essential it is to put the risk and impact of stigma and discrimination at the core of the responses targeting children affected by or living with HIV. As discussed in section 4.4, stigma and discrimination have negative impacts on treatment uptake and adherence, but stigma, or simply the fear of experiencing HIV-related stigma, affects children even when they are not living with HIV. Stigma was already highlighted as a significant issue in the earlier 2013 evidence review, concluding that it was a significant but relatively undocumented issue. One challenge noted in the previous study is that, whilst there are important results emerging from studies using GNP+'s Stigma Index tool, it is hard to obtain ethical consent, and thus children younger than 16 and people with disabilities that inhibit understanding or communication should not be interviewed.³³

33 The People Living with HIV Stigma Index: An index to measure the stigma and discrimination experienced by people living with HIV. User's guide (n.d.) <http://www.stigmaindex.org/>.

In both Nigeria and Zimbabwe, stakeholders strongly argued that there were very high levels of discrimination within homes, especially where a child is living in the extended family.

'I would say that around 80 per cent [of the children registered as OVC in the programme] have HIV as one of the main causes of their vulnerability. Lots of children are vulnerable, but it is more critical when it comes to HIV. Children have seen sick and dead parents and it's not possible to separate this trauma from their situation. Children are stigmatised at home and we have found that a greater number of HIV-affected children end up working as maids [because their family reject them].'
—CSO programme officer, Cross River State, Nigeria

Discussions with adolescent girls at school in Zambia endorsed recent documented evidence showing that children affected by or living with HIV face discrimination and stigma by relatives, neighbours, community members and schoolmates and that one of the biggest barriers related to disclosure of HIV of adolescents was fear of stigma and discrimination.³⁴

Box 8: Understanding and addressing HIV stigma experienced by children makes it possible to identify and respond to child protection risks and barriers to HIV care and support

Combatting stigma is at the very heart of the Zvandiri approach. Zvandiri means 'as I am'; it was the name chosen by a founding member of the first support group, Amanda. 'She wanted to say, I may be HIV positive, but "accept me as I am".'³⁵ Zvandiri support groups offer life-skills training designed and delivered by adolescents with the support of 20 adult staff and volunteers where necessary. The topics covered are chosen by the young people in the groups, addressing in an age-appropriate way issues such as HIV treatment, puberty, sexual health, contraceptive services, PMTCT and young parent support groups. There is a strong focus on psychosocial support and developing practical skills around communication, assertiveness and self-esteem. A key factor for successful HIV adherence – one of the programme's key aims – was reported to be children's growth in confidence and self-esteem. This not only enabled children to have the persistence to stick with treatment but also strengthened their ability to take charge of their lives in other ways. Examples include going back to or staying in school, making positive choices about relationships, improving communication with caregivers and providing feedback to care providers about what type of HIV and other treatment is best. Although not explicitly addressing violence, abuse, exploitation or neglect, it is clear that the focus on tackling negative self-images of HIV also led to more discussion about issues such as abuse in the home.

34 Mburu, G. et al (2014), 'Responding to Adolescents Living with HIV in Zambia: A social-ecological approach', *Children and Youth Services Review* 45: 9–17.

35 'Interview with Nicola Willis, Founder of the AFRICAID Program'
http://takunda.files.wordpress.com/2013/05/nicola_willis_interview_for_breakthrough_is_imminent.pdf.

'The support, peer-led activities and advocacy work which has taken place has really changed my life, despite the challenges I have been facing at family level. Zvandiri has given me love, developed my confidence and my vision for my life.'

—Loyce, Zvandiri Support Group member and CATS volunteer.³⁶

Kasisi Home, Zambia, has placed a strong emphasis on making sure that children living with HIV are treated no differently from other children. They live, play and study amongst their peers. They receive their anti-retroviral therapy (ART) in the same medical clinic and together with other children who are receiving vitamins or other medications. 'It [HIV] is treated as a natural part of life so that those living with or affected by the disease do not let it determine who they are or what they can be.'³⁷ The issues of stigma and discrimination within schools, families and places of employment are not shied away from and are discussed openly, frequently utilising the real-life experience of HIV-positive care leavers. Recognising that stigma is an issue, the staff of Kasisi also ensure that children living with HIV have a positive self-image. This is reflected in the words of one HIV-positive care leaver when asked to provide advice to those caring for HIV positive children: 'Firstly they should show positive children that they are loved. That being positive is not the end of life.'

Nigeria's HIV and AIDS Anti-Stigma and Discrimination Bill, passed in April 2014, legislates against mandatory HIV testing. The bill, when passed into state law, has been used to support children in cases of discriminatory exclusion from school, for example.

Both HIV and child protection sectors have to recognise that HIV is a profoundly significant issue, especially when children are not living with biological parents. Child protection actors need to incorporate HIV stigma and discrimination reduction activities robustly and actively in their work.

The programmes featured in this report have not monitored the extent to which HIV stigma and discrimination increase family abuse and neglect, or whether violence, abuse and neglect, in turn, reduce access to effective HIV testing and treatment for children. The global evidence does strongly suggest that this is the case.³⁸

A related form of stigma is the continuing taboo surrounding sexual abuse. Sexual abuse is an area where child protection and HIV are directly linked, but in general the issue was actively addressed only when there were specialist organisations focusing on this issue, such as UReport and Childline, that had some type of confidential mechanism where children and

³⁶ Foreword, *AFRICAID Annual Report 2013*. <http://www.africaid-zvandiri.org/our-programmes/>.

³⁷ Although HIV professionals strongly advocate that children living with HIV have the right to live alongside other children with no segregation, this is still not the case in most residential care facilities.

³⁸ Cluver, L., Bowes, L. and Gardner, F. (2010), 'Risk and Protective Factors for Bullying Victimization among AIDS-affected and Vulnerable Children in South Africa', *Child Abuse and Neglect* 34:793–803; Lachman, J. M. et al., 'Positive Parenting for Positive Parents'.

adolescents could ask about, report on and receive support for sexual abuse. Addressing sexual abuse, in both boys and girls, is a core part of linking HIV and child protection, but this study highlights the necessity of paying increased attention to sexual abuse and violence, ensuring that it does not remain hidden whilst other, possibly less taboo forms of child protection violation, are more easily addressed.

4.7 Improving communication between children and their caregivers from an early age

Reducing children's exposure to risk from HIV infection and from violence, abuse, exploitation and neglect requires giving children a voice. This voice is most important within the family environment and with peers. Reducing children's exposure also requires supporting parents and caregivers to communicate clearly with their children about important issues such as HIV disclosure or concerns about child protection violations. Globally, the evidence shows that improved child-caregiver communication increases childhood resilience and minimises risk-taking.³⁹ Supporting parents to disclose their own HIV status has been found to have long-term positive impacts on the well-being of children, parents and family in general.⁴⁰ In the three countries, although there is limited documented evidence, children who participated in the initiatives highlighted in this report reinforced that the ability to communicate and to be heard is a critical part of strengthening resilience.

Children and adolescents all said that they appreciated having forums like Childline or UReport to get information, but they really wanted to be asking their parents questions. In Zambia, adolescent girls and young women in a focus-group discussion at a secondary school for girls in Lusaka⁴¹ said that they wished they could communicate with their parents, but, because of cultural practices and taboos around talking about HIV and sex, they were forced to get information from other sources, which were quite often inaccurate. The inability to communicate within an extended family, often when the child was experiencing rejection or discrimination on entering the new home, was one of the most common challenges that Zvandiri Support Group leaders reported: 'Even in my own family, I was not taken seriously and was being pushed aside. When I joined the support group, I regained confidence.'

39 For example, Betancourt, T., Meyers-Ohki, S.E., Charrow, A. et al. (2013), 'Annual Research Review: Mental health and resilience in HIV/AIDS-affected children – a review of the literature and recommendations for future research', *Journal of Child Psychology and Psychiatry* 54(4): 423–44.

40 Qiao, S., Li, X., Stanton, B. (2013), 'Disclosure of Parental HIV Infection to Children: A systematic review of global literature', *AIDS and Behavior* 17(1): 369–89.

41 The girls participated with the approval of the school's principal; many of the participants were youth leaders in Child Helpline's outreach work so Child Helpline knew them and facilitated the meeting.

Box 9: Giving space for children to speak out to protect themselves

In the Zvandiri programme, CATS volunteers run workshops with caregivers of children living with HIV, providing space for older caregivers to get support in the challenges that they face caring for children living with HIV. The CATS volunteers assist caregivers in thinking through how to disclose to the children they care for and how to communicate with children about the death of their parents. It is a forum where caregivers can talk about the difficulties that they face in parenting and share ideas with young people on how to improve relationships and how to bridge the knowledge gap on reproductive health and protection rights of children and adolescents living with HIV.

Strengthening the monitoring and evaluation components of these programmes would be an important contribution to the evidence base and would help address key issues affecting the scale up of integrated HIV and child protection programming. Key questions concern the child protection–related causes and consequences of nondisclosure to a child; the impact of better family support, communication, and caregiver well-being on both child testing and treatment outcomes and also the risk of violence, abuse and neglect at home; the elements of family support that deliver the most positive results (such as parenting programmes, economic strengthening, intergenerational communication skills or a combination of them); and the impact of care and support interventions on reducing adolescent sexual risk-taking. Much evidence on these questions is coming from elsewhere in sub-Saharan Africa.⁴²

Children, practitioners and some policymakers talked about the need for interventions that improve caregiver-child communication. Such communication would help children to live positively with HIV because of greater ability to disclose status and then access health and HIV care; they would also be able to address potential child protection violations. For example, one nurse from a CSO in Benue State, Nigeria, noted, in relation to high rates of treatment failure when children with HIV became adolescents, that ‘we [health workers] don’t have the skills to talk about adolescence. Often we first have to talk about this when a child living with HIV is pregnant. We need to know more about how to empower parents so that they can provide guidance.’ A focus-group discussion with girls in school in Zambia suggested that events targeting HIV prevention for children and youth (for example, concerts) should also include parents/caregivers so that information and a common language are provided to both children and their parents, thus encouraging open communication around subjects that have been taboo in family discussions.

One of the most important points, and one that continuously came up, was the need to start early in providing parents with such skills. Although communication can be learned at any stage, key informants felt that starting early in the parenting process, such as through prenatal classes or early childhood development (ECD) initiatives would allow parents ample time to

42 Ismayilova, L., Ssewamala, F.M. and Karimli, L. (2011), ‘Family Support as a Mediator of Change in Sexual Risk-taking Attitudes among Orphaned Adolescents in Rural Uganda’, *Journal of Adolescent Health* 50: 228–35; Lachman, J.M. et al., ‘Positive Parenting for Positive Parents’; Qiao, Li and Stanton, ‘Disclosure of Parental HIV Infection to Children’.

become familiar with and accustomed to speaking openly with their children about a range of issues. The hoped-for result would be an impact on adolescent behaviour and HIV infection. In providing these skills early in the parenting experience, it is hoped that open communication built on trust will continue throughout the child's developmental stages, making issues like sex and HIV prevention easier to talk about during adolescence. Ideally, longer-term research could be designed to measure whether ECD interventions, particularly around parent/child communication, have an impact on adolescent risk behaviour and HIV infection.

The study was not able to meet with and review ECD or parenting support initiatives within the three highlighted countries that could be successfully supporting caregivers to deal with depression or other challenges that appear to be strong drivers of children's HIV risk in later years, as evidence from countries such as South Africa shows.⁴³ In Zimbabwe, the NAP II includes expansion of community-based family clubs intended to be a preventive service to strengthen families in which children are at risk of abuse, violence, neglect or exploitation. Including HIV-related risks and addressing HIV stigma would be an obvious intervention for such groups; however, this initiative had not started at the time of the review. One key finding of this study is that very limited links currently exist among HIV actors, child protection actors and ECD specialists. This is an area where key synergies exist, and strengthening these should be a priority for policymakers and practitioners.

⁴³ For information on the impact of caregiver depression and mental ill health on children's exposure to neglect and abuse and later increased risk of sexual and other risk-taking behaviour, see Long and Bunkers, *Building Protection and Resilience*.

5. From evidence to action: Expanding combined HIV and child protection prevention and response

The 2013 study identified potential entry points where combined HIV and child protection interventions can offer a more preventative, sustained and integrated response. In reviewing the identified promising practices, this study has tried to document the interventions that appear to have the most traction in terms of generating positive results related to the safety, health and resilience of children vulnerable to violence, abuse, exploitation, neglect and HIV.

The findings in this study should be considered only a partial snapshot of a selection of initiatives from three countries, representing only a small number of the many partners currently engaged in child protection and HIV programming for children. In the case of Nigeria this is especially important to emphasise because of the immense size and variation of the HIV and child protection context. However, some overall observations can be made about both what is working and where significant challenges remain to implementing combined interventions. This final section draws together some of the key lessons emerging from the findings.

5.1 Entry points

1. Ensure that HIV and child protection are explicitly linked in the development of a national policy, strategic plan or framework for children (for example, a national plan for children, OVC or MVC, a vulnerable children's strategy or priority agenda for children, or a national HIV and AIDS strategy) as a means to understand the interlinked economic, HIV and child protection vulnerabilities faced by children and families. The framework should set out results for both economic (social protection) and child protection vulnerabilities and must feed into national targets on HIV prevention, treatment and impact mitigation. It would need to articulate clearly how the relevant ministries coordinate and collaborate and how they are accountable for delivering on the same results. This is needed to ensure that child protection is addressed across the HIV continuum of care and not just treated as an HIV impact-mitigation link; it also would ensure that HIV is factored within child protection and related social welfare elements.
2. Include a focus on understanding and addressing HIV-related stigma and discrimination, as children experience them, within HIV and child protection guidance, standards and operating procedures. For example, address the issue of HIV-related stigma in alternative care guidelines, HIV testing protocols, paediatric HIV treatment, care and support guidelines, and PMTCT counselling guidelines that include a focus on adolescent girls.
3. Ensure that children and young people, especially those living with and affected by HIV and AIDS, are included throughout all phases of programming. For example, one entry point is adolescent and youth HIV counselling and testing, in order to provide specialised support to children and youth on abuse, sexuality and sexual orientation. HCT is a key entry point to identify the significant nonmedical barriers to paediatric HIV treatment and to targeted HIV prevention for adolescent girls for use in national planning.

4. Involve child-protection experts in national and subnational working groups on HIV prevention and HIV treatment, care and support, as well as in OVC or impact-mitigation groups; this could lead to improved HIV prevention and treatment outcomes that are negatively affected by child violence, abuse, exploitation and neglect. The same is true for child protection working groups at national and subnational levels requiring HIV expertise to ensure that issues of testing, treatment, care, support and stigma are addressed, including in humanitarian response settings.
5. Invest in a strong, integrated case management system that improves outcomes for HIV-affected children and families within a system that is aimed at supporting all vulnerable children and families, linking them to adequate care and support services, building resilience and supporting improved outcomes in all areas. This would include HIV along with all other health, economic strengthening/social protection and child protection interventions. Ensuring that HIV is included in such a system can improve paediatric HIV testing and treatment outcomes and support HIV-affected children and families who are at risk of harm. A case management system (as opposed to exclusively informal referrals) that is endorsed by government and understood and utilised consistently by all key stakeholders, including those conducting community-based and often informal child protection and child welfare interventions, would lead to increased capability to provide care and support to the MVC and families, and lead to better outcomes, greater accountability, enhanced quality control and measurable results.
6. Use the development of family-based alternative care or family strengthening strategies and programmes as an opportunity to recognise and respond to neglect and abuse of children living with HIV in all forms of family and other alternative care; and to provide access for children with HIV to appropriate testing, treatment and care and also access for their parents and caregivers to HIV-related treatment, care and support.
7. Pay special attention to the needs of children from key populations, considering how to ensure that boys who have sex with men or boys, transgender children and children involved in sex work (or children of sex workers) are reached with both HIV and child protection-related services.
8. Include one or more specific indicators on HIV/child protection synergies in national social workforce strengthening strategies and other existing paediatric HIV and child protection monitoring and evaluation systems, irrespective of where these sit within national government structures.
9. Build on the global attention to violence against children and gender-based violence to link specialised services on sexual and reproductive rights, including addressing issues of sexuality, sexual orientation, and sexual abuse and violence with child protection case management and HIV prevention, treatment and support programmes.
10. Use opportunities offered as new PMTCT and paediatric HIV treatment guidelines are adopted to include priority child protection basic information and referral protocols into job descriptions and protocols and standards, such as standard operating procedures. For example, in Nigeria, new task-shifting guidelines for primary health care and specialised HIV staff could be used to see how child protection actors and OVC actors could play a role in increasing HIV coverage and care for vulnerable children.

11. Include positive parenting to encourage communication and disclosure between parents/ caregivers and children and adolescents by bringing together expertise from ECD, parenting support, social protection and HIV prevention initiatives to inform family strengthening programming.
12. Ensure that the national child protection system (mapping, strategy and budget) articulates the specific linkages between HIV impact and subsequent child protection risks, and vice versa, based on national and comparative evidence.
13. Advocate, educate and ensure that HIV-specific child protection risks and inclusion of HIV-affected groups are clearly articulated and included within child protection laws, policies, guidance and standards, including a focus on HIV stigma.
14. Ensure that child protection and HIV programmes prioritise interventions that are family focused, and include abuse/violence prevention, positive parenting techniques, early childhood development and economic strengthening initiatives as part of a standardised package of services available to vulnerable children and families.
15. This study has highlighted the fact that *barriers to HIV treatment and support in the health sector depend on addressing child protection-related issues in the home*. It has also drawn attention to the continuing need to link child protection and HIV alongside other people working on early years support.

Table 3 situates these potential entry points within a systems strengthening framework, identifying the results they could achieve and who must be involved to achieve the results. As this report notes, the models are emerging and have primarily evolved from field experiences. The overarching finding of this study is that linkages need to be made and that this has to happen at the policy level with a more intentional process of requiring sectors to work together on these two issues. The HIV and child protection linkages must be discussed and considered at the policy level and much more explicitly prioritised by both child protection and HIV policy. Sections 5.2 and 5.3 look further at these priorities.

Table 3: Priority areas for action

Systems component	Entry point	Action points	HIV/child protection result for children	Actors
Policy, planning and legal	National action plans for vulnerable children (or equivalent) and/or National priority agendas or commitments for children	Review children's economic, HIV- and child protection vulnerabilities through, where possible, one vulnerable child policy and legal framework as existing NAPs are evaluated and as new plans prepared. Combine child protection and HIV impact mitigation for children and their families under one policy framework, ensuring equal accountability from health and social welfare/ development ministries, with results feeding into the national HIV strategy. Ensure that children who are from key populations or who have caregivers from key populations are reflected in these plans and policies.	Children's economic, HIV- and child protection vulnerabilities are appropriately reflected in one national policy (i.e. a holistic, evidenced-based child policy) which should enable prioritised targeting of interventions towards children and families who are most vulnerable to either/or HIV, economic and child protection vulnerabilities. National plans of action relating to gender-based violence (GBV), violence against children and so forth are aligned with/integrate HIV-specific elements of national HIV responses.	National AIDS and national child protection coordinating mechanisms need to engage with social welfare, social protection, education and health-sector ministries to ensure that child protection, social protection and HIV are equally involved in strategic development. Civil society and community-focused actors must be included to ensure that policies place family strengthening and community-based responses at the centre.
Policy	National HIV and child protection plans	Document children's experiences of HIV-related stigma and discrimination (disaggregated by age and gender, and other factors influencing stigma such as sexual orientation and gender identity) and integrate into national policy and plans. Include mechanisms to address children's HIV-related stigma and discrimination within HIV and child protection standards and operating procedures, e.g. alternative care guidelines, HIV testing protocols, paediatric HIV treatment, care and support guidelines, PMTCT counselling guidelines that include a focus on adolescent girls.	Child protection responses can understand, and effectively respond to, the abuse, violence, exploitation and neglect of children that is caused by HIV-related stigma and discrimination.	National child protection stakeholders must involve HIV prevention and treatment specialists (health sector) in development of standards and protocols. Alternative care stakeholders must consult with those overseeing case management and referral mechanisms from child protection, HIV and health sectors and include community-based actors and interventions.

Table 3 (continued): Priority areas for action

Systems component	Entry point	Action points	HIV/child protection result for children	Actors
Coordination	National HIV sector working groups – prevention, treatment, care and support and impact mitigation. National child protection working group	National and subnational HIV working groups (or equivalent) should involve child protection specialists not only in impact-mitigation meetings but also in HIV prevention and treatment, care and support. Child protection working groups must include representative from the HIV sector to address specifically issues of HIV vulnerabilities of children who have suffered protection violations and the unique protection vulnerabilities of children affected by or living with HIV, including in humanitarian settings.	Inclusion of key child protection factors (sexual and physical abuse or violence, neglect) into HIV prevention, treatment and impact-mitigation components of the HIV response. Inclusion of key HIV factors (family stress due to sickness and stigma, HIV-related stigma, HIV prevention and other sexual and reproductive health issues for adolescents, PMTCT, treatment uptake).	National AIDS coordinating mechanism oversight body needs to engage both health and social welfare ministries in agreeing on mechanisms for coordination. National child protection working group (typically led by ministries of social welfare, or equivalent) engages representatives from health and national AIDS coordinating body.
Coordination	A robust case management system	Design and implement a case management and referral system for vulnerable children and families that facilitates coordination of HIV and child protection services, at the national level if possible and at the local level, especially ensuring linkage from community-based often informal actors to health, education and social welfare sectors.	Increased identification of and referral to HIV and child protection specialist services. Integration with health, social protection, education and any other relevant services.	National ministry responsible for child protection must work with the ministry of health to agree on a mutually supportive case management and referral mechanism that will work across HIV and child protection sectors; active engagement of civil society service providers and community mechanisms in referral systems.
Policy and legal/ workforce	National alternative care guidelines or operating standards	Ensure that issues related to HIV testing, treatment and care are included in alternative care standards or guidelines and in social welfare workforce capacity strengthening programmes. Incorporate standards and procedures in relation to children's experience of stigma and discrimination in all HIV and child protection guidelines and standards developed by government, e.g. alternative care guidelines, HIV testing protocols, etc.	Increased identification of, support to and improved health and well-being outcomes for children living with HIV in alternative care.	National child protection stakeholders must involve HIV prevention and treatment specialists (health sector) in development of standards and protocols. Alternative care stakeholders must consult with those overseeing case management and referral mechanisms from child protection, HIV and health sectors.

Table 3 (continued): Priority areas for action

Systems component	Entry point	Action points	HIV/child protection result for children	Actors
Monitoring and evaluation	National child protection information management system	Child protection indicators include specific indicators related to children affected by or living with HIV in alternative care. Examples include per cent of HIV workforce (auxiliary and professional, e.g. HCT/PMTCT counsellors, adherence support volunteers, HIV treatment staff) trained in basic child protection/case management protocols; per cent of social welfare workforce trained in/receiving regular updates in HIV information; HIV referral protocols included in all social welfare workforce job descriptions/standard operating procedures. HIV indicators include specific indicators related to children whose HIV risk is exacerbated by abuse, violence, exploitation and neglect. Examples include per cent of referrals from HCT and PMTCT to specialist child protection services; HIV testing, treatment, care and support coverage for children living in alternative care (family-based and residential). Indicators should also measure how HIV-impact-mitigation and child protection programmes reinforce outcomes, e.g. do parenting programmes affect adolescent adherence? How do age of consent laws affect HIV testing coverage?	Increased data availability on HIV prevention and treatment issues facing children at risk of abuse, violence, exploitation and neglect, and stigma and discrimination, leading to improved referrals to HIV programmes.	National child protection stakeholders must involve HIV prevention and treatment specialists in development of indicators.
Service delivery	Violence against children/GBV	Ensure that initiatives to develop GBV prevention and response strategies or violence against children strategies link specialised violence prevention and reduction programmes to child protection and HIV treatment services where potentially abused children are being identified, counselled and supported.	Increased referral to post-rape HIV services for children; improved counselling and support to children living with HIV and other children who have experienced violence and abuse. Data on scale and scope of physical and sexual violence against boys and girls can increase evidence-based programming for HIV prevention and affect mitigation in national HIV and AIDS strategic plans.	Both HIV and child protection actors must be involved in development of GBV programmes at strategy design phase.

Table 3 (continued): Priority areas for action

Systems component	Entry point	Action points	HIV/child protection result for children	Actors
Service delivery	HIV counselling and testing treatment uptake and adherence	Use HCT as entry point for providing specialised support to children and youth on abuse, sexuality and sexual orientation. HCT is a key entry point to identify significant nonmedical barriers to HIV treatment and targeted HIV prevention for adolescent girls.	Increased access to HIV treatment services; improved referral to sexual violence and other GBV services; (long-term) improvements in HIV prevention, especially for adolescent girls.	Ministries of health and HIV treatment specialists must consult with children living with HIV and child protection/GBV specialists.
Service delivery	PMTCT and paediatric treatment programmes	Include priority child protection information and referral protocols in revised treatment/PMTCT guidelines and protocols (e.g. task shifting or paediatric ART guidelines).	Increased referrals to family support programmes leading to increased resilience.	Ministries of health and HIV treatment specialists must involve children and young people living with HIV and child protection/GBV specialists throughout such programmes.
Service delivery	Early childhood development, PMTCT, social protection programmes	Include positive parenting to encourage communication and disclosure between parents/caregivers and children/adolescents by bringing together expertise from ECD, parenting support, social protection and HIV prevention initiatives to inform family strengthening programming.	Increased coverage of programmes that support stressed HIV-affected families, leading to reduced neglect and abuse and improved well-being outcomes.	Ministries of education, social welfare/child protection, health.
Crosscutting	Understand the role of HIV-related stigma and discrimination, as experienced by children, as a potential child protection risk	Draw on the experiences of children living with HIV, and their families, to identify HIV stigma-related issues that may lead to abuse and violence; use this information to improve current family-based and community-based HIV, child protection and OVC programming and in workforce training.	Improved understanding of how HIV stigma affects HIV prevention and treatment outcomes and child protection programming.	Ministries of health, HIV service providers and child protection actors must identify ways routinely to involve children and young people living with HIV throughout such programmes.

5.2 Longer-term policy challenges and opportunities

As this study progressed, it became clear that promising models are primarily being initiated by individual implementers and service providers. There is still no overarching recognition amongst either child protection or HIV/health policymakers that success in the individual sectors requires a concerted effort for joint action.

This section highlights some of the challenges that were encountered during this study process and that are best dealt with at the global or regional level.

First, and most important, the emerging practices all demonstrate the absolute necessity of maintaining awareness that protection, care and support of children are fundamental to the HIV prevention and treatment agenda. In all three countries the tangible results of getting numbers of people on treatment, or the clear steps that can be taken to punish perpetrators of abuse against children, for example, were reported as being more easily addressed than underlying social and economic drivers. This study highlighted the importance of having a strong and very clear set of policies and guidance around what child protection services are *required* if children are to be able to access and adhere to treatment, for example, and what HIV services must do to enable children to be protected from harm. The lack of explicit focus on these synergies at policy level makes it extremely hard for small, emerging practices to scale up.

Second, there needs to be the balance between moving from welfare-oriented and HIV-targeted OVC programmes to a response for vulnerable children that is HIV sensitive and not HIV blind. While the move away from targeted OVC programmes is welcome, the risk is that the specific HIV needs of children and adolescents will be overlooked. In Zimbabwe, for example, some actors in the response were reticent to ask questions about HIV when researching children's experiences within households or in relation to service delivery (for example, in monitoring the impact of cash-transfer programmes and assessing reasons for school drop out). This has led to lost opportunities to find out essential information – for example, research on girls' and boys' experience of violence and a study exploring reasons for school dropout did not include questions on potential HIV-related factors. The global evidence clearly shows that HIV-related stigma and discrimination in families is leading to abuse and neglect. HIV-sensitive policies must continue to be able to understand and to design appropriate responses to the unique HIV-related factors experienced by children and their families.

Another broad challenge that appears to limit the ability to integrate HIV and child protection is the belief of some donors and implementers that child protection is synonymous with OVC programming and, hence, is an 'impact-mitigation problem'. This was particularly noticeable in Nigeria, where USAID-funded implementing partners tended to talk about child protection when delivering basic materials to children identified as orphans or vulnerable. The global evidence strongly shows that neglect, abuse and violence experienced by children, and HIV-related discrimination against children and their families, reduce children's ability to access HIV treatment and care, and increase children's exposure to HIV risk. HIV prevention and

treatment actors need to recognise much more clearly the need to look at the social and economic drivers and make the right linkages.

The most exciting examples of good integration were those run by and working with adolescents and youth. Despite searching for examples, it was not possible (at least, in the very short time frame and small study area in these three countries) to identify and include programming with younger children. In part, it is possible that child protection and HIV sectors find it even harder to coordinate with the education sector than with each other. There has been an enormous increase in targeted early childhood interventions because of the proven beneficial impact on physical, cognitive and other developmental outcomes.⁴⁴

One issue that was raised, but only discreetly, in discussions with key informants in all three countries was an increasing need to address and respond to questions and concerns regarding male rape and questions about child and adolescent sexual orientation. Recognising that this is still a very difficult and culturally sensitive topic, and that homosexuality has been criminalised in Nigeria and Zimbabwe, the issue requires an informed response. At this point in time there are no services in place to address these issues appropriately, and it is unlikely that community-based or clinic service providers will be able to address an issue that is so socially taboo. It will be important for policymakers to draw on the growing number of evidence-informed guidance documents, such as UNICEF's recent position paper on eliminating discrimination against children and parents based on sexual orientation.⁴⁵

Child protection actors need to incorporate HIV stigma-reduction activities robustly and actively in their work. As the 2013 study concluded, a child-specific definition of HIV stigma is needed if we are to be able effectively to reduce barriers to HIV prevention and treatment and address HIV-specific abuse, violence, exploitation and neglect. For example, the national study on stigma in Zimbabwe found that only 4.1 per cent of respondents reported that they had been dismissed, suspended or prevented from attending an educational institution as a result of their HIV status, but more than 80 per cent of respondents reported that their children had been dismissed, suspended or prevented from attending an educational institution.⁴⁶

44 Engle, P., et al. (2007), 'Strategies to Avoid the Loss of Developmental Potential in More than 200 Million Children in the Developing World', *Lancet* 369(415): 229–42.

45 UNICEF, *Eliminating Discrimination against Children and Parents Based on Sexual Orientation and/or Gender Identity*.

46 GNP+ (2014), *Zimbabwe People Living with HIV Stigma Index 2014*.

Conclusions

Practical linkages between HIV and child protection programmes are still emerging primarily on an intuitive basis within programmes. Across all three countries emerging practices were not developed out of an explicit intention to improve HIV outcomes by addressing child protection risks, or vice versa. The emerging promising practice models were generated in the course of designing or delivering individual initiatives. Of the three countries, Zimbabwe was the only one where there was an example of how policy was encouraging the synergies to be made. And even in this case there needs to be continued vigilance to ensure that a combined child protection and social protection framework for addressing children's vulnerabilities does not become HIV blind. Policymakers must generate opportunities actively to build in linkages in policies and strategies. Globally, HIV and child protection actors must build on the evidence available to support the development of more integrated policies.

The findings in this study highlight how much children living with HIV feel that abuse, violence, exploitation and neglect *do* compromise their ability to access and adhere to treatment. The strongest voices were from – or representing – children living with HIV and the risks faced by stigma and related child protection risks. Their greater involvement across HIV prevention, treatment and impact mitigation is an obvious entry point.

We still do not know enough about the experiences of children living within communities in informal extended family care, in residential care or within key populations, such as children of sex workers, in relation to their HIV experiences. The study shows that there are strong grounds to suggest that a large proportion of children are being discriminated against because of HIV, are suffering unintentional neglect because families are themselves HIV affected and cannot provide for the child, or are exposed to HIV risk through early sexual debut, and so on. A stronger policy lead from alternative care practitioners and a case management approach may be needed effectively to reach the most vulnerable children, parents and caregivers and generate benefits at scale.

Some of the most obvious entry points are relatively simple for either child protection or HIV prevention and treatment stakeholders to implement. They just need to ask the right questions:

- Do HIV or HIV stigma have anything to do with the problem that this child is facing?
- Are the desired HIV prevention or treatment outcomes being affected by abuse, violence or neglect, by increasing risk of HIV infection or by restricting access to prevention or treatment information and services?
- What people do we need to talk to find out the answer to this, and can we involve them in our programme or policy design?

There are many examples on the ground of policymakers and practitioners asking these questions themselves. The priority must be to feed examples into national policies, strategies and action plans by getting practitioners around the same table during the formulation of strategies affecting HIV and child protection service delivery.

The study has highlighted the courage and energy of people who are already addressing these issues. Children living with HIV and children experiencing a range of protection violations do speak out when given a safe space and support to do so. But those working with children must remember to ask children questions. In all three countries it was clear that children did have critical information that could help inform the work that adults are doing, but the key is for the adults intentionally to include children and encourage them to speak. Finding the ways and means to encourage this involvement must be a priority. These examples also reflect the courage of policymakers who have taken steps outside the 'business as usual' approach to involve children living with HIV, have taken the time to hear what children and youth are saying, and have acted upon what they have learned.

Annex I: List of stakeholders

The following participants contributed generously of their time and insights.

Nigeria

Elizabeth Abua (Cross River State Child Protection Network), Austin Abugh (The Royalties Care Foundation, Benue State), Mrs Asi Achibong (Cross River State Ministry of Women Affairs), Mrs Abdulkadir (Ministry of Women Affairs and Social Development), Dooshima Ageh (Mimidoo Initiative for Empowerment, Benue), Dr Mercy Agemba (NACA), Fadekemi Akinfaderin-Agarau (Education as a Vaccine – EVA), Sir Nick Ahor (IHP, Catholic Diocese of Makurdi, Benue), Dr Olusoji Akinleye (UNICEF Enugu), Mrs A. A. Aliu (Ministry of Women Affairs and Social Development), Irene Alom (Cross River State AIDS Coordinating Agency), Justine Apebende (Oden Ita Foundation), Priscilla Atoza (Ministry of Women Affairs and Social Development, Benue State), Mary Atser (Manna Love and Care Foundation), Nathaniel Awuapila (CORAFID/Benue State Child Protection Network), Richard Balentine (Cross River State Child Protection Network), Dominion Bassey (Oden Ita Foundation), Rajimor Bassey (Passion Universal, Cross River State), Mrs U. Bassey (Cross River State AIDS Coordinating Agency), Sir Melford Bisung (Ministry of Social Welfare and Community Development, Cross River State), Ola Florence Bose (Catholic Women Organization, Okpokwu, Benue), Nwamaka Chude-Onwurah (UNICEF Enugu), Enrique Delamonica (UNICEF), Mr I. A. Ebuaja (Cross River State Child Protection Network), Maryam Enyiazu (UNICEF), Gloria Ephraim (Cross River State Ministry of Justice), Nicholas Eval (Cross River State Child Protection Network), Dr Yinka Falola-Anoemuah (NACA), Pamela Gado (USAID PEPFAR), Rachel Harvey (UNICEF), Joy A. Ijuwo (Okaha Women and Children Development Organisation, Benue), Mary Osiwa Ikeh (Nigerian Red Cross Society, Benue), Terkura Iperfen (Gboko Local Government Council, Benue), Beetor Ishangev (Victory Development Services, Benue), Victoria Isiramen (UNICEF), Ann Kangas (UNICEF), Kwaggbbee Jack (Emmanuel Teryila Memorial Liberty Foundation, Benue), Doreen Magaji (USAID PEPFAR), Blessing C. Nkem (Bena Charity Care Foundation – BENCARE, Benue), Mr Eddy Peter Ofem (Cross River State Child Protection Network), Onoja Great Okibe (Great Future Care Home, Benue), Stella Okon (Oden Ita Foundation, Cross River), Lucy Onazi (Ministry of Women Affairs and Social Development, Benue State), Evelyn Oti (Bama Health Foundation, formerly Conscientising Against Injustices and Violence – CAIV), Dennis Tsegba (Ministry of Women Affairs and Social Development, Benue), Ms Elizabeth Uquak (Cross River State Child Protection Network), Peter Utenger (Initiative for Community Change and Social Development, Benue), Arjan de Wagt (UNICEF), Grace A. Wende (Benue State AIDS Coordinating Agency), Joanna Wusu (USAID PEPFAR), Ann Yaji (Ministry of Women Affairs and Social Development, Benue).

Zambia

Florence Chileshe-Nkhuwa (Child Helpline), Akekelwa Chitonka (Child Helpline), Maud Droogleever Fortuyn (UNICEF), Beyant Kabwe (Save the Children), Rita Kalamatila (National AIDS Council), Elizabeth Kazembe (Elizabeth Glaser Paediatric AIDS Foundation), Priscilla Chomba Kinywa (UNICEF), Andre Lesa (UNICEF), Dr Luula Mariano (UNICEF), Dr Jack Menke (Elizabeth Glaser Paediatric AIDS Foundation), Sister Mariola Mierzejwska (Kasisi Children's Home), Anna Mubukwanu (Ministry of Community Development and Mother and

Child Health), Pumula Mundale (Ministry of Gender and Community Development), Irene Munga (Ministry of Community Development and Mother and Child Health), Catherine Muyawala (National AIDS Council), Justine Mwiinga (National AIDS Council), Dr Leah Namonje (Ministry of Community Development and Mother and Child Health), Daisy Ngambi (Ministry of Gender and Community Development), Timeo Phiri (Child Helpline), Rosanna Nyendwa Sammon (CHAMP), Crispin Sapele (CHAMP), Bruce Sikazwe (Child Helpline), Dr Landry Tsague (UNICEF), Cornelia Van Zyl (Save the Children), John Zulu (Ministry of Gender and Community Development) and 15 girl students between the ages of 15 and 22 from a secondary girls school in Lusaka.

Zimbabwe

Lilian Chapanga (Case Care Worker, Epworth), Monica Chisororo (Centre for Operations Research and Evaluation), Beatrice Dupwa (Ministry of Health and Child Care), Noriko Izumi (UNICEF), Lovemore Magwere (UNICEF), Nicholas Mdada (Case Care Worker, Epworth), Stella Motsi (Childline), Ndangariro Moyo (UNICEF), Precious Muwoni (World Education Incorporated), Mr Mvanochiya (Department of Social Services, Ministry of Public Service, Labour and Social Welfare, Epworth), John Nyathi (Department of Social Services, Ministry of Public Service, Labour and Social Welfare), Line Rasmussen (UNICEF), Beula Senzanje (UNICEF), Bernadette Tachivona (UNICEF), Aaron Zinyanya (NAP II Secretariat), Felicitas (Zvandiri), Nigel (zvandiri), Chengetai (Zvandiri), Mather Mawodzeke (Zvandiri) and two CATS volunteers who contributed their insights.

Annex 2: Bibliography

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Annex 3: Recommendations from 2013 global study

National-level recommendations

1. Ensure that the national child protection system articulates specific linkages between HIV and subsequent child protection risks, and vice versa, based on national and comparative evidence.
2. Ensure that HIV-specific child protection risks and inclusion of HIV-affected groups are included within child protection laws, policies, guidance and standards, including a focus on HIV stigma.
3. Ensure that there is a baseline and means for ongoing monitoring on how HIV affects children living in alternative care settings.
4. Ensure that services that are being delivered by the child protection and social welfare sector include HIV-specific prevention, care and support components.
5. Prioritise interventions that are family focused and include abuse/violence prevention, positive parenting techniques, early childhood development and economic strengthening initiatives as part of a standardised package of services available to vulnerable children and families.
6. Include HIV-specific indicators within child protection monitoring and evaluation frameworks.
7. Ensure that core HIV components are included in regulations, standards and operational guidelines for all child protection personnel.
8. Ensure that child protection and children's HIV vulnerabilities, including the synergies between these two, are reflected in emergency preparedness and response plans and are monitored.
9. Calculate cost effectiveness of delivering to children affected by AIDS through a child protection system compared to stand-alone programmes.
10. Ensure that strong coordination exists between national plans of action for children and child protection systems strengthening efforts.
11. Include at least one child protection outcome in national HIV and AIDS national indicators.⁴⁷
12. Ensure that child-focused HIV regulations, standards and operational guidelines include child protection training for HIV staff and provide a mandate for child protection support and referrals.
13. In HIV programming for children affected by HIV, prioritise interventions that are family focused and include abuse/violence prevention, positive parenting techniques, early childhood development and economic strengthening initiatives as part of a standardised package of services available to vulnerable children and families.

⁴⁷ UNAIDS (2011), *Global Aids Response Progress: Guidelines for construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS*.

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



World Vision International
Executive Office
1 Roundwood Avenue,
Stockley Park
Uxbridge, Middlesex UB8 3PH
United Kingdom

World Vision Brussels &
EU Representation ivzw
18, Square de Meeûs
1st floor, Box 2
B-1050 Brussels
Belgium

World Vision International Geneva
and United Nations Liaison Office
7-9 Chemin de Balexert
Case Postale 545CH-1219
Châtelaine
Switzerland

World Vision International New York
and United Nations Liaison Office
919 2nd Avenue, 2nd Floor
New York, NY 10017
USA

www.wvi.org

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The United Nations Children's Fund
3 United Nations Plaza
New York, NY 10017, USA

www.unicef.org

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