Assessment of Protection Risks and Failures for Children Vulnerable to and Affected by HIV and AIDS in Pakistan
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Pakistan 2008
(data collected August - October 2007)
ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ARVs</td>
<td>Antiretroviral Medicines</td>
</tr>
<tr>
<td>AWARD</td>
<td>Association of Women and Rural Development</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CPWB</td>
<td>Child Protection and Welfare Bureau</td>
</tr>
<tr>
<td>ECPAT</td>
<td>End Child Prostitution, Child Pornography and Trafficking of Children</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FATA</td>
<td>Federally Administered Tribal Area</td>
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<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IDUs</td>
<td>Intravenous Drug Users</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>KABP</td>
<td>Knowledge Attitude Beliefs and Practices</td>
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<tr>
<td>MSW</td>
<td>Male Sex Worker</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
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<tr>
<td>NCCWD</td>
<td>National Commission for Child Welfare and Development</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NWFP</td>
<td>Northwest Frontier Province</td>
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<tr>
<td>NSP</td>
<td>Non State Provider</td>
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<tr>
<td>OVC</td>
<td>Orphan and Vulnerable Children</td>
</tr>
<tr>
<td>PBM</td>
<td>Pakistan Bait-ul-Mal</td>
</tr>
<tr>
<td>PLHIV</td>
<td>Person Living With HIV</td>
</tr>
<tr>
<td>PPA</td>
<td>Participatory Poverty Appraisal</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
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<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>SACHET</td>
<td>Society for the Advancement of Community, Health, Education and Training</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNCRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<tr>
<td>UNESCAP</td>
<td>United Nations Economic and Social Commission for Asia and the Pacific</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office for Drugs Control</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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</tbody>
</table>
ACKNOWLEDGEMENTS

The National AIDS Control Programme (NACP) and UNICEF would like to acknowledge the following for their contribution to this report:

• The men, women and children who agreed to take part in focus group discussions and to be interviewed. It was a difficult task to find families infected or affected by HIV and AIDS because of stigmatisation and the fear of further disclosure. Similar acknowledgement and praise also goes to the sex workers and injecting drug users who participated in discussions.

• The National Commission for Child Welfare and Development of the Ministry of Social Welfare/Special Education for their ongoing commitment to protecting children in the context of HIV and AIDS.

• Dr. Andrew Dunn, Dr Riaz Malik and Mahmooda Nasreen of SoSec along with their district research teams for fieldwork and analysis of data. Thanks also go to the Government officials, NGOs, and community and religious leaders who agreed to give up their valuable time to be interviewed.

• Ms. Rachel Odede in the UNICEF Regional Office South Asia for her support in building capacity to understand and address issues of children living with HIV and AIDS.

• The family pictured on the front of this report for agreeing to be photographed and interviewed by Nai Zindagi for a study on the dual impact of HIV and injecting drug use in families. The HIV status of the woman in the picture is unknown.

• Finally, the Department for International Development (UK) for their regional support in ensuring the needs of children affected by HIV and AIDS are addressed throughout the region through reports such as this one.

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Inside Document: UNICEF/Giacomo Pirozzi/Asad Zaidi
FOREWORD

Pakistan is signatory to the Millennium Development Goals (DGs), 2000. The MDGs set eight goals to be achieved by 2015 including combating HIV/AIDS. Pakistan being member State participated in the United Nations General Assembly Special Session on Children (UNGASS) 2002. The outcome document *A World Fit for Children* set a comprehensive future agenda focused on four key priorities: promoting healthy lives; providing quality education for all protecting children against abuse, exploitation and violence; and combating HIV/AIDS.

Following the outcome document of UNGASS, Government of Pakistan committed to combat HIV and AIDS by 2015. It is noted with grave concern that there is a lack of information on the issue of HIV and AIDS especially its prevalence among children, which required to be addressed on priority basis - particularly the impact of AIDS epidemic on children, identification of vulnerability of children from first most at risk populations, and gaps in the protective framework is of crucial importance.

The current study is a result of intensive work done by UNICEF and National AIDS Control Programme. I must appreciate their hard work and encourage them to effectively use the findings of the study for prevention of HIV/AIDS and to improve the lives of infected and affected people, including children. I am confident that the study will result in immediate action by the concerned agencies to ensure full protection to the targeted population.

Ministry of Social Welfare and Special Education ill undertake all possible means to facilitate implementation of recommendations of the study.

G.M. Sikander
Secretary
Ministry of Social Welfare and Special Education
FOREWORD

The National AIDS Control Programme and UNAIDS estimate that there are currently 85,000 adults aged 15-49 years living with HIV or AIDS in Pakistan, 0.1% of the adult population. Given the high rates of marriage amongst Pakistani adults and the average birth rate of four children, we can estimate that even if only 50% of the 85,000 are married, then we need to consider there may be over 150,000 children affected by HIV and AIDS living in Pakistan.

Children affected by HIV and AIDS often fall out of protective networks as they become isolated by extended family members due to stigma and discrimination and are often forced to care for their ailing parents, becoming adept at administering medicines and offering palliative care. These are unnecessary burdens on children that come too early when the protective system fails them.

The most critical protective element for children affected by HIV and/or AIDS is to ensure that their parents are kept alive. This means increasing access to Voluntary Counselling and Testing (VCT) for high risk populations, migrant workers and wives of all to ensure those who need care, support and eventual treatment receive it so that families can remain whole and healthy.

The National AIDS Control Programme has taken a rights-based approach in their National Strategic Framework 2008 – 2013, extending rights of access to all persons infected or affected by HIV, realising that persons affected face multiple challenges like: reduced access to education, reduced income streams, reduced capacity to perform domestic work, reduced capacity to take care of dependents and possibly structural changes within household cohesion that ultimately destroy the society.

This assessment, conducted jointly with the Ministry of Social Welfare with the support of UNICEF, examines the welfare of children with one or more HIV positive parents through the lens of protection systems and mechanisms. It is a first step in working towards a multi-sectoral approach to address the multiple burdens of HIV spanning medical and social strata.

With this assessment we can begin to address, holistically, the protective needs of affected children, understanding that increasing access to services that can diagnose and keep parents alive longer is the most important step in protecting children.

Dr. Hasan Abbas Zaheer
National Programme Manager
National AIDS Control Programme
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1. EXECUTIVE SUMMARY

The rationale for this assessment was to provide information to help understand the reality for children and their families affected by HIV and AIDS so that appropriate service provision can be advocated for with evidence. A qualitative assessment was needed to help increase the understanding of the impact of the HIV and AIDS epidemic on children. This is important in Pakistan, since children affected by HIV are invisible in national and sub-national multi-sectoral responses. The assessment objectives were to examine the policy and legal frameworks, social protection systems and safety nets and to analyse the current care and protection system for children who could be made vulnerable because of HIV and AIDS. The assessment would also look at the impact on families and their coping strategies. The study was guided by the International Orphans and Vulnerable Children Framework.

The study comprised a literature review and information collected from key informants in 7 Districts where UNICEF was operational. Focus group discussions and in depth interviews were conducted with People living with HIV and AIDS and from other high risk groups in the same Districts. Children also participated in the study.

The information from the literature review indicated Pakistan had nearly 4,000 reported cases of HIV and AIDS but the UN estimated 85,000 people were infected. Documented high risk groups include intravenous drug users, commercial sex workers and returning migrant workers with HIV from risk behaviours. Homeless and working children are also documented as being at risk because of the manner in which they are abused and sexually exploited. Apart from Punjab, laws and structures for child protection are outdated and reform processes are only just beginning. Abuses against groups of children were well documented in the literature but there were only isolated reports of action being taken to end these abuses.

Information from key informants was that poverty was a major cause of exclusion and discrimination. The problems of street children and children whose parents were from the high risk groups were well known. Family and community support for vulnerable children is declining because all poor families feel they have reduced capacity to meet increasing demands. Generally it was admitted that services were not reaching these groups who were also being failed by social safety nets. Only Non Government Organisation (NGOs) who targeted services at people living with HIV (PLHIV,) their families and at other risk groups were seen as providing support. Informants thought that policy and laws existed only on paper, were old and ineffective.

SoSec who conducted the field work found PLHIV difficult to contact and gather together even with assistance from Provincial AIDS Control Programmes (PACPs) and NGOs. There were complex issues of status disclosure within families and in groups that had to be handled sensitively. There is fear of exposure and increased discrimination, however, injecting drug users (IDUs) and sex workers appeared more willing to participate.

1 www.nacp.gov.pk.
There is probably not the evidence base from PLHIV to draw specific conclusions and make recommendations. It appears that HIV and AIDS where people are known to be infected brings an increased level of discrimination and exclusion, probably as great as that afforded to intravenous drug users (IDUs) and sex workers. Expectations of support from family, friends and community were variable and some people had been cut off from support. Others knew they could get support for their children. Apart from NGO services particularly to PLHIV most groups were excluded from social safety nets. Access to education and health care was difficult. For some families children were working because parents were sick.

Where there is knowledge or disclosure a proportion of children affected by HIV and AIDS are likely to face issues of exclusion from basic services and may find it difficult to be accepted into relatives’ families if their own parents fall ill or die. There was evidence of people dying from HIV and AIDS or being in ill health which must be a concern with regard to delivery of treatment and support. Homeless children, children whose parents are IDUs and sex workers face numerous risks particularly from: violence, drug and substance abuse, sexual abuse and exploitation. The rights of these children to protection, survival and development are being ignored and violated. The only support available appears to be offered by NGOs.

Children are vulnerable because of poverty, and at risk because of family breakdown, violence, abuse and exploitation. Children affected by HIV and AIDS may have joined these groups and some are in danger of joining if treatments and healthcare for parents are not of good quality. Social protection and child protection services are failing these children. Social protection in its widest sense needs to be improved as its failure contributes considerably to exposure of children to most of the protection risks.

Recommendations are for immediately improving the access to voluntary counselling, and treatment for the 85,000 persons who are estimated to be infected. Provision of treatment can keep parents alive and they in turn are able to better protect their children. It is recommended that social protection and child protection systems are reformed to make them effective in reaching vulnerable children; this needs to be given long term priority. There are some positive beginnings in terms of national policy development and legislative models. It is important that the government addresses the issue of discrimination by service providers against PLHIV and other risk groups. It is further recommended that UNICEF take a long term strategic approach to improving protection for children in Pakistan and works with the government to develop a strategic plan. It is perhaps necessary for a major assessment of the social protection system with regard to how it could improve its assistance to vulnerable children.
2. RATIONALE FOR THE ASSESSMENT

There was a need for more information in order to understand the reality for children and their families affected by HIV and AIDS so that appropriate service provision including health, access to treatment, social services, psychological support as well as social legislation and other protective measures can be advocated for with evidence.

A qualitative assessment was wanted to help increase the understanding of the impact of the HIV and AIDS epidemic on children. This is important in Pakistan, since children affected by HIV are invisible in national and sub-national multi-sectoral responses. Their numbers are not known; their situation and needs have not been assessed and resources have not been identified to provide care and support. Children affected by HIV and AIDS may also be orphans (having lost one or both parents to AIDS) leaving them especially vulnerable.

3. INTERNATIONAL ORPHAN AND VULNERABLE CHILDREN (OVC) FRAMEWORK

The assessment was guided by the five strategies outlined in the Framework for the Protection of Orphans and Vulnerable Children. These are intended to target key action areas and provide operational guidance to governments and other stakeholders as they respond to the needs of orphans and vulnerable children:

- Building the capacity of families
- Mobilising and supporting community-based responses
- Ensuring access to essential services
- Ensure that Governments protect the most vulnerable children
- An enabling environment: the legislative framework

4. ASSESSMENT OBJECTIVES

The general objective of the study is to increase the understanding of the impact of the HIV and AIDS epidemic on children in Pakistan, in particular children of most-at-risk populations. The study tried to examine the ways children from most at risk populations and children infected and affected are more vulnerable, and point out some of the most important protection risks as well as gaps in the protective framework.

The assessment sought to identify whether at family and community levels the issues of discrimination and stigma surrounding HIV and AIDS and most-at-risk populations, (male and female sex workers, intravenous drug users) impact how affected children are able to access traditional coping and caring systems and services.

The assessment sought to address the following 4 specific objectives:

1. Determine family and community-level impact, perceptions, existing coping methods and alternative mechanisms of support for community based programming for children of most at risk populations and for children and families affected by HIV and AIDS.

2. Critically analyse overall system of care for children vulnerable to and affected by HIV and AIDS and make recommendations for policy development, advocacy and targeted evidence-based strategies for programming (including family and community-based options, institutional services and delivery / access of basic services).

3. Investigate the policy and legal frameworks for protecting the rights of children, especially those made vulnerable to and by HIV and AIDS.

4. Review the efficacy of safety nets for protection of vulnerable children of most at risk populations and migrant workers in Pakistan given the current trends and expected severity of the epidemic (Zakat, public welfare assistance, access to health, education and welfare systems).

5. STUDY METHODS

The fieldwork was conducted by SoSec over 10 days during a 2-month period in the following districts: Faisalabad, Lahore, Larkana, Karachi, Mardan, Peshawar and Quetta (see Appendix 1 for Fieldwork assessment methodology and tools). The intention of the assessment was to gather information directly from PLHIV, affected children, community leaders, NGOs and other service providers about the effect of HIV and AIDS on children and families. We wanted to talk to people who had direct experience of the problem. The researchers were asked to avoid talking simply to high risk groups of children whose life experiences and knowledge are well documented through knowledge attitude beliefs and practices (KABP) and other studies.

In each of the 7 Districts at least 6 Key informant interviews were to be conducted with informants selected from:

- Community Leaders
- Nazims or Councillors
- Provincial Social Welfare staff
- Provincial AIDS Control Programmes
- Religious Leaders
- NGOs
- Community Development Officers

Focus Group Discussions Held:

<table>
<thead>
<tr>
<th>District</th>
<th>Faisalabad</th>
<th>Karachi</th>
<th>Lahore</th>
<th>Larkana</th>
<th>Mardan</th>
<th>Peshawar</th>
<th>Quetta</th>
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<tbody>
<tr>
<td>IDU</td>
<td>√</td>
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<td>√</td>
<td>N/A</td>
<td></td>
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<tr>
<td>PLHIV</td>
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<td>√</td>
<td>√</td>
<td>√</td>
<td>N/A</td>
<td></td>
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</tbody>
</table>
In each District an in depth interview was to be conducted with a PLHIV and an affected child.

The entry point for the district research was the National AIDS Control Programme and the Ministry of Social Welfare who had agreed to help identify the NGOs working with the main groups at risk. The District research teams worked through the NGOs to contact the vulnerable and risk groups.

The policy and legal frameworks were assessed through literature review and key informant interviews. Street children and other children at risk through sexual abuse and exploitation were not specifically targeted in the field work as it was felt that the protection risks and concerns for these children had been sufficiently documented by NGOs and other researchers.

6. CONSTRAINTS

Pakistan has relatively few reported cases of HIV infection. The very issues of stigmatisation and discrimination that the study wanted to examine made people difficult to find and reluctant informants.

According to the lead researcher from SoSec it was “difficult to interview PLHIV because of secrecy and stigma about HIV and AIDS. The PLHIV did not want to be interviewed by research team who knew who they are and where they come from. They prefer to be interviewed by people outside their clan.”

Although the assessment was primarily to collect qualitative information it would have been useful to have some precise figures on number of affected children. This information was not available. The field workers found that it was very difficult to obtain data on PLHIV from provincial government offices. Attempts to obtain secondary data from the Child Protection Welfare Bureau was also not fruitful as the Bureau maintained to SoSec that they could not release reports or documents in draft form. This therefore forced the researchers to rely mainly on information/data provided by NGOs.

7. HIV AND AIDS IN PAKISTAN

According to National AIDS Control Programme (NACP) there is low prevalence of HIV and AIDS in the general population, but reports confirm concentrated epidemics >5%
among injecting drug users and male sex workers whose linkages and sexual networking with mainstream population makes Pakistan vulnerable to the threat of a generalised epidemic. Poverty, high fertility rates, gender inequality, a large population aged below 25 years\textsuperscript{6} and a concentrated epidemic is the current scenario. These at risk reproductive age populations converge through sexual networks; plus many are married which increases the likelihood of mother to child transmission and expands the pool of children affected by HIV and AIDS.

Pakistan has a history of nearly 4000 recorded cases of HIV and AIDS since 1986. It is estimated that fewer people\textsuperscript{7} are registered for treatment and in contact with treatment centres or health facilities. The actual number of children affected by HIV and AIDS is not certain, and the figures are not disaggregated by age.

The UNAIDS modelling estimate of 85,000 persons living with HIV or AIDS in Pakistan reflects adults 15-49 years (sexually active) and comes to 0.1\% of the general population. As the majority of persons living in Pakistan with HIV or AIDS do not know their HIV status, the specific vulnerabilities of their children related to HIV remains unclear. If for argument, using a low figure of 50\% being married with an average of four children per family, there could be between 100,000 to 200,000 affected children living in Pakistan today.

Apart from homeless children and child labourers not much is known about the protection issues faced by vulnerable children. There are no reports of children being orphaned due to the death of their parents from HIV and AIDS. There are clearly groups of children unwittingly vulnerable to HIV and AIDS because of exploitative sex and abuse.

\textbf{7.1 High Risk Groups}

In Pakistan particular behaviour patterns or exposure to potential risk make some groups of people more-at-risk of infection, and these groups include children, women and men who engage in sex work, injecting drug users, prisoners and migrant workers. These high risk groups of people are frequently married and have children.

The existence of risky sexual behaviours among the general population, internal and external migration, high level of injection use, unsafe invasive medical practices and inadequate health and social services are some of the factors increasing the spread of HIV. Other Asian countries have witnessed IDUs together with sex workers being the route by which HIV infects the general population.

According to the HIV 2\textsuperscript{nd} Generation Surveillance Report that surveyed female sex workers (FSW) in 2005, the HIV prevalence among FSWs is 0.2\%\textsuperscript{8} while for male sex

\textsuperscript{6} United Nations Statement on HIV AIDS in Pakistan.
\textsuperscript{7} The Body HIV Treatment Website: U.S. Centers for Disease Control and Prevention • International News Pakistan Battles HIV/AIDS Taboo April 12, 2007, excerpted from BBC News 04.09.2007; Ashfaq Yusufzai: “Pakistan has recorded 3,933 HIV/AIDS cases, among whom 618 registered for treatment, to a Ministry of Health report.”
\textsuperscript{8} HIV 2\textsuperscript{nd} Generation Surveillance in Pakistan, National Report Round 1 2005 NACP.
workers (MSW) the average prevalence is 0.4% rising to 4% in Karachi.

7.1.1 Intravenous Drug Users and their families

Pakistan is one of the countries hardest hit by drug abuse in the world. United Nations Office for Drugs Control (UNODC) estimates the prevalence of opioid use in Pakistan is at around 0.7% of the adult population or around 640,000 opioid users. Of these around 77% (500,000) are estimated to be heroin users. Opiates were usually smoked and inhaled but recently the practice of injecting has been observed which raises concerns about transmitting hepatitis and HIV through the process of needle sharing. The prevalence of injecting drug users is estimated to be around 0.14% of the adult population with corresponding estimates of around 130,000 injecting drug users in the country. The estimated number of injecting drug users in Pakistan has doubled since 2000. There are also increased risks of unprotected sex during intoxication, and selling sex for drugs. Injecting drug users threaten an HIV epidemic.

In Karachi the number of infected IDUs has risen from just one case to 26% in the same community when retested over a seven month period in 2004. In Larkana, almost 10% IDUs tested HIV positive. The HIV prevalence among IDUs in other cities is also reported to be increasing; by 2.5% in Lahore; 12% in Sargodha; 0.5% in Rawalpindi; 1% in Sialkot; and 9.5% in Faisalabad. The recent National surveillance report now puts the overall HIV prevalence for IDUs at 10.8%.

In the recent participatory poverty assessment, increasing numbers of people addicted to drugs was a reported trend in many areas. People from urban areas in Balochistan, Northwest Frontier Province (NWFP), Punjab and Sindh commonly complained about the negative effects of drug addiction and saw it not only as a health problem, but also a cause of increased domestic violence against women and the loss of productive labour and, as a result, a decrease in family income. The poor were unable to afford proper and adequate treatment to address this problem. However, the problem was not solely confined to poorer households.

7.1.2 Male sex workers, female sex workers and their children

There is little information in the literature about the children of sex workers. According to the recent Report, 61% of FSW are married and 85% have one or more children. 84% of MSW were reported to be unmarried and only 12% had children.

10 Based on 91 million adult population (15 to 64 years); Source: UN Population Division Data.
11 PNAS 2006 UNODC.
12 Ibid.
14 Altaf et al., 2004.
15 Ministry of Health Pakistan, 2005.
16 Shah et al., 2004.
18 HIV 2nd Generation Surveillance in Pakistan, National Report Round 1 2005 NACP.
20 HIV 2nd Generation Surveillance in Pakistan, National Report Round 1 2005 NACP.
21 HIV 2nd Generation Surveillance in Pakistan, National Report Round 1 2005 NACP.
7.1.3 Migrant workers and their families

In Pakistan it is a common practice for men to travel away from their homes to find work, either within the country or abroad. In addition there are certain professions such as long distance truck drivers who are thought to be at risk. In a mapping study, the mean age for drivers was 33 years and the majority were married. Of these 72.4% of drivers and cleaners indulged in extramarital or premarital sex. Other people at risk are those who are posted in-country or abroad or businessmen who remain away from their families for long periods. Separation from spouses, families and communities can increase vulnerability to sexual behaviour where there is a risk of acquiring HIV which can then be transmitted to others. Migration for work appears most common in Federally Administered Tribal Areas/Federally Administered Northern Areas (FATA/FANA) and NWFP – this geographical area probably accounts for significant numbers of children infected and affected. However, many PLHIV from FATA/FANA and NWFP register in other provinces for treatment including antiretroviral medicines (ARVs), care and support. Although this group represents the type of case that is most often reported, they proved a more difficult group of people to meet probably because of the distances they live from Peshawar and fear of exposure.

8. CHILDREN AFFECTED BY HIV AND AIDS, OR AT RISK

In summary there is considerable documentation about the risk behaviour of the high risk groups – MSW, FSW and IDUs, but very little information is available on children. There is still no information concerning the care of any children whose parents may have died from AIDS. The information that is available is known to NGOs and practitioners working with PLHIV and their families. This information is treated confidentially by these people and organisations. Disclosure of a positive HIV status is still extremely rare. People still find it difficult to disclose within marriage and the family.

From the literature study the following groups of children may be at risk and in need of protection:

- **Children and young people under 18 years of age who are HIV positive.** The number of infected children in Pakistan is not known. However the focus group discussions and case studies in this report reveal that there are infected children and some infected children have already died.

- **Children living in or coming from a family where one or more parents or caregivers are HIV positive and children who have lost one or both parents or primary caregiver/s due to AIDS.** Death of one parent or both parents from HIV and AIDS related illnesses has a tremendous social, emotional and economic impact on children. The type of support that these affected children need depends upon their social and economic circumstances. There are very

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22 20 million in-migration annually reported by the Labour Force Survey.
25 The Draft National Plan of Action for Children 2005 reports 46 children (0 – 19 years who are HIV infected, but this is based on reported figures, not total estimates.
few reports of children being orphaned through AIDS, though it is clear from this assessment that parents are ill and others have died.

- **Children of male and female sex workers.** Girls following their mothers or relatives into sex work are not uncommon and the involvement of children in commercial sexual exploitation appears to be known to the families. “Many of the girls under the age of 18...sell sex under the guise of dancing girls and dance students. Researchers found that a majority of those girls are the daughters and relations of other prostitutes working in the area. A majority of them are involved in prostitution only in the daytime – travelling in from other parts of Lahore or small adjacent cities – and return home in the evening.” These girls, it seems, are not protected from risks by the family, community or State.

- **Children and drugs.** About 50% of IDUs are married and 44% have children. With the current infection rates for IDUs, many children may be affected by HIV and AIDS. Children are also at risk from drugs, when a sample of street children in Karachi were asked about substance abuse or using drugs, almost all (89.9%) responded ‘yes’ for solvent abuse followed by charas (56.3%) and then heroin (3.8%). More recently the increased risk (because of HIV) brought about by children associating with IDUs and using drugs themselves is also being reported. Studies by Society for the Advancement of Community, Health, Education and Training (SACHET) and DOST in NWFP reveal that street children are constantly at risk of abuse from drug users. In the SACHET survey only two boys out of 183 street children mentioned the use of condom for prevention purposes. The survey concluded that “there is a definite lack of information (regarding) street children especially in context of HIV/AIDS.” In a survey 60% of the 3500 registered drug users with DOST admitted to having sex with street children. Only 30% of the street children had heard of the term HIV or AIDS and less than 10% had any useful knowledge of the disease.

- **Children who are sexually abused and exploited.** Sexual activity among high risk groups commences early, 14 years for Hijra's and 17 years for FSWs. The practice of keeping or using boys for sexual purposes has been well documented and there are many reports about the vulnerability of street children and the risks they face, but until recently it was only relation to sexual abuse rather than as risk behaviour in relation HIV and AIDS. Research conducted by NCCWD revealed that out of 159 boy sex workers, 98 were working from small wayside hotels and offering masseur services. The boy sex

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27 HIV 2nd Generation Surveillance in Pakistan, National Report Round 1 2005 NACP.
29 HIV/AIDS – A Pilot Study on Vulnerability of Street Children in Pakistan, SACHET 2005, draft for UNESCO.
30 Summary of Street Children Survey, DOST 2006.
32 Community Perceptions of Male Child Sexual Abuse in North West Frontier Province, Pakistan, NGO Coalition on Child Rights NWFP.
34 Sexually Exploited and Abused Children: a Qualitative Assessment of their Heath Needs and Services Available to them in Pakistan, ESCAP.
workers were also found at bus stands and terminals; hotels and restaurants, while others were found in cinemas, video shops and public parks. To a large extent it is known where the boys live and where they work.

- **Homeless children and children living on the street.** It appears that there are an increasing number, of about 70,000 children living on the streets nation-wide. 2003 estimates put the number of children living on the streets of Karachi at 8000 but the later Azad Foundation figures are closer to 12,000, an increase of 50 percent. In Lahore it is estimated that 7000 children live on the streets, while in Peshawar there are a further 5000; another 2500 in Quetta and 3000 in Rawalpindi. According to the NGO statistics, in Karachi 54.1% of the street children left their homes between the age of 10 and 12. They also estimate that 45% of street children are involved with criminal activity in order to survive while 49% are at a high risk of HIV through intravenous drug usage and sexual abuse. According to Azad, four out of every 10 street children examined were infected with sexually transmitted diseases.

The vulnerability of these children appears to be considerable. From the Karachi KABP sample it is recorded that street children and youth had been sexually molested/abused. They had frequently played the role of passive partners (63.4%) and by multiple partners. Only few (27.3%) reported to have only one partner during intercourse. Likewise the behaviours are placing the children at risk; 67% of the children had actively been involved in sex. There age at first sexual intercourse was reported as 10-12 years (19.7%), 13-15 years of age (53.2%) and 16-18 years (23.8%).

In view of the considerable literature on street children and boys who are sexually exploited and abused by men it was not felt necessary to further study these groups. This issue does not appear to be viewed by society as child abuse and there is no documented evidence to hand of action being taken to protect the child from further abuse or action taken against the perpetrator. The problems of these children are well known within the NGO community, UN and probably Government but the abusers continue to act with impunity and the children go unprotected.

The above list always needs to be balanced with other issues: for a Quetta community leader the issue of HIV and AIDS had not yet affected Pakistan to any extent so he thought it was not a debate-able issue. He saw the problem in these terms: “Young boys are more at risk as compared to girls because they usually remain inside their houses, but the girls were involved in domestic work are equally vulnerable. Children involved in domestic work are at high risk and become victim of physical punishment and accused of theft.”

35 Pakistan, Number of street children on the rise. Asia Child Rights Newsletter, Vol 4, No 25. 22/06/05.
36 Children Outside Parental Care In South Asian Countries, UNICEF Regional Office For South Asia, September 2006 taken from At the Margin, Street Children in Asia and Pacific; Andrew West, ADB.
9. CHILD PROTECTION SERVICES

The documented evidence of protection system failures and gaps are from child sex workers and children who are commercially sexually exploited. There appears to be no information or studies on the capacity or willingness of the current care and protection systems to assist children affected by HIV and AIDS.

Government and private residential care institutions exist for the care, protection and development of destitute or abandoned children. Government institutions are financed out of public revenue, while private institutions are supported through philanthropic donations and Zakat funds. The Ministry of Women Development, Social Welfare and Special Education (National Zakat Foundation) is establishing homes at the district level, under the name of Apna Ghar, for the protection and rehabilitation of destitute children which will be followed by the establishment of similar homes at the district level.

Decentralisation shows differences in approaches, sensitivity, engagement and actions taken at the local level. Some Provinces are examples for others, like the Punjab Home Department which has established a Child Protection and Welfare Bureau (CPWB). Its website states: “17 notorious gangs involved in child beggary, sexual abuse and trafficking were caught and convicted on the information and assistance of CPWB38 with the help of local police.”

**Government Services in the Punjab**

The Family Support Programme39 is designed to deal with social factors behind begging, drug addiction, child labour. A comprehensive strategy is planned by Child Protection and Welfare Bureau Punjab that includes Micro Financing, Skill Development and Education for Family Support Programme. Micro financing can be a vital element of effective poverty reduction plan. Improved access and efficient saving can enable the poor to manage their consumption, enhance their earning capacity and enjoy better living standard. In order to establish micro financing scheme for the rehabilitation of destitute and neglected children’s families following steps will be undertaken:

a) Identification of prospective clients
b) Selection criteria
c) Disbursement of loan
d) Recovery process

The same provincial administration has developed ‘Minimum Standards for Alternative Care of Children without Family Support’40. The Minimum Standards deal mainly with

the physical infrastructure and leave many aspects on the quality of care rather vague. Crucial issues such as criteria for admission and discharge, child protection policies, and placement review are not sufficiently developed in the document.

Institutionalisation seems to be the only formal placement contemplated by the law in Pakistan. In the periodic reports for the United Nations Convention on the Rights of the Child (UNCRC) the government describes the services provided in these institutions as satisfactory. The Government recognises non-government organisations for their efforts in caring and protecting for children outside parental care, there are 53 registered institutions caring for children without family support or from other figures 55 orphanages. According to the 2nd Periodic Report to the Committee on the Rights of the Child there are 15 children’s homes, two of which are run by the Government and the rest by NGOs. In the Punjab alone there are apparently 31 registered orphanages and five centres are being run in the NWFP by NGOs. A Darul Falah (orphanage) is also functioning in Quetta. There are differences in the reported number of children’s homes which is probable caused by differences in definition. Nationally residential care is developed as a long-term solution for children in need of alternative care. In 2001 there were approximately 4236 children in residential care placements.

Some institutions have also established “advanced babies homes” or Gehwaras. Dar-ul-Flah and SOS villages are deemed exceptionally good institutions, providing such services as shelter, with free board and lodging, basic education, vocational training and recreational facilities.

Despite the fact that institutions declare that they are caring for orphans, it seems that the criteria for admission are rather wide, including at the time children without parental support, abandoned, unwanted, and destitute children. The vast majority of institutions are exclusively for males. There is at present no mechanism for a periodic review of the cases of children who have been placed with various institutions.

Another aspect of institutionalisation in Pakistan is the ‘Madrassah’. The objective of these institutions is religious education, but there is no current data on the number of children being educated in Madrassahs that are orphans or living without parental care. In 1998, more than 13,000 such institutions were counted throughout the country. The Ministry of Social Welfare and Special Education, Follow-up Unit, Research Study on Orphan Care, in 2001, listed 3706 Madrassahs). These are institutions where children live their entire day.

9.1 The Emergency has brought new ways of working

After the earthquake in 2005 families were willing to care for orphaned children of

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42 Ministry of Social Welfare and Special Education of Pakistan, Follow Up Unit, supported by UNICEF (2001); Research Study on Orphan Care, 2001, pages 70-73.
46 See - periodic review of placement (art. 25 CRC).
47 Religious schools run by religious organisations, parties, or sects.
relatives but for humanitarian agencies it also highlighted the absence of policy
guidance in the area of child protection. For many children residential care was used as
a first resort with relatives and children still awaiting reunification processes to take
place some two years later. The number of orphans \(^{49}\) (children without fathers in this
context) rose from a pre-quake figure of 51,500 children to around 81,000 in the affected
areas. Severe shock and trauma was widespread among young survivors and very little
psychosocial support was readily available in the immediate aftermath. Precise figures
are not known but according to Save the Children, children whose relatives could not be
immediately found were placed in children’s homes in different parts of Pakistan and are
still waiting to be reintegrated with their extended families. Although this was an
emergency it does give pointers as to how an “orphan” issue would be dealt with in
Pakistan.

In the emergency earthquake area new ways of working were developed
together by the NWFP and AJK Government with the support of ERRA and
UNICEF.

Child Protection Units in Mansehra, Abbotabad and Battagram District in NWFP
and Bagh, Neelum and Muzaffarabad District in AJK were set up in the District
Social Welfare Departments. The Units are part of a mechanism to strengthen
the gate keeping function at the local level by introducing a single point of contact
for orphans and other vulnerable children and their families who need assistance
and protection, assessing their needs, referring them to the appropriate services
and diverting them from inappropriate placement in institutions such as
orphanages and madrassas. The staff of each unit is comprised of a child
protection officer, two child protection case workers, assistant child protection
officer and an assistant database manager.

To increase effectiveness, building the staff capacity was essential in child rights
and protection, the legal framework of child rights and protection, gatekeeping,
case management and the follow-up of individual child cases and their families,
mentoring families and in child participation.

These units have been extended into new social protection schemes within the
Social Welfare Department of the earthquake-affected Districts, with support from
ERRA, in order to institutionalise the child protection services while at the same
time extending the outreach of the services to trained and registered community-
based organisation (CBOs) for children protection. These CBOs, composed of
various community members, identify and provide initial community-based
support, care and solutions to orphans and other vulnerable children and their
families with a possibility to refer the children and their families to the Child
Protection Units at the District level for professional follow-up. There are great
hopes that these district child protection mechanisms will be replicated
throughout Pakistan.

10. CHILD PROTECTION POLICIES AND LAWS

The number of orphans in a society from HIV and AIDS has become an indicator for

\(^{49}\) http://www.unicef.org/pakistan/consolidated_report_to_march06.pdf
vulnerability and risk. The definition of orphan varies from country to country in South Asia. In some countries, children who have lost both or either of their parents (father or mother) are called orphans. In others, a child may be called orphan when both parents or just the father has died. Although it is difficult to ascertain the exact number, as of 2003 the estimated number of orphans in South Asia was 48 million, there are an estimated with 4.8 million orphans in Pakistan. The number of orphans compared to the population under 18 is generally around 8%, with the exception of Afghanistan where the estimated figure is as high as 13%, while the estimated figure for Pakistan and Sri Lanka comes to around 6.5%. In Pakistan care of children upon incapacity or death of parents is usually provided by relatives.

Islamic law, national law and tradition recognise the right as well as responsibility of parents and relatives to provide sustenance, care and protection to the child. The primary responsibility for child rearing and upbringing rests with the parents. Ordinarily, the custody of the male child up to age 7 and of the female child until the age of puberty is automatically given to the mother. The father is responsible for providing maintenance, while the children are in the custody of the mother. If for any reason the parents are unable to protect the child, a guardian is appointed for the purpose by the court. If the child has attained sufficient maturity, his preferred guardian is generally accommodated. In all decisions the court is expected to take into consideration the child’s best interests.

There are over 1000 pages of Federal and State Laws that apply to children and these can be found at the NCCWD website. Many are from the colonial period and need modernisation to reflect the present socio-economic conditions in Pakistan.

Laws prohibit a child under the age of 12 being deserted or abandoned by parents or a guardian. It is a criminal offence for a person other than a parent having the control or charge of a child, to wilfully fail to provide for his food, clothing, lodging or medical needs. Numerous other provisions protect the child from abuse, neglect and exploitation either by parents or relatives or any other person responsible for the protection of the child.

The courts in Pakistan have given a ruling that there is nothing in Islamic law that is similar to adoption as recognised under Roman legal systems. Instead, Islamic law provides for a very strong system of guardianship through the immediate as well as the extended family; this concept of guardianship assures protection of family life and ensures that the child knows his/her paternity. Guardianship is recognised under the Guardians and Wards Act (Annex 7, Appendix XVIII), which provides for the care of children without parents. Foster placement is not recognised in Pakistan under any

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50 UNICEF (2005). *State of the World’s Children, 2005*, (35m in India, over 5m. in Bangladesh, 1.6m in Afghanistan, 1 million in Nepal and 90,000 in Bhutan).
51 *Children Outside Parental Care Are In South Asian Countries*, UNICEF Regional Office for South for South Asia, September 2006.
52 The report does not clarify the definition of orphan; it might therefore indicate children that have lost one or both parents alike.
55 Infringement is punishable with imprisonment for up to 7 years, or with fine, or both.
Apart from the Sindh Children Act 1955 and the later Punjab Destitute and Neglected Children Act 2004 where there was established a Child Protection and Welfare Bureau, the other formal systems and structures in Pakistan appear to rely on social protection payments to registered persons and residential care for orphans and destitute children provided by Government or NGOs.

There have been developments: UNICEF was asked by Government to cooperate in developing a policy on child protection together with an implementation strategy.

11. SOCIAL PROTECTION AND SAFETY NETS

“In recent years number of orphan and helpless individuals has multiplied which give rise to low living standard, inflation and over population.” - Quetta key informant to which Religious Leaders added: “The method of distribution of Zakat is not systematic rather inappropriate at some places. There is no proper centre which could deal with problems of people and their solutions. People do not have confidence on any established institutions.”

According to Save the Children about one-third of the population lives in poverty. Over 70 million Pakistanis do not have access to health facilities, and about nine out of 100 children die before they reach their first birthday. Compared to their number in the population, children under 15 years of age have higher rates of chronic or persistent vulnerability. In a recent social protection strategy paper commissioned by DfID, children are recognised as meriting special mention due to the depth and range of vulnerabilities that they face: poor schooling, poor health care and nutrition, and hazardous employment. The main characteristics of poverty for children are living in large households, over-crowding, poor sanitation, incomplete immunisation, poor nutrition and health care.

Out of 40 million children in the 5-14 age groups, about 22 million are estimated to be out of school. Some of them never had access to education, and others dropped out before completing their primary education. The child labour figures are correspondingly high; according to ILO, 3.3 million children between 5 and 14 years are working. Analysis in the social protection strategy estimates that 2.5 million children, or 1 in every 6, are working, and among the chronically vulnerable, one in four children are working.

In both urban and rural areas, it is “human shocks,” usually health related, that cause damage to household capacity. The death or illness of a family member, particularly an

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59 Social Protection Strategy for Pakistan, Government of Pakistan 2006. The document was commissioned by DFID at the request of the Government of Pakistan for assistance with the development of a Social Protection Strategy.
income earner and increased expenditure on treatment can plunge a household into profound poverty. For women especially, the death of their husband or an able-bodied son was a severe shock, which resulted in many women and their children being forced into extended poverty. In most of the PPA sites, being a widow was a particularly vulnerable condition for a woman.

The main social safety nets for the vulnerable currently available in Pakistan are Pakistan Bait-ul-Mal (PBM) and the Zakat Fund: PBM provides financial assistance to deserving families. Sizeable amounts of money are disbursed to widows, orphans, the disabled and victims of natural disasters; it is funded by government and managed by public servants in the Ministry of Social Welfare and Special Education. Recent evaluations suggest that the programme is not very effective; applying for assistance is a time consuming procedure; and transparency and leakage appear to be problems. The transfers are evaluated as having a limited impact on poverty. The Zakat Fund is a religiously mandated levy on income for distribution amongst poor Muslims. It is funded through compulsory religious obligations, implemented through local Zakat committees, while centrally administered by the Ministry of Religious Affairs, Zakat and Ushr. The beneficiaries are selected by the community, which means that there is room for misuse and abuse of power by the community leadership. The Zakat programme poverty-targeting analysis shows that only 49% of Zakat beneficiaries are poor. However, according to the PRSP, it is now revamped and intended as a key instrument for social rehabilitation and reducing vulnerability to shocks. Disbursement procedures have been revised to make them simple, transparent and better targeted. Monitoring and control methods have been further strengthened and an independent measurement of Zakat’s impact being made. The Poverty Reduction Strategy aims to strengthen the existing mechanism of cash transfers through Zakat.

The reality is that Zakat and Bait ul mal are perceived as being of little use to the poor in times of crisis. Disease, illness, disability and death of the main providers or heads in a household, are major shocks to the livelihood strategies of the poor and a major financial drain which push people into poverty. The Pakistan PPA found that weak institutions fail the poor and most of their project sites reported very little contact with the formal social protection systems and worse: “findings from across the Pakistan PPA sites suggested that programmes were ineffective due to the low value of the transfer, narrow coverage, ineffective targeting of the needy, and corruption.”

Effectively there is no comprehensive national social protection strategy in place in

63 Others include Workers Welfare Fund (WWF), and Social Security.
65 Armando Barrientos and Rebecca Holmes, Social Assistance in Developing Countries, version 2.0 March 2006, DFID, IDS, University of Sussex.
66 PRSP.
67 Under the Zakat and Ushr Ordinance, Zakat is used as assistance to the needy, the indigent and the poor particularly orphans and widows, and the handicapped and the disabled, for their subsistence or rehabilitation, either directly or indirectly through deeni madaris (Islamic seminaries) or educational, vocational or social institutions, public hospitals, charitable institutions and other institutions providing healthcare; and also as assistance to the needy persons affected or rendered homeless due to natural disasters and for their rehabilitation - Preliminary Inventory: Social Policy Interventions To Overcome Social Exclusion to Reach the MDGs In South Asia, UNICEF ROSA March 2007.
68 Ibid.
70 Between Hope and Despair, Pakistan Participatory Poverty Assessment.
Pakistan. This leads to lack of direction and poor coordination on the part of individual agencies and programmes working in this area. The existing programmes for providing social protection are also clearly insufficient in terms of their coverage of poor and vulnerable households and in terms of the type and levels of support provided. The agencies and programmes traditionally considered to be safety net providers, such as labour welfare institutions and micro-credit providers are not primarily for providing social protection to the very poor and the vulnerable.

12. SERVICE DELIVERY – PUBLIC PRIVATE PARTNERSHIPS (PPP)

Non-State provision has developed in response to government struggling to provide adequate services: nationally, almost half of households rely on qualified private practitioners to meet their health care needs, and less than one-third use government practitioners.

Analysis of the relationship between the government and non-state providers (NSP) of basic services in Pakistan reveals the potential for cooperation has been extended by key changes in policy: support for devolution, public-private partnership and community participation. However in terms of monitoring and regulation, although controls exist on paper they are rarely applied. In the health system, even where governments have formed agreements with particular providers, they have insufficient capacity to assert policy direction or to monitor and evaluate the NSP’s activities.

The National and Provincial AIDS Control Programmes currently rely heavily on World Bank finance to support the development of public private partnerships. Service delivery of voluntary counselling and testing is provided by NGOs. The NACP is trying to ensure transparent competitive tendering and accountability and have risk management strategies in place. There are potential concerns for the future sustainability of some aspects of delivering services if the government has to maintain the services with its own revenue.

In regards to child protection and delivery of services for PLHIV there are likely to be issues of quality, regulation and the setting of standards. Are the PPPs sustainable? As AIDS treatment with ARVs is for a lifetime, what happen if standards are not met or continuity is not achieved?

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13. FINDINGS

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<thead>
<tr>
<th>Score the negative impact</th>
<th>Respondents average scores in the range 1 to 5</th>
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<tbody>
<tr>
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<td>Nazims Councillor</td>
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<tr>
<td>Death of their father</td>
<td>4.8</td>
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<tr>
<td>Death of their mother</td>
<td>3.7</td>
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<tr>
<td>Having to move away from parents</td>
<td>4.0</td>
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<tr>
<td>Having to drop out of school</td>
<td>3.3</td>
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<tr>
<td>Doing exploitative work</td>
<td>4.3</td>
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<tr>
<td>Sex work</td>
<td>4.5</td>
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<tr>
<td>Not having a home or any shelter</td>
<td>3.8</td>
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<tr>
<td>Absence of support from NGOs</td>
<td>3.5</td>
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<tr>
<td>Absence of good health care</td>
<td>3.8</td>
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<tr>
<td>Insufficient food</td>
<td>3.8</td>
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<tr>
<td>Using glue or drugs</td>
<td>4.2</td>
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<tr>
<td>Suffering any abuse (violence)</td>
<td>4.5</td>
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<tr>
<td>Corporal punishment</td>
<td>3.5</td>
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**Ranking Exercise**

All informants were asked to score from 1-5, (5 being the worst) the negative impact following issues these issues would have on the lives of children or for children on themselves. The highest average score is for the loss of father by the children, which also attracts high scores from sex workers and PLHIV; the 2nd highest is for the use of glue or drugs by government officials.

**13.1 Findings from Key Informants in the Districts**

**13.1.1 Inclusion and Exclusion**

The general consensus from informants was that poverty is the major cause of social
exclusion and that “bad habits develop out of poverty.” They recognised that poor people and PLHIV suffered from exclusion and that the government supported only “their own people.” PLHIV were grouped together with beggars, orphans, the homeless, people with disabilities, drug users, hijra, prisoners, prostitutes, and exploited children.

13.1.2 Who is being stigmatised?

Poverty was the overall determinant of stigmatisation. The most stigmatised/disliked group of people were drug users, followed by street children, sex workers, PLHIV and beggars. It is possible to discern layers of discrimination determined by gender, poverty, lifestyle and then health status.

13.1.3 Who are the children at risk?

Generally all children under 12, but specific groups most frequently mentioned were street children, beggars, children of drug users, children of PLHIV and children of sex workers. Other groups less frequently mentioned were children without parental support, child labourers, children in prison, children who were in “early marriages” and those “who pierced their noses and ears.”

As expected, street children, beggars, and working children are the most visible and are most frequently mentioned. The less visible such as victims of early marriage and children in prison are mentioned less frequently. One informant saw children of drug users being caught in a double bind: “They have fathers who cannot look after them, but they are not able to go to the orphanages.”

Children affected by HIV and AIDS were frequently mentioned as being at risk although many respondents had had no contact with these children. They were described as “children (who) have had their personality damaged,” or “HIV and AIDS has destroyed the future of children”. One religious leader thought that: “Society has avoided meeting these families and owing to that behaviour, they are going deeply into discrimination.”

From an NGO informant: “Suppose the FSW’s husband dies and she had no clients, but had children. Ultimately she uses the children, forces them to indulge in sex and gets the money” and “yes it has affected the welfare of children, kids need attention from parents, but didn’t get proper attention, due to indulging they get this disease.”

From Quetta there were other dimensions to child protection: “Numbers of orphans are increasing because of civil wars, terrorism and outside forces.”

13.1.4 Informant’s definitions of orphans

In many countries where the pandemic has had a greater impact orphan-hood has been seen by many as a major determinant for the provision of assistance. In Pakistan the definition of an orphan given by most informants was the death of the mother and father. However there were other factors, mainly to do with the independence of the child,
considered as contributing to the socio economic status of a child without parents. The death of the father was seen as the most important loss, but there were also elements of the child being able to survive, aged under 15, having no relatives to act as carers, and the child being dependant and not a wage earner.

There were no reported cases of the death of parents being attributable to AIDS.

13.1.5 Family and community support

Key informants saw the most effective role being played by immediate and extended family members but that the ability to play this role was diminishing while the scale of the problems facing poor families was increasing. Faisalabad families feel they have less ability than in the past to support their members. In Karachi there are some feelings that families are not as capable as they used to be in providing support to extended family members, In Lahore it was said that the community of sex workers help each other. “Poor families are struggling to cope with their own (children) willingness is there but not necessarily the means.” In Larkana it was reported that “previously shared common values to help have diminished in the family and community, but the number and diversity of addiction, unemployment, and begging is increasing. Some saw society as now more discriminating and not empathetic.” From government officials, “some uneducated relatives can beat up these children and throw them out – they are not supportive.” In Peshawar informants talked of stigma against children affected by HIV and AIDS, though this depended on the lifestyle and social condition of the families.

Generally the trend of the family helping other members was more prevalent in the past.

13.1.6 Informants views on service provision

The NGO informants believed that they were more effective at delivering services to parents and children affected by HIV and AIDS than Government. Many informants thought that the Zakat system was becoming increasingly ineffective and inefficient. In Karachi an informant thought Zakat distribution was tedious and that sex workers and AIDS patients were discriminated against. One person saw the absence of women in government service as a major blockage to delivering Zakat and other services to women. The absence of policy guidance to assist with criteria for targeting assistance and insufficient resources were seen as major problems.

13.1.7 Policy and Law

Informants saw the Government systems as quite old and over complicated. Some informants thought that no proper policy or laws had been made to help vulnerable children. Others thought that there were laws but that these are only on paper and improvements are needed in service delivery. The NGOs felt that policy formulation and implementation required improvement in the field of opportunity, provision, family support and help. A Government informant wanted special technical skill development within the institutions responsible for PLHIV, disabled children and the poor.
13.1.8 Informants' suggestions for improvement

Three informants wanted improved accountability and transparency with technical support to improve existing capacity and service delivery. Two informants wanted the number of orphanages to be increased to look after these children. Another informant wanted to see separate schools for children whose parents were living with AIDS.

In Larkana it was advanced that child labour should be eradicated, one person wanted the construction of separate school for PLHIV, plus special help and social facilities for HIV and AIDS.

For social protection, more women were wanted on the Zakat committees and there was a general call for the distribution of Zakat to be made more effective.

There was support for the growth of public private partnerships, greater trust in NGOs to deliver services and a plea for more financial support. More funding was wanted to support existing work rather than the development of more projects.

13.2 Focus Groups and in depth Interviews

Interviewing people and running focus groups was anticipated as being difficult but consents were given. There was understandable reluctance to disclose HIV status and share information. There was uncertainty in the minds of the interviewers when working with existing groups or interviewing families with regard to what information was common and what information had not been shared between the group or within the family. With hindsight perhaps greater use should have been made of in-depth interviews with PLHIV and the affected children. The full weight and complexity of the problems experienced by PLHIV is evident from the case studies at the end of this report.

13.2.1 The impact of HIV and AIDS on families and children

Most PLHIV respondents were poor and experiencing discrimination or feared discrimination if they disclosed their status: “we don’t have many friends in our community. We don’t interact much, so there is no much discrimination, people don’t know about my HIV situation.” Several were returning migrants who were now unemployed or were earning less money. Those respondents using drugs or who were sex workers appeared to experience even greater discrimination and exclusion from society. MSW in Lahore: “We are treated badly. Sometimes police officers annoy us, they snatch our money and pinch us. People don’t let us live in their locality.”

13.2.2 Death, illness and family breakdown

Several families had experienced the death of someone from AIDS. There had been discrimination and anger even within the family: “My husband had died because of AIDS
People expressed concerns and fears for their future and that of their children, particularly in Peshawar where it was said that HIV positive people have no future. According to one woman when she declared HIV positive her husband arranged a second marriage and cut relations with her and her children.

In Mardan focus group members said that HIV positive patients have a “dark future.” Parents expressed many worries concerning the future of their children with regard to: education, health, shelter, food and other basic necessities which are required. When children were asked in Lahore about whether anyone in the family had recently died or was ill, two replied that the father had died and mother was ill, for another the father was ill, and for a fourth child the mother had died and the father was ill.

13.2.3 Discrimination and exclusion

Discrimination and stigmatisation are ever present. Members of the Peshawar PLHIV focus group reported: “society stigmatises HIV patients and think that they can catch the disease from us, but it is not like this, people are infected in other ways.” In Mardan society treated the children with indifference and the PLHIV focus group members were concerned that they were being stigmatised because of the lack of awareness about HIV and AIDS. From Lahore: “children are not discriminated because children are normal and studying with normal children.” They said we do not get proper awareness about our health and any sympathy for our status but that things can be worse.

Responses were mixed about whether or not the children suffered discrimination. PLHIV in Lahore were aware of discrimination and stigmatisation of their children. Parents said “the children are going without food, education and health care as they do not have enough money: people discriminate and stigmatize us, so they should be given awareness about this disease.” For other PLHIV in the general population there is not always discrimination: “No, people treat our children normally.” Generally for the children whose parents were living with HIV there was little perceived discrimination unless there was disclosure by the parents or knowledge in the community. Family, friends, school and social exchanges were “normal.” However where the lifestyles and employment of parents were more visible there was more reported discrimination. When it appears if the community knows that the children belong to FSW then they discriminate. Two FSW said that their family would not even meet them and there will be no help for their children. Other FSW said about their children: “if they go outside the mohalla then other people know that they belong to the red light area.”

13.2.4 Poverty

Many families had recently moved house and children reported the selling of household assets, a particular problem for IDU families. Poverty was seen by the children as the
The children in Lahore knew their parents are very poor and struggled to provide the needed basics for their life like food, education, health, and money for house rent. Mardan: “Yes, before declaring HIV positive I was working in UAE as a driver but after becoming HIV positive we were deported from there, our income source finished and now we can’t pay the school fees and other expenses of our children.”

In response to question: if for any reason your family runs out of money for food or other essentials what does the family do to remedy the situation? A Karachi child responded: “It is a very difficult question; our families will start begging after selling off all the property.”

13.2.5 Family, Community Support and Care of Children

MSW in Karachi said they frequently think about that what will happen to their children when they die: “We are sick of our profession but it is our compulsion that we are sex workers. We are anxious about our children education, health and family support.” Male sex workers thought their work had an effect on the development of children: “When they are 1-4 years they don’t know what their parents are doing but when they grow they feel that their parents are not good and involved in bad habits. Our children’s friends avoid meeting our children.”

For the children of IDUs, life is particularly hard. Community members look down on the drug user’s children: “All the time they are wandering the streets, when we are under addiction we also beat our children.” They had been previously given help by an NGO, but “now they are not taking care of us. Government is giving us aid but all the funds are being captured by the central hospital in Faisalabad.”

Views on orphanages were various, when expressed, and ranged from an IDU in Karachi: “My neighbour suggested I admit my children into an orphanage,” to a sex worker from Karachi: “Our children will never go to orphanage.”

Many said that their immediate family members gave help and that neighbours are also very co-operative, but it was acknowledged that some children could be forced onto the labour market: “PLHIV Children will have to work as a tailor or something.”

In Lahore, when asked what are your relationships like with family and community the children enjoyed good care from parents who were alive and clearly missed the people in their family who had died: “I miss my father… when he was alive he got us so many things, now we don’t have anything and I don’t even ask from mother.” Neighbours were seen as supportive. In Karachi reactions of children towards relatives and neighbours were less positive: “We don’t go to our neighbour because there behaviour is not good with us.”
13.2.6 Access to basic services

Most participants expressed concerns about access to basic services: “We have worries regarding our children’s future like their education, food, health and shelter.” One PLHIV in Lahore travelled once a month to the health centre which was 200 kilometer distant at a cost of 300 rupees a person.

Access to education and health care were major issues for the children of sex workers and IDUs. The children of FSW were not in school. In Lahore SoSec noted the pathetic condition of children of FSW. There are insufficient resources to provide education and health care. Some FSW said they were doing sex work only for the sake of their children: “In one government school our children were written off from school because they belong to FSW.”

In Peshawar, education of PLHIV children has been affected: “Yes, they stop their studies and start work in very early age.” Higher education for the children appeared out of the question.

Most of the children in the Lahore focus group went to school except one: “I don’t miss the school but haven’t gone to school after mother’s death.”

13.2.7 Service provision and assistance from government

Lahore PLHIV: “We heard about ZAKAT (KASHAF) but never get it as it’s a long procedure. We all don’t have I.D. cards. We are too weak to struggle for this.”

In Peshawar PLHIV wanted the government to provide extra care and facilities to our children; food, education, proper shelter, health facilities and job facilities to HIV patients. Fear of disclosure is considerable: “The government is not doing anything for the PLHIV children and in such conditions they will surely have to disclose their identity which is their greatest fear.”

There was an expressed need for financial aid for food and education. PLHIV thought that the deserving people do not get assistance from Zakat funds or Bait ul mal and there is fear of disclosure to authorities: “Government is not doing anything for PLHIV children and in such conditions they will surely disclose their identity which is our greatest fear.”

MSW were worried about the stigmatisation of their children and how they would be perceived as fathers as their children grew up: “Our work has a bad psychological impact on our children because when they grow up and find out about our work they will get frustrated.”

The situation for the drug user’s children appears to be the most desperate. They used phrases like: “No care is provided for our children or society considers our children a burden and as we do not earn anything, the house is being run by the money the and
Attitudes to children from Government and NGOs in Quetta: “Children should not be given check on their daily spending, teachers should have positive attitude towards children, undue love and favour, so that their future expectations increase and result in parent’s disability to meet them. Parent should not give undue favour to their children keep check on their daily spending, teachers should have positive attitude towards children.”

13.2.8 Violence and Abuse

Some MSW’s had been sexually abused as children. Drug users admitted to being violent: “Due to our drug addiction, we are also involved in giving physical punishment to our children, which we repent afterwards. Our children are psychologically harassed and keep on crying most of the times.”

Good Practice on Child Sexual Abuse

Aangan is a resource centre working to enhance the emotional health of children, dealing particularly with the issue of child sexual abuse. In The Bitter Truth72, the Aangen project provides an analysis of 200 letters from victims and survivors of child sexual abuse where the perpetrators were mostly male family members, household staff or were already known to the family. Aangan provides training primarily involving professional groups such as doctors, medical students and psychologists. One of the most important aspects of Aangan’s work is to provide counselling and support services to children and adults affected by child sexual abuse.

13.2.9 Child Labour

Some children have to work. A father in ill health in Lahore reported: “Both of my children working, because I can’t work. The rickshaw we rent but I can’t work on daily basis.” Three sex worker participants said their children are doing work in Lahore. All PLHIV participants in Lahore said “no” to children dropping out of school, one participant said: “My sons don’t go to school any more, they’re working at a workshop for financial reasons.”

IDU Karachi: “When I was in a job I supported my children now brother-in-law supports.” Most of drug user children are not going to school: “Our child was not regular at school that’s why teacher writes off his name.”

14. THE PROTECTION RISKS AND FAILURES

This is a qualitative study. It makes known the problems and views of individuals and groups. It was the view of one official in Peshawar, that the following was needed to improve the lives of the vulnerable: “1: proper planning, 2: technical assistance, 3: financial support.” In Karachi the response was similar regarding improvements that needed to be made: it should be done “through motivation and proper planning, and coordination, with financial help, community sensitized and the implementation of formulated policies.” These are mainly recommendations as to process. Community leaders in Karachi were keen on PPP: “Every programme should be implemented through public-private partnership. Local representatives should be involved in it.” Others from Faisalabad thought the existing system was simply in need of more money: “Pakistan Bait ul Mail is working very effectively; we don’t need more projects but more funds to run already existing programmes more actively. The budget of food support program should be increased.”

There is not statistical data to complement the views of the people interviewed. There are probably too few PLHIV willing to be identified and take part in a statistical survey. However there is a consistent view from the PLHIV, that the at-risk groups and their children suffer discrimination, exclusion, and receive no financial or other support apart from that given by NGOs.

Pakistan is a large country with many different characteristics and local problems. However, the groups of people in this study appear to face very similar problems: poverty, possible family breakdown, discrimination, violence and abuse, and systems failure. In many ways the children of sex workers and IDUs plus homeless children appear to face greater protection risks than the children of PLHIV who have access to treatment.

It appears that the children looked at in this assessment are at increased risk because of HIV and AIDS and because they are not being helped by social protection systems or safe guarded by child protection systems.

Children are vulnerable because of poverty:

- Unemployment means that fathers migrate for work and increase their risk of infection.
- Poverty traps people into sex work.
- Poverty reduces people’s access to health care and treatment, crucial for PLHIV, which means they become more ill, less economically productive, and can die.
- Poverty can mean parents and children going onto the street to find work and becoming homeless.
- Children have dropped out of school because of the death or illness of a parent and are having to work. Children are also working to counteract the spending of drug using parents. In some cases the children are actually excluded. Education above primary level is currently beyond the imagination of these families. To be educated is a right and is important for securing productive employment and
national development. Children of IDUs and sex workers are also being excluded from schools.

Children are at risk from family breakdown:
- Most people in the ranking exercise saw the death of parents, particularly the father as having the worst impact on children.
- Many PLHIV and children thought that the extended family would be supportive and care for the children but this was not unanimous and some parents were thinking about children’s homes. While some families were very supportive, some were not and quality future care of any children may be an issue. Some parents were contemplating perhaps having to rely on residential care. Many key informants thought that the ability of the extended family to provide support and mitigate health and other shocks was declining. Hardly anyone in the assessment talked about AIDS orphans being an issue or a problem but many children in the group discussions reported the death of a parent or illness. The children we talked to in the study were still living with their families, but there was no information regarding the care of children where parents had died of AIDS related health problems. Evidence from the 2005 earthquake is that relatives in Pakistan are generally willing to care for orphaned children. Greater efforts will need to be made to ensure that if parents do die or can no longer care that extended family care can be supported by the service providers.
- Death of parents can effect a child's nutrition, education and health care.
- There is evidence from this study of stigmatization, discrimination and potential rejection of children from families where parents are infected with HIV and AIDS or who use drugs or are involved in sex work.

Children are at risk from violence, abuse and exploitation:
- IDUs are beating their children and their children are working to support drug use.
- Male sex workers were sexually abused as children.
- There is evidence of trans-generational female sex work, with daughters becoming involved below 18 years.
- Street and homeless children are being sexually abused and exploited.

14.1 The Protection failures

Children are placed at greater risk because of a failure of social protection services.
- There is a failure to provide education for children of IDUs and sex worker’s children. It appears that these children suffer exclusion and discrimination as well as other barriers that affect the poor.
- For most PLHIV the problems emanate from failures to seek or be provided with health care or the family’s financial incapacity to cope with the declining health of

Social protection is widely understood to encompass measures to prevent and respond to risk and vulnerability. For children, the risks of poverty and loss of livelihood are compounded by the risk of losing family care, because families provide children’s first line of protection. Social protection measures including income transfers, family support services, and alternative care can help mitigate the impact of AIDS by reducing poverty and family separation, and can contribute to better health, education and protection outcomes: *Enhanced Protection for Children Affected by AIDS: A companion paper to The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS – UNICEF 2006.*
a productive adult. With regard to children infected or affected by HIV and AIDS, the UNAIDS modelling estimate is that 85,000 persons live with HIV or AIDS in Pakistan. However less than 4000 people are currently reported to be living with AIDS. There must be a concern over whether these risk groups and other excluded groups have access to quality health care, including treatment care and support for those HIV positive, and where appropriate, VCT. In the focus groups conducted in the 7 districts MSW, FSW and IDUs were often married and mostly have children. It is important that the missing people in the estimates are helped to have VCT.

- The usual social safety nets are not being made available to PLHIV or the high risk groups (IDUs and sex workers). No PLHIV or anyone from any of the high risk groups reported receiving any assistance from traditional forms of social welfare like Zakat or Bait ul mal. Some people had applied and been rejected, others were put off by the paperwork and the tedious lengths that had to be gone through, not to mention the discrimination. It appears from the literature study that both of these social transfer systems are under funded and that the groups of people in this assessment are not considered deserving. NGOs are providing support to PLHIV, IDUs and sex workers sometimes through PPPs but there are questions concerning timely disbursement of funds, monitoring, capacity and sustainability. It is most important to ensure that these and other parents have access to a range social protection measures and supportive community care programmes so that they and their children are not pushed into compromising health or undertaking high risk behaviours in order to survive or support their family. This is even more important in order to prevent children being forced into sexually exploitative work.

There are inadequate systems and structures in most of the Districts to protect children and safeguard them from harm:

- The absence of readily available data on child abuse and child protection systems hinders planning.
- Social Welfare must strengthen programmes to tackle child sex abuse and to protect the children. The sexual exploitation of boys by men is well documented. Even if there was no risk of HIV and AIDS this is child abuse but there is little evidence of agencies trying to prevent it taking place. It is known where the activities take place and who the perpetrators are, but few actions are taken by the authorities either to protect the children and take them to somewhere it is safe and seemingly a criminal offence is being committed but no action is taken against the perpetrators.
- There is a general failure to prevent trans-generational poverty and sex work in female sex worker’s families.
- No action is being taken to protect children whose parents misuse drugs. These children report being beaten and having to work.
- Residential care appears to be the only method of alternative care used. It seems as if there is currently a predominantly institutional response to separation and orphanhood by the social welfare authorities and at the same time there is evidence of inadequacy in terms of a comprehensive child protection system.

74 In 12 focus groups held in 5 districts, the parents were looking after 209 children.
There were no reports of social welfare assisting children of families upon the death of parents from AIDS. Social welfare appears to engage only peripherally with the issue of HIV and AIDS.

The exploitation of boys (and girls) is most recently documented in the *Situational Analysis of Prostitution of Boys in Pakistan* (Lahore and Peshawar).75 The behaviours, practices, services laws and policies in place for this group of children are thoroughly discussed. Many of these children are runaways from abuse and exploitation by their own families. Among the recommendations is the view that government needs to improve services, policies and laws:

- “Existing child protection and rehabilitation services in Pakistan are highly inadequate. There is a dire need for the government to establish such services to address the issue of the commercial sexual exploitation of children in a meaningful way.”
- “There is no mandated system for reporting child sexual exploitation, abuse and neglect, leading to a paucity of reliable statistics and published data on the prevalence of child sexual exploitation, abuse and neglect.”

15. **RECOMMENDATIONS**

The missing people on the UN estimates must be found

Finding, counselling and testing, then following up the missing group of 85,000 people who according to the UN estimates are infected is very important. This is a critical measure to protect the child by prolonging the lives of parents and preventing family breakdown. This means ensuring HIV positive parents have consistent access to appropriate facilities for follow-up including diagnostic monitoring and treatment of opportunistic infections, and when clinically indicated, access to antiretroviral therapy and to monitoring the treatment, including sustained adherence counselling.

Long term improvements are needed to the Protection Systems

The failure of the social welfare system to assist the at risk children in this study, coupled with poor access to health and education makes many children vulnerable and at risk. In summary there needs to be improvements made to:

- The Social Protection System

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74 In 12 focus groups held in 5 districts, the parents were looking after 209 children.
75 ECPAT and Pakistan Paediatrics Association 2006.
• The Child Protection System

Getting access to basic services and improving social transfers are enormous challenges. Social protection should not be viewed narrowly; there is a need to move away for old-style social welfare provided to the “deserving poor” (e.g. widows and orphans, or people with disabilities). There are good arguments for investments in young people, given the evidence that certain elements of childhood poverty, like poor education and health lead to the transmission of poverty over a lifetime and to future generations.

These vulnerable children need to be included in service delivery and providers need to prevent the exclusion of children considered “non deserving.” It probably needs to be re-emphasised that reducing poverty keeping families together, providing education and quality health care including ARVs will prevent most child protection problems for children affected by HIV and AIDS.

Using a wide definition of social protection; it is these systems that ensure all poor and vulnerable people can manage risk and overcome deprivation. This would include social transfers, access to education, health and housing. Improvements to these systems would reduce vulnerability and exposure to risk and most importantly in this context keep families together and support families to raise any orphaned relatives.

The Child Protection system needs to be more effective at preventing and protecting children from harm. This implies to prevent family separation where possible but also to prevent children being abused and exploited within or outside their families.

In many of the Provinces the child care and protection systems appear to be in need of modernisation to meet current international standards and the socio-economic changes in Pakistan which includes delivering services in large urban areas. Such modernisation will also help those children affected by HIV and AIDS. The State needs to take a greater lead in dealing with child abuse and exploitation. Even in the old laws there are residue powers for the police and other agencies to take action to protect the child and deal with the perpetrator. For child protection to become a reality investment is usually needed in district capacity. This can be very often achieved by police and social welfare departments together with NGOs working to improve justice for children. Children must be included in access to justice programmes. In terms of child protection there is an important role for social workers to perform where there is abuse and neglect and this should include as a minimum:

- Work on prevention of abuse and family breakdown
- Assessment
- Case Management

Child protection focuses on keeping children safe from harm. From the Children’s Act 1989 England and Wales: “Child Protection is to safeguard and promote the welfare of children and also to make enquiries when there is concern that a child may be suffering or is suffering harm. Child protection is the general term commonly used to describe work with children who have been identified as suffering or at risk of suffering significant harm - in other words, children requiring protection from harm. Usually social services or social welfare departments have lead responsibility for safeguarding and promoting the welfare of children, but safeguarding and promoting the welfare of children is everybody's business.”


The state has another role in setting and maintaining standards that ensure the quality of child care and protection work being undertaken by its own staff and by NGOs. This should include standards of care in children's homes, shelters and day care facilities, and social work in communities. A more complete picture of the number of homes, their facilities and information on the children in them would be advantageous for policy making. Social care resources are scarce and residential care is expensive. The question needs asking as to whether the children in the homes are the ones in most need of protection from harm or whether the resources should be redirected to those children who are being abused or who are homeless.

This will require changes to policy, law, structures and practice, and should be a long-term goal of the Ministry of Social Welfare and Special Education.

**Improved information systems and participation**

This was an assessment of protection risks and failures in relation to HIV and AIDS not a comprehensive assessment of child protection and care in Pakistan. The absence of readily available data on child protection leads to the recommendation that there is a need for more complete and participatory assessments of the current care and protection system to improve understanding and learning. The stake-holders in child protection and the children themselves need a greater voice in influencing the developing of policy.

**Discrimination must be addressed**

The issue of discrimination at all levels by service providers needs to be addressed. Progress is being made as a current draft of the MoSW policy on OVCs now contains sections to prevent discrimination by social welfare staff: “Discrimination by staff of Child Protection Units is prohibited on grounds of race, gender, disability, colour, language, ethnicity, religion or HIV status.” The staff will have a duty to help PLHIV access appropriate care and treatment. The Government will not be allowed to register CBOs or other organisations that practice discrimination. Residential Care facilities will be expected to provide HIV and AIDS awareness training for staff and users.

It is recommended that these practices on discrimination be incorporated into employment codes of conduct and contracts.

**International Standards and Guidelines**

The State needs to consider again its obligations under the CRC for the protection of children and consider its work in the light of new international standards in child care coming into operation in the next 5 years. If HIV and AIDS spreads through the risk groups and makes a greater impact on the lives of the general population it is important that government shows that it is prepared to engage with the problem. The International OVC Framework is a good design and attention needs to be given to all the elements in Pakistan. The challenge is to include HIV and translate the policies and plans into
action. The design of national policy and implementation strategies is a welcome development, with the government writing new policies, drafting laws and making plans. It is hoped that the new policies and laws give greater prominence to the role of the state as parent and the role of the state in child protection.

The two recent papers *The Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS*79 and *Enhanced Protection for Children Affected by AIDS*80 need to be widely distributed to policy makers, planners and practitioners. UNICEF should make these papers widely available.

**Expanding Public Private Partnerships into Child Protection should be considered**

The role of the NGOs funded through PPPs is important at the moment for developing good practice and bringing services to PLHIV and their families who would otherwise be excluded from service provision. These PPPs will need to be sustained by government finance if levels of external funding decrease or there will have to be a strong commitment by social welfare departments to engage with the problems and learn from the NGO good practice. Or alternatively it may be the case that PPPs can be expanded into other areas of child protection where NGOs under a system of licensing and working to quality standards can be responsible for child protection in given areas.

15.1 A strategic role for UNICEF in Child Protection

It is recommended that UNICEF critically examine its method of developing best practice through funding of model projects unless resources for replication are ensured.

There is evidence of strong UNICEF and NACP support to NGOs and some projects are ground breaking in Pakistan in the area of support to affected children. For UNICEF there is a challenge to ensure that the present model of support to projects leads to sustainability and replication where appropriate.

**It is recommended that UNICEF is more strategic regarding the development of child protection systems and structures.**

This would include working with government on a long term strategy to improve child protection over a 10 year period. The length of time and commitment necessary to develop a system that more fully protects children cannot be underestimated.

It is recommended that UNICEF use OVC work and HIV and AIDS as an entry point for supporting long term reform of child protection, (although a very appropriate entry point for working on child protection, HIV and AIDS may not become the issue in Pakistan that overshadows other child protection concerns as it does in some African and other Asian countries).

80 UNICEF 2006.
Long term support to child protection could be supported by joint UNICEF and the ministry work on a strategic plan for improving child protection and a road map to take the process forward.

Next steps could be a review of the use of residential care, leading to the development of modern quality standards, gate keeping and the redirection of resources.

It is recommended that UNICEF review and examine in the current social protection systems in detail in order to recommend precise ways that vulnerable children could benefit from social transfers.

81 See “Changing minds, policies and lives” from Innocenti Research Centre, UNICEF.
Case study 1

Muneeb 15, child affected by HIV and AIDS

I had to leave school because my father could not work, but now I have no regrets; life is good. The 15 years old young lad is very spirited about his future as motor mechanic.

Leaving schools was little difficult as my friends advised me not to do that. But when I thought about my father and brother the decision was made immediately. I understand my responsibilities as elder son and brother, my family needs me. Now I see my future as owner of a workshop and I am working hard to recover my family. I’m longing to see my father hale and hearty again and my younger brother who also had to quit school would be getting high degrees in education.

My father gave us everything when he used to work. My mother loved us a lot, cooked delicious food, she also helped us in home work and prayed for our bright future.

After her death everything changed but I have no complaints, I still have loving grandfather I share my feelings with him. My school friends also accompany me on weekends and every time they come they press me to rejoin school, but I think learning a skill is better, at least I can support my family with it. Also my father told me that even if I got a number of degrees I would not get any job without skill.

I love watching TV at weekends, I like playing cricket and football but hardy get time for sports. I earn Rs 30/day from workshop that is used to bring food and medicines of father. My grandfather also helps us when my father’s health breaks down, but it distracts me during work.

If I am asked to make one wish on the expense of life I would wish health of my father.
Case study 2
Migrant workers: Pewaiz and Aneela Bibi

I worked in Oman for many years; I came back Pakistan to spend some time with my family. Then somebody suggested I try for a Muscat visa, but my visa was refused because of my HIV status. It was than I first heard this word HIV, I did not know what it meant, the embassy did not tell me anything either.

I dejectedly came home and threw the travel documents in the garbage. I tried to learn about HIV but no hakim or wise man of our village could entertain me.

Then Pak Plus organization contacted me as they have links with the Embassy they got to know about my disease and approached me.

I could not believe that I am severely ill, I was an active person who used to work on its fullest. But when the reality was revealed it was too late, as my wife had also been infected. I have 5 children, 3 sons and 2 daughters. I keep on thinking about them all the day long, my biggest concern is their future. Who would take care of them if something happen to me and my wife? I am not able to earn for my family now as this disease slowly draining away my energy, I feel myself unwell and tired all the time. I cannot practice driving also. Because of my condition my children could not continue their studies; my daughters take care of household unlike the others girls of their age group.

My children know driving, I want for them a Toyota van could that they could live by themselves after me, but I do not know if there is any aid, Zakat scheme for HIV positive in Pakistan.

There’s nobody else except GOD for me and my children.
Case study 3
A woman married to migrant worker

Maria happily married her first cousin Khalid who came back Pakistan after serving in the army in Somalia for one year. But she was unaware that he had been previously “married” to an HIV infected person.

Khalid was actually deported from Somalia because he was HIV positive. He was advised not to get married, but his HIV status was not revealed to him. Back in Pakistan, an NGO was alerted to his status and they took him in confidence and series of counselling sessions were conducted with him just to persuade him not to get married and not ruin the life of another human being.

In spite of all information and awareness, he not only proposed to his cousin but also did not reveal his HIV status to her. Maria contentedly started her new life. But all her dreams were broken, when she had a HIV positive daughter. She did not know whether she should celebrate the birth of first child or mourn over the deadly disease she and her daughter have caught.

Life had been so ruthless to her but she did not leave her husband. Then again, she had a son with HIV. The boy did not survive for more than a year. After the son died Khalid was totally devastated. He felt severe pangs of remorse and guilt. He cursed himself for his selfishness, and impatience. He died in 1998. He was apologetic to Maria and his late child. Maria was left alone with her baby girl. She came back to her father’s house but a year after her husband’s death her daughter died as well.

Quaiser was his brother’s friend and supported Maria as he was himself working with an NGO dealing with HIV positive people and AIDS patients. He decided to marry her. He faced discouragement both from the NGO he worked with, as well as from relatives and friends.

They finally got married and have been together five years. They have two daughters. Quaiser is healthy and fit and still working for the same NGO.

One of their daughters is HIV positive due to non-availability at the time of her birth of prevention of parent to child transmission services. They have second daughter who is HIV negative.

Quaiser has no regrets over his marriage.
Case study 4  
Ashiq

If I or any of my siblings fall ill my mother never has money to bring us medicine, she tries to therapy us using wet cloth on our forehead. This is the story of Ashiq aged 12 years from Faisalabad.

My father is a drug addict: he does not earn a penny. Me and my brother work at a workshop. Ustad give me 10 rupees daily that is used to bring cigarettes for my father. If we refuse to give him money he beats my mother and younger sister. My mother is always harassed of his behaviour. My father never listens to us or talks to us. If we try to restrain him from smoking he yells at us and abuses us loudly.

All of our relatives cut-off with us just because of the behaviour of my father. My neighbour who is a shopkeeper is a kind man he lends us food articles from his shop and we return this loan in small instalments.

My mother always remains gloomy and depressed. I want to cheer her up. If we try to console her by saying that we would change the circumstances soon, she starts crying. I know she cry not on her own agony, but she can't tolerate her kids working at workshop and being beaten on minor blunders.

I want to become a doctor, though I have never been to school. I am over age for school education now but still my passion is there. If I would be given a chance to work in the morning and study in evening I will heartily avail this opportunity and turn over my fate.
Case study 5

I am haemophilic. I had been taking treatments from number of clinics, during one of the treatments; I was diagnosed as HIV positive. But the respective doctor did not disclose my HIV status to me. I was married and in contact with my wife.

An NGO learnt that I am HIV positive and approached me, and I was shocked to learn that I am suffering from one of the most deadly diseases. It broke me from inside; I used to think for hours about my disease and life of my children and wife after me. As I am not an educated person I did not know a lot about this disease.

Than I thought no matter how little my life is left I am not going to make it miserable by thinking about my disease. I phoned the NGO again, I had long telephone counselling sessions with them. They advised what protection I should use and how I can prevent my wife and children from becoming infected. I had been given medicines also, now I feel better my wife and children wee also tested for HIV but they all are negative.

Life is turning bright again; I use the medicines regularly and these keep me alive.

I am tailor by profession but cannot work hard now; my passion to design new styles is drifting away just because I can toil any more. My family has to face financial crisis from time to time. But I am grateful to the NGO that they at least provide food to us.
### Ranking Exercise Tables

#### Reponses from Local Nazim & Counselor

<table>
<thead>
<tr>
<th>Options</th>
<th>Scores out of 5 (for the worst) negative impact of each of the following on children</th>
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#### District and Province Key Informants

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### Ranking Exercise from NGO informants

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### Scores out of 5 (for the worst) negative impact of each of the following on children

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<th>Doing Exploitative Work</th>
<th>Sex Work</th>
<th>No Home/Shelter</th>
<th>No NGO Support</th>
<th>No Good Health Care</th>
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<th>Using Glue or Drugs</th>
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Scores out of 5 (for the worst) negative impact of each of the following on children

FGD Ranking Exercise of Sex Workers

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<th>Sex Work</th>
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<th>No NGO Support</th>
<th>No Good Health Care</th>
<th>Insufficient Food</th>
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<th>Suffering any Abuse</th>
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**SEX WORKER**
Scores out of 5 (for the worst) negative impact of each of the following on children

FGD Ranking Exercise of PLHIV

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Scores out of 5 (for the worst) negative impact of each of the following on children

FGD Ranking Exercise of Children

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Appendix 1

Fieldwork Assessment Methodology and Tools

Each SoSec District Assessment Team was asked to provide:

1. A District Profile\(^\text{82}\) to include information on:
   a. HIV and AIDS in the district.
   b. Collecting materials on best practice from Government and NGOs.
   c. Scale and size of other at-risk groups, e.g. street children, orphans, including any data on early marriage, trafficking, sex abuse or exploitation.
   d. Number of day shelters or refuges for children.
   e. Number of vocational training centres for children.
   f. From Provincial Social Welfare – number of child welfare homes:
      I. Name of home and district.
      II. Number of children in each home by gender.
      III. Reasons for admission of children e.g. orphan, any due to AIDS, poverty, abused, IDU father, parent in prison.

2. Two focus group discussions with adults selected from the following categories:
   a. IDUs, concentrating on IDU PLHIV who have children.
   b. Sex workers who have children.
   c. Migrants/general population who are PLHIV and have children.

3. One focus group discussion with children comprising:
   a. Children who are infected or who are affected by HIV and AIDS, particularly children of PLHIV.
   b. Children who are at risk of infection because of their lifestyle or vulnerability

4. At least 6 Key informant interviews selected from:
   a. Community Leaders
   b. Nazims or Councillors
   c. Provincial Social Welfare staff
   d. Provincial AIDS Control Programme
   e. Religious Leaders
   f. NGOs
   g. Community Development Officers

5. Three case studies on a child or sibling children at least one affected and one infected.

6. Three interviews with PLHIV preferably one IDU, one sex worker and one migrant.

Two field researchers conducted the FGDs (one facilitator and one recorder); one field researcher conducted the key informant interviews and individual case interviews.

Finalised tools:

- Focus group discussion guides for use with sex workers who have children and may or may not be living with HIV.

\(^{82}\) These profiles were not provided.
- Focus group discussion guides for use with IDUs who have children and may or may not be people living with HIV
- Focus group discussion guides for use with people living with HIV and AIDS.
- Focus group discussion guides for use with children (not all parts suitable for those under 6 years old - over 8 years determined best).
- Interview questions for children living with HIV, or those who are directly affected by HIV and AIDS.
- Interview questions for use with community and religious leaders who know of the risk groups.
- Interview questions for use with Government officials.
- Interview questions for use with NGOs.
- In-depth Interview questionnaire for people living with HIV.
Appendix 2

NGOs and Institutions - planned visits by SOSEC:

<table>
<thead>
<tr>
<th>District</th>
<th>Organisations / Institutions visited and their focus</th>
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<tr>
<td>All Districts</td>
<td>• PACP, AIDS Consortia, Dept of Social Welfare, Local Nazims, Bait ul Mal and/or Zakat</td>
</tr>
<tr>
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<td>• Contech (FSW/Hijra/MSW)</td>
</tr>
<tr>
<td></td>
<td>• Vite N’ Hope (children of IDUs/FSW/MSW)</td>
</tr>
<tr>
<td></td>
<td>• Child Protection Welfare Bureau</td>
</tr>
<tr>
<td></td>
<td>• Pak Plus Society (PLHIV)</td>
</tr>
<tr>
<td></td>
<td>• New Light AIDS Control Society (PLHIV)</td>
</tr>
<tr>
<td>Faisalabad</td>
<td>• Hayat Foundation (at-risk adolescents)</td>
</tr>
<tr>
<td></td>
<td>• Contech (Hijra/MSW)</td>
</tr>
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<td>• Pakistan Society (IDUs)</td>
</tr>
<tr>
<td></td>
<td>• New Light AIDS Control Society (PLHIV)</td>
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<tr>
<td></td>
<td>• Marie Adelaide (IDUs/many PLHIV @ hospice)</td>
</tr>
<tr>
<td></td>
<td>• AMAL (FSW)</td>
</tr>
<tr>
<td></td>
<td>• Green Star (FSW)</td>
</tr>
<tr>
<td></td>
<td>• AL-Nijat Welfare Society (IDUs)</td>
</tr>
<tr>
<td></td>
<td>• Pakistan Paediatrics Association (Dr. Ayesha)</td>
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<tr>
<td>Larkana</td>
<td>• Mehran Welfare Trust (IDUs/FSW)</td>
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<td>• CDNF (IDUs)</td>
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<td>• EDO Finance and Planning</td>
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<td>• Roshan (IDUs)</td>
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<td>• WASFRD</td>
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<td>Quetta</td>
<td>• Voice (VCT/PLHIV)</td>
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<td></td>
<td>• Legends Society (IDUS)</td>
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<tr>
<td></td>
<td>• Prof Siddiqui (Dept. of Social Welfare, University of Balochistan)</td>
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<td></td>
<td>• Pakistan Paediatrics Association (Dr. Amir Jogezai)</td>
</tr>
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<td></td>
<td>• Seher</td>
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<td>• AMAL (at risk adolescents)</td>
</tr>
</tbody>
</table>