MAPPING OF SOCIAL PROTECTION MEASURES FOR CHILDREN AFFECTED BY HIV AND AIDS

IN ASIA AND THE PACIFIC










A report by the Economist Intelligence Unit

Commissioned by:

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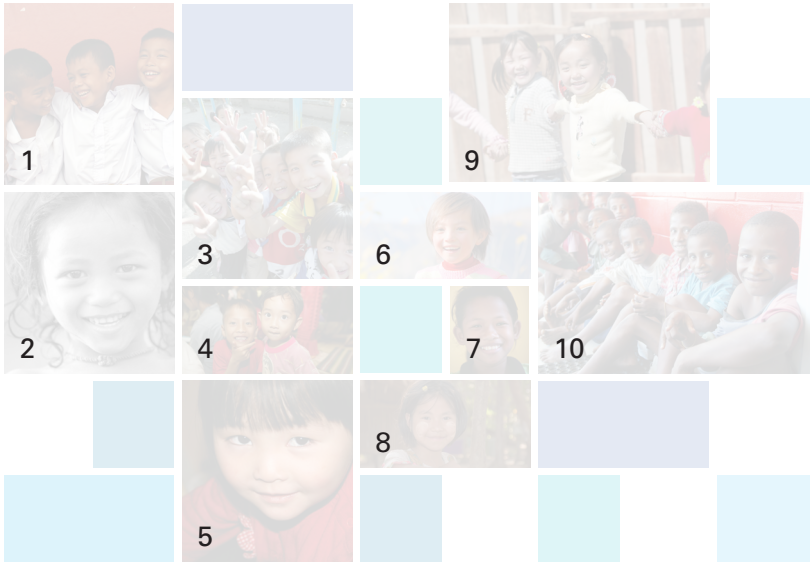

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This report on "Mapping of social protection measures for children affected by HIV and AIDS in Asia and the Pacific" reviews the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in nine countries – Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam.

The Economist Intelligence Unit (EIU) was commissioned by UNICEF East Asia and Pacific Regional Office (EAPRO) based in Bangkok, Thailand to research and write this report.

During the period of September 2010 - March 2011, the Economist Intelligence Unit research team led by Manisha Mirchandani and Manoj Vohra gathered data, conducted interviews, and authored this report, which presents its findings as of June 2011.

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The analysis and views expressed in this report are those of the Economist Intelligence Unit, and do not necessarily reflect the views of the individuals or entities acknowledged.

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Country Summaries

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Acronyms

ADB	Asian Development Bank
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARISE	Appropriate Resources for Improving Street Children's Environment (Bangladesh)
ART	antiretroviral therapy
BEHTRUWC	Basic Education for Hard-to-Reach Urban Working Children (Cambodia)
BISP	Benazir Bhutto Income Support Programme (Pakistan)
BKM	Bantuan Khusus Siswa/Special Student Assistance (Indonesia)
BLT	Bantuan Langsung Tunai/Direct Cash Assistance (Indonesia)
BOS	Bantuan Operasional Sekolah Programme (Indonesia)
BPJS	Badan Pengelola Jamin Sosial/Social Security Management Agency (Indonesia)
BPS	Central Statistics Agency (Indonesia)
CABA	children affected by AIDS
CBHI	community-based health insurance
CCT	conditional cash transfer
CFS	Child Friendly School Initiative (Thailand)
CHAC	Child Health Advisory Committee (Papua New Guinea)
CODI	Community Organisations Development Institute (Thailand)
CSC	children in special circumstances
CT	cash transfer
DDC	district development committees
DFID	Department of International Development (UK)
DWD	Department of Women Development (Nepal)
EAPRO	UNICEF East Asia and Pacific Regional Office
EFA	Declaration on Education for All (Thailand)
EGS	100-day Employment Guarantee Scheme (Bangladesh)
EIU	Economist Intelligence Unit
EOBI	Employees Old Age Benefits Institutions (Pakistan)
FBO	faith-based organization
GDP	gross domestic product
GES	Graduate Employment Scheme (Pakistan)
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria

GSB	Government Savings Bank (Thailand)
GTZ	German Technical Cooperation
HEF	health equity fund
HIV	human immunodeficiency virus
IDU	injecting drug user
IGVGD	Income Generation for Vulnerable Group Development (Bangladesh)
ILO	International Labour Organisation
KPP	Khushal Pakistan Programme/People's Works Programme (Pakistan)
LP	Lukautim Pikinini (Nepal)
MARPs	most-at-risk populations
MLD	Ministry of Local Development Act (Papua New Guinea)
MLSS	Minimum Living Standard Scheme (China)
MOES	Ministry of Education and Sports (Nepal)
MOET	Ministry of Education and Training (Viet Nam)
MOEYS	Ministry of Education, Youth and Sport (Cambodia)
MOH	Ministry of Health
MOHP	Ministry of Health and Population (Nepal)
MOLISA	Ministry of Labour Invalids and Social Affairs (Viet Nam)
MOP	Ministry of Planning
MOSW	Ministry of Social Welfare
MOSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation (Cambodia)
MSM	men who have sex with men
MWCSW	Ministry of Women, Children and Social Welfare (Nepal)
NACP	National AIDS Control Programme (Pakistan)
NEGS	National Employment Guarantee Scheme
NGO	non-government organization
NHA	National Housing Authority (Thailand)
NPAC	National Programme of Action on Children (Viet Nam)
NPC	National Planning Commission (Nepal)
NPCE	National Project on Compulsory Education in Poor Areas (China)
NPCI	National Composite Policy Index
NRCMS	New Rural Cooperative Medical Scheme
NREGS	National Rural Employment Guarantee Scheme (Bangladesh)
NRSP	National Rural Support Programme

NTPPR	National Targeted Programme on Poverty Reduction (Viet Nam)
NZF	National Zakat Foundation (Pakistan)
OD	operational district
OECD	Organisation for Economic Co-operation and Development
OI	opportunistic infection
OPK	Special Market Operation (Indonesia)
OVC	orphan and vulnerable children
PBM	Pakistan Bait-ul-Maal
PCAR	Protection of Children At Risk (Bangladesh)
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PESP	Primary Education Scholarship Programme (Bangladesh)
PESRP	Punjab Education Sector Reform Programme (Pakistan)
PFSS	Punjab Food Support Scheme (Pakistan)
PHCT	Public Health Concern Trust (Nepal)
PKH	Programme Keluarga Harapan/Household Conditional Cash Transfer Programme (Indonesia)
PLHIV	people living with HIV
PML	Pakistan Muslim League
PPTCT	prevention of parent-to-child transmission of HIV
PRSP	Poverty Reduction Strategy Paper
RCIW	Rural Community Infrastructure Works Programme (Nepal)
RGC	Royal Government of Cambodia
ROSC	Reaching Out Of School Children (Bangladesh)
SDDNCF	Socio-economic Development of Destitute and Neglected Children's Families Programme (Pakistan)
SDIP	Safe Delivery Incentive Programme (Nepal)
SEQEAP	Secondary Education and Quality Enhancement and Access Project (Bangladesh)
SHI	Social Health Insurance Plan (Cambodia)
SSMP	Support to Safe Motherhood Programme (Nepal)
SW	sex worker
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund

URC	University Research Company
USAID	United States Agency for International Development
VAAC	Vietnam Administration for AIDS Control
VDC	village development committees
VGD	Vulnerable Group Development (Bangladesh)
WHO	World Health Organization
WFP	World Food Programme
WWF	Worker's Welfare Fund

Part I: Overview

This report reviews the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in nine countries – Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam – in the region. A set of child- and HIV-focused criteria were used to examine existing policies and programmes, with the goal of understanding country trends around implementation, funding, coverage, mechanisms for monitoring and delivery, and national priorities.

Introduction

Countries in Asia-Pacific have faced a number of challenges in recent years including the global financial crisis, food-price volatility and climatic shocks. Among these, HIV is one of the factors impacting households in the region. The environment for children affected by HIV[1] remains complicated and highly diverse across the region. Regional estimates suggest that there are 180,000 children between 0 and 14 years of age living with HIV[2] and 1.1 million children who have lost one or both parents to AIDS. The number of children affected by HIV – living in a household where at least one adult is HIV-positive, or whose well-being is threatened or altered by the disease[3] – is difficult to ascertain. While HIV in the region is primarily driven by high-risk behaviours related to sex work, men who have multiple sex partners and injection drug use, the epidemic is trickling down to the partners of high-risk groups, therefore putting more children at risk of being affected by the disease.

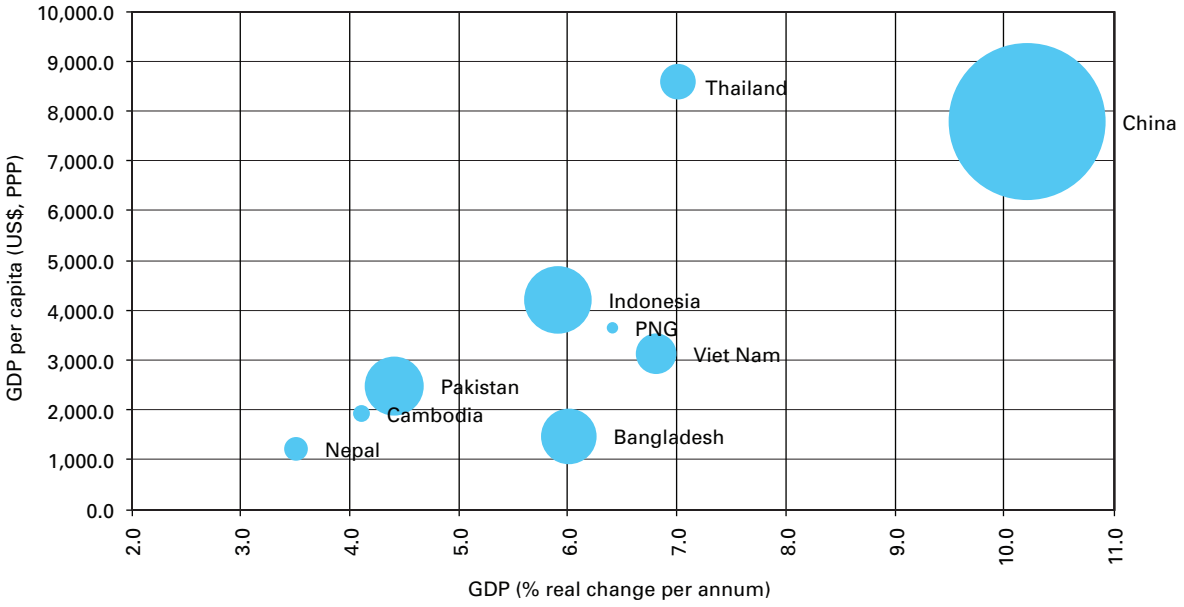
The socio-economic context for children affected by HIV in Asia and the Pacific

Asia-Pacific's robust economic performance of recent years has brought impressive gains in terms of development and poverty alleviation. The high GDP per capita countries of Thailand and China are achieved relatively strong growth in

1 The term HIV is used when referring to both HIV and AIDS, The term AIDS is used for specific references to the advanced stage of infection.
2 United Nations Children's Fund, *'The State of the World's Children 2012: Children in an Urban World'*, UNICEF, New York, February 2012.
3 United Nations Children's Fund, *'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, New York, March 2007.

2010, at 7 and 10 per cent respectively, as indicated in Figure 1; while the majority of South and South-east Asian countries in the sample have a purchasing power of below US$5,000 per capita, and are expected to attain respectable levels of GDP growth in the wake of the global financial crisis of 2008-09. However, while economic growth has resumed in many economies, the overall employment outlook is uncertain, with unemployment of youth, vulnerable groups, and working poverty continuing to be a driver of vulnerability at the household level.

Figure 1: GDP growth, purchasing power and population of countries, 2010 estimates

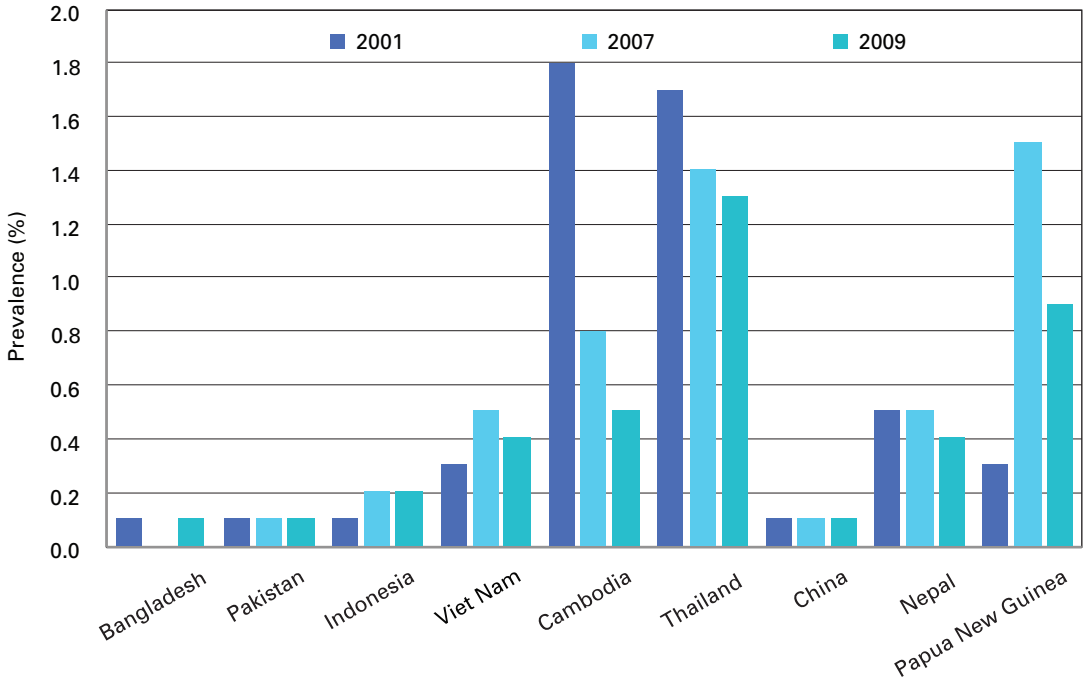


Note: Size of bubble represents population.
Source: Economist Intelligence Unit.

Despite the improving economic outlook, access to and equity of resources remain problematic in a region that is largely still developing, and where much of the population remains exposed to a range of economic and environmental risks. Employment in the formal labour market remains predominantly agricultural, leaving the majority of the region's workers exposed to climate shocks such as failure from drought or flooding, and seasonal unemployment. Meanwhile, the informal labour market continues to flourish in developing Asia, exposing millions to income instability.

Vulnerability refers to the risk of an adverse event and the likelihood that the event will have serious negative consequences, and the level of exposure given a subject's economic resources or place within the community. In the context of HIV, both poverty and social stigma are relevant – and interlinked – causes of vulnerability. The robust economic growth experienced across Asian countries in recent years has not reduced vulnerability for affected populations. Not only is HIV infection still a risk, but many exposed groups, especially children, remain ill-equipped to deal with the economic and social consequences.

Figure 2: HIV prevalence trends in Asia-Pacific



Source: UNAIDS (2010).

Poverty is not the sole driver of HIV prevalence in the region. The interactions between socio-economic status and HIV risk are complex, and the impact varies significantly among groups.[4] In fact, in the Asia-Pacific context, higher levels of disposable income are required to purchase drugs and sex, behaviours which remain drivers of the epidemic in the region. A regressive legal environment and a weak human rights context are also important enablers of new infections in low and concentrated epidemics. Given that high-risk behaviours remain unlawful in many countries across the region, social attitudes and the legal environment are important factors in conditioning the HIV response.

Income inequality, though, has a strong association with HIV prevalence. Cross-country analysis has indicated that countries with greater inequality tend to have higher HIV prevalence, particularly in Sub-Saharan Africa, and to a lesser extent, in Latin America.[5] The trend holds true in Asia-Pacific, with the exception of China and Nepal, which have relatively high income inequality, but low HIV prevalence rates. Recent trends in prevalence show progress towards the Millennium Development Goal 6a to have "halted by 2015 and begun to reverse the spread of HIV", with notable successes in Cambodia and Thailand since 2001 (see Figure 2), suggesting that appropriate national responses can be highly effective. However, the prevalence trends exhibited in several countries tell another story – that ongoing vigilance is necessary, even in low-prevalence environments, and that lost ground can be quickly gained, as has been the case in Viet Nam and Papua New Guinea from 2007 to 2009 (see Figure 2).

4 Greener, Robert, 'Poverty is one part of HIV risk, but not the most important part', Conversations For A Better World, 2009, www.conversationsforabetterworld.com/2009/08/poverty-is-one-part-of-hiv-risk-but-not-the-most-important-part, accessed June 2011.

5 Gillespie, Stuart, Suneetha Kadiyala, Robert Greener, *'Is poverty or wealth driving HIV transmission?'* AIDS, 2007, 21(Suppl. 7):S5: S5–S16.

Social protection and HIV

Global pledges on HIV, such as the 2001 and 2006 UN Declaration of Commitment on HIV and AIDS, affirm care, support and treatment for children orphaned and made vulnerable by HIV and emphasize the need for strengthened social welfare systems to meet the needs of these children. The individual's right to social protection is enshrined in various international covenants, including the Declaration of Human Rights, which ascribes an adequate standard of living and security for all, with "special care and assistance afforded to motherhood and childhood" – speaking directly to the specific, age-dependent vulnerabilities of children. A 'child-sensitive' approach to social protection has been adopted by UNICEF and partners[6] with a focus on recognizing the rights of women and children, achieving gender equality and reducing child poverty. The principles of child-sensitive social protection include early intervention; consideration of age- and gender-specific vulnerabilities; special provisions for the particularly vulnerable and excluded, including children without parental care or who are marginalized by their families or communities due to gender, disability, or other factors; and consideration of intra-household dynamics and mechanisms in reaching children.

The implementation of programmes and policies that are child-sensitive in their design and execution can specifically address the risks and vulnerabilities that children are born into, or later acquire by external shocks. As such, the provision of nutrition and basic needs to children and caregivers is a desired outcome of child-sensitive social assistance, which enables access to cash and food grants for children and families. The mitigation of economic shocks to households with children can be achieved through access to child-sensitive social insurance, comprising health, maternal support, nutrition and unemployment support targeted at caregivers.

Increasing caregiver's access to employment/income generation, and access to child-sensitive social services in the form of employment initiatives for caregivers and families, as well as supporting families and caregivers in their childcare role, is an important component of child-sensitive social services. The other is to ensure basic services for the poorest and most marginalized through rights to health care, psychosocial support, and alternative care for children and families. Finally, child-sensitive social protection policies, legislations and regulations would facilitate the prevention of discrimination and child abuse in and outside the home. Specifically, this can be achieved through established rights to basic services for children and caregivers and the existence of a legal framework that protects children.

Physical and psychological immaturity and a dependence on caregivers for care and protection translate to a higher level of vulnerability in children to social, economic and health risks,[7] and that vulnerability in turn is highly influenced by the external environment. In addition, the lifecycle-approach to

6 Department for International Development, United Kingdom et al., '*Advancing Child-Sensitive Social Protection*', Joint Statement, June 2009.

7 Jones, Nicola, William Ahadzie and Daniel Doh, '*Social Protection and Children: Opportunities and Challenges in Ghana*', UNICEF Ghana and Ministry of Employment and Social Welfare, Accra, July 2009.

child development suggests that risks are age-dependent, and that the impact of shocks will vary at different stages. The potential of social protection to address the specific risks associated with childhood is well-established in both developed and developing countries,[8] and there is growing evidence for social gains from investment in social protection for children in the areas of poverty alleviation and school attendance.[9] Of particular note are the numerous cash transfer and conditional cash transfer (CCT) schemes, many of which have been modelled on Brazil's flagship Bolsa Família programme, which extends to over 12.4 million households. The scheme, which gives mothers a small grant to keep their children in school and receive medical check-ups, has been credited with significant gains in Brazil's primary and secondary school attendance and income equality.[10]

When compared to food, cash transfer has its strengths and weaknesses in different contexts, and the consideration of this through an HIV and AIDS lens is an important area for further research. Given the potential logistical, economic and political issues involved with the scale up of food transfers, the proliferation of cash transfer schemes in recent years is unsurprising, in light of the lower administrative inputs required and the potential for rapid scalability. In particular, cash transfers have been gaining momentum in recent years in countries looking at bolstering their national social protection systems for children affected by AIDS.[11]

Research approach

Social protection has typically been viewed as a means of addressing the specific vulnerabilities faced by children, or as a potential 'booster' for achieving universal access to HIV prevention, treatment, care and support within the national HIV response. Yet, children affected by HIV – those vulnerable to infection, infected and negatively affected by the impact of HIV – are exposed to a troubling configuration of risks that may not be fully addressed by stand-alone child- or HIV-specific social protection approaches. The reduced capacity of families and the fragmentation of the household as a result of chronic illness means that affected children may fall outside the sphere of family care and protection, increasing a child's exposure to exploitation and discrimination. General risks to children such as susceptibility to child labour, psychosocial harm, and children's more limited access to health care, nutrition and education are further magnified in the context of HIV.[12]

8 As evidenced by the substantial body of research by the OECD, UNICEF and others on social protection for children.

9 Temin, Miriam, Better Care Network, *Expanding Social Protection for Vulnerable Children and Families: Learning from an Institutional Perspective,* Working Paper, Inter-Agency Task Team on Children and HIV and AIDS: Working Group on Social Protection, March 2008.

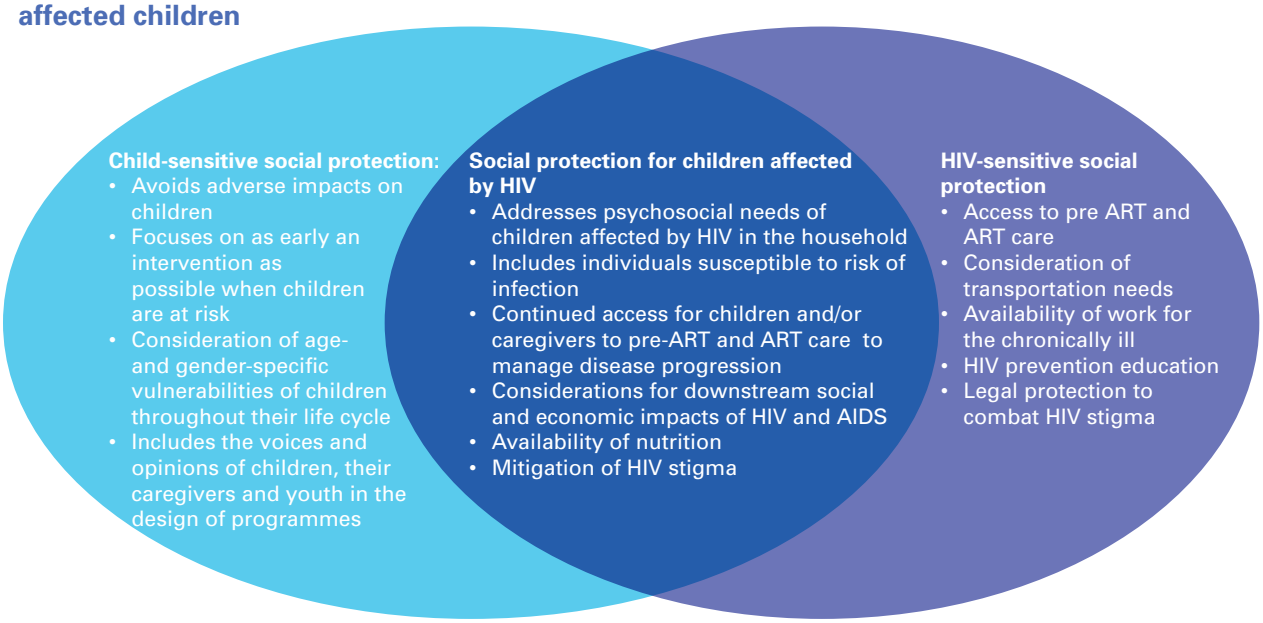
10 Findings from Fundaçao Getulio Vargas. See *The Economist*, How to get children out of jobs and into school, July 2010. About one-sixth of the poverty reduction can be attributed to Bolsa Família, the same share as that accorded to the increase in state pensions, but at a much lower cost of around 0.5 per cent of GDP. Despite its stunning success, concerns remain around the impact and gains of the programme in urban areas.

11 Adato, Michelle and Lucy Bassett, '*What is the potential of cash transfers to strengthen families with HIV and AIDS? A review of the evidence on impacts and key policy debates'*, Working Paper, Joint Learning Initiative on Children and HIV/AIDS, March 2008.

12 Greenblott, Kara, '*Social Protection for Vulnerable Children in the context of HIV and AIDS: Working Towards a More Integrated Vision'*, Working Paper, Interagency Task Team on Children and HIV and AIDS, July 2008.

HIV-sensitive social protection makes prevention, treatment and care accessible by ensuring that social protection mechanisms address specific needs of people living with HIV, and vulnerable and at-risk populations. Key elements comprise: access to services; ensuring financial protection for households and individuals affected by HIV; and the development of HIV-sensitive social protection policies, legislation and regulation to uphold the rights of vulnerable groups (see Figure 3). These principles can be translated into the design of social protection instruments that facilitate access to pre-ART and ART care, consideration of transportation needs, financial protection in the form of available work for the chronically ill, and legal protection to combat HIV stigma in the case of upholding the rights of vulnerable groups through a favourable policy, regulatory and legal environment.[13]

Figure 3: Identifying social protection policies and programmes for affected children



Source: UNICEF and Economist Intelligence Unit analysis.

To gain a regional perspective of the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in Asia-Pacific, from September to December 2010 the Economist Intelligence Unit conducted a nine country review across Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam. A set of child- and HIV-focused criteria were used to examine existing policies and programmes, with the goal of understanding country trends around implementation, funding, coverage, mechanisms for monitoring and delivery, and national priorities. Guided by a child-sensitive social protection framework,[14] an analytical review of secondary data and documented evidence was conducted to identify key policies and programmes designed to meet the needs of children, with the intention of identifying the initiatives with the widest scope and scale. Using an objective set of criteria, these

13 Social Protection Working Group, *UNAIDS Expanded Business Case: Enhancing Social Protection*, Joint United Nations Programme on HIV/AIDS, Geneva, May 2010.

14 Department for International Development, United Kingdom et al., *'Advancing Child-Sensitive Social Protection'*, Joint Statement, June 2009.

policies and programmes were then reviewed through a second, 'HIV-sensitive' lens to understand the extent to which key social protection initiatives for all vulnerable children are able to address the needs of children affected by HIV.

Without addressing the quality of these policies and programmes, a scoring key was developed to convey a sense of programmatic activity and the extent to which existing country initiatives account for children affected by HIV. To represent perceived levels of programmatic and policy action across each social protection instrument and type of transfer, existing programmes and policies were examined against a set of HIV-sensitive criteria.

Access to nutrition and basic needs for children affected by HIV and their caregivers is one desired outcome of HIV-sensitive social assistance – as such social assistance programmes with provision of cash and food grants for at-risk children (orphans, street children, institutionalized and stateless children) and poor families was a key criteria. In considering HIV-sensitive social insurance schemes, the mitigation of economic shocks to households affected by HIV was the key priority, and insurance schemes related to health, maternal support, nutrition and unemployment accessible to poor households and vulnerable groups were considered in the review.

With respect to HIV-sensitive social services for affected children, access to drugs, keeping caregivers alive and the provision of treatment to infected children are priorities. At the same time, social services programmes which enabled access to employment and livelihood initiatives for chronically ill caregivers were also of interest, given the importance of availability of employment/livelihood options for caregivers affected by HIV. Finally, programmes which provided for access to health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children were reviewed.

With respect to HIV-sensitive policies, given the harmful impact of stigma and discrimination in the community, policies and legislation which enshrined explicit rights to essential services for children affected by HIV were examined (as opposed to HIV-specific policies). Finally, the existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration, and school enrolment was considered.

Across the categories examined – social assistance, social insurance, access to social services, and policies and legislation – each programme or policy was conferred a coding from 'limited' to 'extensive'. Countries with a 'limited' coding have few policy initiatives, and nascent programme activity. A 'moderate' code reflects some policy initiatives and programme activity. Evidence of a substantive policy framework and moderate programme activity earned a 'substantial' coding. Programmes and policies were deemed to be 'extensive' if the policy framework was comprehensive, and there was evidence of robust programme activity.

Limitations

This review is limited to social protection initiatives of significant scale and reach, and in general captured those managed by government agencies or key development partners. Information on coverage and impact of existing programmes has been collected from the public domain; however, there were many cases where monitoring and impact data was not publically available. Several programmes notable for innovation in design and delivery have also been highlighted as examples of how social protection instruments can be adapted nationally. It should be noted that this analysis is not intended to serve as a study of the efficacy or impact of existing programmes. Rather, this review serves as a snapshot of the regional landscape, with the intention of capturing the extent to which existing national social protection policies and programmes meet the needs of all vulnerable children, as well as the extent to which children affected by HIV could benefit. While the potential of social protection to contribute to HIV prevention is acknowledged,[15] the primary focus of this analysis is to assess the availability of child- and HIV-sensitive social protection, and the extent to which existing policy and programming facilitates access to treatment, care and support for children affected by HIV. Analysis of social protection programmes that aim for HIV-specific prevention responses comprising prevention of mother-to-child transmission and behaviour change communication for primary prevention is outside of the scope of this study.

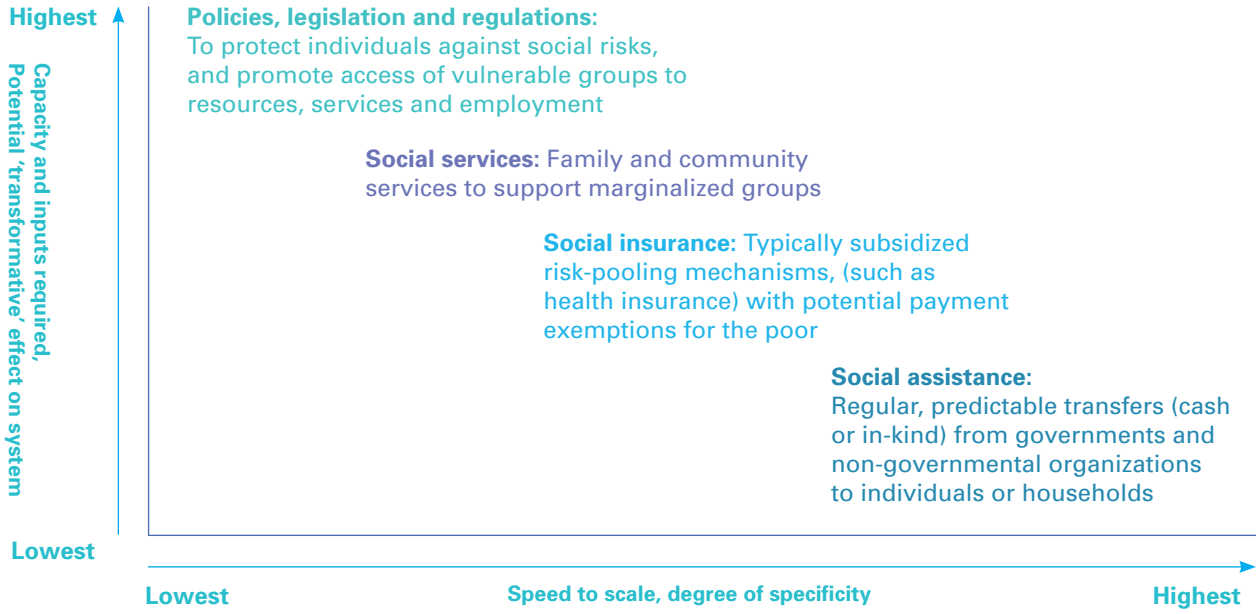
In its broadest sense, social protection is understood to comprise a set of measures to prevent and respond to social and economic risk and vulnerability, with the objective of reducing the economic and social susceptibility of poor and marginalized groups,[16] at the core of which is the concept of predictable and equitable transfers. Modern definitions look beyond the traditional disbursements of education, health care and income support to a set of instruments which can be adapted to mitigate and manage a much more complex spectrum of risks and vulnerabilities.[17] To prevent the chance of infection (susceptibility) and mitigate the consequences of HIV on individuals (vulnerability), social protection in the context of children affected by HIV must address issues of access for the most vulnerable. Social protection can be conceived as a set of transfers and services to reduce economic and social vulnerability, protect against livelihood risks, and ensure a minimum standard of dignity for marginalized people. As such, the 'transformational' potential of equitable legislation and policies that promote access of socially-excluded groups to assistance, insurance and services is also of interest given the possibility of lasting, structural change (see Figure 4 on pg. 9).

15 United Nations Children Fund, Joint United Nations Programme on HIV/AIDS and Institute of Development Studies, *'Enhancing Social Protection for HIV Prevention, Treatment, Care & Support – The State of the Evidence'*, Brief, 2010.

16 Devereux, Stephen and Rachel Sabates-Wheeler, *'Transformative Social Protection'*, Working Paper, Institute of Development Studies, Brighton, October 2004.

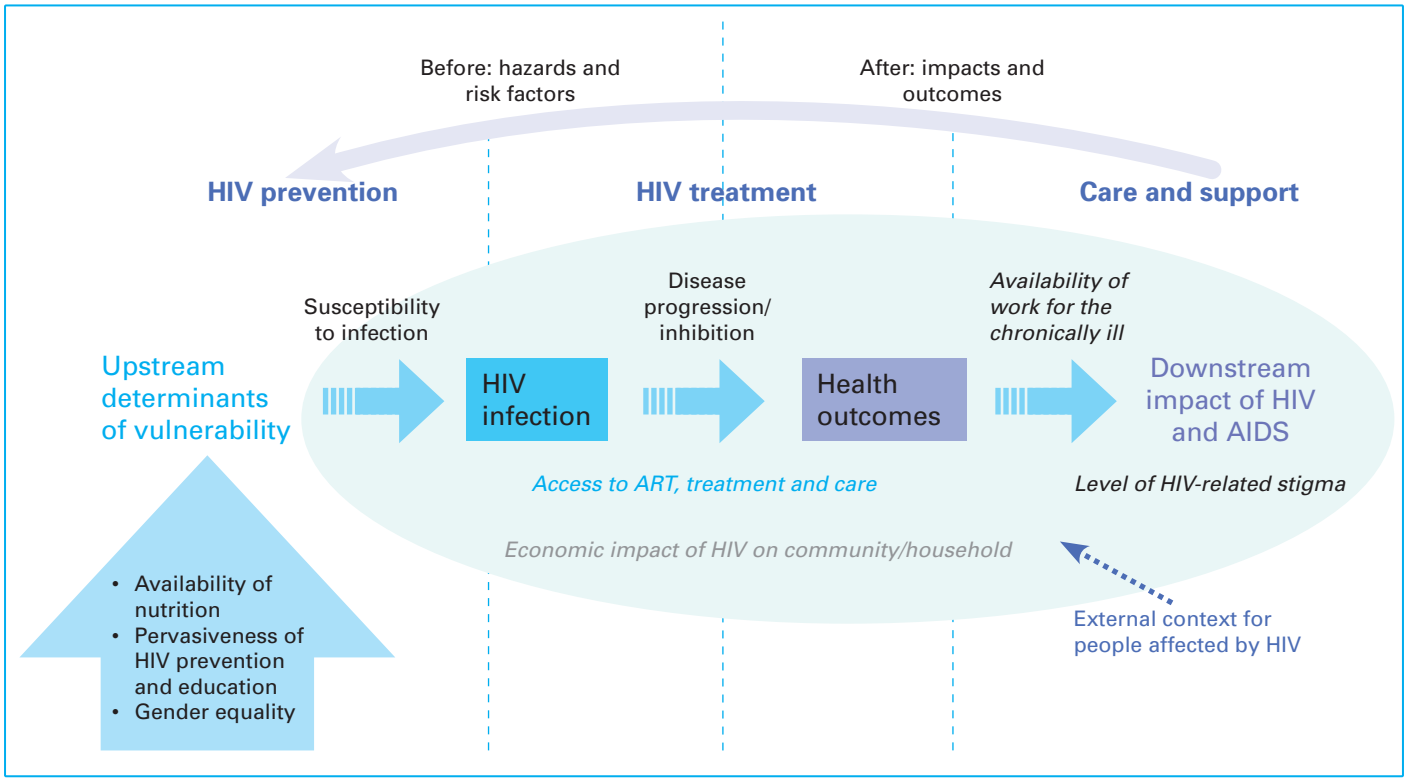
17 There is no consensus on the types of interventions covered by social protection, and our focus on social assistance, social services and social insurance is determined by the broader, child-sensitive concept of social protection. Microcredit is generally excluded, though the environment for microcredit as an enabler of social insurance is noted.

Figure 4: Range of social protection instruments and specific outcomes



Source: Adapted from Adato and Bassett (2008).

Figure 5: Vulnerability along the pathway of HIV



Source: Adapted from Edstrom (2010).[18]

18 Temin, Miriam, *'HIV-sensitive Social Protection: What does the evidence say?'*, Joint United Nations Programme on HIV/AIDS, Geneva, October 2010.

People infected and affected by HIV are subject to different, but no less complex configurations of risks and vulnerabilities than children. As such, a multi-dimensional approach to social protection which allows for the consideration of transfers, livelihood support and HIV-related rights, is relevant here (see Figure 4 on pg. 9 for a depiction of vulnerability at various stages along the HIV 'pathway'). Social protection has the potential to mitigate risks for individuals susceptible to infection (such as children of most-at-risk population groups), or subject to the consequences of HIV, and to supplement the response at all points along the pathway: to address susceptibility to infection (improve knowledge and empowerment to prevent HIV), to manage disease progression (enable continued access to ART) and to cushion the downstream social and economic impacts on households and communities.

Table 1: Framework for analysis of social protection measures for children affected by HIV

Social protection instrument	Policy or programme criteria	Anticipated outcomes
Social assistance	Provision of cash and food grants for at-risk children (orphans, street children, institutionalized children, stateless children) and poor families	Access to nutrition and basic needs to children affected by HIV, and their caregivers
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Mitigation of economic shocks to households affected by HIV
Social services (access to)	Availability of treatment (ART and OI) for mothers and children	Access to drugs, keeping caregivers alive and providing treatment for infected children
	Employment and livelihood initiatives for chronically ill caregivers	Availability of employment/livelihood options for caregivers affected by HIV
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Addresses rights to services and the emotional well-being of children affected by HIV Strengthens families and communities, and encourages the development of caregivers to look after the psychological and emotional needs of affected children
Policies, legislation and regulation	Explicit rights to access essential services for vulnerable children	Mitigate impact of stigma and discrimination in the community
	Existence of a legal framework that specifically protects vulnerable children through inheritance rights, birth registration and school enrolment	Legal protection to safeguard the rights of children affected by HIV

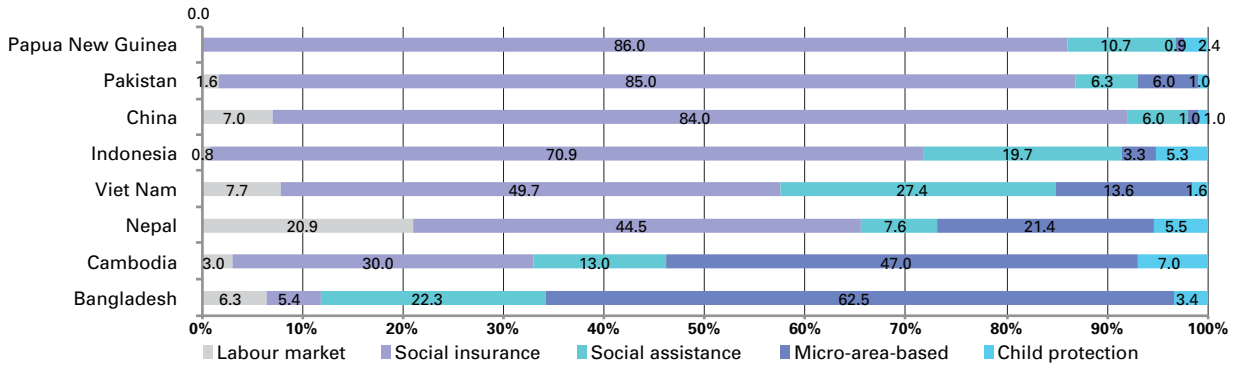
Source: Adapted from Nolan, A. (2009) Social Protection in the Context of HIV and AIDS, Irish Aid; Economist Intelligence Unit.

Existing social protection measures in the region

The importance of social protection within the national policy agenda is reflected in the tone of development policy and expenditure on social protection programming. Social protection objectives and their prominence within national development strategies suggest a rising interest and a growing commitment to addressing issues of risk through social protection instruments. While definitions are not harmonized across agencies and countries, data provided by the Asian Development Bank (ADB) classifies social protection expenditure by programme type conveys an approximation of national priorities across the region. Research for over 30 nation states conducted for the Social Protection Index indicated that on average, countries in the Asia-Pacific region spend around 5 per cent of GDP on social protection, with around 57 per cent of the poor (by national poverty standards) receiving some form of social protection in 2008.[19] This average does mask a high degree of divergence across the region with respect to coverage priorities and preferences for delivery.

Social insurance dominated social protection spending across the countries of interest, comprising over 70 per cent of all social protection expenditure in Pakistan, China, Indonesia and Papua New Guinea, reflecting a historical tendency toward social protection for formal sector or state workers. Social assistance spending featured significantly in Indonesia, Viet Nam and Bangladesh, with about a quarter of the social protection budget allocated to support and services to vulnerable groups. Meanwhile, micro-area-based interventions comprised the majority of expenditure in Bangladesh (62.5 per cent) and Cambodia (47 per cent), highlighting significant micro-insurance and social fund activity occurring in both countries (see Figure 6 below).

Figure 6: Social protection expenditure by category of programme[20] (% share)



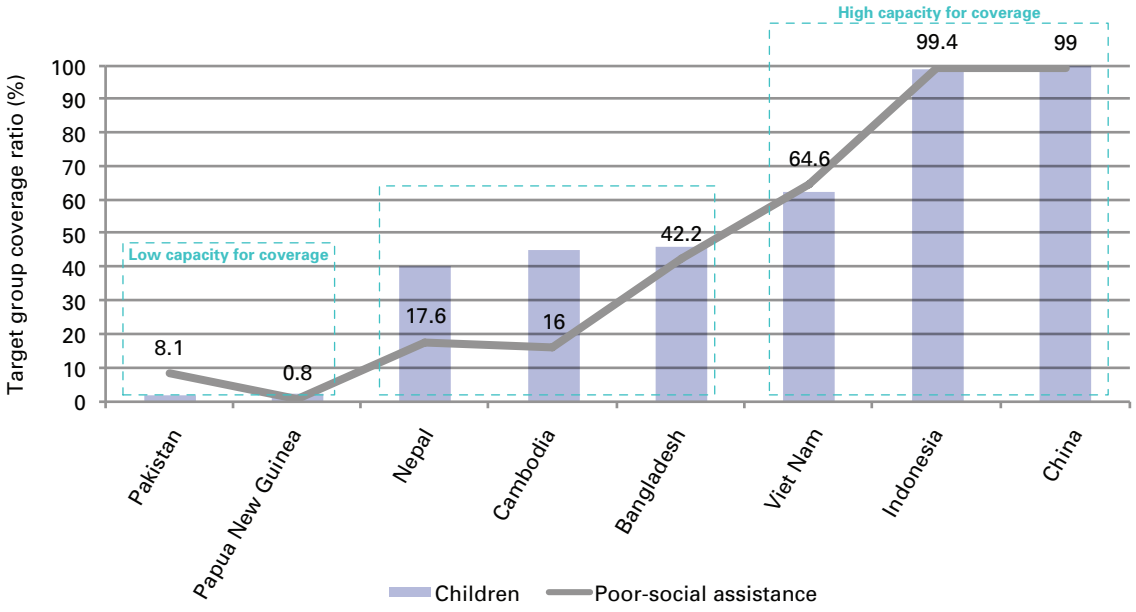
Source: ADB (2008), Social Protection Index for Committed Poverty Reduction – Volume 2: Asia, Manila, Philippines.

19 Asian Development Bank, *'Social Protection Index for Committed Poverty Reduction – Volume 2'*, ADB, Manila, 2008.

20 According to the Asian Development Bank's *Social Protection Index*, "labour market policies and programmes" are designed to promote employment, the efficient operation of labour markets and the protection of workers; "social insurance programmes" to cushion the risks associated with unemployment, ill health, disability, work-related injury and old age; "social assistance and welfare service programmes" for the most vulnerable groups with no other means of adequate support, including single mothers, the homeless, or physically or mentally challenged people; "micro- and area-based schemes" to address vulnerability at the community level, including micro-insurance, agricultural insurance, social funds and programmes to manage natural disasters; and "child protection" to ensure the healthy and productive development of children. Thailand was not included.

The coverage of social protection for targeted groups presents a similarly varied picture across the region. Programmes examined by the ADB in China, Indonesia and Viet Nam perform well across activities for the poor and children, with coverage of both groups reaching almost 100 per cent in Indonesia and China and more than 60 per cent in Viet Nam. Nepal, Cambodia and Bangladesh cover about 40 per cent of the targeted children, but coverage for the poor is less successful. Coverage of intended beneficiaries is low across both groups in Papua New Guinea and Pakistan – as shown in Figure 7 below – reflecting potential issues around capacity, access and resources.

Figure 7: Target group coverage ratio (%)[21]



Source: ADB (2008)[22], *Social Protection Index for Committed Poverty Reduction – Volume 2: Asia*, Manila.

Though in many Asia-Pacific countries, social protection has gained considerable traction as a means of responding to issues of poverty, economic volatility and food insecurity, HIV has not been the primary focus of many existing social protection schemes in the region. However, there is growing recognition of the potential for social protection to contribute to the HIV response[23] and to address both susceptibility to infection and vulnerability to the harmful effects of HIV on individuals and communities.[24]

21 The health care category only includes programmes funded through social insurance or targeted at particular groups of the population; directly-funded health (and education) services are excluded.

22 The Asian Development Bank's comparative study analysed and distilled data for the *Social Protection Index*. Targeting criteria likely varied slightly across countries.

23 United Nations Children Fund, Joint United Nations Programme on HIV/AIDS and Institute of Development Studies, *'Enhancing Social Protection for HIV Prevention, Treatment, Care & Support – The State of the Evidence,'* Brief, 2010.

24 Bishop-Sambrook, Claire, *'HIV Susceptibility and Vulnerability Pathway: A Tool for Identifying Indicators, Role Models and Innovations'*, Food and Agricultural Organization for the United Nations, Rome, October 2003.

Impact of HIV on households in China, Cambodia, and Indonesia

There is growing evidence to support the acute and long-term impact of HIV on the dynamics and economics of the household. Chronic illness and the direct and indirect costs to the caregiver means that access to support and coping mechanisms are critical in mitigating the shock of HIV to family members, who are negatively affected across nearly all socio-economic indicators related to livelihood. The impact of HIV on income, employment, education of children, and the role of females in affected families was examined across three of the nine study countries – Cambodia, China and Indonesia (Tables 2, 3, 4) – by the United Nations Development Programme (UNDP) in 2010.[25] Despite the diverse socio-economic contexts, household surveys revealed that affected families and children in all three countries experienced additional economic burdens and reduced access to basic services. Annual household income was found to be lower, health expenditure was higher and the incidence of dropout among school-aged children was also likely to be higher.

Household income

The data collected across the three countries suggests that there is a correlation between the earning potential of HIV-affected households, which tend to earn less than similar unaffected households. While this may be unsurprising given the impediments faced by PLHIV, including chronic illness, discrimination or time lost to treatment and care, trends in household incomes are striking: unaffected households earn 26.5 per cent more across the provinces surveyed in China, and an average of 17 per cent more (for the same occupation) in Cambodia. Therefore, 27 per cent of those diagnosed cease to earn any income, while the average income of households affected by HIV is half of what it was before diagnosis. Across seven provinces in Indonesia, unemployment is much higher for PLHIV, although social support from the government and NGOs goes a long way to redress the income imbalance between affected and unaffected households.

25 United Nations Development Programme China, *'The Socio-economic Impact of HIV at the Individual and Household Levels in China – a Five Province Study,'* UNDP China, Beijing, December 2009.

Table 2: Cross-country comparisons on income, UNDP socio-economic impact study

	Household income for HIV-households	Household income for unaffected households
Cambodia (nationally representative)	27% of PLHIV reported that they stopped earning income after diagnosis – higher absenteeism rate – particularly among girls living in HIV affected households.	Earn 17% more on average for same occupation.
China (five provinces)	Rmb14,920 annual average (US$2,238).	Rmb18, 875 (+26.5%) (US$2,838) annual average.
Indonesia (seven provinces)	11.7% income derived from social support.	5.2% of income from social support.

Source: UNDP (2010)[26].

Health care expenditure

The impact of HIV on health care expenditure is particularly strong in Indonesia, where affected households spend nearly five times as much as unaffected households on health care, while the difference comes in at 49 per cent more in China. Interestingly, there are no significant differences in consumption between affected and unaffected households in Cambodia, which may be attributable to low base income levels, and the support of the country's numerous Health Equity Funds and community care schemes which typically subsidize expenses associated with access to health care. Sustainability of these numerous schemes, however, is tenuous in the medium- to long-term given that they are primarily supported by external resources.

26 Tables 2, 3 and 4 were created from data reported in three studies: United Nations Development Programme China, *'The Socio Economic Impact of HIV at the Individual and Household Levels in China – a Five Province Study'*, UNDP China, Beijing, December 2009; United Nations Development Programme, *'The Socio Economic Impact of HIV at the Household Level in Cambodia'*, UNDP Phnom Penh, August 2011; United Nations Development Programme, *'The Social Economic Impact of HIV at Individual and Household Levels in Indonesia – a Seven Province Study,'* UNDP Jakarta, September 2010.

Table 3: Cross-country comparisons on health care spending, UNDP socio-economic impact study

	Health care expenditure for HIV-affected households	Health care expenditure for unaffected households
Cambodia (nationally representative)	In terms of overall consumption, HIV-affected households consumed 6% less than unaffected households. Per capita spending US$557. No significant differences in allocation toward health care.	US$590 per capita spending.
China (five provinces)	Rmb3, 700 (+49%) (US$555).	Rmb1,900 (US$285).
Indonesia (seven provinces)	Households spend up to five times more on health care than unaffected households, lowering spending on non-food consumption. Annual average health care expenses are about Rp480,000 (US$53).	Annual average health care expenses around Rp90,000 (US$10).

Source: UNDP (2010).

Education prospects

HIV has had a marked impact on educational prospects for girls, as suggested by the gap in dropout rates between boys and girls in Indonesia and China. Almost twice as many girls drop out of school in the affected households compared to boys in Indonesia, whereas the opposite trend is true of unaffected households. Children in HIV-affected homes are more likely to work in Cambodia, though the school enrolment rate remains on par with that of unaffected homes.

Table 4: Country comparisons on education attendance, UNDP socio-economic impact study

	Education attendance, HIV-affected households	Education attendance, unaffected households
Cambodia (nationally representative)	Workforce participation rate for children is higher, by 50%. School enrolment is 86%. Higher absenteeism rate – particularly among girls living in HIV-affected households.	Statistically equal to affected households at 85%.
China (five provinces)	School dropout rate of 11.1% for children 10-14, and 13.8% for girls.	School dropout rate of 4.4% for children 10-14, and 0.9% for girls.
Indonesia (seven provinces)	School dropout rate of 34.2% for boys, and 54.8% for girls.	School dropout rate of 65.8% for boys, and 45.1% for girls.

Source: UNDP (2010).

A drop in household incomes and diminished educational prospects for children, particularly girls, emerged as key themes. All households bore the burden of increases in health care expenditure; although social protection in the form of the provision of cash or in-kind assistance may have trickled down to alleviate the economic impact of treatment and access in Cambodia. The impact of cash and in-kind support to households appeared to have achieved some degree of success in alleviating the economic impact of income loss and additional health care expenditure in Indonesia. However, UNDP research suggests that discrimination and stigma in the community also remain a challenge.

Lessons can be drawn from these case studies with respect to the design of social protection for affected children and the mechanisms with which to deploy the most appropriate tools to improve coverage and effectiveness of programmes in Asia. However, by focusing on the household unit, the needs of children who survive outside of family care – orphans, street children, the institutionalized and children who may be economically active across large informal economies in the region – are not necessarily met. These gaps in 'formal' coverage for households and registered workers are of particular interest in considering the most vulnerable children affected by HIV who lack the protection afforded by family care.

Key drivers of social protection for children

This review of nine countries (Table 5) revealed a high degree of diversity in the national response to social protection for children, and in turn, social protection for children affected by HIV. To understand the overall landscape for social protection for children, information was collected on programmes and policies which were 'child-sensitive' in their conceptualization and design, with a specific focus on the needs of caregivers – and children. The key features of some of the major child-sensitive programmes and policies have been identified and collated, giving an overall sense of key areas of activity in each country, the types of instruments preferred and the coverage attained.[27]

In assessing social protection policy and programming for children, there were several points of differentiation in the design of programmes that are specific to the needs of children affected by HIV. Among these were an awareness of the vulnerability of the caregiver to income and shocks, the health status of caregivers and children and an acknowledgement of the informal status of the 'invisible' children, who fall outside the household unit. Programme designers and policy makers in low-prevalence settings face a tricky balancing act in managing limited resources, capturing these most-vulnerable children and at the same time, avoiding potential stigmatization of the HIV-affected. To date, programme activity that is sensitive to the needs of children affected by HIV has varied in intensity across the region, with sectoral responses, historical preferences around social protection instruments and cultural norms defining the context for implementation.

27 See appendix for country capsules, including information on specific programmes and policies.

Table 5: Analysis of activity around social protection for children affected by HIV

	Social assistance	Social insurance	Social services (access to)			Policies, legislation and regulation	
Criteria	Provision of cash and food grants for at-risk children (orphans, street children, institutionalized children and stateless children) and poor families	Insurance schemes – health, maternal support, nutrition, unemployment – for poor households and vulnerable groups	Access to ART for caregivers and children	Employment and livelihood initiatives for chronically ill caregivers	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children (access/ affordability)	Explicit rights to access essential services for children affected by HIV	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment
Bangladesh	Substantial	Moderate	Moderate	Limited	Moderate	Substantial	Substantial
Cambodia	Substantial	Limited	Moderate	Moderate	Substantial	Moderate	Limited
China	Extensive	Substantial	Moderate	Limited	Substantial	Substantial	Extensive
Indonesia	Substantial	Moderate	Substantial	Limited	Limited	Moderate	Moderate
Nepal	Substantial	Moderate	Moderate	Moderate	Substantial	Substantial	Moderate
Pakistan	Moderate	Limited	Moderate	Limited	Moderate	Moderate	Limited
Papua New Guinea	Limited	Limited	Moderate	Limited	Moderate	Substantial	Limited
Thailand	Substantial	Substantial	Extensive	Limited	Substantial	Extensive	Extensive
Viet Nam	Moderate	Substantial	Moderate	Limited	Substantial	Substantial	Extensive
Key Trends	Most extensive in developing countries with a robust civil society network. China's national focus on targeting rural households is notable here.	Many formal high-coverage programmes preclude affected children. China and Thailand's focus on maternal support and improving access to health care for informal workers is notable.	Programmes targeted at mothers and children are scaling up. A history of high prevalence in some countries has resulted in stronger capacity and programme activity.	This is an area that remains weak across the region – employment schemes are often high-impact and unsuitable for chronic illness. An emphasis on service-orientated initiatives may be helpful here.	Many countries have substantial activity in this space. Government or civil society has taken the lead in providing resources and capital, while civil society groups often support access.	A child's right to essential services is high on the agenda across most countries, and enshrined in legal frameworks. Thailand's child protection laws are particularly comprehensive.	The agenda is mixed here – China, Thailand and Viet Nam's histories in addressing children's and women's issues are reflected. Bangladesh's robust civil society has driven progress.

Source: Economist Intelligence Unit analysis.

Key:
Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Civil society continues to be a critical force in capturing affected children. Sub-national government is poised to play a more active role

National governments are key drivers of the social protection agenda, with NGOs playing an active role in the development and delivery of programmes. The most interesting developments have occurred with respect to the role of civil society, which has been at the centre of the efforts to deliver services to affected children in resource-constrained settings. Such efforts, by local NGOs, faith-based organizations (FBO) and other community-based groups often happen at the grassroots level, where experimentation and 'frugal innovation' is unbridled. Being close to the community, civil society can help address the needs of informal workers and vulnerable children lacking formal paperwork and eligibility for services, who could be missed by government programming. In Papua New Guinea, a monitoring and care programme run by the Catholic Diocese in Kundiawa has had notable success in supporting children in HIV-households and reducing the stigma surrounding HIV for those children. The programme primarily focuses on monitoring the situations of HIV-households, and particularly, the children of those households. If the situation deteriorates, volunteer programme members scale-up their response and support for the affected child. In addition, the group conducts trainings on HIV to build community awareness and reduce popular prejudices, while the church also retains funds for school fees to support the neediest children.

Civil society is often uniquely equipped to reach children who, because of capacity or access, are overlooked; in some cases connecting these children with existing social protection measures. In Thailand, civil society has been instrumental in providing social protection to most-vulnerable children in 'hard-to-reach' urban and border regions. Examples include support and care programmes provided by NGOs to address the health and psychosocial needs of vulnerable persons and their dependants – a PEPFAR initiative provides a range of services in high-risk urban areas of Bangkok, Chiang Rai and Kanchanaburi in the form of telephone counselling, income-generating loans, home-based care and access to ART. In a similar fashion, the faith-based Human Development Foundation runs a home-care visitation programme for 100,000 low-income residents of the Klong Toey slum area in Bangkok, where people living with HIV and children receive medical checkups, counselling and basic commodities. A pilot project in the northern provinces of Thailand conducted by Chiang Mai University and a coalition of NGOs has taken an interesting approach to reaching children by targeting and supporting their elders as a means of impact mitigation.

Civil society does have its shortcomings, however. While often more flexible and more reactive than government, issues arise around scalability and sustainability. Inconsistent funding can be problematic in the long-term, and the grassroots position that is an asset in the community context is not easily applied at a larger scale. State and non-state partnerships between civil society and government are emerging as a way of bridging capabilities.

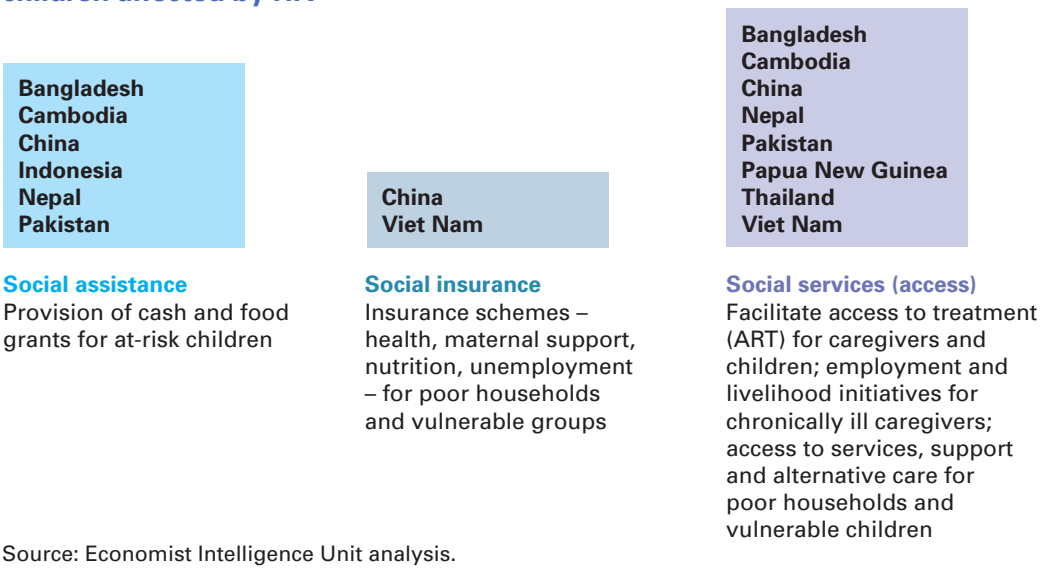
Sub-national governments have traditionally participated in the disbursement of social protection services, but the devolution of funds and decision-making rights to sub-national actors has seen their role evolve in recent years. As only 17 per cent of Indonesians are covered under the nationally-run health insurance scheme, the wealthier provincial and regional governments have begun to set up additional programmes to cover a wider segment of the poor in their areas, but data is not readily available on the extent of coverage from these localised efforts. In Thailand, nearly all government social assistance has been devolved to local, regional and community authorities, on the rationale that these ensure appropriate responses at the local level. Programmes developed by local government in Nepal, Pakistan and Bangladesh have seen sub-national governments taking the initiative in programme design, suggesting that there is opportunity to work more closely with such entities to emphasize the HIV-sensitivity of various schemes. This has been the case with recent 'child-friendly' local government initiatives in Nepal, where efforts were made to advocate and educate the sub-national government on a child-sensitive approach to provincial-level policy making.

Social protection aimed at improving access to social services is the most prominent response in the region

Divergent, and sometimes contradictory needs, are to be met through the social protection safety net for children affected by HIV/AIDS – urgency for nutrition may be more appropriate in some settings, while sustainable support, care and treatment may be a priority in others. Enabling access to social services, employment initiatives, ART treatment and the provision of essential services is challenging by virtue of high resourcing requirements and difficulties associated with co-ordination and outreach. Yet, there is a proliferation of schemes addressing barriers to access of social services, despite the low-resource settings examined in the nine countries covered. Programme activity which included children affected by HIV was moderate in most countries, particularly in relation to accessing essential services, though availability of suitable livelihood initiatives remains limited.

Promoting access to HIV-sensitive social services is a key social protection response to address the needs of affected children in the region, despite capacity and resource constraints, though civil society have been active in supplementing gaps. In particular, access to livelihood initiatives, featuring a cash or in-kind component, is gaining traction as a model in the region. This is particularly the case in South Asia where, for example, food and cash have been applied as incentives to encourage attendance at skills training programmes (see Figure 8 on pg. 20).

Figure 8: Preferred instruments for disbursement of social protection to children affected by HIV



Source: Economist Intelligence Unit analysis.

Employment generation schemes are not currently accounting for the limitations faced by people and caregivers living with HIV

There are a number of successful employment generation schemes in Asia, with the majority of activity emanating from South Asia. Many target poor households with the intention of supplementing household incomes and mitigating the volatility of agricultural and seasonal work. For instance, Bangladesh's 100-day Employment Guarantee Scheme is designed to drive employment generation in the lean seasons, and support the income of the poorest segment of the community; with the intention of generating 100 days of employment, at a wage of Tk100 per day for 2 million people. The scheme focuses on the landless population, on temporary workers with an income of under Tk300. The "Food-For-Works" Rural Infrastructure Development Programme covers around 1 million participants annually, and provides food assistance for those who partake in rural infrastructure projects. Both programmes are child-sensitive in that key target groups are households headed by vulnerable women, who have been widowed, deserted or left destitute. However employment options are limited for those afflicted by chronic illness. Infrastructure projects require high-impact labour, and there are few options for the physically debilitated, for whom service-orientated, low-impact labour is more suitable.

Employment generation schemes need to be carefully balanced with assistance schemes and made more suitable to the very ill, or households with a high dependency ratio. These households may not be in a position to take advantage of employment opportunities, particularly if the work is 'high impact', or may need more continuous assistance for extended periods of time. Social assistance, in the form of cash transfers and food for education programmes fill these needs, even for households that are labour constrained.

The Food Security Vulnerable Group Development (VGD) in Bangladesh established by the Ministry of Women and Children's Affairs and the Ministry

of Disaster Management and Relief is an interesting example of blending social services and social assistance tools to create medium-term employment and skills training for women. An offshoot of the scheme is the Income Generation for Vulnerable Group Development (IGVGD), which seeks to develop life skills for women to encourage savings and to raise social awareness about disaster management and nutrition through training. Focused on women of the household – and by proxy, their dependents – participants receive a monthly food ration of 30kg of wheat, life skills training over a period of 24 months and links to microcredit service providers. To receive benefits, women must demonstrate that they are saving for the household and attending the requisite hours of training and group meetings. Among participants, there has been a noted decline in landlessness and an increase in homestead land ownership; a decline in begging; increased ownership of basic household goods; and a slight rise in income. However, around one-quarter of the respondents found it difficult to cope once food aid was rescinded, and there was evidence of widespread corruption and poor-targeting, encouraging the creation of black markets.

Given the lower capacity required and the speed of implementation of social assistance, there is potential for its further use in resource-constrained settings to mitigate the impact of HIV on children and households, and to achieve high rates of coverage rapidly. For instance, Indonesia's National Independent Community Empowerment programme reports funding more than 180,000 projects in its first year. Pakistan's Child Support Programme began as a pilot scheme in 2006, with plans to scale up by 100 per cent by 2011.

Cash transfers are gaining traction in scope and scale

Unlike Latin America and, to a lesser extent, sub-Saharan Africa, conditional benefits are a relatively new concept in Asia and not as widely utilized. Yet, cash transfer programmes are increasingly perceived as an effective tool for poverty alleviation in the region.[28] These are either unconditional, or conditional (CCT), with a focus on tackling long-term poverty by the transfer of cash to the poor. It requires that beneficiaries accept various conditions related to behavioural change, for instance, the enrolment of children in school, maintaining adequate attendance levels, attending pre- and post-natal care training and participation in skills training.

The debate on the strengths of CCT programmes versus cash transfer programmes is ongoing worldwide, particularly in Asia. Some studies have shown a marked increase in the likelihood of school enrolment as a result of conditional programmes, while other studies question that validity. In assessing the *Oportunidades* CCT programme in Mexico, Samson et al. summarized the problem. The programme combined grants to increase household income with awareness initiatives emphasizing the importance of human capital and conditions and linked receipt of cash transfers with behaviour that supports human capital development. Evaluations have indicated that all three factors combined can generate good

28 Asian Development Bank, '*Conditional Cash Transfer Programmes: An Effective Tool for Poverty Alleviation?*', Economics and Research Department, ERD Policy Brief Series No. 51, Manila, July 2008.

outcomes but studies to date have not been able to isolate, or identify, whether income, awareness or conditionality is the most important determinant.[29]

Proponents of cash transfers argue that the funds and awareness are the most crucial factors to success. CCT advocates propose that the conditionality provides the additional incentive needed for behaviour change. In Asia-Pacific both types of cash transfers are currently being used, though CCT is more common, potentially as a result of favourable reports from other regions.

In high-prevalence environments, evidence suggests that cash transfers have the potential to reduce poverty and support livelihoods.[30] Across the Asia-Pacific countries reviewed, the emphasis of social assistance on education has emerged as a key trend, with studies demonstrating the effectiveness of cash and in-kind transfers in driving educational outcomes and expanding access to the 'social vaccine' of education against HIV infection.[31] Along with fee exemptions, such cash transfers can help cover the costs of school materials for orphans and other vulnerable children, and to improve girls' educational prospects, which are negatively affected by HIV within the household.[32]

CCTs have been employed in Cambodia to provide the families of children at high-risk of non-attendance with stipends and in-kind support for their education. The Scholarship for the Poor programme is one of the largest of these. In 2008, after just two years of operation, preliminary analysis showed that the programme had produced an improvement of between 20 per cent and 25 per cent in school attendance rates among the beneficiaries.[33] In Bangladesh, the Cash for Education or Primary Education Stipend Programme (PESP) has benefited 6 million children, with bank-initiated payments to cardholding mothers or guardians for 85 per cent school attendance and 40 per cent scores on annual exams. Indonesia's Programme Keluarga Harapan (PKH) provides cash transfers based on health and education related obligations, such as complete immunizations for children and 85 per cent school attendance for primary school age children.

There is a strong body of international evidence demonstrating how both conditional and unconditional cash transfers have served as effective risk management mechanisms in the household, from preventing loss of savings to preventing the removal of children from school to earn income.[34] At the same time, cash transfers that depend on girls' school attendance or those that are transferred to female beneficiaries address issues of gender disparity, which is critical to child- and HIV-sensitive approaches. A number of programmes across Bangladesh, Nepal,

29 Samson, Michael, Ingrid van Niekerk and Kenneth Mac Quene, *'Designing and Implementing Social Transfer Programmes'*, Economic Policy Research Institute, Cape Town, 2006.

30 Schubert, Bernd, *'The Impact of Social Cash Transfers on Children Affected by HIV and AIDS, Evidence from Zambia, Malawi and South Africa',* United Nations Children's Fund, Eastern and Southern Africa, Lilongwe, July 2007.

31 United Nations Children Fund, Joint United Nations Programme on HIV/AIDS and Institute of Development Studies, *'Enhancing Social Protection for HIV Prevention, Treatment, Care & Support – The State of the Evidence,'* Brief, 2010.

32 See discussion on "Education prospects", p15.

33 Filmer, Deon and Norbert Schady, *'Getting Girls Into School: Evidence from a Scholarship Programme in Cambodia,* "Cambodia Safety Net Review", Cambodian Council for Agriculture and Rural Development, World Food Programme, World Bank East Asia Human Development Unit, May 2009.

34 Farrington, John, Paul Harvey and Rachel Slater, *'Cash Transfers in the Context of Pro-Poor Growth',* Briefing, Overseas Development Institute, London, July 2005.

and more recently, Pakistan have pioneered the placement of the female head of household at the centre of social assistance schemes in the region.

The scalability of cash transfers has led to impressive gains in coverage. In 2008, the Benazir Bhutto Income Support Programme (BISP) was established by the Pakistan's People Party in an attempt to mitigate the impact of food instability and price inflation on the poorest families. Sensitive to the caregiver, the programme is designed around the female adult as the recipient of cash grants. With an initial allocation of US$425 million for its first year of implementation, the programme aims to cover 15 per cent of the country's entire population.[35] Although there have been large-scale 'wins' in the region, cash transfer programmes can be difficult and costly to monitor. Problems with the programmes often revolve around 'leakage', where funds are diverted to ineligible recipients or where recipients do not receive the full funds they are eligible for. For example, Bangladesh's PESP programme, initiated in 2002, has experienced consistent leakage of funds, with evidence that 46 per cent of beneficiaries did not receive the full amount and 27 per cent of children from affluent (and thus ineligible) households received the stipend. A different CCT programme in Indonesia, the Bantuan Operasional Sekolah Programme (BOS) provided grants directly to schools to improve facilities, but allegations of officials appropriating funds for their own use prompted the World Bank to start a partner programme, BOS-KITA, to strengthen transparency. The programmes are also subject to political distortion, with some fearing that cash or food transfers to the poor may be used to buy votes or electoral support for a party of candidate. The long-term success of these programmes is unproven in the Asia-Pacific, and there is limited evidence to inform an understanding of the sustainability of cash transfers relative to other services. More research is required to quantify the long-term reach and success of these programmes in the region.

Imperatives to enhance social protection for children affected by HIV

Social insurance is not always inclusive of HIV-affected children. Still, there are opportunities to experiment and innovate in this area

Established to provide protection to private- and public-sector workers, existing social insurance frameworks in many countries across the region have not historically been conceived to meet the needs of those who fall outside the scope of the formal workforce. This is a key problem area in Asia-Pacific given the high mobility of migrant workers, and the large number of affected children and their caregivers outside of the parameters of formal citizenship. Linked to this issue is the vulnerability of migrant workers, with respect to the enforcement of policies and legislations around HIV-related rights and discrimination. There are reports

35 Jamal, Haroon, *'A Profile of Social Protection in Pakistan: An Appraisal of Empirical Literature'*, Social Policy and Development Centre, Karachi, 2010.

of migrant workers who are tested for HIV without their permission or informed consent, and deported if the test is positive, regardless of whether or not the country has testing laws, with respect to destination countries of Thailand and origin countries of Bangladesh, Cambodia, Indonesia, Nepal and Pakistan.[36]

Informal workers have little or no access to the preventive benefits of social insurance, despite efforts made across several of the larger countries to expand the reach of social insurance beyond the remit of the urban, formal worker. In 2003, China's State Council issued the Decision to Establish a New Rural Cooperative Medical Scheme (NRCMS) to establish health insurance for the rural population, which by 2000 had seen over 87 per cent of the rural sick paying for their own medical treatment, and 25 per cent borrowing to cover costs.[37] The 2003 reform introduced subsidies from multiple levels of administration, at the township, county, principal and central level; while in 2008, basic medical insurance included provisions to cover the health care needs of special groups, including people living with HIV/AIDS. As of the end of 2009, around 833 million people are covered by the NRCMS, according to the Ministry of Health.

While the programme continues to widen in scope and scale, a number of issues; such as payment structure (for users[38] and providers limitations of the service package) continue to hinder the participation of the poorest and most vulnerable segments of the rural population and their dependents. Of the national programmes that do exist in Indonesia, Jamkesmas is a health insurance scheme for the poorest segment of society, which is open to all citizens. Those who are admitted to the programme have the majority of their health care fees waived or reimbursed, although payment mechanisms vary locally. As only 17 per cent of Indonesians are covered under this plan, the wealthier provincial and regional governments have taken the initiative to establish additional programmes to cover a wider segment of the poor in their areas.[39]

Intensive activity in the areas of microfinance and micro-insurance provide a potential solution to improving access. Already, community-based pooled-risk schemes are providing alternative forms of social insurance. In Nepal, the non-government Public Health Concern trust has established a pooled co-payment insurance scheme, where more than 45,000 members contribute a small annual fee of US$1.2-US$2.4. Members pay approximately 50 per cent of the cost of medical treatment, and 80 per cent of the cost of an annual check up is covered,[40] while children receive free checkups and subsidized medicine.[41]

However, studies suggest that while microcredit programmes have been successfully utilized by many poor people, they do not tend to benefit the ultra-

36 Coordination of Action Research on AIDS and Mobility Asia, '*Malaysia National AIDS Conference'*, Presentation, Kuala Lumpur, December 2010.
37 Dumoulin-Smith, Adrien, '*Social Health Insurance in China: An Example of Nascent Social Security in China'*, Cornell University, Ithaca, 2010.
38 The annual cost of medical coverage is RMB50 (US$7.4) per person. (Utilizing the Economist Intelligence Unit's 2010 average exchange rate in 2011 of US$1: Rmb6.77), Of that amount, RMB20 is paid in by the central government, Rmb20 by the provincial government and a contribution of Rmb10 (US$1.5) is made by the patient.
39 There is no data available on the extent of coverage from these local programmes.
40 Tabor, Steven R., *'Community-Based Health Insurance and Social Protection Policy',* Social Protection Unit, Human Development Network, World Bank, Washington DC, March 2005.
41 Interview with multilateral practitioner involved in social protection and labour issues in South Asia.

poor who still face barriers to access. Issues of stigma and discrimination mean that microcredit programmes in high AIDS-affected areas can pose risks to borrowers and lenders.[42] At the same time, there are contributory microcredit and insurance schemes run by NGOs which have been adapted to mitigate risk in AIDS-affected contexts, for instance, through death benefit insurance and educational trusts for children.[43] According to the United Nations Capital Development Fund/Special Unit for Microfinance, contributory schemes will reach fewer households and are more likely to miss the most vulnerable groups, but contributory schemes may have some traction where the recipient is still productive, or targeted to living or surviving family members.[44]

For informal worker populations that are not considered to be ultra-poor, the development of various models which confer affordable 'opt-in' access presents a model for the expansion of existing government social insurance mechanisms. In Thailand, the 9th Economic and Social Development Plan extends social security to the informal economy through a mechanism for voluntary self-insurance.[45] Self-insured informal workers who made an annual contribution of THB3,360 were entitled to benefits in maternity, invalidity, sickness, death and old age for the participant and direct dependants, and up to four indirect dependants. While the programme is unique and innovative in its accessibility for informal workers, and child-focused in its coverage of both direct and indirect dependents, it remains optional and cost-prohibitive for many, impeding the uptake and participation of vulnerable households.

Both contributory insurance and tax-based schemes are effective to some extent, but in both cases have faced challenges in reducing financial barriers for the ultra-poor. Vouchers, exemptions, and user-fee elimination can reach the neediest patients, but to be effective in promoting access to services, voucher schemes need to cover transport costs along with medical expenses and all options must ensure that providers are reimbursed.

Through universal or targeted programming, there are opportunities to extend social protection for children affected by HIV

Across the region, there is scope to develop the HIV-sensitivity of social protection instruments for children. While programmes are in place to aid chronically ill caregivers, there is little emphasis on enhancing caregiver capacity through training or support to manage the needs of HIV-affected children. Whether through an HIV- or a child-specific entry point, the heightened vulnerability of the caregiver to shocks must not be overlooked. Likewise, the psychosocial needs

42 Adato, Michelle and Lucy Bassett, '*What is the potential of cash transfers to strengthen families with HIV and AIDS? A review of the evidence on impacts and key policy debates'*, Working Paper, Joint Learning Initiative on Children and HIV/AIDS, March 2008.

43 Adato, Michelle and Lucy Bassett, '*What is the potential of cash transfers to strengthen families with HIV and AIDS? A review of the evidence on impacts and key policy debates'*, Working Paper, Joint Learning Initiative on Children and HIV/AIDS, March 2008.

44 United Nations Capital Development Fund/Special Unit for Microfinance and Joan Parker, *'Microfinance and HIV/AIDS'*, Donor Brief, Consultative Group to Assist the Poor, World Bank, Washington DC, July 2003.

45 International Labour Organization Sub-regional Office for East Asia, Ministry of Labour and the National Statistics Office, *'Thailand Social Security Priority and Needs Survey'*, ILO, Bangkok 2004.

of children affected by HIV are not being consistently addressed, and must be taken into consideration in light of age- and gender-specific risks. The informal sector and migrant workers have limited access to formalized social protection instruments. Finally, provisions for suitable employment generation for the chronically ill, or for caregivers in high-dependency households are limited.

Based on a qualitative assessment of programmes across the region, a focus on facilitating access to social services is currently the most preferred instrument for reaching vulnerable children in the Asia-Pacific, while social assistance schemes are now prevalent in almost as many countries. China is the only country in which social assistance, social insurance and social services are all poised to offer children affected by HIV some form of support. Cash transfers, though not extensively proven, are being used in some countries with success, especially to encourage continued education for at-risk children and gender equality by raising the status of women in the household. Civil society and, increasingly, sub-national governments are crucial to the implementation and oversight of programmes to reach the 'invisible' children. The growing strength of the regional response to women's development holds great promise as a potential 'entry point' for developing social protection that is sensitive to the needs of children affected by HIV.

Yet, social protection for key affected populations – sex workers (SW), injecting drug users (IDU), and men who have sex with men (MSM) – is lacking in the region. Of the reviewed programmes, only a handful focuses specifically on these highest-risk groups. The epidemic in Asia-Pacific is increasingly moving outside of these populations to the children and women who come in contact with IDU, MSM and whose partners visit sex workers. Avoiding specificity and providing sensitive social protection to larger groups through an HIV-sensitive approach may be the best route to decreasing stigmatization and discrimination while reaching the most vulnerable, but at the same time children of high-risk groups are potentially an 'entry point' in responding to the epidemic in low and concentrated settings.

Debates continue around the best approach to designing and delivering social protection for affected children. In a low-prevalence, concentrated setting, approaches that target children affiliated with high-risk populations are valid. The policy direction in some countries is one that supports specification. For example, Viet Nam's National Programme of Action on Children (NPAC) has a wide range of targets, with the objective of increasing medical, educational and psychosocial support specifically to children affected by HIV, by improving the quality of services available to them, although a 2010 UNAIDS Viet Nam National Composite Policy Index notes that many of the programme's elements have yet to be implemented, and the true impact on the ground has still to be ascertained. Meanwhile a strategy for Children Affected By AIDS (CABA) is under development in Nepal.

Table 6: Programme design features for children affected by HIV

	Child-sensitive	Sensitive to children affected by HIV	HIV-sensitive
Coverage	Household and children outside of family care	Household and children outside of family care, informal and mobile populations	Household and informal, mobile populations
Employment generation	Income generation for caregiver	Income generation for chronically ill caregiver and high-dependency households	Income generation for chronically ill and high-dependency households
Insurance	Maternity, health care, nutrition and employment	Maternity, health care, nutrition and employment with provisions for chronic illness and informal workers	Health care, nutrition and employment with provisions for chronic illness and informal workers
Ability of adult to care for dependants	Health and livelihood of caregiver	Health and livelihood of caregiver, and survival	Health and livelihood and survival
Access to essential services	Child and caregiver access to nutrition, education and health care	Child and caregiver access to nutrition, education and health care, including ART and alternative care	Access to nutrition, education and health care, including ART and alternative care

Source: UNICEF, Economist Intelligence Unit.

The stigmatizing effect of an HIV-specific approach presents a case for targeting all vulnerable children and communities[46] to develop the resilience of affected children. In Papua New Guinea for instance, a social protection agenda is being developed around the concept of most-vulnerable children. Potential issues with targeting a broad group include the diffusion of impact, and the danger of programming being spread too thinly.

For children affected by HIV, the risks are ubiquitous and multi-dimensional. Gender, age and family relationships matter, while chronic illness in the household and vulnerability to orphanhood also have an impact. As such, support to caregivers is critical to prevent affected children from falling outside the realm of family care, and should be at the centre of any social protection agenda for affected children. At the same time, a more nuanced approach to informal and mobile populations is necessary to ensure that these most-vulnerable children do not fall through the gaps.

46 Levine, Anthony, 'Orphans and Other Vulnerable Children: What Role for Social Protection?', World Bank, Washington DC, 2001.

Part II: Country summaries

Mapping of social protection policies and programmes for children and children affected by HIV

To gain a regional perspective of the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in Asia-Pacific, the Economist Intelligence Unit conducted a nine country review across Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam, from September to December 2010. A set of child- and HIV-focused criteria were used to examine existing policies and programmes, with the goal of understanding country examples around implementation, funding, coverage, mechanisms for monitoring and delivery, and national priorities.

Guided by a child-sensitive social protection framework,[47] the research team conducted an analytical review of available documentation, including reports, websites and policy documents to identify the key policies and programmes designed to meet the needs of children, with the intention of identifying a set of initiatives with the broadest coverage. Policies and programmes which were innovative in the delivery of social protection for children have also been included, despite limited coverage in some cases, to highlight new approaches and models.

The policies and programmes identified were then reviewed through a second, 'HIV-sensitive' lens to understand the extent to which key social protection initiatives for all vulnerable children are able to address the needs of children affected by HIV. Without addressing the quality and impact of policy and programmes, a code was applied to convey a sense of programmatic activity and the extent to which existing country initiatives account for children affected by HIV.

To represent perceived levels of programmatic and policy action across each social protection instrument and type of transfer, existing programmes and policies were examined against an HIV-sensitive criteria, and conferred a coding from 'limited' to 'extensive'. Countries with a 'limited' coding have few policy

47 Department for International Development, United Kingdom et al., '*Advancing Child-Sensitive Social Protection*', Joint Statement, June 2009.

initiatives, and nascent programme activity. A 'moderate' classification reflects some policy initiatives and some programme activity. Countries with evidence of substantive policy framework and moderate programme activity earned a 'substantial' ranking. Programmes and policies were deemed to be 'extensive' if the policy framework is comprehensive, and there is evidence of robust programme activity. Where programmes are 'blended' and comprise aspects of two or more instruments, it is allocated to the most significant category.

Throughout the tables, 'N/A' has been used where information was not relevant, or not available.

Bangladesh

Bangladesh's most substantial social protection efforts are in the areas of policies, legislation and regulations, and social assistance. The legal framework that protects children affected by HIV is established, and cash and food grant programmes exist for high-risk children. Fitting with the regional trend, Bangladesh's most limited area of social protection lies in employment and livelihood initiatives for chronically ill caregivers.

Table 1: Overview of social protection for children affected by HIV in Bangladesh

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	Over 6 million children have benefited from the Primary Education Scholarship Programme cash transfer programme for education.
Social insurance	Insurance schemes – health, maternal support, nutrition, unemployment – for poor households and vulnerable groups	Moderate	
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	Employment for chronically ill caregivers is a weak spot in the region, and is limited in Bangladesh. Areas of activity include: the Sarkari Shishu Paribar children's homes that have rehabilitated over 45,000 orphans since 1961; the Protection of Children at Risk programme for children living and working on the street; and multiple programmes to provide education or enhance education offerings for children.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Moderate	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	Bangladesh has child-sensitive legislation dating back to 2004, with a National Action Plan for Children since 2005.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Substantial	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 2: Overview of key child-sensitive social protection policies and legislation in Bangladesh

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Bangladesh Country Assistance Strategy (2011-2014) Responsible agency: Government of Bangladesh Funded by: World Bank Time frame: Ongoing			
Several new programmes initiated such as: the Bangladesh Food Crisis Development Support Credit (2008-09); Additional Credit for Second Poverty Alleviation Microfinance Project; Emergency 2007 Cyclone Recovery and Restoration Project Additional Financing (2007-10); and the Empowerment and Livelihood Improvement "Nuton Jibon" Project (until September 2010).	Comprehensive programmes from the World Bank have supported Bangladesh's social protection programme. However, recent efforts have failed to get beyond negotiation, such as the Bangladesh National Social Protection Project (2008). Currently, broad development strategies for Bangladesh are in place.	Countrywide; coverage: national	Varied
Programme title: National Children Policy of 1974, Children Act 1974 and the Children Rules 1976 Responsible agency: Ministry of Women and Children Affairs Funded by: Government of Bangladesh Time frame: 2004-2011			
National Plan of Action for Education for All (2001-2015)	The National Children Council was formed to safeguard the interests of children and implement the policy directives. Initiatives for children were laid down in global conventions. Support is also being given to organizations (mainly NGOs) to train teachers and oversee the quality of education in community schools.	Out of school children; coverage: more than 500,000 children	About 5% of the students who are not eligible are excluded from programme.
Programme title: National Education Policy 2000 Responsible agency: Ministry of Education Funded by: Government of Bangladesh Time frame: Not stated			
Poverty Reduction Strategy Paper 1 (PRSP-1)	NEP proposed that a one-year course of pre-primary education should be created to encourage children's interest in education and school. The policy offers a broad educational framework for the country, with the intent to cover all children and adolescents attending school. Broad measures are in place.	Countrywide; coverage: national	N/A
Programme title: National Plan of Action for Children (2005-2010) Responsible agency: Ministry of Women and Children Affairs Funded by: Government of Bangladesh Time frame: 2005-2011			
Various schemes of the Ministry of Women and Children Affairs were made comprehensive under this policy initiative.	To protect children from abuse, violence, discrimination and sexual exploitation, including trafficking, within the framework of the government policies and programmes.	Countrywide; coverage: national	N/A

Table 2: Overview of key child-sensitive social protection policies and legislation in Bangladesh (continued)

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Poverty Reduction Strategy Paper (PRSP) 2009-2011 Responsible agency: Government of Bangladesh, Planning Commission Funded by: World Bank, other donors Time frame: 2009-2011			
The vision is to attain pro-poor growth and economic development that is child-centred and ensures basic rights, as well as fulfilling livelihood needs of the children of Bangladesh.	Children's advancement and protection of their rights are covered by the slogan – World Fit for Children. The strategy provides direction to proposed programmes and schemes.	Countrywide; coverage: national	A consultative process has been created where social protection is integral to the larger development framework.

Table 3: Overview of key child-sensitive social services in Bangladesh

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: 100-day Employment Guarantee Scheme (EGS) Responsible agency: Department of Local Government, Engineering Department; Department of Social Services; other departments Funded by: Government of Bangladesh Time frame: 2008			
Inspired by India's National Rural Employment Guarantee Scheme (NREGS).	Supports incomes of the poorest community segments. Up-scaling of the 'Cash for Work' programme which generated 6,700,000 person-months of work at the cost of US$15 million in 2007-08. US$293 million has been allocated for the scheme in 2008-09.	Countrywide; coverage: to expand across the country by early 2011	Review ongoing
Programme title: Amader Shishu (Our Children) Responsible agency: Ministry of Women and Child Welfare, Department of Social Service, Ministry of Education and Government of Bangladesh Funded by: UNICEF Time frame: 7 *upazilas* (administrative units: sub-districts)			
Part of the Ministry of Women and Child Welfare, Department of Social Service work plan of 2002.	Supports orphans and vulnerable children by promoting family-based care, providing conditional cash transfers and strengthening the capacity of the social welfare system.	Children; coverage: 2,100 orphans	N/A
Programme title: Food For Work (Rural Infrastructure Development Programme) Responsible agency: Department of Local Government Engineering Department; Department of Social Services; other departments Funded by: Government of Bangladesh Time frame: 1997			
N/A	Intended to create employment for the poor through the construction and maintenance of infrastructure, as well as developing and maintaining rural infrastructure.	No specific entitlement; coverage: about 1 million participants annually	N/A

Table 3: Overview of key child-sensitive social services in Bangladesh (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Vulnerable Group Development (VGD) Responsible agency: Ministry of Women and Children's Affairs and Ministry of Disaster Management and Relief Funded by: World Food Programme (WFP) Time frame: 1997 to present			
An evolution of the Vulnerable Group Feeding (VGF) Programme.	Provides medium-term employment (18-24 months) and imparts 150 hours of training on marketable skills. The VGD programme beneficiaries are selected by local government officials.	Coverage: national. Around 750,000 ultra-poor women, across nearly 300 districts are beneficiaries.	In the 2000s, impact assessment found positive changes in beneficiaries' livelihoods, including an increase in homestead land ownership; a decline in begging; and an increase in ownership of basic household goods.
Programme title: Primary Education Development Programme-II (PEDP-II) Responsible agency: Government of Bangladesh, Planning Commission, Ministry of Education Funded by: Asian Development Bank (ADB)-led donor consortium. Time frame: 2004-2009 (until 2010 in some districts)			
Primary Education Development Programme-I (PEDP-I)	Focused on improving the quality of education and devolving education planning to the district level.	Country-wide; coverage: districts with low school enrolment rates and limited infrastructure	N/A
Programme title: Protection of Children at Risk (PCAR) project Responsible agency: Department of Social Services, Ministry of Social Welfare Funded by: UNICEF (since 2007) Time frame: 2007 to present			
PCAR is the continuation of the Appropriate Resources for Improving Street Children's Environment (ARISE) project under the Ministry of Social Welfare, with financial and technical support of UNDP from April 1999 to March 2007.	Objectives are to protect children living and working on the street without parental care from violence, abuse and exploitation, and to support the development programmes targeted at strengthening survival skills of street children.	Review ongoing	N/A
Programme title: Reaching Out of School Children (ROSC) Responsible agency: Government of Bangladesh, Directorate of Primary Education under the Ministry of Primary and Mass Education Funded by: World Bank, Swiss Development Co-operation initiated support in 2006 Time frame: From 2003			
National Plan of Action for Education for All (2001-15), and complements the government's PEDP II by identifying children who are not yet in school.	Objective to contribute to achieving the government target of universal education. Direct transfers are made in the beneficiary's name to the mother/guardian's bank account.	Coverage: focused on low-enrolment, high-poverty areas	Project encourages out-of-school children to attend learning centres called 'Ananda Schools'. In 60% of the project areas, cash stipends or educational allowances to eligible children and grants to schools are provided. In the remaining 40% grants to Ananda Schools are provided.

Table 3: Overview of key child-sensitive social services in Bangladesh (continued)

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Sarkari Shishu Paribar (State Children Home) Schemes Responsible agency: Department of Social Services, Ministry of Social Welfare (MOSW) departments Funded by: Government of Bangladesh Time frame: 1961 to present			
Bengal Orphan and Widow Act (1944) was promulgated for the management of orphanages. At the government level, the Primary Education Directorate was initially responsible for running state orphanages.	Specific objectives are to protect, and to provide food, education, training, medical care and recreational facilities for orphans.	Children with no parents or guardians; coverage: 76 *upazilas* (district)	85 state children's homes offer services to more than 10,000 orphans. A total number of 45,084 orphans have been rehabilitated through this programme as of December 2009.
Programme title: Test Relief (Rural Infrastructure Maintenance Programme) Responsible agency: Ministry of Food and Disaster Management Funded by: Government of Bangladesh Time frame: 1992 to present			
VGD and Income Generation for Vulnerable Group Development (IGVGD)	The beneficiary receives 3.5kg of food grains per day for a maximum of 30 days. The labour requirement is considerably lighter than other employment generation programmes.	Impoverished communities; coverage: more than 100,000 beneficiaries	N/A

Table 4: Overview of key child-sensitive social assistance initiatives in Bangladesh

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Abashan Project Responsible agency: Abashan Project Management in the Prime Minister's Office, Department of Social Services, (MOSW) Funded by: Government of Bangladesh Time frame: 2004 to present			
Prime Minister's Office	Rehabilitate the landless.	Vulnerable segments of society; coverage: 180 *upazilas*	21,308 beneficiary families
Programme title: Basic Education for Hard-to-Reach Urban Working Children (BEHTRUWC) Responsible agency: Ministry of Education and Government of Bangladesh Funded by: UNICEF Time frame: 2006 to present			
N/A	The programme offers basic education for urban working children aged 10-14 years focusing on comprehensive life skills.	Child labourers; coverage: 170,000 targeted urban working children in six city corporations	N/A
Programme title: Children with Disabilities Stipend Responsible agency: Department of Social Services MOSW Funded by: Government of Bangladesh Time frame: 2007 to present			
The Union Budget	Encourages children with disabilities to attend school.	Children with disabilities; coverage: national	12,000 student beneficiaries

Table 4: Overview of key child-sensitive social assistance initiatives in Bangladesh (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Secondary Education and Quality Enhancement and Access Project(SEQEAP) Responsible agency: Ministry of Education, Directorate of Secondary and Higher Education Funded by: World Bank and donor consortia, Government of Bangladesh Time frame: FSSAP initiated in 1982. FSSAP-II ended in 2008. SEQEP was launched in 61 districts in 2009, and 122 districts in 2010.			
Follow up of FSSAP-I and II, and the Primary Education (Compulsory) Act 1990	FSSAP provided stipends conditional on school attendance and attainment of a certain level in test scores, and tuition assistance to all eligible girls. Under the SEQEP, stipends and tuition are disbursed based on Proxy Means Testing (PMT) to male and female students.	Proxy socio-economic variables are used to select beneficiaries of the programme. Stipends and tuition are given to the ultra-poor students, while poor students receive tuition fees	A total of around 845,000 poor and ultra poor students are beneficiaries of the PMT programme – around 522,000 in 2009 enrolled, and 323,000 in 2010.
Programme title: Primary Education Scholarship Programme (PESP) Responsible agency: Ministry of Education, Department of Primary Education Funded by: Government of Bangladesh Time frame: 2002 to present			
Evolved from the Food for Education scheme which covered economically disadvantaged rural areas.	The largest cash transfer project in the education sector.	6,000 schools; coverage: 40% of primary-level students of each union. The PESP operates in all rural areas	More than 6 million children have benefited from PESP.
Programme title: School Feeding Programme Responsible agency: Ministry of Education Funded by: WFP Time frame: 2005-2011, subject to extension with approval of WFP Executive Board			
Education for All and PRSP.	Fortified biscuits are provided to 600,000 students of primary schools.	School-going children; coverage: by October 2009, 600,000 primary schoolchildren in over 4,000 schools	Extended to urban working children in early 2011.

Cambodia

Cambodia's core activities lie in cash and food grants, and social services. Antiretroviral treatment for mothers and children are extensively available, and Cambodia has a moderate proliferation of employment generation options for chronically ill caregivers, primarily stemming from efforts by civil society. Social insurance schemes for poor households and vulnerable groups, and an existing legal framework to protect HIV-affected children are areas of weakness.

Table 5: Overview of social protection for children affected by HIV in Cambodia

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	There are several social assistance initiatives that have been audited with favourable results by international bodies. There is substantial support for veterans' family members and the Scholarship for the Poor programme has shown between 20% and 25% higher school attendance rates.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Limited	There is a Master Plan for Social Insurance, adopted in 2005, but it is not yet fully implemented.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	The Buddhist Leadership Initiative and other programmes providing care and support to orphans and vulnerable children affected by HIV/AIDS provide a package of support including capacity-building training, community awareness, psychosocial support and income grants in addition to education and food support. Grants are primarily geared to improve health or education access) rather than to generate income. Civil society efforts have added emphasis to income generation for caregivers, as exemplified by SEADO, Save the Children and Salvation Center of Cambodia initiatives. However, activity remains fragmented and not necessarily sustainable, given the reliance on external funding.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Moderate	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Moderate	Several national strategic plans were enacted in 2006 to respond to HIV and poverty in the population. The National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children was enacted in 2008 to target at-risk children. A national social protection strategy was developed in 2010; however, it continues to await approval.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Limited	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 6: Overview of key child-sensitive social protection policies and legislation in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Alternative Care Policy Responsible agency: Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) Funded by: UNICEF technical and financial support Time frame: 2006 to present			
MoSVY	Established a hierarchy of options of care for orphans, with institutional care as a last resort and a temporary option only. Legal regulations have been implemented. However, there is no monitoring system established.	Orphans; coverage: national	Policy implementation is in the testing stage.
Programme title: National Strategic Plan for a Comprehensive & Multi-sectoral Response to HIV/AIDS from 2006 to 2010 (NSP II)Health Strategic Plan, 2008-2015 (HSP2) (BEHTRUWC) Responsible agency: National AIDS Authority Ministry of Health Funded by: Funding for the national response is provided by donors and the government of Cambodia Time frame: 2006-2010; 2008-2015			
National Strategic Plan for a Comprehensive & Multi-sectoral Response to HIV/AIDS from 2001 to 2005 (NSP I) HSP2	The NSP II details high-level goals and specific objectives to achieve them, including improved prevention coverage, with children living and working on the street as one of the target groups; increased coverage of comprehensive care, particularly home-based care and community-based care; increased impact mitigation measures, including increasing nutritional support for families affected by HIV. Aims for universal coverage by 2015.	General population, with some measures specific to HIV affected populations; coverage: national	N/A
Programme title: The National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia, 2008-2010 (to be extended to 2015) Responsible agency: The National AIDS Authority and the Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) Funded by: UNICEF, UK Department of International Development (DFID), Save the Children Australia, and Family Health International Time frame: 2008-2010			
Strategic Plan, 2006-2010 (ESP 2006-2010)	Establishes five key strategies for increasing the wellbeing of the target population. The Plan does establish a nationally agreed upon a minimum package of food and support that should be provided to all orphans and vulnerable children (OVC).	Orphans, children affected by HIV and other vulnerable children; coverage: universal	N/A

Table 7: Overview of key child-sensitive social services in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Buddhist Leadership Initiative Responsible agency: Ministry of Cults and Religions Funded by: UNICEF Time frame: Established 2003			
National Policy on the Religious Response to HIV/AIDS	Training programmes for Buddhist monks in psychosocial support for people affected by HIV, mechanisms for raising awareness within their communities about HIV, and home-based care techniques.	People affected by HIV, with a particular emphasis on children; coverage: Takeo Province	In 2010, 400 monks were trained on awareness techniques and psychosocial support. Established home-based care teams of monks caring for 4,977 people living with HIV and 3,358 orphans and other vulnerable children in 329 communes (administrative units, sub-districts), in 12 provinces.
Programme title: Support for OVC affected by HIV/AIDS work platform Responsible agency: National Centre for HIV/AIDS, Dermatology and STD. NGOs (supported by Global Fund and USAID). Funded by: Global Fund, USAID are the two main donors Time frame: N/A			
National Strategic Plan for a Comprehensive & Multisectoral Response to HIV/AIDS, 2011-15 (NSPIII)	Diverse programmes which employ a range of measures to support orphans and other vulnerable children affected by HIV. Programmes provide home-based care, formal education support, transfer of school and food supplies, referral to health care and income generation grants to orphans of HIV and OVCs. They also raise awareness in communities with a high HIV-prevalence about HIV, child transmission and available treatment.	Orphans and vulnerable children	44,371 children's households received external support (UNGASS Cambodia 2010 report).

Table 8: Overview of key child-sensitive social insurance in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Master Plan for Social Health Insurance (2003-2005) Responsible agency: Ministry of Health Funded by: Various donors, NGOs Time frame: Published in 2003; updated and adopted in 2005			
Master Social Health Insurance (SHI) Plan	A policy document designed to consolidate insurance initiatives and move towards universal social health insurance. However, it has not yet been fully implemented. Various organizations still operate health equity funds (HEFs) and community-based health insurance (CBHI), both of which are the major providers for informal sector workers. CBHIs tend to reach the 'not-so-poor', while HEFs reach poorer communities.	Varies; coverage: random (although the government is aiming for universal coverage)	Not yet fully implemented

Table 9: Overview of key child-sensitive social assistance initiatives in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: HEF Schemes Responsible agency: Ministry of Planning (MoP) Funded by: USAID, the World Bank, the Asian Development Bank (ADB), and the Royal Government of Cambodia (RGC); implemented by University Research Company (URC), UNICEF Time frame: 2002-2013			
Health Master Plan	Eligible individuals receive the costs of health care, and their transportation is covered. The patient's caregivers are also provided with stipends to cover food costs. Around 32 HEFs exist reaching about 9.8% of Cambodia's population.	Those identified as "poor" by the programme; coverage: 35 Operational Districts (ODs) across Cambodia	In cases where pre-identification was complete, utilisation rates of inpatient services were three times higher than with self-paying users. Suggested linkage between findings that 55% fewer households in districts covered by HEFs had cases of household debt due to health care costs than in the districts not covered.
Programme title: Identification of the Poor system (IDPoor) Responsible agency: Ministry of Planning (MoP) Funded by: German Technical Cooperation (GTZ) Time frame: 2007 to present (ongoing; no information indicating end date)			
Ministry of Planning Initiative	System that identifies the poorest of society, who then qualify for fee exemptions at health facilities in their area, which are run through local health equity funds (HEFs). Specific measures are in place to identify the poor through surveys and interviews. This measure facilitates fee waivers for health care and it is meant to be used for the provision of all social assistance.	Poor communities; coverage: soon to be national	A report on social safety nets, led by the World Bank, reported that a qualitative review of the IDPoor programme indicated general satisfaction with the ability of the system to properly identify the most needy in the community.
Programme title: Invalidity pensions and care services Responsible agency: Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY); Department of Veterans' Pensions; Municipal and Provincial Department of Social Affairs, Department of Finance and Supplies Funded by: The Government of Cambodia Time frame: N/A			
MoSVY work platform	Provides cash and food allowances for parents or guardians of deceased soldiers, spouses of the disabled. Retirees and people who have lost their ability to work receive an allowance of CR3,200 (proposed to be raised to CR6,000).	Veterans, the disabled, and family members; coverage: categorical	N/A
Programme title: Scholarship for the Poor programme Responsible agency: Ministry of Education, Youth, and Sport (MoEYS) Funded by: World Bank, ADB Time frame: 2006 to present			
N/A	Provides $45 and $60 grants for households with children at risk of dropping out of secondary school. Grants are conditional on school attendance. The programme is under the World Bank's Education Support Project.	Households with children at risk of dropping out of secondary school; 'very poor' of poor families; coverage: all provinces except Phnom Penh	Between 20 and 25% higher attendance rates among those who received the scholarships. The project is now being put forth as a model for conditional cash transfers in other sectors (infant health and regular hospital check-ups in particular). MoEYS has also piloted a primary school scholarship programme out of the education budget.

China

China has extensive cash and food grant programmes for vulnerable children, and a well-established legal protection for children affected by HIV. With moderate and substantial programme coverage elsewhere, China's coverage is weak in employment initiatives for the chronically ill.

Table 10: Overview of social protection for children affected by HIV in China

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Extensive	Several social assistance initiatives exist, including one specifically targeted to the caregivers of children orphaned by HIV and one for the elderly and orphans.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Substantial	There are several social insurance schemes. The national Basic Medical Insurance programme does not extend to families, but local governments are working to extend coverage to all citizens.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	Since April 2004 AIDS patients are eligible to receive free treatment, and school tuition is waived for children whose parents have died from HIV. Employment options for the chronically ill are still limited.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	China has laws at both national and sub-national levels designed to protect children's safety and give them legal rights.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Extensive	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 11: Overview of key child-sensitive social protection policies and legislation in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Law of the People's Republic of China on the Protection of Minors and Revision Responsible agency: Various ministries (Civil Affairs, Labour and Social Security, Health, Education, Commerce) and government bodies (National Working Committee for Children and Women, National Development and Reform Commission, China Disabled Persons' Federation) Funded by: Various Time frame: Revision effective June 1st 2007			
Adopted on September 4th 1991, effective January 1st 1992. Revision approved in 2002	Designed to protect children's personal safety in school, at home, and in all other social settings. The revised law explicitly specifies the rights of Chinese minors and calls for institutionalizing such protection. The law protects minors' rights in all institutional settings (schools, courts of law, orphanages, hospitals, etc).	All children; coverage: national	N/A
Programme title: National Programme of Action for Child Development 2001-2010 (NPA) Responsible agency: The National Working Committee for Women and Children and local governments. Funded by: Local governments Time frame: 2001-2010			
1992 ratification of the United Nation's Convention on the Rights of the Child	Formulation of policies and adoption of measures specifically targeting children. The programme states that one of its major objectives is to "improve the social security system and promote the survival and development of children in difficulties (poor children, children with disabilities, orphans, children living and working on the street)".	All children; coverage: national	N/A
Programme title: The Shanxi Province Minor Protection Regulation ("Left Behind Children" Draft Regulation) Responsible agency: Shaanxi Women's Union Funded by: Local governments Time frame: December 2nd 2008			
Adoption Law (1999 amendment)	Protect children who have been left behind in the villages while their parents go to find work in the cities. Aimed at reuniting these children with their extended families or created networks of external/institutional care.	Children with no legal guardian; coverage: Shanxi Province	N/A

Table 12: Overview of key child-sensitive social services in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Four Frees and One Care Responsible agency: Ministry of Health and local authorities Funded by: Various Time frame: Launched in 2004			
State Council Notice on China HIV/ AIDS Containment, Prevention and Control Action Plan, 2001-05, (State Council General Office Document. 2001, No. 40)	Aim to address obstacles preventing access to treatment. Provides free education to AIDS orphans and has implemented community-based treatment and care pilot projects in provinces with severe HIV epidemics, providing free counselling, screening and anti-retroviral treatment to HIV-positive pregnant women.	Vulnerable populations (people with HIV, children orphaned by HIV/AIDS, pregnant women); coverage: pilot programmes in seven central Chinese provinces	Pilot programmes implemented in high-prevalence counties covered by China CARES. Existing budgets are not sufficient and the free education for children only applies to those children who have lost both parents.

Table 12: Overview of key child-sensitive social services in China (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Project on Compulsory Education in Poor Areas (NPCE) Responsible agency: Ministry of Education Funded by: A total of Rmb12.4 billion was invested in the first phase and Rmb7.25 billion in the second phrase Time frame: Two phases: 1995-2000 and 2001-2005			
N/A	Aims to extend education providing children with basic learning needs (universal primary and lower secondary education) as a tool for long-term poverty reduction. The project provides basic school facilities, training of teachers and principals, free distribution of textbooks, and information communication technologies.	All children; coverage: 250 million children in 852 poor counties	By 2000, enrolment rates in the project counties reached 99% at the primary level and 91% at lower secondary school levels. Among the 852 project counties, 428 achieved national literacy standards, and 242 counties achieved universal primary education.
Programme title: Notice on strengthening assistance to AIDS patients, their relatives, orphaned children and lonely elders Responsible agency: Ministry of Civil Affairs Funded by: N/A Time frame: May 2004			
N/A	Promotes financial assistance to children and families, foster care and financial assistance to care givers. Stresses that children need to be raised in a family environment, which includes adoption, fostering and facilities which includes institutional care.	HIV orphans, pregnant women, vulnerable/at-risk populations, poor people in highly-affected areas, caregivers; coverage: Hubei Province	N/A
Programme title: Regulation on Free treatment for AIDS patients Responsible agency: Ministry of Health, Ministry of Finance Funded by: Local governments Time frame: April 2004			
Regulations on the Prevention and Treatment of AIDS	Poor PLWHA – urban or rural – are eligible to receive free treatment. School tuition is waived for children whose parents have died from HIV. Free testing. Pregnant women in the 31 areas with highest prevalence can receive free testing and treatment.	'AIDS orphans', pregnant women, vulnerable/at-risk populations, poor people in highly-affected areas	N/A

Table 13: Overview of key child-sensitive social insurance in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Basic Medical Insurance in Urban Areas Responsible agency: Ministry of Labour and Social Security Funded by: Basic medical insurance. Enterprises contribute 6% of the total payroll while the individual pays 2%. The system itself combines a social pooling fund and an individual account Time frame: Launched in 1998			
Decision of the State Council on Establishing the Urban Employees' Basic Medical Insurance System	Medical insurance in urban areas is composed of three parts: i) basic medical insurance for urban employees; ii) free medicine; and iii) comprehensive insurance for migrants. The social pooling fund pays medical expenses of inpatients and chronic illnesses treated in clinics while the personal account pays outpatient and small illness costs.	The scheme provides for those who have jobs or are retired from jobs covered by the scheme; coverage: urban	The number of beneficiaries of free medicine is estimated at 50 million and the total outlay around Rmb38 billion. Family members are not protected by the scheme, but some local governments are trying to extend the coverage to all citizens (including underage dependants).
Programme title: New Rural Cooperative Medical Scheme (NRCMS) Responsible agency: Ministry of Health (MoH) Funded by: Through a mixture of individual, local and central government funding Time frame: Pilot programmes launched in 2003			
This scheme was first piloted in selected counties in each province with pooling at the county level	Provide basic medical coverage in rural areas. Farmers voluntarily participate by contributing Rmb10 per person per year. An equal amount for each person is added by both central and local governments. In most pilot counties the reimbursement covers the majority of inpatient costs and part of outpatient costs (for household medical care).	Rural population; coverage: 11th Five Year Plan (2006-2010) stipulates that the scheme is aims to cover more than 80% of the rural population by the end of the plan period	So far, 310 pilot projects have been launched in 30 provinces, autonomous regions and municipalities in China, involving 95 million agricultural people, while 69 million farmers have participated in NRCMS (a participation rate of 72.6%).
Programme title: Work Injury Insurance Responsible agency: Ministry of Labour and Social Security, Department of Medical Care Insurance, provides guidance while local social insurance agencies and participating enterprises administer programmes Funded by: Employer contributions vary according to three categories of industry and the assessed degree of risk. The average contribution rate in provinces is 1% of total payroll Time frame: Launched in 1996			
First law: 1951. Current laws: 1953, 1978 (permanent employees), 1986 (contract workers), 1996, 2003 (employment injury), and 2004 (rural migrants)	Temporary disability benefits, permanent disability benefits and medical benefits are given to the affected worker. Survivor benefits are given to the spouse and/or other dependants (children, parents, grandparents, grandchildren, brothers and sisters).	Employees in all enterprises; coverage: formal workforce	Family members and dependants are covered by some of the scheme's packages (permanent disability and death of provider). By the end of 2007, the total number of subscribers was 121.7 million.

Table 14: Overview of key child-sensitive social assistance initiatives in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Assistance for the Extremely Poor Households (Tekun) Responsible agency: Ministry of Civil Affairs, Ministry of Labour and Social Security Funded by: Central and local authorities Time frame: N/A			
N/A	*Tekun* schemes have been promoted in less economically-developed rural regions as an alternative to the *Dibao* (Minimum Living Standard Assistance) system to provide temporary relief to households impoverished by major illness or loss of family labour.	N/A	Progressively replaced by the generalization of the *Dibao* in rural areas.
Programme title: Five Guarantee Programme (Wubao) Responsible agency: Central and local authorities Funded by: Central and local authorities Time frame: Launched in the 1950s			
N/A	A collective safety net catering to the rural elderly and orphans without family caregivers or sources of income. Recipients (families) are provided with a locally-defined rate of benefits in cash and in-kind.	Rural elderly and orphans without family caregivers and sources of income	N/A
Programme title: Minimum Living Standard Assistance (MLSA, or Dibao) Responsible agency: Ministry of Civil Affairs through city authorities (civil affairs departments) Funded by: A large part from the central government, the rest from local authorities Time frame: Launched in 2003 for urban households and 2007 for rural households			
The first Minimum Living Standard Scheme (MLSS) was launched in Shanghai in June 1993, reaching 207 cities by July 1997	The *Dibao* programme provides regular cash and/or in-kind support to poor households up to a locally defined poverty line which is based on a means test. The programme ensures a basic safety net for poor urban households.	Households whose per capita income falls below a locally-determined minimum level; coverage: 22.5 million beneficiaries	Excludes unregistered migrants. Local authorities have called for a revision of the means test (toward standardised poverty line).
Programme title: Provision of financial subsidies to families who care for HIV/AIDS orphans Responsible agency: Ministry of Civil Affairs Funded by: Local governments Time frame: N/A			
N/A	Provides financial support to families who care for children orphaned by HIV/AIDS.	Caregivers of children orphaned by HIV/AIDS	Dedicated funds for this group have not yet been fully distributed, but national authorities are in the process of setting measures to do so.
Programme title: Two Frees One Subsidy Responsible agency: Ministry of Education Funded by: N/A Time frame: Launched in 2004, extended in 2005			
N/A	Provides compulsory education to pupils from poor families with free textbooks. Exempts them from paying miscellaneous fees, makes boarding schools affordable, grants living allowances.	Children in poverty-stricken rural areas	Between 2006-07 the abolition of miscellaneous fees for compulsory education was extended to all rural areas in central, eastern and western China.

Indonesia

Indonesia has established social protection for children in the form of cash and food grants for at-risk children, and antiretroviral treatments for mothers and children. However, other social services including the provision of health care, education, welfare, work options for the chronically ill, and psychosocial support remain limited.

Table 15: Overview of social protection for children affected by HIV in Indonesia

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	There are several social assistance programmes in Indonesia and although the programmes have faced some challenges in deployment, overall results look promising. Currently 12 million households are benefiting from the Rice for Poor Households programme.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Moderate	Jamkesmas, which is a nationally run health insurance scheme for the poorest segment of society, though only around 17 % of Indonesians are covered under this plan. Plans are in the works for a reform.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Substantial	HIV-sensitive social services are limited in Indonesia, though there has been significant expansion in the provision of ART to adults. Child protection and HIV responses have been quite distinct to date.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Limited	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Moderate	Several national strategies and policies have been written that either do not have national authority or were not implemented. The National HIV and AIDS Strategy and Action Plan does not currently have recorded results.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Moderate	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 16: Overview of key child-sensitive social protection policies and legislation in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: 2010-14 National Medium-Term Development Plan (RPJMN 2010-2014) Responsible agency: Multiple agencies Funded by: Government of Indonesia Time frame: 2010-2014			
Second implementation phase of 2005-2025 National Long-Term Development Plan (RPJPN 2005-2025)	Serves as the basis for all of the ministries' individual strategic plans, focusing overall on building democratic structures and economic growth. Although child protection is not one of the top 11 priorities, it is one of the four cross-cutting issues listed for attention.	Poor communities across the country, with a focus on underdeveloped regions as a whole; coverage: national	N/A
Programme title: Law on Child Protection No. 23 2002 Responsible agency: Ministry for Women's Empowerment Funded by: N/A Time frame: 2002 to present			
N/A	Details a series of rights for children, including the right to education and health care, to protection from violence and discrimination, and the government's obligation to protect children from exploitation.	Children; coverage: national	N/A
Programme title: National HIV and AIDS Strategy and Action Plan 2010-2014 Responsible agency: National AIDS Commission Funded by: N/A Time frame: 2010-14			
National HIV and AIDS Action Plan 2007-2010	The policy has four focus areas: prevention; care, support, and treatment; impact mitigation; and conductive environment. It identifies 137 high-risk districts for focus. While the strategy mentions support for orphans and other vulnerable children, children are not addressed in any great detail.	Sex workers, injecting drug users, men who have sex with men (MSM), children living and working on streets; coverage: national with particular focus on 137 high-risk districts	No results yet available
Programme title: Special Policy in Combating HIV and AIDS in Children Responsible agency: Policy was endorsed at the directorate level Funded by: N/A Time frame: Written in 2007			
N/A	Policy focuses on: • Conducting HIV-prevention education initiatives • Increasing the capacity of families to provide economic and psychosocial support to vulnerable and affected children • Guaranteeing access to essential services across sectors • Building community support and acceptance for children and families affected by HIV • Increasing the use of social service facilities • Increasing participation of children in planning	Children affected by HIV, and other vulnerable children; coverage: national	Endorsed at the directorate level, this policy does not have national authority. No data available on implementation

Table 17: Overview of key child-sensitive social services in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: CAKAP Merauke (HOPE programmes in Papua) Responsible agency: World Vision Funded by: World Vision Australia Time frame: N/A			
N/A	Aims to improve the quality of HIV and AIDS programming in Papua by providing correct knowledge and practical skills.	Faith communities in Merauke, Wamina, and Jayapura, all in Papua; coverage: same	N/A
Programme title: CAKAP Sambas (Prevent AIDS with Love and Care in Sambas) Responsible agency: World Vision Funded by: World Vision Netherlands Time frame: 2009-2012			
N/A	Aims to reduce and prevent the impact of HIV and AIDS; and child and female trafficking.	Youth aged 13-18 years, and AIDS affected people; coverage: Sambas, Borneo	N/A
Programme title: Child Welfare Services Programme (Pelayanan Kesejahteraan Sosial Anak) Responsible agency: Ministry of Social Affairs Funded by: N/A Time frame: 2009 to present			
N/A	N/A	Children; coverage: national	N/A

Table 18: Overview of key child-sensitive social insurance in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Jamkesmas Responsible agency: Social Security Management Agency (Badan Pengelola Jamin Sosial or BPJS) Funded by: Government of Indonesia Time frame: 2008 to present			
Implementation of Law No. 40/2004 on National Social Security System; 2008 Health Insurance Law	Programmes that provide health care fee waivers and reimbursements for the poorest of society. Payment mechanisms vary regionally between fee waivers and disbursements.	'Poor'; coverage: national	Only covers 17% of the population. Out-of-pocket health care spending remains among the highest in the region.
Programme title: Jamsostek Responsible agency: Ministry of Manpower and Transmigration Funded by: Employees and private employers Time frame: 1995 to present			
Government Decree No. 36 in 1995	Benefits are provided for old-age, permanent disability, survivors, and minimal health coverage. There is an opt-out clause for private sector companies with alternative coverage.	Private sector employees of employers with a workforce of 10 or more; coverage national	Currently covers 1.3% of the population, of a potential 40-50% of private sector workers.

Table 19: Overview of key child-sensitive social assistance initiatives in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Direct Cash Assistance (Bantuan Langsung Tunai, BLT) Responsible agency: Co-ordinating Minister for People's Welfare the co-ordinating organ; Ministries of State Development Planning; of Social Affairs; Home Affairs; and of Communication all involved in the implementation Funded by: Government of Indonesia Time frame: 2005; six months			
Instructions of the President No. 2/2005	Provided direct cash transfers to poor families in an attempt to mitigate the economic shock of the removal of government gas subsidies. Poor households were classified as households where monthly per capita expenditure was lower than Rp175,000 (US$17 at the time). Such households received Rp100,000 per month for six months. Until 2006 it was the largest cash transfer programme ever undertaken worldwide, in terms of coverage and total volume of transfers. Due to a lack of formal household income data, they used 14 proxy indicators of household expenditure, collected from the annual national socio-economic survey, Susenas.	All households with a monthly expenditure lower than Rp175,000; coverage: national	Although 94% of funds reached the intended beneficiary, nearly all village heads surveyed in an after programme assessment reported that the programmes created social unrest, and made it more difficult for the local governments to ask community members to participate in mutual assistance programmes.
Programme title: Household Conditional Cash Transfer Programme or Family Hope Programme (PKH) Responsible agency: Ministry of Social Affairs Funded by: N/A Time frame: 2007 to present			
N/A	Provides conditional cash transfers to households classified as 'poorest'. The funds are conditional on families meeting specific health- and education-related obligations. Local health facilities and schools report lack of compliance. If the recipients continue to fail to meet their obligations after a set number of warnings the transfer of funds is terminated. The money is managed and distributed by local post offices.	'Poor' and 'poorest' households in which there is a pregnant mother or elementary school-aged children; coverage of only certain provinces across Indonesia, chosen through a complex selection process	No systematic data is available. Qualitative studies say that the programme has provided some assistance to families, but still does not address the underlying issues of poor health and educational facilities in rural areas.
Programme title: National Independent Community Empowerment Programme or Community Conditional Cash Transfer programme (PNPM) Responsible agency: Coordinator Ministry for the People's Welfare Funded by: World Bank, Government of the Netherlands, and several other small donors Time frame: 2007 to present			
N/A	Builds on the decentralization process in Indonesia to empower local groups to contribute to the development of their community. Creates community planning processes in which local poverty issues are identified. All proposals are from local citizens.	Poor communities across the country; coverage: national, however has not yet been scaled up to reach all rural communities	By 2008 PNPM had funded more than 180,000 infrastructure, economic, and social development projects. The majority appear to have been concentrated on infrastructure and environmental management. There have also been allegations of 'leakage' of funds from the programme, totalling up to Rp100 billion from the start of the programmes in 2007 through mid-2010.

Table 19: Overview of key child-sensitive social assistance initiatives in Indonesia (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Rice for Poor Households (known as Raskin) Responsible agency: National Food Logistics Agency (BULOG) Funded by: Government of Indonesia; funded by the extra cash flow from the reduced oil subsidy in 2005 Time frame: 1998 to present			
The successor of the Special Market Operation (OPK) programmes	Originally created in response to the 1997 financial crisis. Distributes rice to households identified as needy in the national government's Central Statistics Agency's data on Poor Households. Each household is entitled to 20kg of rice per month (though there are reports that some have received less due to popularity of the scheme).	'Poor households', as determined by nationally gathered government data through the Central Statistics Agency (BPS)'s data on Poor Households; coverage: national	The programme was originally intended to reach 8 million households, but by 2006 the number of beneficiary households had expanded to 12 million. Problems have included: ineffective targeting; high costs of programme management; poor monitoring and evaluation to measure results; and a low programme transparency.
Programme title: School Operational Aid programme (locally known as BOS) Responsible agency: Ministry of National Education Funded by: Government of Indonesia; the World Bank funds a supporting programme called BOS-KITA to improve transparency Time frame: 2005 to present			
N/A	Direct cash transfer programmes for schools, providing funds that are intended to help buy resources to expand and improve the quality of education. One of the goals is to ensure compliance with the compulsory education rule for children through Grade 9.	Children ages 7-15; coverage: national	The programme is viewed as successful, but in need of adjustments. The programme has had a positive impact on attendance rates and motivation of the poor in school, with government reporting a fall in the dropout rate by 3%. There have also been problems with the misuse of funds.
Programme title: Special Student Assistance (Bantuan Khusus Siswa or BKM) Responsible agency: Ministry of National Education Funded by: Government of Indonesia Time frame: 2003 to present			
N/A	Aims to reduce dropout rates by providing students with monthly stipends. Beneficiaries are identified by the school board. The national government sends cash payments directly into the target students' accounts at their respective schools.	Poor students at risk of dropping out of school	In 2003, the programme spent Rp48,600 million to help 683,550 students.

Nepal

Nepal has either substantial or moderate programme coverage across the spectrum of social services, with strengths in the areas of cash and food grants, explicit rights for access to services for children affected by HIV, and the provision of health care, education, welfare and other social services for vulnerable children. In terms of implementation, civil society activity is dominant.

Table 20: Overview of social protection for children affected by HIV in Nepal

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	Education For All Scholarships provide incentives for households to encourage children's enrolment in schools. Focuses on disadvantaged groups.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Moderate	The Public Health Concern Trust reaches 45,000 families with no ethnic, race or caste restrictions.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	HIV prevention programmes within the country have received favourable monitoring reports, and free services and drugs are available to people living with HIV/AIDS (PLWHA) in certain regions of the country.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Moderate	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	Nepal features a number of examples to incorporate children's issues into recent policies and legislation, including the Three Year Plan, Constitution drafting, and a drafting process towards a National Social Protection Framework and initiatives, such as Child Friendly Local Governance.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Moderate	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 21: Overview of key child-sensitive social protection policies and legislation in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Children's Act (1991) Responsible agency: Ministry of Women, Children and Social Welfare (MWSW) Funded by: N/A Time frame: From 1991			
N/A	Specifies the obligations of guardians and other members of society to ensure the rights of children to nutrition, health, education and humane treatment.	All children; coverage: national	From 2001, at least seven schemes have been launched at the national level to address the rights of children, with three focussing on education, one on child labour rehabilitation, one on vulnerable children in urban areas and two addressing home-based care.
Programme title: Child-friendly Governance Initiative Responsible agency: Ministry of Local Development Funded by: N/A Time frame: From 2008			
N/A	Objective to address the needs of vulnerable children at the municipal and city level.	All children; coverage: sub-national	Children's issues have been incorporated into new policy documents. including the municipal plan and poverty reduction strategy in the five pilot municipalities of Jumla, Dang, Sunarai, Tanahu, Kavre and Biratnagar in 2008.
Programme title: National HIV/AIDS Strategy Responsible agency: Ministry of Health and Population (MoHP), National Planning Commission and Government of Nepal Funded by: N/A Time frame: 2006-2011			
N/A	Focuses on universal access and prevention, treatment and care to support at-risk populations and PLWHA.	Specific focus on high risk populations; coverage: national	HIV/AIDS has been accorded high priority in national policy. Yet, around 90% of AIDS spending is being managed outside the public sector. An HIV-specific (rather than sensitive) approach to develop a National Strategy on Children Affected by AIDS (CABA) is in development.
Programme title: National HIV/AIDS Action Plan Responsible agency: HIV/AIDS and STD Control Board Funded by: Grants from United States Agency for International Development (USAID), UK Department of International Development (DFID), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Round 2, 7, and components within the World Bank's revised Health Sector Programme commencing in 2010 Time frame: 2008-2011			
N/A	Implementation plan for the National HIV/AIDS Strategy, with a focus on youth-friendly and targeted services to reach most-at-risk populations (MARPs).	Emphasis on MARP; coverage: national	The epidemic is levelling off in some most-at-risk populations, but there remain concerns around the epidemic evolving and trickling down to the youth.

Table 22: Overview of key child-sensitive social services in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Cash for Work: One Family, One Employment Responsible agency: Ministry of Local Development (MLD) through district development committees (DDCs) or village development committees (VDCs) Funded by: Government of Nepal Time frame: 2005 to present			
N/A	Funds are disbursed among the 30 VDCs in the Karnali zone. Applicants form a team with at least five unemployed people from separate families and submit a project proposal. Unemployed persons in remote parts of the country are offered jobs yielding between NRs180 and NRs350 per day.	30 VDCs in the Karnali region; coverage: Karnali Zone (Mid-Western Development Region)	Within the 2008/09 budget year, 270,000 people received employment for 100 days through a 'labour-oriented development programme', based on people's participation, local infrastructure development programmes and the Karnali Employment Programme.
Source policy/ initiative	**Brief overview/specific measures**	**Target group/coverage**	**Results/outcomes**
Programme title: HIV/AIDS Prevention among Labour Migrants and Young People and Care for affected Responsible agency: Ministry of Health of Nepal Funded by: GFATM (Round 2) Time frame: 2006-2008			
N/A	Access to services and free drugs; prevent HIV infection from spreading among migrant labourers and young people; and provide care and support to PLWHA.	Migrant labourers, youth, and to provide care and support to PLWHA; coverage: eight districts along the border between Nepal and India	Vulnerable communities were provided access to knowledge, services and drugs. It received a good rating in GFATM quarterly monitoring reports.
Programme title: Integrated Food Security Project within the Rural Community Infrastructure Works Programme (RCIW) Responsible agency: Ministry of Local Development (MLD) Funded by: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), now Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) Time frame: 1996 to present			
N/A	To improve the food supply situation of about 40,000 food-deficit families annually. The project provides rice as a remuneration for the participation of family members in Food for Work (FfW) projects.	Coverage: 25 districts with roughly 1,200 self-help groups in about 1,000 food-deficit villages	More than 2,000 new permanent jobs were created. More than 250,000 food-deficit households found temporary employment for about three months. Improved the self-help capacity of more than 1,200 groups, each comprising about 150 poor rural families.
Programme title: Scaling Up Coverage and Quality of HIV & AIDS Prevention targeted to Most at Risk Population and Treatment Care and Support Services to PLWHA Responsible agency: Save the Children USA, Himalayan Country Office as principal recipient Funded by: GFATM (Round 7) Time frame: 2008-2010			
N/A	Access to services and free drugs.	Vulnerable populations and PLWHA; coverage: west, mid-west and far-west development regions of Nepal	Improvement in health systems, health delivery, targeting ARV drugs and creating systems for delivery. It received a good rating in GFATM quarterly monitoring reports.

Table 23: Overview of key child-sensitive social insurance in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Public Health Concern Trust (PHCT) Responsible agency: PHCT, monitored by MLD for legal compliance Funded by: Village development committees receive donations from donors and the government to supplement premiums Time frame: 1992 to present			
N/A	Established as a cooperative. Members must deposit between 25 to 50 paisa per day (equivalent of US$1.2 to US$2.4 per year). A co-payment structure has members pay 50% of the cost of each treatment. 80% of the cost of a general annual medical check up is covered. Children, orphans and the elderly given subsidized medicines and free check ups.	Families, no ethnic, race or caste restrictions; coverage: more than 45,000	Widely considered as a model of good practice in Nepal.

Table 24: Overview of key child-sensitive social assistance initiatives in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Child grant cash transfer Responsible agency: MLD implementation, has links to National Planning Commission (NPC) and MOHP Funded by: Government resources, complementary funds for system and capacity building from UNICEF and Asian Development Bank (ADB) Time frame: Initiated late 2009, first round implemented mid-2010			
N/A	Child grants to promote right-based approach and social cohesion. Linkages to birth registration and nutrition.	Children 0-5	First round in 2010 had high coverage due to complimentary birth registration.
Programme title: Child Labour Elimination Fund Responsible agency: Ministry of Labour and Transport Management (MLTM), municipal offices Funded by: Government of Nepal, International Labour Organization or ILO (the IPEC Core TBP Project supported by the US Department of Labour) and UNICEF Time frame: 2006 to present			
N/A	A mix of schemes offered to households to encourage children to attend schools.	Working children between 5-14 years of age; coverage: 1,000,000 children nationwide	N/A
Programme title: Education For All Scholarships Responsible agency: Ministry of Education (MoE)/ school management committees Funded by: Government of Nepal Time frame: 2004 to present			
N/A	Providing incentives for households to encourage children's enrolment in schools (NRs400 per year).	National programme; coverage: Dalit children, girls (50% dis-advantaged), disabled, Karnali, marginalized and conflict-affected children	N/A
Programme title: Food for Education Responsible agency: Ministry of Education and Sports Funded by: World Food Programme Nepal Time frame: January 2002 to present			
N/A	Increase access to basic education for families in food-deficit districts with high educational needs, and improve the health and nutritional status of school children.	Poor communities and households; coverage: Hills District in the far Western Development Region	For the 2002-2009 period, the World Food Programme implemented operations worth US$282 million; and the portfolio grew significantly from US$25 million to US$98 million.

Table 24: Overview of key child-sensitive social assistance initiatives in Nepal (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Government education scholarship Responsible agency: Funded by donors, but funds are channelled through the government Funded by: Government of Nepal Time frame: 1999 to present			
N/A	The primary scholarship programme is aimed at improving access to education for Dalits and disadvantaged girls, quality and management efficiency of basic and primary education in Nepal.	Dalits and disadvantaged girls (50% of those in disadvantaged groups); coverage: entire country	Large-scale misappropriation has been reported in some districts. Also, uneven disbursement has made it difficult for school administration and students to sustain education efforts.
Programme title: Reaching the Most Disadvantaged Groups in Mainstream Rural Development Responsible agency: Department of Women Development, (DWD), Ministry of Women, Children and Social Welfare (MWCSW) Funded by: Funded and designed by ADB Time frame: Completed: 2007-2009			
N/A	Reduce extreme poverty and discrimination among 1,000 of the most socially and economically disadvantaged households through increased effective participation of women. Conditional cash transfer to meet the urgent needs of households (livelihood protection); NRs1200 transfer per month to families with orphans and vulnerable children.	Most disadvantaged households, including those from ethnic and low-caste groups; coverage: four districts of rural Nepal, Bajhang, Jumla, Mahottari and Rahuthahat	Slow uptake and poor absorption of funds delayed the desired trickle-down effect from the project. According to ADB's internal evaluation report, the project strengthened capacity of local bodies, including the most vulnerable households and improved the ability of households to participate.
Programme title: Support to Safe Motherhood Programme (SSMP)/Safe Delivery Incentive Programme (SDIP) Responsible agency: Ministry of Health and Population Funded by: Ministry of Health with support from DFID and NGOs Time frame: January 2005 to present			
N/A	To improve maternal and newborn health and survival, especially for the poor and excluded. The Department of Health Services (Ministry of Health) allocates funds to the districts. The District Public Health Office provides parts of the funds to health institutions for distribution. The health management committee distributes the incentives. Some districts (six) provided emergency obstetric care (EMOC) support.	Adolescent girls and women. All pregnant women and birth attendants; coverage: 19 districts	Some key targets have been achieved. Institutional deliveries have increased, maternal and infant mortality rates have decreased in 25 districts.
Programme title: Welcome to School (WTS) campaign under Education for All Responsible agency: Ministry of Education and Sports (MOES) Funded by: UNICEF Time frame: 2004 to present			
N/A	Increase and hold enrolment rates, especially among female students.	Poor communities and households; coverage: national	In addition to scholarships awarded to girls, some 125,000 scholarships were provided for first time learners by the Ministry of Education and Sports.

Pakistan

Pakistan's social protection offerings are limited in several areas: social insurance for vulnerable groups, employment initiatives for the chronically ill and established legal protection for children affected by HIV. Social protection coverage is moderate in other areas, including cash and food grants, ART availability, and silence on the rights of access to essential services for children affected by HIV.

Table 25: Overview of social protection for children affected by HIV in Pakistan

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Moderate	The Punjab Food Support Scheme has shown increased school enrolment, and the Benazir Income Support Programme specifically targets women without male support.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Limited	There are several insurance schemes available, but only one extends to workers' children, and there is evidence of 'leakage' of funds within the programmes.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	A 100-day employment scheme has been announced, but not yet initiated. A People's Works programme has resulted in a 42% growth in infrastructure projects, but this is commonly work unsuitable for the chronically ill.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Moderate	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Moderate	With limited legal rights conferred to the child, the legal framework for children affected by HIV remains weak.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Limited	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 26: Overview of key child-sensitive social protection policies and legislation in Pakistan

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Strategic Framework Responsible agency: Ministry of Health, National AIDS Control Programme (NACP) (MLTM), municipal offices Funded by: More than US$17 million has been spent on HIV since 2007, with 97% from external sources and 3% from the government. DFID will fund HIV until 2011, while the World Bank has agreed to fund HIV through a pooled funding mechanism (UNGASS, 2010) Time frame: 2007-2011			
National AIDS Policy (1995)	It aims to broaden the scope of HIV/AIDS control efforts in the country to include women, children and young adults, and stresses the need for the support of spouses and children of key populations.	Entire country, with specific focus on high-risk populations and pregnant women; coverage: national	N/A

Table 27: Overview of key child-sensitive social services in Pakistan

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Rural Support Programme (NRSP) Responsible agency: NRSP Funded by: Government of Pakistan and donor consortia Time frame: Completed: 1991 to present			
N/A	NRSP works with more than one million poor households organized into a network of more than 12,000 community organizations, helping the community to identify and financially support activities to address specific needs.	1.4 million rural men and women; coverage: national;	The Punjab Government expanded the NRSP education project into Punjab Education Sector Reform Programme (PESRP). The programme covers 4,335 schools in Punjab.
Programme title: Socio-economic Development of Destitute and Neglected Children's Families (SDDNCF) (sub-segment of the NRSP) Responsible agency: NRSP Funded by: Government of Pakistan and a donor consortia Time frame: November 1st 2008 - October 31st 2011			
N/A	Project components include small-grant assistance for income generation activities; vocational and technical skills training and microcredit support.	10,250 households; coverage: five pilot districts in Punjab	N/A
Programme title: People's Works Programme Responsible agency: Ministry of Labour, and various other ministries Funded by: Government of Pakistan and a donor consortia Time frame: 2001 to present			
Termed the Khushal Pakistan Programme (KPP) and Tameer-e-Watan Programme in the tenures of the Pervez Musharraf and Pakistan Muslim League (PML) governments respectively	Targeting unskilled labour, the main objective is to provide income support to the poorest households through guaranteed employment of up to 100 days in the year.	Eligible labour force, unskilled workers in poor households; coverage: national	Growth of 42% recorded in terms of infrastructure projects initiated. Based on this, the government has announced two schemes that are not yet implemented. A National Employment Guarantee Scheme (NEGS) for the poor and the Graduate Employment Scheme (GES) for graduates in the country.

Table 28: Overview of key child-sensitive social insurance in Pakistan

Source policy/initiative	Brief overview/ specific measures	Target group/coverage	Results/ outcomes
Programme title: Employees Old Age Benefits Institutions (EOBI) Responsible agency: Ministry of Labour Funded by: Employee-funded Time frame: 1976 to present			
Announced in 1967, but introduced in 1976	N/A	Pensioners from government and public sector organizations; coverage: national	N/A
Programme title: Government Servants Pension Fund Responsible agency: Ministry of Labour and Department of Personnel Funded by: Employee-funded Time frame: 1954 to present			
Union Budget 1953/54	N/A	Government servants with 20 years or more work experience; coverage: national	N/A
Programme title: Provincial Employees Social Security Scheme (Employees Social Security Institutions) Responsible agency: Ministry of Labour Funded by: Employee-funded Time frame: 1967 to present			
Introduced in the Union Budget 1964, but operationalised in 1967	N/A	Provincial employees and public-sector employees; coverage: national	N/A
Programme title: Public Sector Benevolent Funds and Group Insurance Responsible agency: Ministry of Labour Funded by: Employee-funded Time frame: 1969 to present			
Planning Commission recommendation to Ministry of Finance and Ministry of Labour, presented in Union Budget 1968	N/A	Public-sector employees; coverage: national	N/A
Programme title: Workers Welfare Funds (WWF) Responsible agency: Ministry of Labour and Department of Personnel Funded by: Employee-funded Time frame: 1971 to present			
Announced in 1969 budget but deferred due to aggression with India. Effective introduction in 1976	N/A	Workers in heavy industry; coverage: national	N/A
Programme title: Workers' Children Education Ordinance Responsible agency: Ministry of Labour and Department of Personnel Funded by: Employee-funded Time frame: 1972 to present			
Announced in 1968 budget but introduced in 1974	N/A	All workers' children eligible for primary and secondary education; coverage: national	N/A

Table 29: Overview of key child-sensitive social assistance initiatives in Pakistan

Source policy/ initiative	Brief overview/specific measures	Target group/coverage	Results/outcomes
Programme title: Benazir Income Support Programme (BISP) Responsible agency: Government of Pakistan Funded by: Government of Pakistan and USAID Time frame: 2008 to present			
The BISP is a new initiative undertaken by the present government	Provides unconditional cash grants to the poorest families in the country. BISP has been initiated with an initial allocation of PRs.34 billion (US$425 million approximately). It is aimed at covering almost 15% of the entire population, which constitutes an estimated 40% of the population below the poverty line.	Widows and divorced women, without adult male members in the family. Any physically or mentally impaired person in the family; any family member suffering from a chronic disease; coverage: national	N/A
Programme title: Child Support Program Responsible agency: Ministry of Social Welfare and Special Education Funded by: World Bank, DFID Time frame: 2006-2010, started as a pilot			
Bait-ul-Maal Act and Programme	N/A	Poor households with children aged 5-12 enrolled in primary school; coverage: in the 2005-06 period, 125,000 households received the benefit.	The programme is projected to scale up by 10% in fiscal year 2008/09; by 30% in 2009/10; by 60% in 2010/11; and by 100% in 2011/12.
Programme title: Pakistan Bait-ul-Maal (PBM) Responsible agency: Ministry of Social Welfare and Special Education Funded by: Government of Pakistan Time frame: 1992 to present			
Under Bait-ul-Maal Act of 1991	N/A	Poor households with young children (5-12 years of age); coverage: in 2008/09, the programme was expanded to districts including Rawalpindi, Multan, Nawabshah, Abbottabad, Kharan, Quetta, Ghanchey and Muzaffarabad	This programme targets the 'deserving needy', but no objective targeting tool (such as proxy means testing) is used. According to the World Bank (2007), "around 27% of *guzara* (monthly cash allowance) beneficiaries and 37% of those receiving rehabilitation grants are not poor, accounting for 32% and 45% of the resources distributed under each modality".
Programme title: Punjab Education Sector Reform Program/Punjab Female School Stipend Program Responsible agency: Ministry of Education Funded by: World Bank, DFID, World Food Programme (WFP) Time frame: 2004 to present			
National Education Policy 2002	N/A	Girls at secondary-school level. Enrolment from grades 6-8 in government girl's schools; coverage: implemented in selected districts of Punjab	Reached 542,259 girls in 2009.

Table 29: Overview of key child-sensitive social assistance initiatives in Pakistan (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/coverage	Results/outcomes
Programme title: Punjab Food Support Scheme (PFSS) Responsible agency: Government of Punjab Funded by: Provincial government with assistance from donor consortia Time frame: N/A			
N/A	N/A	Coverage: Punjab province	The programme drove school enrolment by 11.1%. The average programme impact between 2003 and 2005 was an increase of six female students per school. Female middle-school enrolment rate increased from 43% (baseline 2003) to 53% in 2005. The share of female enrolment in government primary and middle schools increased from 45% in 2003 to 50% in 2005, and female dropout rates between grade 5 and 6 decreased by 25%, and they in middle school decreased by 20%.
Programme title: Zakat Responsible agency: Ministry of Religious Affairs, Ministry of Finance has created a Ministry of Zakat and Ushr in 2009. New governance is unclear Funded by: Government of Pakistan Time frame: 1980 to present			
Central Zakat Council allocates funds to the National Zakat Foundation (NZF)	N/A	The NZF provides grants to NGOs for rehabilitation of widows, orphans and the disabled; coverage: national	N/A

Papua New Guinea

Given that social protection is a fairly nascent area of policy and programming in the country, Papua New Guinea has the most areas of limited social protection coverage, with social assistance and social insurance programming being limited and little legal framework for children affected by HIV. However, legislation is currently being enacted that should support the most vulnerable children and health provisions are substantial. There are very moderate provisions for education and psychosocial support for HIV-affected children, but little in the way of documented results as yet.

Table 30: Overview of social protection for children affected by HIV in Papua New Guinea

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Limited	UNICEF conducted a feasibility study that shows that a cash transfer model would be successful in Papua New Guinea, but programming is currently limited.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Limited	Social insurance excludes short-term workers and non-citizen participation is voluntary.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	ARV access is fairly well developed by the government and the church, but other social services are less available. Mother-to-child transmission prevention services are being scaled up in more antenatal care (ANC) centres. In 2010, 45 of the 270 ANC sites also offered mother-to-child transmission prevention services; 9 of 59 ART treatment sites also offer paediatric HIV services.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Moderate	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	A National Strategic Plan on HIV covers prevention, care and community support and a Child Health Plan addresses health issues such as access to ARV and preventing mother-to-child transmission. In 2010, the Operational Plan for PPTCT (prevention of parent-to-child transmission) and Paediatric AIDS for 2011-15 was approved, containing a framework for action to meet universal access targets by 2015.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Limited	

Key:
Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 31: Overview of key child-sensitive social protection policies and legislation in Papua New Guinea

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Lukautim Pikinini (LP) Act Responsible agency: Office of the Director of Lukautim Pikinini in the Department for Community Development Funded by: Government of Papua New Guinea with support from UNICEF Time frame: Enacted in March 2010			
Lukautim Pikinini Act 2009	Contemporary, rights-based child protection legislation. Prohibits institutional care for orphans and other vulnerable children, and recognizes that those groups need rights-based care. Additionally, while parents have a primary mandate to care, this mandate goes to the state if the parents are unable or unwilling.	All children; coverage: national	No measurable results to date; National Lukautim Pikinini Coucil not yet launched; rolling out of training on the LP Act is underway, with the aim to fully develop mechanisms in 2011. measurable results to date; National Lukautim Pikinini Coucil not yet launched; rolling out of training on the LP Act is underway, with the aim to fully develop mechanisms in 2011.
Programme title: National Child Health Plan Responsible agency: Child Health Advisory Committee (CHAC), within the Department of Health Funded by: Supported by WHO/UNICEF initiatives Time frame: 2008-2015			
N/A	A plan built in response to the WHO/UNICEF Child Survival Study conducted in 2006; implementing the majority of recommendations from the study. It focuses on expanding programme of immunization into rural areas, preventing parent-to-child transfer of HIV, increasing hospital access to ARVs nationwide, and increasing coordination between the national and local levels for Integrated Management of Childhood Illness. High-level programmatic plans for a range of child health issues, including HIV. Detailed information to be collected for monitoring and evaluation, as well as planned trainings. It does not delegate responsibility for monitoring to specific governmental bodies or groups.	Children; coverage: national	N/A

Table 31: Overview of key child-sensitive social protection policies and legislation in Papua New Guinea (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Strategic Plan on HIV/AIDS 2006-2010; National HIV and AIDS Strategy 2011-2015) Responsible agency: National AIDS Council Funded by: N/A Time frame: 2006-2010, 2001-2015			
N/A	High-level strategy from prevention through care and treatment. The majority of the 2006-10 framework focuses on the Papua New Guinea population at large or HIV-infected patients, although the section on family and community does prescribe youth-friendly prevention information. For 2011-2015. The National AIDS council has developed a more comprehensive response framework to minimize the impact on individuals, families and communities, and to increase awareness for children who are vulnerable to sexual exploitation.	General population; some components specifically for HIV-infected citizens or HIV-affected communities; coverage: national	N/A
Programme title: Protection, Care, and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in Papua New Guinea (2008 -2011) or Protection for Vulnerable Children Strategy Responsible agency: Department for Community Development, Government of Papua New Guinea Funded by: N/A Time frame: 2008-2011			
Protection, Care, and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in Papua New Guinea (2008-2011) or Protection for Vulnerable Children Strategy	High-level policy document, detailing the current situation of vulnerable children within the context of HIV in Papua New Guinea, and also enumerating policy objectives and strategies to meet them. It advocates piloting a social cash transfer programme for the most vulnerable families, and making the formal alternative care system more restricted and child-friendly.	Most-vulnerable children; coverage: national	N/A

Table 32: Overview of key child-sensitive social services in Papua New Guinea

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Most Vulnerable Children Programme Responsible agency: Catholic Diocese of Kundiawa Funded by: Catholic Church with funding from UNICEF (broader HIV and AIDS programmes funded by Australian Agency for International Development, AusAID) Time frame: N/A			
N/A	Members of the church monitor households with HIV-positive parents, and provide support as necessary. Support may include school fees, childcare if parent dies, etc. All volunteer-based. Community awareness to help combat the social stigma of HIV. Care provided to children done in a stigma-sensitive manner. Case-management care includes any measures needed for the patient to have sustainable care: i.e. transportation assistance, water purifying mechanisms, etc.	Children of HIV-infected parents; coverage: sections of the Simbu Province (not fully documented)	Does not appear to have any formally documented results. However anecdotal evidence shows the programme has been successful in providing support for children while avoiding the social stigma often caused by HIV-related social support.
Programme title: Rural Initiative Program Responsible agency: Pilot programme commissioned by the Department of Health; implemented by the Clinton Foundation Funded by: AusAID Time frame: Operating since 2007 (received extension through Global Fund 2010, end date unknown)			
Self-directed	The pilot programme aimed to build a model for providing access to high-quality HIV testing, care and treatment to rural areas in Papua New Guinea. The programme focuses on providing total care to patients by training health extension officers (HEO) in case management and providing support in secondary aspects to treatment, such as stipends for transportation, rain water catchment units to purify water, micro-loans for food or income generating activities to mitigate the economic impact of HIV-related stigmas.	HIV-infected population in the Eastern Highlands; coverage: Eastern Highlands; the programme is being expanded to the Southern Highlands	Opened the first government operated District Health Centre ARV Clinic in Papua New Guinea, followed by many others. Improve paediatric care: from 1 patient on ARV in January 2007, numbers have increased to 60 positive children in care and 35 on treatment by October 2009; scaled-up HIV testing and HIV services in the context of primary health care, TB and STI detection and treatment, and Women's Health Care in the capital and in the pilot district; improved quality and quantity of adult testing, care and treatment at Provincial Hospital.

Table 33: Overview of key child-sensitive social insurance in Papua New Guinea

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Superannuation program Responsible agency: Department of Labour and Industry Funded by: Funds contributed solely by employee and employer Time frame: 2002 - present			
Superannuation Amendment Act of 2002	Government mandated insurance programme for all employees of companies with 20 or more personnel. The programme provides old-age, disability and survivor insurance, with limited health care benefits also covered at government clinics, with a nominal co-payment.	General working population; all employees of firms with over 20 employees; participation for non-citizens is voluntary; short-term workers employed by a firm for three months or less are excluded; coverage: national	N/A

Table 34: Overview of key child-sensitive social assistance initiatives in Papua New Guinea

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Cash Transfers to Improve the Protection and Care of Vulnerable Children and to Empower Families in the Context of the HIV Epidemic in Papua New Guinea Responsible agency: Department for Community Development, Institute of National Affairs, UNICEF Funded by: UNICEF Time frame: Study conducted and published in 2008			
However, references plan for a pilot cash transfer programme in the National Strategy for the Protection, Care and Support of Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in Papua New Guinea	Feasibility study which analyses the compatibility of societal and political structures, and the cultural and economic environment of Papua New Guinea with a social cash transfer programme. Findings indicate that the patterns of poverty, HIV, and child abuse in Papua New Guinea all lend themselves to a cash transfer programme.	Orphans and other vulnerable children; vulnerable women; coverage: recommends focusing on Highlands regions	Recommends developing an evidence-based social cash transfer programme targeted at geographic areas with high concentrations of women caring for vulnerable children. Expected roll out of a cash transfer programme in 2012.

Thailand

Thailand has the most extensive social protection provisions in place for HIV-affected children out of the countries reviewed. However, there are limited employment and livelihood opportunities for chronically ill caregivers. In the region, Thailand has the most explicitly stated rights of access for vulnerable children to essential services.

Table 35: Overview of social protection for children affected by HIV in Thailand

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	Social assistance provision has been devolved to local and regional governments. An array of local-level initiatives have emerged which are focused on providing targeted subsidies to households.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Substantial	Social security covers 20% of the population and coverage for the remainder was a priority of the 9th Economic and Social Development Plan. New initiatives to address the informal population have been piloted.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Extensive	There is Long-Term Policy and Strategy for Early Childhood Development, providing programmes for infants. More than 96% of the population has access to universal health care.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Extensive	The Child Protection Act is designed to protect all children from discrimination and ill-treatment in all social contexts, including health. The constitution guarantees women's and children's rights to all Thai citizens.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Extensive	

Key:
Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 36: Overview of key child-sensitive social protection policies and legislation in Thailand

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Constitution Responsible agency: Government of Thailand Funded by: Government of Thailand Time frame: 1997 and 2007			
National Constitution 1997, 2006 and 2007	The Constitution guarantees women's and children's rights to protection, assistance, livelihood and access to the minimum resources to live adequately. Basic rights of youth and children, and the state's obligation to uphold these rights are integrated into the Constitution.	All Thai citizens, regardless of age, gender, social and health status, and other discriminating criteria; coverage: national	Community-based and locally-implemented initiatives are encouraged and supported by central authorities to best fill gaps in national/central planning, especially concerning poor and vulnerable children (children living and working on the street, migrants, HIV -infected/affected, sexually abused or trafficked children).
Programme title: Child Protection Act Responsible agency: Ministry of Interior, Ministry of Social Development and Human Security, Ministry of Education and Ministry of Justice Funded by: Ministry of Finance through the Child Protection Fund Time frame: Drafted in 1994, adopted in 2003			
Child Protection Act, B.E. 2546 (2003)	Designed to protect all children from discrimination, ill-treatment and violence, and to enforce their well-being in all social contexts (education, adoption, health, etc.). The Child Protection Act led to the creation of a National Child Protection Committee, which has the authority to carry out any tasks related to social welfare, safe protection and promotion of the behaviour of the child.	All children including orphans, street children, disabled children, vulnerable/at-risk children, children in 'difficult circumstances', trafficked children, sexually abused children, neglected children, etc.; coverage: national	One of the most significant results of this Act is the introduction of the Child Protection Committees at the provincial level to develop locally relevant policies.
Programme title: Long-term Plan for Development of Children and Youth (2002-2011) Responsible agency: Government of Thailand Funded by: Government of Thailand Time frame: 2002-2011			
National Children and Youth Development Plan (1982-2002)	The plan aims to streamline all initiatives pertaining to the environment and the well-being of children. It recognizes children in difficult situations as a focus group for social assistance.	All children in Thailand, with a special focus on HIV/AIDS-impacted children; coverage: national	The monitoring and evaluation framework for the plan implementation is under preparation.
Programme title: Child Friendly School (CFS) Initiative Responsible agency: Ministry of Education and UNICEF Thailand Funded by: Ministry of Education and UNICEF Thailand Time frame: Launched in 1999			
1990 Declaration on Education for All (EFA) agreement and 1990 Convention on the Rights of the Child	Enforces education programmes and policies where children are at the centre. The initiative led to the transformation of schools so that they are child-friendly, inclusive, healthy and safe for children's emotional, psychological and physical well-being, equal and actively engaged with communities.	All children from poor backgrounds. In 2008, UNICEF estimated that there were 1,400 participating schools in 25 priority districts.	Development of practices allowing all children (especially vulnerable ones) to benefit from a quality education adapted to their needs.

Table 36: Overview of key child-sensitive social protection policies and legislation in Thailand (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Policy and Strategy on the Prevention of Sexual Exploitation of Children in the Tourism Industry Responsible agency: Government of Thailand Funded by: Ministry of Tourism and Sports, Ministry of Justice, Ministry of Immigration, the Tourist Police and civil society groups Time frame: Launched in 2002			
Child Protection Act (2003)	Designed to protect all vulnerable people from being sexually exploited or abused. Key areas of protection, prevention and sanction are addressed.	All people potentially exploitable; the government estimates the number of women employed in prostitution to be between 150,000 and 220,000. There are no clear estimates for the number of children involved; coverage: national	Over the past 10-15 years better living conditions and better education have led observers to see declines in the number of children being sexually exploited.
Programme title: Long-Term Policy and Strategy for Early Childhood Development (2007-2016) Responsible agency: Ministry of Education, Ministry of Social Development and Human Security, Ministry of Public Health and Ministry of Interior Funded by: Ministry of Education, Ministry of Social Development and Human Security, Ministry of Public Health and Ministry of Interior Time frame: 2007-2016			
National Education Act (1999), Agenda for Children and Youth (January 2007) and National Scheme of Education (2002 -2016)	Provision of quality early childhood development institutions, child development centres and kindergartens. One of the policy's main objectives is to ensure infants are given as much programmatic attention as children and youth.	Children aged 0-5 years old, parents, family members, would-be parents and those directly involved in the provision of childcare services; coverage: national	N/A

Table 37: Overview of key child-sensitive social services in Thailand

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Fourth Development Plan for Children and Youth Living in Remote Areas (2007-2016) Responsible agency: Ministry of Education Funded by: Ministry of Education and the Royal Projects Fund Time frame: 2007-2016			
Long-Term Policy and Strategy for Early Childhood Development (2007-2016)	The plan focuses on six inter-related objectives, one of which is women and children's health, nutrition, education and vocational training. The plan promotes increased educational opportunities for all, develops the academic potential of individuals, and provides relevant skills and training.	Women and children; coverage: remote rural areas	To date a total of 711 schools are involved in the project.

Table 37: Overview of key child-sensitive social services in Thailand (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Universal Health Care coverage system Responsible agency: Ministry of Public Health Funded by: The bulk of funding comes from public revenues (65% in 2004) Time frame: Launched in 2001			
National Health Security Act B.E. 2545 (2002)	Originally known as 'the 30 baht project', in line with the small co-payment charged for treatment, the universal health care system was designed to replace means-tested health care for low income households with a new and more comprehensive insurance scheme. In 2006 the 30 baht co-payment was abolished and the UC scheme was made free. The system is intended to provide equal access to quality care regardless of income or socio-economic status.	Low income households; coverage: national	The system has proved popular with poorer Thais, especially in rural areas and survived the change of government after the 2006 military coup. In 2005 some 95.6% of the population was covered by the scheme. The remaining 4.4% were not covered because of a lack of awareness, absence of an identification card, and/or incorrect housing registration.
Programme title: Tonkla-Archeep skills training programme Responsible agency: Ministry of Labour and Social Welfare Funded by: Government of Thailand Time frame: Launched in March 2009			
N/A	A mechanism developed for job creation in direct response to the recession of 2008-2009.	Unemployed and new graduates; coverage: national	Trained more than 200,000 unemployed people and re-employed 140,000.

Table 38: Overview of key child-sensitive social insurance in Thailand

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Social Security Responsible agency: Ministry of Labour provides general supervision, the Social Security Office collects contributions and pays benefits, medical benefits are delivered by hospitals contracted by the Social Security Office Funded by: Social security contributions are made at the same rate proportionate to the salary base Time frame: 1990 (revised in 1994 and 1999)			
Social Security Act B.E. 2533 (A.D.1990)	Formally employed workers and their dependants benefit from social insurance and livelihood support in case of work injury, disability, death, maternity, etc. The Social Security Fund (SSF) was introduced in 1991 to cover life-time contingencies like non-work related sickness, invalidity, death or maternity of the private employees, and gradually expanded to include the benefits of child allowance (1998), old-age pension (1998) and unemployment (2004).	Employees of the formal sector aged 15 to 60; coverage: national	Between 1998 and 2004, old age, child support and unemployment benefits were added to the Social Security Act B.E. 2533. Among other priorities, the scheme extends social security coverage to the informal economy through a mechanism for voluntary self insurance, as per the 9th Economic and Social Development Plan.

Table 39: Overview of key child-sensitive social assistance initiatives in Thailand (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Community-level social assistance Responsible agency: Community Organizations Development Institute (CODI) Funded by: Government of Thailand. Funds delegated to sub national level Time frame: N/A			
N/A	These are made available to communities in various ways, amongst which the most child-sensitive are: scholarships and loans for school fees; grants for medicines and hospital fees; revolving fund loans for income generation activities for very poor families; the establishment of child development and day-care centres, and funding for community playgrounds. Grants have also been disbursed to provide support and build shelters for PLWHA.	Coverage: sub-national, rural and urban	The majority of social assistance initiatives target medium- to long-term development objectives at the community level.
Programme title: Baan Eur Arthorn and Baan Mankong housing schemes Responsible agency: National Housing Authority (NHA), CODI Funded by: Government of Thailand Time frame: Launched in 2003			
N/A	The programme set out to build 600,000 units and upgrade another 300,000 units.	Households with a monthly income lower than THB15,000 (US$500); coverage: national	Another 100,000 units were assigned to the Government Savings Bank (GSB) for the provision of direct financial support.
Programme title: 15-Year Free Education Policy Responsible agency: Ministry of Education Funded by: The government distributes its funds to all schools nationwide. Schools then manage the funds themselves (THB18 billion for 2009) Time frame: Launched in May 2009			
National Education Act (1999) and Policy statement presented to Parliament in December 2008	Aimed at reducing the financial burden of parents and enabling children to have equal access to quality education. It provides all children with access to 15 years of cost-free education, from kindergarten to secondary education.	Children; coverage: national	The fund covers the costs of tuition fees, textbooks, uniforms, education tools and materials, and school activities. Only the money for uniforms is directly received by parents (two uniforms a year). 12 million students benefit from the 15-year free education policy.

Viet Nam

Like other countries in the region, Viet Nam offers little in the way of employment and livelihood initiatives for chronically ill caregivers, but other social protection offerings are well developed. The legal framework for protection of children affected by HIV is particularly strong, with government attention given to the Law on Child Protection, Care and Education.

Table 40: Overview of social protection for children affected by HIV in Viet Nam

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Moderate	A national cash transfer decree is hindered by the weak capacity of local social welfare agencies, a limited awareness and the stigma associated with seeking aid.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Substantial	Approximately 35% of the total population are members of the national Social Health Insurance.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	National policies ensure free primary education for all and free health insurance for vulnerable people including children under the age of six.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Substantial	Viet Nam's Law on HIV/AIDS Prevention and Control is considered a landmark because it gives people living with HIV the right to employment, education, and health care, and forbids stigmatization.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Extensive	

Key:
Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 41: Overview of key child-sensitive social protection policies and legislation in Viet Nam

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Family Strategy Responsible agency: N/A Funded by: N/A Time frame: Issued May 16th, 2005			
Prime Minister Decision 106/2005/QĐ – TTg	Created to address the gap in support for vulnerable children and families.	Poor families and families with children at risk of becoming vulnerable children	N/A
Programme title: Five-year national Social Protection Strategy Responsible agency: At the end of 2009, the strategy had not been finalised Funded by: N/A Time frame: N/A			
N/A	The strategy serves as a legal framework providing national standards and rules, guiding the development of national policies and programmes in response to specific issues regarding poverty reduction, social insurance, health insurance, education for vulnerable children and child protection.	N/A	N/A
Programme title: Implementation of the Law on the Protection, Care and Education of Children Responsible agency: Finance Ministry and the Planning and Investment Ministry Funded by: N/A Time frame: Enacted in 2005			
Decree No. 36/2005/ ND-CP	Enacted to address the fact that children's issues were not given explicit space in the annual budget. The law mandates that the Finance Ministry and the Planning and Investment Ministry ensure that child protection, care and development are incorporated into annual and long-term socio-economic development funds. As well as building mechanisms to 'mobilize funding sources' for such activities.	N/A	N/A
Programme title: Law on Child Protection, Care and Education Responsible agency: None directly, specifies responsibilities for different agencies under child protection, with Ministry of Labour – Invalids and Social Affairs (MOLISA) as the lead Funded by: N/A Time frame: First enacted in 1990; amended in June 2004			
Decree No. 25/2004/QH11	Defines 'children in special circumstances' (CSC), which is used through other programming to direct special attention to vulnerable children. CSC as is defined by the law includes (but is not limited to) children affected by HIV.	Children; coverage: national	Anecdotal evidence suggests that enforcement of some children's rights remains weak.

Table 41: Overview of key child-sensitive social protection policies and legislation in Viet Nam (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National strategy on HIV/AIDS prevention and control in Viet Nam until 2010 with a vision to 2020 Responsible agency: None directly; however, the Viet Nam Administration for AIDS Control (VAAC) is the primary implementer Funded by: N/A Time frame: 2004-2010			
Prime Minister's Decision 36/2004/QD-TTg	The priorities of the overall programme are prevention via an expanded informational campaign, aimed at changing risky behaviours, expanding interventions to mitigate the medical and psychosocial affects of the disease; improving counselling, care and treatment for those infected; and strengthening programme management and monitoring and evaluation of activities.	General population; coverage: national	Coverage of ARV treatment has improved; from 18.1% in 2006 to 54% (for adults) in 2009 with an HIV prevalence rate, of less than 0.3%
Programme title: National Plan of Action for Children (NPAC) and AIDS Until 2010, with a vision to 2020 Responsible agency: MOLISA Funded by: Government of Viet Nam Time frame: 2009-2010			
N/A	Details high-level strategies for improving services for children in relation to HIV on all aspects: prevention, care and treatment, as well as support for children affected by HIV.	General population; coverage: national	N/A
Programme title: The Law on HIV/AIDS Prevention and Control 64/2006/QH11 (Law on HIV) Responsible agency: N/A Funded by: N/A Time frame: Enacted in 2006			
N/A	The law on HIV Is considered a landmark legislation because it gives people living with HIV and AIDS (PLWHA) the right to employment, education and access to health care services. The law prohibits placing a stigma on PLWHA, people suspected of having HIV or those associated with them.	General population; coverage: national	N/A

Table 42: Overview of key child-sensitive social services in Viet Nam

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Plan of Action for Children affected by HIV and AIDS (NPAC) Responsible agency: Ministry of Labour, Invalids, and Social Affairs (MOLISA), houses coordinating committee, made up of MOLISA, Ministry of Education and Training (MOET), Ministry of Health and other stakeholders Funded by: Government of Viet Nam; Time frame: 2009-2010			
NPAC	Information on programmatic activity only available via the NPAC: Aims to increase access to, and availability of, quality health and education services for children affected by HIV. Sets the target of 70% of adult HIV care clinics offering paediatric diagnosis, care, and treatment by the end of 2010. Also plans to train health care officials in schools and community-based organizations to identify the signs of HIV-affected children and refer them to the appropriate social services facilities. Aims to train local NGOs to provide home-based care and nutritional guidance to children living with HIV. In addition, it includes an information and education campaign.	General population; coverage: national	The 2010 Viet Nam National Composite Policy Index (NPCI) report is the only evaluative information available, which says: "Operational models for the implementation of the National Programme of Action, especially community-based models have not been fully developed or disseminated."
Programme title: National programme on free health insurance for vulnerable people, including children under six Responsible agency: Ministry of Health (MoH) Funded by: Government of Viet Nam; Time frame: N/A			
Law on the Protection, Care and Education of Children (Article 15.2)	Orphans and vulnerable children under six years old have access to free medical care according to the general regulation on the free medical examination and treatment of children under six.	Children under six; coverage appears national	Due to limited funding, difficulty of assessing eligibility and lack of awareness of the programme, people are not always able to access free services through this programme and others.
Programme title: National programme on free primary education for all children Responsible agency: Ministry of Education Funded by: Government of Viet Nam; Time frame: N/A			
Law on Protection, Care and Education of Children (Articles 16, 28)	Provides financial support to local schools to ensure that all children are able to attend primary school.	Primary school-aged children; coverage appears national	Universalization rates achieved in 2005; literacy rates increased to 94.5% among youth. However secondary-analysis suggests that many families still have to pay indirect costs for education, and that poor areas lack quality facilities and teachers.

Table 42: Overview of key child-sensitive social services in Viet Nam (continued)

Programme title: National Targeted Programme on Poverty Reduction (NTPPR), 2006-2010 Responsible agency: Ministry of Labour, Invalids, and Social Affairs (MOLISA), housing the Government Steering Committee for implementation of the national target programme on poverty reduction period 2006-2010 Funded by: Government of Viet Nam, with minor support from international donors Time frame: 2006-2010			
Prime Minister Decision No: 20/2007/QD-TTg	Vast poverty reduction initiatives that include activities spanning nearly all sectors of social protection. The focus is on vocational training and capacity building for income-generating activities, supporting construction of essential infrastructure, exemption or reduction in school fees for poor families, support for poor households to gain access to clean water and legal assistance for the poor.	Poor households. With priority given to poor households with a female head, of ethnic minorities, or with children with 'special circumstances'; coverage: national	The programme's predecessor, the National Target Programme on Hunger Eradication and Poverty Reduction 2001-2005, was reported by the government to have reduced the rate of poor households from 17.2% in 2001 (2.8 million households) to 8.3% in 2004. For the NTPPR the government has identified remaining 1.1 million poor households to be supported by the programme (7%). No results were available for the NTPPR. No third-party mechanism to verify government results.

Table 43: Overview of key child-sensitive social assistance initiatives in Viet Nam

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Cash transfer programme for vulnerable children (no official name given; typically referred to as 'cash transfer programme from Decree 67'			
Responsible agency: Ministry of Labour, Invalids, and Social Affairs (MOLISA) Funded by: Government of Viet Nam; information is unavailable on whether international donors also contribute Time frame: Established in 2007			
Decree 67/2007/ND-CP	Provides subsidies of up to D540,000 – an unconditional cash transfer – to families supporting children labelled vulnerable due to a range of issues, including children orphaned by HIV/AIDS, and children deprived of, or missing, one parent. The programme specifies different minimum levels of funds that are to be provided for families depending on where the child is housed: a commune, a ward, a social protection centre, etc. Information was not available on the mechanisms for identifying beneficiaries or for delivery.	Vulnerable children; coverage: appears to be national	The only information available on results is from the 2010 NCPI report: "The effective implementation of Decree 67 is hindered by the weak capacityof local social welfare agencies, awareness of the decree, limited monitoring of its implementation and stigma and discrimination preventing those in need from accessing the support."

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