HIV/AIDS AND WORKING CHILDREN IN NEPAL

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with
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Through the United Nations' General Assembly Special Session (UNGASS) on HIV/AIDS, His Majesty's Government of Nepal committed itself to the following measures to protect children orphaned and made vulnerable by HIV/AIDS:

By 2003, develop and, by 2005, implement strategies for creating supportive environments for orphans, girls and boys infected and affected by HIV/AIDS by providing: counseling and psychosocial support; enrolment in school; access to shelter; good nutrition; health and social services; and protection from abuse, violence, exploitation, discrimination, trafficking and loss of inheritance (Para. 65)

Ensure non-discrimination and protection of the human rights of children orphaned and made vulnerable by HIV/AIDS, through the promotion of an active and visible policy of de-stigmatization (Para. 66)

Urge donor countries, civil society and the private sector to complement national programmes to support children orphaned by, or made vulnerable to, HIV/AIDS (Para. 67)*

HIV/AIDS is the greatest epidemic that the world has ever faced. Today, 42 million people are infected, and the disease is moving quickly through all populations. There are no safe havens that we can retreat to; we must confront this challenge together. As Secretary General Kofi Annan has stated, "We must make people everywhere understand that the AIDS crisis is not about a few foreign countries, far away. This is a threat to an entire generation; this is a threat to an entire civilization."

We at the International Labour Organization have recognized that people of working age are most vulnerable to infection by HIV/AIDS. Building on our strong and historic partnerships with government, trade unions, and employers’ councils, we are taking action. We have already invested in social protection mechanisms, such as health micro-insurance schemes through the ILO/STEP programme. Health micro-insurance schemes provide some support in the form of health awareness and protection for family members, should they fall ill. We are also developing HIV/AIDS education programmes especially suited for the workplace.

One of every three children in Nepal is economically active, and many of these children are engaged in hazardous work in mines, quarries, and carpet factories. The ILO/IPEC Time-Bound Programme aims to remove children from the seven worst forms of child labour and to provide them with opportunities for education, health care, legal protection, sports and recreation. We took the initiative of commissioning this report because of the need to respond to emerging threats to working children in Nepal. The same factors that make children vulnerable to becoming involved in exploitive child labour-poverty and discrimination-make them vulnerable to HIV/AIDS infection. In addition, we are concerned about children ending up in the worst forms of child labour as a means of survival, as adults become ill from HIV/AIDS, and are no longer able to provide for their families.

There are no easy answers, but there are lessons learned from countries that have already been hard hit by HIV/AIDS. For example, we should respond to HIV/AIDS in the context of improving health care in general. We need to recognize that young people have an important role to play as HIV/AIDS peer educators, and we need to build HIV/AIDS and life skills into the national curriculum. Above all, we must not wait for more research before we take action. We must move now to protect Nepal’s children and youth.

Leyla Tegmo-Reddy
Director
International Labour Office in Nepal
Preface

HIV/AIDS is also a threat to working children along with youth everywhere-including Nepal. Poor children and youth are vulnerable to exploitation at the hands of their employers, including sexual abuse. In Nepal, the threat of HIV/AIDS to working children and youth is compounded by the phenomenon of trafficking of both girls and boys for sex, and for labour. We can only imagine the misery of these children, separated from their families and communities, living on their own in a foreign land.

The National Center for AIDS and STD Control of His Majesty’s Government of Nepal is committed to mobilize the necessary resources to protect the nation’s children and youth from HIV/AIDS. We recognize the increased vulnerability of youth who are not attending school, and who have little access to information about how HIV/AIDS is transmitted, and how they can protect themselves. We understand the special needs of girls and young women, and the importance of employing peer educators to reach significant numbers of youth with information about HIV/AIDS that is both accurate and credible. The late Dr. Jonathan Mann of the Global Programme on AIDS often stated that “AIDS is everyone’s business.” We believe that all sectors of society must take up the challenge of confronting HIV/AIDS, including youth leaders, coaches, and teachers. We must work together, in a coordinated and strategic manner, to protect Nepal’s youngest citizens.

In an important report ILO/IPEC has made clear that “the HIV/AIDS pandemic poses a particular challenge for the elimination of child labour, and constitutes a real threat to the significant results achieved so far in the worldwide fight against child labour”. The Time-Bound Programme aims to eliminate the worst forms of child labour in Nepal, including trafficking in children. For real progress to be made in combating child labour, real progress must also be made in defeating HIV/AIDS.

I welcome this report on HIV/AIDS and Working Children in Nepal, the first of its kind in South Asia, as an important step in identifying the challenges that we face, and in delineating our priorities for action.

Dr. Ram Prasad Shrestha, MD
Director, NCASC
Table of Contents

Prefaces iii
Executive Summary ix
Acknowledgements xiii
Abbreviations xiv

1. Introduction 1
   1.1 Background 1
   1.2 Purpose, Development and Structure of the Report 2

2. HIV/AIDS in Nepal 4
   2.1 Nepal’s HIV Epidemic 4
      2.1.1 Risk Behaviour Among Young People 4
      2.1.2 Potential for a Rapid Spread of HIV/AIDS in Nepal 5
   2.2 Nepal’s Response to HIV/AIDS 6

3. HIV/AIDS and Nepal’s Working Children 7
   3.1 HIV/AIDS and Children 7
   3.2 HIV-Affected Children and Labour Market Entry 7
   3.3 Working Children and HIV/AIDS 10
   3.4 HIV/AIDS and the Worst Forms of Child Labour in Nepal 13
   3.5 Understanding Vulnerability to HIV/AIDS Among Working Children 14
   3.6 HIV+ Working Children 15

4. Programming for HIV-Affected and Working Children 16
   4.1 Rationale for Involvement of the ILO/IPEC Nepal Time-Bound Programme 16
   4.2 HIV/AIDS and Working Children: A Programming Framework 17
   4.3 Intervention and Partnership Options 19
      I. Enabling Environment for HIV/AIDS and Working Children 20
      II. Prevention of Child Labour Among AIDS-Affected Children 21
      III. HIV/AIDS and Working Children – Prevention and Care and Support 27

5. Conclusion 35

Appendix A: Policy, Coordination and Institutional Recommendations 36
Appendix B: Programme Principles for Orphans and Vulnerable Children 37
Appendix C: ILO/IPEC Nepal Time-Bound Programme’s Objectives 38
Appendix D: Bibliography 39
Appendix E: List of Interviewees 43
There is a growing body of evidence suggesting that in Nepal (1) increasing numbers of children are being driven into the labour market by the HIV infections and deaths of their parents, and (2) that working children have a high risk of contracting HIV. This growing double scenario of Nepali children affected by the HIV infections and deaths of their parents (HIV-affected children), and children who are at risk of infection or are already infected (HIV-infected children), poses a challenge to child labour programming.

Given the current HIV/AIDS situation in Nepal, and the knowledge of the links between HIV/AIDS and child labour, it can be assumed that the following outcomes are likely to occur in Nepal over the coming years:

- Increasing numbers of children will enter the labour force as a result of their HIV infected parents who are sick, or who are already dead.
- Increasing numbers of children will leave school due to family impoverishment caused by HIV and the requirement to earn a living, as well as stigma and discrimination.
- Increasing numbers of child-headed households (CHH).
- A disproportionate burden of care for ill parents and younger siblings will be placed on girls. Also, in as much as groups marginalized by gender, ethnicity and caste are disproportionately represented in the worst forms of child labour, so too will they have a disproportionate risk of HIV infection.
- Increasing stress will be placed upon extended families and communities to care for the growing number of HIV-affected children.
- Increasing numbers of children will migrate from their communities in order to both earn a living and escape community stigma and discrimination.
- HIV will infect increasing numbers of child labourers, particularly those in some of the worst forms of child labour.
- Health and social services (given their current level of function) will be unable to meet the needs of increasing numbers of working children who are HIV+.

While there is limited statistical evidence in Nepal to support these assumptions, it should be stated that evidence from other countries indicates that there is a link between HIV/AIDS and child labour. Currently, the National HIV/AIDS Strategy does not address this issue. This leaves Nepal unprepared should there be (1) a rise in the numbers of HIV-affected children or (2) a rise in the number of working children vulnerable to HIV/AIDS or HIV+. Given the experience of other countries and the growing empirical evidence in Nepal, developing a programming response should not be delayed to allow for more study, though further research should be a part of the response.

The following recommendations, which are placed throughout the body of the report, are intended to provide ILO/IPEC Nepal with programming directions and options.
Rationale for Involvement of the ILO/IPEC Time-Bound Programme:

Recommendation 1: That the ILO/IPEC Nepal Time-Bound Programme include within its Immediate Objectives the following words or intention: "At the end of the Time-Bound Programme, the local capacity to protect and enhance the well-being of working children will be enhanced in targeted sectors/districts." The well-being of working children should include, but not be limited to, promotion of safer/healthier working environments, access to food and shelter, access to legal assistance, and access to health and social services.

Recommendation 2: With regard to integrating HIV/AIDS programming into the ILO/IPEC Nepal Time-Bound Programme, there is a need to extend programming to working children who are not in a "worst form of child labour" but face an equal or greater risk of HIV infection.

Recommendation 3: With regard to integrating HIV/AIDS programming into the ILO/IPEC Nepal Time-Bound Programme, the primary focus of programming partnerships should be NGOs and CBOs.

HIV/AIDS and Working Children: A Programming Framework:

Recommendation 4: That HIV/AIDS and working children programming begin with the acceptance of working children as autonomous beings, and that any interventions to reduce high risk sexual and drug-using behaviour be based upon an acceptance and respect for this autonomy.

Recommendation 5: That the ILO/IPEC Nepal Time-Bound Programme, through mainstreaming HIV/AIDS into its relationships with tripartite partners and delivery partners and programmes, takes leadership in building awareness and coordination on HIV/AIDS and working children, as well as supporting the development of specific programming.

Enabling Environment for HIV/AIDS and Working Children:

Recommendation 6: The ILO/IPEC Nepal Time-Bound Programme should develop its relationship with the NCASC in order to ensure that a child labour dimension is integrated into the National HIV/AIDS Programme, including access to both prevention, and care and support services by all working children. It should also encourage its HMG/N partners to work together with the NCASC, on a multisectoral approach to HIV/AIDS and working children.

Recommendation 7: The ILO/IPEC Nepal Time-Bound Programme should mainstream HIV/AIDS prevention and care and support into its relationship with partners, and its existing/planned programming.

Prevention of Child Labour Among AIDS-Affected Children-Strategies for Community-Based Solutions

Recommendation 8: Any efforts to protect AIDS-affected children from child labour must be built upon a foundation of aware, supportive and mobilized communities. These efforts should be integrated into existing community structures, using familiar methodologies.

Recommendation 9: The development of programming options for orphans and vulnerable children should be done primarily through building community capacity. This programming should be accessible to all community orphans and vulnerable children whether or not they are AIDS-affected.

Recommendation 10: Where possible, an HIV/AIDS and working children’s perspective should be built into appropriate existing and planned programming, particularly in the areas of HIV/AIDS, community development, migration and trafficking. Affected families and children should play the leading role in determining the needs and programming options for orphans and vulnerable children.
Recommendation 11: The best place for orphans and vulnerable children is within their communities and (extended) families. The priority for programming should be to support communities and families so they can care for their children. Community-based foster parenting should be investigated as a care option. Institutional care should be seen as a temporary solution, or a last resort.

Prevention of Child Labour Among AIDS-Affected Children-Social Risk Management:

Recommendation 12: Micro-health insurance schemes should be piloted in communities with an assumed higher incidence of HIV/AIDS (i.e. western districts with high rates of male migration to India). Such schemes should include HIV/AIDS/STD health promotion and treatment coverage for the standard HIV/AIDS opportunistic infections and pain management. Efforts should also be made to investigate the benefits of integrating these schemes with community-based HIV/AIDS care and support initiatives, as well as STD programmes.

Prevention of Child Labour Among AIDS-Affected Children-District Child Welfare Boards:

Recommendation 13: District Child Welfare Boards (DCWB) should be the natural advocates for HIV/AIDS and working children at the district level. There is also an opportunity for them to coordinate their work with that of the District AIDS Coordinating Committees (DACC). For these benefits to occur, the DCWBs must be mobilized and supported.

HIV/AIDS and Working Children-Research Needs:

Recommendation 14: That the ILO/IPEC Nepal Time-Bound Programme advocate for a consortium of street-based working children NGOs in Kathmandu to conduct a qualitative Behavioural Surveillance Survey (BSS) of street-based working children. This BSS should be undertaken in compliance with standards recognized by UNAIDS; the resulting findings should form the basis for HIV/AIDS prevention programming.

Recommendation 15: That the ILO/IPEC Nepal Time-Bound Programme support a series of pilot projects with partners to develop programming approaches to working children at risk of HIV infection and working children who are already HIV+.

HIV/AIDS and Working Children-Building Alliances and Networks:

Recommendation 16: That the ILO/IPEC Nepal Time-Bound Programme facilitate the development of an alliance of organisations offering frontline services to working children. Such an alliance should first be attempted in an urban centre, and initially with street-based working children.

HIV/AIDS and Working Children-Health And Social Service Needs:

Recommendation 17: That the ILO/IPEC Nepal Time-Bound Programme, starting in selected urban centres, advocate and facilitate the development of coordinated and interlocked networks of health, counselling and support services for working children. As required, the ILO/IPEC Nepal Time-Bound Programme should support limited pilot projects to investigate different programming approaches.

HIV/AIDS and Working Children-Education and Skills Development:

Recommendation 18: That the ILO/IPEC Nepal Time-Bound Programme facilitates the development and integration of non-formal education, formal schooling, job training and placement, apprenticeship, and business development services into a network of services for working children.

HIV/AIDS and Working Children-Peer Education and Youth Networks:

Recommendation 19: That the ILO/IPEC Nepal Time-Bound Programme looks for opportunities to support peer education and child/youth networks for the prevention of HIV/AIDS among working children. In addition, the Time-Bound Programme should also look
for opportunities to involve working children in the implementation of programming.

**HIV/AIDS and Working Children-Street-Based Working Children**

Covered by several previous recommendations.

**HIV/AIDS and Working Children-Invisible/Isolated Working Children**

**Recommendation 20:** That the ILO/IPEC Nepal Time-Bound Programme look for opportunities to support specific programming for child domestic workers and factory workers, paying particular attention to the risks of sexual abuse and exploitation faced by girl workers and their easy shift into commercial sex work.

**Recommendation 21:** That the ILO/IPEC Nepal Time-Bound Programme determine whether it should become involved in specific HIV/AIDS programming for child and youth commercial sex workers.

**Recommendation 22:** That the ILO/IPEC Nepal Time-Bound Programme consider a special public awareness focus on child domestic workers, given their employers possible susceptibility to pressure and public perceptions.

**HIV/AIDS and Working Children-Sector-Based Working Children:**

**Recommendation 23:** That the ILO/IPEC Nepal Time-Bound Programme advocate for a working child perspective to existing HIV prevention and labour programmes for specific sectors such as portering.

**Recommendation 24:** That the ILO/IPEC Nepal Time-Bound Programme look for opportunities to integrate a child labour perspective into child trafficking prevention and "safe migration" projects.
This report is an attempt to provide the ILO/IPEC Nepal Time-Bound Programme on the Elimination of the Worst Forms of Child Labour in Nepal with both a programming framework, and with suggestions for the integration of HIV/AIDS into its existing and future activities.

The author and research assistant wish to acknowledge the many people whom freely and generously gave their time, and their opinions. In particular, the research assistant would like to thank the many street-based working children in Kathmandu who participated in this report.

By necessity, the report was required to cover and discuss several difficult subjects such as the sexual abuse and exploitation of working children in Nepal. It is hoped that this was done with both sensitivity and honesty. While the paper was reviewed and commented upon by a widely based panel of stakeholders, the opinions expressed in this report are those of the author alone, as are any errors. The author takes full responsibility for the contents of this report.

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Abbreviations

AIDS  Acquired Immune Deficiency Syndrome
ANC  Antenatal Clinic
BCC/BCI  Behaviour Change Communication / Behaviour Change Intervention
BSS  Behavioural Surveillance Survey
CBO  Community-Based Organisation
CGWB  Central Child Welfare Board
CHH  Child-Headed Households
CWIN  Child Workers in Nepal Concerned Centre
CWISH  Children Women in Social Services and Human Rights
DACA/UNICEF’s Decentralised Action for Children and Women Programme
DACC  District HIV/AIDS Coordination Committees
DCWB  District Child Welfare Board
DHS  Demographic and Health Survey
DoHS  Department of Health Services, Ministry of Health
FHI  Family Health International
GIPA  Greater Involvement of People Living with AIDS
HIV  Human Immunodeficiency Virus
HMG/N  His Majesty’s Government of Nepal
IEC  Information, Education and Communication
IDU  Injecting Drug User
ILO  International Labour Organisation
ILO/AIDS  Programme on HIV/AIDS and the World of Work
ILO/IPEC  International Programme on the Elimination of Child Labour
ILO/STEP  Strategies and Tools Against Social Exclusion and Poverty
M&E  Monitoring and Evaluation
MoES  Ministry of Education and Sports
MoH  Ministry of Health
MSM  Men who have Sex with Men
NAC  National AIDS Council
NACC  National AIDS Co-coordinating Committee
NCASC  National Centre for AIDS and STD Control
NGO  Non-Governmental Organisation
OI  Opportunistic Infections
PE  Peer Educator / Education
PSI  Population Services International
SRH  Sexual and Reproductive Health
STD/I  Sexually Transmitted Disease/Infection
SW  Sex Worker
TBP  Time-Bound Programme on the Elimination of the Worst Forms of Child Labour
UNAIDS  Joint United Nations Programme on AIDS
UNDP  United Nations Development Fund
UNGASS  United Nations General Assembly Special Session on HIV/AIDS
UNICEF  United Nations Children’s Fund
VACC/MACC  Village/Municipal AIDS Coordinating Committee
VCT  Voluntary Counseling and Testing
1.1 Background

The recently released National HIV/AIDS Strategy (2002-2006) for Nepal states that:

... a 'low to moderate growth scenario' would make AIDS the leading cause of death in the 15-49 year old population over the coming years.2

Nepal, like all of South Asia, is in the midst of a concentrated epidemic, marked by high HIV prevalence among vulnerable sub-populations (i.e. sex workers (SW), injecting drug users (IDU), migrants) and a low prevalence amongst the general population. His Majesty’s Government of Nepal (HMG/N) currently estimates that 60,000 people are infected. However, in the absence of a strong national surveillance system and in the face of significant risk factors, the real prevalence rate is probably higher. It is also possible that Nepal is only a few years away from a generalized epidemic.3

The National HIV/AIDS Strategy has identified young people, between the ages of 15 and 24, as a vulnerable group given their general risk behaviour and their predominance within specific vulnerable groups: SWs, IDUs, men who have sex with men (MSM), and migrants. The Strategy, however, does not specifically identify children as vulnerable despite evidence that (1) approximately 111,000 children1 are affected by the HIV infection of their parents, and (2) many Nepali young people under fifteen years are sexually active.5

This double scenario of children affected by the HIV infections and deaths of their parents (HIV-affected children) and children who are at risk of infection or are already infected (HIV-infected children) poses a challenge to child labour programming, as growing numbers of children are driven into the labour market by the HIV infections and deaths of their parents; and, increasing numbers of children become vulnerable to HIV/AIDS through their work.

Given the current HIV/AIDS situation in Nepal and the growing knowledge of the links between HIV/AIDS and child labour, it can be assumed that the following outcomes are likely over the coming years:

- Increasing numbers of children will enter the labour force as a result of HIV infected parents who are sick or are already dead.
- Increasing numbers of children will leave school due to family impoverishment caused by HIV and the requirement to earn a living, as well as increasing levels of stigma and discrimination.
- Increasing numbers of child-headed households (CHH).
- A disproportionate burden of care for ill parents and younger siblings will be placed on girls. Also, in as much as groups

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1 ILO/IPEC IPEC Action Against Child Labour: Highlights 2002, Pp.50
3 The World Health Organization defines a concentrated epidemic as a HIV prevalence rate of less than 1% of the general population but more than 5% in at least one defined sub-population. A generalized epidemic is characterized by HIV prevalence being consistently over 1%.
5 The 2001 Demographic and Health Survey (DHS) stated that the median age of first sex was 18.8 years for males and 16.7 years for females. Other studies showed far lower median ages of first sex, indicating a rapid change in societal norms and sexual behaviour for younger people.
marginalized by gender, ethnicity and caste are disproportionately represented in the worst forms of child labour, so too will they have a disproportionate risk of HIV infection.

• Increasing stress will be placed upon extended families and communities to care for the growing number of HIV-affected children.
• Increasing numbers of children will migrate from their communities in order to earn a living, and to escape community stigma and discrimination.
• HIV will infect increasing numbers of child labourers, particularly those in some of the worst forms of child labour.
• Health and social services (given their current level of function) will be unable to meet the needs of increasing numbers of working children who are HIV+.

While there is limited statistical evidence in Nepal to support these assumptions, it should be stated that evidence from other countries, indicates that there is a link between HIV/AIDS and child labour. Currently, the National HIV/AIDS Strategy does not address this issue. This leaves Nepal unprepared should there be (1) increasing numbers of HIV-affected children in Nepal, resulting from the HIV infection and death of parents/caregivers, and (2) increasing numbers of these HIV-affected children entering the labour market.

The first issue is to determine whether there are (1) increasing numbers of HIV-affected children in Nepal, resulting from the HIV infection and death of parents/caregivers, and (2) increasing numbers of these HIV-affected children entering the labour market.

The second issue is to determine the risk of HIV infection among Nepali child labourers, as a result of both (1) the unaccompanied status of child labourers, and (2) the levels of sexual exploitation and abuse that child labour may entail (HIV-infected children).

The third issue is to determine whether specific interventions are required in Nepal to (1) ensure that HIV-affected children are not forced into the labour market, and (2) reduce the risk that child labour will result in increasing numbers of HIV-infected children.

The fourth issue is to identify how programmes and partners can best prevent (1) increased child labour amongst HIV-affected children, and (2) increased numbers of HIV-infected children among child labourers.

In developing this report, several constraints are acknowledged:

• The causal linkage between HIV/AIDS and child labour has only recently been recognized outside of Nepal.
• While many Nepali stakeholders possess a portion of the knowledge and expertise (e.g. working/street children, HIV/AIDS, sexual and reproductive health (SRH), trafficking, addictions, social protection, education, etc...), no stakeholder has a complete picture of the issue, or a unified vision of how to proceed.
• The amount and quality of data on both HIV/AIDS and child labour is not sufficient to draw statistically valid conclusions. The

1.2 Purpose, Development and Structure of the Report

It is the goal of this report to propose appropriate programming interventions and partnerships to reduce the vulnerability of HIV-affected children to enter into the worst forms of child labour, and to reduce the risk of child labourers becoming HIV-infected children. As such, it will respond to the issues below, which together comprise the report’s framework, and will be used to structure the findings and recommendations.
current data on (1) adults and children living with HIV and (2) **HIV-affected children** is subject to debate.

- The impact of HIV/AIDS on individuals, families and communities is difficult to study given current levels of both incorrect knowledge of HIV/AIDS and stigma and discrimination against those who are affected and infected by HIV/AIDS.
- Child labour is difficult to study given its often hidden and mobile nature.
- There is a general reluctance in the literature to deal with the sexuality of people below the age of fifteen. This is despite evidence that many Nepali are sexually active (either through coercion or by consent) prior to their fifteenth birthday.
- Nepal, with its currently understood low HIV/AIDS general prevalence, has chosen to focus its initial HIV/AIDS programming efforts on prevention. As such, issues like social protection for **HIV-affected children** are not a priority.

To develop this report, the consultant reviewed the existing literature on HIV/AIDS and child labour for Nepal, the South Asia region, and internationally. A bibliography has been attached as **Appendix D**. The Consultant also interviewed members of His Majesty’s Government of Nepal (HMG/N), international organisations, and international and local non-governmental organisations (NGOs) on the links between HIV/AIDS and child labour, the impact of such a link, and possible programming responses. The list of interviewees has been attached as **Appendix E**. The research assistant conducted interviews with child labourers on the experience of being vulnerable to HIV/AIDS, and the links between HIV/AIDS and child labour. The draft report was reviewed by a select group of stakeholders from both the HIV/AIDS and child labour fields.

This Document is organized into the following sections:

**Chapter 1: Introduction** - background, summary of findings, and purpose, development, and outline of report


**Chapter 3: HIV/AIDS and Nepal’s Working Children** - **HIV-affected children** and their entry into the labour market, and the risk of HIV infection among working children

**Chapter 4: Programming for HIV-Affected and Working Children** - rationale for the involvement of the ILO/IPEC **Time-Bound Programme on the Elimination of the Worst Forms of Child Labour in Nepal**, as well as intervention options

**Chapter 5: Conclusion**

**Appendices** - programming principles for orphans and vulnerable children, estimates of affected and infected children and adults, coordination and institutional recommendations, ILO/IPEC Nepal **Time-Bound Programme objectives**, bibliography, and list of interviewees.
Two

HIV/AIDS in Nepal

“The (HIV/AIDS) epidemic can rob households and communities of the capacity to produce or afford food, turning a food shortage into a crisis. If such an emergency is allowed to persist, it can generate further social displacement, disrupting education and health systems, spurring migration, and worsening the sexual exploitation of women and children – all factors that favour the further spread of HIV/AIDS.”

2.1 Nepal’s HIV Epidemic

Nepal’s first cases of AIDS were reported in 1988. Like much of South Asia, Nepal is experiencing low HIV/AIDS prevalence among the general population but concentrated epidemics among several high-risk groups. Given the existing medical and public health infrastructure and the limitations of the national HIV/AIDS surveillance system, it is probable that the actual number of cases is much higher. The experience of other countries has been that once a strong HIV/AIDS surveillance system is in place, the epidemic is recognized as being more widely spread than earlier believed.

Table 1: Summary of Nepal’s Current Epidemiological Situation

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<thead>
<tr>
<th></th>
<th>Data</th>
<th>Date</th>
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<tbody>
<tr>
<td>Reported HIV cases (including AIDS)</td>
<td>3,244</td>
<td>November 2003</td>
</tr>
<tr>
<td>Reported AIDS cases</td>
<td>704</td>
<td>November 2003</td>
</tr>
<tr>
<td>Estimated number of adults &amp; children living with HIV/AIDS</td>
<td>60,018</td>
<td>End 2002</td>
</tr>
<tr>
<td>Estimated adult and child mortality due to HIV/AIDS</td>
<td>2,958</td>
<td>2002</td>
</tr>
<tr>
<td>HIV prevalence: IDUs (Kathmandu)</td>
<td>68%</td>
<td>2002</td>
</tr>
<tr>
<td>IDUs (National)Female</td>
<td>40.4%</td>
<td>2002</td>
</tr>
<tr>
<td>SIVs (Kathmandu)</td>
<td>15.6%</td>
<td>2002</td>
</tr>
<tr>
<td>STI patients</td>
<td>0.7 - 4.6%</td>
<td>2000</td>
</tr>
<tr>
<td>Blood donors</td>
<td>0.28 - 0.48%</td>
<td>2001</td>
</tr>
<tr>
<td>Antenatal Clinic Attendees (ANC)</td>
<td>0.2%</td>
<td>1999</td>
</tr>
<tr>
<td>Migrants (Mumbai, India)</td>
<td>7.7 - 10.0%</td>
<td>2001</td>
</tr>
</tbody>
</table>

Information from the wider South Asia region is similarly worrying. Despite an assumed low prevalence rate in India, its large population means that it is second only to South Africa for the absolute number of people living with HIV/AIDS (PLWHA). As of 2002, four Indian states reported HIV prevalence rates among antenatal clinic (ANC) attendees in excess of 1%. Like Nepal, the epidemic is marked by low general prevalence but high prevalence among Female SWs, IDUs, MSM, and mobile populations. This is particularly worrying for Nepal as an estimated 600,000-1,300,000 Nepali men and boys migrate to India every year, approximately 400,000 of these going to Mumbai. Nepali migrants to Mumbai have a significantly larger risk of HIV infection. This is believed to be due to the high HIV prevalence among female SWs in Mumbai.

2.1.1 Risk Behaviour Among Young People

“While it is difficult for many adults to admit it, large numbers of young people begin sexual activity at a relatively early age, are sexually active before marriage, are not monogamous, and do not use condoms regularly enough to ensure protection. In many countries, a significant proportion of young people start sexual activity before the age of 15, and many of them are already married… Marginalised young people... are at particular risk if they are excluded from health services, exposed to unprotected sex… or use illicit drugs.”

Sources:
Nepal’s National HIV/AIDS Strategy has made HIV prevention activities for young people, a major focus of future programming. This is in recognition of several facts, including the low median ages of first sex and birth, the predominance of young people in high risk groups (i.e. SWs, IDUs, migrants), as well as changing societal mores on sexuality. This is a global reality, with half of all new HIV infections worldwide occurring among young people.

Increased higher risk sex among young people has been confirmed by several studies. One study revealed that 44% of 13-14 year olds and 56% of 16-18 year olds admit to having had pre-marital sex. Among IDUs, MSM, sex workers and migrants, young people predominate. A Family Health International (FHI) study of 800 students reported that 71.5% claimed to have had sex before the age of 19. Only 8.1% of these students were married.

TABLE 2: A UNICEF/UNAIDS Survey of Teenage Behaviour in Nepal

In 2001, UNAIDS and UNICEF funded a survey of the knowledge, attitudes and practices of Nepali teenagers. The following key findings were made:

- Premarital sex is becoming more acceptable
- 22% of boys and 9% of girls report having sex; 35% and 26% of boys and girls respectively reported that they did not use a condom during sex
- Unprotected sex: 14% pregnancy rate; STD rate of 2% for boys and 13% for girls
- 92% were aware of HIV/AIDS and the majority was able to identify the main mode of transmission (sexual intercourse – 85%) and condoms as a means of protection (74%)
- Desire for more information on prevention and services

Unfortunately, the sexual behaviour and vulnerabilities for young people, particularly those below the age of fifteen years, are not subjects that can yet be discussed openly. As noted in States of Denial: AIDS and South Asia, “…in the Subcontinent, sex is a theme that cannot be discussed publicly, individual choice for young adults in fundamental matters is strictly limited, and women’s ability to assert their rights and preferences, particularly when sexual issues are concerned, is illusory.”

Raj (17) and Bishnu (17)

One of their friends died a few days ago; they think it was due to TB but they also think it could have been due to AIDS since the boy shared needles with different people. Lots of their good friends have died.

2.1.2 Potential for a Rapid Spread of HIV/AIDS in Nepal

“Orthodox South Asian values, it was assumed, would be a sufficient vaccine against the rampant virus. This unfortunate attitude still persists, with devastating consequences.”

It is now widely recognized that in the absence of effective interventions, HIV prevalence in Nepal may increase over the coming decade to 1.0% – 2.0% of the 15-49 year old population. For Nepal, this would mean that by 2010 between 100,000-200,000 young adults will become infected, and between 10,000-15,000 annual AIDS cases and deaths may be expected. This would make AIDS the leading cause of death in the 15-49 year old population.

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9 UNAIDS and UNICEF A Survey of Teenagers in Nepal for Life Skills Development & HIV/AIDS Prevention
10 Gupta, P. “States of Denial: AIDS and South Asia” Himal South Asia, Pp. iii
12 UNICEF (ROSA) A Force for Change: Young People and HIV/AIDS in South Asia, Pp. 28
13 Gupta, P. “States of Denial: AIDS and South Asia” Himal South Asia, Pp. i
2.2 Nepal's Response to HIV/AIDS

In an effort to strengthen the implementation of the national HIV/AIDS prevention and control strategies, Nepal has established a National AIDS Council (NAC) under the Prime Minister, a National AIDS Coordinating Committee (NACC) under the Minister of Health, and a National Centre for AIDS and STD Control (NCASC) which is responsible for providing technical support to HMG/N.

The National HIV/AIDS Strategy, which was endorsed by the NAC in October 2002, emphasizes prevention as the mainstay of an effective response. To a lesser degree, it also highlights the need for care and support for people infected and affected by HIV/AIDS. This is not only important in its own right, but it is also an important contribution to effective prevention. In the Strategy five priority areas are identified:

- Prevention of STIs and HIV infection among vulnerable groups.
- Prevention of new infections among young people.
- Ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS.
- Expansion of monitoring and evaluation through evidence-based effective surveillance and research.
- Creation of an effective/efficient management system for an expanded response.

Based upon the Strategy, a national programme has been drafted, and is currently being considered by HMG/N.

With regard to HIV/AIDS and working children, the Strategy makes no specific provision for the vulnerabilities to HIV infection of young people of less than 15 years. It has also decided, based upon the assumed immature stage of the epidemic and the need to make prevention a priority, not to prioritise care and support areas such as community-and home-based care and social support for those who are HIV-affected. This will mean that the social protection measures required to keep HIV-affected children in school and out of the worst forms of child labour, as well as the prevention measures required to prevent HIV infection among working children, will not be significantly addressed by the planned National HIV/AIDS Programme. Working children who are HIV+ should be able to access the care and support options (i.e. management of opportunistic infections) developed by the Programme.
## 3.1 HIV/AIDS and Children

As noted, the impact of HIV/AIDS on children is multifaceted: households become impoverished as assets are liquidated; the number of orphaned and vulnerable children rises as families disintegrate; children are driven from their schools, homes, and communities by poverty and discrimination; and, the labour market absorbs many of these children. Their new status as working children increases their risk of HIV infection.

Girls bear a disproportionate risk as both affected and potentially infected children. At home they are more likely to be withdrawn from school to care for infected parents and to perform household duties. As working children, they are more likely to be sexually abused and more likely to end up as sex workers, increasing the risk of HIV infection.

While HIV/AIDS is a gathering crisis for Nepali children, it is important to note that overall health indicators are not good. The current health system is finding it difficult to respond to the non-HIV health needs of Nepali children, and will be further stretched by a growing HIV/AIDS epidemic. It should also be noted that the two leading killers of Nepali children, acute respiratory infections and diarrhea, are also the leading HIV/AIDS opportunistic infections.

### 3.2 HIV-Affected Children and Labour Market Entry

“Global studies have shown that once parents begin to get sick because of AIDS, household roles and responsibilities dramatically change. Children are pulled out of school due to labour obligations at home, and care of younger children becomes increasingly difficult. In many cases, children will be looking after siblings and also their own sick

### TABLE 3:
State of the Health of Nepal’s Mothers and Children

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 78,000 Nepali children die each year from disease and malnutrition; the majority of these deaths</td>
</tr>
<tr>
<td>occur within the first 12 months of life.</td>
</tr>
<tr>
<td>• 7 out of 10 childhood deaths results from (1) acute respiratory infections, (2) diarrhoea, (3)</td>
</tr>
<tr>
<td>measles, (4) malaria, and (5) malnutrition.</td>
</tr>
<tr>
<td>• Nepal has one of the world’s highest maternal mortality rates with 539 maternal deaths</td>
</tr>
<tr>
<td>for every 100,000 live births. Health professionals attend only 13% of all births.</td>
</tr>
<tr>
<td>• Official data reports that by the end of November 2003 only 56 children were HIV+15, while</td>
</tr>
<tr>
<td>unofficial estimates for the children of sex workers, IDUs and migrants, indicate numbers as</td>
</tr>
<tr>
<td>high as 48,000 HIV+ children.16</td>
</tr>
<tr>
<td>• Prevention of Mother-to-Child Transmission (PMTCT) treatment is not yet available in Nepal,</td>
</tr>
<tr>
<td>though the National HIV/AIDS Strategy has made provisions for it.</td>
</tr>
</tbody>
</table>

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14 ILO/IPEC Action Against Child Labour: Highlights 2002, Pp.51
16 Hunter, S., et al. The Increasing Vulnerability of Children in Nepal, Pp. 17 (NOTE: Dr. Hunter recognizes that her estimate may be high. It is presently difficult to accurately estimate the numbers of HIV+ adults and children, and HIV-affected children. Existing data varies greatly. This problem will continue in the absence of a national HIV/AIDS surveillance system.)
parents, reversing the caring roles. When the caring capacity of the family is decreased, the consequences are of poor nutritional status, poor health status, no educational status and lack of affection, care, support, and recreational time for the child. In many cases, girls are the first to suffer, to be taken out of school to care for siblings and sick parents. Girls may also be made to get married earlier as a coping mechanism to lessen the household running costs.⁷

UNICEF believes that children suffer profoundly when their households become vulnerable as parents fall sick and die of HIV/AIDS. This suffering includes:

- **Psychosocial distress.** …worsened by the pervasive stigma and shame.
- **Economic Hardship.** …children are forced to take on the frightening adult responsibility of supporting a family.
- **Withdrawal from School.** …withdraw(al) from school, even while their parents are living. The pressures to abandon schooling intensify when… parents die.
- **Malnutrition and Illness.** …more likely to be malnourished or to fall ill – and less likely to get the medical care they need.
- **Loss of Inheritance.** …regularly cheated out of their inheritance.
- **Fear and Isolation.** …often forced out to unfamiliar and hostile places.
- **Increased Abuse and Increased Risk of HIV.** Impoverished and without parents to educate and protect them, orphans and affected children face every kind of abuse and risk, including HIV infection. Many are forced into exploitative work – including exchanging sex for money, food, ‘protection’ or shelter.⁸

A recent draft ILO/IPEC report said, “It is clear that the link between the HIV/AIDS pandemic and increases in child labour, including its worst forms, do exist and are intensifying.”⁹ This groundbreaking study of HIV/AIDS and working children in Tanzania, Zambia, Zimbabwe, and South Africa observed a direct causal link between HIV/AIDS and child labour. It was estimated that in Zambia between 23% and 30% of working children came from HIV/AIDS affected households while in South Africa approximately 1/3rd of all child labourers were AIDS orphans. HIV/AIDS caused vulnerable households to go deeper into poverty, which in turn forced children out of school and into the labour market in order to supplement household income or support themselves. The study also showed that girls were disproportionately affected, as they were more likely to be withdrawn from school because of family illness and more likely to suffer sexual abuse and exploitation in the work force.

The prognosis for Nepal’s HIV-affected children is not as dire as the prognosis for Sub-Saharan African children. However, as UNAIDS warns, there is a need for countries like Nepal, with new and growing epidemics, to make preparations for the impending growth of the numbers of AIDS orphans and vulnerable children.

In *The Increasing Vulnerability of Children in Nepal*, it is estimated that there are 111,000 Nepali children affected by HIV, meaning one or both parents are HIV+ and/or are dead from AIDS. Approximately 13,000 of an estimated 835,000 Nepali orphans are AIDS orphans. Given current HIV/AIDS projections, these numbers will grow with time.

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⁸ UNICEF Orphans and Other Children Affected by HIV/AIDS: A UNICEF Fact Sheet, Pp.2
⁹ Rau, B. HIV/AIDS and Child Labour, Pp. 66
It should be noted that while the number of orphans is predicted to drop, AIDS orphans will increase in absolute numbers, and as a percentage of all orphans. This is because current HIV prevalence rates, which are rising, will determine the pattern for the next decade.

As HIV-affected children are vulnerable children, it is useful to understand how HIV/AIDS increases the risk of child labour:

- The inevitable impoverishment and destitution of an affected household, as household assets are consumed to pay for medical, traditional and faith-based treatments for the sick family member (usually male). In addition, treatment is often difficult to access, of poor quality, and expensive. It is also important to note that any debilitating disease and any incapacitation or loss of a household wage earner, not just because of HIV/AIDS, will bring about the same outcomes.

  ... treat child labour and HIV/AIDS as outcomes of processes of impoverishment of households, communities and nations.\(^{21}\)

- The pattern of household infection is often the transmission of HIV from husband to wife, leaving the wife both widowed and infected. In Nepali society, there is little protection for a widow and her children, and they are frequently victims of property and inheritance theft, and eviction by the deceased husband’s relatives.

- AIDS widows and orphans face double stigmatisation and discrimination. They suffer the ignorance, fear and judgement often felt by people affected by HIV. They also suffer a more deeply rooted cultural discrimination against widows and orphans (aamaabaa tokuwaa: “parent eater”). This discrimination drives widows and orphans from their homes and communities.

- Outside of the parental home or marriage, there is no safe place for the vast majority of Nepali girls or women. With no access to resources, abandoned and widowed women and orphaned girls are often forced into sex work.

- The withdrawal of children from school because school fees can no longer be paid. The withdrawal of girls from school to provide care for the sick family member, and to work around the home.

- Emotional loss to affected children as they experience the sickness and death of their parents, impoverishment, and social isolation. One result of this loss is that they are more vulnerable to abuse, including sexual exploitation.

- Loss of parenting, supervision, and emotional support, resulting in AIDS orphans being required to make decisions that they are not equipped to make, including work, migration, family separation, sexual initiation, and use of drugs and alcohol.

- The lack of legal protection for vulnerable children and those infected and affected by HIV, including inheritance rights, citizenship, guardianship, labour protection,

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\(^{21}\) Rau, B. HIV/AIDS and Child Labour: A Synthesis Report, Pp. 75

\(^{22}\) Hunter, S The Increasing Vulnerability of Children in Nepal Ibid, Pp. 31

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**TABLE 4:** Orphan Estimates for Nepal by Year, Country, Type and Cause

<table>
<thead>
<tr>
<th>Year</th>
<th>Total # of Children 0-4 years</th>
<th>Total # of Orphans</th>
<th>Orphans as % of All Children</th>
<th># of AIDS Orphans</th>
<th>AIDS Orphans as % of All Orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>2001</td>
<td>9,656,000</td>
<td>835,000</td>
<td>8.6</td>
<td>2,000</td>
<td>11,000</td>
</tr>
<tr>
<td>2005</td>
<td>10,420,000</td>
<td>825,000</td>
<td>7.9</td>
<td>5,000</td>
<td>22,000</td>
</tr>
<tr>
<td>2010</td>
<td>1,247,000</td>
<td>804,000</td>
<td>7.1</td>
<td>9,000</td>
<td>38,000</td>
</tr>
</tbody>
</table>

...most vulnerable families in Nepal are female headed because of the lack of access to resources under the law and loss of inheritance and property...\(^{22}\)
institutional care standards, and child marriage. Limited access to medical care and formal social protection measures.

All these factors combine to reduce the options for a child with sick or dead parents, and inevitably drive many of them into the labour market. In Nepal, this labour market is often exploitative and dangerous, and despite the efforts of HMG/N, external development partners, and NGOs, child labour continues to be a pervasive societal ill.

As described in Table 5: State of Child Labour in Nepal, child labour constitutes a serious risk to the well-being and future opportunities for one third of all Nepali children.

3.3 Working Children and HIV/AIDS

“Children orphaned by AIDS are at greater risk of malnutrition, illness, abuse, child labour, sexual exploitation than children orphaned by other causes and these factors increase their vulnerability to HIV infection.”

Working children and HIV/AIDS cannot be separated from the wider societal issue of child sexual abuse. A recent study conducted by CWIN and Save the Children Norway of 5,500 school children and 200 out-of-school children in the Kathmandu Valley showed that 15% of girls and 13% of boys, 11-14 years old, were sexually abused. The rates of sexual abuse among street children were higher.

24 Children Suffer Sexual Abuse Silently, Nepali Times, #151, Pp. 5
In 1997, the ILO/IPEC-supported National Child Labour Survey estimated that the number of children, 5-14 years old, was 6,225,000, or 29.3% of the total population. It also categorized child labourers as "Working Children", "Economically Active Children", "Waged Child Labour", and children in the "Worst Forms of Child Labour".

- ILO estimates that while 45.2% of Nepali children are economically active, only 30.1% of Bangladeshi, 14.4% of Indian, and 17.7% of Pakistani children are economically active.
- There is a correlation between child labour and district-level poverty in Nepal, with the highest levels of child labour in the poorest districts. These districts are also the main suppliers of working children to more prosperous areas.
- Approximately 60% of children entering the labour force are between 10-14 years old.
- Waged Child Labour and Worst Forms of Child Labour are most vulnerable to abuse and exploitation. The worst forms of child labour include trafficked children, bonded labourers, porters, mine/quarry and carpet factory workers, domestics, and rag pickers.
- Approximately 8% of children, 5-14 years old, are migrant workers, while 80% of children in the worst forms of child labour are migrants. This is an indication of both the mobility of Nepali child labour and the relationship between mobility and exploitation.
- Approximately 12,000 children, mostly girls, are trafficked each year from Nepal, mostly for sex work. 20% of female sex workers in Nepal are between the ages of 12 and 15 years. Girls who were forced into prostitution in brothels reported an average stay of two years and an average of fourteen clients a day.
- 84% of children involved in the ILO rapid assessments worked 12-14 hours a day.
- Wages in the worst forms of child labour mostly ranged from minimal to non-existent.
- Many sources believe that the sexual abuse of female child domestic workers by the male members of the employing family is a large hidden issue.

**Table 5:**
State of Child Labour in Nepal

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Child Population of Nepal</td>
<td>6,225,000</td>
</tr>
<tr>
<td>Working Children</td>
<td>2,596,000</td>
</tr>
<tr>
<td>Economically Active Children</td>
<td>1,660,000</td>
</tr>
<tr>
<td>Waged Child Labour</td>
<td>279,000</td>
</tr>
<tr>
<td>Worst Forms of Child Labour</td>
<td>127,000</td>
</tr>
</tbody>
</table>

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25 Gilligan, B, Child Labour in Nepal: Understanding and Confronting its Determinants, Pp. 5-9
Similarly, a recent report on the education sector indicated:

“Perhaps the most disturbing survey finding with respect to teacher behaviour is what appears to be fairly widespread sexual relationships between male teachers and female students at secondary schools.” 27

It is clear from the study of working children in other countries that they face high levels of risk of both sexual abuse and exploitation. These risks are given in more detail in Table 6: Working Children and Sexual Abuse, and are related to the unaccompanied status, age, size and gender, physical, psychosocial and emotional vulnerability, and survival needs of working children. These risks also relate to working conditions and the access that abusers have to working children, as well as the seriousness with which society responds to abuse through its mechanisms (i.e. laws) and agents (i.e. police).

**TABLE 6:** Working Children and Sexual Abuse

<table>
<thead>
<tr>
<th>“(In South Asia) More girls than boys are engaged in child labour although their labour is hidden, particularly as child domestic workers. More girls are sexually abused than boys.” 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Case studies and information from adult domestic workers indicate that these children and adolescents (child domestics) are victims of exploitation, racial discrimination, various types of mistreatment and sexual abuse.” 29</td>
</tr>
<tr>
<td>“…there are already indications of pernicious connections between the offers of domestic work and forms of sexual exploitation.” 30</td>
</tr>
<tr>
<td>“…; it is culturally accepted among employer families for domestic workers to ‘participate’ in the sexual awakening of the families’ sons.” 31</td>
</tr>
<tr>
<td>“Most children who are sexually abused are boys and girls between 13 and 18 years and the average age seems to be falling. … the underprivileged and marginalized, religious and ethnic minorities or caste groups, those with disabilities, in institutional care, children in work places, migrant children, bonded child labourers are particularly vulnerable to sexual exploitation.” 32</td>
</tr>
<tr>
<td>20% of female sex workers in Nepal are between the ages of 12 and 15 years. 33</td>
</tr>
<tr>
<td>“With increasing rates of HIV infection in the region, sexual abuse of children places them at increased risk of sexually transmitted infections such as HIV / AIDS.” 34</td>
</tr>
<tr>
<td>“Many children working in restaurants, hotels, workshops, and factories and especially in the transportation industry are expected to have fallen prey to prostitution.” 35</td>
</tr>
<tr>
<td>“Orphaned children are especially vulnerable to abuse, more so as communities becomes less able to care for them. Children whose parents are sick or deceased turn to child labour, and frequently to sex work, to support their families and themselves, thus increasing their vulnerability and continuing the cycle of infection, illness and death.” 36</td>
</tr>
</tbody>
</table>

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27 MoES Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal (Draft), Pp. 31
29 ILO/IPEC Child Domestic Workers: A Highly Vulnerable Population, Pp. 6
30 Ibid, Pp. 6
31 Ibid, Pp. 7
33 Gilligan, B Child Labour in Nepal: Understanding and Confronting Its Determinants, Pp. 5-9
34 South Asia Strategy against Commercial Sexual Exploitation and sexual Abuse of Children: Second Congress against Commerical Sexual Exploitation of Children, Pp. 1
35 Save the Children Sweden and Child Rights and Abuse Committee Confronting Reality: Sexual Exploitation and Abuse of Children in Pakistan (Draft)
36 UNICEF (ROSA) and Save The Children South Asia Regional Forum for Young People on HIV/AIDS, Pp. 13
At the base of this abuse is a widely held and self-serving belief amongst the middle and upper classes of many countries that working children are in fact more responsible and “mature” (particular in sexual matters), and therefore more culpable for both their behaviour and their living conditions. This is usually observed through the acceptance and justification by societal elites of child labour and the harsh manner in which the police and justice system deal with working children. It is not without reason that many child workers, including sex workers, perceive the police as exploiters and abusers. This further empowers sexual abusers and exploiters of children.

It is also important to recognize the reality of “consensual” sex among child workers. This behaviour may come from group socialization, normal adolescent sexual growth, and a lack of family guidance and supervision. The need for food, shelter and security also results in children engaging in “survival sex”. These factors contribute to the sexual abuse of younger working children by older children and girls by their boy co-workers.

In the absence of awareness raising and behaviour change interventions, this behaviour increases the risk of pregnancy, STDs and HIV/AIDS. The current primary school curriculum does not include HIV/AIDS or sexual and reproductive health (SRH), as it was felt that SRH is inappropriate, even though many primary students are post-puberty.

3.4 HIV/AIDS and the Worst Forms of Child Labour in Nepal

During the preparation of the Time Bound Programme, ILO/IPEC Nepal developed a series of rapid assessment reports on the worst forms of child labour. A review of those documents highlights some issues around the sexual abuse of working children, as well as listing the different vulnerability factors that each type of the worst form of child labour may have to HIV infection.

**Child Porters...** … are often away from their homes, and are often in the care of non-family adults. Alcohol consumption is common. Short-haul urban porters are exposed to the risks of a street-based life.

**Rag Pickers...** … are often away from families and in the care of non-family adults and older children. There is considerable evidence of high risk consensual and non-consensual sex, commercial sex, and drug and alcohol abuse by rag pickers. Are exposed to the risks of a street-based life.

** Trafficked Children...** … boys are trafficked into agricultural and industrial/construction work in India and are often away from families and in the care of non-family adults. Girls are trafficked mainly for the purposes of sex work and face huge risks of HIV infection in Indian brothels. In the rapid assessment “…, three-fifths of the respondents either reported that their clients used condoms sometimes, rarely or not at all, and all of these girls were thus at risk of contracting sexually transmitted diseases while working in the brothels.”

**Miners/Quarry Workers...** … are away from families, sometimes in the care of non-family adults and older children.

**Factory Workers...** … are away from families and in the care of non-family adults and older children. Living conditions may include secluded work sites, as well as mixed sex and unsupervised dormitories. A study of

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37 KC, B.K., et al. Trafficking in Girls with Special Reference to Prostitution: A Rapid Assessment, Pp. 26
In reviewing the ILO/IPEC Nepal Time-Bound Programme it is apparent that HIV/AIDS was not seen as a significant issue at the time of its development. First, the risk of HIV/AIDS was not a criterion used to determine what was and was not a worst form of child labour. Secondly, HIV/AIDS (as well as the broader issue of the health needs of working children) was not integrated into programming for the Time-Bound Programme. The ILO/IPEC Time-Bound Programme Project Document makes only cursory reference to the need to ensure that children involved in the worst forms of child labour have access to existing health care services.

### 3.5 Understanding Vulnerability to HIV/AIDS Among Working Children

It is clear that there are Nepali working children who are not in one of the worst forms of child labour as defined by the ILO/IPEC Nepal Time-Bound Programme, but who are vulnerable to HIV infection. If the Time-Bound Programme is to integrate HIV/AIDS into its programming, this fact should be taken into consideration. To do so, it is important to formulate an understanding of factors that increase the vulnerability of working children to HIV infection. This understanding can be created through analysing different forms of child labour using the four criteria found in Table 7: Determining the HIV/AIDS Vulnerability of Working Children.

#### Table 7: Determining the HIV/AIDS Vulnerability of Working Children.

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does a family member supervise the child worker?</td>
</tr>
<tr>
<td>Is the child worker isolated and hidden from public view?</td>
</tr>
<tr>
<td>Is the type of child labour an access point to child sex work?</td>
</tr>
<tr>
<td>What is the gender of the child worker?</td>
</tr>
</tbody>
</table>

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39 Sharma, S., et al. Situation of Domestic Child Labourers in Kathmandu: A Rapid Assessment, p. 23
Does a family member supervise the child worker?

The separation of child workers from their families increases their vulnerability to sexual abuse and exploitation, as well as to drug and alcohol use. This increases the risk of HIV infection. It could be suggested that child workers in some of the worst forms of child labour have a lower risk of HIV infection because they work with family members who would provide both guidance and protection. This is observed with long distance porters, boys trafficked/migrating to India, and children working as stonebreakers. A possible exception to this are the daughters of sex workers.

Is the child worker isolated and hidden from public view?

Working children, who are isolated behind home, brothel, and factory walls, or by the transport industry, are particularly vulnerable to repeated sexual abuse by employer family members, by work supervisors and peers, and by sex work clients.

Is the type of child labour an access point to child sex work?

There may be many types of child labour that have a low risk of injury but are viewed as access points to commercial sex work by both the child worker and sexual predators. Experience from other countries speaks of the ability of paedophiles to informally network and organize themselves to gain access to child sex workers. These may include children working in tea and raxi paisals, factories, cabin restaurants, discos, hotels, and cinemas.

What is the gender of the child worker?

Male and female child workers have different risks of sexual abuse and exploitation in different types of work, and in different situations. Working in homes, factories, hotels, and cabin restaurants implies high risks for girls. Similarly, boys engaged in street-based work are vulnerable to abuse and exploitation by child and adult co-workers, supervisors, and sexual predators.

A recent CWIN and Save the Children Norway study on the sexual abuse of children in the Kathmandu Valley reported similar levels of sexual abuse for boys and girls, but very different circumstances. The abusers were exclusively male. This is consistent with the pattern of other countries, where the abuse of boys by adult males is both widespread and denied. It also points to the cultural practice of placing a high value on the sexual “purity” of girls (i.e. the equation of female virginity with female virtue and family honour) while ignoring the risks of sexual abuse to boys.

3.6 HIV+ Working Children

A final consideration on HIV/AIDS and working children is the access of working children who are HIV+ to care and support services. There is evidence of increased HIV/AIDS awareness over the last few years, with more street-based working children knowing a peer whom they suspected was ill, or who had died as a result of HIV infection. This has led to an increased demand from these children, as well as from frontline organisations, for Voluntary Counselling and Testing (VCT), and care and support services.

Rajesh (17)

“Boys don’t use condoms even if they know about unsafe sex practices.” Lots of his friends have died in the past due to various illnesses, and some have died due to HIV/AIDS.”

Anecdotal evidence suggests that HIV+ working children have limited access to health services, and in some case, are being denied services. Over the coming years there will be an increasing need to provide these children with treatment for opportunistic infections, and eventually palliative care.
Four Programming for HIV-Affected and Working Children

Empowering affected children first of all means regarding them as active participants, rather than mere victims. Many children already function as heads of households and as caregivers. They are a vital part of the solution and should be supported in planning and carrying out efforts to mitigate the impact of HIV/AIDS in their families and communities.\textsuperscript{40}

4.1 Rationale for Involvement of the ILO/IPEC Nepal Time-Bound Programme

The ILO/IPEC Nepal Time-Bound Programme on the Elimination of the Worst Forms of Child Labour in Nepal was developed during 2001. At that time HIV/AIDS was only beginning to be viewed as a national priority, and the links between HIV/AIDS and working children were not yet understood. The first national HIV/AIDS strategy was released in December 2002; the operationalisation of this strategy is currently underway.

Still, the ILO/IPEC Nepal Time-Bound Programme’s project documents identified sexual abuse as a “severe problem” for rag pickers, domestic workers, and trafficked children.\textsuperscript{41} In addition, while HIV/AIDS was not then viewed as a major issue, the need to protect families from health emergencies that pushed children into child labour was identified.

Since the development of the ILO/IPEC Nepal Time-Bound Programme, the ILO has done considerable work to develop its own approach to HIV/AIDS through the Programme on HIV/AIDS and the World of Work (ILO/AIDS). Focussing on the mobilization of its Tripartite Partners (government, trade unions, and employers), ILO/AIDS (1) raises awareness of HIV/AIDS as a workplace issue, (2) supports workplace initiatives in prevention, care and support, and (3) supports initiatives to end workplace stigma and discrimination. While these initiatives reflect the ILO’s prioritisation of HIV/AIDS and are well suited for the conditions of the formal sector, they are less practical for Nepal’s working children who are predominantly in the informal sector.

ILO/IPEC now acknowledges the links between HIV/AIDS and child labour, and is discussing the integration of HIV/AIDS into its Time-Bound Programmes. A recent ILO/IPEC workshop, “Impact of HIV/AIDS on Child Labour in Sub-Saharan Africa”\textsuperscript{42} proposed a macro-level response, including (1) reinforcement of existing national and international commitments, (2) identification of key intervention areas, (3) fostering partner cooperation and communication, (4) awareness raising; and (5) risk reduction.

It is recognized that the ILO’s tripartite partners play an important role in creating an enabling environment to prevent child labour, and to improve the lives of working children. However, the work of dealing directly with HIV/AIDS and working children will fall to NGOs and community-based organisations (CBOs). Any decision by the Time-Bound Programme to involve itself in either preventing HIV/AIDS-induced child labour or the HIV infection of existing working children will require NGO and CBO partners.

\textsuperscript{41} HMGN and ILO Project Document on the Time-Bound Programme on the Elimination of the Worst Forms of Child Labour in Nepal, Pp. 17
\textsuperscript{42} ILO/IPEC ILO/IPEC Tripartite Workshop – Participant Strategy Paper, Pp. 1-4

\textit{Deepak (13)}

\textit{Since the TV never said how HIV/AIDS is contracted, he doesn’t know about it.}
The current ILO/IPEC Nepal Time-Bound Programme project document provides sufficient flexibility to allow it to mainstream “HIV/AIDS and working children” into its contribution to HMG/N’s Master Plan for the Elimination of Child Labour. There is also sufficient flexibility to allow the Programme to prevent HIV-affected children from being driven into the labour market. The Time-Bound Programme is less clear on HIV/AIDS and existing working children. A list of the Time-Bound Programmes Intermediate Objectives is found in Appendix C.

Recommendation 1: That the ILO/IPEC Nepal Time-Bound Programme include within its Immediate Objectives the following words or intention: “At the end of the Time-Bound Programme, the local capacity to protect and enhance the well-being of working children will be enhanced in targeted sectors/districts.” The well-being of working children should include, but not be limited to, promotion of safer/healthier working environments, access to food and shelter, access to legal assistance, and access to health and social services.

Recommendation 2: With regard to integrating HIV/AIDS programming into the ILO/IPEC Nepal Time-Bound Programme, there is a need to extend programming to working children who are not in a “worst form of child labour” but face an equal or greater risk of HIV infection.

Recommendation 3: With regard to integrating HIV/AIDS programming into the ILO/IPEC Nepal Time-Bound Programme, the primary focus of programming partnerships should be NGOs and CBOs.

4.2 HIV/AIDS and Working Children: A Programming Framework

To develop programming options for HIV/AIDS and working children, a simple two-part framework is proposed to organise intervention and partnership options.

Part 1:
1. Programming for HIV/AIDS and working children is divided into three components:
   I. Creation of an enabling environment for HIV/AIDS and working children.
   II. Prevention of AIDS-affected children becoming working children.
   III. Prevention of HIV infection among working children, and the provision of care and support to working children who are HIV+.

2. Each of these components requires different interventions and partnerships.

3. The prevention of HIV infection among working children could include, but not be limited to, removing working children from work that involves a risk of infection.

Part 2:
1. In order to organize intervention strategies and implementation partnerships, programme development for working children who are vulnerable to HIV infection, or who are HIV+, should include risk factors such as accompanied status, visibility/invisibility, accessibility by sexual predators, and gender.

2. To achieve this, intervention and partnership options for working children who are vulnerable to HIV infection or who are HIV+ can be divided into three programming categories: (1) street-based working children, (2) invisible/isolated working children, and (3) sector-based working children.

a. Street-Based Working Children: Shared interventions and partnerships can be implemented for street-based working children, including rag pickers, short-haul porters, beggars, tempo khalasi, and
tea/raxi paials, cabin restaurant, disco, hotel, and cinema workers. These children can be reached using a single programming approach due to their shared space and street culture, and similar risk factors. Street-based child-workers are easy to identify and reach with programming interventions by trained and supported community health workers.

b. **Invisible/Isolated Working Children:**
Interventions and partnerships for working children who are isolated within homes, factories and brothels, or by the transport industry will each require discrete programming approaches and potentially different partners. This is because of the isolating nature of their work, and the need for programming interventions to reach children at their work sites.

c. **Sector-Based Working Children:**
Interventions and partnerships for these working children should not be separated from those intended for adult workers in the same sector. This is because the known risk of HIV infection for a child agricultural worker, long distance porter, or boy migrant to India appears not to be significantly different than the risk to adults in these sectors. The programming approach should ensure that child workers in these sectors are included in sectoral HIV/AIDS prevention and care and support initiatives.

3. It is recognized that working children may move between these categories or be simultaneously covered by more than one programming approach. Working children do not live in the boxes created by this or any other programme.

4. The framework can be implemented by the ILO/IPEC Nepal Time-Bound Programme through sensitising and mobilizing various stakeholders to ensure that the needs of working children are met through existing programming, or through supporting new programming interventions.

In developing the options contained in **Section 4.3: Intervention and Partnership Options**, the following choices and assumptions were made.

1. The work of advocating for policy and coordination initiatives with Tripartite Partners, including the mainstreaming of HIV/AIDS and working children, is not the main focus of this report. Instead, this document will focus on specific intervention and partnership options for children at risk of being driven into the labour market by HIV/AIDS, and working children who are at risk of HIV infection.

2. The work of preventing HIV-affected children from entering the labour force is not exclusively a child labour issue, but rather an issue of **orphaned and vulnerable children (OVC)**, where child labour is one of several possible outcomes. Programming options will be discussed in the context of community development.

3. Working children are independent actors engaged in their own survival. As such, they need to be treated as full players in their lives and not as passive victims. All programming decisions should be based on the best interests of the child, and that decisions should **do no harm** to the children reached.

4. Children may be sexually active and drug-using by consent, and in the absence of guardianship, their choices to engage in these high risk behaviours must be accepted as a reality of their lives. While removing a
child from a high risk situation might be the ideal, it is not practical in many cases. As such, any programming involving HIV/AIDS and working children must begin by accepting the reality of their lives, and work towards reducing the harmfulness of their behaviour and providing options, in order to reduce the risk of HIV infection. This will require a range of responses from harm reduction, to community and family reintegration.

5. Any programming that highlights the risk of HIV infection among an identified group creates a risk of increased discrimination and marginalisation of that group. Such programming must consider this possible outcome and work to mitigate its impact.

Recommendation 4: That HIV/AIDS and working children programming begin with the acceptance of working children as autonomous beings, and that any interventions to reduce high risk sexual and drug-using behaviour be based upon an acceptance and respect for this autonomy.

4.3 Intervention and Partnership Options

As discussed in the previous section, intervention and partnership options will be divided into three parts:

I. Creation of an enabling environment for HIV/AIDS and working children.

II. Prevention of AIDS-affected children becoming working children.

III. Prevention of HIV infection among working children, and the provision of care and support to working children who are HIV+.

The report’s main focus will be on parts II and III.

In discussing interventions and partnerships to deal with HIV/AIDS and working children, the experience of developing this report was instructional. The main lessons were:

1. The understanding of a causal linkage between HIV/AIDS and working children in Nepal is a recent phenomenon. NGOs and CBOs that work with street-based working children have only recently noted a rise in HIV infections and high risk behaviour (high risk sex and injection drug use).

2. Very few of these organisations have an ability to deal with the HIV/STD and addictions issues that now confront them.

3. Many of these organisations are proposing institutionalisation of high risk children (i.e. rescue) as the desired response. This strategy should not be encouraged.

4. The issue of HIV/AIDS and working children crosses many different government jurisdictions, organisational missions, and academic disciplines. These include working/street children, HIV/AIDS/STDs, sex work/trafficking, non-formal education, community development, social protection, policy/regulatory and human rights.

While this new awareness, the lack of both experience and programming, and a multitude of stakeholders may appear to be a significant challenge; it also represents a leadership opportunity. There is a need to mainstream HIV/AIDS into organisations focusing on working children, and to mainstream child labour into HIV/AIDS organisations. This is a role that could be assumed by the ILO/IPEC Nepal Time-Bound Programme.

Recommendation 5: That the ILO/IPEC Nepal Time-Bound Programme, through mainstreaming HIV/AIDS into its relationships with tripartite partners and delivery partners and programmes, takes leadership in building awareness and coordination on HIV/AIDS and working children, as well as supporting the development of specific programming.
I. Enabling Environment for HIV/AIDS and Working Children

This report will only briefly touch on the enabling environment, including the integration of HIV/AIDS and working children into ILO/IPEC Nepal’s relationships with its tripartite partners. This is because much of this work is already underway.

The ILO/IPEC May 2003 workshop, “Impact of HIV/AIDS on Child Labour in Sub-Saharan Africa” proposed a series of objectives for Time-Bound Programmes in dealing with HIV/AIDS and working children. They included general commitments to build awareness, mobilize partners and communities, enlist the media, work through the policy process, and conduct research in order to develop programming guidelines. Three specific points of relevance to the Time-Bound Programme in Nepal are:

- HIV/AIDS concerns are mainstreamed in current projects...
- District level resources and leadership are used...
- Existing national funds allocated for HIV/AIDS prevention progressively integrate the child labour dimension in a gender sensitive manner.⁴³

To achieve these, the ILO/IPEC Time-Bound Programme in Nepal should continue to build and sustain links with HMG/N and the United Nations in the following areas:

1. HMG/N and UNICEF’s Master Plan of Operations for the Implementation of the Country Programme of Cooperation, 2002-2006, specifically its communication, advocacy, and life skills programmes.⁴⁴

2. HMG/N’s National Master Plan on Child Labour (2001-2010) and Joint Initiative Against Trafficking in Women and Girls. There is an urgent need to build an HIV/AIDS perspective into the Master Plan, and to ensure that HMG/N takes increasing responsibility for the fate of Nepali youth trafficked to, and apprehended in, a foreign jurisdiction.

3. ILO/AIDS and Strategies and Tools against Social Exclusion and Poverty (ILO/STEP). In particular, the use of the ILO Code of Practice on HIV/AIDS and the World of Work, in the ILO’s work with its Tripartite Partners. While Nepal’s working children do not work in the formal sector, this in no way lessens the responsibility of His Majesty’s Government, formal sector employers, and unions to act to prevent HIV infections or care for those who have become infected.


5. Integrate child labour perspectives into the NCASC’s National HIV/AIDS Programme. Ensure that working children are neither stigmatised nor discriminated against by the wider society, nor denied access to health and social services, including HIV/AIDS prevention, and care and support services.

6. Encourage the MoWCSW and the Ministry of Labour and Transportation (MoLT), in keeping with the ILO Code of Practice on HIV/AIDS and the World of Work, to advocate for a multisectoral approach to HIV/AIDS and working children, and to participate, with NCASC and other line ministries, in the mainstreaming of HIV/AIDS into ministry portfolios.

In developing the enabling environment, it would be useful to consider some of the findings of a technical workshop, entitled

⁴³ ILO/IPEC ILO-IPEC Tripartite Workshop – Participant Strategy Paper, Pp. 3-4
“Moving the HIV/AIDS and Child Labour Agenda Forward” held in Lusaka, Zambia in May 2003.

Beyond the current work that ILO/IPEC is doing with its United Nations’ and tripartite partners in Nepal, the following is a list of measures that would enhance the enabling environment for dealing with vulnerable children, including working children:

- Continued promotion of the rights of working children: joining with the NCASC to promote the rights of people infected and affected with HIV/AIDS.
- Communication strategies to highlight the role of men in sexually abusing and exploiting children.
- Continued promotion of the every child’s right to citizenship, including improved birth registration processes.
- Working with women’s organisations to promote continued strengthening of the property and inheritance rights of women and children.
- Promotion of the state’s duties to orphaned children, including guardianship.
- Advocacy for a reduction of the minimum working age to twelve years for “light work” in order to include currently working children, particularly child domestic labourers within the jurisdiction of the Labour Act.
- Advocacy with the national police force on the rights of working children; establishment of initiatives to investigate and deal with instances of police (sexual) abuse of working children; establishment of initiatives to deflect working children from involvement in organized criminal activity

**Recommendation 6:** The ILO/IPEC Nepal Time-Bound Programme should develop its relationship with the NCASC in order to ensure that a child labour dimension is integrated into the National HIV/AIDS Programme, including access to both prevention and care and support services by all working children. It should also encourage its HMG/N partners to work together with the NCASC, on a multisectoral approach to HIV/AIDS and working children.

**Recommendation 7:** The ILO/IPEC Nepal Time-Bound Programme should mainstream HIV/AIDS prevention and care and support into its relationship with stakeholders, and its existing/planned programming.

### II. Prevention of Child Labour Among AIDS-Affected Children

By strengthening and promoting existing or new community based safety nets for children and families prone to child labour, the ILO/IPEC Nepal Time-Bound Programme further aims to reduce the vulnerability of poor rural households when confronted with sickness, poor health, family dysfunctionality and/or the death of a breadwinner.

As discussed, the development of intervention and partnership options to prevent AIDS-affected children from becoming working

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**TABLE 8:**

**Key Issues for HIV/AIDS and Child Labour in Sub-Saharan Africa**

- The number of children affected by the HIV/AIDS pandemic will continue to grow for at least another decade.
- The magnitude of the problems experienced by orphaned and vulnerable children and the communities in which they live will expand.
- National responses will have to be greatly accelerated to keep pace with the pandemic...
- …good practices, in the form of projects and programmes… can provide models for scaling up effective responses to the linked problems of HIV/AIDS and child labour.

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children is presented from the perspective of programming for orphan and vulnerable children. This is because AIDS-induced child labour is only one of several possible outcomes for AIDS-affected children.

In HIV/AIDS programmes, this issue normally falls within care and support programming. Given the early stages of the epidemic in Nepal, the National HIV/AIDS Strategy has placed a relatively low priority on care and support, preferring instead to focus mainly on prevention. The issue of social protection for families and children affected by HIV/AIDS remains undeveloped, and will need to be expanded over the coming years.

In November 2001, the UNAIDS Committee of Co-sponsoring Organisations endorsed strategies for working with HIV-affected children. They are presented in Table 9. Twelve programming principles were also endorsed and are listed in Appendix B.

The first three strategies focus on building capacity, and mobilizing children, youth, families and communities to develop and implement their own options to protect and care for their orphaned and vulnerable children. These three strategies are already being implemented in Nepal to support community development and social protection initiatives, ranging from community forestry to adolescent sexual and reproductive health, from community public health to income generation. They rely on tools such as Participatory Learning and Action (PLA), Participatory Rural Appraisal (PRA), peer education, and community mobilisation methodologies.

The focus of any programming to protect orphaned and vulnerable children (whether from HIV/AIDS or other causes) should be built upon the local capacity to support affected households. This can be accomplished through a number of strategies:

1. Raise the awareness of communities in order to sensitise them on the issue of HIV/AIDS, reduce stigma and discrimination, and mobilize them to support households affected by HIV/AIDS.

2. Build capacity and mobilize local government and community organisations to provide services to households affected by HIV/AIDS. Provide resources and authority to local organisations.

### TABLE 9:
Strategies for Working with HIV/AIDS Orphans and Vulnerable Children

<p>| | |</p>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Strengthen and support the capacity of families to protect and care for their children</strong> – by providing free basic education and expanding social welfare and income-generating programmes.</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Mobilize and strengthen community-based responses</strong> – by establishing community-level orphan monitoring committees and community day-care centres.</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Strengthen the capacity of children and young people to meet their own needs</strong> – by providing educational materials, life-skills education and vocational training.</td>
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<tr>
<td>4.</td>
<td><strong>Ensure that governments develop appropriate policies, including legal and programmatic frameworks, as well as essential services for the most vulnerable children</strong> – to promote legal reform (inheritance, property, adoption and fostering laws) and ensure access to social services for children.</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Raise awareness within societies to create an environment that enables support for children affected by HIV/AIDS</strong> – to combat stigma and discrimination generated by HIV/AIDS.</td>
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UNICEF Orphans and Other Children Affected by HIV/AIDS: A UNICEF Fact Sheet, Pp. 3-4
3. Build the capacity and mobilize local officials and professionals, particularly care providers, to provide services to households affected by HIV/AIDS.

4. Develop and implement self-help schemes for households affected by HIV/AIDS.

Currently in Nepal there are several projects implementing these strategies, with some degree of success.

An example of a district-level project that is not specific to HIV/AIDS and working children, but which provides opportunities to build relevant local capacity, is UNICEF’s Decentralised Action for Children and Women Programme (DACAW). DACAW aims to build the capacity of various Nepali bodies responsible for the well-being of women and children. The main strategy is to strengthen decentralised governance, service provision, and participation of people at the local level.

“Access to social services continues to be a challenge for many communities due to the limited availability, as well as restrictive social conventions. Thus far, communities have been mainly passive beneficiaries of available services. There has been little community involvement in management and influence over service delivery.”

While there is no specific HIV/AIDS focus to this programme, the ability of districts and communities to set priorities, manage resource allocations, and plan and implement programmes, will allow them to provide for the most vulnerable households.

The success of district and community-level capacity building is dependent upon a number of factors, including awareness and acceptance of the issue, and community ownership of and participation in both the process and the benefits.

“Areas made vulnerable by HIV/AIDS can and should be targeted but, within these communities, residents and local governments should provide assistance to the most vulnerable children and households, regardless of the specific causes of vulnerability. Experience shows that successful programmes are those that are child-centred, family- and community-focused, and respect and protect the rights of the child.”

**Strategies for Community-Based Solutions...**

In developing a community’s ability to provide care and support for HIV-affected households, including orphaned and vulnerable children, a number of specific strategies have proven themselves to be successful.

- Programmes for orphaned and vulnerable children should be for all such children, as the singling out of AIDS-affected children could result in stigma and discrimination.
- The use of youth peer educators, such as with Safe the Children UK has in Achham, Jappa, Ilam and Morang, can be successful in building general community awareness of HIV/AIDS, and reducing stigma and discrimination. The Southern African experience has proven youth peer educators to be one of the most effective vehicles to reach children on issues relating to health promotion.
- The utilisation of traditional community and extended family abilities to care for sick family members and orphans has been successful in Africa. Poor communities and families, properly sensitised, mobilized and supported, can take ownership of the issue, and support affected families and orphans. The required support usually includes community capacity building, food subsidies, school support, and income generation opportunities. Save the Children USA has used this approach on a limited basis in Kanchanpur District.

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“…it is communities that are at the forefront of creating scores of orphan-care programmes to ensure that vulnerable children have access to care and support.”

- The building of capacity among local care providers to provide community and home-based care for people who are HIV+ has also been successful. This can involve the community and the affected family in providing care for the afflicted family member, and keeping him or her healthy and productive for a longer period of time. In Nepal, there has already been some success with training community health volunteers (Female Community Health Volunteers (FCHV)) in limited home-based care and support, and lay counselling.

- Mobilising district and community bodies to provide services not covered by a national health system, and to support community mobilisation efforts, can be productive. In Nepal, local Nepal Red Cross Society chapters, Mothers’ Groups, youth clubs, peer educators, and schools have been mobilized in support of prevention and care and support activities. There are examples of local bodies funding drug costs for AIDS-affected families.

- Income generation and skills development opportunities for affected households, including children, have been successful in reducing household impoverishment, and preparing children to eventually support themselves and their younger siblings.

- As AIDS-induced child labour is a sub-set of poverty-induced child labour, existing safe migration projects for boys and anti-trafficking projects for girls could be leveraged to prevent migration and trafficking, or to make migration safer.

- The involvement of affected-families in succession planning for their children has had some success in protecting the inheritance rights of affected children in other countries. Similarly, ensuring that all children have a birth registration and citizenship is important to protect their rights.

- While it is not yet an issue in Nepal, the development of community based supports for child-headed households will be necessary over the coming years. In addition, Nepal will need to build on the expertise of other counties and develop non-institutional models of care for an ever-increasing number of AIDS orphans.

In proposing these strategies, one must remember the limited capacity of poor communities and families to provide support for orphaned and vulnerable children. However, experience from Africa has shown that minimal external support, in the form of food subsidies and school fees, are far more cost effective than placing children in residential care. Unfortunately, in Nepal there has been a tendency to respond to orphans (and to working children) with orphanages, transit homes, and other residential facilities. The result has been a rapid uncontrolled growth of institutions with no standards or licensing. Given recent reports of physical and sexual abuse of children in care in Nepal, external development partners and NGOs should exercise caution in supporting any institutional approaches. In addition, keeping the child in the extended family and/or community is more beneficial to the child’s development. While orphanages are a necessary component of a care system, they should be seen as a temporary solution, or as a last resort. There is a need to emphasize responses based upon “…reunification and reintegration, together with community-based care solutions…”

**Recommendation 8:** Any efforts to protect AIDS-affected children from child labour must be built upon a foundation of aware, supportive and mobilized communities. These efforts should be integrated into existing community structures, using familiar methodologies.

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51 Krueger, A. Assessment of Separated Children in Nepal, Pp. 23
Recommendation 9: The development of programming options for orphans and vulnerable children should be done primarily through building community capacity. This programming should be accessible to all community orphans and vulnerable children whether or not they are AIDS-affected.

Recommendation 10: Where possible, an HIV/AIDS and working children’s perspective should be built into appropriate existing and planned programming, particularly in the areas of HIV/AIDS, community development, migration and trafficking. Affected families and children should play the leading role in determining the needs and programming options for orphans and vulnerable children.

Recommendation 11: The best place for orphans and vulnerable children is within their communities and (extended) families. The priority for programming should be to support communities and families care for their children. Community-based foster parenting should be investigated as a care option. Institutional care should be seen as a temporary solution, or as a last resort.

Social Risk Management...

In recent years much has been written about measures that would assist households and communities to better manage risks in the absence of a functioning public health system or social safety net.

“Poverty relates to vulnerability since the poor are typically more exposed to risk while they have limited access to appropriate risk management instruments. Hence the provision and selection of appropriate (Social Risk Management) instruments becomes an important device in order to reduce vulnerability and provide a means out of poverty.”

Traditionally, risk management has been undertaken through informal measures:

- Reduce Risk – crop diversification, building surpluses
- Share Risk – extended family, community sharing mechanisms
- Respond to Risk – sell surplus, child labour

ILO/STEP is currently working on how social protection systems can contribute to the fight against HIV/AIDS, particularly in the informal economy. Of primary interest is the need to develop community-level micro-health insurance schemes.

“…a dynamic innovation… in enhancing the capacity of communities to cope with health issues and to interact with providers of health and other services. Micro-insurance is also relevant in enabling communities to address the HIV/AIDS pandemic to cover other risks, such as expenses linked to death – whether or not it is caused by AIDS – and to assure children’s education.”

In the context of a widespread HIV epidemic, such schemes are challenged to be self-supporting owing to the debilitating and terminal nature of HIV/AIDS. Experience from Africa indicates that external funds might be required to maintain solvency. However, Nepal is not at that stage of HIV/AIDS. There is an opportunity to develop general health schemes through existing community groups such as Mothers’ Groups and credit clubs, organisations such as the Nepal Red Cross Society and public hospitals, or private care providers. There is also a need to develop formal relationships with care providers in order to manage costs. If successful, these schemes could help to maintain the productivity of infected household members and preserve family assets, which in turn would spare children from being driven into the labour market.

Given the relatively low prevalence of HIV in communities, there is an opportunity for ILO/STEP to take certain HIV/AIDS-measures, as it assists in the development of micro-health insurance schemes. Firstly, HIV/AIDS/STD health promotion should be a standard part of

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54 Ibid, Pp. 6-7
all schemes. Secondly, such schemes should include treatment coverage for STDs, standard HIV/AIDS opportunistic infections (i.e. tuberculosis, acute respiratory infections, diarrhoea), and pain management for palliative care. This would allow the schemes to cover the majority of the treatment needs of people who are HIV+, without focusing on HIV/AIDS.

**Recommendation 12:** Micro-health insurance schemes should be piloted in communities with an assumed higher incidence of HIV/AIDS (i.e. western districts with high rates of male migration to India). Such schemes should include HIV/AIDS/STD health promotion and treatment coverage for the standard HIV/AIDS opportunistic infections and pain management. Efforts should also be made to investigate the benefits of integrating these schemes with community-based HIV/AIDS care and support initiatives, as well as STD programmes.

**District Child Welfare Boards...**

Since their establishment under the Child Act, the District Child Welfare Boards (DCWB’s) have, for the most part, not been active advocates and protectors of the rights and well-being of children. In large part, this can be explained by the insurgency and suspension of local governments. However, if the solution to orphaned and vulnerable children lies at the district and community level, then a strong district level body is required to set priorities, develop capacity, and build awareness on a range of children’s issues amongst other district-level offices. There is also an opportunity to build district-level relationships with the District AIDS Coordinating Committees (DACC), and to reach into communities through the Village and Municipal AIDS Coordinating Committees (VACC/MACC).

**Recommendation 13:** District Child Welfare Boards (DCWB) should be the natural advocates for HIV/AIDS and working children at the district level. There is also an opportunity for them to coordinate their work with that of the District AIDS Coordinating Committees (DACC). For these benefits to occur, the DCWBs must be mobilized and supported.

**Education Support for Affected Children...**

The links between education and working children are well documented. With respect to HIV-affected households, the descent into poverty means that children, starting with girls, will be withdrawn from school. This occurs because school fees cannot be paid, girls are needed for household duties and to care for infected family members, and households need the extra income, or can no longer afford to feed all the children.

A necessary part of keeping AIDS-affected children out of the labour market is to keep them in school. The Ministry of Education and Sports (MoES) maintains a bursary for underprivileged children, equaling 7.8% of total enrolment. Awareness raising is required to ensure that AIDS-affected children have access to these bursaries. There is also a need to look at the sustainability of this fund should the epidemic grow. Children whose parents are sick or are dead as a result of HIV/AIDS need to be protected from harassment and bullying by other students and by teachers.

**Research...**

There is a need for research on how HIV/AIDS contributes to household vulnerability, disintegration and child labour in Nepal. There is also a need to know what distinguishes affected households that are able to cope from those households that cannot. The experience of other countries indicates that it is the quality and types of support systems available that make this critical difference. These systems can be traditional family and community systems, or more formal ones developed by governments, NGOs and CBOs, or a combination of both.
III. HIV/AIDS and Working Children – Prevention and Care and Support

If preventing AIDS-induced child labour is a community development issue, with a strong emphasis on participatory methodologies and community mobilization, then preventing HIV infection among working children is an issue of social welfare, harm reduction, and protection, with a strong emphasis on health and social service interventions, many of them short-term. As discussed, preventing HIV infection among working children needs to start from a non-judgemental acceptance of the reality of their lives and respect for them as autonomous beings. This includes acceptance of the reality of sexual and drug-using behaviour. It also includes the strategies listed in Table 10.

Research Needs...

The current claims of some service providers on HIV prevalence among working children in Kathmandu and other urban centres are entirely anecdotal. Although there is a reported growth in high risk sexual and drug-using behaviour, there is no evidence that this is resulting in an increasing rate of infection. There is also very little known about the sexual and drug-using behaviours, and networking of working children.

Given the perceived growth of HIV infections, it is important to conduct a structured behaviour surveillance survey (BSS) of sexual and drug-using behaviour, including networking. A size estimation of different types of working children, and an understanding of how HIV is entering this population and being spread from it, is also essential. A priority for a study like this would be street-based working children of Kathmandu, given their perceived risk levels and their immediate and easy access. This study could then be replicated in other urban centres for street-based working children, as well as invisible/isolated and sector-based working children.

TABLE 10: Strategies for Helping Young People Protect Themselves from HIV/AIDS

| • Protecting and promoting the rights of the child… |
| • Providing HIV/STI prevention, sexual and reproductive health and life-skills education and information to young people, whether they are in school or not; |
| • Providing reproductive health services…; |
| • Targeting programming to particularly vulnerable groups such as young IDUs and young men who have sex with men; and |
| • Combating sexual exploitation of young people. |

A major focus of the impending National HIV/AIDS Programme is the prevention of HIV infection among young people. Any prevention interventions for working children must use this Programme as its starting point. Such coordination would also enable access to condoms, Information, Education and Communication (IEC) materials, and STD and addiction treatment services.

The following areas are some of the major programming components that must be addressed if HIV infection among working children is to be prevented, and working children who are HIV+ are to receive care and support.

Narayan (16)

On the one hand he doesn’t care even if he contracts HIV/AIDS, but on the other hand, he finds it scary because if it he has HIV/AIDS, his health will not allow him to work and make money. Lots of his friends have died due to different diseases, and some have died due to AIDS.

There is also a growing need to pilot approaches for the prevention of HIV infection among working children and to provide care and support for working children who are HIV+. To this end, the ILO/IPEC Nepal Time-Bound Programme should consider supporting a series

of carefully selected pilot projects in various intervention areas. These pilot projects should be structured as learning opportunities, and should have the ability to capture, analyse and disseminate lessons learned.

**Recommendation 14:** That the ILO/IPEC Nepal Time-Bound Programme advocate for a consortium of street-based working children NGOs in Kathmandu to conduct a qualitative Behavioural Surveillance Survey (BSS) of street-based working children. This BSS should be undertaken in compliance with standards recognized by UNAIDS; the resulting findings should form the basis for HIV/AIDS prevention programming.

**Recommendation 15:** That the ILO/IPEC Nepal Time-Bound Programme support a series of pilot projects with partners to develop programming approaches to working children at risk of HIV infection and working children who are already HIV+.

**Building Alliances and Networks...**

The increasingly interlocking fields of working children and HIV/AIDS suffer from a high level of competition between NGOs and CBOs, and a lack of coordination. Driven by donor demands, service delivery and organisational capacity are built without reference to existing services and capacity, or the needs of working children. The result is an inefficient use of existing resources, and an inability to effectively serve working children.

There is a pressing need to build formal alliances and networks of NGOs/CBOs and appropriate frontline government bodies (i.e. police, courts) to communicate and coordinate efforts. An ideal initial step would be to create an alliance of working children’s organisations of some or all the relevant bodies in Kathmandu. This alliance could share information on existing services and carry out joint assessments and proposal creation for new initiatives. Furthermore, given time, this alliance could create shared objectives for alliance members, including the following:

- Inventory of existing services and capacity,
- Needs assessments for both working children and organisational capacity,
- Development of a joint plan of action,
- Development of joint proposals,
- Development of coordination, referral and networking mechanisms; and
- Development of shared mission, principles and codes of conduct.

There is also a need for organisations working with street children to develop a shared communication strategy. The purpose of such a strategy would be to communicate the importance to the wider community of reaching working children, and why the methods used are in the best interests of the community.

**Recommendation 16:** That the ILO/IPEC Nepal Time-Bound Programme facilitate the development of an alliance of organisations offering frontline services to working children. Such an alliance should first be attempted in an urban centre, and initially with street-based working children.

**Health and Social Service Needs of Working Children...**

There is an urgent need, as identified in the impending National HIV/AIDS Programme, to develop youth-friendly services. Such services should be accessible, confidential, welcoming, and non-judgemental. They would offer a range of health, counselling and support services, and not require the consent of a parent or guardian.

On this matter, UNAIDS has the following to say in its 2002 annual report:

“Current best practices in youth-friendly health services show that they should be affordable, cater to minors or unmarried adults, and offer low-cost or free condoms in an atmosphere that guarantees confidentiality. And, in many settings, flexible opening hours for young people who work or study will make a big difference to the number of people who use such services.”

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The development of health, counselling and support services should be determined by research, needs assessment, behavioural surveillance, and pilot projects. The experience of other countries has indicated that a range of interlocking and coordinated services is required to provide for working children, particularly those who are at risk of HIV infection, or who are already HIV+. It is also important that these services recognize and respect the autonomous nature of these children, and focus on their overall health and well-being, not just on their HIV status.

A potential list of services could include the following:

- **Outreach:** lay/crisis counselling, assessment/referrals, IEC materials, condoms
- **Drop-In/Resource Centres:** lay/crisis counselling (i.e. crisis, short-term, not in-depth), assessments/referrals, IEC materials, condoms, food, showers/cloth washing, non-formal education classes, health/counselling services, recreation, storage of personal effects
- **Emergency/short-term shelter and food**
- **Education and skills development; job placement**
- **Economic development:** micro-credit, youth business support
- **Youth Health Services:** general health (including occupational injuries and sickness), STD treatment, OI management, VCT, abscess management, reproductive health
- **Health Promotion:** hygiene, nutrition, sexual and reproductive health, including HIV/AIDS/STD awareness/prevention, drugs/alcohol prevention, and harm reduction
- **Counselling:** general, pre-test/post-test, addictions/substance abuse, anger management, life skills, group counselling
- **Legal Support:** youth and the law, youth and employers
- **Conflict mediation**
- **Referral Services:** addictions treatment (detox and substitution), shelter/food, health services/promotion, counselling, education/training/job placement, legal
- **Support for voluntary family/community/regular school reintegration**
- **Recreation**
- **Organizational network/capacity development; staff training**

In terms of developing a network of services, the first steps would be to determine which services do exist, and to build a network based upon these services. There is also a need for additional resources and community mobilisation. As implied in the above list, to make services relevant to working children, they should not have a single HIV/AIDS focus but rather a street health and social services perspective, capable of dealing with (directly or through referrals) a range of youth health, counselling and support issues. There is also a need to look at the geographical spread of services within a given area.

The ‘Juventa’ medical centre in St. Petersburg, Russia provides one good model of youth-friendly programming that is street/working children “friendly” but open to all youth/children. It provides a range of services including HIV counselling and testing, contraception and abortion, treatment of sexually transmitted infections, sexual abuse counselling, and legal assistance. Services for people under 18 are free.

The Humsafar Trust, a MSM support group in Mumbai, provides another model for providing sexual health services to working children: high quality referral services; confidential, safe and non-judgmental; group discussions on safe and healthy sexuality; and a continuum of care for those who are HIV+.

In developing a network of health, counselling and support services, the following issues should be take into consideration:
• The development of a service network should start from where services already exist, such as Kathmandu, Pokhara, and some of the towns of the Terai. This first step would be to rationalize and coordinate existing services.

• There is a need for sexual health information and counselling for street-based working children, given the reported high levels of sexual abuse and exploitation among working children of different ages (older boys abusing younger boys) and different genders (boys abusing girls), and the high levels of sexual abuse and exploitation of working children by adults.

• Given the long-term nature of HIV infections and the disinclination of young people to think long-term, it is important to develop HIV preventative behaviours in the context of safe sexuality to prevent all STDs, particularly those which are more rapidly symptomatic.

• Given the nature of child labour, there is a need for service providers to teach conflict resolution and mediation skills. These skills would be required to deal with conflicts between competing groups or types of working children, and between working children and communities, including local residents, business owners, police, and local government representatives.

• There is an ongoing and expanding need for temporary shelters for working children, which are low cost, and which provide a place for working children to wash, interact with trained staff, relax, access health services, play sports, and store possessions.

• Given that the risk of HIV infection for many working children comes from injection drug use, youth-friendly health services require the ability to provide addiction services, including awareness, counselling and referrals to what limited services do exist. Some further discussion will be required on child addicts and addiction treatments, and whether substitution therapy is a viable and acceptable option in the political and cultural context of Nepal.

**Rag Pickers, Dharan**

Some of the boy ragpickers have had sex with little girls… They reported that adult junkies would try to have sex with them...

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**TABLE 11: Lessons Learned in Working with Injecting Drug Users**

• Protecting the rights of injecting drug users and creating environments in which they are not afraid to seek information, services and care works.

• Offering drug users humane treatment choices, including substitution treatment that helps reduce the frequency of drug use and provides hope for a drug free life works.

• Providing active injecting drug users who are not in treatment with clean needles and syringes, and with condoms, to help them avoid infection works.

• Providing outreach services to drug users with limited access to services and to women who face special risks works.

• Harmonization of drug control and HIV prevention policies so that they are mutually reinforcing works.

• Involving people who are vulnerable to or living with HIV infection in policy development and programme design – respecting their experience and listening to their concerns – works.

• Giving drug users real alternatives – and access to education, training and gainful employment - instead of bombarding them with advice and information works.

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57 Cravero, K. Remarks by Kathleen Cravero, Deputy Executive Director, UNAIDS at the Conference on Harm Reduction, 2003, Pp.2
- Given the reported high levels of inhalant abuse: glue (toluene) and petrol (benzene), among street-based working children, there is a need to address these issues.
- There is an urgent need to build the capacity of organisations to provide trained and professional counsellors to working children. This includes frontline/outreach lay counselling in crisis intervention, prevention of HIV/AIDS/STDs, referrals, as well as more complex types of counselling, including general psychosocial, addictions and pre-/post-test. Currently, UMN offers a two-week course in prevention and referral counselling, while CVICT offers a four-month programme of training and coaching in general psychosocial counselling. There is currently no pre-test/post-test counselling training in Nepal, though it is likely to be required after the impending release of VCT guidelines by NCASC.

Education and Skills Development...

An important component of the health, counselling and support services described above is the development of education and job training/placement services for working children, and micro-credit and youth business development services.

There is an ongoing need for non-formal education services for working children that are appropriate to the reality of their lives. These include scholarships, practical curricula, flexible hours, and school fee subsidies. In addition, there is a need to foster employer support for working children school attendance.

“To transform education from being a part of the child labour problem into a key part of the solution will entail considerable innovation and the use of non-traditional techniques.”

Programmes that assist working children to reintegrate into the regular school system are also important, as are programmes that develop employment skills, that provide job placement, and that help working children to establish their own micro-enterprises.

Recommendation 18: That the ILO/IPEC Nepal Time-Bound Programme facilitates the development and integration of non-formal education, formal schooling, job training and placement, apprenticeship, and business development services into a network of services for working children.

Peer Education and Youth Networks...

Consistent with involving child workers in the design and implementation of health, counselling, and support services, is the mobilization of children and youth as peer

Worker, Youth Club, Bharatpur
Child ragpickers have relations with other child labourers, especially with hotel/restaurant boys and Tempo conductors. Some children who had worked in hotels/restaurants before are also found ragpicking now.

Recommendation 17: That the ILO/IPEC Nepal Time-Bound Programme, starting in selected urban centres, advocate and facilitate the development of coordinated and interlocked networks of health, counselling and support services for working children. As required, support limited pilot projects to investigate different programming approaches.
educators, and the development of child and youth networks. Experience in Southern Africa has shown this to be the most cost effective method of increasing awareness and changing behaviour around HIV/AIDS, or any issue. Peer education is appropriate for both in-school and out-of-school children and youth. Peer education can be used to encourage children and youth to question gender and cultural roles that increase the risk of HIV/AIDS, as well as the responsibilities of adults and older working children towards younger working children. It can also transform children and youth into agents of change within their own communities.

“Peer education has been adopted by many prevention programmes, both for young people and for other groups, and is regarded as a key strategy for reaching young people who are not in school, as well as those who are.”

Nepal already has a network of children and youth clubs which could be utilized for HIV/AIDS prevention messages and behaviour change. However, these clubs may need to be developed for working children. Some consideration would need to be given on how working children can be mobilized as peer educators and into networks. In Bangladesh, the Bangladesh Rural Advancement Committee (BRAC) has developed the Adolescent Peer Organized Network (APON). Maiti Nepal has started to use HIV+ former Female SWs in Chitwan as community peer educators.

There is an opportunity to involve working children, including HIV+ working children, in working with others to prevent HIV/AIDS. Given appropriate training and mobilization support, peer educators and networks could raise awareness and deliver out-of-school life-skills training.

To be successful, there is a need to develop a range of fun, interactive, and interesting IEC materials, for use by peer educators and networks.

Recommendation 19: That the ILO/IPEC Nepal Time-Bound Programme looks for opportunities to support peer education and child/youth networks for the prevention of HIV/AIDS among working children. In addition, the Time-Bound Programme should also look for opportunities to involve working children in the implementation of programming.

The final section of this chapter will briefly discuss the three programming categories of working children: (1) street-based working children, (2) invisible/isolated working children, and (3) sector-based working children.

I. Street-Based Working Children

Street-Based Working Children: Shared interventions and partnerships can be implemented for street-based working children. This would include rag pickers, short-haul porters, beggars/thieves, tempo khalasi, and tea/raxi paisals, cabin restaurant, disco, hotel, and cinema workers. These different child workers can be reached using a single programming approach due to their common shared space and street culture, and similar risk factors. Street-based child-workers are concentrated in numbers and relatively easy to identify and reach with programming interventions.

Street-based working children, except for street sex workers, appear to be predominantly boys. CWIN believes that there are over 500 female sex workers in Kathmandu under the age of 18. Currently, in Kathmandu and several other large urban areas, these children receive services from a confusing array of NGO and CBO service providers, with the resulting duplication and waste of resources.

These children are highly mobile, moving between employment, prostitution, theft, and begging. They share an environment and street culture that leaves them vulnerable to HIV infection. Due to their unaccompanied status, and the easy access that adults and older working children have to these children, they have a high risk of sexual abuse and exploitation.

There is a need to develop a network of health, counselling and support services for this population in major urban centres, offered by alliances of service providers working in coordination with each other. Given their shared environment and culture, street-based working children are relatively easy to access via street-based services.

Recommendations covering street-based working children have been made earlier in this section.

II. Invisible/Isolated Working Children

**Invisible/Isolated Working Children:** Interventions and partnerships for working children, whom are isolated within homes, factories and brothels, or by the transport industry, will require discrete programming approaches and different partners. This is because of the isolation that these child workers find themselves in, and the need for programming interventions to reach the child workers at their work sites.

While it is difficult to determine exact numbers, it is within this category that the largest number of girls are involved. Given the hidden nature of their work, creative programming is required to reach these working children. In particular, there is a need for specific programming for child domestic workers, factory workers, transport workers, and sex workers. There are a number of programmes dealing with sex workers, although they do not separate child sex workers from the adults. There are also several NGOs reaching child domestic workers and carpet factory workers.

The risk of HIV infection for invisible and isolated working children comes from their unaccompanied status, their isolation, the access that abusers and exploiters have to them, and, in the case of girls, their gender.

It has been noted by several studies that the level of sexual abuse of girls in domestic service and in factories is high, and that many girls move from these types of employment directly into commercial sex work. This speaks mainly to the absence of alternative work opportunities for girls.

With the exception of commercial sex workers who appear to be serviced by a number of projects, there is limited information on HIV/AIDS among children in invisible or isolated forms of child labour. There is also no information on health and social service needs. If properly developed, the street-based health, counselling and support services discussed in the previous section could also be used by these children, although more outreach would be required to make these children aware of these services.

The NGO, Children Women in Social Services and Human Rights (CWISH) directs its programming at child domestic workers.

Experiences that have worked in Latin America for child domestics include the use of rapid assessment methodologies and mechanisms for attending to their needs. The work of CWISH is an example of an NGO selecting a specific type of child labourer who is difficult to reach, and who has a range of specific programming needs. The work of CWISH has included:

- Non-formal education
- Rights and empowerment education
- Awareness building among employers, including voluntary registration of child domestic workers
- Awareness raising of the children of employers of child domestic workers, advocating for basic employment standards and the right to education
- Removal and rehabilitation of child domestic workers from abusive situations
- Operation of ten clubs in Kathmandu for child domestic workers

In CWISH’s estimate, 20% of domestic labour in Kathmandu is under the age of fourteen years, the majority of these working in middle or upper
class households. This offers the ILO/IPEC Nepal Time-Bound Programme an advocacy and awareness-building opportunity, as these types of households may be susceptible to a public perception that they are exploiters of child labour, including possibly sexual exploiters of children. Any such initiative should consider the principle of “do no harm”.

Recommendation 20: That the ILO/IPEC Nepal Time-Bound Programme look for opportunities to support specific programming for child domestic workers and factory workers, paying particular attention to the risks of sexual abuse and exploitation faced by girl workers and their easy shift into commercial sex work.

Recommendation 21: That the ILO/IPEC Nepal Time-Bound Programme determine whether it should become involved in specific HIV/AIDS programming for child and youth commercial sex workers.

Recommendation 22: That the ILO/IPEC Nepal Time-Bound Programme consider a special public awareness focus on child domestic workers, given their employers possible susceptibility to pressure and public perceptions.

III. Sector-Based Working Children

Sector-Based Working Children: Interventions and partnerships for these working children should not be separated from those intended for adult workers in the same sector. This is because the known risk of HIV infection for a child agricultural worker, long distance porter, or boy migrants to India is not significantly different than the known risks for adults in these sectors. The programming approach should ensure that child workers in these sectors are included in sectoral HIV/AIDS prevention and care and support initiatives.

Since the risk of HIV infection does not appear to be different between the child and adult workers in these sectors, the ILO/IPEC Nepal Time-Bound Programme would best be served by partnerships with NGOs and CBOs that are working with the entire sector. This would include organisations advocating for better working conditions for porters and agricultural workers, and organisations working for safe migration to India.

Given the size of the male migration to India, and migration as one of the major risk factors for HIV infection in Nepal, coordination with any ILO initiatives in Nepal or India would be useful.

Recommendation 23: That the ILO/IPEC Nepal Time-Bound Programme advocate for a working child perspective to existing HIV prevention and labour programmes for specific sectors such as portering.

Recommendation 24: That the ILO/IPEC Nepal Time-Bound Programme look for opportunities to integrate a child labour perspective into child trafficking prevention and “safe migration” projects.

60 One possible exception to this assumption, are boys working in the trucking industry. While the evidence from Nepal is only anecdotal, the widespread sexual abuse of boys in the transportation sector in other parts of South Asia has been documented. This requires further study.
The conclusion of this document is a simple one: there is a need for ILO/IPEC Nepal’s Time-Bound Programme to engage with local non-governmental and community partners to integrate HIV/AIDS into programming for working children. While it is important to continue the ILO’s traditional work with its tripartite partners, and to build an enabling environment, this is not sufficient to prevent HIV/AIDS driving increasing numbers of vulnerable children into the labour market, and exposing growing numbers of these working children to HIV infection.

There is at present considerable work being done to prevent vulnerable children from HIV-affected households from being forced from their homes, schools and communities into the labour market. This work is most successful when it is done in the wider context of community development initiatives for households and children made vulnerable by HIV/AIDS. The ILO/IPEC Nepal Time-Bound Programme should look for opportunities to work with and support such broad-based initiatives.

There is a far more urgent need for ILO/IPEC Nepal to take on the challenge of preventing HIV infection among working children. In particular, there is a pressing need for ILO/IPEC Nepal to promote the coordination of efforts by existing organisations already working with working children. These efforts should focus on ensuring the widest and highest quality coverage of working children by health, counselling and support services. Along with leadership, there is also a need for ILO/IPEC Nepal to provide seed funding for local non-governmental and community organisations that are reaching working children with innovative health promotion programming.
Appendix A: Policy, Coordination and Institutional Recommendations

A. National Policy and Coordination

1. Formation of technical working group under the National Strategic Plan ..., to develop a strategy and guide development of an action plan for orphans and children living with families affected by HIV/AIDS.

2. Review the Child Act (1992) to strengthen and clarify the care and protection of vulnerable children, especially in terms of: birth registration and citizenship; mechanism to identify vulnerable children in the communities; mechanisms to monitor the situation of property and inheritance of orphans; mechanisms to provide services to orphans and vulnerable children.

3. Strengthen the capacity of the Central Child Welfare Board and of the District Child Welfare Committees (DCWC) to carry out the mandate of the Child Act including the role of monitoring and supervision of vulnerable children.

B. Institutional Care


2. Carry out a rapid assessment of the conditions of existing care institutions.

C. District Coordination and Planning

1. Orientation of the DDCs and line agencies on basic rights and provisions for orphans and children affected by HIV and AIDS.

2. Training of the DCWC members on the use of standard guidelines for institutional care of children.

3. Strengthening information systems for better flow from VDCs to the DCWC.

D. In UNICEF/HMG DACAW Districts - VDCs

1. Expand and accelerate capacity of the DCWC staff to undertake their duties in relation to the Child Act (1992).

2. Ensure that an information system is in place from the ward levels to the VDCs and the DCWCs in relation to orphans.

3. DACAW CAP VDCs, carry out the orientation of village facilitators and community mobilisers on orphans and linkages to basic services.

4. In select DACAW CAP VDCs, where there is a higher prevalence of HIV/AIDS, undertake a rapid assessment through village facilitators and community mobilisers on orphans, living conditions, and access to services.

5. In DACAW CAP VDCs, include orphans, disaggregated by age, in community information boards in CAP community organizations.

6. Strengthen the involvement of child clubs in raising awareness on HIV, including reduction of discrimination.

Appendix B: 
Programme Principles for Orphans and Vulnerable Children

The following programming principles evolved from the consultations during the XII 
International AIDS Conference in South Africa in July 2000.62

1. Strengthen the protection and care of orphans and other vulnerable children within their extended families and communities.
2. Strengthen the economic coping capacities of families and communities.
3. Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children, and their caregivers.
4. Link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS, and efforts to support orphans and other vulnerable children.
5. Focus on the most vulnerable children and communities, not only those orphaned by AIDS.
6. Give particular attention to the roles of boys and girls, and men and women, and address gender discrimination.
7. Ensure the full involvement of young people as part of the solution.
8. Strengthen schools and ensure access to education.
9. Reduce stigma and discrimination.
10. Accelerate learning and information exchange.
11. Strengthen partners and partnerships at all levels and build coalitions among key stakeholders.
12. Ensure that external support strengthens and does not undermine community initiative and motivation.

### Development Objective: To Contribute to the HMG/N Master Plan for the Elimination of Child Labour

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<thead>
<tr>
<th>Component I: Creating an enabling environment for the elimination of the worst forms of child labour</th>
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<tr>
<td><strong>Intermediate Objective 1:</strong> child labour related legislation will be coherent and in conformity with international standards, and capacity for enforcement, including its monitoring, will have been strengthened.</td>
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<td><strong>Intermediate Objective 2:</strong> education and training policies reflect the needs of child labourers and children at risk, considering in particular the special situation of the girl child.</td>
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<td><strong>Intermediate Objective 3:</strong> labour and social policies will target communities prone to child labour, vulnerable families, women and children.</td>
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<tr>
<td><strong>Intermediate Objective 4:</strong> poverty and employment policies will target the poorest of the poor and government programmes, donor and other development programmes will be mobilized to contribute to the elimination of the worst forms of child labour.</td>
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<tr>
<td><strong>Intermediate Objective 5:</strong> public awareness of the negative consequences of child labour will have increased and the IPEC partners will be mobilized against the worst forms of child labour.</td>
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<th>Component II: Reducing the incidence of selected worst forms of child labour</th>
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<tr>
<td><strong>Intermediate Objective 2:</strong> local capacity to detect and prevent situations of exploitation of children will have been enhanced in targeted sectors/districts.</td>
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<td><strong>Intermediate Objective 4:</strong> children at risk and in the worst forms of child labour will have access to primary, non-formal or vocational education in targeted sectors/districts.</td>
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<tr>
<td><strong>Intermediate Objective 6:</strong> community safety nets are established or strengthened to reduce family vulnerability to the worst forms of child labour in targeted sectors/districts.</td>
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<tr>
<td><strong>Intermediate Objective 8:</strong> the economic vulnerability of families with children at risk or engaged in the worst forms of child labour will have been reduced in targeted sectors/districts.</td>
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Appendix E:
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