

Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia: A Situation and Response Assessment, 2007

**The National Multi-sectoral Orphans and
Vulnerable Children Task Force**

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List of Participants to the National Validation Workshop of the OVC Situation and Response Assessment

ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
AusAID	Australian Agency for International Development
CARE	Cooperation for Assistance and Relief Everywhere – CARE Cambodia
CBO	Community-based Organisation
CDHS	Cambodian Demographic and Health Survey
CNCC	Cambodian National Council for Children
CPN	Child Protection Network
CRC	Convention on the Rights of the Child
DFID	United Kingdom Department for International Development
DIW	District Integration Workshop
DOSVY	Department of Social Affairs, Veterans and Youth Rehabilitation
EMIS	Education Management Information System
FAO	Food and Agricultural Organization
FBO	Faith-based Organisation
FHI	Family Health International
FI	Friends-International
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
HSSP	Health Sector Strengthening Programme
ILO	International Labour Organization
INGO	International Non-governmental Organisation
IO	International Organisation
IOM	International Organization for Migration
IPEC	International Programme on the Elimination of Child Labour
KHANA	Khmer HIV/AIDS NGO Alliance
LICADHO	Cambodian League for the Protection and Defense of Human Rights
MoCR	Ministry of Cults and Religions
MoEYS	Ministry of Education Youth and Sports
MoH	Ministry of Health
MoI	Ministry of Interior
MoJ	Ministry of Justice
MoLVT	Ministry of Labour and Vocational Training
MoP	Ministry of Planning
MoRD	Ministry of Rural Development
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoU	Memorandum of Understanding
MoWA	Ministry of Women’s Affairs
MRD	Ministry of Rural Development
NAA	National AIDS Authority
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NGO	Non-governmental Organisation

NOVCTF	The National Orphans and Vulnerable Children Multi-sectoral Task Force
NSP-II	National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV/AIDS for 2006-10
OD	Operational District (of the MoH)
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PLHIV	Person/People Living with HIV
PMTCT	Preventing Mother-to-Child Transmission
PRDC	Provincial Rural Development Committee
RGC	Royal Government of Cambodia
SCA	Save the Children Australia
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infection
TPO	Transcultural Psychosocial Organisation
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteer
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counselling and Testing
WFP	World Food Programme

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1 INTRODUCTION

1.1 The Cambodian Context

Children and young people aged 18 and under make up almost half of Cambodia's 13.8 million population. A large proportion (85%) of the population lives in rural areas and 59% rely on subsistence agriculture for their livelihood; more than 30% of the population lives under the poverty line.¹

Cambodia is experiencing a period of relative stability after more than 3 decades of social and economic devastation from civil war and genocidal regime.² Economic recovery since then has been relatively rapid, although the gains have not benefited people equally. Despite increases in service sector employment, unemployment remains high. Approximately 300,000 young people enter the labour force each year, and 27.8% of 15 to 19 year olds and 16.6% of young adults aged 20 to 24 are unemployed.³

There are still many forms of vulnerability in Cambodia.⁴ Most of the population is engaged in subsistence agriculture, and rice yields are dependent on what can often be erratic weather conditions.

For the urban poor, and especially migrants, lack of secure housing tenure leaves many in a precarious situation, often in squatter settlements with a high risk of sudden eviction. Rural to urban migration also further increases children's vulnerability, both in situations when they are "left behind" in the village or when accompanying their parents to insecure urban conditions.

The country is experiencing an HIV and AIDS epidemic that is the sum of many micro-epidemics and characterised by high levels of infection among sex workers, their clients, men who have sex with men and the small but growing number of injecting drug users. Prevention efforts have been relatively successful, and HIV sentinel surveillance (HSS) data show a steady decrease in HIV prevalence in the general population from a high of 3.0% in 1997 to the current level of 0.9% among people in the age group 15 to 49. The HIV prevalence among antenatal care attendees is decreasing, and in 2006 was estimated at 1.1% nationally, although this masks some persistent variations and higher prevalence in urban areas.⁵

¹ National Institute of Public Health, National Institute of Statistics [Cambodia], et al. Cambodia Demographic and Health Survey 2005 (Phnom Penh and Calverton, Maryland: National Institute of Public Health, National Institute of Statistics, 2006)

² C. Hughes and T. Conway, Understanding Pro-Poor Political Change: the Policy Process in Cambodia (London: ODI, 2004)

³ Morris E., Promoting Employment in Cambodia: Analysis and Options, ILO (2007)

⁴ The following paragraphs on vulnerability are synthesized from Managing Risk and Vulnerability in Cambodia: An Assessment and Strategy for Social Protection (The World Bank, June 2006)

⁵ HIV Sentinel Surveillance Consensus Workshop on 2006 HIV Estimation for Cambodia Dissemination Meeting, Phnom Penh, 28 June 2007

It was estimated that in 2006 there were approximately 65,000 adults and 6,000 children living with HIV and AIDS in Cambodia.⁶ As a result of the HIV and AIDS epidemic, many children have been orphaned or made vulnerable as their households experienced income shocks, escalating medical expenses and reduced productivity.

Impact mitigation for orphans and other children affected or made vulnerable by HIV and AIDS is a relatively new area of national attention. However a number of development partners and non-governmental organisations (NGOs), including Save the Children Australia (SCA), the United Nations Children's Fund (UNICEF), World Vision Cambodia, the United States Agency for International Development (USAID) through Family Health International (FHI) and Catholic Relief Services, Khmer HIV/AIDS NGO Alliance (KHANA) and CARE Cambodia have developed a service response and advocacy strategies for improving the quality of life of orphans and vulnerable children (OVC).

⁶ Ibid.

1.2 Background to the report

This report was commissioned by the National Orphans and Vulnerable Children Multi-sectoral Task Force (NOVCTF) as a background study to inform the development of a Multi-sectoral National Plan of Action. These documents are being released simultaneously.

The Task Force was established in July 2006 by the Royal Government of Cambodia's Minister of Social Affairs Veterans and Youth Rehabilitation (MoSVY). The Task Force priorities for 2007 were to:

- conduct a national assessment of responses to mitigate the impact of HIV and AIDS on children including: mapping the type, location and coverage of responses, review existing policies and strategies and size estimation; and
- develop and implement a national plan to guide efforts to mitigate the impact of the HIV epidemic on children.

1.2.1 The Purpose of the Situation and Response Assessment

The purpose of this report is to document and create a common understanding of the situation of OVC, their families and communities in Cambodia and to capture key elements and gaps in the response at this time. The process of developing the situation and response assessment brought stakeholders together to identify lessons learned and opportunities for improving the response over the next 5 years. The process contributed to raising awareness about and advocating on behalf of OVC. The findings and recommendations contained in the report will be used to inform the development of a national multi-sectoral action plan for the protection, care and support for OVC.

1.2.2 Methodology

The Situation and Response Assessment was conducted between January and June 2007 by two consultants, one international and one Cambodian. A mapping of the service response to OVC was conducted as a separate exercise by two other consultants. The four consultants met regularly and were supported by a Steering Committee. While key maps have been incorporated into this overall situation and response assessment, the detailed mapping report has been published separately. In addition, a fifth consultant, an expert in statistical packages, performed a secondary analysis of Cambodia's Demographic and Health Survey (CDHS) 2000 and 2005. This secondary data analysis was conducted in September 2007⁷ and complemented the initial findings of the situation analysis.

Data Collection Methods

⁷ The raw data from CDHS 2005 was not available earlier.

1. A literature review of over 150 documents related to OVC and HIV and AIDS in Cambodia and internationally was conducted to ascertain issues faced by OVC, the impact of HIV and AIDS on children and their caregivers, and to identify key components of the response.
2. The data and reports from 2 CDHS surveys were analysed using the Statistical Package for the Social Sciences (SPSS). The statistical analysis included frequencies of selected variables and bi-variate and multi-variate analysis controlling for factors such as gender and type of residence (urban/rural). Chi-square statistical tests of selected variables were also conducted. UNICEF collated the findings from the CDHS into the overall situation assessment.
3. A national mapping of essential services provided to OVC was conducted by two consultants through SCA. The mapping was developed following a literature/desk review and interviews with representatives from key ministries and NGOs.
4. Targeted in-depth interviews and discussions were conducted with 84 informants, and 3 focus group discussions were facilitated with women living with HIV and children affected by HIV. Five working groups with a total of 87 participants were formed to further identify and examine the situation of and response to OVC.
5. Four Steering Committee meetings, 2 Secretariat meetings and 2 National OVC Task Force meetings, with a total of 55 participants, were held. During these meetings drafts and progress reports were submitted and key issues discussed.
6. A National Validation Workshop was held over 2 days (26 and 27 April 2007) to review the findings and conclusions drawn from the assessment.

Data Analysis

The literature, plus information generated through the interviews, working groups and formal and informal discussions related to the situation and the responses, were analysed largely using an iterative approach. This preliminary analysis identified the issues that were then explored in more detail during subsequent working group and steering committee meetings and interviews and through the literature. The information was then triangulated through a National Validation Workshop held over 2 days on 26 and 27 April 2007. Drafts of the written report were circulated to Steering Committee members for comment and feedback.

Limitations

It is important to note that findings from the secondary data analysis of CDHS derived from an analysis of household surveys, and therefore by definition children living outside of households, such as street children or those living in institutions, were not represented. Also, there were some differences between the CDHS 2000 and CDHS 2005 that affected the ability to compare them. For example, in CDHS 2000, questions about parental survival status were only asked of children under 15, whereas in CDHS 2005, the questions were asked of children under 17. Therefore, comparisons between the two surveys used the shorter period, while individual analysis of the data from CDHS 2005 used children 0 to 17 years old.

2 DEFINING AND QUANTIFYING CAMBODIA'S ORPHANS, CHILDREN AFFECTED BY HIV AND OTHER VULNERABLE CHILDREN

Orphans and vulnerable children are defined in the 2006 national Policy on Alternative Care.⁸ As much as possible, this Situation and Response Assessment will follow that definition. Thus, the information provided in this assessment will cover children orphaned from all causes, children affected by HIV, as well as other vulnerable children to the degree that data is available.

2.1 Orphans

The Definition of Orphans

An orphan is a child below the age of 18 who has lost one or both parents. Children who have lost both parents are called double orphans.

Maternal orphans are children under the age of 18 whose mothers, and perhaps fathers, have died (includes double orphans).

Paternal orphans are children under the age of 18 whose fathers, and perhaps mothers, have died (includes double orphans).⁹

The combined effects of poverty, poor nutrition, inadequate sanitation, accidents and injuries, HIV and other health problems, together with limited access to quality health care services, means life expectancy in Cambodia is low. Consequently, children face a considerable risk of losing their mother or father at a young age.

Orphans in the Age Group 0 to 14 Years: Trends from CDHS 2000 and 2005

Orphan prevalence

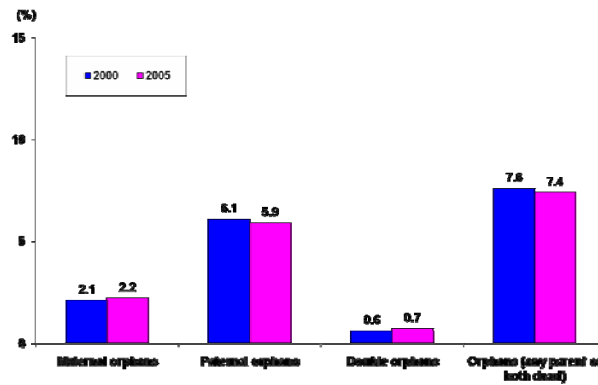
The overall picture for orphans aged 0 to 14 years in Cambodia changed little between 2000 and 2005 (Figure 1). In 2000, 7.6% of Cambodian children aged 0 to 14 years had lost a parent, and the figure was 7.4% in 2005. There are many more paternal orphans in Cambodia (6.1% in 2000, 5.9% in 2005), compared to maternal orphans (2.1% in 2000, 2.2% in 2005). This may reflect the higher proportion of male HIV prevalence in the country in the last 10 years, although orphanhood in the data may be due to any causes of death, such as all diseases, injuries and violence, and not just AIDS. Only a small number of children are double orphans.

Figure 1. Orphan Status Among Children Aged 0 to 14 Years in 2000 and 2005 (CDHS)

⁸ "Children exposed to one or more of the vulnerability situations described below have been categorised into protection or children at risk: children in need of special protection include: orphans; abandoned children; HIV; abused children whether sexually; physically or emotionally; street children; children in conflict with exploitation whether sexually or any forms of harmful labour; children with disabilities; children addicted to basic physical needs are not being met." (MoSVY, *Policy on the Alternative Care for Children*, 2006, p. 7)

⁹ L.A. Gulaid, *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living with AIDS*, 2004, 2004

The overall picture for orphans aged 0 to 14 years in Cambodia changed little between 2000 and 2005.



Provincial Distribution

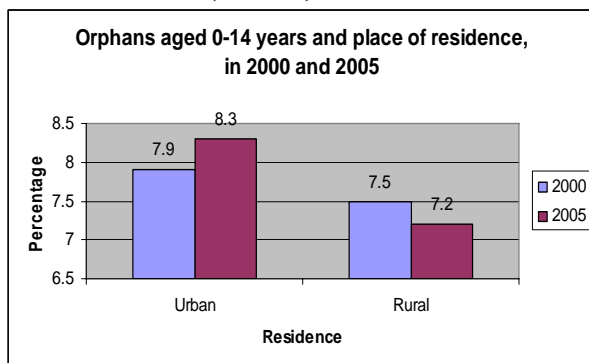
There is great variation in orphan prevalence across the provinces throughout the country. In 2000, Kep (19.5%), Siem Reap and Kampong Thom (12.2%) had the highest proportions of orphaned children. Oddar Meanchey had the highest level of double orphans (2.7%) in the country.

In 2005, CDHS chose a different cluster sampling frame, and thus some provinces which were individually sampled in 2000 were grouped together in 2005. Direct comparisons of the prevalence in some provinces are therefore not possible. The provinces with the highest proportion of orphans in 2005 included Battambang/Pailin (grouped together with 9.8%), Oddar Meanchey (9.4%) and Siem Reap (9.0%).

Gender and Place of Residence

The gender distribution is nearly equal among orphans. The prevalence of orphans is nearly the same in urban and rural areas; however the overall number of children in rural areas is much higher, therefore the burden of addressing the needs of orphans is greater in rural areas as well. There appears to have been a modest shift in the place of residence of orphans aged 0 to 14 years from rural to urban settings between 2000 and 2005, as shown in Figure 2. In 2000, 7.9% of children were orphans in urban settings, while in 2005 this figure reached 8.3%. Similarly, the percentage of children who were orphans residing in rural areas declined from 7.5% to 7.2% in the same period.

Figure 2. Orphan Status by Place of Residence Among Children Aged 0 to 14 Years in 2000 and 2005 (CDHS)



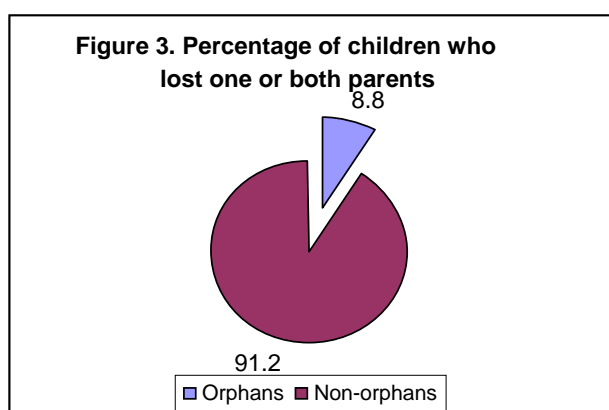
Although the prevalence of orphans between urban and rural is very similar, rural areas carry a greater burden addressing the needs of orphans because there are more children living there.

Orphans in the Age Group 0 to 17 Years in 2005

Prevalence and types

Data from CDHS 2005 indicate that 8.8% of children below 18 years of age were orphans (double and single) (Figure 3). If we apply numbers to these percentages, using the 2004 Population Projection figures,¹⁰ it is estimated that there were 553,000 orphans living in households in Cambodia in 2005, in addition to those living in orphanages.

Figure 3. Percentage of Children who Lost One or Both Parents (CDHS)



8.8 % of children in Cambodia were orphans in 2005. The majority of them lost their father.

Of all children, 2.6% lost their mothers, whereas 7.0% of them lost their fathers and 0.8% lost both parents. There is no significant difference in gender distribution. These children lost their parents from a range of causes, and there are no current estimates of the number of children orphaned as a result of AIDS.

In addition to orphans in households (553,000), there were 6,121 orphans living in orphanages, according to the MoSVY 2007 alternative care report.¹¹ Among these children in orphanages, 60 were known to have lost one or both of their parents to AIDS.

Prevalence of orphanhood by age

As one would naturally expect, the likelihood of losing a parent increases over a child's life. Indeed, among children aged 15 to 17 years, nearly 1 in 6 (16%) had lost a parent, according to the 2005 data, as shown in Table 1. It is important to examine the age pattern of orphaned children, as the needs of children of different ages differ, as would programmes to address them.

¹⁰ Ministry of Planning, National Institute of Statistics, *Population Projections 1998-2020*, June 2004

¹¹ Ministry of Social Affairs Veterans and Youth Rehabilitation (MoSVY), *Alternative Care Report 2007* (unpublished).

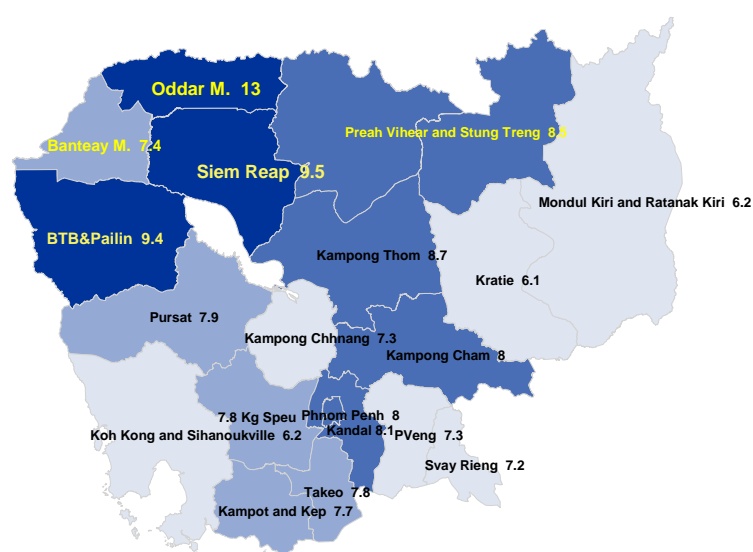
Table 1. Orphan Status by Age Group Among Children 0 to 17 Years, 2005 (n=33,649) (Quantitative Secondary Data Analysis of CDHS 2000 and 2005, C. Wolf , Cambodia 2007)

	% Maternal Orphans	% Paternal Orphans	% Double Orphans	% Orphans (One or Both Parents Dead)
Age Group				
0-4	0.7% (55)	2.1% (176)	0.2% (13)	2.6% (218)
5-9	2.0% (183)	5.3% (483)	0.6% (57)	6.7% (609)
10-14	3.6% (389)	9.4% (1012)	1.1% (121)	11.8% (1280)
15-17	4.7% (252)	12.8% (684)	1.4% (75)	16.1% (861)
All Children 0-17	2.6% (879)	7.0% (2355)	0.8% (266)	8.8% (2968)

Provincial distribution of orphans

The map in Figure 4 shows the proportion of orphaned children (single or double) according to the province in which they were living in 2005. This data reveal that the provinces with the largest proportion of orphans are generally concentrated in the north and northwest of Cambodia. These are also areas where Khmer Rouge activities persisted longest, and where landmines remain concentrated. There is also a high HIV prevalence in these northern border areas and in Siem Reap.

Figure 4. Percentage of Orphans by Province in 2005 (CDHS)

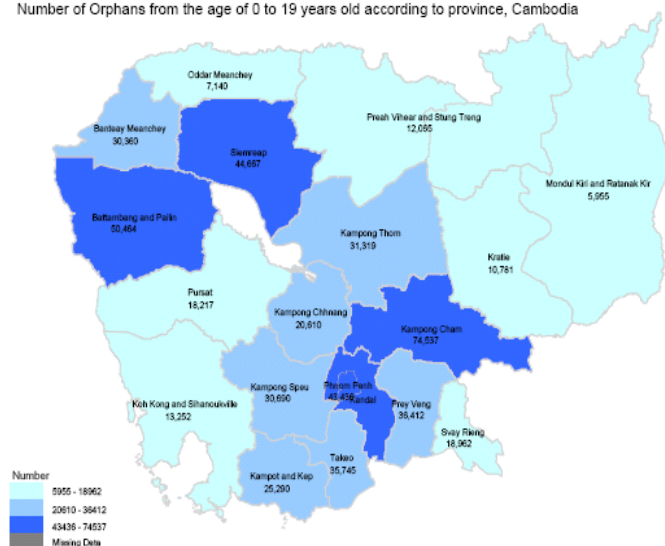


However, when the percentages of orphans are applied to population projections for each province, the province with the highest number of orphans is Kampong Cham, with almost double the number of other provinces, followed by Battambang/Pailin and Siem Reap (Figure 5).

Figure 5. Number of Orphans Aged 0 to 19¹² Years by Province (CDHS 2005 and Population Projections 2004)

¹² The age group 0 to 19 years was used for this particular map because the 2004 Population Projections do not provide data by single year of age by province.

Number of Orphans from the age of 0 to 19 years old according to province, Cambodia



2.2 Children Affected by HIV

Children affected by HIV comprise (1) children under 18 years of age who are living with HIV; (2) children who have lost one or both parents due to AIDS; (3) children whose survival, well-being or development is threatened or negatively impacted by HIV; and (4) children living in affected families and/or those families that have taken in children orphaned or displaced by HIV.¹³ No estimates are currently available for the number of children affected by HIV.

2.2.1 Children Living with HIV

The 2007 National Consensus Building Workshop on Cambodia's HIV Estimates estimated that there are approximately 3,800 children living with HIV in Cambodia. In addition, the data from the national HIV testing programme indicate that in 2006, 10,378 children under 14 years of age were tested for HIV (5,176 boys and 5,202 girls). Of those tested children, 1,448 (14 percent) were identified as HIV positive (692 boys and 756 girls).¹⁴ This rate cannot be generalised to the total population of children.

It is currently estimated that one third of all new HIV infections in Cambodia occur as a result of mother-to-child transmission;¹⁵ most children who are infected are infected in this way. With 1.1% of pregnant women living with HIV, and without prevention of mother-to-child transmission (PMTCT) interventions, an estimated 1,547 babies are born with HIV each year.

¹³ UNICEF, *Child Protection and Children Affected by HIV and AIDS* (New York: UNICEF, 2006)

¹⁴ P. Sok, "HIV Testing for Children," First National Conference on Paediatric AIDS Care In Cambodia, Phnom Penh, 5-6 February 2007

¹⁵ Monitoring the AIDS Pandemic (MAP), *AIDS in Asia: Face the Facts*, 2004

Children can also become infected through sexual activity. Among young women who have had sex (aged 15 to 24), there is an estimated HIV prevalence of 0.6%; young men (aged 15 to 24) have an estimated prevalence of 0.3 %. The small number of sexually active 15 to 18 year olds in the CDHS 2005 survey makes it impossible to accurately estimate HIV prevalence in this group.¹⁶

The Sexually Transmitted Infection (STI) Surveillance Survey 2005 reported that 28% of participating men who have sex with men were aged 15 to 19, and that 8.6% of them had an STI. HIV prevalence was not reported by age group, however a survey conducted in Phnom Penh found that 8.7% of men having sex with men were HIV positive, and overall HIV prevalence for all MSM was 5.1%.¹⁷

2.3 Other Vulnerable Children

Compared to adults, all children are vulnerable by virtue of their younger age, smaller size, and limited life experience, maturity and means, but some children are more vulnerable than others. Some specific vulnerabilities are outlined below, and, where available, estimates of the number of children affected are included. It is important to note, however, that many of the vulnerabilities are overlapping, and a vulnerable child could easily fall under multiple categories, hence the difficulty of accurately estimating the number of these children.

2.3.1 Children with Chronically Ill Parents

Prevalence of children with chronically ill or dead parents

While the death of a parent places challenges on children, the sickness of a parent also has an impact on health and development indicators as demonstrated by the CDHS data. For example, children with chronically ill parents are significantly less likely than orphans and non-orphans to possess basic materials, such as shoes and two or more sets of clothes. Overall, according to the 2005 data, 6.1% of children aged 0 to 17 had one or both parents who had been very sick for 3 or more months the previous year. It is important to note that chronic illness includes all diseases and other health impairing injuries, not just HIV or AIDS.

In 2005, 6.1% of children 0-17 had one or both parents who had been very sick for three or more months the previous year.

Using the 2004 population projection figures, this percentage represents about 383,000 children with one or both parents very sick for 3 months or more.

Provincial distribution of children with chronically ill parents

The burden of chronic illness is not uniform across Cambodian provinces, but is likely to be higher in rural areas. The provinces with the highest proportion of children with a chronically ill parent in 2005 were Kampong Thom (20.3%), Kampong Speu (12.1%) and Banteay Meanchey (11.2%). Of particular note is Kampong Thom, where 20% of children have a chronically ill parent, and over 1 in 4 (27.7%) have either a chronically ill or dead parent.

¹⁶ National Institute of Public Health, National Institute of Statistics [Cambodia], et al, *Cambodia Demographic and Health Survey 2005* (Phnom Penh and Calverton, Maryland: National Institute of Public Health, National Institute of Statistics, 2006)

¹⁷ NCHADS, STI Sentinel Surveillance 2005, 2006

2.3.2 Street Children

Street children are considered to be among the most vulnerable children in Cambodia *“because they are absolutely desperate and are ready to do anything in order to survive. They are also extremely naive and not equipped to face the realities of street life and without guidance children often make dangerous choices and decisions.”*¹⁸

Street children are often divided into three groups: 1) street-living children – who have no ties with their families and have made the streets their home; 2) street-working children – who work on the streets but return home at least irregularly; and 3) children who are living with their family on the streets – numbers are seasonal and vary between a few hundred to a few thousand.

There is limited documentation of the numbers of street children; however data is available for Phnom Penh, Siem Reap and Sihanoukville. According to Mith Samlanh¹⁹, it is estimated that there are 17,000 street children in Phnom Penh, 1,200 in Pailin, 1,500 in Siem Reap, 1,300 in Banteay Meanchey and 3,700 in Kampong Som. A conservative estimate would then be 24,700 street children. Street children are also reportedly visible in large numbers in Battambang and towns along the Thai border.

2.3.3 Children Living in Extreme Poverty

Thirty five per cent of the households in Cambodia, a total of 885,000 households, are living below the poverty line (Source: World Bank 2005). Approximately a third of these households live in the most extreme poverty. It is estimated that extreme poverty affects 300,000 children.²⁰

2.3.4 Children of Migrating Families

Migration to look for work is an issue for the country’s poorest families. Seasonal internal migration to the cities, border areas and areas where unskilled work is available is common. International migration often takes places illegally, due to the long waiting times, prohibitive expense and centralised process for applying for a Cambodian passport. Children who participated in Small Also Have Something to Say stated that this poverty-related migration was devastating their families and represented an HIV risk for children. They perceive that their fathers can return home HIV positive, and then their mothers and younger siblings can also become infected.²¹ No estimate of the number of children of migrating families is currently available.

¹⁸ Mith Samlanh, 10 Years - Mith Samlanh: A Program for Street Children, Their families and Their Community. (Phnom Penh: Mith Samlanh, 2004)

¹⁹ Mith Samlanh, “2006-2007 Snapshot Survey”

²⁰ Estimate computed during the Siem Reap Costing Exercise Jan 24-30, 2007. See Technical Report: Costing the National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia, 2008-2010 (Phnom Penh, 2008)

²¹ L. Daines and E. Ireland, Small Also Have Something to Say. (Save the Children, 2006)

2.3.5 Children Victims of Abuse, Exploitation, Neglect or Violence

The actual number of children victims of abuse, including sexual abuse, and exploitation in Cambodia is not known because there is no reliable national system of reporting. Sexual violence and sexual exploitation of children is, however, recognised as a significant issue in the region.

There are currently no available data on number of children who are sexually exploited through trafficking. An International Labour Organization (ILO) study in 2007 linked trafficking and sexual exploitation of women and girls with work as domestic workers, gender-based norms, high levels of debt in the families, and family dysfunction and crisis.

Data collected through the anti-human trafficking police reported cases show that in 2007, 771 (272 children) victims of trafficking, sexual exploitation or sexual abuse/rape were rescued. Among those, 583 were reunited with families, 130 referred to the MoSVY social workers and 58 referred to NGOs.

Children experiencing violence is not uncommon in Cambodia. Research done by World Vision in 2005 in Kandal Stung district showed that 56% of boys and 19% of girls aged 12 to 18 reported having been beaten by teachers. Both teachers and parents interviewed for the study confirmed they used physical violence to discipline children.²² The issue of violence at the hands of teachers was raised by half of the children interviewed for this report.

Although there is no national data collection of violence against children, several studies have documented children's experiences of violence, for example:²³

- 50% of boys and 36% of girls have been beaten by their parents
- Most young people experienced violence from someone other than a spouse, usually from a parent
- Children experience violence from parents of both sexes
- Violence by parents is viewed as legitimate by adults and children
- Young women experience the threat (and reality) of rape, for example 3% of 15 to 19 year olds experienced forced sex the first time they had intercourse²⁴

According to the CDHS 2005 report, 8% of girls who have ever been married aged 15 to 19 had experienced violence in the previous 12 months, and 20 percent had experienced violence since they had turned 15.

Persistent abuse, neglect and exposure to trauma and danger can rob children and young people of hope. Children with no hope become vulnerable to homelessness, drug use and coming into conflict with the law.²⁵ In order to survive, children may engage in activities that are harmful, such as prostitution, drug use and petty crime.

2.3.6 Children Involved in Child Labour

²² World Vision Cambodia, *Wise Before Their Time*, 2005

²³ I. FitzGerald, "Violence Against Women and Youth Attitudes: Research Directions," Youth Violence in Cambodia – Risk Factors Affecting Youth Workshop, Phnom Penh, 2 July 2007

²⁴ National Institute of Public Health, National Institute of Statistics [Cambodia], et al, *Cambodia Demographic and Health Survey 2005* (Phnom Penh and Calverton, Maryland: National Institute of Public Health, National Institute of Statistics, 2006)

²⁵ Discussion/interview between Jenne Roberts and Holly Bradford from Korsang Harm Reduction NGO, Phnom Penh, 24 April 2007

Children forced out of school and into labour to help their families make ends meet are denied the opportunity to acquire knowledge and skills needed for gainful future employment, thereby perpetuating the cycle of poverty.²⁶ A National Institute of Statistics survey from the Ministry of Planning in 2003 estimated that there were at that time 1.5 million child labourers and 28,000 domestic workers in Phnom Penh between the ages of 7 and 17. A World Bank/ILO/UNICEF report of 2006 also stated that nearly 1.5 million Cambodian children age 7 to 17, or 40% of the age group, were engaged in child labour.

According to the same report, most economically active children are found on farms and work for their families. A very high proportion of economically active children face work-related hazards and dangers, leaving them vulnerable to injury and illness.

2.3.7 Children Using Drugs and the Children of Illicit Drug Users

A small number of children are vulnerable due to their – or their parents’ – drug use. Due to the easy availability of drugs, the number of drug users in Cambodia is increasing. A survey by the National Authority for Combating Drugs estimated in 2003 that there were 4,387 drug users in the country and that 30% of them were children.²⁷ In addition to children using drugs, there are a small number of children whose primary caregivers are drug addicts, and these children live very precarious lives.

2.3.8 Children with Disabilities

Children can become disabled due to congenital factors, complications around the time of birth, accidents or injuries, malnutrition or infectious disease. Disabilities are classified by MoSVY as falling into 9 categories: difficulties moving, difficulties seeing, difficulties hearing, difficulties speaking, difficulties learning, fits, difficulties feeling (e.g. leprosy), strange behaviour and others.

There is a lack of data on prevalence of childhood disability, although a few community-based rehabilitation NGOs have carried out village-level surveys. In Pursat, for example, a cross-disability survey in 9 villages by Disability Development Services Pursat (DDSP) found 44 disabled children aged 0 to 12 years, or 0.41% of the villages’ total population. This would provide an extrapolated national figure of approximately 57,000 disabled children aged 12 and under. There is a similar lack of data on the main types or causes of childhood disability in Cambodia. Undernutrition (including iodine deficiency) is likely to lead to a high prevalence of learning difficulties. Poor hygiene is likely to lead to ear infections, such as otitis media, causing hearing difficulties, while birth complications caused by inadequately trained birth attendants and high fever in newborns likely lead to a high prevalence of cerebral palsy.

Another common cause of disability is accidents and injuries. Preliminary results from a 2007 national survey on accidents and injuries show that drowning is the most common cause of mortality from accidents and injuries among children aged 1 to 14 years. Road traffic accidents, however, are the most common cause of morbidity from accidents and injuries among children aged 1 to 17.²⁸

²⁶ The World Bank, ILO, UNICEF, *Children’s Work in Cambodia: A Challenge for Growth and Poverty Reduction* (Rome: Understanding Children’s Work Project, 2006)

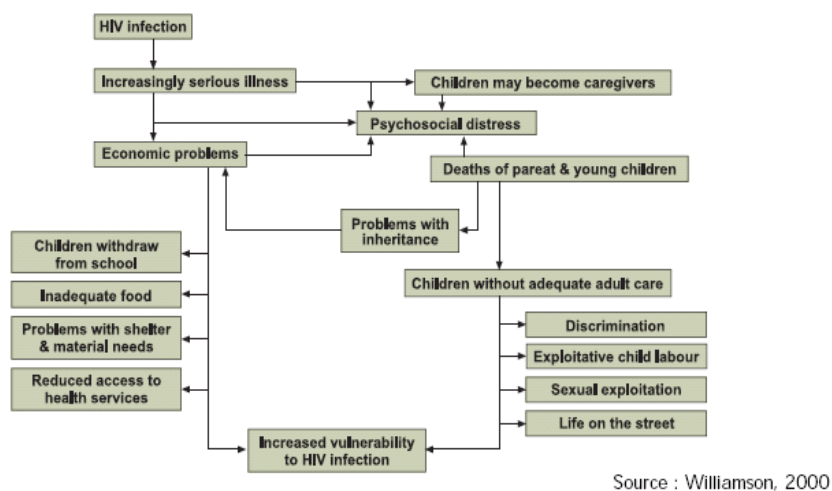
²⁷ NGO Committee on the Rights of the Child, “Child Rights”, <<<http://www.ngoforum.org.kh/Development/Docs/CG%202004/Child.htm>>>, accessed 29 May 2007

²⁸ National Institute of Statistics, National Institute of Public Health, UNICEF, The Alliance for Safe Children, “Preliminary Data, Cambodia Accidents and Injuries Survey, 2007”

3 UNDERSTANDING THE SITUATION OF ORPHANS, CHILDREN AFFECTED BY HIV AND AIDS AND OTHER VULNERABLE CHILDREN IN CAMBODIA

The Framework for Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS (July 2004)²⁹ has identified a range of issues that have an impact on the lives of HIV affected children. These are reported in the figure below, which illustrates how the different problems may interrelate with each other.

Figure 6. Problems Among Children and Families Affected by HIV (Framework for Protection, Care and Support of Orphans and Vulnerable Children Living with in a World with HIV&AIDS, July 2004)



Many of these problems are also shared by children orphaned by other causes as well as other vulnerable children. This chapter attempts to shed more light on the situation of OVC, particularly with regard to their rights to life, survival, development and protection.

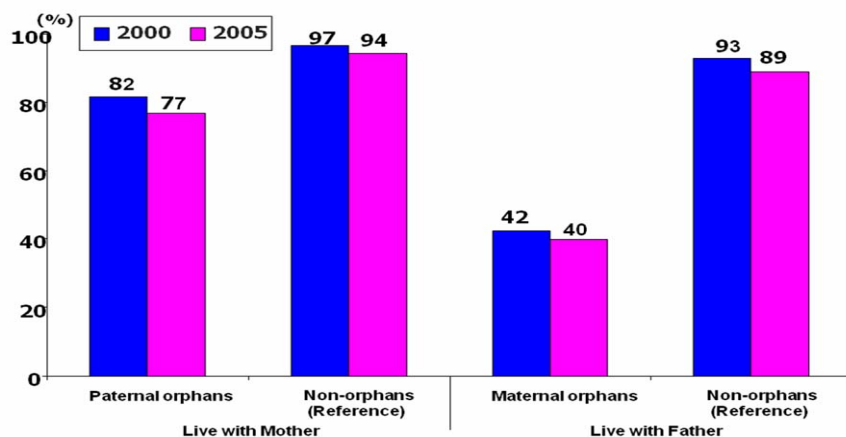
3.1 Living Arrangements and Relationship to Heads of Households

According to the CDHS data, from 2000 to 2005 there was a decrease in the number of children, orphans as well as non-orphans, living with their biological parents. This may be

²⁹ L.A. Gulaid, The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, July 2004

partly due to more children living with other relatives related to increased schooling patterns, which are presented later in this report. Nonetheless, it is important to note that while paternal orphans (children with dead fathers) are likely to live with their mothers (82% in 2000 and 77% in 2005), this is very different for children with dead mothers, as only 4 in 10 maternal orphans live with their father (42% in 2000 and 40% in 2005), as shown in Figure 6.

Figure 7. Living Arrangement by Orphan Status Among Children 0-14, 2000 and 2005 (Quantitative Secondary Data Analysis of CDHS 2000 and 2005, C. Wolf, 2007)

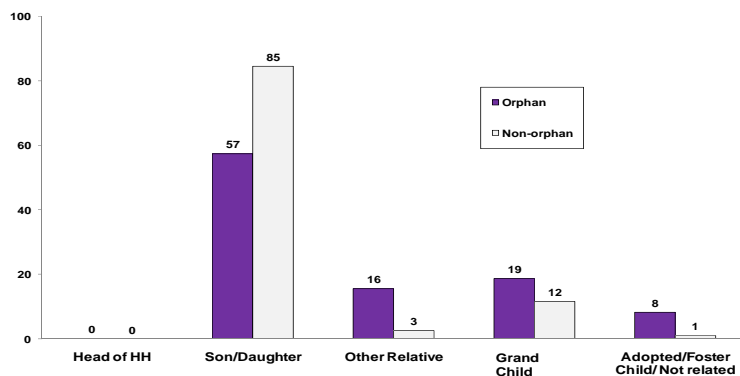


Data from CDHS 2005 (Figure 8) also indicate that about 1 in 5 orphans (single or double) have a grandparent as head of their household. This is particularly important given the fact that many grandparents may no longer be able to earn an adequate income to provide for the children. The same data also reveal that 8% of orphans versus 1% of non-orphans are either adopted, fostered or are not related to the head of household.

- 19% of orphans have grandparents as their head of household
- 8% of orphans are adopted/fostered/not related to head of household

Figure 8. Relationship to Head of Household by Orphan Status Among Children 0 to 7 years (CDHS 2005)

Relationship to head of household by orphan status among children 0-17, 2005



Separation of Siblings

Upon the death of a parent, children may be dispatched to different households as a strategy for adults responsible for the child to reduce their burden of care. The separation of siblings from one another may be a significant source of stress that adds to the trauma brought about by the loss of a parent.

According to the CDHS 2005 data, 17% of orphans were not living with all their siblings who were also under the age of 18. It is more common for orphans to be separated from their siblings when it is either their mother (24%) or both parents who have died (28%), than if the father has died (14%).

In 2005, 17% of orphans were not living with all their siblings who were also under the age of 18, adding significant stress to the trauma brought about by the loss of a parent.

Distribution varies across provinces, ranging from Kampong Speu and Takeo, where up to 30% of orphans are separated from his/her siblings, to Battambang/Pailin, where the figure is less than 3%.

Children-headed Households

Upon loss of parents and in the absence of other relatives or carers, children may be forced to take on responsibilities as heads of households. Data from CDHS 2000 and 2005 indicate that there are very few (less than 0.02%) children-headed households in Cambodia.

Children in Orphanages

A number of OVC live in orphanages. By mid 2007, there were 197 registered orphanages in Cambodia. The 2007 report from MoSVY's residential care database indicate that 8,666 children (and an additional 1,638 people aged 18 and over) are living in orphanages. Among those children, 71% (6,121) are orphans, and 33% (2,855) have lost both parents. In addition, 32 known children living with HIV and 60 children known to have lost their parents due to AIDS live in orphanages. Poverty is an important factor leading some parents and relatives to leave children in orphanages.

3.2 Health and Nutrition Status

The health situation for children in Cambodia is slowly improving; however rates of infant, under-five and maternal mortality remain high.³⁰ One in every 12 Cambodian children dies before reaching the age of 5, and most (four-fifths) of these deaths occur in the first year of life.

The key determinants of child health in Cambodia are malnutrition (54% of all childhood mortality is associated with malnutrition); mother's education; the high prevalence of communicable diseases; inappropriate health-seeking behaviour; the limited quality and coverage of health services;³¹ and a lack of water and sanitation infrastructure. In the end, all determinants of child health can be linked to poverty.³²

While food insecurity contributes to malnutrition, it is only part of the problem. Disease and infection causing micronutrient deficiency, inappropriate hygiene practices and management of diarrhoea, and mothers' poor knowledge of nutrition and feeding practices, especially during illness, can also contribute to malnutrition.

3.2.1 Orphans

An analysis of the CHDS 2005 nutritional data among children under 5 years of age by parental status found that while orphans do not appear to differ significantly from other children with living parents with regard to weight for height and weight for age, maternal orphans and double orphans are significantly more likely to be severely stunted than other children. Stunting reflects a failure to receive adequate nutrition over a long period of time and is exacerbated by chronic illness.

Maternal orphans and double orphans are significantly more likely to be severely stunted than other children.

3.2.2 Children Affected by HIV and AIDS

The link between malnutrition and HIV is well documented from studies conducted in other parts of the world. While malnutrition accelerates the progression towards AIDS, AIDS exacerbates malnutrition through increased metabolism, decreased food ingestion and decreased absorption of nutrients.

In Cambodia, the relationship between malnutrition and HIV in children was documented in a study of 50 children living with HIV conducted in Siem Reap in 2004.³³ The study concluded that untreated HIV-infected children tend to be both severely immune suppressed and malnourished. There also seemed to be a trend indicating a correlation between the degree of malnutrition and the degree of immune suppression. This, however, needed to be confirmed by a larger study.

³⁰ National Institute of Public Health, National Institute of Statistics [Cambodia], et al, Cambodia Demographic and Health Survey 2005 (Phnom Penh and Calverton, Maryland: National Institute of Public Health, National Institute of Statistics, 2006)

³¹ S. Oum, P. Keat, V. Saphonn P. Oum, "Human Resources for Health and Child Survival in Cambodia,"

<<<http://www.aaahrh.org/reviewal/Cambodia%20-%20Draft.pdf>>> accessed 2 July 2007

³² "Fighting Child Mortality – the Child Survival Partnership Visit," June 14, 2004,

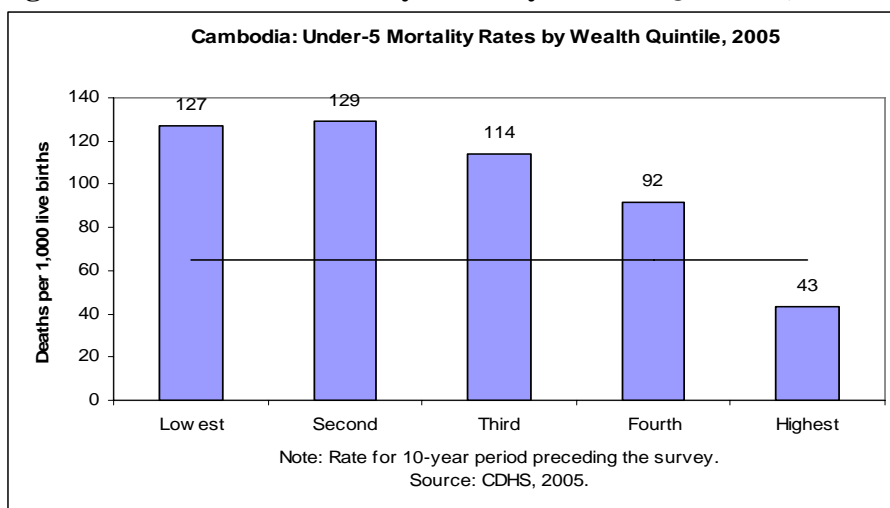
<<http://www.foodsecurity.gov.kh/News_Events_Ann.aspx?IdNews=183&chk=News>> accessed 2 July 2007

³³ S. Seitboth, M.F. Brady, M. Lurie, K. Akao, K. Hendricks K and D. Pugatch, "Malnutrition in HIV-infected Cambodian Children," 15th International AIDS Conference (July 11-16, 2004), abstract no. B10504, <<<http://gateway.nlm.nih.gov/MeetingAbstracts/102276462.html>>>

3.2.3 Other Vulnerable Children

Infant and child mortality is influenced by socioeconomic characteristics of mothers. Data from the CDHS 2000 and 2005 show that infant and child mortality decline markedly as household wealth increases. As seen in Figure 9 below, the wealthiest households had infant and under-five mortality rates 66% lower than the rates in the poorest households. Children whose mothers are in the lowest wealth quintile have a three times greater risk of death than those whose mothers are in the highest wealth quintile.³⁴

Figure 9: Under-five Mortality Rates by Wealth Quintile (CDHS 2005)



Children whose mothers are in the lowest wealth quintile have a three times greater risk of death than those whose mothers are in the highest wealth quintile.

Similarly, the proportion of children with symptoms of acute respiratory infections, a leading cause of morbidity in children, decreases steadily as the wealth quintile of the household increases – from a high of 12% among children living in the lowest wealth quintile households to a low of 3% among children living in households in the highest wealth quintile. Dehydration caused by diarrhoea is also a major cause of childhood morbidity and infant mortality. Twenty-two percent of children under 5 years of age in the lowest wealth quintile households had diarrhoea in the 2 weeks preceding the CDHS survey. This rate steadily declined as household income increased, to a low of 14% in the highest wealth quintile households.

Mortality also declines markedly as mothers' education increases. Children of educated mothers with secondary and higher levels of education experience 59% lower infant mortality and 61% lower under-five mortality compared to children born to mothers with no education.

Children of educated mothers with secondary and higher levels of education experience 59% lower infant mortality and 61% lower under-five mortality compared to children born to mothers with no education.

³⁴ National Institute of Public Health, National Institute of Statistics [Cambodia], et al, *Cambodia Demographic and Health Survey 2005* (Phnom Penh and Calverton, Maryland: National Institute of Public Health, National Institute of Statistics, 2006)

Children's nutrition status is also influenced by mother's wealth. The 2005 CDHS Survey found that increasingly greater proportions of children aged less than 5 years were classified as malnourished as household wealth declined. For example, 53.3% of children in the lowest wealth quintile were classified as low weight for their age compared to 25.9% among the highest wealth quintile households. Even in the highest wealth quintile households, approximately 1 in 4 children under the age of 5 are either stunted or low weight for their age, which reflects the chronic food insecurity across most of Cambodia.

Poor access to health services is also linked to poverty. According to the CDHS 2005 data, children in the poorest families are less likely to be born in a health facility (6.5% of children in the lowest wealth quintile compared to 67.4% of births among women in the wealthiest households). In addition, children in the poorest families are less likely to be vaccinated against childhood diseases (87% compared to 93% of children in the wealthiest households).

3.3 Food Security

According to a recent report from the World Food Programme (WFP), up to 50% of children in Cambodia are food insecure. All of Cambodia is classified as chronically food insecure except for the provinces of Battambang and Phnom Penh. Overall, the food security situation has worsened over the last 3 years, mostly because of persistent drought, unstable rainfall patterns, inadequate economic opportunities in rural areas, land grabbing, low yields, poor infrastructure and population growth. Increasing food prices over recent years have further reduced poor households' access to food.³⁵

Food Security for Children Affected by HIV

While food security is clearly a challenge facing many children, food insecurity is more severe among children living in HIV-affected households.

While food insecurity is clearly a challenge facing many children, food insecurity is more severe among children living in HIV-affected households. A recent study found that children living in HIV-affected households have experienced prolonged suffering from food insecurity related to reduced expenditure on food.³⁶

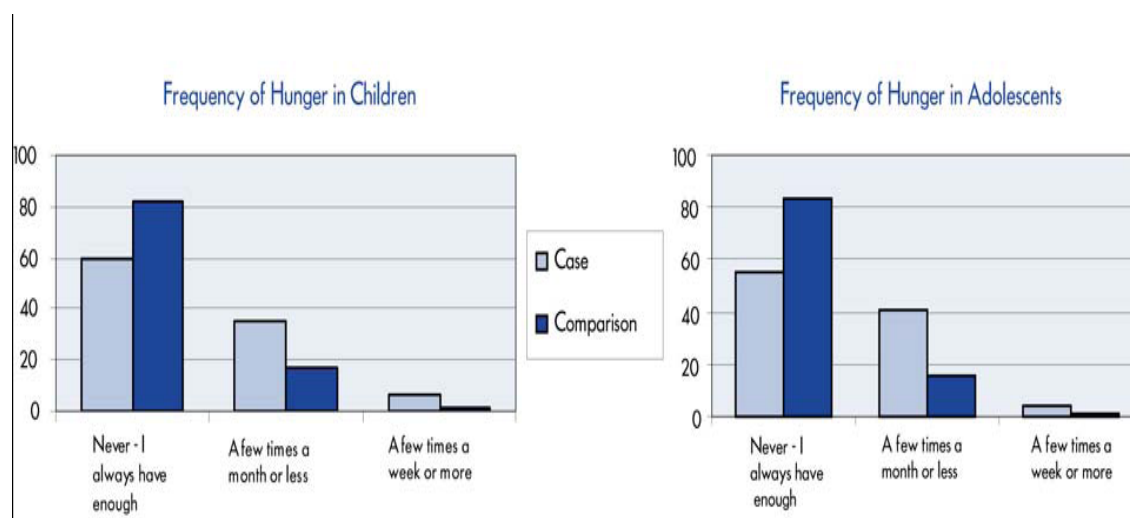
The Social and Economic Impact of HIV/AIDS on families with Adolescents and Children in Cambodia reports on a case comparison study of two groups of 500 households. A total of 2,455 children (aged 6 to 18) were interviewed. The case households included at least one guardian living with HIV. The comparison was the household within closest proximity where there was no HIV. The study reports that children and adolescents in HIV-affected households are more likely to eat fewer meals and experience hunger more often than their peers in non-HIV-affected households.³⁷

³⁵ World Food Programme, Executive Brief: The Integrated Food Security and Humanitarian Phase Classification, Cambodia: WFP, April 2007

³⁶ A. Thwin, Food Support To PLHA And OVC With Home Based Care: Evaluation And Baseline Survey 2006 Cambodia (Phnom Penh, Cambodia: KHANA, USAID, WFP, 2006

³⁷ S. Alkenbrack, T. Chettra, et al., The Social And Economic Impact Of HIV/AIDS On Families With Adolescents And Children In Cambodia. (Cambodia: MoSVY/USAID/Policy Project, 2004)

Figure 10. Frequency of Hunger Reported by Children and Adolescents Affected by HIV (Alkenbrack, et al (2004), p 30, Table 10)



Nb. Case = HIV-affected households, and comparison = non-HIV-affected neighbouring households

Children and adolescents in HIV-affected households are more likely to eat fewer meals and experience hunger more often than their peers in non-HIV-affected households

A Cambodian study entitled The Psychological Well Being of AIDS-Affected and Vulnerable Children found that whether or not a child was receiving enough food was closely related to psychological well-being. Of the 123 HIV-affected and 61 vulnerable children interviewed (total 184), 41% said they did not have enough food to eat every day; this was significantly correlated with depression, anxiety and stress. Those who did not have enough food also had a significantly higher number of psychological, social and environmental problems than children in the study who said they had enough food to eat every day.³⁸

Not having enough food to eat every day is significantly correlated with depression, anxiety and stress among children affected by HIV as well as other vulnerable children.

3.4 Access to Education

Access to basic education for all children is expanding. Among children of primary school age, the enrolment rate is 77%, up from 68% in 2000, and the gender parity is 0.96, indicating that there are slightly fewer girls enrolled than boys. Progression through the grades remains challenging, and only 28% of secondary school age children are in school at the appropriate level for their age.³⁹

³⁸ K. O'Connell, The Psychological Well Being of AIDS-Affected and Vulnerable Children; A Cambodian Perspective (Phnom Penh: NYEMO, 2003)

³⁹ National Institute of Public Health, National Institute of Statistics [Cambodia], et al, Cambodia Demographic and Health Survey 2005 (Phnom Penh and Calverton, Maryland: National Institute of Public Health, National Institute of Statistics, 2006)

3.4.1 Orphans' Access to Education

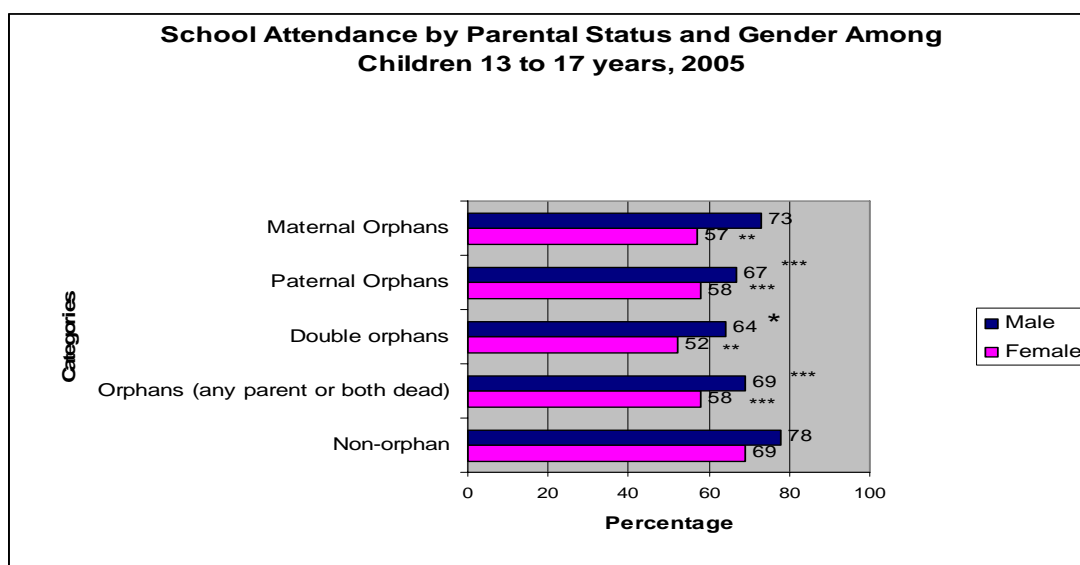
The differences in rates of participation in education between orphans and other children vary according to age groups. Three age groups (6 to 12, 10 to 14 and 13 to 17) were examined.

According to CDHS 2005 data, when children's educational attendance during the previous school year was analysed for the 6 to 12 age group, there was no significant difference between male or female orphans when compared to children with living parents.

However, this was not the case for children aged 13 to 17, where a difference was evidenced. As shown in Figure 11, orphans fare considerably worse in terms of school attendance, and this is true for both boys and girls. Double orphans fare the worst of all. Barely half (52%) of female double orphans attended school compared to 69% of those with healthy living parents. Among boys, only 64% of double orphans attended compared to 78% of boys with healthy, living parents; these gaps between the orphans and non-orphans are statistically significant. It is important to note that attendance in school during the previous school year is not an indicator of active participation, retention or success at grade level.

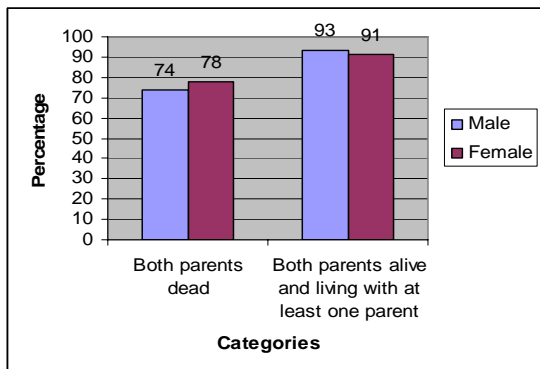
Figure 11: School Attendance by Parental Status and Gender Among Children 13 to 17, 2005 (CDHS)

Among 13 to 17 year olds, orphans fare considerably worse in terms of school attendance, and this is true for both boys and girls.



School attendance for the age group 10 to 14 (UNGASS indicator) was also analysed (Figure 12).

Figure 12: Percentage of Children Aged 10 to 14 Attending School by Survival Status of Parents (CDHS 2005, Table 19.2 School Attendance by Survival Status of Parents, Page 259)



For the age group 10 to 14, the 2005 CDHS data found a clear relationship between survival of parents and children’s attendance at school. Only 74% of boys and 78% of girls aged 10 to 14 who had lost both parents attended school, as compared to 93% and 91% respectively of boys and girls of the same age whose parents were both alive.⁴⁰

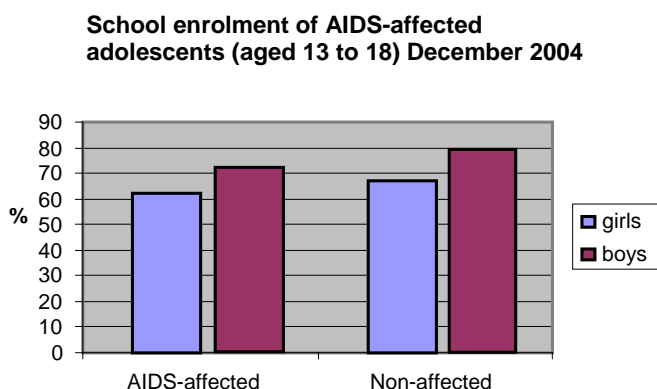
Only 78% of girls aged 10 to 14 who had lost both parents attended school in 2005, as compared to 91% of children of the same age whose parents were both alive.

3.4.2 Education and Children Affected by HIV

Besides orphans aged 13 to 17 years, HIV- and AIDS-affected children are also less likely to participate in school than other children.

A study looking into the social and economic impact of HIV and AIDS on families conducted in Phnom Penh, Battambang and Takeo found that children affected by HIV had lower enrolment rates than other children (Figure 13). Among 13 to 18 year olds, girls have lower rates of enrolment than boys, and this is more pronounced in girls affected by HIV than among all children. According to the study, 62% of adolescent girls and 72% of adolescent boys affected by HIV are enrolled compared to 67% of adolescent girls and 79% of adolescent boys in non-HIV-affected households.⁴¹

Figure 13: School Enrolment of AIDS-affected Adolescents (Aged 13-18 years) (Alkenbrack, Ty and Forsyth, 2004)



In general, girls have lower rates of school enrolment than boys, and this is more pronounced in girls affected by HIV.

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⁴¹ S. Alkenbrack, T. Chettra, et al. The Social and Economic Impact of HIV/AIDS on Families with Adolescents and Children in Cambodia (Cambodia: MoSVY/USAID/Policy Project, 2004)

Qualitative data gathered from programme implementers and children interviewed for this study reported excessive disruptions to schooling for orphans and children affected by HIV. The need to work, take care of sick parents, child care responsibilities and general fatigue all disrupt children's participation in education. Informants also stated that, in their experience, children living with HIV may be denied an education, as investment in them is not considered a high priority as they are often sick, or because they need to travel regularly to receive medical care. HIV-affected children reported that they miss a lot of school and often remain in the same grade for several years. A disruption to attendance affects progression through the grades.

Moreover, children affected by HIV who were interviewed identified not being able to participate in schooling as one of the issues that affects them now and makes them worry for their future. Without an education, the children believe they will have no future and that it will be hard for them to earn money, attract a husband or wife and look after themselves effectively.

3.4.3 Education and Children Living in Poverty

The overall financing of education is still heavily reliant on private contributions from students to teachers to make up for low salaries and the lack of public resources. Although surveys vary widely in their estimates of the family contribution for schooling and the awarding of grades, even conservative socioeconomic surveys report that on average, unofficial monthly school fees for attending primary school are 3,500 riel per student, 8,000 riel for attending lower secondary school and 10,200 riel for the upper secondary grades. These payments are for tuition only and do not include teaching materials or books and stationery.⁴²

Household-level decision making regarding school enrolment, attendance, progression to the next grade and overall participation are all affected by household resources. It is not just a straightforward issue of availability of funds, however, as the educational background of parents and expectations of future employment and earning prospects also affect decision making.⁴³

The 2006 World Bank/ILO/UNICEF study, Children's Work in Cambodia: A Challenge for Growth and Poverty Reduction, has evidenced that children's work is also a key factor for late school entry and drop out in the upper primary grades. Furthermore, children's work has a significant detrimental effect on learning achievement.

⁴² National Education for All Committee, MoEYS, "National Education For All Plan 2003 - 2015," Phnom Penh: National Education for All Committee, MoEYS, p. 112.

⁴³ C. Keng, "Household Determinants of Schooling Progression Among Rural Children In Cambodia." International Education Journal Vol. 5, No. 4, 2004

3.4.4 Education and Children with Chronically Ill Parents

According to CDHS 2005 data, females aged 13 to 17 with one or both parents chronically ill from any cause are less likely to attend school (62%) than females with no chronically ill parents (69%). The difference was statistically significant ($p < .05$). No statistically significant difference was found for boys.

3.5 Alternative Care

Alternative care is defined in the Policy on Alternative Care of Children as care for orphaned and other vulnerable children who are not under the care of their biological parents. There are two broad categories of alternative care: institutional or residential care, and non-institutional or non-residential or family/community-based care. Examples of non-residential care include foster care, kinship-care, adoption, children-headed households and group-home based care.

The number of children living in alternative care is currently unknown. Orphanages are the only type of alternative care for which data is available. The Holt International Cambodia Orphanage Survey in 2005 found that most children in orphanages do not have clear legal status or a legal guardian, and that there are no plans in place for them to leave the orphanage in order to join a family or community. Very few orphanages have the capacity to support family reintegration or explore alternative care in adoptive families.⁴⁴

Most children in orphanages do not have clear legal status or a legal guardian. There are no plans in place for them to leave the orphanage in order to join a family or community.

Currently, data for children in community-based care is not routinely collected by any one organisation; however data is available for inter-country adoptions. According to the law, children above 8 years of age are not eligible to be adopted. In 2006, 294 inter-country adoptions and one in-country adoption were approved. The low number of in-country adoptions reported by MoSVY does not indicate that in-country adoptions are not taking place, as in-country adoptions are usually arranged informally at the community level or officially with authorisation of the Commune Council (which are sanctioned to do this by the Marriage and Family Law). With the passage of the new Civil Code in 2007, in-country adoptions would now have to be processed through a formal petition with and decision by the Courts.

Qualitative data gathered from children interviewed for this review clearly indicate that children want to stay with their parents even if the situation is difficult. Mothers also stated they want to keep their children with them, but would often require support in the form of child care, material and financial support in order to achieve this.

A KHANA report looking at the needs of children affected by HIV reinforces this finding. While adults often perceive orphanages as the answer to succession planning, children,

⁴⁴ Holt International, *Cambodia Orphanage Survey 2005* USAID (USAID, September 2005)

Women's Voices

Speaking on behalf of women living with HIV at the National Validation Workshop for this analysis, Ms Pen Moni described how having their children around them and depending on them gave women a sense of purpose and a will to live. Parenting helps them stay focused on living rather than dying.

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orphan

ages, disagreed. Most of the 495 children who participated in the appraisal, many of whom were orphans, said they would prefer to live in a family.⁴⁵

3.6 Succession Planning

The 2004 Alkenbrack study⁴⁶ in Phnom Penh, Battambang and Takeo comparing HIV-affected households with non-affected household found that it is uncommon for all people to make plans for the future. Among the households sampled, less than 2% of both HIV-affected and non-affected had a written will, and only 21% of those without a will were interested in having one.

More than half of all caregivers could name the person who would look after their children in the event that something happened to them. However, among caregivers who could name the future guardian of their children, less than 1% of them had a written agreement to ensure that this would take place. The authors also stressed that this lack of formal planning could create serious consequences for children, both economically and psychosocially, after the death of their caregivers.

Interestingly, according to the CDHS 2005 data, 90% of male caregivers and 72% of female caregivers had a "succession plan" in the event of their death. In addition, 74% of primary caregivers reported having made arrangements for alternative care. The CDHS, however, does not specify whether the succession plan was in the form of a written or verbal agreement.

3.7 Distress and Psychological Burdens

The load of chronic extreme poverty, loss of a parent, chronic illness and stigmatisation not only affect children physically, but also bring about heavy psychological burden and distress.

The local NGO NYEMO conducted a study of 123 children affected by HIV and 61 other vulnerable children in 2003. Three in four of those children were orphans, and among those who lost one or both parents, the majority had lost them to AIDS. The psychological status and needs of children affected by HIV were compared to those of a comparison group of children who are vulnerable, but not affected by HIV.

Comparisons between children affected by HIV and other vulnerable children revealed no differences with regard to depression, anxiety, stress, quality of life or behavioural problems. However, scores for depression and anxiety were particularly high compared to rates among children in the general population. For children affected by HIV, being discriminated against was the biggest predictor of whether or not a child showed anxiety, depression or stress. This was closely followed by the children reporting that they were hungry every day. Hunger was

⁴⁵ KHANA, *Children Affected by HIV/AIDS: Appraisal of Needs and Resources in Cambodia*. (Phnom Penh: KHANA, 2000)

⁴⁶ S. Alkenbrack et al, *The Social and Economic Impact of HIV/AIDS on Families with Adolescents and Children in Cambodia*, (Cambodia: MoSVY/USAID/Policy Project, 2004)

found to significantly correlate with depression, anxiety and stress in children affected by HIV.⁴⁷

Discrimination and hunger are the two biggest predictors of signs of psychological distress among children affected by HIV.

The same study found that female adolescents showed greater emotional problems, poorer personal relationships, were more likely to be discriminated against, were less satisfied with their home and physical environment, had less access to information and showed greater anxiety than male adolescents. The qualitative data analysis also found that female adolescents were concerned about being sexually abused or married into an abusive relationship.⁴⁸

Gender differences in psychological burdens were also confirmed by a 2005 SCA study of the situation of 471 OVC (132 boys and 349 girls).⁴⁹ This study administered the Depression, Anxiety and Stress Scale (which has been validated for use in Cambodia) and found girls had higher levels of anxiety (17% among girls versus 11% among boys); depression (21% among girls versus 11% among boys); and stress (26% among girls versus 11% among boys).

Another study examining the psychosocial well-being of OVC in the Thai and Cambodia border areas confirmed the presence of depression and anxiety. Approximately one out of ten of the interviewed adolescents reported not wanting to live anymore, feeling like self-harming and wanting to run away.⁵⁰

3.8 Birth Registration

Birth registration is crucial for children as it not only helps them access essential services, but also helps to ensure that their inheritance is protected. It also, if necessary, allows them to trace their families at a later stage. In recent years, government and partners have set up a registration system and process. Parents can apply to the Commune Council for an official birth certificate signed by the District Chief. This document currently costs 30,000 riel.

CDHS 2005 data show that birth registration rate and possession of a birth certificate among children varies with age, wealth status of households and survival status of parents. According to that data, only 55% of children under 2 years of age had had their birth registered. Rates of registration increased with the children's age, with 74% of children aged 2 to 4 being registered.⁵¹

The level of registration varies widely according to income. As wealth increases, the likelihood that children will be registered and possess a birth certificate increases. For example, 45% of children from the lowest wealth quintile have birth certificates, while 66% of the children from the highest wealth quintile households have one.

A further analysis of the 2005 CDHS data shows that among children under 5 years of age, maternal orphans and double orphans were less likely to have their births registered or to

⁴⁷ K. O'Connell, *The Psychological Well Being of AIDS-Affected and Vulnerable Children: A Cambodian Perspective* (Phnom Penh: NYEMO, 2003)

⁴⁸ K. O'Connell, *The Psychological Well Being of AIDS-Affected and Vulnerable Children: A Cambodian Perspective* (Phnom Penh: NYEMO, 2003)

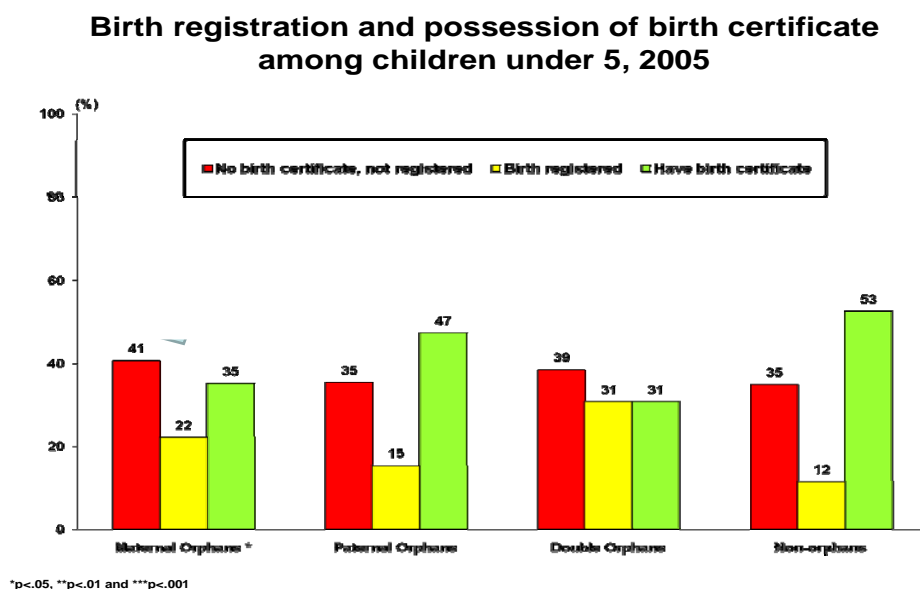
⁴⁹ I. Ramage, G. Pictet and K. Lyhun, *Girls and Buddhist Nuns Research Report* (Phnom Penh: Domrei Consulting, 2005)

⁵⁰ K. Carswell, I. Ramage et al., *The Psychosocial Wellbeing of Orphans and Vulnerable Children in the Thai/Cambodia Border Areas* (CARE, 2005)

⁵¹ Due to the recent mobile campaign for birth registration, these rates are now estimated to be significantly higher.

have a birth certificate (Figure 14). While 53% of children with healthy, living parents were in possession of birth certificates, for maternal orphans the figure was only 35%. Only the difference for maternal orphans when compared to non-orphans is statistically significant at the $p < .05$ level, as shown in the figure below.

Figure 14. Birth Registration and Possession of Birth Certificate Among Children Under 5, 2005 (Secondary Analysis of CDHS 2005, C. Wolf)



Children who have lost their mothers (maternal orphans) are less likely to have their births registered or to have birth certificates.

3.9 Other Impacts of HIV on Children's Daily Lives

Economic impact

When a parent is ill for a protracted period, whether as a result of HIV infection or for any other reason, a number of changes take place in the family that affect the children physically and emotionally.⁵² One of the first effects of serious illness is to increase the proportion of household income spent on health care, and consequently reduce the funds available for food, education and household expenses. Out of necessity, children often assume adult roles, such as caring for or nursing the sick parent, running the household or caring for other children in the family.

Alkenbrack's 2004 study assessed the impact of HIV at the household level and looked at the socioeconomic variables that change quickly in response to a serious illness. The study, designed to be replicable to gauge changes over time, used a case comparison design. From the same village, 500 caregivers for 725 children in HIV-affected households were compared to 500 caregivers for 730 non-HIV-affected children. The two groups of households were

⁵² S. Fox, *Investing In Our Future, Psychosocial Support For Children Affected By HIV/AIDS: A Case Study in Zimbabwe and the United Republic of Tanzania*. (Geneva: UNAIDS, 2001)

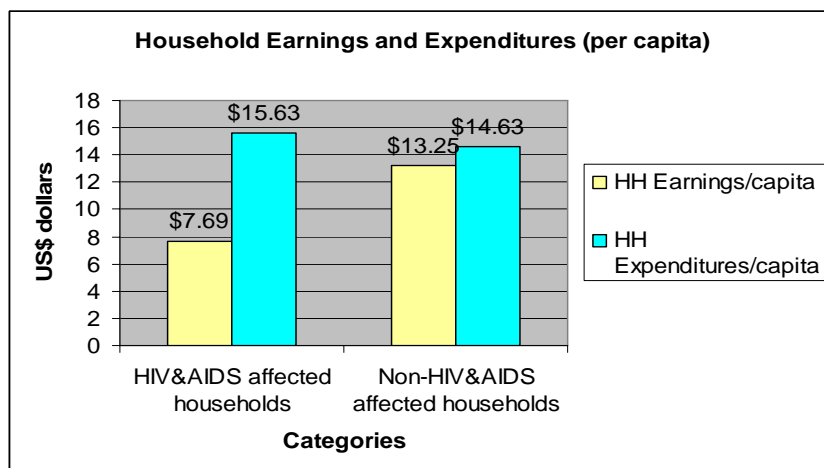
located in similar environments, caregivers had similar education levels and the households had similar characteristics.⁵³

The study found that monthly household income (per capita) was 42% lower among HIV-affected households than among comparison households ($p < 0.001$) (Figure 15). Case household earnings were \$7.69 per person per month, relative to comparison household earnings of \$13.25 per person per month. Spending among HIV-affected households was at approximately the same rate as non-affected households.

The study's author indicated that these differences in income were not unexpected given that many of the guardians were reportedly too sick to work. Unemployment rates were also significantly higher among the case population (49%) than among the comparison group (30%) ($p < 0.001$). Among those working, absenteeism rates were significantly higher for HIV-affected adults.

AIDS-affected households have significantly lower income than non-affected households.

Figure 15. Household per Capita Monthly Income and Expenditure (2004)
(Alkenbrack et al., 2004)

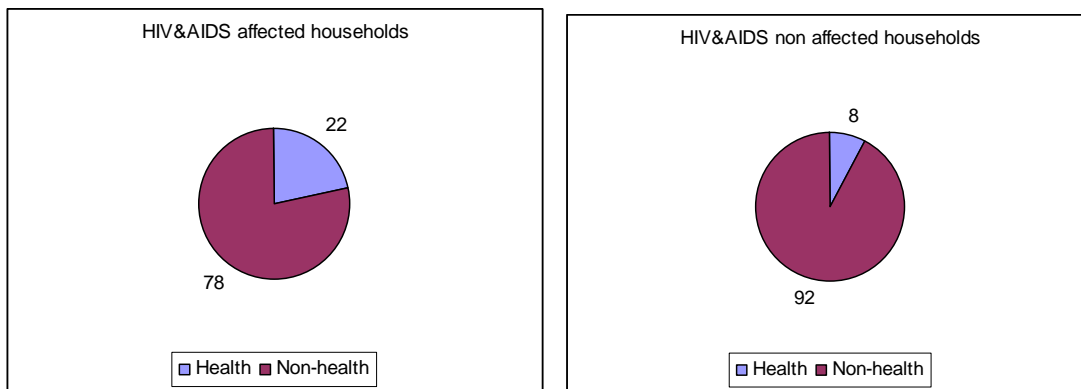


Despite similarities in the rate of overall expenditures, the same study found that HIV-affected households spend much more on health care and much less on other non-health expenditures when compared to non-HIV-affected households ($p < 0.001$) (Figure 16). In the case population, 22% of household expenditures is spent on medical care, compared with only 8% of household expenditures in the non-HIV-affected group.

HIV-affected households spend much more on health care and much less on other non-health expenditures when compared to non HIV affected households

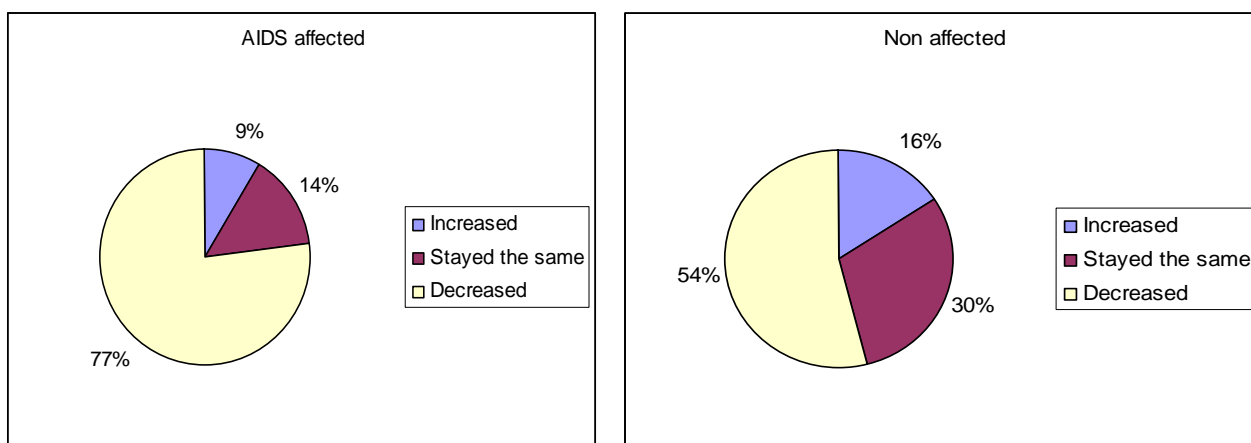
Figure 16: Proportion of Health and Non-health Expenditures in HIV-affected and Non-affected Households (Alkenbrack et al., 2004)

⁵³S. Alkenbrack, et. al. *The Social And Economic Impact Of HIV/AIDS On Families With Adolescents And Children In Cambodia* (Cambodia: MoSVY/USAID/Policy Project, 2004).



The study also assessed income and expenditures over time, and respondents were asked whether their income had increased, stayed the same or decreased over the previous year. As shown in Figure 17, 77% of HIV-affected households reported a decrease in income, compared to 54% of the comparison population ($p < 0.001$). This suggests that a loss in income was occurring in both the case and comparison populations, but was more likely to occur in HIV-affected households.

Figure 17: Change in Income Over the Previous Year (Alkenbrack et al., 2004)



A look at the long-term impacts of HIV on economic security found that HIV-affected households reported that they were twice as likely to sell off assets to pay for health care, about twice as likely to sell off assets to pay for funerals and about two and a half times as likely to sell off assets to pay for general expenditures, when compared with non-HIV-affected households.

A mother of children whose father had died described their downward spiral into economic vulnerability: *“Before my husband died, I had sold my entire family assets... land, bicycle, motorcycle and gold in order to treat him. Now I have nothing except this small hut to live in.”*

Impact on the family

Other impacts at the household level relate to the separation of family members. Women with HIV-affected children interviewed for this study reported having to send children to live with

relatives while they care for sick husbands and work to raise money. Other mothers describe relatives taking their children and separating siblings.

Changes after parental death

Carswell's study on the psychosocial well-being of 190 OVC aged 6 to 18 in the Thai and Cambodia border areas documented the changes experienced by children following the death of a parent.⁵⁴ Over a third of the children interviewed indicated that they had less food and less money after the death of a parent. The same proportion also reported more chores, whereas about 1 in 5 of the children cited a reduction in schooling, and slightly over 1 in 10 said they had to take care of a parent. A third of the children reported having to care for small children and 1 in 10 reported having no shelter.

After the loss of a parent, children report less food, less money, less schooling, more chores and having to take care of small children or/and parents.

⁵⁴ K. Carswell, I. Ramage et al., *The Psychosocial Wellbeing of Orphans and Vulnerable Children in the Thai/Cambodia Border Areas* (CARE, 2005)

Children's Voices

In addition to a review of the literature, 21 children aged 7 to 17 were interviewed for this review about the issues they face, their life experiences, how their lives have been affected by HIV and what support they currently receive. All the children were either orphaned or affected by HIV. The children identified the problems they face today and their fears for the future.

Problems faced today:

- hunger, fear of hunger, never have enough to eat
- the family does not have enough money and no livelihood
- can't access health care or afford medicine when they are sick
- have to work and earn money for the family
- living with sick family members, taking care of them and watching them die slowly
- stigma - people call us "son of AIDS" or "AIDS child"

Fears for the future

- separation from parents and siblings and being unsure if they will ever be able to find their siblings in the future
- fear of forgetting my mother/father/siblings' faces
- can't go to school or get an education, so no future
- not sure if I can ever get married because I have no one to arrange it
- worry that I will live in this orphanage forever
- think about killing myself
- worry that [the caregiver] will die
- sadness that I will never see or know my real parents

These findings are consistent with other research conducted in Cambodia of children affected by HIV and AIDS.

4 THE NATIONAL RESPONSE TO DATE

Even with the continued decline in HIV prevalence, childhood mortality and malnutrition, and poverty reduction in urban areas, the number of children orphaned by AIDS or made vulnerable by HIV is expected to increase in the coming 5 years as parents succumb to advanced stages of the disease. Maternal mortality rates remain unchanged and the gap between the rich and the poor continues to widen. Due to the pervasive nature of poverty in Cambodia, it is challenging to identify where the HIV-related impact mitigation role ends and where other interventions begin.

At the programme level, the response has focused on the needs of all orphans, children affected by HIV and other vulnerable children and to developing age- and gender-appropriate interventions in the areas of most need. A range of responses are needed to help communities and governments mitigate the impact of HIV and AIDS on children and families. There is evidence of the emergence of appropriate and effective models of care, protection and support that will form a sound basis for national programming and scaling up of services.

The Role of Each Actor in the Response

The State

The state – in the form of various government ministries, inter-ministerial committees, Commune Councils, technical working groups and government health, education and social workers – provides the highest level of protection as well as leadership through national policies and plans, legislation and regulations. It also contributes to the response through national-level data collection and surveys, and through high-level and ongoing advocacy.

International development partners

Cambodia's international development partners are making a number of key contributions to the response in the areas of technical and financial resources, policy input, programming support, evaluations, advocacy, capacity building and system strengthening, research, social mobilisation and service delivery.

Civil society

Civil society includes local NGOs, community- and faith-based organisations (CBOs and FBOs) (including monks and pagoda associations), children's groups, village- or commune-level development committees, child protection networks and human rights organisations. The majority of services are provided or initiated by NGOs and implemented by civil society. Civil society makes a vast contribution to local programming, the implementation of national plans and advocacy, which enables people to access services and exercise their rights, mobilisation of the community and resources, and support to CBOs. The information needed to support decision making is often collected by and from civil society, whose participation in monitoring, evaluation and research is crucial.

Community

The community, in the form of family and neighbours, community-based child protection networks, networks of people living with HIV (PLHIV), children's group leaders, and children themselves, provide the first line of support for families and children whose resources are under serious strain. Unpaid, neighbourly support allows many children to continue to receive care in their own homes in a familiar environment, and to remain with their primary caregiver. Village-level animators, focal points, volunteers, adults providing trusted accompaniment for OVC and children's group leaders all provide essential material and social support to children and their caregivers.

Children and their caregivers

Ultimately, impact mitigation occurs or is experienced among the OVC and their caregivers. Children, families, foster carers and other caregivers are on the front line providing care, protection and support for children, supporting children to participate in schooling and providing life skills and guidance as well as love and affection. Children and their caregivers also play a role in the response through advocacy, leading child-led research, participation in research, social mobilisation and facilitating and participating in children's groups.

As part of this situation assessment, Save the Children Australia conducted a detailed mapping of the service response by government, international development partners and NGOs. While only key findings from the mapping are included in this document, a separate companion document, [Mapping the Response: Protecting, Caring for and Supporting Orphans and Vulnerable Children in Cambodia](#), provides more details on the national response to date.

4.1 The Government Response

The National Multi-sectoral Orphans and Vulnerable Children Task Force (NOVCTF)

The Task Force, established in 2006, is responsible for strengthening the national response to progressively fulfil the rights of survival, development, protection and participation of all OVC. The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) chairs the Task Force and houses the Secretariat. The National AIDS Authority (NAA) provides support and capacity building in line with their responsibility for coordinating the overall multi-sectoral response to HIV and AIDS.

The Cambodian National Council for Children (CNCC)

This Council, established in 1995, is a high-level group that is presided over by the MoSVY Minister and is composed of representatives of 11 ministries, the Council of Ministers and the Cambodian Red Cross. Its primary responsibility is to promote the implementation of the United Nations Convention on the Rights of the Child (CRC) in Cambodia and to act as a coordinating entity to protect the rights of all children. The CNCC has four inter-ministerial sub-committees responsible for counter trafficking and exploitation of children; child labour; legislation; and small children's development. The Council is lacking in resources and does not meet regularly.

The National AIDS Authority (NAA)

The National AIDS Authority (NAA), established in 1999, received its legal mandate under The Law on the Prevention and Control of HIV/AIDS 2003 to play the central role in coordinating Cambodia's national multi-sectoral response to HIV and AIDS. This role includes coordinating impact mitigation; mobilising resources from national and international institutions and agencies; advocating for legislative support; and reviewing and approving HIV information, education and communication programmes in all sectors.

The NAA coordinated the development of The National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV and AIDS for 2006-2010, known as the NSP II (because it is the second national multi-sectoral plan). The NSP II includes strategies for HIV prevention among young people and impact mitigation with OVC which are aligned to the Cambodia Millennium Development Goals.

A national consultation in November 2006 paved the way towards Universal Access for HIV prevention, treatment and impact mitigation by 2010. The Royal Government of Cambodia (RGC) and its partners committed to reach country-specific targets in access to HIV prevention, care and support by 2010. Making progress on this agenda is a priority for the NAA. Issues related to children have been well articulated in the Universal Access commitment documents, and include the necessity to scale up targeted interventions for high-risk populations, including drug users, and prevention in institutional settings such as orphanages. The Universal Access indicators and targets that focus on OVC include:

- percentage of households with OVC that receive minimum package of care (target 2008 – 30%; 2010 – 50%); and
- percentage of communes with at least one organisation providing care and support to households with OVC (target 2008 – 50%; 2010 – 100%).⁵⁵

The NAA is working with the Joint United Nations Programme on HIV and AIDS (UNAIDS) to develop a comprehensive national monitoring and evaluation system to assess and report on progress towards the response to HIV. The system will include an explanation of the indicators and guidelines for measuring and collecting appropriate data for monitoring progress.

The NAA has also undertaken operational research on the decentralisation of the multi-sectoral response to HIV. One of the pilot sites (Svay Rieng) has prioritised OVC coordination at the provincial level, and mechanisms and work plans have been developed.

The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY)

The care and protection of children is a priority for MoSVY, which chairs the NOVCTF and plays a leadership role in coordinating the response to OVC. The MoSVY response to OVC is concentrated in The Directorate of Technical Affairs, which oversees policy, planning and programming for child welfare, alternative care and child protection at the central level. The Directorate includes the following Departments, which have direct responsibilities related to OVC:

- Department of Child Welfare
- Department of Youth Rehabilitation

⁵⁵ HIV/AIDS Coordinating Committee (HACC), Proceedings - Civil Society Pre-Consultation on Universal Access - Cambodia's Road Map to the National Response to HIV/AIDS

- Department of Social Welfare
- Department of Rehabilitation (of disabled)

Alternative Care

The Department of Child Welfare has responsibility for 20 state orphanages (in 17 provinces and cities) and the regulation of all NGO-run residential alternative care services, of which 160 out of 197 registered orphanages are covered by a Memorandum of Understanding (MoU) with MoSVY.

Through MoSVY, Cambodia has made progress in developing a regulatory framework for alternative care for children without primary caregivers, including OVC. MoSVY adopted the Policy on Alternative Care for Children and the Minimum Standards of Care for Children in Residential Care in 2006. Monitoring guidelines have been developed along with a national database on alternative care. In 2008, MoSVY and partners also developed Minimum Standards of Community/Family-based Care to promote quality of care in pagodas, group homes, kinship care and foster care. Monitoring of compliance with the standards commenced in 2007 and is showing low levels of compliance.

There has been no systematic attempt to map the provision of community alternative care in Cambodia. Community alternative care models include foster care, supporting child-headed households, kinship care, pagoda-based care and group homes. Projects promoting all 5 of these models exist in Cambodia. In July and August 2007, MoSVY conducted its first, basic nation-wide mapping of community alternative care service providers. The report will be published by mid 2008. MoSVY is also linking up with NGO efforts in community-based care, so that both government and development partners can strengthen community-based support structures that are culturally appropriate and effective in meeting the basic needs of OVC.

Ongoing social work training, in the form of a two-week ‘basic’ course and a three-week (with practicum) ‘professional’ course for social workers, is conducted by MoSVY with UNICEF support. The focus is on district-level staff. The training includes a module on HIV and AIDS. Training in the provision of psychosocial support and counselling commenced in 2006, also with a focus on district social workers. The MoSVY curricula are updated periodically to reflect policy and other changes. Both the basic social work and the counselling courses are attended by 100 staff per year.

Inter-country adoptions (and to a much lesser extent in-country adoptions) are formally processed via the Bureau of Adoption within the Child Welfare Department of MoSVY.

Child Protection

Cambodia has just acceded to the Hague Convention on the Protection of Children and Cooperation in respect of inter-country adoption and is in process of finalising the Draft Law on Inter-Country Adoption. Cambodia does not have a Child Protection Law; a national law and policy is required to protect children from abuse and exploitation. In the absence of a comprehensive child protection law and policy, there are various local laws, international conventions and protocols that the government has ratified and enacted that can be used to protect children.

In collaboration with UNICEF, MoSVY operates a Child Protection Network (CPN) in Prey Veng and Svay Rieng provinces. This is a community-based, multi-disciplinary approach to

child protection with a strong focus on child rights and child participation. The main components of the network are:

- prevention of abuse and exploitation through community awareness raising, carried out by children themselves, Department of Social Affairs, Veterans and Youth Rehabilitation (DoSVY) social workers and village social helpers;
- peer education⁵⁶ by local child representatives, elected by children in each village;
- identification of children at risk and children in need of special protection; and
- taking action, by referring children to services and providing assistance through a village social fund.⁵⁷

The CPN has coordination meetings at the commune and provincial level in which children and local authorities participate. The CPN is currently operating in selected communes in 6 districts in the aforementioned 2 provinces with UNICEF support. NGOs are establishing CPNs in other provinces, and DoSVY has sought NGO and government funding for CPNs elsewhere. There is strong political will in MoSVY to expand CPNs. A recent evaluation of the CPN found that the CPN faces some challenges and needs to be restructured for it to have more impact. The network has created parallel structures at village and commune levels, rather than using existing structures.

The Ministry of Cults and Religions (MoCR)

In May 2002, the RGC approved a National Policy on the Religious Response to HIV and AIDS. The policy commits religious leaders (Buddhist, Christian and Muslim) to playing a role in responding to HIV through: educating themselves and their communities on HIV; reducing discrimination against people living with HIV; improving access to care and support for HIV-positive children and adults; and maintaining a multi-sectoral approach throughout.⁵⁸ The policy was developed by the Ministry of Cults and Religion (MoCR) in conjunction with the country's most senior religious leaders.

The MoCR has developed national guidelines for pagodas to address the needs of OVC. In collaboration with UNICEF, Partners in Compassion and Salvation Centre Cambodia, the Buddhist Leadership Initiative has been established. This programme is designed to mobilise Buddhist monks, nuns and lay teachers to lead community-level HIV care and prevention, with a view to increasing access to care and acceptance of PLHIV as well as building HIV resilience in communities. This initiative is currently being implemented in 11 provinces⁵⁹ in Cambodia, reaching 365 communes (of a total 1,621 communes in the country). In their communities, monks facilitate the establishment of self-help groups for PLHIV, visit affected families at home and provide education about the disease. Where possible, monks ensure that orphans receive proper medical care, clothing, school items, and, where necessary, food. UNICEF provides financial support to the Provincial Departments of Cults and Religions for the implementation of the Buddhist Leadership Initiative. A small proportion of the funds is raised from communities. The monks receive training from UNICEF.

⁵⁶ 8 Peer Education training courses on the four basic child rights were conducted in 2006 with 794 children throughout Prey Veng and Svay Rieng participating (MoSVY, *Annual Report 2006*)

⁵⁷ 237 children in Prey Veng and 105 children in Svay Rieng Province received support and services as well as special protection in 2006 (MoSVY, *Annual Report 2006*)

⁵⁸ UNICEF, *The Buddhist Leadership Initiative*, August 2003.

⁵⁹ Pursat, Kampong Thom, Prey Veng, Kampong Chhnang, Kampong Speu, Kampong Cham, Takeo, Sihanoukville, Stung Treng, Phnom Penh

Ministry of Education Youth and Sports (MoEYS)

Cambodia has made significant progress over the past 5 years in increasing access to primary education, although completion of the full cycle of primary education remains a challenge. Primary net enrolment increased from 85.5% to 91.9%, and the gender gap in primary net enrolment has also been substantially reduced (from 31.2% more boys than girls enrolled in 1998-1999 to a difference of 22.7% in 2001-2002).⁶⁰

The MoEYS's Life Skills Policy was developed in 2005 and commits the Ministry to providing HIV-related life skills to children and young people both in and out of school. As of 2007, life skills activities are being implemented in 14 provinces. General and pre-vocational skills that include HIV education are also taught as part of the Basic Education Curriculum. A pre-service training to equip teachers with skills to teach HIV prevention information initiated in 2005 now covers 18 teacher training colleges. HIV is now integrated in pre-service training for all teachers (and literacy trainers).

UNICEF is supporting MoEYS to deliver the Life Skills Education directly in Prey Veng using existing personnel, but in all the other provinces, an NGO is delivering the programme in the schools using a standardised curriculum. Usually the NGO will establish an office in the province. Initially they hold a provincial orientation workshop followed by one in each district so that people become aware of the project. The NGO trains and pays district trainers, some of whom may be teachers, to reach out to teachers and children. Three teams are formed: the first team teaches grade 5 and 6 students; a second team goes to secondary schools and trains peer educators in grades 8 and 11; and a third team works with out-of-school children and young people. The NGO monitors the programme and provides back up.

Increasing the number of girls that complete lower secondary school has been achieved by providing conditional cash transfers. Families receive cash transfers of \$45 per year for 3 years provided their daughter is enrolled in school, maintains a passing grade and is absent fewer than 10 days a year. The programme is operating in 93 lower secondary schools. Within each of these schools, approximately 45 girls who were beginning grade 7 were awarded \$45 annual scholarships for the 3 years of the lower secondary cycle (Known as a scholarship, it is actually a direct transfer linked to school participation.). A recent evaluation of the programme found a positive effect on enrolment and attendance at programme schools of 30-43%. The impact of the programme appears to have been greatest among girls from the poorest families at baseline.⁶¹

The Ministry of Health (MoH)

Health Equity Funds have been established in Cambodia to improve access to health care services for the poorest by paying the provider on their behalf. The funds provide a safety net for many OVC and their caregivers. The fund operator selects the eligible patients and decides which health services they will compensate for (e.g. antenatal care) and if they will pay for external costs such as transport. There are Health Equity Funds and government subsidies for the poor covering 3 national hospitals and 30 of 77 Operational Districts. The MoH is preparing to scale up the coverage of Health Equity Funds.⁶² The Health Equity Fund system is developing a standardised system of identification of the most vulnerable

⁶⁰ National Education for All Committee, MoEYS, "National Education for All Plan 2003-2015," page 82

⁶¹ D. Filmer and N. Schady, *Getting Girls into School: Evidence from a Scholarship Program in Cambodia*. The World Bank Policy Research Working Paper 3910, Washington, DC: World Bank, May 2006

⁶² M. Noirhomme, B. Meessen, F. Griffiths et al. "Improving Access to Hospital Care for the Poor: Comparative Analysis of Four Health Equity Funds in Cambodia" *Health Policy and Planning*, 2007, 22 (4)

households which could be of significant benefit in promoting consistent criteria when identifying children in the poorest households.⁶³

Health Equity Funds are operating in 10 provinces. In addition, there are 4 pilot community-based health insurance projects also working to eliminate barriers to accessing health care among the very poor.

National Centre for HIV/AIDS, Dermatology and STDs (NCHADS)

With leadership from the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), Cambodia has rapidly scaled up health facility-based opportunistic infection (OI) and antiretroviral treatment (ART) services in the public sector. By the end of 2006,⁶⁴ there were 20,131 individuals receiving ART, including 1,787 children. However there were 4,869 people in need of ART who were not yet receiving the treatment (including 1,213 children). By the end of 2006, the number of Voluntary Confidential Counselling and Testing (VCCT) sites had scaled up to 150, and at the time of the mapping, there were 19 functioning paediatric AIDS care sites (Figure 18), where children receive prophylaxis and treatment of OIs as well as ART. CD4 testing for children, to test immune system strength, is conducted at the Pasteur Institute in Phnom Penh and at the National Institute of Public Health. Among sites that provide paediatric care, the proportion of children still alive and on ART after 12 months was 93.2%, similar to that found in other countries.⁶⁵

The number of home-based care teams providing services to people living with HIV, including OVC, has been scaled up from 52 teams in 2001 to 292 teams in 18 provinces and Phnom Penh at the end of 2006.⁶⁶ NCHADS has established a robust routine data collection system in the form of quarterly reports from service delivery sites (VCCT sites, sexually transmitted infection [STI] clinics, OI/ART sites) and home-based care programmes.

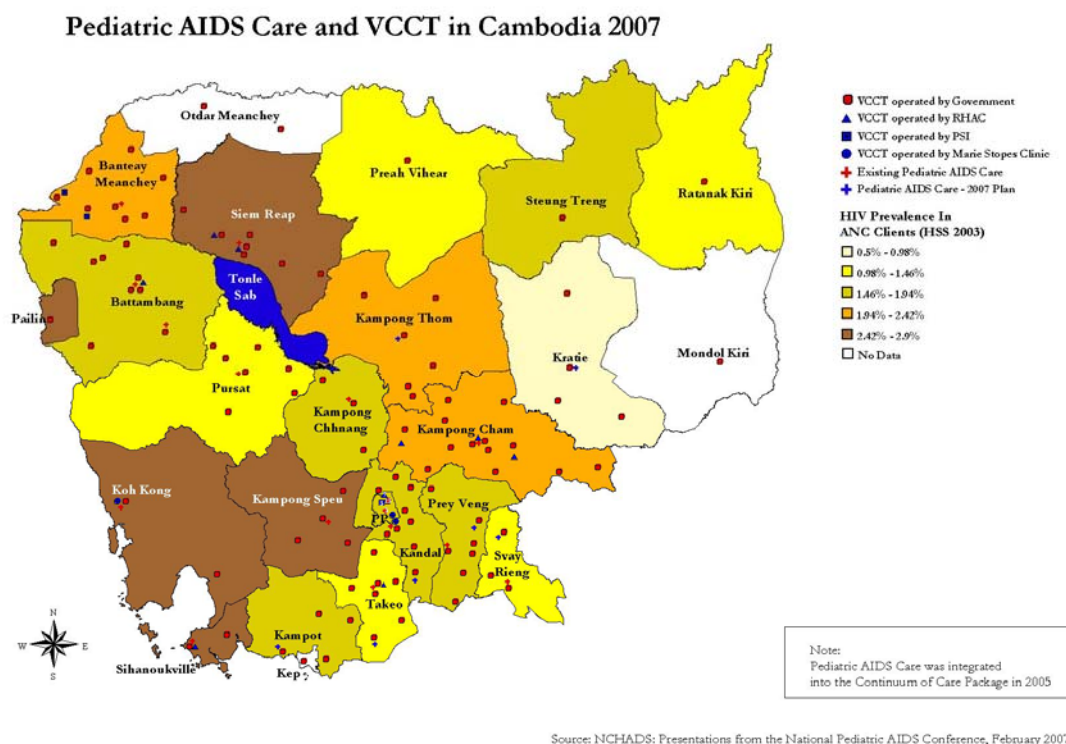
⁶³ GTZ and the Ministry of Planning (undated) Identification of Poor Households; Chhim K, Hean S and R Henke (2006) Evaluation of the Most Vulnerable Families Listing Process in Kampot, Centre for Advanced Studies and GTZ

⁶⁴ By the third quarter of 2007, this figure reached 22,981 adults and 2,372 children receiving ART. Regularly updated data on the number of adults and children on ART can be found on the NCHADS website at www.nchads.org

⁶⁵ National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), Ministry of Health (MoH), *Annual Report 2006*.

⁶⁶ Chhi Vun Mean "Opening Address – Update on CoC including Paediatric AIDS Care," First National Conference on Paediatric AIDS Care in Cambodia, Phnom Penh, 5-6 February 2007

Figure 18. Map of Health Facilities Providing Paediatric AIDS Care and HIV Testing Services in Cambodia (2007)



National Maternal and Child Health Centre (NMCHC)

A third of all new HIV infections take place among children, mostly via mother-to-child transmission.⁶⁷ In mid-2007, Cambodia had 69 facilities in 21 provinces that provided prevention of mother-to-child transmission services, including 39 at referral hospital level. A total of 39 Operational Districts had at least one health facility providing these services.

Despite government efforts to scale up the services, in 2006⁶⁸ only 29,677 (6.4%) of the total annual number of pregnant women received an HIV test result, and only 323 (3.3%) of HIV-infected pregnant women received a complete course of ARV prophylaxis to reduce mother-to-child transmission. Although the coverage of services to prevent mother-to-child transmission has increased from 24 sites (32,760 women seen for a first visit at antenatal clinics [ANCs]) in 2005 to 69 sites (48,010 women seen for a first visit at ANCs), as depicted in Figure 18, coverage remains low and costly.⁶⁹

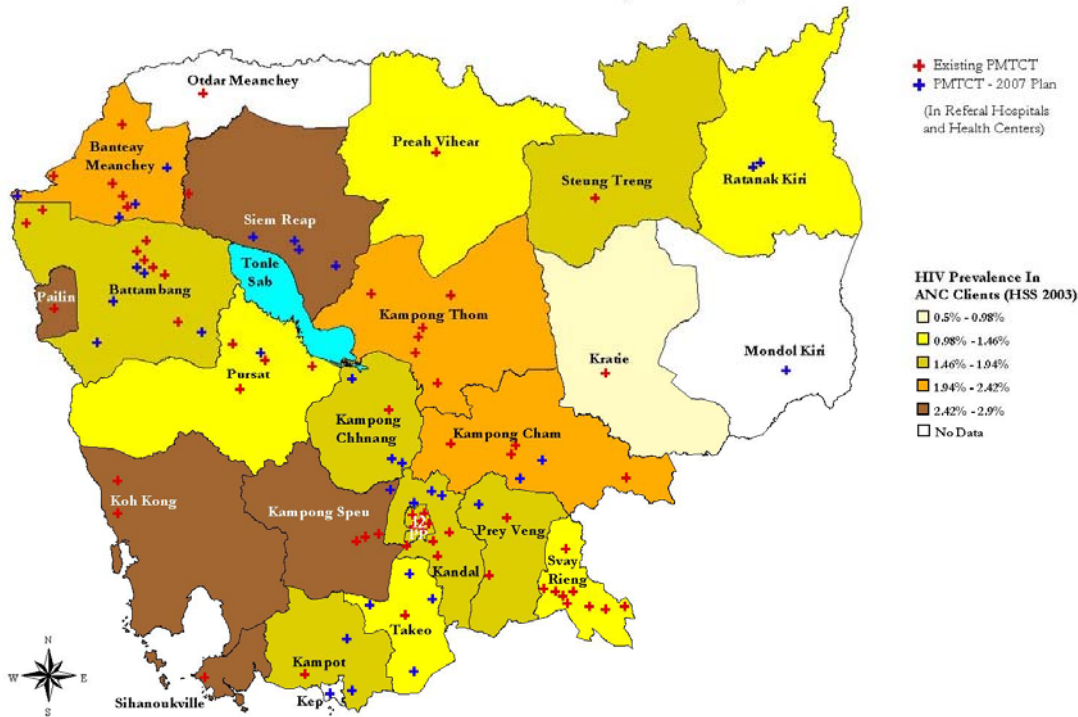
Figure 19. Map of Health Facilities Providing Services to Prevent Mother-to-Child Transmission (Data collected by Save the Children Australia, 2007)

⁶⁷ Panha Sok, "HIV Testing for Children," First National Conference on Paediatric AIDS Care in Cambodia, Phnom Penh, 5-6 February 2007, Slide # 12 5 Feb 2007.

⁶⁸ As of September 2007, with support from different partners, there were 73 health centres and 40 referral hospitals in 43 operational districts in 24 provinces providing services to prevent mother-to-child transmission. In total, 113 health facilities country-wide were providing these services.

⁶⁹ NCHADS, MoH, *Annual Report 2006*

Prevention of Mother to Child Transmission (PMTCT) sites in Cambodia 2007



Source: Personal Communication with National Maternal & Child Health Center (NMCHC), Ministry of Health May 2007

The Ministry of Interior (MoI)

By the end of June 2006, 10.7 million Cambodians had been issued birth certificates. This represents coverage of approximately 84% of the population as a result of the National Mobile Civil Registration Project carried out by the Ministry of Interior (MoI), with support from Plan International-Cambodia (Plan), UNICEF and the Asian Development Bank (ADB). More than 13,000 officials from the country's 1,621 Commune/Sangkat Councils were trained in the registration process and 185 districts were fully mobilised. Plan staff and United Nations Volunteers (UNVs) held hundreds of community meetings around the country to sensitise people about the benefits of civil registration. The MoI established 24 provincial committees and a national committee which are being supported by Plan. Plan and UNICEF also supported the MoI in organising the first National Workshop on Birth Registration and collaborated on creating educational materials.

In cooperation with UNICEF and World Vision, the Ministry continues to build the capacity of anti-human trafficking and juvenile protection (AHTJP) police in the fight against trafficking, sexual exploitation and sexual abuse of children. MoI also contributes to the implementation of MoUs between Thailand and Cambodia and Vietnam and Cambodia to eliminate the trafficking of women and children.

The MoI also supports Commune Councils, which were established in 2002. The Commune Councils assume an important role in the promotion of local development and delivery of services. The Commune Law, approved in 2001, requires each commune to have its own financial resources, budget and assets. The Commune Law and its subsequent regulations mandate all communes to adopt and implement a five-year Commune Development Plan. The Commune Development Plan provides the framework for a multi-year Commune Investment Programme and for the preparation of the annual budget.

A critical step in the Commune Development Plan process is the District Integration Workshop (DIW). At these workshops, commune chiefs meet formally with other agencies involved in local development – including provincial departments of national ministries, donor-funded programme implementation units and NGOs – and negotiate the financing and implementation of projects and activities that either emerge from local needs analyses or as a result of local advocacy. The DIW provides an institutional mechanism for the communes to articulate local demands with regard to infrastructure and services. There is an opportunity for responses to OVC, including social transfers, coordination mechanisms and village-level support groups, to be included in Commune Development Plans.

The Ministry of Labour and Vocational Training (MoLVT)

The Ministry of Labour and Vocational Training (MoLVT) created the Child Labour Unit to monitor the conditions of working children in Cambodia. The RGC has ratified Convention 182 on the Worst Forms of Child Labour and Convention 138 setting out the Minimum Age for Employment which was developed by MoLVT in conjunction with the ILO/International Programme on the Elimination of Child Labour (IPEC).

The Ministry of Rural Development (MoRD)

The Ministry of Rural Development's Rural Health Care Department developed a five-year strategic plan for 2002-2006 (with support from the ADB, the United Nations Development Programme [UNDP] and the NAA) to empower communities to respond to HIV using villages' development committees, health volunteers and community-based youth volunteer groups. With technical and financial support from UNICEF, a work plan was developed, and a Community Youth Volunteer Programme to fight against HIV was implemented in Kampong Speu and Kampong Chhnang. An evaluation of the programme was conducted in 2006 and found to have limited impact on the intended beneficiaries. The programme was brought to an end in phases in 2007.

The Ministry of Tourism

The Ministry of Tourism has an MoU with Friends-International (FI) to support the ChildSafe programme FI has developed. The programme includes the training of motodops, tuk tuk drivers and hotel staff on ChildSafe activities in Phnom Penh, Siem Reap and Sihanoukville. The Ministry is working on a ChildSafe tourism project with the ILO in Phnom Penh, Siem Reap and Sihanoukville.

The Ministry of Women's Affairs (MoWA)

The Ministry of Women's Affairs (MoWA) developed the Women, the Girl Child and STI/HIV/AIDS Policy, which was adopted in 2003. The Ministry's project Promote Social Ethics and the Value of the Khmer Family involves training in life skills. The project is being implemented in 6 provinces: Prey Veng, Mondul Kiri, Takeo, Banteay Meanchey, Oddar Meanchey and Kampong Thom. The programme does not have complete coverage due to

budget constraints. The Ministry has recently developed a policy on spousal transmission of HIV.

The Ministry is also promoting women's and girl's education in collaboration with MoEYS with funding from the ADB. This project is being implemented where there are existing centres for students to stay, including Siem Reap, Kampong Thom and Kratie. MoWA is responsible for identifying women and girls who have given up their studies and then encouraging them to stay at the centre to study.

MoWA also implements the Seth Komar project, which educates parents of children aged 3 to 6 about the benefits of sending their children to kindergarten and pre-school.

The Ministry of Planning (MoP)

At the provincial level, the Ministry of Planning (MoP) is responsible for providing guidelines to the line departments on how to develop provincial plans. It also supports the Provincial Rural Development Committees with information and technical support to assist decision making and allocation of Provincial Investment Funds. These are government and development partner funds that are made available to line departments based on commune priority lists and plans developed with data from the Ministry's commune database.

The commune database is a comprehensive data source (with over 500 data fields) from which village and commune profiles are built. It is used by the Commune Councils to inform commune plans.

In Cambodia, most approaches to target the poor for development activities or social transfers have been done by identifying poor areas. Within a village, however, there may be significant differences between the very poor, the poor and the general population, and interventions run the risk of overlooking the very poor if they live in a less poor village. As a consequence, interventions may fail to reach the poorest and most vulnerable families.

Together with the Provincial Rural Development Committees in Kampot and Kampong Thom, the MoP, supported by German Technical Cooperation (GTZ), has developed a participatory approach to identifying the most vulnerable families at the village level. The Most Vulnerable Household List is established by the villagers under the leadership of the Commune Councils. Once fully established, this list is intended to be used by authorities at the local, district and provincial level as well as by national government institutions, NGOs and international development partners to better target the poor. Once on the list, poor families are exempt from having to pay annual contributions to the commune project fund, and are able to access free health services and locally initiated education scholarships.

The government response already includes the key elements needed for success

As can be seen from the summary of OVC- and HIV-related key initiatives outlined above, many of the systems necessary to mitigate the impact of HIV and AIDS on children, and support the rights of OVC, are already in place. In addition to achievements outlined earlier, key elements needed for success are evident in the following.

- The decentralisation of government functions, which supports the establishment of participatory community-based structures
- Commune Councils have received a social work mandate, including a mandate for women and children and capacity building opportunities
- The Cambodian Millennium Development Goals and the National Strategic Development Plan address the needs of poor households and recognise their need for increased support.
- Several advances related to reducing cross-border trafficking of children have been achieved, including greater formal and informal cooperation with neighbouring countries
- The RGC has ratified many conventions and protocols related to child rights. By doing so, the government has made a commitment to protecting and ensuring children's rights and has agreed to hold itself accountable for this commitment before the international community.

Financial sustainability plans and strategies to mobilise government funds for OVC programming are needed.

4.2 The International Development Partners' Response

International development partners are providing substantial technical and financial resources, programming support, evaluations, advocacy, capacity building and system strengthening, research and resources for campaigns for social mobilisation. However, coordination opportunities to ensure that individual development partners are aware of where they could add value or extend coverage are missing. There is insufficient analysis and interpretation of data to identify under-serviced areas in order to better target funds. During interviews for this report, many multilateral and bilateral donors spoke of the costs involved in developing context analysis to inform programming and generating their own data due to gaps in national data sets or difficulty and delays in accessing raw data. Having functioning coordination mechanisms at each level as well as nationally agreed plans drawn from a joint situation assessment could help to address this. There is a need for harmonisation of effort through multi-sectoral planning, the NOVCTF and existing government structures.

A programming and monitoring issue arises in Cambodia due to the range of criteria used to identify OVC, and the range of indicators used to identify who is living in poverty and which households are most vulnerable. Many NGOs and FBOs responding to the needs of OVC undertake their own mapping and vulnerability assessments, and there are no standardised systems to ensure that the most vulnerable children are linked to services.

This work duplicates efforts by the MoP to identify and map vulnerable households as part of the Health Equity Funds project. WFP and the Food and Agriculture Organisation (FAO) have also been undertaking vulnerability assessments and mapping of food insecurity. OVC would benefit from service providers working with the MoP to combine and coordinate efforts in this area.

A social protection system has not been fully established in Cambodia, although social protection for vulnerable groups is one of the working principles included in the Health Sector Support Programme (HSSP). Limited safety nets, in the form of the Health Equity Funds, do exist in some areas. However, there is a large labour surplus, education and health services are not provided free of charge and there is no income support system for households experiencing income shocks. Once families have lost land and productive assets, it is very difficult to move out of poverty; therefore a social protection system needs to intervene before productive assets are converted to cash if children are to be spared living in chronic poverty.

Many different approaches among the development partners' responses are evident; some areas would benefit from coming under one national programme with shared objectives, reporting systems and core components of service delivery. For example, in the area of child protection, a national system could be established that draws on the good practices of the four different systems that currently operate. This would allow for ease in calculating coverage and making comparisons, less duplication of effort and national consistency.

Multilateral Agencies Responding to OVC

The multilateral development partners are providing support for:

- programmes aimed at securing children's rights;
- sectoral plans (health, education etc), including the HSSP; and
- multi-sectoral plans, such as the NSP II, Education for All and The National Plan of Action Against Trafficking and Sexual Exploitation of Children 2006 – 2010.

Funds are directed through donor harmonisation mechanisms, which allows for discussion and reporting that meets the needs of development partners and government. Under the auspices of bodies such as the Government-Donor Joint Technical Working Group on HIV and AIDS, the partners have been able to set shared targets and priorities. The development of a national plan for protecting, caring for and supporting OVC and systems for tracking the response and coordination mechanisms provides opportunities to the multilateral development partners, such as the multilateral development banks, to contribute their resources and expertise.

Guided by the NSP II Strategies for OVC Impact Mitigation and the Universal Access targets agreed to in 2006, the multilateral agencies are supporting a range of activities. At the national level, technical and financial support is provided to develop policy and legal frameworks, provide advocacy for OVC and capacity building. At the provincial level, intensive support is provided for improvement and innovation in service delivery and coordination.

To reduce food insecurity and vulnerability, home-based care teams and village-level self-help and psychosocial support groups are being provided with monthly food aid for OVC and PLHIV. School feeding programmes, take-home rations for schoolgirls and nutrition supplements for malnourished children and mothers are also provided.

Essential services for OVC, such as birth registration, health care including infant vaccination, early childhood development programmes and support to achieve 9 years of basic education for every child, are priority activities receiving support. Access for children to safe drinking water and improvements in home and school sanitation are also supported. Children in need of special protection and children in need of alternative care are supported through capacity building activities for MoSVY staff in basic social work skills, programme and policy development and collaborative research and evaluations.

The development of good practice guidelines and global frameworks, treatment protocols and other documents that provide guidance and technical assistance to country-level managers and decision makers are key to the ongoing success of national programmes responding to OVC. Key documents include:

- The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, (2004)
- The International AIDS Alliance OVC Toolkit and Stepping Stones
- The World Bank's Toolkit on how to support Orphans and Other Vulnerable Children in Sub-Saharan Africa
- Scaling Up the Response for Children documents produced by UNICEF and partners
- The Self Care series of booklets produced by USAID through FHI, which provide essential tools for use at country level

Bilateral Agencies Responding to OVC

Funds are directed from bilateral donors through bilateral agreements developed under MoUs with the RGC. This allows for development partners to provide direct support to international and local NGOs, FBOs and for advocacy events. Many bilateral development partners are engaged in direct service delivery, partnerships with government and capacity building.

The international development partners have provided leadership in developing good governance and democratic structures, often by mandating the involvement of children, PLHIV and affected communities in planning, implementation and monitoring. In the HIV sector, local partners have built up confidence and expertise and are beginning to demand a greater role in decision making. Many international development partners are responding positively to this, and expatriate advisors and managers are increasingly being replaced with local staff.

Child survival, access to quality health services and pharmaceuticals, reducing childhood malnutrition, food insecurity and preventable diseases and promoting HIV prevention and treatment are the focus of many development partners. All of these activities benefit children. Bilateral support to the Health Equity Funds, the Child Survival Strategy, the National Nutrition Program, Prevention of Mother to Child Transmission of HIV and the MoH National HIV and STI Programme actively target support for the poorest families and most at-risk children.

Several agencies are contributing to the government's Health Sector Strategic Plan, which aims to increase access to quality health services, especially for mothers and children. Project components include: increasing the availability of essential health care services, support for the Health Equity Funds, and support to the MoH to plan, manage, finance and monitor progress in the sector.

Bilateral donors support government-led efforts to mitigate the impact of HIV on children through the MoH, MoEYS, MoCR, MoSVY and the NAA. Scaling up of OVC impact mitigation programmes is already underway in 16 provinces (see [Mapping the Response: Protecting, Caring for and Supporting Orphans and Vulnerable Children in Cambodia](#) for a detailed analysis of activities) and VCCT and services to prevent mother-to-child transmission and blood safety programmes are also being rapidly scaled up with development partner support.

The protection of children from sexual abuse and exploitation, trafficking, exploitative labour and other forms of abuse is receiving attention. Several bilateral agencies are directing efforts towards mobilising communities to protect children and promote child safety in areas of high tourism and where trafficking networks operate. Existing projects aim to support families and communities in protecting children. Awareness raising activities are directed at adults and children to prevent sexual exploitation, human trafficking and abuse. A leading task force and a national task force on anti human trafficking, human smuggling, labour exploitation and sexual exploitation of women and children have been established, and steps to develop a coordinated response that includes prevention, protection and reintegration and prosecution, brings together government, non-government and civil society with funds and secretarial support provided by bilateral development partners.

Social protection for the poorest families is extended through the Health Equity Funds, education scholarships, material and cash support to the caregivers of the poorest and most vulnerable children, foster carer payments and direct support to residential alternative care providers. Social protection is challenged by difficulties in identifying the poorest, which is done through a variety of non-standardised mechanisms that sometimes identify poor families and at other times poor communities. To promote equity in programmes such as the Health Equity Fund programme, the efficacy of household-level vulnerability mapping is being assessed in collaboration with the MoP.

Building the capacity of local organisations and government staff is high on the agenda for international development partners. This includes providing external audit opportunities, overseas study and conference scholarships and training for staff. Capacity building for CBOs is helping improve local identification of problems and priorities and is steadily increasing the ability of local staff and volunteers to play an active role in advocacy and planning for OVC.

4.3 The Civil Society Response

Civil society has been active in initiating programmes that increase access to essential services for orphans, children affected by HIV and OVC and that promote children's rights to survival and development. This Situation and Response Assessment has mapped over 400 organisations that have at least one programme providing protection, care or support to OVC.

International non-governmental organisations (INGOs) play a lead role in needs assessment, resource mobilisation, programme design, service coverage planning, capacity building for civil society and programme monitoring and assessment. Some organisations also deliver services directly, for example World Vision, while others partner with local NGOs and FBOs. Many of the INGOs target the poorest of the poor, while others work with children and their families to prevent them from selling productive assets and becoming even poorer. For example some livelihood and income generation schemes work with PLHIV caregivers to reintegrate the family back into the labour force with incremental support that includes

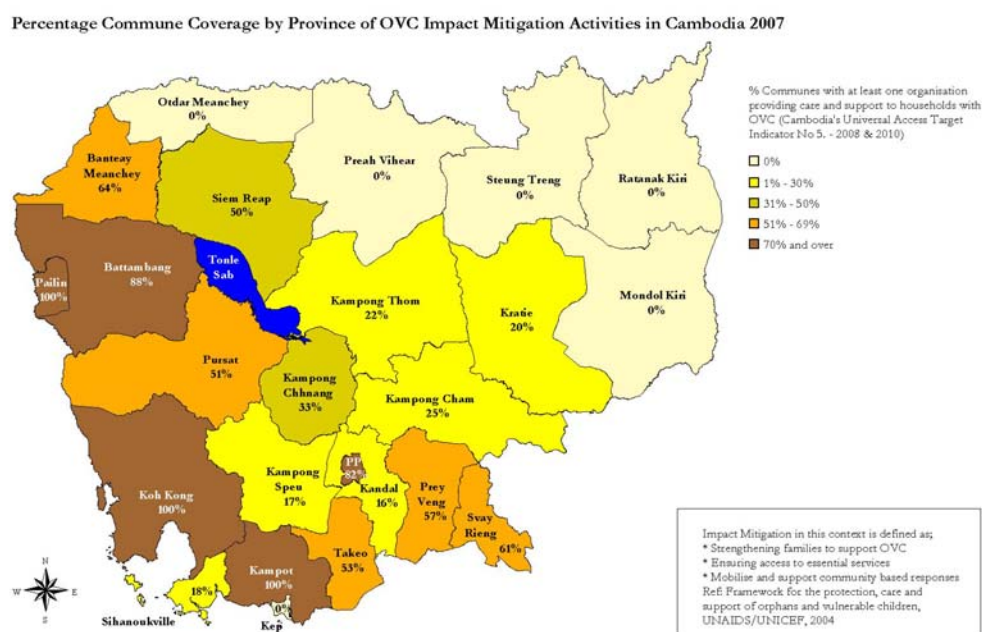
training, home production of saleable items, future planning and eventually micro-credit, once the caregiver or older OVC is ready to take on that responsibility.

The documentation of coverage of impact mitigation programmes (Figure 20) includes only those organisations that have an OVC-focused programme in the community that include one or more of the following:

- strengthening the capacity of families to support OVC: through food aid, income security and livelihood programmes, psychosocial support and succession planning (including identifying family and community-based alternative care);
- access to essential services: education, HIV services, healthcare; and
- mobilising and supporting community-based responses: anti-stigma and discrimination, OVC support and self-help groups, child clubs/play groups.

Across Cambodia, 711 communes had at least one organisation that was providing the basic package of integrated services to OVC listed above. This constitutes 44% of the 1,621 communes in Cambodia. The Universal Access target for Cambodia for 2008 is 50% and for 2010 the target is 100%.

Figure 20. Commune Coverage (by Province) of OVC Impact Mitigation Activities (Data collected by Save the Children Australia, 2007)



Source: Data collected by Save the Children Australia 2007

4.3.1 NGO Response to Orphans

There are at least 227 alternative care centres providing shelter to orphaned and abandoned children, including orphanages, shelters and group homes. Alternative care has often meant residential care, however there is a growing understanding of the need for family- or

community-based options. A number of NGOs use community-based approaches in providing alternative care, such as kinship care (e.g. Spien and Aspeca), foster care (e.g. World Vision and Maryknoll), pagoda-based care (e.g. ICC-Hosea and Krousar Thmey), group homes (e.g. Hagar and Meataphum Komar) and supporting child-headed households (eg. TASK). In February 2007, a national consultative workshop on Moving Toward Community-based Care brought together many of these NGOs and identified a number of issues requiring collective effort, including reporting activities using standard terms and definitions, a lack of information-sharing mechanisms and sustainability of care.

INGOS supporting foster care have found that many extended families taking in orphans are over-extended and unable to ensure an appropriate quality of care. For this reason, some form of means tested foster care grant system is desirable, if it could be financially feasible.⁷⁰ NGOs are providing social support, school support, succession planning and psychological support to orphans living in the community and support for repairs and maintenance to family home and residential care centres.

4.3.2 NGO Response to Children Affected by HIV

NGOs responding to the needs of children affected by HIV frequently include treatment and adherence support, income generation programmes, succession planning and village-level social support groups. Partnerships and collaborations are common. For example Maryknoll collaborated with the National Paediatric Hospital in Phnom Penh to establish the first Paediatric AIDS Care site in 2003. This model of providing treatment to children in their homes or through children's centres has grown in popularity, and there are now several orphanages and day care centres that provide medical treatment for children, educational support from pre-school to grade 6, counselling (through art therapy, peer groups, life skills workshops), sports activities, vocational training and nutrition support.

Social support groups for children have been added to the HIV and AIDS Continuum of Care, and support centres at provincial hospitals now actively refer children to social support services in their community, and some hold regular children's meetings. The groups, mostly supported by NGOs and FBOs, help children participate in decision making around family future planning and succession planning, access essential services and adhere to treatment. They also help children solve immediate problems and help them combat stigma and discrimination.

Many organisations that work with parents living with HIV and caregivers of OVC help them plan for the future of their children. These initiatives encourage HIV-positive parents to disclose their HIV status to their children, appoint and negotiate with standby guardians, create memory books (journals of lasting record of life together and family information) and write wills before they die. Documentation of the child's identity, family assets and plans for the dispersal of assets help protect the memories as well as the future of children.

4.3.3 NGO Response to Vulnerable Children

The response to all vulnerable children includes:

- promoting birth registration
- village-level self-help groups

⁷⁰ World Bank, "A Toolkit on how to support Orphans and Other Vulnerable Children in Sub-Saharan Africa," 2006

- pagoda-based social care programmes
- advocacy, catch-up classes, material support and cash transfers for school participation
- food aid
- income generation, livelihood programmes and vocational training
- non-formal education and life skills
- children's rights awareness raising and advocacy training
- social support, children's clubs and play groups

This range of programmes is provided by both child rights groups and HIV and AIDS organisations operating at the local level. Often the activities are provided in partnership with a local Buddhist pagoda or Christian church. Most organisations provide a range of these activities, though very few provide all of them. Some service providers have good referral networks and funds to take clients to other services when needed.

NGOs are helping MoEYS expand the coverage of Child Friendly Schools to 70% of all primary schools to improve education outcomes for 'hard to reach primary school age children who have no access to primary education.' This programme not only creates school environments that nurture the well-being of every child, but also seeks out children excluded from school due to HIV and AIDS, poverty, disability, ethnicity or gender.

Education support programmes vary from those providing some material support in the form of books, school uniforms and stationery, to more comprehensive services that identify the most vulnerable children and provide them with support in the form of formal and non-formal education programmes appropriate to their individual needs. Several organisations are involved in support of inclusive education for children with disabilities.

Many NGOs specialise in supporting vulnerable children with special needs related to exposure to violence, exploitation, abuse or drug use. Most services for drug users are concentrated in Phnom Penh, although training provided by Friends-International and Mith Samlanh to both government and NGO partners has increased the coverage to the provinces, in particular Battambang, Kratie, Sihanoukville and Siem Reap.

The Directory of Organisations Working on the Prevention of Child Sexual Exploitation in Cambodia⁷¹ lists over 80 organisations working in the field, from prevention, prosecution and law enforcement, to protection and victim support, policy, advocacy and research. NGOs, UN agencies and government bodies are working in all provinces but with high concentration in Phnom Penh and Poipet (one of the main transit areas for trafficked persons and migration). There are many programmes working on prevention, identifying at-risk children, community education, practical solutions to keep families together, as well as programmes that support child victims of trafficking, exploitation and violence.

Psychosocial support provides physical, emotional and social support to enable children to gain/regain a sense of normality and strengthen or re-establish connections with family, friends and community.⁷² Poorly trained or supervised staff can subject children to secondary trauma, and so basic social work and counselling training programmes are provided to social workers, although coverage is still limited.

Psychosocial support services combine a number of the following activities:

⁷¹ Save the Children Australia, World Vision Cambodia, AusAID, 2006

⁷² H. Widdowfield, H, "Module 1 Psychosocial Introduction" (Cambodia, International Organisation for Migration, 2006)

- reconnecting children with family members, friends and neighbours where this does not represent the possibility of further danger or trauma to the child;
- normalising daily life, so the child is living with the same number of other people as is usual in their cultural context, has daily routines and is able to anticipate what is likely to happen in a range of usual situations (e.g. at mealtimes) and knows what is expected of them in a range of situations they encounter daily;
- promoting a sense of self-confidence and competence by supporting children to master developmental challenges appropriate for their age and stage;
- actively encouraging the participation of children in planning for their future;
- providing counselling and helping children to see themselves as being able to solve problems, take risks and successfully tackle challenges;
- providing activities for children where they can play, feel included, identify with a group, experience acceptance and express themselves safely;
- providing children with opportunities to talk about their experiences, feel good about the way they survived adverse events or managed themselves in dangerous, distressing or depressing circumstances.

Village-level self-help groups that operate under a variety of names have been established and are often supported by FBOs and NGOs able to support community leaders to mobilise support from within the community.

While there are only a limited number of specialist services providing psychological support for children (Transcultural Psychosocial Organisation [TPO], Social Services Cambodia, Mercy Teams International), many agencies have incorporated social support, counselling (which for the untrained consists mostly of providing advice to children) and psychological support into an integrated service.

4.4 The Community Response

The response of families and communities to children orphaned or made vulnerable by HIV and AIDS has been compassionate and remarkably resilient given the trauma experienced over the last 3 decades and the country's widespread poverty. However, families and communities are struggling under the strain. To date, few resources are reaching the families and communities providing this front-line response, although some attention is given to children in the National Strategic Development Plan and poverty reduction strategies.

This assessment has found that many individuals are prepared to absorb OVC into their families, but need assistance to do so. They are willing to enter into partnerships with NGOs that can provide material and psychosocial support in order to keep children in kinship-based care or their home communities. If the potential of these partnerships to support OVC and their caregivers is realised, it will go a long way to easing some of the most severe causes of children's distress, including stigma and discrimination, poverty, family separation and isolation, and disruptions to schooling.

Some children and young people are already playing a leading role in developing and evaluating interventions and peer education messages that affect their lives. A number of CBOs have been formed by young people, such as children's clubs and health clubs. Children are also involved in writing and performing music or plays, meeting kids from other areas, forming focus groups to discuss messages and evaluate campaigns. Mondul mith chewey mith (Friends help Friends) groups for children and young people have been incorporated into the HIV and AIDS Continuum of Care. Where effective mechanisms have been

developed to create this kind of space and involvement of young people, they need to be replicated and incorporated as core components of programme implementation. This is true for both HIV and OVC programmes. Any involvement must ensure that children affected by AIDS are not publicly differentiated and that participation is voluntary.

The situation of OVC must be understood and addressed in the context of gender-based inequality. The way decisions are made regarding condom use, succession and future planning and relinquishing children disempowers women in many families. The consequences of the failure to address gender and power imbalances are having a devastating effect on children. Interventions to ensure that women have equal control over the means of production for family income generation, eliminate the complacency around gender-based violence and promote the status of women are shamefully under-resourced and continue to be regarded as peripheral to the mainstream response to OVC and HIV.

Many parents are able to keep their children with them, and neighbours and extended families provide additional support, but the demands on family resources increase with the presence of HIV. Many of the coping strategies adopted by households in response to increased medical expenses and reduced income involve actions that compromise the health of children or damage the family resource base and limit opportunities for future capacity for income generation. For example, the sale of productive assets and family land and the incurring of debt that is transferred to women and children when parents die, creates a cycle of long-term poverty and hardship from which many of today's OVC will be unable to break free.

Mothers who participated in the focus group discussions for this report spoke of hiding their HIV status from their children as a way of protecting them. However, when parents revealed their status, many children replied that they were already aware that their parent had a life-threatening illness. One mother explained how she told her daughter she had hepatitis, however when confronted by her daughter, she revealed the truth about her HIV status. Her daughter now supports her HIV adherence and helps her with combating stigma and discrimination. Children consulted during the preparation of this report repeatedly recounted stories of hearing about their parents' HIV status from other children and neighbours or the Pagoda Committee when they came to assess the family's eligibility for emergency assistance. The monks from the Pagoda Committee stated they were not aware that the children had not been previously advised of their parents' HIV status.

Service providers and caregivers interviewed for this report indicated that village-based voluntary child support and vulnerable families' groups, often initiated and supported by local NGOs and CBOs, provide significant support that strengthens families and allows parents to keep children with them. For example, volunteers repair homes and patch roofs before the wet season, or help with harvests or home gardens. They also intervene on behalf of children who are being victimised at school.

Although much support and solace comes from the community and extended family, many extended families take over decision making and fail to take the mother's wishes into account or to consult children and give them the opportunity to participate in decisions that affect them. Although these actions may be taken with the best of intentions, the outcome can be traumatic for children. Many women living with HIV interviewed for this assessment gave examples of their extended family or in-laws seizing the families' children and assets, sometimes while their husbands were still alive. The issues are complex, and one woman told a story that illustrates a common family response to the needs of orphan and vulnerable children:

When my HIV+ husband was still alive, he decided that I would take care of him and earn money and that he would send our two smallest children to stay with my aunty. The children were very young, and they broke things in the house, so my aunty sent them back. They were very confused and unsettled. Then my husband died in 2004 and I lost our house. I had no money and I could not feed the baby. The relatives tried to take the children from me because I was very poor. I resisted.

When my parents found out that I had HIV they tried to take the children back to my aunty. Six of my 8 children were still alive and I wanted them to stay with me but now only my 17-year-old son lives with me. The other children are all living with relatives, separated from me and each other. Four of my children I have not seen for 3 years. Some of my older daughters have been moved around to different relatives. When I ask why, my husband's parents say it is because they are growing up and must be kept away from the men. I don't know if anyone explains this to the girls or if they are just uprooted repeatedly. Maybe the men beat the children-or worse, I don't know.⁷³

There is also evidence that some OVC are mistreated, exploited and abused by their guardians and other adults. Children are sold into the sex trade or domestic slave labour, often by family members. Many children interviewed for this report, and clients of SCA, living with extended families spoke of the beatings and other forms of physical and verbal abuse they are subject to.

⁷³ Jenne Roberts, interview with NS an HIV-positive mother receiving treatment from Médecins du Monde, at Preah Kossamak hospital 11th April 2007

5 DISCUSSION OF FINDINGS, GAPS, OPPORTUNITIES AND RECOMMENDATIONS

Currently, there are no common criteria or comprehensive data sets that can be used to identify the number of OVC or the overall number of programme beneficiaries, therefore quantifying the level of unmet demand is challenging. There are, however, a number of promising developments taking place that could make this task easier. For example, the MoP, with support from GTZ, is piloting a national system of identifying the most economically vulnerable families. Once established, this listing could be analysed in conjunction with CDHS data so more precise estimates of the number of OVC could be made.

5.1 Service Coverage and Geographical Areas of Unmet Demand

The following provinces have been identified as having the largest number of orphans. Some of them, most notably Kampong Cham, Siem Reap, Kampong Speu and Kampong Thom, have high orphan numbers and low impact mitigation coverage.

Table 2. Priority Provinces for Scaling Up of OVC-related Services (Mapping the Reponse, 2007)

Province	Estimated number of orphans (2005)	Estimated total number of children 0-15 years (2004)	% of communes with a comprehensive OVC service ⁷⁴ (2007)
DATA SOURCE	CDHS 2005	National Institute of Statistics	<u>Mapping the Response</u>
Kampong Cham	74 537	627 245	25%
Battambang and Pailin	50 464	402161	88% and 100%
Siem Reap	44 667	311 060	50%
Phnom Penh and Kandal	43 436	289 954 + 446 313	82 % and 16 %
Prey Veng	36 412	396 083	57%
Kampong Thom	31 319	239 765	22%
Kampong Speu	30 690	273 508	17%

Coverage of OVC services is limited, and significant numbers of OVC do not yet receive sufficient support from government and civil society. For example, only 6 provinces have OVC impact mitigation services in more than 70% of communes. Coverage of impact mitigation services is less than 30% in 13 provinces.

Organisations tend to cluster together in towns and cities along the national highway routes and in Phnom Penh, Battambang, Siem Reap and Sihanoukville, leaving many remote areas under-serviced. The poor transport and communications infrastructure can make working with remote communities unattractive and expensive.

⁷⁴ Comprehensive OVC Service, as identified in Mapping the Response, includes at least 1 of each of the following: 1) family strengthening intervention; 2) support to access essential services 3) a local self help group supporting OVC and/or PLHIV

Evidence from the KHANA and WFP distribution of food support through home-based care shows that outcomes for OVC and their caregivers improve across a range of indicators if food is provided as part of a standard package of home-based care. Anecdotal evidence suggests families will take in OVC if they receive material support, especially food. Many children continue to remain food insecure, and scale up should prioritise areas where under-five malnutrition and HIV prevalence among pregnant women is highest and existing coverage is limited. The provinces with the highest rates of stunting in under-five year olds, a reflection of chronic malnutrition, include:

- Pursat (with 63% stunting, 18,217 orphans and 51% OVC impact mitigation coverage);
- Siem Reap (with 53% stunting, 44,667 orphans and 50% OVC impact mitigation coverage);
- Oddar Meanchey (with 47% stunting, 7,140 orphans and 0% OVC impact mitigation coverage);
- Kampong Cham (with 37% stunting, 74,537 orphans and 25% OVC impact mitigation coverage)

At the time of this report, there were no recorded NGOs working on OVC impact mitigation activities in the province of Oddar Meanchey, Preah Vihear, Stung Treng, Ratanak Kiri and Mondul Kiri. However the number of orphans is relatively low in these provinces and HIV prevalence among antenatal care attendees is also relatively low.

5.2 Strengthen the Capacity of Families to Protect and Care for Orphans and Vulnerable Children

Discussion of Findings, Gaps and Opportunities

Strengthening families requires a social protection system: The core problem facing Cambodia's orphans and vulnerable children is poverty. There are several social protection systems operating, such as the Health Equity Funds and the cash transfer system for school attendance for girls mentioned earlier. Social transfer systems are most needed by households where the caregiver/s are unable to generate an income due to their age, illness or disability, child care responsibilities or a high dependency ratio. Support directly to caregivers could provide the poorest children with a real alternative to institutional care, promote school attendance and reduce children's working hours.

Income generation schemes must operate on sound business principles: NGOs have been providing support to OVC and their family members to gain access to livelihood security, income generation and vocational training programmes. Programmes such as the Grassroots Business Initiative and the Oxfam America poverty reduction programme have indicated a willingness to collaborate with OVC support organisations to scale up and provide technical support, retail outlets and micro-credit, or help people bring their products or skills to the market place. Small to medium enterprises, such as cafés, small guest houses and handicraft outlets, are providing employment and on-the-job training that allows people to secure employment in the fastest growing sector of the economy. However, NGOs running the programmes do not always have access to information that would help target vocational training programmes or the expertise to ensure income generation schemes are operating on sound business principles. The sector responding to OVC and HIV and AIDS would benefit from closer links with the World Bank and their partners and other technical assistance agencies with substantial experience in the area of assistance to grassroots business organisations, livelihood security and running profitable small to medium enterprises.

Children need food security: Long-term, sustainable responses to increase food security need to be consistent with evidence-based strategies, such as the National Nutrition Plan and the Child Survival Strategy. These strategies address early infant feeding, increased food productivity, age-appropriate nutrition education and treatment for severely malnourished children.

Children benefit from life skills education that builds resilience: Children in families under pressure and those without adequate adult support are at risk of not developing the ability to participate in their own development, recover from trauma, prevent HIV and avoid exploitation. However, there is a school-based life skills education programme operating in partnership with MoEYS in 14 provinces that develops these skills in young people. Many NGOs also provide smaller-scale programmes or life skills for children with special needs, such as drug users.

Families need psychosocial support: Many organisations provide a vast array of psychosocial support that can help families to protect and care for their children. Social support is often derived from village- or commune-level self-help groups supported by the Commune Council, NGOs and FBOs. These services are providing consistent, timely and appropriate support as well as building social capital and reducing stigma and discrimination.

Many different activities are targeting the needs of local populations. A comparative analysis, where organisations are willing to open their programmes up to external scrutiny in the interests of improving the outcomes for families and OVC, would provide useful information about models of good practice.

Organisations working with OVC have an obligation to do no harm: Most organisations working with children have no recruitment or staff supervision policies in place to protect children from harm. World Vision Cambodia, SCA and Child Wise have developed resources for ensuring organisations responding to the needs of OVC are child safe, as well as child protection policies for internal use that set the standard for agencies working directly with children. More work is needed in this area to expand the number of organisations and social workers so that interactions with children are not left to chance.

Keeping parents alive protects children: Cambodia has set targets for universal access to treatment and care for people living with HIV. Over 80% of adults who need it are now estimated to be receiving treatment and home-based care and support. Keeping parents and other primary caregivers, such as grandparents, alive protects children. Children with both parents alive have higher levels of participation in education and are generally in need of less support than those who have been orphaned.

Improving women's health protects children: Women's health services, including Safe Motherhood and family planning services, are limited and not receiving the attention needed to have a significant impact on maternal and infant mortality rates. These services, where they exist and are functioning well, play a key role in the prevention of mother-to-child transmission of HIV and in prolonging the lives of mothers.

Quality counselling and social work training: The provision of emotional support is a key component of home-based care for PLHIV, as well as a much needed skill for people working with OVC. MoSVY provides basic social work and counselling training to district social workers. NCHADS, in collaboration with the National Mental Health Programme, has developed a training module for home-based care teams. Quality basic social and counselling training for staff working with NGOs is provided by Social Services Cambodia and TPO (for counselling). However, the scale of the training needs to be expanded significantly across all training programmes to ensure good coverage and to safeguard children.

Developing the links needed to strengthen families: The NOVCTF could play a leadership role in building the links between the work of the MoP, NGOs supporting the poor, and the World Bank to further efforts in relation to identification and effective responses to older OVC and caregivers.

Recommendations:

1. Increase the economic capacity of households by expanding the coverage of effective income-generation and livelihood programmes and by increasing food security, agricultural productivity and ensuring income-generation schemes are based on sound business principles utilising appropriate technology.
2. Strengthen and expand quality child-centred psychosocial support services at the village level that meet the needs of OVC.
3. Promoting birth registration, succession planning and inheritance protection should form a core component of all psychosocial support programmes.
4. Increase efforts to prolong the lives of parents and children living with HIV by providing families with the means to access testing and treatment and social and adherence support.

Scale up life skills education to build resilience among children and young people, and to ensure that they are better equipped to handle everyday life situations and issues in an optimum way. This includes equipping them with skills that help them to make informed decision about HIV prevention.

5. Scale up access to basic social work and counselling training that emphasises a child-centred approach and works with children's strengths. Link training to competency assessments and ongoing supervision and support.

5.3 Mobilise and Support Community-based Responses to Care for, Protect and Support OVC

Findings, gaps and opportunities

Communities can provide the most timely, consistent and cost-effective support:

Families are often faced with pressures on a number of levels, and a holistic response is needed to make a significant and tangible difference. Local leaders, NGOs, CBOs and FBOs play a vital role in providing support to OVC and those affected by HIV and AIDS. They have been able to mobilise timely, effective support from within communities. Such support utilises the knowledge, skill and resources of local people. Village-level self-help groups show evidence of being sustainable and effective. This community mobilisation builds social capital and binds people together, creating sustainable, long-term benefits.

Monks play a key role in mobilising the community and reducing stigma: The role of monks in the identification of OVC and mobilising community support cannot be underestimated. They also play a vital role in reducing stigma and discrimination. NGO efforts and programmes such as the Buddhist Leadership Initiative have been successful in mobilising monks to respond to OVC. Home visits and empathy shown by monks create an environment where people can talk more openly about the impact of HIV and AIDS on their community.

Local authority involvement benefits NGO programmes: There is limited collaboration between many NGOs and the local authorities, especially the Commune Councils. Without the involvement of the Commune Councils, it is hard to ensure sustainability and ownership. Commune development plans often do not reflect the development activities of NGO involved in strengthening social supports.

Further efforts to work with and involve the Commune Councils, particularly the Provincial Rural Development Committees (PRDC) and the women's and children's affairs committees, in the implementation of OVC-related activities are required. The Commune Councils must meet the NGO sector halfway in efforts to increase cooperation.

Organisations working within the decentralisation process and with Commune Councils have found that their programmes are working more smoothly. They provide a model for mobilising local leaders and increasing the Commune Councils' investment in children.

Local responses benefit from OVC and PLHIV involvement: Instead of being treated as passive beneficiaries, OVC, their caregivers and supporting agencies can all benefit from working together during programme planning, development, implementation, and monitoring and evaluation. Many paid positions in organisations could be earmarked for the caregivers of OVC to ensure they benefit from the programme in a variety of ways.

Most OVC are being cared for in the community: There are an estimated 570,000 orphans, including 66,000 double orphans, and less than 10,000 children are in residential care. This indicates that, in line with government's Policy on Alternative Care for Children, orphanages and other institutions are the option of last resort. However, residential care dominates the alternative care services for children. Community-based care, especially foster care and local adoption, are still not widely accepted. Community-based care offers children the opportunity to remain in a family environment. Efforts to increase the profile of community-based care options must go hand in hand with efforts to improve the quality and regulation of all alternative care options.

Recommendations

1. Increase local ownership, effectiveness and sustainability of community-based programmes for OVC by engaging commune leaders and OVC in responding to the immediate needs of OVC.
2. Scale up programmes that enable community members to talk openly, accurately and without discrimination about HIV and AIDS and support monks to increase their understanding of relevant issues, make home visits, coordinate local self-help groups and advocate effectively for OVC.
3. Increase the commune-level coverage of programmes that mobilise community members to provide effective, timely and compassionate support to OVC and HIV- and AIDS-affected families.

5.4 Ensure Access (for OVC) to Essential Services

Finding, gaps and opportunities

Coverage of essential services increases under national programmes: Many essential services and infrastructure are provided by development partners and NGOs. Services not integrated into a national programme provide much needed emergency relief, but unless they are contributing to building the national response, they are unlikely to be sustainable once external donor commitment wanes.

The NGOs and FBOs are developing effective and appropriate services, and the challenge is to ensure that those services are linked, scaled up and have the potential to be replicated or adopted into sustainable national programmes.

An effective network of essential services requires some basic elements: Access to essential services requires clear entry points, systems for identifying OVC requiring support, referral options and adequate coverage of quality services. A common framework for case assessment and management aids consistency and quality assurance. Services are potentially most effective when decision making is supported by regular and rigorous monitoring and evaluation. Evaluation aids decision making and can be used to adjust current operations and inform future programming. A range of services, linked by active referral networks, is needed to ensure that children receive targeted responses that meet their individual needs.

Additional support is needed to increase school attendance and attainment: Various effective interventions supporting access to education have been identified, including programmes to reintegrate children into formal education, material support in the form of books and school uniforms, as well as advocacy and negotiation where informal fees, bullying or discrimination is occurring. Interventions to support girls and OVC to access education are having a positive effect, and school participation is increasing. However, progression through the grades is limited, especially for orphans and children affected by HIV. School support efforts need to be targeted to these children and scaled up.

Reducing mother-to-child transmission of HIV: Reducing mother-to-child transmission of HIV is a major challenge for Cambodia, as approximately one third of all new infections are transmitted that way. HIV prevalence remains high among pregnant women in provinces such as Siem Reap, Sihanoukville, Koh Kong, Kampong Speu, Kampong Cham and Pailin. Family planning is a core component of services to prevent mother-to-child transmission in low prevalence countries; however there are limited family planning services available in Cambodia, and the unmet need for contraceptives among married women remains high, despite recent gains in this area.

Implementation of minimum standards for all forms of alternative care is needed: The Minimum Standards for community-based alternative care have been developed and were adopted by MoSVY in March 2008. The process has been led by MoSVY with the participation of NGOs running community alternative care programmes. For the dissemination, there is need to learn lessons from the dissemination of the Minimum Standards on residential care, which so far has been less than adequate. The dissemination of these Minimum Standards has not yet been accompanied by guidance or advice on how to meet them and there is no clarity on placement criteria or procedures nor is there trained government staff to make appropriate placement decisions and regularly review them. MoSVY's monitoring staff has limited capacity to provide constructive advice to residential care providers to improve their quality of care. This problem is likely to be even more evident when monitoring community alternative care, an area in which MoSVY has less experience than residential care.

National data on alternative care is not yet available: Alternative care is an essential service for the many children living on the streets or in abusive or exploitative situations. There are many different forms of alternative care for OVC; however, there is no national data on the number of children in each type of care. This information is needed as a matter of urgency for monitoring and to inform planning and decision making.

Street children need more support: The social reintegration of street children into their society as well as prevention efforts to reduce the number of children coming to the streets is needed in areas where there is an established or growing network of street children. Such areas include Phnom Penh, Siem Reap, Sihanoukville and Battambang towns. Services including outreach, harm reduction, placement into alternative care, reintegration into education, vocational training, child protection, job placement and family reintegration in accordance with the Convention on the Rights of the Child need to be scaled up. Services for street children should also be included in planning negotiations when families are being evicted en masse.

Direct food aid is beneficial: The collaboration between KHANA, the WFP and NCHADS has established the benefits of direct food aid to HIV-affected households where there is no possibility of sufficient income or food being generated. School-feeding programmes and direct food aid to OVC through pagodas and self-help groups has also increased the food security of OVC. The expansion of emergency food support for distribution through home-based care teams and self-help groups and children's clubs is recommended, due to the clear benefits for children and their families. Whenever possible, however, support to more sustainable strategies for increasing food security of families is preferable.

Recommendations:

1. Define minimum packages for essential services so that service responses become standardised and comparisons are possible across the sector.

2. The NOVCTF should be linked to the Food Security and Nutrition Technical Working Group and MoWA's Counter Trafficking Task Force so as to align efforts.
3. Programme implementation addressing food security should be consistent with the National Nutrition Strategy, which includes age-appropriate interventions. Programmes should also be linked, where appropriate, with food security and agriculture technical expertise.
4. Alternative care priorities include implementation of the Policy on Alternative Care for Children, monitoring compliance with the Minimum Standards, developing placement criteria and procedures and training government staff to make appropriate placement decisions, establishing and utilising a national database on community and residential care, strengthening the Alternative Care Coordination Committee, promoting community-based care and permanency planning for children in residential care.
5. Support for OVC to access education should focus over the next 5 years on increasing school enrolment, reducing disruptions and improving attendance for OVC, including orphans, HIV-affected children and children living with HIV. Additional efforts to support the participation of girls are required. Successful small-scale models, including establishing child care centres on school grounds to relieve older girls of child care responsibilities that prevent them from attending school, as well as the conditional cash transfer scheme, should be scaled up.
6. Children's health interventions should contribute to achieving universal coverage of high-impact child survival strategies, including prevention of mother-to-child transmission, as outlined in the Cambodia Child Survival Strategy. Implementing agencies could also promote access to the Ministry of Health's minimum package of activities by providing transport, trusted adult accompaniment for OVC and access to Health Equity Funds or government subsidies for the poor.
7. Expand the Alternative Care Minimum Data Set to include an annual census covering all the different forms of alternative care for OVC. A Minimum Data Set Working Group should be formed under the Alternative Care Coordinating Committee to develop the data set (building on the work already achieved in this area by MoSVY and UNICEF).

5.5 Ensure that the Government Protects the Most Vulnerable Children through Policy, Planning and Legislation

Findings, gaps and opportunities

The laws to protect and support the most vulnerable children are inadequate: Laws designed to protect children are fragmented, often remain in a draft state for several years and are not fully implemented or enforced. After so many years of conflict, the legal framework is still evolving. Where a legal framework exists, implementation remains a challenge. A Child Protection Law and policy is needed to provide a framework for a comprehensive child protection system. While service delivery will continue to be provided by NGOs, in the long term, opportunities to identify what works, is replicable and sustainable should be pursued. The state should strengthen its role for standards setting, coordination and oversight of service provision.

Community-based child protection networks have local, donor and political support: In many provinces the community has been mobilised to protect children from harm resulting from exploitation, neglect and abuse. Community-based child protection networks have been established and enable children to meet, discuss and raise their concern with other children and supportive adults.

The MoSVY programme, supported by UNICEF, has been evaluated in 2008, providing an opportunity to do a comparative analysis with other child protection services developed by World Vision, SCA and FHI. This could lead to the documentation of a model of good practice and to the identification of the core elements needed to provide an effective network. This information could feed into the development of a comprehensive child protection system which should build on these experiences as well as the emerging local governance structures such as Commune Committees for Women and Children and Commune Women and Children Focal Points. The development of a national system is timely given the high level of local, donor and political support for child protection.

Addressing gender-based inequities, violence and exploitation strengthens families and protects the most vulnerable: Once families' basic material needs are met, there is an opportunity to address the underlying issues that render many children vulnerable, such as gender-based inequities, violence, abuse of power and exploitation. Programmes that address HIV and AIDS vulnerability in the context of raising awareness about the long-term impact of gender inequity and violence have had some success; however they are small scale and often marginalised from the overall HIV response.

Government capacity to protect the most vulnerable children needs strengthening: MoSVY takes a lead role in the protection of children and regulating alternative care, however capacity and resources are limited. For example, there is a ratio of approximately one district social worker from the Office of Social Affairs, Veterans and Youth Rehabilitation (OSAVY) for every 25,000 people. Basic social work training programmes have been established but a comprehensive analysis of the core functions and competencies needed to advance child protection, rehabilitation and alternative care have not been developed.

MoSVY is experiencing some system weaknesses. The Ministry would benefit from taking action to develop systems that would promote donor confidence. Institutional accountability could be strengthened by building transparent and well-functioning systems to safeguard investment and mobilising donors around a clear set of priorities linked to the costed National Plan of Action for OVC. Individual accountability could be built through performance- and output-based job descriptions linked directly to annual work plans that provide staff with a clearer understanding of the role they play in protecting OVC.

The NAA, UNICEF, SCA and DFID have offered substantial and ongoing support to strengthen the capacity of MoSVY that will provide significant benefit to OVC in the long term.

Recommendations:

1. Develop a Child Protection Law and create a national child protection system. Community-based child protection mechanisms, such as those being piloted by MoSVY and NGOs should be assessed and eventually feed into the national system.

2. Build MoSVY capacity to enforce Minimum Standards for Alternative Care and The Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption and promote family- and community-based care. This will require considerable external long-term support.
3. Develop long-term systematic plans for the clarifying and strengthening the child protection responsibilities of government, including the roles of relevant sectors such as Health and Education.
4. Advocate for the rapid enactment of the draft Inter-country Adoption Law and the necessary revisions to procedures, strengthening of capacities, and establishment of enforcement mechanisms to ensure implementation of the law. Domestic adoption procedures should be made known and domestic adoption encouraged over inter-country adoption.
5. Build MoSVY's capacity by identifying priority areas for strengthening within the Child Welfare Department, addressing priorities identified in a functional task analysis and strengthening the systems that promote accountability and transparency.
6. Investigate opportunities for further linking HIV prevention to addressing gender-based inequity and preventing violence.

5.6 Create an Enabling Environment for a Coordinated, Effective Response to OVC

Findings, gaps and opportunities

Visible leadership is needed: Problems of the magnitude identified in this report require strong, ongoing leadership and a long-term commitment to transform a diverse array of services into a system that strategically provides care, protection and support to OVC. This type of leadership has been fostered and developed in the HIV and AIDS sector, and the results can be seen in the successful and relatively comprehensive response to prevention and treatment.

Leadership needs to be visible and to communicate strategic directions and results widely. Leadership is needed at the national, provincial and local level. In communities, Commune Councils and religious leaders should be supported to maintain a prominent role.

The mechanism for leadership exists in the NOVCTF, and this forum requires support and technical assistance to develop the agenda for OVC. A thoughtful long-term approach is needed, with high-level champions willing to respond to the evidence and be proactive where none exists but anecdotal evidence is strong. The challenge for the leadership will be to facilitate all stakeholders into a coordinated and strategic network of services able to have a demonstrable impact on outcomes for OVC. To achieve this will require a high level of political will, leaders who are able to make timely and well-informed decisions and two-way communication.

Communication is needed: The emphasis of development actors is sometimes on staging events rather than facilitating participation and ensuring plans, research and other documents are disseminated to those who could make use of them. There is a need for donors to insist on robust dissemination strategies when funds are granted to develop key documents.

Communication is often a challenge for a coordinated multi-sectoral response, therefore it is essential to establish and maintain systems for networking, sharing lessons learned and participation that enable stakeholders to be regularly in touch with one another and expose them to a credible leadership.

Coordination is needed at every level: The central role of the NOVCTF is to promote and facilitate coordination, discussion and information sharing among key stakeholders working with OVC. Coordination must extend down to the local level and work within existing decentralized structures for development.

The NAA is supporting a pilot provincial HIV coordination project to benefit OVC. The project aims to improve the response for OVC through coordination and capacity building. Once Commune Councils and local leaders are familiar with the OVC situation and priority needs, they can input this information into the Provincial Rural Development Committees and Commune Investment Plans. This pilot, if it is successful, could serve as the model for establishing provincial- and district-level coordination. Funding comes from USAID through NAA. The budget includes: 1) money for training to the Commune Councils to include OVC issues in the Commune Investment Plan; 2) advocacy and awareness-raising campaigns; and 3) coordination meetings.

Advocacy must target every level: Advocacy needs to take place at every level in order to mobilise government, the community and development partners to support OVC. Sectoral plans could miss opportunities unless advocacy for key components of a multi-sectoral response is strong and timely. Links between the NOVCTF and key ministries, especially those with HIV planning processes, are vital.

The NAA has developed an HIV and AIDS Advocacy Strategy that includes OVC impact mitigation as a priority. This provides an opportunity for the NOVCTF to collaborate with the NAA to achieve advocacy goals.

Multi-sectoral cooperation is important: Cooperation is essential between agencies and between NGOs and the government if there is to be an effective, coordinated multi-sectoral response that benefits OVC. Child participation must be a core value of the collaboration, and community participation is important for success, sustainability and accountability. Coordination is difficult to achieve when timelines and deadlines are very tight. However if regular opportunities to meet and exchange ideas are systematised people will have the chance to develop the personal relationship upon which quick turnaround times and real collaboration depend.

An effective response to OVC requires resources: Issues related to planning, setting priorities and mobilising resources are inter-linked. The process involves deciding on key strategies, setting targets, costing interventions and then revising targets and priorities based on the resources required and available. Funding is competitive and short-term priorities can often be determined externally by donors. This can result in tenuous support for even the most successful programmes. The skills needed to analyse opportunity costs and benefits are not well developed in Cambodia, and resources are not always channelled through a donor harmonisation mechanism. Costing the national plan will facilitate decision making. Capacity building is needed to increase effectiveness in resource utilisation.

Monitoring and evaluation: Many government and NGO interventions have not been evaluated, and most CBOs are only able to carry out the most rudimentary monitoring, as they operate with substantial volunteer input, have limited access to computers and limited monitoring skills. The international development partners have been building monitoring and evaluation capacity among local NGOs and CBOs, but the deficit of critical analytical skills and information makes identifying lessons learned and impacts difficult. The work being done to strengthen monitoring systems to measure progress towards achieving Universal Access targets provides an opportunity to reflect on how best to assess and monitor progress.

There are systematised disincentives for independent assessment, even as the commitment to reporting against national indicators grows. There is a great deal of competition for funding, and the funding to HIV and AIDS interventions is substantial. There is considerable pressure to report success and little incentive for publicising failure when so much money, as well as jobs and careers, are at stake.

Only a small number of key national performance indicators should be included in the National Plan for OVC, in line with the Universal Access targets and the NSP II.

Recommendations:

1. To promote coordination, the NOVCTF should:
 - develop national-, provincial- and local-level coordination mechanisms linked to existing structures, and draw on the lessons learned from the NAA decentralisation pilot project and outcomes for the OVC group in Svay Rieng.
 - ensure mechanisms and systems are in place to facilitate the coordination of effort, including mapping the response at regular intervals, analysing coverage, monitoring unmet demand and documenting duplication of services
 - host regular study tours and information exchanges using guided observations, building on the model successfully implemented by World Education and MoEYS
 - develop and implement a two-way communication strategy between the national leadership (NOVCTF and other technical working groups and task forces), local coordination mechanisms and across sectors and geographic locations
2. Strengthen the capacity of policy makers, programme planners, advocates and activists (collectively and individually) to advocate for OVC and have input into the development of OVC-related policies and plans by:
 - supporting the ongoing development and implementation of the NAA Advocacy Strategy
 - ensuring relevant and timely information is available through the NOVCTF Secretariat including: national policies and plans; policy analysis briefings to support decision making; coverage data and information on progress towards reaching targets
 - representing the interests of OVC on national coordination mechanisms
3. Develop the monitoring and evaluation systems required to ensure that information for decision making is available, accessible, interpreted and utilised.
4. Develop the NOVCTF capacity to identify, mobilise and effectively allocate the resources needed to implement responses that result in a significant and lasting difference for orphans, children affected by HIV and other vulnerable children.

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