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Summary Report from Key Informant Interviews and Desk Review

INTEGRATING VIOLENCE AGAINST CHILDREN PREVENTION AND RESPONSE INTERVENTIONS WITHIN PEPFAR HIV PEDIATRIC TESTING, CARE AND TREATMENT

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Authors

Aften Beeler, Severine Chevrel, Siân Long, Kristin Weinhauer

Reviewers

Gretchen Bachman, Colette Bottini-Peck, Maury Mendenhall

Cover photo

Oscar Leiva Silverlight for CRS

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome	KI	Key Informant
ALHIV	Adolescent Living with HIV	KII	Key Informant Interview
ART	Anti-retroviral Therapy	LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
CABA	Children Affected by HIV and AIDS	MNCH	Maternal, Newborn and Child Health
CLHIV	Children Living with HIV	OVC	Orphans and Vulnerable Children
CSI	Child Status Index	PEPFAR	Presidential Emergency Plan for AIDS Relief
DSW	Department of Social Welfare	PITC	Provider-initiated Testing and Counseling
GBV	Gender-based Violence	PMTCT	Prevention of Mother-to-Child transmission
HIV	Human Immunodeficiency Virus	VAC	Violence Against Children
HTC	HIV Testing and Counseling	VACS	Violence Against Children Study
HTS	HIV Testing and Services		
IPV	Intimate Partner Violence		

Executive Summary

This report presents the preliminary findings from an ongoing project undertaken by 4Children that seeks to identify key opportunities to incorporate violence prevention and response interventions within priority PEPFAR Program Areas at clinical and community levels. The initial focus is on HIV testing and services (HTS) and pediatric care and treatment — a priority identified at an introductory meeting with selected members of the OVC and Gender Technical Working Group Advisors held in July 2015. The findings presented here draw on conclusions from the introductory meeting, a desk review and over 25 interviews, including 18 country-level key informants covering nine countries.

EVIDENCE FROM THE GLOBAL LITERATURE

Although national Violence Against Children Studies (VACS) and other global studies show consistently high levels of physical and sexual violence against boys and girls,¹ exploration of the potential impact of HIV on violence against children (VAC) in the VACS has been limited so far. However, a growing body of evidence suggests a direct link between all forms of violence in childhood and increased risks of acquiring HIV in later life, and between the impact of HIV on child and/or household members and the child's exposure to violence, especially physical and emotional violence and neglect, is often linked to stigma and discrimination. A global literature review sought to find documentation of effective interventions to address HIV and violence linkages, and explored how this might be addressed within the clinical setting. Global guidance on HIV testing for children and adolescents recognizes the need to address violence, but generally lacks concrete suggestions on how to identify all forms of violence or how to prevent and respond in a clinical setting. While there are evidence-based violence reduction programs for adults, these have not yet been shown to work with children or adolescents living with HIV. Further exploration of how best to do this can build on emerging evidence on successfully addressing intimate partner violence (IPV) through prevention of mother-to-child transmission (PMTCT) programs and through gender-based violence (GBV) initiatives for women (primarily) and men in HIV treatment programs. Global evidence on home-visiting programs providing parenting support for vulnerable children shows emerging positive findings related to HIV prevention, addressing depressive symptoms, and supporting expansion of social networks in Africa. Programs that focus on effective communication between parents and their children about sexuality and safety in romantic partnerships would appear to be a potentially important entry point.

FINDINGS FROM THE FIELD

There was considerable interest and recognition by most policymakers and practitioners of the critical need to link and/

or integrate violence prevention and response within the HIV continuum of care.

Service providers know that abuse is widespread and do identify cases of abuse, in particular sexual abuse. Practitioners noted that the violence against children they are witnessing within their services covers all ages and genders. Younger children appear to be at greater risk for physical violence, and adolescent girls for sexual abuse. Physical abuse is less likely to be reported, because it is often more accepted in the country's social norms. Physical abuse and neglect may be more common among children who do not live with their biological parents or children who are HIV positive. Such information was felt to be difficult to confirm due to the lack of inclusion of VAC on clinic registers, limited HIV clinical staff with sufficient experience and tools in detecting and addressing violence, and the short window of time that a healthcare worker has with a patient. Informants noted a wide and diverse range of points at which children at risk of or experiencing violence are identified by HIV services, including clinics such as maternal health or outpatient, social or case workers employed by HIV clinics, HIV community workers providing child- or adolescent-specific services and referrals from the police and one-stop centers.

Interviewees identified a diverse, often ad hoc, range of ways in which VAC is being or could be identified. In some clinical settings, child vulnerability records are used to evaluate the child's overall well-being which could be used for preliminary screening for referral to a more skilled social worker or counselor in cases of possible VAC. In Mozambique, one informant suggested that the government GBV guidelines could be adapted to reflect adolescent- and child-specific needs. The contact-tracing ("index case") approach for following up individual cases of women living with HIV and experiencing violence was noted as useful to identify children at risk or subject to violence. Health extension workers were also mentioned to use screening tools that include basic screening questions to identify violence within the household as well as other social issues and links to clinical services.

The review sought, but was not able to identify, specific examples of violence prevention in pediatric HIV services and/or HTS settings. However, a number of community- and a fewer number of clinic-based peer groups were felt to offer the *potential* for prevention. Teen clubs and peer support groups were cited as valuable ways to prevent and respond to issues of violence. Linking clinic services with community-based child protection awareness and training could enhance linkages between violence prevention and clinic services.

Informants noted the following barriers and opportunities:

¹ In addition, children who lose or live away from parents, or who are displaced, are at heightened risk of violence compared to those who are not. Children generally know the perpetrators, and a large proportion of sexual violence before age 18 is perpetrated by romantic/intimate partners.
http://www.togetherforgirls.org/wp-content/uploads/2017/10/OCTOBER_2015_Summary-Report-Together-for-Girls-Expert-Meeting.pdf

BARRIERS	OPPORTUNITIES
<ul style="list-style-type: none"> • Insufficient collaboration between OVC and clinical workers, both in the field and within donor agencies; • Lack of tools for systematically identifying violence in HIV settings, including at assessment phase; • Insufficient investment in human resources; • Lack of shared policy dialogue between HIV and OVC policymakers, who should ensure greater strategic linkages in national plans. 	<ul style="list-style-type: none"> • Simple standardized tool to identify and assess VAC; • Training of healthcare workers to recognize warning signs and know the services to provide/refer to; • Establishment of a minimum essential package of services; • Greater investment in referral processes, especially between community/auxiliary workers and clinics; • Integration of VAC prevention and response interventions at every point of contact; • Involvement of trained community members to increase their and health workers' time spent with patients, create safe spaces for disclosure, and offer a comprehensive package of services; • Greater engagement of HIV staff with both children and caregivers, separately and together; • Increased community awareness about HIV/VAC linkages; • Greater focus placed on the potential of addressing VAC as a means of HIV prevention and treatment adherence.

RECOMMENDATIONS AND NEXT STEPS

The majority of practitioners interviewed felt strongly that there was a critical need to address issues of violence against children within HTS and pediatric care and treatment. The following specific opportunities to further link and/or integrate violence prevention and response within HTS and pediatric care and treatment were identified as the highest priorities:

PREVENTION AND EARLY DETECTION	IDENTIFICATION, ASSESSMENT AND RESPONSE
<ul style="list-style-type: none"> • Make linkages with existing home-visiting and parenting programs and home-based counselors and/or index clients to identify risks or early signs of abuse and neglect of children. 	<ul style="list-style-type: none"> • Develop a screening tool/checklist to identify all forms of violence against children within HTS and pediatric care and treatment service with accompanying training and procedures.
<ul style="list-style-type: none"> • Integrate VAC awareness training into HIV health staff pre- and in-service training. Such training should start by discussing health workers' own cultural or social norms and attitudes relating to all forms of violence, and include the use of prevention messages at every point of contact across the continuum of care. 	<ul style="list-style-type: none"> • Develop simple job aids and/or consider how to introduce counseling for identification of violence into the job descriptions of clinic-based counselors to ensure that they can allocate time in counseling to conduct basic identification.
<ul style="list-style-type: none"> • Link/integrate family and social support for violence prevention, early identification and disclosure and support within HTS and pediatric HIV treatment and support services, building on evidence-informed family support and parenting programs. 	<ul style="list-style-type: none"> • Integrate training to respond to VAC with HIV health staff pre- and in-service training through adoption or adaptation of existing national VAC training that has been developed for social workers where available, or through development of simple modules that address GBV from a child and youth perspective.
<ul style="list-style-type: none"> • Explore the introduction of "family days" at HIV treatment clinics that make space for children and adults to participate in separate and group discussions about parenting and family relationships — together and in age-specific groups — and the use of audiovisual materials to convey prevention messages. 	<ul style="list-style-type: none"> • Normalize links between health, social workers and community-based workers by ensuring that clinic managers or staff are routinely involved in local multisectoral child protection forums and referrals to HTS, and that pediatric treatment services staff avail themselves of all tools and are included in national child protection training opportunities; support the participation of HIV clinical staff in national child protection forums.

PREVENTION AND EARLY DETECTION	IDENTIFICATION, ASSESSMENT AND RESPONSE
<ul style="list-style-type: none"> Explore how interventions that integrate HIV testing and disclosure with IPV prevention and reduction could be adapted to specific issues for adolescents. 	<ul style="list-style-type: none"> Strengthen integrated referral and case management systems with multidisciplinary team meetings and case conferencing, especially between community/auxiliary social welfare workers and HIV clinics, using standardized trainings and procedures.
<ul style="list-style-type: none"> Where there are community-based HTS programs, support their volunteers to recognize potential issues of violence when reaching out to adolescents and provide referrals for prevention and support services. 	
<ul style="list-style-type: none"> Identify how teen clubs and peer support groups could be further supported and strengthened to best identify and prevent violence against children through child protection training, and ensure early referrals for violence response. 	
<ul style="list-style-type: none"> Identify a child protection focal point within the clinic responsible for VAC awareness raising and implementing prevention activities suggested above and/or others relevant to local context, and provide specialist support for referrals. 	
STRENGTHENING THE EVIDENCE	
<ul style="list-style-type: none"> Undertake operational research to explore potential barriers to child and adolescent disclosure of violence in HTS or pediatric treatment and support services, and identify the violence-specific barriers to HIV testing and treatment and the HIV service-related barriers to those at risk of or experiencing violence. Review global guidelines on HIV testing for both children and adolescents to ensure that guidance enables clinical workers to assess and refer in cases of violence in HTS and pediatric treatment services. Identify means to routinely integrate VAC data identified within HTS. 	

A number of next steps are suggested, starting with additional specialist interviews across the health, GBV and child protection sectors. The findings will then be presented at a stakeholder meeting to discuss the preliminary recommendations and identify gaps and required follow-up steps. This will inform revised findings and recommendations, including a summary list of recommended opportunities of integration and development of required guidance for final review, updates, and, once approved, dissemination.

I. Background

Emerging data from a growing number of country Violence Against Children Surveys (VACS) and a growing number of global meta-analyses on VAC are increasingly able to illustrate the extensive scale and scope of physical, emotional and sexual violence against girls, boys and transgender children and adolescents (0–18 years). The data emphasize the urgency of responding effectively.

There has been a growth in policy focus through national action plans and of evidence-informed tools on VAC. Such policies and tools aim to enable policymakers and practitioners to identify risks, protective factors and health

consequences, as well as better understand the degree to which children are accessing available services and the barriers that children face when seeking help.²

Concurrently, the children affected by HIV and AIDS (CABA) community increasingly focused on the links between child protection and HIV. VAC is a key element of this. A recent review of the synergies between child protection and HIV consolidated available evidence of the increased vulnerabilities of HIV-affected children to child protection violations and the worsened HIV exposure and impact risks faced by children who experience protection violations.³ In 2014, the Global Partners Forum’s “Call to Action for Protection, Care and Support for an AIDS-Free Generation” noted that global targets to reduce vertical HIV transmission, increase HIV treatment, and prevent new HIV infections cannot be achieved without addressing underlying factors of child abuse, violence, exploitation and neglect.⁴

This report presents the preliminary findings from an ongoing project undertaken by 4Children, which seeks to identify key opportunities to incorporate violence prevention and response interventions within priority PEPFAR Program Areas at community and clinical levels. The initiative is starting with a focus on HIV testing and services (HTS) and pediatric care and

2 As of end 2014, VACS have been completed in Cambodia, Haiti, Indonesia, Kenya, Lao PDR, Malawi, Nigeria, Swaziland, Tanzania, Zambia and Zimbabwe; Botswana, Colombia, Côte d'Ivoire, Rwanda, Mozambique and Uganda are in various stages of planning for and implementing the survey. <https://www.togetherforgirls.org/violence-children-surveys/> The CDC developed the evidence-based Thrives – A Global Technical Package to Prevent Violence Against Children: <https://stacks.cdc.gov/view/cdc/31482>; UNICEF developed Ending Violence Against Children: Six Strategies for Action, which provides evidence of effective programs that address violence against children: http://www.unicef.org/publications/index_74866.html

3 Long, S. and K. Bunkers. (2013) *Building Protection and Resilience: Synergies for child protection systems and children affected by HIV and AIDS. For the IATT on Children Affected by HIV and AIDS.* <http://bit.ly/2EtqPGK>

4 Global Partners Forum (UNICEF, PEPFAR, UNAIDS, USAID, The World Bank, The Coalition for Children Affected by AIDS) (July 2014) *Protection, Care, and Support for an AIDS-Free Generation: A Call to Action for All Children.*

treatment. These priority program areas were identified and recommended during an introductory meeting held by members of the Gender and OVC Technical Working Group in July 2015.

These findings will inform the development of strategies and approaches for preventing and responding to violence along the continuum of care. The preliminary findings and recommendations will be discussed in an upcoming meeting that will identify the most appropriate guidance to be developed.

II. Methodology

The overall aims of the study were three-fold: 1) to gain a better understanding on how well VAC issues are known

and taken into account within PEPFAR program areas; 2) to investigate what PEPFAR HTS and pediatric care and treatment programs are currently doing to prevent and respond to VAC; 3) to gather suggestions on what could be done to improve existing PEPFAR-supported initiatives and other opportunities to prevent and respond to violence within the HIV continuum of care.

An introductory meeting with selected members of the OVC and Gender Technical Working Group Advisors was organized in July 2015 to identify current efforts underway, key documents and next steps forward. The meeting drew on a summary matrix of recommended VAC prevention and violence interventions based on CDC THRIVES and other relevant guidance. Participants identified and discussed potential areas of integration and linkages across the HIV continuum of care. HTS and pediatric care and treatment were recognized as the priority program areas to identify opportunities for integrating VAC prevention and response interventions. The group recommended reviewing PEPFAR’s Technical Considerations, in particular HTS and pediatric care and treatment, and the technical update Strategies for Identifying and Linking HIV-Infected Infants, Children, and Adolescents to HIV Care and Treatment.⁵

The information gathered at this meeting informed the development of a key informant interview (KII) guide (Annex A) reviewed by USAID’s OVC Team, which aims to gather further in-depth information from technical experts and members of the HTS and Pediatric Care and Treatment Technical Working Groups and from in-country practitioners. The KII guide covered the following topics:

- where and how HTS and pediatric HIV care and treatment programs encounter children who may have experienced or be at risk of experiencing violence;
- the types of VAC presenting in these programs;
- current VAC prevention and response actions within these programs;
- examples of how VAC prevention and response activities are being integrated within these programs, and the impetus for the integration;
- untapped opportunities for integrating VAC prevention

and response interventions into HTS and pediatric care and treatment;

- existing barriers that need to be addressed to enable integration; and
- the most significant opportunities for including VAC prevention and response services within HTS and pediatric care and treatment services.

Key informants (KIs) from the technical working groups were identified and recommended by USAID’s OVC team. One-hour Skype or phone-conference interviews were conducted with eight pediatric care and treatment and HTS global technical advisors from USAID and CDC. These KIs then suggested other relevant literature and informants at global, regional and, in particular, country levels. Interviews were subsequently conducted with 18 practitioners working in nine countries.

	GLOBAL-LEVEL EXPERTS	COUNTRY-LEVEL PRACTITIONERS
Number of key informants (KIs) interviewed	8	18
Countries covered	Botswana, Côte d’Ivoire, Kenya, Mozambique, South Africa, Swaziland, Tanzania, Uganda and Zambia	
List of informants involved in the key informant interviews (KIIs) and meetings can be found in Annex B.		

Limited literature was identified during the KIIs, so a further desk review was conducted. The review consisted of an online search of academic, peer-reviewed journals published since 2012 and relevant grey literature. Combinations of the following key words, covering both child/adolescent, were used to identify relevant articles: HIV counseling, testing, treatment, violence, abuse, maltreatment. In addition, global and national guidance on pediatric HTS and pediatric/adolescent HIV treatment were examined to identify references related to the following topics: 1) violence and abuse; 2) the prevention of and response to violence, abuse, exploitation or neglect; and 3) HIV prevention, treatment, care and support. The review focused on low- and middle-income countries.

The main constraint of this study was limited availability of informants at global and country levels. This increased the overall timeline required to conduct the interviews. In addition, the KIIs relied on Skype and phone-conferencing, which, although very cost effective, was not as effective as in-person meetings. Only one interview was conducted in person, building on a scoping mission in Swaziland, and this enabled lengthy and in-depth discussions. The snowball sampling method used to identify country-level KIs meant that most KIIs were with Baylor College of Medicine Children’s

5 <https://www.pepfar.gov/documents/organization/244347.pdf>

Clinical Centers of Excellence. Baylor clinics are typically located in urban settings, and may be more resource-rich than other clinics. Interviews were conducted in English, French and Portuguese, but most preliminary email communications were conducted in English, which might have been a barrier and influenced which practitioners were recommended for and agreed to participate in the KIIs.

III. Preliminary findings

A. GLOBAL EVIDENCE ON SCALE AND SCOPE OF HIV AND VIOLENCE AGAINST CHILDREN

There has been an increase in evidence about the two-way linkages between violence and poor HIV outcomes. This section focuses on recent evidence showing the scale and scope of different forms of violence and their HIV consequences, and vice versa.

1. SCALE AND SCOPE OF VIOLENCE AGAINST CHILDREN

National Violence Against Children Studies (VACS) have, for the first time, generated large-scale evidence of the scale of VAC.⁶ These studies show consistently high levels of physical and sexual violence against boys and girls (see chart with figures on the following page). Most children who experience any violence report more than one type.⁷

There is limited mention of HIV in the earlier VACS surveys; however, newer VACS surveys have added some HIV-related questions. There is also generally limited focus on HIV in other significant global studies on violence; for example, a 2014 global assessment of quantitative VACS⁸ fails to cite the potential impact of HIV in contradiction to the emerging evidence summarized below.

2. VIOLENCE AGAINST CHILDREN AS A FACTOR IN INCREASED HIV RISK OR WORSENER HIV OUTCOMES

There is a growing body of evidence suggesting a direct link between all forms of violence in childhood and increased risks of acquiring HIV in later life. The evidence suggests that there are pathways from physical, sexual and emotional violence to earlier initiation of HIV risk behaviors than peers who have not experienced violence, and — although less directly documented — links between violence and reduced ability to access pediatric treatment and support.

The pathways are varied and rely on a range of other variables, but in all cases, violence appears to increase either exposure or impact from other risks, including increased risk of HIV exposure, infection and impact.⁹ While few studies demonstrate a direct causal link between violence and increased HIV infection rates, largely due to the methodological and ethical challenges in looking for direct causation, there is strong circumstantial evidence.

The clearest evidence of a direct HIV link and violence comes from one South African study that demonstrated a direct link between childhood sexual, emotional and physical abuse and higher rates of HIV infection and herpes (HSV-2) for both women and men, and problematic drug and alcohol use for men. Nearly one in seven new HIV infections was estimated to have been preventable in the absence of physical or sexual abuse of young women.¹⁰

A wide range of studies over the past ten years, largely from Asia, Europe and North America, reveal that children who have already experienced violence enter into riskier sexual relationships and/or sexually exploitive work at an earlier age than their non-abused peers, and that younger sexually exploited boys and girls experience heightened vulnerability to physical and sexual violence, along with a greater risk of unsafe drug injecting practices than their older peers.¹¹

3. HIV AS A FACTOR IN INCREASED RISK OF VIOLENCE

Emerging evidence again suggests that there is a direct link between the impact of HIV on the child and/or household members and the child's exposure to violence. The evidence is strongest in relation to physical and emotional violence and neglect.

Three case studies from Nigeria, Zambia and Zimbabwe that explored HIV and child protection linkages found anecdotal evidence across all three countries that children's experiences of neglect within the home (emotional and, often, physical violence) negatively impacted their access to HIV testing, care and treatment.¹² In high HIV-prevalence states in Nigeria (Benue and Cross River), health and NGO workers who provided HTS and/or worked with children in vulnerable homes observed high treatment drop out, which was often in part due to family neglect. One project noted that "around half of all children enrolled in a pediatric treatment program were experiencing abuse and violence from family members

6 VACS determine the prevalence, incidence and circumstances surrounding emotional, physical and sexual violence against boys and girls prior to age 18, as well as risk and protective factors, service use and consequences of violence. As of end-2014, VACS have been completed in Cambodia, Haiti, Indonesia, Kenya, Lao PDR, Malawi, Nigeria, Swaziland, Tanzania, Zambia and Zimbabwe; Botswana, Colombia, Côte d'Ivoire, Rwanda, Mozambique and Uganda are in various stages of planning for and implementing the survey. http://www.togetherforgirls.org/wp-content/uploads/2017/10/OCTOBER_2015_Summary-Report-Together-for-Girls-Expert-Meeting.pdf

7 In addition, children who lose or live away from parents, or who are displaced, are at heightened risk to violence compared with those who are not. Children generally know the perpetrators, and a large proportion of sexual violence before age 18 is perpetrated by romantic/intimate partners. http://www.togetherforgirls.org/wp-content/uploads/2017/10/OCTOBER_2015_Summary-Report-Together-for-Girls-Expert-Meeting.pdf

8 UNICEF Child Protection Monitoring and Evaluation Reference Group (October 2014). Measuring Violence against Children: Inventory and assessment of quantitative studies. http://www.unicef.org/ecuador/CP_MERG_REPORT.pdf

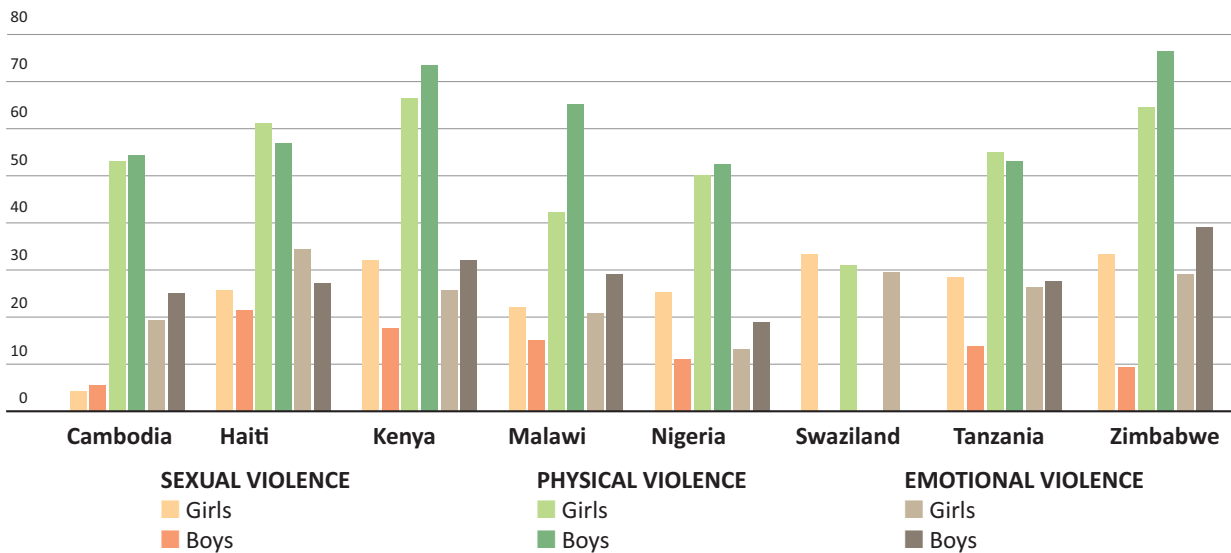
9 Two studies demonstrate this: among men and women reporting childhood sexual and physical abuse in a community randomized study in South Africa, Tanzania and Zimbabwe (6%-29% of young adult men and women in the study), there was a significant link with increased risk of early sexual debut (0.6-0.7 odds ratio), alcohol and drug use (from 1.4 to 3 times greater risks), intimate partner violence (2 to 3 times increased risk of recent forced sex or being hurt by a partner). Richter, L., Komárek, A., Desmond, C., Celentano, D., Morin, S., Sweat, M., Chariyalertsak, S., Chingono, A., Gray, G., Mbwambo, J., Coates, T. (2014) Reported physical and sexual abuse in childhood and adult HIV risk behavior in three African countries: findings from Project Accept (HPTN-043). *AIDS Behavior* 2014; 18:381-89. Doi: 10.1007/s10461-013-0439-7. In Kenya, Swaziland, Tanzania and Zimbabwe, sexual and physical violence in childhood was linked to inconsistent condom use and increased number of sexual partners later in life for both males and females, and in Kenya, an increased risk of STIs and transactional sex for men.

10 Jewkes, R.K., Dunkle, K., Nduna, M. et al. (2010) Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth. *Child Abuse & Neglect*, 34(11):833-41.

11 Silverman, J.G. (2009) Adolescent female sex workers: invisibility, violence and HIV. *Arch Dis Child*, 96, 478-481.

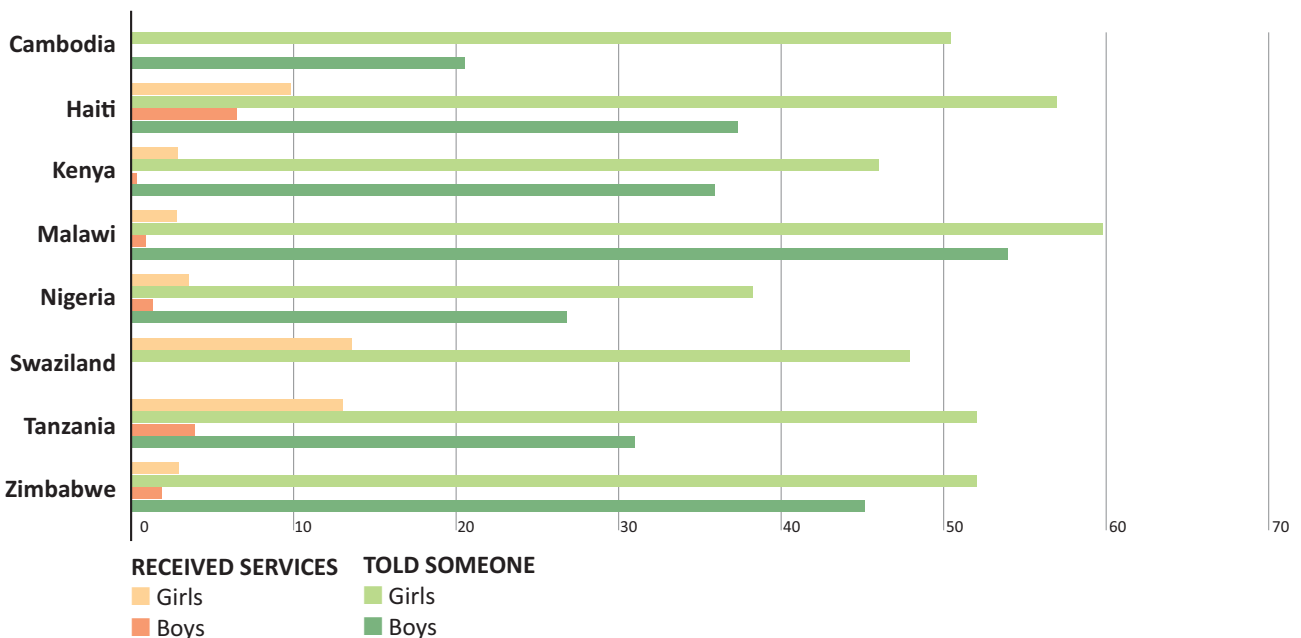
12 Long, S. and K. Bunkers. (December 2014) Prevent and protect: linking the HIV and child protection response to keep children safe, healthy and resilient. A report for World Vision International and UNICEF. <http://ovcsupport.net/resource/prevent-and-protect-linking-the-hiv-and-child-protection-response-to-keep-children-safe-healthy-and-resilient/>

**% prevalence of violence amongst girls and boys
MVACS 2007–2015 (% of informants)***



*Data drawn from national VACS (see footnote 1), reporting experiences of violence under the age of 18 by informants ages 18–24 years.

**% service-seeking behavior of boys and girls who experienced sexual violence
NVACS 2007–2015**



or neglect and discrimination, such as being denied schooling or engaged in exploitative labor,” and this often led to treatment dropout. The same neglect or emotional violence and treatment link was also noted in Zimbabwe. Adolescents living with HIV and the staff in support organizations noted a large number of children whose families were not willing or able to access HTS. A 2014 study of barriers to provider-initiated testing and counseling (PITC) in Zimbabwe found that a fear of stigma was a common reason for health care workers not offering HIV tests to children presenting with potential HIV-related symptoms. Children were far less likely

to be offered the test when they attended with a male or younger caregiver.¹³ This needs further exploration to further understand how age and gender of caregiver and child affect whether HIV tests are offered, including exploration of issues of stigma discrimination and related child neglect.

In South Africa, studies have found a growing link between violence and children living with an AIDS-sick caregiver. AIDS-orphaned adolescents living with an AIDS-sick caregiver are three times more likely to experience severe emotional and physical abuse, and girls are six times more likely to be engaged in transactional sex than their peers.¹⁴ Children living

13 Kranzer, K., Meghji, J., Bandason, T., Dauya, E., Mungofa, S., Busza, J., Hatzold, K., Kidia, K., Mujuru, H., Ferrand, R. A. (2014) Barriers to Provider-Initiated Testing and Counseling for Children in a High HIV Prevalence Setting: A Mixed Methods Study. *PLoS Med*, 11(5): e1001649.
 14 Cluver, L., Orkin, M., Boyes, M., Gardner, F., Meinck, F. (2011) Transactional sex amongst AIDS-orphaned & AIDS-affected adolescents predicted by abuse & extreme poverty, *Journal of Acquired Immune Deficiency Syndromes* 2011;58:336-343.

with AIDS-sick caregivers are also at higher risk of physical and sexual abuse victimization, often because of higher levels of poverty and disability, than children in similar households, but affected by other chronic illness.¹⁵

The evidence suggests a need to consider HIV and violence linkages affecting children who live in extended family/outside the family home. One study of adolescent girls (15–17 years) from 13 countries in sub-Saharan Africa found that the lack of a father in the home (due to death or absence) placed girls at heightened risk for childhood sexual abuse.¹⁶ A review of 15 studies in sub-Saharan Africa found that children living in extended family care, of whom the majority were likely to be HIV affected, consistently experienced discrimination within the home, material and educational neglect, excessive child labor, exploitation by family members and psychological, sexual and physical abuse.¹⁷ It is clear that programs should ensure they are reaching HIV-affected children living in extended family care, and are conscious of the risk of exploitation and violence.

In South Africa, a study found that HIV had both a direct and indirect impact on increased risk of severe physical and emotional abuse among children ages 13 to 19. The HIV-related factors that were found to have a correlation included the number of caregiver changes, living with a stepparent (not always, but often caused by HIV orphanhood) and AIDS-related stigma. Other factors included experience of family conflict, unequal food distribution, inconsistent discipline, food insecurity, bullying, sexual abuse, school nonattendance and nonachievement.¹⁸

4. EVIDENCE ABOUT INTERVENTIONS TO ADDRESS HIV AND VIOLENCE RISK

There are few studies that document effective interventions to address HIV and violence linkages; this is not surprising given the overall lack of studies on this issue. The evidence about “what works” is still quite speculative. However, practitioners interviewed in this study all felt strongly that there *is* a need to address this. This section focuses on evidence from existing literature relating to HTS and pediatric and adolescent care and treatment.

VACS findings in all countries indicate that children face many barriers to getting help, including fear of retaliation or abandonment by the perpetrator; not knowing that the violence perpetrated against them is wrong; and not knowing to whom they could report.¹⁹ The global evidence reinforces the need for HIV programs to actively make linkages with

community services that are working with child survivors of violence in order to improve the likelihood of positive treatment. A recent multi-country study on community HIV support conducted in South Africa, Tanzania and Zimbabwe argues that survivors of violence must be identified if HIV detection and treatment outcomes are to be addressed. The study found that men and women abused in childhood experienced greater stress levels and HIV-related stigma, and men had significantly lower rates of HIV test result disclosure to current partners. This is likely to be especially true for adolescent boys; men tend to disclose less than women, although data on disclosure rarely focuses on adolescent girls and boys. The study concludes that “*it is critical for HIV prevention interventions to advocate for the primary prevention of child abuse, for early identification of adolescents and adults who report experiencing childhood abuse, and to address stigma and stress-related attitudinal, behavioral and relationship difficulties experiences as an aftermath of early abuse that increase their risk of HIV.*”²⁰

The emerging data from the previously cited national VAC studies shows the importance of not exclusively targeting services at girls. While sexual abuse is generally higher among girls, it is also high among boys – and much higher than previously estimated. Physical violence against boys versus girls is also not consistently predictable across countries. In some countries, such as Zimbabwe, boys have higher rates of physical abuse than girls, but in others, such as Haiti and Tanzania, girls experience marginally higher rates of physical violence.

Child protection-related data on key populations of children is hard to find for PEPFAR countries. The high levels of stigma, cultural resistance and criminalization mean that data on violence against young men who have sex with men, young lesbians, and especially transgender and intersex youth is extremely scant. However, data on adult lesbian, gay, bisexual, transgender and intersex people (LGBTI) overall shows that HIV rates are significantly higher than among their peers,²¹ and LGBTI people experience significantly greater rates of violence, discrimination, intimidation and harassment than their peers.²² This is especially the case in the majority of PEPFAR-supported countries in sub-Saharan Africa, many of which have criminalized homosexuality.

a) Identifying children at risk of facing violence through HTS programs

Global guidance on HIV testing for both children and adolescents recognizes the need to address violence. The WHO’s 2010 global policy guidance on HIV testing for

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- 15 Meinck, F., Cluver, L., Boyes, M. (2015) Household illness, poverty and physical and emotional child abuse victimisation: findings from South Africa’s first prospective cohort study. *BMC Public Health* 2015;15:444. <http://bit.ly/2rZ5O4i>.
- 16 Kidman, R. and T. Palermo. (2016) The relationship between parental presence and child sexual violence: Evidence from thirteen countries in sub-Saharan Africa. *Child Abuse & Neglect* 2016;51:172–180. Doi: <http://dx.doi.org/10.1016/j.chiabu.2015.10.018>.
- 17 Morantz, G., Cole, D., Vreeman, R., Ayaya, S., Ayuku, D., Braitstein, P. (2013) Child abuse and neglect among orphaned children and youth living in extended families in sub-Saharan Africa: What have we learned from qualitative inquiry? *Vulnerable Children and Youth Studies* 2014;38(2):304–16. <http://bit.ly/2Gzi7HN>.
- 18 Meinck, F., Cluver, L., Boyes, M., Ndhlovu, L. (2015) Risk and Protective Factors for Physical and Emotional Abuse Victimization amongst Vulnerable Children in South Africa. *Child Abuse Review* 2015; 24(3):182–97. <http://bit.ly/2nuZijW>.
- 19 See table on page 9 for data on numbers of children who told someone about a sexual violation and who received professional services.
- 20 Richter, L., Makusha, T., Komárek, A., Daniels, J., Coates T. (2015) Exploring the Impact of Childhood Abuse on HIV Social and Attitudinal Factors Among Adults With and Without this History in Sub-Saharan Africa: Findings from NIMH Project Accept (HPTN 043). *AIDS Behavior* August 2015;E-pub ahead of print:1-9. <http://link.springer.com/article/10.1007%2Fs10461-015-1166-z>.
- 21 Beyrer, C., Baral, S.D., Van Griensven, F., Goodreau, S., Chariyalertsak, S., Wirtz, A.L., Brookmeyer, R. (2012) Global epidemiology of HIV infection in men who have sex with men. *Lancet* 2012; 380(9839):367–377. Doi: [http://dx.doi.org/10.1016/S0140-6736\(12\)60821-6](http://dx.doi.org/10.1016/S0140-6736(12)60821-6); Baral, S., Poteat, T., Strömdahl, S., Wirtz, A.L., Guadamuz, T.E., Beyrer, C. (2013) Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infectious Diseases*;13(3):214–222. Doi: [10.1016/S1473-3099\(12\)70315-8](http://dx.doi.org/10.1016/S1473-3099(12)70315-8).
- 22 UNICEF. (2014) <http://uni.cf/2npsbuM>.

children and adolescents notes that national guidelines should have clear protocols, guidelines and requirements in cases of sexual abuse;²³ however, it does not refer to other forms of violence. Likewise, WHO's Africa-specific guidelines note that children may have experienced sexual abuse, but only state that this would need specialist counseling, without sharing details regarding how such abuse might be identified or which responses should immediately follow within the HTS setting. More recent 2013 WHO guidance on adolescents acknowledges the risks of violence, both physical and sexual, as a cause and consequence of HIV infection,²⁴ and the guidance identifies global evidence of the need for this, but lacks reference to effective models. Some national HTS guidelines for children provide guidance on support for children who have experienced sexual violence already,²⁵ but not on identifying potentially undisclosed sexual or other forms of violence. PEPFAR's 2014 Technical Brief on Strategies for Identifying and Linking HIV-Infected Infants, Children, and Adolescents to HIV Care and Treatment does not reference the need to link with child protection services at all, and only acknowledges the potential dual-risk of abuse or violence in the context of "orphaned children" who, it states, may be at risk of sexual abuse or early sexual debut.²⁶

Violence reduction programs that work for older adults have not yet been shown to work with adolescents, nor with younger children who acquired HIV perinatally and are not yet in intimate sexual relationships. The global WHO guidance on HTS for children and adolescents notes that the quality of evidence about effective HTS interventions for adolescents is still extremely slow; there are very few evidence-informed global models that have been proven yet to work, and none that specifically refer to violence detection and response.

There is a growing body of evidence on how to address intimate partner violence (IPV) for women testing positive for HIV through prevention of mother-to-child transmission (PMTCT) programs. This is an area where it would take little to adapt existing positive interventions to further explore the impact of IPV on the woman's children. A systematic review of interventions that integrate HIV testing and disclosure with IPV reduction found two interventions, in Uganda and South Africa, but the projects do not draw out specific issues for adolescents.²⁷ This would be an important element to consider because the national VACS demonstrate that sexual violence is largely perpetrated by intimate partners

in the case of children and adolescents. In Zimbabwe, the VAC study found that IPV affected more than three in four females (77.7%) and one in four males (26.7%) of those who experienced sexual violence;²⁸ in most other countries rates were lower, but still at least half of all cases for girls and for boys, violence was perpetrated by romantic partners or school peers/neighbors. Across all countries, support-seeking was extremely low (for example, under 3% for both boys and girls in Zimbabwe, under 5% in Nigeria and under 10% in Kenya). The majority of those who sought support did not receive it. Therefore, HTS may be the first entry point at which abuse is identified — when coerced sex is even defined as "abuse" or "violence" by the victim.²⁹ It is evident that there should be a greater focus on identifying the potential violence, with more information needed about the barriers that prevent support-seeking. More needs to be done to understand adolescent-specific experiences of IPV and HIV risk.

b) Identifying and supporting children at risk of facing violence through HIV treatment programs

HIV treatment programs may either find that prior experiences of violence are disclosed by children during HIV treatment, care and support, or that HIV testing or disclosure exacerbates violence against children. Global evidence suggests, albeit with limited robust data, some children living with HIV face high levels of stigma or neglect already, along with physical and emotional violence, although the scale is unknown.

There are a growing number of initiatives training clinical staff to address issues of GBV, primarily for women but also for men in HIV treatment programs.³⁰ However, these initiatives have also not yet specifically focused on adolescents or younger children.

In terms of global evidence of interventions that are effective in their own right — and that therefore are presumably likely to be able to identify potential violence and/or HIV risks — home-visiting programs that provide parenting support for vulnerable children have been found to be effective. These have almost exclusively been implemented in upper middle-income countries, but there are pilot programs in Ethiopia, South Africa and Zimbabwe. The emerging findings from South Africa suggest that the intervention is effective in supporting women regarding HIV prevention, and also works to address depression symptoms

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- 23 World Health Organization and UNICEF. (2010) Policy Requirements for HIV Testing and Counselling of Infants and Young Children in Health Facilities. <http://bit.ly/2rVru14> Operational Guidelines on HIV Testing and Counselling of Infants, Children, and Adolescents for Service Providers in the African Region.
- 24 World Health Organization. (2013) HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf?ua=1
- 25 For example, South Africa's guidelines: Grant, K., Lazarus, R., Strode, A., Van Rooyen, H., Vujovic, M. (2012) Legal, ethical and counselling issues related to HIV testing of children. Cape Town: Human Sciences Research Council. <http://www.hsrc.ac.za/uploads/pageContent/3181/HIVcounsellingandtestingofchildren-implementationguidelinesWEB.pdf>
- 26 Centers for Disease Control and Prevention, PEPFAR, and USAID. Strategies for Identifying and Linking HIV-Infected Infants, Children, and Adolescents to HIV Care, and Treatment. Retrieved from <http://www.pepfar.gov/documents/organization/244347.pdf>
- 27 Kennedy, C.E., Haberlen, S., Amin, A., Baggaley, R., Narasimhan, M. (2015) Safer disclosure of HIV serostatus for women living with HIV who experience or fear violence: a systematic review. *Journal of the International AIDS Society* 2015; 18(6Suppl 5): 20292. Doi: 10.7448/IAS.18.6.20292
- 28 Rumble, L., Mungate, T., Chigijji, H. Salama, P., Nolan, A., Sammon, E., Muwoni, L. (2015) Childhood sexual violence in Zimbabwe: Evidence for the epidemic against girls. *Child Abuse & Neglect* 2015;46:60–66. Doi: <http://dx.doi.org/10.1016/j.chiabu.2015.04.015>.
- 29 An ongoing UNICEF-supported, multi-country initiative in sub-Saharan Africa seeks to strengthen adolescent HTC uptake and referral for adolescents, using innovative communication approaches. The issue of reluctance to disclose to partners is persistent, in part due to fear of raising suspicions and accusations of infidelity or negative past behaviour and, for adolescent males with HIV, less willingness to disclose, report experiences, or seek help following rape or sexual violence. It is clear that more operational research is needed in this area.
- 30 For example, Khan, A. (2011) Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. http://www.salamandertrust.net/resources/AIDSTAR-One_GBV_Guidance.pdf

and support expansion of social networks.³¹ Furthermore, the use of home-based counselors and/or index clients is highlighted as a promising practice for identifying children for HTS. This could be an opportunity to also identify early signs of abuse and/or neglect.³²

Among the most significant elements of HIV treatment success are family and social support for disclosure and treatment support. Adolescents consistently say that being able to talk to their parents or caregivers is crucial, and very many report how hard this is.³³ While not a clinic-based service, the most potentially promising intervention currently being evaluated is the CDC-supported Families Matter! Program,³⁴ which focuses on effective communication between parents and their children (9–12 years) about sexuality and safety in romantic partnerships and includes a module specifically focused on child sexual abuse. It does not identify linkages with HIV services, but would appear to be a potentially important entry point. The program reports an outcome evaluation was conducted in Zimbabwe in 2014–15 to assess the impact of Families Matter! across a range of measures related to child sexual abuse and physical and emotional violence, but results are not yet available. Other parenting programs conducted in middle- and low-income countries include [Sinovuyo Kids](#) and [Sinovuyo Teens](#),³⁵ [Philani Plus Mentor Mothers](#) in South Africa, [Parents Make the Difference](#) in Liberia³⁶ and [Project Teens and Adults Learning to Communicate \(TALC\)](#) in high-income countries.

B. FINDINGS FROM THE FIELD

This section summarizes the emerging issues from KIIs. The analysis has pulled out the key findings based on the areas of focus outlined in the methodology.

1. SERVICE PROVIDERS' AWARENESS OF AND ENGAGEMENT WITH POTENTIAL VAC-HIV SYNERGIES

Overall there was considerable interest in and recognition by most policymakers and practitioners regarding the critical need to link and/or integrate violence prevention and response within the HIV continuum of care. However, despite a widespread search for potential examples, with follow-up on country leads, the scoping exercise identified limited practical experiences. Practitioners working with pediatric HIV clinics acknowledged the linkages and are attempting to address these issues.

Service providers know that abuse is widespread, and do identify cases of abuse, particularly sexual abuse. As a result of the nature of HIV clinics, practitioners noted that sexual abuse was most commonly seen. Perpetrators are often someone close to the family or someone that the child knows, possibly even another child who has also been abused. Sexual abuse is seen across all age groups, but multiple interviewees

discussed adolescent girls being especially vulnerable targets. One clinician who worked in Zambia estimated the following pattern of sexual abuse by age: 20% of cases occur with victims under age 5; 20% ages 5 to 10; 60% over age 10. Incidences of children exchanging sex for food as a means of survival were also reported.

“We experience a lot of reports of abuse coming from our patients — sexual abuse comes in different ways: defilement, rape, incest. But it is across the board. The majority is the girl child, but also boys who have been sexually abused. Abuse covers the whole age group — boys speak out at an adolescent age, and it also happens at a young age.”

—KI, Botswana-Baylor

Multiple informants noted that violence was experienced by children of different ages and genders – younger children appear to be at greater risk for physical violence, especially at school where corporal punishment is considered a teaching tool. Physical abuse is less likely to be reported, because the cultures within many sub-Saharan African countries accept some degree of physical violence, and it is not taken as seriously as sexual abuse.

“Yes, there is lots of physical abuse from caregivers – parents sometimes when they feel they are disciplining their children; when parents are stressed and take out severe beatings on children; there end up being some bruises from that discipline. If the child is not taking medicine this becomes a burden, so when they exhaust all they can do to mold the child, they start beating. It is also common that there are households where there is lack of discipline, for example, where there are marriage problems, family violence where mother and father fighting. This ends up involving the kids — the father beats the mother and ends up beating the kids. This is common in our country.”

— KI, Baylor–Botswana

“Most of them (children) think this is the norm, especially physical violence. If you’re late to school, you are beaten. If you leave your shirt untucked at school, you are beaten. Culturally it is not as frowned upon as I wish it was. It is pretty common. Not only at the home, but at the school level.”

— KI, Baylor–Tanzania

Physical abuse and neglect may be more common among children who do not live with their biological parents or

31 Rotheram-Borus, M.J., Tomlinson, M., Le Roux, I.M., Harwood, J.M., Comulada, S., O’Connor, M.J. et al. (2014) A Cluster Randomized Controlled Effectiveness Trial Evaluating Perinatal Home Visiting among South African Mothers/Infants. *PLoS ONE* 9(10): e105934. <http://bit.ly/2rUKUDk>

32 Kanesathasan, A., McCleary-Sills, J., Vujovic, M., Brakarsh, J., Dlamini, K., Namisango, E., Nasaba, R., and Fritz, K. (2011) Foundation for the Future: Meeting the Psychosocial Needs of Children Living with HIV in Africa.

33 World Health Organization. 2013. *Ibid*; Long, S. and Bunkers K. (December 2014) *Ibid*.

34 <http://www.cdc.gov/globalaids/publications/fmp-2-pager-final-jan-2014.pdf>. The program is being implemented in Kenya, Tanzania, Côte d’Ivoire, South Africa, Zambia, Botswana, Mozambique and Zimbabwe.

35 Sinovuyo Kids and Sinovuyo Teens are run by Clowns without Borders in a number of sub-Saharan African countries, including South Africa where a clinical trial on its effectiveness is being conducted. Other countries where the program is being conducted include DR Congo, Lesotho and Zambia.

36 Child Protection Evaluation Reference Group. (2014, February) Latest Updates in Child Protection M&E. CP MERG Newsletter.

those who are HIV positive, according to some practitioners. In some cases, HIV-positive children, whether living with their parents or extended families, were not taken to a clinic and were not given their medications, and experienced other forms of emotional violence, for example, being made to eat from separate plates at home.

“For the kids that we see, I think that if they are in a situation where they aren’t being cared for by a parent, they can be seen as an ‘add on’ to the family and no one takes primary responsibility for them...”

—KI, Baylor-Tanzania

“We’ve had a number of parents recently come in that were (HIV) positive with (HIV) positive children. They’ll stigmatize the positive child to ones who are negative. They’ll have separate plates, spoons and forks for the positive child to use.”

—KI, Baylor-Tanzania

The neglect — and possibly violence in relation to denial of potential treatment — is possibly perpetrated because of the stigma that adults fear that children may face, and the possibility of neglect and emotional abuse. Some clinicians reported that they were hesitant to test children that appear healthy because of the stigma these children may face.

Many practitioners interviewed found it difficult to provide information on the types of violence against children they were seeing, because, in their experience, most HIV clinics do not have a place to record this type of information in their registries. In addition, the KIIs highlighted in general a **lack of collective understanding or knowledge of violence beyond sexual or extreme physical abuse**. Some pediatric clinics that have specific teams set up to respond to violence against children were more able to provide information on the type of violence to which they were responding, albeit, as mentioned above, this was mostly for sexual abuse.

“I would say that most programs that I’ve seen don’t have any place in the registry to record [VAC] information so anything that I heard was anecdotal.”

— KI, CDC, USA

Emotional abuse is difficult to detect in a clinical setting, according to informants, because of the short window of time that healthcare workers have with patients. In that short time, they are only able to capture a snapshot of a child’s life.

The findings seem to indicate that, until now, policy level and senior planners have demonstrated **less recognition of and engagement in the need to prevent and respond to violence in HIV settings**. With the absence of clear evidence and directives that would provide simple guidance, it is difficult for practitioners to focus on this issue even if they feel there is a critical need. Therefore, in practice, limited concrete linkage has occurred. The lack of policy guidance and lack of concrete examples have made it hard to address this. When projects such as Botswana-Baylor do see the links, and wish to make

“We work hand-in-hand with the local government. We work with local social workers. Once we have a patient where we realize that there is a problem, we talk to the local social worker, because they can easily visit the family when they are in the community in their working hours... We also report cases to the police. We find that parents don’t know where to go or where to start, so we try to direct the parents to the right place where they can get immediate help...[but] most of the cases, they take time to get resolved or attended to. So, with our little resources we try, but we have limitations — you find that time passes without a child getting assisted.”

— KI, Baylor-Botswana

them, they often have to do so in their own time and link with largely under-resourced social welfare workers from the government sector, which is a challenge. The HIV and social welfare actors are rarely linked consistently.

2. HOW HTS AND PEDIATRIC CARE AND TREATMENT PROGRAMS ENCOUNTER CHILDREN WHO HAVE EXPERIENCED OR ARE AT RISK OF EXPERIENCING VIOLENCE

There is a wide and diverse range of points at which children who have experienced violence or are at risk of experiencing violence are identified by HIV services. One entry point noted by several informants is the healthcare clinic: from those in which pregnant women, mothers and their infants are tested for HIV, to outpatient clinics that offer walk-in care. Clinic-based referrals also come in from a wide range of individuals, including police and “one stop” centers when these exist and are nearby.

ENTRY POINTS NOTED BY KEY INFORMANTS

- HIV care and treatment programs that employ social workers /case workers within the clinic
- Non-HIV clinics referring for HTS
- Referrals from community health workers or community development workers
- Referrals from caregivers, neighbors, teachers, community leaders
- Police
- One Stop Centres (when they exist and are nearby)

Referrals were more easily noted (or at least, more easily talked about during KIIs) when **HIV care and treatment programs had social workers or case workers who were appointed directly by the HIV treatment services, and either based within the HIV treatment clinic or worked alongside existing social workers**. For example, Baylor-Botswana’s full-time social worker provided counseling and advice support to children and adolescents and their caregivers when they attended the clinic. In other cases, the clinical service made

ongoing connections with existing government staff who worked with communities around the clinic. In Uganda, for example, clinic staff noted that government community development officers, whose responsibilities include identifying violence and child abuse, were an important point for referrals. VAC issues are often seen when children living with HIV receive services through Orphan and Vulnerable Children (OVC) programming. In Swaziland, Baylor has two social workers who conduct home visitations for all new clients and can identify issues of violence. However, **social/case workers currently working within HIV programs are not systematically linked or part of the broader social workforce.** Approaches are not harmonized and referral mechanisms are not systematic. Ideally, health or social welfare-employed social workers should be allocated to work at the clinic on a regular basis, and during times when clients are attending for HTS. In practice, due to the limited workforce available and the mandatory investment to have required workforce, this is currently not feasible in most if not all PEPFAR-supported settings. Where resources are constrained, formalizing linkages with local social/case workers would support an integrated case management approach to VAC prevention and response and bi-directional referrals, as well as help with spreading the workload.

Violence was reported to be more easily and effectively identified and responded to in child- or adolescent-specific services. In Botswana, Tanzania, Swaziland and Zambia, pediatric clinics or pediatric-specific days at HTS clinics are more child focused. These child-friendly settings are staffed by health workers well-versed in approach and communication techniques that enable them to better listen to and support children and adolescents, and ensure a more direct and effective response to issues of violence, particularly sexual abuse. For example, in adolescent clinics, healthcare workers are able to speak directly with children and adolescents instead of their caregivers. This child focus enables counselors or health workers to ask intimate questions, such as “Are you sexually active?” in a way that makes the child/adolescent feel more comfortable answering. Children’s and adolescents’ responses to these questions can reveal their levels of risk and/or provide a safe space in which they can report an incident of abuse. However, adolescent-specific services often require additional resources and time from caregivers, many of whom live with HIV themselves, as this requires two trips to the clinic (once for adult treatment and a second trip for the child), and doubles transportation costs and time out of work. No examples were found of how to make general HIV clinics more family friendly. This is one area for which further guidance would be useful.

In Mozambique, a GBV coordinator noted that there was far **greater potential for reaching adolescents who were experiencing violence through community-based HTS volunteers** — the Mozambican government health service model; this is a model that the local implementing organization wishes to expand upon. They noted that this worked better for adolescents, who feel more comfortable in a less formal setting in which there are more opportunities to speak confidentially. However, the same coordinator noted that health centers were better equipped to help younger children, because there are

nurses there who are trained in GBV and can explore issues of abuse against children while supporting children’s caregivers with their own GBV experiences.

As highlighted in the previous section, **disclosure tends**

“Children 15–18 years have more ability to reveal GBV in the community than in the health center. There is capacity to do something there. The health center can do more with younger children; we need to think about this much more. Children under 5 years go to health centers, but for children 5–10 they don’t go to health centers. The health centers need to focus on parents and caregivers.”

— KI, Jhpiego, Mozambique

more to be sexual abuse than other forms of violence (physical and emotional) or abandonment and neglect, especially if living with extended family, because violence other than sexual is often considered as “just normal.” This acceptance of violence occurs as much among health workers and other clinic staff as among children and their family and community members. It is critical that interventions addressing social norms are in place and integrated with clinical settings, such as reaching children and families in the clinics, as well as ensuring clinic staff are included in these interventions.

POTENTIAL ENTRY POINTS IN CLINICS FOR GREATER IDENTIFICATION OF AND RESPONSE TO CHILDREN EXPERIENCING VIOLENCE

- Appointment of focal point for identifying and responding to violence in clinics, such as social worker, counselor or other professional.
- Formalized linkages with local statutory child protection services, through membership of local child protection coordination forums and inclusion of HTS within statutory child protection referral protocols with social workers, police, schools, etc.
- Child- and adolescent-friendly services, or “spaces,” within existing clinical times, including awareness raising and communication sessions on violence.
- Include a focus on adolescents and children, and integrate violence awareness, prevention and response within community outreach services, such as community HTC.
- Establish family-friendly clinics, for example, by providing adult-child communication sessions during waiting periods at the clinic, offering caregiver-only and child/adolescent-only group sessions in which violence can be included in the curriculum.

However, KIs noted that it is also not uncommon to see medical charts in which warning signs were noted, but

nothing was done either because of a lack of time on the part of the healthcare provider or a lack of resources or social services to refer the client. In addition, as mentioned by a KI, a primary reason for nondetection of violence within clinic settings is due to HIV clinics' "focus on HIV detection and treatment, abuse is secondary." This gap requires active application of norms and standards in the clinic setting, ensuring that suspected violence is considered within assessments and counseling, and action taken whenever there is a suspicion or report.

"Interactions between children and healthcare providers is brief. Clinics are crowded and understaffed and patients are underserved. The culture of medicine is such that you quickly dispense drugs, check off the lists of mandated things you are required to ask about, and then move on to the next person. It's not uncommon to look at a chart and see that there were warning signs that went unattended ... Overcrowding and the clinic being full of high needs makes it difficult and as a result there are quality issues. Sometimes issues get glossed over; social issues such as violence can be tricky to pick out and there's variability in what gets picked out."

— KI, CDC, USA

"So they (HIV clinics) certainly are identifying some (VAC). Do I think they identify them all of our children that are having issues (VAC)? No, I don't... I think it is hard to know what the denominator is (to track how many VAC there are)."

— KI, Jhpiego, Mozambique

Furthermore, resource constraints and/or lack of investment in key resources within the clinic possibly indicate that **counseling time has been reduced, making it harder to provide time for violence disclosure.** As explained by an informant, HIV counseling was born out of a prevention paradigm: it was believed that counseling could impact sexual behavior, and results suggest that HIV counseling can have moderate effects on sexual behavior in the short term. As children rarely transmit HIV, they have not been a priority within this paradigm and prevention strategy. There is a need to look at the purpose of pediatric HIV counseling with a focus on supporting gradual and age-appropriate status disclosure with the child, family and community, as well as identifying, responding or mitigating existing or potential risks of abuse, neglect and stigma, as further explored below.

The study was not able to explore any potential differences in violence risk, identification, prevention and response for children who enter HIV care and then become exposed to violence, compared with children who were already exposed to violence prior to HIV detection. Further research is needed on this topic.

3. EXISTING PRACTICES TO PREVENT AND/OR RESPOND TO CASES OF VIOLENCE AGAINST CHILDREN WITHIN EXISTING SERVICES

Overall, it was clear from KIIs that practices that emerge are ad hoc and in response to cases, rather than set out in policy and programming guidelines. That said, all KIIs from the field had

a wide range of ideas about how to prevent and respond, and could see how their own services could further address this issue.

a) Existing practices to identify cases of violence

Key informants identified a wide, diverse – and often ad hoc – range of ways in which abuse is being identified.

Community-based HTS volunteers are a valuable resource for identifying children that may be at risk or have experienced violence. In Mozambique, one KI noted that community-based HTS volunteers were familiar with the families and are firsthand observers of their conditions.

In some clinical settings, OVC assessment tools are being used to evaluate the overall well-being of the child. The Child Status Index (CSI) was highlighted as a potential approach when developing simple tools to identify situations or risks of violence, although the KI noted that it was not widely used at clinics. However, although this was a suggestion from one KI, it seems unlikely that the CSI would be the most appropriate tool. Other initial assessment tools in pediatric or HTS settings that are slightly more complex could be used for preliminary screening, with clear referral guidance to a more skilled social worker or counselor, based in or near the clinic. For example, KIs noted that initial assessment in pediatric clinics can identify violence, although they do not have a standardized set of questions about violence. At the Baylor Clinic in Tanzania, new children coming into the clinic are asked about their home environment and this gives health workers a sense of how at-risk they are. The clinic has a standardized checklist for new patients, and it covers what to do at each visit and at each follow-up in terms of medical, social and emotional needs. If the clinic treats a child who is referred for GBV, they have a checklist for procedures of referrals/treatment. However, there isn't a standardized list of questions related to violence that is asked of every child that comes through the clinic, and it is unlikely that detailed assessment would be appropriate or feasible for all children. In cases of HIV testing or children who have already been HIV-exposed, however, it could be a part of a more detailed screening. ICAP's clinic in Kenya also uses a psychosocial assessment tool that enables them to identify psychosocial elements; this provides them with a better understanding of the child's life. The tool is a checklist and looks at performance in school and other aspects of the child's

"The Child Status Index (CSI) is one simplified way that has been looked at in different settings to evaluate 5 areas of the overall wellbeing of the child in the context of the family, community, etc. It has not been broadly used, and we don't have any simple tools that busy health care providers can use to rapidly assess a child's risk or actual experienced violence. I don't think that it is routine to check for this. There may be a psychosocial section in the assessment, but it's not something that a healthcare provider would be able to get something meaty out of it, and if they did, I don't know that they would know who to refer them to."

— KI, CDC, USA

well-being, which will then alert them to how well the child is coping and their overall well-being. This information helps them determine the type of support the clinic should provide.

In Mozambique, Jhpiego's HIV programs use the **government guidelines (algorithm) for GBV**, which is not designed specifically for children or adolescents, but which could be adapted to reflect adolescent- and child-specific issues and needs, for example, by including specific child-friendly approaches to engage and communicate with children; listing potential entry points specific to children and adolescents, such as maternal child health services, nutritional rehabilitation centers for infants or reproductive and sexual health services; and including child- and adolescent-friendly referrals. In particular, the first part of the algorithm explains how to recognize signs of possible physical or sexual violence. In maternal, newborn and child health (MNCH) clinics, staff should look for signs and signals of children who are experiencing sexual and physical violence. However, the KI noted that the guidance does not provide a protocol for what to do after violence against a child or adolescent is suspected. It would be useful to develop clear protocols and child- and adolescent-friendly referrals drawing on existing guidance, such as the Companion Guide on Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents Who Have Experienced Sexual Violence.³⁷

Jhpiego Mozambique has also found that using the **contact tracing (“index case”) approach for following up individual cases of women living with HIV and experiencing violence was useful to identify children at risk or subject to violence.**

“When we have included GBV identification and follow-up within HIV testing, it has been possible to identify some children.”

—KI, Jhpiego Mozambique

At the community level, in Namibia, health extension workers use screening tools (available on request) that include basic screening questions to identify violence within the household and other social issues. In Swaziland, Bantwana and other NGOs who initially worked within the community and schools and focused on HIV pediatric adherence issues, initiated a pilot. Through home visitations, community care workers identify, assess and track children who were abused. Community care workers linked with the Department of Social Welfare (DSW) and clinics. The home visits were not triggered by referrals from the clinics, and it would be useful to identify how these models could be further linked with the clinics to be an extension for clinical care.

b) Existing practices to respond and follow up on cases of violence against children

There are a range of approaches and protocols being used to respond and follow up on cases of violence.

At Baylor in Botswana and Swaziland, when a sexual abuse incident is brought to the clinic, patients are followed up clinically at one month and then again three months after

the event to monitor the victim's HIV status. Social workers engage at the community level and with the police to ensure that proper legal recourse is taken against the perpetrator. At the center in Botswana, after a child who has experienced violence is identified, the clinic works in tandem with the local government to address the situation. Cases are reported to the police, and social workers do home visits, as they do at Baylor-Tanzania also. In Swaziland, Baylor's two social workers will follow up through home any cases of abuse identified and responded to at the clinic as well as other cases flagged by the clinical staff with home visitations. Triggers for follow-up in addition to abuse include nonadherence, missed appointments, failing treatment or changing treatment regimen. In addition, one day per week, doctors and social workers work together to see patients and identify barriers to successful treatment. The social workers also ensure follow-up happens with the justice and legal system through the one-stop center in Mbabane. In Kenya, following a home assessment, the health center makes referral to the Children's Department for any cases that show signs of violence other than sexual abuse. Sexual abuse is assessed or treated at the health center or GBV clinic. KIs noted that in rural areas, where there aren't social workers at many clinics, nurses must take the initiative to do this in a very low resource environment.

According to many informants, there is a lack of continuity between a worker suspecting or identifying potential violence and consistent follow-up and action. KIs also noted a lack of guidance and lack of someone to whom they can refer cases, or in some cases lack of confidence that a referral can be made, as mentioned above (section 2.1 and 2.2).

c) Clinic-based violence prevention strategies

The review sought, but was not able to find, specific examples of violence prevention in pediatric HIV services or HTS settings. However, a number of community- and a fewer number of clinic-based peer groups were felt to offer the *potential* for prevention.

Teen clubs and peer support groups are a valuable way of responding to issues of violence, although this is not currently taking place in a systematic way. Because these are safe spaces, adolescents can share their experiences, receive support, and learn how to access the range of response services that are available to them. At the Baylor College of Medicine Children's Clinical Centre of Excellence in Botswana, the clinic manager noted that peer group sessions are the spaces where adolescents build up confidence to talk about emotional and other concerns, and it is here where violence disclosure often occurs. HIV counseling primarily focuses on status disclosure, medication adherence and health. Abuse and violence are also raised in Baylor-Tanzania's teen groups, where children appear to find it easier to talk as a group than disclose in individual counseling sessions. Further research would be required to identify good child protection training curricula for different age groups, including adapting evidence-based curricula from high-income countries, which could be useful to peer support as highlighted in the recommendations section.

37 Levy, M., Messner, L., Duffy, M., Casto, J. (2016) Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: A Companion Guide. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.

“We’ve had more success with our teen support groups (identifying children that have experienced violence) than we have with trying to do it individually. In those sessions one teen begins talking about what they’ve experienced and then another teen adds their experience.”

— KI, Baylor-Tanzania

In addition, Baylor-Tanzania conducts some **educational community events where they include issues of child safety and children’s rights** within their community PMTCT awareness-raising sessions. For example, this includes awareness raising of children’s right to safety from violence, and the right to treatment access. One gap noted was the lack of continuity in these community-based activities. Training is a one-off event, rather than a process of enabling people to explore the issues and know where to refer when cases are suspected. More could be done to intentionally link these efforts with ongoing community awareness raising (in general) and more explicit child protection training, where this exists.

“One thing that we’ve been doing with our community-based interventions is introducing the idea of children’s rights. As we’ve been doing trainings and brought up this idea, it’s been an eye-opener to see that it’s a novel concept to many.”

— KI, Baylor-Tanzania

4. BARRIERS FOR MAKING VAC AND HIV LINKAGES

KIs noted a number of barriers in their work ranging from operational to more policy or “systems” level barriers.

There is insufficient collaboration between OVC and clinical workers, both in the field and within donor agencies. Currently there is little communication between the two groups, leading to a lack of referral from community-based projects that are working with highly vulnerable children and a lack of, or limited, cross-referral for case management of violence. The example that has been seen in Kenya, where the OVC and clinical partner are the same, seem to indicate that close collaboration and coordination has led to better HTS outcomes for children. Allocating social workers to HIV clinics, or formalizing the linkages with local social/case workers, is lacking and yet this is essential to enable a case management approach to VAC prevention and responses to be taken. These linkages would also allow for bi-directional referrals to be made in order to spread the workload. In most settings, there are district (or equivalent) child protection forums, which are opportunities for all actors to come together and jointly plan (ideally) or undertake informal referrals or case conferences. Having a consistent representation from pediatric HIV clinical staff would be a way to strengthen this collaboration, as well as increase the potential for cross-sector skills sharing and shared support for children facing both violence and HIV

risks. Similarly, and as previously mentioned and further discussed in the recommendations section, ensuring social workers involved in violence prevention and response are consistently represented in the clinics for joint planning and on an ongoing basis would be an approach to strengthen these linkages.

Tools are lacking for systematically identifying violence in HIV settings. Several KIs requested that there be a tool that can be rapidly used to assess all forms of violence routinely in HTS and HIV treatment for children and adolescents. Several informants mentioned that the CSI tools are used, but that they are not necessarily making the linkages, and it is not clear if the CSI would be the most appropriate for this purpose. No KIs were currently using such a tool. Several informants speculated that a “minimum package of services” should include VAC.

There must be investment in building up the evidence of the benefits of integrating HIV and VAC: a lack of evidence means HIV and VAC integration stays off the agenda. Once generated, if the data does support the integration of VAC into HTS/pediatric care and treatment, then all healthcare providers should be trained on VAC prevention and response interventions, and it should become a part of standard clinical procedures. This will eliminate any notions of VAC being an “add on” that clinicians should only address if they have time. However, it should be recognized that integrating VAC into clinical practices will require more work from healthcare providers and increase the amount of time spent with each patient.

Investment in human resources is essential to provide time and space to talk to children and cover core issues, especially in rural settings. During the KIs, clinicians explained that they have little to no time off, and that simply testing everyone is already a challenge, without adding additional screenings and protocols. Psychosocial support for clinicians that emphasizes stress management would also be useful.

KIs all noted the **lack of consistent in-service training**. The Child Maltreatment Medical Curriculum³⁸ currently used to train health workers working in Malawi one-stop centers to identify and respond to cases of maltreatment was identified as a potential useful curriculum that could be further adapted for HIV clinical staff. It is only recently introduced and is currently not systematically evaluated, but is being monitored and shows early signs of promise.

The importance for **policymakers and donors to better understand these barriers and opportunities and appropriate funding accordingly** was highlighted. This reinforces the importance to ensure policymakers work together when developing investment opportunities for HIV and OVC interventions. For example, social workers and community case workers currently employed through clinics and HIV programs should be further linked and integrated with the social and case workers supported by OVC programs. Further cohesiveness and clarity of the roles and responsibilities is needed of the different paraprofessionals

38 Miller, A. J. and M. Kaufhold. (2016) Child Maltreatment Medical Curriculum. Retrieved from <http://www.branchpartners.org/branch-child-maltreatment-medical-curriculum>. Evaluation of the training can be found at: <http://bit.ly/2naLp7h>

from the health and social sector supported by HIV and OVC programs and how they link to the formal system. This was discussed in depth during the February 2016 meeting to develop considerations for OVC programs to increase access to HTS for children and their families. In particular, the need to have a “one team” approach across clinical and OVC programs was recommended.

5. OPPORTUNITIES FOR MAKING VAC AND HIV LINKAGES

KIs noted the following opportunities that potentially existed ranging from service to systems-strengthening levels. These tend to focus on response to violence in clinical settings, since this tends to be the first priority. Prevention opportunities not identified directly by KIs are explored further in the following section.

Simple standardized tool (checklist/screening tool) to identify and assess violence against children with accompanying training and procedures are needed. KIs felt that they would benefit from tools that would help them identify routinely and more consistently cases of violence. Some KIs noted that a routine tool would have to be well designed in order to identify children who need some form of intervention because of the severity of the risk; almost all children are vulnerable/at risk of violence or neglect in one sense or another. The VAC information gathered through such a tool should be used for both individual case management and for routine monitoring. Where local health information management systems permit, such a tool could trigger an alert so that child protection and health services are able to link up their response, better supported by the information gathered within their MIS and ideally linked to the OVC IMS. Routine recording would enable the national health and welfare systems to start to track evidence about violence and HIV linkages. It is important to build on the emerging learning from women experiencing IPV information systems.

Greater investment in referral processes should be demonstrated, especially between community/auxiliary workers and clinics. There are opportunities to link into initiatives that are strengthening referral and case management processes (at policy and practice levels). **Standardized trainings and procedures for referrals** also need to be developed. Once the instrument, trainings and procedures have been developed and validated, countries can then adapt these to their unique contexts. Additionally, informants mentioned that it would be useful to establish a **minimum essential package of services**.

HIV care and treatment sites could serve as referral points into specialist services, given how widespread they are already – far more than other services that identify violence. Healthcare workers should be trained to recognize warning signs and know when a child should be referred to a child protection agency. A representative from the agency could then take a case management approach and make referrals to other types of clinics for legal and mental health services. As a result, there would be a concentration of services and a dedicated person responsible for following up the case.

Multidisciplinary team meetings and case conferencing can help strengthen the referral and case management systems, and cases can be followed through a more holistic approach to HIV treatment. Doctors, nurses, social workers and community-based (health and social) workers can work together to ensure that any barriers to treatment are addressed so that HIV positive children who have also experienced violence have full access to a range of psychosocial and medical services. Some informants noted that an effective approach to address VAC issues is the use of multidisciplinary one-stop centers, where victims receive legal, medical and mental healthcare all in one location. Informants felt that this would enable an increase in the number of cases that are filed against perpetrators because victims and their caregivers are made aware of where and how to access the full range of services. However, others noted that this may not work in rural settings. The primary need appears to be for an accountable multidisciplinary working team and “case management” of referrals of violence. Other than several models that are located in urban areas without mobile outreach, informants did not identify currently working referral processes that were systematically combining the two.

VAC prevention and response interventions need to be integrated at every point of contact. One KI provided the example of when a nurse is weighing a child living with HIV; this is an opportunity to talk about the importance of nutrition and ask questions to learn more about the child’s eating habits and the foods that are available to him/her. Although not noted by any KI, but further discussed in the recommendations section, other prevention messages could be delivered within the clinical setting and along the continuum of care, including prevention efforts drawing from existing evidence-based parenting trainings mentioned in the previous sections. Having all healthcare professionals address VAC issues would create a cohesive message across the continuum of care that violence has many forms (physical, sexual, verbal, emotional), and that it should not be tolerated. Teen support groups and clubs are also an area where leaders can raise the topic for discussion.

More focus needs to be placed on the potential of addressing VAC as a means of HIV prevention and adherence. The main objectives of HTS are to identify people who are HIV positive, and engage and retain them in care so that viral suppression can be achieved. VAC strategies that reduce and prevent sexual abuse will subsequently prevent others from being exposed to and contracting HIV. Further, the integration of VAC strategies that address the stigma and emotional abuse that HIV-positive children often face as a result of their diagnosis will reduce their morbidity. Children who are safe in their home environment and whose physical and emotional needs are being met are more likely to regularly take their medication and attend clinic, the priorities of HTS and pediatric care and treatment.

Expanding and making the most of teen support groups and group counseling/peer support groups was felt to be a useful entry point. Many clinics have teen groups that

meet regularly and these meetings are a comfortable and safe space for young people to bring forward issues of violence. The leaders of these groups should be trained on VAC prevention and response strategies, and be capable of making appropriate referrals. This will require a strong referral system in which all service providers are trained and subsequently feel comfortable working with children and adolescents who have experienced violence. In addition, it would be useful to adapt child protection training to inform prevention efforts within peer support groups as previously mentioned and further discussed in the recommendations section.

The waiting room is an untapped opportunity for integration. Patients often wait an hour or more to be seen by a healthcare worker in adult and PMTCT clinics and that wait time could be used to teach parents and caregivers about early childhood development and violence prevention. One informant suggested this could be done via audiovisual materials, as many clinics have TVs and DVD players, and also through posters or short books with pictures. The Baylor clinic in Tanzania has used this opportunity, and created a small book that explains to children what HIV is and why they must take their medication. It would be useful to collect existing resources to inform potential guidance. Additionally, one informant mentioned this might be an opportunity for child protection workers to go to clinics on a weekly or monthly basis and raise awareness on VAC issues and existing services and interventions, and/or do additional screenings in the waiting room. As further discussed in the recommendations section, this might be an opportunity to have multidisciplinary teams go to the clinics to support prevention, screening and case management efforts.

In some countries, **clinics are trying to decongest their office by relying on designated community members to retrieve ART medications from clinics**, and deliver them to community members whose cases are stable. This service model allows more time to be spent with each patient for screening and for a more holistic approach to the patients' care. Community-based workers working in and often from the community are able to build more trusted relationships with children, families and the community than clinic-based staff. Taking more time with patients, creating a safe space for them to report violence, and offering them a comprehensive package of services will improve patient outcomes.

There should be greater engagement of HIV services with both children and caregivers, separately and together. KIs informants noted that education on violence should be available to both children and caregivers, noting that children are not always believed when they disclose violence, and not all children know that violence is wrong even when it is perpetrated by a family member or someone trusted. This is a particularly relevant point in HIV services, where there are often the resources to provide counseling and support to adult caregivers of children living with HIV. Counselors are well placed to support caregivers to permit HTS for potentially exposed children in their care, and

should be able to start to raise issues of violence, neglect and coercion in a culturally sensitive way with caregivers. Hence the importance of adapting child protection training to these settings.

"... there has been a huge push within the adult technical working group to further community based ART services. They want to use communities to deliver medications to people who are doing well in order to decongest clinics. That way only the people who need intense support will go to the clinic. There are models of this in Mozambique and the people that belong to one of these groups only go to the clinic twice per year. This could be something that you could capitalize on."

—KI, CDC, USA

Increased community awareness about HIV/VAC linkages and increased engagement with HIV services should occur.

KIs suggested the following: targeted links through trusted community leaders or others, such as teachers and church leaders and possibly ECD centers. This can draw on models of addressing male involvement and GBV.

"Our clinic works closely with a shelter in Lusaka. They go around the community and teach about issues of abuse. People come in from various walks of life and are trained to raise awareness and identify issues of abuse. People like teachers, church leaders and others who are respected in the community are trained to be more aware of abuse, and then these people share the information. They can use every opportunity they have with community members to raise awareness within the broader community,"

— KI, clinic, Zambia.

IV. Recommendations and Next Steps

1. PRELIMINARY CONCLUSIONS AND RECOMMENDATIONS

The majority of practitioners interviewed felt strongly that there was a critical need to address issues of violence against children within HTS and pediatric care and treatment. Issues of violence identified through these services are affecting children regardless of age and gender. However, there is a lack of tools to systematically identify and address these issues through prevention and response services, nor is there a process through which to gather data on violence throughout the HIV continuum of care. The lack of sufficient data also makes it hard to demonstrate the evidence robustly.

There are clear systems constraints within the health sector. There is a lack of clear demonstrated understanding of the linkages, and insufficient time and opportunities to talk with children and their caregivers within the clinical setting. Clinical

workers are not supported to be sufficiently involved with the social welfare sector, and are often left to handle issues of violence with limited guidance. Cases often identified within the community by OVC and other community-based programs are not often automatically linking with health sector. There is a need for stronger integration, including through an integrated referral and case management process that either allocates social workers to clinics or formalizes linkages with social/case workers.

The need for further investment in human resources and training is also critical, as well as a better understanding of barriers — and opportunities — by policymakers, senior planners and donors who can then appropriate funding accordingly.

Through desk review and KIIs, the following specific opportunities to further link and/or integrate violence prevention and response within HTS and pediatric care and treatment were identified as the highest priorities.

a) Prevention and Early Detection

- Identify a named individual or function within the clinic who can serve as a child protection focal point responsible for ensuring VAC awareness and implementing the suggested prevention activities below and/or other interventions relevant to the local context, as well as increasing linkages across clinical and community settings as further described in these prevention and response recommendations. Where there are insufficient clinic-based staff, arrange for a relevant local child protection worker, for example, a ChildLine volunteer or local social worker, to go to clinics on a regular basis (weekly or monthly) and raise awareness on VAC issues and existing services and interventions and/or conduct additional screenings in the waiting room.
 - Integrate VAC awareness training into HIV health staff pre- and in-service training. Such training should start by discussing health workers' own cultural or social norms and attitudes relating to all forms of violence, including emotional and physical violence, which is often more accepted and harder to detect. Child protection training curricula such as the Keeping Children Safe's safeguarding training tools are a useful entry point.³⁹ The training should discuss issues of stigma that might prevent children from access to treatment and put them at risk of violence (including denial of treatment), as well as additional risks faced by children living with family or outside of family care. The training should also include prevention messages to be integrated by health workers at every point of contact with the child and their caregivers and along the continuum of care, drawing from existing evidence-based parenting trainings. Having all healthcare professionals address VAC issues would create a cohesive message across the continuum of care that violence has many forms (physical, sexual, verbal, and emotional) and would include tools to address how it can be prevented.
- Strengthen family and social support for violence prevention, early detection and disclosure and support. Evidence-informed family support and parenting programs that are already being undertaken in communities could be used or adapted to be used within HTS and pediatric HIV treatment and support services. Investment in linking or integrating HIV services and parenting trainings for early years or teen programs also provide an opportunity to enhance effective communication between caregivers and their children about sexuality and safety in romantic partnerships, and could strengthen relationships within the family. These would be an opportunity to address issues of stigma or fear of stigma that could lead to denial of treatment, as well as issues faced by children living with kin or outside of family care.
 - Explore the introduction of “family days” at HIV treatment clinics both in pediatric and adolescent clinics and in general clinics.
 - “Family days” could make space for children and adults to have both separate and group discussions about parenting and family relationships, together and in age-specific groups.
 - These efforts could include prevention and group work during waiting times.
 - Prevention messages could be developed to support these efforts, including the use of posters, child-friendly books with pictures, audiovisual and other materials. These prevention messages could be built on materials already existing, such as small books developed and used by Baylor-Tanzania that explain to children what HIV is and why they must take their medication. It would be useful to collect existing resources to inform these prevention approaches.
 - Explore how interventions that integrate HIV testing and disclosure with IPV prevention and reduction could be adapted to specific issues for adolescents.⁴⁰ In addition, existing positive IPV interventions could be adapted to further explore the impact of IPV on the woman's children, with a focus on prevention of violence against the child or by the child as a consequence of exposure to family violence.
 - Where there are community-based HTS programs, support their volunteers to deliver prevention messages within the household, and heighten awareness of potential issues of violence when reaching adolescents, who may find the home- or community-youth-friendly counseling an easier place to discuss and disclose violence issues. These efforts should be followed by appropriate referrals for prevention and support services as further described in the

39 PEPFAR has worked with Keeping Children Safe (KCS) on child protection training at a national level. Each PEPFAR office may already have adapted curricula that can be used as starting point. <https://www.keepingchildrensafe.org.uk/>

40 Kennedy, C.E., Haberlen, S., Amin, A., Baggaley, R., Narasimhan, M. Safer disclosure of HIV serostatus for women living with HIV who experience or fear violence: a systematic review. *Journal of the International AIDS Society*, 2015; 18 (6Suppl 5): 20292. <http://bit.ly/2BHgbJz>

response recommendations. Prevention messages and discussions should include emotional violence in addition to physical and sexual violence, issues of stigma and other risks faced by children living with kin or outside of family care.

- Identify how teen clubs and peer support groups could be further supported and strengthened to best prevent and detect early signs of violence against children, including through the delivery and discussion of prevention messages and child protection training, and ensure early referrals to specialist child protection or GBV services for violence response. In particular, such groups could be an important entry point for identifying and reducing stigma and discrimination that manifests as emotional violence or neglect, especially addressing the results of living with HIV, as well as specific risks children living outside of family care or with kin might be facing.
- Make linkages with existing home visiting and parenting programs and home-based counselors and/or index clients to detect early signs and risks of abuse and/or neglect of children.
 - These linkages could build on Jhpiego's experience in Mozambique of using the contact tracing ("index case") approach for following up individual cases of women living with HIV and experiencing violence and potentially detect children at risk or subject to violence.
 - This approach could also explore training counselors, who counsel and support adult caregivers of CLHIV, and who are well placed to support caregivers to permit HTS for potentially exposed children in their care, to raise awareness on issues of violence, neglect and coercion in a culturally sensitive way with caregivers. It would present opportunities to discuss issues of stigma and caregivers' fears of stigma for their children which can lead to denial of potential treatment. It would also be an opportunity to discuss additional risks faced by children living with kin and/or outside of family care.

b) Identification, Assessment and Response

- Develop a screening tool/checklist to identify all forms of violence against children within HTS and pediatric care and treatment service with accompanying training and procedures. This should build on existing simple standardized tool(s).
 - It is worth assessing emerging practices from Tanzania and Kenya and elsewhere, where the use of a preexisting generic OVC assessment tool is being explored in clinical settings. The tool could also build

on lessons learned from Jhpiego's HIV programs in Mozambique that used the government guidelines (algorithm) for GBV for adults, which could potentially be adapted to children or adolescents. These tools could also draw on existing screening tools from the broader pediatric sector used to identify maltreatment, including in high-income countries.

- In community settings, it could also explore the results of and identify how to build on and scale up the use of basic screening questions by Health Extension Workers in Namibia to identify violence within the household and linking to clinical services. Increasing screening by community-based and clinical workers with strong linkages across both cadres would enable a spread of workload across the workforce and increase time spent with children and their caregivers — together and separately.
- Develop simple job aids and/or consider how to introduce counseling for identification of violence into the job descriptions of clinic-based counselors, to ensure that they can allocate time to basic identification. This should also be reflected in staff supervision guidance.
- Integrate training to respond to VAC into HIV health staff pre- and in-service training, through adoption or adaptation of existing national VAC training that has been developed for social workers where available, or through development of simple modules that address GBV from a child and youth perspective. Ultimately such training should become part of the standard clinical procedures. This preliminary review has not yet identified evidence-informed curricula, but potential entry points could expand and build on existing guidance and training such as The Child Maltreatment Medical Curriculum,⁴¹ The Clinical Management of Children and Adolescents who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs,⁴² and that volume's Companion Guide on Strengthening Linkages between Clinical and Social Services for Children and Adolescents who Have Experienced Sexual Violence.⁴³ This could also draw on the growing number of initiatives training clinical staff to address issues of (GBV) for women (primarily) and men in HIV treatment programs⁴⁴ which could be adapted for adolescents or younger children as well as existing curricula from the broader pediatric sector used to identify maltreatment including in high income countries.
- Formalize links between health, social workers and community-based workers by first ensuring that clinic managers or staff are routinely involved in local multi-sectoral child protection forums; ensuring that referrals to HTS and pediatric treatment services are included in

41 Miller, A. J. and M. Kaufhold. (2016) Child Maltreatment Medical Curriculum. Retrieved from <http://www.branchpartners.org/branch-child-maltreatment-medical-curriculum>

42 Day, Kim and Jennifer Pierce-Weeks. (2013) The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. <https://aidsfree.usaid.gov/resources/prc-tech-considerations>

43 Levy, M., Messner, L., Duffy, M., Casto, J. (2016) Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: A Companion Guide. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project. <https://aidsfree.usaid.gov/resources/prc-companion-guide>

44 For example, Khan A. (2011) Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. https://aidsfree.usaid.gov/sites/default/files/gbv_guidance_sept2012_eng.pdf

national child protection training opportunities, standard operating procedures, protocols, such as referral flowcharts, and in operational guidelines or terms of reference for statutory child protection; having HIV clinical staff participate at national level in development of child protection plans and programs, for example through national multisectoral child protection forums.

- Identify one person within the clinic with the relevant skills (e.g., clinic manager, social worker, family support worker, counselor) to be the child protection focal point, responsible for coordinating VAC activities, such as raising awareness on VAC issues with staff and clients as mentioned in the prevention section, and providing specialized support for referrals. As previously noted, where there are insufficient clinic-based staff, arrange for a relevant local child protection worker, for example a ChildLine volunteer or local social worker, to go to clinics on a regular basis (weekly or monthly).
- Strengthen integrated referral and case management systems, with multidisciplinary team meetings and case conferencing, especially between community/auxiliary social welfare workers and HIV clinics, using standardized trainings and procedures. This could build on existing initiatives focusing on integrated case management.⁴⁵ Multidisciplinary team meetings and case conferencing will help strengthen the referral and case management systems and cases can be followed through a more holistic approach to HIV treatment. Doctors, nurses, social workers and community-based (health and social) workers can work together to ensure that any barriers to treatment are addressed so that HIV-positive children who have also experienced violence have full access to a range of psychosocial and medical services.

c) Strengthening the Evidence

- Undertake an operational research to explore potential barriers to child and adolescent disclosure of violence in HTS or pediatric treatment and support services, exploring the violence-specific barriers to HIV testing and treatment and the HIV service-related barriers to those at risk of or experiencing violence. This should consider any specific barriers facing children at increased risk, such as children from key populations and children living outside parental care.
- Review global guidelines on HIV testing for both children and adolescents, when feasible, to recommend that there are clear national protocols, guidelines and requirements in cases of all forms of violence, so that the guidance enables clinical workers to be aware of the need to assess and refer in HTS and pediatric treatment settings.
- Identify means to routinely integrate VAC data identified within HTS (for example, using the above tool or checklist) within Health MIS, where feasible, to enable routine and consistent tracking of VAC; this would build the evidence on HIV-VAC linkages.

- The evidence of the benefits of integrating HIV and VAC must be strengthened to ensure it is on the agenda, through advocacy with national and global policymakers and donors to support policies and appropriate funding to ensure the relevant guidance, tools, training and investment are in place.

2. RECOMMENDED NEXT STEPS

These emerging findings and preliminary recommendations are first to be reviewed by USAID OVC and other TWG and in-country colleagues as identified appropriate by USAID OVC team.

The findings will then be presented at a stakeholder meeting. This meeting is planned to be hosted to discuss the findings and preliminary recommendations from the KIIs and desk review, identify any gaps and required follow-up activities. It will be critical for in-country practitioners to participate in and inform the discussions. The following next steps would inform updating the summary of findings and a summary list of recommended opportunities that will outline specific HTS and pediatric care and treatment interventions and entry points. These next steps will also serve to identify how specific violence prevention and response strategies and activities could be layered on top and/or integrated into these interventions, tools and resources to support the implementation of the layered and/or integrated interventions and provide evidence to support the effectiveness of these tools and strategies.

We would also recommend:

- a. Conducting additional KIIs with other key experts from the health, GBV and child protection sectors, such as WHO, UNICEF, ISPCAN, CCABA, American Academy of Pediatrics, Know Violence, Together for Girls, African Network for the Care of Children Affected by HIV/AIDS (ANECCA), Pediatric AIDS Treatment for Africa (PATA), etc. These additional KIIs will also aim to gather additional resources that might be useful to adapt to HTS and pediatric care and treatment services, such as screening tools to identify child maltreatment used in the health sector and existing child protection trainings and other relevant resources as requested by USAID. This could include further exploration of how the responses differ between children already living with HIV (either experiencing violence connected to their HIV status or experiencing violence due to other causes) and children who are either undiagnosed or HIV-negative, but at risk of violence, and being identified through HIV prevention or other services.
- b. Incorporate further relevant findings and recommendations resulting from the February 2016 meeting on “considerations for OVC programs to increase access to HTS for children and their families.”
- c. When in-country visits are conducted to identify approaches to increase linkages between OVC and HTS programs, as well as to develop remaining case studies on referral and case management (from other 4Children

⁴⁵ 4Children is currently developing a number of case studies of HIV-sensitive case management and referral systems; Philbrick, W.C. and J.L. Roby [draft, in development]. Landscaping report: Strengthening integrated case management systems in Eastern and Southern Africa. Background literature review on integrated case management for UNICEF Eastern and Southern Africa Regional Office.

projects), a set of questions should be asked to gather additional information relevant to this project.

- d. Incorporate any relevant findings from the pilot of the Companion Guide on Strengthening Linkages between Clinical and Social Services for Children and Adolescents Who Have Experienced Sexual Violence⁴⁶ to inform required guidance and efforts on how best to integrate and/or link VAC prevention and response interventions within HTS and pediatric care and treatment.

The above will then inform revised findings and recommendations, including a summary list of recommended opportunities of integration as described above and required guidance for final review, updates and, once approved, dissemination.

⁴⁶ Levy, M., Messner, L., Duffy, M., Casto, J. (2016) Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: A Companion Guide. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project. <https://aidsfree.usaid.gov/resources/prc-companion-guide>

Annex A: Key Informant Interview Protocol

Name of Key Informant:	Date of Interview:
Position/Title:	Agency:

BACKGROUND

As highlighted in all Violence Against Children Surveys (VACS)⁴⁷ to date, emotional, physical and sexual violence against children is prevalent in all countries, with physical violence being the most prevalent type and experienced by more than half of girls and boys in most countries. Sexual and emotional violence are also widespread, though levels vary widely by country. Most children who experience any violence report more than one type.⁴⁸ Violence against children has serious negative health consequences, including increased risks for HIV, both short and long term, direct and indirect.⁴⁹ VACS findings in all countries indicate that children face many barriers to getting help, including fear of retaliation or abandonment by the perpetrator, not knowing violence is a crime and not knowing to whom they could report.⁵⁰ The vision behind the VACS is to produce data that will foster engagement and mobilize policy and programmatic response to violence against children.⁵¹ Whenever possible, the approach should build on existing programs and activities and integrate violence prevention and response into preexisting platforms. This includes, for example, ensuring that violence response is integrated with HIV testing, care and treatment services where possible, and where not possible or appropriate, strong referral linkages are developed and maintained.⁵²

We would like to talk to you about how your programs currently experience, respond to violence against children (VAC) issues, and mitigate risks of potential violence as a result of the child or adolescent accessing the service. We are interested in how violence prevention and response activities can be integrated into HIV testing and counseling and/or pediatric care and treatment.

We would like to discuss how HIV testing services have prepared for the possibility that the child who was tested is positive because of sexual abuse. In addition, we would be interested in discussing how are testing services prepared for the possibility that the child that was just tested might suffer from discrimination and maltreatment when she/he goes home (emotionally or physically abused, not being fed/ kicked out of the house, etc.). We would also like to discuss how preventing risk or addressing issues of violence through existing services can help with increasing access to HTS and bringing children to testing services (for example by identifying vulnerabilities children might be facing that might be hindering access to services and strategies to address these issues such as family separation, abandonment, neglect, etc.).

In addition, violence against children has a direct effect on children's health outcomes and can also be a barrier to enrollment in and adherence to care and treatment. In addition, how children are being enrolled can in some instances result in maltreatment. We would like to discuss how pediatric care and treatment services take into account issues of violence against of children, respond to potential and identified violence, and take steps to mitigate potential risks of violence as a result of accessing these services, including discrimination within the family, community, etc.

Questions

1. Within existing HTC and pediatric care and treatment programs, where and how do program staff encounter children who might have experienced or be at risk of experiencing violence?
2. Within HTC and/or pediatric care and treatment programs, what types of violence against children are your programs seeing?

47 VACS determine the prevalence, incidence and circumstances surrounding emotional, physical and sexual violence against boys and girls prior to age 18, as well as risk and protective factors, service use and consequences of violence. As of end-2014, VACS have been completed in Cambodia, Haiti, Indonesia, Kenya, Lao PDR, Malawi, Nigeria, Swaziland, Tanzania, Zambia and Zimbabwe; and Botswana, Colombia, Côte d'Ivoire, Rwanda, Mozambique and Uganda are in various stages of planning for and implementing the survey.

48 In addition, children who lose or live away from parents, or who are displaced, are at heightened risk to violence compared to those who are not. Children generally know the perpetrators, and a large proportion of sexual violence before age 18 is perpetrated by romantic/intimate partners.

http://www.togetherforgirls.org/wp-content/uploads/2017/10/OCTOBER_2015_Summary-Report-Together-for-Girls-Expert-Meeting.pdf

49 In the Swaziland VACS, sexual violence against girls was associated with increased risk for HIV, unwanted and complicated pregnancies, mental health disorders and substance use. In the Kenya, Swaziland, Tanzania and Zimbabwe VACS, sexual and physical violence in childhood was linked to increased sexual risk-taking later in life, such as inconsistent condom use and increased number of sexual partners. Among men ages 18-24 in Kenya, a history of sexual violence in childhood was associated with a higher likelihood of sexually transmitted infection (STI) symptoms and having received money or goods for sex. In addition, sexual violence often leads to pregnancy, as illustrated in the Kenya VACS, where 30% of girls who experienced physically forced or coerced sex before age 18 became pregnant as a result.

http://www.togetherforgirls.org/wp-content/uploads/2017/10/OCTOBER_2015_Summary-Report-Together-for-Girls-Expert-Meeting.pdf

50 In Kenya, less than half of the children who experienced sexual violence told anyone; less than one-fourth sought services for sexual violence; and even fewer (less than 4% of girls and 1% of boys) ultimately received services.

51 http://www.togetherforgirls.org/wp-content/uploads/2017/10/OCTOBER_2015_Summary-Report-Together-for-Girls-Expert-Meeting.pdf

52 In Swaziland, the survey report included recommendations to integrate efforts to address violence against children into existing infrastructure for HIV/AIDS and reproductive health. http://www.togetherforgirls.org/wp-content/uploads/2017/10/OCTOBER_2015_Summary-Report-Together-for-Girls-Expert-Meeting.pdf

3. How are HTC and/or pediatric care and treatment programs currently either preventing or responding to cases of violence against children within existing services?
4. Where have you see integration of specific VAC prevention and response activities occur within HTC and/or pediatric care and treatment programs, and what was the impetus for the integration?
5. Where do you think there are untapped opportunities for integrating VAC prevention and response interventions into HTC/pediatric care and treatment? What might be done to maximize these opportunities?
6. From your perspective, what are the biggest opportunities for including violence prevention and response services within HTC/pediatric care and treatment services, and which services? Choose one or two, and describe ideas for taking advantage of opportunities.
7. What barriers need to be addressed to enable integration? How do you think these barriers could be addressed?
8. What could be done to encourage practitioners to integrate VAC prevention and response interventions into HTC/pediatric care and treatment?
9. How could these integration efforts support HTC/pediatric care and treatment objectives and priorities?
10. From the list below of evidence-based recommended VAC prevention and response strategies, which do you believe would be the most/least effective to integrate into HIV testing/pediatric care and treatment?

Recommended VAC prevention and response strategies	LEAST TO MOST FEASIBLE/EFFECTIVE TO INTEGRATE IN HTC/PEDIATRIC CARE			
	Scale 1–10	Why?	What might help or inhibit the integration of this strategy?	How might it help to achieve HTC and care and treatment goals?
Parenting training: home visitations, training in small groups in community settings				
Interventions to address Social norms: community-mobilization interventions; small group programs focused on changing girls, boys, men’s and women’s adherence to social norms (within schools, health centers, community centers, faith centers, etc.); mass media awareness-raising campaigns.				
Improved services to children survivors of violence: <ul style="list-style-type: none"> • Counseling/therapeutic interventions delivered by professionals or trained community workers; • Emotional and practical support groups led by professionals, lay workers or peers; • Medical, legal and psychosocial services (including case management, referrals to social workers, child protection units within the police, hotlines/helplines, etc.); • IPV screening in clinical settings; etc. 				

Recommended VAC prevention and response strategies	LEAST TO MOST FEASIBLE/EFFECTIVE TO INTEGRATE IN HTC/PEDIATRIC CARE			
	Scale 1–10	Why?	What might help or inhibit the integration of this strategy?	How might it help to achieve HTC and care and treatment goals?
Household economic-strengthening interventions: cash transfers, group savings and loans, microfinance combined with training, etc.				
Education support and life skills programs: school enrollment and attendance, life skills and health programs; dating violence and rape prevention programs; adolescent girls' empowerment programs; etc.				

11. Do you have any resources you can share concerning integration of VAC prevention and response services within HTC and/or pediatric care and treatment?
12. Who else would you suggest that we speak with to identify other useful strategies and interventions to integrate prevention and response activities to violence against children?

Annex B: Key Informants Interviewed

KEY INFORMANT NAME	TITLE	ORGANIZATION	LOCATION
Sandra Amondot	Social Work Supervisor, PSS Services	Baylor College of Medicine Children's Clinical Centre of Excellence	Uganda
Jason Bacha	Pediatrician and Texas Children's Hospital Global Health Service Corp Co-clinical Director	Baylor College of Medicine Children's Clinical Centre of Excellence	Tanzania
Gretchen Bachman	Team Leader and Senior Technical Advisor, Orphans and Vulnerable Children	USAID, Office of HIV/AIDS	USA
Ana Baptista	GBV Coordinator	Jhpiego	Mozambique
Efrat Barnes-Wald	Clinician	The Teddy Bear Clinic, Charlotte Maxeke Hospital	South Africa
Magnus Beneus	Pediatrician	Baylor International Pediatric AIDS Initiative Swaziland	Swaziland
Charlene Brown	Medical Officer for HTC	USAID, Office of HIV/AIDS	USA
Cari Courtenay-Quirk	Behavioral Scientist, HIV Prevention Branch	CDC	USA
Didier Boua	OVC Care and Support Program Manager for the Kenya Project in Côte d'Ivoire	Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)	Côte d'Ivoire
Doris Naitore Odera	GBV Clinic Staff	ICAP	Kenya
Eric Dziuban	Medical Officer, Global HIV Program	CDC	USA
Zodwa Gamedze	Program Coordinator	Baylor International Pediatric AIDS Initiative	Swaziland
Rokaya Ginwalla	Physician	Previously with CDC	Zambia
Mark Hawken	Country Director	ICAP	Kenya
Makhosazana Hlatshwayo	Executive Director	Baylor International Pediatric AIDS Initiative	Swaziland
Mogomotsi Matshaba	Deputy Director	Baylor College of Medicine Children's Clinical Centre of Excellence	Botswana
Maury Mendenhall	Sr. Technical Advisor, Orphans and Vulnerable Children	USAID, Office of HIV/AIDS	USA
Aaron Miller	Executive Director	Building Regional Alliances to Nurture Child Health (BRANCH)	USA (supporting Malawi One Stop Centres)
Onthibile Tshume	Clinic Manager	Baylor College of Medicine Children's Clinical Centre of Excellence	Botswana
Diane Nguyen	Global Health Coordinator	Baylor International Pediatric AIDS Initiative	USA

KEY INFORMANT NAME	TITLE	ORGANIZATION	LOCATION
Shaheda Omar	Director of Clinical Services	The Teddy Bear Clinic, Charlotte Maxexe Hospital	South Africa
Ryan Phelps	Medical Officer Advisor for PMTCT and Pediatric HIV	USAID, Office of HIV/AIDS	USA
Diana Prieto	Acting Director, Office of Gender Equality and Women's Empowerment at USAID	USAID, Office of HIV/AIDS	USA
Molly Rivadeneira	Medical Officer, Global HIV Program	CDC	USA
Peter Rumunyu	Program Director	ICAP	Kenya
Janet Saul	Senior Gender Adviser	CDC, Division of Violence Prevention at the National Center for Injury Prevention and Control	USA
Shannon Shea	Co-Clinical Director of Texas Children's Hospital Global Health Service Corp	Baylor College of Medicine Children's Clinical Centre of Excellence	Tanzania
Meena Srivastava	Medical Officer Advisor for PMTCT and Pediatric HIV	USAID, Office of HIV/AIDS	USA
Tapiwa Tembwe	Social Worker	Baylor College of Medicine Children's Clinical Centre of Excellence	Botswana
Monique Widyono	Gender Advisor	USAID, Office of HIV/AIDS	USA
Vincent Wong	Senior Technical Advisor for HTC	USAID, Office of HIV/AIDS	USA

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Coordinating Comprehensive Care for Children (4Children) is a five-year (2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International, and Westat.

