

Addressing Children of Key Populations

July 2018



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I. Introduction

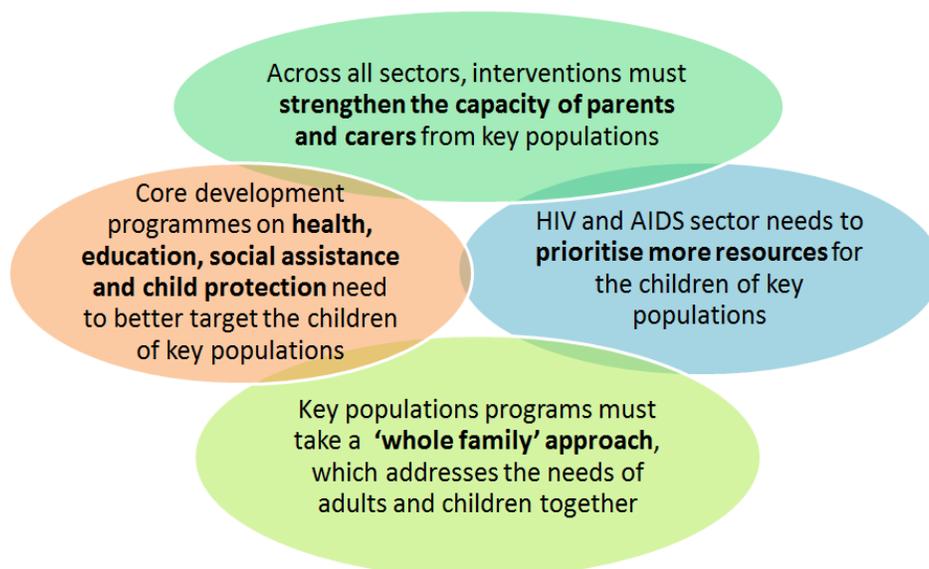
Key Populations (KP) are part of family units and the needs of their children can be overshadowed as they face a double burden: both the effects of HIV/AIDS and associated marginalization and exclusion encountered by their parents. Stigma and discrimination experienced by female sex workers (FSWs), people who inject drugs (PWID), men who have sex with men (MSM) and transgender people (TG) can negatively impact their children's access to health, education, and protection services. In 2015, a UNAIDS-Lancet Commission on *Defeating AIDS – Advancing global health* issued a report that included KP, yet a response, *Defeating AIDS but missing children*, cited concerns that the recommendations were entirely adult-focused, excluding children and adolescents in their agenda:^{1,2}

“The attention to key populations - MSM, IDUs, SWs, prisoners, and residents in hot spots - are entirely adult referenced. MSM, IDUs, SWs, and prisoners may well have children whose needs could be overshadowed.”

In 2016, a similar call to action advocated for programs to not only address maternal mortality and morbidity among FSWs, but also the health and well-being of their children.³ Programming for KP is primarily focused on adults with a priority on reducing their risk of HIV infection through prevention interventions and linking them to treatment if needed. To date, there is limited evidence for integration of services for vulnerable children of KP with their parents and caregivers to reduce the risk of both generations becoming infected with and transmitting HIV.^{4,5}

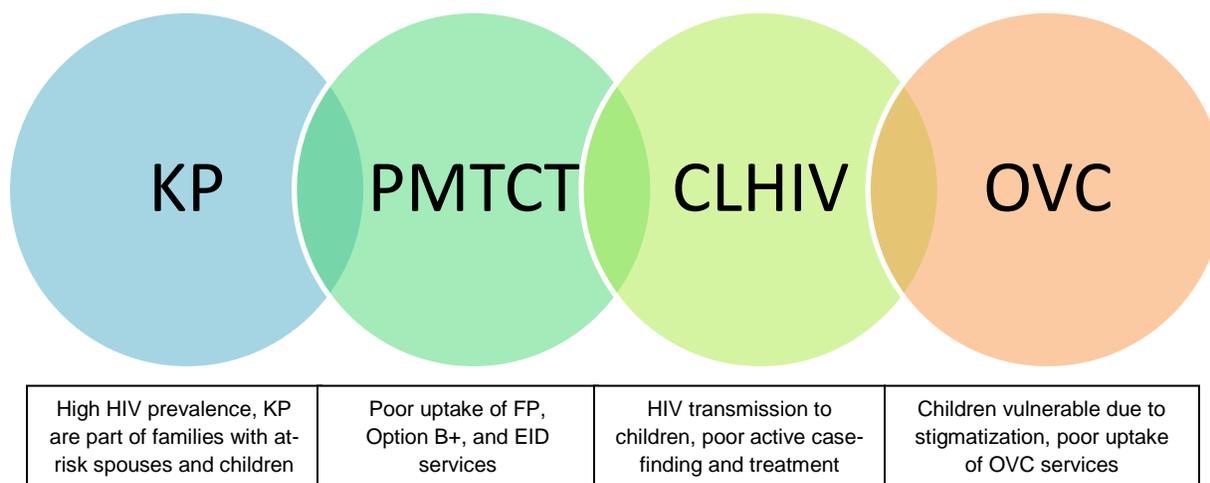
A review of the literature reveals that children of KP experience extreme levels of vulnerability and risk in all core areas of care, development, and protection including: lack of birth certificate, food insecurity and malnutrition, lack of school enrollment, poor access to essential health services, lack of childcare, physical and sexual violence, and stigmatization by families, neighbors, and other children in the community.^{4,5,6,7} These factors contribute to elevated HIV risk and gaps in HIV case-finding, linkage, treatment coverage, retention and viral suppression for KP and their children exist in current programming. As show in Figure 1, the following strategic priorities are needed for programs to comprehensively address KP and their children.

Figure 1: Strategic Priorities for KP and their Children



Marginalized KP and their children are more likely to participate in HIV interventions if they are designed to meet their unique needs and supporting these children is an essential way to link and retain families in services. A family-centered approach is fundamental and programs must build models of treatment, care, and support that are inclusive of KP, their children, and partners/spouses; this will require bringing multiple partners and sectors together.⁸ Access and uptake must be improved for early infant diagnosis (EID), HIV testing and treatment, as well as to other critical health, social and economic strengthening interventions as a priority for children of KP and their families. For female KP who are pregnant or breastfeeding, the four prongs of prevention of mother-to-child transmission (PMTCT) of HIV should be addressed: 1) Primary prevention of HIV for PMTCT, 2) Preventing unintended pregnancies among HIV-positive female KP, 3) Preventing HIV infection from HIV-positive female KP to their children and, 4) Treatment, care and support to HIV-positive female KP, their children and families. This approach should build upon current service delivery platforms through integration of KP, Family Planning (FP), PMTCT, Pediatric HIV and Orphans and Vulnerable Children (OVC) services resulting in strengthened adult, adolescent and pediatric clinical cascades and reduced impact of HIV on families. Figure 2 displays the integrated program areas of KP, PMTCT, Pediatric HIV (children living with HIV – CLHIV) and OVC required to reach partners, spouses and children of KP.

Figure 2: Family Dynamics & Household HIV Risk



Motherhood is common among FSWs and many have at least one biological child; with low contraceptive use and high burden of unintended pregnancy, they have poor reproductive outcomes and avoidable mother-to-child transmission risk.⁹ PWID, MSM, and TG are also part of families and have at-risk spouses and children in their households; data from India reveals that approximately 55% of HIV-positive MSM and PWID are living with a spouse or children.¹⁰ Within these social and family networks, there is risk of transmission not only to sexual partners, but also to spouses and children of KP.

II. Goals and Objectives

Given the significant programmatic and evidence gaps regarding treatment, care and support for children of KP, the U.S. Agency for International Development (USAID) developed a KP/Families taskforce which aims to advance family-based, integrated KP, OVC, and PMTCT/Pediatric programming that: a) addresses the priority needs of children, adolescents, parents/caregivers, and families as an entire unit and b) strengthens the adult, adolescent and pediatric continuum of care to meet UNAIDS 95-95-95 goals. This guidance is targeted to country teams, with a focus on Health/HIV team leads and KP, OVC, PMTCT/Pediatric HIV focal points, program managers, local implementing partners and field staff.

The goals and objectives of this guidance are to:

- 1) Highlight key considerations, including data points, for the design of effective treatment, care and support models targeting FSW mothers and their children.
- 2) Share information on current working models and service packages with priority interventions which may inform program development and service planning.
- 3) Provide recommendations for monitoring and evaluation, including targeting considerations, data collection and reporting and expected outcomes in order to enable program assessment and adaptation.

While this guidance focuses on FSWs and their children, it is important to recognize its relevance to and potential adaptation for families of MSM, PWID and TG. There is no “one size fits all model” for addressing KP sub-populations and they exhibit unique risk factors and needs; however, children in these families commonly experience elevated HIV risk as well as other critical vulnerabilities.

III. Critical Challenges

a. Consultations with KP

Consultations conducted by the Coalition of Children Affected by HIV/AIDS (CCABA) with KP and their families found there was a serious lack of service provision for children of KP. Parents identified the following primary challenges:⁴

- 1) Child protection and safeguarding
- 2) General stigma, discrimination, social exclusion and bullying of children
- 3) Exclusion from or decreased access to education
- 4) Displacement and dislocation from communities of origin
- 5) Inadequate, missing or siloed services
- 6) Separation of children from parents
- 7) Legal barriers, lack of legal protection and lack of human rights protection
- 8) Compounding effects of poverty, which affect children by extension
- 9) Internalized stigma
- 10) Lack of birth registration

Figure 3: Key Issues for Children of KP¹¹

Issue 1: Inadequate or siloed KP-sensitive services for children.

Issue 2: General stigma & discrimination, and its effects on children, including its result in self-stigma (internalized stigma).

Issue 3: Lack of KP-sensitive child care, protection & safeguarding services, which fit the realities of parents' lives, and which are bias-free.

Issue 4: Exclusion from safe, bully-free educational services and other opportunities from early childhood through adolescence.

Issue 5: Legal barriers and lack of legal advocacy support, which can lead to: a) the inability to register birth or identity, b) the problematic or forced registration of KP, c) criminalization of parents, d) child endangerment by authorities and e) lack of protection from and response to child abuse.

Between November 2014 and September 2016, an international working group led by CCABA gathered and analyzed information for children of KP. The group convened with community, donor and non-governmental (NGO) partners to identify key issues, develop advocacy goals and began to draw a roadmap for an advocacy strategy.¹¹ The five top issues identified for children of KP are highlighted in Figure 3.

Focus group discussions conducted by USAID staff and implementing partners in Cameroon, Ethiopia, India and Tanzania reveal the following challenges and vulnerabilities cited by FSW mothers (Figure 4):

Figure 4: Challenges Cited by FSW Mothers in Cameroon, Ethiopia, India and Tanzania¹²

Focus Group Discussions with FSW Mothers	Separation from children
	Neglect and lack of child care while mothers work
	Lack of school fees and low school enrollment
	Poor access to health and social services
	Food insecurity and malnutrition
	Poor access to economic strengthening interventions
	Physical, sexual and emotional abuse (perpetrated by clients)
	Social marginalization, stigma and discrimination

As a result of these challenges, children miss out on school, health care, social assistance and many other services and support, including HIV testing and treatment. The multiple and compounding vulnerabilities have immediate impacts on children's health and development as well as long-term consequences for both their physical and psychological well-being and opportunities in adulthood.

b. Index Case Testing

Index case testing is a priority strategy to identify children living with HIV but historically has not been a focus within family networks for KP. Recognizing that KP are part of families, the coverage of index case testing for spouses and children is largely unknown. However, routine, systematic, provider-initiated testing and counseling should be provided to all children of adults receiving any HIV service (KP, PMTCT, Antiretroviral Therapy - ART) through facility or community-based index case testing.

Data from a number of studies reveals the risk of HIV for children of FSWs, MSM and PWID and the gaps in uptake of services. In a study from Côte d'Ivoire, although FSWs were engaged in HIV testing and prevention services, only 59% had received HIV testing before childbirth during their last pregnancy and 30% had lost ≥ 1 child.¹³ Results from a study in South Africa found that nearly one-third of children with an HIV-positive FSW mother had never received HIV testing.¹⁴ In Cameroon, nearly 70% of HIV-positive FSW mothers reported that none of their children had been tested for HIV before age 5 (326/481), and 17/481 (3.5%) reported one or more of their children had been diagnosed with HIV.¹⁵

Studies from India found that wives of MSM bear a high burden of HIV infection: disclosed MSM and their wives had an HIV prevalence of 46.9% and 27.5% respectively; undisclosed MSM had an HIV prevalence of 22.8% and their wives are at high risk of HIV infection yet unaware of their husband's status and less likely to engage in care.¹⁶ Married MSM with higher HIV prevalence makes them an important bridge population; their wives and children are at high risk for HIV and likely have low risk perception.^{17,18} Data collected from male (n=5653) and female (n=796) PWID in Northeast India found that prevalence of HIV was significantly higher among women than men (53% vs 18.4%, $p < 0.01$).¹⁹ Furthermore, 49% of men and 55% of women reported being in a relationship (married or long-term partner) and therefore, integrated HIV services are needed that address factors at individual, interpersonal, family and community-levels for PWID.¹⁹

For these reasons, ensuring that index case testing is scaled up for KP, their partners, spouses, and children is essential to improving early case identification and achieving UNAIDS 95-95-95 targets. The differentiated care model to incorporate index testing, linkage to ART, and retention in care will need to be implemented by trusted providers within a thoroughly designed system

that maintains confidentiality of HIV status of KP and their children.²⁰ This confidentiality is especially important as KP parents fear their children may be removed from home because of judgement from child protection workers who may believe that a situation of abuse or neglect is present merely due to parenting by an adult from a key population.

IV. Estimating the Burden of HIV-infected and affected Children of KP

Globally, the majority of FSWs are mothers raising millions of children. Studies from countries in Table 1 below have collected demographic data for FSWs and found large proportions are mothers:³

Table 1: Proportion of FSWs who are Mothers*

Country	Proportion of FSWs who are Mothers
Côte d'Ivoire ¹³	68.5% (319/466)
Kenya ²¹	80.2% (321/400)
India ²²	80.7% (254/325)**
Indonesia ²³	68.7% (2970/4324)
Mexico ²⁴	93.3% (295/316)

*Adapted from Willis, B et al. Health of female sex workers and their children: a call for action. *The Lancet Global Health*, May 2016.

**Weighted percent

The number of children of KP remains largely unknown as they have not been included in standard assessments and surveys, but obtaining estimates for HIV-infected and affected children and adolescents of KP is a priority. KP programs need to mandate exercises to better document the number of children and adolescents of their target populations in order to sufficiently resource service provision. Although challenges exist in collecting accurate data for KP, it would be useful for programming and scale up services to understand prevalence of pregnancy and breastfeeding amongst HIV-positive FSWs - and the PMTCT and EID clinical cascades for FSW mothers and their infants. Risk of HIV transmission is likely high if programs for FSWs do not provide opportunities to either bring their HIV-exposed infants into service delivery points with their mothers for testing or have strong referral mechanisms in place.

a. FSW Mothers and Children

Baseline data collection should capture the following data points to better characterize the burden of FSW mothers and children: FSW size estimate, HIV prevalence, and number of HIV-positive FSWs (IBBS – Integrated biological and behavioral surveillance survey, program data), fertility rate (DHS - Demographic health surveys, program data), number of children per FSW (program data) and other demographic data including age and sex of children. As an example, below is a table representing estimates for FSW mothers and children from a subset of countries. By multiplying FSW size estimates with fertility rate, estimates of the number of children of FSWs are determined as shown in Table 2.

Table 2: Burden of FSW Mothers and Children

Country	FSW Size Estimate	Fertility Rate ²⁵	# Children of FSWs
Cameroon	112,580 ^{26,27}	4.7	529,126
Côte d'Ivoire	59,040 ^{28,29}	4.9	289,296
Ethiopia	193,270 ³⁰	4.3	831,061
Haiti	40,400 ³¹	3.0	121,200
India	860,686 ³²	2.3	1,979,578
Tanzania	155,450 ³³	5.1	792,795

b. HIV-positive FSWs and HIV-exposed Infants, HIV-infected and affected Children

To better understand the number of HIV-infected and affected children of HIV-positive FSWs, the following data points can be collected for FSW and pediatric clinical cascades (Table 3).

FSW Cascade: FSW size estimate, HIV prevalence and number of HIV-positive FSW (IBBS, program data), fertility rate (DHS), number of HIV-positive FSWs on ART, retained, and virally suppressed (program data).

Pediatric Cascade: Number of children of HIV-positive FSWs (based on fertility rate), number enrolled in OVC services, number of children of HIV-positive FSWs tested, number newly identified HIV-positive children, number of HIV-positive children on ART, retained and virally suppressed (program data).

Table 3: Burden of HIV-positive FSW Mothers and HIV-exposed Infants, and HIV-infected and affected Children

Country	FSW Size Estimate	HIV Prevalence	HIV+ FSWs	Fertility Rate ²⁵	# Infants and Children of HIV+ FSWs
Cameroon	112,580	36.5% ^{26,27}	41,092	4.7	193,131
Côte d'Ivoire	59,040	11.4% ^{28,29}	6,731	4.9	32,980
Ethiopia	193,270	23% ³⁰	44,452	4.3	191,144
Haiti	40,400	8.7% ³¹	3,515	3.0	10,544
India	860,686	1.56% ³²	13,427	2.3	30,881
Tanzania	155,450	26% ³³	40,417	5.1	206,127

As noted, data sources can include program data, IBBS, DHS, surveys and UNAIDS estimates. A similar analysis for other KP could include mapping of HIV-positive PWID, MSM and TG and those that are married with number of children per household. This would help determine the number of HIV-infected and affected children who are part of families of PWID, MSM and TG and allow for appropriate target setting, programming and service provision.

V. Developing Models of Care and Defining Service Delivery Packages

A fundamental first step includes analysis of program budget and human resource capacity in order to determine feasible targets, scope of support and services and service delivery mechanisms for reaching children of KP. Determination of service packages also requires meaningful engagement with KP to define the following: critical vulnerabilities and risks they face with their children; services and support they prioritize for improvement in child and caregiver well-being; and the preferred service delivery structures for effective access and uptake. It is recommended that programs define and deliver an initial package of essential services to meet the most critical needs of children and parents in the short-term which can subsequently be expanded mid and long-term as program capacity and resources increase.

It is critical to utilize existing program platforms and structures for efficient, low-cost service integration. For example, drop-in centers for KP that provide HIV testing services (HTS) for adults may also be used to provide pediatric HTS; drop-in centers that facilitate peer support groups for FSWs may integrate sessions on positive parenting; social behavior change and communication (SBCC) sessions for HIV prevention that include mothers of young children may be supplemented by a session on early childhood development. In addition, utilizing existing program cadres is critical, while being mindful of their capacity and ensuring they are not overburdened. Expansion of support through existing cadres requires assessing which types of additional training, skills-building and competencies may be required and which cadres may be better suited to assume an additional role and responsibility (e.g. a senior peer educator for KP with extensive experience in community outreach vs. an OVC case manager with qualifications and capacity in complex family case management) or need to collaborate together.

A family-based approach to service delivery is key to ensuring both support for children and their parents/caregivers to have the most direct and lasting impact on children’s care and well-being. An illustrative menu of services for children and KP and their parents/caregivers is included below in Figures 5 and 6:

Figure 5: Package of Services for Children of KP

Children of KP				
Health	Psychosocial Support	Nutrition	Education	Protection
<ul style="list-style-type: none"> Referral to HTS for children and siblings. Linkage to ART, retained in care and treatment, and virally suppressed. Include in family-based KP-friendly differentiated care models. Linkage to child survival, essential health services and adolescent sexual and reproductive health services. 	<ul style="list-style-type: none"> Provide age-appropriate disclosure and psychosocial support. Enroll in peer support groups, child, teen and adolescent clubs. Provide safe child-friendly care. Conduct home visits for outreach and support. Provide enhanced adherence and counseling. 	<ul style="list-style-type: none"> Ongoing growth monitoring and nutritional assessment at facility and community level. Appropriate management of malnutrition including referral to hospital-based services for severe acute malnutrition. Linkage to food supplementation. 	<ul style="list-style-type: none"> Access to educational subsidies and support. Early childhood development (home and facility-based). Support for primary school enrollment and transition to secondary school. Monitor school attendance and retention. 	<ul style="list-style-type: none"> Child protection and risk mitigation policies in place. Linkage to social protection services. Facilitate access to birth certificate. Guarantee rights of children. Violence prevention, screening and response (including gender-based violence and post-rape care).

Figure 6: Package of Services for KP

KP				
Health	Psychosocial Support	Socio-economic Support	Knowledge & Capacity Strengthening	Protection
<ul style="list-style-type: none"> Referral to HTS for KP, their spouses and partners. Linkage to ART, retained in care and treatment, and virally suppressed. Include in family-based KP-friendly differentiated care models. Access to FP, pre- and post-natal, reproductive health and PMTCT services (female KP). 	<ul style="list-style-type: none"> Provide counseling on disclosure practices and support to children (parental coaching). Enroll in KP, parental and family support groups. Increase peer support for mothers, fathers and caregivers in distress. Provide enhanced adherence and counseling. 	<ul style="list-style-type: none"> Access to educational subsidies for children and household economic strengthening interventions (savings and loans groups, vocational training). 	<ul style="list-style-type: none"> Skills-building in child care and development (health, nutrition, protection, early childhood development) Positive parenting and mentoring (through SBCC classes). Access to child care support. Skills-building in health and health-seeking behavior. 	<ul style="list-style-type: none"> Child protection and risk mitigation policies in place. Linkage to social protection services. Guarantee rights of parents. Violence prevention, screening and response (including gender-based violence and post-rape care).

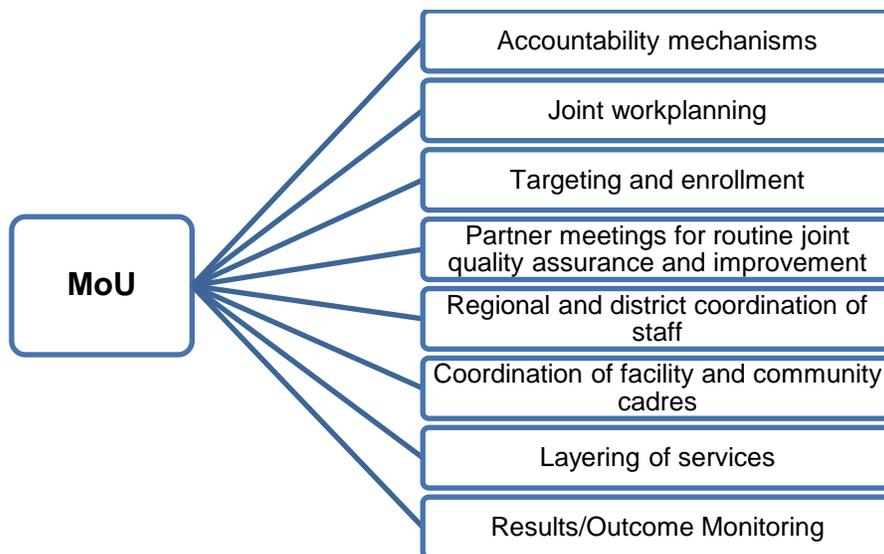
a. Risk Mitigation and Meaningful KP Participation

When interacting with children of KP, programs must proceed with circumspection and caution to not increase the vulnerability of these already highly vulnerable populations. Applying the “do no harm” principle is key. In addition, development of a risk mitigation strategy and operationalization of a child protection policy are required. Government, KP, OVC and clinical partners, including health facility staff and community workers, should be trained in and apply these policies. Continued engagement and consultation with KP in program design to ensure their meaningful participation in program implementation, monitoring and evaluation can support these policies. Identified priorities from KP and their children are required to develop responsive service packages, referral mechanisms, and improve acceptance and uptake of services.

b. Partner Coordination

Government, KP, OVC and clinical partner coordination is essential, with a common goal of putting KP and their families first. Partner coordination at all levels is needed to ensure an effective and efficient continuum of care for families to improve outcomes. Government engagement and a Memorandum of Understanding (MoU) coordinated by the Chief of Party, Agreement and Contracts Officers are essential for specifying partner roles, responsibilities, and coordination and accountability mechanisms. Figure 7 shows illustrative MoU components at all levels for stakeholders addressing children of KP. Benchmarks for coordination should be set and include yearly joint or shared work-planning, monthly partner meeting updates, routine technical staff engagement at regional and district level, and coordination of facility and community cadres. Layering and integration of services should be prioritized within KP, OVC and clinical programming and can include: providing OVC services in drop-in centers, integrating pediatric HIV, parenting and early childhood development into SBCC classes, enrolling children from KP service delivery points into OVC programming, ensuring that HTS counselors screen children for risk factors such as an HIV-positive parent and link to testing.

Figure 7: Coordination among Key Stakeholders to Address Children of KP
Components of MoU



VI. Monitoring Outcomes and Estimating Resources

As treatment, care and support activities evolve, it is important to support KP programs to research and accurately document the number and needs of children of KP in communities in order to adequately resource service delivery models. Enumerating the number of children of KP and supporting HTS data collection and analysis (to demonstrate high yield produced through the integration of KP, PMTCT, pediatric/adolescent and OVC programming) can be accomplished through the following monitoring/evaluation and target setting interventions:

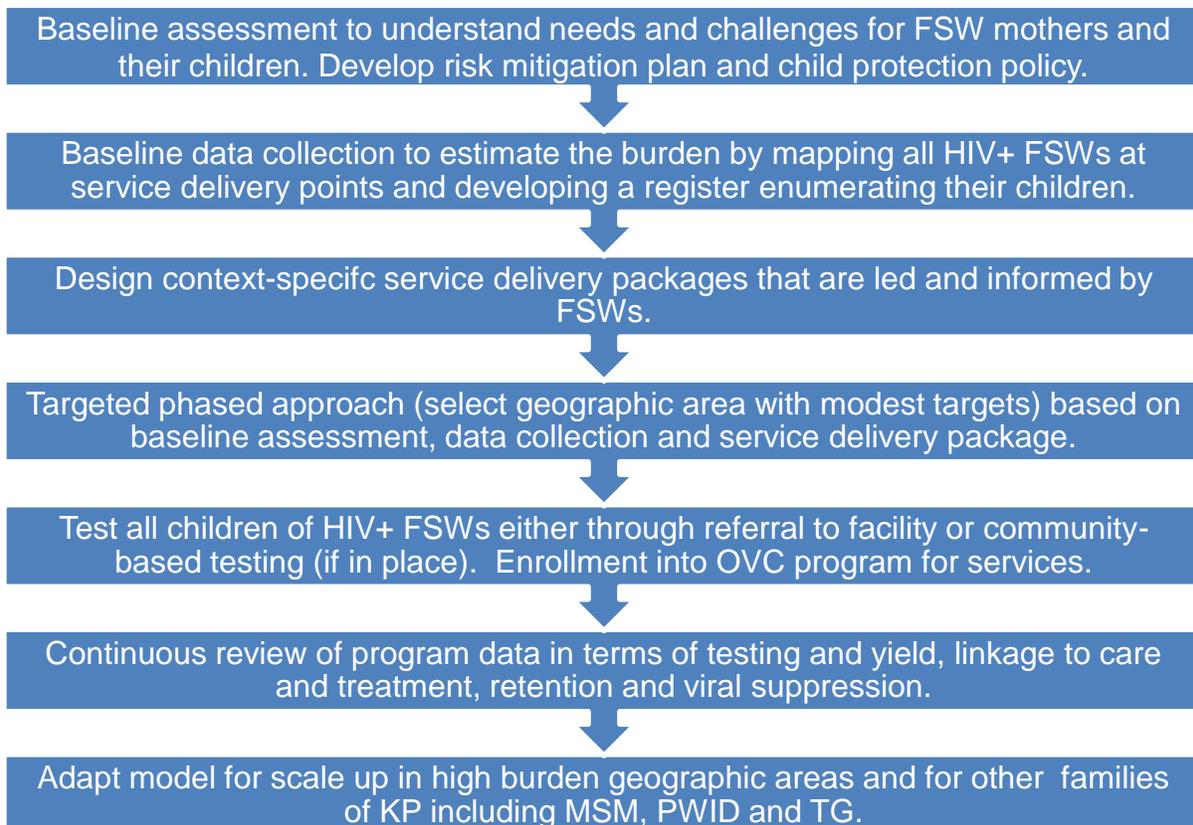
- Capture clinical cascade indicators for KP and their children.
- Ensure Option B+ coverage for HIV-positive female KP and EID coverage for their HIV-exposed infants.
- Set testing targets for number of infants, children and adolescents of KP tested based on number of HIV-positive KP estimates.
- Ensure linkage to treatment, care and support services for KP and their children identified as HIV-positive.
- Ensure KP and their children are retained in HIV care, adhere to ART and achieve viral suppression.
- Set targets for children of KP to be served as part of OVC program caseload.
- Link HIV-infected and affected children of KP to OVC services.
- Include children of KP and their parents in family-based KP-friendly differentiated care models.

The following PEPFAR Monitoring, Evaluation, and Reporting Indicators (MER, see section XI. Annex) and outcomes should be prioritized to monitor progress and results of family-based KP-friendly service delivery models:³⁴

- PMTCT_STAT, PMTCT_STAT_POS, PMTCT_EID, PMTCT_EID_POS
- HTS_TST, HTS_TST_POS, TX_NEW, TX_CURR, TX_RET, TX_PVLS (disaggregated by adults and children)
- KP_PREV, OVC_SERV, OVC_HIVSTAT
- Other customized indicators developed by partners to monitor HIV outcomes

An illustrative phased scale up plan for service delivery is highlighted below in Figure 8:

Figure 8: Phased Scale up Plan for Service Delivery Targeting FSW Mothers and Children



Other components of a design and implementation plan include:

- Capacity assessment on how well equipped partners are to implement children of KP package of services.
- Develop a checklist and/or set of questions for standardized reference sheets and helpful tips to address common issues including schedule of key program design activities and assessment tools.
- Design essential components of operational approach. Develop a standard program design with breakdown of different service platforms (clinic vs community outreach), cadres and service packages.
- Recruitment of peers, ratio of peers to clients, scope of work for peers and assessment of capacity strengthening needs. Include denominators for hotspot, HIV prevalence and staffing ratio for site(s).
- Cadre level services - peer educators, community case workers, child care facilitators - map out respective roles, referral protocols and case flow chart.

a. Developing Budgets and Allocating Resources

Once a package of services has been developed (with KP, OVC, clinical and outreach components) and targets have been set, determining an appropriate budget for reaching children of KP is necessary for strategic planning and activity-based resource projection. To enable a program-based and incremental budgeting process, PEPFAR released a Funding Allocation to Strategy Tool (FAST) in 2018. Agencies utilize the FAST to allocate funding to implementing mechanism level strategic objectives, program areas (care and treatment, prevention, OVC and health systems strengthening), and approaches which will enable an understanding of how all program activities align with PEPFAR priorities and expected results. Coordination and leveraging of HIV testing, KP, PMTCT, adult and pediatric care and treatment and OVC programming should be considered when developing strategic objectives, approaches, budgets and geographic focus for scale-up.

Understanding existing historical country-specific cost estimates for each program area and analyzing with respect to planned support can help determine an appropriate budget for reaching children of KP in lieu of prospective costing of implementation. Of note, when planning for implementation of activities, country teams should consider what cost components within each intervention and program area would need to be incrementally increased or if current program budgets would be sufficient to absorb costs of implementation.

b. Expected Outcomes

With continuous engagement of KP and their children in program design, implementation and monitoring and evaluation, key expected outcomes include:

- Improved parental capacity (health, emotional well-being, knowledge/skills, economic security) to meet critical needs of children.
- Improved well-being for children of KP (health, nutrition, education, protection, emotional).
- Increased access to HTS and improved adult and pediatric case identification.
- Improved coverage of adult and pediatric treatment, including improved adherence and retention in care.
- Reduced HIV incidence among adults and children.
- Reduced violence against children and parents/caregivers.
- Improved access to protection services (including post-GBV care) among parents/caregivers and their children.

Ongoing outcomes monitoring and documentation of best practices as well as challenges will be critical for program learning, quality improvement and adaptation of models of care. The development and dissemination of data resources will be especially important in order to

demonstrate the extent to which investments contribute to meeting the overarching goal: 95% of FSW mothers and their children access HTS, 95% of HIV-positive FSW mothers and children are linked to ART, retained in care and virally suppressed.

VII. Current Working Models and Evidence

The countries highlighted below have begun to develop program models and deliver service packages for FSW mothers and their children. In particular, Cameroon, Ethiopia, Tanzania, India, Côte d'Ivoire and Haiti have developed promising practices and models that can inform current and future programming.

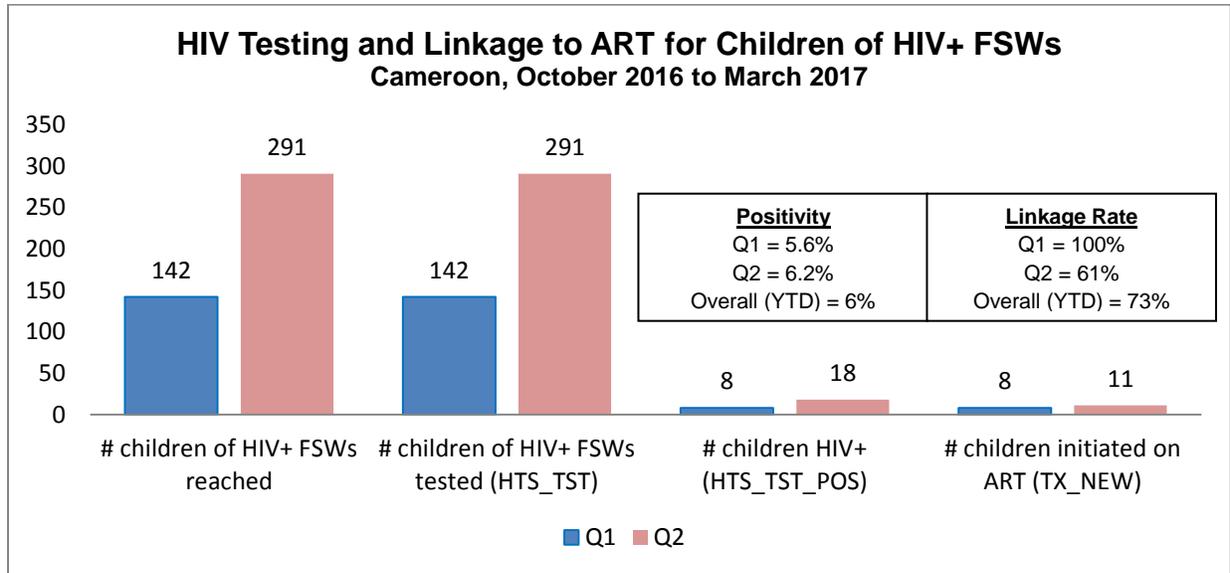
a. Cameroon

In September 2016, USAID-funded partners - Continuum of Prevention, Care and Treatment of HIV/AIDS with Most-At-Risk Populations (CHAMP) and the KIDSS project providing comprehensive care and support for OVC - piloted an integrated approach to improve HIV outcomes and overall well-being among children of FSWs. In consideration of program budget and human resource constraints, fundamental strategies included: prioritizing and targeting initial support to children of HIV-positive FSWs; layering interventions on existing service delivery platforms; and utilizing existing program cadres for efficient and effective service delivery. The establishment of a bi-directional referral system enabled rapid identification of children of HIV-positive FSWs, holistic assessment of children's needs, and referral to HIV and other health and social services.

CHAMP's community drop-in centers (DICs) serve as entry points to identify children using a register of HIV-positive FSWs. Subsequently they provide onsite counseling and HIV testing for 100% of children of HIV-positive FSWs. Following HTS delivery, all children and mothers are referred for enrollment in the KIDSS program. Case managers are introduced to children and their mothers and conduct a comprehensive assessment using a tool developed by KIDSS (see section XI, Annex) which includes assessment of nutritional status, school enrollment, household economic security and protection needs among others areas. These assessments result in individual care plans for a package of services to meet priority needs of each child and family. The KIDSS menu of services includes: early childhood development, household economic strengthening, sexual and reproductive health (SRH) education and risk avoidance, post gender-based violence (GBV) care package, educational support (school block grants and scholarships), nutritional assessment including counseling and referrals for nutrition supplementation, linkage to ART and retention support, and age-appropriate adherence counseling and psychosocial support. In addition, adolescent girls are referred to a CHAMP sub-partner, RENATA, which is a national network of teenage mothers with extensive experience providing services to women and girls who have experienced violence. RENATA provides comprehensive SRH services (including condoms), GBV prevention and a comprehensive post-GBV care package.

Preliminary results show that of 433 children (142 reached in Q1 + 291 reached in Q2) of HIV-positive FSWs reached for HTS, 100% of children were tested with 6% positivity and 73% of HIV-positive children linked to ART (Figure 9).³⁵ The lower linkage rate of 61% in Q2 is likely because children were linked to ART in the following Q3, but not captured in the data set. 100% of eligible children are receiving OVC services and support. PEPFAR indicators referenced below include: HTS_TST (# children receiving HTS services), HTS_TST_POS (# children testing HIV-positive), and TX_NEW (# children newly enrolled on ART). The timeframe for this data is Fiscal Year 17 Q1 and Q2, which is October 1, 2016 to March 31, 2017.

Figure 9: HIV Testing and Linkage to ART for Children of HIV+ FSWs in Cameroon³⁵



b. Ethiopia

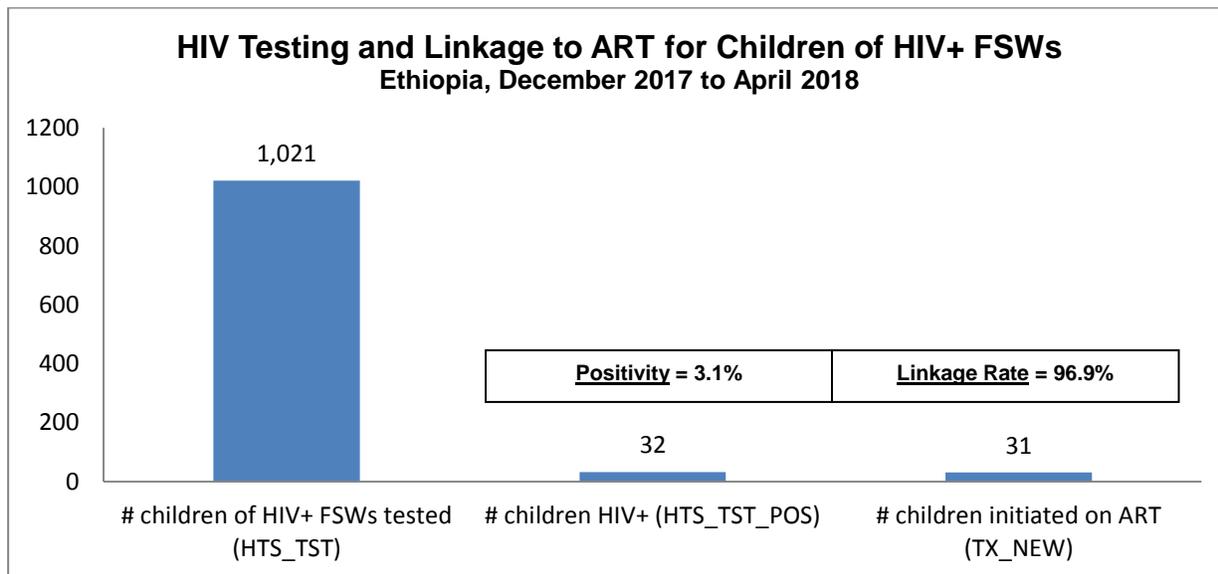
In Ethiopia, the Caring for Vulnerable Children (CVC) project, funded by USAID and led by FHI 360, is addressing care and support for FSW mothers and their children in coordination with Project MULU, another USAID-funded KP partner led by PSI. CVC has taken a dynamic approach in their OVC programming to reach children of HIV-positive FSWs through a combination of recruitment, training, outreach and case management strategies. The model includes standard operating procedures and job aids for identification, enrollment and assessment of OVC by priority sub-populations, including children of HIV-positive FSWs; and procedures, tools and resources to assist with case management. Specialized recruitment practices and tailored training by HIV and linkage coordinators for health workers, social workers and case workers at the local and regional level stress the importance of targeting OVC sub-populations utilizing high yield entry points. A clinic-community coordinator supports each health facility implementing the model and trains health facility staff on OVC eligibility criteria in order to increase referrals at the facility level. In addition, the clinic-community coordinators identify at-risk OVC and their families in health facilities, facilitating access to HIV services and ensuring follow-up. Services are carefully targeted to reach OVC, including children of HIV-positive FSWs, through mapping at community level in collaboration with health workers and people living with HIV (PLHIV) networks.

Continued coordination and outreach with OVC, KP and pediatric programs to identify HIV-positive FSWs and their children are conducted through home visits by case workers and in DICs. Children, adolescents and their mothers are offered a comprehensive package of services, including HTS, linkage to ART, referral for sexually transmitted infection (STI) diagnosis and treatment, SRH/FP services, children and adolescent club and mentoring support sessions, economic strengthening, and essential maternal and child health services.

For DICs supported by Project MULU, MOUs were signed with CVC to collaborate in identification of HIV-positive FSWs and their children. In geographic areas where there are no DICs, Community Care Coalitions (CCCs) are used to identify FSWs and enroll them and their children for support. For HIV testing, most at-risk children were tested at health facilities factoring in comfort level of providers and proximity; however, DICs are increasingly being used as testing entry points. A formal assessment and review is planned to identify specific needs of children of FSWs. For now, the case management approach is used to identify needs and provide services.

Per program data from December 2017 to April 2018 as show in Figure 10 below, 1,021 children of HIV-positive FSWs were tested, 32 were HIV-positive (3.1% positivity) and 31 (96.9%) were linked to ART.³⁶

Figure 10: HIV Testing and Linkage to ART for Children of HIV+ FSWs in Ethiopia³⁶



c. Tanzania

In Tanzania, SAUTI, a USAID-funded project led by Jhpiego, aims to strengthen the continuum of care for KP and is addressing treatment, care and support for FSW mothers, their partners and children. They are working closely with Pact and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the OVC and clinical partners in Tanzania, to scale up a model of care to meet the clinical and social service needs of FSW mothers and their children.

The service delivery model utilizes mobile HIV testing clinics in some areas and in others, community-based service delivery points such as homes, brothels, and SBCC group sessions. At these service delivery points, clinicians provide services including STI screening, HIV testing, and FP. If FSWs are identified as HIV-positive, they are then referred to the nearby health facility for ART; a case worker within the KP program facilitates linkage to treatment and retention in care by escort.

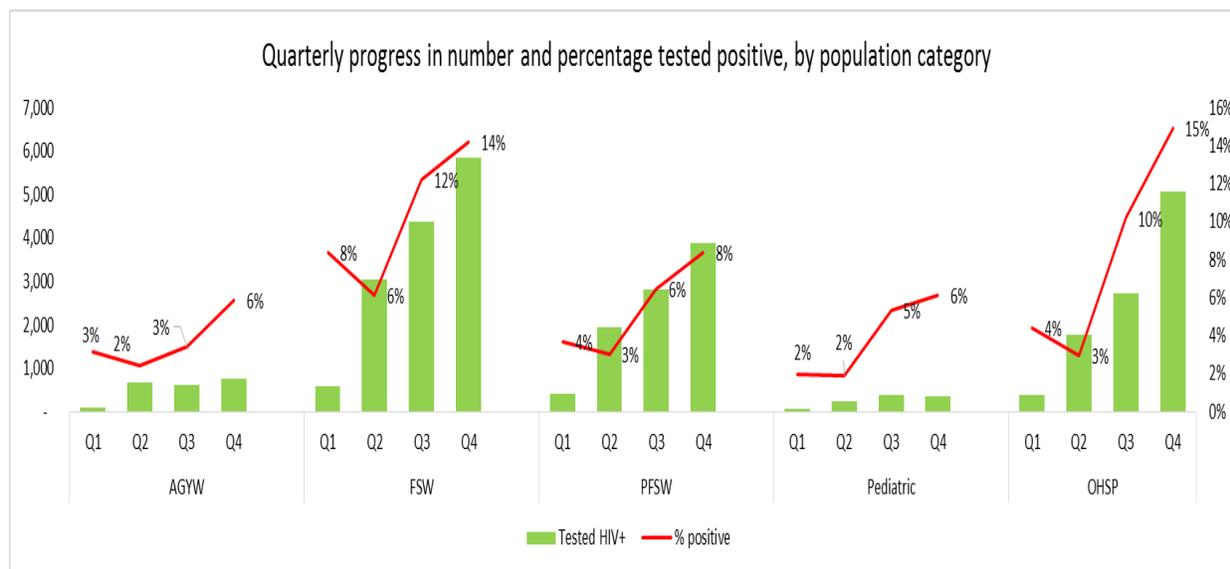
Within these service delivery points, SAUTI delivers an SBCC package for HIV and STI prevention that comprises ten classes. Once FSW mothers are enrolled and comfortable with the peer educator and members of the class, SAUTI encourages them to bring their children for HIV testing at the on-site mobile clinic. After establishing a relationship with FSW mothers, the willingness to bring children for testing during the SBCC classes increases given the education received and support from FSW peer educators. If children of FSWs are HIV-positive, they are linked to ART along with their mothers at a nearby health facility. A case worker from the OVC partner, coordinating with the FSW peer educators within the KP program, also ensures the child and FSW mother are enrolled in the OVC program. Figure 11 below shows the service delivery model and referral process that occurs at hotspots.

Figure 11: Service Delivery Model for Reaching FSW Mothers and their Children in Tanzania



SAUTI program data shows that of FSWs and their children who are tested, positivity rate for HIV is approximately 11% and 4%, respectively and increased each quarter (Figure 12).³⁷ This testing data warrants much more focus and attention to prioritize reaching children of HIV-positive FSWs as an active case-finding strategy to not only link them to treatment, but to also ensure they are enrolled in the OVC program and access a comprehensive service package.

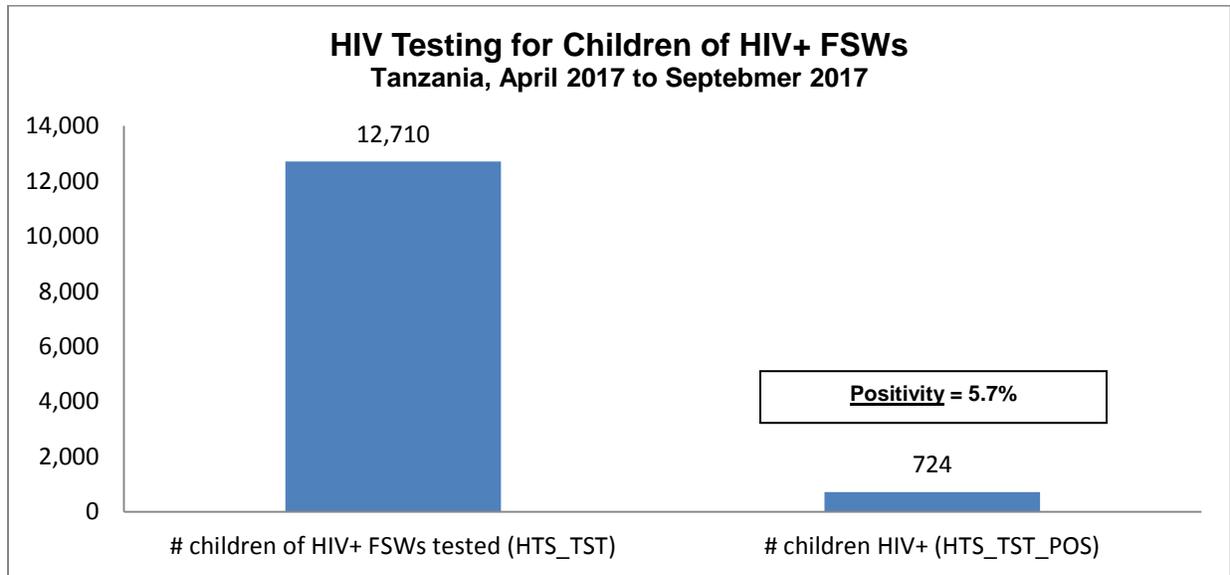
Figure 12: Quarterly Trends in Number and Percentage Testing HIV+ by Population Category October 2016 to September 2017



*AGYW (Adolescent girls and young women), PFSW (Partners of FSWs), OHSP (Other Hotspot)

From April 2017 to September 2017 as shown in Figure 13, 12,710 children of HIV-positive FSWs were tested for HIV, 724 were HIV-positive, resulting in a positivity rate of 5.7%. A limitation to note is that there may be a small number of children who were tested whose mothers are not FSWs, however this data point was not fully captured.

Figure 13: HIV Testing for Children of HIV+ FSWs in Tanzania³⁷



This increased testing yield is largely attributed to the “Diagnose One, Link One” strategy, a daily performance target for biomedical and care providers to identify and diagnose at least one HIV-positive client per day and ensure that the client enrolls in treatment the same day or within a few days of receiving their HIV status.³⁸ HIV counselors submit daily reports through WhatsApp instant messaging groups. Providers were trained and supported through WhatsApp Networks, and operational plans were developed based on ward and district hotspots and prevalence data. HIV yield increased across all population categories following the rollout of the strategy, with an increase in quarterly yield across all regions in the pediatric group.

Recommendations moving forward to further develop this model include strengthening FSW mothers’ knowledge and skills through SBCC classes on PMTCT and the importance of testing children of FSWs; this may also include layering sessions that address positive parenting and early childhood development. In addition, FSWs may access economic strengthening support through savings groups for caregivers supported by the OVC program. Increasing children and mothers’ access to protection services, including GBV prevention and response, will also be a priority. Continuous improvement and scale up of the model of care in all priority regions of Tanzania, and monitoring clinical cascade data for FSWs and their children will be key moving forward. For the OVC program, including mobile clinics and fixed clinics as service delivery points to enroll and assess children of FSWs is important. This will entail community case workers from the OVC program visiting KP entry points on a routine basis and consistently exchanging information to ensure mobile services occur during flexible and optimal times for FSWs to bring their children.

d. India

In India, the National AIDS Control Organization (NACO) is focused on saturating coverage of KP with targeted interventions (TI) and ensuring increased availability and coverage of ART for all PLHIV. The OVC Social Protection project, led by the Karnataka Health Promotion Trust (KHPT) in collaboration with LINKAGES, led by FHI 360, aligns with NACO’s objectives of increasing the coverage of services among KP; both USAID-funded partners together are reaching KP, their spouses and children through introduction of stigma-free, family-friendly, child-centered interventions to address the complex social relationships that KP navigate and promote uptake of HIV and OVC services. Program strategies include assessment of the needs of children of KP, assessment of family profiles including a vulnerability analysis, and improving linkages with health, education and social protection services. Child care facilitators work in sync with peer navigators and outreach workers based at TIs to reach, assess and enroll spouses and children of KP for OVC services.

KHPT developed an assessment tool (see section XI. Annex) and undertook a rapid assessment of FSWs and their children to identify their needs and challenges. This assessment occurred in PEPFAR priority districts in the states of Maharashtra (Thane, Pune and Mumbai) and Andhra Pradesh (East Godavari, Guntur and Krishna) at existing TI NGO sites providing services to FSWs; it included two focus group discussions with FSWs and 7 focus group discussions with their children 13-18 years of age. Key findings include the following.³⁹

- 5,469 FSWs with 9,516 children were assessed
- 54% of FSWs assessed have children (< 18yo)
- Average number of children per FSW = 1.7
- 60% of children of FSWs are between 10-18yo
- 93% of children 6-16yo are in school.

While current work is focused on FSWs, an assessment tool and implementation plan will be developed for reaching children of PWID and MSM.

e. Côte d'Ivoire

The USAID-funded LINKAGES program focusing on services for KP and led by FHI 360 and the RÊVE OVC program have finalized an MoU specifying their respective roles and responsibilities for identification and enrollment of children of FSWs; linkage to HTS, care and treatment; and OVC service delivery. Children of HIV-positive FSWs will be prioritized for the initial program phase. In addition, the RÊVE program, through its local partner Espace Confiance, has supported 88 FSWs with 178 children, providing linkage to HTS, a standard OVC service package, GBV response services and psychosocial support. Preliminary testing results showed 5.7% positivity among children of HIV-positive FSWs.⁴⁰ Espace Confiance utilizes community care workers who specialize in support for FSWs and facilitate home and center-based activities. Next steps include documentation of clinical cascade results for children and increased targeting and coverage of children of FSWs.

f. Haiti

The BEST OVC program, funded by USAID and led by the CARIS Foundation, is providing care and support for approximately 200 children of FSWs, including educational support, health care and protection services. BEST plans to increase targeting and coverage of adolescents of FSWs through implementation of DREAMS-like activities (**D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored and **S**afe). The LINKAGES KP program currently refers children of KP to the BEST program in order to improve access to OVC services and they are exploring the feasibility of offering pediatric testing services at DICs in order to increase children's access to HTS and linkage to care and treatment.

VIII. Summary and Next Steps

Technical assistance is available to support children of KP program design, development of priority service packages for children and their caregivers as well as risk mitigation strategies, and activity monitoring and evaluation (strategic data collection, analysis, and presentation, e.g. clinical cascade). Support can be provided for annual work planning for OVC, KP and clinical programs to include children of KP activities as well as program evaluation design and protocol development (to include critical questions and indicators for children of KP). HQ technical advisors for HTS, PMTCT, FP, Pediatric care and treatment, KP and OVC can provide on-site or virtual support and share resources (see section XI. Annex). In addition, program teams can access technical assistance for documentation of best practices and lessons learned as well as multi-phase program planning in order to continually strengthen and adapt children of KP program models and service packages.

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IX. Contacts

USAID/Washington DC, Bureau for Global Health, Office of HIV/AIDS

Meena Srivastava	PMTCT/Pediatric HIV Technical Advisor	asrivastava@usaid.gov
Sarah Dastur	OVC Technical Advisor	sdastur@usaid.gov
Tisha Wheeler	KP Technical Advisor	twheeler@usaid.gov
Allison Ficht	Program Analyst	aficht@usaid.gov

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XI. Annex

- I. [Children of KP Learning and Sharing Webinar \(May 2017\)](#)
- II. MER Guidance
 - a. [MER 2.0 Indicator Reference Guide V 2.2](#)
 - b. [MER 2.0 Indicator Frequency Table](#)
 - c. [MER 2.0 Infographic](#)
- III. Focus Group Discussion Questions
 - a. [Female Sex Workers](#)
 - b. [Peer Navigators](#)
- IV. Country Resources
 - a. Cameroon
 - i. [Assessment Tool](#)
 - ii. [TDY Outbrief](#)
 - iii. [Solution Framework](#)
 - b. India
 - i. [Assessment Tool](#)
 - ii. [TDY Outbrief](#)
 - c. Tanzania
 - i. [TDY Outbrief](#)
 - ii. [Solution Framework](#)

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