
Children of female sex workers and injection drug users: a review of vulnerability, resilience, and family-centered models of care in low and middle-income countries

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February 2010

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The USAID | Project SEARCH, Orphans and Vulnerable Children Comprehensive Action Research (OVC-CARE) Task Order, is funded by the U.S. Agency for International Development under Contract No. GHH-I-00-07-00023-00, beginning August 1, 2008. OVC-CARE Task Order is implemented by Boston University. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the funding agency.



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Abstract

Background: Injection drug users and female sex workers are often categorized as two of the populations most at risk for becoming infected with HIV in countries with concentrated epidemics. Many of the adults who fall into these categories in low and middle income contexts are also parents, but little is known about the vulnerabilities faced by their children, their sources of resilience, or programs providing services to these often fragile families.

Methods: We reviewed the peer-reviewed and gray literature to synthesize current knowledge on the situation of these children and families, and interventions currently in place in low and middle income countries. Organizational websites and references of all relevant sources were manually searched, and key informants from service organizations were contacted by phone and email.

Results: A large amount of literature assessing the vulnerability and resilience of children of drug users and alcoholics in developed countries was found. Their children can face unique risks, stigma, and discrimination, but child vulnerability and resilience are associated in the substance abuse literature with the physical and mental health of parents and family context. Research on the situation of the children of sex workers is extremely limited. Interventions have been implemented in low and middle-income contexts but they tend to be small, piecemeal, struggling to meet demand; and undocumented, and most have not been evaluated. We present preliminary descriptive data from an organization working with pregnant and new mothers who are drug users in Ukraine and an organization providing services to sex workers and their families in Zambia.

Discussion: Because parents' drug use, sex work, or same sex relationships are often illegal and hidden, identifying their children can be difficult and may increase their vulnerability and marginalization. Therefore, researchers and service providers must proceed with caution when attempting to reach this population. Promising components of family-centered care include: strengthening family caring capacity through home visitation and peer support, providing early childhood development programs and crèches or drop-in centers for children; economic strengthening and job skills training for parents. Integration of legal assistance with health and other social services is also gaining increased international attention.

1.0 Background

Female sex workers (FSW) and injection drug users (IDU) are often categorized as two of the four populations “most-at-risk” for becoming infected with HIV due to behaviors that heighten their vulnerability to the virus. According to UNAIDS, the term “most-at-risk populations” (MARPs) refers to men who have sex with men, injection drug users, sex workers and their clients. These risk behaviors are believed to drive the HIV epidemics in Western countries, former Soviet republics, and Asia where HIV is concentrated in specific populations (1). Interventions for most-at-risk populations tend to focus on the needs of adults with the objective of reducing their risk for HIV through prevention and behavior-change education and risk reduction strategies. But, to date, little attention has been paid in the published literature to the vulnerabilities faced by their children or to interventions focused on keeping these potentially vulnerable families together, improving the wellbeing of both parents and children, and reducing the risk of both generations for becoming infected with or transmitting HIV.

This review, therefore, aims to synthesize evidence from disparate sources (including research, advocacy, and programmatic information) describing the vulnerabilities and sources of resilience of the children of female sex workers and injection drug users in low and middle-income countries, and document some of the models of care that have been put in place to assist them. In the pages that follow we analyze peer-reviewed and gray literature to begin to answer four research questions:

1. What are the vulnerabilities faced by the children of IDU and FSW?
2. What are their sources of resilience?
3. Are there interventions that have focused on mitigating the vulnerability and fulfilling the needs of these families?
4. What do we know about the effectiveness or impact of these interventions?

Synthesizing what is known about the types of vulnerability and resilience experienced by these children, the types of assistance they and their families need, and the effectiveness of the interventions that exist is useful for several reasons. First, attention needs to be drawn to the reality that FSWs and IDUs are often parents whose children potentially face vulnerabilities unique to their family situation. Second, understanding the needs of these children is necessary for creating relevant, evidence-based interventions focused on supporting their families. Finally, documenting the types of care that do exist and assessing their effectiveness is critical for scaling up and adapting successful interventions to new contexts.

2.0 Methods and Definition of Key Terms

This literature review utilized both electronic and manual search methodology to locate relevant peer-reviewed articles and gray literature from all countries regardless of HIV and orphan prevalence or income level. The following online databases were searched to identify relevant studies: Ovid/Medline, PubMed, Child Development and Adolescent Studies, PsychInfo, Published International Literature on Traumatic Stress (PILOTS), Sociological Abstracts, Social Services Abstracts, Web of Science, Google

Scholar, Popline/One Source, the New York Academy of Medicine Grey Literature Report, and Public Affairs Information Service Archive. Organizational websites and references of all relevant sources were manually searched. Our search paired the terms parent, child, youth, and orphan with the following using various combinations¹: most at-risk populations (MARF), risk factors, sexual behavior, HIV/AIDS, commercial sex worker, female sex worker, prostitution, drug user, drug use, substance abuse, substance abusing parents, addiction, men who have sex with men (MSM), homosexual, sexual orientation, intervention, child care, education, prevention, child victims, injection drug use (IDU), intravenous drug use (IVDU), child welfare, parent-child, child of impaired parents.²

The review of available programs is the result of a desktop research methodology that attempted to be systematic but ended up becoming a snowball sample comprised of information from material published on the Internet and from contacting individual programs discovered through personal contacts. Correspondence and phone interviews with these key informants were the most fruitful source of information on interventions.

Terminology and definitions

This review has at its core a number of semantic challenges. First, the definition of “sex work” is profoundly unclear and can run a wide gamut of very different types of transactional sex, including but not limited to:

- Caste-based Devadasis in India or Kanjar families in Pakistan
- Brothel-based prostitutes
- Waitresses/bar girls who sell sexual favors within the establishments where they are employed
- Street walkers
- Dancing girls
- Courtesans or taiwaifs who entertain men they call “husbands” and receive cash and other material gifts.

This list does not even begin to account for the various types of male sex workers or women and children who have been trafficked into sex work. For the purposes of simplicity we use the term “female sex workers” (FSW) to include all categories of women participating in transactional sex.

While we began our search on children of drug-addicted parents with a focus on the children of IDU, we quickly found that the literature is more broadly focused on drug and alcohol addiction in general. The terms drug abuse, drug addiction, drug dependence, substance use and substance abuse are used interchangeably to denote all forms of drug dependence. The distinctions between substance use and

¹ The terms in this list are a combination of medical subject heading (MeSH) terms and key words.

² *Child of impaired parents* is a MeSH term used by the National Library of Medicine. This term combined (using the Boolean AND) with synonyms denoting categories of risk behavior was the most fruitful in terms of relevant citations found. Use of the pejorative term ‘impaired’ was purely practical and does not reflect the opinions of the authors. Likewise, the arguably pejorative terms *addict* and *substance* or *drug abuser* are used in this review because they are common in the research literature.

abuse are finely wrought and beyond the scope of this article. Our focus is on adults who are dependent on drugs, including alcohol, rather than occasional users.

Finally, we set out to look at the vulnerabilities and interventions for the children of drug users and sex workers, using search terms specific to each group. However, overlap between these two groups is common as drug dependency can create a gateway into sex work and visa versa. In the following we present information that is either generalizable across the two groups or distinct to each; however, we were not able to find data assessing the impact of “co-morbidity” on children whose parents are both substance abusers and sex workers.

3.0 Results

Population estimates

The United Nations Office on Drugs and Crime (UNODC) estimates 11-25 million injection drug users worldwide (2); the proportion who are parents is unknown. Some country-specific estimates of children living with drug users have been calculated based on national household data. For instance, almost half a million children in the United Kingdom live with parents who reported drug use and problem drinking in the last year (3). Not surprisingly, similar estimates of the number of children affected by parental substance use are not available for countries without similarly sophisticated, national health care tracking systems.

Vandepitte et al. provide estimates of sex workers in urban areas of sub-Saharan Africa (0.7%-4.3%), Asia (0.2%-2.6%), former Soviet countries (0.1%-1.5%), Eastern Europe (0.4%-1.4%), Western Europe (0.1%-1.4%), and Latin America (0.2%-7.4%) (4). But they admit that arriving at such estimates is precarious at best due to inconsistent definitions of what sex work entails. Overall global estimates of the children of sex workers could not be found; however, some context-specific data show that the vast majority of female sex workers are mothers (5). In Bangladesh, Save the Children report that sex workers in two large urban brothel communities have little access to or knowledge of contraception, making pregnancy “a well-known hazard” (6).

Vietnam was the only country found to specify children of FSWs and IDUs as vulnerable along with children who have been trafficked, street children, and children who are themselves engaged in drug use and sex work. While the Ministry of Labour, Invalids, and Social Affairs (MOLISA) is able to give estimates of the numbers of children who fall into the latter categories, they indicate that data is not available on children of sex workers or IDU (7).

Vulnerability and resilience

Research on the children of drug users in general focuses on their vulnerability to numerous forms of deprivation and abuse. A review of key articles from the last two decades yields a relatively long list of possible negative outcomes for children ranging from cognitive developmental delays to neglect and

abuse as a result of pre and post-natal exposure to parental addiction. However, research findings on the determinants of these various risks tend to be inconclusive, with family and community support networks, parental physical health, and mental health, and other socioeconomic and environmental factors mediating child development and resilience (8-20).

For the purposes of this paper, the primary limitation of these research findings on the possible vulnerabilities faced by children of drug users is that they are almost completely focused on high-income countries. Arguably, the risks and sources of resilience faced by children of addicted parents are potentially universal in any context where certain drugs are illegal, drug addiction is stigmatized, and rehabilitation and risk-reduction programs are difficult to access if available at all. But, overall, the generalizability of the information collected from wealthy countries to low and middle-income countries is unknown. At best, these findings can be useful for establishing research questions unique to lower-resource contexts.

The literature on the children of sex workers, by contrast, is very small, largely qualitative and ethnographic, and focused on South Asia. Specific vulnerabilities that have been documented affecting children of sex workers include: separation from parents, sexual abuse, early sexual debut, introduction to sex work as adolescents, low school enrolment, witnessing mother's sexual interactions with clients, and social marginalization (5,6,21-25). The research on sex workers and their families, tends to have a particular focus on girls and their potential for sexual abuse, early sexual debut, witnessing adult sexual activity, grooming to enter the trade, and trafficking. Sex work is often handed on from parent to child, as the family trade in some cases or out of a real or perceived lack of other options (6,26). Ethnographer, Louise Brown, explains the way a family legacy of transactional sex works for taiwaif families in Lahore: "A girl who gave birth to a daughter when she was 15 would have someone to replace her in the business when she was 30. Giving birth to a girl was like producing your own personal pension plan because a daughter's youth and beauty sustained her family" (26).

None of these researchers cited above looked specifically at the children's sources of resilience but Pardeshi and Bhattacharya found that Devadasis had strong family support in their native village, tended to leave their children with their mothers and sisters when they returned to the brothel, but visited the child once or twice a year (22). Their earnings, interventions, supportive peers, and brothels organized around native villages were found to make child rearing easier for those women whose children remained with them. In terms of availability of resources, Pandey et al. found that 73% of the 300 children of sex workers interviewed felt that they had not been discriminated against in school because of their family association with prostitution. Most (58%) also reported receiving vocational or professional training. And, among the 500 mothers interviewed, 72% and 95% of mothers claimed that they could access health check-ups and immunizations respectively, and 53% had received referrals for specialized care (5).

Models of family-centered care for children of substance abusers

Zuckerman notes that an addicted mother's interest in her baby is often the "healthiest" part of her life. But this interest is a double-edged sword that can exacerbate feelings of failure as much it can

provide a positive impetus to begin methadone maintenance or enter a rehabilitation program (10). In the US, drug rehabilitation programs traditionally focused on the needs of men and did not accommodate a mother's reluctance to leave her child in order to enter residential treatment programs (10,27). This started to change in the 1990s with the development of outpatient family-focused treatment integrating screening of mothers during pregnancy for addiction and drug rehabilitation counseling, with primary health care for her and her children, legal assistance, food assistance, housing, etc. (10).

MAMA+ for IDU in Ukraine is the single program for which we were able to find solid, if limited information. As can be seen in Table 1, the integrated, family-centered, "one stop shopping" model of care offered by MAMA+ is similar to that pioneered in the US by Zuckerman and others during the 1990s.

MAMA+ for IDU was recently piloted by HealthRight International in Ukraine with funding from the Open Society Institute as an extension of the USAID-funded MAMA+ program offered to HIV-positive pregnant women in Russia and Ukraine (28). The original project set out to reduce the proportion of children born to HIV-positive mothers abandoned at the maternity hospital by establishing networks of agencies and specialists to identify seropositive pregnant women and mothers. The reasons identified for abandonment were lack of information on HIV/AIDS and prevention of mother to child transmission, stigma and discrimination at medical and social institutions and by families, financial pressure and homelessness, unplanned pregnancy, and lack of social and peer support.

Thirty-five percent of MAMA+ clients were IDU and 44% had a criminal record, but in the original incarnation of the project their drug addiction was not taken into consideration as a risk factor requiring additional support. In order to adequately meet the needs of this substantial portion of their target group, MAMA+ conducted a six-month pilot intervention focused on providing drug-addicted women with drug and alcohol counseling, risk-reduction, drug replacement therapy, and legal assistance (28). The referral network was adapted to include harm reduction, drug substitution therapy, and rehabilitation programs. A drug and alcohol addiction consultant was hired and new peer support groups focused on the challenges created by dependence on illegal drugs were added. The comprehensive approach combined early identification and enrollment with home visits, and provided material, psychological, and legal support (Table 1). Within six months of launching the project, 25 HIV-positive IDU pregnant women and new mothers were receiving services, in addition to 27 children and 19 other family members. Forty-seven families were referred to other agencies; 4 women were enrolled in substitution therapy, and 27 children at risk of abandonment were still with their mothers (28). HealthRight has just concluded the first year of the MAMA+ for IDU project and is hopeful that funding will be renewed to continue the project. They currently have no plans to expand the IDU-focused program to other countries.

Models of family-centered care for children of sex workers

We found information on 18 organizations providing care for the children of sex workers in Bangladesh, Cote d'Ivoire, Kenya, India, Nepal, Vietnam, Zambia. The information available on the

programs was largely gleaned from internet searching and correspondence and phone interviews with program implementers. It is, therefore, limited in terms of programmatic detail, information about the population served, and data on effectiveness or long-term impact. The interventions we found tend to provide multifaceted assistance to mothers and children across several categories, providing children with educational opportunities and a safe place to play, study, or sleep when their mothers are working. Likewise, the same programs provide vocational training and alternative income generation opportunities to mothers who want to leave sex work or reduce the number of clients they need to entertain in order to provide for their families. Other types of assistance provided include: peer support, nutrition, housing, and health care.

TASINTA (We Have Changed), started in Zambia in the 1990s, is the program for which we were able to gather the most comprehensive information [Personal Communication, January 4, 2010]. TASINTA started as a program to help sex workers protect themselves from HIV, but input from the women themselves made it clear that a more broadly based, family-centered approach was necessary. Detailed information about TASINTA's services to FSWs and their children is provided in Table 2.

TASINTA's partnership with residential care facilities to serve as a boarding school for children whose mothers have died may at first seem antithetical to the family-centered care model. However, after experimenting with reuniting orphans with extended family, TASINTA found that they were no longer able to monitor the care and safety of the children and faced a situation where family members were selling the children into prostitution. Program managers and clients working for the organization found themselves, not infrequently, searching for children and rescuing them, hence, the decision to place them in a residential environment they knew to be safe where the children can remain close to adults they know and trust [Personal Communication, January 4, 2010].

4.0 Discussion

Key findings and limitations

An overarching summary of this review of the vulnerabilities faced by children of IDUs and FSWs, their sources of resilience, and promising models of care can be distilled into eight key findings:

1. Many IDUs and FSWs are parents;
2. These children can face unique risks, stigma, and discrimination as a result of their parents' addiction or profession;
3. Potential vulnerability can be mediated by numerous potential sources of resilience connected to support networks, parent health, parent-child bonding, education, economic situation, and other environmental factors;
4. Because their parents' drug use or sex work is often illegal and hidden, identifying these children can be difficult and even increase their vulnerability and marginalization;
5. Measuring the magnitude of child vulnerability derived from parental sex work or drug use is difficult and, in some instances, likely not possible;

6. Interventions tend to focus on the needs of at-risk adults without addressing their families, particularly their children;
7. Some interventions have been implemented in low and middle-income countries to assist these families, but they tend to be small, piecemeal, and struggling to meet demand;
8. Most interventions have not been evaluated for short-term effectiveness or long-term impact.

We also faced several limitations, most of them related to the availability and quality of available information on the lives of children of sex workers and injection drug users. Definitional issues were paramount, as mentioned above. Another limitation is our focus on the children of FSW and IDU alone. We looked at the children of sex workers who sometimes run the risk of entering the profession or being trafficked but not at children who have been trafficked or are who have entered prostitution through means other than “inheriting” it from their mothers. Children can end up as sex workers through a wide variety of circumstances having to do with family circumstances. For instance they can run away from abusive homes and end up in the business; they can be sold by their families; and they can end up as sex workers because their fathers are the sons of sex workers even though their mothers are not (26). We have also not dealt with the complex distinction between those who are trafficked and those who enter the profession with some degree of agency (29). We do not deal with male sex workers or their children or examine the relationship between the children of FSW and their fathers, who are often their mothers’ clients (e.g. the fourth MARP category).

Context, complexity, and next steps

Understanding the specific context in which drug addiction or transactional sex interact with a parent’s ability to take care of a child is of critical importance. However, we must carefully weigh competing risks and benefits when making generalizations about vulnerability, need, and best family-centered practices. The environment in which these children live can increase their vulnerability, but removing them from said environment can also mean separating them from parents who love them and are doing the best to raise them. Yet family placement can in some cases also increase risk. Unfortunately, the peer-reviewed and gray literature focused on the children of IDU and FSW in low and middle-income countries is largely silent on what sort of interventions are most effective as well as on strategies for accessing these often hidden, hard-to-reach families. The literature is also silent in regard to strategies for designing, implementing, and scaling up interventions for children of parents whose behavior is illegal and perceived to be immoral in many countries.

Research from the US and Europe can provide us with a useful place to start, but we must take up the challenge to find and (when they cannot be found) develop strategies that help keep fragile families together (30). The net results of the findings from this review, the UNICEF Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS (31), and the Joint Learning Initiative on Children and AIDS (32) highlight some core approaches backed by evidence of success in higher resource contexts. These include integrated interventions for families and communities similar to those already being implemented by MAMA+ for IDU and TASINTA:

- Strengthening family caring capacity through home visitation and peer support for vulnerable parents to provide mental health support, parenting skills coaching, and monitor of child welfare;
- Early childhood development programs for children, educational assistance, crèches and drop-in centers;
- Economic strengthening and job skills training projects.

Integration of legal assistance into family-centered services is a strategy gaining increased international attention. Medical-legal partnership was pioneered in the US by the Boston Medical Department of Pediatrics in 1993 and has caught on in the US to the extent that a National Center for Medical-Legal Partnership was initiated in 2006, representing over 120 health clinics and hospitals partnering with legal-aid organizations, pro-bono attorneys, and law schools (33). In terms of global scale up, the Open Society Institute (OSI) started piloting this strategy in low-resource countries, and published a report documenting numerous projects in Ukraine employing this strategy (34). While the OSI-supported MAMA+ for IDU pilot is not specifically mentioned, its legal assistance component is clearly part of this growing movement to provide IDU and other highly vulnerable parents with expert assistance to keep their families together, and help them access resources to which they have legal rights. However, before we start duplicating and scaling up these promising strategies, we need to document and evaluate extant programs providing assistance to the families of IDU and FSW while tailoring new programs to the needs and conditions of specific contexts (31).

We should also collect baseline data on these families when possible, being careful not to expose or further compromise fragile families often existing on the fringes of the law. A case in point is the situation facing the families of IDU and FSW in Vietnam. MOLISA's clear objective to highlight the needs of this hidden subset of extremely vulnerable children in the National Plan of Action for Children Affected by AIDS illustrates the complexity and possible danger of documentation and heightened attention. In particular the NPA notes contradictions between public health policy and the legal system that can increase vulnerability (7). Identification of children whose parents use illegal drugs or sell sex may land parents in 05/06 rehabilitation centers or prison effectively leaving their dependent children social orphans who may themselves end up incarcerated with them or placed in other social protection centers [Personal communication, January 6, 2010]. These institutions often do not separate juvenile inmates from adults and offer little in the way of HIV prevention education or harm reduction services, thereby perpetuating the cycle of vulnerability (7,35).

The situation in Vietnam is an extreme, but not anomalous, example of the tension that can exist between drawing attention to vulnerable families in order to provide services and advocacy and pushing an invisible population into a spotlight they have long shied away from. Documenting the illegal behaviors of parents in many national contexts (including the US) can lead to scrutiny from child welfare advocates and law enforcement, and indirectly lead to separation of children and parents. While such separation may occasionally improve the well-being or at least reduce the immediate risks faced by an abused or neglected child, it can also do collateral damage to already fragile but otherwise

positive family situations, leading to depression and self-blame on the part of the parent and thwarting child-parent attachment (10).

5.0 Conclusion

In a number of ways, this literature review has created as many questions as it has answered. We have synthesized research on the vulnerabilities faced by children of drug users and female sex workers and documented two of the family-centered interventions being implemented in Ukraine and Zambia. But much remains to be done as we work to make any gains toward implementing the UN Convention on the Rights of the Child for the children of highly vulnerable, socially marginalized parents around the world.

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