From Shadows to Light:

Advocacy for Children of HIV-Affected Key Populations

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- a South African sex worker

"I just want to live and raise (my) children, (be a) loving husband and not be afraid to die or go to jail. I think I have that right, and really want to use it."
- a Russian injecting drug user

The quotes above remind us that—unsurprisingly—parents from key populations share much in common with parents the world over; in particular, parents have in common the love they have for their children and a willingness to make sacrifices for them. But after love, a safe place to live and food on the table, what do the children of HIV-affected key populations need? Moreover, why do we not know the answer to this question?

Emerging information and anecdotal reports indicate that these children require special attention because of they may be negatively affected as result of either direct or associative relationship with their parents who are themselves members of key populations. But what are these children's issues and how might they be different from their peers? We know their parents face endemic violence, criminalisation, stigma, social-exclusion and discrimination globally, but what do we know of the children's needs? We may occasionally ask adults from key populations about their issues as parents, but do we ask about their children?

For many years now, the children of HIV-affected key populations—sex workers, transgender people, people who use drugs, and gay men and other men who have sex with me—have remained in the shadows, figuratively tucked behind their parents' legs, out of sight.

A broad alliance of community groups, NGOs and funders is emerging to bring these children into the light.

Between November 2014 and September 2016, an international working group gathered information, analysed it, and then came together with community, funder and NGO allies to identify the key issues and develop advocacy demands—and began to draw a roadmap for an advocacy strategy.

The five top issues identified and associated advocacy demands, are:

Issue 1: Inadequate or siloed key population-sensitive services for children
The first issue is inadequate or siloed (i.e.: segregated, separate and/or incomprehensive) key-population-sensitive services for children, including: a) care & support; b) health services including HIV testing & adherence; and c) social protection packages that mediate the compounding effects of poverty.

Advocacy demands to address Issue 1 include:

1. **Developing or strengthening—and properly resourcing—models of treatment, care & support**
   We must ensure that health and service providers develop or strengthen models of pediatric treatment and of psychosocial care support that are sensitive to the specific needs of children of key populations, and their parents. These models must be properly resourced.

2. **Ensuring rights-based access to HIV testing, treatment, healthcare & support for the children**
   Over and above the development of sensitive models of general treatment, care and support, children of HIV-affected key populations must be ensured, as a right, access to early infant diagnosis, and pediatric and adolescent HIV testing and treatment, as well as to other healthcare and support services that help children grow and thrive.

3. **Supporting key population groups to properly document the numbers and needs of their children**
   The numbers of children of HIV-affected key populations remains largely unknown. We must ensure that there are better estimates of these children. In a criminalized and stigmatised environment, key populations remain wary or fearful of efforts to count and register their children. Key population groups must therefore oversee exercises to better document the numbers of children in their communities, so that adequate services can then be properly rolled out and resourced.

Issue 2: General stigma & discrimination, and its effects on children, including its results in self-stigma (internalised stigma)

Children experience stigma, discrimination and bullying by association with their parents from key populations.

They experience it from members of these individuals' communities, including neighbours, family members, teachers, clergy, social service and health workers, and even other children.

And, that stigma is then internalized, resulting in what is commonly known as self-stigma—in this case, when a child becomes ashamed and becomes critical of herself or her parents.

Advocacy demands to address Issue 2 include:

1. **Ensuring a properly funded confirmatory exercise, engaging with the children themselves to further explore the negative effects of stigma and discrimination upon their lives**
   Due to lack of resources, and the time to engage in proper ethical reviews, the working group in this project did not consult directly with children. Instead, it consulted with parents about the needs of their children. Going forward, it is imperative to ensure that the views of the children themselves are documented, while ensuring that children are properly protected from further trauma in the consultation process. This exercise can be resource intensive and must be properly funded.

Advocacy demands to address Issue 2 include:

2. **Ensuring organizations develop or adapt tools for combatting stigma so that they address the stigma faced by these children**
   Much global work has taken place in the last decade to develop tools to measure or combat stigma of key population adults. The organizations doing this work must be supported to develop or adapt these tools so that they also measure and address stigma directed at the children of key populations.

3. **Ensuring—with separate funding—that organizations that undertake anti-stigma and discrimination campaigns include children of key populations in those campaigns**
   There remains the difficult work of rolling out anti-stigma and discrimination campaigns. Stigma and discrimination has demonstrably different consequences for key populations adults and their children—even though there is some overlap. Organizations must be separately funded to combat the effects of stigma and discrimination on children of key populations.

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

This issue was named in some way by the vast majority of consultants on this project, and fall into three categories:

1) lack of childcare, especially at night – leaving children open to neglect and abuse;
2) child neglect caused by police when arresting parents; and
3) child removal in situations not related to an objective determination of neglect or abuse.

Advocacy demands to address Issue 3 include:

1. **Ensuring social welfare ministries build structures and services —informed by key population communities—that better serve the care and protection needs of children of key populations**
   Key population parents need childcare options for their children that fit the realities of their lives. For instance, in the case of sex workers, safe child care (informal or formal) is mostly not available during evening and nighttime hours. Because of this and other situations, they need structures and services that will ensure their children are cared for when they are at work, and protected from people who would prey on their children because, among other reasons, those people don't value the lives of their parents. These better structures and services must be informed by key population communities.

2. **Ensuring that the children of key populations are cared for with high-quality services that prioritize and support the child staying in a family environment—family being defined broadly**

Advocacy demands to address Issue 3 include:

In addition to being safe for children, high-quality services must be provided to key population families with the goal of supporting those key population families to stay together. These services must support key populations to be parents or primary caregivers, and to live as a family, in the ways that they choose. If it isn't possible for children to stay with their parents, they must be supported to stay in another safe family environment—extended family or some alternative, rather than in institutional settings, which are known to cause long-term harm.

3. **Ensuring that children of key populations are supported to be agents of change in decision-making in their own care and protection**
   We must ensure that as services and programs are developed for children of key populations, they should be actively involved, in age-appropriate ways, in decisions about their own care and protection, including decisions about what is in their best interest.

Issue 4: Exclusion from safe, bully-free educational services and opportunities from early childhood, though middle childhood and adolescence

Children of key populations face enormous barriers to staying in school and enjoying a safe learning environment—which compound the other barriers facing HIV-positive children or children from resource-poor families.

Advocacy demands to address Issue 4 include:

1. **Ensuring that all children, including the children of key populations, have access to educational enrolment, a safe learning environment, and academic progression through their lives**
   Children of key populations, like other children deserve to be supported to enrol in school and stay in school—and to enjoy a safe learning environment so that they may progress onwards through secondary education—and if possible, beyond.

2. **Ensuring that education systems, schools and institutions provide safe, stigma-free environments, and implement policies and responses to bullying and exclusion of children of key populations**
   We must ensure schools are sensitive to the particular needs and vulnerabilities of children of key populations so that schools may protect them from harassment and bullying. In order to do this, education systems must have proper curricula, policies, trainings, and sanctions that protect these children from their classmates, from teachers, from administrators and even from other parents.

3. **Ensuring schools play a role as champions in upholding the rights of key populations and their children–and thereby: a) provide links and referrals to appropriate health and social welfare supports; b) advocate with parents; and c) generally challenge social norms and stereotypes**
   Schools must be not only safe spaces, but must advocate for children of key populations. Schools must be champions, referring onwards to supportive health and social services when

Advocacy demands to address Issue 4 include:

necessary, and engaging in anti-discrimination and equity work that helps to transform their communities into supportive environments.

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

The legal barriers facing key population parents, including those mentioned above, have extremely negative effects on their children. This is compounded by the general lack of legal advocacy support and support services.

Advocacy demands to address Issue 5 include:

1. **Ensuring children are guaranteed their right to a birth certificate or identity document**
   Without proper identification, children are denied access to a host of services provided by the state. We must ensure children are guaranteed their right to a birth certificate regardless of the health status, drug use, identity, or work of their parents.
2. **Ensuring there are no specific requirements for key population registration based on identity, sexual orientation, health condition or gender identity—as this can in some cases have negative consequences for both parents and children**
   Because of their consequence on both key population parents and their children, laws and systems must be changed to remove registration requirements.
3. **Because criminalization policies have negative consequences on children of key populations, we must ensure that advocates & law enforcement entities be made aware of the child-specific consequences—in aid of furthering the aims of the broader decriminalization movement**
   As a step in alliance with the broader movement to decriminalize key populations, both advocates and law enforcement must be informed and/or trained so that they become aware of the consequences that criminalization can have on parents and on children.
4. **Ensuring that laws and law enforcement entities not facilitate the separation of children of key populations from their families, unless it is in the best interest of children, and never on the basis of key population status alone**
   Prejudices often exists in the law and in law enforcement institutions, which lead to assumptions that children are better off living without their key population parents. We must combat these laws, and institutional and individual assumptions, so that children are only removed from their parents if it is objectively and without prejudice in the children's best interest.

This report and its recommendations are a challenge to all actors to consider their role in advancing and expanding advocacy efforts:

- **Advocates**: Are you thinking of the needs of children of key population in the development of your advocacy strategies?
- **Funders**: What *dedicated* funds can you develop either for advocacy, or for programming for children of key populations?
- **Non-key population health & social support implementers**: How can you work with key population groups to identify the gaps in programming in your region, and develop stigma and barrier-free services for key population families?
- **Government policy makers**: What advocacy demands in this report are in your purview? How can you ensure an equitable response for key population families?
- **Law enforcement entities**: How can you work to reduce the barriers and harms to children of key populations posed by individual and systemic attitudes, and by punitive laws?
- **Key population organizations**: Have you consulted with parents specifically about their children? Are you providing the services they need? Have you consulted directly with their children?

1. Emerging from the shadows

"My children need to know that I'm working for them."
- a South African sex worker

"I just want to live and raise (my) children, (be a) loving husband and not be afraid to die or go to jail. I think I have that right, and really want to use it."
- a Russian injecting drug user

The quotes above remind us that—unsurprisingly—parents from key population share much in common with parents the world over; in particular, the love for their children and a willingness to make sacrifices for them. But after love and food on the table, what do the children of HIV-affected key populations need? Moreover, why don't we know the answer to these questions?

Emerging information and anecdotal reports point to these children requiring special attention because of they may be negatively affected by society, either directly or by association with their parents from key populations. But what are their issues and how might they be different? We know their parents are facing an appallingly difficult situation globally, but what do we know of the children's needs? We may occasionally ask adults from key populations about their issues as parents, but do we ask about their children?

For many years now, the children of HIV-affected key populations—sex workers, transgender people, people who use drugs, and gay men and other men who have sex with me—have remained in the shadows, figuratively tucked behind their parents' legs, out of sight.

Adults from key populations are coming to be globally recognized as deserving of attention, although in many countries and settings, that attention is arguably counterproductive and detrimental, as these adults are criminalized, imprisoned, subjected to structural, physical and sexual violence, discriminated against and/or bullied.

In the context of the global HIV pandemic, key populations are particularly at risk, and yet stigma-free services, funding for those services, and the human rights protections that will enable their uptake, are still lagging[1]. Promising changes are, however, starting to take place in some parts of the world, and in others, the backlash has worsened the situation—as is the case in Russia, for instance. At the High-Level Meeting on Ending AIDS by 2030, a block of governments un-empirically and moralistically opposed language that would explicitly name key populations, language which would aim for human rights protections and services. Civil society must move forward and push for change despite ongoing opposition and barriers.

At a meeting on 'family-centred HIV services' held by the Coalition for Children Affected by AIDS (henceforth 'the Coalition') in May 2010, parents from key populations expressed their strong wish that HIV-sensitive services be designed for their whole families, including their children. Nonetheless, these same parents have in some instances purposefully kept their children hidden from the spotlight. They have had good reason to fear that, by association with them, their children's lives might well be made more difficult if they highlighted their children's issues, or even their existence. In some cases, they have feared their children will be removed from them by child protection workers who, because of those

[1] On the fast track to ending the AIDS epidemic Report of the Secretary-General, April 1 2016

workers' biases, believe that a situation of abuse or neglect is necessarily created merely by being parented by an adult from a key population.

Consequently, even as adults from key population have organized and demanded human rights protection, better service provision and better treatment in general, the voices of their children have not been heard.

That is now changing. In the last five or more years, key population networks are being told by their members that their children are suffering by association even in the shadows, and that it is time to bring them into the light in order to demand better for them, too. These parents are telling the networks they would like to document the problem and engage in advocacy to see their children's lives improved.

Concurrently (and anecdotally) funders and service providers are noticing that children of key populations have needs that are simply not being met. UNICEF country offices in Eastern and Southern Africa have reported that this is an issue that is coming up more and more[2].

2. Into the light: A project to improve the lives of children of key populations

To begin to address this problem, in November of 2014, the Coalition for Children Affected by AIDS gathered an international Project Working Group of key population networks and a few other organizations who, like the Coalition, consider themselves allies of those networks.

The Project Working Group, until September 2016, consisted of the following organizations:

- The Coalition for Children Affected by AIDS (The Coalition);
- The Global Network of Sex Work Projects (NSWP);
- The Global Network of People Living with HIV (GNP+);
- Harm Reduction International (HRI);
- The International HIV/AIDS Alliance (The Alliance);
- The International Network of People who Use Drugs (INPUD);
- The Global Forum of Men who have Sex with Men (MSMGF);
- The Regional Interagency Task Team on Children and HIV for Eastern & Southern Africa (RIATT-ESA); and
- The UCSF Center for Excellence in Transgender Health.

The Project Working Group met in London, UK, in June 2015, and launched a project plan whose first phase was an international consultation process. The steps in the consultation process have included:

1. An organizational scan by email survey: A survey of organizations on our working group's stakeholder list in July 2015.

2. A review of collected documents: A review, summarizing and classification of the contents of a cloud-based folder of materials collected over the last decade by project partners in October-November 2015.

[2] Conversation with Anurita Bains, HIV/AIDS Regional Advisor, UNICEF-ESARO and John Miller, January 19th 2016.

3. Community consultations to document the voices of parents speaking about their children: 8 community consultants interviewed parents and produced reports for the Project Working Group.

A draft version of this final report, with preliminary findings and recommendations, was tabled at a meeting of advocates, community members, funders and NGOs in Amsterdam in September 2016. Based on discussions at that meeting, a set of key issues and advocacy demands were developed.

Details on these steps in our info-gathering, and a list of participants in the September 2016 advocacy meeting, can be found in the Appendices.

3. Top Issues Facing Children of Key Population & Associated Advocacy Demands

Key Population parents want to provide for and protect their children. A sex worker from South Africa put it best:

> *"My children need to know that I love them. I am working for them."*

Overwhelmingly, parents in the consultations expressed that they were trying hard to be the best possible parents. Some are doing better than others (just as is the case with all parents).

They are often blamed for their shortcomings. But, while their children are struggling and sometimes suffering—and we heard that many children are (we also heard, it should be stressed, about resilience)— the parents overwhelmingly identified overlapping systemic challenges to good parenting, such as lack of services, lack of childcare, poverty compounded by stigma that shuts them out of opportunities, criminalization, etc.

They also pointed out that, compared to HIV-positive or economically struggling parents who are not members of key populations, even fewer services and resources were available to parents from key populations.

Our consultations were not exhaustive, and there were differences from one country to the next, as some countries make strides in one area or another to address health and social protection challenges. For instance, consultant Kinesha Thom writes: "Children in the Caribbean get access to general public services such as health and education. There are no issues as it relates to children accessing these services." And, consultant Lia Andriyani also stated that the Indonesian sex workers she interviewed stated that their children did not experience any discrimination in health care.

Yet, despite some good news stories, the bad news stories piled up. At a meeting in Amsterdam, The Netherlands, from September 28-30 2016, the working group gathered with NGO, government and funder allies to discuss preliminary findings and agree on the top issues and advocacy demands. These issues emerged from the findings of a draft report, and are detailed in the next sections.

Issue 1: Inadequate or siloed key population-sensitive services for children[3]

The first issue is inadequate or siloed (i.e.: segregated, separate and/or incomprehensive) key-population-sensitive services for children, including: a) care & support; b) health services including HIV testing & adherence; and c) social protection packages that mediate the compounding effects of poverty.

On the whole, the feedback of parents in the consultant reports indicates that very little support is given by local groups, and that there are barriers to access to health and social services for their children. In fact, some mentioned that social service groups are funded to provide support only to adults, even when they know that their clients have children. Some were even critical of key population organizations for dropping the ball on children.

In terms of health care services, parents specifically indicated wanting access to the following:[4]

- health care for HIV-positive parents from key populations, so they can stay healthy and support their children;
- mobile healthcare support for parents and children living with HIV, including testing, HIV & TB treatment, antiretroviral therapy, immunization; and
- viral load testing for children living with HIV

Consultant reports showed that health and social services that should be supporting children of key population fell short in several ways. The following examples were named in the reports:

- Lack of health services (specifically those focussing on pregnancy and perinatal support; needing better access to health care and child immunization[5]);
- Lack of social services[6];
- Lack of services in rural areas, versus in the big cities—compounded by the lack of watchdog advocacy organizations to track gaps in service or advocate for the children;[7]
- Siloing of services: one consultant named the problem of social workers whose job it is to work with adults failing to look at the issue of children.[8]
- Lack of uptake of services: on this last point, consultant Daisy Nakato of Uganda writes:

> *"Children are emotionally traumatized by the stigma and sex workers do not even understand the role of counseling and psychological support so do not have their children supported by any professional to overcome the trauma early in life."*

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[3] The consultant reports referencing the issue are mentioned in footnotes, by the initials of the consultant. For instance, if consultant Lia Andriyani's report mentions an issue, the initials LA will appear in the footnote.

[4] EN, DD, LA

[5] DD

[6] DN, EN, LA, DD, LD, IK

[7] IK

[8] IK

Of social support, Consultant Erastus Ndunda writes:

> *"There is not a single sex worker-led organization that support children of sex workers. The reason is that most groups are focused on addressing the issues faced by sex workers themselves." (note that this was specific to Kenya—in other countries, key population organizations do provide support).*

Some 'Orphans and Vulnerable Children' (OVC) organizations provide support to children, but many appear to discriminate. Many parents mentioned having to hide their identity or work in order to have their children access these programs. A sex worker in Kenya:

> *"The group I know is the church group that gives nutrition support (to) those who are living positively. When they discover you are a sex worker they talk bad about you. Sometimes they can even remove you from the program!"*

Where there was some support, the following were identified—and were mostly (but not exclusively) given out by key population-led organizations:

- Hampers given out for adults and children[9];
- School supplies given out[10];
- Social security for families including key populations[11];
- Peer support and support by families given through organizations[12];
- Memory projects/ identity work done with children of key populations[13];
- Social support for children through gay churches, Muslim LGBTQI organizations, sports associations, and some social development organizations and schools[14].

Clearly, clinics, institutions and social support organizations need to be examining their roster of services, as well as their barriers, including in some cases the prejudicial attitudes by staff, that may be leaving these children behind.

Advocacy demands to address Issue 1 include:

1. **Developing or strengthening—and properly resourcing—models of treatment, care & support**

   We must ensure that health and service providers develop or strengthen models of pediatric treatment and of psychosocial care support that are sensitive to the specific needs of children of key populations, and their parents. These models must be properly resourced.

[9] KT
[10] KT
[11] KT
[12] DD, DN
[13] DN
[14] LD

Advocacy demands to address Issue 1 include:

2. **Ensuring rights-based access to HIV testing, treatment, healthcare & support for the children**

   Over and above the development of sensitive models of general treatment, care and support, children of HIV-affected key populations must be ensured, as a right, access to early infant diagnosis, and pediatric and adolescent HIV testing and treatment, as well as to other healthcare and support services that help children grow and thrive.

3. **Supporting key population groups to properly document the numbers and needs of their children**

   The numbers of children of HIV-affected key populations remains largely unknown. We must ensure that there are better estimates of these children. In a criminalized and stigmatised environment, key populations remain wary or fearful of efforts to count and register their children. Key population groups must therefore oversee exercises to better document the numbers of children in their communities, so that adequate services can then be properly rolled out and resourced.

Issue 2: General stigma & discrimination, and its effects on children, including its results in self-stigma (internalised stigma)[15]

Children experience stigma, discrimination and bullying by association with their parents from key populations.

They experience it from members of these individuals' communities, including neighbours, family members, teachers, clergy, social service and health workers, and even other children.

And, that stigma is then internalized, resulting in what is commonly known as self-stigma—in this case, when a child becomes ashamed and becomes critical of herself or her parents.

Community consultations showed how this stigma is sometimes directed at the child, and how sometimes when the child witnesses their parents' experiences, the child feels the stigma keenly. is felt keenly. For instance, a female sex worker in Uganda said:

> *"The father of my children refused to pay school fees, saying that my children will also be prostitutes like me and so they don't need education, so I have to work hard and ensure that my children finish school, but it's very difficult to manage because the rates are high."*

[15] DN, LA, LD, IK, EN, DD, SN, KT

A female sex worker in Indonesia:

> *"Stigma and discrimination are directly obtained by the children in the form of a bully from school's friends and from home environment because of she is a 'child of a pelacur' (derogatory term for sex worker)"*

A female sex worker from South Africa:

> *"We are sex workers. Our children even get raped and people say they deserved it because their mother is a sex worker."*

Consultant Lia Andriyani writes about a female sex worker in Indonesia who had tried to supplement her income by selling a flavoured powdered milk drink. When neighbours discovered she was also a sex worker, they organized a boycott of her business, as did the teacher in the local school.

Consultant Leigh Davids writes about exclusion from religious life that comes from the stigma in mosques and churches in South Africa:

> *"Living in a country such as South Africa that still revolves around morality and religious beliefs, these children are regularly expected to ... preach to their parents with regards to their way of life. This then confuses the children and they then suffer tremendously of confusion, depression and isolate themselves from these social and potentially supportive spaces."*

Where it was reported that children do not face stigma, it was not necessarily because discriminatory attitudes did not exist in that community, but rather because parents in those cases were so good at hiding from their children that they were members of key populations. For instance, Igor Kouzmenko of Ukraine writes,

> *"Mostly parents hide this fact from their kids or kids are too small to understand."*

Mr. Kouzmenko also cites situations where either the children are too young to understand, or where they are being raised by extended family who hide their parents' drug use from the children.

Internalized stigma, often referred to as 'self-stigma' is a particular problem. Children take on the shame and discriminatory preconceptions, generalisations, and demonization that others throw at them and their parents. Their parents often struggle to cope. For instance, Janice, a sex worker in Guyana[16] said:

> *"When my daughter found out what I did for a living, she was devastated. So I try my best to give her all she needs (so as) not to think that this is all she can do."*

A female sex worker from Kenya:

> *"Discrimination should stop. I have not seen pastors' kids or teachers' kids being discriminated because of their parents' occupations. Neither have I seen nurses' kids being discriminated. Sex work is work just like any other profession. I would be more glad if people take it just like any other business and not give it a bad name tag."*

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[16] KT

Advocacy demands to address Issue 2 include:

1. **Ensuring a properly funded confirmatory exercise, engaging with the children themselves to further explore the negative effects of stigma and discrimination upon their lives**

   Due to lack of resources, and the time to engage in proper ethical reviews, the working group in this project did not consult directly with children. Instead, it consulted with parents about the needs of their children. Going forward, it is imperative to ensure that the views of the children themselves are documented, while ensuring that children are properly protected from further trauma in the consultation process. This exercise can be resource intensive and must be properly funded.

2. **Ensuring organizations develop or adapt tools for combatting stigma so that they address the stigma faced by these children**

   Much global work has taken place in the last decade to develop tools to measure or combat stigma of key population adults. The organizations doing this work must be supported to develop or adapt these tools so that they also measure and address stigma directed at the children of key populations.

3. **Ensuring—with separate funding—that organizations that undertake anti-stigma and discrimination campaigns include children of key populations in those campaigns**

   There remains the difficult work of rolling out anti-stigma and discrimination campaigns. Stigma and discrimination has demonstrably different consequences for key populations adults and their children—even though there is some overlap. Organizations must be separately funded to combat the effects of stigma and discrimination on children of key populations.

Issue 3: Lack of key population-sensitive child care, protection & safeguarding services, which fit the realities of key population parents' lives, and which are bias-free[17]

This issue was named in some way by the vast majority of consultants on this project, and fall into three categories:

1) lack of childcare, especially at night – leaving children open to neglect and abuse;
2) child neglect caused by police when arresting parents; and
3) child removal in situations not related to an objective determination of neglect or abuse.

[17] KT, DD, EN, LA, IK, LD, DN & Kate Iorpenda, a member of our working group

A. Lack of proper childcare[18]

One of the most prevalently issues raised, one raised consistently across key population categories, but most worryingly with children of sex workers and people who use drugs, was the lack of safe, affordable child care options. This was especially a problem during evening or overnight hours, when parents might be working or using drugs.

A female sex worker from Uganda said:

> *"I don't even know how many times my baby cries when am at work because I lock her in the house the whole night, am so worried that one time if the house catches fire my child will die of if thieves enter the house something wrong might happen. But again I have nothing to do because I cannot afford a maid to take care of her at night."*

And in fact some have faced grave danger left on their own. As consultant Daisy Nakato writes,

> *"The children are at times left alone in the houses where they live with their mothers irrespective of age, some babies have been burnt or chocked to death in absence of the mothers while at work. Some have been given overdose of sleeping pills that are given to keep them asleep until the mothers return from work in the morning."*

A female sex worker in Kenya describes how an accidental fire broke out in her house, and her son put it out with a book and a curtain. Later when she came home, her child reproached her:

> *"(He said), 'Mum your work is just to (go) out at night leaving me alone. Yesterday I almost died.' I went to ask the care taker but she did not know which house had fault but she knew there was a problem because there was no electricity. But the words that really hit me hard were 'Mum you know I almost died!'"*

A male sex worker in Kenya noted:

> *"Sometimes I am forced to take my young girl to stay with a lady friend who is a sex worker also, when I go for sex work in other towns in the country. When I return back I find that sometimes my daughter has fallen sick, or maybe she has not she been eating well."*

But leaving a child with a single caregiver does not always protect that child—especially if that caregivers is untrained, unscreened or unmonitored or unsupervised. A female sex worker in South Africa:

> *"My children are very young and I leave them with my neighbor but [one of my children] got raped…there was no support for me even now I never go for counseling…the person who raped my child is the son of my nanny…she denied [it] and said her son never did such a thing."*

And another South African female sex worker left her children with a nanny while going out to work, and discovered that the nanny was trafficking her child to older boys and men. She reported it to the police. As consultant Leigh Davids writes:

[18] DD, DN, LA, LD

"The police officer taking the statement then blatantly says to her, 'You now don't have money to pay the nanny. Now you're coming here to waste my time and energy in opening this docket? Or have you yourself not sold your child to one of your clients?'"

What do key population parents wish for? A female sex worker in Indonesia put it this way:

"I wish there was a sort of temporary night-care/shelter/drop in center for children of sex workers, so when the mother works, their children can be leave for temporary care and will be taken when the mother came home from work and when put to temporary daycare the child also can learn how to read, write and count."

B. Parents arrested with no plan put in place for childcare

Although this did not come up in the consultations, it was referenced in Ian Hodgson's Threats facing the children of sex workers in Myanmar and Bangladesh: a qualitative study. In it, he mentions sex workers arrested and jailed for two months without any regard by police for who might take care of or feed their children while they are in jail. Other community members must step in to care for the children.

There were several ways in which children ended up being separated from their parents, but not as a result of common mechanisms that lead to child separation in other families.

C. Child removal[19]

It is a common complaint of parents who are sex workers and people who use drugs—and sometimes of gay men and transgender people too—that child protection authorities remove children in situations where there is no neglect or abuse and the sole reason cited for removing child custody is the drug use and/or sex work of the parent, or the fact that the parent is a gay man or a transgender person.

Igor Kouzmenko of Ukraine reported another situation: his contact, a specialist from State Social Services, indicated that many children of people who use drugs are being placed in the orphanages for children with special needs. It is not known if this was as a situation where marginalized children were purposefully being housed together and out of sight, or if there was a resource issue at the heart of this decision.

Regardless, there is a widespread child protection issue that needs resolving. These services must become bias-free so that authorities only intervene in real situations of child safeguarding.

Advocacy demands to address Issue 3 include:

1. **Ensuring social welfare ministries build structures and services—informed by key population communities—that better serve the care and protection needs of children of key populations**

[19] IK

Advocacy demands to address Issue 3 include:

Key population parents need childcare options for their children that fit the realities of their lives. For instance, in the case of sex workers, safe child care (informal or formal) is mostly not available during evening and nighttime hours. Because of this and other situations, they need structures and services that will ensure their children are cared for when they are at work, and protected from people who would prey on their children because, among other reasons, those people don't value the lives of their parents. These better structures and services must be informed by key population communities.

2. **Ensuring that the children of key populations are cared for with high-quality services that prioritize and support the child staying in a family environment—family being defined broadly**

   In addition to being safe for children, high-quality services must be provided to key population families with the goal of supporting those key population families to stay together. These services must support key populations to be parents or primary caregivers, and to live as a family, in the ways that they choose. If it isn't possible for children to stay with their parents, they must be supported to stay in another safe family environment—extended family or some alternative, rather than in institutional settings, which are known to cause long-term harm.

3. **Ensuring that children of key populations are supported to be agents of change in decision-making in their own care and protection**

   We must ensure that as services and programs are developed for children of key populations, they should be actively involved, in age-appropriate ways, in decisions about their own care and protection, including decisions about what is in their best interest.

Issue 4: Exclusion from safe, bully-free educational services and opportunities from early childhood, though middle childhood and adolescence

Children of key populations face enormous barriers to staying in school and enjoying a safe learning environment—which compound the other barriers facing HIV-positive children or children from resource-poor families.

Through the different mechanisms mentioned below, parents report that children of key populations are hindered from being educated[20].

[20] KT, DD, EN, LD

A. Because of stigma, discrimination and harassment in the classroom[21]

Children are taunted and harassed by their peers, and sometimes by their teachers, for their association with their parents. For instance, Leigh Davids writes of the children of transgender parents:

> *"Teachers and fellow scholars don't understand them, bully and tease and see them as abnormal. Teachers are also not sensitized on how to treat and react to the ways of these children. This then has major effects on their daily learning and the does not allow them the education received by their peers."*

A Kenyan male sex worker with a daughter put the consequences this way:

> *"She has developed no interest in school nowadays. I have to plan how to tackle this problem…because I see she may end up dropping from school, she performs poorly in school. She is young but I noticed she has psychologically disturbed. I am equally stressed."*

A sex worker from South Africa:

> *"If my children get some of support of doing homework or food parcel and also [if] teachers [could know] about us…our children [could] be protected against stigma and benefit well from education."*

B. Discrimination from family members[22]

A gay man from Kenya told this story:

> *"My wife investigated me and discovered that I sleep with men... She told my entire family and said she can't live with kid of a homosexual... Likewise my parents said the same…but continued to stay with my kid...they refused to take him to school because he was born of a gay father. When he became a teenager he was chased away from home and was told to come to the city to look me and my husband…he was called all sorts of names…he hates me so much…he blames me for his failures in life…. I wish I didn't marry."*

C. The stigma and discrimination leads to drop-out or truancy, dropping out or changing schools frequently[23]

Because parents want to protect their children from harassment and because parents badly want their children to receive an education, there are instances of parents moving their children from school to school. But, after a while, this moving from school to school has consequences. Some parents reported that their children were missing classes or dropping out of schools where they do not feel safe.

A male sex worker in Kenya made a plea for removing discriminatory administrative barriers to bursary programs in high school education:

> *"My son finished class eight. He passed very well. I didn't have money to take him to high school…I approached government office that offers bursaries to disadvantaged children …weeeeh I was asked for my documents, including supporting letters for what I do for a living. Now, I couldn't*

[21] KT, DD, EN, LD

[22] EN

[23] KT, DD, EN, LD

I say I hustle as a sex worker and I am a man. (I) was told to produce many documents that I could hardly find to support the bursary processing. Simply I realized my son could not qualify for the bursary. I gave up. Now he is working as in small-scale farms in the village. I pity him. Sometimes I get stressed when I remember his missed opportunity for high school education."

Advocacy demands to address Issue 4 include:

1. **Ensuring that all children, including the children of key populations, have access to educational enrolment, a safe learning environment, and academic progression through their lives**

   Children of key populations, like other children deserve to be supported to enrol in school and stay in school—and to enjoy a safe learning environment so that they may progress onwards through secondary education—and if possible, beyond.

2. **Ensuring that education systems, schools and institutions provide safe, stigma-free environments, and implement policies and responses to bullying and exclusion of children of key populations**

   We must ensure schools are sensitive to the particular needs and vulnerabilities of children of key populations so that schools may protect them from harassment and bullying. In order to do this, education systems must have proper curricula, policies, trainings, and sanctions that protect these children from their classmates, from teachers, from administrators and even from other parents.

3. **Ensuring schools play a role as champions in upholding the rights of key populations and their children–and thereby: a) provide links and referrals to appropriate health and social welfare supports; b) advocate with parents; and c) generally challenge social norms and stereotypes**

   Schools must be not only safe spaces, but must advocate for children of key populations. Schools must be champions, referring onwards to supportive health and social services when necessary, and engaging in anti-discrimination and equity work that helps to transform their communities into supportive environments.

Issue 5: Legal barriers & the lack of legal advocacy support—which can lead to: a) the inability to register birth or identity, b) the problematic or forced registration of key population adults; c) criminalization of the parents d) child endangerment by authorities; and e) lack of protection from/ response to child abuse[24]

[24] KT, DD, LD, EN, DN

The legal barriers facing key population parents, including those mentioned above, have extremely negative effects on their children. This is compounded by the general lack of legal advocacy support and support services.

It is an understatement to say that the law is not on the side of key populations, and it does not seem to be doing much better by their children. The following were problems cited by the project consultants that specifically affect the children:

- the criminalization of sex work & drug use hinders parental ability to seek support;
- sex workers' inability to get insurance or open a bank account—affecting their ability to provide support to their children;
- lack of human rights protection when children or adults are discriminated against;
- laws, discrimination or fear of discrimination[25] or lack of government identification of the parent—leading to failure to register children's birth or identity; and
- disregard and harassment by police, even in the most terrible situations of child abuse.

A female sex worker from Uganda noted:

> *"My child was defiled at 5 years and I got to know the man who did it, when I went to local authorities to report the case I was told that am a prostitute and so I should not complain about what happened to my child. I felt bad that no one was willing to listen to me and I went through a lot of pain but fortunately enough when I tested my child she was HIV negative."*

Some of the hoped-for changes that parents specifically named[26] included a) decriminalization of key populations; b) human rights protection and redress of human rights abuses against parents and their children; c) reform of insurance laws to allow parents to protect their children by purchasing insurance; and d) reform of banking laws to allow anyone to collect savings and thereby provide for their children.

Advocacy demands to address Issue 5 include:

1. **Ensuring children are guaranteed their right to a birth certificate or identity document**

   Without proper identification, children are denied access to a host of services provided by the state. We must ensure children are guaranteed their right to a birth certificate regardless of the health status, drug use, identity, or work of their parents.

2. **Ensuring there are no specific requirements for key population registration based on identity, sexual orientation, health condition or gender identity—as this can in some cases have negative consequences for both parents and children**

   Because of their consequence on both key population parents and their children, laws and systems must be changed to remove registration requirements.

[25] DD

[26] KT, EN, DN, SN, DN

Advocacy demands to address Issue 5 include:

3. **Because criminalization policies have negative consequences on children of key populations, we must ensure that advocates & law enforcement entities be made aware of the child-specific consequences—in aid of furthering the aims of the broader decriminalization movement**

   As a step in alliance with the broader movement to decriminalize key populations, both advocates and law enforcement must be informed and/or trained so that they become aware of the consequences that criminalization can have on parents and on children.

4. **Ensuring that laws and law enforcement entities not facilitate the separation of children of key populations from their families, unless it is in the best interest of children, and never on the basis of key population status alone**

   Prejudices often exists in the law and in law enforcement institutions, which lead to assumptions that children are better off living without their key population parents. We must combat these laws, and institutional and individual assumptions, so that children are only removed from their parents if it is objectively and without prejudice in the children's best interest.

4. Other Issues Facing Children of Key populations

The working group's consultations revealed other issues that, while important, were not chosen as the top issue to focus on immediately. These included:

1. Dislocation from communities – moving to reduce discrimination[27]

Consultant Kinesha Thom of Guyana writes:

> *"Many sex workers (in the Caribbean) leave their villages and country to work elsewhere to reduce the discrimination."*

... and a female sex worker in Indonesia writes:

> *"After the birth of my second child, I have no choice but to bring the child to Jakarta... because of the stigma to a child whose born without a father, it will become the object of gossip, and the stigma will be attached the child for a lifetime, but I also undecided, if my child stay with me in Jakarta… then how do I work? Who will took care of her while I go to work at night?"*

[27] KT, LA, EN

2. Separation of children from MSM parents

In addition to the issue of removal of children by child protection systems because of discrimination against key population parents rather than because of abuse or neglect, the issue of MSM fathers being dislocated from their children came up.[28] MSM faced a form of discrimination from family—and sometimes fuelled by self-stigma—that leads to others raising their children, sometimes with little parental access.

Consultant Lia Andriyani of Indonesia writes about a male sex worker whose daughter is being raised by his parents-in-law, who limit his access to his child, and the information they provide to him. The only way he has to receive updates about his daughter is by monitoring his ex-wife's social media presence.

And a sex worker from Kenya noted:

> *"I had to take her to a boarding school to avoid chances of her knowing even from neighbours and when she is on holiday she goes to her grandparents. I can't allow her to know."*

3. Being part of key population group often compounds poverty—which affects children.[29]

While the many causes and effects of poverty are not intricately discussed here, what is clear from many of the reports is that the overlapping barriers and challenges that society places on key populations means that parents are often further driven into poverty, or prevented from digging out of it. This affects their children by association.

Several parents mentioned food insecurity that results in children going hungry or receiving improper nutrition, and others mentioned that it compounds their lack of access to school fees and transportation to schools and clinics, which affects their children's education and health.

4. And still other issues

Additional issues raised in consultant reports included:

- Lack of skills programs for their children[30];
- Lack of nutrition support[31];
- The needs for community centre/ activities & social support and interaction for children[32]
- The need for alternative, stable or supplementary income sources—and the vocational support to get there[33]; and
- Family reintegration services[34].

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28 EN, LA

29 IK, DD, EN, LD, KT

30 KT

31 DN

32 KT, DD, IK, EN, SN, DN

33 ED, DN

34 DN

5. Next steps: What can you do?

An expanded group of allies, brought together in Amsterdam in September 2016, is working together to develop a plan of collective action based on the top issues and advocacy demands identified in this report.

Each of the participants who jointly determined those priorities has made institutional commitments to promote this report and its issues, to gather allies, to develop tools and/or, where possible, to identify areas of potential funding for advocacy.

The working group would like to challenge all organizations reading this report to consider their role in advancing and expanding advocacy efforts:

- **Advocates**: Are you thinking of the needs of children of key population in the development of your advocacy strategies?
- **Funders**: What *dedicated* funds can you develop either for advocacy, or for programming for children of key populations?
- **Non-key population health & social support implementers**: How can you work with key population groups to identify the gaps in programming in your region, and develop stigma and barrier-free services for key population families?
- **Government policy makers**: What advocacy demands in this report are in your purview? How can you ensure an equitable response for key population families?
- **Law enforcement entities**: How can you work to reduce the barriers and harms to children of key populations posed by individual and systemic attitudes, and by punitive laws?
- **Key population organizations**: Have you consulted with parents specifically about their children? Are you providing the services they need? Have you consulted directly with their children?

Together, we will improve the lives of children of key populations.

6. Acknowledgements

The author is grateful to the working group—and the participants in the September 2016 meeting in Amsterdam—for its guidance.

The analysis of collected information couldn't have been done without the careful work of organizing and annotating raw data from surveys and from the cloud-based document folder, done by Lucy De Luca and Sofia Lyn Sicro respectively. We are also grateful to the consultants who produced reports for us

Finally, we are grateful to all the parents who shared extremely personal and sometimes painful experiences with us. We hope that this project will improve the lives of their children.

7. Contact

For questions or comments regarding this report, please contact:
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The Coalition for Children Affected by AIDS
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8. Appendices

1. Info gathering exercise #1: Surveys of service and advocacy organizations

While the working group did not have the capacity or the reach to do a proper research project collecting and analysing the activities, interests or challenges or organizations, we did send out a survey to our key organizational stakeholders – primarily the list of organizations connected to:

1. The Coalition;
2. RIATT-ESA; and
3. The key population networks that were part of the working group.

The responses were sorted into:

a) non-key population organizations primarly providing service; and
b) key population organizations.

We received 35 responses from non-key population organizations of 217 surveys mailed, and 10 responses from key population organizations, of 32 surveys mailed.

Only between one-fifth and one half of all organizations surveyed provided any services to children of key populations – with key population organizations providing more than non-key population organizations.

Many wished they could do more, but lacked either capacity, or funding to do so, and some didn't really know what exactly they should be doing.

The key message from this exercise is that there is a great untapped opoprtunity for organizations to do more, if supported and encouraged.

A. Methods

The Coalition for Children Affected by AIDS and the Regional Interagency Task Team on Children and HIV for Eastern & Southern Africa (RIATT-ESA) pooled our list of stakeholders organizations—mostly local (and some international) service organizations with children's programming. However, some key population groups providing services to families appear on this list.

We sent out a survey to a second list provided by our network partners and The Alliance—a list of organizations working primarily on key population issues, and mostly doing peer support and advocacy.

It is important to understand that this survey was only meant to be an indicatively anecdotal scan, and that there are likely other organizations doing work that we did not learn about.

The scan was done with the intention of finding out two main pieces of information:

- Of those organizations serving children, how many are working with children of key populations – or doing advocacy?

- Of those key population organizations, how many were serving children?

We sent out a survey made up of the following questions:

1. Are you providing any services or support that specifically target the children of people who use drugs, transgender people, sex workers, and gay men and other men who have sex with men affected by HIV—or specific strategies to include those children in your services or support? If yes, what are you doing (please send any documents you might have)?
2. Is your organization doing advocacy specifically on the needs of—or the stigma and discrimination against—children of people who use drugs, transgender people, sex workers, and gay men and other men who have sex with men affected by HIV?
3. If you are not providing services or support, or engaging in advocacy for these children, are you willing to or planning to take on such activities in the next year or two?
4. What are the barriers to your engaging in this work?
5. Do you know of other organizations doing this work?

The names of other organizations forwarded to us were added to the survey. If organizations sent us documents, and few did, we added them to our Review of collected documents exercise (see Appendix 2).

B. Service organization survey results

Of the child-focused service organizations, we sent out 217 surveys and received 35 responses, and only 6 indicated that they provided services specifically to children of key populations.

The following themes emerged from their responses:

1. There were a few shining examples of focus on children of key populations, but more than four-fifth had not yet designed programs or strategies to address their issues—or made them feel included in their regular programming.

2. Even fewer service organizations are doing any sort of advocacy—only three of the thirty-five.

3. Of those providing services, it was mainly school support, but some provided health care support, child care, or were advocating for rights including getting children proper documentation. A couple of organizations were providing extremely comprehensive programming on a number of fronts. For instance, SWEAT in South Africa, offers:

    a. referrals to health care;
    b. educational opportunities;
    c. legal support (relating to maintenance support, custody issues, housing etc);
    d. support with food and other consumables (clothing, nappies, etc);
    e. advocacy for the inclusion of children at shelters.

4. A good half of the organizations (17/35) wanted to provide services or do advocacy—or were planning to in the next two years. Only 5 of these 17 organizations indicated they wished to provide this type of support but either lacked funding or capacity, or were unclear how to respond. An example of an organization that wished to more was Sahara, in India, which wishes to provide the following:

a. A residential/daycare shelter that provides crèche facilities, health care, food, educational support,
b. Recreational activities;
c. Legal aid in terms of documentation that would allow children to be enrolled in government schools, health and other social welfare schemes;
d. Crisis management in emergencies (shelter in circumstances of violence, hospitalization, special needs, school fees etc.);
e. Access to and enrollment in diploma courses under sponsorship for technical and other job skill courses;

C. Key population organization survey results

Of the key population-focused organizations, we sent out 32 surveys and received 10 responses, of which 4 indicated they were focusing on children as part of their work.

The following themes emerged from their responses:

1. Though the sample is admittedly extremely small, nearly half of the organizations provided support, a much greater percentage than the general service organizations.

2. Those that provide support are offering many integrated services:

    a. psychosocial support;
    b. food and nutrition;
    c. legal support and referrals;
    d. health advocacy;
    e. school fees/ scholarships;
    f. general advocacy to deal with exclusion & discrimination.

3. Though many want to do more of this work—even those already providing support—they identified significant barriers, including:

    a. Funding/ capacity of the organization;
    b. Mobility of parents (and presumably, a lack of ability to respond to that mobility);
    c. Internalized-stigma – it was indicated that some parents are doing what they feel is protecting their children from the peer organizations that conversely want (and have the capacity) to help;
    d. Lack of government support.

D. Opportunities

The surveys showed that more organizations wanted to provide support or do advocacy than were able to do so. Some only had begun to consider it recently (some perhaps even as a result of our survey). Capacity, as always, is a barrier to small overstretched organizations

There is an opportunity: 1) for advocacy with and sensitization of organization to the issues; and 2) for targeted funding to support specialized programming.

2. Info gathering exercise #2: Review of collected documents

The working group's second information gathering exercise was a review of a Dropbox folder of documents, which had been collected by the Alliance over a 10-year period. The Alliance did some analysis of the folder, but the project stalled in that there was no momentum about what to do with the analysis.

A student sorted, classified and annotate the fifty two documents that were in that folder. The documents were of different types: some were research, others were programmatic models, some were only brief program descriptions. Consequently, comparing and analysing them was difficult.

However, the key message we can take away is that while there were some interesting pieces of research and models that jumped out, a more comprehensive literature review is clearly needed–and one that encompasses all four of the key population categories.

Another conclusion is that more primary research is needed—but research that beings from an agenda identified by key population parents, and which looks at the issues from a system perspective (much research on children of key populations analyses the behaviour of parents and is dislocated from a systems viewpoint).

A. Methods

Starting in 2006, the Alliance started collecting documents, research articles, program information and advocacy briefs that may or may not have dealt with children of key populations, but that seemed to deal with the issue based on the title—or indication from the source. The Alliance did some analysis of the folder, but the project stalled in that there was no momentum about what to do with the analysis.

As a result of our survey a few documents were added to this folder. There were fifty-two documents in total.

A student at University of California San Francisco analyzed the folder, classifying the documents in a number of way for analysis, including which ones pertained mostly to children of key populations, which dealt with both children and parents, and which did not discuss children at all. The classification also identified which key populations were the primary subject of the document—and gave a small summary of the content.

The full results of this summary are available as an appendix to this document.

B. Commentary

Forty-seven of the fifty-two documents focused in some way on children, and thirty of those focused solely on children.

Of the ones on parents and children together, a number of them were articles or documents that tend to place the blame of negative effects on children on the shoulders of key population parent—either overtly or by implication.

Imogen Byrne's thesis, 'She just adored the ground I walked on', which itself contained a literature review of research on drug-using parents, in fact points out the above-mentioned problem in other researchers' or analysts' work.

The abstract reads:

> *"While a large body of research has shown that problematic drug use does impede parenting skills, there are a wider range of experiences of functional drug using adults and their families that research has historically ignored."*

Fortunately, other researchers have examined the problem and found that society's lack of protective systems and supports are the problem. For instance, a study in Vulnerable Children and Youth Studies, 17 June 2013, by Brian Wills et al, *The health and social well-being of female sex workers' children in Bangladesh: A qualitative study from Dhaka*, *Chittagong, and Sylhet* documents the voices of older children of sex workers who found that stigmatization of and discrimination against these children and their mothers compromise their access to safe housing, childcare, health care, education, and the protection of law enforcement. They point out that the threats those children face may exceed those of other children in Bangladesh and include sexual exploitation, exploitive labor, trafficking for adoption, and forced entry into crime. And, Ian Hodgson's September 2010 study *Threats facing the children of sex workers in Myanmar and Bangladesh: a qualitative study*, calls for safer child care options.

A few articles and program interventions stand out in either:

a) calling for support to children of key populations; or
b) demonstrating by example how supports can benefits these children.

Document	**Support called for, or illustrated**
• MAMA+ intervention in Ukraine, adapted for families with drug-using parents. Provided home visits; harm reduction; treatment; counseling; social, material, psychological and legal support; assistance in accessing health and social services including opioid substitution therapy, and peer support groups. Of the 25 families, all 27 children (100% of them) at risk of abandonment or child removal stayed with their families. BUT... they identified an ongoing need to do advocacy and training with state medical providers to address exclusion from stigma. • The model of service delivery from SWEAT, a sex-worker support organization in Cape Town, South Africa. • Imogen Byrne, Unpublished BSc Thesis, School of Global Studies, Social Science and Planning, RMIT University, October 2010 'She just adored the ground I walked on': Challenging dominant discourses of injecting drug-using parents,	Multi-service family support
• Geeta Pardeshi, S. Bhattacharya, Department of Preventive and Social Medicine, SVNGMC, Yavatmal, BJMC, Pune, Maharashtra, India—India/Nepal, 2006, Indian Journal of Medicine.*Child Rearing Practices Amongst Brothel Based Commercial Sex Workers*:	Day and night shelters for children

Document	Support called for, or illustrated
• Amrita Bendi, FHI, Jan 2010 - How India's *Aastha Project Supports the Children of Sex Workers*.	
• Amrita Bendi, FHI, Jan 2010 - How India's *Aastha Project Supports the Children of Sex Workers*. • *Education as Empowerment Tool for Children of Sex Workers*, Manipadma Jena, Feb 17, 2010, Inter Press Service article. • Ian Hodgson, Save The Children & University of Dublin, September 2010, *Threats facing the children of sex workers in Myanmar and Bangladesh: a qualitative study*	Stigma-free educational support
• Amrita Bendi, FHI, Jan 2010 - How India's *Aastha Project Supports the Children of Sex Workers*.	Medical care
• Ian Hodgson, Save The Children & University of Dublin, September 2010, *Threats facing the children of sex workers in Myanmar and Bangladesh: a qualitative study*	Child care

What is clear is that a comprehensive review of published and "grey" (unpublished) documents has on the children of key populations as a group has never been properly undertaken. Such a review was beyond the resources and scope of this project. It is an imperative area for further research.

3. Info gathering exercise #3: Community consultations to document the voices of parents speaking about their children

It was critical that we heard from parents: what were the issues faced by their children? While asking children themselves would have been the ideal, ensuring that proper measures were put in place for child participation was beyond the resources of our working group. We did the next best thing: we consulted with the parents.

The purpose of the consultations was to gather the voices of parents regarding:

- the issues that their children face;
- any benefits and support given by local groups for their children (i.e. any positive stories); and
- what they would like to see to help make their children's lives better—concrete supports, or societal change.

The Project Working Group identified fourteen organizations in ten countries and commissioned community consultants. Eight reports were completed.

Consultant	Organization	Country	Community that was consulted
Ms. Lia (Liana) Andriyani	OPSI	Indonesia	cisgender[35] female sex workers & male sex workers
Ms. Daisy Nakato	WONETHA	Uganda	cisgender female sex workers
Ms. Kinesha Thom	CSWC	Guyana	cisgender female sex workers
Ms. Dudu (Duduzile) Dlamini	SWEAT - Mothers for the Future	South Africa	cisgender sex workers
Miss Leigh Davids	SWEAT - Sisonke	South Africa	transgender sex workers
Mr. Erastus Ndunda	HOYMAS	Kenya	gay men, MSM, sex workers, sex workers, both male & female
Mr. Igor Kouzmenko	ENPUD	Ukraine	people who use drugs
Mr. Sam Nugraha	PKNI	Indonesia	people who use drugs

The consultants' task was to choose their own most appropriate methodology from amongst: individual surveys; interviews or focus groups; or a combination of these. They were then to ask parents in their communities the following questions:

1. What issues are your children facing?
2. Are your children receiving any benefits and supports from local groups?
3. What do you need to help make your children's lives better?

The results of these consultations are woven through the detailing of issues contained in the main report.

4. Participants in the advocacy planning meeting, September 28-30 2016, Amsterdam, The Netherlands

In alphabetical order by family name, the participants in that meeting were (members of the working group are indicated with a single asterisk, and the community consultants who attended the meeting are indicated by a double asterisk):

1. **Ms. Anurita Bains**, HIV/AIDS Regional Advisor, UNICEF-ESARO
2. **Mr. John Barnes**, Executive Director, Funders Concerned About AIDS
3. **Ms. Niké Buijze**, Policy Officer Sexual Reproductive Health and Rights, Ministry of Foreign Affairs, Government of the Netherlands
4. **Ms. Machteld Busz**, International Program Manager, Mainline - Drugs and Health
5. **Ms. Corinna Csáky**, Coalition Manager (as of October 2016), The Coalition for Children Affected by AIDS
6. **Ms. Anke van Dam**, Executive Director, AIDS Foundation East-West (AFEW)
7. **Ms. Duduzile Dlamini****, Community Consultant, SWEAT – Mothers for the Future (South Africa)
8. **Ms. Yvette Fleming**, Manager STOP AIDS NOW! Programmes, STOP AIDS NOW!/ AIDSFonds
9. **Ms. Janneke Fokkema**, Policy Officer, Ministry of Foreign Affairs, Government of the Netherlands

[35] Referring to people whose gender self-identity conforms with their sex at birth; i.e. the opposite of transgender.

10. **Ms. Olga (Olya) Golichenko**, Senior Adviser: Harm Reduction Advocacy, International HIV/AIDS Alliance
11. **Ms. Noreen Huni*** -- attending by phone, Executive Director, REPSSI & The Coalition for Children Affected by AIDS
12. **Ms. Kate Iorpenda***, Senior Advisor: HIV Children and Impact Mitigation, International HIV/AIDS Alliance (until Sept 2016) & The Coalition for Children Affected by AIDS
13. **Ms. JoAnne Keatley***, Former Director, Center for Excellence in Transgender Health & Chair, International Reference Group on Transwomen
14. **Mr. Dominic Kemps**, Director, ViiV Positive Action for Children Fund
15. **Mr. Kent Klindera**, Key Populations Advisor, Office of HIV/AIDS / Global Health Bureau, USAID
16. **Ms. Els Klinkert**, Senior Health Advisor, Ministry of Foreign Affairs, Government of the Netherlands
17. **Dr. Jay Levy***, Acting Executive Director, International Network of People who Use Drugs
18. **Ms. Laura Martelli**, Chargée de programme populations exclues (Program Officer, Key Populations), Sidaction
19. **Ms. Julie McBride**, Policy Officer -- Bridging the Gaps, AIDSFonds
20. **Ms. Maartje van der Meulen**, Policy Officer, Ministry of Foreign Affairs, Government of the Netherlands
21. **Ms. Ruth Morgan-Thomas***, Global Coordinator, Global Network of Sex Work Projects
22. **Mr. John Miller***, Coalition Director (until end October 2016), The Coalition for Children Affected by AIDS
23. **Ms. Daisy Nakato****, Community Consultant, WONETHA (Uganda)
24. **Mr. Erastus Ndunda****, Community Consultant, HOYMAS (Kenya)
25. **Ms. Omosalewa (Salewa) Oyelaran,** Orphan and Vulnerable Children Program Specialist, Office of Global Health and HIV, Peace Corps
26. **Ms. Maria Phelan***, Deputy Director, Harm Reduction International
27. **Dr. Meena Srivastava**, Medical Officer specializing in PMTCT and Pediatric HIV, USAID
28. **Ms. Kate Thomson**, Head, Critical Enablers & Civil Society Hub, The Global Fund to Fight AIDS, Tuberculosis and Malaria
29. **Mr. Mark Vermeulen**, Programme Manager -- Bridging the Gaps, AIDSFonds

5. Other Documents Referenced

The following documents are available as separate documents (for copies, contact the Coalition for Children Affected by AIDS):

1. Raw Survey Results-Organizations about Children of Key Populations - Aug 2015.xlsx
2. Survey roll-up -Organizations about Children of Key Populations - Aug 2015.docx
3. Document review classification and summaries - children of key pops - Nov 2015.xlsx
4. Consolidated consultant reports - children of key pops - June 2016