

The time is now: closing the pediatric treatment gap and building resilience among female sex workers and their children

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Motherhood is common among female sex workers (FSWs) and many have at least one biological child. Preventable mother-to-child transmission of HIV can occur given poor uptake of contraception coupled with high rates of unintended pregnancies among FSWs. Globally, there are 2.1 million children living with HIV, and antiretroviral treatment coverage is dismally low at 43%. Without timely diagnosis and treatment, half of all children born with HIV will die by the age of 2 years. By integrating services for key populations and their children, prevention of mother-to-child transmission of HIV uptake among FSW mothers and early infant diagnosis can improve and therefore reduce transmission of HIV. This field note addresses the needs of FSWs and their children, and advocates for programs to develop and scale up comprehensive, integrated, stigma-free services for this vulnerable population. Sensitive, confidential, child-friendly, tailored services that protect FSWs while addressing their children are essential to saving these young lives and breaking the transmission cycle of the virus. By siloing programs that neglect children of FSWs, we are missing opportunities and existing entry points to take an innovative, holistic, family approach to care, support, and treatment services that could improve outcomes. Given the high prevalence of HIV in FSWs and other stigmatizing factors which affect access to services, children of FSWs can no longer afford to be left behind and the time is now to prioritize them in current and future HIV programming.

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In the parking lot of an auto garage in northern Tanzania sit three pop up tents. Except for a sign in front of the tents, they are relatively inconspicuous. Mechanics on the lot glance over at the tents occasionally, but otherwise go about their work. Inside these tents, 20 young women hold small

children in their laps and attentively watch a peer educator demonstrate proper condom usage. These women are at their workplace too, but they are not mechanics. This auto garage functions as a ‘hotspot’ – a site where female sex workers (FSWs) meet a majority of their clientele.

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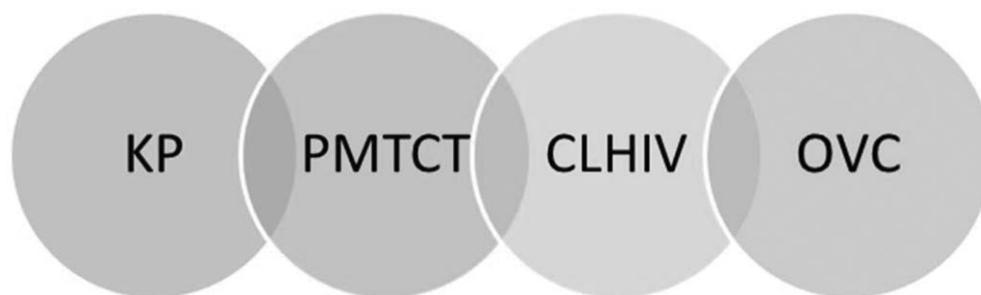


Fig. 1. Family dynamics and household HIV risk. Family-based approaches should build upon current service delivery platforms through integration of KP, PMTCT, Pediatric HIV and OVC services resulting in strengthened adult, adolescent and pediatric clinical cascades and reduced impact of HIV on families. KP, key population; OVC, orphans and vulnerable children; PMTCT, prevention of mother-to-child transmission.

On this day, the peer educator is halfway through a core curriculum of 10 classes designed for FSWs that focus on family planning, sexually transmitted infection services, and HIV testing services offered through a local non-government organization [1]. Motherhood is common among FSWs and many have at least one biological child. Preventable mother-to-child transmission of HIV can occur given poor uptake of contraception coupled with high rates of unintended pregnancies among FSWs [2]. Globally, there are 2.1 million children living with HIV (CLHIV), and antiretroviral treatment (ART) coverage is dismally low at 43% [3]. Without timely diagnosis and treatment, half of all children born with HIV will die by the age of 2 years [4,5]. For these reasons, HIV-positive FSWs at the hotspot were asked to bring their children for testing. If children are HIV-positive, they are linked through an escort referral to the health facility for life-saving ART and enrolled in orphans and vulnerable children (OVC) services. Finding these children is just the first step, as FSWs are sometimes reluctant to provide consent to test their children. A positive test for the child likely means addressing multiple dilemmas: a positive test for the mother, something that many of these women do not want to confront, judgement from health service providers, accusations by child protective services, or worse. Stigma against people living with HIV is often high, and disclosure of a positive HIV test could potentially ruin business for an FSW, resulting in loss of the main source of income for her family. Yet, the consequences of not testing a child for HIV are life or death. By integrating services for this key population and their children, prevention of mother-to-child transmission (PMTCT) uptake among FSW mothers and early infant diagnosis can improve and therefore reduce transmission of HIV. Integrating services also makes it more likely FSWs will trust providers and use them. Figure 1 depicts program areas that reach FSW mothers and their children to better understand family dynamics and household-level HIV risk.

During focus group discussions in Cameroon, Tanzania, and Ethiopia, FSWs are extremely forthcoming with the

struggles they combat in their work and personal lives. They speak candidly about their exposure to extreme vulnerabilities and stigma within the community for both themselves and their children; they cite food insecurity and paying school fees as major challenges, along with violence and lack of childcare. An FSW revealed that she had been physically abused the night before; her client did not want to pay the initial amount agreed upon and she tells the group, 'I didn't get cash money, but I got beaten last night.' FSWs feel they have no recourse and avoid seeking assistance from the police or any authority, including health providers, both because of the illegality of their sex work and concerns with inadvertently reporting a client. Stigma runs rampant through communities, affecting both economic opportunities and access to HIV testing and treatment services for FSWs and their children. FSWs have attempted to quit sex work through the creation of savings and lending groups, but failed when their community refused to patronize their businesses or allow access to local credit. The sense of urgency is clear as FSWs desire services and economic opportunities they can trust.

Children of FSWs face high levels of stigma, double burdened by their mother's HIV status and profession. Some FSWs self-stigmatize and hide their work from their children, leaving them at home or with other caregivers. Concerns for fire, rape by intruders, kidnapping, and exposure to abuse, violence, and exploitation are significant, yet FSWs report they have few options as there are no child care services available in their communities. Because FSWs experience stigmatization and discrimination in healthcare facilities, they are reluctant to seek antenatal care for themselves and services for their children. Missing out on standard HIV screening and PMTCT services significantly increases their child's chance of acquiring HIV, and without proper diagnosis and treatment, these HIV-exposed infants experience high rates of mortality, morbidity, and vulnerability. Without knowing the HIV status of a child, it is impossible to access life-saving treatment.

A combination of efforts is needed to prevent and treat HIV infections among children and ensure that their FSW mothers remain healthy. Community support systems are invaluable to effectively support FSWs and their children, and ensure that they have access to HIV and OVC services for clinical and psychosocial support, including services such as HIV self-testing and differentiated models of care. Current models include an outreach approach where FSWs and their children who test HIV-positive are immediately enrolled in care at the same testing point and supported with adherence counseling, which improved linkage and retention in care. Sensitive, confidential, child-friendly, tailored services that protect FSWs while addressing their children are essential to saving these young lives and breaking the transmission cycle of the virus. By siloing programs that neglect children of FSWs, we are missing opportunities and existing entry points to take an innovative, holistic, family approach to care, support, and treatment services that could improve outcomes. Given the high prevalence of HIV in FSWs and other stigmatizing factors, children of FSWs can no longer afford to be left behind, and the time is now to prioritize them in current and future HIV programming.

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