Meeting Report

The Road to Melbourne: Young Children Born into HIV-affected Families

Meeting #2: Successful and Promising Approaches to Meeting the Holistic Needs of Young Children Born Into Families Affected by HIV and AIDS

a meeting held at the Premier Hotel Cape Manor, Cape Town, South Africa, December 5-6 2013, organized by the Coalition for Children Affected by AIDS and co-hosted by the Eastern & Southern African Regional Inter-Agency Task Team on Children & AIDS, and UNICEF

February 5 2014

The authors of this report, Janine Ward, Kate Iorpenda, Lisa Bohmer, Stuart Kean, and John Miller wish to thank the meeting organizers, co-sponsors, presenter and participants for their contributions.

Executive Summary

Now, more than ever, there is need to reach young children affected by HIV and AIDS. We know that the first five years are pivotal. They're pivotal because of the brain development that occurs and because with early learning efforts to stimulate young children, combined with adequate nutrition and health, children do better in school and can become more productive adults, which can break the cycle of poverty. At the same time, we know that HIV poses a biological risk for child development and that HIV exposed and infected children experience higher rates of development delays. Despite this need and opportunity to reach children from birth to five years, many at risk children are going unnoticed – and there is a critical service gap for infants and very young children.

The Coalition for Children Affected by AIDS ("The Coalition") believes that children born into HIV-affected families need to be made a higher priority in the international response to HIV and AIDS. Our 2012-2014 'Road to Melbourne' meeting series focuses on early interventions for children born into HIV affected families. Its three meetings focus on:

1. the research and policy landscape (New York meeting, May 2013),
2. country-level programmatic evidence (Cape Town meeting, December 2013) and
3. policy implications of the evidence for advocacy (London meeting, February 2014).

The findings and recommendations from these meetings will feed into the Coalition-Teresa Group's symposium in Melbourne in July 2014 - http://www.teresagroup.ca/melbourne/ - the 2014 Global Partners' Forum on children and the XXth International AIDS Conference –AIDS 2014.

This report summarizes the second meeting in Cape Town, which focused on promising approaches for integrated programming for young children born into affected families. It brought together implementers, government officials, researchers and donors. Presentations and discussions also examined what has worked and what has not been successful as well as structural barriers and opportunities to scale-up programs. Key themes and recommendations from the meeting are summarized below:

Multiple entry points to integrated interventions: There is need to break down silos to deliver integrated services that place vulnerable children and families at the center. Integration can start with one entry point that other services are added on to. Efforts to prevent mother-to-child transmission of HIV (PMTCT) present an ideal entry point for early identification of HIV infected and affected children and greater promotion of infant well-being. However, there are many opportunities to integrate services at community and clinic levels within the health system, approaches to early childhood development (ECD) and the system of services for orphans and vulnerable children. Promising approaches exist and there is need to accelerate and scale these efforts.

Reaching the youngest children from birth – three years of age: the youngest children are often not reached by existing programs, meaning that they face adverse outcomes for health , education and general well-being. Much greater priority should be placed on reaching both parents/primary caregivers and the youngest children.

Key Populations: children of key population such as sex workers—particularly young children—have been largely invisible and ignored and services may be stigmatizing. There is need to ensure

that ECD services reflect the needs of sex workers in a non-judgemental manner. Peer support to mothers who are sex workers should be included as should positive role modelling by parents from key populations to promote self esteem.

Workforce development: there is need to look at ways to ensure that there is a sufficiently trained and resourced workforce to deliver integrated interventions to vulnerable children and families. This requires increased investment on the part of government to professionalize the work force – for example parasocial workers and increased collaboration between government and civil society organizations to address the questions regarding appropriate payment or stipend for volunteer community workers.

Stronger linkages between government and civil society: civil society can play many roles to advocate for early childhood development interventions and to convince governments to increase their commitment and investment. It is critical to identify and support strong government champions that may include First Ladies.

Advocacy: There is need for advocacy efforts at community, national and global levels utilizing a variety of for a including drama, community radio, TV….Advocacy is needed to increase awareness and demand.

There is growing interest in integrated interventions with multiple outcomes. For example there is recognition that by addressing early childhood development, health and nutrition within communities affected by HIV and AIDs, there is opportunity to identify more HIV exposed children and to ensure that they access and are retained in HIV care and treatment. At the same time, there is opportunity to better integrate interventions targeting HIV positive mothers and children, to ensure that they have what they need to survive and thrive.

Health services must better integrate services so that when a young child is brought to a health facility, they have access to all relevant services across the HIV and AIDS, nutrition, health and development spectrum.

Overall, while there are many promising developments towards more integrated service provision for young children born into HIV affected families, there are many yet untapped opportunities to integrate services within both communities and clinic settings, requiring greater efforts from both governments and civil society organizations. At the same time, there is need to put more resources and emphasis on training and mentoring to better equip the work force as well as caregivers and to engage communities to increase awareness for and demand for services, while empowering them to play greater roles in supporting more optimal early childhood development. A key aspect of the effort to integrate services centers on the need to break down program silos that exist between HIV and AIDS; maternal and child health, child protection etc. Integrated programs require broader objectives and outcomes, coordination among donors and provide the opportunity to achieve double or triple dividends as HIV and AIDS free children are able to not only survive but to thrive within stronger families and communities.

I. Introduction

Now, more than ever, there is need to reach young children affected by HIV and AIDS. We know that the first five years are pivotal given the brain development that occurs and that with early learning efforts to stimulate young children, combined with adequate nutrition and health, children do better in school and can become more productive adults, which can break the cycle of poverty. At the same time, we know that HIV poses a biological risk for child development and that HIV exposed and infected children experience higher rates of development delays. Despite this need and opportunity to reach children from birth to five years, many at risk children are going unnoticed.

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These Road to Melbourne meetings build on the previous Road to Washington series that focused on community engagement for improving PMTCT outcomes, drawing out programmatic implications and promoting a more integrated HIV response to strengthen the synergies between PMTCT services and protection, care and support services for children and their families.

The second Road to Melbourne meeting (the subject of this report) brought together a diverse group of people representing Community-based Organisations, national government departments, national and international NGOs, donors and academics, and was convened by the Coalition in partnership with UNICEF and RIATT. It was held in Cape Town from 5 – 6 December 2013. The objective of this meeting was to afford implementers the opportunity to share successful and promising practices, with a view to this better supporting programming at the national level. Discussions at this meeting will also inform the Coalition's advocacy discussions in the third meeting to be held in London in February 2014.

Meeting objectives:

- To share promising approaches and models for integrated programming for young children born into affected families;
- To examine the existing evidence for what works as well as for what has not been successful;
- To identify structural barriers to integrated early childhood programming and avenues for overcoming them; and
- To understand what it takes to scale-up integrated programmes to reach more of the young children and families that need them.

II. Emerging Themes:

Several key themes emerged during the meeting, all of which are presented below.

A. Multiple entry points to integrated interventions
   - The Health System
   - The Early Child Development System
   - The OVC system

B. Working with children 0-3 years old
C. Working with children from key populations
D. Government and civil society partnerships
E. Workforce development
F. Capacity building and training for organisations
G. Advocacy

A. **<u>Multiple entry points to integrated interventions</u>**

It is encouraging that more implementers across the globe are iproviding integrated services in an effort to increase access tocare andservices for children born into HIV-affected familiesand to break down the service silos that have long existed.. Progress is being made to address critical service delivery gaps forchildren in the crucial yeasr of 0 to age six, although there is much more to be done. Some of the implementers attending the Cape Town “Road to Melbourne” meeting are using one service as an entry point to one or more other types of services which are often previously provided in isolation. There are many approaches in use that provide examples that others may learning from.

The entry points can be grouped into three categories:

- **The Health System**, including:
  - PMTCT services;
  - Early infant diagnosis/treatment (EID);
  - Pediatric treatment/ARV programs;
  - Maternal, newborn and child health services (MNCH);
  - Early nutrition/ infant and young child feeding programs (IYCF); and
  - Both clinic-based services and community level services provided by community health workers.

- **The Early Child Development System**, including:
  - Parenting programs;
  - Child care services; and
  - Preschool education and stimulation programs.

- **The Orphans and Vulnerable Children System,** including:
  - Orphans & vulnerable children (OVC) programs;
  - Child protection programs;
  - Economic strengthening & social savings schemes;
  - Programs strengthening caregivers; and
  - Palliative care services.

Examples of programming presented in Cape Town that fit into these categories appear in the section below. A full list of successful practices presented at the meeting is contained in the appendices.

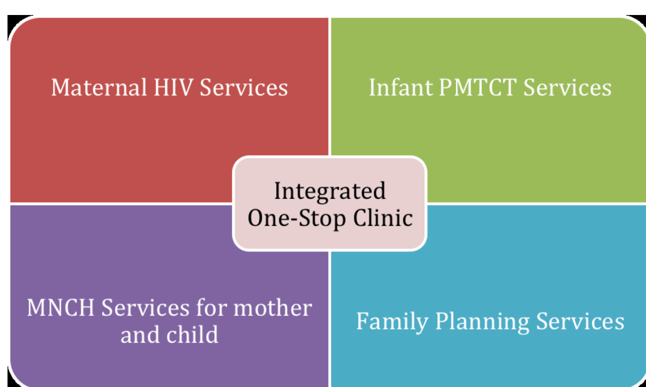
1. The Health System

We know that to reach children and families and to avoid loss to follow-up, clinical services cannot work in isolation. The following services are using health services as entry points to reach affected children from pre-pregnancy to age six, and in doing so are reaching and supporting their caregivers and identifying and enrolling other siblings in the household into care and support. There are important opportunities to address multiple health and development issues as part of clinic visits and home visiting efforts. Antenatal care programs provide opportunity to address parenting and child development.

For example:

In Malawi, **Abwenzi Pa Za Umoyo** integrates paediatric HIV services into nutritional programmes. All children (from 1 – 12 years old) entering the nutritional programme are tested for HIV; all children under 24 months whose mothers test HIV positive are DNA PCR-tested; malnutrition screening has been improved in community as well as mobile HTC services, and all village Health Workers have been trained in malnutrition screening and HIV testing education. This integrated approach has led to an increase from 5 people on ART in 2007 to an impressive 5,448 ART patients in 2013. The training of village Health Workers has been integral in ensuring this success, as community-based patients are more easily reached and the same message addressing stigma is delivered at all levels of the health service spectrum.

In Rwanda, **Inshuti Mu Bushima, working with Partners in Health,** found that separate and disintegrated health services contributed to higher rates of vertical HIV transmission,, fertility , and morbidity and mortality, and lower retention in care, for mothers living with HIV and their infants.



The Combined Clinic for HIV-Exposed Infants is a model of integrated services to reduce obstacles to care for the mother-infant pair in order to improve retention in care and thereby decrease morbidity and mortality for both mother and infant. Since November 2010, Partners In Health has supported 37 public health facilities to integrate services . As of October 2012, 973 mother-infant pairs had been served by these clinics.

In Zambia, **the Elizabeth Glaser Pediatric AIDS Foundation** has connected HIV care within primary health care services to early childhood development services to screen and treat young children for developmental delays – the first service of its kind in Zambia. "Survive and Thrive Units" have been established in two clinic compounds and clinicians have been trained to screen children for delays while volunteers to door-to-door to promote ECD and refer children

experiencing delays to the units. Specialists provide needed therapies and parents receive education on cognitive, social and physicial development.

2. The Early Child Development System

Integrated early childhood development (ECD) interventions that include attention to both the biological and psychosocial risk factors are critical for addressing inequality and helping children develop to their full potential. Early childhood is a time of rapid biological development that is supported by positive early care that provides strong foundations for physical, psychosocial, social and emotional development. Within communities and families affected by HIV development of children in their early years can be hindered. The impacts of parental illness and death, economic hardship, social exclusion as well as the potential impacts of HIV exposure to brain development can negatively affect young children.

ECD systems (that may be delivered both formally by governments and informally via the efforts of communities and civil society organizations) address this critical period by providing enriching, protective and nurturing environments and interventions to maximise children's development. Much of this is done through the child and caregiver relationship in home settings and provide entry point to holistic programming for young children. In addition, formal and informal pre-school centres may exist and provide other opportunities to reach both children and caregivers with a range of needed services.

The following programs have used services in the ECD system as entry points to other services, thus extending their reach to include other siblings and their parents, or to provide other necessary services for young children born into HIV-affected families.

For instance:

LETCEE, South Africa focuses on providing accredited training for ECD workers who visit homes on a weekly basis in rural KwaZulu-Natal, and offer learning through play, parenting support and nutrition and health education, screen and referral. These home-based ECD services are further strengthened through community Toy Libraries.

A summary of LETCEE's interventions is included in the table below:

Early Education	Early cognitive stimulation Social skills	Pre-school activities with a variety of toys and equipment Play sessions at Toy Library with bigger group of children
Parenting support	Strengthening empathic relationships Non- violent discipline	Weekly group workshops Modelling and discussions
Nutrition	Improve family food security Screen for malnourishment	Assist to establish food garden Monthly food parcels Regular weighing and measuring of children
Health	Disabilities and illness IMCI Maternal	Inclusion of all abilities in programme Encourage and assist with referrals to hospitals and clinics Encourage treatment adherence Share information with caregivers Encourage early clinic visits Screen for depression
Protection	Awareness	Community meetings and conversations to raise

		Safety	awareness of children's rights Links with government services	

Episcopal Relief & Development with Zambia Anglican Council, Zambia, have established 53 community based early childhood centers within three provinces and built a wide range of services around them. Children under five years attend the centers weekly, caregivers receive support – including income generation opportunities, home visiting ensures that vulnerable families are connected to needed services. Linkages with the Ministry of Health mean that HIV testing, counselling and referrals are available periodically at the ECD center as well as growth monitoring and provision of bed nets. This program will soon scale up to a total of seven provinces in Zambia. It is working to mentor and support a large cadre of volunteers.

3. The Orphans and Vulnerable Children System

Many OVC services have failed to capitalize on opportunities to link with services that could provide a whole-child/ whole family approach. Others enroll children too late, missing opportunities to work with pregnant women or with families during the critical early years from birth to age three. There is also acknowledgement that there is need to ensure that vulnerable young children have access to health services that include HIV testing and treatment.

The following implementers at the Cape Town meeting are examples of integrated OVC programs :

The Tanzania Home Economics Association (TAHEA)--with the Firelight Foundation, works with vulnerable children and families in Tanzania's fishing communities of the Mwanza area. TAHEA starts by mobilizing communities to build trust and awareness of the importance of early childhood development and focuses on strengthening the entire family by supporting community managed micro finance (including access to soft loans, a building fund for ECD, and a housing fund). Early childhood services are provided via childcare centers and pre-primary classes that are fully funded and managed by the community. Health and nutrition services are also provided and these services combine to create improved income levels and quality of life for households, which in turn have led to improve care and education for vulnerable children. The average household income grew by six times in the first four years of the program.

PATH has extensively adapted the Essential Package model produced by CARE, Save the Children and the Consultative Group on Early Childhood Care and Development and the Care for Development model developed by UNICEF / WHO, in working with vulnerable caregivers and children from pregnancy to age 5 years. Toys and visual aids have been developed using locally available and appropriate materials, and trained community workers visit caregivers and children in their homes to deliver integrated messages. Caregiver practices are explored and improved activities are sensitively suggested, with much encouragement and support. The programme in Mozambique has also developed a planning tool for care workers to prepare their visits. The integration of HIV and ECD means care workers have increasing amounts of messages to deliver and observations to make that can be overwhelming. The planning tool helps them select targets for each household visits of key messages for families and specific measures of development and health status to focus on.

B. Working with the youngest children, aged 0-3

Much has been achieved in the response to HIV and AIDS, particularly in prevention and treatment. There is a more integrated response to children affected by AIDS, from treatment to social protection to care – however, millions of families and children continue to be affected by the social and other challenges associated with the long-term treatment of HIV as a chronic disease globally.

In particular, responses exist from pregnancy to infancy and from childhood to adolescence, but there is a large gap in services for care and support services for children from birth to aged three; the youngest children are less likely to access HIV treatment and children from birth to age three across the board are less likely to access early child development services. Many equate early childhood development with pre-school and there is limited understanding regarding the developmental needs of young children and effort to education caregivers regarding early stimulation. More emphasis must be placed on preventing harm, rather than waiting for a child to face hardships and then require intervention. These children will grow up to become the parents of the future; therefore a comprehensive 'whole-life' response is required, rather than the current situation where interventions exist at certain life points only.

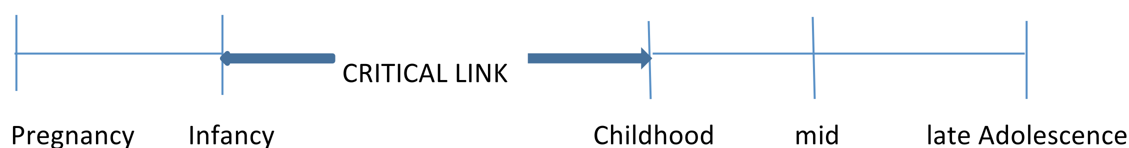


Figure 1: Making the link – preventing harm

Making the link in this period is critical to ensuring that children affected by AIDS enjoy long-term health and wellbeing – this period being the foundational stage of brain development. Risk factors affecting the child could include economic hardship, abuse, an ill caregiver and poor access to services. Overlapping risk factors create greater risk, and the more risk factors present, the more negative the impact on the child. More emphasis needs to be placed on the role of parents and community caregivers – these are the people who engage with the youngest children on a daily basis and are with them most often. Investing in training and capacity building programmes that improve the skills of these key people in the lives of the 0 -3 age children is critical to ensuring the continuum of care.

Multiple entry points exist for reaching this critical target group, and much can be achieved by engaging in dialogue about ECD with the personnel involved at these entry points. There are opportunities to integrate within the formal health care system, including "prenatal touch points" where there is natural interest in care and development. For example, there are opportunites to include care and development messages as part of new mother support groups and peer support for HIV positive women in PMTCT programs. Training is needed to address the limited knowledge of healthcare staff on ECD. Awareness creation is also needed within the community to stimulate demand and to build upon the positive childcare practices that exist in every community. Primary caregivers are critical for education and support.

Hope Worldwide conducts accredited training in:

- ✓ parenting (5 day)
- ✓ play and development (1 day)
- ✓ ECD parenting (1 day) – focused on building caregiver self-esteem, positive parenting and basics of ECD

C. Working with young children from key populations

The challenge in working with young children from key populations is that because of stigma, discrimination and criminalization of their parents, these children are not easily found through mainstream health and welfare services (ANC, PMTCT, MNCH and ECD, etcetera). Children of key populations need to be reached in the early years, just like any other children, through *trusted* community-based organisations, preferably led by key populations themselves, and integrated into existing support services. For instance, support groups for sex worker mothers, led by sex workers themselves, could be integrated into other services for their children—services free of stigma and discrimination.

Training and capacity building are required to deal with specific needs, and that provide knowledge and dispel myths about key populations–this is however difficult in criminalized environments. Examples of capacity-building topics include breastfeeding and drug use, supporting sex workers through pregnancy, childbirth and early infancy,and pre-service and in-service training to change general attitudes about sex workers and their right or ability to parent.

"I am a parent first!"
Champion message for key populations

The fact that little evidence was available about working with young children from key populations was offered as a challenge to the Cape Town meeting participants by **Sisonke Sex Workers' Movement, South Africa**. Stigma and moralistic attitudes prevail amongst service providers and criminalization remains a stumbling block. Some Cape Town meeting participants admitted openly to never having considered the the fact that sex workers had children.

Programmes working with young children of all key populations should focus on promoting the self-esteem of the parents, and creating an environment where the children of key populations are seen in the same way as children of any other populations.

D. Government and civil society partnerships

Government ministers and civil society members of three countries were represented (Malawi, Tanzania and Zambia), and a robust panel discussion highlighted the areas where collaboration was working well to improve integrated interventions for HIV-affected children, and to identify areas where more emphasis was needed.

In all three countries, relations between government and civil society have improved, with Zambia realigning and renaming its ministries in order to create an enabling environment. Furthermore a new ministry (Ministry of Chiefs and Traditional Affairs) has been established in Zambia – a ministry which has proven to be a powerful resource for change at the community level. In Malawi, the ECD policy is integrated and all departments are equally important. The Essential Package developed by Save the Children Fund is available online and provides vital community-based support to identify children's individual needs. In Tanzania the ECD services are provided through partnerships between government, NGOs, CBOs and ECD networks using a multi-sectoral approach.

Whilst there has been improvement, the challenge remains in filtering the integrated approach adopted at national level down to community level structures. Civil society representatives feel that government is taking too long to implement the approach at community level. Although an individual may hold a key ministerial position, he or she may not be the key driver for change in that

ministry. Civil society members struggle to identify who the key person in a ministry is – a process which can seriously delay implementation on the ground.

On the other hand, CBOs acknowledge that their own organisations sometimes duplicate services because of a lack of coordination with other CBOs. The age-old challenge of limited funding and resources continues to create tension and mistrust between government and civil society, as the two sectors compete for the same resources. The meeting was challenged to view local resources differently and to start with what countries already have.

> **A tree is not just there for charcoal – when you look at it, see pencils and rulers too!**
> - Prof. Nkandu Luo, Min of Chiefs & Traditional Leaders, Zambia

The following comments emerged from small group discussion:

Regarding government roles and engaging with government officials and politicians:

- We must have policies, structures and plans in place (critical architecture) for things to move forward—government has an important role to play in advocating for ECD policies and plans to be in place.
- We need real macro-level arguments for investments in ECD—long term return on investing in young children leads to healthier more productive populations—increased employability of population.
- We should not underestimate the importance of Treasury, Finance or Planning ministries in getting government to invest. We should invite them to meetings and make more efforts to involve them and convince them; we need a management plan in place that can get funded—there needs to be a line item in the budget; ideally you get line items in the budgets of each relevant ministry.
- It is critical to identify the specific individuals who can be change agents in different government ministries especially MOH, which is arguably most critical ministry for ECD for younger children; find your champions (or First Ladies with a foot in each ministry); identify your advocacy target groups and advocate for Ministries to designate a point person at the right level with whom civil society can work.

Regarding community's and civil society's role

- Civil society and government players need to define their expectations and understand their complementary roles; then engage in joint planning and joint financing of integrated interventions for the benefit of the child.
- Civil society can play an excellent role in using data and compiling evidence that can help government to be convinced that investment in ECD and action is important; civil society can conduct trials.
- Civil society needs to work together through a communication strategy to agree on a coherent government engagement strategy so that we are not furthering fragmentation tendency.
- At the community level, the structures and linkages are there, but there is a disconnect between communities and policy makers. Civil society has an important role in being the connector or bridge.
- Link the civil society programme data and reporting into government data collection and coordination systems; feeding into the National MIS/HIS systems.

- Linkages with the community health workers and volunteers are important to achieve integrated services at household level.
- Build linkage between health system and volunteers/community-based programmes through such things as child health days, using volunteers for education and counselling at facilities
- Strengthen the referral systems from the community to health and social welfare services; work towards a feedback loop; standardized referral form that includes space for feedback that goes back to the household with the client

E. <u>Workforce development</u>

The need for workforce development came up frequently during the discussions. A very diverse work force addresses the needs of young children - social workers, health professionals, volunteer community caregivers and teachers. Discussions revolved around the challenges of building competency Iacross all thedifferent sectors noted above in order to improve program quality and achieve the goal of improving development outcomes for young children . In addition, participants grapplied with the issue of whether we should be relying on volunteer efforts as opposed to paid community workers.

There was consensus regarding the importance of properly developing a workforce in order to successfully reach young children born into HIV-affected families with impactful programming. Key considerations were:

i. **To pay or not to pay -** The vast majority of program implementers rely on unpaid community volunteers to provide services to vulnerable children and families. These volunteers are most often vulnerable themselves and they must balance the struggle to provide for their own families with the demands of caring for a frequently large caseload of children in home visiting programs or center-based pre-school. Training and on-going mentoring efforts are often weak in the case of community volunteers and turnover is frequently high. As a result, program quality may suffer. Participants asked – given that this work is so important, should we be relying on poorly paid and trained volunteers? In addition, given that these volunteer are facing economic hardship: is it fair not to compensate them?

> **Elizabeth Glaser Pediatric AIDS Foundation in Zambia** has an innovative way to compensate volunteers – performance-based asset transfer (purchase of goods/ supplies for volunteers that can enhance their lifestyle). But, in the broader sector, the debate continues as to what kind of volunteer services should be properly compensated, and which might retain special characteristics because of their voluntary nature. Meeting participants agreed that we need to move to making basic services remunerated.

ii. **Professionalizing the workforce** – training, certification and payment could form part of a development strategy to grow a more professional and respected body of workers, and improve quality standards. Suggestions were made for a specfic cadre focused on the youngest children- community child care workers. Examples of this approach were provided by two organizations participating in the meeting: LETCEE and Isibindi – both working in South Africa. While this offered dedicated resources concerns were raised about creating further silos, given the need to ensure integrated, multi-secotral programming.

iii. **Capacitating existing ECD workforce** – Participants also discussed opportunities to provide training tailored to the needs of community volunteers such as the certificate programs offered by REPSSI. A key challenge relates to how to ensure that community workers receive the training and on-going mentoring necessary to develop the skills to better support children and families facing multiple challenges, and to model approaches to engaging infants and young children to foster optimal development.

iv. **Mainstreaming ECD in other professions** – ECD is a cross-cutting issue that could be integrated into other professions such as social work, teaching and health care.

> **Isibindi,** in South Africa, is integrating ECD training into its child and yough worker training – and then using child and youth care services as an entry point to do early stimulation, but this is just one organization – a system-wide approach is needed, so that workers in one profession are taught cross-cutting skills.

F. Capacity building and training for organisations

Organisation-level capacity-building and training was identified as a key priority, a way to overcome the challenges implementers at the Cape Town meeting face in providing integrated interventions, and indeed in ensuring their staff have the necessary skills to work effectively with young HIV-affected children and their caregivers. This training is critical given that there is still limited understanding regarding why early childhood development is important (including the science that underpins these efforts) and how to support parents and caretivers of young children to promote the cognitive, social and physical development of their young children.

At the organizational level, it was acknowledged that more integrated programming often requires that program leaders and managers are trained in multiple sectors. For example, many organizations working in the health and nutrition sphere are integrating parenting and early childhood approaches to stimulation and play as part of their existing programming. Examples oftraining and capacity building approaches included:

> **PATH** is one of many organizations that are utilizing the *Essential Package* – a framework of tools and training for delivering integrated messages and referrals for families of young children via home visiting programs. The *Essential Package* was developed by Save the Children, CARE, ChildFund and the Consultative Group on Early Childhood Care and Development. It includes visual guides for use by home visitors as well as guidelines for monitoring and evaluation. PATH has trained community health workers and MNH nurses to deliver messages and support to caregivers in the areas of stimulation, nutrition, HIV and AIDS, child protection and hygiene.

III. Advocacy emerging from the meeting

Meeting participants met in small groups to identifying their priority advocacy initiatives, and who they wish would take up the challenge to implement them. No decisions were made at the Cape Town meeting, nor was work done at the meeting to refine or interrogate the suggestions.

In this report's annex is a table that was generated for the purpose of further discussion at the 3rd Road to Melbourne meeting, to be held in London in February 2014.

Following the meeting, the Coalition for Children Affected by AIDS released "The Cape Town Statement", which the Coalition believes encapsulates the meeting's emerging message. The statement is as follows:

> **Dec. 6, 2013, Cape Town, S.Africa** — "The Coalition for Children Affected by AIDS concluded its meeting today in advance of the International Conference on AIDS and STIs in Africa (ICASA), exploring evidence and practice around early child development and linking that work to long term development of children affected by the HIV epidemic.
>
> "This meeting took on even greater importance upon learning of the passing of Nelson Mandela. President Mandela was a resolute, unapologetic advocate for children, saying 'there can be no keener revelation of a society's soul than the way in which it treats its children'—his determination to help the children of the world will live on.
>
> "We know with good evidence that any child born into a family affected by HIV faces immediate and longer term biological, environmental and psychosocial challenges. We know that if these challenges are not addressed early, they threaten a child's ability to cope and thrive.
>
> "We also know that there are proven interventions that can prevent and mitigate the damaging effects of HIV and AIDS. By integrating clinical and developmental interventions for young children born into families affected by HIV and AIDS, we can provide children at risk with a strong foundation for the rest of their lives.
>
> "There were a number of emerging opportunities for integration of early childhood development and HIV services discussed during the Coalition meeting. Efforts to prevent mother-to-child transmission of HIV (PMTCT) present an ideal entry point for early identification of HIV infected and affected children and greater promotion of infant well-being. Early child development expertise and programmes should be integrated with other caregiver-focused and pediatric HIV initiatives to improve a multitude of outcomes for children and families.
>
> "As the HIV and AIDS community gathers this week in Cape Town for ICASA, one of Mandela's most famous quotes comes to mind: 'Give a child love, laughter and peace, not AIDS.' The Coalition calls on governments, implementers and other stakeholders to join our effort to stop HIV and AIDS from impacting another generation of children in Africa and around the world."

IV. Conclusions

Overall, while there are many promising developments towards more integrated service provision for young children born into HIV affected families, there are many yet untapped opportunities to integrate services within both communities and clinic settings, requiring greater efforts from both governments and civil society organizations. These untapped opportunities exist within the health systems, the ECD systems and the OVC systems.

At the same time, there is need to put more resources and emphasis on training and mentoring to better equip the work force as well as caregivers and to engage communities to increase awareness for and demand for services, while empowering them to play greater roles in supporting more optimal early childhood development. Greater priority should be placed on reaching the youngest children from birth – 3 years of age.

A key aspect of the effort to integrate services centres on the need to break down program silos that exist between HIV and AIDS; maternal and child health, child protection etc. Integrated programs require broader objectives and outcomes, coordination among donors so that they may provide the opportunity to achieve double or triple dividends. This way, children born into HIV-affected families will see their families and communities strengthened, and will therefore be able to not only survive but to thrive.

The Coalition for Children Affected by AIDS intends to explore these ideas more in its third meeting, but it is hoped that this report will provide useful examples of promissing programming for implementers wishing to take up the challenge of integrated inteventions for children born into HIV-affected families.

Report Annexes:

1. Meeting presentations

Meeting presentation can be found at

http://www.ccaba.org/road-to-melbourne-series-presentations-from-cape-town/

2. Summary of Successful and Promising Practices

In this section of the report the most successful and promising practices offered by community-based implementers is summarised. These practices are presented according to the emerging themes as presented in Section 3 above, and include all the work of all the implementers present at the Cape Town meeting.

Promising Practice	Description	Key Challenges	Organisation
1. Multiple entry points for integrated services			
(a) Within the Health System			
Paediatric HIV services integrated into nutrition programme	• All children (1-12 years) admitted in the malnutrition program tested for HIV Since 2011 • DNAPCR tests for all children under 24 months if mother tests HIV positive • Strengthen the malnutrition screening in the community as part of mobile HTC Services • Training all village Health Workers in malnutrition screening and HIV testing Education	• Paediatric HIV cases only picked up if child is sick (hospital visit) • No advocates for paediatric HIV testing at community level • Getting all parents with malnourished children tested for HIV.	• Partners in Health, Abwenzi Pa Za Umoyo (APZU), Malawi
Combined clinics – PMTCT, ANC, immunization & family planning services, HIV care	• Services provided for infant and mother: • post-partum care • continuation of Nevirapine/ART treatment • routine infant care, breastfeeding support and counselling	• only informal training available • no national integration of protocols, reporting and charts • mothers and infants lost to care because of high cost of clinic	• Partners in Health, Inshuti Mu Bushima, Rwanda

	• nutrition counselling, safe food and water preparation • malnutrition screening and malaria prevention • recognition and treatment of neonatal and early childhood illness • family planning • psychosocial support for PLWH	visits - $8 per visit	
"Survive & Thrive" Units - ECD linkages with clinical services (PMTCT and paediatric HIV care and treatment)	• First project of its kind in Zambia to closely connect primary health care services and HIV care and support with ECD services • natural extensions of existing clinics, which provide a full complement of primary care services for children and families • community volunteers trained to go door-to-door to identify children at risk and refer them to Units • performance-based asset transfer (purchase of goods/ supplies for volunteers that can enhance their lifestyle)	• Many stakeholders and relevant • Ministries • Demand is greater than Supply • Unmet Basic Needs (Maslow's Hierarchy) • Need for greater public private • partnerships • Need for high and medium level • networks that follow the 3 C's	• Elizabeth Glaser Paediatric AIDS Foundation (EGPAF), Zambia
Adaptation of Essential Package (EP) and Care for Development Package (CfD) into health services to address HIV and ECD	• EP extensively adapted for appropriate local use during home visits, to deliver key intervention messages and demonstrate best practices • CfD manual used with toys made from local material, in health facility waiting rooms and home visits • Community health workers and maternal and child health nurses observe and ask caregiver about their relationship and interaction with child; share messages and model and support caregiver to practice a relevant activity (nutrition, hygiene, care or stimulation), offering praise and encouragement for caregiver to continue the practice at home • Signs of promise: increased male caregivers' involvement in parenting, increased presence of toys in households, greater use of household hygiene techniques, and more kitchen gardens;	• Inadequate knowledge and acceptance of the integrated ECD model at national and provincial government levels (ECD still seen as synonymous with pre-school) • government supervisors reluctant to carry out additional supervision activities without additional allowances • community health workers carry heavy caseloads and some feel adding a care and stimulation component will further increase their workload • focus too much on physical games; need more stimulation for language and thinking skills	• PATH (Kenya and Mozambique) • http://www.ovcsupport.net/s/library.php?ld=1154

	nurses feel that CfD can enrich their group sessions for mothers of children at risk and can easily integrate into their consultations	• EP visual guides not written in local languages	
Child Health Days	• quarterly community-based event hosted by a pre-school, community child care centre or ECD space; focusing on service provision to IECCD (integrated early childhood care & development) for children from 3-6 years of age and infants • child-friendly and participatory day-long monitoring and evaluation field activity to assist project staff and orphans and vulnerable children (OVC) to appreciate critical issues affecting the children's lives • household health: simple health treatments, insecticide-treated net distribution, TB screening, maternal depression screening, HIV counselling & testing, blood pressure screening and counselling on non-communicable diseases • child health: simple health treatments, deworming, growth monitoring, immunizations, disability screening, PMTCT follow-up, counselling on exclusive breastfeeding • nutrition: cooking/gardening demonstrations, counselling and education, vitamin supplements • protection and parenting support: birth registrations, counselling on domestic abuse, demonstrations of toys made from locally available materials • water, sanitation and hygiene: counselling and education, handwashing demonstrations	• Bringing stakeholders together • Informal linkages and referral networks • Long distances to bring all supplies together • ECD centres and preschools are not in all districts • Shortage of disability specialists who can participate in Child Health Days • Shortage of food supplies in vulnerable households	• Catholic Relief Services, Malawi • "Guidance for Implementing Station Days: A Child-Centred Monitoring and Evaluation Tool" available at www.crsprogramquality.org
(b) Within the ECD system: Integrating HIV testing , treatment, care and support into ECD programmes			
ECD learning through home visiting programmes, community safe parks and training of caregivers	• ECD programme which integrates child and youth care work and OVC programmes through home visits to stimulate early learning in homes and safe parks • Five interactive core components:	• Lack of uniformity in implementation of the programme amongst CYCW's, Isibindi Projects and provinces • Understanding the fit –	• Isibindi, South Africa

	➢ Integrating stimulation in lifespace work ➢ Structured home visits and stimulation plan ➢ Cluster workshops for gogo's/caregivers ➢ Playgroup for children under 6 years ➢ Safe Park activities for children under 6 years	structured programme vs lifespace work • Integration of ECD into lifespace work - how to train? how to assess? • Designing appropriate data collecting tools • Creating synergy with the five components • Understanding workforce development in the welfare sector • Practice Realities: Rural, distance, space, Poverty	
Enabling HIV-affected children to reach their development milestones through integrated ECD, child health, family livelihoods and nutrition and food security programme *Services are built around a community ECD center*	Key objectives: • promote strong cognitive, language, social-emotional and motor skills development – through training community volunteers to visit households , establishing caregiver support groups, running ECD centres for children under 5, and providing psychosocial counselling to caregivers • improve the health of orphans and vulnerable children under 5, addressing special needs of those affected by HIV – through community health worker training, monthly health education and growth monitoring sessions, forming and training WASH committees and constructing handwashing facilities, agriculture training, training about and distributing nets for malaria prevention, savings groups and referrals to adult literacy and microcredit, and referring children to health services when necessary • because of the community-based nature of this programme and the use of faith-based volunteers, there has been strong volunteer and community	• Indicators to measure developmental milestones need refining • greater demand for services because of increased awareness • caregiver family size can affect developmental growth of under 5 children • heavy burden on older caregivers • one-year gap exists when children leave ECD programme and have to wait to turn 6 before entering formal schooling • Ethical concerns around volunteer workforce built on a sense of religious duty	• Episcopal Relief & Development in partnership with the Zambia Anglican Council

	engagement and local stakeholder commitment		
Community-initiated integrated response – centered around a school for vulnerable girls	• Kibera resident (school drop-out at age 10) started with 50c to buy a football • three-pronged programme focusing on: • education – Kibera girls' school for most vulnerable girls promotes gender equality, and Margaret's Safe Place for girls who have been raped • health for HIV-affected children – starts before the child is born through diagnosis and treatment of HIV-affected parents • economic development through SHOFCO Women's Empowerment Programme (SWEP) – assists HIV-affected women earn income through production and sale of bags and jewellery; and Group Savings & Loans (GS&L) teaches financial literacy and provides access to capital for small business ventures	• current infrastructure inadequate – need to establish HIV paediatric department to ensure integration of ART services and nutrition • parents cannot afford to feed their children who are on ART treatment • inconsistent supply of ART treatment by government • profound stigma against women who test HIV positive – they are abandoned by husbands and therefore need urgent economic development	• Shining Hope for Communities (SHOFCO), Kenya
(c) Within the OVC system : Integrating ECD components into the care and protection programmes			
Integrating ECD through home visits with parenting support, nutrition, health and protection issues	• Trained Home visitors provide weekly visits to selected families to provide a range of Early Childhood Development services including: ➢ Learning through play (early cognitive stimulation and social skills) ➢ Parenting support (workshops on non-violent discipline, and strengthening empathic relationships) ➢ Nutrition and Health education (food gardens, food parcels, child weighing, encourage early clinic visits for illness, screen mothers for depression) • A community Toy Library enriches the ECD services	• Tensions and breakdown of programme due to not involving community • Children not always high on political and traditional leadership agenda	• LETCEE, South Africa
Community response to AIDS through an integrated ECD care and	• Community mobilisation to identify and address key issues affecting children • nutrition support – assessment, provision of	• High illiteracy level, poverty and HIV make support for these programmes problematic	• Namwera AIDS Coordinating Committee, (NACC) Malawi

support programme	therapeutic and supplementary foods, food processing and preservation, counselling and referral • health care – deworming, growth monitoring, HIV testing, immunization, screening for special needs, hygiene and sanitation • Household economic strengthening –savings, loans, livestock and business training, • children's clubs/corners for safe play, learning and interaction • protection – teaching about primary caregivers'' and children's rights		
Community Managed Micro finance for ECD	• Integrated ECD services (nutrition, stimulation and early learning, care and health) • Micro-finance services (income generating activities, access to soft loans) and financial services (business fund, education fund, housing fund, capacity building fund) • These services combine to create improved income levels and quality of life for households, which in turn have led to improved care and education for vulnerable children in the community. (The average household income grew by 6 times in the first 4 years of the programme)	• Most stakeholders working with young children still do not know the ECD concept • Integration is required in service provision	• Tanzania Home Economics Association
Integrating OVC and ECD programmes by providing positive parenting training for caregivers & parents, economic strengthening of families and nutritional training and support	• **Centre-focused interventions**: formal ECD training, first aid, fire management and financial management training, nutritional support, play materials, infrastructure support, compliance workshops and support on government norms and standards • **Caregiver-focused interventions**: caregiver orientation workshops, parent support groups, building self-esteem with parents and caregivers, 1 day and 3 day packages build knowledge of ages and stages and development, referrals • Community-based interventions: access to grants	• Sectoral planning still predominates • Lack of child-focused service providers for children including medical, social and legal at local sites • Inadequate number of social workers • Massive infrastructure challenges • Low levels of qualifications, insufficient training,	• Hope Worldwide www.hopeww.org/SSLPage.aspx?pid=1937

	through service delivery 'imbizos1' • (In 2013, in partnership with SASSA (South African Social Security Agency), Hopeww was able to facilitate access to 265 welfare grants)	professional support • Challenging and expensive process of getting ECD Centres registered • Lack of enabling documents such as Identification documents and birth certificates prohibit children from receiving services • Priority of funding to centre-based programs • Low levels of self-confidence impact knowledge uptake • High attrition rates at Parent Support Group (PSGs) Meetings	
2. Government and Civil Society partnership			
Civil society and government partnership – focus on the child	• integrated services focusing on child in the centre, then family, then community, then community-based organisations, then government, then iNGOs and sponsors	• clarity of roles at each level • maintain focus on the child • capacity-building of government ministry staff needed in ECD • ECD standards not adequately reinforced • ECD system relies heavily on un- or under-qualified volunteers	• Ministry of Gender, Children and Social Welfare, Malawi
Multi-level structures for coordination	• national level: ECD Steering Committee and Technical Committee offering advice to National ECD Secretariat • civil society represented by Tanzania ECD Net Work • community level: Tanzania Junior Council in schools to teach children's rights and HIV; and Focal Development Colleges for parents and	• difficult to scale projects down to grassroots level • inadequate resources to implement programme across the whole country • too few ECD technical staff to manage the ECD programme nationally	• Ministry of Community Development, Gender and Children, Tanzania

	caregivers to receive practical skills and knowledge		
Coordinating Ministry with which all other ministries work for the benefit of the child	• Ministry of Chiefs and Traditional Affairs formed to coordinate all activities relating to child development with other ministries (Education, Home Affairs, Child Development, Health, Labour, Youth & Sport) • This Ministry has become a powerful resource for change at community level	• difficult and time-consuming to find individual driver within a ministry to champion efforts • limited resources in the country creates competition and mistrust between civil society and government	• Ministry of Chiefs and Traditional Affairs, Zambia
3. Working with Key Populations			
Reaching sex workers through existing SW prevention programmes	• provide testing day within centre • family day inviting children to attend with mothers -childcare activities to allow mothers to have clinical services and counselling • support groups and a support 'buddy' for psychosocial support and encouragement with treatment adherence • SMS reminders of clinic dates for mother and baby • home visits to identify domestic violence and substance abuse	• Negotiating with health care providers for sex worker friendly services • Maintaining momentum with mothers who are members • Capacitating the peer network of sex worker mothers • Mobilizing resources to implement the program continuously i.e. funding	• Sisonke Sex Workers' Movement, South Africa
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3. Advocacy priorities

The following table was generated by Cape Town meeting participants in a session identifying their priority advocacy initiatives, and who they wish would take up the challenge to implement them. The table was generated for the purpose of further discussion at the 3rd Road to Melbourne meeting, being held in London in February 2014.

Level	Documentation	How this will be shared	By whom?
General	• A slogan/one-liner should be used on all publications • (something like 'strong beginnings' or 'neurons to neighbourhoods')	• Include on all publications, press releases etc	• Through champions, including celebrities (at all levels)
Global/ international	• Policy brief with key messages (1-2 pages)	• The Coalition website should have separate page on this subject which others can have links to • Facebook/twitter; • (e-)newsletter by The Coalition • Better Care Network (BCN) discussion forum on website about using the new insights – co-facilitated with The Coalition? • Members' websites • Organise event for 20th international year of the family, targeting UNGA/AU (www.family2014.org)	• The Coalition • Members of The Coalition • Through: Interagency Task Team on Children Affected by HIV (IATT) / The Global Partners' Forum (GPF) / International AIDS Society (IAS) / Internal UNICEF
	• Evidence paper /issues paper (8-10 pages)	• Websites and e-newsletters of Coalition members and affiliates (e.g. WVI/BCN/UNICEF/IATT/Pediatric AIDS Treatment Africa - PATA) • At events that are organised by members or affiliates (such as PEPFAR events/ continental PATA forums) • Organise donor conference • Members of The Coalition can ensure use of new insights in their programmes and document these practices to be shared again • GSSWA webinars on best practices on ECD workforce capacity development	• The Coalition • Members of The Coalition • Global Social Services Workforce Alliance (GSSWA)
	• Communications strategy: • -Press kit for journalists media (The Coalition) that can then be translated into press releases by Coalition members and others	• The Coalition website • Members' websites • Webinars / google groups/ clouds / social media	• The Coalition • members

Level	Documentation	How this will be shared	By whom?
	• News articles and striking headlines to promote the topic. e.g ' pre-schools or prisons'		
	• Fund research for policy/advocacy		• PEPFAR
	• Online repository for data to gather from wider audience	• Website (The Coalition/Better Care Network?) • Facebook page where people can submit stories	• The Coalition • members • Through champions/ ambassadors of e.g. UNICEF and/or celebrity spokespersons
	• Programme guidance docs (practical tools/checklists) on integration/links , including e.g. videos showing good examples, visuals/infographics • (best practices write-up)	• Websites • Host webinars, The Coalition, RIATT • through network of members and affiliates	• UNICEF • Hire a CAO (Communication Advocacy Officer?) to assist! • Actors at regional level: RIATT, SADC, AV, ADEA, East Africa Community
	• 1 pager on investment case for governments and ministries of finance	• Webinar to talk through data with expert analysis	• ??
	• Promote corporate social responsibility messaging with products and services around ECD and HIV	• Website • Member networks	• Members
	• Develop a data package - simple presentations of strategic information to promote the evidence base as well as current gaps in programming	• Speakers' tours	• The Coalition • Members
	• Research findings and evidence around HIV and early childhood into sound bites, lay language	• Presentations at conferences	• The Coalition • Members
	• Impact evaluation report	• Publicise findings	• HSRC, Hilton Foundation and other members
	• Develop Post2015 MDG target and good indicators	•	• UNICEF, UNDP
National	• Policy brief and brochures with key messages/ newsletters	• At national events (such as PATA Forums) • Websites • Include messages in in-house communications and advocacy calendars of members and partners • Parenting advice, messages through cell phone	• Champions, including celebrities • Members and partners of members

Level	Documentation	How this will be shared	By whom?
		technology- 'counting with your baby', 'Give your child a hug today'. • Flight TV ads with simple parenting messages to be used by any adults	
	• Include the message in existing training manuals and other materials (by members and partners of The Coalition, e.g. PATA)	• Through: Coalition members and national child rights networks and wider church networks, including • church leadership • PATA building bridges mentorship & twinning programme (PATA, Daniella)	• • Members • affiliates • National networks
	• Collect data/examples at national level to have context-specific data/ best practices	• Through networks of partners at national level •	• national partners
	• Case studies of effective models (civil society mentor)	• Project visits and mentoring • Orientation meetings with stakeholders at national level • Talk show national TV / • National radio • Participation in ministerial planning processes and meetings to insert into agenda (civil society)	• National partners (via members?)
	• Communications strategy	• Workshop for preparing the mass media – 1 day (@ hotel) • TV documentary • Tele-novelas (soaps) • Weekly radio programme • - Workshops/trainings/national learning sessions/annual meetings • TV ads at prime time • Open lectures • Soundbites for government (to set an example for governments) • Newspaper articles • Bill boards • Training and assistance by artists and communication experts for messaging – include training of reporters • Advocacy calendar in programmes	• National partners/networks • UNICEF • Ministry, First Lady, national champions!
	• Election talking points for candidates		• National partners/networks
District		• Orientation meetings with stakeholders at district level	• NGOs/CBOs at district level

Level	Documentation	How this will be shared	By whom?
		• Quarterly meetings in district health teams to update on project activities	• NGOs/CBOs at district level
Community/ local	• Sensitization campaigns	• Community leader meeting; traditional leader meeting; community structures; using traditional ceremonies; using international and local commemoration days	• Community leaders as champions
	• Education, Information materials: • Posters/pamphlets/stickers/ branded materials/brochure/visual guides • CD/DVD • Testimonials/stories of beneficiaries • Mobile messages	• Continuing education programmes	• CBOs/FBOs/para-socials
	• Radio spots	• CBOs organise listening clubs to reinforce the messages; • CBOs and health programmes – integrate messages as part of existing programmes	• CBOs/NGOs
	• Popular theatre / docu-theatre/ Flashmob	• Theatre performances in the communities	• CBOS, INGOs, community leaders

4. Meeting Participants

Speakers & Participant List	
Meeting Rapporteur	
1. **Ms. Janine Ward** Consultant	Jwinspace@gmail.com
Panel Moderators, Opening & Summary Remarks	
2. **Ms. Kendra Blackett-Dibinga** Member, The Coalition for Children Affected by AIDS & Senior Technical Specialist, Orphans and Vulnerable Children, Save the Children	KBlackett@savechildren.org
3. **Ms. Lisa Bohmer** Member, Coalition for Children Affected by AIDS & Senior Program Officer, Children Affected by AIDS Initiative, Conrad N. Hilton Foundation **** Program co-lead***	lisa@hiltonfoundation.org
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5. **Ms. Doortje 't Hart** Member, The Coalition for Children Affected by AIDS & Senior Advisor Children affected by AIDS, STOP AIDS NOW!	dthart@stopaidsnow.nl
6. **Ms. Noreen Huni** Member, The Coalition for Children Affected by AIDS, Executive Director, REPSSI & Chair, The Regional Interagency Task Team on Children and AIDS for Eastern & Southern Africa	noreen.huni@repssi.org
7. **Ms. Kate Iorpenda** Chair, Coalition for Children Affected by AIDS, & Senior Advisor: HIV Children and Impact Mitigation, International HIV/AIDS Alliance **** Program committee***	kiorpenda@aidsalliance.org
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12. **Professor Lorraine Sherr** Member, Coalition for Children Affected by AIDS & Professor of Clinical and Health Psychology, University College London	l.sherr@ucl.ac.uk
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15. **Mr. Francis Chalamanda** ECD National Coordinator, Ministry of Gender, Children and Social Development, Malawi	francischalamanda@gmail.com
16. **Mr. Fidelis Chasukwa Mgowa** Catholic Relief Services Malawi	Fidelis.chasukwa@crs.org
17. **Dr. Chris Desmond** Member, The Coalition for Children Affected by AIDS & Chief Research Specialist, Human Sciences Research Council & University of Witwatersrand, South Africa	desmondchris@yahoo.com
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23. Mr. Benedict Missani Director of Children, former ECD focal person, Ministry of Community Development, Gender and Children, Tanzania	bmissani6@gmail.com
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25. Mr. Kennedy Odede President, Shining Hope for Communities, Kenya	kenodede@gmail.com
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30. Dr. Niyigena John Wilson Coordinator, Infectious Disease Program at Partners In Health Rwanda/Inshuti Mu Buzima	niyigenajohn83@gmail.com
Invited Participants	
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61. Ms. Kelly Wolfe Sr. Director, Child Protection, Save the Children	kwolfe@savechildren.org

5. Agenda

DAY ONE: THURSDAY 5TH DECEMBER 2013

TIME	AGENDA ITEM
8:30 - 9:00	***Registration & Tea***
9:00 - 9:15	**Welcome** • *Ms. Kate Iorpenda* Chair: Coalition for Children Affected by AIDS International HIV/AIDS Alliance & • *Mr. Tom Fenn* Regional Chief, Children and AIDS, UNICEF Eastern & Southern Africa Regional Office & • *Ms. Noreen Huni* Chair, The Regional Interagency Task Team on Children and AIDS for Eastern & Southern Africa
9:15- 9:45	**Setting the scene** • *Dr. Linda Richter &* • *Dr. Chris Desmond* Human Sciences Research Council, South Africa, & member, Coalition for Children Affected by AIDS
9:45 – 10:45	**Presentations by implementers** Moderator • *Ms. Lisa Bohmer* Conrad N. Hilton Foundation & Coalition for Children Affected by AIDS Presentations • *Ms. Grace Mazala* Zambia Anglican Council & Episcopal Relief & Development • *Mr. Niyigena John Wilson* Partners in Health, Rwanda • *Ms. Duduzile Dlamini* Sisonke Sex Workers' Movement, South Africa • *Ms. Zeni Thumbadoo* Isibindi, South Africa
10:45 - 11:15	***Tea/ Coffee***
11:15 – 12:00	**Presentations by implementers (continued)** Presentations (continued) • *Mr. Kennedy Odede* Shining Hope for Communities, Kenya
12:00 – 13:15	**Programmes working within a national response** Moderator • *Mr. Dominic Kemps* ViiV Healthcare Positive Action Programme & • *Mr. Craig McClure* UNICEF HIV & AIDS Section Panelists: Community 1. *Ms. Mary Kabati* Tanzania Home Economics Association 2. *Mr. Saeed Wame* Namwera AIDS Coordinating Committee, Malawi 3. *Dr. Susan Strasser* Elizabeth Glaser Pediatric AIDS Foundation, Zambia Panelists: Government 4. *Mr. Benedict Missani*

TIME	AGENDA ITEM
	Ministry of Community Development, Gender and Children, Tanzania 5. *Mr. Francis Chalamanda* Ministry of Gender, Children and Social Welfare, Government of Malawi 6. *Professor/ Minister Nkandu Luo* Minister of Chiefs and Traditional Affairs, Zambia
13:15 – 14:15	***Lunch***
14:15 – 16:00	**The Successful Practice Marketplace** Moderators • *Mr. John Miller* Coalition for Children Affected by AIDS & • *Ms. Kate Iorpenda* Coalition for Children Affected by AIDS & International HIV/AIDS Alliance CBO representatives sharing their best practices Group 1 1. *Ms. Mary James* LETCEE, South Africa 2. *Dr. Marc Aguirre* Hope Worldwide, South Africa 3. *Mr. Saeed Wame* Namwera AIDS Coordinating Committee, Malawi 4. *Ms. Grace Mazala* Zambia Anglican Council & Episcopal Relief & Development 5. *Mr. Kennedy Odede* Shining Hope for Communities, Kenya 6. *Mr. Blessings Banda* Abwenzi Pa Za Umoyo (APZU), Malawi 7. *Ms. Zeni Thumbadoo* Isibindi, South Africa Group 2 8. *Ms. Duduzile Dlamini* Sisonke Sex Workers' Movement, South Africa 9. *Ms. Mary Kabati* Tanzania Home Economics Association 10. *Dr. Susan Strasser* Elizabeth Glaser Pediatric AIDS Foundation, Zambia 11. *Dr. Niyigena John Wilson* Partners in Health, Rwanda 12. *Mr. Fidelis Chasukwa Mgowa* Catholic Relief Services Malawi 13. *Ms. Svetlana Drivdal* PATH
16:00 – 16:30	***Tea/ Coffee***
16:30 – 17:00	**The Successful Practice Marketplace - *plenary discussion*** Moderators • *Mr. John Miller* Coalition for Children Affected by AIDS & • *Ms. Kate Iorpenda* Coalition for Children Affected by AIDS & International HIV/AIDS Alliance Discussants: • *Mr. Domenic Kemps* ViiV Healthcare Positive Action Programme • *Ms. Zanele Sibanda-Knight* Firelight Foundation

TIME	**AGENDA ITEM**
	• *Dr. Daniella Mark* Pediatric AIDS Treatment Africa
17:00 – 17:15	***Wrap up & preparation for day 2*** Moderator • *Ms. Kendra Blackett-Dibinga* Coalition for Children Affected by AIDS & Save the Children
18:30	***Group supper – La Mouette*** 78 Regent St, Sea Point lamouette-restaurant.co.za Getting to the restaurant: A group will be walking to the restaurant and will be leaving the lobby of the Premier Hotel Cape Manor at 18:00. The walk takes less than 20 minutes, and is about 12 city blocks. Those who do not wish to walk may take taxis. Dinner guests will be expected to make their own way home.

DAY TWO: FRIDAY 6TH DECEMBER 2013

TIME	**AGENDA ITEM**
8:45 - 9:00	***Tea/ Coffee***
9:00 - 9:30	**Welcome and recap of Day 1** Moderator • *Ms. Kate Iorpenda* Coalition for Children Affected by AIDS & International HIV/AIDS Alliance Recap of Day 1 *Prof. Lorraine Sherr* Coalition for Children Affected by AIDS & University College London
9:30 - 10:45	**Small group discussion on key topics emerging from the previous day's presentations (Part 1)** Moderator • *Mr. John Miller* Coalition for Children Affected by AIDS SMALL GROUP TOPICS, determined by the working group at the end of day 1 were: 1. How do we best develop the workforce to better integrate the services for young children born into HIV-affected families?; 2. In addition to addressing stigma, what are the entry points and strategies that will help programmes reach young children of key populations;? 3. How do we make sure ECD interventions are sensitive to young children born into HIV-affected families?; 4. What are the challenges and strategies for integration of services for children 0-3? 5. How do civil society and (multiple arms of) government work together better to achieve integrated interventions for young children born into HIV-affected families?
10:45 - 11:15	***Tea***
11:15 – 12:30	**Small group discussion on key topics emerging from the previous day's presentations (Part 2)** Moderator • *Mr. John Miller* Coalition for Children Affected by AIDS
12:30 – 1:30	**Lunch**

TIME	AGENDA ITEM
1:30 – 2:45	**How can we communicate the best practices to those who aren't in the room: ideas for advocacy** Moderator • *Ms. Doortje 't Hart* Coalition for Children Affected by AIDS & STOP AIDS NOW!
2:45 – 3:00	**Break**
3:00 – 4:00	**Feedback on best practices identified and discussion** Moderator • *Mr. Dominic Kemps* ViiV Healthcare – Positive Action Programme Rapporteur • *Ms. Janine Ward* Consultant
4:00 – 4:30	**Summary, wrap-up, next steps, farewells and closure** • *Ms. Kate Iorpenda* Coalition for Children Affected by AIDS & International HIV/AIDS Alliance **&** • *Mr. John Miller* Coalition for Children Affected by AIDS