Towards an AIDS Free Africa
– Delivering on the frontline

Lessons from the PATA 2017 Continental Summit

23-25 October 2017, Johannesburg, South Africa

In partnership with:

The ELMA Foundation

Supported by:

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Acknowledgements

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Acronyms

3TC	lamivudine
ABC	abacavir
ACT	Accelerating Children's HIV/AIDS Treatment
AFHS	adolescent-friendly health services
ALHIV	adolescents living with HIV
ARASA	AIDS Rights Alliance for Southern Africa
ART	antiretroviral therapy
ASRU	AIDS and Society Research Unit
CHAI	Clinton Health Access Initiative
DSD	differentiated service delivery
DTG	dolutegravir
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
ECD	early childhood development
EFV	efavirenz
EID	early infant diagnosis
FACES	Family AIDS Care and Education Services
HTS	HIV testing services
IAS	International AIDS Society
KYCS	Know Your Child's Status
LPV/r	lopinavir/ritonavir
MMP	multi-month prescriptions
NIMART	nurse initiated management of ART
OPD	outpatient department
OVC	orphans and vulnerable children
P2Z	Peers to Zero
PACF	Positive Action for Children Fund
PATA	Paediatric-Adolescent Treatment Africa
PCR	polymerase chain reaction
PITC	provider initiated testing and counselling
PMTCT	prevention of mother-to-child transmission
POC	point of care
QIP	quality improvement plan
READY+	Resilient & Empowered Adolescents & Young People
REPSSI	Regional Psychosocial Support Initiative
SOP	standard operating procedure
SRHR	sexual and reproductive health and rights
TAP	Technical Advisory Panel
TAT	turnaround time
UCSF	University of California, San Francisco
UKZN	University of Kwazulu-Natal
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation
Y+	Y+ Leadership Initiative
YAP	Youth Advisory Panel
YCC	youth care clubs
YPLHIV	young people living with HIV

Team PATA

Executive summary

Towards an AIDS Free Africa – Delivering on the frontline was the focus of the PATA 2017 Continental Summit, held from 23-25 October 2017 in Johannesburg, South Africa. The meeting brought together over 200 delegates including frontline health providers from 56 health facilities across 15 sub-Saharan African countries. They were joined by programme implementers and policy-makers from across the globe, to link and learn across programmes, policy and geography.

The summit centred around three pillars – FIND, TREAT and CARE – which support the UNAIDS super-fast-track framework for ending AIDS among children, adolescents and young women globally by 2020. The three-day meeting used plenary sessions, programme showcases, workshops and panels to provide technical guidance, highlight best practices, discuss programmatic barriers and solutions and build skills.

The summit culminated in attending health facility teams completing a draft quality improvement plan (QIP) to implement a simple, feasible activity or promising practice that will improve paediatric and/or adolescent HIV service delivery in 2018. Together, these 53 projects will support collective efforts on the frontline to reach the urgent global HIV targets.

This report highlights key lessons emerging from the summit. The outcomes of the summit include 15 recommendations that, if enacted, will improve service delivery across the FIND-TREAT-CARE HIV service continuum. Each of these recommendations has the health provider as its central actor. This is because at the heart of HIV management lies one very critical entry point to patient-centred care: the health provider.

15 recommendations for improved paediatric and adolescent HIV outcomes

1. Actively identify infants, children and adolescents living with HIV, and use robust tracking systems
2. Perform routine screening in the sick and the well
3. Find children through their connection with HIV-infected adults, such as optimised PMTCT follow-up and EID, index case testing and family testing
4. Use targeted rather than generalised community testing
5. Implement after-hour testing for adolescent populations
6. Complete linkage
7. Don't delay the start of ART
8. Use simplified initiation processes and consider same-day test and start, but ensure treatment readiness
9. Promote nurse initiated management of ART
10. Provide the best treatment available and advocate for better paediatric formulations
11. Use a differentiated care approach
12. Use the clinic as an entry point to intervene early and build caregiver resilience and skills
13. Adopt a family care approach
14. Support early disclosure
15. Offer peer-led, supportive, integrated services for ALHIV

The PATA 2017 Continental Summit at a glance: Key lessons

	FIND	TREAT	CARE
Barriers	• HIV-related stigma in families, communities and health facilities • Reluctance of some caregivers to test their children • Health providers not suspecting or testing for HIV in older children • High age of consent for testing and guardianship issues • Testing not being allowed in schools • Test kit shortages • Lengthy turnaround time for HIV test results to reach families • Poor data quality and monitoring • Human resource constraints • Limited capacity for community testing • Adult-centred and inflexible health systems • Clinic operating times conflict with school hours • Incomplete referral systems	• Suboptimal formulations and increasing levels of drug resistance • ART stockouts • Coinfections that require staggering the initiation of both treatments • Heavy workload of health providers • Lack of confidence on the part of health providers to initiate and manage ART in children • Poor treatment literacy and treatment readiness • Adherence challenges • Services not friendly or convenient • Limited access to viral load and resistance testing for effective monitoring and management • Laws criminalising HIV transmission • Stigma and discrimination	• Lack of disclosure and stigma • Shifting caregivers • Bulging health system, with high patient load and health provider burnout, reducing capacity for psychosocial support • Poverty and socio-economic issues, including disrupted or broken family, alcohol or drug abuse, clinic user fees, long distances to clinic and high transport costs, and food insecurity • Limited access to early learning centres and safe and supportive youth spaces
Recommendations	• Actively identify infants, children and adolescents living with HIV, and use robust tracking systems • Perform routine screening in the sick and the well • Find children through their connection with HIV-infected adults, such as optimised PMTCT follow-up and EID, index case testing and family testing • Use targeted rather than generalised community testing • Implement after-hour testing for adolescent populations • Complete linkage	• Don't delay the start of ART • Use simplified initiation processes and consider same-day test and start, but ensure treatment readiness • Promote nurse initiated management of ART • Provide the best treatment available and advocate for better paediatric formulations • Use a differentiated care approach	• Use the clinic as an entry point to intervene early and build caregiver resilience and skills • Adopt a family care approach • Support early disclosure • Offer peer-led, supportive, integrated services for ALHIV
Cross-cutting messages	• Smart testing strategies enhance yield • Case finding requires dedicated resources, supportive policy, clear operational guidance, training, mentorship and/or supervision and robust monitoring • Effective linkages, strengthened referral systems and joint activities between clinic and community are imperative, with community health workers playing a critical role as testers, counsellors and in follow-up • Electronic patient record systems are needed to improve tracking and linkage • Continuous rather than once-off testing must be ensured	• Care must be patient-centred. If this is not done, no matter how efficacious the intervention, it will not be taken up. • Increased investment is needed to reach targets and sustain programmes • Comprehensiveness of service (a 'one-stop shop' or 'supermarket' approach) must not compromise quality	• Training, supervision, tools and support must be in place to enable quality counselling • Identify, link and monitor referrals to community-based organisations for psychosocial support
	STRENGTHEN THE HEALTH WORKFORCE		

PATA: A decade of linking and learning

Paediatric-Adolescent Treatment Africa (PATA) is an action network of multidisciplinary teams of frontline health providers caring for HIV-infected children and adolescents. Our MISSION is to mobilise and strengthen a network of frontline health providers to improve paediatric and adolescent HIV treatment, care and support in sub-Saharan Africa. Our VISION is that all children and adolescents living with HIV in sub-Saharan Africa receive optimal treatment, care and support and live long, healthy lives. PATA believes that frontline health providers are an effective entry point to and channel for improving paediatric and adolescent HIV outcomes.

The largest PATA summit to date, the PATA 2017 Continental Summit reflects just how far the PATA network has come. Since the first small PATA forum in 2005 – when attending health providers decided to form an informal knowledge-sharing hub – PATA has grown into a thriving community of practice for health providers from over 360 health facilities across sub-Saharan Africa. To date, PATA has convened 53 smaller forums and large summits at local, sub-regional, regional and continental levels. Health providers in the PATA network now have access to PATA's various linking and learning platforms, as well as PATA-supported local incubation projects and programmes. PATA proudly celebrated this growth with a birthday celebration at the PATA 2017 Continental Summit, in recognition of the 10-year anniversary since its formal registration as a non-profit company in 2007.

The PATA 2017 Continental Summit

Achieving global super-fast-track targets and implementing World Health Organisation (WHO) guidance on the immediate initiation of antiretroviral therapy (ART) for all ages, irrespective of disease progression, requires urgent upskilling of and task-sharing amongst health providers. Health systems across sub-Saharan Africa typically have limited human resources and overburdened health facilities. Therefore, high-impact, innovative approaches (that also maximise community linkages) must be implemented at each step of the HIV prevention, treatment and care cascade to meet the unique and diverse needs of children and adolescents living with HIV. Only then will we be able to reach the 90-90-90 global HIV targets and achieve an AIDS Free generation in sub-Saharan Africa.

The PATA 2017 Continental Summit was entitled Towards an AIDS Free Africa – Delivering on the frontline, and held from 23-25 October 2017 in Johannesburg, South Africa. The summit brought together over 200 frontline health providers, programme implementers and policy-makers from Cameroon, Cote D'Ivoire, DRC, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Nigeria, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. This unique pool of stakeholders facilitated multi-faceted deliberation, dialogue and joint planning.

The 56 attending health facilities together care for 85026 infants, children, adolescents and young people on ART. Represented facilities were 80.36% urban or peri-urban and 19.64% rural. Forty percent were primary level and the remainder were secondary or tertiary. Sixty-eight percent were government-run. Each facility was represented by two health providers selected by the health facility, one serving a clinical role, the other psychosocial. The attendance profile included clinicians, clinical officers, paediatricians, nurses, counsellors, social workers and psychologists.

The agenda focused on three pillars: FIND, TREAT and CARE. These align with the UNAIDS super-fast-track framework for ending AIDS among children, adolescents and young women globally by 2020[1].

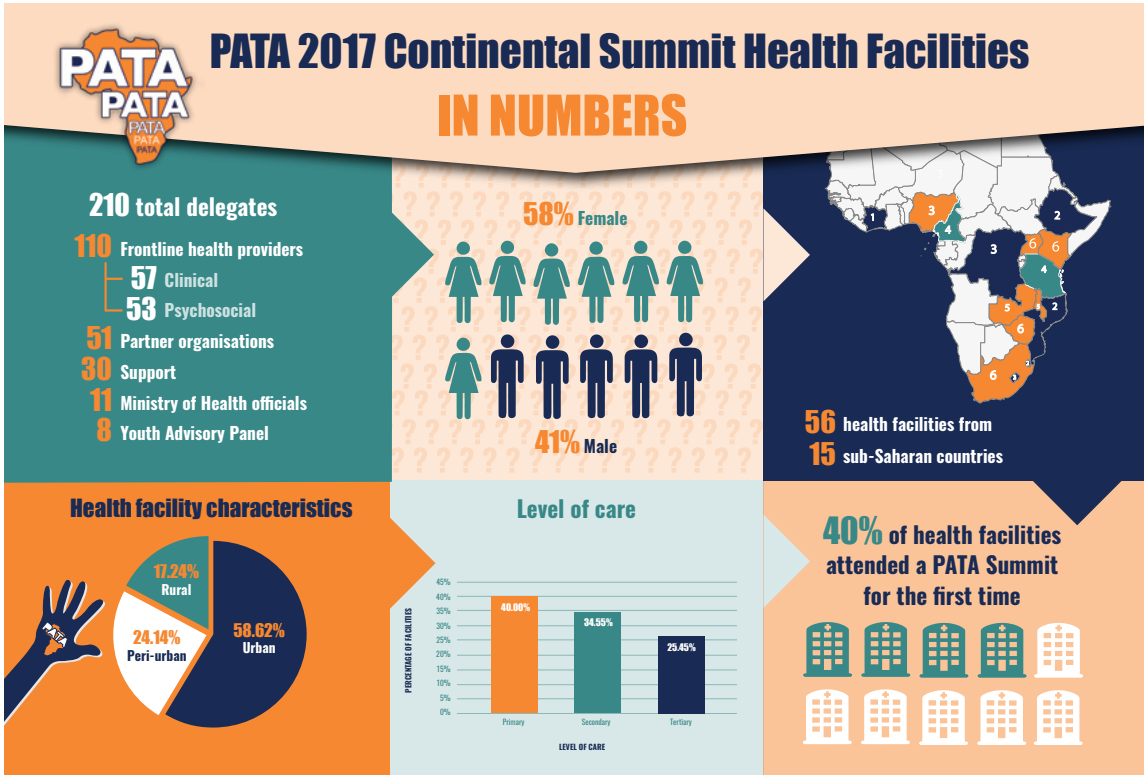
[1] UNAIDS. A super-fast-track framework for ending AIDS in children, adolescents and young women by 2020. https://free.unaids.org/. Accessed 03/03/2018

The summit set out to:

- Introduce the latest global frameworks and guidance, with a focus on the AIDS Free super-fast-track targets
- Share best practices, research evidence and local case studies to guide the development of QIPs
- Facilitate dialogue between health providers and Ministries of Health to translate policy into practice and practice into policy
- Prioritise and operationalise the AIDS Free agenda, with a focus on differentiated service delivery models
- Explore the need for a regional learning collaborative for Africa-based policy-makers and programme implementers for ongoing exchange and learning

> "Countries are facing similar challenges and I learned how different clinics tackled some of the challenges my clinic is facing."
> Nurse, Swaziland

> "The biggest thing I learned is that the simple things I do at my clinic are very important."
> Clinician, Kenya



The PATA summit purpose and methodology

PATA's summit methodology has been refined through 12 years of experience in bringing stakeholders together to build regional action around paediatric and adolescent HIV treatment, care and support. These meetings support health providers, policy-makers, partner organisations and young people living with HIV (YPLHIV) from across the region to link and learn, share experiences, access global guidance and technical input and discuss solutions to service delivery challenges.

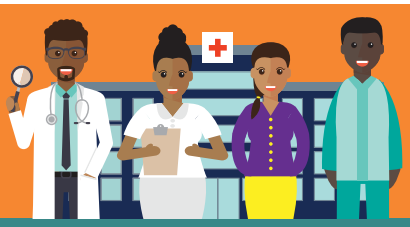
PATA summits and forums are a place for reflection by health providers, who then commit to refining or redesigning specific health service areas on their return to their home countries. PATA then supports these facilities to strengthen implementation, document and evaluate some of these emerging promising practices. PATA is engaged in various global and regional working groups and coalitions, and uses these platforms to advocate for best practice in paediatric and adolescent HIV care by sharing the health provider experience at the centre of service delivery.

> "The PATA 2017 Continental Summit drove home how far health providers are willing to go to make HIV services, treatment and care adolescent- and child-friendly and how much passion and dedication exists across sub-Saharan Africa to ensure that we leave no child or young person behind. The summit also created a space where those on the frontlines of delivery who don't have an opportunity to access such platforms were provided an opportunity to have their voices heard, engage and share experiences with their peers, and learn from one another and regional experts."
>
> — Luann Hatane, Executive Director, PATA

Linking and learning - local to global

1 NETWORK

Build and support the PATA network of frontline health providers



2 LINK & LEARN

PATA Forums and Summits are platforms to collaborate, share lessons and identify best practices through peer-to peer and south-to-south knowledge exchange

3 COMM□NICATE

□lobal guidance, information, capacity-building and tools shared with the PATA network

4 IMPLEMENT

Incubation projects and programmes to improve service delivery and develop best practice models

□ RESEARCH & EVIDENCE

Strengthen evidence to advocate for policy and programmatic change

□ COLLABORATE & ADVOCATE

Policymakers, donors and programme managers to invest, scale-up and intergrate promising and best practice models

□ IMPACT

Mobilised and strengthened frontline health providers, improved access to □uality HIV treatment, care and support services for children and adolescents living with HIV

The summit structure employs a variety of session formats that are informative, interactive and oriented toward moving discussion from policy to practice and practice to policy. These sessions take place during (i) strategic touchpoints with the full delegation for shared learning, engagement and dialogue, and (ii) focused breakaway sessions to workshop key priority areas across different participant groups.

The summit structure features:

- Plenaries for technical guidance, frameworks and policies
- Africa Cafés as a rapid showcase of best practice examples
- Peer-to-Peer dialogues for discussion around discipline-specific barriers and solutions (clinical/ psychosocial/ programmatic)
- Cross-cutting interdisciplinary panels
- Skills-building workshops
- Next steps planning for quality improvement

Celebrating health providers

For the first time, PATA held a gala dinner and awards ceremony at the summit to recognise, honour and celebrate nominated health providers for their contribution to adolescent- and child-friendly service.

Health providers were nominated by young peer supporters and HIV service users from attending health facilities. The following health providers were nominated: Dr Ateba Ndongo Francis, Billy Chichete, Charles Phiri, Cynthia Dizha, Damarice Achieng, Eric Joseph Dondolo, Esther Kangave, Faustin Kitetele, Gloria Kokwijuka Rwezahura, Martha Kalula Msiska, Meria M Nankhuni, Namusoke Asia Mbajja, Richard Kilonzo, Russell Dickson Msiska, Sphiwe Gumbo, Talla Clarisse, Tsepang Setaka and Winner Elimwaria.

While PATA celebrates and acknowledges each of the nominees, Dr Ateba Ndongo Francis, Charles Phiri, Esther Kangave, Richard Kilonzo and Sphiwe Gumbo were announced winners of the awards – celebrated for their commitment to going above and beyond to touch the lives of children and adolescents living with HIV.

The awards ceremony was also an opportunity to recognise the role that other stakeholders are playing in supporting PATA's work and forwarding child and adolescent friendly service. Blessings Banda from WeCare Youth Organisation in Malawi and Newlands Clinic in Zimbabwe were awarded in this category.

Taking it a step further

The UNICEF Learning Collaborative expanded participation and learning beyond those in attendance by broadcasting a three-day webinar series live from the summit.

The summit culminated in each health facility team drafting a QIP to implement a simple, feasible activity or promising practice that will improve paediatric and/or adolescent HIV service delivery in 2018. Once providers return home to their facilities, the QIP is finalised within the broader service team and submitted to PATA. PATA is available to provide guidance and support towards implementation of QIPs, and promotes ongoing peer-to-peer engagement. Aligned to specific programme, PATA is able to offer remote capacity-building, mentorship and occasionally small demonstration grants to support implementation. Participating health facilities report to PATA annually on progress.

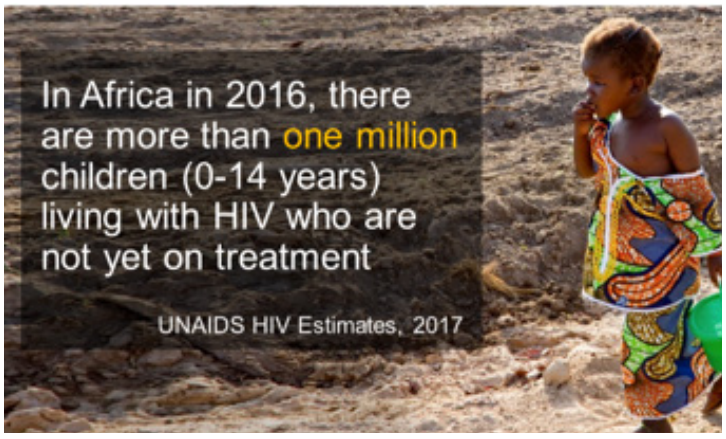
> "The [PATA] summit comes at an opportune time as we all strive to make sure that this segment of the population is not left behind and that our actions keep pace with what's happening with the adults. Adults are beating us – we are still lagging behind. We have to meet the same coverage targets, but I would like to ask that we actually beat them."
>
> Dr Nonhlanhla Dlamini, National Department of Health, South Africa

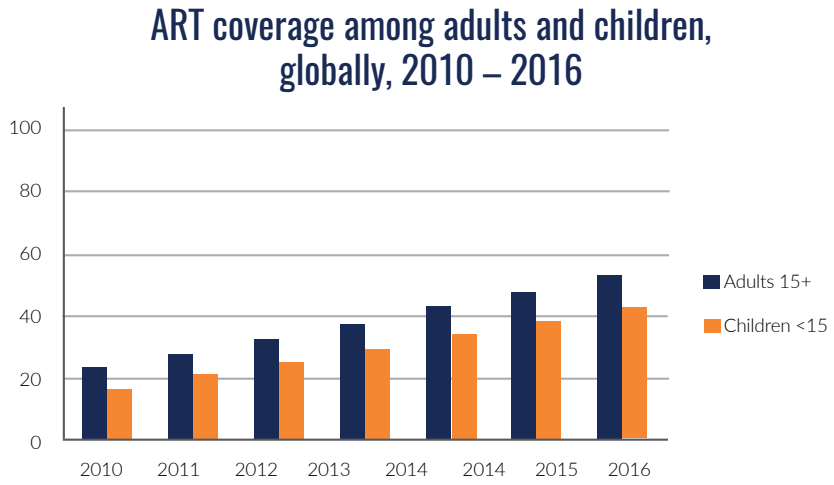
FIND

One of the key targets of the Start Free. Stay Free. AIDS Free framework is to provide lifelong ART for 95% of children and adolescents living with HIV by 2018.[2] Yet in 2016, only 43% of children living with HIV were receiving ART, compared with 54% of adults. Paediatric coverage in West and Central Africa is significantly lower at 20%. Treatment coverage rates are poor across the paediatric age spectrum, but worst in those under four years and 15-19 years.[3]

In 2016, of the 1.2 million HIV-exposed infants in the 21 priority countries, only 51% had access to early infant diagnosis (EID) within two months of birth; of these, only half had this result returned.[4]

To close the treatment gap and progress in the 'unfinished business' of paediatric HIV, we need to expand the narrow scope of an elimination agenda focused on prevention of mother-to-child transmission (PMTCT) to reach all children and adolescents living with HIV and find those that have been lost along the PMTCT cascade. Providing ART to HIV-positive pregnant women in order to prevent their infants from acquiring HIV, PMTCT programmes have been shown to be highly successful. Since 1995, at least 1.6 million new HIV infections among children have been prevented because of these programmes.[5]





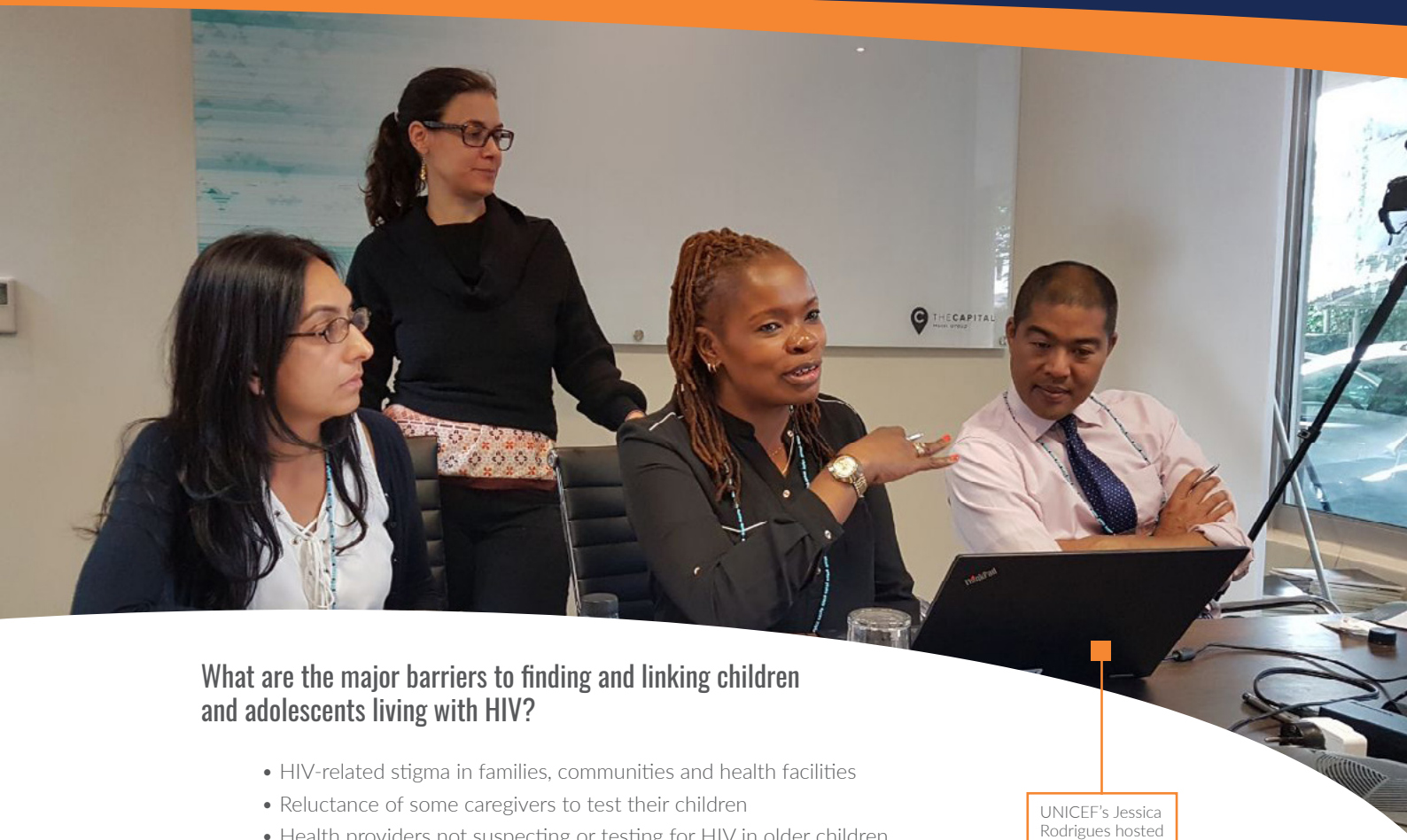
Dr Shaffiq Essajee and Laurie Gulaid (UNICEF) presented global data and trends to highlight the paediatric treatment gap

[2] UNAIDS. *A super-fast-track framework.* https://free.unaids.org/

[3] Dr Shaffiq Essajee (UNICEF): PATA 2017 Continental Summit presentation

[4] Elizabeth Glaser Pediatric AIDS Foundation. *Issue Brief: Point-of-Care Early Infant Diagnosis* (2017). http://www.pedaids.org/wp-content/uploads/2018/01/doing-more-faster.pdf

[5] Avert. *Prevention of mother-to-child transmission (PMTCT) of HIV.* https://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child. Accessed 03/03/2018



UNICEF's Jessica Rodrigues hosted daily webinars at the summit.

What are the major barriers to finding and linking children and adolescents living with HIV?

- HIV-related stigma in families, communities and health facilities
- Reluctance of some caregivers to test their children
- Health providers not suspecting or testing for HIV in older children
- High age of consent for testing and guardianship issues
- Testing not being allowed in schools
- Test kit shortages
- Lengthy turnaround time (TAT) for HIV test results to reach families
- Poor data quality and monitoring
- Human resource constraints
- Limited capacity for community testing
- Adult-centred and inflexible health systems
- Clinic operating times conflict with school hours
- Incomplete referral systems

> "The main challenge the facility have is linking children and adolescents into care. Usually the identified children are not initiated timely (initiated maybe after 2 months) especially those still under custody of parents, mainly because of denial from caregivers or religious beliefs of the caregivers... Retention in care is far below 90%, leading to high numbers of treatment failure which requires children to be switched to next line of treatment."
>
> Nurse, Swaziland

> "The time frame to receive results for infants is too long, that has resulted in major complications even deaths."
>
> Nurse, Zambia

Recommendations for finding and linking children and adolescents living with HIV

Actively identify infants, children and adolescents living with HIV, and use robust tracking systems

An intensified and systematic approach that is 'consistent and persistent' must be adopted to find mother-baby pairs, children and adolescents who have not presented at the health facility.

Watch a LIVE interview with Sister Thelma Nkumane from Lobamba Clinic, Swaziland at the PATA 2017 Continental Summit.

> "What we mean by case finding is being alert and active."
> Anne Magege, The ELMA Foundation

> "There are missed opportunities because we only target those who visit health facilities."
> Doctor, Zimbabwe

> "Children who test positive on site are brought directly to the clinician by the counsellor. A weekly facility based report is sent from the lab of every child who tested PCR positive. Those children are then contacted immediately and asked to come in. A spreadsheet of every positive child (obtained from stats sheets filled in by the testing counsellor as well as the lab PCR reports) is created. This is then reviewed monthly to make sure every single child did indeed access care. If they have not, they are phoned. If phoning fails to bring them in, our social workers are able to do a home visit"
> Witkoppen Health and Welfare Centre, South Africa

However, health system obligation and responsibility in finding children and adolescents should not infringe on caregiver or adolescent rights and agency in choosing whether or not to access testing and care. For example, consent for home visits is critical before initiating home-based index case testing.

Perform routine screening in the sick **and the well**

Provider initiated testing and counselling (PITC) at health services most commonly used by HIV-exposed children like TB clinics, malnutrition services and paediatric wards is a high-yield strategy and requires standard operating procedures (SOP), dedicated human resource capacity, training and supervision. For example, 'cough officers' in Mozambique successfully identify children living with HIV in TB clinics, who are then escorted by peer supporters to HIV treatment sites.[6]

However, an exclusive testing focus on sick or symptomatic children will identify many children too late. What is needed is a high index of suspicion across multiple case finding entry points to improve opportunities for identification. Because testing children in outpatient departments (OPD) is time- and resource-intensive due to high patient volumes, a targeted testing approach within these settings can help to optimise resources. Kanchana Suggu (CHAI) presented a five-question algorithm which has been administered to children 5-19 years attending OPD in Zimbabwe. The algorithm was effective in testing and identifying more children and adolescents living with HIV, and has now been adopted into Zimbabwe's HIV testing services (HTS) guidelines.[7]

[6] E.Karajeanes & N. Ramanlal (Fundação Ariel Glaser). PATA 2017 Continental Summit presentation
[7] Dr Kanchana Suggu (CHAI). PATA 2017 Continental Summit presentation

Clients responding yes to 1+ questions were offered a test		
For children and adolescents 5 – 14 years, ask:	**YES**	**NO**
1. Has the child ever been admitted to hospital?		
2. Has the child had recurring skin problems?		
3. Has 1 or both of the child's natural parents died?		
4. Has the child experienced poor health in the past 3 months?		
Only for adolescents 15 – 19 years, also ask them:	**YES**	**NO**
5. Have you experienced any symptoms and/or signs of an STI, such as vaginal/ urethral discharge or genital sores?		

Dr Kanchana Suggu (CHAI) presented a five-question screening tool for children and adolescents attending OPD

Find children through their connection with HIV-infected adults, such as optimised EID, and index case/ family testing

HIV-exposed infants require systematic and active follow-up until 18 months or the end of the breastfeeding period. Point of care (POC) EID should be rolled out in high-volume sites to offer at-risk infants timely access to testing.

Index case testing is an effective strategy beyond PMTCT to identify children most likely to have been exposed to HIV, with testing itself performed at the health facility (facility-based index testing) or in the home (community-based, door-to-door index testing). Sensitisation of health workers is a critical first step. Data collection tools and documentation such as index case testing SOPs, family registers, family referrals slips and index case testing reporting templates increase the efficiency of programmes.

Family testing events like Know Your Child's Status (KYCS) campaigns encourage adults on ART to bring their children to the facility for testing on a specific day. Same-day ART initiation for those diagnosed positive may be considered. KYCS has successfully driven identification, particularly in older children, and has high linkage rates; however, yield diminishes with time.[8] Focus on family members of people newly diagnosed as HIV-positive may be particularly effective.

> "Since 2013, we have successfully implemented the Know Your Child's Status program, which involves community outreach sessions, and encouraging clients to bring their children for testing. We have also partnered with other organisations that work with orphans and vulnerable children in the surrounding communities to test children after receiving consent from their guardians. We have trained some of our clients as peer educators who reach out to the community, educating and referring parents and their children for testing."
>
> Alive Medical Services, Uganda

[8] Elizabeth Glaser Pediatric AIDS Foundation. PATA 2017 Continental Summit presentation

In deploying index case testing strategies, a comprehensive definition should be used, with wide-ranging categories of people as index cases, such as:

- Parents
- Siblings
- Adolescent partners
- The deceased

> "The index may not always be the parent. Sometimes it is the adolescent who is the index for the siblings or the parents."
>
> Dr Elizabeth Okoth, EGPAF

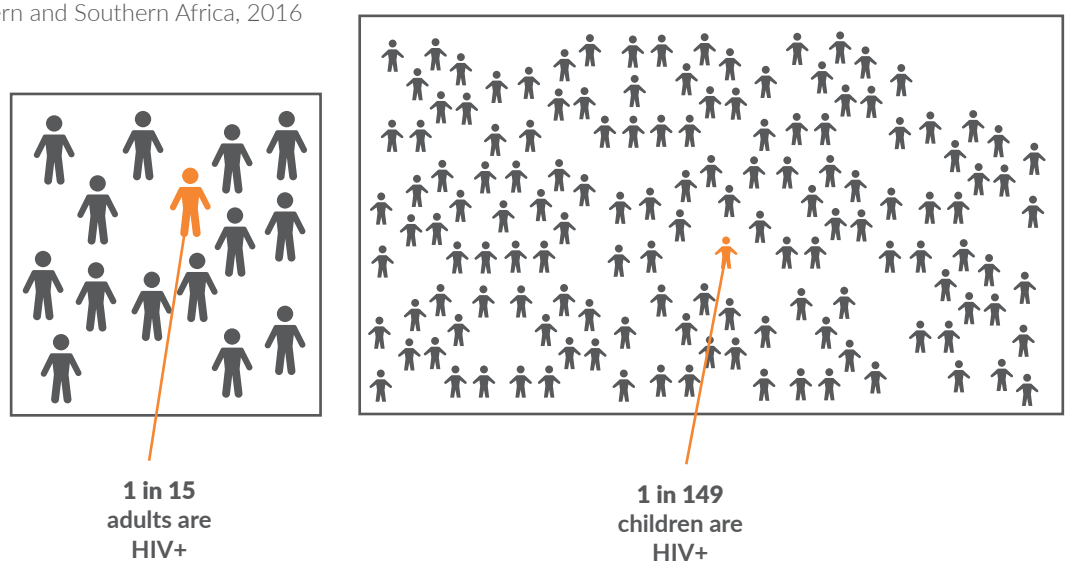
Use targeted rather than generalised community testing

Despite lower yields in universal community testing versus facility-based testing, community-based testing strategies are important to find children who would not otherwise present at a facility. Because the prevalence of HIV in children is lower than in adults, case identification through community testing is more challenging in paediatric populations. For this reason, it is important to prioritise, using targeted community testing that is customised to the epidemic in a particular setting to generate the highest yield. In the context of paediatric and adolescent populations, this would include outreach testing in epidemic hotspots, such as orphans and vulnerable children (OVC) centers and orphanages for example.

> "There is plenty of room for local innovation."
>
> Laurie Gulaid, UNICEF

Finding HIV+ children is relatively harder given low prevalence

Estimated HIV prevalence for adults and children
Eastern and Southern Africa, 2016



In resources-limited settings, prioritising and targeting case finding can help

Dr Kanchana Suggu (CHAI) provided analyses using World Bank Population Data from Eastern and Southern African countries and the UNAIDS 2017 Gap Report

Implement after-hour testing for adolescent populations

Tailored testing service times that accommodate school hours, such as evenings, weekends or school holidays, should be implemented.

Dr Elizabeth Okoth (EGPAF) shared this sign which is displayed at a Kenyan clinic offering extended testing hours for adolescents

Complete linkage

Effective linkage to treatment must be ensured regardless of testing strategy. Once HIV status is known, children and adolescents living with HIV must be efficiently and swiftly connected to treatment and care services. Electronic patient tracking systems are important, as well as mobile technology for community health workers to trace patients, correct false physical addresses and record outreach activities. Programmes which place a focal person such as a peer supporter or case manager at testing to physically escort the client to the treatment entry point have seen success.

> "With the implementation of physical escorting as well as use of the triplicate referral forms, all those testing positive irrespective of whether you are a pregnant mother, lactating mother, child, adolescents or adults, all get to the enrolment desk and are successfully linked to care."
>
> Lira Infectious Disease Clinic, Uganda

Facility snapshot

Of the 56 attending facilities, active paediatric or adolescent case finding was reported by:

- PITC: **81%** (TB services **60%**; inpatient wards **53%**; immunisation clinics **49%**)
- Index case testing: **77%**
- Community/ home-based testing: **49%**

Sixty-eight percent assign a unique identifying number to mother-baby pairs.

Key cross-cutting messages and lessons

- Smart testing strategies enhance yield
- Case finding requires dedicated resources, supportive policy, clear operational guidance, training, mentorship and/or supervision and robust monitoring
- Effective linkages, strengthened referral systems and joint activities between clinic and community are imperative, with community health workers playing a critical role as testers, counsellors and in follow-up
- Electronic patient record systems are needed to improve tracking and linkage
- Continuous rather than once-off testing must be ensured

TREAT

WHO global guidance to treat all children living with HIV has now been taken up at national level by almost all countries in the region. In the era of 'treat all', it is no longer about whom to treat or when to treat, but how to treat. To successfully initiate and adhere to ART, children and adolescents living with HIV must receive the comprehensive, high-quality services they need.

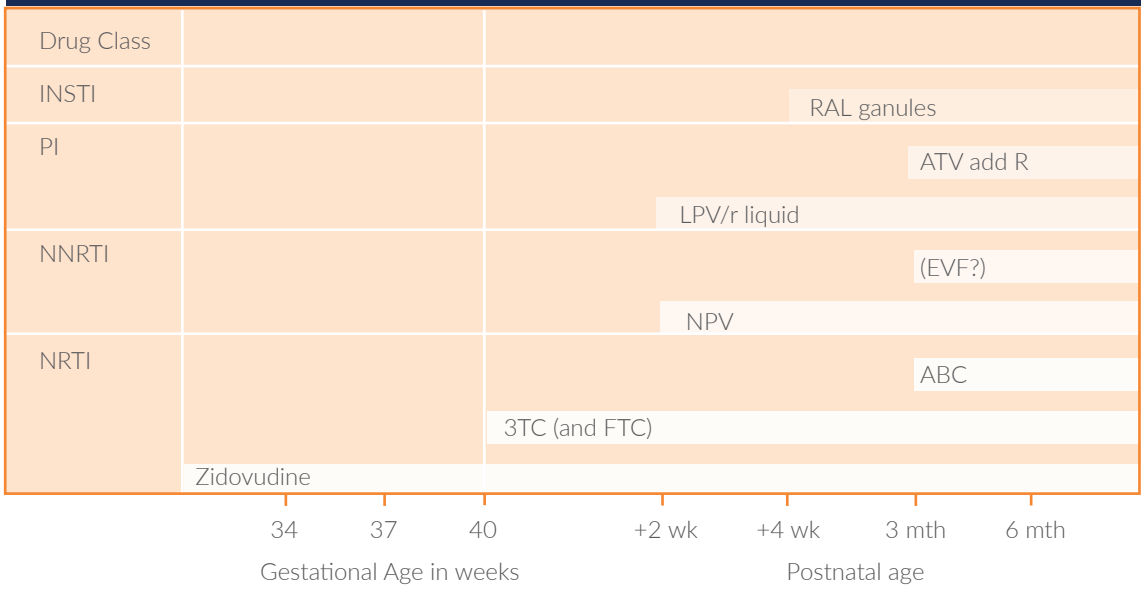
What are the major barriers to treatment of children and adolescents living with HIV?

- Suboptimal formulations and increasing levels of drug resistance
- ART stockouts
- Coinfections that require staggering the initiation of both treatments
- Heavy workload of health providers
- Lack of confidence on the part of health providers to initiate and manage ART in children
- Poor treatment literacy and treatment readiness
- Laws criminalising HIV transmission

Is this the best we can do?

Watch a LIVE interview with counsellor Immaculate Monica Awor fom Mityana Hospital in Uganda, at the PATA 2017 Continental Summit.

The Limited Repertoire of ARV Drugs for Infants



Dr Nandita Sugandhi (ICAP) **reported on** the limited formulations available for paediatric populations, and challenged the global HIV community to ask ourselves: "Is this the best we can do?"

Recommendations

Don't delay the start of ART

Children who start treatment early have superior neurodevelopmental outcomes, including both cognitive and motor function, as well as consistently higher CD4 counts.[3]

> "There should be zero 'pre-ART' children in your clinic registers. If there are, treat them! If there are any who have been lost to follow-up, tracking, finding and bringing them back to care should be a priority."
> Dr Shaffiq Essajee, UNICEF

Use simplified initiation processes and consider same-day test and start, but ensure treatment readiness

Where possible, initiate ART on the same day that testing occurs. Nevertheless, it is imperative to maintain standards of adequate preparation, ensuring patient readiness because hasty treatment initiation without sufficient readiness preparation and support is itself a driver of early loss to follow-up. This relies on appropriate, quality counselling and support by health providers or peers with good counselling skills, both before initiation and during follow-up.

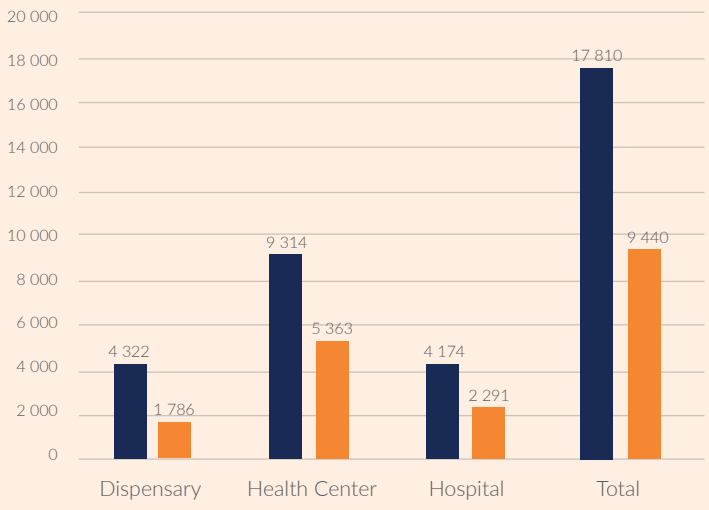
> "One major challenge has been increased defaulting because clients are expected to go home with medications the same day they test positive without necessarily accepting the conditions."
> Counsellor, Cameroon

Promote nurse initiated management of ART

Nurse initiated management of ART (NIMART) is a proven strategy and has been shown to increase treatment coverage for children[3]. NIMART enables nurses to perform ART-related responsibilities previously assigned only to doctors and medical officers, preserving health system resources and decentralising care for patients.

Promote nurse-initiated ART for children

- In Tanzania in 2013, Peds coverage was just **26.5% coverage**
- Severe physician shortage (0.03 per 1,000 population)
- Nurse initiated management of ART (NIMART) proposed to address this
- Policy adoption → SOP → in-service training → nurse serive delivery model permitting testing, ART, and dispensing



Dr Shaffiq Essajee (UNICEF) presented data from the ACT Report supporting NIMART for children

Provide the best treatment available and advocate for better paediatric formulations

We have insufficient drug options for paediatric populations. While lopinavir/ritonavir (LPV/r) is the preferred drug for infants and children under three years, it requires cold chain, has a bitter taste, is heavy to carry and hard to store. For children 3-10 years, the preferred regimen is abacavir (ABC), lamivudine (3TC) + efavirenz (EFV), but there is currently no triple fixed dose combination available, and multiple tablets must therefore be taken.

What is ART optimisation?

- Potent
- Low toxicity
- Well tolerated and easy to take/administer
- High generic barrier to resistance/durable
- Improve sequencing/switching options
- Can be harmonized across special populations
- Reduce cost

Dr Nandita Sugandhi (ICAP) outlined the requirements for improved paediatric formulations

Today, optimisation of ART for children includes some important developments. LPV/r oral pellets are finally available, which relieve cold chain requirements. However, challenges with administration in infants under three months must be considered. Field evaluations are ongoing to gather experiences and inform wider uptake. Dolutegravir (DTG) is rapidly becoming a preferred drug for adults and adolescents and is currently approved down to 12 years; in the near future we are expecting data to support the use of DTG in children down to six years.[9]

In the context of limited formulations, providers must optimise the best treatment available:

- For neonates diagnosed in the first month of life, the options are not simple, but these are the only possible regimens for use considering age indications and availability of current formulations:

	0-2 weeks →	2 weeks – 3 months →	3 – 36 months
Preferred	AZT + 3TC + NVP	ABC or AZT + 3TC + LPV/r syrup	ABC or AZT + 3TC + LPV/r pellets
Alternative	AZT + 3TC + NVP*		ABC or AZT + 3TC + LPV/r pellets
Special circumstances	AZT + 3TC + NVP	ABC or AZT + 3TC + RAL (from 4 weeks)	

- For children, RAL and ATV/r are now included in second line:

[9] Dr Nandita Sugandhi (ICAP): PATA 2017 Continental Summit presentation

	Children including adolescents	First-line ART regimen	Second-line ART regimen
LPV/r-based first line	Younger than 3 years	ABC + 3TC + LPV/r	AZT or ABC + 3TC + RAL
		AZT + 3TC + LPV/r	
	3 years and older	ABC + 3TC + LPV/r	AZT + 3TC +EFC or RAL
		AZT + 3TC + LPV/r	ABC or TDF + 3TC + EFV or RAL
NNRTI/r-based first-line regimen	All ages	ABC + 3TC + EFV (or NVP)	AZT + 3TC + ATV/r or LPV/r
		TDF + 3TC + EFV (or NVP)	
		AZT + 3TC + EFV (or NVP)	ABC or TDF + 3TC + ATV/r or LPV/r

- **Adolescent treatment is harmonised with adults**

While ART adherence is often understood as a clinical experience, emerging research presented by Mzantsi Wakho at the summit on the 'Yummy or Crummy' experiment highlighted the multi-sensory and socio-economic dimensions of medicines-taking, including taste, smell, size, colour and volume of medicine as well as dependable supply of running water.[10] Thus increased advocacy must be undertaken to drive ongoing improvements to drug formulations, taking taste, size, packaging, look and feel into account.

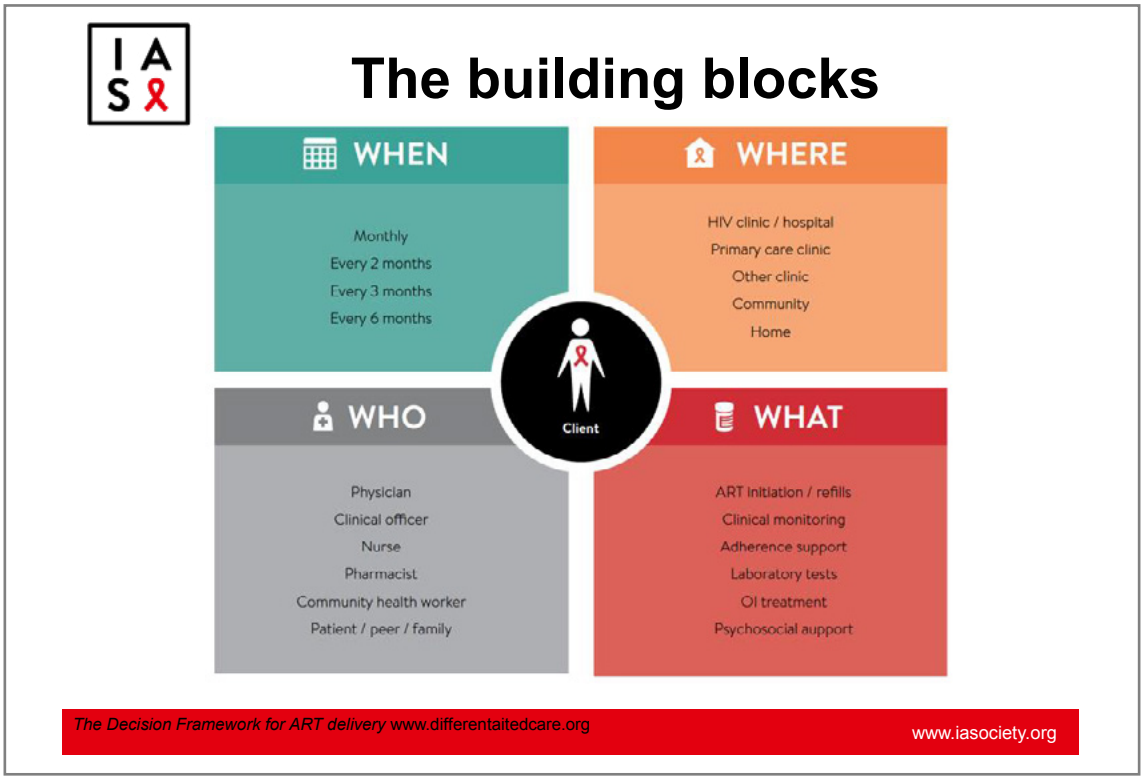
Watch a LIVE interview with Nehaben Ramanlal from Fundacao Ariel Glaser in Mozambiquei at the PATA 2017 Continental Summit.

Use a differentiated care approach

HIV services have historically been provided through health facilities only. Patients are expected to attend a health facility for an HIV test; if testing positive, the patient must come back to the facility to start ART. Once on ART, the patient is required to return to the facility for a clinical consultation and ART refill, usually monthly, for the rest of their lives. This approach treats all patients the same despite their differing needs and does not leverage our scarce health resources towards those most in need. A differentiated care approach, or differentiated service delivery (DSD), requires us to shift our thinking about how to provide HIV services, and begin to provide different groups of patients with different models of service delivery at different points along their HIV treatment pathway in order to provide responsive care and decrease the health service burden.

[10] Mzantsi Wakho. PATA 2017 Continental Summit presentation

Differentiated care, of differentiated service delivery (DSD), is a **client-centred** approach that **simplifies** and adapts HIV services **across the cascade** to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while **reducing unnecessary burdens on the health system.**



Dr Anna Grimsrud (IAS) defined DSD, and presented a decision framework that determines when (how often), where (facility or community), by whom (provider or community member) and what services patients should receive

In the context of paediatric and adolescent DSD, it is important to remember:

- After the age of two years, six-monthly clinical consultations are sufficient to detect weight changes that require ART dosage adjustments. For stable children to receive longer supplies of drugs, they should ideally be taking pellets or tablets rather than syrups (which often have shorter shelf lives and are more bulky for transporting to and from collection points)
- Clinical visits should include expedited ART collection
- For adolescents, six-monthly clinical consultations provide sufficient opportunity to identify mental health and sexual and reproductive health and rights (SRHR) needs, with adolescents able to see a clinician in between six-monthly visits if required. For those in school or university away from home, visit schedules should be aligned to the school calendar
- Clinically stable children and adolescents 2-19 years can therefore transition to multi-month prescriptions (MMP), with clinical consultations and ART refills three to six monthly
- Psychosocial support can be provided more or less often (one to six monthly), in person or virtually by trained lay providers or peers
- Family DSD models simplify access and reduce cost. In Zimbabwe, a family DSD model relies on a single family member to collect and distribute ART refills for those in the family group older than two years, with clinical consultations more frequent for young children and psychosocial support accessible for adolescents in the community [15]

[11] Dr Anna Grimsrud (IAS). PATA 2017 Continental Summit presentation

Find tools and resources on differentiated care here.

> "We can't keep doing the same thing and expect to double our patient cohort."
> Dr Anna Grimsrud, IAS

Facility snapshot

Of the 56 attending health facilities,
77% report providing DSD* for children, and
89% for adolescents.

*as defined as 'individualised care based on a client's stability and adherence to ART'

Programme spotlight: Witkoppen Health and Welfare Centre DSD for children and adolescents, South Africa

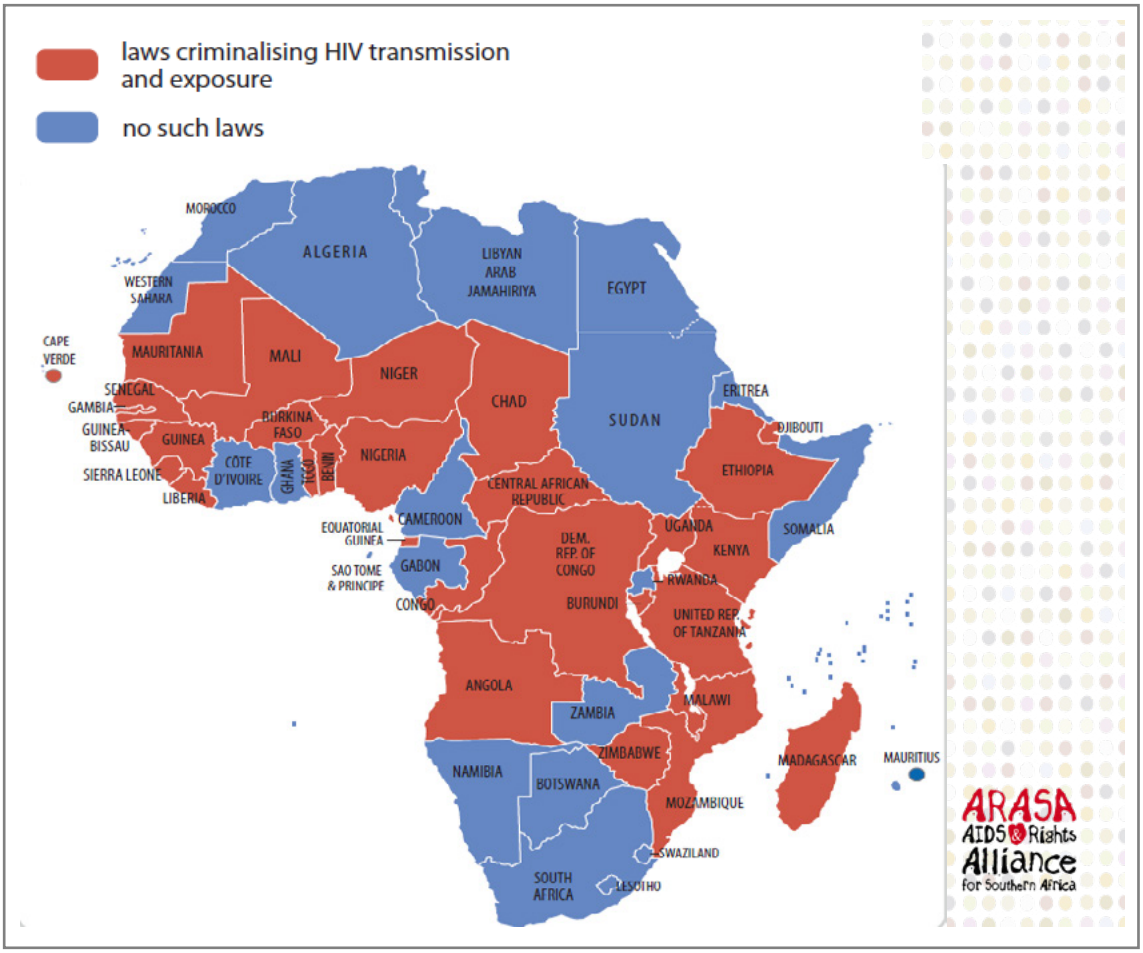
Witkoppen Health and Welfare Centre harmonises mother-child visits to minimise clinic visits for families. At clinic visits, mothers and children are seen together. Stable children are seen three-monthly and stable mothers six-monthly. Drugs are issued every three months so the mother receives her ARV refill at her child's three-monthly visit. On those visits, the mother does not need to see the clinician; they can go directly to the pharmacy after the child's consultation and collect medication for both of them. Stable adolescents are seen three-monthly. Prior to the booked visit, the files are pulled, scripts written and medication pre-packed. On the clinic visit day, the adolescent has his/ her vitals done, attends a support group session with peers and has a provider consultation afterwards. The adolescent then collects medication directly from the counsellor and does not wait in the pharmacy queue. All of these activities happen in the same area. If blood tests are needed, the forms are given at the previous visit so that the adolescent can attend the clinic to have blood drawn and results will be ready by the next visit.

Key cross-cutting messages and lessons

- Care must be patient-centred. If this is not done, no matter how efficacious the intervention, it will not be taken up.
- Increased investment is needed to reach targets and sustain programmes
- Comprehensiveness of service (a 'one-stop shop' or 'supermarket' approach) must not compromise quality
- Addressing key barriers for inadequately served populations

> "If you don't give me what I want as a patient at your facility, I will go somewhere else and I won't mention you."
> Paddy Masembe, AY+

> "We are being asked to double our cohort in the context of flatlining resources, and I don't want anyone to think that acting creatively or DSD is the panacea. We need investments from lots of places."
> Dr Anna Grimsrud, IAS



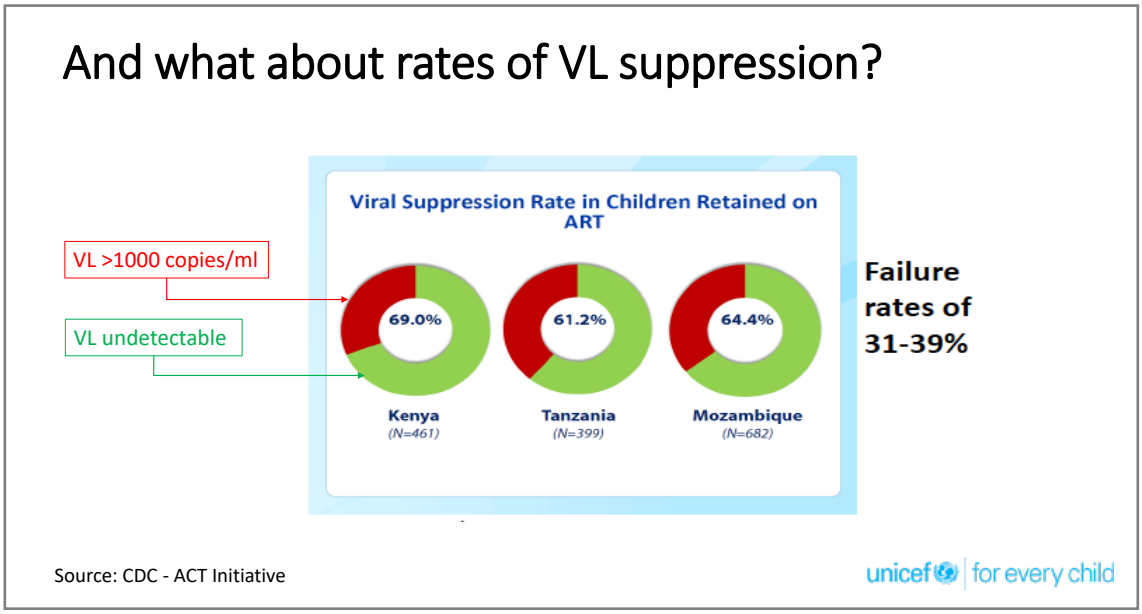
Four key 'pressing threats' to human rights-based responses to HIV and TB

- Changing funding context and landscape, ***"HIV Fatique"***
- India "no longer the pharmacy of the South" = *International trade challenges hindering access to new medicines and commodities*
- Progressive guidelines in low-resource environments which cannot accommodate contextual realities (e.g 'Test add Treat')
- Proliferation of criminal 'sanctions' toward certain people and disease(s):
  - Laws/policies promote **child marriages**, but do not provide for **'age of consent'** for accessing SRH services, incl. access to sage abortions
  - Laws/Policies which refuse female primogeniture & proliferation of child-led households with no psycho-social support
  - State-sponsored stigma & discrimination through policies which force HCWs to provide access to

Lynette Mabote from ARASA called attention to how the provision of adolescent and youth friendly programming requires an enabling policy and legal environment and is challenging in the midst of pervasive criminalisation of HIV transmission.

CARE

Retention of HIV-infected children and adolescents in care is essential for preventing HIV-related morbidity and mortality. To achieve and maintain viral suppression, high-quality support services and an accommodating facility and community environment are critical.



Dr Shaffiq Essajee (UNICEF) presented data from the ACT Report showing high viral suppression failure rates

> "We have to get to the last 90% for everybody. We can't just get to 90% for the total patient population. We need to get to 90% for each population group."
>
> Dr Nandita Sugandi, ICAP

What are the major barriers to care for children and adolescents living with HIV?

- Lack of disclosure and stigma
- Shifting caregivers
- Bulging health system, with high patient load and health provider burnout, reducing capacity for psychosocial support
- Adolescent psychosocial challenges
- Health provider stigma
- Poverty and socio-economic issues, including disrupted or broken family, alcohol or drug abuse, clinic user fees, long distances to clinic and high transport costs, and food insecurity
- Limited access to early learning centres and safe and supportive youth spaces

> “Some care givers do not give drugs to their children in fear of being divorced by their spouses once they find out that they are taking ARVs.”
> Nurse, Zambia

Recommendations

Use the clinic as an entry point to intervene early and build caregiver resilience and skills
The first 1,000 days of life – from conception to two years – is a critical period for development that is foundational to lifelong health and wellbeing. It is therefore the time when the greatest support is needed to optimise a child’s development.

> “The first 1,000 days in a child’s life are critical for overall health and development. Nurturing interactions between parents, caregivers and the child stimulate healthy brain development and growth, paving the way for better results in schooling and overall increased productivity in life.”[16]

Over 200 million children will not fulfil their development potential, preventing us from reaching SDG 4, which impacts on the ability to meet targets for SDGs 3 and 5. Poor development of children is exacerbated in low-income countries facing serious social and health issues. Furthermore, these settings have high rates of HIV, which has been shown to lead to substantially worse developmental outcomes for HIV-exposed children.

The caregiver’s psychosocial and mental wellbeing is a critical enabler of both early childhood development (ECD) and retention, through early stimulation, positive attachment and emotional and adherence support. However, an HIV-positive mother often faces challenges including stigma and discrimination, disclosure, poverty, mental health issues and gender-based violence. During this period especially, mother-child pairs accessing HIV services should be supported beyond clinical treatment, with the facility as an entry point to:

- Child growth and development monitoring
- Caregiver psychosocial support, including engagement and education around ECD, responsive parenting and nutrition
- Social protection services

> “We want to build caregiver resilience so that families can support children to stay in care... But it’s important for us to realise that once-off psychosocial support interventions don’t work. What works is ongoing support. There are no quick fixes when it comes to psychosocial support for sustained wellbeing.”
> Noreen Huni, REPSSI

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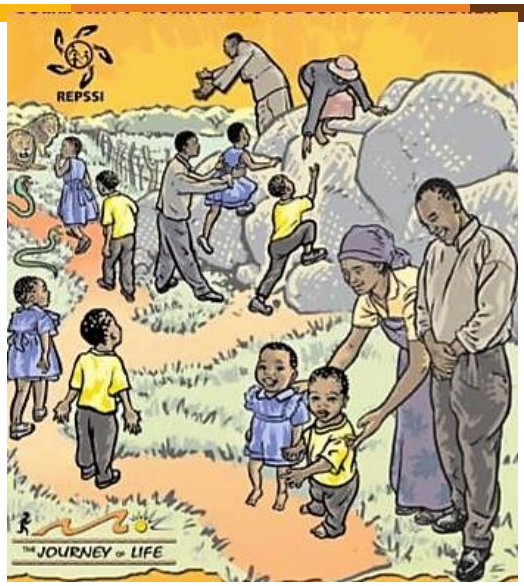
FAMILIES & COMMUNITY MOBILIZED TO CARE & SUPPORT FOR RETENTION

Community parenting – able to identify families that need parenting support (teen parents)



Watch a LIVE interview with REPSSI's Noreen Huni at the PATA 2017 Continental Summit.

Community as a social safety net – customs and traditions that support the parent/caregiver.

Resilient families and communities can deliver positive change for children – ensuring retention in care

REPSSI

Noreen Huni (REPSSI) described the importance of leveraging community capital to support resilience in children and families

Programme spotlight: Maboleni Clinic, Zimbabwe

Maboleni Clinic has established training groups for HIV-positive mothers of children under five years. In preparation, five days of training on early childhood stimulation were provided for a nurse, two village health workers and a teacher. This trained team then provided sensitisation and training for the mother groups on the importance of the first 1,000 days of life, responsive parenting and stimulation, toy-making, signs of infection in children, PMTCT, family planning, nutrition and income generation. Mothers completing all training sessions within the group are awarded certificates. The trained village health workers then undertake regular home visits to these mothers to support progress and ongoing learning. The programme reported improved mother-child communication and increased HIV testing of children.[12]

[12] Chrispo Madhovoyo, Maboleni Clinic, Zimbabwe. PATA 2017 Continental Summit

PATA Youth Advisory Panel

Adopt a family care approach

Services should be tailored to keep families together, including harmonised family visits for ART refills, clinical consultations and psychosocial support. Harmonised family visits can also be used to encourage attending family members to mobilise any remaining family members for testing. While facility-based psychosocial care for children should be offered, this support is best provided on a day-to-day basis by the family itself. This means that facility psychosocial support services must be strongly linked to the family in order for the home to continuously reinforce messaging and behaviours.

Support early disclosure

Disclosure remains a major challenge and is a barrier to treatment initiation, adherence and retention. Merely having tools and guidance is not enough and disclosure to OVC is particularly difficult without parental support. Efforts around counselling on disclosure must be intensified. Disclosure to a child is a gradual process best started early and centred around age-appropriate discussions. Children are then encouraged to disclose to those significant others who can be a critical resource for adherence and retention.

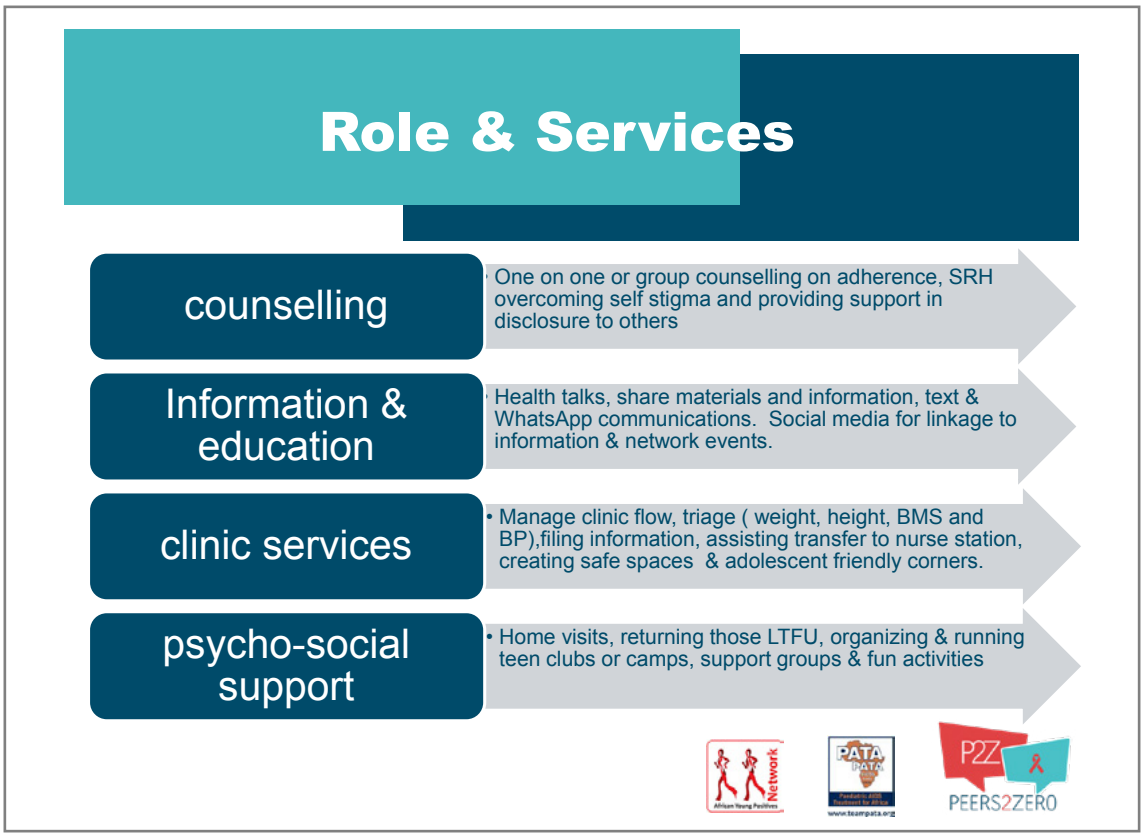
> "Due to fear of stigma and discrimination families or caregivers do not disclose the status of theirchildren. Even the children do not know their status at least to 16 years old; so there is poor linkage due to caregivers do not allow for children to go to clinic."
> NGO manager, Ethiopia

Offer peer-led, supportive, integrated services for ALHIV

The adolescent period presents unique challenges to ART adherence, viral suppression and retention in care. Adolescents living with HIV (ALHIV) require access to integrated HIV and SRHR services – with reduced waiting time – that address their distinct needs and are fun and engaging.

> "Adolescents have been poorly managed at our facility. We admit it is a special needs population that needs concerted effort by not only the clinic alone but all stakeholders. We could only reach few of them and poorly retaining the same few in care."
> Nurse, Zambia

Direct peer support services, where YPLHIV deliver support for their peers, is a key methodology and should be maximised. Young peer supporters must be meaningfully engaged and involved in all relevant aspects of AFHS service delivery, from programme design to delivery of services and monitoring of results. YPLHIV are a critical resource in their unique understanding of their peers' challenges and can use this understanding to shape responsive services. In this way, peer support can be used as part of a package of youth friendly services to make facilities feel safer and more accessible for young people.



Grace Ngulube and Lubega Kizza (REACH and P2Z) outlined some of the key roles that peer supporters can fulfil, as well as the nuts and bolts of peer support programme implementation

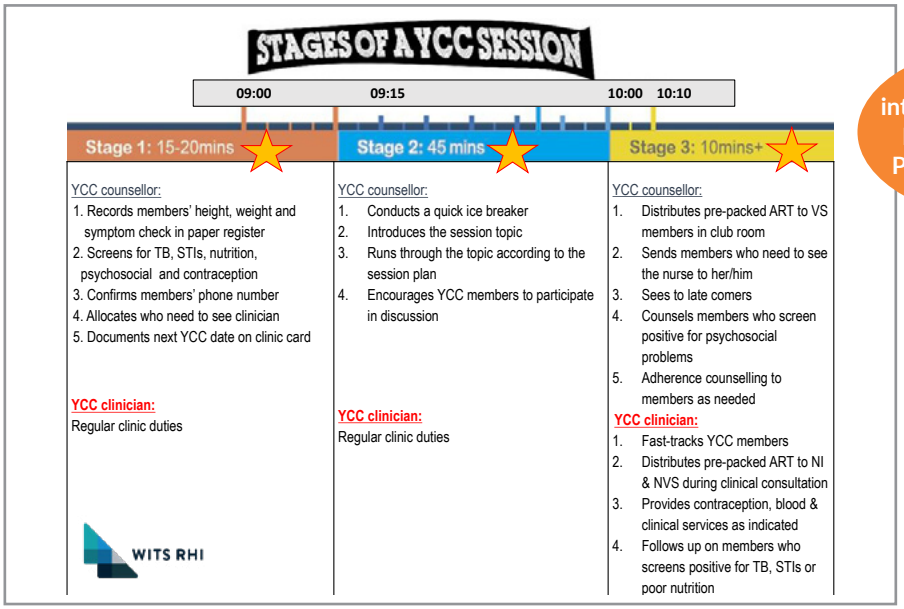
But how are young peer supporters recognised, integrated and supported? Facility hierarchies mean that peer supporters are infrequently engaged as equal partners in delivery of care and have great responsibility with limited support. The cadre is generally not accredited, often uncompensated and has restricted opportunities for professional growth and future prospects.

> "What is the difference between me as a peer supporter, providing services from 09h00-17h00, and a counsellor, providing services from 08h00-16h00? We do similar work, but the counsellor is getting a salary, and I am getting a stipend. We want to be employed and not only be seen as volunteers."
>
> Kelvin Makura, GNP+ and READY+

Programme spotlight: Wits RHI Youth Care Clubs, South Africa

Wits Reproductive Health & HIV Institute (RHI) recognised the challenges that ALHIV face in accessing HIV services. They were aware that young people report limited privacy in health facilities, having to miss school to attend visits with long waiting times, and judgemental attitudes from health providers.[13] They set out to better support the complex needs of adolescents through youth care clubs (YCC) that are scalable and replicable in the public health sector.

YCC are closed groups of 20 adolescents and young people living with HIV categorised by age: 12-15 years, 16-19 years and 20-24 years. Members are at various stages of their ART journey – with some new on ART, others not yet virally suppressed and others suppressed. The clubs are run by existing facility staff – specifically, a lay counsellor, supported by a clinician (most frequently a nurse) who have both attended a four-hour long YCC training. YCC meetings are held at the clinic, with integrated clinical and psychosocial support: clinical consultations, pre-packed ART refills, contraception, routine health screening and interactive discussion in one quick visit. For the first 12 months, YCC meetings are monthly; thereafter, each club decides if it wants to continue meeting monthly or extend to every second month.



Each YCC meeting is 1-2 hours, and includes three stages [13]

Watch a LIVE interview with Wits RHI's Ruth Henwood at the PATA 2017 Continental Summit.

[13] Ruth Henwood, Wits RHI. PATA 2017 Continental Summit presentation

There are currently 325 YCC members, with retention in care 88% at six months and viral suppression 81% at last viral load. Some of the challenges encountered include the cost of providing refreshments due to food insecurity and malnutrition, rigid clinic hours limiting YCC meeting times, facility staff having no prior training in supporting adolescents and young people, high staff turnover and insufficient private space at the facility.[13]

Key cross-cutting messages and lessons

- Training, supervision, tools and support must be in place to enable quality counselling
- Identify, link and monitor referrals to community-based organisations for psychosocial support

Facility snapshot

The 56 attending facilties report an aggregate viral suppression rate of **49%** for infants, children and adolescents on ART. Ninety-six percent track missed visits and **87%** conduct home visits for patient tracing.

Ninety-eight percent offer family counseling, and **98%** disclosure support and counseling.

Ninety-three percent provide peer support groups for adolescents; **86%** of these are separated by age, **35%** by gender. Seventy-two percent offer peer support activities such as sports, arts or camps.

SPECIAL FOCUS: STRENGTHENING THE HEALTH WORKFORCE

Across the summit, one message was clear: We must take better care of health workers – a responsibility which requires heightened attention as we increase the burden of care in the context of flatlining resources.

> "Strengthening the healthforce is critical for implementation."
> Dr Angela Mushavi, Ministry of Health and Child Care, Zimbabwe

> "We can't do anything without people. People are at the centre of the system."
> Dr Stephanie Thomas, Zoë-Life

Long working hours and the requirement to provide empathetic care without adequate emotional support, leads to high risk of burnout, compassion fatigue, low morale, increased absenteeism and high attrition rates in health facilities. Responses from managers to problems of quality often include disciplinary action and more intensive monitoring and are not acknowledging or building. A stress test taken by attending health providers at the start of the summit showed that 37% may be at risk of burnout, with those in clinical and psychosocial roles reporting similar levels.[14]

THIS IS OUR SPACE in time to be CREATIVE AS LEADERS

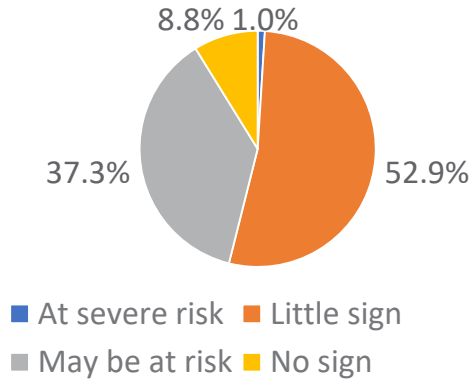
By acknowledging that people are the most important component of our system, lets think about:

WHAT DO WE KNOW?	LOOK FOR GOOD PRACTICE	THINK ABOUT SYSTEM WIDE IMPROVEMENTS
About the state of our people?	To see what is possible and stimulate creativity	That could make a significant contribution

Watch a LIVE interview with Elleloang Susan Damane from Queen Elizabeth II Hospital, Lesotho at the PATA 2017 Continental Summit.

[14] Dr Stephanie Thomas (Zoe Life). PATA 2017 Continental Summit presentation.

WHAT DO WE KNOW ABOUT US?
Risk of burnout by delegates (n=102)



- Average score: 30.3 (Little sign)
- Clinical (30.7), psychosocial (29.4) and designation unknown (32) reported similar levels of burnout
- The maximum burnout score was 51 (At severe risk) (n=1)

Dr Stephanie Thomas, Zoë-Life, looked at the stress levels of delegates

> "We have noted burnout among counsellors affecting productivity, increased number of sick days, increased disagreements among counsellors, and frustration and despondency about normal work challenges."
> Doctor, South Africa

> "Ministry of health should know that down here we are struggling. We seriously get burnt out."
> Doctor, Lesotho

Build resilience in health providers

To avoid health provider burnout and isolation, we should use health provider skills-building opportunities to embed resilience-strengthening activities. Examples include debriefing, sharing feelings and experiences, listening, self-awareness exercises, practicing self-care routines, stress release and fun and laughter.

> "How do we support our own resilience as parents and caregivers? And how do we support those around us? We feel responsible. To be responsible, you need to be able to respond, and to do this, you need to be physically and emotionally healthy."
> Kate Harrison, AVERT

> "We need a place of work to be a space that supports us without blame or shame, and that recognises us."
> Dr Paul Cromhout, Small Projects Foundation

Provide skills-building opportunities

Despite NIMART's proven efficacy, scale-up of nurse-managed ART programmes for children lag behind those of adults. Nurses often do not feel confident in managing children, have fewer opportunities to see children and be mentored on paediatric ART, and delay accepting down-referred new paediatric ART cases at a programmatic level.

In-service training and skills-building for providers is therefore critical, and may be implemented in various ways:

- On-site or off-site. In low-resource contexts, both modalities present inherent challenges; facility-based training is met with competing priorities for busy providers and potential for distraction, while off-site poses difficulties in maintaining patient services
- Facilitated, self-learning or team learning

Programme spotlight: Anova Health Institute nurse mentorship at benchmarking sites, South Africa

The Anova Health Institute has established seven benchmarking sites in Johannesburg, South Africa, where paediatric ART volume is high and children are seen on a specific day each week. Nurse providers from other facilities are invited to visit these sites on the paediatric day to gain exposure and experience. At these visits, a resident nurse or doctor provides mentorship. While the ANOVA programme is able to offer roving nurses to cover duties of at mentee home facilities while they are attending mentorship, the offer is rarely taken up, indicating that this mentorship model may be replicable by lower resourced programmes. Over the past 12 months, the programme has mentored 58 nurses and shown improved paediatric ART linkage and initiation.[15]

Programme spotlight: Small Projects Foundation self-learning teams, South Africa

The Small Projects Foundation has implemented self-learning with health provider and community health worker teams at 49 facilities in the Eastern Cape. Learning teams self-study modular learning materials in two-week blocks and then gather fortnightly to learn together, discuss cases, debrief and perform self-care exercises. Early programme successes include increased knowledge, with 96% of learners achieving a test score of >80%.[16]

Regardless of approach, presenters provided a few overarching principles and recommendations:

- Episodic, intensive skills-building must be supported by ongoing learning, such as supportive super vision or mentorship
- Facility-level and sub-district buy-in is important to support participation and implementation
- Friday afternoons tend to be a suitable time for on- or off-site training, when the clinic is quiet and peer-to-peer learning can be facilitated

Increase provider to patient ratio and engage lay health workers

Investment in the health workforce is about more than training and capacity-building. Ensuring that sufficient numbers of health providers are in place to implement programmes, manage the increasing patient burden and meet ambitious targets is crucial. Throughout the summit, health providers described intensive workloads as a barrier to effective service delivery, and being confronted by long queues and huge patient numbers in their endeavours to put their skills to use. Pragmatic human resource policies like task shifting and task sharing will support cost-efficiency.

> "It's not me. It's the situation I am in." Counsellor, Uganda

[15] Carol Tait (Anova Health Institute). PATA 2017 Continental Summit presentation

[16] Dr Paul Cromhout (Small Projects Foundation). PATA 2017 Continental Summit presentation

Involve health providers in policy development

As we set global priorities, health providers must be heard, valued and invested in within a human rights context especially as the work demands increase.

> "Did you get the opinions of counsellors – who see 20 people a day? The moment we don't involve people at all levels, then policies made at the top won't lead to anything. Let's use a bottom-up approach."
> Social worker, Kenya

SILOS AND SCHISMS IN HIV SERVICE DELIVERY: CROSSING THE DIVIDE

Throughout the summit, participants referred to fragmented health teams, practices, approaches and systems, including:

- Hierarchies in health provider-patient interactions
- Blame between different roles within the health team
- Disparate recognition and remuneration systems for health providers and lay health workers
- Disconnect between policy-makers and frontline implementers
- Prioritisation of clinical over psychosocial needs
- Poor linkage between testing and treatment services
- Competing prevention and treatment messaging
- The health system and community-based responses operating in isolation
- Insufficient time to record data and implement services versus time to analyse and reflect on results and lessons
- The aspiration of best practice versus the reality on the ground

While we operate within silos, maintaining an either/or approach to service delivery, we are unable to improve efficiency, care and outcomes for our patients. The wide gap between policy and practice is bi-directional with laws and local protocols often failing to keep pace with best practice.

The answer? We must adapt our ways of working as a global response, community and health service team, becoming more expansive and assimilating the siloed pieces. We must connect the proverbial dots between healthcare and community, supporting people across the various dimensions of their lives through partnership, collaboration, strengthened referrals and joint responsibility. We need to create an integrated health system that cares for a patient holistically, incorporating allied clinical and psychosocial services. Within health teams, we must facilitate solidarity and teamwork, prioritising communication and co-operation, with clinicians, nurses, counsellors and lay providers speaking 'one language' and striving towards common goals in partnership with patients.

Summit outcomes and follow-up

The PATA 2017 Continental Summit culminated in attending health facility teams participating in a workshop process to complete a QIP for a simple, feasible activity to improve paediatric and/or adolescent HIV service delivery in 2018. Together, these 53 projects will support collective efforts on the frontline to reach urgent global HIV targets. PATA will support these facilities to document and evaluate some of these emerging promising practices.

Just over half (53%) of facilities elected to focus on the summit's CARE theme, 39% on FIND and 8% TREAT. FIND projects include community engagement and mobilisation, weekend testing for adolescents, sibling index case testing, KYCS testing days, targeted community testing in recreational parks, and PITC in paediatric wards and OPD. TREAT projects focus on differentiated service delivery and intensified viral load monitoring. CARE projects include ECD community groups for HIV-positive mothers, peer support groups, adolescent service integration and flexible clinic hours.

> "Every client who will pass through the clinical area will be asked about the siblings at home. We will give them slips to give to their siblings. Others who will not make it due to transport problems, will be home visited, and tested at home."
> Tisungani Clinic, Malawi

> "We will establish a triage station and identify an officer to review files the day before. We will use multi-coloured stickers to segregate the clients according to the services due (pharmacy pick-up, psychosocial counselling, contact visits, VI testing). We will also prepack drugs at pharmacy into brown paper bags and label for each client."
> Kilgoris Subcounty Hospital, Kenya

> "We want to improve care for HIV+ adolescents by introducing differentiated care services and Youth Care Clubs. We will implement a segmented day, age group and time specifically for HIV+ adolescents to access supermarket services (ART, SRHS, life skills), adapting the model of adolescent-centred services shared by groups from Zimbabwe and South Africa."
> Ipusukilo Clinic, Zambia

> "We will engage HIV+ adolescents to engage their fellow ALHIV and defaulting. The practical steps include: 1. Home visits, 2. One-on-one counselling and 3. Differentiated support groups."
> Chazanga Health Centre, Zambia

As we move towards 2020, the commitment, focus and determination of attending health facility teams will continue to drive local efforts.

Conclusion

Deliberations at the PATA 2017 Continental Summit confirmed that as an HIV service community, we face enduring barriers to the targets we have set ourselves. Despite scientific advances and operational improvements, HIV-related stigma, discrimination, and isolation continue to kill. For children and adolescents, suboptimal formulations, high age of consent for testing, caregiver reluctance to disclose and adult-centred health systems present hurdles to each of the three 90's, and the paediatric treatment gap is a violation of the rights of children in the region.

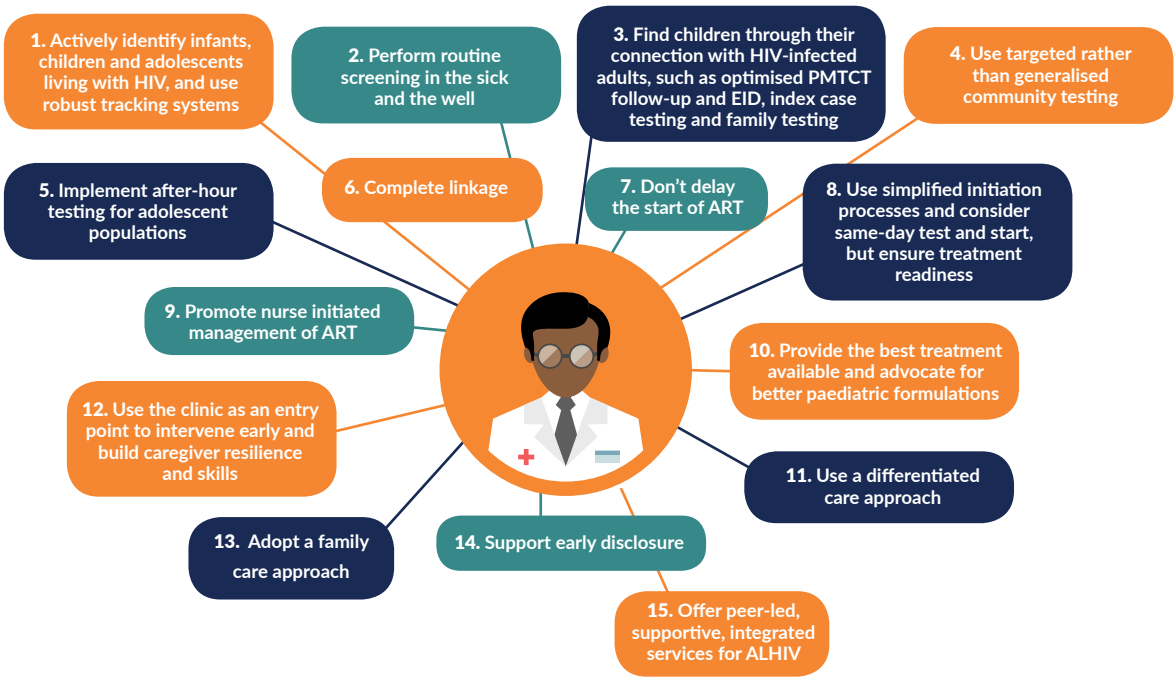
The outcomes of the summit include 15 recommendations that, if enacted, will improve service delivery across the FIND-TREAT-CARE HIV service continuum. Examined closely, each of these recommendations has the health provider as its central actor. This is because at the heart of HIV management lies one very critical entry point to patient-centred care. That entry point is the health provider. Providers have the power to determine how a child, an adolescent or a mother receives healthcare. While there is research and ongoing debate about whether providers are the solution or the problem – in reality, they can be either, depending on their environmental context.

Health providers remain central and fundamental, and as we arm ourselves with evidence, tools and innovation, let us not forget by whom these interventions will be implemented on the ground. Yet health provider behaviour is not based exclusively on intrinsic motivation and personal values. Providers operate within settings that are either enabling and supportive, or constrained by resource shortages, dearth of training, inadequate policies and stockouts. As the landscape shifts, we tend to add new responsibilities downward, with increasing obligations and load carried by providers. Yet this burden is often not accompanied by additional support, management or training. Whilst health provider stigma has been highlighted as one of the key barriers to HIV access, we are reminded that to provide patient-centred care, the person providing the care must also be cared for, acknowledged and valued.

Let us plan for, invest in and make time to build the resilience and skills of the first responders on the frontlines of service delivery, and recognise their role and contribution. We can shape the context in which providers exist and support their resilience in settings where systems are brittle.

It is up to all of us.

Health providers at the centre of the 15 recommendations for improved paediatric and adolescent HIV outcomes



Feeding back on the summit:

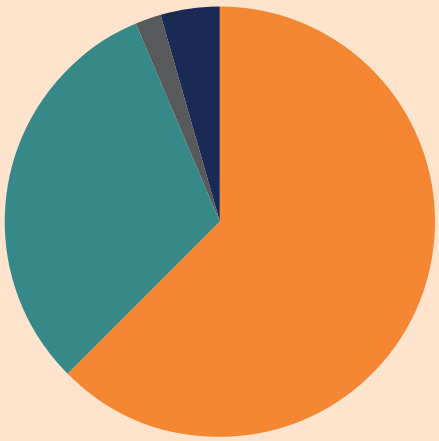
The PATA 2017 Continental Summit received stellar feedback. In an evaluation, summit attendees ranked the quality of speakers, the quality of facilitators and the format and style of sessions throughout the three-day event as either excellent or good. Comments included: **"Presenters were prepared and had ownership over their work"** and **"the presenters were on point, excellent and professional and delivered their presentations with current data that is informed by practice"**. The relevance to the work that health providers do was also rated highly with 62.5% of respondents categorising it as excellent and 31.3% of respondents as good.

The QIPs were also flagged as being relevant and useful to health provider work, with summit attendees commenting that the QIPS **"are very useful for implementation"**, **"provide good support for preparing improvement plans"** and **"allow us to practically put this into action"**. One attendee also commented, **"I left all of the sessions with vast ideas to help improve my service delivery to clients."**

The majority of attendees valued the opportunity for networking, with the summit creating an important platform for learning and sharing across countries with many requesting more time and greater opportunity to stay connected. The daily highlights shared through the UNICEF learning collaborative webinars was greatly appreciated, providing increased visibility and access to lessons shared from the frontline at the summit.

"I learned that the simple things that I do at my clinic are very important," **"I learned that every country has its challenges",** and **"I learned how communication impacts our patients if not done correctly."**

The relevance of the PATA 2017 Continental Summit to health provider work:



62.5% excellent

31.3% good

2% neutral

4.2% not answered

Key resources and links

Avert: Global information and education on HIV and AIDS for professionals.
https://www.avert.org/professionals

IAS and partners: Compendium of tools and evidence for differentiated service delivery.
http://www.differentiatedcare.org/

Bettercare: Self-learning for health providers.
https://bettercare.co.za/

ICAP: Information on the CQUIN network and resources for differentiated service delivery.
http://cquin.icap.columbia.edu

PATA: Resouce hub, including all presentation from the summit.
https://teampata.org/pata-resource-hub/

PATA YouTube Channel: Useful videos, including interviews from the summit.
https://www.youtube.com/channel/UCiqaENFNWjqWJxV0XcGt1Pw?view_as=subscriber

PEPFAR and CIFF: Report on the ACT initiative.
https://www.pepfar.gov/documents/organization/270700.pdf

UNAIDS: 2017 report.
http://www.unaids.org/en/resources/documents/2017/20171120_right_to_health

UNAIDS, PEPFAR and partners: Information on the Start Free Stay Free AIDS Free super-fast-track framework for ending AIDS in children, adolescents and young women by 2020.
https://free.unaids.org/

UNICEF: Links to summit webinars.
https://www.youtube.com/watch?v=5UE3i8ysqWU, https://www.youtube.com/watch?v=iqEBP0MHwEA, and https://www.youtube.com/watch?v=02hGt18_Nf4

Annex 1: Participating Health Facilities

Country	Health facility
Cameroon	Chantal Biya Foundation
Cameroon	Hôpital de District de Zoetele
Cameroon	Lolodorf District Hospital
Cameroon	Nkwen Baptist Health Centre
Côte d'Ivoire	Centre Médico-Social Wale
DRC	CAP Heal Africa
DRC	Centre of Excellence
DRC	Nundu General Referral Hospital
Ethiopia	ALERT
Ethiopia	Mekdim Ethiopia National
Kenya	Ahero Subcounty Hospital
Kenya	Kenyatta National Hospital Comprehensive Care Centre
Kenya	Kilgoris Sub County Hospital
Kenya	LVCT Health
Kenya	Migosi Sub County Hospital
Kenya	RCTP - FACES: Tuunange Youth Clinic
Lesotho	Baylor Lesotho
Lesotho	Mabote Filter Clinic
Lesotho	Queen II Hospital
Malawi	Neno District Hospital
Malawi	Partners in Hope
Malawi	Tisungane Clinic
Malawi	Zalewa Clinic
Mozambique	Centro de Saude de Boane
Mozambique	US de Marracuene (ADECC)
Mozambique	Ponto focal de Moçambique Y+ (ADECC partner)
Nigeria	Ekiti State University Teaching Hospital (EKSUTH) ADO
Nigeria	General Hospital Yauri
Nigeria	Infectious Disease Institute, University of Ibadan
South Africa	WhizzKids United Health Academy
South Africa	Bisho Hospital
South Africa	Empilweni Gompo Community Health Centre
South Africa	Groote Schuur Hospital
South Africa	Witkoppen Health and Welfare Centre
South Africa	Hillbrow Community Health Centre
Swaziland	Lobamba Clinic
Swaziland	Piggs Peak Government Hospital
Tanzania	Infectious Disease Centre (IDC)
Tanzania	Mafia District Hospital
Tanzania	Tunduma Health Centre
Tanzania	PASADA- Upendano
Uganda	Alive Medical Services
Uganda	Baylor Uganda
Uganda	Fort Portal Regional Referral Hospital
Uganda	Lira Infectious Disease Clinic
Uganda	Mityana Hospital
Uganda	Mulago COE ISS Clinic
Zambia	Chazanga Health Centre
Zambia	Chikupi Rural Health Centre
Zambia	Estates Clinic
Zambia	Ipusukilo Clinic
Zambia	Kafue District Hospital
Zimbabwe	Harare Children's Hospital OI Clinic
Zimbabwe	Maboleni Clinic
Zimbabwe	Mpilo Central Hospital
Zimbabwe	Rutsanana Clinic
Zimbabwe	Waterfalls Clinic
Zimbabwe	Newlands Clinic

Annex 2: Summit programme

SUMMIT DAILY SCHEDULE

See full summit schedule here











ANOVA
HEALTH INSTITUTE


ARASA
AIDS & Rights
Alliance
for Southern Africa


AVERT
AVERTing HIV and AIDS


BAYLOR COLLEGE OF MEDICINE
Children's Foundation
UGANDA


CLINTON
HEALTH ACCESS
INITIATIVE

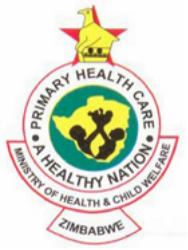

ELIZABETH GLASER
PEDIATRIC AIDS
FOUNDATION
www.pedaids.org


FONDATION CHANTAL BIYA


I A
S


ICAP
COLUMBIA UNIVERSITY
Mailman School of Public Health


International HIV/AIDS
Alliance


PRIMARY HEALTH CARE
A HEALTHY NATION
MINISTRY OF HEALTH & CHILD WELFARE
ZIMBABWE


MZANTSI
WAKHO


health
Department:
Health
REPUBLIC OF SOUTH AFRICA


for Children Func
POSITIVE
ACTION


REPSSI
Psychosocial Wellbeing For All Children


Right
to care
Treating Health Seriously


SAfAIDS
Knowledge for action: The power to make a difference!


SMALL
PROJECTS
FOUNDATION


UCSF
University of California
San Francisco


UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI


unicef


CARE


University of the Witwatersrand
WITS RHI


zoë-life
AUTHENTIC ABUNDANCE


University of Cape Town
iYunivesithi yaseKapa
Universiteit van Kaapstad
SPES BONA


GLOBAL NETWORK OF
YOUNG PEOPLE
LIVING WITH HIV

For more information

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Wyecroft Road, Mowbray Cape Town 8000

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www.teampata.org
/PaediatricAdolescentTreatmentAfrica/
/teampata
/teampata

Paediatric-Adolescent Treatment Africa
Registered as: Paediatric AIDS Treatment for Africa
NPC. NPO 2007/01297/08.PBO 930034219