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**Summit presenters and facilitators:**
Dr. Shaffiq Essajee, UNICEF, PATA, BOD Chairperson; Luann Hatane, PATA; Ider Dungerdorj, UNICEF; Laurie Gulaid, UNICEF; Dr. Eleanor Namusoke Magongo, Ministry of Health, Uganda; Faith Kiruthi, Nairobi Metropolitan Services; Wame Jallow, ITPC; Dr. Patrick Oyaro, Stawisha Pwani; Duduzile Dlamini, SWEAT; Dr. Pasquine Ogunsanya, Alive Medical Services; Dr. Brian Zanoni, Emory University; Dele Fayemi, IAS Health Provider Award winner 2020; Dr. Enow A.G Stevens, Hadassah Medical Center, OHISA; Helena Nangombe, ATHENA Network; Dr. Thalia Ferreira Brizido, Empilweni Services Research Unit; Ismail Harelimanana, African youth Advisors, EGPAF; Prof. Jackie Hoare, Groote Schuur Hospital; Joshua Ochieng, Africa Youth Advisors, EGPAF; Mthobisi Simelane, Baylor; Dr. Nosisa Sipambo, WITS; Dr. Judith Kose, EGPAF; Dr. Anna Grimruds, IAS; Cosima Lenz, EGPAF; Linda Ndlovu, PATA; Tinashe Rufurwadzo, Y+ Global; Acia Macovela, Raven Health Services; Erwin Fisser, Aidsfonds; Andrew Kimera, Katooke HC III; Dr. Esther Mtumbuka, CHAI; Nzisa Kiko, Ylabs; Dr. Margret Elang, PATA; Angela Motsusi, Unjani Clinic; Julian Kerboghossian, ATC; Linda Whitby, Frontline AIDS; Merian Musinguzi, Aidsfonds; Wole Ameyan, WHO; Prof. Elona Toska, UCT; Dr. Fileuka Ngakongwa, PATA; Julie Diallo, UNFPA; Degan Ali, Adeso; Eugene Mupakile, Kabangwe Creative Initiative Association; Dr. Christina Laurenzi, Institute for Life Course Health Research; Lynette Mudekunyeye, REPSI; Agnes Ronan, PATA; Dr. Mohrendran Archary, King Edward VIII Hospital; Bongiwe Salwe, UCT; Babalwa Taleni, UCT; Charné Glinski, UCT; Dr. Daniella Mark, PATA; Dr. Umahi Izuchukwu, ICAP Global Health; Dr. Nandita Sugandhi, PATA Board Member; Dr. Pascal Atanga, Cameroon Baptist Convention Health Services and University of Buea; Epic Fanny Ndh, Cameroon Baptist Convention Health Services; Dr. Graeme Hoddinott, Stellenbosch University; Dr. Franklin Emerenini, ICAP Global Health; Lois Chingandu, Frontline AIDS; Nakita Sheobalak, WITS RHI; Dr. Jackie Dunlop, Anova Health Institute; Nkunda Vundamina, WITS RHI; Nobuhle Mthethwa, Ministry of Health, Eswatini; Nokuthula Heath, Zoe-Life; Nomnika Mjwana, GPN+; Dr. Rebecca Sher, Groote Schuur Hospital; Sbonelile Nkos, GNP+; Simon Moore, AVERT; Sharifah Nalugo, JRC; David Ogiti, Cibe; Sibulele Sibaca, Impact Drivers; Richard Ochen, HNU; Ethel Manyerere, Zvandiri; Dr. Jane Mutanga, Ministry of Health, Zambia; Idoreyin Ezekiel Charles, young person.

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Luann Hatane; Thandi Moyo; Agnes Ronan; Dr Puri González Díaz; Dr Margret Elang; Heleen Soeters; Lynn Phillips; Yvette Fleming; Linda Ndlovu, Olwethu Mlanzeli, Glynis Gossman, Chiedza Makoni, Isobella Chimativa, Margail Brown, Angelita Silva, Dr Daniella Mark, Dr Fileuka Ngakongwa, Aveneni Mangombe, Dr Teles Nhanombe.

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**Report Writer:**
Melissa Wallace

**Design:**
Theresa Acker
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Feedback on the Summit
Acronyms

AIDS  Acquired Immunodeficiency Syndrome
AGYW  Adolescent Girls and Young Women
ALHIV  Adolescents Living with HIV
ART  Antiretroviral Therapy
ARV  Antiretroviral
AYP  Adolescents and Young People
AYPLHIV  Adolescents and Young People Living with HIV
CALHIV  Children and Adolescents Living with HIV
CBO  Community-Based Organisations
CHAI  Clinton Health Access Initiative
CHW  Community Health Worker
COVID-19  Coronavirus Disease 2019
CTX  Co-trimoxazole
DOT  Directly Observed Therapy
DSD  Differentiated Service Delivery
DTG  Dolutegravir
EID  Early Infant Diagnosis
EGPAF  Elizabeth Glaser Pediatric AIDS Foundation
GBV  Gender-Based Violence
HCW  Health Care Worker
HEI  HIV-exposed Infant
HIV  Human Immunodeficiency Virus
HP  Health Provider
IAS  International AIDS Society
IEC  Information, Education, Communication
INGO  International Non-Governmental Organisation
IPV  Intimate Partner Violence
ISP  Inadequately Served Populations
ITPC  International Treatment Preparedness Coalition
LTFU  Loss to Follow Up
MH  Mental Health
MMD  Multi-Month Dispensing
MoH  Ministry of Health
OTZ  Operation Triple Zero
PATA  Paediatric-Adolescent-Treatment Africa
PHC  Primary Health Care
POC  Point of Care Testing
PMTCT  Prevention of Mother to Child Transmission
PrEP  Pre-Exposure Prophylaxis
SDF  Service Delivery Framework
SSA  Sub-Saharan Africa
ST  Self Testing
VL  Viral load
WHO  World Health Organisation
YAP  Youth Advisory Panel
YPLHIV  Young People Living with HIV
Background and Introduction

Paediatric-Adolescent Treatment Africa (PATA) is an action network of multidisciplinary frontline health providers who deliver HIV prevention, treatment and care services to children, adolescents and families living with and affected by HIV. PATA’s mission is to mobilise, strengthen and build resilience in a network of health providers, facilities, and communities on the frontlines of paediatric and adolescent HIV service delivery in sub-Saharan Africa. PATA’s vision is that all children and adolescents living with HIV in sub-Saharan Africa receive optimal treatment, people-centred care and support, and live long, healthy lives. The PATA network offers a powerful platform for regional collaboration, capacity building and peer-to-peer exchange – closing gaps and building bridges for linking, learning and partnership in the paediatric-adolescent HIV response.

The PATA 2021 Summit

The PATA 2021 Summit, titled “Clinic and Community in Conversation: closing the gap for children and adolescents in the HIV response” was held from 1-3 November 2021. The thematic focus of the 2021 summit placed health providers at the centre to build their capacity across clinics and the community. It promoted conversations between these two service delivery platforms, facilitating strengthened partnership and improved HIV service delivery pathways for children and adolescents, in order to achieve services that are better coordinated and more impactful.

The summit saw a total of 1311 participants attending from across 38 countries through a virtual online hub and connected remotely or in person through attendance at a main, or satellite spoke. Participants included frontline health providers and community partners, as well as the broader PATA network of key global experts, policy makers, networks of YPLHIV, donors, and Ministry of Health representatives. Health providers and community partners from 12 PATA priority countries (Eswatini, Cameroon, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe) were brought together along with programme managers, policy makers and strategic partners from 26 additional countries, to link and learn from one another.

PATA Summit Participant Attendance

- Virtual Hub Attendees: 73%
- Spoke Attendees: 27%
- Summit Speakers: 4.59%

- 176,434 Overall clients on ART at health facilities
- 528 CHWS & Other
- 210 Counsellors/Social Workers/Psychologists
- 155 Peer Supporters
- 420 Nurses & Doctors
- 22 Summit Spokes in 12 Countries

PATA 2021 SUMMIT DASHBOARD

1311 Summit Participants
303 Health Facilities represented
38 Countries Represented

102,576 Children and adolescents on ART at health facilities

22 Summit Spokes in 12 Countries

Cameroon: Bafoussam
Eswatini: Mbabane
Ethiopia: Adama City
Kenya: Nairobi
Malawi: Blantyre, Mzuzu, Lilongwe
Mozambique: Beira, Inhambane
Nigeria: Awka, Abuja
South Africa: Eastern Cape, Johannesburg
Tanzania: Dar es Salaam, Kagera
Uganda: Kampala, Soroti
Zambia: Kafue, Lusaka
Zimbabwe: Buluwayo, Harare (x2)
The summit aimed to:

- Identify and close gaps in paediatric and adolescent HIV service delivery
- Amplify breakthrough strategies, tools, and comprehensive service delivery models that accelerate HIV case finding, linkage and access to treatment
- Foster a link and learn platform to strengthen partnership, clinic-to-community collaboration and coordinated action at all levels
- Share HIV service delivery adaptations and lessons in mitigating and building back from setbacks
- Stand up to stigma and safeguard the rights of all, in the delivery of treatment, prevention, and care services
- Call for improved access to training, tools, supported and safer working conditions for frontline health providers

PATA summit methodology

The PATA summit methodology has been refined through 16 years of providing a platform to bring stakeholders together to build regional action around paediatric and adolescent HIV treatment, care, and support, through PATA’s tried and tested ‘link and learn’ approach, which is well recognised and valued in the sector. This approach provides a foundation to those on the frontlines of service delivery through which to network, share promising practices, develop service delivery improvements, build capacity, access guidance and technical input, as well as facilitate intergenerational and intersectoral dialogue that links local practice to policy making.

PATA Summits are unique in that they are not abstract driven, hold no registration fee for successful applicants and provide a reality check on service delivery, with a keen focus on keeping it REAL (Reviewing service delivery models, Engaging peers, Accessing experts, Learning and sharing home grown solutions) in a way that places health providers at the centre of the HIV response. In 2020, propelled by COVID-19 travel and lockdown restrictions, PATA rapidly pivoted to a hub and spoke Summit model, combining virtual and in-country attendance in a blended approach. This method was further refined for the PATA 2021 Summit which was held via a centralised virtual platform (hub), connected to several in-country forums (main and satellite spokes). The centralised virtual hub allowed for programme sessions to be held in real time whilst also facilitating information-sharing and interaction through an online platform, running in parallel to the in-country spokes. Favourably, the mix of virtual and in-person delivery of the summit crossed digital and geographic divides, allowing many more people to engage than in a traditional in-person summit.

Programme Structure:

Each day began at 08h30 SAT with an in-country forum at a satellite spoke, allowing for country specific updates and local networking, whilst recapping and discussing the previous day’s virtual sessions in more detail.

The afternoon, beginning at 11h00 SAT then provided everyone with an opportunity for virtual connection - facilitating connection across time zones.

Table: Programme Structure

<table>
<thead>
<tr>
<th>Date</th>
<th>Session Time</th>
<th>Virtual Programme</th>
<th>Duration</th>
<th>Language</th>
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<tbody>
<tr>
<td>1-3 Nov Mon – Wed</td>
<td>11h00</td>
<td>Opening Prime Session</td>
<td>75 mins</td>
<td>English, French, Portuguese and Kiswahili</td>
</tr>
<tr>
<td>1-3 Nov Mon – Wed</td>
<td>13h00</td>
<td>Africa Café 1</td>
<td>75 mins</td>
<td>English and Kiswahili</td>
</tr>
<tr>
<td>1-3 Nov Mon – Wed</td>
<td>13h00</td>
<td>Africa Café 2</td>
<td>75 mins</td>
<td>English, Portuguese and French</td>
</tr>
<tr>
<td>1-3 Nov Mon – Wed</td>
<td>14h30</td>
<td>Special Session or Lekgotla</td>
<td>90 mins</td>
<td>French, Portuguese and Kiswahili</td>
</tr>
</tbody>
</table>
Broader PATA Network
The first day focused on the health provider in the facility setting, with sessions focused on clinical issues and facility-based service delivery.

The opening session included updates on progress for children, adolescents, and young people, highlighting global guidance (from UNICEF), providing a national programme example that draws attention to key game changers (the Ministry of Health, Uganda), with two additional contributions, one being the collision and impact of COVID-19 (ITPC), as well as an address from a frontline health provider on the year of the health worker, celebrating the role of health heroes who shift and shape the HIV response every day.

Dr Shaffiq Essajee from UNICEF, and Chairperson of PATA’s Board of Directors welcomed everyone to the summit, reminding them that the focus is on looking at how we can close the gap for children and adolescents in the HIV response, and importantly, how PATA can enable health providers in this goal.

Laurie Gulaid, UNICEF’s Regional HIV/AIDS Adviser for Eastern and Southern Africa set the scene for the prime session with her presentation on the ongoing inequities but also inspirations for treatment and care for children and adolescents discussing how we can and must accelerate progress to achieve the 2030 goal of ending inequities and ending AIDS. Laurie highlighted successes and inspirations, in terms of prevention.

One of the most significant public health accomplishments globally, is the rapid scale up of service to prevention of vertical transmission of HIV. Across SSA an estimated 2.25 million babies born to mothers with HIV since 2010 remained HIV free. Laurie Gulaid

However, in the area of treatment, there is need for urgent attention to address inequities for children and adolescents.
While there was steady progress in terms of paediatric ART coverage from 2010 to 2017, beginning in 2017, progress began to falter, and with the onset of COVID-19, has flat lined. In addition, viral suppression rates are lower in AGYW than older women across the region.

A further area of concern is the large and growing number of children HIV and ARV exposed in utero, with emerging evidence of elevated risk of mortality and morbidity in this group.

Other vulnerabilities emerging due to the COVID-19 pandemic include the loss of at least one caregiver through COVID-19; increasing poverty and food insecurity; millions of children missing out on education, spikes in GBV and unintended pregnancies, and constrained health care service provision and uptake, particularly for prevention.

Challenges to closing the gap include EID delayed and limited follow up; difficult paediatric drugs and regimens; suboptimal services; multiple deprivations; and a lack of disaggregated data to guide programming and clinical care.

**What needs to be done to close these gaps:**
- Improve EID with strategic placement of POC technology
- Improve follow up of older children with family index testing
- Bring friendly testing services to adolescents and others
- Fully transition to WHO recommended optimal paediatric ART regimens
- Ensure regular VL monitoring for children and adolescents

**For care and support:**
- Implement peer, buddy and other developmentally appropriate support for CALHIV
- Ensure referral and linkage to support across sectors e.g. MH, nutrition, GBV, social protection

**For systems strengthening:**
- Invest in age disaggregated digitized data systems to guide clinical care and programmes
- Improve HR policies and undertake values clarification and morale building with HCW
- Reinforce appointment and tracking systems
- Strengthen health systems e.g. supply chains, laboratories etc.
Dr Eleanor Magongo, Ministry of Health, Uganda, provided a country example, highlighting strategies that have helped Uganda exceed its targets.

Uganda has implemented a range of interventions at all levels in order to achieve the 95-95-95 goals with children and adolescents.

When we are looking at children and adolescents, we need to look at them in a holistic way. Most of the time we fix or we focus our efforts on the services that are provided to them at the health facility, but this provides just a small component of the entire care that the children need. And you will notice that the rest of the care that the children need is outside of the facility. Eleanor Magongo

**Continuum of care for children and adolescents**

**YOUTH EMPOWERMENT (AGE APPROPRIATE) PROGRAMMES**
- Apprenticeship/vocational for out-of-school & in-school-based life skills

**HEALTH SERVICES**
- MCH, HTC, ART, PMTCT, Malaria, post-rape service
- ASRH

**ECONOMIC RECOVERY**
- Consumption support
- Livelihood opportunities for youth
- ES programming for families
  - SILC/ VSLA & additives

**EDUCATION**
- Enrolment in school
- Negotiating school fees or school barriers
- Supporting regular school attendance
- School-based life skills
- Girl Scholarships

**FOOD & NUTRITION**
- NACS & referral
- Food Distribution lists

**PROTECTION**
- Birth registration
- Settling legal family issues
  - e.g. land disputes

**CHILD PROTECTION PSS**
- Parenting skills
- Alternative care
- Family tracing & re-union

**GBV**
- Services for survivors
- Counselling/PSS

**Lessons learned**

In a talk entitled, Parallels and Paradoxes: a collision of pandemics leaves children and young people vulnerable, Wame Jallow, ITPC’s Director of Global Programs and Advocacy, shared ITPC’s approach to identifying areas of vulnerability for adolescents and young people on the ground when COVID-19 hit, and young people were disproportionately affected by LTFU and were particularly isolated. They use a community-led monitoring and advocacy framework to allow for building the voice of the community, collecting evidence quantitatively and qualitatively, and using it to engage with health facilities and policy makers.

**Community engagement framework**

Dr Magongo shared some ‘game changers’ which have made a difference to Uganda’s performance.

- Developing literacy materials
- Strengthened integration of OVC services into HIV programme
- Care givers DOTS model
- Community ECHO model
- Implementation of the YAPS model
What is Community-led Monitoring & Advocacy?

When problems uncovered through CLM aren’t resolved, communities escalate with evidence-based advocacy and campaigning until they achieve implementation of corrective actions by duty bearers.

- **Take targeted action** to work with policymakers to fix or improve the services, systems, policies, laws or practices that underlie these problems.
- **Learn about the science behind the disease(s)** and normative standards for optimal prevention, treatment, care and support interventions, including on COVID-19.
- **Document community experiences** accessing health services, compile that information, and identify trends and problems.
- **Discuss these findings** with a wider group of stakeholders, such as a Community Consultative Group (CCG).
- **Advocacy**
- **Education**
- **Engagement**
- **Evidence**

The final presentation was from Faith Kiruthi, Nairobi Metropolitan Services, reminding us of the significant role health providers play and the challenges they face daily in delivering services, in this, the WHO Year of the Health and Care Workers.

When the COVID pandemic came around, most of the health care workers, frontline workers, put their lives in front to serve their community. Some lost their lives, some lost their loved ones because they transmitted the virus as they were doing their daily work. During this PATA summit I speak on behalf of the many frontline workers who request that we get support, a supportive system in terms of regulation of allowances, infrastructure and tools to do our work. We need responsive health systems, so that when we ask for space to provide services, or we require PPE, these requests are heard and acted upon. As health providers we also need spaces like the PATA Summit where we can come together to meet, talk and share our experiences, best practices from within and between different countries. Faith Kiruthi

The most critical thing for us moving forward is for us to empower our youth, empower young people to be at the table with information and evidence, to demonstrate where the issues are and how we can integrate some of the services and tailor them to the needs of young people. And in order to do that we must be able to give them the tools and resources but also believe that at the end of the day, as we say in the Citizen Science approach, people are experts of their own lives. Young people and youth understand what they need. Wame Jallow
Stigma is a well-documented barrier to health-seeking behaviour, engagement in care and adherence to treatment across a range of health conditions globally. Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health. According to the Stigma Index, stigma remains one of the biggest barriers preventing people living with HIV from accessing healthcare. The objective of this panel discussion was to explore how we can make our SRH/HIV services for AYP inclusive and stigma free; the panel asked some pertinent questions including looking at what is needed to address stigma in the health care setting; what health providers need to understand better in order to do so; and the role of bodily autonomy and integrity in ensuring stigma free youth friendly services.

I must acknowledge that it is really a concern, that we sit still in the 21st century, still to have a conversation about human rights violation and especially in the health care facility, to an extent which it really affects women living with HIV, even those that are pregnant, especially ALHIV that also do not have much information.

Helena Nangombe

Stigma is defined as a complex social process of devaluing a person, beginning with marking or labeling someone’s differences, and attributing negative values to these and leads to the social and economic exclusion of individuals or groups based on real or even perceived characteristics. So stigma is a key determinant of health and health inequity.

Dr Pasquine Ogunsanya
Africa Café 1 Poll

1. What would you recommend for services to be integrated and to reach all AYP and to be person centred?
   - 71% Inclusive services that are stigma free, youth friendly and integrated – as in one service for all.
   - 29% A dedicated service tailored to specific needs of a particular marginalised, key or inadequately served population.

2. What is the biggest challenge in my country providing services to all adolescent and young people and reaching key or inadequately served population?
   - 70% Adolescent and young people do not disclose if they are from a key or inadequately served population.
   - 12% Criminalisation laws make providing services challenging.
   - 18% Health provider stigma.

3. What does bodily autonomy mean?
   - 61% Bodily autonomy is the right to exercise agency over your body, free from external interference, social or legal sanctions, violence, and discrimination.
   - 24% Bodily autonomy is the right to sexual choices and reproduction.
   - 15% Bodily autonomy is the right to individualism, and to individual choices, it undermines group decision-making.

4. What is needed to better serve all and ensure inclusive services for health providers?
   - 85% Dedicated staff who are more equipped and professionally training to deliver tailored services.
   - 12% More sensitisation training.
   - 3% Services that are delivered in the community.
Key take home messages:

- Stigma remains one of the main barriers preventing people living with HIV from accessing healthcare
- Stigma needs to be discussed and considered in policy development, programming and implementation and strategies need to be put in place to address it
- Significant gains can be made in ensuring all health providers are trained and sensitised to deliver stigma free youth friendly SRHR/HIV services
- It is also beneficial to train young people to know their rights and demand quality services
- Clinic community collaboration and joint advocacy (Advocacy in Action) should be used to tackle and stand up against stigma
- Inclusive differentiated and integrated stigma free youth friendly services for all, that are peer-led, is the way forward and most sustainable
- It is essential to involve the community and engage service users and design services in conjunction with them
- For the delivery of child and adolescent friendly services to be a key performance area for all health providers
- Develop quality improvement plans that are informed by service users who are able to regularly give feedback on or score their service experience

What does a safe space look like?

A safe space is an environment that provides clients with responsive services that are stigma and discrimination free.

Esther Vurigwa

This is a place where a client (a young person) is welcomed, treated with dignity. It can also be described as a friendly environment to air his/her own views without criticism, discrimination and judgmental attitudes. It is also a space where young people can access free services in relation to SRHR and where no derogatory language is used.

Zimbabwe, Bulawayo Spoke (audience)

Key takeouts from audience:

Stigma can be addressed through sensitisation and probably offering trainings to community supporters including adolescents living with HIV.

Ng’uni Maxwel (audience)

How do we best address stigma in the healthcare setting?

Communities need to be placed at the centre of the response. Dr Enow

What should other HCPs be doing?

As health workers we can and must take responsibility for reducing discrimination in our facilities. Talk about discrimination whenever the opportunity arises, talk about it. Accept without judgment who people are and how they choose to live their lives, and the choices they make.

Dr Enow

Click here for RESOURCES
Tailoring transition: supporting the successful care and treatment transition

This session provided the opportunity to share practical guidance and tools on supporting AYPLHIV’s navigation of a range of transitions, in home, clinic and school settings to support their care and treatment needs. It included facilitation of learning through interactive case studies demonstrating individualised, tailored approaches to enable AYPLHIV to transition smoothly. In addition, young people shared personal experiences and youth led approaches as well as their insights from engagement in the development of the transition toolkit.

Dr Judith Kose, Associate Director of Pediatric Services at EGPAF, began the session by presenting the Transition of Care Toolkit, a practical step by step guide, developed with youth, to guide HCW to support CAYPLHIV and caregivers in navigating transitions in care and life settings.

Dr Nosisa Sipambo, Specialist in Paediatric Infections, Chris Baragwanath Hospital, South Africa, presented her experience working at Harriet Shezi Children’s Clinic, and the transition process from hospital to primary health care, sharing key learnings.

One thing that was quite key in our transition journey was partnerships, and this included partnerships with CBO’s, the PHC clinics themselves as well as implementing partners. Nosisa Sipambo

"Transition is defined as the purposeful and planned movement of adolescents and young adults with chronic physical and mental conditions from child-centred to adult-oriented health care systems. Judith Kose"
Transition of Care Toolkit Structure

Different forms of transition are discussed outlining key considerations and action items for each of the following steps:

1. Planning and preparation
2. Client (and caregiver/treatment supporter) case review and assessment
3. Transition tasks
4. Follow-up procedures
5. Tracking and reporting

Key learnings

- Situation analysis
- Partnerships
- Capacity building
- Tailor-made transition pathway
- Standardised transition letter
Youth Voices

Three youths, Ismail Harelimana, Africa Youth Advisors, EGPAF, Uganda, Joshua Ochieng, Africa Youth Advisors, Kenya and Mthobisi Simelane from Baylor, EGPAF, Eswatini, facilitated by Dr Brian Zanoni, Emory University, USA, presented ‘Transitioning pathways - youth perspectives on transitions between schools, health facilities and homes’, and shared realities on the ground, peer-based support and strategies, and their input into the toolkit.

In terms of self-management, some of the barriers identified included a lack of engagement by adolescents and the need to start preparing them as early as possible, which requires advocating for a friendly or enabling environment.

Three key areas arose from these discussions:

- the importance of disclosure
- assistance with navigation through the system
- the involvement of caregivers

Case Discussion

CLHIV not yet switched to DTG-containing regimens, due to multiple factors:

1. Previous complex treatment regimen history
   - Multiple NRTIs + NNRTI/PI based regimen

2. Potential Resistance to drugs in previous regimens
   - Duration on treatment regimens
   - Time period on drugs with low vs. high barrier to resistance

3. Virological failure is common - Explore this!
   - Psychosocial issues affect adherence
   - Rely on parents give medication
   - Changing schedules (weekends, holidays)
   - Side Effects

What will motivate the patient to be adherent?
- Lower pill burden and regimen simplification are important

Conclusions & Recommendations

- Children on DTG-containing regimens do well
- Adolescence and extensive, prolonged ART experience (>10 years) complicate switching to DTG
- Despite this, many children have transitioned to DTG. 1/3 of DTG switches have been complex regimen or second line switches
- If a DTG switch is made under complex circumstances, patients should be monitored closely (e.g. VL after 3 months)
- Do not switch if you are concerned about resistance when on a PI-based regimen
- Further research needed regarding unconventional switches with complex regimen histories

Dr Thalia Ferreira, Medical Officer at Empilweni Clinic Research Unit, Rahima Moosa Hospital, South Africa then presented a case study describing drug transition in an adolescent patient.

We need peer support at all levels, from paediatric, to adolescent, to adult. Ismael Harelimana

You need to first accept yourself and connect with other YPLHIV who are also in the transition phase. Mthobisi Simelane
As older children and adolescents enter into young adulthood, they may experience additional challenges, including emerging mental health issues and exposure to different types of violence. There is growing evidence that AYLHIV are at heightened risk of poorer HIV outcomes when they experience mental health issues and violence, and the stigma associated with these challenges and living with HIV. Approaches to address these complex issues in clinics and communities exist and can be replicated. This session, chaired and led by Dr Christina Laurenzi, Institute for Life Course Health Research and Dr Elona Tosca, University of Cape Town provided an overview of this important area and included the sharing of some examples of interventions.

Eugene Mupakilie, Creative Initiative Association, Zambia, began the session by providing a definition of GBV: Any harmful act that might be directed at an individual. Can take many types of forms including physical, mental, social or economic abuse that is directed at someone based on their gender. Likely to lead to some harm.

Experience of GBV (which includes IPV) has a range of short-term and long-term consequences – in this presentation, the focus was on mental health.

A recent meta-analysis shows very high rates of IPV found across SSA:
- Emotional 29.4%
- Physical 25.9%
- Sexual 18.75%

Just to put it in perspective, these (rates of GBV) are very high numbers and we need to think a little bit more about what this means for the models of care we are providing.

Christina Laurenzi
Gea, a peer supporter in Tanzania, living with HIV, shared her experiences of supporting young people regarding GBV.

What are the challenges young people are facing in this regard?
- lack of awareness – young people don’t know about mental health issues
- high levels of self-stigma
- unsupportive environment

What types of support are most helpful for young people?
- Having group sessions with young people to educate them and increase awareness.

Where do peer supporters fit in?
- To listen and be non-judgemental
- To refer young people to the right support/place when needed

Mental Health Myths

1. There is no hope for people with mental health problems. Once someone develops a mental health problem, he or she will never recover.
2. You only need to care for your mental health if you have mental health problem or disorder.
3. If things are going well in your life, you have nothing to be depressed about.

Violence Myths

1. It only happens to certain kinds of people (young, reckless, poor, etc.) they must have done something to deserve it.
2. If it were bad enough, they would have reported it.
3. It is a couple’s/family’s business, it does not affect us?

Analyses of factors associated with ART non-adherence among adolescents and young people living with HIV in South Africa found that exposure to four types of violence/negative experiences were individually associated with worse adherence: physical violence at home, teacher violence at school, witnessing domestic violence in adults at home, and being shouted at by providers. The graph shows the “dose” effect of exposure to violence: adolescents exposed to more types of violence were more likely to report past-week non-adherence.
What can we do? What are ways that we can respond?

Determine what kind of response is needed and how quickly:

- Code Black – suicidality
- Code Red – sexual/physical abuse
- Other needs – grants, hunger/food insecurity, HIV test, substance use

Think about the provider and peer supporter team too:

- Safety (yours) first
- Over-exposure and vicarious trauma

It is important for young people to overcome internalised shame, blame and stigma.

Dr Fileuka Ngakongwa, psychiatrist and PATA country representative, Tanzania, shared some simple solutions and tools for supporting mental health.

Peer supporters’ experience in providing mental health support: Mental and social health challenges frequently reported by their peers:

- Self-stigma
- Poor living conditions; challenges in eating regularly due to financial difficulties
- Poor knowledge of HIV and care
- Unsafe HIV disclosure; finding out accidentally, or yet to know HIV status
- Getting tired of taking medication

Peer supporters’ experience in providing mental health support

Simple solutions:

- Having support group session/clubs sharing experiences
- Provide health talks about HIV care
- Having social media groups like WhatsApp as a forum for psychosocial support
- Sharing life stories
- Providing resources on financial/food aids
- Safe disclosure of HIV status to significant people who provide support

Screening of mental disorders (depression and anxiety)

- Preference to use open ended questions because questions engage the client to share more

The most important thing is to follow what we call the golden rule...the most important one is to just tell the young person or the client that absolutely nothing about what has happened to them or their family is their fault, and the more you can say this, the better it is. Elena Tosca

Julie Diallo, UNFPA, Eastern and Southern African Regional Programme Specialist, shared experiences from some innovative models.

She reminded the audience of the alarming statistics on this topic:

1 in 3 women have been subjected to either physical and/or sexual, intimate partner violence or non-partner sexual violence in their lifetime. Julie Diallo

54% of the respondent adolescent girls reported that their first sexual encounter was forced. And I just wanted to share that and insist on that because this is of critical importance for us as service providers, in the way that we deliver our services, in the way that we put in place prevention interventions, in the type of services as well that we deliver. Julie Diallo

This is exacerbated by the fact that the status of related legislation in the region is poor. Nineteen AU member states do not have specific legislation on domestic violence; a minority of women seek help; there are very limited services available and where they exist, they are found mainly in cities.

Reasons why women do not use GBV services:

- Poor quality services
- Lack of knowledge about services
- Do not expect any help from services
- Doubt that services will keep them safe
- Lack of availability of services
- Shame and stigma of reporting
Experience from Zimbabwe: Mobile One Stop Center

MOSC model is a multi-sectoral team providing quality GBV comprehensive services on "wheels", in the most remote and hard to reach areas.

MOSC model addresses service de-prioritisation and reduces access constraints:

- Reduce distance between survivors and services
- Address challenges related to transport fees
- Flexibility of the mobile outreach according to the evolving needs
- Behaviour Change facilitators to enhance community mobilisation and timely referrals of critical cases to higher level of care contributing to community-based GBV surveillance

I was scared of moving around due to the lockdown. But one day I decided, I got up very early and waited for them. I was a bit anxious if they were going to help me or not. When they arrived I was soon assisted by the welcoming counsellors. I managed to get clinical care and was given Post exposure prophylaxis. I was also taken to the shelter for safety while the Victim Friendly Unit officer had gone to pick up my uncle for arrest. If the mobile One Stop Centre had not come, I would have missed the opportunity to get PEP, and to be protected. At the shelter I feel very safe. The court processes are going on and I am hopeful.

Faith, a SGBV survivor supported at a Mobile One Stop Centre

Solution: Essential services packages in GBV, containing 7 modules:

Module 1: Overview and Introduction
Module 2: Health
Module 3: Justice and Policing
Module 4: Social Services
Module 5: Coordination and Governance of Coordination
Module 6: Implementation Guide
Module 7: Guidance on estimating resource requirements for a minimum package of services
The second day focused on clinics and communities collaborating for improved service delivery. Given the increasing recognition that community-based service delivery is essential to ending AIDS, and the heightened urgency due to COVID-19, sessions on day two highlighted how clinics and communities can work together effectively for coordinated and collective impact. It featured skills-building sessions on how clinics and communities come together to plan, efficiently deliver, and monitor services, including sharing and using common data. Practical examples showcased community-based models, for example, community screening/testing, community case management and ART distribution, strengthening referral pathways and supportive systems, psychosocial support interventions as well as highlighting mechanisms needed for successful collaboration.

Prime Session

The focus of this session was on how HPs in community can work together. There is increasing recognition that community-based service delivery is essential to ending AIDS, and COVID-19 has not only heightened the urgency for these collaborations but has also shown how communities play an integral part in providing uninterrupted service delivery for children and adolescents living with HIV. This session built on the first day by highlighting service delivery that works at the country and community level, and was chaired by Dr Patrick Oyaro, Stawisha Pwani and PATA Board of Directors, Kenya.

Dr Esther Mtumbuka, Country Director at Clinton Health Access Initiative (CHAI), Tanzania shared her experiences of scale up of game changing strategies to close the gap for children and adolescents living with HIV. Children are lagging behind in terms of ART initiation and viral load suppression in SSA. New infections remain high due to stagnating PMTCT, low EID coverage and drop offs along the cascade. As children transition to older age groups, they face new challenges to staying in care and virally suppressed.

CHAI is working to address this through a partnership with Ministry of Health to introduce and scale game changing strategies.

When we engage MoH colleagues from the very beginning, we tend to get ownership. We need to identify key performance indicators together. Esther Mtumbuka
Working together with Ministry partners to improve outcomes for CALHIV, CHAI has introduced and scaled game changing strategies:

- Targeted testing to find harder to reach children
- Active monitoring of mother-infant pairs to improve retention
- Scaling of POC-EID and infant exposure screening outside of PMTCT
- Accelerated uptake of DTG for children and use of weight-based monitoring
- Patient-centered models of care and community engagement and monitoring

The targeted strategies used by CHAI led to increased identification of children.

National Quality of Care dashboard

Issues to consider going forward

1. How can facilities and communities collaborate and leverage resources to improve access to testing and linking resources for children?
2. How can we make data more accessible to communities, clinicians and program managers in order to drive change?
3. How can we ensure more equitable progress across populations, countries and regions?

4 components of paediatric optimization:

1. Starting children on preferred regimens in optimal formulations
2. Changing formulations as children grow and can take more optimal formulations
3. Transitioning to better regimens and formulations as improved regimens are available
4. Switching to appropriate 2nd or 3rd line regimens in optimal formulations when VL failure

Dr Judith Kose, Associate Director of Paediatric Services for EGPAF, Global presented on accelerated access: progress and challenges in scaling up optimal paediatric treatment.
Challenges and solutions related to supply chain, service delivery, and caregiver capacity:

<table>
<thead>
<tr>
<th>Supply Chain</th>
<th>Problem</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surplus of suboptimal legacy formulations (e.g. NVP, LPV/r solutions)</td>
<td>• Advocated with MOH and donors to allow for wastage/disposal of suboptimal legacy formulations after adequate supplies of optimal pediatric ARVs arrived in country</td>
<td></td>
</tr>
<tr>
<td>• Shortages/stock-outs at central and health facility levels</td>
<td>• Removed legacy products from health facilities and returned to central warehouse</td>
<td></td>
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<tr>
<td>• Temporary decrease in manufacturer production capacity</td>
<td>• Guided health facilities on how to temporarily transition children from regimens in short supply to those with larger supplies e.g. LPV/r 100/25mg vs 200/50mg</td>
<td></td>
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<tr>
<td>• Advocated with MOH and donors to allow for wastage/disposal of suboptimal legacy formulations after adequate supplies of optimal pediatric ARVs arrived in country</td>
<td>• Redistributed ARVs from facilities with larger stocks to those with shortages</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service delivery</th>
<th>Problem</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of confidence among health workers to transition children</td>
<td>• Developed training materials, job aids and SOPs to support rapid transition of eligible children</td>
<td></td>
</tr>
<tr>
<td>• Weak pharmacovigilance (PCV) systems to track AT and ADR</td>
<td>• Orientated, trained, and mentored health workers, pharmacists and community workers on new guidelines and administration of optimal paediatric formulations</td>
<td></td>
</tr>
<tr>
<td>• Not enough stocks of ARVs to provide multi-month dispensing (MMD)</td>
<td>• Labeled patient files and called caregivers to facilitate prompt switching to optimal ARVs</td>
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<tr>
<td></td>
<td>• Revised PCV reporting tools and trained clinicians and pharmacists on monitoring and reporting adverse drug reactions in children</td>
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<td></td>
<td>• Closely monitored ARV stock levels and redistributed stocks, as needed, to support MMD</td>
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</table>

<table>
<thead>
<tr>
<th>Caregiver capacity</th>
<th>Problem</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complexity of administering LPV/r pellets, granules and dispersible tablets</td>
<td>• Trained lay counselors and mentor mothers to teach caregivers correct administration of LPV/r solid formulations</td>
<td></td>
</tr>
<tr>
<td>• Limited guidance from clinicians or lay counselors</td>
<td>• Developed customized literacy materials for caregivers, including videos and flip charts, and translated them into local languages</td>
<td></td>
</tr>
<tr>
<td>• Lack of customized caregiver literacy materials</td>
<td>• Enhanced caregiver counseling during clinical consultations on correct ARV dosing &amp; administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provided bags to help caregivers carry multi-month refills of LPV/r granule formulations</td>
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<tr>
<td></td>
<td>• Enhanced clinical and psychological support through phone calls and home visits to ensure treatment continuity and retention in care and treatment</td>
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</tr>
</tbody>
</table>
**Recommendations for accelerated access to paediatric optimal treatment**

1. Strong coordination and leadership from MOHs through existing technical working groups are critical in ensuring a smooth transition from legacy regimens to optimal paediatric ARV formulations.

2. The transition to optimal paediatric ARV formulations must be planned well in advance (this includes health worker training and caregiver education and must be supported as on-going effort during the transition process).

3. It is critical to ensure the consistent and continual availability of optimal ART formulations so infants and children can be transitioned effectively and maintained on optimal paediatric ARV formulations.

4. There must be a greater emphasis on pharmacovigilance and active monitoring of acceptability, tolerability and ADRs as part of transition planning, health worker capacity building and post-training mentorship, and caregiver education.

5. Establish a system to monitor the progress of paediatric ART optimisation.

6. Incorporate learning from COVID-19 into future transitions to optimal paediatric ARV formulations.

---

Children exposed to HIV have poorer ECD outcomes. Considerations include:

- Timing of HIV Testing/ART
- Viral suppression
- Safe delivery
- Breastfeeding
- SES
- Physical/mental health
- Safe sex /condom/partner status/GBV
- Poor birth outcomes (LBW, prem)
- Increased morbidity/mortality
- Suboptimal nutrition
- Increased risk of social stresses
- Vulnerable caregiver
- Poverty/orphanhood
- Exposure to HIV/ART/CTX
- Retention/access to support/care

---

**Comprehensive Package of Care for HEI**

**Infant diagnosis**
Timely identification of infants living with HIV by testing at multiple timepoints and ensuring infant diagnosis

**Maternal testing, treatment and monitoring**
Identifying mothers through ANC and MCH services ensuring they start ART and remain virologically suppressed

**Nurturing care**
Implementing simple interventions to promote early childhood development at the facility and in the community

**Postnatal care**
Routine postnatal care including immunization, growth and development monitoring infant feeding counselling and support

**Postnatal prophylaxis**
Timely provision of ARVs to prevent HIV acquisition in all infants exposed, with particular attention to those at high risk

**CTX**
Timely provision of CTX to prevent PCP and mortality in infants and children who are living with HIV

Dr Jane Mutanga Mutembo, Medical Doctor and Epidemiologist, Livingstone Central Hospital, Zambia, presented on Nurturing Care: Reaching all Children who are HIV Exposed.

The challenge here is to harmonise all the interventions so the children are able to access what they need, in a combined manner, like they can just go to one point and get everything they need. This will improve care and make access for these children easier. Jane Mutanga
Components of Nurturing Care

Nurturing care is strategies to help children attain their full potential and it has 5 interrelated components of care which include good health, adequate nutrition, responsive caregiving, security and safety, and opportunities for early learning. Jane Mutanga

Key take home points
- We need to find all children exposed to HIV
- When we do, we must ensure that they remain HIV-free, survive and thrive with optimal early childhood development
- Whenever you see an adult collecting ART or testing for HIV, ask if they have children

Fathers are a very important part of the whole responsive caregiving process. They also need support. But the environment is hostile. If it is hard for a mother, it is even harder for a father. To address this, we have created an environment that is friendly for the fathers and group activities for mothers. Jane Mutanga

In terms of putting this into practice, simple strategies can make a big difference, for example using the child health card to monitor nutrition and growth; interaction with mother and child when they visit the clinic; modelling responsiveness to children’s needs; and creating early learning spaces at facilities or in community.

Dr Margret Elang, medical doctor and public health specialist, PATA’s Country Representative in Uganda presented on the Breakthrough Partnership: a collective, coordinated partnership for children and young people currently being implemented in Mozambique, Uganda and Nigeria.
## Collective Impact in Clinic Community Site

<table>
<thead>
<tr>
<th>HIV Cascade</th>
<th>Problem</th>
<th>Solutions</th>
</tr>
</thead>
</table>
| Locate, Link, Treat and Retain Service delivery | • Long turnaround time for infant test results  
• Inadequate Health Provider knowledge/skill on paediatric/adolescent ART management e.g. ART initiation and Dosage estimations for infants and children  
• Concerns in task shifting capacity and confidence  
• ARV stockouts  
• Lack of adolescent-friendly services | **PATA** - PATA provides health-provider training in peer integration (YAPS), advocacy skills building and integrated AYP peer supporters at the HFs as part of adolescent service delivery. Linking health providers to quarterly PATA webinars and PATA Summit, to enhance learning  
**UNICEF** - is implementing EPDI/EID integration, using mentor mothers/coaches at HFs and testing of siblings/children of HIV-positive mothers and performing point-of-care EID  
**Regional HIV implementer** - technical support and health-provider training in ART management |

<table>
<thead>
<tr>
<th>Community gaps identified</th>
<th></th>
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</tr>
</thead>
</table>
| • Low caregiver awareness on how to take care of a CLHIV  
• Challenges in tracking babies for subsequent EID tests and linkage to care when positive PCR results are back  
• Lack of transport fare to health facilities where client is receiving care  
• Lack in caregiver knowledge in drug administration  
• Lack of caregiver commitment for subsequent visits  
• Stigma | **EGPAF** is building the capacity of the Ariel peers/caregivers in literacy  
• Strengthen community service delivery  
• Support peer-lead advocacy  
• Strengthen community PSS through peers, Community leaders | **Aidsfonds** is addressing community system challenges by conducting home visits, raising awareness in the community, performing follow-up for effective referral, economic empowerment (VSLAs), community dialogues to address stigma. |

### Summary of key messages

- Collaboration and effective partnerships are not simple and require flexibility in determining where to work
- Coordination requires
  - Careful planning and ongoing review and adjustment
  - Patience, as the road to effective partnership is longer and more complex but the reward of a more comprehensive and coordinated response can add much greater value and enhance service delivery
- Partnership provides an opportunity to scale different tools, leverage strengths from different partners

*UNICEF SDF has highlighted interventions across the continuum of care and divided across age bands. Health providers and peer supporters must collaborate and identify age bands affected, have a brainstorming session to identify the challenges, and then adopt and contextualize the interventions in the framework.*

Margaret Elang
Differentiated service delivery is a person-centered approach. It simplifies and adapts HIV services across the cascade of HIV care to reflect the preferences and expectations of various groups of people living with or at risk of acquiring HIV while reducing unnecessary burdens on the health system.

This session, chaired by Dr Anna Grimsrud, IAS, South Africa, drew meaningful attention to how DSD is relevant for children and young people. It also highlighted how DSD models for HIV can be expanded to meet the other health needs of children and young people.

Differentiated service delivery, or differentiated care, is a person-centered approach. It simplifies and adapts HIV services across the cascade of HIV care to reflect the preferences and expectations of various groups of people living with or at risk of acquiring HIV while reducing unnecessary burdens on the health system. Anna Grimsrud

Building Blocks of Service Delivery

**WHEN**
- Monthly
- Every 2 months
- Every 3 months
- Every 6 months
- Every 12 months

**WHERE**
- HIV clinic / hospital
- Primary care clinic
- Other clinics
- Community pick-up point
- Home
- Drop-in centre
- Pharmacy

**WHO**
- Physician
- Clinical officer
- Nurse
- Pharmacist
- Community health worker
- Patient / peer / family

**WHAT**
- ART initiation / refill
- Clinical monitoring
- Adherence support
- Laboratory tests
- OI treatment
- Psychosocial support
- Contraceptives
- TB preventative therapy
- NCD treatment refills
Four models of DSD for HIV treatment

Model 1:
Operation Triple Zero, Franklin Emerinini, RISE NG: focus is adolescents and young people 10 to 24 years

DSD for HIV treatment is about more than just ARV therapy and it’s about more than just HIV. Young people living with HIV, they have needs beyond just drug refills and they have health needs beyond HIV. And so we need to take this into consideration when working with children and adolescents to provide quality services. Anna Grimsrud

Building Blocks of OTZ

<table>
<thead>
<tr>
<th>WHEN</th>
<th>ART REFILLS</th>
<th>CLINICAL CONSULTATIONS</th>
<th>PSYCHOSOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONTHLY</td>
<td>Health Facility • OTZ Centre • At home</td>
<td>Adolescent Centres in health facility</td>
<td>• Adolescent Centres • Youth clubs • At homes</td>
</tr>
<tr>
<td>3 MONTHLY</td>
<td>Clinicians • Case managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 MONTHLY</td>
<td>TLD Optimal Regimen</td>
<td>Clinicians</td>
<td></td>
</tr>
</tbody>
</table>

Key outcome: Viral load coverage and suppression has increased with rollout of OTZ.
Lessons learned

- Adolescents and young people have other interest beyond ART, addressing these needs improves commitment to clinics
- Specialized children, adolescents and young person’s package of care improves overall treatment outcomes
- Adolescents and young people’s involvement and commitment to self care, including peer-to-peer mentoring, makes adherence easier and should be encouraged
- Caregivers involvement in health care improved outcomes among adolescents and young people
- Non-judgemental approach to counselling is vital to adolescents’ commitment to treatment and should be encouraged

Model 2: Peer led adolescent support groups for chronic illnesses in SA, Rebecca Sher

This model brings together adolescents with many different chronic illnesses including HIV. Despite different conditions, they are struggling with similar experiences of illness related to stigma and isolation. In consultation with adolescent patients, they trained peer supporters living with a variety of different conditions and set up a weekly support group. Attendees are 13-21 years, living with a range of conditions including HIV, mental illness, kidney disease, endocrine and respiratory conditions. Groups are not focused on illness, and not focused on adherence, adolescents are tired of talking about this. The focus is rather on life, relationships, friendships, sex, the future. Disclosure of condition is not a requirement, but it is reassuring for all to know that everyone is living with some condition and there is unity in this and shared understanding.

Building Blocks of the Programme

<table>
<thead>
<tr>
<th>ART REFILLS</th>
<th>CLINICAL CONSULTATIONS</th>
<th>PSYCHOSOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHEN</strong></td>
<td>2 Monthly (average)</td>
<td>4 Monthly if stable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More often as required</td>
</tr>
<tr>
<td><strong>WHERE</strong></td>
<td>Hospital pharmacy</td>
<td>Groote Schuur Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adolescent IDC</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td>Pharmacist to patient</td>
<td>Doctor consult</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lay counsellor</td>
</tr>
<tr>
<td><strong>WHAT</strong></td>
<td>ART and any other</td>
<td>HIV care</td>
</tr>
<tr>
<td></td>
<td>medication</td>
<td>SRH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General health</td>
</tr>
</tbody>
</table>

“Bringing people together, both HIV-positive and HIV-negative can actually decrease stigma, rather than increase it.” Rebecca Sher
Lessons learned and next steps

- It is acceptable and sustainable for adolescents with a side range of chronic conditions, including HIV, to form "mixed groups" to support each other
- Mixed groups may lead to decreased isolation and stigma
- Research is underway to measure the impact of group attendance on mental health outcomes
- Rollout to other hospitals: manual available

Feedback from participants

You come out of that group feeling more alive than when you went in.

It has made a huge difference even in my life coping with my disability.

I never thought that I would have so much fun.

I don’t feel as alone as I used to.

You come out of that group feeling more alive than when you went in.

It has made a huge difference even in my life coping with my disability.

I never thought that I would have so much fun.

I don’t feel as alone as I used to.

Model 3: David Ogiti, Family Centred Care Model PAMA

Building Blocks of the Programme

<table>
<thead>
<tr>
<th>Psychosocial support</th>
<th>Family caregiver Literacy sessions</th>
<th>Clinical consultation</th>
<th>Leveraging on Orphan and Vulnerable Child (OVC) support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHEN</strong></td>
<td><strong>WHERE</strong></td>
<td><strong>WHO</strong></td>
<td><strong>WHAT</strong></td>
</tr>
<tr>
<td>Monthly</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Monthly</td>
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<tr>
<td>Every 2-3 months</td>
<td>Every 2-3 months</td>
<td>Every 2-3 months</td>
<td>Every 2-3 months</td>
</tr>
<tr>
<td>HIV clinic</td>
<td>HIV clinic</td>
<td>Clinician</td>
<td>Clinician</td>
</tr>
<tr>
<td>Hospital Home</td>
<td>Hospital</td>
<td>Adherence counsellor</td>
<td>Adherence counsellor</td>
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<tr>
<td></td>
<td></td>
<td>Peer educator</td>
<td>Peer educator</td>
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<tr>
<td></td>
<td>Monthly</td>
<td>Clinician</td>
<td>Clinician</td>
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<tr>
<td></td>
<td>Every 2-3 months</td>
<td>Adherence counsellor</td>
<td>Adherence counsellor</td>
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<td>Peer educator</td>
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<td>Monthly</td>
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<td>Peer educator</td>
<td>Peer educator</td>
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</tbody>
</table>

- Joint family adherence counselling
- Engagement of the caregivers
- Case management model for the unsuppressed
- Children play therapy
- Family OVC support
- Health literacy
- Stigma and discrimination reduction strategies
- Disclosure support
- Nutrition and ART medication management
- Adherence counselling
- OVC support
- Provision of comprehensive standard package
- Medication / ART optimization
- Appointment synchronization
- Multi-month dispensing (MMD) for the stable
- Multidisciplinary Team (MDT) case reviews
- OVC support
- Referral and linkages
- Engagement with stakeholders
- Screening and linkage for enrollment and support
- Consideration of socioeconomic needs
- Supporting Drug Witnessed Ingestion (DWI) for those failing ART regimen

Key outcome: There has been a positive impact on viral suppression
Lessons learned and next steps

- Family unit engagement
- Comprehensive psychosocial support
- Tailored differentiated care models
- Structured engagement of OVC programmes

Cosima Lenz, EGPAF gave a presentation related to providing extended refills for children and adolescents.

Strategies for scale up of MMD for children and adolescents

- DSD guidelines with compressive guidance
- Orientation, follow-up support and monitoring
- Financial support
- Forecasting and qualification
- Redistribution of paediatric ARVs

Strategies to increase MMD uptake among paediatric populations:

- Family-centred approach (enroll children and adolescents on the same MMD refill dates as parents)
- Adherence focused activities
- Engage and capacitate village health workers

Strategies to increase MMD uptake among paediatric populations:

- Engaging with learning institutions
- Integrated into DSD service delivery models for adolescents and youth

Lessons learned

- Systems-level approach to support MMD provision
- Tailored strategies to meet the needs of children and adolescents
- Capacity building of facility and community-based cadres to support ongoing provision and adherence support particularly for vulnerable children

Idorenyin Ezekial Charles, CHAI gave a presentation on provision of HIV self-testing kits in Nigeria.

He described a project where adolescent champions provide HIV ST kits to peers at adolescent at youth friendly centres. IEC materials, ease of use and privacy have facilitated acceptance with youth.

Strategies for scale up of MMD for children and adolescents

- Provide incentives, such as condoms, to encourage and attract adolescents
- Educate and build public awareness on the accuracy of HIVST results to foster trust and acceptance
- Distribute information, education, and communication (IED) material sat strategic entry points such as Youth Friendly Clinics, adolescent clinics, and support group meetings frequented by adolescents to drive demand.
- Continue to engage with community gatekeepers

Adolescent-friendly service is a service that is responsive to the needs of adolescents, and it should be acceptable to the adolescents, meet their basic needs and ...where the adolescent is made a co-creator of the health system, not just a recipient...and their voices should be heard.

Franklin Emerinini
What are the barriers and facilitators to supporting scaled implementation of DSD for HIV treatment for children and adolescents?

Poll Responses

Poll 1

90% of the audience agreed that children and adolescents can access DSD for HIV treatment in their countries.

70% of the audience said that, in the facilities they work in, children who are established on ART and receive 3 monthly refills or longer.

88% of the audience said that, in the facilities they work in, adolescents who are established on ART, receive 3 monthly refills or longer.

85% of the audience agreed that, in the facilities they work in, adolescent peers are a recognised and valued cadre in HIV service delivery.

55% of the audience said that, in the facilities they work in, adolescents can access HIV self-testing kits.

Poll 2

90% of audience thought that Covid encouraged frontline providers to think differently about how to best provide services.

78% of the audience thought that the lessons learned from COVID-19, are beneficial for the HIV response.

82% of the audience thought that more advocacy is needed for the revising of policies that support DSD of HIV services for children and adolescents.

Most of the audience thought that both advocacy and a better understanding of what DSD is, is required to support the scale up of DSD for HIV treatment for children and adolescent.
This session, chaired by Erwin Fisser, from Aidsfonds, Netherlands posed a central question: in a rapidly growing era of digital health innovations, where is the place of the health provider in digital health solutions for HIV/ SRH/ mental health/ GBV integrated services? Technology and digital platforms are tools and cannot replace the care and support from health providers. The focus should rather be on how these technologies can complement the work of the frontline health providers – facilitating access to services, while safeguarding the rights of their clients and end users. This session provided an opportunity to look at what we have learnt so far about using digital interventions and e-health tools, through sharing some examples of these, where they have been useful, what has worked, as well as challenges experienced in implementing them. It also raised important questions that need careful consideration: Who owns the technology? How are these tools scaled up? What are the human rights implications? How do we protect our users?

Example 1: Nkunda Vundamini and Nakita Sheobalak from Wits RHI presented on accelerating digital innovation to engage AGYW in SA.

What is the problem?

- Gap remains for market entry through a sex positive narrative that is relatable to young people
- Linkage to YF SRH services through digital innovations remains sparse
- Lack of access to digital health technologies that respect the digital rights of everyone, especially the most vulnerable

In response to this gap and particularly to facilitate education around PrEP, MyPrEP interventions were developed.
MyPrEP digital Interventions


Benefits and Challenges:

- Increased self-awareness and improved sense of accountability over health choices
- Building knowledge by providing bite-sized information that is relatable and youth friendly
- Instant answers to FAQs
- Providing support for continued use of PrEP and facilitating linkage to additional care and services
- Keeping young people engaged

Best practices/recommendations:

- Content for different audiences and combine digital platforms
- Human rights – access to health services-anonymity and data protection
- Monitor, evaluate and improve
- Accommodate limited space on mobile phones, lack of Wi-Fi, data or signal coverage
- Ensure sustainability and find a suitable service provider

Example 2: Nzisa Kioka, YLabs, Rwanda: Designing digital sexuality education platforms to grow demand for health information and services among youth, Kenya.

What is the problem?

- High teenage pregnancy rate
- High unmet SRH needs
- High school dropout due to early and unintended pregnancy

They worked in partnership with young people to design digital platforms and created AskDoki chat bot (this means ask a doctor in slang) – to learn new life skills, find the nearest health facility and hotlines for GBV, child abuse, and mental health support. The chatbot also has a safeguarding/child protection aspect – it tries to recognize potential harm/abuse situations. AskDoki does not require data for access on Whatsapp and conversations can be deleted once completed, to protect privacy.

Design principles derived based on user feedback:

- Privacy is key
- Elicit trust through authority figures
- Don’t judge and don’t ask unnecessary questions
- Don’t beat about the bush and don’t leave young people hanging
- Option to be frugal with data usage

It is also important to keep the user at the centre of the innovation because the user informs what the innovation is going to look like in the end and how the innovation is going to work. Nzisa Kioka

Best practices:

- Clear key messages
- Keep the user at the centre of your innovation
- Create room for interaction in conversation
- The tone and voice of the bot should be friendly and easy to talk to
- Design for check-ins and reflection prompts
- Vary the speed the chatbot replies at
- Get buy in from local authorities

Remember that these are living tools and need enhancement in order to stay relevant. Nkunda Vundamini
Example 3: Simon Moore, AVERT: Be in the know Zambia – a digital SRH intervention.

The goal of this project was to understand how a digital communications intervention could improve knowledge, confidence and uptake of SRH services in Zambia in those 18 to 24 years old. The project began with formative research and co-creation of a digital product involving young people. This resulted in the development of the Be in the Know mobi site. Users start by choosing a character they can identify with, they are then taken through a comic strip dilemma and have to think about their response in that situation. They recruited participants to the study through Facebook.

Results so far are promising:
- App was found to be acceptable by young people
- It increased knowledge and intentions on some indicators
- Going forward the researchers will look at differences between high and low users

Learnings so far:
- Online recruitment worked
- Digital co-creation works
- Digital health communication can be part of powerful change engines for young people

Example 4: Nomtika Mjwana, project manager for VOICE+ at the Global Network of People Living with HIV: Reflecting on VOICE+ and Digital Health Rights research project.

What is the problem?
- Limited access to services during COVID-19 pandemic
- Concerns around inconsistent messaging and poor access to information

This led to VOICE+ which aimed to develop a digital solution to these challenges – to support people to access accurate information. It is a smartphone app linked with a Whatsapp chatbox initially launched in Oct 2020, and then underwent evaluation in 2021. They learnt that this is not a quick, easy process; it requires a lot of engagement with end users who are not a homogenous group. It requires careful consideration to meet everyone’s needs.

The Digital Health Rights Group (DRAG) is leading a study through this group, looking at what human rights violations look like in digital health – it maps digital health policy and legal frameworks and how they are applied to current interventions – in Ghana, Vietnam, Kenya.

Key Learnings

1. Access
   - Infrastructure
   - Smartphone penetration
   - Data access
   - Inclusive design
2. Policy and Governance
   - Legal and Policy frameworks on data protection vague in most contexts
   - E-health strategy implementation and adaptations
   - Compromised safety for criminalized communities
3. Privacy and security
   - Data protection / storage and access
   - Privacy policies understood by recipients of care
   - Measures in place to ensure user security

Key takeaways regarding characteristics of successful digital interventions:
- Well-planned – tool development is coordinated and responsive in an overarching digital health architecture that is interoperable and flexible, with a consortium of implementers who come together to share the interventions being developed – to add to the design, rather than create whole new solutions
- Endorsed by and led by national governments with the support of global partners. Working with government is key because they know what is happening on the ground and who the stakeholders are
- Anchored in local context and driven by local needs, even if this requires using multiple digital platforms
- Co-creation with different groups of people (end users) from the outset ensures very tailored messages, that are particularly relevant to your audience
- Accessible – closing barriers around digital literacy, shortage of connectivity etc.
- Complimentary: not a one size fits all solution, tailored and complement traditional services, rather than replace them
- Situated in a regulatory framework: human rights centred offering safeguarding and protection of personal information

Put the person you are designing for at the centre of your intervention. Don’t make the mistake of designing without them. Nazisa Kioka

Find a tech partner you can trust and build a relationship with. Simon Moore
PATA REAL is a new and exciting regional platform by and for health care providers working on paediatric and adolescent HIV service delivery. It is a safe space for providers to share real, unfiltered, day-to-day experiences and challenges in case finding, testing, initiating ART, retention and supporting children and adolescents on their treatment journey to achieving viral suppression, good health and wellbeing. This quarterly webinar series brings together health care providers for case-based practical peer-to-peer learning to improve paediatric and adolescent HIV service delivery across sub-Saharan Africa. The objective is to build health provider skills, expertise and confidence in managing paediatric HIV clinical cases. Dr Daniella Mark, PATA chaired the session, where three cases were presented, and feedback was provided by the expert panel.

Dr Acia Macovela, Ravene HC, Mozambique presented the first case; Dr Umahi Izuchukwu, Ikpe Ikot Nkon General Hospital, Nigeria presented the second case; and Andrew Kimera, Katooke HC III, Uganda presented the final case.

Expert feedback was provided by Dr Moherndran Archary, South Africa; Dr Pascal Atanga, Cameroon; and Dr Nandita Sugandhi, PATA, South Africa.

The cases highlighted the following:

**Social and contextual issues:**
- Importance of looking at the whole patient and addressing social issues, logistical issues
  - Transport
  - Food security
  - Nutrition support
- Importance of the HP remaining supportive and non-judgemental, no matter what the circumstances are
- The importance of nutrition for children

**Medication related issues:**
- Need for more paediatric friendly treatment formulations – better tasting, lower pill burden, as this can significantly impact adherence
- HP uncertainty in prescribing and using DTG
- The need for lower mg DTG tablets
- The need to look at other issues when the child is not responding to treatment
Addressing additional issues – disability:

- Disability brings additional challenges for families and the health team
- Disability brings additional stigma, on top of HIV stigma
- Additional support and advocacy needed for children with disabilities
- Children with disabilities need proper assessment to establish their limitations and potential

Key suggestions for optimising treatment:

- Ensure referral for additional support services and programmes that can address key social and contextual issues
  - Transport support
  - OVC programmes
  - Nutritional support
- Provide additional adherence support where needed
  - Intensified adherence counselling
  - DOT
- Ensure training for HCP so that they are confident in prescribing and using DTG
- Make use of resources for teaching children how to swallow tablets without gag reflex
- Consider other issues when a child is not responding to treatment e.g. Absorption issues; ensuring the child’s dosage has been increased in line with their weight gain
- Simple interventions can improve outcomes for children with disabilities; caregivers need education and support to provide these – community-based rehabilitation organisations can assist

It’s about keeping the patient at the centre of all your decisions. Mohenndran Archary

There are all sorts of pieces that clinicians need to keep in mind while ensuring that the clinical care is of a high quality. And I think that must be really challenging, to do when you have got a very long queue of patients waiting to see you, to also then think about siblings who might not be diagnosed, what are the psychosocial issues, how can those issues be met by resources in the clinic, outside of the clinic…. Daniella Mark

One thing that does come up sometimes, is making sure that we adjust dose as weight changes and that’s something that sometimes gets missed…so we have definitely seen that before, where the child gains weight and the dose is not adjusted accordingly. Nandita Sugandhi

What struck me the most is that what was really successful here is that these cases all represented taking a child focused approach, taking the child and looking beyond just the HIV, to look at the whole child, the family in the social context. Nandita Sugandhi
The last day of the summit focused on Health Providers as advocates, placing them at the centre of the conversation. This provided them with a platform and a voice to engage and interact with their peers and policy makers on the challenges they face when putting policies into practice in the dynamic and complex environments they operate within. Sessions shared the experiences and preferences of health providers on the frontline and included health provider capacity-building as advocates for themselves, and for their clients, with stakeholders at district or national level in their respective countries.

Since the beginning, people living with and affected by HIV have been the backbone of the HIV response. They have campaigned for their rights, expanded and informed evidence-based programmes, supported and guided the design and implementation of HIV programmes and health services. Yet, we are still to see stronger leadership of frontline health providers, community-based organisations and young people driving the HIV response. How can we effect change and ensure that health providers, clients, community-based organisations, networks of PLHIV are leading the response with the required mandate, structures, and investment? This question was at the centre of the prime session, chaired by Wole Ameyan, WHO, which included a number of presentations on the critical role of the global south and young people in health systems change.

The first presentation was from Degan Ali, Kenya Executive director of Adeso: Strengthening Southern leadership and community-driven system change.

What does “decolonisation” mean and what does it have to do with aid?

Calls to ‘decolonise’ are about ‘recognising, making visible and working to address the legacies that colonialism, empire, and racism, continue to have, and envisioning a world beyond these repressive structures’. It is also about recognising the repressive neo-colonial global governance systems that ensure economic, financial and political hegemony of the Global North.

What are the issues?

Local NGOs are treated as second class citizens in the HIV response. They have no real power in decision making forums yet are the most at risk. Only 0.2% of global humanitarian funding and about 2 to 4% of development funding goes directly into the budgets of local civil society. There are so many layers of intermediaries.
Definitions

• DEI addresses issues of diversity of staff, leadership, pay equity, diversity of governance in organisations – mostly HR and governance functions.

• Localization is seen as primarily about shifting more funding to local organisations and meeting the 25% Grand Bargain Commitment. Maybe it is also worth considering how INGOs can work in complementarity with local organisations.

• Decolonisation means that the problem requires an external review of an organisation’s business model and how the organisation behaves or is complicit in perpetuating the colonial power structures in its strategy, policies, practice, partnerships, financing, advocacy and solidarity with global south communities, governments and civil society. It also means undertaking an in-depth critique of the mechanisms that perpetuate economic, financial and political colonialism.

At the heart of the issue is the need to decolonise the global governance system. Systems are still controlled heavily by former colonizers and empire builders. Africa is a source of raw materials, yet not a source of the final product, for example rubber and tyres, cocoa and chocolate. Africa cannot benefit from these systems, and the outcome of this is that Africa is continually exploited, and does not have funds to invest in support for its citizens in terms of health, education, food security, and as a consequence, its has to rely on aid.

What needs to happen?

For true justice, the global south and north should have equal voting and representation in the governance systems.

We need a level playing field. Degan Ali

That’s what we need for ourselves, to be able to fund our own services. Degan Ali

Decolonising our Relationships with Global South Countries

• National and local governments along with civil society should be at the centre of humanitarian and development services in support of country development agendas.

• USAID or other donor driven HIV and Health investments should be in support of government budgets and provided at the most local level to have impact. Not to intermediaries like contractors and INGOs.

• Investing in community and health system strengthening as key priority. Patients should be at the centre of the investment

Local Civil Society – Local Ngos

• Significant effort needs to be made in developing the pipes/infrastructure to create enabling environment to move money DIRECTLY to local NGOs. Grand Bargain has been a Grand Failure.

• Language about risk and capacity building is racist. INGOs and UN agencies need serious capacity building, are risky and have had massive fraud events which are never discussed openly.

• Unrestricted and core funding needs to be provided to local NGOs to improve their compliance systems. INGOs have received such investment through partnership frameworks for over 50 years.

• Voices, choices and feedback of communities needs to be prominent in the design and implementation of programs.

Example of COVID-19:

Our health strategies are still global north driven. And I found it very shocking that our governments were willing to have their health policies [during the COVID-19 pandemic] be determined by global north actors without any real reflection or interrogation if this was the right thing. Degan Ali
She concluded by saying we should be driving our own health strategies and policies, and that what works in the north, isn’t necessarily right for us.

The next presentation was from Angela Motsusi, health provider, professional nurse and social entrepreneur, living positively with HIV, who owns and runs Unjani Clinic, South Africa. Angela talked about ‘Leading positively as health providers’. What does it mean to lead positively as a HP? Angela shared her reflections:

- Advocating against stigma and discrimination
- Being proactive and equipping herself with knowledge
- Understanding that HIV is more than a health problem
- Understanding limitations as a nurse clinician and knowing when to refer: the need to involve social services
- Being sensitive to stigma
- Knowing that a HIV diagnosis is life changing.

Angela shared some of the challenges that health providers face in terms of supporting patients to remain on treatment.

**How can we as Frontline Health Providers be Supported?**

**How can these Challenges be Overcome?**

- Continuous mentorship of nurses and updates on guidelines
- Providing platforms for HCW to raise their challenges
- Integration of the maternal child and women’s health and ART program
- Case management model for newly diagnosed mother and child for at least 6 months
- Linkage to a comprehensive nutrition program

Tinashe Rufurwadzo, programme director Y+ Global, Zimbabwe, spoke about Empowered young people: leading the conversation, and the different roles young people have played.

- He argued that young people are the most effective advocates for their own wellbeing, and that they need to push for conversations even when these are difficult. He provided the example of the READY movement, where young people have successfully advocated to lower the age of consent for testing for HIV from 18 to 15 years
- In addition, young people should not only be considered subjects of research, but also researchers themselves
- They have also played a role as peer educators, and the way they do this has evolved, to respond to real questions and experiences of young people
- Young people are no longer recipients of care but are active as service providers

In summary, young people are increasingly recognized as experts of their own lives, and it must become the norm for young people to be at the centre, with HCW as their key partners.

**The days of being on the sidelines are over. We must be at the centre of these initiatives.**  
Tinashe Rufurwadzo

Merian Musunguzi, Aidsfonds Programme Co-ordinator in Uganda, then spoke about the Partners in health: clinic-community collaboration.

**Unmet need**

- Children are born and raised in communities yet;
  - Care services are mainly health facility based and do not reach most children
  - Linkage between health facilities and communities remains weak
  - Those in dire need of being enrolled in care are not being found
- The persistent gaps in the paediatric HIV response require new and additional ways of reaching the last child

CHW provide the perfect link between the home and the health facilities and can play an important role in bridging the gap on unmet needs regarding paediatric HIV outcomes. However, they are not adequately linked, facilitated, trained, supported or reimbursed. Many are still working as volunteers.

They are therefore working to develop a stronger system, the TAFU model, based on the CHW resource, which is focused on addressing the barriers at different levels. The focus is on the complete wellbeing of the child, taking into account the environment in which the child lives and develops.
TAFU Approach

Multi sectoral approach;

- Addressing barriers at family, community and health facility level
  - Creating awareness
  - Addressing stigma
  - Facilitating econom. empowerment
  - Assisting families in coping with other (individual) barriers
- Empower communities to find, link and follow up children
  - Start & strengthen treatment support groups,
  - Capacity building and facilitation to community resource persons,
- Work with MoH, CHWs, HCII & HCIII to create a strong coordinated system

- Lobby & advocacy to improve quantity & quality of services

Working through a community system approach TAFU seeks to complement ongoing interventions that are largely health facility based

- Emphasis on collaboration between health workers;
  - Coordination meetings
  - Community outreaches
  - Joint follow up visits
  - Joint community dialogues
  - Sharing client lists for follow up

Wole Ameyan provided a summary of the key points:

- We cannot continue to put our heads in the sand. A lot needs to be done in terms of addressing global governance systems.
- We need to acknowledge the critical role of health providers, the incredible work they do and the impact of their lack of support.
- The bottom line is about communities, placing them and young people at the core of the response.

Call to action

- Advocacy for community investment
- Communities should be better equipped to meet their needs in an organised way
- Strong and coordinated link between H/Fs and Communities
- Support for community led monitoring
- Recognition and financial support for health providers at all levels
- Willingness and commitment to avail resources for a coordinated community and health facility approach

Click here for RESOURCES
This session, chaired by PATA’s Agnes Ronan, placed a spotlight on health providers in the context of the pandemic. Both collective and individual voices from the frontline shared the impact of COVID-19 on their daily lives. The session also included presentations on some of the efforts made to mitigate these impacts as well as some practical examples and tips on how to facilitate implementation.

At the outset of COVID-19 in May 2020, PATA conducted a survey among its network of health providers to better understand their experiences. Just over a year later PATA went back to do a ‘temperature check’ to see how HP are doing. Dr. Fileuka Ngakongwa, PATA Country Representative from Tanzania set the scene for the session by providing a sneak preview into the preliminary results of the second PATA Health Provider Survey entitled, Voices from the frontline: the impact of C19 on health providers. In the first survey in 2020, 188 HP participated. In this second phase, this increased to 215 HP representing 15 countries.

23% had missed work through having COVID-19. A further 42% missed work due to suspected COVID-19. 35% missed work as they did not feel protected against COVID-19. Alarmingly, 48% reported that they did not have sufficient access to PPE.
The survey revealed the high impact of COVID-19 on mental health, with 61% reporting feeling extremely stressed about COVID-19 and 80% acknowledging it is something they think about all the time. Most are stressed about their own health and the health of their family with 40% having a family member or friend who has had COVID-19.

**Summary**

- Very few respondents felt safe and sufficiently protected from COVID-19 at work.
- There is still a need to ensure that frontline health providers have access to enough PPE to protect themselves when they see clients.
- Health providers are largely stressed about their own health and the health of their family and friends, when it comes to their biggest concerns about COVID-19. These concerns resulted in health providers feeling increased levels of anxiety for themselves and others.
- The wellbeing and mental health of health providers are also affected in that many of them personally know people that have died of COVID-19 related causes, and this excludes patients/clients.

The second presentation was led by a trio from the Hey Baby team at Mzantsi Wakho from UCT and University of Oxford. The three presenters, Charné Glinski, Bongiwe Saliwe and Babalwa Taleni shared qualitative data from research with frontline health workers, providing reflections of Public Health Care Nurses during the first wave of the COVID-19 pandemic in the Eastern Cape Province of South Africa.

The Hey Baby project aims to assess resilience-promoting pathways for adolescent parent families living in adversity. The qualitative study with nurses began at the start of the COVID-19 pandemic in response to social need. Qualitative semi structured interviews were conducted with nurses in order to understand their experiences and try to identify ways/strategies to assist them to navigate their way in the pandemic.

**Findings highlighted three key themes:**

- **Resource constraints**
  - Shortages
  - Rapid depletion and delayed restocking
- **Psychosocial burdens**
  - Daily dilemmas
  - Internal conflicts
- **Adaptive responses**
  - Willingness to meet the needs of patients
  - Including responses for YPLHIV

**Recommendations:**

**Holistic support of healthcare workers:**

- Continued, sustainable concrete forms of psychosocial support
- Encouragement alongside emotional and practical support from hospital management

**Finding innovative ways to ensure AYLHIV continue to access healthcare services:**

- HCWs are uniquely placed to understand the dynamics of their communities
- Task shifting e.g. community health workers tracing defaulters and delivering medication
- This may reduce workload and COVID-19 burden on healthcare facilities
The third speaker was Prof Jackie Hoare, Head of the Division of Consultation Liaison Psychiatry, University of Cape Town. Prof Hoare spoke about some of the initiatives she and her colleagues have been running during the pandemic to provide support and maintain morale for frontline health providers, highlighting how in these circumstances, some of the more traditional approaches may not be sufficient. She described her hands on approach and how she came to adopt this and begin working in the high flow units and the ICU as part of the health worker team at Groote Schuur hospital in Cape Town. She described how in March 2020, she and her team tried to prepare HCWs for what was to come. She realised early on that providing skills for resilience training, coping etc. was not enough. Telling HCW they needed all these skills, felt as though they were being blamed and pathologised. Instead, what became acceptable was a contained space/group where they could share their experiences and anxieties, which only happened when she became part of the team. It was important for her to normalise their reactions, in order to dissipate the stigma. She provided a space for fear to be expressed safely. When she joined the team, the HCWs became more willing to share, show vulnerability and admit the need for support. Jackie explained that trauma can bind people who have experienced the same trauma together, and thus, a peer support model proved more appropriate to support clinicians during the pandemic. She also noted that the experience has given a window into questions regarding the welfare of clinicians who are constantly working in under-resourced settings, in the longer term.

The last speaker was Graeme Hoddinott, Research psychologist and Co-Investigator at the Desmond Tutu TB Centre at Stellenbosch University, South Africa. He shared results of the extensive work conducted by the Panagora Group to explore existing debriefing platforms in South Africa, in response to reports that HCWs were distressed. Their work provides key recommendations and practical tools to facilitate implementation and for strengthening existing platforms.

They aimed to explore the mental health experiences of HCWs during the COVID-19 pandemic in seven high-burden HIV and TB provinces in South Africa; determine what support is needed by them to better cope; and assess what resources are available to support HCWs during the COVID-19 pandemic.

What were the Findings?

<table>
<thead>
<tr>
<th>Theme categories</th>
<th>Theme clusters</th>
</tr>
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</table>
| What is it like to be a HCW working during the COVID-19 pandemic? | • Range of extreme emotions  
  • Guilt for not being able to provide quality care  
  • Fear of acquiring COVID-19 |
| How are HCWs coping under the COVID-19 pandemic?       | • Coping mechanisms among HCWs  
  • Intersection of culture and gender as a barrier to the uptake of mental health support  
  • Resilience and adaptability of HCWs |
| What additional support do HCWs need?                  | • Support to manage the everyday burden of work to perform optimally  
  • Support and referral for stressor events  
  • Support and referral for mental health disorders |
| What additional support do supervisors recommend?      | • Appreciation towards staff  
  • Professional mental health support |
What are the practical recommendations?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-service training</td>
<td>• On mental health and the support available</td>
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<tr>
<td></td>
<td>• On the different types of mental health support needs</td>
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<td></td>
<td>• On the intersection of culture, gender, and mental health</td>
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<td></td>
<td>• On COVID-19 misinformation, accurate information on COVID-19 vaccines,</td>
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<td></td>
<td>and adverse events</td>
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<tr>
<td>Routine staff meetings</td>
<td>• Routine debriefing sessions</td>
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<tr>
<td></td>
<td>• Integrate debriefing about work-related challenges into routine meetings</td>
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<tr>
<td>Staff recognition and awards</td>
<td>• Creating opportunities for motivation and recognition by showing</td>
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<td></td>
<td>appreciation for staff in a challenging environment</td>
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<tr>
<td>Supportive supervision</td>
<td>• Supportive supervision site visits for mentoring</td>
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<td></td>
<td>• Supportive supervision for PPE stock control</td>
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<tr>
<td>Healthy workplace</td>
<td>• Widely circulate mental health support information</td>
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<tr>
<td></td>
<td>• Quarterly mental health check-ins</td>
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</tbody>
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Key take home points:

- There is a sense that the pandemic is bleeding into every element of the HP’s reality, and they have lost the ability to separate work and home.

- HCWs feel guilty to share that they are struggling. Encourage HCWs to create safe spaces whether in person or virtually, where they can share with each other, vent and debrief.

- The most important intervention in terms of supporting HCWs is the acknowledgement that they are the most valuable resource in the healthcare system and need to be cared for as such.

- Remember the power of peer support. It helps to keep people working together in the same teams. It creates bonds and also enables them to offload with one another as they have shared the same traumatic experiences.

- In order to deliver quality care, you need to be well yourself. MH of HCW should be central to everything that is done so that HCW are optimal tools. It has to be integrated across everything.
Dos and don’ts of disclosure

The disclosure process can come with many challenges – ones that can affect self-esteem and cause fear. As a result of some of the negative impacts of disclosure, caregivers of children living with HIV and young people living with HIV can be reluctant to disclose their status. Disclosure is, however, critical to HIV treatment adherence, as well as for the prevention of HIV transmission. Health providers are critical in the disclosure process as they prepare the caregiver or young person living with HIV regarding how to disclose their status. The objective of this session, chaired by Julian Kerboghossian, ATC, Lebanon was to highlight barriers towards disclosure and identify and share practical solutions or lessons to overcome these barriers and support health providers in the disclosure process across various levels/scenarios.

Lynette Mudekunye, REPSSI, South Africa started the session by providing an introduction to the disclosure process. She highlighted that this process can improve psychosocial wellbeing or be detrimental to psychosocial wellbeing; thus when and how it is done, is very important. Essentially it is about sharing information with those who care about you in order for them to support you, it is important to do this well. However, in practice, this can be challenging due to fear (because of stigma), lack of confidence and poor communication.

REPSSI advocates that disclosure begins early, and that it is a process, not a one-off event. This is important because it can become all too easy for disclosure to happen by accident. It is better that children are comfortable with their status before they reach adolescence, as so many additional challenges and changes arise during this phase, making it preferable to give them the opportunity to become comfortable with that aspect of their identity earlier in their lives.

The remainder of the session involved participants attending breakout rooms to discuss four different disclosure scenarios and giving feedback regarding the main barriers to disclosure that they had identified, as well as their recommendations for key actions.

Facilitators for breakout rooms: Nokuthula Heath, Zoe-Life, South Africa; Epie Fanny, Cameroon Baptist Convention Health Services, Cameroon; Linda Whitby, Frontline AidS.
### Breakout room 1: HCW disclosing a child’s status to their caregiver

**Barriers to disclosure:**
- Fear of the stigma the child is going to experience
- Denial of diagnosis due to lack of information regarding modes of transmission
- Fear of caregiver regarding initiating the child on treatment
- Limited training of HP in the disclosure process

**Key actions by HP:**
- Ensure the caregiver understands the information: HP needs to provide comprehensive counselling
- Services and HP need to be friendly
- Prepare the scenario for possible positive results i.e. antenatal care
- Avoid accidental disclosure
- Attitude of HP should not be judgemental, but rather open to discussion
- People must not be cut off if they are visibly upset or crying
- Disclosure must never be given in public
- The caregiver must not interrupt the child

### Breakout room 2: Caregiver disclosing child’s status to them

**Barriers to disclosure:**
- Disclosure is more challenging if the child to caregiver relationship is poor
- Level of comprehension of the caregiver and the child; the caregiver not having the necessary information needed to disclose to the child
- Other siblings in the family who are not HIV+
- Fear of the reaction of the child

**Key actions by HP:**
- Ensuring the caregiver feels supported by the HP
- Correct and easy to understand information provided by the health facility to be used in the disclosure process
- Educating caregivers around HIV and how to adapt to their child’s HIV status
- Preparing the caregiver for what the child’s reaction might be to the disclosure process
- Allowing the caregiver to role play different scenarios in preparation for the disclosure process
- Once the child has been disclosed to, the HP can provide support to the child

### Breakout room 3: An 18 year old male living with HIV wants to start a relationship and is seeking support from HCW on how to disclose.

**Barriers to disclosure:**
- Fear of rejection or abandonment by partner
- Fear of physical, emotional or sexual abuse
- Breach of trust and confidentiality
- Stigma and cultural perceptions around HIV
- Partner not being well informed about HIV

**Key actions by HP:**
- HP should be non-judgemental and not make assumptions regarding his sexuality, promiscuity and lifestyle choices
- Support him to bring partner along to the clinic to receive education about HIV
- Prepare him for different outcomes - acceptance or rejection
- Provide support if his partner does not respond well
- Empower him to make his own decisions and be confident to disclose
- Provide a disclosure dry run session with him
- Provide him with information about SRH
- Connect him with peer support

### Breakout room 4: Young person disclosing their HIV status to caregiver

**Barriers to disclosure:**
- Not all health providers are adolescent-friendly
- Caregiver may react with anger, abuse, rejection

**Key actions by HP:**
- HP needs to be capacitated to provide adolescent-friendly services
- HP needs to be equipped to dispel HIV myths
- HP needs to be able to access and share resources with the adolescent and/or household that will support them in this process
- After disclosure, HP should support the adolescent in dealing with the reaction of the caregiver
- Need to prepare the adolescent for a range of possible outcomes, positive and negative
- Educate the caregiver
- Be non-judgemental
It is well-established that the COVID-19 pandemic, lockdowns, quarantines, and disruptions have interrupted services and slowed progress in reaching global targets. Even before the COVID-19 outbreak in March 2020, progress in meeting global goals, related to paediatric HIV, for children and adolescents was alarmingly off track. In 2019, just 59% of HIV-exposed children globally had been tested by two months of age, and just 53% of children who required lifesaving ART, had access. The treatment and service gap for children is increasingly acknowledged, and with the additional COVID-19 impacts on education, social protection and health, these gaps have widened further.

While we have the policies and may know what works best, much more investment, capacity strengthening and focus must be placed on implementation, and quality service delivery in getting the job done.

- What exactly does 'getting the job done' mean, and what will it take?

- What does decisive leadership, increased funding, and resources, together with scaling up proven interventions and tools for prevention, treatment and care look like?

- How do we make sure that these efforts are prioritised and coordinated at community level, reaching the most marginalised?

- Importantly, how do we keep the momentum and focus on children, on young people, on service delivery and comprehensive care so that we can realize the goal of eliminating AIDS as a public health threat by 2030?

In a Lekgotla led by Sbongile Nkosi, GNP+, South Africa, this was debated by a robust group of panellists, each of whom represented a particular stakeholder group who collectively assisted us to unpack the bigger picture on what it will take.
Epie Fanny, CBCHS, Cameroon began by considering the needs of health workers.

What do health workers need to close the service delivery and treatment gaps?

- There is a need for communities and service providers to collaborate and provide services across the continuum of care.
- Service providers need to provide services to adolescents and children in the same way as they do for adults.
- We need frontline workers to be trained to provide adolescent-friendly services, necessary tools, the right support, the right SOPs.
- There is a need for infrastructure – service providers need appropriate space and infrastructure in which to perform their roles.
- Service providers need platforms where they can learn and grow.
- More work needs to be done on developing health workers who are advocates.

Sharifah Nalugo, JCRC, PATA BOD, Uganda considered the needs of young people.

What is needed from the perspective of a young person to build a trusting relationship with service and health providers?

- There is nothing for us without us – young people need to be involved in developing services that are for them.
- Services can also be improved and strengthened if you ensure feedback is elicited from the young people using them.
- Young people need services that are integrated and comprehensive and provided by youth workers / peers who do not judge or discriminate.
- It is important to build capacity and invest in local youth structures.
- Support is needed for addressing other issues like mental health and GBV.
- Ensure that every platform includes a youth advocate.

Richard Ochen, HNU, Uganda shared the needs of CBOs.

What will it take for CBOs to provide the support that is needed and to be the most effective partners in health?

- CBOs need resources.
- CBOS need support and long-term commitment from government and donors.
- There is recognition that there is a greater role communities can play. Reliable systems exist within communities but they need better investment.
- Community leaders including religious and cultural leaders have influence. They can demand services, share information, provide advocacy. We need to work more closely with them.
- CBOs must be assisted to organise and strengthen community systems.
- We need collaboration around health service provision – funding agencies can collaborate to support joint actions.

Lois Chingandu, Frontline AIDS, Zimbabwe considered the role of the INGOs and the global donor community.

What is needed from INGOs and the global donor community to ensure we create an enabling environment for local community-based organisations to lead and partner effectively and more sustainably?

We need to look at addressing development differently in an already changed world that continues to change. In this changing world, it is inevitable that we all need to adapt in terms of the way we do business, and in our attitudes towards communities. How can we make this practical?

- Greater investment in Southern leadership and community responses. We must provide unrestricted resources in order for organisations to be able to better respond to local challenges timeously. Often local CBOs do not have a buffer, they therefore need flexibility in the funds they manage. We need to start supporting communities to become self-reliant and not continue to rely on external organisations.
- We need to build better support – tools, equipment, capacity that will remain within the community eg. prioritise local people when making appointments.
- We need equality in development and creating shared leadership.

"When you empower communities, they can hold people to account." Lois Chingandu

We can’t continue with these development models where there are such power imbalances between the West and the North and the South, between the person who has money and the one who has no money, between the NGO and the community – these models can’t work anymore. We need to talk about shared leadership. How do we share leadership and with shared leadership comes shared decision-making about use of resources- where do resources go? Lois Chingandu
It is also important for NGOs to change. NGOs need to ask themselves - whose agenda are we delivering anyway? Are we delivering our own agenda, or that of the donors? We ask these questions of donors, but we need to ask this of ourselves too. Are we ready to make these changes?

Bringing all of this together, Eswatini provides an excellent example of a country that has managed to achieve its targets. Nobuhle Mthethwa, Eswatini Ministry of Health highlighted some of the key elements that have led to the success of Eswatini’s response.

She emphasized that HCW are central to success. In addition, it is essential to put the child at the centre of everything. Key strategies she highlighted were:

- Close collaboration between MoH and partners
- Prioritisation of paediatric HIV in Eswatini
- An enabling legal environment
- Scaled up prevention
- Scaled up treatment including VL coverage

In addition, overall, there is decisive leadership and co-ordination, a strong healthcare team that is very dedicated, and effective engagement and collaboration with partners.

What about the how? What are the common strategies that all stakeholder and partners are implementing in order to achieve what is necessary?

- We need to understand each stakeholder’s role. If we have clarity on this, then we avoid overlaps and each person will take responsibility for what they must do.
- We need to have one united voice when talking to donors and funders – we need to work as a team; and engage community at all levels.
- Clinic-community conversation is key, with or without funding.
- We need to have proper planning. Quantifying activities and giving timelines to activities and evaluating what is working and what is not, is key. This will ensure we invest in strategies that are changing our indicators and ultimately, helping our children.
1. Is that it will take us all – what has come out loud and, clear it’s the health provider, the community partner and, central to our collective success what is a partnership with the caregiver, child and young person living with HIV - a partnership based on trust, and respect, which is free of stigma and conditionality.

2. We need committed governments, strong national strategic plans and managers who are passionate and committed to getting the job done; who work tirelessly to ensure effective coordination, health systems, tools and commodities are in place; and ensuring that we are putting our resources in strategies that are proven to work and are targeting efforts in places that make the most impact.

3. Strong civil society – NGO partners that provide supporting and completion services, who can often contribute most to the 4th 90, that of care and support, addressing many of the social drivers, barriers and ongoing inequities that drive HIV and limit access to effective prevention, treatment and care services.

4. To be innovative – to do things differently, smartly and more efficiently – during the summit so many examples have been shared of service delivery models, digital and mobile health interventions, all adapted and expanded as a result of COVID-19 – using innovations and best practices from other countries/programmes can help us build back better.

5. Keeping health providers, children and young people part of the conversation. How do we do this in a meaningful way? What are effective ways to build bridges, ensure greater collaboration and ensure that services are child-and youth friendly and centred, and that young people can inform, and influence the way in which they receive services? Also, how do we share the experiences of those on the frontline and involve them in decision making processes in a way that builds capacity and agency?

6. Development and programming must be led by countries, and by local organisations and citizens. We need to invest much more in Southern-led leadership and we must drive our own agenda in securing universal health care for all where HIV service delivery is integrated and accessible to all.

Conclusion and key take home messages, Luann Hatane, PATA

Thank you to all Summit sponsors
SUMMIT AWARD WINNERS

As PATA Summits have always been a time for PATA to recognise the efforts and dedication of frontline health providers. At the 2021 PATA Summit, 4 ‘just for fun’ awards were presented to health providers and participants, in recognition and celebration of the remarkable efforts and dedication of frontline health providers.

BE BRAVE DANCE CHALLENGE WINNERS:

- Kwekwe General Hospital-Zimbabwe
- Sharifah Nalugo from PATA’s YAP and the peer supporters in Uganda
- Beira, Mozambique Satellite Spoke Social Media Enthusiast award winners:
- Phakamani from FSD-Zimbabwe
- Ruta Black from Uganda
- Ngosa Musonda and Florian

HEALTH HERO AWARD WINNERS:

- Sister Upendo Simwanza, Mary Msunya and Dr Sara Makene from Mwanganyamali Regional Referral Hospital in Dar-e Salam, Tanzania and the peer supporters from WAMATA.
- Epi Fanny and the peer supporters working with Cameroon Baptist Convention Health Services’- Nkwen Baptist Hospital.

SATELLITE OF THE YEAR:

Thank you to all the Partners who organized a Main or Satellite Spokes

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<th>Country</th>
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Thank you to all the PATA 2021 Summit Satellites, who are all winners in our eyes.
The summit evaluation survey was completed by a total of 318 participants (39% of summit attendees), of which 88% were health providers. Of these participants, 87% attended a satellite spoke and 13% connected directly and independently online to the virtual hub. The PATA 2021 Summit received positive evaluation feedback from participants, with 92% of participants rating the summit experience as satisfactory. The graph below depicts participants feedback on various aspects of the PATA summit:

Summit participants indicated that the forums highlighted key concerns and provided effective strategies on service delivery improvements, linking and learning on the frontline (85%). Participants also reported that the prime sessions were informative and practical (71%), the Africa Cafés focused on sharing pragmatic lessons and were informative and practical (85%), and that the Lekgotlas were interesting and facilitated dialogue and debate between stakeholders (81%).
Particularly at the satellite spokes, attendees indicated that they enjoyed the experience of meeting other colleagues in-person and this created a sense of community across the different facilities involved in the sessions and in the country in which they are based. Many expressed that they learnt a lot and were very keen to be involved in upcoming PATA summits and activities. Summit topics were contextually relevant and reflected realities that many of the participants were facing and thus able to really impact on their potential activities when they return to their health facilities and organisations.

Participants felt that some improvements could be made for future PATA summits. As a hybrid model was used, limited time for discussions within satellite spokes have come up as a challenge. Satellite spokes would, however have to ensure that the morning sessions are utilized to their maximum to ensure discussions and engagement.

I thank Team PATA for organizing such a wonderful summit, our presenters and participants all-over the world who made our summit a success. God bless you all. Team work always win. Thank you.  Peer Supporter Kenya

One thing I have learnt about adolescents and young people is that they need lots of patience and support and I am so proud to be a Community Adolescent Treatment Supporter. CATS Zimbabwe

At the end the community, adolescents and health care worker involvement makes a huge change in the country and the whole world. However, this can only be achieved if the health care provider manages to have a good rapport with the community so as to work hand in hand to support adolescents. Together we can make it! Health provider Zimbabwe