

2. The PATA Story: A historical overview

The PATA initiative has its roots in Groote Schuur Hospital, Cape Town, South Africa, where One to One Children's Fund began funding much needed ARV medication in a pilot project for 250 families. The project demonstrated extraordinary results and boosted the case for sharing the treatment model with other treatment sites across the continent. Whilst the ARV effect was dramatic and over 90% of the children soon returned to full health, it became clear that the complexities surrounding HIV/AIDS treatment required a holistic rather than a rigidly clinical approach.

The most successful model has been based around the formation of dedicated 4-person professional teams consisting of a physician, a nurse, a psychologist/counsellor and a pharmacist. As a unit, such a multi-disciplinary team can handle almost any clinical, social or educational problem likely to be encountered in an HIV-affected family.

Towards the end of 2004, the South African government finally accepted the responsibility of developing a national ARV programme. The One to One Children's Fund, with its local partner, the Kidzpositive Family Fund, began to formulate plans for the creation of an Africa-wide network of treatment teams to improve and expand the delivery of care and treatment to thousands more children and their families.

Initially, treatment teams from other regions in sub-Saharan Africa were invited to Cape Town to see the Groote Schuur model in action. This initiative was funded by Sidaction and the Rotary Club of Claremont. From these treatment team visits, the first PATA conference (forum) was conceived.

In 2009, PATA received national recognition in South Africa. An award for Excellence in Health care from the Health Professionals Council of South Africa is an acknowledgement of the work of PATA in improving the lives of sub-Saharan children living with HIV/AIDS. By reaching out and touching communities and health professionals, and helping to build capacity in Africa, PATA aims to create a ripple effect of treatment action that will give a growing number of children access to life-saving antiretroviral therapy and holistic care. PATA does not tell people what to do, but helps them discover common goals and to collaborate to get things done. PATA is proud of this acknowledgement. We hope that the award will inspire others also to take on challenges and develop new ideas.

3. Core PATA activities

PATA is a network of paediatric HIV clinics in sub-Saharan Africa. Clinics volunteer to become affiliated to the PATA network. Traditionally, they have heard about PATA from colleagues in the field. More recently, clinics are increasingly contacting PATA directly through the **PATA website** www.teampata.org.

Individuals and clinics that contact PATA are added to the PATA mailing list and they receive a monthly **PATA newsletter** electronically. This newsletter is deliberately sent out in a small-byte-size format to make it easier for clinics with limited email access to open. The PATA secretariat updates PATA clinics on news from the PATA steering committee through the newsletter, and clinics share stories on their activities and progress.

In 2009, the PATA website and newsletter were coordinated and updated by **TeamPATA** which consists of the PATA Project director (Melanie Evans), a journalist (Toast Coetzer), two rapporteurs (James Millar and Hannah Hussey) and our French translator (Virgile Mahoro), with academic guidance from Dr Paul Roux.

Project Director Melanie Evans, with leadership from the steering committee, coordinates the annual **PATA forum** (conference), the flagship PATA activity. The forum is attended by invited multi-disciplinary treatment teams from across Southern Africa who participate in a structured workshop process centered on the key conference themes. At each forum, attending treatment teams select tasks/goals for the upcoming year. The **Forum proceedings** are the written output from this meeting and include an account of all of the presentations, a summary of the workshop discussions and the list of tasks selected by teams. Dr Paul Roux, has written and edited these proceedings since the inception of the Forum. They are available in hard copy or can be downloaded off the PATA website.



4. Growth in the PATA network

From our first meeting in Cape Town (2005) we have grown and developed through successful and inspiring meetings in Nairobi (2006), Swaziland (2007), Rwanda (2008) and Johannesburg (2009).

The first PATA forum in 2005 brought together 23 treatment teams from 12 African countries. The themes of the first conference were **Access, Adherence and Acumen**. The conference resulted in recommendations for best practice in critical areas.

In Nairobi, Kenya, 33 teams from 18 countries attended PATA 2006 where the themes of **Communication and Disclosure** were the focus of the forum. An outcome of this forum was the launching of PATA's **Expert Patient** programme at interested clinics within the network. In June 2007, 20 teams from within the network opted to participate in this programme with 73 expert patients being employed within these clinics.

40 treatment teams from 20 countries attended PATA 2007 in Manzini, Swaziland, where the focus of the workshop was on **TB/HIV, the Adolescent with HIV and Caring for the Carer**. Based on the preliminary success of the Expert Patient programme, the One to One Children's Fund extended their sponsorship of the Expert Patient programme to 33 treatment teams.

The 2008 PATA Forum was attended by 43 treatment teams from 17 Sub-Saharan countries. For the first time, nutritionists joined doctors, nurses, counsellors and pharmacists at the conference which focused on **Care of the Very Young Infant with HIV, Nutrition and Making Changes** in your service. PATA is developing and adjusting to new challenges. At the end of the 2008 PATA forum the steering committee decided to alter the time-table of our meetings to accommodate our expanding network. Regional meetings are to be held in the Southern, Eastern and Western African regions approximately every nine months.

The first PATA regional forum was held for the Southern African region in November 2009 in Gauteng. This regional forum was attended by 30 teams from the following 10 Southern African countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The forum themes were **Advanced ARV therapy, Adolescent Care** and a **Psychosocial Clinic Toolkit**.

A list of the teams who have participated in PATA forums and the Expert Patient programme can be found in Appendix II.

4.1 Clinic Tasks

At each PATA forum, clinics select tasks to improve the quality of their service. An analysis of the tasks (Table 1) demonstrates the impact of the annual PATA forum themes on the goals set by clinics. As Table 1 shows, some tasks (e.g. staffing issues) are ongoing and cannot be dealt with in just one year, so they come up again each year. Because clinic-task selection is influenced considerably by the theme of the PATA forum each year, future forum topics must be selected carefully.

Tasks relating to staffing formed the majority of the tasks each year and included goals to increase the number of staff, task shifting to volunteers, staff training, as well as feedback and general support for the staff. Caregiver support and education, which includes counselling and support groups, formed an integral part of the tasks each year. The fact that it continued to do so suggests that this is a key area where work is needed. General community issues, including income-generating projects, have been consistently raised by clinics. Tasks relating to administrative support and improvement, as well as monitoring and evaluation, featured each year.

Tasks related to TB appeared for the first time in 2007, when TB/HIV was one of the key conference themes. Child-friendly clinic tasks were prominent in 2005 and 2006, but then dropped off slightly in later years, possibly because by then clinics had already addressed this issue. Tasks relating to transport were important in the first two years only. Hopefully this suggests improved access in recent years. Treatment teams attending the 2006 forum were exposed to a presentation on involving youth in HIV education through football activities, and many clinics selected football projects in the following year. Three successful football events funded by the One to One Children's fund, have since been held in Port Elizabeth (SA), Accra (Ghana) and Rustenburg (SA).

Nutrition tasks, including gardening projects, were relatively common in all the years, but peaked dramatically in 2008 when this became one of the forum themes. Goals around HIV testing were relatively low throughout the years, but increased dramatically in 2008 when Care of the Very Young Infant was a key forum theme. This theme also influenced clinics to draw up tasks specifically relating to PMTCT and antenatal care for the first time.

After the 2009 regional PATA forum, roughly fourteen different categories of tasks could be identified, reflecting the diverse array of problems the clinics have to deal with on a daily basis. A number of clinics set goals relating to the PATA forum theme of Advanced ARV therapy by actively looking for lipodystrophy in young patients, reviving the development of protocols for drug toxicities e.g. Tisungane Clinic (Malawi) and identifying all failing children and those on fragile regimens e.g. Tygerberg clinic (SA).

A recurring category for PATA clinics is that of providing child-friendly care centres. The George clinic (SA), for example, wants to build a play area and implement the 'Say and Play' materials which are aimed at caregivers of children aged 0 to 6 years. Many clinics also plan to improve their networking with other clinics in order to exchange information; the Baylor Botswana clinic want to improve their collaboration with Mpilo Ol clinic (Zimbabwe) by exchanging information regarding best practices.

Dora Nginza Hospital (SA) planned to set up community meetings to strengthen their foothold in the community and Bophelong (Lesotho), Zoe-Life (SA) and Newlands (Zimbabwe) clinics all intend to improve their administration by compiling training materials. Infrastructure was a category which six clinics wanted to focus on and a handful also intended to improve the functioning of their pharmacies.

Table 1 PATA FORUMS, 2005-2009

Task Category	2005	2006	2007	2008	2009	Comment
Staff	34	27	15	21	17	
Caregiver support & education	27	35	12	29	11	
Child-friendly clinic	20	21	4	13	12	
Community	14	18	6	12	6	
Networking	16	15	0	11	6	
Administration	14	17	11	13	6	
Transport	10	12	1	0	0	Relates to 2005 PATA forum theme of access
Pharmacy & Drug-related	15	11	1	13	0	Relates to PATA 2005 forum themes of adherence, access and acumen
Sporting activities, soccer	0	13	3	0	0	2006 PATA forum grassroots soccer presentation
TB	0	1	12	1	0	2007 PATA forum theme
Expert Patient Programme (Task-shifting)	0	0	16	17	0	Pilot EP results presented at the 2007 PATA forum; teams reported back on EP programme at 2008 forum
Nutrition	10	20	6	37	3	2008 PATA forum theme
HIV Testing/VCT	1	2	1	11	5	Relates to 2008 PATA forum theme of 'Care of the Very Young Infant'
Antenatal Care/PMTCT	0	0	0	7	0	Relates to 2008 PATA forum theme of 'Care of the very young infant'
Adolescents	8	8	17	2	19	2007 & 2009 PATA forum theme
Toxicity, lipodystrophy and 2nd line regimens	0	0	0	0	4	Relates to PATA 2009 forum theme of Advanced ARV therapy
Implementation of 'Say and Play' and 'Auntie Stella' materials	0	0	0	0	8	Presented as masterclasses at 2009 PATA forum

4.2 Team-specific projects

From time to time PATA and other organisations will collaborate on more intensive projects in geographically specific areas, in order to facilitate planning to meet particularly urgent needs. Examples of these activities include a PATA-sponsored workshop to address prospective adolescent health care needs (held in Cape Town during 2008, in partnership with Kidzpositive) and a regional training and planning workshop for the Peddie district (during 2008, with the Keiskamma Health project). Currently, Kidzpositive and Partners In Health are assisting the Keiskamma Health project in planning an extension of the Peddie village health worker project and training additional village health workers.

5. PATA activities in 2009

5.1 Human resources

PATA is led by co-founders David Altschuler and Dr Paul Roux, who are supported by a steering committee of leading thinkers and practitioners in the paediatric HIV/AIDS field (Appendix 2). PATA is heavily reliant on the time and energy that is volunteered by steering committee members and the co-founders. In 2009, PATA welcomed Dr Victor Musiime (Uganda), Dr Andrew Kiboneka (Uganda), Dr Francis Ateba (Cameroon) and Prof Claire Penn (South Africa) to the steering committee.

Until September 2007, only a part-time group consisting of a journalist, web designer and rapporteur were employed by PATA. This changed in September 2007 when a project director position was created and filled by Melanie Evans. In 2009, as a result of funding from the Children's Investment Fund Foundation (CIFF) through a grant made to the Global Aids Alliance to support the Campaign to End Paediatric AIDS (CEPA), the position of Advocacy officer/ Assistant project director was created. This means that PATA now employs a full-time project director, assistant project director/ advocacy officer and a part-time translator, rapporteur and bookkeeper. Ashley Petersen filled the role of advocacy officer for 3 months until December 2009. This position is now filled by Rebecca Norman (American) until Taru Jaroszynski (South African) is able to commence working for PATA in June 2010.

Virgile Mahoro, a Rwandan living in Boston, continues to translate PATA documents and emails. Portuguese translation has been organized on an ad hoc basis. In 2009, Hannah Hussey and James Millar contributed to the newsletter as rapporteurs. Hannah has now graduated as a doctor from UCT and is working in the Eastern Cape, South Africa. James continues to work for PATA on a part-time basis whilst studying medicine. PATA journalist, Toast Coetzer, continues to be involved on a consulting basis.

It is PATA's second year of sharing office premises with the Kidzpositive Family Fund at 14 Bridge Street, Rosebank, near Mowbray Maternity Hospital in Cape Town. Kidzpositive's office manager, Vuyiswa Mboji assists PATA with transactions. Ann Hutchings continues to work as PATA's bookkeeper and is also based in the Bridge Street offices. PATA is very grateful to One to One Children's Fund's project director, Nathalie Renaud who has ably managed all PATA payment transactions from the UK to countries outside South Africa for the Expert Patient Programme. Nathalie volunteered at the 2009 PATA regional forum in Johannesburg, and was an integral part of teamPATA which consisted of Kidzpositive staff members (Lil Hobbs, Vuyiswa Mboji and Lucia Matshoba), Wits Health Communication Project researcher (Jennifer Watermeyer) and Wits Communication Science and Disorders staff members (Joanne Barratt and Victor De Andrade).

5.2 Communication with teams

In 2009, the PATA secretariat has continued to keep in touch with PATA teams through the newsletter (8 editions in 2009) and the website. 450 PATA members receive the electronic newsletter in English, and 40 in French. The PATA website is under the management of magic8 designers and continues to receive a large volume of visitors.

5.3 National Coordinators' meeting, Cape Town (May, 2009)

One representative from each of 9 Southern African countries attended PATA's first national coordinators meeting in Cape Town. PATA is very grateful to Rightwell Zulu (Namibia), Edson Mwinjiwa (Malawi), Gertrude Guveya (Zimbabwe), Bakani Johnson (Botswana), Scelile Zwane (Swaziland), Robert Fubisha (Zambia) and Hortensia Afonso da Trindade (Angola) for participating in the two day workshop. Portuguese interpreting was provided by Fernando Hono. Participants discussed challenges that PATA's strategy poses for the Southern African region and worked towards defining PATA in this region. Table 2 summarises participant responses about the goal and purpose of PATA in the Southern African region and some proposed ideas on how this can be achieved, including what structures are needed in order to do so.

Table 2 Defining PATA in our region. What is the goal and purpose of PATA in Southern Africa? How can this be achieved? What structures need to be in place?

PATA's main role as described by the National Coordinators

Sharing and equipping: whatever we do should filter down to the clinic level so that they are ready, equipped, capacitated to have good clinical practice. We work to distribute information through manuals, models of best practice, updates and documenting operational research, sharing best practices and bench-marking. Knowledge can be spread out, quickly and widely, through sharing online, on the website and in the newsletter.

We support continuous exchange programmes within a country, as well as twinning / mentorship programmes. This was a goal the beginning of PATA and is something we need to keep going.

One of the selection criteria for attending the workshop is to have a work-plan for cascading; those who attend the workshops must then go back to their clinics and teach health workers there.

How to run a meeting: a demonstration of how to do this in our forums. PATA needs to be relevant and prophetic: Advocacy at the training and institutional levels.

Bringing experts within the teams – varying skills and ideas contribute to a more holistic and balanced approach.

To identify training needs, relevant courses and to facilitate uptake of these skills.

Mentors need to be allocated in a systematic way to get ongoing support on a regular basis through the telephone and online.

Caring for care providers: We need a moment of appreciation for the provider. This must be acknowledged at every forum and in every clinic.

Advocacy and activism: Identifying needs, researching needs and options, engaging and identifying your target group are all steps in systemic advocacy. Fulfilling these steps with our partners, communities, teams and governments should use these needs to bring about change.

National Coordinator suggestions on how PATA can achieve this role

We will hold regional forums to express common needs within each region.

We will create space for teams to work together.

We have a PATA directory of all of the partners – who they are and what their mandate is.

We will facilitate training and skills sharing. This is done through the forum, exchange visits, formal short courses, mentorship and visits on-site.

Teams must have a voice in selecting a national coordinator: we support functional leadership rather than directional.

We take part in dissemination and sharing of resources.

Discussion of the importance of dreams: as well as what we are not going to do:

We will not become an exclusive club and we will stay focused on our goals.

Our priority is to serve the child. We are not a threat to other funders and organizations; we will work towards inclusion

We will not police or bully; we are here to be a resource and facilitator for the models of best practice.

We will not take part in "talk shops." We will be an organization of action.

5.4 PATA 2008 Forum proceedings

The PATA 2008 proceedings were compiled and edited by Dr Paul Roux with the assistance of Melanie Evans and Hannah Hussey, and were released in June 2009. Copies of the proceedings were posted on request and were distributed at the PATA 2009 forum in Johannesburg. The proceedings are available on the PATA website.

5.5 Southern African Regional Forum, Gauteng (November, 2009)

The fifth PATA forum, held in Gauteng, South Africa, was the first of our regional meetings and the first PATA forum held in South Africa since the inaugural meeting in Cape Town in 2005. Thirty treatment teams were invited to this first Southern African regional meeting: Five from Angola, four from Mozambique, three from Zimbabwe, two from Lesotho and Namibia and one each from Malawi, Swaziland, Botswana and Zambia. Ten South African teams, representing five of the nine provinces, were invited.

The 5th PATA forum followed the successful model of previous meetings. Our 'headline' topics for the three days were 'Advanced ARVs for Children', 'Caring for the Adolescent' and 'A Psychosocial Toolkit'. We were fortunate to attract an excellent teaching faculty who could offer plenary input on these topics prior to team deliberations on each day. Master Classes were offered during late afternoon sessions on Days One and Two. Teams enjoyed talks from Leon Levin (Paediatric anti-retroviral therapy), Jonathan Brakash and Barbara Kaim (Tools with which to engage with young children and adolescents) and Jennifer Watermeyer (Communication for Pharmacists). At the dinner held on the second evening, our participants received further information on the care of adolescents from Donna Futterman, a pioneer of HIV/AIDS care for adolescents.



Day One of the Gauteng PATA forum addressed the headline clinical topic of 'Advanced anti-retroviral therapy'. We are grateful to Leon Levin (Right to Care); Tammy Myers (Wits); James Nuttall (Red Cross Children's Hospital and UCT); Diane Gray (Groote Schuur Hospital and UCT); and Helena Rabie (University of

Stellenbosch) for presenting participants with the latest knowledge relevant to the day's workshop questions.

On Day Two, participants were asked to deliberate on the care of the adolescent with HIV/AIDS. They heard presentations from Melanie Pleaner; Barbara Kaim (TARSC, Zimbabwe); Diane Gray and Lucia Matshoba (Groote Schuur Hospital and UCT); Karl Technau (Wits ECHO); Daniella Mark (Desmond Tutu HIV Institute and UCT); and Shanaaz Kapery Randeria (Wits ECHO). These plenary speakers covered the topics of adolescent clinics, life-skills training, ARVs for adolescents, practical experience from an adolescent clinic, psychosocial support and peer group educators.

The Day Three plenary session presented a selection tools developed for psychosocial support in a paediatric HIV/AIDS clinic. Bakani Johnson from Baylor Botswana introduced the session with a presentation on caring for the carers. Her presentation was followed by Dean Solomon (ARK) who presented an outline of his curriculum for training patient advocates; Vaughan Stannard (Beautiful Gates Ministries) who presented the role of faith-based organisations; Jenny Watermeyer (Wits) who gave an overview of her PATA-sponsored book on communication for pharmacists; Jonathan Brakarsh on his 'Say and Play' instrument and Paul Roux (Groote Schuur and UCT) on HIV and Ethics.

An excellent session then followed, during which a selection of teams had an opportunity to inform their colleagues of their successes and

challenges. In this 'speaker's corner' we then heard from the Nyanga clinic in Namibia, Tisungane in Malawi, Mpilo clinic in Bulawayo, Zoe Life in Kwazulu Natal, the Health Ministry in Mozambique and the Livingstone clinic from Zambia.



A critical component of the PATA forum each year is the workshop facilitation. At the 2009 Southern African regional forum, Dr Sara Stulac from Partners In Health in Rwanda coordinated the facilitation, with her team of Gertrude Guveya from Zimbabwe, and Victor de Andrade, Melanie Pleaner and Trish Struthers from South Africa. Dr Paul Cromhout from Small Projects Foundation in South Africa prepared teams ahead of planning their grids for 2010. This team of facilitators made a most important contribution to the success of this meeting and deserves our warm thanks.

We enjoyed a working partnership with Prof Ashraf Coovadia and his Wits ECHO team. An active, interested and efficient conference partner makes a very big difference to the organising committee. We look forward to a fruitful partnership in the future.

Toast Coetzer and his team of rapporteurs put together an excellent set of early morning conference newsletters to make up the fifth edition of 'L'Equipe PATA'. We were particularly proud of the Portuguese edition which reported on events taking place during the final day and are grateful to Victor de Andrade for his Portuguese translation.

The responses of our plenary experts to the PATA process during this PATA Johannesburg forum have been heart-warming. One and all have volunteered to serve as PATA ambassadors and consultants in the year to come. Our membership can expect their active input in the Newsletters and on the Web site in time to come.

5.6 Dissemination of materials

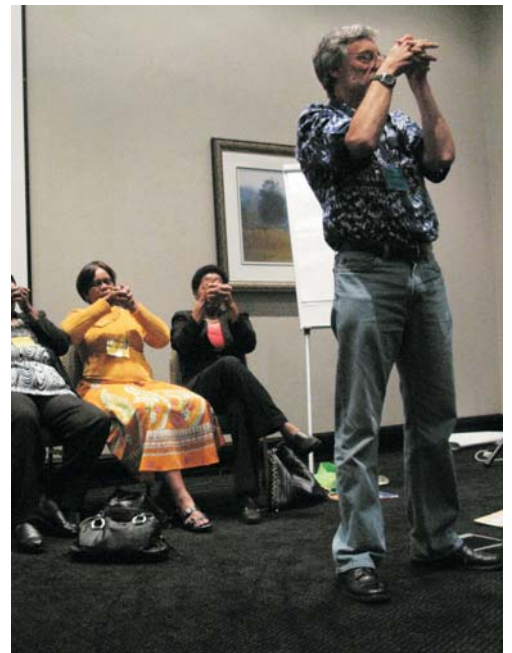
A number of new resources were shared with PATA clinics in 2009. These included Auntie Stella (a programme for adolescents to talk to each other about sex), Say and Play (a programme for caregivers of children aged 0-6 years), Working across Language and Culture Barriers: Communication Skills for Pharmacists and a CD with child disclosure materials compiled by MSF. PATA is grateful to Claremont Rotary Club, Kidzpositive, TARSC, MSF and the Wits Health Communication project for funding these materials and making them available to PATA-affiliated teams.

5.7 Campaign to End Paediatric AIDS

PATA was invited by Global AIDS Alliance to participate in the Campaign to End Paediatric AIDS (CEPA) as a regional partner. Other participating regional networks included the African Network for the Care of Children with AIDS (ANECCA) and the Pan-African Treatment Access Movement (PATAM). PATA's role in the campaign is to witness events on the ground in clinics and to pass this information on to advocacy organizations. Through PATA's collaboration in CEPA, we have become more involved in the East African region. We are particularly grateful to the following PATA colleagues for attending CEPA meetings on behalf of PATA: Melanie Evans, Paul Roux, Cecilia Keiru, Elisabeth Obimbo, Victor Musiime, Andrew Kiboneka and Ashley Petersen. PATA will no longer be participating in CEPA as a funded regional partner, but will be operating in a supportive role instead. PATA will continue encouraging clinics to be the 'eyes and ears on the ground' to feed information into the campaign. A number of PATA-affiliated clinics have highlighted advocacy activities in their task grids for 2010. Baylor Botswana for example have identified the need to meet with relevant stakeholders to engage in dialogue of restrictive family planning laws.

2009 PATA Forum: Southern African Region





5.8 Participation in the Children's Rights Centre 'Disclosure to Children' workshop

Melanie Evans represented PATA at a Disclosure to Children workshop that was hosted by the Children's Rights Centre in Durban on Thursday the 25th February. Other South African PATA-affiliated teams that were represented included Zoe-life, Wits Echo and Right to Care. The minutes and resources shared at this meeting will be posted on the PATA website. Also available on the PATA website is a CD compiled by MSF with materials on Child Disclosure.

5.9 Monitoring and evaluating the expert patient programme

The Expert Patient programme was launched at the 2006 PATA Forum held in Nairobi. The programme has grown from 21 clinics in 2007 to 47 clinics in February 2010 with a total of 200 expert patients being employed in 14 Sub-Saharan African countries. On average, expert patients work for 25 hours per week. Clinics now receive \$260 per month for expert patients. The increase of \$60 per month since July 2009 is to assist clinics in meeting the reporting requirements.

Marion Stewart has been contracted by One to One children's Fund to pilot monitoring and evaluation of the Expert Patient programme. Marion has completed a desktop review on the expert patient programme and has proposed an evaluation framework which was presented to Expert Patient supervisors, expert patients, PATA staff and a steering committee representative at a workshop held in Cape Town on the 25th February 2010. This framework is currently being modified based on feedback from the workshop. It is envisaged that data collection will commence at 5 pilot sites May 2010.

Growth in the Expert Patient Programme			
Date	Number of countries	Number of clinics	Number of expert Patients Employed
June 2007	6	23	74
January 2008	11	31	104
June 2008	13	33	136
February 2010	14	47	200

'Through PATA there is a linkage between facility and the community... many lives have been saved through defaulter tracing and returning [the patients] to their drugs.'

(Expert Patient at Bungoma clinic, Kenya)

Table 3 Clinics participating in the Expert Patient Programme

Country	Number of participating clinics	Clinic Names
Burkina Faso	1	CHUSS
Cameroon	1	Chantal Biya Hospital
DRC	2	CAP/Heal Africa Kalembelembe
Ethiopia	2	Tikur Anbessa (Black Lion) Alert
Kenya	7	Kenyatta National Hospital Gertrude's Children's Hospital FACES Suba FACES Migori FACES Kisumu Bungoma Transmara
Lesotho	2	Queen Elisabeth II Hospital Baylor Clinic
Malawi	6	Tisungane Clinic Zomba EID Zomba PMTCT Mayake Clinic Matawale Clinic Baylor Clinic
Namibia	2	Oshikuku Nyangana
Rwanda	5	PIH Kirehe PIH Rwinkwavu PIH Rukira PIH Mulindi Butaro
South Africa	11	G25, Groote Schuur Hospital Worcester Paarl Keiskamma Dora Niginza Uitenhage Tygerburg Harriet Shezi Harriet Shezi (Zola Clinic) Harriet Shezi (Lillian Ngoyi) Idas Valley
Swaziland	3	Baylor Clinic Dvokolwako Emkhuzweni
Tanzania	2	Songea CTC Mbeya Referral Clinic
Uganda	2	Taso JCRC
Zimbabwe	1	Newlands Clinic
Ghana	1 (previously)	Princess Marie Louise Hospital
Total	47 clinics	14 Countries participating

6. Financial review: PATA 2009

PATA continues to be reliant on funding sourced by its two founding organizations, One to One Children's Fund and Kidzpositive Family Fund. Details of the PATA sources of revenue, expenditure and donor contributions are summarized in the tables below.

In 2009, PATA received R 3,194,147.00 in donations. 70% of PATA funding came directly from One to One Children's Fund or through donations made to PATA via One to One Children's Fund. 18% came from an anonymous foundation via Kidzpositive and 10% for PATA's participation in the Campaign to End Paediatric AIDS (CEPA) as illustrated in Table 4.

PATA spent R3,122,315.00 in 2009. 36% of this was used for PATA forums and training activities; 38% on the Expert Patient Programme, and 18% on infrastructure costs as summarised in Table 5.

This summary does not account for a small proportion of clinic self-funding (e.g. for transport to attend PATA forums) which is difficult to quantify.

In the spirit of the 'PATA-effect', PATA encourages partnerships with clinics and other NGOs for any PATA initiatives. For example, some clinics participating in the PATA expert patient programme rely on both PATA funding and the funding of local governments or other NGOs to supplement this funding. In Cape Town, South Africa, at Groote Schuur Hospital, PATA funds the expert patient salaries and Kidzpositive funds their transport costs; in Malawi, PATA-funded expert patients comprise only some of the expert patients who are working in Tisungane clinic, others are funded by Dignitas International, a Canadian NGO.

Table 4: PATA sources of revenue in 2009

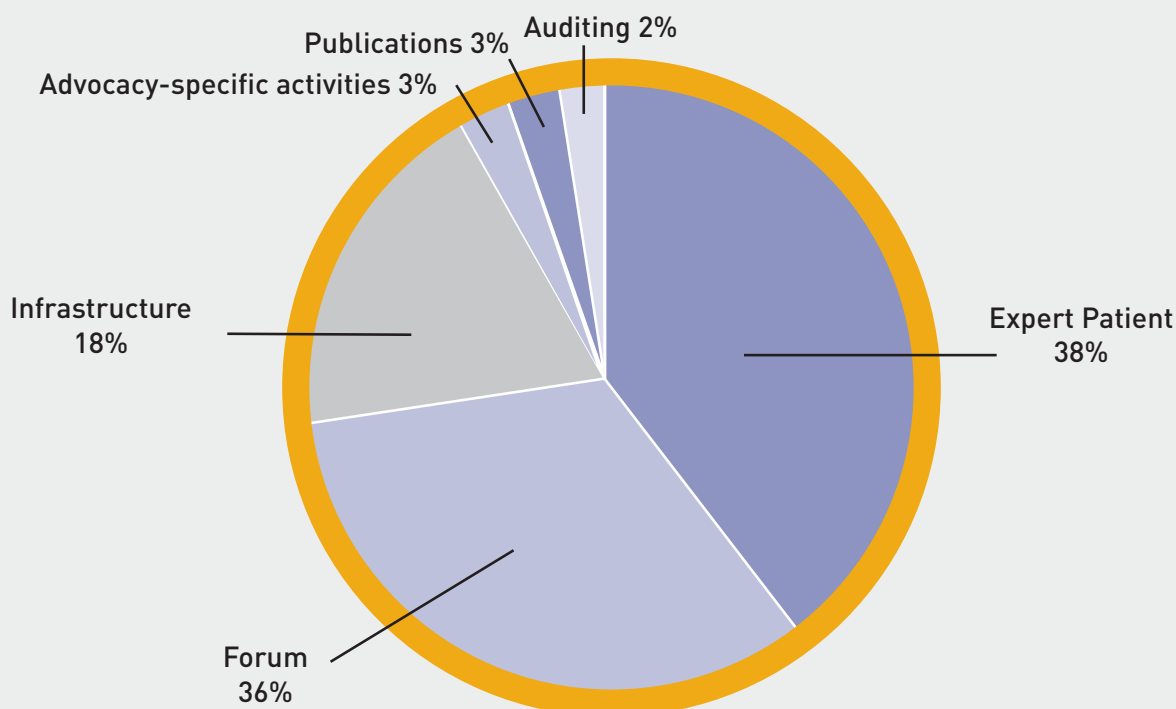
	ZAR equivalent	Percentage of total
One to One Children's Fund	2230730	70%
Anonymous Foundation	573000	18.5%
CEPA	338284	10%
Other donations	33930	1 %
Interest received	18194	0.5%
TOTAL	R 3,194,147.00	

Table 5: PATA expenditure March 2009 – February 2010

Description	ZAR equivalent	% of total
Expert Patient	R 1,188,030.00	38%
PATA forum	R 1,121,201.00	36%
Infrastructure	R 558,907.00	18%
Advocacy-specific activities for GAA	R 105,261.00	3.4%
Publications	R 96,446.00	3%
Auditing & bookkeeping	R 52,470.00	1.6%
TOTAL	R 3,122,315.00	

PATA would like to gratefully acknowledge the following donors who contributed to PATA and the Expert Patient programme through One to One Children's Fund: **Argentarius Foundation; Aurum; Fieldhem Limited; Gary and Karen Lubner; Harris Family Charitable Trust; Jonathan Penkin and Goldman Sachs; Synchronicity; The Brian Murtagh Trust Fund and The Funding Network.**

PATA expenditure 2009



7. The PATA Network strategic partners

Although the PATA teams are the backbone of the PATA network, PATA has benefited enormously from the involvement of strategic partners including UNICEF, the Clinton Foundation HIV/AIDS initiative, Partners In Health, Baylor and the Kenya Paediatric Association to name a few. Equally valuable, is the network of expertise that continues to expand with each PATA forum. PATA teams have been exposed to the teachings and insights from experts from the following academic institutions and organizations that have made up the faculty at PATA forums:

Table 5 Academic Institutions and Organisations that have contributed to PATA Forums

Albert Einstein College of Medicine	www.einstein.yu.edu
Absolute Return for Kids (ARK)	www.arkonline.org
Baylor Botswana	www.bayloraids.org
Beautiful Gate Ministries	www.beautifulgatelesotho.org
Clinton Foundation	www.clintonfoundation.org
Connaught Clinic	
Desmond Tutu HIV/AIDS Research Centre	www.desmondtutuhivcentre.org
Groote Schuur Hospital	www.gsh.co.za
HIV Clinicians Society	www.sahivsoc.org
Health Communication Project	
Institute of Health Care Improvement, South Africa	www.ihc.org
Kenyatta National Hospital	www.knh.or.ke
Lux-Development/ TRAC	
MRC Uganda	www.mrc.ac.ug
Mothers to Mothers to Be	www.m2m.org
Partners In Health	www.pih.org
Queen Elizabeth II Hospital	
Red Cross Children's War Memorial Hospital	www.childrenshospitaltrust.org.za
Reproductive Health Research Unit	www.rhru.co.za
Right to Care	www.righttocare.org
Small Projects Foundation	www.spf.org.za
The AIDS Research and Support Centre (TARSC)	www.tarsc.org
University Hospital of Kigali	www.chk.org.rw
University of Cape Town	www.uct.ac.za
University of Cardiff	www.cardiff.ac.uk
University of Malawi, College of Medicine	www.medcol.mw
University of Stellenbosch	www.sun.ac.za
University of the Witwatersrand	www.wits.ac.za
Wits Echo	www.witsecho.org.za
Wits Health Communication Project	
Zomba Central Hospital	

Appendix I: PATA Steering Committee

David Altschuler, Chair of One to One Children's Fund, UK

Dr Paul Roux, Paediatrician, University of Cape Town, South Africa

Dr Jennifer Altschuler, One to One Children's Fund, UK

Prof. Stephen Rollnick, Professor of Healthcare Communication, UK

Dr Henry Karyaija Barigye, Medical Doctor, Uganda

Dr Sara Stulac, Director of Paediatrics, Partners In Health, Rwanda

Dr Shaffiq M Essajee, Paediatric HIV/AIDS advisor Clinton Foundation, Assistant Professor of Paediatrics, Department of Infectious Diseases, USA

8. Looking ahead to PATA 2010

PATA has reached a critical point in its growth, and reports from PATA-affiliated clinics attest to the impact that the PATA knowledge sharing model is having in improving delivery of care. The PATA forums are central to this process. The growth of the PATA network has hastened the regionalisation of PATA forums and we are delighted with the outcome of our first regional forum for Southern African clinic teams.

Two regional PATA forums are planned for 2010. The PATA East Africa Forum is scheduled to be held in Uganda in October. Host organisations will include TASO, JCRC and the Ugandan Paediatric Association. The selected themes are Advanced Antiretroviral therapy, Adolescent Care and Disclosure to Children. Teams from Kenya, Uganda, Tanzania, Rwanda, Ethiopia and Sudan will be participating. Later in the year, we are planning to hold PATA's first Francophone regional forum in Cameroon.

PATA continues to face changes. We are in the process of developing an advocacy role to ensure that PATA makes its mark and augments its work with governments, alongside organisations such as the Clinton Foundation, MSF and UNICEF that currently interact with governments. We will continue the process of devolving responsibilities and activities to country level. PATA-affiliated clinics will be encouraged to arrange team exchanges, in the same way that PIH teams in Rwanda have done. Staff exchange programmes should be a powerful way of spreading the PATA effect.

PATA's Expert Patient programme is also poised for further expansion. In 2010 PATA, with funding from One to One Children's Fund, is extending the programme to 207 expert patients in 50 affiliated clinics. We believe that the delivery of ART programmes for children and families can be greatly improved by task shifting in clinics through the recruitment and training of expert patients as paid community health workers. There is now an opportunity to extend the PATA model to a wider community of clinics and their healthcare teams.

Our growth and impact can only be sustained through developing further funding partnerships, and we are committed to develop our fund-raising capacity and to institute more formal monitoring and evaluation processes to measure the impact and outcomes of PATA as a continental quality-improvement intervention.

We continue to be inspired by the work of the PATA-affiliated teams working on the ground in clinics. Already this year, teams are reporting back on the progress made in many of their self-initiated projects. We wish all of the PATA teams well as they continue to strive to improve the quality of care in their clinics.

Dr Paul Cromhout, Small Projects Foundation, South Africa

Dr. Elizabeth Obimbo, Paediatrician, Kenyatta National Hospital, Kenya

Sr. Gertrude Guveya, Nursing Sister, Zimbabwe

Dr Prithi, Lesotho

Prof Claire Penn, Wits University, South Africa

Dr Francis Ateba, Paediatrician, Cameroon

Dr Victor Musiime, Paediatrician, Joint Clinical Research Centre, Uganda

Dr Andrew Kiboneka, Paediatrician, The AIDS Support Organisation, Uganda

Appendix II: Teams involved in the PATA Network February 2011

CLINIC	COUNTRY	Joined in 2010	PATA 2009	PATA 2008	PATA 2007	PATA 2006	PATA 2005	EXPERT PATIENT
ALERT	Ethiopia			Y				Y
ANEMO	Mozambique		Y					
ANSS	Burundi			Y	Y	Y		
Augusta Ngangula	Angola				Y			
Baylor BCM-BMS	Lesotho		Y					Y
Baylor Botswana	Botswana		Y		Y	Y		
Baylor Malawi	Malawi		Y					Y
Baylor Swazi	Swaziland		Y	Y	Y	Y		Y
B J Vorster Hospital	South Africa	Y						Y
Black Lion (Tikur Anbessa)	Ethiopia			Y		Y	Y	Y
Bungoma	Kenya							Y
CAP Heal Africa	DRC			Y	Y	Y		Y
Centre Mère et Enfant	Cameroon			Y	Y	Y		Y
Children of God Relief Institute	Kenya			Y				
CHU de Yopougon	Cote D'Ivoire			Y	Y	Y		
CHUSS	Burkina Faso			Y	Y	Y		Y
CNCS Mozambique	Mozambique		Y					
Coast Provincial Hospital	Kenya			Y		Y		
Connaught (Newlands) Clinic	Zimbabwe		Y	Y	Y	Y		Y
Cunene Provincial Hospital	Angola		Y					
Dora Nginza	South Africa		Y		Y	Y		Y
Dvokolwako	Swaziland				Y			Y
Eben Donges	South Africa				Y	Y		Y
Emkhuzweni	Swaziland				Y			Y
Equipa de Beira	Mozambique				Y			
FACES Kisumu	Kenya			Y	Y	Y		Y
FACES Migori	Kenya			Y	Y	Y		Y
FACES Suba	Kenya			Y	Y	Y		Y
George Hospital	South Africa		Y				Y	
Gertrude's Children's Hospital	Kenya			Y	Y	Y		Y
Groote Schuur Hospital, G25	South Africa				Y	Y	Y	Y
Gugulethu Hannan Crusaid	South Africa						Y	
Harare Children's Hospital	Zimbabwe				Y			
Harriet Shezi/ Wits Echo	South Africa		Y					Y
Harriet Shezi Lillian Ngoyi	South Africa							Y
Harriet Shezi Zola	South Africa							Y
HIV/AIDS Quality of Care Initiative (HAQOCI)	Zimbabwe		Y					Y
Hospital Da Malange	Angola		Y					
Hospital General Luanda	Angola		Y					
Hospital Pediatrico Luanda	Angola		Y					
Hospital Provincial Cunene	Angola		Y					
Hospital Provincial Uige	Angola		Y					
Hottentots Holland Hospital	South Africa						Y	
Idas Valley, Paarl	South Africa		Y					Y
Joint Clinical Research Centre (JCRC)	Uganda			Y	Y	Y		Y
Kakamega	Kenya			Y	Y	Y		
Katutura	Namibia					Y		
Keiskamma (Hamburg)	South Africa		Y	Y	Y	Y	Y	Y
Kibagabaga	Rwanda			Y				
Kibong'oto	Tanzania			Y				Y
Kibuye	Rwanda			Y				
King George V	South Africa				Y			
Kiwoko	Uganda			Y	Y			
Kenyatta National Hospital	Kenya			Y	Y	Y		Y
Kenyan Paediatric Association	Kenya				Y	Y		
Lagos State General Hospital Isolo	Nigeria		Y					
Langa Clinic FAMSA	South Africa						Y	
L'hôpital pédiatrique de Kalembelembe, Kinshasa	DRC			Y				Y
Livingstone Paediatric Centre of Excellence	Zambia		Y		Y	Y		
Luanda Paediatric Hospital	Angola		Y					
Lux Dev	Rwanda			Y	Y			
Madwaleni, Transkei	South Africa		Y					
Mafikeng Provincial Hospital	South Africa						Y	
Maputo Central Hospital	Mozambique					Y		
Maragua District Hospital	Kenya					Y		

Teams involved in the PATA Network February 2010

CLINIC	COUNTRY	Joined in 2010	PATA 2009	PATA 2008	PATA 2007	PATA 2006	PATA 2005	EXPERT PATIENT
Matawale	Malawi		Y					Y
Malanje Day Hospital	Angola		Y					
Mayaka	Malawi		Y					Y
Ministry of Health Mozambique	Mozambique		Y					
Ministry of Health, Nkhata Bay	Malawi				Y	Y		
Mpilo Ol Clinic, Buluwayo	Zimbabwe		Y					
MRC Uganda	Uganda				Y			
Nampula	Mozambique				Y			
Nyangana RC Hospital	Namibia		Y	Y				Y
ONG	Angola		Y					
Oshikuku RC Hospital (Catholic Health Services)	Namibia		Y	Y	Y	Y		Y
Osindisweni	South Africa				Y			
Paarl Paeds	South Africa		Y	Y	Y	Y		Y
Phatsima Khanya Clinic	South Africa		Y	Y				
Phuca U Hanya	Mozambique		Y					
Partners In Health (PIH) Butaro/ Burera	Rwanda			Y				Y
PIH Kirehe	Rwanda			Y	Y	Y		Y
PIH Mulindi	Rwanda		Y					Y
PIH Rinkwavu	Rwanda			Y	Y			Y
PIH Rukira	Rwanda			Y	Y			Y
Princess Marie Louise	Ghana			Y	Y			Y
Queen Elizabeth II Hospital	Lesotho		Y	Y	Y	Y		Y
Right To Care	South Africa		Y					
Robertson Hospital	South Africa		Y			Y		
Rustenburg Provincial (Job Shimankana Tabane Hospital)	South Africa		Y	Y	Y	Y		
Red Cross Children's War Memorial Hospital	South Africa						Y	
Sendwe Clinic, Lubumbashi	DRC			Y				
Songea CTC	Tanzania	Y			Y	Y		Y
TASO Gulu	Uganda			Y	Y	Y		
TASO Mbara	Uganda				Y			Y
Tisungane	Malawi			Y				Y
TRAC	Rwanda			Y	Y			
Transmara District Hospital	Kenya			Y	Y	Y		
Tygerberg	South Africa		Y	Y	Y			Y
Uíge Provincial Hospital	Angola		Y					
Uitenhage Provincial	South Africa		Y		Y	Y		Y
Umphumulo	South Africa		Y		Y			
Worcester	South Africa		Y	Y	Y			Y
World Wide Orphans (WWO)	Ethiopia			Y				Y
Zoe-Life, Durban, KZN	South Africa		Y					
Zomba EID Paeds	Malawi		Y					Y
Zomba PMTCT	Malawi		Y					Y



TRAC PLUS – Center for Infectious Disease Control
TRAC – PNILP – PNILT

MAC AIDS FUND

