



Paediatric AIDS  
Treatment for Africa

# PATA General Report 2008 - 2009

[www.teampata.org](http://www.teampata.org)

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**PATA means 'to reach out' (in kiSwahili & isiXhosa), and 'to touch' (in isiZulu):** 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 reach a growing number of children.



Nutritionists participated as members of multidisciplinary treatment teams for the first time at the 2008 PATA Forum held in Rwanda.

## 1. PATA's Vision and Mission

**MISSION:** PATA is an organization of individuals dedicated to expanding access to care for children affected and infected with HIV and their families throughout the African continent. PATA values and promotes models of care that address both the medical and psychosocial needs of the child and that offer high quality, integrated, patient-centered, and affordable services. The organization will work collaboratively with healthcare teams, serving as a resource to support achievement of their stated goals. PATA will facilitate the development of local capacity for high quality HIV care through promotion of learning through team work, sharing of experiences, and spreading of good practice.

**VISION:** The vision of PATA is for all HIV-infected and affected children in Africa to have access by 2015 to comprehensive, high quality health services including ART. PATA believes that this can best be achieved by supporting committed health care providers to enhance, expand and extend their work to impact others through a ripple effect in the community (the 'PATA effect').

**VALUES:** The following values serve as guidelines for our members as we strive toward the attainment of our vision:

- **Integrity:** We will abide by and promote honesty, trustworthiness, openness, and respect for others in all our interactions on behalf of PATA.
- **Commitment to the Vision:** We will demonstrate our commitment by passionately harnessing our efforts to make our vision of quality healthcare for all HIV-affected/infected children a reality.
- **Professionalism:** We will work professionally, be goal-oriented and ensure accountability. We are committed to the professional development of others and will work with care and consideration of our colleagues.
- **Compassion:** We will exhibit compassion in our interactions as we strive toward our goals.
- **Team work:** We are committed to working as a team, enabling, empowering, and encouraging others. We will participate enthusiastically and accept differing opinions respectfully.

**FOUNDATION AND PURPOSE:** The foundation of PATA lies with the PATA teams – multidisciplinary **Treatment Teams** of nurses, pharmacists, counsellors, doctors and nutritionists who work together at clinics across Sub-Saharan Africa to form a community of compassionate and committed individuals who provide treatment and care to children infected with HIV and their families.

The **fundamental purpose** of PATA is to assist Treatment Teams to improve the quality of health care they deliver to their patients.

The **principle** of PATA lies in the belief that Treatment Teams can best improve themselves, (collectively and individually) and the quality of their work through self-initiated projects in which they have a sense of ownership, responsibility and pride.



## 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/ counselor 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. From this, the first PATA conference (forum) was conceived.

## 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 been nominated by strategic partners UNICEF, Clinton Foundation and Partners in Health, or have heard about PATA by word of mouth from colleagues in the field.

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.

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

The project director, 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 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 their inception. They are available in hard copy or can be downloaded off the PATA website.

## 4. Growth in the PATA network:

PATA continues to develop and grow. From our first meeting in Cape Town, in 2005, we have grown and developed through successful and inspiring meetings in Nairobi (2006), Swaziland (2007) and Rwanda (2008).

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 conference. An outcome of this conference was the launching of **PATA's Expert Patient** project 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 pilot, 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 child with HIV**, **Nutrition** and how to **make changes in your service**.

A list of the teams who have participated in PATA forums and the PATA expert patient programme is included at the end of this report.

### 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 below) clearly demonstrated the impact of the annual PATA forum themes on the tasks taken on by clinics.

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.

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 very 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 Elisabeth (SA), Accra (Ghana) and Rustenburg (SA).

Caregiver support and education, which included issues such as counselling and support groups, formed an integral part of the tasks each year, and the fact that it continued to do so suggests that this is a key area where work needs to continue. Likewise, general community issues, including income generation projects, have been consistently raised by clinics each year. Tasks relating to administrative support and improvement, as well as monitoring and evaluation, featured each year. Clinics were relatively uninterested in setting goals for research.

Nutrition tasks, including gardening projects, were relatively common in all the years, but peaked dramatically in 2008 when this became one of the conference themes. Pharmacy and drug related issues were also common in the first two years, but decreased later, and then rose again in 2008, when ARV issues were brought up in the conference.

Goals around HIV testing were relatively low throughout the years, but increased dramatically in 2008, as Care of the Very Young Infant was a key theme in the conference. This theme also influenced clinics to, for the first time in 2008, draw up tasks specifically relating to PMTCT and antenatal care.

As this analysis shows, some tasks (eg staffing issues) are often ongoing and cannot be dealt with conclusively in just one year, and so come up again each year. Clinic-task selection is influenced considerably by the theme of the conference each year. And thus future conference topics need to be selected very carefully.

## Number of teams selecting tasks (by category) each year

Task category	Number of teams selecting that task			
	2005	2006	2007	2008
Staff	34	27	15	21
Interdisciplinary / Networking	16	15	0	11
TB	0	1	12	1
Child friendly clinic	20	21	4	13
Child-related				
General	0	12	0	3
Sporting activities, Soccer	0	13	3	0
Adolescents	8	8	17	2
Caregiver support & education	27	35	12	29
Expert Patient	0	0	16	17
Nutrition	10	20	6	37
Transport	10	12	1	0
Pharmacy & Drug Related	15	11	1	13
HIV testing/VCT	1	2	1	11
Community	14	18	6	12
Admin & Technical	14	17	11	13
Research	0	1	0	3
Antenatal Care, PMTCT	0	0	0	7

## 5. PATA activities in 2008

### 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. PATA is heavily reliant on the time and energy that is volunteered by steering committee members and the co-founders. In 2008, PATA welcomed Dr Prithiviraj from Lesotho 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. 2008 has been the first full year of employment in this position, although Melanie had been involved with PATA through her contribution to the newsletter, since 2007, and as a volunteer at the first PATA conference in 2005 and a masterclass presenter at the 2006 PATA Forum.

The human resources employed to manage PATA's expanding network has grown in 2008. PATA now employs a full-time project director, and part-time translators, rapporteurs and a bookkeeper.

Virgile Mahoro, a Rwandan living in Boston, continues to translate PATA documents and emails. Portuguese translation has been organized on an ad hoc basis with Fernando Hono, an Angolan living in Cape Town.

The PATA network has benefitted considerably from the addition of Hannah Hussey and James Millar in December 2008 to the newsletter team. Both Hannah and James are medical students at UCT in South Africa. Hannah has been assisting with administrative tasks and is employed by PATA. James is employed by Kidzpositive to assist with their recently launched gardening project, and writes articles for the PATA newsletter. PATA journalist, Toast Coetzer, continues to be involved on a consulting basis.

PATA moved into office premises for the first time in 2008. Our new offices are situated at 14 Bridge Street, Rosebank, a stone's throw from Mowbray Maternity Hospital in Cape Town. These offices are shared

with Kidzpositive, and this arrangement continues to strengthen the relationship between Kidzpositive and PATA. PATA is very grateful to the Kidzpositive office manager, Vuyiswa Mboyi who assists in transactions. Vuyiswa has been involved in PATA activities since 2005. Ann Hutchings was appointed as PATA's bookkeeper in 2008, and also works from 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 and the PATA Forum. Nathalie speaks both English and French, and this has been particularly beneficial in improving PATA's communication with Francophone teams.

Leading up to the PATA 2008 Forum in Rwanda, PATA employed Richard Mugisha and Christina Bryant in part-time positions to assist Dr Sara Stulac from Partner's In Health with the conference preparations. PATA is very grateful to them as well as to the team of volunteers who assisted at the forum, namely: James Millar, Georgina McConnachie, Nina Gobat, Lisa Van Vlaanderen, Joanne Barratt, Virgile Mahoro, Nathalie Renaud and Craig de Villiers.

### 5.2 Communication with teams

In 2008, the PATA secretariat has continued to keep in touch with PATA teams through the newsletter (8 editions in 2008) and the website. 350 PATA members receive the electronic newsletter in English, and 40 in French. The PATA website underwent a facelift and complete overhaul in June 2008 and is now under the management of magic8 designers. The content is updated monthly. The website is receiving a large volume of visitors. In April 2009 for example, 2984 hits were recorded during that month.

### 5.3 The Adolescent Workshop, Cape Town (May, 2008)

In May, 160 multidisciplinary health care workers from clinics across the Western Cape, South Africa, and youth attending these clinics, participated in a 2-day PATA workshop focusing on adolescent care. The workshop was a collaboration between Kidzpositive, PATA and the Provincial Government of the Western Cape HIV/AIDS Directorate and was funded by One to One Children's Fund. Adolescents with HIV/AIDS have special needs and are particularly vulnerable to non-adherence

# Teams tackling the challenges associated with 'Nutrition' and 'Caring for Very Young Infants with HIV' at the 2008 PATA Forum.



and anti-retroviral treatment failure. The region lacked a specific adolescent health care service or a strategic framework for health care delivery for this group. The primary aim of the workshop was to identify and to prioritise the key requirements of a health portfolio for HIV-positive adolescents in the Western Cape. Participants received plenary input on the following wrt adolescents: Reproductive health needs, an overview of the epidemiology of HIV/AIDS in the Western Cape, the health care needs expressed by youth, the mental health needs, what it means to be an adolescent-friendly service and the legal issues and implications of the Children's Act for adolescent clinics.

A task team was established from participants volunteering to take this process further. The outcomes of the meeting are summarized in the Adolescent Workshop proceedings and a poster presented at the South African AIDS Conference held in Durban in April 2009, by the Kidzpositive project director, Ronelle de Villiers, titled 'Planning HIV/AIDS Care for Adolescents in the Western Cape' [available on the PATA website].

#### 5.4 Poster Presentation at the World AIDS conference (August 2008)

Melanie Evans and Shaffiq Essajee presented a poster on the impact of the PATA Expert Patient Programme at the World AIDS conference in Mexico in August 2008, titled "Task Shifting in Paediatric HIV clinics through employment of 'expert patients' ". The poster summarized the successes and challenges of the Expert Patient Programme to date. It is available for download on the PATA website.

#### 5.5 Regional PATA Forum, Hamburg, South Africa (August, 2008)

In August 2008, 40 health care workers from the Peddie district in the Eastern Cape participated in a two day workshop hosted by the Keiskamma Trust in Hamburg. The workshop had the dual purpose of disseminating accurate information from leading experts in paediatric HIV and to develop a district approach to a comprehensive paediatric HIV/AIDS programme. The workshop aimed to address challenges associated with the referral system in the district, the diagnosis & Treatment of TB and PMTCT to paediatric care link.

The majority of participants were primary health care sisters. They received plenary input on PMTCT and the M2M2B approach (Justus Hofmeyer), Care of the child with HIV/AIDS; Elements of care, IMCI approach, Nutrition and growth monitoring and EPI programme (Paul Roux); Clinical diagnosis, staging, when to start treating, regimen 1 and testing (James Nuttall); The natural history of TB, diagnosis, prophylaxis, treatment, MDR, IRIS, TB and HIV and ARV and TB treatment (James Nuttall and Paul Roux). In addition to the didactic training, the workshop was successful in strengthening the ties between these primary health care sisters and other health care workers, from whom they often feel very isolated.

#### 5.6 PATA 2007 Forum Proceedings (October 2008)

The PATA 2007 proceedings were compiled and edited by Dr Paul Roux and were released in October 2008. Copies of the proceedings were posted out on request and were distributed at the PATA 2008 conference.

In addition to the 2007 PATA Forum proceedings, Dr Roux compiled the proceedings of the Western Cape Adolescent Workshop. This was posted to participants with a copy of the adolescent workshop DVD, which can be used as a teaching aid on adolescent care.

#### 5.7 The Fourth PATA Forum, PATA Rwanda (November, 2008)

The 4th PATA forum was co-hosted by Partners In Health (PIH) and the Rwandan National HIV Programme, TRACPlus-CIDC and was held at Novotel in Kigali. The forum began with Master Classes, held on the afternoon of Tuesday 25 November, to take advantage of the fact that most teams arrived in Kigali in flights landing on or just after midday. Teams were entertained and informed by talks from Gail Todd (The skin in HIV/AIDS) Tom Heikens (Nutrition), Mitch Besser (managing the prevention of Mother to Child Transmission) and Leon Levin (Paediatric anti-retroviral therapy). At the welcoming dinner that night,

guests of honour included the British Ambassador to Rwanda Nicholas Cannon' and the Secretary of the Rwandan Minister of Health, Dr Agnes Binagwaho. At dinner, our participants received further information on nutrition in HIV from Dr Joia Mukherjee (PIH); and would have gone to bed wondering how we would maintain the high standards and pace of the first six hours of the forum.

Day One of the Rwandan PATA forum addressed the headline clinical topic of 'Care of the very young infant'. We were very fortunate to have attracted an excellent training faculty to present plenary input for Day One small group discussion. We are grateful to Mitch Besser (Mothers to Mothers to Be); James Nuttall (Diagnosis of HIV in young infants); Mark Cotton (Implications of findings from the CHER study); Simone Honikman (Caring for mothers of sick infants); Cyprien Baribwira (Delivery of ARVs to infants in Rwanda); and Leon Levin (Ideal care for the very young infant), for presenting participants with the latest knowledge relevant to the day's workshop questions.

On Day Two, participants answered questions relating to the delivery of nutrition. They heard presentations from Josephine Kayumba (Nutrition problems we encounter in Rwanda); Tom Heikens (Translating the WHO Ten Steps in the care of HIV/AIDS); Charlotte Adamczick (Therapeutic and weaning foods in HIV/AIDS); Agnes Malamule (The counsellor's role with orphans) and Alexandra Peltier (The psychosocial consequences of malnutrition)

Day three took the entire forum out to Rwinkwavu, where Partners In Health have established a comprehensive health care and training centre. Participants were welcomed to the training centre by Sara Stulac and heard a stirring speech by Paul Farmer, co-founder of PIH, before beginning with the day's plenary session. This took the form of a round table discussion around traumatised children and post-traumatic stress disorder. The round table session included delegates from the DRC, Zimbabwe, Kenya and Rwanda and was led by Jenny Altschuler, who was assisted by Alexandra Peltier. Stephen Rollnick presented a paper on leadership-, clinical- and parenting styles and Shaffiq Essajee rounded off the plenary input with a talk on ways of implementing change in one's service.

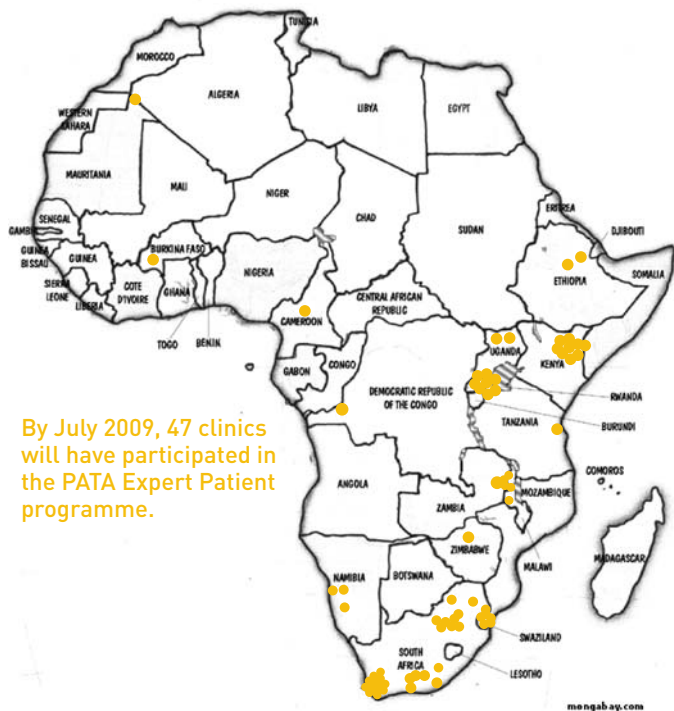
After the plenary session, teams took turns in completing their selection of quality improvement tasks to be undertaken during the following PATA year; and in visiting the many elements of the PIH facility at Rwinkwavu. Dr Paul Cromhout summarised the key aspects of the team grids in the afternoon plenary session.

The PIH teams in Rwanda, and Sara Stulac in particular, were most efficient and generous hosts. Our warm thanks to them. The visit they arranged to Rwinkwavu was a never-to-be-forgotten highlight of the forum and Paul Farmer's words of recognition and encouragement will go a long way to support our energies on PATA's long road into the future.

#### 5.8 Expanding 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 33 clinics in April 2009 with a total of 136 expert patients being employed in 12 Sub-Saharan African countries. On average, expert patients work for 25 hours per week. Clinics have been receiving \$200 per month for expert patients, but this will be increased to \$260 per month from July 2009, increasing the expenditure on expert patients from \$80,000.00 per annum, to \$120,000.00 per annum. In May 2009, 15 new applications were received from clinics in 9 countries to participate in the Expert Patient programme, namely: DRC (1), Ethiopia (2), Lesotho (1), Malawi (5), South Africa (1), Tanzania (1), Uganda (1), Zimbabwe (1) and Rwanda (2). It is the first time that PATA has received applications from Ethiopia and Zimbabwe. All 15 of these applications were successful, taking the number of participating clinics up to 47.

## Map of Clinics participating in the Expert Patient Programme



By July 2009, 47 clinics will have participated in the PATA Expert Patient programme.

## 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
June 2009	14	47	200

## 6. 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:

### Academic Institutions and organizations that have contributed to PATA Forums

- Albert Einstein College of Medicine
- ARK
- Clinton Foundation
- Connaught Clinic
- Desmond Tutu HIV/AIDS Research Centre
- Groote Schuur Hospital
- HIV Clinicians Society
- Health Communication Project
- Institute of Health Care Improvement, South Africa
- Kenyatta National Hospital
- Lux-Development/ TRAC
- MRC Uganda
- Mothers to Mothers to Be
- Partners In Health
- Red Cross Children's War Memorial Hospital
- Reproductive Health Research Unit
- Right to Care
- University Hospital of Kigali
- University of Cape Town
- University of Cardiff
- University of Malawi, College of Medicine
- University of Stellenbosch
- University of the Witwatersrand
- Zomba Central Hospital

## 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 Malawale 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
<b>Total</b>	<b>47 clinics</b>	<b>14 Countries participating</b>

## 7. 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. James Nuttall**, Paediatrician, Red Cross Children's Hospital, South Africa

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

**Dr. Telahun Teku**, Paediatrician, Department of Paediatrics and Child Health, Ethiopia

**Dr Paul Cromhout**, Small Projects Foundation, South Africa

**Dr. Robert Gass**, UNICEF

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

**Sr. Gertrude Guveya**, Nursing Sister, Zimbabwe

**Dr Prithi**, Lesotho

## 8. Financial review : PATA 2008

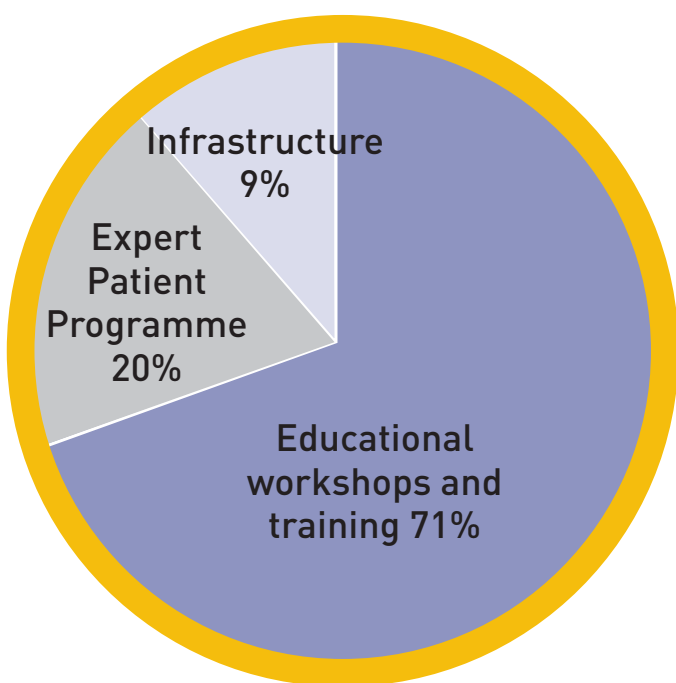
PATA continues to be reliant on funding sourced by its two founding organizations, One to One Children's Fund and Kidzpositive Family Fund. Details of the PATA sources of revenue, expenditure and donor contributions are summarized in the tables below.

In 2008, 77% 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. The remaining 23% of funding came from an anonymous philanthropy and SidAction, via Kidzpositive. PATA spent 4.1 million Rand in 2008. 71% of this was used for PATA forums and training activities; 20% on the Expert Patient Programme, and 9% on infrastructure costs.

This summary does not account for a small proportion of clinic self-funding (eg 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.

## PATA use of revenue 2008 - 2009



## PATA Funding

	\$
One to One donations to PATA	86500
Funding secured by One to One Children's Fund for PATA	247128
Funding secured by Kidzpositive:	
Sidaction	30000
Anonymous Philanthropy	66 900
Interest received	1400
<b>TOTAL</b>	<b>\$ 431 928.00</b>

## 9. Looking ahead to PATA 2009

PATA faces incisive changes in the coming year. We have grown and are coming of age. Although only 43 teams could be accommodated at the 2008 forum, over 80 treatment teams applied to attend. This has made it necessary to find creative solutions to enable PATA to reach all of these teams. Hence the steering committee, with due consideration of wishes expressed by PATA participants, have decided to move the focus of PATA activities to annual regional meetings, with less frequent continental 'summit' meetings. There is also a need to devolve responsibilities and activity to regional/ country level, and 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.

At the same time, PATA-affiliated clinics will be encouraged to arrange team exchanges, in the same way that PIH teams in Rwanda have done in the last year. Staff exchange programmes are likely to be a powerful way of spreading the PATA effect. The responses of our plenary experts to the PATA process during the PATA Kigali 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.

PATA hosted a National Co-coordinators meeting in Cape Town at the end of May 2009, to discuss the role of national coordinators and a vision for PATA in the Southern African region. PATA has embarked on a process of monitoring and evaluating the expert patient programme so that we can report more extensively to our funders on the impact of this programme as well as to continually strive to improve it. PATA is in the process of discussing a partnership with an advocacy organisation, Global Aids Alliance, in their Campaign to End Paediatric AIDS (CEPA).

Within the organisation's management, the PATA steering committee are faced with the challenge of reorganising governance structures to ensure a broader decision making base and greater involvement at a committee rather than an individual level. PATA will need to invest heavily in its infrastructure to enable devolution to a regional level, and to manage the growth of the PATA network.

## PATA Expenditure

Use of PATA revenue	ZAR	% Contribution
<b>01/03/2008 – 28/02/2009:</b>		
Educational workshops/ training/ conferences including 2007 proceedings, Adolescent Workshop, Mexico Conference, Hamburg Workshop & Rwanda Forum	2900000	71%
Expert Patient Programme	805870	20%
PATA Office infrastructure, communication & salaries	396870	9%
<b>TOTAL</b>	<b>4102740</b>	

## Clinics participating in the PATA Network

Clinic	Country	Joined in 2009	PATA Forum 2008	PATA Forum 2007	PATA Forum 2006	PATA Forum 2005	Expert Patient Programme
ALERT	Ethiopia		Y				Y
ANSS	Burundi		Y	Y	Y		
Augusta Ngangula	Angola			Y DNA			
Baylor BCM-BMS	Lesotho	Y					Y
Baylor Botswana	Botswana			Y	Y		
Baylor Malawi	Malawi	Y					Y
Baylor Swazi	Swaziland		Y	Y	Y		Y
Black Lion (Tikur Anbessa)	Ethiopia		Y		Y	Y	Y
Bungoma	Kenya						Y
CAP Heal Africa	DRC		Y	Y	Y		Y
Catholic Health services	Namibia		Y	Y			Y
Centre Mere et Enfant	Cameroon		Y	Y	Y DNA		Y
Children of God Relief Institute	Kenya		Y				
CHU de Yopougon	Cote D'Ivoire		Y	Y	Y		
CHUSS	Burkina Faso		Y	Y	Y		Y
Coast Provincial	Kenya		Y		Y		
Connaught (Newlands)	Zimbabwe		Y	Y	Y		Y
Dora Nginza	SA			Y	Y		Y
Dvokolwako	Swaziland			Y			Y
Eben Donges	SA			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	Y
George Hospital	SA						
Gertrude's	Kenya		Y	Y	Y	Y	Y
GSH	SA			Y	Y	Y	Y
Gugulethu Hanen Crusaid	SA						
Harare Children's Hospital	Zimbabwe			Y			
Harriet Shezi 1	SA						Y
Harriet Shezi Lillian Ngoyi	SA						Y
Harriet Shezi Zola	SA					Y	Y
Hottentots Holland Hospital	SA						
JCRC	Uganda		Y	Y	Y		Y
Kakamega	Kenya		Y	Y	Y		
Katutura	Namibia					Y	
Keiskamma	SA		Y	Y	Y		Y
Kibagabaga	Rwanda		Y				
Kibong'oto	Tanzania		Y				
Kibuye	Rwanda		Y				
King George V	SA			Y			
Kiwoko	Uganda		Y	Y			
KNH	Kenya		Y	Y	Y		Y
KPA	Kenya			Y	Y		
Lagos State General Hospital Isolo	Nigeria	Y				Y	
Langa Clinic FAMSA	SA						
L'hopital pediatrique de Kalembelembe, Kinshasa	DRC		Y				Y
Livingstone Hospital, Eastern Cape	SA	Y					
Livingstone General	Zambia			Y	Y		
Lux Dev	Rwanda		Y	Y			
Madwaleni, Transkei	SA	Y				Y	
Mafikeng Prov Hospital	SA						
Maputo Central Hospital	Mozambique				Y		
Maragua District Hospital	Kenya				Y		
Matawale	Malawi	Y					Y
Mayaka	Malawi	Y					Y
Ministry of Health, Nkhata Bay	Malawi			Y	Y		
MRC Uganda	Uganda			Y			
Nampula	Mozambique			Y			
Nkatha Bay	Malawi			Y			
Nyangana	Namibia		Y				Y
Osindisweni	SA			Y			
Paarl Paeds	SA		Y	Y	Y		Y
Phatsima Khanya Clinic	SA		Y				
PIH Butaro/ Burera	Rwanda		Y				Y
PIH Kirehe	Rwanda		Y	Y	Y		Y
PIH Mulindi	Rwanda	Y				Y	Y
PIH Rinkwavu	Rwanda		Y	Y	Y	Y	Y
PIH Rukira	Rwanda		Y	Y			Y
Princess Marie Louise	Ghana		Y	Y			Y
QE II	Lesotho		Y	Y	Y		Y
Robertson Hospital	SA				Y		
Rustenburg Provincial	SA		Y	Y	Y	Y	
RXH	SA						
Sendwe Clinic, Lubumbashi	DRC		Y DNA				
Songea CTC	Tanzania			Y	Y		Y
TASO Gulu	Uganda		Y	Y	Y		
TASO Mbará	Uganda			Y			Y
Tisungane	Malawi		Y				Y
TRAC	Rwanda		Y	Y			
Transmara District Hospital	Kenya		Y	Y	Y		
Tygerberg	SA		Y	Y			Y
Uitenhage Provincial	SA			Y	Y		Y
Umphumulo	SA			Y			
Worcester	SA		Y	Y			Y
WWO	Ethiopia		Y				Y
Zomba EID Paeds	Malawi	Y					Y
Zomba PMTCT	Malawi	Y					Y

Y DNA = Yes, but did not attend: Usually due to visa or airline difficulties; beyond their control



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