**“It was giving them a feeling that they’re not alone in this”: Perspectives of caregivers and clinicians on a camp for UK adolescents with HIV**

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**Abstract**

There are a number of challenges for adolescents living with perinatally acquired HIV (PAH), including adherence to antiretroviral medication and managing HIV stigma. Offering psychosocial interventions residentially (camps) is one approach offered to some adolescents with chronic illness as a way to reduce isolation, increase self-esteem and wellbeing, enhance medication adherence and increase condition- specific knowledge. There have been studies on the experiences of young people with HIV who have attended camps but no studies exploring the view of other key informants. Examining the perceptions of caregivers and clinicians of young people with PAH who have attended camps may provide a fuller picture of the experience and impact of camps for young people, allowing for corroboration or comparison between the views of different informants. We interviewed seven caregivers and eight clinicians of eleven young people who had attended a UK intensive support camp, analysing data using thematic analysis. These eleven young people had been sampled representatively. Participants referred to expectations that they had before the young person had attended camp, their perception of the young person’s experience there, as well as the perceived impact of the camp. Perceived benefits of the camp covered social (relationships and communication), psychological (independence, empowerment, confidence), cognitive (HIV knowledge), and health behaviour (ART adherence) domains. The study revealed benefits of camps that corroborate the views of young people. Future studies could explore the similarities and differences in experiences between low and high HIV prevalence settings.

**Key words: HIV; adolescence; camp; clinician; caregivers; qualitative**

1. **Introduction**

In 2017, an estimated 2.1 million children (0-15 years) globally were HIV positive ([UNAIDS, 2018](#_ENREF_15)). With advances in antiretroviral therapy (ART), children born with HIV can have comparable life expectancy to their HIV-negative counterparts ([Wada et al., 2014](#_ENREF_16)). There are, however, a number of challenges for children living with the condition. These include adjusting to being told that one is HIV-positive (paediatric disclosure or HIV naming), managing ART adherence in the context of long histories of medication use with suboptimal regimens ([Sohn & Hazra, 2013](#_ENREF_14)), and anxiety about sharing one's HIV status with others (onward HIV disclosure) ([Greenhalgh, Evangeli, Frize, Foster, & Fidler, 2016](#_ENREF_6)). Some challenges, for example managing feelings of isolation, may be particularly relevant in low HIV prevalence settings such as the UK ([Hogwood, Campbell, & Butler, 2013](#_ENREF_7)).

There is evidence of higher levels of emotional and behavioural problems, including psychiatric disorders, in young people living with perinatally acquired HIV (PAH) compared to young people unaffected by HIV ([Mellins & Malee, 2013](#_ENREF_10)). There remain relatively few psychosocial interventions reported in the literature, however, for adolescents living with HIV ([Skeen et al., 2017](#_ENREF_13)). Offering psychosocial interventions residentially (camps) is one approach offered to children with chronic conditions as a way to reduce isolation, increase self-esteem and wellbeing, enhance treatment adherence and increase condition- specific knowledge ([Odar, Canter, & Roberts, 2013](#_ENREF_11)). Camps refer to programmes of educational, creative, recreational and social activities that take place in a setting where participants remain overnight away from home.

There is evidence in other chronic conditions (e.g., obesity, cancer, diabetes and asthma) of increased youth self-esteem after attending camps ([Odar et al., 2013](#_ENREF_11)) although little quantitative assessment of outcomes for young people with HIV, with some exceptions ([Evangeli, Lut, & Ely, 2019](#_ENREF_3)). There have also been qualitative studies with children living with HIV in the US exploring the experience of camps ([Gillard & Allsop, 2016](#_ENREF_4); [Gillard, Witt, & Watts, 2011](#_ENREF_5)). These have suggested that camps can help in the formation of caring connections, provide reprieve, recreation and a sense of escape, and increased knowledge, skills and attitudes, through facilitating a sense of belonging, enjoyment, freedom to be oneself and personal growth ([Gillard & Allsop, 2016](#_ENREF_4); [Gillard et al., 2011](#_ENREF_5)).

Recently, we conducted a longitudinal qualitative investigation of the experiences of a camp for HIV positive adolescents (12 to 16 years old) in the UK, which included undertaking interviews both at the end of the intervention and six months later ([Lut, Evangeli, & Ely, 2017](#_ENREF_9)). Six main themes were identified: connecting with new friends and feeling less alone (involving forming positive and supportive peer relationships at camp that were maintained afterwards); gaining HIV knowledge and learning about living with HIV; developing a positive self-image; communicating more purposefully; becoming more autonomous; and a desire to engage further with the HIV community. The majority of these themes were reported at the six week and six month follow-up points. Participants felt that the intervention had been normalising, increased their confidence, decreased their anxiety about sharing their HIV status and widened their support network.

Exploring the views of the non-professional caregivers (usually family members such as parents) and clinicians of young people with HIV may corroborate (or contradict) their views and in doing so provide a fuller picture of the experience and impact of camps for young people. Investigating the alternative perspective of these stakeholders may be particularly important given the age range of those attending camps, as they will mostly still be living with their caregivers. Furthermore, caregivers and clinicians of the young people may be less influenced by expectations of what the researcher anticipates, and they may be better able to articulate evidence of change or a lack of change. In addition, if behavioural changes occur in young people due to camp attendance, some evidence of this should be noticeable to others. One recent study has investigated health care professionals’ perceptions of camps, revealing positive views about their capacity to normalise, provide a sense of belonging, ownership and confidence in healthcare-related tasks, and to strengthen relationships between children and professionals. The impact of external barriers to lasting change was also expressed, however ([DiDomizio & Gillard, 2018](#_ENREF_1)).

We aimed to investigate the views of both the caregivers and the clinicians of the young people involved in the study by Lut and colleagues ([Lut et al., 2017](#_ENREF_9)) to allow comparison with youth perspectives and to corroborate their previous reports of behaviour change attributed to camp. There have been no longitudinal studies that examine the lasting benefits of such an intervention from the perspectives of those involved in both caring for and delivering health care services to this population. Such studies are important given both the potential benefits of camps and the significant resources required to offer them.

1. **Methods** 
   1. ***Study design***

The study used a cross sectional qualitative design.

* 1. ***Intervention***

The intervention was provided by the UK Children’s HIV Association (CHIVA) and was a week- long intensive peer engagement support camp with individual emotional support. The Camp Team comprised Social Workers, a Child Participation officer (who’s role is to ensure that young people have opportunities to participate in decision making processes around their care and input into development of policy and practice) and a Nurse, as well as the volunteer team. The latter consisted of Camp leaders (young adults aged 18-24 with HIV) and Key Workers of varied professional backgrounds, including people living with HIV and adults who had previously attended camp when younger as participants.

Sports activities consisted of rafting, volleyball and football. Creative and performing arts workshops (music, poetry, drama and art) aimed to encourage expression of growing up with HIV. HIV workshops included HIV information, addressing transmission and HIV rights and HIV experience, reflection on issues of importance to these particular young people. The intervention was offered to all 12-16 year olds living with HIV in the UK. All of the young people wishing to attend gained a place (n=77). Forty eight (62%) camp attendees had not attended before and 45 (58%) were not receiving any specialised HIV support services beyond clinic (i.e., social care or voluntary sector support). Further details of the camp have previously been reported ([Lut et al., 2017](#_ENREF_9)). The aims of the camp were to reduce isolation, increase HIV knowledge and understanding of living with HIV, increase confidence and self-esteem.

***2.3 Sample***

We invited the 11 caregivers of the 11 young people interviewed in our earlier study (Lut et al., 2017) to participate, along with the clinician of each young person. As some of the clinicians looked after more than one of the young people, this resulted in eight clinicians being invited to participate. All the clinicians invited to interview, and seven out of the 11 caregivers, agreed to participate. The remaining four caregivers invited to participate either did not respond to the invitation or were not available for interview. Written informed consent was obtained from all participants.

The sample were, therefore, seven caregivers and eight clinicians of the same group of 11 young people (6 females, median age 15 years) who had attended camp, and whose interviews have been reported previously ([Lut et al., 2017](#_ENREF_9)). These eleven young person participants were chosen using random sampling stratified for age and gender. We chose to focus on specific young people to assist in comparing the views of different respondents. The caregivers and clinicians were interviewed six months after the end of camp. The six-month time point was selected to coincide with the administration of self-report measures that evaluated the impact of camp and with qualitative interviews with the young people.

* 1. ***Ethics***

Ethical approval was given for the study from Royal Holloway University of London Psychology Department Ethics Committee (2015/052).

* 1. ***Procedure***

Questions were generated by the research team, in addition to questions sourced from previous evaluations of the camp and an evaluation of a residential camp for HIV positive youth in the United States ([Gillard et al., 2011](#_ENREF_5)). Separate interview guides were designed for the clinicians and caregivers (available as supplemental documents). The interview questions addressed the time before, during and after camp. For the caregivers, question included, “*What were your expectations about the experience [NAME OF YOUNG PERSON] would have at camp?”* and “*How* *could* *camp* *be* *improved* *based* *on* *your* *conversations* *with* [*NAME*]?”). For clinicians, questions included, *“Why did you recommend that [Name of young person] go to camp?*” and, *“To what extent did [NAME] speak to you about camp?”* and “*Has [NAME] used anything they learned at camp in daily life in the past 4-6 months?*”). Care was taken to avoid leading and closed questions throughout. The interviews were conducted by the final author, who was trained using role play techniques, by the first author (an experienced Clinical Psychologist). All interviews were recorded by an audio recorder and subsequently transcribed verbatim by the final author (who was present during the camp but not part of the Camp Team). Transcripts were reviewed by the first author. Interviews lasted between 20-30 minutes and took place either via telephone, skype, or face to face (with clinicians in the clinic, and with caregivers in their home). The transcripts files were password protected and saved on a secure server. Audio recordings were destroyed after transcription.

***2.6 Analysis***

Thematic analysis (Braun & Clarke, 2006) was used to generate themes and subthemes. An inductive approach was used. The transcripts were divided between the second and third author, each analysing half of the caregiver and half of the clinician interviews. Both read through all interviews. Lines that referred to the particular young person whom the caregiver and clinician was asked to focus on and references to camp were coded. Both the second and third author compiled and reviewed their codes, generating focused codes and concentrated these further into main themes. These codes were reviewed by the first author. Discrepancies between authors were resolved through discussion, and further revisions were made, until agreement was reached.

***2.7 Quality***

Quality standards were used to inform this study ([Elliott, Fischer, & Rennie, 1999](#_ENREF_2)). The analysis was grounded in examples, credibility checks of the second and third authors’ coding were used (by the first author) and reflexivity was maintained (through repeated discussion between the first, second and third authors).

1. **Results**

Participants made reference to nine main themes (see Table 1).

**Table 1 here**

The themes relate to the expectations that they had before the young person attended camp, their perception of the young person’s experience at camp, as well as the impact the interviewees believed the camp had on the young person after they had attended, reflecting the areas covered in the interview guide. Perceived benefits of the camp covered social (relationships and communication), psychological (independence, empowerment, confidence), cognitive (HIV knowledge), and health behaviour (ART adherence) domains. Expectations that participants had about camp covered all of these domains and were, in general, perceived to have been met.

***3.1 Expectations of camp***

Hoping that the young person would meet other young people with HIV was commonly reported. Thinking that the young person would make new friendships was reported by two of the clinicians, whereas three of the caregivers and two clinicians expected the young people to benefit from meeting other people who were going through a similar situation as them.

*“It was bringing those kids (with HIV) together and for me it was giving them a feeling that they’re not alone in this.”* [Caregiver 3]

Both caregivers and clinicians thought that going to camp would improve the young person’s self-esteem and self-confidence.

*“I think it’s just to make them feel confident. Just because they’ve got HIV, doesn’t mean that it’s the end of the world for them and they can still live just like everyone else but just to learn that if they decide to have sex, have protected sex and things like that.”* [Caregiver 6]

Both caregivers and clinicians expected the young people to be educated about protected sex and the sharing of their HIV positive status to a sexual partner, as well as learning more generally about how to live with HIV.

*“Well sex I think because we do ask about using condoms and they’re aware of it and I’m sure that’s something that’s discussed in camp and I think that’s an environment in which the message gets through pretty much better than us talking about it in clinic”* [Clinician 6,7,9 – i.e., clinician of 3 camp attendees]

Three caregivers expected camp to be a good environment for the young people to talk about their HIV positive status, thus increasing communication about HIV in general.

*“Well I guess she would have the opportunity to discuss things that she wouldn’t discuss with her own peers so there would have been yea… a new perspective I think.”* [Caregiver 11]

*“Yeah it gives her somewhere to go where she can talk openly and freely about her condition with other people who have the same condition”* [Caregiver 9]

One caregiver and one health care professional hoped that the young people would enjoy themselves at camp.

*“I was expecting her to really enjoy it. I was expecting her to make friends very easily because [NAME]’s very sociable and [NAME], she has a big family and she doesn’t get lots of attention sometimes at home so I was expecting her to enjoy the attention she was getting from people at camp.”* [Clinician 2]

***3.2 Relationships during and after camp***

The relationships that were formed between the young people at camp and how they developed after they had left camp was a prevalent topic reported by both clinicians and caregivers. Five of the clinicians and three of the caregivers referenced these relationships, with both groups detailing the benefits of having peer support and the apparent longevity of the relationships.

*“They’ve made contacts that continue for a long time through social media and find that ability spending that week living without a secret an incredibly uplifting and realising they’re not alone; they’re not the only one.”* [Clinician 11]

*“She can speak out about her diagnosis and they can completely understand, which is very difficult to speak to friends in school and friends in normal life. People in school it’s very difficult to speak about (HIV) cause you don’t know how they’ll react so she definitely felt happy about that”* [Caregiver 3]

*“I’m glad she did go because when she got back she made loads of friends that she keeps in touch with”* [Caregiver 9]

Three caregivers and three clinicians suggested that the friendships between the camp attendees might have formed due to the young people having HIV in common. More specifically, it appeared that the opportunity to be open about their HIV with other people in the same situation was thought to be uniquely supportive:

*“It gives her somewhere to go where she can talk openly and freely about her condition with other people who have the same condition”* [Caregiver 9]

*“So it’s helped him actually, going to the camp because he’s made friends. Because it’s… they’ve got a common denominator. Because he has met other people that are the same as him, then it becomes easy for him to talk about sensitive issues that he can’t talk to his friends”* [Caregiver 6]

***3.3 Increased knowledge of living with HIV***

Improvements in the young peoples’ HIV knowledge were reported by both caregivers and clinicians. Two caregivers and two clinicians reported that the young people understood more about HIV since attending camp.

*“I think she does understand more about her condition though since she’s been going to camp.”* [Caregiver 9]

*“There were so many things that he told me… learning about HIV, how to live with HIV, puberty.”* [Caregiver 6]

Clinicians reported on specific topics that camp had taught the young people, and the importance of repeating information previously presented in clinic:

*“[NAME] talks about learning some new things while he was at camp”*

*Interviewer: Like what?*

*“About resistance and things like that and [NAME] talked about moving on really and transitioning and how she finds that important cause she’s at that age where she wants to move on.”* [Clinician 6,7,9]

*“When they go to camp they learn things and it’s a reaffirmation and what’s good about it is that it’s not coming from us……They get the same information but it’s a different perspective.”* [Clinician 4]

***3.4 Improved communication***

Reports of improved communication about HIV and sexual health were prevalent among both caregivers and healthcare professionals. Participants reported that camp seemed to help the young people to discuss sexual health with each other and peers, and ask questions without embarrassment. Three caregivers and two clinicians referenced how camp may have helped the young people open up about their HIV positive status to people who do not have HIV. When discussing how one young person was debating sharing their HIV status with their best friend, one interviewee said:

*“I think the camp on that – issues like those ones – the camp is a benefit for him because I think they talk about it and they open up to people at the camp and they give them proper questions – proper answers actually.”* [Caregiver 6]

The interviewees also thought that attending camp with other young people helped them to talk about HIV with each other, an alternative to their caregivers.

*“Interviewer: Do you think hearing other people’s stories and what they’re dealing with has helped him?*

*Caregiver 8: Yeah because I think, not necessarily with us but with his peer group he’s shared some of his problems and it’s a good thing to be able to share our problems cause they suddenly become half the problem they were.”* [Caregiver 8]

***3.5 Camp* *was* *a* *positive* *experience***

This was a commonly expressed theme. The clinicians and caregivers spoke highly of camp and the positive effects it had on young people in relation to psychological outcomes.

*“Things used to get him really really angry and that’s come down a lot. He would shout and threaten me and that’s calmed down a lot. He was very apologetic afterwards but his temper can go and that has calmed.”* [Caregiver 8]

*“He seems more open to engaging with us and also coming to the support group as well which he hadn’t done before so a little bit more comfortable with that as well.”* [Clinician 5]

The majority of the caregivers and clinicians spoke of the young person’s enjoyment of camp and their wish to return to camp.

*“Everything. He enjoyed every part of it.”* [Caregiver 6]

*“He just told me how much fun they had.”* [Caregiver 7]

***3.6 Increased* *independence***

The clinicians, in particular, reported an increase in independence shown by the young person after attending camp (5 out of 8). For some of the young people, camp would have been the first time away from home in a new environment and for all of them, an opportunity to meet new people.

*“Well [NAME] always talks about camp and anything involving CHIVA anyway every time he comes to clinic. He really finds that quite empowering. I think it gives him his bit of control in his life.”* [Clinician 6,7,9]

*“She’s able to make decisions for herself much more easily than she would if she hadn’t gone to the camp.”* [Caregiver 11]

*“Her mum still comes but she comes in and sees us on her own and she’s happy to talk about her medicines and everything, which I don’t think she had that confidence before” Camp gave her the confidence to come in by herself.”* [Clinician 6,7,9]

It was sometimes difficult for participants to identify the reason for behavioural changes. For example, one young person demonstrated increased independence after camp by attending the clinic without parental supervision. However, the same clinician who noted this behavioural change commented that this indicator of increased independence may have resulted from the young person growing up rather than a consequence of camp.

*“It is difficult to judge whether this independence is a result of growing up rather than camp installing confidence into the young people. I’m sure that would have happened probably around that sort of time anyway.”* [Clinician 6,7,9]

***3.7 Empowerment and confidence***

Seven clinicians and two caregivers noticed a difference in the young person’s confidence and self-esteem since attending camp.

*“A couple of months after the camp and she openly stood up and spoke about her own experience of telling friends and telling friends at school about her own diagnosis as well so she shared that with the group….I don’t think she would have been as confident before camp.”* [Clinician 3]

*“But I definitely think the camp experience in general has made him a little bit more confident in speaking to us when he comes to the clinic because he’s quiet……. but he smiles a lot more and is starting conversations whereas before he would just answer your questions.”* [Clinician 5]

“*She’s able to make decisions for herself much more easily than she would if she hadn’t gone to the camp.”* [Caregiver 11]

One young person’s increase in confidence was noted by a clinician discussing the transition to the adult clinic.

*“She knew she wanted to do something different and [camp] gave her confidence to talk so that was a big positive.”* [Clinician 6,7,9]

***3.8 Medication* *changes***

One caregiver and two clinicians spoke about camp influencing ART adherence. Participants spoke of improvements in the young people taking their medication after attending camp.

*“Yeah he’s improved. He’s improved, really. He’s taking his medication.”* [Caregiver 6]

*“She’s much happier in herself in terms of things at home, her medication taking.”* [Clinician 3]

***3.9 Camp in the context of young peoples’ lives***

The final theme reflected participants’ uncertainty as to whether changes had been caused by camp, given the range of other influences in their lives. More clinicians (6) than caregivers (2) spoke of this when questioned about the cause and presence of change.

*“But it’s hard to say his behaviour is changed …cause like I say he’s one of our really complex young people who’s got a lot of stuff going on outside the world of HIV.”* [Clinician 8]

Both clinicians and caregivers were cautious in assigning camp as the single main cause of change.

*“Yeah I can’t really pinpoint the fact that if it’s cause she’s been to camp or the fact that she’s getting older and she is going to peer support more and learning more about health and taking more of an interest really.”* [Clinician 3]

1. **Discussion**

We aimed to compare, contrast and corroborate the views of caregivers and clinicians, with those of the young people involved in our earlier study (Lut et al., 2017). Caregiver and clinicians made reference to nine main themes. The themes relate to the expectations that they had before the young person attended camp, their perception of the young person’s experience there as well as the impact the interviewees believed the camp had on the young person after they had attended. Perceived benefits of the camp covered social (relationships and communication), psychological (independence, empowerment, confidence), cognitive (HIV knowledge), and health behaviour (ART adherence) domains. These themes were broadly consistent with the aims of the camp and corroborated the views of the young people reported previously ([Lut et al., 2017](#_ENREF_9)).

There were many pre-camp expectations reported, across social, psychological and health behaviour domains. Participants hoped that young people would meet and make friends with others with HIV, improve their self-esteem and self-confidence, and learn about sharing their HIV status, safer sex and living with HIV. It may have been that caregivers and clinicians thought that existing needs in these areas were unmet by other services. Also, expectations may have been shaped by previous exposure to camp and its consequences (particularly for clinicians), as well as being influenced by post-camp discussions with the young people.

Many of the themes concerning the camp itself and its effects mirrored those reported by the young people reported previously ([Lut et al., 2017](#_ENREF_9)). In particular, positive and supportive peer relationships during camp that were maintained afterwards were commented upon by the majority of the sample. This appears to be a particular powerful and consistent aspect of the camp experience ([Gillard et al., 2011](#_ENREF_5)) and is consistent with the positive youth development approach ([Lerner, Almerigi, Theokas, & Lerner, 2005](#_ENREF_8)). It may also be particularly important in the context of the geographical isolation and the lack of access to specialist HIV support services beyond clinic (i.e., social care or voluntary sector support) of many of the UK camp attendees. In addition, both young people, and those who care for and delivering health care services to them (albeit a minority of the sample) reported increases in HIV knowledge, consistent with the maintained improvements in HIV knowledge scores seen at six months in our quantitative evaluation of the same camp ([Evangeli et al., 2019](#_ENREF_3)). Increases in independence and self-confidence were also reported frequently across both young people and caregivers/clinicians. These findings are also consistent with improvements in self-perception reported ([Evangeli et al., 2019](#_ENREF_3)) in our quantitative study.

Some themes apparent with young people in our earlier study ([Lut et al., 2017](#_ENREF_9)) were not mentioned by caregivers and clinicians, however, for example, a desire to engage further with the HIV community. It may have been that this desire was not expressed by young people to their caregivers or clinicians. In addition, some themes are not backed up by quantitative evidence derived from evaluation of the same camp. For example, reports of improved communication about HIV sit alongside an absence of evidence of an increased frequency of HIV communication or HIV disclosure. It may be that merely assessing frequency of communication fails to capture the *quality* of information communicated or to whom. In addition, observations of medication adherence remain to be corroborated by changes in self-reported missed doses. Finally, understandably, some aspects of young person participants’ internal experiences are more difficult to observe by others (e.g., experiencing the camp as normalising and reduced anxiety about sharing one’s status) and were not reported by caregivers and clinicians.

Strengths of the study included the good response rate, the use of a representative sampling strategy, and the fact that interviews were many months after camp (allowing for more evidence of effects to be observed and for initial effects to have dissipated). In addition, the linking of young people, and caregiver and clinicians participants across this and our previous qualitative camp study ([Lut et al., 2017](#_ENREF_9)) allowing comparisons to be made. Limitations include the possibility that respondents may have been motivated to present a positive picture of the effects of camp (despite efforts made to ensure that questions were not leading and to stress the independence of the research to those providing the intervention). Participants were, however, able to acknowledge that they were uncertain whether it was the camp that caused changes. Additional limitations include the small sample size, which may have resulted in data saturation not being achieved for some themes.

Future studies could be conducted in regions of higher prevalence where camps take place, for example in sub-Saharan Africa ([Serious Fun Children's Network, 2019](#_ENREF_12)), to examine whether similar themes are elicited. This study, along with our previous qualitative study with young people, has potential practice implications for both routine services and those offering camps. Young people with HIV should be offered the opportunity to meet and share experiences with their peers with HIV. We have shown that this is important in a low HIV prevalence setting. It may be that it is equally or even more important in a high HIV prevalence setting. They should also be provided with accurate and timely HIV information in routine care, although it is unclear whether the specific conditions present at camp (e.g., the supportive and engaging atmosphere, additional time, interactive methods, opportunities for modelling, the large number of peers) made it more likely that HIV knowledge (and other) gains would be seen at camp than in routine care. Finally, caregivers or clinicians who are unsure about whether to encourage young people to attend camp may benefit from hearing about the positive experiences reported by the caregivers and clinicians in this study.

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| --- | --- | --- |
| **Themes** | **Focused Codes** | **Open Codes** |
| 3.1 Expectations of camp | Expecting education | Expecting young person to learn about safer sex and HIV partner disclosure |
| Expecting young person to learn more about living with HIV |
| Expectations of meeting other young people with HIV | Expecting young person to meet similar children so they would not feel so alone |
| Expecting young person to make new friendships |
| Expecting increased confidence and self-esteem | Expecting camp to improve young person’s confidence |
| Expecting increases in self esteem |
| Expecting increased communication about HIV | Expecting young person to talk about HIV at camp |
| Expecting young person to enjoy camp | Expecting young person to have fun |
| 3.2 Relationships during and after camp | Relationships formed with other young people at camp | Camp allowing access to peer support for young person which can help them less alone |
| Young person developing relationships with each other, due to having HIV in common |
| Relationships with other young people continuing after camp |
| 3.3 Increased knowledge of HIV | Increased knowledge of living with HIV | Camp teaching about antiretroviral resistance |
| Camp teaching about transitioning into adult care |
| Young person understanding more about HIV since camp |
| 3.4 Improved communication | Improved communication about HIV and sexual health | Camp may help young person open up about HIV to people who do not have HIV |
| Camp helping young person discuss sexual health and ask questions without embarrassment |
| Young person can talk about HIV with other young people, an alternative to their carers |
| Young person benefitting from being able to talk about HIV and have questions answered at camp |
| 3.5 Camp was a positive experience | Positive changes since camp | Camp producing positive psychological outcomes |
| Wishing to return | Young person would like to return to camp |
| Enjoyment | Young person enjoying camp |
| Young person returning from camp happy |
| 3.6 Increased Independence | Increased independence | Camp providing young person with more control in their lives, allowing them to make own decisions |
| Camp providing young person with independence such as attending clinic without parental supervision |
| 3.7 Empowerment and confidence | Empowerment and confidence | Believing camp empowers young person and boosts confidence and self-esteem |
| Confidence gained from camp makes it easier for young person to discuss transitioning and medication |
| 3.8 Medication changes | Medication adherence | Learning about medication improved medication adherence after camp |
| 3.9 Camp in the context of young peoples’ lives | No changes | No changes in the young person since camp |
| Changes may be due to other factors | Uncertainty of changes in young person as a result of attending camp. |

**Table 1: Table of Themes**