



OFFICE OF THE PRESIDENT OF THE REPUBLIC OF RWANDA
NATIONAL AIDS CONTROL COMMISSION



Rwandan Paediatric Conference on HIV and AIDS

REPORT
of
**The 6th Annual National Paediatric Conference
on Children Infected and Affected
by HIV and AIDS - 2010**

**“EDPRS sectors’ response to HIV and AIDS- focus on
the Education sector”**

**17th-19th November 2010,
Serena Hotel, Kigali-Rwanda.**

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ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Anti-Retroviral Therapy
BSS:	Behavioral Sentinel Surveillance
CDLS:	Comité de District de Lutte contre le SIDA (District AIDS control committee)
CNLS:	Commission Nationale de Lutte contre le SIDA (National AIDS Control Commission)
DHS:	Demographic and Health Survey
EDPRS:	Economic Development and Poverty Reduction Strategy
ESSP:	Education Sector Strategic Plan
HIV:	Human Immunodeficiency Virus
JRLO:	Justice, Reconciliation, Law and Order
MAP:	Multi-sectoral AIDS Project
MDG:	Millennium Development Goals
MIGEPROF:	Ministry of Gender and Family Promotion
MINAGRI:	Ministry of Agriculture
MINALOC:	Ministry of Local Government, Community Development and Social Affairs
MINEDUC:	Ministry of Education
MINIJUST:	Ministry of Justice
MININFRA:	Ministry of Infrastructure
MININTER:	Ministry of Internal Security
MINISANTE:	Ministry of Health
MINIYOUTH:	Ministry of Youth
MoE:	Ministry of Education
MoH:	Ministry of Health

NCDC:	National Curriculum Development Center
NRL:	National Reference Laboratory
NSP:	National Strategic Plan (for HIV and AIDS)
NUR/LAC:	National University of Rwanda / Legal Aid Clinic
OVC:	Orphans and other Vulnerable Children
PAYA:	Pan-African Youth against AIDS
PEPFAR:	Presidential Emergency Plan for AIDS Relief
PLACE:	Priorities for Local AIDS Control Efforts
PLHA:	People Living with HIV and AIDS
PMTCT:	Prevention of Mother to Child Transmission of HIV
PRSP:	Poverty Reduction Strategic Plan
PS:	Permanent Secretary
PSI:	Population Services International
PSTA:	Plan Stratégique pour la Transformation Agricole (Strategic plan for agricultural transformation)
RADA:	Rwanda Agriculture Development Authority
RARDA:	Rwanda Animal Resources Development Authority
RCS:	Rwanda Correctional Service
RNP:	Rwanda National Police
RNYC:	Rwanda National Youth Council
RRP+:	Réseau Rwandais des Personnes vivant avec les VIH (Rwandan network of PLHAs)
SP:	Strategic Plan
STI:	Sexually Transmitted Infections
TIG:	Travaux d'Intérêt Général (Community work for prisoners)
ToR:	Terms of Reference

TRAC Plus: Center for Treatment and Research on AIDS, Malaria and Tuberculosis

TWG: Technical Working Group

UNESCO: United Nations Education, Science and Culture Organization

UNICEF: United Nations Children's Fund

VCT: Voluntary Counseling and Testing (of HIV)

VUP: Vision 2020 Umurenge Program

I. INTRODUCTION

i. Conference background

Rwanda made tremendous commitments to fight against HIV and AIDS at a global level. These commitments include the Millennium Development Goals (MDG6 “Combat HIV&AIDS, Malaria and other diseases”, 3X5 initiative, Universal Access to HIV prevention, care and treatment. Recognizing that the national response to HIV and AIDS had been largely focused on the health sector, CNLS in collaboration with UN formed a task team early 2006 to lead the overall process of integrating HIV into the Economic Development and Poverty Reduction Strategy (EDPRS) and to provide ongoing technical support to the non-health sectors (Agriculture, Education, Youth, Justice, Infrastructure, Social Protection, Private Sector) identified to focus on the response to HIV and AIDS.

In order to tackle HIV and AIDS in Rwanda, the EDPRS (Economic Development and Poverty Reduction Strategy) 2008-2012 provides the framework for multi-sectoral actions on HIV and AIDS, and each sector’s strategic plan includes areas of action on HIV and AIDS. The government has developed a multi sectoral response to the HIV epidemic, placed under the coordination of the National AIDS Control Commission (CNLS). In 2009, Rwanda has developed an evidence-based and results-focused national strategic plan (NSP) 2009-2012 to fight against HIV&AIDS streamlining children and HIV issues around Prevention of HIV among young people, Prevention of HIV transmission from mother to child (PMTCT), Pediatric care and treatment to children infected by HIV, then, Protection of OVCs against HIV and AIDS. The expected result is the inclusion of key HIV and AIDS response in the sectoral planning, implementation, monitoring and evaluation as well as resources allocation and mobilization.

As the Ministry of Education is one of sectors that were identified in EDPRS 2008-2012 to implement HIV and AIDS response, it is therefore fundamental for MINEDUC to streamline HIV response in education sector from upstream strategic planning to downstream operational planning. The same ministry sets up policy, norms and standards for the education sector, oversees the formal system at pre-primary, primary, secondary, technical and vocational training, teacher training and tertiary and is also responsible for adult literacy. MINEDUC also undertakes education sectoral strategic and operational planning, implementation, monitoring and evaluation at the national and decentralized levels. The ministry targets two distinct groups: children between the ages of 5-14 who are at much less risk of attracting the HIV infection and thus constitute a ‘window of hope’, and youths between 14 and 24 years old who are at high risk category due to the sexual behavior. In all cases students in both categories need to be informed on HIV prevention and to be helped to adopt protective measures in order to reduce the risk of being infected by HIV.

Within this context, the 6th Annual National Pediatric Conference on children and HIV will focus on the role of sectors in fighting against AIDS streamlining children and HIV issues around Prevention of HIV among young people, Prevention of HIV transmission from mother to child (PMTCT), Pediatric care and treatment to children infected by HIV, Protection of OVCs against HIV and AIDS, with great emphasis on education sector.

ii. Justifications

One of the major weaknesses identified during the evaluation of Rwanda's first PRSP 2005-2008 was that HIV actions were only implemented by the health sector while the other sectors failed to address issues related to the HIV epidemic in their programs. Rwanda, by recognizing HIV as a major factor limiting the development of the country, witnesses tremendous commitment and willingness of the Government to address the scourge by integrating HIV and AIDS as a cross-cutting issue into the EDPRS 2008-2012. To achieve the overall objective of reducing HIV prevalence rate and improving treatment, care and support to people in need, a multi-sectoral strategic framework was developed under the leadership of the National AIDS Control Commission (CNLS), in collaboration with different partners and civil society. It is mandatory for each of the six (6) identified sectors (Education, Agriculture, Justice, Infrastructure, Social Protection and Youth) to contribute to the HIV response through the implementation of sector-appropriate HIV actions and programs. In regards with the 2010 national pediatric conference on children and HIV the role of sectors will be focused on with a particular attention to the education sector. The reasons are below highlighted:

The last Rwanda Demographic and Health Survey 2005 (RDHS 2005) found that the prevalence rate in the age group of 15-19 is 0.5% with 0.6 % for girls and 0.4 % for boys. This is a particular difficult period of puberty and adolescence where young people (both in and out of school) often try to investigate their sexuality by heterosexual or homosexual relations exposing them to the risk of being infected by HIV and other sexually transmitted infections. The HIV prevalence rate in the age group of 20-24 years is 2.5 % for girls and 0.5% for boys. It means that 5 girls are infected against 1 boy. This is also the age group where young women are having babies and therefore contributing to increased transmission of HIV to their infants. In addition, there are school children adolescents who were born HIV positive and need support in terms of positive prevention of HIV. About the knowledge of HIV by young people, in the age group of 15-19 years, 99.7% of female against 99.8 % of male have heard about HIV/AIDS; 87.9% of female against 97.2% of male know how to prevent HIV. In the age group of 20-24 years, 100% of both sex have heard about HIV/AIDS; 90% of female against 99. % of male knows the modes of HIV prevention. However the proportion of comprehensive knowledge among young people aged 15-24 who both identify ways of preventing the sexual transmission of HIV and who rejected the major misconceptions

about HIV transmission decreased slightly from 12.9% (BSS 2006) to 9.4% (BSS 2009) for girls, and 16.8% (BSS 2006) to 11% (BSS 2009) for boys.

In the age group of 15-19 years, only 16.3% of female utilize the condom during sexual intercourses with males. In the age group of 10-25 years a little proportion of 3% of female utilizes the condom and 5% of males (DHS 2005). In the age group of 20-24 years 1.2% of female utilize the condom with spouse or cohabiting partner, 26.2% utilize the condom with non cohabiting partner and 3.6% of female utilize the condom with who ever. This information lead to a clear reflection of the level of risky sexual behavior and the gender inequalities in decision making around heterosexual intercourse, the major cause of HIV transmission in Rwanda, and the level of advocacy for scale-up of interventions on children including those in schools. According to 2008 EPP-Spectrum, an estimated number of 22,000 children below 14 years old are infected with HIV and 30% of them are under the ARV treatment. This situation is complicated for HIV infected school children under ART where adherence to treatment may be limited by lack of proper follow-up, psychological counseling, lack of treatment of opportunistic infection, etc. The 2008 annual report of MINEDUC shows that 87% of children between 10 and 20 years old go to school and they usually spend more time there. This age group faces many significant challenges including HIV related ones. School settings offer an adequate environment for HIV and AIDS response if we want to reach a great proportion of children and young people in a sustained way.

Although Rwanda has scarce data on school absenteeism due to HIV, evidence from other countries in the region is a valid proxy. Experience shows that in generalized HIV epidemics children frequently drop out of schools to nurse sick relatives; this is the case especially for girls, which challenges the country's goal of increasing their school uptake and retention. As adults grow sick, children also have to leave school to take up income generating activities in urban areas or subsistence agriculture in rural areas. Reduced household income leads to reduced attendance at school due to inability to afford the costs involved. On the supply side, teachers' absenteeism increases with HIV.

Few actions in terms of HIV response are undertaken in several sectors including education, although there are prevailing needs of reinforcement of all HIV program pillars. As the education sector will be focused on in the 2010 National Paediatric Conference on children infected and affected by HIV and AIDS, it is of great importance to describe in details the sectoral challenges in the response to HIV.

iii. Main challenges facing the education sector in HIV

- ***HIV prevention.***

At primary/basic level, many children, girls and boys reaching puberty are experiencing adolescent's challenges. There is often lack of information and understanding about HIV and AIDS in terms of infection, prevention, care and treatment and this affects both pupils and teachers. About the prevention of HIV in school, the condom policy does not offer opportunity to student to access

condoms for HIV prevention. Despite the long discussion around condom in school, there is still no hope to provide a positive response.

Post-basic education provides particular challenges for boys and girls. For the teachers and non-teaching staff there is the challenge of dealing with HIV/AIDS in the workplace due to stigma, and most teachers do not know to handle the subject in the curriculum. In addition there is a lack of reliable statistics on HIV in school settings. Poor coordination and monitoring and evaluation at national and decentralized levels inhibit further progress in addressing HIV in schools.

- ***Protection of OVC***

The education of learners with special needs focused exclusively on learners with disabilities and, though this view has been pervasive, the current policy is to view all educationally vulnerable groups of learners such as orphans, street children, children infected with or affected by HIV/AIDS or children heading households - commonly referred to as OVCs - as learners with special needs. There are a number of Government policies and laws that cater for people with special needs including educationally vulnerable learners, most notably the national Constitution and the 2007-2011 Strategic Plan for Orphans and other Vulnerable Children developed by MIGEPROF. There is also a Special Needs Education (SNE) policy. Civil society is particularly active in this area and has supported the formation of clusters for SNE/OVCs organized around the child friendly school concept. But there remains a lack of common understanding about the categories of learners with special needs as often the focus has been on learners with physical disabilities when other groups including learners infected and affected by HIV also need tailored support.

- ***Strategic Priorities***

The major focus is to improve the general state of health of students in schools as regards to HIV and AIDS. One major priority is to mainstream HIV in educational policy, plans and curriculum. The school Health Policy integrating HIV, Nutrition and Hygiene and its operational plan as well as the school health package need to be completed and operational. HIV and AIDS response needs to be reinforced in school curriculum at all education levels with age appropriate and updated educative material. Also capacity building of teachers needs to be a priority. The mechanisms for monitoring and evaluation of HIV response is also a priority to enable the national and decentralized entities to be aware of the response and challenges in order to foresee the strategy to address those issues. Children infected or affected by AIDS need special attention in terms of psychological counseling, care and treatment and integration of them in the school society to avoid stigma and discrimination. Further ideas and expertise at national and global levels will be articulated in the technical sections of the conference report.

iv. Conference theme, purpose and expected results

- *Conference Theme:*

“EDPRS sectors’ response to HIV and AIDS-focus on the Education sector”

- *The conference purpose*

Understand the current status of mainstreaming HIV and AIDS in the EDPRS sectors and to provide an opportunity to reinforce the need to plan for HIV in the sectors.

- *Specific objectives*

- ✓ Review the status of HIV response within EDPRS sectors (Education, Agriculture, Justice, Infrastructure, Social Protection and Youth), highlighting gaps.
- ✓ Focusing on the education sector, propose concrete actions to address gaps to accelerate the response to HIV and AIDS;
- ✓ Formulate action-oriented recommendations for accelerating HIV response within EDPRS sectors (Education, Agriculture, Justice, Infrastructure, Social protection and Youth);

- *Expected Results*

Through a participatory approach involving all sectors defined in the EDPRS 2008-2012, HIV implementing partners, development actors, children, the expected results of the 2010 National Paediatric Conference on children infected and affected by HIV and AIDS are as follows.

- ✓ Reviewed the status of HIV response within EDPRS sectors (Education, agriculture, Justice, Infrastructure, Social Protection and Youth) highlighting gaps;
- ✓ Proposed concrete actions to address gaps to accelerate the response to HIV and AIDS, focusing on the education sector;
- ✓ Formulated action-oriented recommendations for accelerating HIV response within EDPRS sectors (Education, Agriculture, Justice, Infrastructure, Social Protection and Youth).

vii. Communication materials

The following communication materials were developed and produced for the conference:

- Banners
- Posters
- T-shirt
- Bag
- Wooden ruler
- Pencil
- Exercise book
- Abstract book
- Conference program booklet
- Award trophies

II. CONFERENCE PROCEEDINGS

Day 1: November 17th, 2010

1. OPENING SESSION

1.1. Introduction to the conference

By Dr Anita Asiimwe, Executive Secretary of CNLS

The Executive Secretary of CNLS, Dr. Anita Asiimwe, started by welcoming all participants and introducing them to the 6th Annual National Conference on Children Infected and Affected by HIV and AIDS. She acknowledged the presence of high level representatives of national and international institutions including the Minister of Education, the Minister of Health, the Permanent Secretary of MINEDUC, the WHO and UNICEF Country Representatives, international key note speakers, other delegates and all participants in general. Then she invited the Chairman of the CNLS board to welcome the participants.

1.2. Welcome and greeting message

By Reverend Rutaganda Desire, CNLS Board of Commissioners

In his speech, Reverend Rutaganda reminded the theme and objectives of the conference and insisted on the role of education in the fight against HIV. He pointed out that this conference is a vital platform for partners to exchange experience, develop a solid synergy and optimize the response to the fight against HIV in the Education Sector. Though, he recognized that there was still much to be done. He ended his remark saying that the conference should help participants to improve their own knowledge and bring their different inputs for reaching the ultimate objective of the conference.

1.3. Children's drama presentation

By Mashirika group.

Children trained by Mashirika performed a piece of drama to point out challenges of sexual education in the family setting. The drama showed that reproductive health and sexual education at a family level can prevent children from trusting ill intentioned peers, internet-based pornographic sites and other sources of information, and thus protect children against premature sexual relationships and other risky behaviors.

1.4. *Education Sector Responses to HIV and AIDS from global and regional response*

Presented by Mr Mathias Lansard, UNESCO

Mr. Mathias Lansard started his presentation by reminding that HIV is not merely a health problem but a crosscutting issue thus requiring a multi-sectoral approach. More importantly, he emphasized the importance of the Education sector in fighting HIV, given that prevention is more efficient when started at younger age (mostly school age), considering that the majority of the population is young and at school, and given that the education sector is often the largest single employer countrywide. This nature of school makes it the best setting for workplace HIV interventions.

Mr. Lansard presented EDUCAIDS, which is a UNESCO initiated framework for developing comprehensive education sector's responses to HIV and AIDS. He drew participants' attention to the limitations of the current HIV mainstreaming in Education, whereby HIV is often a diluted and not examinable school subject.

He invited all countries to rethink HIV mainstreaming and gave examples of good practices in Swaziland, Lesotho, Namibia and Kenya. In concluding, he recommended that HIV interventions be considered not as an "add on" in policies and strategies but instead as part of the core business of all sectors. For the education sector, he recommended that the EDUCAIDS framework be operationalized by the Ministry, adopting a holistic approach that promotes knowledge, skills and values, i.e. an approach that allows children to KNOW, to BE and to DO.

1.5. HIV Mainstreaming within the education sector: Process, achievements, challenges and lessons learnt – the Kenyan case

Presented by Mrs Grace Ngugi Maina, Kenya Institute of Education.

According to Mrs Maina, ages 0-19 are critical formative years for behavior and skills development in an individual. Therefore, young people need to graduate from school empowered with both intellectual and psychosocial competences to take charge of their own lives in a world beset by many challenges, especially by HIV and AIDS.

The presenter summarized the 18-year Kenyan experience in mainstreaming HIV and AIDS in the Education sector, and she concluded on the following recommendations:

- In order to mainstream HIV in Education, emphasis should be put on undertaking all steps expeditiously from surveys, monitoring, review and feedback.
- Paradigm should change from Transmission to Transformation in designing the curriculum
- HIV and AIDS should be an examinable school subject at national level
- Capacity building of teachers should be reinforced, TOTs organized for them at national and decentralized levels; teachers attending TOTs and orientation workshops should share information with fellow teachers at their schools
- Increase the use of PLHAs and indigenous resource persons
- More aggressive awareness campaigns especially in the rural areas should be increased
- Provide audio visual materials and mobile cinemas on HIV and AIDS
- Institutionalization of Life Skills Education into the school system as a standalone subject, experiential and based on the real life of students.

1.6. Children's drama presentation

By Mashirika group

The second presentation of Mashirika group was about discrimination of HIV infected children. The drama aimed at showing that an HIV infected young person can still go forth and achieve his or her dreams and be very useful to his/her community or society. This requires self determination and discipline. The show was followed by children's song entitled "Ni abacu", meaning "They [children infected and affected by HIV] are ours". The song asks us to support those children, not to abandon them and to respect their rights.

1.7. Remarks of development partners' representative

By Dr Joseph Foubi, Representative of UNICEF, Rwanda.

The Representative of UNICEF delivered a speech on behalf of Development Partners. He firstly congratulated CNLS, the Government of Rwanda and other partners for their work, and acknowledged that Rwanda can be taken as a model in the fight against AIDS in Africa. After acknowledging the presence of delegates from the East African Community and other parts of the world, Dr Foubi reminded the theme of the conference, rejoicing that it comes on time. He stressed the fact that youth are the most vulnerable to HIV, pointing out that 15000 children are infected every single day in the world.

Given the school enrollment rate which is about 95% in Rwanda, and given that around the 3rd of the Rwandan population is under 25 years of age, Dr Foubi believes that focus on education will offer the best opportunity to combat the HIV scourge in the country. He said to be optimistic in that regard, considering that partnership in the fight is stronger and broader, resources invested for children are considerable and the rollout of early infant diagnosis and treatment has been tremendously reinforced (e.g. Portion of children on ART increased ten-fold). He ended his speech by expressing his gratitude to all participants and wishing them a successful conference.

1.8. Opening Speech

By Honorable Dr Richard Sezibera, Minister of Health

On behalf of the Government of Rwanda, Honorable Dr Sezibera expressed his sincere gratitude to other Ministers participating in the conference. He admitted that the event was a wonderful initiative. He acknowledged participation of UN and bilateral partners and other international participants and also invited them to discover beauties of Rwanda.

After reminding some key figures showing that there is still a long way to go in fighting HIV and AIDS, the Minister of Health insisted on the need to focus on our youth and to reach them wherever they are, particularly in the Education sector, underlining that the success of our fight depends much on our education.

He expressed thanks to CNLS for choosing the appropriate theme of the conference, and he said he was confident that the conference will give us a momentum for implementing the EDPRS strategies, especially for fighting HIV among our youth and preparing an AIDS free generation. It was on those remarks that Honorable Dr Richard Sezibera declared open the 6th Annual National Conference on Children infected and affected by HIV and AIDS.

Day 2: November 18th, 2010

2. TECHNICAL SESSIONS

2.1. SESSION ONE: SYMPOSIUM ON EDPRS SECTORS RESPONSE TO HIV AND AIDS IN RWANDA

2.1.1. Part one: Results of the rapid assessment of 5 EDPRS sectors response to HIV and AIDS

Presented by Dr Anita Asimwe, CNLS Executive Secretary

Introduction

The session was based on the presentation of findings of an assessment conducted on 6 EDPRS sectors response to HIV and AIDS in Rwanda. These sectors are Agriculture, JRLO (Justice, Reconciliation, Law and Order), Infrastructure, Social Protection, Youth and Education.

The assessment was conducted in two parts: A rapid assessment for the first five sectors, examining the existence of policies, strategies, and action plans, and a special assessment for the Education Sector with deeper analysis of the HIV situation and response, from policy making to implementation.

Findings

Background

- HIV is a crosscutting issue in EDPRS, to be addressed by all sectors.
- HIV M&E Framework was developed for EDPRS sectors
- There is a person in Charge of HIV mainstreaming in EDPRS at CNLS
- There is also a staff in charge of supporting sectors in implementing HIV strategies.
- HIV Focal points are appointed in all Ministries and related agencies
- There are 2 HIV coordinators, one in MIFOTRA for the public sector and one in MINICOM for the private sector.
- HIV is integrated in the policies, strategic plans and/or work plans of some sectors.

Challenges:

- Some institutions still have insufficient understanding of the comparative advantage of HIV mainstreaming in their sectors.
- Some sectors do not participate in capacity building and planning sessions on HIV.
- High turnover of trained focal points.
- The coordination role of CNLS in HIV mainstreaming is not fully understood by some sectors.

- Some sectors are still lacking workplace HIV interventions, and the existing workplace interventions are not comprehensive.
- Insufficient allocation of resources to HIV activities in sectors' work plans.

Recommendations

a) Recommendations for sectors

AGRICULTURE:

- Follow-up of recommendations of the PLACE study on agriculture sites (DETAILS)

INFRASTRUCTURE

- Strengthen HIV prevention interventions focusing on their target population
- Expand HIV prevention intervention for transporters beyond knowledge room (e.g. VCT and care and treatment)

SOCIAL PROTECTION

- Ensure mainstreaming of HIV in the social protection strategy as it is being finalized.
- Finalize the OVC database to inform strategic planning and financial allocation

JUSTICE, RECONCILIATION, LAW & ORDER

- MINJUST to strengthen the legal framework for HIV prevention and protection.
- MININTER should reinforce the VCT services in TIG camps.

YOUTH

- The coordination of HIV prevention among the youth needs better clarity among stakeholders.

b) General recommendations

- Continuous high level advocacy for HIV mainstreaming in EDPRS non-health sectors and adequate resources allocation.
- Strengthening capacity within sectors to effectively mainstream HIV within sectors' policy, strategies and plans with appropriate indicators.
- CNLS should reinforce the work place response by proposing effective and innovative HIV mainstreaming strategies for public and private institutions.

Discussion points

After the presentation of the assessment findings, participants made comments and provided the following inputs related to their respective sectors and institutions.

- **Agriculture:** Fighting HIV in this sector is very crucial, given that Agriculture is the key Economic sector of our country. What we do is to provide crops that can enhance the nutritional status of the vulnerable.

- **Infrastructure:** We are happy to be involved in implementing HIV activities. We need to do more, not only in transport but also in other infrastructure sub-sectors. When we connect a center (to electricity), you can see that in a short time there is development around the infrastructure. We need to emphasize what we started, and do more to increase awareness even among our families. The Ministry of Infrastructure is committed to mainstreaming HIV in the sector.
- **Social protection/MINALOC:** VUP Umurenge targets the extremely poor. The ministry (MINALOC) is committed to sensitizing these vulnerable people against HIV and AIDS.
- **Social protection/MIGEPROF:** very much has been done in mainstreaming HIV and AIDS in the Social protection sector, especially in the policy and the strategic plan. We implement a project financed by Global Fund, targeting children infected and affected by HIV. In phase 1 from 2008 to 2010, 17,300 children were supported in 10 districts. In phase 2 from 2011 to 2013, MIGEPROF and GF will scale up the interventions to 30 districts to target 38,000 children in secondary schools (provision of school fees), 20,000 children in Primary school (provision of school materials), and we shall provide RWF 100,000 for IGA support to each out-of-school child support by our project. Also children in nursery schools are not forgotten as they will be selected for obtaining cows. The identification of our beneficiaries is already done and the database will be ready in February 2011. We will collaborate with the ID card project, CNLS and CHF/Higa ubeho.
- **Justice, Reconciliation, Law and Order (JRLO)/MINIJUST:** Discussions have been held on how to mainstream HIV in the sector; we have launched a strategic plan on Gender and HIV for 2010-2013 and we made sound recommendations to the Ministry of Justice. There is a draft penal law addressing AIDS issues. We are committed and we have a person in charge of Gender and HIV in the Ministry. We will collaborate with our JRLO secretariat to reinforce the response starting with the next year.
- **JRLO/Rwanda National Police:** HIV mainstreaming is very important in our sector. Our personnel are at high risk of HIV infection, given the environment in which we intervene. In National Police we do not discriminate recruits based on HIV status; and they can access all facilities and support. We do have many HIV programs: prevention, impact mitigation, treatment, and we recently adopted a new approach: fighting GBV in our One stop center, which produces tremendous results. Such centers are also established in Gishari and Huye. Nevertheless, we encounter some challenges in terms of funds; we are dynamic and able to efficiently combat HIV, and we are committed to reinforce the fight against HIV in the National Police.
- **JRLO/Rwanda Correctional Services:** there is a committee in charge of fighting HIV in prisons, and there are 12 prisons where inmates are tested for HIV and get ART. 1079

inmates are under ART, and 2902 are on Cotrimoxazole treatment. We recognize that there is still a big gap of VCT services in TIG camps, but we are carrying out a mapping to know how much beneficiaries we have in those camps. The only HIV service currently provided to “Tigists” is to refer them to the nearest Health Facility for obtaining an appropriate service.

- **Youth sector:** MINITYOUTH is in charge of coordinating HIV Prevention at national level. There is a stakeholder forum which discusses various issues including HIV. Our policy is being updated and will focus on HIV. We collaborate with CNLS; we have a youth mainstreaming program and a strategic plan for HIV (not only prevention). However, there is lack of capacity at district level for coordinating HIV interventions. Also the alliance to fight AIDS among youth needs revival. Despite those challenges, we are going to work hard for reinforcing HIV prevention.

2.1.2. Part two: Results of the assessment of the Education sector’s response

Presented by Dr Anita Asimwe, Executive Secretary of CNLS

Background:

HIV Mainstreaming in Education is justified by the following facts:

- Considerable size of the young population under 25 years: 67% (census 2002)
- HIV Knowledge gap and high vulnerability in youth.
- Most youth are at school
- High prevalence of HIV among teachers.

Findings

- HIV/AIDS is addressed by Vision 2020 as a major economic challenge potentially impeding productivity; also the strategy addresses comprehensive human resources development, encompassing education, health, ICT skills as one of its pillars.
- In EDPRS, HIV/AIDS is a cross-cutting issue calling for a multi-sectoral response. The Education Sector is considered as well-placed to reduce transmission of HIV among children (12-18 years).
- The Education policy recognizes achievements and makes specific recommendations for fighting HIV and AIDS
- The Education Sector Strategic Plan also calls for integration of school health issues into the curriculum and distribution of materials;
- Also HIV is included in some curricula and in anti-AIDS clubs’ activities

Challenges

The following policy provisions and recommendations are not yet implemented:

- AIDS workplace program for all Education Sector staff
- Integration of a National AIDS and reproductive health curriculum in education hierarchy

- Development of a school health policy and guide (still a draft)
- HIV/AIDS related text books and teaching materials
- Training activities organized for teachers by the central level dwindled since 2006
- Coordination mechanism of NGOs interventions;
- Creation of an M&E HIV/AIDS system in the education sector.

Other challenges:

- Insufficient time and focus for HIV in school syllabuses
- HIV/AIDS is not part of the examinable part of the curriculum
- Low comfort level of teachers to address HIV/AIDS
- Lack of reference material (text books, other teaching material)
- Anti-AIDS clubs activities are isolated and unmonitored and lack standards
- Use of condoms is strictly prohibited yet students reported sexual activity.
- Stigma and discrimination
- Higher learning institutions, especially private ones, without HIV or health interventions

Recommendations

Central level

- Empower and define the role of national level capacity (HIV/AIDS Advisor), prioritizing coordination, management and system development roles.
- Ensure access to technical support on issues beyond the capacity or expertise of full-time staff of the Ministry of Education.
- Develop capacity at district and school levels beyond basic HIV/AIDS awareness and knowledge to program planning and management.
- Integrate HIV coordination within the Education SWAP
- Ensure appropriate allocation of resources and funding to HIV/AIDS in the education sector.
- Establish legal provision protecting young students from sexual violation (sugar daddies and mummies) and involve parent and communities in preventing students from indulging with sugar daddies and mummies
- Define or provide clear guideline of the minimum service package to be offered by different levels of the academic hierarchy;
- Diversify and disseminate HIV/AIDS related information materials for schools. Use radio, TV or videos in addition to print materials
- Finalize, adopt and disseminate the school health policy, and school health guide, implement a nationwide training program on it.
- Address system management issues to ensure effective implementation through improved planning, monitoring and evaluation
- Work with CNLS and other stakeholders to develop age appropriate teaching material on HIV.
- Conduct an assessment to determine condom need in older secondary school students.

High learning institutions

- Advocacy with institutional leadership.

- Integrate HIV/AIDS prevention and care in research agendas of institutions to generate knowledge and evidence for informed planning.
- Plans and programs in all institutions for supportive environment for infected lecturers and students.

District and school level

- Targeting. Prioritize programs in schools targeting higher risk (for instance, engage students to discuss sugar daddy/mummy)
- Strengthen Anti-AIDS clubs and peer education by providing materials, guidelines, training and support of facilitators
- Develop capacity of the district level to implement HIV/AIDS responses:
- Developing formal local, district and national networks with partners who can be a resource to schools (eg NGOs, health services)
- Training of District mentors (e.g. District Education Officers) who can then support roll-out acquired skills to each school.
- Address needs of infected and sick children in schools, provide guidance on HIV counseling and testing programs (for instance through mobile VCT).
- Promote interventions targeted at establishing safer school and home environments to mitigate sugar daddy phenomenon
 - Oversight by parents and communities
 - Empowering girls to realize their potential
 - Sensitize lodge/hotel and bar owners to put in place measures to deter the practice in their facilities

2.1.3. Discussion points

- The fight against HIV is multisectoral and needs a holistic approach. We need another conference fully on Mainstreaming HIV in Education.
- In-school HIV infected children have a lot of problems to be addressed: long travel, lack of appropriate diet for those under ART, physical weakness preventing them from sitting for exams, stigma (children stops taking drugs to avoid stigma), etc. These children need special care, treatment and support.
- HIV is an area that we keep very private; we do not speak out about it; the Ministry of Education makes what is necessary to provide a good education system (coordination at district level, teacher training, etc), but children and educators should help in providing enough information to the Ministry so that necessary decisions can be taken. Such a decision can be, for instance, placing HIV infected children in nearest schools.
- School children need to be informed about family planning, but no decision is yet made on distributing FP products to children in schools.
- Concerning what is done to support OVCs, a participant from MIGEPROF explained that they liaise with authorities of OVC centers to know the needs of these children throughout the

country and to support them according to their needs. Regarding cooperatives, when OVCs are living in MIGEPROF supported centers, the Ministry advocates for their integration in normal life (at district level) and in relevant cooperatives; in that regard, OVCs obtain materials and tools according to their vocational area (carpentry, masonry, hairdressing, etc.); that support will be reinforced with the next Global Fund financing.

- As a Civil Society Organization, UPHLS identifies specific needs of children with disabilities (according to the type of handicap); these children are integrated in the strategic plan aligned to the HIV NSP and current services provided to them consist mainly of HIV/AIDS information, as they mostly need education; there are more than 32 special schools for children with mental disabilities, and 30 for other types of handicap. Educational materials are adapted to their special needs. When they become adults, that's when they can be supported to join cooperatives.
- According to the Ministry of Education, HIV interventions are not yet enough but will be considerably reinforced in the next 5 years. HIV education will be extended to all schools and to parents as well.
- Concerning which strategies to be used for sensitizing farmers on HIV Prevention, the representative of MINAGRI explained that IEC materials prepared by CNLS will be used in farmers' gatherings; there is also a weekly radio show that can be used to deliver HIV related messages; it was also reminded that farmers are grouped into cooperatives that can be used to reach them with HIV messages and services. As HIV is a crosscutting issue, it will be included in the next action plan; children are then encouraged to discuss HIV issues with their parents most of which are farmers.
- About male circumcision, the Executive Secretary of CNLS reminded that it is not enough as a preventive method; she advised people to use condom even when they are circumcised, and remark that circumcision is easier and cheaper when done for younger boys.

2.2. SESSION TWO: HIV PREVENTION AMONG YOUTH AND ADOLESCENTS

2.2.1. Global situation of the reproductive Health and Sexual Education targeting youth and adolescents

Presenter: Pierre Robert, UNICEF HQ

Moderator: Amadou Seck, UNICEF Rwanda

Introduction:

The presenter started by showing that a considerable number of young people are living with HIV (about 4.9 millions in 2008) in developing countries, and he justified the need for sexual education by the fact that there have been significant declines in HIV prevalence in 22 African countries probably due to increased efforts in sexual education and Behavior Change Communication that promoted increased condom use, reduced number of sexual partners and delayed sexual debut. He also underlined that many young people approach adulthood faced with conflicting and confusing messages about sexuality and gender, thus requiring more reliable information.

Findings

Mr Pierre Robert presented some facts from research to support the importance of sexual education among youth and adolescents:

- Comprehensive sex education and HIV/STI prevention programs do not increase rates of sexual initiation, do not lower the age at which youth initiate sex, and do not increase the frequency of sex or the number of sex partners among sexually active youth.
- Sex education and HIV/AIDS education interventions in developing countries proved to significantly influence delayed sex, decreased the number of sexual partners, increased the use of condoms or contraceptives, or reduced the incidence of unprotected sex.
- Sexuality education programs do not increase sexual activity.

Then the presenter explained the consequences of not knowing, namely early pregnancies, violence and dangerous relationships, inadequate preparation of adulthood and HIV infections.

Challenges

The biggest challenges are linked with the sensitivity of sexual education among youth, conspiracy of silence and embarrassment of parents and educators, insufficient understanding of the role of parents, educators and religious leaders, etc.

Recommendations

- Education can be an answer to HIV and Reproductive health by providing awareness and skill development through age-appropriate and accurate sexuality education. The return on the investment of sound sexuality education will have countless returns in all sectors.
- Evidence based approaches should be used to ensure that programs are effective: they should delay sexual debut, decrease number of sexual partners, increase use of condoms and reduce unprotected sex among youth
- The Education sector should partner with health sector to increase youth's access to SRH services.
- Overcoming the sensitivities around sexual education requires science, evidence and mostly COURAGE.

2.2.2. Situation of Reproductive Health and Sexual Education targeting adolescents and youth in Rwanda

Presenter: Dr Bayingana, MEDISAR

Background

The Rwandan youth is under the mandate of the Ministry of Youth (MINIYOUTH) as a policy making institution and of the National Youth Council as an implementing partner. The latter has structures from central level up to cell level. The following facts were also noted:

- Rwanda's population is young: 2/3 of Rwandan population is under 25 years old
- The Rwandan youth is dominated by adolescents aged 14-19 years whose proportion is estimated at 31.9%.
- The HIV prevalence rate among youth aged 15-24 in Rwanda was reported to be 1.0% (DHS 2005) in comparison to the 3% of the whole country.
- Only 5% of boys and 7% of girls aged 15-19 years had ever had an HIV test,
- 5% of girls and 15% of boys aged 15-19 years have sex before the age of 15, and almost 30% of youth have sex for the first time before age 18. Sex debut was reported to be 11 years old among youth aged 15-18 years (DHS 2005).
- Only 12% of boys and 7% of girls used a condom at first sex (DHS 2005).
- Young girls aged 15-24 are 3.8 times more likely to be HIV+ than boys (DHS 2005)

- HIV Prevention interventions (including condoms) are reaching youth through youth friendly centers, peer education trainings, mass media campaigns, Abajene! youth radio program, community events

Challenges

- Little number of youth friendly centers offering VCT services,
- Health facilities without youth friendly services,
- Little number of operational anti-AIDS clubs,
- Anti-aids clubs need technical and financial support,
- No linking between youth friendly centers, schools and health facilities,
- Weak child-parent communication around sexual and reproductive health.

Recommendations

- Increase the number of VCT and Sexual and Reproductive health services,
- Health facilities should offer VCT, Sexual and Reproductive health services in a youth friendly way,
- Establish new and strengthen existing Anti-AIDS clubs.
- Strengthen the linkage between youth friendly centers, Health Facilities and schools.
- Promote child-parent communication about sexual and reproductive health.

2.2.3. Sexual Behavior and free condom distribution at the NUR

Presented by Janvier Mungarulire, CNLS

Context

The National University of Rwanda set up an anti-AIDS club called “University League for AIDS Control (LUCS)”. The latter has as principal mission to stop the progression of HIV/AIDS among NUR students and staff and in the general population, and to coordinate research in the field of HIV/AIDS; to fulfill that mission, strategies have been adopted:

- Sensitization of the university community
- Distribution of free of charge condoms to students

Concerning the free distribution of condoms to students, LUCS installed distribution boxes in all toilets, labeled « Use condom ». Unfortunately LUCS does not have auto-evaluation system to know how those condoms are used and which impact is produced.

A study was then conducted in order to evaluate the level of NUR students' knowledge on HIV transmission and identify factors of condom at NUR.

Findings

- It appears that 46.4% of students have had unprotected sexual intercourse at least once;
- The condom has been used by 48.2% of all respondents among whom 25.4% have used it 1-5 times, whereas 53.8% have not used condom during the 6 months preceding the study.
- Almost half of interviewed students have had a feeling of satisfaction when LUCS installed condom boxes in the toilets of the university campus while others had feelings of resistance or indifference, respectively 20.5% and 30.0% of the respondents. The satisfaction of these students has also been expressed in relation to the quantity of condoms and location of the boxes (61.4% and 59.9%).
- In general, unprotected sexual intercourse is still an important problem among NUR students and it is highly correlated with the ignorance about HIV transmission and insufficient information about LUCS and its services.

Recommendations

- Necessity of preparing appropriate messages comprising all preventive methods against HIV, in order to offer to NUR students several choices/options.
- The activities of LUCS should be further supported and reinforced as they have a significant contribution to the adoption of safe sexual behavior. They should also be expanded to other universities in Rwanda.

2.2.4. HIV and sexual education equally imperative in under 7 years

Dr Rutaramana Bayingana, UNR

Introduction

This survey was conducted in 8 secondary schools of Huye and Gisagara Districts, aiming at establishing sexual background and HIV/AIDS knowledge of students that would participate in HIV and Sexual Education trainings, organized by the National University of Rwanda.

Findings

The results of the study showed that 42.5% of males and 79.7% of boys had never had any sexual intercourse. Concerning their age, 17.5% of males and 7.6% of females (14.9% for both) declared to have had sex before 7 years of age. None of them was able to use a condom or could suspect the risk of HIV.

Recommendations

- Further studies with a wider sample should be conducted to confirm the findings.
- Studies on parents' perceptions concerning open discussion with their children on sexuality can be of an advantage so as to adequately deal with our cultural norms about sexuality.
- Stronger and harsher penalties should be enacted by GOR to punish adults who have sex with minors (protect against cross generational sex)
- Sexual and reproductive health education should begin in primary school and through village based projects to educate youth about the importance of abstinence for a bright future

2.2.5. Integration of HIV in pre-nuptial education,

Presented by Father Jean Robert Bayingana, Director of CARITAS Cyangugu

Introduction

Father Bayingana presented an approach used by CARITAS in 2 districts (Rusizi, Nyamasheke) to fight HIV among couples:

- Organization of a TOT and monthly training sessions for 378 pre-nuptial young couples to educate about SRH, VCT, PMTCT, FP (training priests and lay people in charge of preparing young couples for marriage, and community peer educators)
- Collaboration with health service providers for delivering VCT, PMTCT and follow-up services to couples before marriage

Observations

After the intervention, all couples accepted to have VCT together, and couples testing increased in health facilities. It was noticed that educating young couples before marriage contributes to the reinforcement of HIV prevention among families through:

- HIV Prevention for the couple and children to be born
- Improvement of living conditions of the family in general and of children in particular.

Recommendations

- High quality prenuptial education programs increase uptake of needed health services (e.g. VCT, PMTCT) and therefore should be expanded and supported
- Young couples should be encouraged to go for VCT together before marriage, and be faithful to one another in marriage
- Promote parent child communication about SRH

2.2.6. Discussion points

- At the National University of Rwanda, condom dispensers should be put in more descent places instead of toilets in which hygiene is not guaranteed.
- Asked whether students get any kind of education on sexual and reproductive health at NUR, the presenter's answer was that the university organizes a training session on HIV Prevention and Reproductive Health for new comers at the beginning of the year.

- Concerning the study on Sexual education for the Under 7, participants wanted to know whether interviewed children had the same definition of “sexual encounter” and whether they were developed enough to answer to the survey questions. The presenter answered that these children were asked to recall when they had their first sexual encounter. They were older than 12 years and in secondary school. They were interviewed in a school environment, selected by teachers responsible of anti-AIDS clubs with the ascent of Directors of Education of their district. However, given that such sexual encounter could be occasioned by sexual violence and pedophilia, the study could not confirm that there was a true sexual intercourse; and considering that these children were too young, the CNLS Executive Secretary reminded that the survey should have sought parents’ consent and approval of the national ethic committee.

2.3. SESSION THREE: PROTECTION OF OVCs

Theme: “Protection of children infected and/or affected by HIV and AIDS. The role of Education Sector”

Moderator: Francesca Morandini, UNICEF Rwanda

2.3.1. Protection of Children Infected and/or Affected by HIV and AIDS: the Role of the Education Sector.

Presented by Sera Kariuki, UNICEF-ESARO

Introduction

HIV impacts on Education in various ways: Lower enrolment and attendance, absenteeism (due to illness, other obligations, lack of interest, etc.), poor concentration, hunger, lower achievement, etc.

Other consequences of HIV are increased poverty because of HIV and AIDS, taking on household and care giving duties, stigma and discrimination due to association with someone living with HIV or died from AIDS, psychological trauma (leading to poor self image), susceptibility to peer pressure, abuse, HIV infection, etc. A study was conducted at Makerere University to identify special needs of HIV Positive adolescents in school.

Findings

The study identified the following special needs of HIV positive adolescents in schools:

- Lack of adequate material support for schooling
- Lack of proper mechanisms for health care in schools
- Lack of training in HIV care and support for caregivers
- Non disclosure of HIV status in school – impediment for appropriate and timely support – a real dilemma!
- Lack of support groups/clubs or services in school
- Discrimination, stigma and physical abuse
- Special concern – HIV+ learners in boarding schools

Recommendations

To respond to learners' needs:

- Keep learners in school
- Provide Life skills and HIV Prevention education for all
- Initiate targeted interventions for young girls and mothers
- OVC - impact mitigation (Social grants – for fees, uniform and other school requisites, Free schooling, School feeding schemes, Referral to services, Psychosocial support for affected and infected learners, Flexible timetables for Young Carers, Support for HIV+ learners, including adolescents).

Also teachers' needs should be addressed:

- Strengthen HIV and AIDS-related awareness, knowledge and practice (Improve teacher training for Life skills, HIV prevention, care and support of learners and referral mechanisms, provide appropriate instructional materials)
- Preparedness, willingness & readiness to teach ('Cultural cost' of teaching sensitive topics, Teachers' difficulties in dealing with sexuality issues, OVC issues, Overloaded curriculum, Life skills/HIV prevention as non compulsory, non examinable, etc.)
- Access to VCT, prevention, treatment & care services (workplace programs, address stigma and discrimination, etc.)

2.3.2. Protection of children infected and/or affected by HIV and AIDS. The role of Education Sector

By Janinah Gasana, MINEDUC/Rwanda

Introduction

The presenter started with the observation that "Education remains a social vaccine and first line defense to HIV prevention due its capacity to reduce the risk of HIV infection". Then she proposed a definition of "Orphan" and "Vulnerable children" according to the Rwandan OVC Policy.

- Orphan: "a child who has lost one or both parents"
- Vulnerable children: "children under 18 years exposed to conditions that do not permit fulfillment of fundamental rights for their harmonious development".

There are not enough data about Rwanda's OVCs, but the root causes of the OVC problem for Rwanda are known: HIV, conflict, poverty and genocide.

OVC situation and achievements

- Ministry of Gender and Family Promotions plans to carry out OVC identification and establish a database by December 2010.
- PMTCT in Rwanda has been successful : Only 2.7% of children born to HIV + mothers get infected (TRAC+ Data)
- Pediatric care is widely accessible: 72% of children who need ART access it (TRAC+ Data)
- ARV accessibility implies an increase in the number of HIV positive school-age children passing through the education system

The Education Sectors' role in OVC Protection:

- The education sector has opted for HIV/AIDS mainstreaming which ensures that HIV/AIDS is not an add-on or separate activity but an integral part of education sector policies, strategies and actions. More efforts are needed to: finalization of the school health policy, curricula development, teacher training, and integration of HIV issues in the Education monitoring and evaluation system.
- Advances are being made in pedagogy to adapt health, nutrition, family life education, children's developmental stages, as well as addressing future sexual and family issues of children living with HIV.
- Nutrition support: The school feeding program is put in place to enhance adherence to ARVs for OVC

Recommendations

- Zero tolerance of stigma and discrimination in school
- Nutrition support to be strengthened for HIV infected and affected children
- Strategies to be put in place for facilitating medical care of HIV infected school children
- Zero tolerance for child abuse
- Promote life skills education

Discussion

The following questions and remarks were made by children participating in the conference:

- School children infected by HIV need comprehensive care and support, not only material support.
- HIV infected children should be authorized to take ARVs in head master's office to avoid stigma.
- Support provided by CNLS and other NGOs is not always well utilized by leaders.
- There is a serious issue of parents who do not tell their children that they are infected (they give them drugs without explanation)
- There should be a forum from village to district level through which HIV infected and affected children can be provided with care and support.
- Is there any solution envisaged for HIV infected orphans without homes?
- What are measures put in place for children with disabilities?
- Will the Ministry of Education provide condoms to school children for HIV prevention?
- How will MoE ensure confidentiality of children's HIV status in school?
- Health practitioners should adapt their messages on RH for HIV+ youth; youth should be given more possibilities so that they can make an informed choice.
- Some kinyarwanda terms meaning "people infected by HIV" are not appropriate; We should not say "abantu babana n'ubwandu" but "abantu babana na virusi itera SIDA" because "ubwandu" conveys a meaning of "dirt"!
- What strategies are there for young CSW? They are increasing and some of them say they cannot find school fees if they leave prostitution.

The following are answers and comments provided by participants:

- For fighting discrimination, there are anti-AIDS clubs in schools although they need more strengthening. With the new School Health Policy, curricula will also be improved and teachers will be trained to handle stigma issues in the school environment; this will lead to improved attitudes and minimized stigma; that environment will be supportive for children taking ARVs at school. MoE has a plan to include RH in school curricula, whereby life skills will be emphasized.

- Regarding confidentiality, school nurses will be put in place and trained for providing psycho-social support, including fighting stigma and discrimination of infected children.
- Concerning school feeding, we cannot discriminate HIV+ children. They take the same diet as other school children.
- For condom distribution, it is OK in higher learning institutions, but the issue is under discussion for secondary and primary education.
- Regarding comprehensive support to OVCs, MIGEPROF is making advocacy and has developed a guide for service providers to give a comprehensive support to children, and it has started. Also IGA support is provided to their families (10 districts are already supported).
- Concerning CSWs and other vulnerable women, MIGEPROF and Kigali City have a program which is being implemented for them. The policy of MoE (Young Girl promotion) is in place and has the mission to reduce drop-outs and poverty among young girls. VUP helps the most poor and vulnerable families; MIGEPROF has also a project to support about 60,000 children and to give cows to 100 poorest families ; there is UBUDEHE program and other projects in MINAGRI all put in place to provide financial support to children among other vulnerable people.

Other recommendations from participants:

- MoE should ensure that infected children who miss class and exam due to illness can be allowed to pursue their studies
- Multisectoral collaboration needs strengthening in order to offer comprehensive support to OVCs.

2.3.3. Life skills and resilience among vulnerable youth: lessons from the 2010 USAID/Higa Ubeho holiday camps

Presented by Jane Mutoni, CHF International/Rwanda

Introduction

CHF International, with financial support from USAID - Higa Ubeho project, organized holiday camps for OVCs during the last holidays of 2010. Preparations consisted of developing a toolkit and a workbook and orienting partners and Community Volunteers (Abahuza) for facilitating the camp activities.

The objectives of the holiday camps were to help OVCs to:

- Develop personal plan for their future.
- Increase ability to assess personal strengths & abilities.
- Enhance their ability to work with others.
- Increase awareness of their personal resilience to deal with challenges.

Conducted activities

- Served over 12,000 secondary school youth
- 19 holiday camps
- Conducted M&E of the camps by conducting 18 site visits, 2 focus groups, using 696 questionnaires and letters from Abahizi

Conclusion

Through the holiday camps, OVCs discovered and recognized the following:

- Setting objectives does not require age or any specialty in life but everyone at all ages and at any time is called to set objectives for his or her life.
- The camp helped them to have another vision and to know that they can do things to help society to achieve development.
- They felt trusted and their opinions appreciated.

2.3.4. Inventory of OVC services and referral network in Musanze

Presented by Eugene Rusanganwa, CARE International/Rwanda

Introduction:

- Despite the high number of providers covering a variety of services, the most vulnerable children do not get all the services they need;
- Perhaps because providers lack capacity to target more OVC, services are not located in areas of highest need, and/or coordination of OVC services need improvement; and
- Such mapping data can help make the referral process more efficient and the geographical distribution of services coordinated for a full package of services and avoid duplication.

Recommendations:

- MUSANZE District should regularly update the database and share all information with service providers; and
- In collaboration with service providers, Musanze District should take into consideration the gaps in referral opportunities while dispatching service providers.
- Service providers should reserve room for referrals and/or have a waiting list; and
- All partners working in the OVC area at the national level should see how the referral system and networks can be created and harmonized in order to respond to all needs of the most vulnerable orphans and other children.

2.3.5. Isange One Stop Centers –How to apply a multidisciplinary approach in fighting child, domestic and gender based violence

Presented by Maj Fagerlund, UNICEF/Rwanda

Introduction

The One Stop Centre model is a comprehensive multi-disciplinary response to child, domestic and gender based violence (CDGBV), intended to complement national efforts in responding to violence. The one stop centers in Rwanda are called “Isange”, which means feel free/feel welcome. Objectives of the centers include: i) increased percentage of those seeking services per cases of violence ii) increased percentage of convictions and iii) improved resilience among survivor and families

Achievements

Two Isange centers have been set up so far, one in Kacyiru Police Hospital (Kigali) and one in Gihundwe Hospital (Rusizi District).

The center is meant to:

- be a specialized free-of-charge referral centre located in a public hospital, where medical care; psychosocial support; police and legal support, including collection of legal evidence, is available.
- work closely with hospitals and health centers providing them training on care for survivors and supervision.

Challenges

- Survivors of violence require a multitude of services, however, interventions are often characterized by sensitization, training and workshop activities without long term vision or strategic intent.
- Long distances, inability to pay for transport, legal and medical support, stigmatization and blame lead to a high drop-out or no care for survivors.
- Without proper care the survivor risks sustaining permanent injuries, sexually transmitted infections (STI) including HIV, as well as deepening the trauma of the violence.
- Insufficient capacities to collect evidence and conduct interviews with survivors also lead to low conviction rates and can expose the survivor to further violence and trauma.

Recommendations

- Ensure a clear model and strategic plan for scale-up of One Stop Centers in Rwanda including strategic visions clarifying the role of all involved service providers.
- Link community initiatives to prevent and respond to violence and to protect survivors of violence with the One Stop Centre model.

2.3.6. Discussion points

- To reach the objectives of the holiday camp, different activities are done; the program uses a tree of hope: done in groups of 20-30 children, the latter write down their dreams on a leaf and hang it on the tree. Then the facilitators analyze them, asking children what will help them to become what they want. Children have to explain their short term, mid-term and long term plans for reaching their dreams.

- CARE in Musanze created a database of all providers and transferred it to the district authorities. They were asked why they didn't do it jointly for the sake of ownership and sustainability. To answer this question, the presenter explained that CARE collaborated with the district at the beginning of the survey; they started with their existing information and agreed to conduct the survey, shared the draft with the district authorities who approved it; then they organized a dissemination meeting chaired by the district authorities. The district bought in those tools. Partners' views were also taken into consideration.
- The authorities of Musanze district were asked how they collaborate with partners, and Musanze mayor answered as follows: "We asked CARE to make a database; they did it and submitted it to the JAF. We wish that all districts could do the same". A participant from MIGEPROF noted that their Ministry is planning the same mapping for the national level.
- Worries about health care providers discouraging PLHAs from having children, or from having sex, etc. We cannot deny them basic rights; we need to give them information on how to enjoy life in safer way and not to infect children.
- A participant from Rusizi pointed out that the "Isange" One Stop center in Gihundwe lacks social services. Sometimes the causes of violence are not addressed. There is a need of a comprehensive package of services for violence survivors.
- Discriminative language used by care professionals: this issue was always raised on different occasions; there are resources of UNAIDS and UNESCO indicating what not to say for avoiding discrimination. Try to translate those terms in Kinyarwanda in an appropriate way.
- RRP+ has made tremendous efforts to sensitize people on HIV, with structures from District to Sector level. Those infected should dare to reveal their status so that they can get support and also contribute to prevention. Concerning nutrition, CNLS is asked to provide support to PLHAs cooperatives by putting in place a mortgage system.
- School feeding: the government is recommending to families to contribute part of their harvest to the school feeding program; this will allow Rwandans to manage their own problems without waiting for external donor support.

DAY 3: November 19th, 2010

2.4. SESSION FOUR: PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV

Theme : « Collaboration between health and education sectors towards elimination of MTCT focusing on young people at reproductive age »

Moderator : Dr Felix Ndagije, CDC Rwanda

2.4.1. Global Situation- « Comprehensive PMTCT can eliminate children AIDS»

By Dr Mary Pat KIEFFER, EGPAF Regional Office

Introduction

PMTCT uses the 4 prongs approach: Primary prevention among young HIV negative girls at reproductive age; Family planning (prevention of pregnancies) for HIV + women ; Reducing MTCT (with drugs, safe infant feeding) among pregnant HIV+ women and Prevention of Paediatric AIDS through Early Infant Diagnosis and Treatment (EIDT).

Findings

- According to research conducted in US, Europe, Thailand and Africa between 1994 and 2009, MTCT is preventable.
- Poor coverage leads to many missed opportunities: missing children.
- MCH service gap leads to high maternal deaths: 19% by HIV and 15% by pregnancy and childbearing complications among 19-45 years old women.
- Comprehensive PMTCT is done along the 4 prongs
- Involvement of men in all 4 prongs is important
- Care providers are sometimes confused by changing guidelines and related messages (promoting BF among HIV+ women)

Recommendations

Virtual elimination of pediatric HIV can only occur on a platform of strong MCH service delivery.

- 100% facility coverage: HIV services must be an integral part of all ANC and maternity services
- All staff trained, mentored and supervised in delivery of comprehensive PMTCT
- All four prongs must be addressed as comprehensive service package
- Political commitment to women and children's health and community engagement

2.4.2. Rwandan situation - « The 4 pillars of PMTCT in Rwanda- Achievements, Challenges, Perspectives and... »

By Dr Nadine Shema, TRAC+, Rwanda.

Introduction

- MTCT is the second commonest way of HIV spread in Rwanda (EPP 2009), with a rate of 4.1% in 2010 (PMTCT midterm review).
- The PMTCT program in Rwanda started in 1999 in Kicukiro Health center (pilot project), with a therapy based on Sdv-NVP regimen.
- A lot of progress has been made since then, in all prongs: family testing is systematic,
- Rwanda recommended 18 months for BF (for HIV+?)

Challenges:

- Reported early sexual debut 12.1% girls and 1.4% boys had their first sexual intercourse with a partner more than 10yrs older.
- Still, 74% of pregnant HIV+ women had unintended pregnancy;
- Late attendance of HIV infected women to ANC
- Home deliveries still high.

Recommendations:

- More efforts in pillar one and two are needed to avoid new HIV infections in child bearing age and in new-born
- Improve evidence based HIV prevention for youth/young women. Monitor HIV incidence!

- Improve PMTCT training curricula need to address all four PMTCT pillars as should monitoring and evaluation programs reviewing PMTCT services
- Strengthen integration of FP services into HIV Programs; Investments to expand FP services for all sexually active persons, and esp. PLWHA who need these services
- Community involvement to improve facility deliveries, early ANC, adequate number of ANC, Male involvement in FP services

2.4.3. PMTCT Prong one: uptake of HIV testing among youth attending VCT program

By Dr Placidie Mugwaneza, TRAC Plus

Introduction

- HIV prevalence increases with age
- The prevalence is highest in women in age group 15-25 compared to men
- HIV prevalence sex ratio (F/M): 3.6/2.3
- MTCT can be virtually eliminated through a four- prong strategy

Achievements

- In Rwanda, an increasing proportion of children and adolescent less than 18 years old and youth aged 18-25 years old attend VCT services,
- The prevalence in this population has decreased between 2005 and 2009.
- This is due to results of the National efforts to reduce the spread of HIV in youth and adolescents in Rwanda.
- From 2005 up to 2009: 4,141,990 HIV testing was performed :
 - **778,321** (18.8%) were children < 18 years old;
 - **1,395,781** (33.7%) were youth aged 18-25 years old
 - **1,967,888** (47.5%) were people > 25 years old.

Recommendation

- Continued efforts should be put in place to further reduce new infections among young people, and young girls in particular if the goals of virtual elimination of MTCT are to be met by 2012.

2.4.4. Towards Universal access to PMTCT services leading to elimination of MTCT in Rwanda,

By Dr Jean Pierre Nyemazi, TRAC Plus

Introduction

PMTCT related activities in Rwanda began in 1999 with a piloting phase in Kicukiro HC.

The goals set up by EDPRS (2008-2012) and the NSP (2009-2012) for PMTCT are the following:

- Achieve 100% PMTCT services coverage
- 90% pregnant women access to ARV prophylaxis
- Reduce MTCT to 2%

Achievements

Dr Nyemazi presented the results of the mid-term review of PMTCT in Rwanda, carried out in May 2010 by TRAC Plus and CNLS. The following are achievements attained at national level.

- HF providing comprehensive PMTCT services increased from 53 (2003) to 373 (2009) which represents 74% PMTCT coverage of total HF in Rwanda
- In Rwanda, 96% of pregnant women attend ANC services at least once,
- 97% of pregnant women attended PMTCT, got tested & received HIV results.
- Increase of partners tested from 32.6% (2005) to 84% (2009)
- HIV prevalence (among tested children) in PMTCT is 2.7%
- In 2009, of the expected HIV infected pregnant mothers, 78% received ARV prophylaxis for PMTCT, with 6% increase compared to 72% in 2007
- Increase in use of strong and most effective ARV combination in PMTCT
- Only 52% of deliveries are supervised by skilled health worker
- HIV infected women reported to give birth in HF more than non infected women
- Of the expected HIV exposed infants, 64.3% received ARV prophylaxis
- EID was 54.5%
- MTCT dropped from 10.4% (2007) to 4.1% at 18 months of age in 2009.

Recommendations

- Develop interventions that encourage expectant mothers to attend 4 ANC visits and to deliver within the HF
- Recruitment, training and retention of health workers
- Strengthen referral system
- Strengthen community involvement in PMTCT activities
- Further expand PMTCT services to all ANC sites
- Reduce long turnaround time of laboratory test results (ELISA, CD4, PCR DNA) for samples taken to district or NRL
- Mobilize and provide more financial resources to operationalize the revised PMTCT policy

2.4.5. PCR Module, an electronic solution to deliver results to Health Facilities in a timely manner via TRACnet system

By Dr John Rusine, National Reference Laboratory

Introduction

- The Pilot phase of EID program in RWANDA took place in 2005-2006:
- Scale-up phase: from 2006-today:
- Pilot sites increased from 3 in 2006 to 399 health centers collecting DBS samples in 2010
- There is 1 laboratory performing PCR test in Rwanda (the NRL)
- DBS is done for children from 6 weeks; the first visit takes place between 6 weeks and 9 months ; Clinical symptomatology is carried out.

The objective of the PCR module is to:

- Make PCR results available at health facility on the same day as they are ready at National Reference Laboratory.
- Produce automated reports to TRAC Plus (PMTCT department) about PCR results

Results

- Usage of the module: from March 8th, 2010
- From the beginning of the module to date, 7483 results are sent to health facilities including 269 HIV positive results (3,5%)
- Timeliness of feedback has improved from 1-3 months to < 1 day
- Average of days from sample collection to sample reception to NRL =13 days versus 33 days in baseline assessment
- Average of days from sample reception at NRL to result availability =7 days
- Average of days from results availability at NRL to result reception to HF=6 days versus 1-3 months in baseline assessment.
- In total 26 days versus 2-4 months

Recommendations

- Assessment needed for result registration in the patient file, result communication to the mother and early initiation of treatment for HIV + infants.
- Health Facilities to assure that positive infants are placed on treatment as rapidly as possible.
- Suggested enhancements in technology/ functionality: notification of the date of ARV initiation via the EID module.

2.4.6. Discussion points

- About drugs, we don't have a choice, children always come last; not enough choices are there for pediatric formulation. We had put more focus on drugs, but we remembered that prevention was also important, even though its impact is hard to measure.
- 22% of pregnant women coming to ANC in the first trimester, what is the plan to convince these women to come early?
- About the presentation, can prong one data be linked to the education sector? These children concerned with prong one are mostly at school; there is a need of close collaboration with schools, to update curricula and make sure that children are informed and can take decision.

- What makes Botswana so special in PMTCT: Botswana has diamonds and more resources than Rwanda, and there was earlier political commitment in the fight against AIDS;
- We often forget men; what is planned for pregnant HIV negative mothers and their husbands? The husband has to get involved; he is the head of the family; we emphasize FP but we don't forget men.
- We should take caution while talking about MTCT rate for children tested at 18 months. It is just the prevalence among children tested at that point of time (because not all of them come for testing).
- Estimates at 18 months cannot tell you what happened before; we have the mortality rate but you cannot know if it is due to HIV or not;
- If HIV prevalence is 2.2% at 6 weeks, how to make sure that negative children remain so? That is a challenge.
- It is difficult to distinguish unwanted pregnancies and wanted ones among HIV+ women, because even if it is wanted the women will not say so because their providers told them not to get pregnant.
- 16% of HIV prevalence in 15-19 youth in Kigali: we try to get the reason why (CSW or not); but we have to come back to the Prong one; Some say do not start sexual education early, but the research showed that it does not push youth to sex; Life skills: how are we helping young girls to have a value of their life? Protection: OVC who are moving from home to home – how to ensure that they don't fall in that bad; are we providing right care to these young girls coming to us with pregnancy?
- It is up to the individual to take a decision about sex; let us help children; the focus is on how to help them stay healthy. If all children could get communication and information from parents helping them understand what is good for them, it would make a difference.
- FP of HIV+ people should consider their rights; they have special needs, pregnancy should be desired; need of good information, counseling, service delivery needed. So unwanted pregnancies have to be avoided at any cost. If pregnancy is unwanted, there is great likelihood of not adhering to ARV treatment.
- "From May to now, I have met with teachers and school authorities: the problem of GDN: I used to ask them if any one saw a pregnant girl or a girl who left school because of GDN: 9%-64%. They said the problem was very serious; they said they could do something; according to Police investigation 1350 show that the perpetrators included parents/educators. The GoR took a serious decision for universal 9 year education for girls; I ask to school authorities to replace parents on sensitizing children on prevention of GDN; two solutions: saying the true Rwandan words without taboo; role of churches (my church I don't know its view, but I know my stand: if you have Jesus, you don't need condom; but if you are not with Jesus, use condom otherwise you die). It is a continuous fight, all people need learning (in Universities GDN are prevalent while they are well educated); I propose

that these documents be translated into Kinyarwanda and disseminated especially in schools. They can help as didactic materials”.

- Data show that HIV is high in youth especially in women; the concern is that condom use is still low, especially female condom.
- Responsibility of educationalists to stop HIV transmission among youth: they need to take parental role; some youth are infected because of lack of psychosocial competence for abstinence. Communication skills constitute a paramount strategy. Let us provide relevant information to those who want to abstain from the early age. Capacity building is needed for teachers.
- Thanks to CNLS for the radio program on integrating HIV prevention in school curricula; the population says that we are late; there is formal education and family education which equally need to orient behaviors of our children. We should strengthen sensitization in family setting, fighting taboo and using the right words (ubusambanyi for non allowed sex, imibonano mpuzabitsina for allowed sex); decentralization of family sensitization and education using holiday camps.
- We have anti-aids clubs but not all children are represented in them (only older children participate but the most vulnerable –younger- have no place there); the recommendation to reinforce HIV education in primary school Kinyarwanda materials”.
- According to a teacher from Nyamagabe District, “HIV prevention has not enough time in school; we gather them and we discuss on it, focusing on the sugar daddy-mommy issue; we put emphasis on young girl, using teachers with parental experience; we also encourage VCT for teachers: we go on but we only need materials and training”.
- One participant from MoE reported the following: I have evidence on what I am going to tell you. I asked parents “when do you think your children start sexual intercourse?” They answered 9 years; I then asked them “when will you admit that it is a serious issue? When your children are pregnant or infected? Think about when you started sex? Who taught you that? Who abandoned it when he had started?” There are a lot of intellectuals who can’t dare talk to their children about it. It is high time we educate everybody, starting with parents; dare to talk with your children, otherwise they will learn from ill-intentioned people!
- The sugar daddy phenomenon is not the only problem. Poverty and promiscuity is also a problem; is it necessary to teach parents to separate boys and girls in bedrooms.

Questions and answers:

- Is there a tracking of the mother’s regimen on the PCR module?
- Answer: Not in tracnet, records are held in HF, as the latter is the one to use them.
- The reduced time from collection to reception of blood sample: is it due to PCR Module?

- Answer: Yes in some way; along with the PCR module we also sensitized HFs in the field; there is a quicker system of transporting blood samples from the field to the lab.
- Can children be tested alone without parents?
- Answer: The protocol allows testing children over 15 years without parents.
- What about PMTCT service which is not in all hospitals and insufficiency of ambulances?
- Answer: PMTCT target is to reach the whole country, now we are at 72%, but we hope to reach 100% by 2012. Now, every district hospital has at least of 1 ambulance; but also you can call an ambulance on 912 any where. For having access, the women need to have a mutuelle de santé (health insurance), and priority is given to emergency cases. We envision that every sector will have its own health center, and each health center have a PMTCT service.
- Can't ARVs have side effects on the child during pregnancy?
- Answer: ARVs have no bad effect as they prevent transmission of HIV to the child. There are drugs which proved to have side effects, but it should be noted that drugs do not have the same effects to all women; that's why blood test is done to ensure that the woman gets the appropriate drug.
- Are ARVs the same as PMTCT drugs?
- Answer: Yes they are the same, but there are different regimens.
- Could you explain more on FP for men?
- Answer: There are FP methods which are irreversible, but the condom can be also used; they need appropriate use and involvement of both partners. Double protection is more efficient (when a method is proposed to each partner).

2.5. SESSION FIVE: PAEDIATRIC CARE AND TREATMENT

Theme: *Effective partnership between the health and education sectors for quality care and social development for HIV positive children and adolescents.*

Moderator: Prof Baribwira Cyprien, Maryland University

2.5.1. Care and Treatment of HIV in Children – Global Perspectives

By Dr Denis Tindyebwa, EGPAF Tanzania

Background

- Number of new pediatric infections continues to drop as PMTCT improves
- Number of children on ART rose to 356,400 in 2009, from 275,300 in 2008 from 75,000 in 2005
- Programs in Sub Saharan Africa achieve treatment outcomes similar to those of North America and Europe
- DBS PCR technology is being scaled up.
- Simplified, more universal and harmonized international guidelines

Findings

- By 2 yrs over 50% HIV infected will die in absence of treatment
- Only 10-50% PMTCT sites offer EID services
- Less than 50% exposed children are tested
- Less than 20% of PMTCT mothers are linked to tested infants
- Average age at 1st DBS is over 6 months – only 40% tested within 3 months
- Less than 50% PCR + started on ART

Recommendations

- Decentralize and integrate care and treatment
- Provide whole site training and mentorship for providers
 - Counseling care givers and children on HIV in children
 - Specific care and treatment of children

- Provide care treatment and support to mother and family
- Simplify care for children
- Establish age disaggregated reporting for children living with HIV (Infants & Young children; Adolescents)

2.5.2. National Program for Pediatric HIV/AIDS Care and Treatment

By Dr Sabin Nsanzimana, TRAC Plus

Background

- The program is aligned to EDPRS and to the NSP 2009-2012
- Rural population: 83% (DHS 2005),
- HIV Prevalence 3% in general population and 4.3% among pregnant women
- Adolescence is an area of focus in HIV treatment at global level. They need special approaches as they are neither true children nor adults

Findings

- A lot has been done: training of trainers, increased number of children on CTX and ART, Adolescent care models initiated...
- By September 2010, children on ART first line regimen were 6024 and those on ART second line regimen were 64
- In 2010, more children than adults started treatment very late in stage 3 and 4, while most adults start in stage 1 and 2.
- Children on ART are 8.6% of all people on ART (7,349 children out of 85,660 people)
- We plan to get 90% of eligible children on ART by 2013
- There is a poorer virologic response in case of delayed switch from 1st to 2nd line regimen.
- There is a system for patients monitoring Clinical follow up: Lab monitoring (CD4, VL, FBC), Drugs side effects, Nutrition status, Adherence, etc.

Recommendations

- Decentralization and integration of HIV services (full coverage)
- Permanent mentorship teams at all levels
- Continuous capacity building at all levels.
- Creation of centers of excellence for management of treatment failure
- Strengthen the community involvement in care

- Strengthen and monitor task shifting.
- Adopt age appropriate approaches to care and treatment of children living with HIV
- Integrated HIV + adolescent services (reproductive health, STI, FP ,..) in all health facilities offering HIV Care package.

2.5.3. HIV Infection and children's intellectual development. An appraisal of the 2009 School Performance of HIV Infected Children Enrolled in Care and Treatment at CHUK.

By Dr Gilbert Tene, ICAP

Introduction

- HIV is a neurotrophic virus and may lead to impairment of the brain maturation and neurodevelopment abnormalities
- Two categories of central nervous system are involved in HIV:
 - Directly related to HIV brain infection such as HIV encephalopathy
 - Indirectly HIV related due to the effect of HIV on the brain such as opportunistic infections
- Risk factors of HIV neurological disease include:
 - The moment of HIV contamination (higher if contamination occurred in utero)
 - The young age (< 3 years)
 - Advanced HIV disease
- Early onset of neurologic signs and symptoms in infants frequently leads to poorer neurodevelopment outcomes
- In older children and adolescents, motor and cognitive dysfunctions appear to be prominent features

Findings

- Children enrolled at earlier WHO stage of HIV infection had significantly better school promotion rate than those with more advanced infection by the time of enrolment
- Children who attended support group activities had significantly better school promotion rate than those who did not
- Children who missed < 4 school days had significantly better promotion rate than those who missed > 4 school
- Children > 12 years of age had significantly better promotion rates than the younger ones
- Children from economically viable families had significantly better school promotion rate than those from very impoverished ones

Recommendations:

- Earlier enrollment for treatment to allow better school results
- Improve the economic situation of children for better school performance
- Treatment is key to intellectual success
- School attendance should be encouraged

2.5.4. Impact of HIV and AIDS on schooling of HIV affected and infected children attending TRAC Plus clinic 2008-2009

By Dr Diane Tuyishimire, TRAC Plus.

Background

- A survey was conducted on 2008-2009
- The clinic started in 2004; the study was conducted in 2008;
- HIV positive Children enrolled at TRAC Plus clinic: 580
- Children on ARVs at TRAC Plus clinic: 309
- School age infants number at TRAC Plus clinic :526
- TRAC plus clinic developed a support project for schooling in favor of infected and affected children

Findings:

- Infected children at school have high risk of stigma and school absenteeism leading to poor school performance
- Affected children are facing stigma as well as nutrition constraints
- Adolescents are most concerned by poor school performance than younger children
- HIV infected girls have lower school performance than boys in general

Recommendations

- Re-enforce family based support and develop strategies to overcome school absenteeism, stigma and nutritional constraints in favor of infected and affected children at school especially with more focus on girls
- Providers should reduce number of medical visits in order to avoid school absenteeism
- Schools staffs should be involved in following up HIV infected, affected children and other vulnerable children enrolled at their school

2.5.5. Modeling health service delivery for adolescents living with HIV in TRAC Plus

Presented by Simon Pierre Niyonsenga, TRAC Plus.

Background

- Over 90 of ALHIV have HIV positive parents (mothers)
- Delayed diagnosis & treatment
- Unprotected sex among both ALHIV and non-ALHIV
- Majority of ALHIV are orphans of at least one parent
- Many are at lower school levels compared to non-infected children of the same age and have proportionately less access to education
- A few models exist but are not scalable and therefore difficult to institutionalize
- Recent program reports from TRAC Plus clinic reveal several challenges among adolescents (Pre and on ART): mainly adherence, risky sexual practices & unmet basic social needs
- TRACnet has no disaggregated data on ADOLESCENT AGE BRACKET
- TRAC Plus initiated a model for adolescent care since April 2010

Results

- Parents and adolescents appreciate the changes
- Improved adherence to services
- Improved staff skills in service delivery for ALHIV
- Improved health and development and reduced risky sexual behavior.

Conclusion

- National initiatives are critical for responding to the emerging challenge of caring for adolescents living with HIV
- This model has great potential for contributing to primary prevention of HIV among young people through peer education
- The model will contribute to informing development of norms and standards of care for ALHIV

2.5.6. Discussion points

Questions:

- Does Rwanda have an experience working with parents in initiating treatment for children? Any experience with clinical mentorship?
- Task shifting: it has been done for Adults on first line ART regimen; is there a plan to allow nurses put children on treatment too?
- Adolescents are neither adults nor children; where in Rwanda do we put them? Will they be back in the pediatric program? Are we going to review our guiding documents?
- Decentralization and integration of treatment for infants: what exactly are we missing?

Answers:

- We still have a long way to go, the MTCT rate is still high; just reaching women with PMTCT is as low as 10% in some settings, 90% in others.
- Institutionalization of mentorship, that is the way; but there is still a staffing challenge; as a starting point, we need very clear guidelines on mentorship: what is it?; we need to train mentors and to identify those who are good ones; Decentralized entities must also be involved in supporting mentors logistically; Some countries are doing well: Mozambique, Zambia, etc.
- We do trainings and supervision with UNICEF support, but we need to improve it as it can be a good solution; we have a plan of mentorship at different levels (national and district); every mentor needs to be mentored as well; we started but we need to make it stronger, drawing experience from other countries. It is a solution for capacity building of service providers. We trained nurses where there are doctors: they are not yet allowed to do prescription; in the future, if they do well with what they are trained in, they may be allowed to give 2nd line treatment to children.
- There is no resistance of patients-mothers; we link with associations of PLHA and it is improving; we have been revising our guidelines for involving families in early testing; the other approach is sensitization; we link with PMTCT; HIV test and FP services for mothers and whole families are provided in ANC; we encourage husbands to be tested too;
- Adolescents are between children and adults: that's why we are designing special tools and programs for them.
- ARVs, immunity and nutrition: even though we give ARVs, they are not easy to take; that's why we ask people to take them in a special ways (time); for children with special nutritional needs, there is a national protocol to give them nutritional support; also doctors have to

test how a given drug is appropriate to a given patient. If necessary, the doctor can change your regimen.

- We should advocate for viral load test for all children; then we should advocate for treatment for all but there is not enough information;
- Findings have shown that early treatment can mitigate the impact of HIV on intellectual status; also children attending support groups do better in school.
- We need to clarify the age issue concerning adolescents: we separate them from children and at the same time we mix them; their definition is overlapping: adolescents are children, but not all children are adolescents; their care and treatment program should be done in pediatric setting.
- Given the good impact of EID, what is planned for HIV test in schools? Is there any legal and moral implication of promoting test in schools? Under 15 years, we need parental ascent, but children above 15 years can be tested unaccompanied.
- Another factor of failure for these children: late payment of their school fees

3. CLOSING CEREMONY

3.1. Introduction

In her introduction to the closing session, the chair person (Permanent Secretary of MoE) invited some high level officials, namely Honorable Minister of Education, the Country Representative of UNICEF and the Executive Secretary of CNLS, to join the panel. Then she invited participants to listen to the conference recommendations from children and adults' sessions.

3.2. Children's recommendations

Presented by Roxane Arakaza Mudenge, from Kicukiro District

- Put in place a special program or course on reproductive health, behavior change and HIV prevention in schools (MINEDUC)
- Improve and reinforce the capacity of anti-AIDS clubs, mobilize participation of youth in those clubs and sensitize school authorities to follow them up (MINEDUC, MINICYOUTH, CNLS)
- Put in place a radio program on HIV in schools (MINEDUC, MINICYOUTH, CNLS)
- Organize holiday camps for primary and secondary school students at sector level whereby the students are thoroughly sensitized on HIV and reproductive health (MINALOC, CNLS, MINEDUC, MIGEPROF, MINICYOUTH)
- Increase efforts in disseminating in schools various studies conducted on reproductive health and AIDS (MINEDUC, CNLS)
- Improve collaboration between schools and parents regarding children's behavior and health (MINEDUC, MIGEPROF, MINISANTE)
- Continue sensitization to fight the sugar mommy/sugar daddy phenomenon in schools (CNLS, MINICYOUTH)
- Strengthen the fight against drug consumption in schools (MINEDUC, National Police)
- Teach secondary school students how to use the condom (MINEDUC, CNLS)
- Increase sensitization of children and youth on benefits of male circumcision for HIV prevention (CNLS)

3.3. Adult sessions recommendations

Presented by Mrs Janinah Gasana, HIV advisor, Ministry of Education

3.3.1. EDPRS Sectors' Response

Infrastructure:

- Expand focus to other groups among the target population of the Infrastructure Sector beyond long distance Truck drivers
- The Workplace HIV Program to be strengthened

Agriculture:

- Implement Recommendations of the 2009 Priorities for Local AIDS Control Efforts (PLACE) Study of the Agricultural Sector

Youth

- The Youth Sector Strategic Plan for HIV to be finalized

Justice, Reconciliation, Law and Order:

- Follow up on the Recommendations for the EDPRS assessment that have been provided to the sector such as reviewing draft of the Penal Laws related to GBV
- **Police:** Scale-up the ISANGE One Stop Center Model to other Provinces and create linkages between the Community and Interventions targeting the Youth for better coordination of the Response of survivors of GBV
- **Rwanda Correctional Services:** It is necessary to reinforce the HIV services in TIG camps where they are lacking,
- Ensure that comprehensive HIV and AIDS services in Prisons reach the Correctional facilities for Children

Social Protection:

- Finalize the development of the OVC database MIGEPROF
- Ensure implementation of the policy against Child labor

Education:

- Follow up and ensure implementation of recommendations highlighted by the EDPRS Sectors' response to HIV assessment (2010)

3.3.2. Prevention of HIV among youth and adolescents

- The Rwandan Education Sector must develop a national policy on sexual and reproductive health including HIV prevention. This policy should include policy/ strategy which must be based on local evidence and with the participation of young people.
- Reproductive health and sexuality education and HIV Prevention must be included in the national curriculum. The curriculum development process should be informed by research. All the steps in the curriculum development process should be adhered to.
- We should ensure linkages between schools, youth friendly centers and health centers to increase access to sexuality education and comprehensive HIV prevention services to youth
- The national policy on Reproductive health and sexuality must be coordinated and implemented with key EDPRS sectors and in collaboration with all national, multilateral and bilateral stakeholders.
- We need to sensitize parents/guardians and equip them with knowledge, skills and tools to provide guidance, life skills and psychological support to their children

3.3.3. Protection of OVCs

- Strengthen multisectoral collaboration to ensure synergy among the partners towards the protection of Children Infected and/or Affected by HIV and AIDS,
- Create an enabling environment for the students infected and/or affected by HIV and AIDS and school including:
 - Training of teachers,
 - Zero tolerance to stigma and discrimination,
 - Ensure confidentiality for Children and Youth living with and/or affected by HIV&AIDS,
 - Scale-up the school feeding program,
 - Provide psychosocial support to Children Infected and/or Affected by HIV and AIDS at school (Counseling, ART adherence, Flexi time, etc),
- Scale up VUP Umurenge to reach all vulnerable groups including sex workers in need,
- Improve referral systems and networks at community level to ensure reach all OVCs,
- Scale up the school holiday camps model with a strong emphasis on life skills development sexual reproductive education and HIV prevention,

- Ensure that Children living with disabilities are also reached by HIV and AIDS Services and protected against Violence and abuse

3.3.4. PMTCT

- Collaborate with other sectors (e.g. education, gender) and local authorities on interventions for early prevention of HIV among our youth, including sexual education and life skills training,
- Ensure availability of appropriate messaging for adolescents: do not tell adolescents and youth what not to do. Instead appreciate that adolescents and youth are motivated by community and family messaging that encourages them to be healthy
- Strengthen the knowledge and skills of health care providers to convey the correct messages to women, for example, correct breastfeeding practices according to the 2010 National PMTCT Guidelines,
- Design and implement multisectoral response (Education, Health, Social Protection) to address the challenges faced by HIV adolescent pregnant girls in the PMTCT program,
- Increase coverage of integrated ANC, PMTCT and Family planning services to ensure that pregnant women are counseled, tested and receive their HIV results, and increase ARV prophylaxis coverage for women living with HIV follow up in PMTCT,
- Engage with the MOH/MCH Department to reduce barriers for compliance to the four recommended ANC visits and continuum of care for mother-babies up to 18 months (e.g. Rapid SMS technology for MCH).

3.3.5. Paediatric Care and Treatment

- Integrate clinical assessment of children to improve EID,
- Simplify care for children and advocate for more Fixed drug combinations for children,
- Speed up the implementation of specific programs for care of adolescents living with HIV,
- Establish age disaggregated reporting for children living with HIV: infants, young children and adolescent
- Continue quality training of care providers for children care and treatment including early recognition of treatment failure
- Implement National guidelines and tools for the mentorship
- Train and mentor nurses on Pediatric care and treatment in the task shifting framework

- Promote close collaboration between health and education sectors to ensure that HIV infected school age children, while achieving care and treatment objectives, also adequately attend schools so as to fulfill their full potential and optimum intellectual development
- Develop a framework between the health and education sectors to ensure that the HIV testing policy for school going children is established and implemented with support of parents and guardians.

3.4. Way forward

By Dr Anita Asiimwe, Executive Secretary of CNLS

- Draw an Action plan based on the conference recommendations: by end January 2010, by the steering committee
- Financing commitments, by GoR and Partners
- Implementation of the action plan: 2011, by GoR and Partners
- Monitoring: 2011, quarterly, by the steering committee
- Suggestions for the theme of the next conference: before 5th February 2010; send suggestions to info@cnls.gov.rw
- Proposed dates for the next conference: 16th to 18th November 2011
- Conference organization: Start of May 2011
- Organize symposia on specific issues: 2 before the conference; suggestion of topics to be sent to info@cnls.gov.rw
- Some suggested symposia:
 - Sexual and Reproductive Health Education for HIV prevention: The role of schools, families and communities.
 - Early Infant Diagnosis and Early Treatment of HIV
 - Comprehensive care and support for HIV infected adolescents, including pregnant adolescents.

3.5. Cultural presentation by Mashirika drama group

“Listen to My heart”: This drama was about discrimination of HIV infected and disabled children. It is about Alex, a disabled child living with HIV. His step father did not accept him as his own child, and Alex became permanently frustrated and desperate despite his mother’s tenderness and care. The mother followed advices of counselors and adhered to treatment and then regained hope. Also other children living with him in the center started by discriminating him but at the end they saw that he was a brave boy and they integrated him in their activities.

3.6. Awards ceremony

Six awards were given to best abstracts according to the following criteria: Innovation (4 awards), Young Investigator (1 award), and Excellent intervention on mainstreaming HIV in EDPRS (1 award).

Concerning the selection process, an award selection committee, representative of the 4 Ps, oversaw the selection process under the coordination of the chair and co-chair of this conference. Winners were selected through a transparent and rigorously documented process.

The following are the award winners:

- Kigali Hope Association for their abstract *“Rwanda young positive are educated on Reproductive Health in accelerating prevention among positive young people”*
- Dr Nadine Shema of TRAC Plus for her abstract entitled *“HIV/EID Module: an electronic solution to deliver PCR results to Health Facilities in timely manner via TRACnet system using SMS”*
- Dr Diane Tuyishimire of TRAC Plus for her abstract on *“Impact of HIV AIDS on schooling of HIV affected and infected children attending TRAC Plus clinic 2008-2009”*
- Mrs Maj Fagerlund from UNICEF, for the abstract *“ISANGE One Stop Centers- How to apply a multidisciplinary approach in fighting Child, Domestic and Gender based Violence”*
- Mr Simon Pierre Niyonsenga of TRAC Plus, as a young researcher, for his abstract *“Modeling health service delivery for adolescents living with HIV in TRAC Plus”*
- Dr Musemakweli of LUCS/UNR, for LUCs excellent intervention in integrating HIV interventions in Education, and for their abstract *“Sexual behavior and free-of-charge distribution of condoms at the National University of Rwanda”*

3.7. Closing remarks

By Dr Charles Muligande, Honorable Minister of Education

The closing speech was delivered by Dr Charles Muligande, Minister of Education. In his remarks, he acknowledged that it was a pleasure to be there on the occasion of 6th National Paediatric HIV conference, and he expressed special gratitude to CNLS and partners for organizing this conference, in particular to children for their participation and contribution.

According to the Minister, there can't be a better terrain than education for the fight against AIDS, especially given the nature of this sector which has the biggest number of beneficiaries: 2.8 million in primary and secondary schools. Given that youth are the future of our country, we need to put all our efforts in their protection.

The Minister of Education reminded the aims of Education in Rwanda: combat all sorts of ignorance, including how to protect ourselves; to produce an intellectual but also a healthier population. He reiterated the government's commitment to the fight by translating into action the 2010-2015 Education Sector Strategic Plan, with emphasis on life skills and health knowledge.

He called on youth to avoid drug abuse and unsafe sex in order to reduce the incidence and mitigate the impact of HIV; he reaffirmed zero tolerance for child abuse and zero tolerance for HIV related stigma, with a view to creating conducive environment in our schools. As the education sector is a vaccine and defense, it cannot combat HIV alone: parents, guardians, partners, etc., are needed.

The Minister emphasized that the conference recommendations should be implemented, monitored and evaluated. Before ending his speech, once again he expressed thanks to the conference organizers and participants, and commended the excellent work done by those who received awards.

On those remarks he declared closed the 6th annual national conference on children infected and affected by HIV and AIDS in Rwanda.

4. Appendices

4.1. Conference Agenda

November 17 th 2010	Afternoon, Serena Hotel, Kigali
Session 0: Official opening	
Theme: "EDPRS Sectors' Response to HIV and AIDS- Focus on Education Sector"	
Chair: Dr. Anita ASIIMWE, CNLS	
Reporters: MUSONI, Mininfra and Jovia, Imbuto Foundation	
Time	Programmed activity
2:30- 2:45	Welcome and greeting message Dr. UWAYITU Apolline, CNLS board of commissioners
2:45- 2:55	Cultural representations from children Drama group: Mashirika
2:55- 3:10	Presentation on global link between HIV and education sector, success, lesson learnt and challenges Mr Mathias LANSARD, UNESCO
3:10- 3:25	International Keynote Speech: HIV mainstreaming within the Education Sector: process, achievements, challenges and lessons learned-the Kenyan case Mrs Grace NGUGI Maina, Kenya Institute of Education
3:25- 3:35	Cultural representations from children Drama group: Mashirika
3:35- 3:50	Remarks from The Representative of Development Partners Mr Aurélien AGBENONCI, UN Resident Coordinator and UNDP Resident Representative-Rwanda
3:50-	Testimony from children

4:05	
4:05-4:20	Remarks from The Honourable Minister of Health Dr Richard SEZIBERA
4:20-4:35	Opening Speech by The Guest of Honour Right Honourable Prime Minister, Mr Bernard MAKUZA
4:35-6:00	Cocktail

November 18 th 2010		Morning, Serena Hotel, Kigali
SYMPOSIUM: EDPRS Sectors response to HIV and AIDS		
Moderator: Dr. Jane MUITA, UNICEF		
Reporters: GAKUNZI SEBAZIGA/CNLS and Susan KIRAGU/UNAIDS		
Time	Programmed activity	
7:00-8:00	Participants registration	
8:00-8:20	Presentation of findings of the assessment" EDPRS Sectors response to HIV and AIDS, Dr. Anita ASIIMWE, CNLS Executive Secretary	
8:20-9:10	Discussion and interaction and recommendations	
Session 1: Prevention of HIV Among Adolescents and Youth		
Theme: "Reproductive Health and Sexual Education as means for HIV Prevention among School Age Children"		
Moderator: AMADOU Seck/UNICEF-Rwanda		
Reporters: Dr. Alison JENKINS/PSI Rwanda & NIYITEGEKA JMV/MINIYOUTH		
9:10-9:20	Key note speech: Presentation on global situation of the Reproductive Health and Sexual Education targeting adolescents and youth Mr Pierre Robert, UNICEF HQ New York	
9:20-9:30	Key note speech: Presentation on Rwanda situation of the Reproductive Health and Sexual Education targeting adolescents and youth BAYINGANA Christian/ MEDSAR/NUR	
9:30-10:15	Discussion and interaction	

10:15-10:45	<p>Oral abstract presentation (10 min each)</p> <ul style="list-style-type: none"> Sexual behaviour and free condom distribution at the National University of Rwanda MUNGARULIRE Janvier, National AIDS Control Commission HIV & sexual education equally imperative in under 7 years Dr RUTARAMANA Bayingana, National University of Rwanda Intégration du VIH/SIDA dans le programme d'éducation pré-nuptiale Abbé Jean Robert RUBAYITA, Caritas Diocésaine de Cyangugu.
10:45-11:15	Discussion and Interaction
11:15-11:35	Coffee Break
11:35-12:15	Discussion and interaction
12:15-12:30	Summary of key recommendations
12:30-1:30	Lunch

November 18 th 2010		Afternoon, Serena Hotel, Kigali
Session 2: Protection of Orphans and Other Vulnerable Children (OVC)		
Theme: "Protection of children infected and/or affected by HIV and AIDS: the role of Education sector"		
Moderator: FRANCESCA Morandini, UNICEF-Rwanda		
Reporters: Emmanuel NZARAMBA, MIGEPROF & Ignace SINGIRANKABO, RCLS		
Time	Programmed activity	
1:30-1:45	<p>Key note speech- Presentation on global situation:</p> <p>Linkages between education sector and other relevant sectors responsible to ensure access to minimum package of services for OVC</p> <p>Sera KARIUKI, UNICEF- ESARO</p>	
1:45-2:00	<p>Key note speech- Presentation on Rwanda situation: "Protection of children infected and/or affected by HIV and AIDS: the role of Education sector"</p> <p>Sharon HABA, Permanent Secretary of MINEDUC</p>	
2:00-2:30	Discussion and interaction	
2:30-3:15	<p>Oral abstract presentations on Protection of OVC (15min each)</p> <ul style="list-style-type: none"> Life Skills and Resilience among Vulnerable Youth: Lessons from the 2010 USAID/ Higa Ubeho holiday Camps Jane MUTONI, CHF 	

	<ul style="list-style-type: none"> • Inventory for OVC services and referral network in Musanze Eugene RUSANGANWA, CARE International • ISANGE One Stop Centers- How to apply a multidisciplinary approach in fighting Child, Domestic and Gender based Violence, MAJ Fagerlund, UNICEF- Rwanda
3:15-3:45	Discussion and interaction
3:45-4:00	Coffee break
4:00-4:30	Discussion and interaction
4:30-5:00	Summary of recommendations
7:30-9:00	<p>Working Dinner (On invitation)</p> <p>Theme: "Narrowing the Gaps to Meet the MDG goals": An equity-focused approach towards health related MDG for children by 2015</p> <p>Discussant: Dr. Joseph FOUMBI, UNICEF</p>

November 19 th 2010	Morning Serena Hotel, Kigali
Session 3: Prevention of Mother-To-Child Transmission of HIV (PMTCT)	
Theme: "Collaboration between health and education sectors towards elimination of MTCT focusing on young people at reproductive age"	
Moderator: Dr. Felix NDAGIJE, CDC	
Reporters: Dr. Jennifer MBABAZI, TRAC Plus & CRYSTALL Milligan, Intrahealth	
Time	Programmed activity
7:30-8:30	Participants registration
8:30-8:45	<p>Key note speech: Presentation on global situation " : "Collaboration between health and education sectors towards elimination of MTCT focusing on young people at reproductive age"</p> <p>Dr. KIEFFER Mary Pat/EGPAF regional office</p>
8:45-9:00	<p>Key note speech: Presentation on Rwanda situation: "Collaboration between health and education sectors towards elimination of MTCT focusing on young people at reproductive age"</p> <p>Dr. Nadine UMUTONI WA SHEMA, TRAC Plus</p>

9:00-9:30	Discussion and interaction
9:30-10:15	<p>Oral abstract presentation (15min each)</p> <ul style="list-style-type: none"> • PMTCT prong one: uptake of HIV testing among youth attending VCT program Dr. Placidie MUGWANEZA, TRAC <i>Plus</i> • Towards universal access to PMTCT services leading to Elimination of MTCT in Rwanda, Dr. Jean Pierre NYEMAZI, TRAC <i>Plus</i> • PCR module: An electronic solution to deliver results to Health Facilities in timely manner via TRACnet system Dr. John RUSINE, NRL
10:15-10:45	Discussion and Interaction
10:45-11:05	Coffee Break
11:05-11:35	Discussion and interaction
11:35-12:00	Summary of key recommendations
12:00-1:30	Lunch

November 19 th 2010	Afternoon, Serena Hotel, Kigali
Session 4: Paediatric care and treatment	
<p>Theme: "Effective partnership between the health and education sectors for quality care and social development for HIV positive children and adolescents"</p> <p>Moderator: Prof. Cyprien BARIBWIRA, Maryland University</p> <p>Reporters: Dr. NDIMUBANZI C. Patrick, CDC & Dr. TENE Gilbert, ICAP</p> <p>Dr. Grace MURIISA/ UNICEF-Rwanda.</p>	
Time	Programmed activity
1:30-1:45	<p>Key note Speech- Presentation on global situation</p> <p>Dr Denis TINDYEBWA, Director Paediatric Care & Treatment, EGPAF</p>
1:45-2:00	<p>Key note Speech- Presentation on Rwanda situation "Effective partnership between the health and education sectors for quality care and social development for HIV positive children and adolescents", Dr. Sabin NSANZIMANA, TRAC <i>plus</i></p>

2:00-2:30	Discussion and interaction
2:30-3:15	<p>Oral abstract presentations on paediatric treatment and care (15min each)</p> <ul style="list-style-type: none"> • HIV Infection and Children's Intellectual Development: An Appraisal of the 2009 School Performance of HIV Infected Children Enrolled in Care and Treatment at the Kigali University Teaching Hospital (CHUK) in Rwanda Dr. Gilbert TENE, ICAP • Impact du VIH/sida sur la scolarisation des enfants affectés/infectés suivis à la clinique TRAC <i>Plus</i>: 2008-2009, Dr. • TUYISHIMIRE Diane, TRAC <i>Plus</i> • Modelling integrated formative supervision in 5 priority district hospitals to contribute to child survival, Dr. Ida KANKINDI, Ministry of Health
3:15-3:45	Discussion and interaction
3:45-4:00	Coffee break
4:00-4:30	Discussion and interaction
4:30-5:00	Summary of recommendations

November 19 th 2010	Evening, Serena Hotel, Kigali
Session 5: Closing ceremony	
Chair: Ms. Sharon HABA, Permanent Secretary, the Ministry of Education	
Reporters: MANIRAGUHA Pontien, CRS & Dr. UBARIJORO Sowaf, EGPAF	
Time	Programmed activity
5:00-5:30	Introduction to Closing Ceremony Ms. Sharon HABA, Ministry of Education
5:30-5:55	Reading of Conference recommendations Session 1-4 GASANAH M. Janinah, MINEDUC
5:55-6:15	Reading of Conference recommendations from child and youth parallel sessions, children delegates
6:15-6:25	Way forward Dr Anita ASIIMWE, CNLS Executive Secretary
6:25-6:35	Cultural representations from children Drama group: Mashirika
6:35-6:50	Award Ceremony Dr. Diane GASHUMBA,EGPAF; Jovia KAYIRANGWA, Imbuto Foundation
6:50-7:00	Closing speech Guest of Honour Honorable Minister of Education, Dr. Charles MURIGANDE

4.2. Conference budget

	Services & materials	Days	Quant	Unitcost (RwF)	Total cost (RwF)	Funding Source	Total per institution (RwF)
	1.0 Venue for the conference & accessories						
budg. for 2 days conference	Venue: conference room 400 part.+ side room+catering+mid afternoon tea/coffee pastries,water, writing pads,pens,mints, PA System with 1 microphone, flipchart,screen, lectern,podium	2	400	24,970	19,976,000	OneUN	19,976,000
	Auditorium Hire	2	2	585,000	2,340,000	EGPAF	11,430,000
	LCD projectors	2	4	0	0		
	Cable to connect Projectors	3	1	30,000	90,000		
	Simoultaneous translation	3	1	3,000,000	9,000,000		
	Participants Badges	1	400	0	0		
	Sub Total				31,406,000		
	2.0 Opening ceremonies						
budg. for 2 days conference	Half day conference package(mid afternoon tea/coffee pastries,water, writing pads,pens,mints, PA System with 1 microphone, flipchart,screen, lectern,podium	1	500	8,100	4,050,000	OneUN	4,050,000
	Auditorium Hire	1	1	590,000	590,000	EGPAF	590,000
	LCD projectors	1	2	0	0	FHI	1,340,000
	Sound system	1	1	500,000	500,000		
	Decoration	1	1	600,000	600,000		
	Transport for youth participating in opening (NYC)	1	2	120,000	240,000		
	Sub-Total				5,980,000		

	3.0 Children participation in the conference						
budget for children participation	Transport for children coming from districts	2	70	10,000	1,400,000		
	Accommodation & dinner for children participants	4	70	20,000	5,600,000		
	Transport for children during conference	3	2	120,000	720,000		
	Medical care (for emergence)	0	0	0	100,000		
	Coordination fees for children and youth participation	5	1	50,000	250,000		
	Transport for children coord to pick children	5	1	0	0		
	Children facilitators	5	1	0	0	UNICEF	8,070,000
	Sub-Total				8,070,000		
	4.0. Communication						
Communication	Press conference						
	Venue	0	0	0	0		
	Water	1	50	250	12,500	UNICEF	12,500
	Radio and TV programs				0		
	Contracts with TV	1	1	600,000	600,000		
	Contracts with radio	1	4	1,200,000	4,800,000		
	Production of radio/TV spots	1	1	750,000	750,000		
	Air time for spots on TV and Radios)	1	1	1,200,000	1,200,000	UNICEF	7,350,000
	Inviting Journalists in opening ceremonies	1	30	0	0		
	Journalists to report on the conference on the website	2	2	50,000	200,000	FHI	200,000
	Flying message on public screen (electronic bill board)	10	5	35,000	2,065,000	FHI	2,065,000
	Abstract book and Conference programme booklet design	1	400	875	350,000		
	Conference programme booklet and abstract book production and multiplication	1	400	12,000	4,800,000	ICAP	5,150,000
	Participants' kit and materials (Conference bags)	1	400	3,000	1,200,000		
	wooden rulers	1	100	2,000	200,000		
	T-shirt for children and Youth	1	200	4,000	800,000		
	Pencils	1	100	1,000	100,000		
Pencil cases	1	100	3,000	300,000	UNICEF	3,472,000	

	Exercise Books	1	840	800	672,000		
	Banners	1	6	100,000	600,000		
	Posters	1	30	10,000	300,000	FHI	300,000
	Award for best abstracts	1	9	150,000	1,350,000	FHI	1,350,000
	Sutotal				19,899,500		
	05. CAG to CNLS from UNICEF						
	Printing ink laser jet	1	1	150,000	150,000		
	Refreshment of steering committee members during preparatory meetings	4	3	30,000	360,000		
	Printing of invitations	1	100	1,000	100,000		
	Printing papers	20	1	3,500	70,000	UNICEF	680,000
	Subtotal CAG				680,000		
	06. Assessment						
	Consultant to carry out the assessment of HIV implementation by EDPR Sectors(Reallocated)	1	1	8,000,000	8,000,000	UNICEF	8,000,000
	Subtotal CAG				8,000,000		
	07. Other costs						
	Traditional attire for conference organisers(women)	1	10	10,000	100,000		
	Extra man power to place boards and posters	2	25	2,000	100,000	UNICEF	200,000
	Mission allowances for district participants (Vice mayors)	3	30	8,000	720,000	CRS	720,000
	Accomodation allowances for district participants (Vice mayors)	2	30	58,750	3,525,000	UNICEF	3,525,000
	Mileage allowances for district participants (vice mayors)	NA	NA	NA	948,000	CRS	948,000
	Mission allowances for district participants (CDLS TA)	3	30	5,000	450,000		
	Accomodation allowances for district participants(CDLS TA)	2	30	37,000	2,220,000	UNICEF	2,670,000
	Transport allowances for district participants (CDLS AT)	2	30	5,000	300,000	CRS	300,000
	Mission allowances for district participants (Teachers)	3	30	5,000	450,000	UNICEF	450,000
	Accomodation allowances for district participants(Teachers)	2	30	37,000	2,220,000	CRS	2,220,000

	Transport allowances for district participants (Teachers)	2	30	5,000	300,000	UNICEF	300,000
	Sub-Total other costs				11,333,000		
	08. Contracts						
	Photographer	3	1	0	0		
	Entertainment(Music Dance, Drama)	1	1	6,500,000	6,500,000	FHI	6,500,000
	Institutional consultant for the reactivation of the pediatric conference website	1	1	0	0		
	Sub- Total				6,500,000		
	09. International Key notes speakers(4 Ps +1 Global)	1	5	3,000,000	15,000,000	UNICEF, INTRA HEALTH, UNFP A	15,000,000
	Sub-Total				15,000,000		
	Total budget RwF				106,868,500		
	Total budget USD				181,133		
	Rate= 590 Rwf/1 USD						

4.3. List of Participants

The entry of conference participants is still under process.