



A Healthy People. A Wealthy Nation

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Rwandan Paediatric Conference on **HIV** and **AIDS**

Report of the Seventh Annual
National Paediatric Conference on children
infected and affected by HIV and AIDS

Kigali, 9th – 11th November 2011

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Acronyms and Abbreviations

4Ps	4 Pillars of the children global campaign
AIDS	Acquired Immunodeficiency Syndrome
ALHIV	Adolescents living with HIV
ANC	Ante-Natal Consultation
ART	Anti Retroviral Therapy
ARVs	Antiretroviral drugs
ASRH	Adolescents Sexual and Reproductive Health
AYFHS	Adolescents and Youth Friendly Health Services
BCC	Behavior Change Communication
BSS	Behavior Surveillance Survey
C&T	Care and Treatment
CD4	Cluster Differentiation 4
CHW	Community Health Workers
DBS	Dried Blood Spot
DHS	Demographic and Health Survey
Dr.	Doctor
DRC	Democratic Republic of Congo
EDPRS	Economic Development and Poverty Reduction Strategy
EGPAF	Elisabeth Glaser Pediatric AIDS Foundation
EID	Early Infant Diagnosis
E-MTCT	Elimination of Mather to Child Transmission of HIV
FP	Family Planning
GLIA	Great Lakes Initiatives on AIDS
GoR	Government of Rwanda
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HQ	Head quarter
ICAP	International Center for AIDS Care and Treatment Programs
IEC	Information, Education and Communication
IHDPC	Institute of HIV/AIDS, Disease Prevention & Control
M&E	Monitoring and Evaluation
MC	Male Circumcision
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MIGEPROF	Ministry of gender and family promotion
MIJESPOC	Ministère de la jeunesse, sport et culture
MINEDUC	Ministry of Education
MINIYOUTH	Ministry of Youth

MoH	Ministry of Health
Mr.	Mister
MSM	Men who have sex with men
MTCT	Mother to Child Transmission of HIV
NACC/CNLS	National Aids Control Commission
NRL	National Reference Laboratory
NSP	National Strategic Plan
NVP	Nevirapine
OVC	Orphans and Vulnerable Children
PCR	Polymerase chain reaction
PMTCT	Prevention of Mothers to Child Transmission of HIV
RBC	Rwanda Biomedical Center
RH	Reproductive Health
RPOs	Rwandan Partner Organizations
SGBV	Sexual and gender based violence
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TRAC Plus	Treatment and research on Aids Center
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly
UNICEF/ESARO	United Nations Children's Fund
USAID	US Agency for International Development
VAC	Violence Against Children
VCT	Voluntary Counseling and Testing
VUP	Vision 2020 Umurenge Program
WFP	World Food Program
YWCA	Young Women Christian Association

1. Introduction

The Global Campaign, "*Unite for Children, Unite against AIDS*" was launched in Rwanda in June 2005 by UNICEF, UNAIDS and other partners around the theme, "Missing face of children and AIDS".

Under coordination of the former National AIDS Control Commission, operationalization of the Global Campaign continued to be through the annual national pediatric conference on children infected and affected by HIV and AIDS and centered a four-pronged approach (Prevention of HIV among adolescents and young people, Prevention of mother to child transmission of HIV, Pediatric Care and Treatment, and Protection of OVC) on addressing HIV/AIDS and children issues.

Looking back to 2005, it is clear that the high level advocacy attained through a technical focus on issues of concern in the achievement of results for children has contributed to the documented change. The six previous conferences had the following themes:

2005- *Children are missing from interventions for HIV/AIDS*

2006- *Ensuring an integrated and harmonized family approach to child survival*

2007- *A focus on Decentralization*

2008- *Equity in financing services for HIV infected and affected children*

2009- *Count down to 2015 targets for children and HIV-Achieving Millennium Development Goal (MDG) 6*

2010- *EDPRS Sectors' response to HIV and AIDS-Focus on Education sector.*

This 2011 year conference focused on "*Focusing on adolescents in the National HIV and AIDS response*". This was seen as a major bottleneck that is especially challenging in the implementation of HIV and AIDS services to attain the goal of universal access to HIV prevention, care and treatment, and social protection of children, young people and women.

1.1. Why focusing on adolescents in the national HIV and AIDS response?

In Rwanda, Adolescents and young people make a majority of the population and constitute the good future of the country. According to the general population census in 2002, 52% are young people under 18 years; 49% of population is under 15 years and 60% are less than 20 years. Adolescence (10- 19 years) is a phase of physical growth and development accompanied by sexual maturation, often leading to sexual intercourses relationships. It is a particularly difficult period of puberty where individuals often try to investigate their sexuality by heterosexual relations or homosexuals' practices exposing them to HIV and other sexually transmitted infections.

According to the rapid assessment of adolescent reproductive health programs (MoH, 2010), 92.0% of interviewed adolescents self-reported being sexually active and estimated age of sexual debut is 12 for girls; 15 for boys). These findings are complemented by findings of the BSS 2009 which found evidence of sexual activity among adolescents even though the average age of sexual debut was much higher than the one estimated by adolescents interviewed during the above assessment. According to the BSS, the median age at first intercourse was 16 and 17 years for males and females respectively. Thirty-one percent (31%) of adolescents and young adults aged 15-25 years reported ever having sex which is a major risk to HIV and AIDS plus STIs if unprotected. The last Rwanda Demographic and Health Surveys (RDHS 2005) showed the prevalence rate of 0.5% in the age group 15-19. There were no significant differences between females and males in this category (females 0.6% against 0.4% for males). However, a remarkable difference was noted among young adult females (2.5%) and males (0.5%).

HIV Prevention knowledge gap is the greatest bottleneck for an effective and sustainable behaviour change among adolescents. According to the Rwanda 2009 BSS, only 9.4% of girls and 11% of boys aged 15-19 had have a comprehensive knowledge of HIV, lower than the country's target of 70% (NSP 2009-2012). Even though the trend to increase the comprehensive knowledge on HIV among adolescent is noted, more likely it has not been translated into positive changes in HIV risk behaviour. The recent 2010 BSS results show that condom use at last sexual intercourse among both the youth aged 15-24 has increased at 43% as compared to previous 2000 and 2006 surveys, whereas consistent condom use among older adolescent (15-19) at last sex remain low (29%BSS 2010). The challenge of consistent condom use among adolescents and young people remains accessibility and availability for attaining the NSP goal of increasing condom use to 93% by 2012. Among various risk factors and situations for adolescents contracting HIV virus are adolescent sex workers, child trafficking, child labor, migrant population, childhood sexual abuse, coercive sex with an older person and biologic (immature reproductive tract) as well as psychological vulnerability. Many young people who know their HIV status often fail to access the health and social services they urgently need, from fear of stigma or judgment, or concern that their HIV status will be disclosed to others. However, national health care systems are not yet adequately tailored to the special needs of this age group. Little guidance on care exists only as a chapter within the 2009 national norms and standards of pediatric HIV care and treatment and many care providers do not have the multidisciplinary skills required for appropriate service delivery.

1.2. Some insights into Rwanda's achievements for adolescents and young people

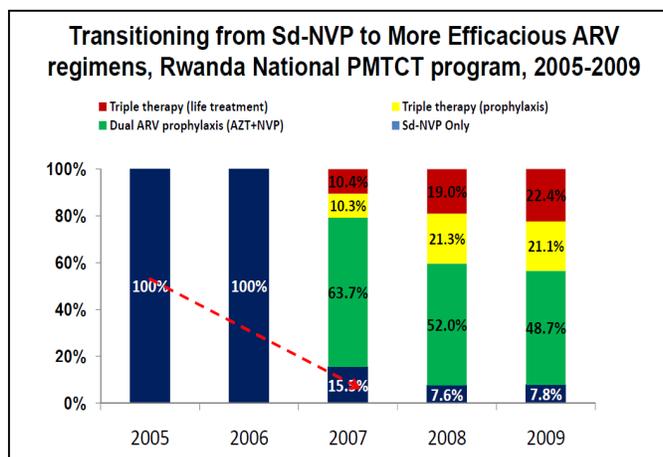
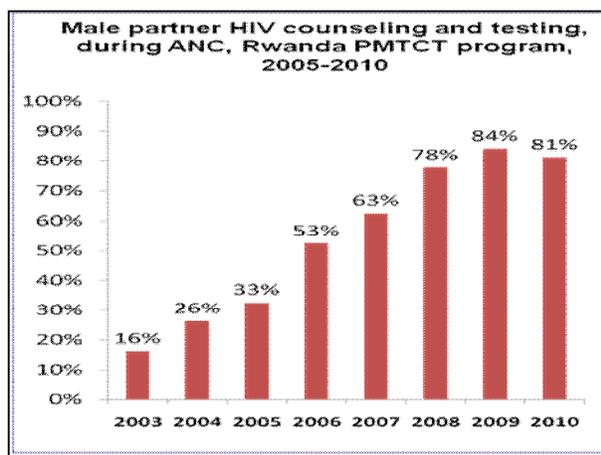
1.2.1. Prevention of HIV among young people

Prevention program has been tailored to the national and local needs and context (National prevention framework NSP). Combination of biomedical, behavioral and structural elements; effective integration of Medical MC as part of the comprehensive package to reduce both the immediate risks and the underlying vulnerabilities; Adolescent sexual reproductive health, right policy, and national strategy; and integration with HIV Prevention among adolescents were designed for better coordination and monitoring of primary prevention. Adolescent girls' awareness increased to limit cross generational sex

and resulted in Voluntary HIV counseling and testing. As a result of increased advocacy, partnerships, increased financing and good coordination, Rwanda has documented a great increase in number of sites offering HIV testing and in people accessing HIV testing. According to UNGASS report 2010, the total of 386 VCT sites were functioning in 2008, the number of VCT sites increased up to 404 in 2009. In 2006, there was an increased number of young people being tested and coming back for their results. In 2000 only 0.8% of girls and 0.9% of boys aged 15-24 had been tested and received the results; whereas in 2006, 12.6% of girls and 11.3% of boys had done so (BSS, 2006). In 2009, these values increased up to 54.8% for girls and 57.7% for boys aged 15-19, showing the success of the Voluntary Counseling and Testing (VCT) policy and its implementation in Rwanda. 50.1% of youth aged 15-24 had an HIV test [Source: BSS (2009)].

1.2.2. Prevention of mother to child transmission of HIV (PMTCT)

The Government of Rwanda aims at reducing MTCT rate below 2% by 2015 and remarkable progress have been made over the past years in scaling up services for pregnant women, their male partners and HIV exposed children. Over the last 5 year significant strides have been made in this area including the introduction of the new PMTCT protocol in 2005 which if well implemented in combination with appropriate infant feeding practices should ultimately eliminate the transmission of HIV from mother to child. Furthermore, with the evolution towards a family approach, men are also increasingly involved in the PMTCT programs: by end of 2006, 74% of men accompanied their partners up from only 9% in 2003. Many sites routinely have over 90% of male partners attending services (UNGASS 2006/2007. The modeling of virtual elimination of MTCT was launched in May 2011 by the Rwanda First Lady in Bugesera District and adolescents and young people will benefit the MTCT services needed. PMTCT is integrated into routine MCH services at all levels, the geographic accessibility to these services has improved, and routine provider initiated HIV counselling and testing of pregnant women with their partners is effective. For instance, 82% of health facilities were providing PMTCT services in 2010 (up from 42% in 2005). About 70% of all pregnant women had access to HIV testing during pregnancy in 2010, and among them 81% were tested with their partners (up from 33% in 2005). Partner testing has



remarkably increased over the past years as a result of a combination of various strategies targeting social norms, behaviours and health systems' bottlenecks.

To increase efficacy of ARV regimens for PMTCT, Rwanda has transitioned from single dose nevirapine (used from 2001) to the more efficacious ARV regimens and has rolled it to all PMTCT sites by 2008. In 2009, more efficacious ARV regimen represented 92% of all the regimens initiated for PMTCT (up from 0% in 2005). However, overall 78% of all HIV positive pregnant women and 74% of all infants born to HIV positive mother received antiretroviral for PMTCT in 2010 (TRACPlus, 2010).

In November 2010, Rwanda adopted the option B for use of ARV in PMTCT of the recent WHO recommendations; therefore, all HIV + pregnant women will receive triple ARV therapy (HAART) starting as soon as possible during pregnancy, and continuing during the entire breastfeeding period up to 18 months.

1.2.3. Pediatric care and treatment

Great achievements over the last 5 years have been documented in care, treatment and support of children infected with HIV. According to March 2011 TracNet report, there were 89,823 people on ART. These include 8,013 children under 15 years of age, representing about 70% of those in need.

The treatment and care guidelines, treatment protocols, and drugs to ensure quality care and treatment are available and are guiding care and support to HIV infected adolescents and young people. The following are key highlights of the increasing focus on HIV positive adolescents at national level: (i) a desk within RBC/TRAC plus in charge of care, treatment and support for HIV positive adolescents (ii) A focus on adolescents within the national norms and standards of pediatric HIV care, treatment and support, (iii) increasing leveraging of partnerships for strengthening national capacity to delivery evidence informed quality comprehensive services at scale. Although still at a modest level, this includes training and mentorship of health workers, reviewing and development of guidance tools and modeling service delivery.

1.2.4. Protection, care and support

The government of Rwanda has put in place an OVC policy and developed a minimum package for care and support for orphans and vulnerable children. Within this policy, care and support of those infected and affected by HIV and AIDS were appropriately addressed. Various studies have been conducted to provide the evidence for programming for OVC. A conducive environment has been set for partners to invest in ensuring survival, development and protection of those affected by HIV and AIDS.

1.3.Challenges that still need to be addressed

1.3.1. HIV prevention

- Comprehensive knowledge: to reach the NSP's target of 70% (curriculum and extra curriculum);
- Consistent Condom use among young people to be doubled;
- Age disparate sex as a driver of the epidemic among young adolescents' girls;

- HIV testing and Counseling with a focus to improve post test counseling and referral;
- Combination prevention: Scale up of medical MC as part of a comprehensive package;
- Focus on Prong 1 & 2 to fill the gap on PMTCT program.

Adolescents and young people continue to be infected with HIV because the great majority of them do not access to services to protect themselves. Attaining an AIDS-free generation means erasing the inequities that fuel the epidemic and protecting those who continue to fall through the cracks. Lack of social protection initiatives, like cash transfers, and efforts to promote access to services; play an important role in linking the cycle of the vulnerability for young people and adolescents in Rwanda. Some report emphasizes the importance of tailoring education program to target the most vulnerable youth – those who are out of school – with information about HIV prevention.

“We must increase investments in young people’s education and health, including sexual and reproductive health to prevent HIV infections and advance social protection,” said Thoraya Ahmed Obaid, Executive Director of UNFPA, the United Nations Population Fund. However, reaching marginalized young people, including vulnerable adolescent girls and those who are not in school, is remaining a challenge. There are no specific HIV prevention activities addressing MSM that were carried out during 2008 and 2009 despite the inclusion of MSM in the NSP 2009-12. According to the MSM 2009 study, the same population felt there was a need for a dedicated, confidential health clinic for MSM, and condom availability lubricants for anal sex. No systematic research has been done for the MARPs including the injecting drug users; there is a great need to generate data on factors of vulnerability to HIV of the MARPS and the most vulnerable adolescents and young people at national levels.

1.3.2. Prevention of mother-to-child transmission of HIV (PMTCT)

There is still highest HIV prevalence among pregnant women (~16% among 15-19 years adolescent cases) and low performance of the PMTCT and other MCH interventions (FP, Delivery in health facilities). Young women still shoulder the greater burden of infection, and in many countries women face their greatest risk of infection before age of 25. The adult HIV prevalence rate in Rwanda is estimated at 3 per cent, and reaches 4.3 per cent among pregnant women, and up to 16 per cent among pregnant women in the City of Kigali. If no interventions were provided to prevent MTCT, during pregnancy and delivery to reduce the risk of HIV transmission to their children, about 20 per cent of them would be born with HIV. Furthermore, 5-20 per cent additional risk of transmission occurs during prolonged breastfeeding with no prophylaxis. This would translate in 6,300 children newly infected by HIV each year in Rwanda.

The cost of inaction is high—most HIV-infected children die within their first two years of life. In addition, children born to mothers with advanced HIV disease are also more likely to die, even if they are not infected. There is also evidence that strengthening of Maternal Neonatal and Child Health (MNCH) platform is a cornerstone to ensure that PMTCT programs reach women and their infants with multiple health interventions at their contact with the health system. Therefore, investment for the achievement of MDG-6 for maternal and child will benefit the achievement of MDG-4 and 5.

While children in general have benefited enormously from the substantial progress made in the AIDS responses, there are millions of women and children who have fallen through the cracks due to

inequities rooted in gender, economic status, geographical location, education level and social status. Lifting these barriers is crucial to universal access to knowledge, care, protection, and the prevention of mother-to-child transmission (PMTCT) for all women and children.

1.3.3. Pediatric Care and treatment

Programming for HIV positive adolescents is an emerging issue given their special needs and the increasing demand for care in a context of little experience and resource constraints. Specific global guidance is not yet available for adaptation to country and cultural contexts. Currently, guidance on service delivery is not yet adequate and exists as a chapter on adolescents in the national norms and standards of pediatric HIV care and treatment. There is need to elaborate more comprehensive and evidence informed tools and approaches to care and to train service providers. Guidance on implementation of the critical transition period from pediatric to adult care needs to be developed and harmonized. In a broader context, adolescent and youth Friendly health services (AYFHS) are not yet developed or institutionalized into the national health care system as recommended by the World Health Organization. Caring for HIV positive adolescents requires multidisciplinary and multisectoral approaches to ensure optimum health benefits. So far, challenges in effective linkages across sectors prevail and hamper access to essential health and social services beyond what can be provided within the health sector. These challenges need to be addressed through clear programming frameworks.

Caring for adolescents living with HIV is an emerging issue. The number of adolescents living with HIV is increasing. This is a result of increasing number of prenatally infected children accessing effective ART and growing up into adolescence and adulthood while a significant number of adolescents acquire HIV infection horizontally including through risky sexual behaviors. In spite of the rapid scale of ART services in Rwanda, several challenges exist with regards to the care of adolescents living with HIV. These include little trained human resources in both quantitative and qualitative aspects, including the health sector. As results, the multidisciplinary team of service providers which are usually required to holistically address the needs of adolescents that are currently lacking in most ART sites in the country. Furthermore, chronic care, for rising number of patients in ART sites, creates a very heavy workload on the already constrained human resource capacity and thus undermines the opportunity to deal with special problem of adolescents living with HIV. Recent routine program reports at TRAC Plus clinic show poor adherence to ART among adolescents, partly attributed to psychological stress and little access to basic needs including education and food. A few incidents of unplanned teenage pregnancies have also been reported.

1.3.4. Protection, care and support

There is an increasing commitment in Rwanda to provide a protective and supportive environment for OVC. This is evidenced by the development of the National Policy on OVC (2003) and other related policies and strategies in social protection, health, education and HIV policy and strategic plan 2009-2012, which include OVC component. A Strategic Plan of Action for OVC which provides the framework for scaled up action in support of OVC (2007) was approved in May 2007. Recently, Rwanda has developed a “Minimum Package of Services for OVC” aiming at ensuring the operationalization of a

holistic approach including psychosocial support, economic empowerment of the household, basic education (formal and non formal), protection against all forms of abuse, violence and exploitation and access to health and nutrition. Access to education is considered as an “essential service” and is included among the key elements of the national response to guarantee OVC access to services on an equal basis with other children as outlined in the UNGASS Declaration of Commitment on HIV/AIDS. As regard to this, Rwanda is likely on track in achieving equal access to education for OVC. Based on the available data from the 2005 DHS, among boys aged 10-14, orphans are 80% likely as non-orphan to attend school; this increases to 87% among girls. However, this is not sufficient to guide countries, organizations and agencies involved in the response to orphan needs. More indicators are required for national level monitoring.

1.4. Conference theme, purpose and expected results

1.4.1. Conference Theme:

Focusing on adolescents in the National HIV and AIDS response

1.4.2. The conference purpose

The purpose of 2011 annual national pediatric conference on children infected and affected by HIV and AIDS was to generate momentum for accelerated and sustainable response (comprehensive, quality, harmonized) to specific issues for adolescents and HIV.

1.4.3. Specific objectives

- Understand the current status of HIV epidemic and response among adolescents;
- Recommend strategic orientations for greater focus on adolescents in the national HIV response;
- Advocate for high level commitment, adolescents participation and multisectoral response to adolescents and HIV

1.4.4. Expected Results

Through a participatory approach involving Government Authorities, all HIV implementing partners, development actors, children, the expected results of the 2011 National Pediatric Conference on children infected and affected by HIV and AIDS, the following were the expected results:

- A better understanding of HIV epidemic and response among adolescents;
- Strategic orientations formulated to ensure a greater focus on adolescents in the national HIV response;
- Advocacy agenda developed for high level commitment, adolescents’ participation and multisectoral response to adolescents and HIV.

1.5. Process and schedule

The coordination of the 7th Annual National Pediatric Conference on children infected and affected by HIV and AIDS involved partners and government institutions working with adolescents in the fight against HIV and AIDS. The Rwanda Biomedical Center/Institute of HIV/AIDS, Disease Prevention and

Control as usual coordinated the process with the support of the children and AIDS steering committee and the Technical Working Groups (TWG). The Children and AIDS Steering Committee provided overall guidance on technical and logistical preparations and ensured advocacy for high-level Conference patronage. The TWGs were responsible for planning and organization of technical issues in their areas of expertise, including developing thematic concept papers, selection of international keynote speakers for their session as needed, mobilize abstracts' submission and their review and coordination of a specific program dedicated to young people.

The 7th Annual National Pediatric Conference on children infected and affected by HIV and AIDS had been held at SERENA hotel from 9 to 11 November 2011.

2. Opening Ceremony

Chaired by Dr. Anita ASIIMWE, the deputy Director General of RBC and head of IHDPC together with Dr. Landry Tsague Chief of HIV section at UNICEF/RWANDA as co-chair, the ceremony started with a warm welcome to the guest of Honor of the event, Minister of Health representing the Right Honorable Prime Minister.

She further addressed a welcoming note to all participants and she presented special guest from the region: Burundi, DRC, Kenya, Uganda and Tanzania. She acknowledged the presence of the UNICEF Regional Deputy Director for Eastern & Southern Africa Region and other key note speakers.

2.1. Welcome remarks from Acting Director General of RBC Dr. Claver KAYUMBA

He began his speech by expressing his greatest satisfaction coupled by the shared joy as he said with all personalities who have made the conference a reality and welcomed the participants on behalf of the RBC-IHDPC and on behalf of all RBC staff who were present in the conference hall of Rwanda revenue authority at Kimihurura.

He recognized that despite multiple activities and busy schedules from participants, They had set aside their preoccupying duties and responded to the RBC invitation and he said also that he thought their efforts and sacrifices they had surmounted all the daunting obstacles to be there to exchange experiences on the response to HIV among adolescents.

He thanked the presence and commitment to accompany the initiative and ambitions of the Government testifying their support and partnership in the fight against HIV/AIDS among adolescents in which our Government is involved and in ensuring the socio-economic welfare and health care for these adolescents.

He also took the opportunity to express his gratitude to the UN family and to the various partners, whose programmes in the fight HIV/AIDS developed in our country have translated the will to win this pandemic which is a threat to all, including children, adolescents or the adults.

He disclosed that Given its theme, the 7th Paediatric Conference was the reaffirmation of government will to promote the education of youth, to help them to become aware of the danger linked to HIV/AIDS and to enable their access to prevention, care and support services to help them successfully face this blight, which is the major objective of the conference during which the knowledge and experiences were shared on steps already made and on the way forward.

Dr. Pierre Claver KAYUMBA said "We wish to express our heartfelt recognition to you all for having given the right place in your busy schedules, to discuss issues related to the fight against the scourge during this important forum that brings us together today so as to continue and consolidate gains we have made for many years since the onset of this pandemic in the 1980's and we salute your contributions towards this struggle".

He ended his speech by expressing a Warm welcome on behalf of RBC and the steering committee on children and HIV, emphasizing that the Reeducation of the youth would be the center of discussion, which should generate recommendations to reinforce programs delivery to value the sacrifice made by all.

2.2. Global situation of the HIV and AIDS response with focus to adolescent

By Mr. Pierre Robert, Adolescent and HIV AIDS specialist UNICEF/HQ

Global snapshot of situation of adolescents and HIV based on the 4Ps as they relate to adolescents

1. Prevention of mother-to-child transmission of HIV
2. Protection of adolescent orphans
3. Paediatric care and treatment of adolescents living with HIV
4. Preventing HIV infections among adolescents and young people

He mentioned that an estimated 5 million [4.3 million – 5.9 million] young people aged 15–24 were living with HIV in 2009. The good news is that a 12% reduction among children has been observed since 2001. However, much still remains to be done, especially in Sub-Saharan Africa region where HIV prevalence is proportionally higher than other regions in the world. In 2009, young people aged 15 – 24 accounted for 890,000 or 41% of all new adult infections (aged 15 years and older). Nearly 1 in every 3 newly infected young people was in South Africa and Nigeria. Rwanda is relatively less HIV prevalent compared to other Sub-Saharan African region countries, but we need to stay vigilant otherwise prevalence might increase.

Important disparities among female and male have been highlighted with higher prevalence for female than male. He mentioned that not enough have been done to keep adolescent girls and young women safe and HIV-Free. Girls have lower levels of comprehensive knowledge on HIV; earlier sexual debut; lower knowledge on where to get condoms; lower rates of condom use; lower knowledge on and higher levels of unmet need for contraception; increased risk for HIV infection as a result of sex with older partners. As a result, adolescent girls aged 15 – 19 years account for 16 million births every year. Driven by the huge numbers and gender disparities in sub-Saharan Africa, young women aged 15 – 24 make up more than 60% of all young people living with HIV globally. In sub-Saharan Africa, they represent 72%.

Mr. Pierre Robert proposed that in order to meet the challenges for adolescents and HIV, the 4Ps have to work in an interconnected manner.

1. P1: PMTCT: Prevention of mother-to-child transmission for adolescents at reproductive age

The challenge faced is that too many adolescents are becoming pregnant too soon. When we look at the percentage of Females 19 years of Age who have started childbearing (DHS-AIS Data), data from the Sub-Saharan region ranges from 63,5% (Malawi) to 34,6 % (Namibia). Rwanda has the lowest rate (14,1%). However, PMTCT services are crucial opportunities for adolescent girls, young women and their male partners.

Recommendations for PMTCT Services

- Age disaggregated programming: PMTCT services need to focus on the specific needs of adolescent mothers which are different than the needs of adults
- Integration of PMTCT and ASRH: PMTCT should serve as an entry point for couples including adolescents HIV testing and counseling and access to Family Planning services.
- Family support and male partner engagement: Ensuring that the family and male partners be involved in the PMTCT process, particularly if they are adolescents or young men.

2. *P2: Protection of adolescent orphans: Protecting Adolescents from the impact of HIV and AIDS*

Adolescent orphans are facing a number of challenges:

- Parent's death (particularly a mother) can lead to increased risk of HIV, especially in young girls. Less likely to complete school, more likely to start having sex and to marry early leading to early pregnancy, STIs and HIV
- Adolescents are often times overlooked in favour of younger children– the assumption is that they can provide for themselves
- Community & faith-based organisations at the forefront of responding to affected children and adolescents – but often in isolation from government policy and services, small scale.
- Despite massive aid efforts the majority of children affected by AIDS are not receiving external care and support (11% in 2011 – global target 80% by 2015)
- 17 countries in East & Southern Africa have National Plans of Action for OVC – but little scale up and not integrated with national development plans.

Recommendations for the protection of adolescent orphans:

- Investments in HIV and adolescent sensitive social welfare and child protection systems, for example cash transfers;
- Investments needed in district and sub-district social welfare systems (both government and non-governmental);
- Improve access to health and social services and ensure that services are delivered to the most vulnerable adolescents;
- Need for better referrals between social welfare (education, housing and nutrition) and health systems, keeping in mind the special needs of adolescents;
- Families and communities need to be central to the effort to improve health and social welfare systems.

3. *P3: Paediatric care of adolescents living with HIV*

An estimated 2 million [1.8 million – 2.4 million] adolescents aged 10 - 19 were living with HIV in 2009, 65% of them adolescent girls.

Paediatric care among adolescent face a number of challenges:

- Adolescents living with HIV contracted the virus either vertically (through MTCT) or horizontally (unprotected sex including rape or child abuse) or through injecting drug equipment with an infected person;
- Limited HIV counseling and testing: The “hidden epidemic” among adolescents: Many adolescents with HIV do not access treatment because they have never been tested;
- Limited access to quality HIV care and treatment: Need to better integrate adolescents services within existing services and develop ways to help transition from paediatric to adult care;
- Restrictive laws and policies: many countries require consent from guardians before adolescents can be tested, and this can delay or prevent their being tested and treated in a timely fashion;
- Overall lack of specialized adolescent clinics and care services.

Recommendations for Better Paediatric Care of Adolescents

Emergent actions should focus on:

- Increasing opportunities for early diagnosis
- Greater involvement of young people living with HIV
- Providing support for disclosure, adherence and elimination of stigma
- Expanding comprehensive services to meet learning, emotional and psychological needs

4. *P4: Preventing HIV infections among adolescents and young people*

In 2010, UNAIDS reported a decline in prevalence among young people of more than 25% in 22 key countries in sub-Saharan Africa between 2001 and 2008. In countries where declines in prevalence have been noted, they have been most marked among young people. However, no single prevention strategy has proved optimal in all circumstances, and many young people remain vulnerable to HIV infection.

In Rwanda data show that condom use among adolescent remains very low, actually the lowest among Sub-Saharan Africa (female 27,75% versus male 37%). There is an urgent need to critically investigate on this (culture challenges?, access to condom?, etc)

Likewise, HIV testing remains low in young men. In sub-Saharan Africa, no entry point comparable to maternal health programmes that provide testing and services for PMTCT for young women. In some countries however, medical male circumcision offers a critical platform for prevention support for young men.

Recommendations for Interventions for prevention

Early Adolescence: Ages 10 – 14

- Sexuality Education
- Mass Media
- Parent-child Communication
- Strengthening the protective environment

Older Adolescence: Ages 15 – 19

- Sexuality Education and Sexual and Reproductive Health
- Harm Reduction and risk reduction through prevention of initiation
- Mass Media and technology

- Engaging young people and the community to change social norms
- Cash transfers to change behaviors
- Addressing stigma, discrimination and legal barriers to access

Young Adults: Ages 20 – 24

- Biomedical interventions including Male Circumcision
- Condom provision and uptake
- Sexual and reproductive health, family planning and PMTCT
- Reaching young people in the workplace

Some progress across all 4Ps

- 12% reduction of HIV prevalence among children has been observed since 2001
- Trends in orphan and non-orphan school attendance ratios increases with time from 1997-2008
- Going beyond medical care: A consensus reached at 2010 global consultation on ALHIV in Uganda, Brazil ALHIV study and Zimbabwe HIV care facilities survey, all agreed that what ALHIV want are: Supportive family, community and school environment, assistance for disclosure with their families caregivers and partners, mental health and psycho-social referrals and if necessary RH services and HIV prevention information, skills and services.
- Safe practices of young injecting drug users
- Young female sex workers: Condom use and HIV testing
- Young men who have sex with men: Condom use and HIV testing

- **Key Recommendations from the Presenter**

Linkages across 4Ps

- **Service Access and Utilization (Prevention and PMTCT & Care and Treatment):**
 - Surveillance and age disaggregation
 - Service provider training and facility changes
 - Outreach, task shifting and innovation to reach adolescents, increase demand and deliver services (risk reduction counseling for HIV negative adolescents, sero-discordant couples)
- **Vulnerability Reduction (Prevention and Protection):**
 - Care and Protection systems
 - Economic empowerment, cash transfers
 - Self efficacy skills
 - Keeping girls in school, getting girls back in school
- **Awareness Raising and Addressing Low Risk Perceptions (Prevention, PMTCT, C&T and Protection):**
 - Risk reduction counseling
 - Family centered care

2.3. Current situation on the National HIV and AIDS response with focus to adolescent

By Dr. Placidie MUGWANEZA, Director of HIV Prevention Unit at RBC-IHDPC/HIV division

She started by presenting the proportion of adolescents to the Rwandan general population whereby adolescents (10-19 yrs) represented 23% of the general population of Rwanda in 2008, the total number being 2.3 million. About 30% of the population will become adolescent in the next 10 years. These show that adolescents are an important portion of Rwanda.

Adolescents and HIV Primary Prevention

Current situation in Rwanda:

- HIV prevalence: 0.5 (15-19 yrs DHS, 2005) similar for boys and girls
- Disparity increases with age: Young girls 20-24 years are 5 times more infected than boys counterpart.
- An estimated of 11,306 adolescents aged 15-19 yrs are living with HIV
- According to recent 2009 National Behavioral HIV Surveillance survey among youth (BSS, 2009), only 12% of youth 15-24 have comprehensive knowledge about HIV/AIDS, a decrease as compare to 24% in 2006, but this is linked to a change in the definition of the indicator. However, all the other indicators are showing positive trends between 2006 and 2009, more young people know their HIV status and are using condom at last sex. About half of youth know their HIV status (up from 26% in 2006), and about 60% of young boy used condom at last sex. But, half of young people do not know their HIV status and about 37% not use condom at all in the last sexual intercourse in the past 12 months.
- Young people in urban area are more sexually active than in rural area. The median age at first intercourse is 16 and 17 yrs for males and females respectively
- According to BSS 2009, only 13% of youth 15-24 reported having been circumcised, majority residing in urban area.

Adolescents and PMTCT

Current situation in Rwanda:

- Among adolescent pregnant women, HIV prevalence ranges from 3-16% based on the 2007 sentinel surveillance data. Adolescent pregnant women in Kigali are more infected with rate reaching 16%.
- Overall, youth have a fairly good knowledge of ways vertical transmission of HIV occurs.

Adolescents and HIV Care and treatment

Current situation in Rwanda:

- In 2011, it is estimated that 37 870 adolescents are in care in a sample of 109 sites in Rwanda, representing 9.5% of all patients in Care.
- The proportion of adolescent on ART has increased overtime (from 4.4% in 2007 to 5.6% in 2011).

Adolescents and OVC

Current situation in Rwanda:

- School attendance among orphans and non orphans aged 10-14 (RDHS 2005)
 - Orphans: Male: 70,1%; female: 78,8%
 - Non-orphans: male: 90,4%; female: 91,5%

Existing strategies, policies and interventions

- Adolescent is a national priority in HIV prevention (NSP 2009-2012)
- Desk of ASRH in Ministry of Health
- Desk in charge of ALHIV in RBC/IHDPC
- ASRH Policy and Strategic plan 2011- 2015
- HIV C&T guidelines
- Integrated Child Right Policy and its strategic plan were developed and approved
- Development of communication guide between parents & Children on sexual relation, reproductive health and HIV/AIDS

National Campaign:

- 2008: WITEGEREZA ("Don't Wait!" - promoting parent-child communication about SRH)
- 2009-2010: SINIGURISHA (I Am Not For Sale!- fighting against cross generational sex)

Youth friendly Centers:

- Voluntary HIV counseling and testing
- family planning
- promotion of correct and consistent condom use,
- STIs screening

Education sector

- Training of teachers in schools

Health facilities:

- Voluntary HIV counseling and testing
- Treatment of sexually transmitted infections (STIs)
- Care and treatment of HIV/AIDS
- Training of trainers on adolescents care and treatment
- Practical training sessions of health care providers in pediatric center of excellence

- **Key Recommendations from the Presenter :**

Key areas of focus for adolescents and HIV programming

- Accessibility of adolescent friendly services
- Availability of adolescent support group in all health facilities
- Package of services for pregnant adolescents

2.4. Remarks and introductory note to UNICEF regional Authorities

By Mrs Norah SKINNER, UNICEF Representative on behalf of UN Resident Coordinator/Rwanda

On behalf of UN family in Rwanda, she was very pleased to join the conference not only to introduce the Deputy Regional Director of UNICEF's Office for Eastern and Southern Africa, but also to congratulate the Government of Rwanda and the RBC/IHDPC in particular for focusing on adolescents and HIV.

She said that Rwanda has made tremendous progress in promoting access to VCT and PMTCT and in launching a national campaign to eliminate the vertical transmission of HIV. However she thinks that we will not be able to sustain gains in prevention, if they do not focus on the needs and rights of adolescents in Rwanda who currently represent 40% of new infections in the country.

This young generation has a right to knowledge, service and care. UN family is particularly pleased that the conference will give these young people the forum to air their views and influence decisions that will affect them. Indeed, the UN family in Rwanda remains committed to offering whatever technical and financial support to ensure that adolescents have universal access to effective prevention and most importantly quality youth friendly care and support services. She said that UN Family is also pleased to be a longstanding partner of the Government of Rwanda in organizing the conference and particularly privileged this year's event. On that note, she invited UNICEF Deputy regional Director to give her remarks.

2.5. Remark from the UNICEF regional Deputy Director

Ms. Elke WISCH, Regional Deputy Director UNICEF/ Eastern & Southern Africa region

In her remarks, she started by thanking Rwanda's Government for inviting her to speak at this very important conference and in particular to be part of such an illustrious panel.

She said that two million adolescents aged 10- 19 already living with HIV and most of them do not know their HIV status: that 2500 young people are infected with HIV around the world every day and that young people aged 15 - 24 account for 41% of new infection globally and 40% in Rwanda, it is clear that the time to act is now.

She congratulated the Government of Rwanda and partners for the timeliness, the incredible progress that has been made in the country to prevent the transmission of HIV from mother to child and also to ensure that children who are in need of treatment have access to it. She mentioned the challenges to transfer these successes to the area of adolescent programming.

According to her, adolescents in Rwanda face three main challenges: (1) lack of information and knowledge about how to protect themselves from HIV and other sexually transmitted infections, (2) many of them do not know their status and are at an age when they are sexually active and engage in unprotected sex, (3) those who live with HIV have often lost one or both parents to AIDS, face stigma and discrimination and sometimes live in child headed households.

In order to go forward, we need to strengthen the continuum of care to help keep children and adolescents HIV- free and meet the special needs of those already infected.

There is a need to:

- Provide young people with information and comprehensive sexuality education;
- Increase the number of adolescents and young people who know their HIV status;
- Scale up proven intervention of HIV prevention and expand comprehensive services for young people living with HIV, paying special attention to adolescents;
- Engage young people like we are doing today to improve the demand and update of effective prevention services and commodities;
- Strengthen child protection and social protection measures to prevent exploitation of vulnerable children and adolescents;
- Establish laws and policies that respect young people's rights.

Rwanda has the political will and the ambition to ensure that crisis facing your adolescents today will be a story of the past, tomorrow. She hopes that after listening to adolescents, we all will feel a renewed commitment as parents, teachers, providers, communities and leaders to build a positive and protective environment for them.

Reference made to Executive Director of UNAIDS, she told to adolescents that they are not only the leaders of tomorrow but the leaders of today. It is only in partnership with adolescents that we will achieve an HIV free generation.

2.6. Opening remark from the Guest of Honor,

Honorable Minister of Health, Dr Agnes BINAGWAHO

She first expressed her great honor to be present in the conference representing Government of Rwanda especially the Right Honorable Prime Minister and other three members of cabinet namely MINEDUC, MIGEPROF and MINICYOUTH which were not able to attend due to others duties.

She recognized the presence of regional delegations, Permanent Secretaries present, Head of RBC specially the Deputy Director General of IHDPC, Dr Anita ASIIMWE, as well as children and HIV steering committee for good preparation and organization of the conference.

She started by reiterating her commitment to implement all recommendations that adolescents will propose. She said that the challenges ahead are many, but she invited kids to challenge us and make us work.

The age of adolescence is a hard one. It is an age where strength is needed, where it is difficult to talk to adult people, where the maturity is not yet reached, etc, but, as we think to sustainable solution, we have to be creative and make it happen for them. We don't compare with people that are worse than us but with people that we want to become.

According to the presentation "Current Situation of the National HIV and AIDS Response with Focus on Adolescents, Rwanda presented by Dr Placidie from RBC/IHDPC, she invited the adolescents to change the data showed in the presentation, as they have to enjoy their lives. The data or the rate of HIV among adolescents is too high in Africa but this is not a fatality or a calamity, because Africa usually does better in other areas.

It is unfortunate that **72%** among adolescents living with HIV are girls. The GoR has taken serious measures to protect and empower young girls through different programs like moving from 9BE to 12BE; VUP; UBUDEHE; training teachers to talk about reproductive health. The GoR strong commitment to change has placed Rwanda into a trajectory of change. We have to choose a strong car, and the way we want to go; a destination whereby all of those bad indicators are history.

She provided an alternative to reflect on, in order to go faster: (1) health facilities, especially health centers are closed during the week end. There is an opportunity to use them in that period as friendly centers and make them work for adolescents. (Example: teach to young adolescent on how to use the condom, family planning, and other relevant aspects.) (2) the necessity to continue mobilize people after closing a campaign.

She said that it is the first time we ask kids to protect beyond themselves and protect others with condom. We ask them a lot; let us create the environment we need for them to be able to achieve what we expect from them.

She again reiterated the commitment of the Government of Rwanda to take every necessary decision and action to protect our future generations.

On that note, she declared the 7th Annual National paediatric conference on children infected and affected by HIV and AIDS official opened and wished participants fruitful discussions.

2.7. Other Activities (Cultural Presentations)

Mashirika Troup performed three performances:

1. Song by young girls choir aged 7-10 year. The title of the song was "Ejo Heza". The key message was to request adult to help them having a decent behavior for a brighter future.
2. Drama: Jessica and Bob Story. Mutandao Jeunne

Drama script:

Jessica and Bob are teenagers and school going, they fell in love following their friends which friends they thought are having a good time as lovers. Couples at their school are fashion and anyone who does not want to be left out of fashion has to look for a partner. Bob is from a humble background; his family is not so rich. Peer pressure makes Bob's life not satisfied with what he has, he too wants to be competitive in all sorts of things from clothing, food and many other things. Bob gets ideas from friends; he too can foot the competition if he accepts to go for a sugar mummy. Jessica is not aware, Much as

Bob is in love with her he has a sugar mummy who satisfies his financial needs and Jessica whom he loves as an age mate who also gives her company at school to feel good amongst other youth. One time Bob agrees with Jessica to have sex, Jessica is quite conscious about her life not getting pregnant and fear of STDs, she insists Bob looks for condoms and Bob goes looking for condoms but he fails to easily access them, he is turned away by the pharmacist where he goes to buy condoms, claiming he is young why engage into sex, eventually Jessica gives in, they make unprotected. Jessica later learns that Bob is in love with a sugar mummy. Jessica becomes suspicious of her life and decides to go for an HIV test and it is not easy for her to access the services, most of the places she visits are the same places visited by older people and she is shy to sit between old people fit to be her parents, big sisters etc. Finally Jessica gets tested and finds herself HIV positive, she breaks the sad news to her boyfriend Bob. Bob doesn't want to believe it but he has to face the reality and has to go for the test, he too experiences the same problems of getting tested for HIV and ends up not tested.

3. Song by young adolescent about HIV prevention.

3. TECHNICAL SESSIONS

SESSION I: PREVENTION OF HIV AMONG ADOLESCENTS AND YOUNG PEOPLE

Theme: [Improving access to comprehensive HIV prevention and SRH friendly services to adolescents](#)

3.1.1. Presentation of International Key Note Speaker

Asha Mohamud, Youth and HIV Advisor, UNFPA-ESA

Rick Olson, Senior HIV Prevention Specialist-UNICEF-ESA and

Amadou SECK, Prevention Specialist Adolescent -UNICEF-Rwanda

The presentation has been prepared by Asha Mohamud and Rick Olson, it has been presented by Amadou Seck on behalf of Asha because the author of the presentation could not attend the conference.

He introduced the presentation on epidemiological background of HIV among youth at global and regional levels. He underlined that sub-Saharan Africa countries are the most affected than other parts of the world. Globally, about 4.9 million of people living with HIV, 80% are in sub-Saharan Africa, 60% in Eastern Africa where Rwanda is situated. Among them 55 % are young people and 70 are female. Above all, globally, 40% of new HIV infections occur among young people 15-24; and 2720 are new infections every day.

In response to this alarming situation, the interesting progress is being made. He noted a **declining HIV prevalence** in some high HIV affected countries. He mentioned **Increasing of number of circumcised young people** because of initiation of national plans to scale up access to medical male circumcisions among the countries with high HIV prevalence and low level of male circumcision. He indicated also the **investment in health systems** and **increasing school enrolment rate**.

Global Leadership on Prevention of HIV among Young People came up with the following outcome results to reduce new infections in young people by 30% by 2015:

- Increase the comprehensive knowledge to 80% (through Sexuality Education)
- To promote the Double condom use
- To promote the Double HIV testing

Some challenges were also identified:

- Insufficient leadership support for responsive prevention services for young people
- Barriers to access to health services including
- Inadequate investment in service delivery for young people.
- Attitudes and competency of health providers
- Underutilization of schools as an entry point for improved service delivery to young people.
- marginalization of adolescents most at risk for infection

- Parents and teachers not well equipped to address sexuality education for adolescents.

3.1.2. Presentation of National Key Note Speaker

NKURANGA Alphonse

Executive Secretary/ National Youth Council-RWANDA

The presenter goes through the data of HIV prevalence among adolescents and young people in Rwanda.

Adolescents between 15-17 and 18-19 are respectively 0, 3% and 1, 0 % (DHS 2005); in rural area HIV prevalence rate in girls between 15 and 19 years of age is higher than in boys (0.6% vs. 0.4%) and in urban areas, the rate rises to 3.9 % for young women and 1.1 % for men.

He talked also about the status of comprehensive knowledge among young people and adolescents where he showed how the Comprehensive knowledge decreased to 9.4% for girls and 11% for boys in 2009 and use of condom still low about 41%. The VCT had increased from 0.8% of girls and 0.9% of boys in 2000 to 54.8% for girls and 57.7% for boys in 2009

Among the achievements the Presenter mention the national policies regarding young people elaborated. He cited the Youth Sector Strategic Plan (MIJESPOC), Adolescent Sexual and Reproductive Health Policy and its strategic plan (Ministry of Health), School Health Policy integrating sexual, reproductive health and HIV prevention and its strategic plan (MINEDUC), Norms and Standards for Youth Friendly Centers in Rwanda (MIJESPOC).

He presented also the main challenges affecting the young people. Some are:

- Lack of strong coordination of Adolescent health programs among ministries and key stakeholders;
- Inadequate access to HIV/SRH friendly services and linkage between health services Youth friendly centers and schools;
- Limited number of adolescent-friendly centers providing HIV comprehensive services;
- Insufficient advocacy for ASRH&R at central and decentralized level;
- Lack of supportive environment to protect adolescents against risky sexual
- Lack of research on ASRH&R, including information on the current trend on substance and drug abuse among adolescents;
- The increased sugar daddy phenomenon among young girls;
- Persistence of cultural barriers on ASRH&R, especially parent-child-communication and sexual education

Discussion and Interaction

- **Regarding challenges to integrate HIV prevention programs into curricula and other school programs**, some progress has been made but there is still a lot to do: An assessment of gaps in curriculum programs conducted; HIV/AIDS program is mainstreamed in Curricula and others programs. National HIV education policy developed assessment of gaps in anti-aids clubs and guide lines of anti-aids clubs under development and training of teachers in HIV and SRH programs to ensure guidance to anti aids clubs in their respective schools.
- The DRC delegate suggested making programs based on disaggregated data of different categories of youth (in and out of school youth, street children, ...)
- **About the appropriate program, approach and strategies to reach** in and out of school youth and marginalized young people, the below programs were implemented: mass mobilization through radios and youth friendly centres.
- A youth living with HIV suggested involving them in program designing and implementation such as in peer education to share the experience with other youth and create forums for schooling youth.

3.1.3. Social and psychosexual relationships among older Adolescents

Esron Niyonsaba

The presenter started by the definitions of some key words used such as Adolescents, Agency and sexuality and he explains the methodology and data collection tools used. He presented some findings; they have their way to define and interpreted AIDS like **Sintinya Indwara Data Atarwaye** (I don't fear a disease from which my father did not suffer).

Some risky behaviour is met among youth:

- Lack of sexuality education or kind of sex education by traumatising and intimidating messages in terms of warnings.
- There is uncontrolled use of technology like phone and surfing on internet to watch porno films.
- There is a lot of peer pressure to call upon youth to do sex to prove their one's manhood/maleness.

The young people confirmed that the ABC is difficult to observe because Abstinence is almost impossible and condom is not correct and regularly used.

3.1.4. Sexual behavior and reproductive health among adolescents living with HIV enrolled at RBC/IHDPC clinic

TUYISHIMIRE Diane

Dr Diane TUYISHIMIRE described the situation of knowledge of young people globally where only 34% of young people possess accurate knowledge of HIV (UNAIDS, 2011 while in Rwanda Among 15-24 years old found that 51% consistently used condom at the last sex, 97% of them have heard about STI, only 12% had a HIV comprehensive knowledge.

She presented the study question what was the Access to Sexual and Reproductive Health services for adolescents in general and for HIV infected specifically and objectives of study such as; To determine the patterns of sexual behavior and reproductive health among adolescents living with HIV followed at IHDPC/RBC /HIV clinic, To assess the sexual behavior patterns of infected adolescents, To assess the level of knowledge they have with regard to the prevention and transmission of HIV infection.

Key findings show that about the knowledge on RH, 81.1% of all adolescents have benefited information and support on reproductive health and 85.5% of girls are more informed on RH than boys. Among 8.4% of adolescent who have ever had sex, all above 15 years, boys (12%) have three times had sex compared to girls (4.4%); Day scholars have ever had sex five times more than boarding ones. 2, 8% of adolescents are trading sex for money, regarding the condom use, 60% of adolescents reported using condoms during last sexual intercourse among 8.4% of adolescents sexually active only 8.7% have disclosed their status to their partners.

She compared the results of study with others of the same domain of the same area from Rwanda Liberia Zambia and Kenya.

3.1.5. Use of hotline to access information on HIV/AIDS, STIs and reproductive health in Rwanda

(A description of callers (10-19 years) from June 2010 to October 2011)

KANZIGA Francoise

Head of Documentation center

RBC-IHDPC

Madame Francoise presented the result of use of hot line to access the information by adolescent (10-19).

The result showed that the 26% of the callers of hot line was the adolescents in the age group of 10-19 years, (22%) are the girls and 78% were male. Adolescents from the Northern Province (34%) used the hotline more frequently. The proportion of female who used the hotline was higher in the City of Kigali (40%) followed by those from the Southern Province (27%).

The most of the questions asked focused on the knowledge of HIV/AIDS (46%), means of HIV/AIDS prevention (30%) and reproductive health (7%). Male Circumcision was a concern of 28% of all male adolescents and 9% of all female asked about the cervical cancer vaccine

Some key challenges highlighted are the quality of the discussions which is affected by the quality of the phone connection, use of mobile phones rather than an appropriate call Center

She mentioned the way forward like the monitoring of the quality and usage of the service, the evaluation the quality of hotline services, test calls to the hotline

1. Discussion and Interaction

- Hot line is a good program but it should be better to extend its working hours (24/24). In this regard, the presenter indicated that hotline programs go with the needs expressed by youth and the period such school vacation period.
- The question related to minimum package for SRH services offered to youth in former TRAC+, it was made clear that the minimum package is available and guide all services.
- On the issues of considering social, cultural, religious and gender factors in HIV program designing, it was highlighted that all programs take into consideration all needs of beneficiaries of the program.
- Regarding promotion of condom use, it was suggested making advocacy to faith based organization to partner with others in this program.
- It was also suggested to set up a protective environment to youth in terms of HIV prevention and establish the network between the young HIV positive with the young HIV negative and promote male circumcision.

RECOMMENDATIONS

- To strengthen coordination & harmonization of youth HIV programs at national and district levels.
- To strengthen utilization of strategic information regarding most-at-risk adolescents (especially marginalized and out of school youth) HIV prevention programming.
- To strengthen HIV is testing and Counseling and condom programming mechanisms targeting youth.
- Sensitize parents to talk about sexuality with their children.
- To promote involvement of adolescents in designing and implementing SRH and HIV programs targeting them.
- To revise sex education programs based on drivers of the SRH needs of adolescents and youth.
- To increase the number of youth friendly VCT centres (at least one in each district).
- To integrate the ASRH friendly services in all health centers.
- To increase number of working hours during night for hotline service.
- To increase comprehensive knowledge on HIV and SRH through sensitization campaigns and other youth popular communication tools.
- To involve more communities and parents in HIV prevention and SRH program implementation targeting youth.

- To promote counseling in schools, especially for youth living with HIV and AIDS to help them to make informed sexual decisions, communicate effectively on sexual issues.
- Identify and scale up the best practices in line with voluntary counseling and testing for youth.

SESSION II: PROTECTION OF ORPHANS AND OTHER VULNERABLE CHILDREN (OVC)

Theme: Building adequate strategies and programs for HIV and AIDS impact mitigation and protection of adolescents

3.2.1. Presentation of International Key Note Speaker

Mr. Pierre Robert

Adolescents and HIV/AIDS specialist

UNICEF, HQ

Summary of the Content or Main ideas of the Speech/ Presentation (5-10 lines):

- HIV very prevalent among people 15-24 years old, especially in females 19+.
- GBV: beyond physical trauma of rape, abuse, forced sex; it includes: non-sexual physical violence, sexual coercion
- GBV and HIV: GBV survivors are at increased risk of HIV. HIV+ people have higher chance of doing risky behaviors. GBV perpetrators are at a high risk of HIV: unprotected sex with unprotected victims. Self-perpetuating cycle.
- **Key challenge:** break the cycle
- How protect youth victims of GBV?
 - Data informed, evidence based
 - Country driven
 - Support interventions: policy, legal reform, primary prevention, services for survivors
- Key findings: 4 factors lead to vulnerability: low household wealth, low education of adults, head of house is not parent or grandparent; parents are missing from the household.
- HIV prevention: social transfers: cash and food transfers get and keep kids in school; school protects girls from HIV infection, HIV+ girls more vulnerable.
- OVC & gender: synergies
 - OVC: food, nutrition, security
 - Shelter and care
 - Protection
 - Health care
 - Psychosocial support
 - Education training
 - Economic strength
 - Gender: equality, including maternal and reproductive health

- Addressing male norms and behavior
- Reducing violence and coercion
- Increase women's and girl's access to income and productive resources and education
- Increasing women's and girls' legal rights and protection
- **Key Recommendations from the Presenter**
- 3 pillars of HIV Sensitive Social Protection:
 - Policies and legislation to : address social exclusion, reduce stigma and discrimination, ensure access to range of essential services
 - Financial protection: including social transfers that protect households affected by AIDS from poverty, reduce negative coping strategies, address inequalities including gender that drive epidemic.
 - Access to affordable quality HIV sensitive services: affordable access to health services, ensure continued access to other services like education, increased access to a family based support.

3.2.2. Presentation of National Key Note Speaker

Mr. Damien Ngabonziza, MIGEPROF

Adolescents include: orphans, street children, working children, kids with disabilities, young sex workers, poor families, child offenders, children in refugee camps.

- Background:
 - Worldwide, adolescents are overlooked
 - In Rwanda, trying to overcome this, but policy is not enough: implementation is still lacking.
- Achievements
 - Conducive environment in Rwanda for protection, development, etc for those affected by HIV/AIDS
 - Laws
- Strong policy and framework, but implementation with focus on adolescents to be improved
- Lack of livelihoods/resilience is one of the factors that aggravate adolescents' risk to sexual abuse/ pregnancy, with consequences: education, family, poor self esteem, depression , STIs, HIV, etc.
- Adolescents can be victims or perpetrators of violence, explore prevention and response among this group.
- Model to build adequate strategies: government' strong staffed and resourced to protect children; communities organized to id. Children and families in crisis and provide social support and safety net; economically stable, nurturing and health-wise families are able to provide for their children; healthy and resilient children are active participants in their own development.

Key Recommendations from the Presenter

- Conduct vulnerability assessment of youth in Rwanda
- Develop integrated adolescent strategy
- Get boys and girls in gen into developmental agenda, not just on the social protection agenda taking advantage of the development in EDPRS2
- Mainstream SGBV and HIV prevention and response
- Revisit strategies to prevent early pregnancy
- Make drug/alcohol abuse strategies.

2. Discussion and Interaction

- Key Points of Discussion, Questions, Answers, Observations of Participants
 1. Participant 1: We need to look at lists of policies and laws to ensure HIV emphasis.
 - a. Damien: yes, thank you for that recommendation, but most of the policies are just beginning to be implemented so it hard to review them. There is a written review of policies of strategic plans and we have just finished the OVC review. This is linked with the child policy. We should strengthen this in our main policies.
 2. Participant 2 of the Faith Connection: there are kids born out of unwanted pregnancies; difficult beginnings without love or kindness. We need to think about them. Also: discrepancy in Rwanda statistics presented today: please clarify.
 - a. Damien: I think it's true, but can we assume that they are necessarily more or less vulnerable as youth to sexual abuse? I think this is another category in our gender policy, but until we have evidence that these children become more vulnerable, which is what an assessment can prove, then we can make more policies from there.
 - b. Good to conduct a study and see the risk for them when they grow up. We did this in DRC, and the risks were much higher: infanticide, rejection from mother or community, and/or becoming street children. Ground breaking study done by MIGEPROF, www.migeprof.gov.rw. Click on VAC conference for more information.
 - c. Damien: statistics: yes, I saw that, too. We should collaborate.
 3. Participant 3 from Drew cares; the African culture guides average people, but its not addressed in these presentations; we need to take culture into account moving forward.
 - a. Culture and sexual behavior: when I was a kid, sexual behavior for males was encouraged, and girls was discouraged. As a young adult, females began to get out, go to school, in mainstream of society, so more exposed. This needs to be studied how culture has changed and modified. It always depends on the country and culture you're in. For example '68 in Europe was a time of sexual freedom. We should see what element in our culture makes it possible: we have

an analysis on culture factor that can encourage or hinder children in sexual violence.

4. Participant 4, of L'agence de Rwanda, In addressing the death penalty, there are cases of women sentenced to death but never executed in Swaziland. Is there a link between women and unnecessary condemnation against them?
 - a. Pierre: I'm not a death penalty specialist nor a specialist on Swaziland, and it would be unfair for me to answer that sort of question. There are others that are more suited to it than me.
5. Participant 5: in Pediatric HIV care and treatment, is there better access to essential social services for adolescents affected and infected by HIV, especially in health, local government, MIGEPROF/education. In Health we have social workers: but don't see them empowered to link people to health facilities, like kids with HIV.
 - a. Damien: Community Health Workers attached to MOH, there are many suggestions to work more with them in terms of social services as well. We still need to explore, also talking about other mentorship systems, developing social work training, using university students working with CHW but closer to social workers. Good to think of and to consider in our policies.
6. Participant 6: UNAIDS South Africa: post exposure prophylaxis: if a young girl is sexually abused, how are they managed in Rwanda?
 - a. Francesca: 2 one-stop centers that provided post prophylaxis, but still need to focus on developing this.

3.2.3. Empowering adolescents and youth through market-led technical vocational education training

Claudine Mutamuliza

CHF: USAID/ Higa Ubeho

Formal secondary school does not always lead to employment, so technical /vocational training gives a step up.

5 steps: identificaton, orientation, training youth, establish links for youth, youth's link to jobs.

- Id human resource and skills gaps: national skills audit, EDPRS; assess quality TVET centers.
 - Orient RPOs and youth with TVET; regional meetings with youth
 - Train youth in TVET 577 students
 - Establish industrial attachment/ internship.
 - Get youth jobs: 42% secured work with 25k-100k per month.
- o Challenges:
- Negative perceptions about TVET: only for students that failed out of school
 - Update info about marketable skills
 - High tuition costs
 - Availability of quality 10/29 centers assessed met minimum criteria for program

- Additional skills needed for employment: English language skills, workforce readiness, entrepreneurial skills, information and communication technologies
- Conclusion:
 - Market-led TVET helps vulnerable youth get employment and self-reliance and confidence

3.2.4. Giving hope

Archimede Sekamana,
YWCA Rwanda

Objectives of the presentation:

- Restore Family relationships and social structures
- Recognize and develop skills of CHH
- Strengthen institutions' capacity to build child – centered empowerment programs and networks

Methodology:

- Children create their own psychosocial support by forming working groups - five to sixteen members (Heads of Households) and choose a mentor (Community Volunteer for Guidance)
- Children create their own personal and Households' "Dreams"
- Children are trained as "peer educators" who train other orphans
- OVC groups plan and implement Income Generating projects that produce a "loan fund" and dividends. (Individual Households simultaneously begin households income)
- OVC working groups are linked to the Community structures to access education, health, and advocacy.

Impact:

- This program has reached 16027 OVCs within 5479 households
- 504 former OVC were elected as leaders in their communities
- 212 families have been reunited resulting in street children and foster families

The presentation has been ended by the video show of one of its beneficiary Martin and his story where they showed what was the effort of Martin to achieve the good results.

3.2.5. Impact of social economic factors in education of HIV+ adolescents followed at RBC/ IHDP/HIV clinic

Christine Umurerwa,

Lack of information about AIDS related problems for kids and why drop out of school

- Objectives: identify social and economic factors influencing education among HIV positive adolescents enrolled in IHDP HIV clinic; to find out living conditions of the youth
- 151 youth: 73 girls and 78 boys; self-administrated questionnaire, parental permission
- 50% (majority) live with family member, aka orphan. Those living w/o parents highest percent of missing school.
- 78% of students that fail are orphans, orphans fail 3x more than non-orphans
 - Key Recommendations from the Presenter
- Need to devise follow up of HIV positive adolescents in school , especially orphans
- Study focusing on day to day life of youth living with HIV

Discussion and Interaction

1. Participant 1: When building capacity to have a plan to mainstream HIV at all levels (TVET Centers, work place)
 - a. Claudine: Work with all stakeholders to incorporate HIV/AIDS in all programs, Anti-SIDA clubs in schools, Holiday Camps for children in USAID/Higa Ubeho program to teach HIV, workforce readiness.
 - b. Archimede: within our program, the youth get various trainings, including HIV prevention training, sex and reproduction health education. There are some leaflets out in the foyer about the various trainings.
2. Participant 2: what criteria do you use to select your target groups?
 - a. Archimede: Work with local authorities to select youth in the programs. Also use ubudehe, local lists of vulnerable people.
 - b. Claudine: with USAID/ Higa Ubeho we use MIGEPROF criteria
3. Participant 3: Looking forward from TVET, how do you see this methodology scaled-up, especially in terms of sustainability?
 - a. Claudine: UHU program works with local organizations; to scale up, we work with civil society so that as Higa Ubeho phases out, the RPOs will take over and implement the program.
4. Participant 3: What are the critical interventions you created in institutions? Are you impacting numbers and results only? Or local organizations that will continue?
 - a. Archimede: many other organizations have copied our methodology, we consult with MIGEPROF to impact their policies, and we hope that other stakeholders will implement the program. The expertise is now being awarded worldwide, and replicated in neighboring countries. For example in Kenya, we're not mentoring them, but they've taken the methodology, and are using it.
5. Participant 3: How are you linking youth within the national policies? Ubudehe, social protection, etc so we can keep kids in schools?

- a. Christine: work with parents, and most of them are in the ubudehe program. Many of the youth are in programs that are involved with Ubudehe. Ubudehe 1 and 2 count for 25% of the population, this is done directly by local authorities, so even though the kids are from the clinic, local entities watch those kids that are defined by Ubudehe 1 and 2. Not all kids drop out from poverty, but for other reasons.
- 6. Participant 4: does the TVET program prepare youth for life after TVET? Numbers are still low.
 - a. Claudine: 42% of TVET graduates get jobs, compared to the national 10% of regular school graduates getting jobs after graduation. We are looking to improve with entrepreneurial skills so that youth can create their own employment.

Discussion

1. Participant 3: regarding youth living with HIV, there is still a level of disconnect at clinical and facility level for comprehensiveness of care and support. The health center seems to be the best point for checking for quality and comprehensive care and support for youth living with HIV/AIDS.
 - a. Claudine: HIV/AIDS referral system is part of the USAID/ Higa Ubeho program.
 - b. Archimede: no discrimination, we don't want to single out those affected by HIV/AIDS; referral system, nothing within our own systems. Dreams give self-confidence, prevent HIV/AIDS acquiring behaviors.
2. Participant 5: Last year's conference addressed nutritional support for youth living with HIV in school. Used to be WFP for food and they've always wanted to scale up this program, but now they've stopped. Food and nutrition is critical in the lives of youth living with HIV in schools.
 - a. Esron: last year addressed a similar question and it was generally decided that it is best not to single out and stigmatize HIV/AIDS youth, but focus on whole-school nutrition.
3. Participant 6: have you identified HIV status among TVET and other youth beneficiaries and what special care to they receive?
4. Participant 7: I support participant's comment, and we should address the limitations at health centers that limit youth living with HIV: sometimes they don't need meds, but psychosocial help. Sometimes they're sick and need the meds. At that age, are they integrated in a host family? Accounting for changing needs? Are they taken into account at the government level? Look at the holistic level of adolescents that addresses all of their needs.
5. Participant 5: how do you control so many actors and such few services? How are these entities kept accountable? Do they have a certificate? Action plan? This should be in partnership with MIGEPROF.
6. Participant 8: students in secondary schools/9YBE: what are the strategies to teach those who are still HIV-? What are the preventative measures being taken? Go to schools and reinforce anti-AIDS clubs, develop a particular strategy.

7. Participant 9: recommendation: among 14 categories of OVC defined in national policy, children in/affected by AIDS are among them. Suggest to MIGEPROF and RBC to ensure they are fully benefiting of the minimum OVC package.

3. Last Recommendations of the whole Session

1. Review policies and legislation to address social exclusion, reduce stigma and discrimination, and ensure access to range of essential services.
2. Establishment of social welfare workforce. Childcare System reform.
3. Mainstream HIV and SGBV policies and programs, especially in targeting adolescents.
4. School feeding programs: nutrition support to students in general, to avoid stigma against those living with HIV/AIDS.
5. Focus on financial protection including: *social transfers* that protect households with adolescents affected by AIDS from poverty reduce negative coping strategies, address inequalities including gender.
6. Conduct more research, specifically on social and cultural norms, and consider a vulnerability assessment.
7. Include adolescents as participants in policy making, particularly mainstreaming child and adolescent issues in EDPRS 2, and consider a global integrated adolescent strategy.
8. Emphasize implementation: knowledge and policies exist, but there is inadequate action taken at critical moments.
9. Emphasize the role of family as main protector, looking especially at cases where the family is poor, parents have low education levels, or parents are not around: these are times when children are the most exposed.
10. Use a holistic approach to address HIV/AIDS, sexuality, and gender roles including: psychosocial and spiritual consequences.

Final Discussion and Recommendations:

1. How do we ensure that single cases in need are identified, integrated, and benefit from current policies, agencies, etc.?
2. How do we encourage strong links between government entities and National Children Commission?
3. How do we measure the implementations of these recommendations and ensure that they are monitored? With the Action plan.
4. What do we do to ensure that children affected with HIV/AIDS have access to school and all the services they need?
5. Use a case by case approach and go to the field more often. Each case is unique.

SESSION III: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT)

Theme: Focusing on PMTCT friendly quality services for adolescents at reproduction age toward elimination of MTCT by 2015

3.3.1. Presentation of International Key Note Speaker

Dr. Miriam CHIPIMO, MD, MPH,
Public health Specialist/UNAIDS/South Africa

Global status of adolescents

Among 33.8 million people living with HIV in 2009, 5.4 million were young people (aged 15-24 years), infected during adolescence or through MTCT, survived into adolescence
Estimated 5.4 million youth living with HIV—majority live in East and Southern Africa.
3.2 million Young people are living with HIV; three young women are infected for every young man (in some countries, ratio is 6 to 1).

Progress addressing adolescent health needs

In 10 countries achieved comprehensive knowledge on HIV above 60%. Unfortunately overall knowledge was only 34% among young people 15-24.

Lessons learned in reaching young people

Dr. Mariam presented strengths and limitations as lessons learned in youth centers, School-based Education, School-based Education, Community-based IEC, IEC Outreach from Health Facilities, Life Skills.

On Challenges to providing adolescent health services, the presented mentioned: Lack of accurate, relevant, appropriate, and non-judgmental information targeting young people, Lack of adolescent services; scarcity of trained health workers, Consent and confidentiality, legal issues, Problems with adherence and disclosure, Stigma, discrimination, and isolation, Transitioning care from pediatric to adolescent to adult.

Progress toward MDG 6 indicators: There is improvement of indicators but progress is not enough: School attendance up 70%, 15-24 age male and female knowledge of HIV 40% but condom use by both sexes is lower indicators 30%

Recommendations

- Take diversity into account for effective policies and programs for adolescents, using a gender-sensitive and human rights-based approach.
- Teach adolescents how to protect themselves from HIV, STIs, and unwanted pregnancies.
- Improve access (multiple entry points) to RH/HIV services, empowering youth to manage their own health.
- Restructure health care systems to be more adolescent-friendly, with dedicated space, staff, and services for adolescents.

Dr. Miriam concluded by **highlighting that Virtual elimination of Mother-To-Child transmission of HIV is possible** with interventions involving adolescents.

3.3.2. Presentation of National Key Note Speaker

Dr Placidie MUGWANEZA,
Director of HIV Prevention Unit/HIV Division/ IHDPC/RBC

The presenter started by giving the background of HIV infection in Rwanda (3%). Young girls 20-24 years are 5 times more infected than boys' counterpart. The rate of MTCT is estimated at 6.9% in Rwanda (2009 PMTCT study) and Rwanda has settled an objective to EMTCT by reducing MTCT below 2% by 2015.

Achievements

The next points discussed were the 4 Pillars of PMTCT and achievement in each pillar 3, and 4. As achievement in pillar 2, the presenter shown that up 87% of infected women received FP services in 2009. Regarding pillar 3, in 2010, the geographical coverage of testing and ARV prophylaxis is evaluated at 82% of HF. 69 % women using ANC services are tested for HIV and know their HIV status. 78 % of infected pregnant women received ARV prophylaxis and 74% of exposed children received ARV prophylaxis. In pillars 4, there is a Follow up of HIV positive pregnant women and their male partners and Specific programs, Family Package, Male Championship, PEARL have been instrumental in supporting this pillar of PMTCT.

Challenges

Dr. Placidie presented challenges faced by pillars as following:

Pillar 1, there are Reported early sexual debut (BSS 2009), Low condom use in young women, **24.5% (BSS 2006)** % vs. 28% (BSS 2009) and Difficulty in measuring impact of HIV prevention program

For pillar2, challenges are: Systematic integration of FP into Care and Treatment and its M&E and Low participation of men in FP services;

For pillar 3: Late attendance of HIV infected women to ANC, only 22% come in first trimester for the first ANC (DHS 2010 and Home deliveries: 38.9% of HIV-uninfected vs. 22.8 % of HIV infected women took place at home (PMTCT, Mid Term Review, 2010);

On Pillar 4, there is Lack of comprehensive care and treatment at PMTCT standalone site and Tracing all LTFU / Inadequate use of data at site level to identify retention gaps.

Way forwards and recommendations:

(i)Strengthen prevention interventions, (ii)Establish routine M&E of integration of FP and HIV program, (iii)Increase the participation of male in family planning program, (iv)Community involvement to improve facility deliveries, early ANC, adequate number of ANC, Male involvement in FP services(v)Provide comprehensive care and treatment at PMTCT standalone site (vi)Involvements of community health workers in follow up of clients in care and treatment

The Key national note speaker, Dr. Placidie concluded by mentioning that " A lot has been done for prong 3 and 4 but to achieve EMTCT objective by 2015 we need to put more efforts in addressing pillar one and pillar two to avoid new HIV infections in child bearing age and in new-born as well"

3.3.3. Impact of evaluation PCR/DBS testing in prevention of MTCT program in Rwanda

Mr. Chaste KARANGWA

RBC/IHDPC

As Background, the presenter highlighted that Number of PCR/DBS test sites increased from 81 in 2007 to 404 sites in 2010 out of 451 health facilities. But by the end of 2010, all PMTCT sites performed PCR/DBS tests. Exposed infant child is tested at 6 weeks by PCR, then at 9 months and 18 months by using serology HIV test.

Objectives: The abstract has three objectives :(1) To Describe Evolution of PCR/DBS sites over years(2007-2010), (2) To describe the performance of sites in PCR testing (3) To show the importance of early diagnosis for early treatment of HIV Exposed infants

Methods: The study analyzed Reports submitted in VCT/PMTCT database and TRACnet system by health facilities, January 2007 – Dec 2010

As Results, For the period 2007 to 2010, 92% of exposed children have been tested by using PCR, the prevalence among one tested is 2,6%

Challenges: HIV exposed infants expected for PCR are not all tested, Delay in DBS samples transportation from sites to NRL, Limited number of laboratories performing PCR/DBS (only NRL)

Conclusion: Results illustrate successful integration of PCR testing in PMTCT program, as indicated by increase in number of sites doing PCR/DBS test and number of HIV exposed infants tested for PCR. PCR tests contribute in early diagnosis and early treatment of HIV+ Exposed infant.

Key Recommendations from the Presenter

- Establish mechanism of identification of all HIV exposed infants throughout the country to be tested for PCR to facilitate follow-up
- Include PCR/DBS training modules in national HIV care & treatment basic training curriculum
- Build PCR/DBS capacity in peripheral laboratories

3.3.4. *Reaching elimination of pediatric HIV in Rwanda: An analysis of seven EGPAF supported districts*

Mrs. Mary pat Kieffer
EGPAF

Objective

To inform the national strategy to reach elimination of pediatric HIV

Methods

1. PMTCT program data from August-December 2010 were analyzed
2. Program data were compared with two different estimates of the number of expected pregnant women per district

Results

PMTCT service uptake statistics were high

There is lost follow up in PMTC cascade

Between 4% and 23% of HIV-positive women are being missed - and in districts where PMTCT facility coverage >90%

Performance is not as good when the analysis includes the HIV-positive women who did not attend ANC.

Key Recommendations from the Presenter

- Ensure that every ANC is able to provide PMTCT services and all women are tested
- Analyze coverage by district to identify gaps and barriers
- Work with communities to improve ANC attendance
- Work with public service and private sector to ensure adequate numbers of trained staff to provide services
- Investigate into the quality of and access to FP counseling; provide counseling at ANC, delivery and postpartum to support women in choosing and starting a method
- Improve uptake of ARVs in ANC facility through analysis of counseling, client flow, supply chain, staff support, documentation
- Conduct birth preparedness planning at ANC

- Assess number and quality of delivery facilities and transportation needs at community level
- Find ways to provide NVP for women who deliver at home, such as provision of 1 wk of NVP at ANC, improving birth preparedness planning with couples
- Develop new indicators, update and coordinate M&E tools
- Integrate HIV screening and care into well-child care

3.3.5. *Securing High level leadership and Mobilizing the community towards EMTCT in Rwanda*

Dr. Ange Anita IRAKOZE,
RBC/IHDPC

Background

High level leaders are committed to E-MTCT by 2015 and to accelerate progress toward reaching MDG 4 and 5. Rwanda is too committed to E-MTCT by below 2% in 2015

Results: Description of the activities

High Level Advocacy and Commitment for Elimination of MTCT

National campaign to raise awareness on EMTCT / provincial level

National campaign to raise awareness on E-MTCT in the community

Recommendations from the campaign

1. To continue talking about EMTCT in various forum (churches, mosques,...) and during community meetings
2. To include EMTCT activities in District performance
3. To sensitize the civil servants on reproductive health and sexual education
4. Avail condoms and make them free of charge (hotels, stadium, toilets...)
5. Emphasize on reproductive Health lesson in schools
6. Increase number of HCs offering ARVs and PMTCT services
7. Improve service delivery
8. Integration of EMTCT in CHW scope of work

Conclusion

Government of Rwanda has secured High level Leadership and Mobilization of community towards Elimination of Mother-to-Child Transmission of HIV below 2 % by 2015

1. Discussion and Interaction

- Key Points of Discussion, Questions, Answers, Observations of Participants

Discussion and Interaction

Among the questions and answers highlighted during the discussion of session 3 include:

Lessons learnt during the implementation of youth friendly centers e.g. Evidence from the Evaluation of youth friendly programs done in Zambia and compared to other countries.

Challenges highlighted during the evaluation include:

Young men running youth friendly centers thus a setback for girls to access the services

Few females in the centers thus a challenge for girls to participate

Parents were not comfortable with children visiting these centers

Therefore, the recommendation highlighted Include:

- ▶ The entire health facility should be friendly and not few in one corner entirely dedicated for youth only .e.g the providers should be youth friendly
- ▶ Involve young people in the planning and implementation of services.
- ▶ All the youth friendly centers should have a Linkage to health services which is crucial

Several other comments highlighted the need to monitor infants in order to ensure better outcomes thus an HIV free generation e.g. by 18 months how many children have we saved.

The strength of health systems is important in achieving total EMTCT in Rwanda.

It was also highlighted that a lot has been done in prong one and two although challenges of monitoring and evaluation exist.

It was also mentioned that, Rwanda has shown greater Male involvement in PMTCT due to the use of several strategies which include: political will and involvement of all authorities, performance contracts, radio and drama, invitation to male partner e.t.c.

Due to increased home deliveries whilst having high ANC uptake of ANC, accessibility of health care facilities is still a challenge. Among strategies adopted to increase delivery at health facilities include:

- ▶ Use of community health workers (CHWs)
- ▶ Use of mobile phones to contact facilities for emergencies

Furthermore, other strategies which include promotion of family planning and couple counseling especially due to challenges of discordance. Family Panning in Rwanda is mostly for women thus need for couple counseling and also to agree on FP method to be used and also possibility of availing medicine to the partner where one is not available.

It was also highlighted that we should reinforce the Linkage between Male Circumcision and PMTCT e.g. counseling of couples on the benefits of male circumcision whilst enhancing provision of MC services.

Concerns on condom use among adolescents were raised e.g.

What strategy should be used to increase the use of condoms?

What strategy is envisaged to reach adolescents considering that parents don't support use of condoms?

It was mentioned that strengthening the message on condom use is crucial and also engage the whole population thus increase dialogue in general.

Increase of information among adolescents is a process and several partners are involved e.g.imbuto foundation

2. Other Activities (Cultural Presentations)

- Name/Theme of the Activity:
- Brief description of Participants:
- Brief description of the Activity and its Results:

3. Main Recommendations of the whole Session

To strengthen coordination & harmonization of youth HIV programs at national and district levels;

To strengthen utilization of strategic information regarding most-at-risk adolescents (especially marginalized and out of school youth) HIV prevention programming;

To strengthen HIV is testing and Counseling and condom programming mechanisms targeting youth;

Sensitize parents to talk about sexuality with their children;

To promote involvement of adolescents in designing and implementing SRH and HIV programs targeting them;

To revise sex education programs based on drivers of the SRH needs of adolescents and youth;

To increase the number of youth friendly VCT centers (at least one in each district);

To integrate the ASRH friendly services in all health centers;

To increase number of working hours during night for hotline service;

To increase comprehensive knowledge on HIV and SRH through sensitization campaigns and other youth popular communication tools;

To involve more communities and parents in HIV prevention and SRH program implementation targeting youth;

To promote counseling in schools, especially for youth living with HIV and AIDS to help them to make informed sexual decisions, communicate effectively on sexual issues;

Identify and scale up the best practices in line with voluntary counseling and testing for youth.

SESSION IV: PEDIATRIC CARE AND TREATMENT

Theme: "Scaling up quality and friendly comprehensive care, treatment and support for adolescent living with HIV in Rwanda "

3.4.1. Presentation of International Key Note Speaker

"Comprehensive care, treatment and support for adolescents living with HIV"

Dr Peter Drobac,

Country Director/PIH

Global Burden of Adolescent HIV

Under 15:

- Approximately 370 000 children were born with HIV in 2009¹
- 2.5 million children under 15 were living with HIV as of 2009.
 - Most were infected through mother-to-child transmission.

Adolescents aged 10-19:

- About 2 million adolescents were living with HIV in 2009²
- Nearly 90% in sub-Saharan Africa

Youth aged 15-24:

- An estimated 5 million young people were living with HIV in 2009
 - 3.2 million young women are estimated to be living with HIV
 - 1.7 million young men are estimated to be living with HIV³
- 41% of new HIV infections

Adolescent HIV Treatment and Care Coverage in sub-Saharan Africa

- Scale-up of ART has contributed to a significant increase in perinatally infected children reaching adolescence.
- In SSA ART coverage of children is generally less than half that of adults⁵
 - Cameroon: 30% adults versus 11% children
 - Mozambique: 32% versus 12%
 - Uganda: 43% versus 18%

Rwanda: 77% versus 60%

Adherence Challenges

- Adherence drops in adolescence⁷
- US Cohort of 154 adolescents: Only 32.4% attained virologic suppression⁸
- Individual and Public Health Risks
 - Drug resistance, treatment failure
 - Ongoing transmission, transmitted drug resistance

Two Distinct Groups

- Perinatally infected adolescents
 - Drug resistance and vulnerability to treatment failure
- Behaviorally infected adolescents
 - Disclosure issues
 - Mitigation of high-risk behavior

Adolescent Specific Challenges to Treatment and Care

- Young people living with HIV require knowledge and understanding of their HIV status.
- Psychosocial stressors:
 - Side-effects from medication, chronic illness, real or perceived stigma, and frequently the death of family members.
- Structural barriers drive risk behavior and non-adherence
 - Food insecurity, Economic Insecurity, access to education

- Adolescents need social, emotional, spiritual, and often material support
- HIV-positive young people need adherence support

Need to make healthy decisions about reproductive and sexual health.

Adolescent HIV Care in Rwanda: The Partners in Health Experience

- Adolescent HIV Care should be:
 - Comprehensive
 - Integrated
 - Youth-friendly

Comprehensive Care and Adherence Support Package

- Daily home-based DOT
- Monthly clinic visits with CHW
- Nutritional support
- Group counseling with diagnosis disclosure for children and parents
- Home visits from social workers, nurses, and CHW
- Assistance with school fees materials

An Integrated Care Model

An adolescent focus group identified barriers and preferences:

- Dedicated “safe space”
- **One stop shopping**
 - Labs and meds given in clinic
 - Family Planning
- Confidentiality and accessibility
- Short waiting times, flexible schedule
- Streamline unscheduled visits

Saturday counseling and education sessions occur monthly

Youth-friendly Services: Support adolescents in managing their own care

- Welcome interaction and encourage trust
- Include teens in decision-making and give them developmentally appropriate responsibility for their own care
- Encourage leadership among peers in healthy decision-making

At age 19, adolescents are transferred to adult clinic but pediatric clinic stays involved for a 3 month transition period

Key Recommendations from presenter

- Increase opportunities for early diagnosis
- Develop dedicated adolescent HIV services
 - Comprehensive
 - Integrated: One-stop shopping
 - Youth-friendly
- Increase use of routine viral load monitoring, drug resistance surveillance

- Strengthen adherence support
 - Behavioral and structural interventions
- Support disclosure, stigma reduction and positive health behaviors
- Close the gender gap: Focus on adolescent girls
- Develop M&E dedicated to the adolescent age group
- Operational research to address knowledge gaps and improve service delivery

3.4.2. **Presentation of National Key Note Speaker**

Dr Kayonde Leonard,
RBC/IHDPC

- Background
 - **Population:** ~10 millions
(26,338 km²)
 - **Rural population:** 83 % (DHS, 2005)
 - **Generalized HIV epidemic**
 - 3% Prev. in general population
 - **Rapid scale up of HIV services***
 - **412 PMTCT sites**
 - **448 VCT sites**
 - **396 ART sites from 3 ped sites in 2004**
 - 99,189 (93% of those in need ...spect proj)
 - Adult:91489 Children:7700
- Overview of Pediatric C& Ttt

The situation assessment of access to care and treatment of adolescents infected with HIV done in 2008 ,indicated that:

- Late HIV testing, without pre-test counseling in 82% of cases
- 96% cases didn't know their sero-status (≥ 10 Yrs)
- Late start of ARVs in severe Immuno-Depression (1-200 CD4)

Current service delivery

Some sites implement some components of the adolescent package

- Two Pediatric centers of excellence in 2 National reference hospitals(CHUB& CHUK)
- Youth friendly centers offer services to youth and adolescents with a fully integrated SRH, VCT services, FP service delivery, peer education training and outreach, IEC materials, and referrals to HF for follow-on clinical services.

Model centers DH offer to the adolescent the following

Re-organization of services :

- 2 Specialized medical and psychosocial consultation /Week
- HIV diagnosis disclosure

- Monthly support group
- Group Quarterly therapeutic Holidays
- Establishment & organization of peer support groups
- Life skills
- Palliative care
- Establishment of family support system: Parents/Guardians sensitization and Education,
- Adolescent annual festival with tutor
- Home visit
- Advocacy for non health needs

STRENGTHS OF THE NATIONAL RESPONSE AND WEAKNESS

STRENGTHS/OPPORTUNITIES

- High level commitment
 - Desk of the in charge of ALHIV in MOH
 - Desk of ASRH
- Some parts of adolescent services implemented – ie . support groups
- Providers practical trainings in 2 pediatric reference centers

WEAKNESS/CHALLENGES

- Current adolescent services not yet tailored to the special needs of HIV adolescents.
- Paucity of data in routine HIS: e.g. lack of appropriate age/sex disaggregation for the 10-19 bracket in TRACnet. (10-14 and 14-19).
- Most of current HIV infected adolescents are orphans and/or poor

Ongoing interventions

- Modelling 2 adolescent comprehensive friendly centres
- A Comprehensive care and treatment guideline of Adolescent living with HIV/AIDS”
Tools & under revision within TWG
- TOT recently done and plan to train providers(3 staff/DH)
- Data age -disaggregated proposal(EMR/OpenMRS)
- 2011 National Pediatric conference “focusing on Adolescent in HIV Response”
- Increasing evidence base on existing approaches of care in Health sector and community level.
- Umbrella of Youth Living with HIV

Program Responses

Development of children and adolescents HIV positive disclosure tool

- Psychosocial care guidelines
- Prevention guideline (HIV Counselling & Testing at ≥ 15Yrs)
- A Comprehensive care and treatment of Adolescent living with HIV

Challenges

- Rwanda generally faces severe human resource constraints in both qualitative and quantitative aspects

- Furthermore, chronic care for the rising numbers of patients in ART sites creates a very heavy work load on the already constrained HR capacity and thus undermines the opportunity to deal with special problems of adolescents living with HIV
- Most of HF are not yet tailored to the special needs of adolescents including those living with HIV.
- Programming for AL with HIV is also hampered by lack of appropriate information from available routine health data.
- Lack of a strong evidence base
- Rwanda setting has specific challenges (most of current HIV infected adolescents are orphans)
- Paucity of data in routine HIS: e.g. lack of appropriate age/sex disaggregation for the 10-19 bracket in TRACnet(10-14 and 14-19).

Way forward

- Validation of comprehensive Care of ALHA tools and Guideline
- Rapid assessment of quality of services and Psychos, clin, biol status of Adolescent enrolled in Ex. TRAC Plus clinic and Ruhengeri DH"
- Implementation and documentation of HIV Adolescent services in other peripheral HF; integration of Adolescent Program into the existing system
- Staff capacity building in "Comprehensive care and treatment of ALHA(3 staff/DH by next yr)
- Organizing onsite trainings on Continuous Quality Improvement system at all DH through Mentorship;
- Generation of appropriate evidence including evaluation of existing approaches of service delivery to inform scale up
- Weekly support group(proposed by Hon MoH)

- Key Recommendations from the Presenter

- Validate comprehensive Care of ALHA tools and Guideline
- Scale up the HIV Adolescent services in other peripheral HF; integration of Adolescent Program into the existing system.
- Build capacity of staff in "Comprehensive care and treatment of ALHA
- Organize onsite trainings on Continuous Quality Improvement system at all DH through Mentorship;
- Evaluate the existing approaches of service delivery to inform scale up

3.4.3. Retention of HIV pediatric patients receiving ART at ICAP supported sites in Rwanda

Dr Tene Gilbert,
ICAP

Background and objectives

- January 2004: Beginning of ICAP care and treatment program in Rwanda
- By September 2010:
 - ✓ 48 sites at Kigali city Butare and in the Western province (2 University teaching Hospitals, 10 district hospitals and 36 health centers)
 - ✓ 4253 pediatric HIV patients enrolled in the program including 2680 (63%) initiated on ART (nearly one third of total children on ART in Rwanda)
- The present study was carried out to assess retention and factors of non-retention of pediatric patients initiated on ART from January 2004 to September 2010 at 34 sites equipped with an electronic database

Methods

- Retrospective observational analysis of retention rates and factors associated with non-retention of pediatric patients (<15 years old) started on ART at 34 ICAP-supported sites equipped with an electronic database in Rwanda
- Kaplan-Meier (KM) curves used to assess the probability of LTF and death at 12 and 24 months
- Cox proportional-hazards models to examine patient and site-level factors associated with LTF and death

Conclusion

- Retention of children on ART was high at ICAP supported sites in Rwanda by December 2010
- Younger age, advanced HIV infection, severe malnutrition and earlier year of ART initiation were significantly associated with children's mortality while young age and recent year of ART initiation were associated with LTFU
- Given that children < 24 months were at higher risk of death and LTFU, emphasis must be put on high quality PMTCT to prevent new children's HIV cases and on starting ART as early as possible for HIV infected ones to reduce their morbidity and mortality
- Key Recommendations from the Presenter

In order to achieve optimal children retention, the combination of the following approaches is necessary:

- Systematic approach for services delivery to children clear and smooth patient flow
- Systematic delivery of a comprehensive package of care services
- Provision of high quality psychosocial support services Systematic counseling at each follow up visit
- Regular age appropriate children support groups

- Regular program monitoring and assessment of the quality of the services delivered to children
- Outreach as needed to recover defaulters

3.4.4. *Improving Health Service Delivery for Adolescents Living with HIV*

NIYONSENGA Simon Pierre,
RBC/IHDPC

Background

- 396 ART sites
- Few have adolescent focused services
- Advocacy during 2008 National Pediatric Conference
- 2 specific recommendations on ALHIV in the 2009 annual national pediatric conference on AIDS: revision of norms & standards & implementation of models to inform program scale up.
- A study on access to comprehensive services for ALHIV in 2008
 - 92% of ALHIV had HIV positive parents (mothers)
 - 82 % never received pre-test counseling
 - 35% started treatment with CD4 counts of <200
 - 13% engaged in unprotected sex
 - Over 60% of ALHIV were orphans of at least one parent
 - About 70 % at lower school levels compared to non-infected children of the same age

Questions to respond

- How to deliver appropriate health services to ALHIV?
- How to integrate adolescent services in existing HIV services?

Objectives

- To implement comprehensive services for ALHIV in 2 health facilities
- To demonstrate what works best to inform program scale up

Model description

- Implementation of comprehensive package in 2 health facilities: Former TRAC Plus Clinic and Ruhengeri DH in 2010 and 2011

Component of package

- Training of Health service providers in adolescent health and development and multidisciplinary skills
- Age appropriate tools
- Infrastructure & surroundings.
- Organization of routine medical services
- Psychosocial care
- Transition
- Essential social services

- Community and family participation
- Involving adolescents

Planned Activities

- Assess the needs of ALHIV
- Develop age appropriate tools
- Train Health workers in multidisciplinary skills including adolescent health and development
- Re-organize routine medical services
- Provide adolescent friendly infrastructure
- Implement week end and holiday psychosocial support activities
- HIV disclosure with an adapted methodology
- Screening Mental health status and referring for mental health services (onsite)
- Systematic adherence assessment for adolescents with appropriate tools
- Provide age appropriate SRH education & services
- Provide education & counseling to parents/primary care givers
- Involve ALHIV in HIV prevention and stigma reduction among adolescents and young people at community level (youth centers, entertainment forums, social mobilization activities...)
- Define and implement transition SOPs

Tools design and development:

- ▶ A Comprehensive C&T guideline of ALHIV
- ▶ Identification of age appropriate tools were developed /adapted:
 - Intake
 - Adherence
 - Disclosure
 - Life skills
 - Mental health screening
 - Sexual history
 - Transition
- **Staff capacity building:** 12 health workers (Doctors, nurses, social workers) trained in adolescent health and development in context of HIV C&T
- Training of 3 trainers on WHO on "**Integrated Management of Adolescent and Adult Illness (IMAI)**" to be adapted to country context

Re-organization of services

- Two afternoons set aside for routine HIV C&T

Wednesday: 10-14 yrs

&

Thursday: >15yrs

- "One stop shop" multidisciplinary services: Pediatric, Psychosocial, Gynecology, Mental health, Dermatology, SRH...

- 600 ALHIV are enrolled and followed in both sites
- Psycho-therapeutic holidays camps were organized
- Education support
- 400 ALHIV participated in psycho-therapeutic holidays camps:
Diagnosis disclosure, Management of disclosure reactions, Adolescence and HIV, SRH, Adherence on ART
- 298 Adolescents received secondary school support in Ex.TRAC+ Clinic
- 25 peer educators identified from former TRAC Plus clinic;
Peer education training manuals: trainers', facilitators' and work plan

Achievements:

- 50 elderly parents/ primary care givers received counseling on care for ALHIV: adherence, psychosocial support
- Campaign on stigma reduction initiated at community level
33 adolescents were transitioned in adult care
- Implementation of all planned activities
- Exploration of mechanisms to involve communities: Schools, in/out- of school anti-AIDS clubs, youth centers in improving psychosocial wellbeing, stigma reduction, HIV prevention
- Establishment of adolescents and youth friendly services in all HFs

Conclusions/Perspectives

- Evaluation of the model to inform review of norms and procedures and program scale up is ongoing:
 - *Assessment of Quality of services and Psychosocial, Clinical and Biological status of Adolescent living with HIV enrolled in TRAC Plus clinic and Ruhengeri DH*

Key Recommendations from the Presenter

- Explore mechanisms to involve communities: Schools, in/out- of school anti-AIDS clubs, youth centers in improving psychosocial wellbeing, stigma reduction, HIV prevention
- Establish adolescents and youth friendly services in all HFs
- Evaluate the model to inform review of norms and procedures and program scale up

3.4.5. Immunological and Clinical Outcomes of HIV Positive Adolescents on ART

Dr NKIKO Gedeon,
EGPAF

Introduction

- HAART changed the nature of HIV infection from a fatal disease to a treatable chronic condition
- HIV-infected children can now survive and grow up to adolescence and adulthood

- Little is known about the course of illness for HIV-infected adolescents in developing countries
- Study aim: to determine the outcomes of adolescents on HAART in Rwanda.

Methodology

- **Study design:** retrospective cohort analysis
- **Period:** 1st to 31st August 2011
- **Location :** 7 health facilities (3DHs and 4HCs)
- **Population:** adolescents aged 10-19 years
- **Inclusion criteria:** adolescents taking ART for at least 3 years
- **Data collection:** from medical charts and pharmacy files.
- **Analysis:** descriptive analysis, Excel & SPSS.

Results

General characteristics

- Data collected for 216 adolescents
- Mean age: 14(\pm 3) years
- Gender: 52% females vs 48% males

Characteristics at treatment initiation

- Mean age : 10(\pm 2) years
- WHO stages 3 and 4 : 65.7%
- Median CD4 count: 400cells/ml.

Conclusion

- Health outcomes for adolescents on ART are satisfactory in Rwanda
- Transfer rate was high during review period
- Treatment failure and drug toxicity rates are higher than in more developed countries

Key Recommendations from the Presenter

- Need
 - ✓ to reinforce patient and provider monitoring and follow up
 - ✓ to strengthen adolescents' education on the importance of adherence
 - ✓ to organize regular chart reviews
- Further studies
 - ✓ to evaluate the impact of task shifting on transfer rates and patients outcomes
 - ✓ to clarify the determinants of adherence among adolescents.

Discussion and Interaction

After the presentations the floor was given to participants to ask questions, give other recommendations.

- How to scale up adolescent focused care in our program? What is the national plan? Simon Pierre from the RBC/IHPDC talked about the achievements of this program talking what has

been make up now including TOT, implementation of model centers and the next step is to scale up the program in other Health facilities.

- Participant 1 suggested to integrate a specific HIV service delivery package for Adolescent Living with HIV and disabilities. This has been noted and put in recommendations. Dr Kayonde from RBC/IHDPC added that the guideline related to that is under preparation.
- Participant 2 asked on how disclosure is conducted because she was worried about some children taking their medication whereas there are not disclosed. Speakers gave clarifications on how disclosure is conducted at Health facilities. Disclosure is a process and begins with parents around 6 to 7 yrs of age but age can change depending on developmental or intellectual level of each children. It is family focused and the family is always supported by health care providers (counselors)
- A question on Pediatric formulations for children as asked by one of participants. She was asking if formulations are available. The answer was that yes and Dr Kayonde added that even chart for calculation doses according to weight are available at all HF's
- How transition of adolescents into adult program can be done: Before transition we need to consider many aspects including assessing the developmental, emotional, physical etc
- The problem of how to scale up the adolescent program has been raised and the main issue is to design the model that we want or need to scale up.
- Have Adolescent C&T tools have been tested? the answer was that tools have been piloted and are under revision.
- The issue of education of parents has been raised. Parents need training and continuous educative sessions in order to involve them in care of adolescents
- One Young + suggested to create special and separated from those of adults because adolescent and adults have different concerns.
- One participant suggested if there is a way to ask adolescents what they really need and what services they really need in order to involve them in developing the adolescent C&T model which can be evaluated their after.
- A questions on the package of care to adolescents including especially SRH (contraceptives, condoms has been asked and the this will be clear in guideline
- As asked in other sessions , youth suggested to be involved in all activities related to them

Main Recommendations of the whole Session

Rec.1: Increase opportunities for early diagnosis (campaigns +++, home based, school based, etc...) and develop dedicated adolescent HIV services delivery: Comprehensive, Integrated (One-stop shopping), Youth-friendly

Rec.2: Increase use of routine viral load monitoring, drug resistance surveillance and strengthen adherence support: Behavioral and structural interventions

Rec.3: Support disclosure, stigma reduction (protection of children) and positive health behaviors and close the gender gap: Focus on adolescent girls (Target the specific services for adolescent).

Rec.4: Develop M&E dedicated to the adolescent age group and encourage the operational research to address knowledge gaps and improve HIV service delivery.

Rec.5: Revise, test and validate the comprehensive care and treatment for Adolescent Living with HIV tools and Guideline.

Rec.6: Strengthen the implementation and documentation of HIV services for adolescents at the peripheral health facilities: *Integration of Adolescent Program into the existing system (SRH,VCT...).*

Rec.7: Reinforce the onsite trainings on Continuous Quality Improvement system at all district health facilities (Mentorship).

Rec.8: Building the capacity of personal in HIV provided delivery service specific on the Comprehensive care and treatment of Adolescent Living With HIV (aiming 3 staff/DH by next yr).

Rec.9: Integrate a specific HIV service delivery package for Adolescent Living with HIV and disabilities.

Rec.10: Set up specific adolescent and youth HIV service delivery centers. (Considering separating HIV service adults and young people at the existing health facilities).

Rec.11: Scaling up a systematic approach for HIV services delivery to children. *Clear and smooth patient flow and systematic delivery of a comprehensive package of care services*

Rec.12: Provide a high quality psychosocial support services. *Systematic counseling at each follow up health facility visit and regular age appropriate children support groups.*

Rec.13: Assess regular program monitoring and quality health services delivered to young people living with HIV.

Rec.14: Encourage and strengthen campaigns on potential stigmatization at community level.

Rec.15: Provide a high quality psychosocial support services systematic counseling at each follow up health facility visit.

Rec.16: Encourage the regular program monitoring and assess the quality health services delivered to young people living with HIV.

Rec.17: Evaluate the impact of task shifting program focusing on transfer rates and patients outcomes (research).

Rec.18: Clarify the determinants of adherence among adolescents living with HIV.

4. Closing Ceremony

4.1. Introduction to closing Ceremony

Dieudonne RUTURWA,
Social Mobilization, UNAIDS

The moderator recognized the presence of the Honorable Minister of Gender and promotion of family; he recognized also the presence of the DRC, Burundi, Tanzania, Uganda delegates

Also he recognized the presence from UN and bilateral delegates. He talk about the participation of different sectors, districts authorities and CDLS, civil society organizations including PLWHIV specifically the Young people living with HIV (Kigali Hope Association representatives), private sector and the participation of adolescents which was very appreciated.

4.2. Reading of Conference recommendations (Session 1-4)

Title or Topic Name of the Speaker/Presenter and His/Her Organization: Dr Diane MUTAMBA, ASRH Coordinator, MOH.

1. Prevention of HIV Among Adolescents and Young people

“Improving access to comprehensive HIV prevention and SRH friendly services to adolescents”

2. Protection of Orphans and Other Vulnerable Children (OVC).

“Building adequate strategies and programs for HIV and AIDS impact mitigation and protection of adolescents”

3. Prevention of Mother-To-Child Transmission of HIV (PMTCT).

“Focusing on PMTCT friendly quality services for adolescent at reproductive age toward elimination of MTCT by 2015”

4. Paediatric care and treatment.

“Scaling up quality and friendly comprehensive care, treatment and support for adolescents living with HIV in Rwanda”

I. Prevention of HIV Among Adolescents and young people

- IEC/BCC

Improve the education of adolescents on HIV/AIDS and Sexual Reproductive Health through parents’ dialogue, school curricula and Peer education with full participation of communities, parents and adolescents themselves.

- Service delivery

Adapt service provision to specific age groups of adolescents (HIV Counseling and Testing, ASRH youth friendly services including in health centers.

To promote implementation of adolescent sexual and reproductive health policy and strategies particularly for those living with HIV/AIDS

- Cross cutting (Strategic Information, Coordination)

To strengthen coordination & harmonization of youth HIV prevention programs at national and district levels, informed by local epidemiology with a special focus on most-at-risk adolescents (especially marginalized and out of school youth).

II. Protection of Orphans and Other Vulnerable Children (OVC).

- **Service delivery**

Improve access to health and social services and ensure that internationally defined minimum package for OVC is delivered to the most vulnerable adolescents particularly girls.

Define and implement referral system between national social protection program (VUP) and health systems, keeping in mind the special needs of adolescents particularly girls.

Establishment of social welfare workforce and Childcare System reform for adolescents in school and out of school.

Investments at all level in HIV and adolescent sensitive social welfare and child protection systems.

- **Policy and protective environment**

Ensure the scale up of interventions that increase adolescents' access to the job market through technical and vocational training.

To strengthen the link between government entities and the National Children Commission in reviewing existing policies and legislations to address social exclusion, reduce GBV, stigma and discrimination and ensure access to essential services.

Include adolescents as participants in policy making, particularly mainstreaming child and adolescent issues in EDPRS 2 to ensure that their needs are met across key sectors.

- **Cross cutting (Strategic Information, Coordination)**

Conduct more research, specifically on social and cultural norms that increase vulnerability of adolescent to HIV in Rwanda.

III. Prevention of Mother-To-Child Transmission of HIV (PMTCT).

- **IEC/BCC**

To continue and sustain high level advocacy for EMTCT at community level through various forums (churches, mosques,...) while ensuring the participation of young people living with HIV.

- **Service delivery**

Adapt PMTCT package and ASRH to the needs of adolescents and young couples (HIV counseling and testing, male circumcision and family planning).

Strengthen mechanism of identification of all HIV exposed infants through immunization services.

To strengthen the quality of FP counseling and provision of FP methods within the continuum of care in PMTCT with greater involvement of male partners.

Ensure post partum provision of ARV prophylaxis for mother-infant pair is increased particularly for most vulnerable mothers.

- **Community participation**

Involve PLWH especially young people in PwP which has an impact on scaling up primary prevention and enhancing the EMTCT

- **Policy and protective environment**

Ensure that age disaggregated data highlighting adolescents is used to inform programming for EMTCT at all level.

IV. Paediatric care and treatment.

- IEC/BCC

To strengthen adolescents' education on the importance of adherence.

Support disclosure, stigma reduction and positive health behaviors

- Service delivery

Evaluate and expand dedicated comprehensive, Integrated (One-stop shopping), Youth-friendly adolescent HIV services delivery.

Increasing opportunities for early diagnosis with a focus on PIT.

Strengthen adherence support including routine viral load monitoring, drug resistance surveillance: Behavioral and structural interventions

Revise, test and validate the comprehensive care and treatment for Adolescent Living with HIV tools and Guideline.

Provide a high quality psychosocial support services systematic counseling at each follow up health facility visit.

- Policy and protective environment

Adapt specific HIV service delivery package for Adolescent Living with HIV and disabilities.

Cross cutting (Strategic Information, Coordination)

Evaluate the impact of task shifting program focusing on transfer rates and patients outcomes (research).

I. Reading of Conference recommendations from child and youth parallel sessions/children delegate

- I.PREVENTION

- Turasaba Leta ko yashyiraho uburyo bwo guteza imbere indangagaciro nyarwanda bashishikariza urubyiruko gukomera ku busugi n'ubumanzi bwabo binyuze mu biganiro n'amahugurwa.
- Kugeza serivise zo gusiramura mubigo nderabuzima , no gushyiraho gahunda yo gusiramura yihariye mu gihe cy'ibiruhuko kandi bikishyurwa n'ubwisungane mu kwifuza (mutuelle) .
- Gushyiraho gahunda yihariye yo kurwanya Virusi Itera Sida mu bana , ingimbi n'abangavu babana n'ubumuga kandi hagategurwa imfashanyigisho zijyanye na buri cyiciro cy'ubumuga
- Gushyiraho kuri buri murenge ihuriro ry'ababyeyi bahuguwe bazajya bahugura abandi
- Turifuza ko bourse yasubiraho kubera ko imibereho mibi ituma urubyiruko rwishora mu mibonano mpuzabitsina bashaka amaramuko.
- Kongerera ubushobozi za clubs Anti sida mu mashuri abanza n'ay'isumbuye no kuzishyiraho aho zitari.

- Gushyiraho gahunda yo kwipimisha kubushake mu bigo by'amashuri byibuze kabiri mu mwaka
- Kongera ibiganiro byihariye ku bana no kurubiruko kuri radiyo na television bigaragaza ububi bwo kwishora mu mibonano mpuzabitsina hakiri kare(bikanyura mu mafirimi, ikinamico n'ibindi)
- Turifuza ko hashyirwaho gahunda zihariye zo kurwanya SIDA zireba abana bugarijwe n'icyorezo cya SIDA kurusha abandi (*abana babyarwa n'indaya, ababyarwa n'inzererezi nabo mu mihanda.*
- Gushyiraho gahunda y'ubukangurambaga ishishikariza ababyeyi gutanga urugero rwiza mu myitwarire, twavuga ba sugar dady naba sugar mummy.
- Gushyira ibigo by'urubiruko kuri buri murenge kugira ngo rubone aho rwisanzurira mu myidagaduro ,imikino, amahugurwa atandukanye no kurwanya SIDA harimo no kwipimisha ku bushake.
- Gukangurira abana ingimbi n'abangavu kutareba amafirimi y'urukozasoni (Pornographie)
- Turasaba ko abana bahagarariye abandi bahabwa ubushobozi bwo kugeza kuri bagenzi babo ubutumwa bakura muri iyi nama byibura muri buri murenge.

II.PROTECTION

- Turasaba ko hakurikiranwa ishyirwa mu bikorwa ry'ingamba za leta zibuza abantu gukoresha abana imirimo ivunanye (mu ngo, mu byayi ...), kandi abana basubizwe mu shuri.
- Ingo zikuriwe n'abana zikenewe kwitabwaho by'umwihariko hashyirwaho gahunda yo gukurikirana ibibazo byabo ku rwego rw'umudugudu
-
- Kumvisha ababyeyi ko abana babana na virusi itera sida bagomba kugira uburenganzira bwo kwiga no kwitabwaho kimwe n'abandi bose
- Turasaba inzego z'ibanze mu gushyira ingufu mu kwita ku bibazo by'abana hitabwa by'umwihariko ku bana baba mu mihanda no kubasubiza mu miryango.
-
- Gushyiraho gahunda zikangurira ababyeyi kwiyubaha no kwiyubahisha bakuraho amakimbirane mu miryango(hagati y'umugabo n'umugore) kuko aribyo bituma abana bajya mu mihanda .
-
- Gushyira imbaraga no kongerera ubushobozi komite zishinzwe ihohoterwa rishingiye ku gitsina (GBV/CP) no gukomeza gukangurira ababyeyi mu kudahishira abahohoterwa abana babo.
- Gushyiraho gahunda zo gufasha abana babana n'ubumuga cyane cyane mu burezi bwabo no mu buvuzi bijyanye na buri bwoko bw'ubumuga
- Gushishikariza no kumenyesha ababyeyi ko umwana ubyaye ari umwana nawe aba akiri umwana kandi uburenganzira bwe bugomba kubahirizwa ariwe ndetse n'uwo abyaye.
- Turasaba ko habaho kongerera ubumenyi ababyeyi n'abayobozi b'inzego z'ibanze ku burenganzira bw'umwana.
- Gushakira ubushobozi abana baba mu mihanda, abataye amashuri bagasubizwa mu mashuri abandi bakajyanwa mu mashuri y'imyuga

III. EMTCT

- Kongera ingufu mu gushishikariza ababyeyi kwipimisha agakoko gatera sida, hakorwa ubukangurambaga mu gihe habaye ihuriro nka nyuma y'umuganda .
- Gukomeza gukangurira ababyeyi no kubigisha ko bagomba kubyarira kwa muganga
- Gukomeza gukangurira ababyeyi kubahiriza inama bakura kwa muganga.
- Gukomeza gukangurira ababyeyi gushaka mutuelle de sante no kubigisha akamaro kayo.
- Gukangurira ababyeyi kwitegura umwana bakimara kumenya ko basamye (ibikoresho).
- Gushishikariza abakobwa batwite kudahisha inda bagakurikirana inama zo kwa muganga.
- Gushishikariza Club Anti-SIDA kuvuga kuri gahunda z'abagore batwite n'abakobwa kugirango bakurikirane ubuzima bwabo ndetse n'ubw'abana batwite, mu butumwa batanga
- Gushishikariza abaganga kwakira neza abakobwa batwite batabana n'abagabo.
- Gushishikariza amashyirahamwe y'ababana na virusi itera SIDA gutanga ubutumwa bwo kubyarira kwa muganga kugirango bongerere amahirwe yo kubyara abana badafite virusi itera SIDA.
- Gushimangira gahunda yo kuringaniza imbyaro ku babana na virusi itera SIDA.
- kwegereza serivisi z'ubuzima abaturage kugirango ababyeyi babashe gukurikiranwa neza, no kongera umubare w'imbangukiragutabara
- Turasaba ko ibigo nderabuzima byose byahabwa ubushobozi bwo gutanga imiti igabanya ubukana bwa virusi itera sida kugirango ababyeyi batwite babana na virusi itera SIDA bashobore kubyara batanduje abana.

IV. CARE AND TRAITEMENT

Gukomeza gukangurira ababyeyi n'abarezi babana n'urubyiruko rubana na Virusi itera sida kubafasha gukomeza gufata imiti igabanya ubukana neza.

Kwihutisha gahunda yihariye yo gukurikirana ingimbi n'abangavu babana na VIH mu bigo nderabuzima byose b'igihugu.

Gushimangira gahunda yo kubwira abana n'urubyiruko rwavukanye virusi itera sida igisubizo cy'uko bahagaze (HIV status disclosure)

4.3. *Way forward*

Dr Placidie MUGWANEZA,
Director of HIV Prevention Unit/HIV Division/ IHDPC/RBC

Draw an Action plan based on the recommendations

When: By end January 2012;

Who: by the steering committee, Financing commitments, by GoR and Partners

- Implementation 2012;

Who: by GoR and Partners

- Monitoring 2012;

When: quarterly,

Who: by steering committee

Preparation of the 2012 conference

- Suggestions for the theme

When: From today till 05/02/ 2012, send to pediatric.conference@rbc.gov.rw

- Proposed dates for the conference 14th to 16th Nov. 2012
- Conference organization: Start of May 2012
- Organize symposium of specific issues: before the conference; suggestion of topics to be sent to pediatric.conference@rbc.gov.rw

Cultural representations from children and Adolescents, drama group: Mashirika

In these scenes, people are living in two different neighborhoods. In one neighborhood is where people seem to have nothing better to do than talk about crap they know nothing about. In another one is where youngsters have decided to put matters of life in their hands (neighborhood where you will find a circumcision services, the first of it's kind in the whole world). Mashirika shown how neighbors and neighborhoods can contribute on the awareness of people, specifically young and adolescents

These scenes continue to make more focus to young girl Bella who was pregnant at 16 years and who found out had HIV. Bella the young sister froze when the nurse told her, she quickly went to tell her partner Papi and all Papi did was turn his back on her and leave. Bella have been chasing after him. Bella was disappointed, after she have been reassured that she is not going to die, and is pretty healthy at the moment. She consider her daughter the best thing to happen to her whenever she feel down she just look at her beautiful smile and think well If she didn't meet him Bella may not have HIV but she also wouldn't have this beautiful ray of light in her life.

Papi was the star in the neighborhood because he played football very well. He has lost it all, he now sleeps with sex workers, he sleeps on the streets with his whole gang of friends, his parents have forced him to go back home but also get a medical check, he looks to like the prodigal son in the bible.

Papi's parents and friends advised him to be tested HIV, then Papi found that whatever happened is not the end of his life.

Summary of the Song

It has been here

It is still here and If nothing is done it is yet to be here to stay,

Some one show me a new window with a ray of hope

Show me a free tomorrow...

Why should someone be a missing face in this era?
It's all about us,
It's all about me and you...

4.4. Award ceremony

BIRUNGI Petronilla,
IMBUTO FOUNDATION

Brief description of the Activity and its Results:

The award ceremony is one of the ceremonies for this year edition of the Annual National Pediatric Conference on Children infected and affected by HIV and AIDS. It is aimed at celebrating excellence, and innovation in responding to the challenges of children and HIV. More importantly, it will promote the work of young investigator, catalyzing knowledge sharing and documentation of the excellent work we are accomplishing in Rwanda.

- Six awards distributed in 3 categories were in competition: Innovation (4 awards), Young Investigator (1 award), and Excellent intervention on Adolescents and HIV (1 award).
- Selection process: An award selection committee, representative of the 4 Ps, oversaw the selection process under the coordination of the chair and co-chair persons of this conference. Winners were selected through a transparent and rigorously documented process.

2011 INNOVATION AWARD

This award acknowledges an author whose work introduces an innovative approach or tool to address a major challenge in the response to the HIV and children epidemic in the Rwandan context.

P1- HIV prevention among adolescents and youth

TITLE OF ABSTRACTS: "12+" – Focusing on adolescents in the national HIV/AIDS response; Adolescent health and HIV/AIDS

AUTHOR: Dr. Diane MUTAMBA, ASRH Coordinataor, MOH

P2- Prevention of HIV Transmission from Mother-To-Child

TITLE OF ABSTRACT: Reaching elimination of paediatric HIV in Rwanda: An analysis of seven EGPAF-supported districts

AUTHOR: Dr. Mary Pat Kieffer, EGPAF

P3- Paediatric care and treatment of children infected by HIV

TITLE OF ABSTRACT: Influence of HIV+ disclosure on taking antiretroviral drugs at school: survey of young adolescents followed at Clinic - HIV DIVISION/RBC/ IHDPC-Kigali

AUTHOR: Soeur Marie Josée MALIBOLI/RBC/IHDPC

P4- Protection of Orphans and Other Vulnerable Children

TITLE OF ABSTRACT: Impact of Social economic factors on education of HIV+ adolescents followed at Clinic HIV Division- RBC/IHDPC - Kigali

AUTHOR: Christine UMURERWA

2011 YOUNG INVESTIGATOR AWARD

This award acknowledges scientific excellence in the work of authors aged below 30 and citizen of Rwanda.

P2- Prevention of HIV Transmission from Mother-To-Child

TITLE OF ABSTRACT: Improved geographical access and utilization of prevention of mother-to-child HIV transmission services in Rwanda from January 2005 to June 2010

AUTHOR: Dr. Ange Anita IRAKOZE

2011 EXCELLENT INTERVENTION ON ADOLESCENTS AND HIV AWARD

P3- Paediatric care and treatment of children infected by HIV

TITLE OF ABSTRACT: Retention of HIV Paediatric Patients Receiving Antiretroviral Treatment at ICAP supported sites in Rwanda

AUTHOR: Dr. Gilbert TENE

Speech: Country Director of UNICEF

The Country Director of UNICEF highlights the appreciation of Children recommendations and adds that the UNICEF is committed to support and raise awareness from recommendation of adolescents

4.5. Closing speech by Guest of Honor

Aloysea INYUMBA,
Minister of Gender and Family Promotion

The Honorable Minister highlights that, the fight against HIV/AIDS can never be successful if adolescents who make a significant proportion of our population and is expected to carry the heavy weight and

responsibility of propagating the heritage which we shall pass on to them are not the centre of attention.

She invited all participants to use these recommendations to review and enrich policies, strategies and plans so to make them operational and useful to all, especially the youth. She ended her speech by thanking all participants for their contribution to this conference, especially to children and the steering committee for their good work preparing and conducting together the conference and the donors and development partners who have financially and technically supported in the organization of this conference and in the fight against the HIV/AIDS pandemic in our country. She also announces the theme of the next children Summit which is: children and equity and promise that all recommendations formulated in these conferences will be implemented.