

**PROJECT TITLE: TRAINING OF LOCAL GOVERNMENT COUNCILLORS AS HIV/AIDS PEER EDUCATORS IN RWANDA**

**LOCATION: NYARUGENGE DISTRICT–KIGALI CITY**

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## **BACKGROUND**

In 1999, the government of National Unity of Rwanda, that had taken over power from the genocidal government in 1994, after realising the dangers and consequences of concentrating power in hands of individuals that had led the whole country into a genocide, decided to use the system of power sharing and collective responsibility, right from the smallest unit of Rwandan administration – the cellule, established the cellule and secteur councils and executive committees respectively. These were charged with the task of managing the affairs of their respective localities. They were elected directly from their communities and tasked to engage their electorate in decision making process and implementation of agreed upon decisions thereof.

Having tested the system for two years, the government adopted the decentralization policy and thereafter in January 2001 passed a law on decentralisation and local governance in Rwanda. This law spelt out political, administrative, legal and finance frame works for the local governments in Rwanda .In March 2001 elections were held country wide for Districts and Municipal Councils and Executive Committees respectively..

The councillors elected to the councils were considered to be people of high integrity, opinion leaders and models of our society and whose behavior we do believe, when changed would automatically influence a positive change in attitudes and behavior of their peers and electorate and forthwith lead to a remarkable decline in HIV/AIDS in the Rwandan society and Kicukiro District in particular. It would lead to a reduction in stigmatisation and discrimination against the HIV/AIDS infected and affected, and hence increased society/community support to the affected and infected. It would be noted that people readily listen, observe, admire and take and follow advise from peers without much emphasis.

The peer educators methods has worked well in Uganda, where the youth were used as Peer Educators in the HIV/AIDS awareness campaign and alternative preventive measures and the use of condom in particularly. This led to a remarkable decline in the HIV/AIDS prevalence rated among the youth in Uganda.

It is against this background that we decided to use peer education as a strategy to fight HIV/AIDS in Rwanda, and chose councillors as peer educators because they are close to the people respected for their integrity, seen as opinion leaders and models by their communities. We do feel that if they are trained and their behaviors and attitudes are changed, the rest of the community will automatically change through immitations and peer pressure.

All in all, there is a need for life skills education among the youth, women groups and the local councillors in general, in areas of interpersonal relationships, self awareness, self-esteem, problem solving, effective communications, negotiating safer sex, maintaining chastity, resisting peer pressure, critical thinking and formation of friendships among others.

The peer education project is aimed at equipping councillors, men, women and youth respectively with the knowledge, confidence and skills in relation to their relationships and behaviours to reduce the risk of contraction and spread of HIV/AIDS and other sexually transmitted diseases among them.

Since they are seen as models and opinion leaders by their communities, once trained will lead to a remarkable behavioural change for the whole society. As they live a safer and changed life themselves, they will be with moral authority to deliver messages and be imitated by their peers and the community at large.

Besides encouraging people to think about the values and consequences of their decisions, behaviours and feeling positive about themselves, peer education helps in gaining self confidence, a fact that enables one to resist pressure and adopt safer behaviours with confidence and influence similar behavioural changes in their peers. One is equipped to challenge views, ideas and arguments that would be geared to resisting the change.

## **PROBLEM STATEMENT**

HIV/AIDS is a tragic challenge for all countries Rwanda inclusive. The Rwandan context is however so unique due to the legacy of the 1994 genocide. Many women and girls were raped during the genocide. There were sexual abuses both in the genocidal and in Rwandese Refugee camps in the neighbouring countries in the post genocide immediate period.

Despite all efforts, both by the government of Rwanda and other concerned Partners, and despite the media campaigns on the scourge, its causes, effects and alternative preventive measures, HIV/AIDS Prevalence rate in Rwanda is 13% of its population, making Rwanda one of the most highly infected countries in the world.

The epidemic is on an alarming increase in rural areas than in urban areas, unlike in the past when it was an urban affair and always connected to urban problems of poverty, slums, unemployment and prostitution.

Likewise the figures for women infected are also on the increase as a result of women status economically, socially and culturally in the Rwandan Society in addition to genocidal legacies and effects.

Studies carried out in the last seven years reveal the following trends:

Year		1996	1997	1998	1999	2000	2001	2002
People infected in thousands	Male	141.35	142.73	160.09	170.68	180.69	195.01	204.65
	Female	113.83	148.21	168.42	180.49	192.25	201.38	221.15

Urban-rural prevalence comparisons for 1996-1997 reveal the following trends:

Area	Prevalence Rates	
	1996	1997
<b>Urban</b>	17.8%	11.6%
Male	14.6%	8.9%
Male	21.8%	13.0%
<b>Rural</b>	1.3%	10.8%
Male	1.3%	11.7%
Female	1.4%	10.1%

Surveillance data indicate that HIV/AIDS infection cases begin to increase in the 15-19 years age group and the peak is reached at the age range of 20-40 years.

The research further reveals that between the 15-19 years of age, the number of girls infected is 3-6 times more than that of boys, while in the age group of 20-40 years the number of women to men is twice as high. The impact is enormous since the above categories of people are the productive age groups of any society. The disease therefore denies the country of its economically productive labour force and taxpayers. At the same time, the orphans left behind are in most cases at the age where they need most the parental guidance and care.

The impact on the Health Care is also very significant as AIDS patients nowadays do occupy most space in hospitals and health centres, making it difficult for hospitals and health centres to cater for other cases and diseases.

The above is coupled with the already existing problems of poverty, inadequate medical supplies and inadequate doctors and nurses.

The infected and the affected are also faced with stigmatisation and discrimination as society do believe that HIV/AIDS is a disease associated with evils, indiscipline and bad behaviour.

In addition to the above, sexual abuse especially to young girls is on the increase as old men do believe that these young girls are HIV/AIDS free, and this has accelerated the spread and increased the prevalence rates in our communities.

## **MAIN OBJECTIVE**

The main objective of the project is to stop the spread of HIV/AIDS and the consequent effects of stigmatisation and discrimination of our society against the infected and the affected.

## **SPECIFIC OBJECTIVES**

1. By the end of the pilot project, we shall have trained 6 trainers and 276 Peer Educators in Kicukiro District.
2. By the end of the pilot study we shall have developed teaching and learning aids/materials, which will reinforce the Peer Educators programmes in their communities. This will increase the awareness and reduce the prevalence rates in Kicukiro District.

3. By the end of the pilot project, we shall have developed a Community Based Approach, that is involving in nature and integrated in scope to fight HIV/AIDS scourge and at the same time reduce stigmatisation and discrimination within our communities.

4. The attitude and behaviour change initiated and reinforced will go a long way in reducing unwanted pregnancies, sexual abuses and measures for fighting the disease like use of condoms, zero grazing and abstinence will be reinforced.

## TARGET GROUP

Our target groups are councillors at all levels of Rwandan Local Governments. These councillors from bottom-up strata, would be 7 people elected at the cellule level as 2 general, 2 women, 2 youth representatives and the cellule coordinator, respectively.

At the secteur level, the group is composed of 10 Executive Committee members. While at the District level the group is made up of the elected District Councillors who may vary from District to District as this depends on the number of secteurs in the District and whether it is rural or urban area.

Taking Kicukiro District, which is our pilot project, the following table shows the number and categories of councillors that are to be trained as peer educators:

<b>Level</b>	<b>No of Admin Units</b>	<b>No of Councillors</b>	<b>Total</b>
District	1	20	20
Secteur Council	6	10	60
Cellule Council	28	7	196
<b>Grand Total</b>			<b>276</b>

## IMPLEMENTATION STRATEGIES

1. Identification and choice of facilitators/trainers/experts. These are very important for their expertise and experience impacts a lot on how successful the overall objective is achieved.

2. Fundraising – The availability of funds determine when and how the project is implemented. Therefore a need to contact different funding agencies, both local and international, private and public to make our project and consequent projects a success. Agencies to be contacted include: the EU, ACTION AID/SIPAA, World Bank, DFID, USAID, DMU-MINALOC, CNLS, CPLS and CDLS.

3. We shall establish a project team, composed of people living with HIV/AIDS, Religious leaders, Local leaders, funding agencies, CBO and NGOs in Kicukiro District that are directly or indirectly involved in the fight against HIV/AIDS.

4. There will be consultations with all the stakeholders and all along the process; it will be a participatory approach that will be applied.

## **ACTIVITIES AND TIME FRAME**

In order to reach our intended objectives the following activities and timing will followed:

<b>Activity</b>	<b>Timing</b>
Meeting stakeholders and funding agencies	May – October 2003
Establishment of the project committee	October – November 2003
Preparation and production of training and learning Materials	October - November 2003
Training of Trainers	November – December 2003
Training councillors as peer educators	December 2003
Impact Assessment and evaluation of the pilot Project	February – March 2004

## **ASSUMED RISKS**

1. Inadequate funding
2. Unforeseen political activities
3. Poor cooperation among the Project Team members
4. Inconsistent attendance by the participants

## **POSSIBLE SOLUTIONS**

1. Since the biggest portion of our budget is on meals and accomodation, we may organise a half-day seminar in a centrally located venue. This will however increase the number of days for the training.
2. While Political Activities may interfere with our timing we shall reschedule our timetable by pushing it forward or backward depending on when these political activities take place.
3. Arranging frequent meetings between the project team members and the project leaders to resolve pending issues and increase cooperation among project team members.
4. Participants will be taken away to a different location far from their residence and work places. Alternatively consult participants on the most convenient time and days when they feel they would attend with minimum interruptions.

## BUDGET

### I. TRAINING OF TRAINERS

Cost Area	No: Days	No: Persons	Cost/Person/ Day RWF	Total RWF
Hiring Conference Room	3	-	20,000	60,000
Accommodation	3	6	6,000	108,000
Meals	3	6	4,000	72,000
Training Materials	-	6	2,000	12,000
Allowances	3	6	1,000	18,000
Facilitators	3	2	20,000	120,000
Consultants	5	2	75,000	750,000
Administrative Costs15%	-	-	-	171,000
<b>Total</b>				<b>1,311,000</b>

### II. TRAINING OF PEER EDUCATORS

Cost Area	No: Days	No: Persons	Cost/Person/ Day RWF	Total RWF
Hiring Conference Room	5	-	20,000	100,000
Accommodation	5	284	6,000	8,520,000
Meals	5	284	4,000	5,680,000
Training Materials	-	276	2,000	552,000
Allowances	5	276	1,000	1,380,000
Facilitators	5	2	20,000	200,000
Moderator	5	1	20,000	100,000
Trainers	5	6	10000	300,000
Administrative Costs15%	-	-	-	2,524,800
<b>Total</b>				<b>19,356,800</b>

### III. IMPACT ASSESSMENT AND EVALUATION

Cost Area	No: Days	No: Persons	Cost/Person/ Day RWF	Total RWF
Team leader	10	1	75,000	750,000
Data collectors	7	4	10,000	280,000
Data analyst	5	1	40,000	200,000
Data entry clerk	7	1	10,000	70,000
Stationery	-	-	-	100,000
Report writing & production			-	500,000
Administrative Costs15%		-	-	285,000
<b>Total</b>				<b>2,185,000</b>

**GRAND TOTAL: I + II + III**

**= RWF 22, 852, 800**