

Strengthening of vulnerable families and building community response to HIV/AIDS in Nyamirama, Mukarange and Ruramira sector in Kayonza District - Rwanda

# Participatory midterm review



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Photo: Lotte Ladegaard

**Chased away**

“My mother died in 2004. I never knew my father. I heard that he died. I used to live with grandmother, but recently she chased me away. Whenever I get temporary work carrying bricks, she wants the money for food for the entire family. I failed to get money, and she chased me away.

Now, I stay with my uncle. I help with household work. Previously I failed going to school, but now SOS Children’s Villages pays my school fees and school materials. I go to school, but I never met any youth clubs or CBOs. I worry about the conflict with my grandmother, and I think I will soon go for volunteer testing and counselling, because I am not performing well.

I wish I could join vocational training and become a mechanic. I also wish I could have new clothes for Christmas like other children.

*Boy, 16 years*

## Introduction

This is the second participatory midterm review carried out by SOS Children's Villages Rwanda. *The UN Convention on the Rights of the Child* states that children have a right to participate in decisions regarding their own lives. Consequently, children are entitled to participate in monitoring, evaluation, accountability and learning concerning activities affecting their well-being. Child rights organisations such as UNICEF and Save the Children have developed guidelines and involved children in all parts of the project implementation cycle, including research for various purposes, for almost two decades.

Participation in monitoring, evaluation, accountability and learning builds empowerment beyond trainings and everyday activities, and it helps increase the children's status in their own communities. The status of children is important if child rights and children's participation are going to become and remain accepted in a society like Rwanda where adults traditionally are not listening to children. Adults have to learn to trust that children are capable and children have to learn to raise their voices towards adults. Research is a vessel for children to practice raising their voices and for adults to build trust in children as capable human beings. Participation in monitoring, evaluation, accountability and learning also empowers children to hold adults in their families, communities, schools and projects accountable.

While children are entitled to participation, adults are responsible for the protection of children against harm, risks and unintended consequences. Therefore, adults always have to accompany children during their research. Adults are also responsible for facilitating true children's participation, for helping set up appointments with adults and for ensuring the quality of the research. This participatory midterm review underpins what staff members, volunteers and members of CBOs have learned and practiced during a number of trainings on child rights, children's participation and children's participation in advocacy.

Creating space for real children's participation takes time and is challenging, because adults do not easily let go of their power and they do not trust children to be qualified. However, we know from decades of best practices with children's participation that children are at least as committed as adults when trusted with important tasks.

### **With children's participation the country will move forwards instead of backwards**

"During the advocacy trainings I learned that you can help people in the community if you come across problems. You do not have to be part of a project to do that. We learned that we are not alone, and that we can make alliances and contact authorities together. We have learned different communication tools so we may change tools if one does not work as expected."

"After the trainings we have been telling parents who force their children to hard labour that they should stop this. We feel mature and confident, and we have started our own advocacy. We asked local leaders to help mobilise a big meeting on child rights. They accepted to support us, but we had to postpone, because the leader did not do what he promised. We want to empower all children, so we will continue. Now, we have requested SOS staff to help us."

"Adults think that we are unable to do things. This is a big challenge. Previously, I could not express myself in front of many people, but you made me do it, and others saw it. It went well, and now I feel very confident. Now, the mind-set of adults is changing, because the entire population saw children perform Theatre for Development during our advocacy training. If you participate in trainings and elders support us, everything is possible."

“This research will help us understand if leaders are actually doing what they promise to do, and we will understand if the project is being properly implemented – also the advocacy part. It is easy. We are from here, and we have learned to do research. We can explain and plan, and we know how to ask.”

“For someone who has never done research it may be difficult to understand that children can do research, but we have experienced that we can. We are confident. It is good to see a big number of children engaged in research, because it is our right. If we had not been invited to participate in the research, we would have felt despised and without value and not able to do anything.”

“Now, we are planning to do more research. After a certain period, we want to check again if our advocacy has changed anything, and we will check if our approaches are OK. SOS staff should be available to support us, especially towards leaders. Then, the country will move forwards instead of backwards.”

*Children and youth who participated in advocacy trainings and midterm review*

## About the report structure

The overall headings in this report originates from INTRAC guidelines to a staff self-review applied as a part of the participatory midterm review. The staff self-review and this report compares, ‘What we said we would do’ to ‘what we in fact did.’ The structure enables project implementers and the facilitator in identifying gaps occurring between planning on the paper and implementation ‘in real life.’

The participatory midterm review takes its point of departure in the indicators attached to the project’s three objectives. Summaries of findings, conclusions and recommendations for each objective are just below this section, which has become more encompassing than foreseen due to a very comprehensive research done by the participants.

Methodology and changes to methodology, project background and detailed findings follow the summaries, conclusions and recommendations.

Generally, the *Strengthening of vulnerable families and building community response to HIV/AIDS in Nyamirama, Mukarange and Ruramira sector in Kayonza District – Rwanda* project is referred to as ‘the HIV project,’ or simply ‘the project.’

### Protection against stigma

While names of authority representatives and others are generally included in the detailed findings, I have omitted the names of children and adults living with HIV/AIDS. This is to protect them against stigma and discrimination. The researchers and the facilitator are aware of all the names.

## Summary of findings: Objective 1

Apart from one person, all 11 caregivers interviewed have been part of the project from the beginning. One male participant says that he was never a part of the project, although he is on the participants list. During the research, the respondent denied to answer questions because of misunderstandings with his wife who participates in project activities. He is also dissatisfied about not having access to loans as expected when he signed up for the project in 2013.

All the remaining 11 project participants engage in kitchen gardening. The HIV project also provides many project participants with seeds and tools for kitchen gardens and farming. Poor nutrition is a big challenge for the project target group. Although kitchen gardening seems to have a positive impact on the project participants' health and nutritional status, a number of project participants are homeless or live in makeshift housing, and they cannot bring their kitchen gardens every time they change their location.

When the project began in July 2013, income-generating activities were included. In March 2015, the approach changed into village savings and loan associations. This fundamental change almost half way into the project implementation has had negative consequences for the project's midterm results, and indicators for objective 1 have probably become unrealistic since the project staff, volunteers and CBOs still struggle to make people understand the value of village savings and loan association.

Although majority of the project participants are members of village savings and loan associations, only 45 percent are active and saving, while 20 percent participate in meetings on a regular basis. Members of one village savings and loan association confirm that not all members are active, and some have left the association due to lack of money, or because they are sick. Some never signed up. Seven families decided to leave the project all together because of the change in approach, because of lack of permanent accommodation, because of moving to other districts amongst others due to loss of biological parents or other personal reasons, while eight adult and three child project participants have passed away. People living with HIV/AIDS are generally weak. This was emphasised by a number of respondents, including local authority representatives and health workers.

Eighty persons, who are active in the village savings and loan associations, have managed to establish small businesses or invest in domestic animals that lead to increased income. Some association members now manage to pay their own health insurance. Statements from several members of village savings and loan associations clearly show that one of the big benefits is the social aspect of the associations; many members appreciate sharing their problems with other people living with HIV/AIDS.

These associations have so far been limited to the HIV project participants, but the plan is to invite other community members in 2016 to increase the economic base and avoid stigma of people living with HIV/AIDS. Some CBOs and youth clubs are establishing their own village savings and loan associations, and youth clubs have already saved and bought rabbits. The rabbits have multiplied and the youth club members have donated the baby rabbits to vulnerable children.

Many respondents mention the need for further village savings and loan association trainings to strengthen the associations and attract more members. Only one training has taken place as part of the budget was already spent on income generating activities before the approach was changed. The remaining part of the budget for income generating activities has been spent on service delivery.

Because of the weakness of the target group, it is impossible to limit the direct services, and no families have so far been ready to exit the project, according to the SOS staff. The staff say that if you stop the services before the family members living with HIV/AIDS have gained enough strength they will fall back to the starting point very quickly. At the same time, the government health centres continue to refer people living with HIV/AIDS to the HIV project for food rather than providing the services themselves.

During my own research, I noticed that some project participants appeared to have decent incomes, land and fairly big and well-equipped houses. One family has, for example taken comprehensive loans, bought land and built a big house, and they have their own permanent shop in a small arcade. Yet, they received

support for school materials as well as health insurance in 2014. The explanation for this may be that the project target group is all caregivers living with HIV/AIDS, non-regarding their economic status. The direct support to at least one of the above families stopped in 2015, but the family has yet to pay its own health insurances.

Local authorities and health workers are praising the project for bringing awareness on HIV/AIDS prevention, services related to the disease as well as nutrition. They say that some project participants have managed to change their living conditions due to village savings and loan associations and the establishment of small businesses. Project participants attend medical services and kitchen gardening has helped reduce malnutrition. However, some project participants are very vulnerable and need direct support, according to the authority representatives, who appreciate that the project pays health insurances and other services for a great number of project participants.

In spite of the payment of school materials, support for school feeding and school fees teachers say that children still drop out from school due to poverty and subsequent child labour. Some parents find that education has no value. Some families and children migrate to bigger towns. The teachers find that there is a need for more trainings on child rights and parenting skills as well as job creation.

Seven groups of siblings, 20 children and one youth in total, confirm this. All seven groups of siblings receive school materials from the project, and almost half of the children's families have health insurances paid and receive seeds. The siblings from five of the families experience dropout from their schools. Most of the children interviewed are aware that the HIV project exists, and a bit more than half of the children have some knowledge about HIV/AIDS.

Although CBOs and volunteers are engaged in project implementation and follow-up on project participants, 352 participating families is a great number to handle for only three staff. Although the volunteers are extremely committed, they are not working full time on the project and the CBOs have, periodically required lots of attention and most members has limited experience from development work and with the target group. Issues concerning CBOs are described more closely under the findings of objective 2 and 3.

Irregular transfer of funds has led to delayed activities and an SOS system that does not encourage budget revisions is also challenging the implementation.

#### **Being a volunteer is a childhood dream**

"We didn't know about advocacy before. Today, if we come across a problem, we know whom to contact. Through advocacy we can solve one issue for many people, and not only for project participants, but for entire communities. We also were not aware of how to conduct research and how to improve the project, and we have understood that there is a link between advocacy and research, because you have to check what has been done and if it works."

"Most of us are studying at university. We can also use the knowledge there. In my university, we have courses on advocacy, but I never understood until now. Now everything is clear. Even in normal life it is important to know how you can gather information and ask questions."

"Being a volunteer is a childhood dream. I always wanted to work with children who are deprived of their rights. I love my work. My dreams have become true."

“Everyone does something for a reason. I felt I should work with poor people. When I was younger, I felt sad about people’s suffering. It made me happy to become a volunteer, and nothing can stop me.”

*SOS volunteers who participated in advocacy trainings and midterm review*

## Conclusions and recommendations for objective 1

**Village savings and loan associations – training and engagement:** According to SOS Children’s Villages Rwanda’s *Bi-annual progress report* from November 2015, representatives of all families participating in the project have completed one village savings and loan association training. Yet, less than half of the project participants are active and saving. To attract more members it is recommended that the HIV project emphasise on the social aspects and the long-term benefits during additional trainings and home visits. This will strengthen the associations, help alleviate poverty and make the associations sustainable.

**Inclusion of further members into the village savings and loan associations:** To increase the economic base and avoid stigma of people living with HIV/AIDS, existing village savings and loan associations plan to invite other community members not living with HIV/AIDS to participate in the associations. This may be beneficial to the members. However, the project staff have to follow the process closely to make sure that the village savings and loan associations are not ‘hi-jacked’ by stronger community members. There is also a risk that the village savings and loan associations lose the social aspects: That members living with HIV/AIDS lose the feeling of the associations as a ‘refuge’ from stigma. It is recommended to pilot the inclusion process in one or two associations in each sector and evaluate the experiences thoroughly after six months. If the results are predominantly positive, the inclusion process may be implemented elsewhere.

**CBO and youth club village savings and loan associations:** As it is, CBOs and youth clubs are having their own village savings and loan associations. It is suggested that the CBO associations merge with the project participants’ associations to encourage everyone to make real efforts in saving.

Some youth clubs, on the other hand, are already doing quite well in generating a surplus, in investment and donation of surplus to vulnerable children. At the same time, the focus on youth and children’s participation is somewhat vague in the project implementation, and the activities carried out by the children and youth receive very little acclaim in the communities. On one hand, inclusion of the youth club saving associations into adults associations would force adults to take the children and youth into consideration. On the other hand, the children are probably not yet empowered enough to challenge adults in village savings and loan associations. If children and youth remain in their own associations they may keep in control of their savings, investments and donations – and learn to do so without adults taking over the processes.

**Change of approach – from income generating activities to village savings and loan associations:** When the project started in July 2013, income-generating activities were included. Following a request from SOS Children’s Villages Rwanda and Denmark the approach changed into village savings and loan associations in March 2015. Seven families decided to leave the project because of the change in approach or for personal reasons.

Fundamentally changing the approach at a stage where the project participants are already deeply engaged in the implementation of income generating activities and have developed clear expectations to the outcome is challenging. SOS Children's Villages should consider extra carefully the risks when changing approaches fundamentally at a point where the project staff have already identified its participants, have promised them a certain support and initiated the activities. The changes in the HIV project will not only affect the project impact. It has also affected the accountability and the trust in SOS Children's Villages.

**Eating a daily balanced diet:** In keeping with findings during the midterm review research all project participants have received training in kitchen gardening, most have established kitchen gardens, and many have received tools and seeds. Some have also received domestic animals. Some caregivers say that their diets have improved. As this component seems to work very well, the project could explore the opportunities for joint kitchen gardens. Future projects could advocate for joint land from the authorities to ensure enough food for everyone on ARV, even for those who are homeless or too ill to maintain their own kitchen garden.

**Families contribute economically to school expenses:** According to SOS Children's Villages Rwanda's *Bi-annual progress report* from November 2015 480 pupils received school materials, 14 pupils had their school fees paid and 52 pupils were supported with school feeding from August to November 2015. Neither the report nor the midterm review research indicate how many caregivers are contributing economically to school expenses. To be able to measure the outcome of the project it is recommended that future reporting take its point of departure in the indicators rather than activities to measure impact.

Even with the direct support, children still drop out from school because of poverty and because some parents find that education has no value. At the same time, some project participants do not belong to the poorest segments of the population. Yet, they received support for school fees and materials as well as health insurance in 2013 and 2014. In the future, the project should clearly assess the status of each family based on observations and in-depth interviews and develop clear criteria for service delivery to the most vulnerable only.

At least one of the better-off families' children have dropped out from school because the family does not pay school fees. The project should therefore focus more on making people aware of their responsibility of giving priority to paying school expenses as a part of child rights activities.

**Project participant selection:** All people living with HIV/AIDS in the project areas are part of the project, non-regarding their economic status and general vulnerability. Although many people living with HIV/AIDS are even more vulnerable than the average poor are, not all people living with HIV/AIDS are per definition poor. It is recommended that future projects apply poverty and level of vulnerability as criteria for project participation, also in HIV/AIDS projects.

**Families contribute to health insurance for children:** The HIV project paid health insurance for 853 vulnerable persons from the project and the community in 2014-15 according to the *Bi-annual progress report* from November 2015. It is not clear how many families participating in the project contribute to

health insurance for their children. To be able to measure the outcome of the project it is recommended to base future reporting on the indicators rather than on activities.

At least one of the better-off families are not paying health insurances. The project should therefore focus more on making people aware of their responsibility of giving priority to paying health insurances as a part of child rights activities.

**Child rights as a tool to make people take responsibility for their own health insurances and school**

**expenses:** While this is a child rights based project almost no project participants know clearly what child rights are and how the *UN Convention on the Rights of the Child* work a foundation for claiming children's rights. Overall, the project implementation seems to focus more on service delivery to caregivers than on empowerment of the actual target group: Children. A relatively limited number of children and youth are active in clubs, while the majority of the children are mere recipients of services via their caregivers. Most of them are hardly aware of their rights, and they are not in any way engaged in claiming their rights. The remaining project period must be dedicated to making adults and children fully aware of child rights and work to engage children in all activities as service delivery and support to adults do not necessarily trickle down to children if the children are not aware that they ought to benefit too.

It is recommended that the project staff, CBOs and youth clubs make real efforts in engaging adult and child participants in activities during Community Days and advocacy activities. During home visits, child rights and adult responsibilities to fulfil these must be a topic given as much value as HIV/AIDS as rights awareness, over time, may lead to change of mind-sets. This has two-fold benefits: The project participants learn what rights are and how to claim their rights themselves or on behalf of their children, and hopefully, over time more children will have their rights to education and health insurance fulfilled by their parents or by the government.

**Limitation of direct services:** While there is still a clear need for direct services to a number of families it is recommended that criteria for delivery of direct services have more emphasis on poverty so that only the poorest receive direct services. At the same time, the HIV project should put extra emphasis on advocacy activities concerning changes in the health insurance system and food for all on ARV as described in the advocacy strategy.

**Limited staff, many project participants:** 352 participating families is a great number to handle. At the same time, advocacy activities require lots of human resources and time. Advocacy cannot just be 'added on' every now and then. It must be a continuous process if it is to carry fruit. The same applies to youth club activities. Best practices for children's participation show that clubs, to work efficiently and continuously, need a fulltime adult facilitator to help initiate new activities, create access to other adults, solve problems and ensure regular meetings, preferably on a weekly basis if the clubs are to have real impact – and sustain. The relatively limited human resources means that the efforts are spread very thinly and that all three staff have to work all-round. Additional staff specialised in child facilitation and advocacy would almost certainly enhance the impact and sustainability of the project.

**Budget challenges:** Delayed transfers of money has led to delayed activities and an SOS system that is not encouraging budget revisions is challenging the implementation. Fixed transfer rules must be established and followed and less rigid rules applied when it comes to budget revisions that are fundamental for the outcome of the project.

## Summary of findings: Objective 2

All local authority representatives interviewed in the three sectors covered by the project are positive about the impact of the project. Although the government itself in partnership with a number of other NGOs are working on the same issues as the SOS HIV project, the in-charges of social affairs in the three sectors say that SOS Children's Villages probably may take the credit for 50-70 percent of the progress concerning the issues and areas covered by the project.

The local government have developed a strategy in cooperation with community health workers and partner organisations such as SOS Children's Villages, FXB, Partners in Health and CBOs. Sensitisation campaigns done in partnership between local government, SOS Children's Villages and other partners play a big role. Many people participated in SOS campaigns, meetings, theatre and games, and so do partners who receive per diems when they participate in campaigns. Amongst these are CBOs, community health workers, local leaders and youth clubs.

The number of pregnant women who attend the health centres for prevention of mother-to-child transmission has increased in all three sectors, according to the in-charges of social affairs. Pregnant women are more committed to going to the health centres for testing during the first three months of the pregnancy. No one gives birth at home any longer except accidentally. Nowadays, no babies are born with HIV in the area due to free ARV and sensitisation campaigns by local government and NGO partners. However, some mothers still do not respect doctors' appointments and husbands are usually not interested in accompanying their wives to the hospital apart from when the wife is about to give birth. The health workers also complain that they do not have condoms to hand out.

The HIV project has trained youth-friendly centre staff on sexual and reproductive health and rights, prevention of mother to child transmission and other services. The centre staff says that update information enabled the staff to provide better information and motivate youth.

Teachers from schools in the three sectors see many changes due to trainings by the HIV project. One school club has organised football competitions with messages about stigma and the transmission of HIV/AIDS. In another school, teachers and pupils have played games and theatre to mobilise people to fight against HIV/AIDS and sexual abuse of children and in favour of investing in health insurance. Some pupils are living with HIV, and they participate in counselling. School club members now know how HIV/AIDS transmits, how to prevent it, how to help people living with HIV/AIDS and how people may learn to live with the infection.

However, the research also reveals that many pupils only are partly aware of HIV/AIDS services. Sometimes, volunteer counselling and testing organised by schools is cancelled due to lack of transport, and children still fear talking about their status to anyone but the health workers and teachers.

The knowledge about child rights is also limited. Three school-going boys can only mention the right to life, to food, education, having a name and identity. They feel that this knowledge has helped them grow up in freedom and security, but they do not provide any examples. They say that HIV/AIDS violates child rights, because “HIV/AIDS kills children” and because “it causes lack of security, happiness and hope.” The boys know that they can get HIV/AIDS services at health centres and hospitals, but they do not know that HIV/AIDS and sexual and reproductive health and rights are related or where to find services concerning the latter.

Most youth clubs involved in the HIV project are active, according to SOS project staff, and the clubs carry out activities with school-going children as well as out-of-school children, the staff say. One club organised a testing session for class 4-6 in primary school. Five clubs are breeding rabbits. They saved for the rabbits, and at the end of the academic year, they donated the rabbits to vulnerable children. The SOS Anti-AIDS clubs also visit vulnerable families.

While the youth club members know the basics about HIV/AIDS, their child rights knowledge is more limited. They are aware that children have a right to registration in civil and legal documents, a name, education, to be heard, to have food and good health, to have names, good health and to protection against hard work and violence. They feel that it helps to know child rights, but the youth have not provided any examples on how it has helped. Some club members are not clear about the linkage between child rights and HIV/AIDS. Their response is that “children do not know much about child rights.” Neither do they know about sexual and reproductive health and rights and the link to HIV/AIDS.

At least one of the clubs have no other partners and do not receive trainings from elsewhere. The club members wishes to strengthen the partnership with SOS Children’s Villages. They request more training and constant support.

CBO representatives disseminate messages about prevention of mother-to-child transmission, volunteer counselling and testing and family planning during meetings in village savings and loan associations. CBO respondents say that prevention of mother-to-child transmission trainings saved many children from HIV/AIDS as pregnant women now go for testing. However, not all CBO respondents have carried out activities related to HIV-services, and a number of new CBO members still lack training in counselling for discordant couples. Those, who have been trained, teach discordant couples how to help each other, to go for tests every three months, in using condoms, how to avoid stigma and to have a balanced diet. Because of the counselling to discordant couples, one man stopped drinking.

One CBO also sensitizes youth to use condoms and HIV services, and they teach them about sexual and reproductive health and rights through youth-friendly centres. One CBO member speaks to youth in the church.

The CBO representatives feel that their efforts make a difference, because people have begun asking for condoms, they ask more questions, and local leaders provide time for the CBOs to speak. However, the CBO says that it has have no condoms left since they already distributed the condoms they got from the HIV project. When asked about if they could get more condoms locally, they responded, “If we have, we will conduct more sessions.” They added that the in-charges of youth-friendly centres, small nightclubs and hotels have been asking for condoms and advertisements telling, ‘Remember to use condoms.’

The CBOs also have a number of other requests, such as more trainings for all members, training syllabuses, boots and bicycles.

## Conclusions and recommendations for objective 2

**Training of health centre staff:** Local authority health representatives are very positive about the impact of the HIV project and to a certain extent, they depend on the services delivered by SOS Children's Villages. However, a number of other NGOs are working on the same issues as the SOS HIV project and some trainings are overlapping with the trainings provided by the government. It is recommended that the HIV project avoids overlap and the creation of dependency and instead uses more human and financial resources on advocacy and child rights in the remaining part of the project.

**Training of CBOs:** Usually, only CBO presidents are trained. However, the presidents' knowledge rarely permeates to all CBO members. This affects the efficiency of the CBOs and their ability to pass on all the relevant information. One thing is to participate in a training. An entirely different thing is to train others AND have them implement what they have learned. In future projects it is recommended to include training of trainers modules so that thoroughly trained people can effectively disseminate what they have learned to others who are equally equipped to bring forward their knowledge at field level. This approach has the added advantage that the knowledge will remain in the project area even beyond the project duration and it releases the staff from carrying out a big number of trainings themselves.

**Increased volunteer counselling and testing:** Although official statistics are unavailable in the SOS *Bi-annual Progress Report* from November 2015 and not provided by the authorities either, estimates given by health staff during the research indicate that the aim of this indicator is likely to be met.

Apparently, adults are increasingly seeking volunteer counselling and testing, while it is more complicated to make children and youth go due to stigma and logistical challenges. Therefore, it is recommended that the HIV project emphasise on volunteer counselling and testing of children and youth during the remaining period of the project.

**Pregnant women following prevention of mother-to-child transmission guidelines:** The number of pregnant women who attend the health centres for prevention of mother-to-child transmission and who give birth in clinics or hospitals has increased in all three sectors. The latter is probably partly because it is now illegal and punishable by law for mothers to give birth at home. However, the efforts of making women go for volunteer counselling and testing should continue since not all women are respecting doctor's appointments, taking their medicine as prescribed and having tests done in time. Efforts should also be made to engage fathers who are apparently not taking much responsibility regarding these issues.

**Youth clubs have organised campaigns:** According to club representatives, they are active and carrying out activities two-four times a year. However, they receive very little credit for these activities in the communities and majority of the respondents, including peers, know little or nothing about child rights and sexual and reproductive health and rights. It is not clear if the project has reached out-of-school children. To reach this vulnerable group and to make the HIV project more child focussed it is recommended that weekly meetings at youth clubs are facilitated by staff or volunteers capable of bringing forward knowledge

about child rights as well as sexual and reproductive health and rights and inspire child rights activities reaching a wider number of children and youth.

**Anti-AIDS school clubs:** Although teachers say that they see many changes due to trainings by the HIV project and HIV/AIDS awareness activities the knowledge does not seem to reduce the stigma and discrimination of school-going children living with HIV/AIDS significantly. School-going children also appear to have limited knowledge about rights and sexual and reproductive health and rights. The project should ensure that awareness about these issues are included in the activities with the schools.

**Stigma and discrimination towards children** living with or affected by HIV/AIDS is still a major problem for children and youth. More emphasis has to be given to awareness raising about HIV/AIDS and how stigma and discrimination affects children living with or affected by HIV/AIDS. The HIV project could benefit tremendously from using school and club based training materials already tested, developed and used by other projects and other organisations. For example:

Anti-stigma training manual for 7-11 year old pupils:

<http://www.lotteladegaard.mono.net/upl/11081/RedBarnet711yearsmanual20sA4.pdf>

Anti-stigma training manual for 12-17 year old children:

<http://www.lotteladegaard.mono.net/upl/11082/RedBarnet1217yearsmanual24sA4.pdf>

Anti-stigma training manual for child and youth clubs:

<http://www.lotteladegaard.mono.net/upl/11080/RedBarnetAntiAidsmanual24sA4.pdf>

Anti-stigma training manual for teachers and school management:

<http://www.lotteladegaard.mono.net/upl/11083/RedBarnetTeachersmanual24sA4.pdf>

**Condoms:** Health workers, CBOs, teachers and others complain that they do not have condoms to hand out. However, condoms are available locally in shops and free of charge at health centres. It is suggested that the HIV project systematically makes all stakeholder aware of where to find condoms free of charge or at a low cost in the communities.

### Summary of findings: Objective 3

More than half of 27 interviewed caregivers say that they have established kitchen gardens and have received seeds for cultivation from SOS Children's Villages. A bit less than half mention that they are members of village savings and loan associations and have learned about nutrition and hygiene.

Approximately one out of three has received tools for farming, school materials, school feeding and food as well as health insurance.

CBOs visit almost all of the 27 homes and provide general advice, sensitisation and counselling on parental skills, living conditions, health, hygiene, kitchen gardening, taking care of domestic animals, avoiding drugs and alcohol and coping with HIV/AIDS. More than half of the respondents have learnt about HIV/AIDS from CBOs. One in three has been encouraged to take ARV as prescribed and respect doctor's appointments. Only one has learned about child rights. The same applies to awareness on prevention of mother to child transmission, encouragement to pay health insurance, and to take children for testing. Almost two out of three have experienced that CBOs advocate free health insurance from SOS Children's Villages or Partners in Health.

The HIV project is collaborating with seven CBOs with 15 members in each. The local government has selected the CBO members. Representatives of people living with HIV/AIDS associations are members of the CBOs, but the HIV project does not work directly with the associations. However, the staff invite them for trainings.

CBOs established during the previous pilot project received funds to start income generating activities, but they failed to make profitable business. They were supposed to provide 20 percent of the surplus for health insurance and school materials to project participants. One CBO got one million RF from the HIV project to buy a graining machine to produce flour. However, the graining machine was out of order, say the members. The new CBOs have established village savings and loan associations, but most of them are not stable. Some project participants complain that some CBO members are not honest and that they have taken animals that rightfully belong to project participants. All CBOs are now receiving intensive support from the project volunteers.

The CBOs function well now, according to the staff, although they find that knowledge from trainings rarely permeates to all members. Usually, only CBO presidents participate in trainings. The CBOs are campaigning and linking up with local authorities, and they speak out during Community Days, according to the SOS project staff. They have also developed joint action plans with youth clubs. Gradually they may put pressure on local government, the staff explain.

The CBOs engaged in the project have signed a Memorandum of Understanding with SOS Children's Villages, and they say they represent the project when visiting project participants. After trainings, they share the message with the project participants about, for example parental skills. They also urge the project participants to engage in the village savings and loan associations, help project participants solve problems, advocate for them and advice to teach children "good morals." According to the CBOs, issues for advocacy have been access to free health insurance, categorization of people depending on their economic status and nutritional support as well as school fees paid by SOS Children's Villages. Today, most people have free health insurance, say CBO representatives.

With youth clubs, the CBOs have trainings, meetings, brainstorming and share ideas. The advocacy they would like to extend to a wider numbers of project participants with games, competitions and awareness raising. The CBO representatives have a long wish list containing trainings for all, guiding manuals, more funds for transport and communication, income generating activities and more support.

Local authorities and social workers follow-up on project activities and participate in a number of trainings, depending on their role in the local government. A cell executive secretary has, for example participated in trainings on volunteer counselling and testing, prevention of mother to child transmission, sexual and reproductive health and rights as well as alcohol and drug abuse. In-charges of social affairs have participated in trainings on prevention of HIV, sexual and reproductive health and rights as well as alcohol and drug abuse.

The local authority representatives praise the HIV project for doing follow up on clients and providing free health insurance, school materials and access to village savings and loan associations. Because of the project, people adhere better to the ARV treatment. Project participants also know where to seek HIV

related services. Prior to the project only seven people used to come for testing per day. Now, every day 23 people come for testing.

Most local authority representatives have participated in advocating free health insurance from Partners in Health, Compassion and SOS Children's Villages. In partnership with NGOs, the Social Affairs Office has issued 13,802 free insurances within a year. Only one respondent is aware that SOS Children's Villages has advocated for health insurance and nutrition support to vulnerable people taking ARV.

The HIV project supports associations for people living with HIV/AIDS with food for the most vulnerable members and milk to malnourished children as well as health insurance. Furthermore, the project empowers the members with knowledge and skills on HIV/AIDS such as prevention of mother to child transmission, behaviour change for discordant couples, drug abuse, family planning and sexual and reproductive health and rights and the relation to HIV/AIDS. SOS Children's Villages also provides volunteer counselling and testing sessions to the associations' youth members.

The associations for people living with HIV/AIDS cooperate with the HIV project on campaigns, and project staff participate in meetings and advice about how to avoid spreading the disease. Association members are encouraged to participate in village savings and loan associations and urged to establish kitchen gardens to ensure better nutrition.

Youth club members have participated in trainings in volunteer counselling and testing, alcohol and drug abuse, fight against stigma as well as sexual and reproductive health and rights. They say that SOS Children's Villages made them work with CBOs to raise the understanding among youth on HIV/AIDS testing, treatment and prevention. The youth clubs teach pupils how to behave to prevent HIV/AIDS via theatre, songs, poems and drama at the end of the term. They also cooperate with CBOs and SOS Children's Villages in disseminating awareness on prevention of HIV/AIDS in the community and organise inter-school competitions, fundraising to support vulnerable children and compete with other clubs on who performs the best. They carry out the activities on quarterly basis in schools or in the community.

During an advocacy training workshop in November 2014 the staff, CBO representatives, children from the project and volunteers developed a draft advocacy strategy. The strategy was adapted and further developed during a couple of coaching sessions ahead of follow-up advocacy trainings in May and August 2015. These trainings were financed by another CISU funded project and included staff from both projects. As the human and financial resources as well as the project period are limited, the HIV project advocacy strategy is focusing on the provision of food to people under ARV treatment as well as changes to the legislation concerning health insurance.

Advocacy usually targets authorities. However, in the present strategy the SOS staff also wishes to target other NGOs for food. Although CBO representatives participated in the three training workshops, they are not very clear about what advocacy is and which issues the project has decided to focus on. The staff as well as the research for the midterm review confirm this.

Community Days are playing a big role according to the project document. According to the staff, sensitization has taken place during Community Days concerning stigma, volunteer testing and counselling, family planning, drug abuse and alcohol, use of condoms, circumcision, and school dropout. Apparently,

project participants are not participating in these days as only one respondent in the entire research mentions that he or she has benefitted from this type of sensitisation.

At the same time, almost all respondents say that there is still stigma towards children and youth living with or affected by HIV/AIDS. According to the SOS staff, many project participants provide testimonies. Hence, adults begin to understand that you can live with HIV, but fearing stigma parents are still hiding children's status, also towards the children. Only one representative from an association of people living with HIV/AIDS experience reduced stigma at schools.

### Conclusions and recommendations for objective 3

**Increased ARV services:** Since the project began in 2013, ARV services have become free of charge for all people living with HIV/AIDS. During an advocacy training in November 2014 it was agreed that this indicator would be changed. It is recommended that changes to the project approach be followed by subsequent updates of all relevant documents, which is not the case yet. A note may be included in track changes for future reference.

**Seven CBOs supporting the communities:** Civil society in Rwanda remains in an embryonic state due to a variety of constraints. The operating context for civil society organisations is one of enforced collaboration with the government's political and development plans. Those civil society organisations working within these boundaries can act relatively freely; those that do not face difficulties<sup>1</sup>. This may explain a number of decisions taken and challenges faced by the HIV project.

According to the project design, associations for people living with HIV/AIDS are supposed to provide psychosocial support, follow-up on village savings and loan associations as well as provide mediation in families and in the community. While representatives of people living with HIV/AIDS associations are members of the existing CBOs, the HIV project does not work directly with the associations. It is unclear if the change of partners is due to pressure from the government. At any rate, the project has created its own CBOs, which, to some extent have failed to deliver and hence have undergone much restructuring. Local authorities have selected the present CBO members. This is critical for a number of reasons.

People selected by the local government are more or less forced members who may or may not accept the membership for the right reasons. If some are members for the wrong reasons, this will affect the project implementation as well as the sustainability of the CBOs. During my own research, SOS volunteers working directly with the present seven CBOs suggested that project participants should select or elect future CBO members among people living with HIV/AIDS. These are able to understand the issues that people living with HIV/AIDS are dealing with, they are not judgemental, and they have personal interest in making life easier for people living with HIV/AIDS, which apparently is not always the case now. The interview with the volunteers is included in a box as a part of the detailed findings.

If SOS Children's Villages Rwanda is not ready to challenge the present working conditions for civil society it may be considered giving up the partnership approach in Rwanda until the political climate becomes more conducive. As it is, many human and financial resources are spent on building partnerships that are not optimum and with a questionable sustainability.

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<sup>1</sup> <http://www.icnl.org/research/monitor/rwanda.html>

**CBOs and youth clubs implement advocacy activities for fulfilment of child rights:** In keeping with SOS Children's definition of advocacy, advocacy is all about taking action to improve policies and practices that undermine the well-being of children at risk of losing parental care, or those who have already lost it. The aim is sustainable changes. Engaging in advocacy always entails certain risks, because advocacy is by nature political and takes place in the public sphere. Targeting decision-makers, advocacy is not always appreciated by governments. For that very reason, it is problematic that CBO members selected by local government are the ones to carry out advocacy activities aiming at changes in health insurance legislation.

In spite of participation in three advocacy trainings, development of an overall advocacy strategy and joint action plans the CBOs and youth clubs are not yet engaging in real advocacy. Neither do they really advocate for the issues included in the advocacy strategy: changes to the health insurance legislation as well as food for people on ARV. Furthermore, the advocacy strategy still need some elaboration to become coherent and encompassing in keeping with the advocacy strategy format developed as a part of another CISU funded project in Rwanda.

For the present project, it is therefore recommended that the SOS staff and volunteers put all efforts into finalising the advocacy strategies for the two issues, clarify the duty-bearers concerning advocacy on food and provide extensive support to the CBOs and the youth club in making real advocacy for the two selected issues. Otherwise, with only two years left of the project, the advocacy on the selected issues is bound to fail.

**CBOs implement advocacy to protect children against stigma and discrimination:** As mentioned under the objective 2, stigma and discrimination is still a problem for children living with and affected by HIV/AIDS. However, stigma and discrimination were not selected as issues for the advocacy strategy during the analysis, and it is questionable if the project can manage to come up with a coherent strategy for yet another advocacy issue, carry out sufficient activities and achieve real changes in policy and practices within the next two years. Instead, it is suggested that the CBOs use the training manuals referred to under the recommendations to objective 2, or similar materials, to train children in communities in the prevention of stigma and discrimination of children living with or affected by HIV/AIDS.

During the facilitator's own research, it became clear that adults living with HIV/AIDS meet on a regular basis to share experiences. This is a much appreciated 'refuge.' Similar regular meetings could be established for children living with HIV/AIDS as suggested by one boy living with HIV and suffering from lots of stigma and discrimination. The interview with the boys is included in a box under the detailed findings.

## General conclusions and recommendations

- **The participatory approach:** Generally, the respondents appreciate that children, volunteers and CBOs conduct the interviews rather than researchers from the outside. One representative of people living with HIV/AIDS associations, for example said that it is much nicer to be interviewed by people he knows instead of strangers from Kigali as, "We can be more open this way." The participatory approach also creates more ownership to the findings. For these reasons, as well as reasons provided by children at the beginning of the report it is recommended that SOS Children's Villages Denmark always apply a participatory approach to future midterm reviews.
- **Volunteers:** The use of volunteers is not mentioned in the project document strategy, but it was found that the handful of very, very committed volunteers play an extremely important role in this

ambitious project with only three permanent staff members. Without volunteers, the monitoring and support to the project participants would probably be scarcer. The volunteers also play a very important role in making the CBOs work coherently. However, the volunteers feel somewhat undervalued compared to other volunteers in other projects. Please see details in box below.

It is therefore recommended that SOS Children's Villages develop common guidelines for all volunteers in Rwanda. These guidelines should at least contain:

- The right to debriefings and counselling
- Common transport fees for all SOS volunteers in keeping with receipts instead of lump sums that are taxable
- Contracts for the duration of a project period
- Health insurance paid
- The rights to recommendations from SOS staff for job applications

#### Volunteer challenges

"During the pilot project we were looking after families in one sector. Each of us used to look after 45 families. Now, we work in three sectors. Now, we look after 120 families each, but we receive very little for transport, so often we cannot go to the families due to lack of money. Every month we get a transport allowance via our bank accounts, but we have to pay taxes, because the allowance counts as salary. Then, there is even less money for transport. If possible, you could provide cash instead according to bills."

"We meet people who are sick and dying. Who leave children behind, and we cannot do anything, because we cannot provide services to all."

"We get contracts for three months only. Why can't SOS Children's Villages provide contracts for the project duration? If we don't work well, they may replace us."

"We have no health insurance paid like fulltime staff, even if we work with people who suffer from various diseases."

"When jobs are advertised we are not considered as professionals, even if we have lots of experience and university degrees. SOS Children's Villages do not value our experience. They don't see experience as an advantage."

*SOS volunteers who participated in advocacy trainings and midterm review*

#### Recommendations for future participatory reviews

- **More focus on development of qualitative indicators:** The formulation of qualitative indicators and subsequent qualitative research continues to challenge. In future projects, qualitative indicators must be included from the beginning and developed further, if necessary, before the midterm review. Development of indicators is time-consuming and challenging even to experts, and the time and patience for reformulation of indicators is very, very limited at the point where the focus is already on the midterm review and on learning how to do research – a discipline that many of the participants had never engaged in before.

- **More focus on qualitative research:** Although an increased focus on the difference between qualitative and quantitative information was included in this year's workshop and at the field training, not all researchers have managed to pose follow-up questions and focus on the quality rather than the listing of activities. This just underlines the necessity of combining the participants' research with the facilitator's own research and provide time for this.
- **Wider use of child-friendly research tools and wider inclusion of child respondents in the research:** Considering that children is the main target group there is a limited number of child respondents in the research. Interviewing children is difficult and a discipline in itself. During the at-the-field training the interviews with children proved to be very challenging for the researchers, and it seems like that the groups ended up using no child-friendly research tools at all for their interviews. SOS staff, volunteers and CBOs should have specialised training in child-friendly research. Such a training will enable SOS Children's Villages to gain better insight into how the project affects children. Equally important, it will also help increase the focus on children as the primary target group, because the more times adults are invited to learn and practice child-friendly behaviour, the more likely it is that all adults engaged in the implementation of the project, over time, will behave child-friendly as a rule rather than an exception.
- **Avoid unclear responses:** In future participatory midterm reviews, it has to be made even clearer for the participants that all the 'who, where, when, why, what' questions must be included – also in the written responses. In the present research a number of questionnaires just mention, for example, 'the CBO advocates for free health insurance,' but it is not clear, towards whom they advocate. Or, 'the respondent has free health insurance.' But who pays the health insurance if the respondent does not?

## What we said we would do

### 1. Aims and methods of the participatory midterm review

The overall methodology worked out ahead of the midterm review states: "A regular midterm evaluation was included in the project document. As the project has a strong child rights and participation focus, and as staff and child and parent representatives have been trained in child rights and participation it was decided to involve the children and parents of the project in the midterm review research. The approach has several advantages:

- The children and parents become further empowered by learning how to conduct research and by taking on the role as researchers in their own communities.
- Children and parents from a specific community are assumed to have access to more in-depth knowledge about individual families and how they benefit – or not benefit - from the project.
- Peer approaches generally work well. Children within a community are assumed to trust other children more than an outsider or an adult and therefore provide more frank answers. The same applies to parents.
- Children and parents, who are themselves benefitting from the project, will know the weaknesses and strengths of the ongoing project from their own lives and may therefore ask questions that are more critical.

However, there may also be weaknesses in having relatively inexperienced researchers, who themselves are participants in the project. Some of their questions may be biased, or their own communities may more easily influence them. They may also avoid asking certain questions because they worry that they themselves may lose support if they are too critical. Jealousy and other internal mechanism in the community may also affect the research. At the same time, relatively inexperienced researchers may not be skilled enough to follow up on indications, answers that are not clear-cut or answers leading in several directions. To counteract such problems, and to ensure that triangulation may take place, focus group discussions with child participants of the project, parents of the project and other community stakeholders will be carried out by the facilitator. Baseline survey, regular monitoring reports and community evaluations will also be analysed and used as an input to the midterm review.

The midterm review will start out with a three-day preparatory workshop where all participants, the facilitator and the Danish programme coordinator will participate. The workshop will decide:

- Who are we doing the midterm review for?
- What is to be measured?
- Methods, tools, numbers of informants, roles and responsibilities. Everything will be planned in a participatory manner.

Amongst the tools to be developed and applied could be:

- Questionnaires that may be worked out based on the children's own questions.
- Mappings, drawings, theatre and other child-friendly tools.
- Semi-structured interviews with children and parents carried out by children and parents. Semi-structured interviews may be developed into cases in the writing process.
- Staff self-reviews.
- Focus group discussions with parents, children and other stakeholders by facilitator.
- Eventual randomized controlled trials if time and resources permit.

When the methodology, tools and plans have been worked out, the research teams will initiate the research at field level. The facilitator will coach the initial interviews and help the teams refine their research methods. The facilitator will also carry out focus group discussions with selected stakeholders, and before she leaves, she will wind up with a half day workshop to help resolve eventual problems in the research design."

## **2. Aims and strategy of the project**

The *Strengthening of vulnerable families and building community response to HIV/AIDS in Nyamirama, Mukarange and Ruramira sector - Rwanda* is a rights based project and builds on the dynamics of the individual as a rights holder with corresponding duty bearers. The rights holder is entitled to claim his or her rights and hold the duty bearers accountable. The duty bearer is obligated to respect, protect and fulfil the rights of the right holders. The project promotes children's rights to protection and health by strengthening community access to HIV/AIDS and sexual and reproductive health and rights related

information and services; prevents the spread of the disease; and builds capacity to support vulnerable children living with or affected by HIV/AIDS.

Strategically, the project works at two levels. It strengthens the health structures as well as the capacity of community stakeholders to campaign and influence local authorities as duty bearers while it also works to build economic and social empowerment of vulnerable families living with or affected by HIV/AIDS and related terminal diseases so they can meet the development needs of their children.

In many developing countries such as Rwanda, women often depend economically and socially on their male partners. As women are the main caregivers for children, children also suffer from gender discrimination. Activities in the project aim to reduce this gender imbalance by encouraging women to become less dependent, diversify their livelihoods, and continue their education.

While activities aiming at prevention of mother-to-child transmission of HIV are primarily targeted at women awareness rising on the issue is also important for men so they can support preventive measures taken to prevent mother-to-child transmission of the disease.

Family development plans family goals and milestones are worked out for all project participants. The family development plan identifies and prioritises the needs of each family, and it stipulates how the family is to achieve the goals and milestones. Project staff and CBO members monitors the families' development and ensures that the family development plans are updated regularly.

Each family has its own unique set of challenges, so all support is tailored to each family's particular circumstances. A family development plan could, for example include participation in income generating activities and milestones related to what to prioritise with the limited economic resources, or how to get help with child care in cases of severe illness.

**Strategic services** are used to support and motivate the most vulnerable households. The needs are assessed on a case-by-case basis and then indicated on the mutually agreed family development plan. Some children have expenses to education and health care covered by the project for a limited period, for example schools expenses and health insurance. Whenever possible, the project staff creates linkages or referral to service providers. Funding for house renovations is sought through private and public means, and the actual work effort is integrated with the mandatory Community Service days Umuganda.

The provision of essential services will be reduced step-by-step while capacities of the families are strengthened within a specific period defined in the family development plan and in keeping with the economic empowerment of the household.

**Capacity building of community** include awareness raising toward the general population on project related issues such as child rights, safe sex, alcohol and drug abuse, HIV prevention, living with HIV/AIDS and terminal diseases will be raised through community workshops and meetings. This is to make people aware of preventive measures and avoid stigmatisation of families living with or affected by HIV/AIDS and terminal diseases.

The primary way to communicate and reach the general population is during Community Days. Sharing of personal stories about HIV and AIDS helps fight stigmatisation and make it clear to others that being tested

positive is not a death sentence. Testimonies will also be used in advocacy activities during campaigns and conference.

**CBOs** are important implementing partners. CBOs members are respected people in the society and considered opinion leaders in the community and represent different institutions of civil society. CBOs for people living with HIV and AIDS will be key partners in this project and be trained in family planning, safe sex, HIV testing and counselling tools, childcare and child rights, hygiene, nutrition and income generating activities. SOS Children's Villages supports the CBOs in developing their organisational structure through basic trainings in administration and management, mobilising of community, planning and evaluating information and advocacy activities.

**Youth clubs** are also partners. The previous pilot project carried out information activities in nine district primary and secondary schools, and good partnerships were established. There are existing youth clubs in all schools, and partnerships with these are to be elaborated in this project as the clubs may reach children and youth who already are or soon will be sexually active. Children up to grade four will participate in child rights awareness raising activities.

The youth clubs will sensitize children, youth and other relevant stakeholders such as teachers, parents and local leaders on child rights, prevention of HIV/AIDS and sexually transmitted diseases, drug abuse and safe sex. The youth club members will participate in trainings on the issues and arrange activities at their schools to raise awareness among peers through drama, games and posters.

The youth groups will also participate in advocacy towards local and district government level and interact with other groups to strengthen their ability to influence duty bearers to provide access to HIV/AIDS and sexual health and rights services for children and youth. Representatives from the youth clubs will also be involved in campaigns on HIV/AIDS and participate in regional and/or national meetings and seminars to advocate for implementation of national policies and strategies. Experience sharing among youth groups as well as planning of joint campaigns and other activities with CBOs will take place on regular basis.

**CBOs and youth clubs act as focal points** where community members can seek information on HIV/AIDS, sexual and reproductive health and rights as well as prevention on mother-to-child transmission. The CBOs and youth clubs work out the information strategy and campaigns in close cooperation with local clinics, hospitals and SOS staff. Amongst the topics will be stigma and prevention of HIV.

Awareness raising activities targeting different groups will be implemented simultaneously to prevent unwanted consequences. If, for example a child or young person learns about child rights and share the information with his or her parents, the parents may feel that their traditions, culture and power are threatened. Information on voluntary counselling and testing and prevention of mother-to-child transmission related information and access to services will be campaigned broadly in the communities in collaboration with CBOs and health centres.

The most vulnerable households will be **empowered economically and socially** through income generating activities aiming at creating economic and social self-reliance so that the families, over time, may become able to meet the basic needs of their children. After working out the family development plan the project participants are sensitised about income generating trainings, processes and possibilities through joint

meetings. The training for income generating activities includes support to start up minor business and agricultural initiatives.

The families will also participate in trainings in basic hygiene and nutrition, child rights, nutrition, early childhood development, household economy, development of kitchen gardens to provide nutritious food and family planning, and they will be offered psychosocial counselling. Trainings also equip the project participants with entrepreneurship skills, preparation of basic business plans, basic accounting, knowledge about markets, supplier chains mechanisms, market access, how to deal with competitiveness, opportunities and types of income generating activities as well as risk management. The trainings also focus on identifying personal skills and competences in order to build on these and avoid people from engaging in projects they are lacking the skills to engage in. SOS project staff carry out personal interviews with all project participants to clarify their personal competences.

CBO members support and act as discussion partners in the development of relevant income generating projects. CBO members also help SOS project staff analyse and approve income-generating projects; they follow the progress, support project participants and help establish a network between the project participants. As committed members of the community, CBO members take ownership of activities in the project and thereby strengthen sustainability.

Project participants are encouraged to form networks of those who engage in related activities or who wish to engage in joint activities, or just to share skills and competencies. When participants become self-reliant and exit the project, they will be encouraged to remain in the networks. The networks may become sustainable platforms for sharing of skills, reduction of costs for common purchases of materials and equipment and eventually they may lead to the establishment of village savings and loan associations.

The project participants are also socially empowered when engaged in income generating activities. Many beneficiaries undergo a change of mind-set and discover, for example that they possess an entrepreneurship spirit, which in some cases have led to engagement with micro-finance institutions. When project participants become self-reliant and cater better for their children, are able to provide two nutritious meals per day, to pay for education and health care, they gain confidence and self-esteem and become productive citizens.

The capacity of CBOs will be strengthened before income-generating activities are being initiated. CBO members will be trained in family planning, safe sex, sexually transmitted diseases, voluntary testing, living with HIV/AIDS, nutrition and communication skills, including counselling tools and conflict management. CBOs members support each other and share experiences and project progress during quarterly meetings.

Children, youth and families will not be enrolled for the entire project period of four years. A continuously replacement of participants will take place concurrently as the families capacities have been built. This period of enrolment will differ from family to family based on the specific situation of the household.

The SOS medical clinic and the four district health centres are close partners and cooperate on **voluntary counselling and testing, distribution of condoms and prevention of mother-to-child transmission** following WHO guidelines<sup>2</sup>. In close cooperation with district authorities, the health centres and the SOS clinic will

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<sup>2</sup> <http://www.avert.org/pmtct-guidelines.htm>

develop and implement a strategy for prevention of mother-to-child transmission and raise awareness among pregnant women on the importance of being tested.

The project is to build capacity among staff in district health centres, among community health workers and the SOS clinic to raise community awareness on the importance of being tested and sharing your status, support and advise the affected families, counselling of individuals and couples, especially discordant couples where conflict risk to split the family.

**Advocacy** will ensure strengthened dialogue with relevant local and district authorities and increase their knowledge of and respect for children's rights. SOS staff has previously participated in trainings on child rights and children's participation. This project will continue building staff capacity and has included advocacy training for key local partners, including youth clubs. The training will build partners capacity to map and analyse problems, carry out research, plan and set realistic objectives for effective and sustainable advocacy. The training will help participants internalise how to cooperate with children's for the most efficient advocacy targeting the most problems facing children and participants will learn how to create space for children's participation in advocacy.

The advocacy strategies in the project will be worked out by CBOs, youth clubs, health centres and local authorities and be carried out through campaigning, lobby meetings with authorities, participation in relevant networks and media exposure through radio spots and articles. Advocacy activities will target district and national authorities to encourage them to provide free health insurances for the most vulnerable families so they also obtain access to treatment for opportunistic diseases.

The pilot project has been successful in raising awareness on HIV/AIDS and sexual and reproductive health and rights through clinics, schools and community meetings during Umuganda. Good relations have been built to district authorities, and advocacy activities has led to increased access to ARV in Nyamirama health centre. In this project, the goal is to make permanent access to ARV in all four health centres in the sector.

The issue of legal rights to land plays a key role, as land is scarce. The project will advocate for local and district authorities to take responsibility for a legal distribution of land so that the most vulnerable families get an opportunity to cultivate their own vegetables that may add to a healthy diet. Advocacy activities will also target local NGOs and local and district authorities to hold them responsible for providing decent housing to the most vulnerable families.

A separate advocacy effort will take place in relation to prevention of mother-to-child transmission. SOS Children's Villages together with district authorities will plan how to roll out a strategy for prevention of mother-to-child transmission in Nyamirama sector. Radio spots will be developed to spread the information.

The district HIV/AIDS NGO Platform will also be involved in raising issues related to the project objectives. Through debate and exchange of knowledge, the Platform can form a basis for joint advocacy activities in support of the objectives of the project. New networks and coalitions may also emerge out of the cooperation. These may strengthen and sustain the interventions.

Approximately half way through the project a national conference will be planned. The conference will focus on the challenges that children and youth living with or affected by HIV/AIDS and other terminal diseases experience. Data collected by the project will be presented together with results so far. The conference will

invite decision makers at all levels, NGOs and CBOs, youth representatives and people living with or affected by HIV/AIDS provide testimonies.

## What we in fact did

### 1. Review of the participatory midterm review methodology

Ahead of the participatory midterm review, I read baseline survey, regular monitoring reports and other relevant materials that could provide input to the participatory midterm review. I recommended that we invite children, members of CBOs and youth clubs, SOS volunteers and staff who had previously taken part in three advocacy trainings arranged by this project and another CISU funded project within the past year. This was to ensure that the child participants had already been empowered and that the adults were used to working with children's participation. If the children had not been empowered it would have been difficult to ensure true child participation. As no parents had participated in the advocacy trainings, they were excluded as researchers in the midterm review.

We initiated the research with a three-day workshop 16-18 November 2015. Experiences from the previous participatory midterm review showed that the participants needed more theoretical input concerning research tools, the difference between qualitative and quantitative research, interview technique and the aim of midterm reviews. This time the workshop included a number of small input sessions and exercises especially the first day, but also scattered in between group work the remaining two days.

A game was used to teaching the participants the importance of using open-ended questions. Another game sharpened their senses to relevant questions to ask during a midterm review of a project like their own. We also spoke about why some research tools are more child-friendly and about indicators and that these may be changed if the existing ones are not relevant any longer, if they are not very clear and easy to measure, or if qualitative indicators are missing. We also did exercises that raised awareness on the importance of body language – both as a researcher as well as a part of observations of interviewees.

In keeping with the participants' own suggestion, I divided them randomly into mixed adult-children groups. Each group got one of the three objectives and the appertaining indicators:

#### Group 1:

##### **Objective 1:**

**By June 2017, 80% of the families/households participating in the project are economically empowered and meet the development needs of their children in Nyamirama, Mukarange and Ruramira sectors in Kayonza District**

##### **Indicators:**

- 95% of participants in the project have completed village savings and loan association (VSLA) training
  - *After one years, 300 participants have completed VSLA training*
  - *After two years, 300 participants have completed VSLA training*
- 75% of families participating in the project eat a daily balanced diet
  - *After three years 50%*

- *After four years 75%*
- 80% of families participating in the project contribute economically to school expenses
  - *After three years 60%*
  - *After four years 80%*
- 90% of the families participating in the project contribute to health insurance for their children
  - *After one year 60%*
  - *After two years 80%*
  - *After four years 90%*

#### Group 2:

##### Objective 2:

**By June 2017, the population of Nyamirama, Mukarange and Ruramira sectors knows where to seek HIV/AIDS related information and services and use of the services has increased**

##### Indicators:

- Health centre staff and CBOs are trained on volunteer counselling and testing, sexual and reproductive health and rights, prevention of mother-to-child transmission and counselling
- Four health centres from Nyamirama, Mukarange and Ruramira and SOS medical clinic have increased volunteer counselling and testing sessions with 50% from baseline
- Pregnant women in Nyamirama, Mukarange and Ruramira sectors following prevention of mother-to-child transmission guidelines have increased to 90% from baseline
- Youth clubs (with approx. 30 participants in each) in nine schools in Nyamirama, Mukarange and Ruramira sector have organised campaigns on child rights, HIV/AIDS prevention and sexual and reproductive health and rights for peers and out of school youth (total number reached in the campaign is at least 7000)

#### Group 3:

##### Objective 3:

**By June 2017, key stakeholders are actively participating in and influencing HIV/AIDS interventions in Nyamirama, Mukarange and Ruramira sectors**

##### Indicators:

- Number of services in relation to ARVs have increased in Nyamirama sector
- 7 CBO's for people living with HIV and AIDS in Nyamirama, Mukarange and Ruramira sectors are supporting the community in areas of psychosocial support, village savings and loan association follow up mediation in families and in community
- CBOs members and youth clubs are implementing advocacy activities to assure that children rights are fulfilled
- CBO members are implementing advocacy activities to protect children, who are living with or affected by HIV and AIDS, against discrimination and stigma

All groups were requested to follow the same process:

### Part one

1. Look at your objective and the indicators. Consider which indicators you already know the answers to from regular reporting. Then focus on the remaining indicators.  
If only quantitative indicators are included in your objective, consider which qualitative information you would like to know. Camilla (coordinator with SOS Children's Villages Denmark) has promised CISU that we will come up with better indicators, so you are more than welcome to include new indicators or change existing indicators if necessary.
2. Find out which people will need to include in your research to ensure that you can evaluate on the indicators you selected to look into.
3. Which research tools are most appropriate to use with these people? Use the toolbox for inspiration.
4. Prepare the selected tools and questions.
5. Test the research tools and questions on the other groups in the afternoon.

### Part two

6. Adjust in keeping with feedback from other groups.
7. Plan whom of you will do what when.
8. Plan how you will register all the responses.
9. Plan how you will ensure that all questions and responses are translated into French or English so that Lotte can read it.

### Part three

10. Present research methods and plans and receive feedback from other groups.
11. Adjust in keeping with feedback from other groups.
12. Plan to test the questions at field level as a part of on-the-job-interview training. Has to be coordinated with Lotte and other groups.

#### Only rules:

- Lotte will select family strengthening programme respondents on your behalf to ensure that they are representative of the programme. Other respondents will be selected by you and evaluated by the other training participants and Lotte.
- The final deadline for the research is December 14.
- Everything must be translated before December 21.
- On December 21, all the translated research must be sent by e-mail to Lotte.
- Be realistic – you cannot do everything in such a relatively short time.

A youth-friendly research toolbox that I have worked out as a part of a Save the Children youth empowerment toolkit was distributed to all. As the participants had been acquainted with the toolbox during previous trainings we did not go through the contents.

Throughout the process, it was underlined that adults have the ultimate responsibility for the protection of children. When youth venture into a public space and start asking questions it may provoke strong

reactions in a community where children usually are not to be heard. Therefore, it was underlined that the child researchers always have to be accompanied by at least one adult.

In order to ensure the quality of the research peer feedback as well as feedback from me was provided to the planning and the groups' research methodology and questionnaires twice during the workshop. The three groups worked out the sample sizes themselves, while I picked the actual household respondents randomly from the participants' list. The three groups selected the remaining respondents such as representatives from health centres, CBOs, people living with HIV/AIDS associations, youth clubs and others. The groups were encouraged to pick respondents in different areas to cover a bigger number of people and avoid overlap in respondents.

When the three groups had worked out their methodology, research tools and plans, they initiated the testing of methods, tools and questionnaires at field level. All three groups chose to be accompanied by another group for peer feedback, and each group decided to spend half a day testing. They all got on-the-job interview training at the same time. The peer feedback group and I provided feedback on the way the interviewers posed questions, their follow-up questions, and the interviewers' body languages, how the interviewers' behaviour and mood influence respondents, the settings, the introduction and the wind-up.

The teams also received feedback on the tools they selected, including the appropriateness and the application. One group, for example had included a game to warm up a mixed group of very young and a little bit older children, but they never really managed to engage the children, and the actual focus group discussion was not very child-friendly with difficult questions and small children having no role. I made a child-friendly demonstration interview afterwards, and the group discussed if they should use drawings for coming interviews with children.

Another group made a very nice friendship game with youth club members, but after the game members of the group and the club ended sitting mixed. On principle a positive feature, but in reality it made it difficult for the group to make a focus group discussion. The club members could not really support each other, and not all got the space to talk. The group was pondering if they could change the game somewhat so that the youth club members would end up together.

After all the field testing and on-the-job research training was over, we had a common follow-up session at plenary before all teams refined their research methods, tools, questionnaires and planning. The last day we all met to share the final planning.

To ensure that triangulation may take place, I carried out focus group discussions with child participants of the project, CBOs, youth club members and volunteers. I also carried out in-depth interviews with a number of people selected by the project staff:

- The in-charge of ARV in Kayonza health centre
- Two interviews with parents: One woman living with HIV and in discordance with her husband and one couple where both are under ARV.
- Two interviews with children: One child who lost his parents to AIDS and one child who is living with HIV.

A staff self-review was also initiated, but due to time limitations it was not finalised.

In the report, I have also included the test interviews. Although they were primarily carried out for testing and for interview practice, they do provide relevant information.

## 2. Midterm review of the project

### Objective 1

#### *Detailed findings from group 1*

**Children:** Group 1 has interviewed 20 children and one youth aged 20 years from seven households. The group wanted to look into 18 households in total. The facilitator selected the 18 households randomly from the project participants' list. The group selected the seven groups of siblings from the 18 randomly selected households. The group interviewed the children in seven focus groups, each group consisting of all siblings from one family. In the questionnaires, it has not been specified if all children in one family receive the same support. Although it could be somewhat misleading, all children in one family are counted as having given the same response to the questions, because that is how it appears in the filled in questionnaires.

The group did not ask the respondents if they received, for example domestic animals or health insurance. Instead, the group let the respondents list the support they receive from the project. The weakness of the approach is that some support may be missing if the respondent has forgotten about it or is unaware of the support. The strength is that it enables the participants to share what comes to their mind right away, which is probably what they value the most or which has made the biggest impression.

All the services are offered to caregivers rather than directly to children.

Project participation: Children	Yes	No	Not mentioned
Knowledge about the project	18	2	0
Knowledge about HIV/AIDS	12	5	3
Health insurance	8	0	12
School materials	20	0	0
Seeds	8	0	12
Hoes	3	0	17
Food allowance/school feeding	4	0	16

To check the real outcome of the project's awareness activities the group asked the children what they know about HIV/AIDS. Amongst others, the children responded:

- "It is a bad disease which leads to poverty and death"
- "HIV is diseases which cause poverty. If you get sick for long you sell everything you have, because you don't go for work"

The children also described eventual changes due to school support provided by the project. For example:

- "The children can now take notes, which has led to increased performance"

- “We are not being suspended from school, because we received school requirements”
- “Since SOS supports us we managed to go back to school”
- “They gave us books and we used them, though they were not enough”

The children also appreciate having their school fees and school food paid:

- “I am no longer making long journeys to go back home to find something to eat, because now I eat at school, which helps me to settle with my studies”

In spite of the support, children still drop out for a number of reasons, the children explain. For example:

- “Because parents don’t value education”
- “Because teachers send children home and parents don’t bother to take the children back to school”
- “Poverty which leads to lack of school requirements and fees”
- “Children want to look for money to take care of their siblings”

The children of two families say that there is no dropout from their schools, while the children of five families experience dropout from their schools.

**Caregivers:** The group interviewed six female and five male caregivers. One of the respondents stated that he was not participating in the project, although he is on the participants’ list. It could be because he is disgruntled about not receiving the support that was promised at the beginning of the project, because he explains, “They [ought to] give us what they promised us in the starting of the project, i.e. money for starting small business.”

The group did not ask the respondents if they received, for example domestic animals or health insurance. Instead, the group let the respondents list the support they receive from the project. The weakness of the approach is that some support may be missing if the respondent has forgotten about it or is unaware of the support. The strength is that it enables the participants to share what comes to their mind right away, which is probably what they value the most, or what has made the biggest impression.

All respondents have been part of the project from the beginning, and they do not all receive the same support.

Project participation: Households	Yes	No	Not mentioned
Kitchen gardening training and establishment of kitchen gardens	10	0	1
Health insurance	4	1	6
School materials	3	0	8
School fees	2	0	9
Seeds	6	0	5
Hoes	6	0	5
School drop-out	3	6	2
Village savings and loan association trainings and membership	8	2	1
Domestic animals	1	0	10
Income generating activities training and job creation	4	0	7
Homelessness	3	0	8

The caregivers also shared the benefits of having kitchen gardens. For example:

- “Now we can’t get affected by malnutrition diseases”
- “Now I can get my own vegetables. I used to go and buy them”
- “I get strength and I don’t even lack blood”
- “I used not to have vegetables. Now I get a balanced diet”

The caregivers whose children dropped out from schools explain:

- “He liked to be on the streets, and he was even forced by peer groups”
- “He gave no reason”
- “Because of too little support”

A number of caregivers gave their opinion about the village savings and loan associations. Amongst others:

- “I know how to interact in groups and I know how to take care of my family”
- “Now I don’t feel lonely. I feel I am with others. It stopped me from being depressed”
- “The trainings helped me to know how to save and something that can lead to development”
- “Now my knowledge is open for doing simple projects”
- “To get capital to start up income generating activities is not easy, even in groups. You find that they lack enough money to use”
- “We are still waiting for the day of sharing our money and see what amount we will get. What’s more important is that we meet and share ideas, and I don’t feel lonely”

One person left the village savings and loan association, because he failed to pay. His wish is to return when he gets a job. Another one never signed up for the association, because she cannot pay.

Requests for remaining project period	Number of respondents who mention the issue
Housing	2
Domestic animals	3
A place to stay for orphans	1
Start-up capital	4
Job	1
School for out-of-school children	1
Food	1

**Three members of village savings and loan association, Musumba Cell:** The association meet once a month and most members save 500 RF per month. Not all members are active, and some have left the association due to lack of money, or because they are sick. Some of the members also fail to pay back loans. Those, who do save, spend the money for the creation of small businesses that lead to income, which enables the members to take care of their families.

The respondents suggest that the HIV project conducts more trainings on village savings and loan associations, that more community members are included into the associations, and that the associations may access loans or support from SOS Children’s Villages to start joint activities.

**Local authorities from Nyamirama Sector: Executive Secretary MUKUNZI Athanase and In-charge of Social Affairs MURORA Suzan:** The local authority representatives are aware that the project provides trainings in kitchen gardening and income generating activities. Concerning campaigns carried out by the project, they mention campaigns on advocacy, HIV/AIDS related services, land rights, nutrition, hygiene, and drug abuse. Then, they know that the project delivers a number of direct services such as health insurance, vocational training for youth, agricultural tools, seeds, domestic animals, school feeding fees and materials. They are also aware that formation of village savings and loan associations and CBOs are part of the project.

The local authority representatives see certain changes in the community such as a changed mind-set towards HIV/AIDS prevention, services related to the disease as well as nutrition. According to the local authority representatives, four children are no longer malnourished. Village savings and loan associations and the establishment of small businesses have led to changed mind-sets towards development, and the beneficiaries have changed their living conditions due to these activities, say the respondents. They note that some beneficiaries attend irregularly, because they are weak and have no means for saving.

The respondents would like to increase the number of youth who attend vocational training, and they suggest that the HIV project initiate joint activities to generate income. Youth clubs could also engage in more activities at community as well as district and even country level.

**Teachers NTEZIRYAYO Anastase and SHYAKA Fabien, Shyogo Cell:** Children still drop out from school due to poverty and subsequent labour, the respondents say. Parents find that education has no value. Some families and children migrate to bigger towns. The respondents suggest that SOS Children's Villages carry out awareness campaigns on the importance of education, including meetings with teachers, parents and children. Each school ought to have a counselling office. Parents also need more trainings on child rights and parenting skills as well as job creation.

**CBO representatives UWIMANA Beyatrice, BENIMANA Cristine and HABYARIMANA Arufonse, Gikaya Cell:** The CBO members are engaged in project implementation; follow up on activities in village savings and loan associations and domestic animals provided by the project. They also help distribute cows, goats, beans and school materials.

Not all project participants are active in the village savings and loan associations, they say, but those who are active meet every month and share ideas about self-development. The association members take loans and invest in cows, goats, hens and pigs. However, the respondents think that there is a need for more trainings on village savings and loan associations and awareness raising towards those who are not active in the associations. The CBO members participate in the associations' meetings and provide advice, and they have their own village savings and loan associations.

The biggest difficulty for the CBO members is the change of project approach – from support to income generating activities to village savings and loan associations: “There are some things that the project promised the beneficiaries, and these things were not fulfilled, so they still demand them.”

**CBO representatives KAKUZE Emeranse and MUKANTABANA Grace, Musumba Cell:** The CBO members are engaged in project implementation; do follow up on activities in village savings and loan associations as

well as domestic animals and health insurance. They also help distribute coats, goats, beans and school materials.

There are several village savings and loan associations in Musumba Cell, and they are all organised differently. One association meets once a month, another meets four times a month, and one meets twice a month to share ideas for self-development. Some association members now manage to pay their own health insurance. However, not all project participants are part of the associations.

One of the main challenges is that people under ARV are suffering from lack of nutrition. Some project participants have passed away.

The CBO representatives suggest more trainings on village savings and loan associations for members of associations and CBOs. The CBO also has its own association.

**Health worker Elisabeth MUKESHIMANA, Umubuga Cell,** says that the project participants attend all medical services and even have helpers who follow them and report to the health workers. The respondents know that the project participants have been trained in kitchen gardening and that they are now aware of and have access to good nutrition during the sunny season. This has helped reduce malnutrition in the area. However, some project participants are very vulnerable and need direct support, according to the respondents.

#### ***Findings from test interviews***

**A group of siblings:** “We know SOS as the one who is giving books, pens and sensitizing about HIV/AIDS. SOS Children’s Villages pays school fees and medical insurance, but we still need more books. I got two books, but in my class, we need 13 books. If children do not have money for school fees, for materials and for uniforms, they drop out. We used to go to school only three times a month. Now we perform better. Some children do not want to study. They just do not want. We have also got seeds for planting, but we also need more seeds.”

**Single mother:** “There are lots of changes. The children perform better because of school materials and a balanced diet. I get small credits from the village savings and loan association. I also got a pig.” Still, one of her children has dropped out of school: “I depend on him. It is his wish.” She would like to have access to micro finance. “I can afford anything but health insurance and school fees.”

**Mother:** She participated in hygiene training, in a village savings and loan associations and income generating activities. Yet, she says that, “There are no changes in our life, because we do not have a permanent shelter, and there is no one to look after my children. I had a kitchen garden, but then we had to shift the house. Before we had the vegetables for a balanced diet. That is difficult now.” However, her children go to school, and she feels stronger and more confident. She has also started selling tomatoes from a small stall by the roadside. “It also helps to feel the togetherness in the village savings and loan association,” she says.

### ***Findings from staff self-review***

**Sensitization:** Meetings on land issues take place, and women are sensitized via village savings and loan associations. Some women are selling agricultural products, are mobile hairdressers, make sweaters, and some sell wood and firewood. Kitchen gardens are established. The project also sensitizes about child rights, according to the staff.

**Service delivery:** According to the SOS staff, it is impossible to limit the direct services, because, “You cannot stop services when someone in a family die or fall very sick. Then, the family will fall back to the starting point again very quickly.” Some project participants actually need increased services, say the staff.

Among the direct services provided by the project is food, health insurance, school materials and uniforms, house renovation, transport and treatment fees, counselling services as well as burial service support.

The government health centres refer people living with HIV/AIDS to the HIV project for food.

Nine families got cows, 12 families got goats. They do well, according to the staff. In December 2015, five families will receive cows, 36 will receive goats, and 18 will get piglets. Some also get seeds, tools and fertiliser.

**From income generating activities to village savings and loan associations:** The approach changed in March 2015 upon a request from SOS Children’s Villages Rwanda and Denmark. According to the staff, the decision was based on several experiences. The village savings and loan associations in the CISU funded child rights project in Gikongoro apparently works very well, while it was difficult to make project participants from the previous HIV pilot project in Kayonza pay back their loans; out of 45 participants, only seven completely paid back their loans. Twenty-seven paid half while 11 never repaid anything. CBOs even filed a case against SOS Children’s Villages, because people wanted to keep the loans. Follow-up on income generating activities and loans was also demanding in terms of human resources.

However, adapting and implementing new approaches is a process, and it hampers a project when the approach changes in the second year of a four-year project. The HIV project recruited project participants holding out prospects that they would receive loans and access to income generating activities. Now, they themselves have to generate the money, but it takes time to build a substantial amount in village savings and loan associations, especially when the savers are economically, physically and mentally weak. According to the staff, people living with HIV/AIDS are weaker than the average member of a village savings and loan association in the child rights project in Gikongoro.

Poor nutrition is a big challenge for the project target group. Without physical and psychological strength, it is hard to engage in village savings and loan associations and business start-up. Without nutrition and treatment, the project participants become weaker. Their children drop out from school and give up health services to support the parents. Domestic animals can provide milk and income that can help the families reach a certain stage where they are able to maintain a job and look after their children. Youth who are living without parental care also need vocational training, but the project can only afford to provide this for 11 young people.

As it is, only 45 percent of the project participants are active and saving, while 20 percent participate in meetings on a regular basis. The remaining project participants are so far not interested. It is a process, say the staff, who plan to continue sharing the benefits of village savings and loan associations with those who are reluctant. In total, there were 234 members of village savings and loan associations in November 2015, but not all are active. All together, they had managed to save 1.186.070 RF. Persons, who take loans, have to pay five percent interest over a three-month period.

So far, only one training in village savings and loan associations has taken place, because part of the budget for income generating activities has been spent on service delivery. At the same time, project participants had already received money for income generating activities when the approach was changed, and they refused to pay back the loans. Seven families decided to leave the project because of the change in approach.

Money has also been spent on training project participants on job creation and entrepreneurship during the first year when income-generating activities were still a part of the project. These trainings are still very relevant, as 80 project participants are engaged in small businesses and more are planning to do so. Unfortunately, there is no budget for refreshment training, and none of the project participants has managed to establish joint enterprises.

**Linkages:** The project has managed to advocate improvements in health insurance categorisation, provision of land to homeless and manpower through Community Days. However, linkages to other NGOs is still a challenge, since NGOs have fixed budgets and project participants.

**Capacity building** is taking place in the shape of trainings, meetings, skills development, village savings and loan associations, job creation, kitchen gardening, child rights, volunteer testing and counselling, prevention of mother-to-child transmission, sexual and reproductive health and rights.

**Stigma:** Many project participants provide testimonies, because they want to provide hope for tomorrow, staff members explain. Adults begin to understand that you can live with HIV, but fearing stigma parents are still hiding children's status, also towards the children.

**Exit from project:** No one has exited the project yet. They are not strong enough, and if anyone exits, it will be challenging to include new households who have not been part of the trainings, and who will have limited time in the project.

**Challenges:**

- Unlike other projects, people living with HIV/AIDS are constantly at risk from dying from their infection and opportunistic diseases. Within the first two years of the project, eight caregivers and three children have passed away.
- People living with HIV/AIDS are unstable caregivers. They are often shifting from place to place, because they do not have their own houses. This hampers, for example the kitchen garden component as kitchen gardens cannot be shifted from place to place.
- 352 families participate in the project. With only three staff, each is responsible for almost 120 families living with and affected by HIV/AIDS. Many of them are very vulnerable.

- Follow-up with 352 families requires transport and phone calls. Volunteers play a very important role in the follow-up. They do not receive any salary, only a transport allowance. The previous pilot project covered 45 families in one sector. With 352 families in three sectors transport and communication costs have increased considerably. However, the HIV project provides the same amount for transport as before and less than the transport allowance received by volunteers in other SOS projects.
- Irregular transfer of funds has led to delayed activities.
- The lessons learnt from the project as well as advocacy trainings has led to the need for a budget revision, but apparently, budget revisions are not encouraged by the SOS system.

### **Facilitator's findings**

**Change of approach:** The project was planned to include income-generating activities. Based on experiences from a CISU funded child rights project in Gikongoro and projects elsewhere as well as a request from CISU the approach was changed into village savings and loan associations in March 2015. This change of approach has had a great deal of impact on the outcome of the objective. As several respondents stated, "It requires change in mind-set."

**Change of indicators:** CBOs say that the percentages in the indicators for this objective are unrealistic. Their scepticism is emphasised by the change from income generating activities to village savings and loan associations almost half way through the project. The CBOs explained that the indicator percentages are very high, when you consider that half of the project period is already over, and that the CBOs are still only sensitizing the project participants to the new approach.

One indicator, for example says that, "90 percent of the families participating in the project contribute to health insurance for their children" by June 2017. According to SOS staff, the 90 percent aim was based on income generating activities and never adapted to the village savings and loan association approach. The CBOs felt that 55 percent would be more adequate. Concerning payment for school expenses, the indicator says that by June 2017, "80 percent of families participating in the project contribute economically to school expenses." Here, 65 percent would be more adequate, according to the CBOs.

SOS staff also felt that the percentages might be too high, since people living with HIV/AIDS are especially challenged by disease and absence from work.

**Village savings and loan associations:** These associations have so far been limited to project participants, but the plan is to make them open to all from 2016. As it is, the economic base is very little when the village savings and loan associations are small. At the same time, village savings and loan associations reserved for people living with or affected by HIV/AIDS are risking to induce stigma.

Some CBOs are already establishing village savings and loan association, while the plan is to engage youth clubs too. One club has already saved and bought rabbits. The rabbits have bred and the new rabbits have been given to vulnerable children.

**Selection of participants:** Village leaders provided lists of all people living with HIV/AIDS in the project areas, and all were invited to participate in the project, non-regarding their economic status. During my

own research, I noticed that some project participants had decent incomes, land and fairly big and well-equipped houses. One family has managed to take comprehensive loans, buy lands and build a big house. Yet, they received support for school fees and materials as well as health insurance the first year.

#### **Couple invests in business – and in their house**

Wife: “My husband fell ill for a long time in 2010, and we both had the test. We are both living with HIV. We have six children. Our oldest girl was 17 years when she got a baby. She lives with us. She has no boyfriend. Our oldest boy failed senior six and now he has temporary work in construction. Some children are still in primary, which is free of charge. Two dropped out because we couldn’t pay the fee.

I am a member of several village savings and loan associations. From the SOS association I borrowed 10,000 RF. I save 600 RF, and I pay back 1,000 RF every month. I borrowed 50,000 RF in a church village and savings association. In that association, I save 4,000 RF a month. I spent the money for my business. I have a small shop with beans, potatoes, soda, etc. near the church. I earn 5,000 RF a month.

SOS Children’s Villages provides seeds for farming, farming tools, a cow, and we are trained in kitchen gardening and how to develop small projects. We are having milk now, and we know about balanced diets. I got four kilos of beans, and I have harvested 30 kilos. We ate some and sold some. We also got fertilisers, so now we can grow passion fruit. We can earn an additional 1,000 RF every week from the passion fruit. Last year SOS Children’s Villages paid our health insurances, but not this year. None of us has insurance now. We are eight family members, and we each have to pay 3,000 RF every year. Fees for secondary school are 4,000 RF every month per child.”

Husband: “I am having temporary work in construction. I earn 3,000 RF a month, but our lives have improved because of SOS Children’s Villages. Our health has improved a lot. I used to drink, but I stopped now. We both take ARV, and we have enough food. Fortunately, our children are not positive.

We used to live in another village. We had a small piece of land. When our present land was for sale, we sold two cows and spent 700,000 RF for this house. We need more money for cement for the floors.

We got a cow from SOS Children’s Villages. It is a revolving system, but some sell the young cows instead of giving it to other project participants. Even CBO leaders sell the animals. Who can stop them? It is fine that CBOs are visiting us, but SOS staff must come too, because some CBOs are corrupt.”

*Couple living with HIV*

## **Objective 2**

### ***Detailed findings from group 2***

Group 2 has interviewed a number of people in the three sectors covered by the project.

#### **Mukarange Sector**

**In-charge of Social Affairs in Mukarange Sector, MUREKATETE Angelique:** The number of pregnant women who attend the health centre for prevention of mother to child transmission has increased because of sensitisation campaigns done in partnership between local government, SOS Children’s Villages and other

partners. Here, SOS Children's Villages play a big role as many people participated in campaigns and meetings, amongst others due to the per diem offered to all participants. SOS Children's Villages may take at least 70 percent of the credit for the progress.

In Kayonza, the sector already has a youth-friendly centre that teaches young people about sexual and reproductive health and rights. Children also learn about their rights in the sector via meetings and children's council meetings. Parents are also sensitized about child rights via meetings, and whoever violates their children's rights are being punished. However, the in-charge still requests more empowerment from SOS Children's Villages.

**CBO representatives MUKANKUBANA Angelique, NSANZUMUHIRE Emmanuel and SEMANDWA J. Felix, Mburabuturo Cell:** The president has participated in prevention of mother to child transmission training. He has not yet shared his knowledge with the other members, but the respondents nonetheless says that the training helps the CBO members facilitate and mobilise women to go to the consultation when they become pregnant. They carry forward the information during meetings in village savings and loan associations.

A number of new CBO members also still lack training in counselling for discordant couples, and none of the respondents has carried out activities related to HIV-services. Hence, they request more trainings, training syllabus and bicycles for transport.

**Coordinator at youth-friendly centre MWISENAZA Jean Claude:** SOS Children's Villages has trained the centre staff on sexual and reproductive health and rights, prevention of mother to child transmission and other services. The respondent says that update information enabled the staff to provide better information and motivate youth.

The problem is that many youth still get wrong information, they are jobless and influenced by a number of sources. The centre lacks materials and has limited funding for activities and few staff that has to offer many services to youth. This is in spite of the centre having a number of international and local partner organisations who support with staff salaries and materials.

The coordinator says that youth need economic empowerment, because everything they do is due to poverty. There is also a need for more campaigns on HIV/AIDS and drug abuse.

**Teacher INGABIRE Angelique, Mburabuturo Primary School:** The school club has been trained in HIV-services, and now the children are more aware of HIV/AIDS, how it transmits and preventive measures. Teachers and pupils have played games and theatre to mobilise people to fight against HIV/AIDS and sexual abuse of children and in favour of investing in health insurance.

The teacher is requesting balls and other items for playing, printed materials about HIV/AIDS and more trainings.

**Three school-going boys aged 15, 10 and 11:** The three boys can mention the right to life, to food, education, having a name and identity when asked about their knowledge about rights. They feel that this knowledge has helped them grow up in freedom and security, but they do not provide any examples. Their only source of information on child rights are their teachers and SOS Children's Villages.

They say that HIV/AIDS violates child rights, because HIV/AIDS kills children; it causes lack of security, happiness and hope. The boys are aware that HIV/AIDS transmits via unprotected sex and other ways where blood is mixed. The use of condoms during sex work, and the fight against drug abuse and unprotected sex is the way to protect oneself against the infection. It is also important not to be in bad peer groups, they say.

The boys know that they can get HIV/AIDS services at health centres and hospitals, but they do not know that HIV/AIDS and sexual and reproductive health and rights are related or where to find services concerning the latter.

They are requesting materials for games and theatre, and they want to visit other school clubs to share experiences.

**Mother who follow prevention of mother-to-child transmission programme:** She has been to the health centre when she was pregnant, and she got medication to prevent that her baby was born with HIV. She felt that the health centre took good care of her. She also got support from community health workers who taught her to take her ARV-medicine and go to the consultations at the health centre. She is receiving health insurance and seeds for cultivation from SOS Children's Villages.

### **Nyamirama Sector**

**In-charge of Social Affairs in Rurambi Cell, SANDE William:** The number of pregnant women attending prevention of mother to child transmission programmes has increased due to the sensitisation of the Rwanda government through community health workers and SOS Children's Villages as a partner. The HIV project may claim credit for about 50 percent of the changes, he says. According to the respondent, SOS Children's Villages helped by passing messages about HIV/AIDS through theatre and games.

The respondent explains that, the office passes messages through traditional cultural meetings for youth, and, "We usually meet child representatives to teach them about rights. African Evangelization Enterprise gives messages about child rights in our sector." The respondent says his office would like more trainings from SOS Children's Villages.

**CBO representatives MUKABUTARE Assia and MUJAWAMARIYA Dative, Shyogo Cell:** The respondents say that prevention of mother-to-child transmission trainings saved many children from HIV/AIDS as pregnant women now go for testing so that their babies may be born without HIV. Four women living with HIV got babies who are not born with HIV, because the mothers took ARV.

The respondents also teach discordant couples how to help each other, to go for tests every three months, in using condoms, how to avoid stigma and to have a balanced diet for their fitness. During village meetings, Community Days and meetings in village savings and loan associations the CBO has sensitised people to attend voluntary testing.

More trainings for all CBO members and not only the president, food and money for some of the most vulnerable families, as well as boots for village visits are on the CBO's wish list.

**Teacher MWIZERWA Wilson, Adventist Primary School:** The teacher sees many changes. The school club members know how HIV/AIDS transmits, how to prevent it, how to help people living with HIV/AIDS and how people may learn to live with the infection. The school's club has organised football competitions with

messages about stigma and the transmission of HIV/AIDS. The HIV project trained school club members in child rights and the fight against stigma, but the children also need to know about CD4 cells and sexually transmitted diseases, the teacher says. At the same time, the pupils are only partly aware of HIV/AIDS services. The respondent therefore suggests that the HIV project provides more trainings, materials and campaigns in partnership with other people outside the school.

The respondent says that the teachers failed to bring pupils for voluntary counselling and testing due to lack of transport. Some pupils are living with HIV, and they participate in counselling.

**Youth club member NSHIMIYIMANA Jean de Dieu, 19 years, Rurambi Cell:** The respondent knows that children have a right to registration in civil and legal documents, a name, education, to be heard, to have food and good health. He says it helps to know child rights, how to protect children and mobilise parents to respect and protect their children. When a mother is giving birth and the baby is born with HIV, the baby's rights are violated, he says.

The respondent is aware that HIV/AIDS is transmitted through unprotected sex, during birth to children and when using sharp materials, and by hanging out with corrupted peers. You avoid HIV by abstaining from sex, by using condoms, via consultations with the health centre when you are pregnant and by giving birth at a clinic or hospital.

The HIV project is the club's only partner, and it only receives trainings from the project. The respondent wants to strengthen the partnership.

**Mother living with HIV/AIDSs, Shyogo Cell:** The mother went to the health centre twice a month for consultation when she was pregnant. She got medication so that her baby would not be born with HIV. She also received flour for porridge and clothes for the baby. She is aware that if she takes her medication, it keeps her CD4 cells strong, and it protects her baby against HIV. She feels well cared for at the health centre. The mother is participating in an SOS village savings and loan association for economic empowerment.

**Community health workers UWIMBABAZI Odelle and HABYARIMANA Froduard, Shyogo Cell:** According to the community health workers pregnant women have become more committed to going to the health centre for testing during the first three months of the pregnancy. Before 2013, women only had the test when they were seven-eight months pregnant. The community health workers are counselling mothers about taking ARV to protect the babies against the infection. The mothers living with HIV/AIDS now take ARV on time and are curious to learn more about HIV/AIDS.

The health centre is caring, and the women are satisfied, but ambulances for emergency cases are missing. Some mothers also are without health insurances for themselves and their babies, so they have to pay 3.000 RF to the health centre when a baby is born in a clinic or at a hospital.

The health workers also provide counselling to discordant couples about living together and family planning, but they do not have condoms to hand out, and some families are in conflict, and yet they continue to give birth to babies. The health centre only provides few condoms to those who attend family planning sessions.

The health workers would like SOS Children's Villages to provide condoms, more trainings, more campaigns and family visits.

### **Ruramira Sector**

**In-charge of Social Affairs in Ryonza Cell, NGABOYSONGA Innocent:** The number of pregnant women who attend prevention of mother to child transmission programme has increased a lot, says the in-charge of social affairs. The local government have developed a strategy in cooperation with community health workers and partner organisations such as SOS Children's Villages, FXB, Partners in Health and CBOs. SOS Children's Villages may take about 50 percent of the credit for the progress. SOS Children's Villages trains people, support people living with HIV/AIDS and provide counselling.

The Social Affairs Office has established a cultural committee of youth, where youth learn about social health, may be tested and receive counselling. Children's Councils teach child rights from village to national level. Parents are also mobilised to send their children to school.

However, the in-charge feels that the office needs more support from SOS Children's Villages such as education for children, empowerment of people and local CBOs that can help the community develop.

**CBO representatives MUKAMUSONI Josee and MUTONIWASE Josee, Umubuga Cell:** The training in prevention of mother-to-child transmission helps the CBOs counsel pregnant mothers to protect their babies during pregnancy and after giving birth. The CBO disseminate messages about prevention of mother-to-child transmission during meetings in village savings and loan associations. People in general and discordant couples especially learn how to live together and to be patient with each other, to avoid stigma, to use condoms, to go for testing together every three months and to be confident and live without fear.

The respondents would like to have more trainings and written handouts that may help them train others.

#### **It is not a good marriage**

"I am living with HIV. I went for a test when I was pregnant. My husband tested positive the first time. Then, he was tested negative. It creates misunderstandings that we have different status. Initially, he wanted to chase me away, but he couldn't, because we are legally married. He thought that I had been unfaithful, but I don't know how I got the disease. He then stopped providing food for the family. I managed to sell goods on the market, and now the project helps us. My husband insists on having another child, but I want him to use condoms. It is too dangerous having unprotected sex. My husband is a soldier, and he is far away most of the time. It is not a good marriage, but I participate in counselling. Now, I am not talking back to my husband any longer. I just let him talk and answer him kindly.

Thanks to the project, I meet other people in the same situation. I have found that other people have the same problems. I understood that even those who have lived with HIV longer than me are still alive. It is a relief. Before the project, no one spoke, and I didn't visit anyone. People didn't know my status, and I didn't tell. My husband stopped me from telling. I was afraid of dying and leaving my children behind. Now I am doing testimonials so that other people can see that I live a normal life.

I have told our eldest son about the disease. He does not talk about it in school, but other children saw that I go to the health centre and hospital. Then, they started discriminating him. I went to their parents and to the local authorities, and it stopped.

I am the leader of a village savings and loan association. It has 25 members who are all project participants. Next year we will let everyone in the community join, because we don't want to isolate ourselves and give people the opportunity to say, 'see, they are infected.' We meet twice a month, we deposit 400 RF, and we have so far saved 130,000 RF. People already got small loans. I SOS Children's Villages has trained me in buying and selling fish, and I will expand my business with a loan.

The village savings and loan association brings cohesion. We meet, we discuss, and we get a little money for investments. However, not all people are happy, because they have to contribute money. You won't be able to construct a house with so little money, and people cannot afford to pay health insurance or school fees. It is just enough money to survive. Nevertheless, we encourage them that if you save a little all the time, it may eventually make you rich."

*Mother, 41 years*

**Teachers NDIKUBWAYO Anaclet and NDAGANO Innocet, Ruramira Primary and Secondary School:** The teachers say that many things have changed because youth club members know about reproductive health, what safe sex is. Some youth club members are tested. The teachers do not have condoms for distribution, but they send the youth to the health centre next door. 45-75 percent of all pupils in primary school and 60-90 percent of secondary pupils are aware of HIV/AIDS services.

The teachers use public awareness and Theatre for Development to sensitize the youth about reproductive health, violence against children, drug abuse and the promotion of child rights in collaboration with CBOs and local authorities. Some children in the schools are living with HIV, the teachers say. They know, because they organised voluntary counselling and testing. However, the pupils still fear talking about their status. They only share their status with health workers.

There is still a need for more trainings for teachers and handouts and banners with HIV information.

**Youth club members IRADUKUNDA Ariane (10), MUTUYIMANA Brandine (14) and TWIZEYIMANA Simon (16), Umubuga Cell:** The children know that they have a right to education, to find food to eat, to have names, good health and to protection against hard work and violence. They say that they got this knowledge from their teachers and school leaders only, and that the knowledge helped them to study well and have a good life. HIV/AIDS violates children's rights because you are stigmatised by others, lack food and drop out from school.

The children explains that HIV/AIDS transmits during unprotected sex, at birth when mothers do not respect doctors' recommendations and when using knives. Youth who use drugs and alcohol and engage in unprotected sex are especially at risk. The children are well aware that they may get HIV/AIDS services at health centres, but they do not know about sexual and reproductive health and rights and the link to HIV/AIDS.

**Community health worker MUKESHIMANA Elisabeth, Umubuga Cell:** She says that many things have changed since 2013. People are now aware of the importance of consulting the health centre, and mothers are committed to do this timely. No one gives birth at home except accidentally. However, some mothers do not respect doctors' appointments, because they believe that it is enough to have a test once or twice

only. Husbands are usually not interested in accompanying their wives to the hospital apart from when the wife is about to give birth.

The health centres provides good care, but there is only one ambulance for three health centres. Some vulnerable mothers do not have health insurance, because it is very costly at 3.000 RF for each member of the family at once and 200 RF for each consultation. The health workers encourage the women to respect the doctors' recommendations. Yet, they know about at least one baby who was born with HIV. The baby died soon after birth.

The health workers also counsel discordant couples and teach them family planning and safe sex.

**Head of Ruramira Health Centre MUSENGIMANA Appolo, Umubuga Cell:** The respondent says that things have changed since the project started. People are now somewhat aware of volunteer counselling and testing. People living with HIV/AIDS are also committed to take ARV regularly.

There are 32 children living with HIV/AIDS registered in the area, but nowadays no babies are born with HIV in the area due to sensitisation campaigns by local government and NGO partners. The health authorities provide ARV freely to all people living with HIV/AIDS, and the government makes a big effort to mobilise the population to change their mind-sets and make organisations support people living with HIV/AIDS.

The health centre also partners with Global Funds and Partners in Health, who pay staff salaries, transport to family visits, foods and flour for porridge for people living with HIV/AIDS and vulnerable mothers who are part of the prevention of mother to child transmission programme.

The head of the health centre is not aware about the number of discordant couples, but they are there, he says. The health centre organises group counselling where people give testimonies and help others cohabitate well. After testing HIV positive people are referred to ARV service and permanent counselling and follow-up.

The head of health centre emphasises that, "We need to strengthen our partnership and plan and follow-up together."

#### **Many people come for advice and testing**

"SOS Children's Villages trained us in how to look after people on ARV, how to make people volunteer for testing and how to do counselling. We have also learned how to cater for women and their children. Usually, we are trained once a year by the government. These trainings are not so different from the trainings of the project. In a way, SOS Children's Villages' trainings are like a refresher.

SOS Children's Villages work in the entire community where they sensitize people on the use of condoms. Before the project, there were no sensitization sessions. These are good. Many people come for health services. Even those who are not sick. They seek advice, and they come for volunteer counselling and testing. Around 15 people come every day. Before it was only one-three a day.

Those who come, come after unprotected sex. Many never had a test before. Sometimes, whole families come. If a wife is suspecting that her husband is unfaithful, she may come alone without telling her husband. We distribute condoms to community health workers. Unfortunately, women cannot force men to use condoms, and some men don't bother. Even those who visit prostitutes don't bother to use

condoms. This is still a big issue in Rwanda. The numbers of newly infected are increasing, but maybe it is because more people are being tested now. Every week there's a new case now.

Then, stigma is reducing. Earlier, people did not even dare to share a cap. Now they share everything.

One big problem is that government does not provide food for those who are taking pills. The most vulnerable need food support. Health insurance is another issue. Some don't have this."

*In-charge of ARV department*

### **Findings from test-interviews**

**Youth club:** The club is mainly engaged in raising awareness on HIV in order to combat stigma. The researchers asked the club members if they understand the linkage between child rights and the fight against HIV/AIDS. Their response was that "children do not know much about child rights."

One youth club member felt that abstaining was the best protection against HIV. He also recommended circumcision and to avoid sharing needles and sharp tools. Some mentioned that you have to avoid unprotected sex and use condoms. Other causes for HIV/AIDS is drug addiction, stressed and depressed people, and people who lack information, the boys say.

They said that they mainly get their sexual education from youth-friendly centres and parents, but they also have participated in training with the HIV project. They also request more training and constant monitoring.

**CBO representatives:** This CBO has been sensitizing parents to use health services during pregnancies. Thanks to SOS trainings, they know how to talk to the families. Usually, the CBO speaks to 20 people every evening, and people receive the messages well. Often the meetings are with members of village savings and loan associations who bring forward their knowledge to the entire community.

The CBO feels that people within and outside the project adopt their family planning messages well. Because of the counselling to discordant couples, one man stopped drinking. The CBO has also worked to sensitize youth to use condoms, HIV services, and on sexual and reproductive health and rights through youth-friendly centres to prevent HIV. At the same time, they speak to elders in meetings to make them aware of how to avoid spreading the disease. Another CBO member speak to youth in the church.

The respondents feel that their efforts make a difference, because people have begun asking for condoms, they ask more questions, and leaders provide time for the CBO to speak. However, the CBO says that it has have no condoms left since they already distributed the condoms they got from the HIV project. When asked about if they could get more condoms locally, they responded, "If we have, we will conduct more sessions." They added that the in-charges of youth-friendly centre, small nightclubs and hotels have been asking for condoms and advertisements telling, "Remember to use condoms."

**Teacher:** Children are now empowered and they understand the dangers of HIV, the teacher says. The Anti-AIDS club discusses how to sensitize others to do volunteer testing. The school committee took three children to for testing, apparently due to the awareness raising. One girl out of three children tested positive. The girl suspected it, because her mother is living with HIV/AIDS. The teachers are counselling the

girl that life continues, and they visited her parents. The parents were happy about the initiative. The family is already receiving support from another organisation. Only the teachers know about the result.

The school has received support to print posters from another organisation. However, the teacher says that children in general do not know about HIV. They are more worried about becoming pregnant. One girl dropped out of school due to pregnancy. The teachers prepared for a session on HIV, but had to cancel it. He would like SOS to supply banners and CDs about HIV/AIDS and sexually transmitted diseases, because “if you just talk, they don’t take it seriously.”

### **Findings from staff self-review**

**Youth clubs:** Most youth clubs are active, according to the staff, and they carry out activities with out-of-school children. One club organised a testing session for class 4-6 in primary school. Five clubs are breeding rabbits. They saved for the rabbits, and at the end of the academic year, they donated the rabbits to vulnerable children. The SOS Anti-AIDS clubs also visit vulnerable families.

## **Objective 3**

### **Detailed findings from group 3**

Group 3 has interviewed 27 caregivers to review the status on the project’s objective three. The group did not ask the respondents if they received, for example domestic animals or health insurance. Instead, the group let the respondents list the support they receive from the project. The weakness of the approach is that some support may be missing if the respondent has forgotten about it or is unaware of the support. The strength is that it enables the participants to share what comes to their mind right away, which is probably what they value the most, or which has made the biggest impression.

<b>SOS support to caregivers</b>	<b>Yes</b>	<b>Not mentioned</b>
Kitchen gardening training and establishment of kitchen gardens	15	12
Knowledge about HIV/AIDS	2	25
Health insurance	5	20
School materials	6	21
Seeds	15	12
Tools for farming and kitchen gardening	8	19
Food and school feeding	5	20
Village savings and loan association trainings and membership	12	15
Domestic animals	3	24
Income generating activities training and job creation	2	25
Hygiene and nutrition training	11	16
Parental skills	1	26
Materials for house construction	1	26
Home visits and advice	1	26
Family development plans	2	25
Counselling	3	24
Help us take our pills	1	26
Share knowledge about prevention of HIV/AIDS	2	25
Paid vocational training	1	26

<b>CBO support to project participants</b>	<b>Yes</b>	<b>No</b>	<b>Not mentioned</b>
Home visits with general advice, sensitisation and counselling on parental skills, living conditions, health, hygiene, kitchen gardening, taking care of domestic animals, to avoid drugs and alcohol, coping with HIV/AIDS, etc.	25	1	1
Sensitization on child rights	1	0	26
CBOs encourage project participants to become members of village savings and loan associations and take loans for small businesses	12	0	15
CBOs visit the village savings and loan association	3	0	24
Encouragement to take ARV as prescribed	9	0	18
Share knowledge about prevention of HIV/AIDS	17	0	10
Encouragement to attend HIV/AIDS services	1	0	26
Encouragement to support children's education	1	0	26
Encouragement to respect doctors' appointments	7	0	20
Counselling for discordant couples	2	0	25
Roofing for house provided	1	0	26
Take us to health centre when we are sick	1	0	26
Encourage to take children for testing	1	0	26
Awareness on prevention of mother to child transmission	1	0	26
Encourage to pay health insurance	1	0	26

<b>CBO advocacy issues</b>	<b>Number of respondents mentioning the issue</b>
Timber from local authorities	1
Land from local authorities	1
Free health insurance from SOS or Partners in Health	16
Toilet and house renovation by SOS	3
Farming seeds and tools from SOS	5
School materials and school feeding costs from SOS	2
Domestic animals from SOS	2
Food	1
Advocate for SOS to provide vocational training to child	1

<b>Requests for remaining project period</b>	<b>Number of respondents mentioning the issue</b>
Domestic animals	13
School fees and school materials	18
Start-up capital	12
Continued advice	1
Free health insurance	5
House	3
House renovation and materials	8
Enrolment of youth in vocational training	2
Food	5
Ensure proper cooperation with CBOs	1
More seeds for farming	3
More trainings on village savings and loan associations	2

The group has also interviewed a number of people engaged in the project:

**Cell Executive Secretary MVURIYE Augustin, Nyamirama:** Has participated in trainings on volunteer counselling and testing, prevention of mother to child transmission, sexual and reproductive health and rights as well as alcohol and drug abuse. The respondent conduct meetings with SOS Children's Villages to follow up on project participants, and the cell provides lists of vulnerable people. It has also selected CBO members and been engaged in advocacy for free health insurance from Partners in Health, Compassion and SOS Children's Villages, and it helps select people to receive domestic animals from SOS Children's Villages.

Furthermore, it has mobilised project participants to establish kitchen gardens and use the subsequent crops to ensure improved nutrition. Together with health centres, the cell has also provided maize flour, oil and rice to people living with HIV/AIDS, but in the respondent's opinion, the support is very limited.

The respondent says that SOS Children's Villages has advocated for health insurance and nutrition support to vulnerable people taking ARV.

He requests that all CBOs are empowered further, especially to be able to carry out activities during Community Days. The CBOs should take the lead on organising campaigns.

**In-charge of Social Affairs MUKASANGA Veronique, Ruramira:** The respondent has participated in trainings on prevention of HIV, sexual and reproductive health and rights as well as alcohol and drug abuse; in meetings on project activities; in the selection of project participants; and in campaigns organised by SOS Children's Villages and CBOs. In partnership with NGOs like Partners in Health, the Social Affairs Office has issued 13,802 free insurances within a year. The Ubudehe programme under Social Community Aid and Vision 2020 Sector Programme provides goats, hygiene materials, mattresses and agricultural crops to the most vulnerable people, including those who live with HIV/AIDS.

The office also engages people living with HIV/AIDS associations in the selection of recipients of health insurance and cows via "the one cow per family" programme, and it advocates that secondary school pupils living with or affected by HIV/AIDS receive school fees from the NGO Komera. The office urges people to construct kitchen gardens and advocate that health centres provide maize flour to people living with HIV/AIDS.

SOS Children's Villages has advocated for health insurance and nutrition support to vulnerable people taking ARV, says the respondent.

**In-charge of ARV Department EZABEL, Ruramira:** The HIV project has trained the department in volunteer counselling and testing, stigmatization, discordant couples counselling, sexual and reproductive health and rights as well as drug and alcohol abuse. The respondent appreciates the update knowledge.

The respondent says that her department is lacking funds to provide nutritional support. Instead, it collaborates with the NGO Friends in Health who provides maize flour. She says that those who have access to good nutrition "of course are good at adhering to taking their pills," while those who have no food have difficulties taking their medication. Friends in Health and Partners in Health also provides free health insurance. Those who have health insurance are encouraged to come for early treatment.

The respondent underlines that direct support is necessary for the most vulnerable participants. Furthermore, health staff need more trainings.

**Social worker MUKESHIMANA Claudette, Nyamirama:** The respondent says that HIV project is a partner, because it supports the social workers with trainings on HIV such as prevention of mother to child transmission, volunteer counselling and testing, drug and alcohol abuse as well as sexual and reproductive health and rights. These trainings help the social workers disseminate their messages better during behaviour change sessions at health centres.

The HIV project also help follow up on clients and provides free health insurance, school materials and access to village savings and loan associations. Because of the project people, adhere better to the ARV treatment. They also know where to seek HIV related services. The number of people coming for volunteer counselling and testing has increased from seven to 23 persons per day.

The respondent says that she and her colleagues support the project participants by advocating free health insurance from SOS Children's Villages, Partners in Health and the government; they mobilise people with health insurance to go to the health centres; and they offer maize flour, oil, rice and milk to malnourished children. When people have enough food, they become able to take their pills as prescribed.

She wants the HIV project to provide direct services to the most vulnerable patients, and it should provide permanent shelters to homeless people. The project should also work hand in hand with people living with HIV/AIDS associations to ensure that all participants are active in village savings and loan associations.

She finds that there is still stigma, a high number of deaths and a high number of newly infected people.

**CBO representatives HABYARIMANA Alphonse, RUZIGAMINTWARI Emmanuel, MUJAWAMALIYA Dative, INGABIRE Claudine and KABANZA Jean Claude, Mukarange, Nyamirama and Ruramira Sectors:** The CBOs have signed a Memorandum of Understanding with SOS Children's Villages, and they say they represent the project when visiting project participants. After trainings, they share the message with the project participants about, for example parental skills. They also urge the project participants to engage in the village savings and loan associations, help project participants solve problems, advocate for them and advice to teach children "good morals."

The respondents say that they link project participants with SOS Children's Villages, and they have small income generating activities. They use 20 percent of the profits to support children from vulnerable families. They also help with house renovation, advocate that project participants get free health insurance and nutritional support, help project participants with self-development and facilitate village savings and loan associations in resolving problems.

The CBO members meet twice a month to share activities. Otherwise, they work at field level and with other stakeholders. They, for example engage in securing free health insurance from religious institutions and Partners in Health. They work with school Anti-AIDS clubs on public awareness and campaigns on children's rights to especially education. Together, they develop action plans to mobilise youth to fight against HIV/AIDS, and they sensitize youth on sexual and reproductive health and rights.

Issues for advocacy has been access to free health insurance, categorization of people depending on their economic status and nutritional support to children. SOS Children's Villages, church leaders and village leaders support the advocacy. Now, most people get free health insurance from NGOs and the government, and health centres support people living with HIV/AIDS with direct services.

They say that SOS Children's Villages ought to provide trainings to all CBO members, so they may gain confidence to speak in public. The CBOs also need guiding manuals for awareness raising campaigns, and they would like to conduct common meetings for CBOs and authorities. They also would like to have support to visit CBOs constantly to evaluate activities and provide nutrition to people on ARV. Furthermore, they need help to identify the most vulnerable participants for support, and they would like to have support to combine CBOs' and project participants' village savings and loan associations.

**People living with HIV/AIDS association representatives KIBUKAYIRE Immaculée, RUZIGAMINTWARI Emmanuel, INGABIRE Claudine, MUREKATETE Alphonsine, MUTSINZI Evariste, MUKAMUSONI Josée, Mukarange, Nyamirama and Ruramira Sectors:** The HIV project supports the associations' most vulnerable members with food, maize flour to caregivers and milk to malnourished children as well as health insurance. Furthermore, the project empowers the members with knowledge and skills on HIV/AIDS such as prevention of mother to child transmission, behaviour change for discordant couples, drug abuse, family planning and sexual and reproductive health and rights and the relation to HIV/AIDS. SOS Children's Villages also provides volunteer counselling and testing sessions to the associations' youth members.

The associations cooperate with the HIV project on campaigns, and project staff participate in meetings and advice about how to avoid spreading the disease.

The respondents encourage members to participate in village savings and loan associations and urge members to establish kitchen gardens to ensure better nutrition.

Partners in Health, Ministry of Health, HEIFA and Friends in Health are the associations' other partners.

Local authorities support people living with HIV/AIDS with domestic animals, free health insurance, in kitchen gardening and involvement in the Vision 2020 Umurenge Programme.

The associations have many requests to SOS Children's Villages. Amongst these are direct services such as house renovation, support to secondary education, free health insurance, start-up capital in village savings and loan associations, vocational training to school dropouts and training in job creation.

**Youth club representatives from different schools MUSABYIMANA Frédéric, INGABIRE Angélique, MUTUMWINKA Alphonsine, MBARUSHIMANA Eldaphonse, MUKARYUMUGABE Euphrosine, NDIKUBWAYO Anaclet and MUHIRWA Wilson:** The youth club members have participated in trainings in volunteer counselling and testing, alcohol and drug abuse, fight against stigma as well as sexual and reproductive health and rights. They say that SOS Children's Villages also made them work with CBOs to raise the understanding among youth on HIV/AIDS testing, treatment and prevention.

The youth clubs teach pupils how to behave to prevent HIV/AIDS via theatre, songs, poems and drama at the end of the term. They also cooperate with CBOs and SOS Children's Villages in disseminating awareness on prevention of HIV/AIDS in the community and organise inter-school competitions, fundraising to support

vulnerable children and compete with other clubs on who performs the best. They carry out the activities on quarterly basis in schools or in the community.

CBOs call for the clubs to work together during awareness raising on HIV/AIDS and child rights, and the CBOs and the youth clubs have developed a common action plan. Every three months SOS Children's Villages invite them for evaluation meetings.

The clubs also work with NGOs ADRA, World Vision and AEER.

The respondents request SOS Children's Villages to arrange more training sessions as well as guiding books and brochures with health messages.

### ***Findings from test-interviews***

**People living with HIV/AIDS association:** One representative of an association of people living with HIV/AIDS feels that the HIV projects supports his association well, because the members have learned about HIV, nutrition, kitchen gardening, ARV, sanitation, hygiene, counselling. People used to die due to bad nutrition. Better nutrition has reduced the problem. Previously, other stakeholders were helping with nutrition, but not any longer.

The respondents says that his members value the services provided by the HIV project. The services include domestic animals and health insurance. However, he feels that the association members need more trainings and more animals. The people who got animals have better lives. He suggests that the associations become responsible for donating and monitoring the animals. Otherwise, there is a risk that people sell the animals. He also suggests that the HIV project donates goats that are more expensive. These are more difficult to sell, you can use their milk, and they are easy to take care of.

Stigma used to be a problem, he says, but youth clubs have raised their voice. The associations also go to the schools and have dialogues. As the clubs and associations are talking to authorities together, there is no more stigma at schools.

**Health centre staff:** People under ARV have health insurance as a number of stakeholders are paying: Red Cross, SOS Children's Villages and the government. However, nutrition is still a problem, while the stigma towards children under ARV has somewhat decreased. Accommodation is another problem for people living with HIV/AIDS.

The health centre staff appreciates that the centre staff may call SOS staff to discuss cases concerning nutrition and treatment, and that SOS pays for health insurance if someone does not have so.

**Members of one CBO:** With youth clubs, the CBO has trainings, meetings, brainstorming and share ideas. The CBO members have a village savings and loan association, and they visit project participants, look into their needs and provide counselling. They help some people go to hospitals and get access to other services. They cooperate with local authorities, and they sensitize on HIV prevention, virus and stigma during Community Days and do advocacy towards SOS Children's Villages. They provide an example: If someone drops out from school, they advocate support for school fees from the HIV project.

The advocacy they would like to extend the activities to reach big numbers of project participants with games, competitions and awareness raising. They already have an action plan. The problem is that only presidents participate in trainings, and the president does not always pass on information. At the same time, the CBO representatives say they need more support for transport and phone cards for communication with project participants.

During the pilot project, this CBO got one million RF to buy a graining machine to produce flour. The idea was that the CBO could keep 80 percent of the income and provide 20 percent in support to project participants. However, the graining machine was out of order, say the members.

#### **We sacrifice ourselves for others**

“We participated in lots of lessons, and we are on the track of doing advocacy, especially with children or in families with poor living conditions. Normally, our obligation is to follow up on project participants who stay in our localities. If someone has problems, we make advocacy to SOS Children’s Villages to make them do something. We made advocacy towards SOS Children’s Villages to get toilets. We participated in digging plots, and SOS Children’s Villages provided iron sheets. We also had sessions with health centres. We select those who can get free health insurance. We also inform leaders about what is going to take place. Once, a house was destroyed by rain. We explained to the local government that it was a big issue, and it provided timbers. We also call on SOS Children’s Villages to provide coffins if someone die, and we look after orphans together with SOS Children’s Villages.

When we conduct home visits, we sensitize caregivers to become members of village savings and loan associations. If someone is sick, we advise to take him or her to the hospital. We also advocate to health centre that they provide treatment, even if people don’t have health insurance. SOS Children’s Villages is the first we advocate towards, but we also approach local authorities. We are sacrificing ourselves to do all this. When we spend five days at a training, we cannot be home, so we need per diems and travel costs.

SOS Children’s Villages gave us 1,530,000 RF to develop a project to sell agricultural products. 20 percent of the profit will be used to support children in the project. The rest is reserved for next season. One CBO got a graining machine, but it didn’t work, and we returned it to SOS Children’s Villages. Some of us are new CBOs. We also want capital like the old CBOs. We are saving 1,000 RF every month in our village savings and loan association. We sacrifice ourselves to support others. We spent our profits to buy clothes for vulnerable people.

We were selected to become CBOs by the local government, because we are honest people. Only when we came to SOS Children’s Villages we understood what we were going to do. We accepted as we were chosen. It doesn’t make us rich. We only sacrifice ourselves for others.”

*CBOs who participated in advocacy trainings and midterm review*

#### **I believe that the participants have to choose CBO members**

“We have recently become members of the CBOs, although we are not selected by the local authorities. We are just looking after the CBOs and supporting them. The CBO members say that we are more educated than they are, and they always ask for advice. Those who were inactive have become active.

They were not active, because they did not understand what they were supposed to do. They were just provided by local authorities. They see us as staff and a channel to take issues to SOS staff.

In one way, it is good that they are selected. If they are honest, people will have confidence in them. On the other hand, it is not so good. Most of them are not living with HIV/AIDS, so how will other people confide their status to them? Moreover, the leaders have not asked if they are willing and have the right spirit. We also hear about abuse by CBOs. Some of them love themselves more than they love other people.

Maybe it would be better to select honest people amongst the project participants instead of choosing other people. Then, he or she must confess to be willing. If someone is speaking about himself, he can explain many things. He or she may share issues during advocacy simply because she or he knows. A third party doesn't. For example, I used to live in a child-headed household. This is our target group. As a volunteer, I put much effort into child-headed households. I can never forget child-headed households. So I believe that the project participants have to choose CBO members."

*SOS volunteers*

### **Findings from staff self-review**

**CBOs:** The staff explains that the HIV project is collaborating with seven CBOs with 15 members in each. The local government has selected the members. Four CBOs were created during the previous pilot project, but they underwent a complete restructuring, including the addition of new members when the new project started. The old partners received funds from the pilot project to start income generating projects, but they failed to make profitable business. They were supposed to provide 20 percent of the surplus for health insurance and school materials to project participants. Some CBOs misused the funds. One CBO received funding for a graining machine that never worked. They failed to find someone who could operate the machine, and they wanted more money. This CBO does not receive any further funding.

The three other old CBOs sell timber, agricultural products and have goats. They are not doing very well either. The new CBOs demand funding too. They have established village savings and loan associations, but most of them are not stable. All CBOs are now receiving intensive support from the project volunteers.

The CBOs function well now, according to the staff, although they find that knowledge from trainings rarely permeates to all members. Usually, the CBO presidents participate in trainings only. The staff and the presidents find that the project needs to train all members. The staff would also like to develop and distribute training in Kinyarwanda.

The CBOs are campaigning and linking up with local authorities, and they speak out during Community Days. They have also developed joint action plans with youth clubs. Gradually they may put pressure on local government, the staff explain.

Representatives of people living with HIV/AIDS associations are members of the CBOs, but the HIV project does not work directly with the associations. However, the staff invite them for trainings.

**Advocacy:** During an advocacy training workshop in November 2014 the staff, CBO representatives, children from the project and volunteers developed a draft advocacy strategy. The strategy was adapted and further developed during a couple of coaching sessions ahead of follow-up advocacy trainings in May

and August 2015. As the human and financial resources as well as the project period are limited, the advocacy strategy is focusing on the provision of food to people under ARV treatment as well as health insurance for all only. In keeping with SOS Children's Villages advocacy definition, the advocacy is targeting the authorities. A challenge is that although CBO representatives participated in the three training workshops they are not very clear about what advocacy is and which issues the project has selected to focus on.

**Sensitization during Umuganda** has taken place concerning stigma, volunteer testing and counselling, family planning, drug abuse and alcohol, use of condoms, circumcision, and school dropout.

**Stigma:** Many project participants provide testimonies, because they want to provide hope for tomorrow, staff members explain. Adults begin to understand that you can live with HIV, but fearing stigma parents are still hiding children's status, also towards the children.

**I would like to have meetings for children too**

"I go to school, and I get fees and materials from SOS Children's Villages, but I perform badly due to my status. Other children abuse me. They tell that I'm infected. That makes me sad. They continue to mistreat me. They avoid me. The headmaster punishes them with a stick. He tells me not to worry. That life continues. I told my mother, and she made me move to another school. Then, it started all over again. The children in the neighbourhood also mistreat me.

There are activities for children like me at the health centre, but only once a month and organised by the health centre. We need more activities for children. The adults have meetings every week. I would like to have meetings for children too."

*Boy, 16 years*



Photo: Lotte Ladegaard