Lessons Learnt in the implementation of Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

2007 - 2010

"Improving Lives of over 76,000 Vulnerable People Affected and infected by HIV in Rungwe and Ngara Districts"

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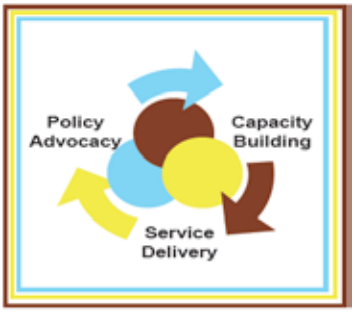
ABBREVIATIONS

AIDS	Acquire Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ARV	Anti-retral Viral Drugs
CHBC	Community Home Based Care
CTC	care and Treatment Centre
DMO	District Medical Officer
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
HDT	Human Development Trust
HIV	Human Immunodeficiency Virus
IEC	Information, Education and communication
IGA	Income Generating Activity
LGA	Local Government Authority
MVC	Most Vulnerable Children
NGO	Non Government Organization
NMSF	National Multisectoral Strategic Framework
PLHIV	People Living with HIV
TFD	Theatre for Development
VCT	Voluntary Counseling and Testing
VSO	Voluntary Services Overseas

ABOUT HUMAN DEVELOPMENT TRUST

Human Development Trust (HDT) is a not for profit, non-government organization (NGO) operating at both the grassroots and national level. Registered under society ordinance 1954 (Rule 5), it has registration number of NO 12060 of February 2004. HDT Head office is located in Dar Es Salaam and has field offices in Mbeya and Kagera, which are the HDT priority regions. It was founded with the intention to partner with communities to develop interventions that improve the health of poor families in Tanzania (including taking care of Most Vulnerable Groups).



HDT is a young learning organization and well structured true NGO, operating in three interrelated pillars namely policy advocacy, community development and service delivery. HDT is continuously growing in its experience and learning, and uses its former experience and sharing to grow and strengthen itself. More information about HDT can be found in the organizational website: www.hdt.or.tz.

Vision and Mission

Vision
HDT's vision is for a society where health is a community priority, where rights of children, women and old people are respected in all undertakings [Using the WHO definition of health as a state of well being and not merely the absence of disease or infirmity].

Mission
HDT's mission is to pioneer and develop new standards of substantive equality life for men, women, children, youth and older people in Tanzania through working with communities and their Organizations. To achieve these, we are working within three interrelated pillars of Policy Advocacy, Capacity Building and Service Delivery.

The work of HDT
HDT is working on three interrelated pillars with the aim of providing quality services to support vulnerable groups and households to improve their livelihoods and effectively manage their life. While we acknowledge that we may not do this in whole communities, we work with and build capacity of community groups to ensure that they are sustainable and are able to equally provide quality partnership with communities to improve health and livelihoods. Through the two programs, HDT learns what works and what doesn't work, we therefore work with other civil society organizations to advocate for policy change, formulation and or implementation of policy statements that may not be implemented.

As a result of above approach, we have gained strong rapport in communities where we work and among peers in the country. We have witnessed families overcoming difficulties and become independent as a result of our services. We have also seen growth of community groups, improved services and size of grants they manage and changes in policies and national budgeting as a result of our advocacy. We believe that our capacity building initiatives will give birth to many HDTs in this country in near future and this will enable health partnership among communities, government and development partners.

FOREWORD

In 2007, HDT became one of the sub recipients under AMREF supported by Global Fund 4th round on "Filling critical gaps for Mainland Tanzania in the national response to HIV and AIDS care and treatment grant TZN- 405 – G07- H)". HDT is indebted to AMREF as institution and its entire staff for their support during the implementation of this project. We salute in particular Dr. Amos Nyirenda, the program Manager, Mr. Omari Mohamed, the financial manager and Andulile Kanza the M&E Manager. We would also like to extend our sincere thanks to the whole administration of Rungwe and Ngara District Councils for their tireless support during the implementation of Global Fund activities. All those who participated in the operational research that is being published for wider use are highly appreciated.

During this period, HDT received and spent a total of Tsh 897 million. 574.8 (64%) million was spent on direct program, 275.4 (31%) on support cost and 47.2 (5%) million on Monitoring, Evaluation and Research.This support has been instrumental to provide services in the following wards: Rulenge, Bugarama, Bukiriro, Kabanga, Murusagamba and Rusumo of Ngara district and Isongole, Nkunga, Kyimo, Suma, Kandete, Itete, Lwangwa, Kambasegera, Masukulu, Mpuguso, Isange, Ikuti, Kiwira, kisiba and Lufingo of Rungwe district. We are indebted for the support from the leaders of these wards.

In February 2009 HDT celebrated its achievements during the first five years of serving its beneficiaries and the community. During that time, selected beneficiaries from all regions of operations were invited to take part in reflection on the work that HDT has done and what we could be doing and how different in next five years. The particular occasion was graced by Dr. Aisha Kigoda, Deputy Minister for Health and Social Welfare, who praised achievements and challenges, the scope of impact and called for expansion into other regions.

Some of participants in the cerebration of 5 years of Services of HDT held at Karimjee Grounds. Feb 2009. The Guest of honor was Dr. Aisha Kigoda

Finally, we salute the leadership of the chair of the board of HDT, Ms Christine Mwanukuzi Kwayu and the entire board. All staff of HDT who in one way or another contributed to the success of this project; the department of Finance and Administration, Capacity Building and Service Delivery. Special thanks to the staff working directly on Global Fund project who are David Bukozo, Dickson Mbita, Moses Kabogo, Henry Siwale, Isack Geofrey and Malanilo Simon. Finally the Executive Director, Dr. Peter Bujari who led the whole team to ensure these lessons reach the reader.

Sincerely yours,

Simon Malanilo
Director of Programs

SUMMARY OF EXPERIENCE AND LESSONS

Summary of experience

HDT has now enriched itself with experience in providing services in many areas including nutritional support for PLHIV and necessary baseline information to be collected, follow-up of patients, working with local government and health facility staff. We also have an experience in undertaking Theater performances and provide mobile VCT services. This was done in collaboration with five trained artists groups to undertake theatre performances. In this event, education on HIV is provided, IEC materials distributed, discussions take place, HIV testing is done and those infected are referred to the nearby health facility or the Community Home Based Care provider in the ward.

Another experience is that of assisting support groups/post test clubs in the villages. This has helped to bring together those tested and also providing psychosocial support to those infected who fear going public. HDT also has gained experience in supporting most vulnerable children (MVC) through caring families. This is based on the philosophy of HDT of involving caring families in ensuring sustainable support to MVC is done accordingly. HDT is one of the sub recipients of AMREF under Global Fund who have published various IEC materials including those in vernaculars languages from Mbeya and Ngara for easy understanding for those communities.

Training and working with Community Home Based Care Providers (CHBC) is another experience HDT has. HDT has been training and increasing the number of CHBC providers. All these providers are trained using the Ministry of Health and Social welfare guidelines.

Summary of Lessons

HDT has learned that Theater for Development is an effective tool in edu-entertainment in mobilizing the communities. We have also learnt that nutritional support for PLHIV on ARV whose health is poor, have proved to be very useful and has enabled them to return to their economic activities within six months.

The Guest of Honour in the event of giving grants/loans to PLHIV groups to start IGA (in a coat) is the Regional AIDS Control Coordinator Dr. Sewangi Julius addressing the public who attended the event and encouraging people to go for VCT on March 20, 2009. on his right side is the ED for HDT, Dr. Peter Bujari

Another lesson is that supporting PLHIV through Income Generating Activities not only creates sustainable support but also ensures earnings of their daily livelihood. This helps also to reduce stigma in the community as PLHIV participate actively in undertaking economic activities.

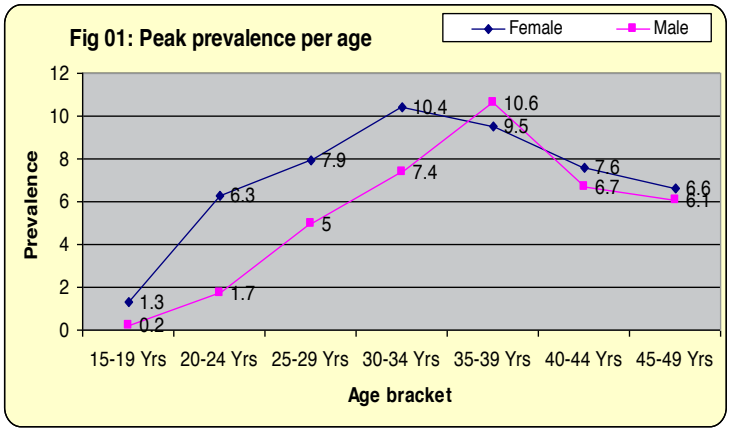
Notwithstanding, there is still low knowledge on HIV in the community compounded with high denial and stigma. In the course of implementing the project, we learnt that some people claimed that the government is wasting money by providing ARVs to PLHIV because when they get good health they infect others.

HDT has also learnt that when implementing a project, Local Government Authorities and other NGOs need to be brought on board for mutual benefit and cross learning.

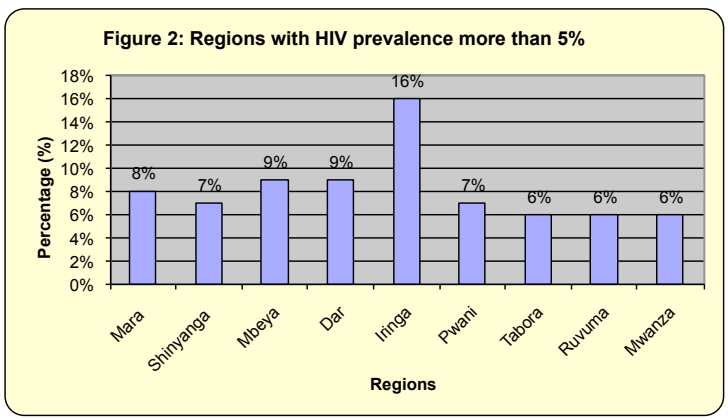
We have learnt that involvement of Local Government is as important as the project itself. We have learnt that when implementing the project, Local government Authorities and other stakeholders need to be brought on board of what is going on so as to get full support and collaboration in the implementation of the project and avoid duplication of service.

1.0. HIV and AIDS situation in Tanzania and its challenges

Tanzania is one of the countries hard hit by HIV/AIDS epidemic and has been declared a national disaster since 1999. Recent reports from the Ministry of Health indicate that since the first 3 cases were reported in 1983 and by 2008, about 2 million people have been infected with the HIV/AIDS virus. HIV/AIDS has become the primary cause of death among adults in the country and is decimating the most productive age group leaving behind misery, suffering and poverty at household. The epidemic is also a big social and economic problem with devastating impact on national development. The national HIV prevalence rate among the sexually active population (defined as the population between 15 and 49 years of age) is reported to be 5.7%, with female having a slightly higher rate than male. Based on this prevalence, it is estimated that 1.3 million people including adults and children are living with HIV or AIDS. There has been significant HIV prevalence decrease in the past five years. (NMSF, 2008 – 2012).



NMSF focuses on four thematic areas namely; Impact mitigation, Prevention of new infection, Care, treatment and support and Enabling environment. The Global Fund implemented by HDT mainly focused on impact mitigation, care, treatment and support and prevention of new infection. Through the operational research done alongside with services delivery on nutrition in care and treatment, policy influencing will be done which is expected to effect wide change nationally.



Looking at the trend of infection, there is immeasurable success to recon with comparing to the last decade. However, the challenges ahead are still on how we prevent new infections;

including infection to innocent children and change of behavior. Other challenges remain, including access quality to care services in rural- urban diversity, including linking livelihood programs with care and treatment so that those who regain health from treatment can be productive to reduce dependence. Funding sustainability particularly to finance care and treatment remains a challenge, which calls for national discussion to devise mechanisms to ensure availability of services.

2.0. The Global Fund project

2.1. About Global Fund Project

HDT became sub recipient in GFATM round four in October 2006 and started implementing Global Fund activities in Rungwe District, Mbeya Region, where it had a field office by then. HDT has therefore been implementing the Global Fund activities starting with ten wards of Rungwe District in 2007. In 2009, five wards were added to make 15 and in year 2010, five wards in Ngara District Kagera Region started receiving services making a total of 20 wards of operation.

Entry and Set-up

The project started with a meeting amongst Local Government Authority (LGA) leaders and other stakeholders to discuss the project objectives and decide which wards should be prioritized. After this meeting, the ward leaders of the selected wards were informed about the start of the project, services envisaged and roles expected of them. A District steering committee made of stakeholders was formed in each District and to give it leadership, the District Executive Director was selected as the chair of the steering committee for the project.

The Project Areas

The projects interventions included the followings:

- Supporting nutritional needs to needy People Living with HIV (PLHIV)
- Promotion and support to Support Groups of PLHIV in each ward
- Community mobilization for HIV prevention and stigma reduction through Theatre for Development (TFD).
- Training to Community Home Based Care (HBC) providers, procurement & distribution of HBC kits and supporting them to provide service.
- Printing and distribution of Information Education Communication (IEC) materials
- Supporting MVC through Caring families

2.2. Supporting Nutritional Needs

Under GFATM projects, 449 PLHIV received nutritional support. Nutritional support was implemented in 15 wards of Rungwe district (50% of the wards in the district). Ten wards were covered in much longer time through round four and other five wards through the funding for block grant.

The nutritional support targeted to PLHIV in need worked in collaboration with the district health system. The aim of the support was to improve their health so that they resume

their normal daily activities. Initial support included local produced food (see picture # 2). The food that was provided presented some challenges including the storage of perishable products such as vegetables. The other challenge was that the same food was being shared with other family members in the same family , and thus the expected outcomes to the intended client were compromised. With the experience above, HDT changed its way of nultritional support to PLHIV and at this time it provided fortified nutrients (E'pap) exported from South Africa. More information about E'pap can be found at the following website: www.epap.co.za

Picture # 2: Beneficiaries receiving locally produced food monthly in 2007

This way of supporting was a major transformation from cumbersome product to well packed, long shelf life and easy to use food. E'pap is used as porridge with a standard number of spoons mixed with water three times a day and its taken every day. Because of its formation and use instructions, it may be perceived as medicine thus preventing all family members to use it. Unlike the first way of supporting, where food could only be used for one week, this time a monthly share was collected. (See picture # 3)

Picture # 3: Patients collecting a monthly share, 6 packets. To the right (in a T-shirt) is Mr. Kabogo, a HDT staff giving them instructions.

To create and strengthen local support, linkages were created with CTC and CHBC in each ward and health centers with the aim of identifying PLHIV on ARV who are critically ill, and refer them to the appropriate facility. Once the health of the PLHIV under nutrition had improved, they were given IGA- training sessions and then given grants for them to set up and run their own livelihood projects. A total of 150 PLHIV established IGAs. PLHIV on the project were also followed up both clinically and energy to document any change for the purpose of learning and possible influencing of policies.

Results and experience

HDTs experience is that once people reach the AIDS stage, their functional capability declines and they have problems inaffording even a single meal. As such when ARVs are provided, they are instructedto eat a balanced diet, which in practice isn't available. We found that at the time of illness, support from neighborhood often declines and almost all livelihood activities stop. Some PLHIV believe that once infected may not be productive anymore, but in reality we found that once supported and counseled they become productive and start assuming parenting and a supportive role to their dependants.

Picture # 4: Mr. MNK who was very sick, bed ridden before he was enrolled in a program. He said: ***"Wanatupa dawa za ARV halafu wanatwambia mkalage sana…..na mi nawauliza viko wapi?'*** *meaning we are given ARVs and told to go and eat plenty….and I ask them where is the food?*

In order to generate information that may have implication beyond service delivery, HDT followed up with 149 patients on nutrition and compared the results with another group in the same area which was not on nutrition. This was done with aim of generating information to inform our advocacy agenda. This study is to be concluded in June and results will be shared widely.

Picture # 5: Mrs. S.M who was very ill in her maize farm in Kiwira ward after recovering.

In general we found that there was a general improvement of health among most of PLHIV using nutrition and in fact they went to be productive without any financial support to restart their livelihood programs. Picture # 5 shows Mrs S.M who was sick and after being on nutrition for three months, she went back to her agricultural production and the picture was taken in her farm at Kiwira. A follow up was made for six months to a group of 149 PLHIV who were on nutrition and 150 who were not on nutrition. A comparison was done on CD4 and BMI before they started nutrition and after six months for the group on nutrition and same period for a group not on nutrition. The table below summarizes the changes in the levels of CD4 between the group on nutrition and the one not on nutrition. There levels of CD4 for those not on nutrition did not show any significant change, but there were significant increase among those on nutrition. Body Mass Index also changes during this time for the group on nutrition, but the same could not be measured among the group not on nutrition because the health system didn't measure the height of patients.

Table 2: Comparison of those on nutrition and control group

On nutrition			Control group	
CD4 range	**Before**	**After**	**Before**	**Six months later**
0-200	80	35	34	44
201-400	54	73	73	70
401-600	9	31	30	27
601-800	2	6	10	9
801+	4	4	3	0

Lessons

What we have leant from this experience is that

- When nutrition is given in combination with ARVs the treatment outcomes are more favorable than when ARVs are given alone.

- Nutritional support does not need to be planned and given for life , but its aim should be to help patients to regain strength and be encouraged to restart their normal livelihood programs as soon as they feel better to do so!!!
- Nutritional support provided using ordinary food at family level, may not be solely used by the patient, instead it is most likely that it is shared with other family members too. As such support may not bring the required results; if locally made food is to be used, it may have to be processed to increase shelf life but also to have a face of medicine so that its not taken for granted as normal food that every body can eat.
- E'pap provided to PLHIV revitalized their health and they went back to being independent .
- Nutritional support is more efficacious on patients with low CD4 level as compared with those with high level of CD4.
- When nutrition is given to PLHIV, supportive psychosocial counseling is important and matching it with start-up capital makes more impact.
- Income Generating Activities for PLHIV bring sustainability support. Supporting PLHIV through Income Generating Activities not only creates sustainable support it also ensures earnings of their daily livelihood. This helps also to reduce stigma in the community as PLHIV are actively engaged in selling products and services in the community while they were expected to die the next day. The idea of Income Generating Activities came up after patients had gained energy but most of them had no idea on how to go about starting one. So the support to start an IGA was very important because itprovided the ability for PLHIV to buy their own nutritional food even after the project has phased out.

2.3. Promotion of Support Groups among PLHIV

Understanding the concept of positive health, prevention and dignity, HDT promoted the formation of 10 support groups for PLHIV in 10 wards of Rungwe District where one support group was formed in each ward. The aim of the supportgroupwastoprovidepsychosocial support to PLHIV to raise their self esteem and restoring their dignity. It also aimed to help them undertaking community HIV education sessions and testimonies in their locality.

Initially the formation of support groups was difficult because most of PLHIV did not want to join as their status would be known and they feared discrimination. This was particularly true for those who were not ready to disclose their HIV status. With the stigma reduction program and support they were receiving, it motivated them to come out and join the groups.

Walidiriki hata kukataa kuja kuchota maji kwangu, walijaribu kuua mifugo yangu… lakini Baada ya HDT kutuweka pamoja, kwa sasa ushirikiaano ni mkubwa. *He says: People refused to fetch water from his tap, others tried to kill his live stock… but now the collaboration is high.*

Picture #7: Mr. NM sharing with other workshop participants on his HIV status.

HDT staff joined meetings at the initial stages to guide the groups, organizing them and trying to ensure they understand their roles. In these initial meetings, each of the 10 groups discussed what should their role be and responsibilities under the guide of HDT. They agreed to meet monthly and one of the roles was to share their experience and know how those who have been on treatment or have lived with the virus for years managed.

They also agreed that once a week, they will be going in the community to educate communities around them on HIV and advice individuals to go for HIV testing.

Thereafter they continually met monthly to exchange ideas and counsel each other. Later, they started encouraging many people to go for HIV testing especially those who had symptoms of HIV. This activity increased the number of those going for VCT services.

Results and experience

The PLHIV, when in groups, are very active and are very resourceful in HIV prevention related activities. As a result, such support is instrumental to both those infected and affected. PLHIV have now confidence and can communicate openly to the public. The support groups in the wards have done a very good job in mobilizing communities using existing avenues like churches and community meetings to avoid added costs. Support groups support both infected and those not infected. A total of 19,826 people received services through support groups.

Support group of Mpuguso ward led by Mr. Frank Gwakisa, had several meetings in different churches to sensitize people on HIV and mobilizing them to go for HIV testing. The most interesting being that there were no funds set aside for them to conduct these except allowances which they receive during their monthly meetings. This was their own initiatives. The support group of Kambasegela has transformed itself into a CBO providing services to those infected and those not infected. The CBO is already registered and started operating in 2009.

This experience gained in working with PLHIV and formation of support groups, seems to strengthen our scope of work and has made HDT involve them individually as well as in their groups to get meaningful involvement of PLHIV (MIPA).

Lessons

- Support groups have been found to be very useful in providing psychosocial counseling to PLHIV.
- They have been very instrumental in referring those in need and fighting stigma in the community which is imperative and effective through the support groups.

- PLHIV get opportunity to support each other and share challenges being one way of empowering each other.
- It makes those who did not really accept their status to accept and feel that they are not alone instead part of a large and a powerful group.

2.4. Community Mobilization for HIV Prevention, testing and Stigma Reduction

HDT is supporting five theater groups to undertake community mobilization through a methodology of Theatre for Development. Theatre is frequently used as a tool for communicating information across a range of sectors, particularly health, to bring about attitudinal and behavioral change, and changes in life style. Theatre for development is also used to analyze, discuss and identify problems and to seek solutions with the participation of the community affected by the specific problems. Through the dialogue, it raises the level of awareness and contributes to the empowerment of all involved. It may also mobilize people to take action and support them in processes of social and political change.

Entry point

Existing theatre groups are identified in the district where intervention is going to take place. The groups are organized as an initial way to prepare for training. This is followed by a training ranging between five to seven days. Normally the training comprises of theory in the class and practical in the villages/field.

Understanding the above methodology, HDT supports and works with five theatre groups (total number of artists is 75; 15 per group) who were trained for theatre for development methodology, three are in Rungwe and two in Ngara district. The performances are focusing on risk behaviors, sexual practices, stigma reduction and increasing VCT uptake.

A performance is developed around a specific theme and a performance is done. Community members then discuss the performance on what issues are being presented, whether the issues depicted are a problem in their community. Once they agree that it is a problem, discussion is conducted on why it is a problem and what should be done to alleviate the problems. Roles for each side are discussed. During the performance, community are allowed to ask questions on various issues of HIV/AIDS.

When theatre performances started in 2007, we only mobilized communities to come to the meeting and learn about HIV and stigma reduction. Some community members who were ready to test, were referred to the nearby VCT to go for testing as we did not have test kits. We constantly had complaints as to why we did not go with a testing team and they even voiced that there we no confidentiality at the facility due to familiarity with the counselors. This need for VCT services was presented in the stakeholders meeting at the district level

and through internal review of the programs; we agreed to change by incorporating VCT as mobile program during theatre performance.

As the result of providing VCT services alongside theatre performance, a number of people attending performances increased significantly.

Since 2007, a total of 16,567 people attended theatre performances which took place in rural villages of Rungwe and Ngara districts. In the course of these performances, 3,661(22%) tested for HIV and received their results. There were some villagers who have never seen HIV being tested, but it happened in their villages. Eg. In Rungwe district Kyobo village, the chairman said " I have never seen an NGO coming here for HIV education and testing but you (HDT) has come, you are warmly welcome. I will also test today, Makandana hospital is far".

Results and Experience

The experience we have gained since we started working using Theatre for Development in 2007, is informing our future work. Our experience has grown and now we use PLHIV to provide community home based care services and ordinary services at care and treatment centres. These two ways have transformed lives of PLHIV into more productive, confident and important players in the communities.

Lessons

Theater performance is an effective tool for mobilizing the community.
For years now HDT learned that Theater for Development (TFD) is an effective tool for mobilizing the communities. People come for entertainment and education. More than 50% of those who attended the performances were convinced to test for HIV. Since stigma is still high, more performances are still needed

HDT vehicle equipped with Public Addressing System during a theatre performance.

One of theatre group (KIHAWIRU) performing the drama during theatre performance at Ushirika

Theatre performances increased Access of VCT services in rural villages.

Its the Government's commitment to provide free VCT and CTC services, but the dream is yet to be realized. Evidence has it that although people may be willing to attend VCT, the distance to the centers still excludes them. ART services also present a challenge on access on the same ground both on initiation and follow up. Whereas the ART access is being addressed by decentralizing to health centers as refill centers, VCT still pose a challenge. Programmatically it calls for mobile VCT to reach people who would other wise not make it to the VCT centers.

There is still low knowledge on HIV in the community compounded by high denial and stigma.

During the project implementation, we noted that some people claimed that the government is wasting the money by providing ARV to PLHIV because when they get good health they infect others. This indicates low

knowledge on HIV and continued stigma is a potential threat to human rights. Such myths and misconceptions needs not only to be solved through sensitization programs, but also serious sessions engaging people to discuss mode of infection and the natural history of the illness. It is through this way that personalities can be valued and seeing that those infected are still human beings and can be as productive as those not infected. To exemplify this, PLHIV have been deprived to register for what is known as "Kikwete Loans" because they believed to die in the near future. There is a notable success such as in Kambasegera where PLHIV engage themselves into school contributions, an example to be emulated.

2.5. Training to Community Home Based Care (CHBC) providers

HDT initial interventions did not include community home based care, but through experience of working through support groups, it was evident that they needed somebody they can trust and who is readily available for them. We explored experience from other parts of the country on the work of home based care and we found out the followings:

- That CHBC were few and that most of PLHIV had not been reached by the health providers. We leant that in most cases there were only facility based home based care providers.
- That some of the Community Home Based Care providers were in fact stigmatizing PLHIV in the course of providing services. We even had instances where PLHIV did not want to see any providers because of the ill treatment they were receiving.
- That some of the Community Home Based Care providers were not linked with health facilities thus referrals and refilling of their kits was problematic.

Based on the above learning, HDT embarked into training of Community Home Based Care provider to support PLHIV in need and the support groups. We agreed that we will be training PLHIV themselves to care for their community members as a way of reducing stigma and restoring their dignity.

To date, we have trained 41 CHBC providers, 10 in Ngara district and 31 in Rungwe district. The need for CHBC emerges from the existing health workers shortage and the fact that HIV is a chronic illness. Due to this shortage, PLHIV who were very sick or have been bedridden for some days or weeks, were not able to reach the nearby health facility and there were no mechanism to reach them. Out of 41 trained, one passed away, may God rest him in eternal peace.

The trained Community Home Base Care (CHBC) providers are instrumental in providing technical knowledge to not only support groups but also to communities around them in general. Apart from providing technical knowledge, the CHBC providers play vital role in taking care of PLHIV at home and give necessary referrals to the seriously sick patients. There

is a linkage with Care and treatment Centers (CTC), Voluntary Counseling and Testing (VCT) and health centers to ensure that with the help of HDT we can cross refer patients depending on their problems. HDT provides CHBC Kits and bicycles to trained CHBC providers which can be used in their work. Since there is no budget for refilling, we solicited the support from the district (District Medical Officer) for refills. The greatest challenge to refill is the shortage of essential medicines at health facilities which is not sufficient for the health facilities.

One of the CHBC providers receiving a Bicycle to help his movement to treat patients in the village. 40 bicycles have already been given to CHBC providers.

Results and Experience

A total of 2,082 patients have been reached by the Community Home Based Care providers. Bicycles are very useful to facilitate movement to and from attending clients at their homes. The challenge with this is that in wards which are very big, CHBC providers get tired. Others have even requested to get motorcycles so that they can reach patients who live very far from where they live.

Selecting PLHIV to be Community Home Based Care providers has added value because PLHIV trust each other and for this reason, they are providing high Collaboration to the CHBC. The bicycles, knowledge, bicycles and kits provided empower them and subsequently help them regain strength and recognition.

Lessons

Working on the human behavior of not wanting to go to health facilities, the community based health care services benefited many people than those that are health facility based. We concluded that mobile services need to be scaled up as they follow people than them following services.

We operated in partnership with local governments, thus expected to have test kits and medicines to refill the home based care kits. However, more often there are often stock outs of medicines at these facilities, and that the kits may not be refilled. At times test kits were also not adequately stocked, and thereby limiting those who need to test. Since the health system now uses Integrated Logistic System (ILS) it may be of value to work with office of the DMO to ensure that they order drugs that are sufficient to cater the needs. In some cases, some health care workers did not acknowledge the support provided, instead they felt that they were being replaced.

There are few districts committed to support CHBC especially those trained by non state actors while some have high interest and are providing full support to the CHBC. There are

some health workers who still assume that CHBC providers are there to replace them and therefore prevent them to have the kits instead, CHBC have to identify patients and refer them to the health facility.

2.6 Printing and distribution Information Education Communication (IEC) materials

The general goal of IEC is to promote and support appropriate changes in behaviour, especially among populations with high-risk behaviour. While cultural differences are likely to require different styles of presentation of material between countries and between different targets groups, the desired behaviours or behavioral changes are towards reduction of risk.

The IEC materials were developed using both Kiswahili and vernacular for Ngara and Mbeya Region. This was done as an attempt to localize the IEC to maximize the impact of the IEC materials. Distribution has been done during the implementation of the project. Posters are displayed in areas where many people are coming together in the wards. Other IEC materials are provided e.g. during the theater performances. Posters are also distributed to our key stakeholders like Council HIV/ AIDS Coordinator, District AIDS Coordinator, District Social Welfare Officer, District Cultural and Youth Development Officer, District Medical Officer and other Community Based Organization's.

Results and experience

IEC materials are useful in ensuring that the message goes across all age groups. Localization of IEC in vernacular (of course translated into Kiswahili) is very useful. Even for those who do not know how to read and write, when someone reads for them, no translation is needed because it's in their mother tongue. In the course of IEC printing and distribution, 37,000 individuals have been reached.

Lessons

We have learnt that IEC materials are sometimes very useful especially when produced in a language used /preferred by many people. Posters produced in local languages in Ngara and Mbeya were very useful and were an innovation which was supported by many community members.

2.7 Support to Most vulnerable children trough caring families

Children in difficult circumstances are among the priority groups of HDT by constitution. During the 2006 annual review, HDT reviewed the approaches used by other service providers, which is mainly supporting orphan children with direct materials. Our review and analysis revealed the followings:

1. When a family is caring for orphans, given the low economical status, all children in that family, regardless of their orphan hood are vulnerable. This is because they share the same scarce resources available. As such, giving support to orphans only created

family disparity between the children and in a way disempowered the guardian as well.

2. Children were in most cases supported with ready made materials such as school materials and often food at school. Most of the support was short term and created no sustainability or addressing other core issues such as shelter or health care.

3. Children remained at a receiving end and they could not actively contribute to their own welfare. The self esteem therefore remained low as they perceived themselves helpless. Care takers felt helpless when foreigners came to provide in their households, which in a way demotivated them.

From the above and in general, the support centred on the children and not the family is contrary to the national plan. As such, many of the approaches failed to empower care takers and in many cases left those care takers not respected by MVC as they cannot provide the needed support.

National Costed Plan of action [NCPA 2007-2010] for most vulnerable children, was developed by the government of Tanzania in collaboration with key stakeholders and presents the national commitment, and also intends to meet UNGAS goal on HIV and AIDS on OVC. Under global fund, HDT supported a total of 480 MVC through their families.

Results and experience

As a result of supporting MVC through caring families, most of those families now have sustainable projects. Projects like animal husbandry (goats in Ngara and pigs in Rungwe) have been increasing and are able to support their children at any time. Others have now the capacity to pay school fees for their secondary school children through the projects established under the support from HDT.

Lessons

MVC can be supported in a sustainable way through foster families. HDT has leant through the pilot project that MVC can be supported sustainably by empowering foster families. This approach increases confidence of foster parents before children and allows children to participate hence increasing their self esteem. We have also leant that provision of ready made materials can serve to address immediate needs, but should be given by the parents. Mentoring families is equally important then provision of grants in order to achieve success.

When implementing projects that include training on Income Generating Activities, it was recognized that most project beneficiaries have little entrepreneurship skills. Besides this, they often have a low capacity on bookkeeping and also on innovation, thinking about the future and savings. Proper record keeping is key to the success of such a project, so this needs much attention during the training and mentoring. During training extra attention should also be given to topics such as how to set up and run a profitable business, how to promote your business and attract and retain customers and how to prepare for the future. After the training, extra attention should be given to supervision and mentoring. Occasion to bring together families to learn from each other in smaller groups as well as children can not be over emphasized.

The power of women is evident and needs to be supported HDT has found that the families we support that are led by women are doing much better than men-headed families. We noticed that the likelihood of a female supported family to do better was about two and half times higher than that of a men headed household. The scale of the assessment is not big enough to be representative, so this needs further research to find out what are the reasons for this situation so that we can take action on the outcomes of this research.

Contents of HBC Kits

ITEM DESCRIPTION	UNITS
Fungstat	10
Dume (kondom)	20
Bandage (2.5 cm)	10
Adhesive Wound Plaster 5cm X 5 mt	1
Benzoic Acid Ointment (White Field)	10
Dettol Soap	10
Disinfectant 5 liters (with 5 empty bottles of 1 litre)	1
Cotton wool (500mg)	3
Panadol tabs 500 mg	1
Gloves (medium size)	20
Aspirin 500 mg	1
Pampas (Adult)	10
Septrine (tins)	2
Eusol	10
Spirit	10
Oral Rehydration Salt (ORS)	10
Vitamin B Compound (1 tin)	1
Torch with Battery	1
Mackintosh Sheet Rubber	1
Kidney Dish Stainless still 24 cm	1
Thermometer auxiliary Clinical Flat type	1
Apron (Plastic)	1
HBC Bag	1