Human Development Trust [HDT]

2006 Annual report

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I: List of abbreviation

AB	Africa Bridge
ABC	Abstain Be faithful and Condom
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
BAKWATA	Baraza la Waislamu Tanzania
CARF	Community AIDS Response Fund
CCT	Christian Council of Tanzania
CHAWATA	Chama Cha Walemavu Tanzania
CMAC	Council Multisectoral AIDS Committee
CSOs	Civil Society Organizations
DAC	District AIDS Coordinator
FCS	Foundation for Civil Society
GFATM	Global Fund For AIDS, TB and Mlaria
HBC	Home Based Care
HIV	Human Immunodeciency Virus
IGA	Income Generating Activities
WAN	Wide Area Network
MKUKUTA	Mkakati wa Kupunguza Umasikini na Kukuza Uchumi Tanzania
MVC	**Most Vulnerable Children**
NPF	NGO Policy Forum
NYP+	National Young Living Positive
PER	Public Expenditure Review
PEs	Peer Educators
PRSP	Poverty Reduction Strategy Paper
RFA	Regional Facilitating Agency
RFE	Rapid Funding Envelope
RH	**Reproductive Health**
SRH	Sexual Reproductive Health
STD	**Standard**
TACAIDS	Tanzania Commission for AIDS
TAF	Tanzania AIDS Forum
TAWG	Tanga AIDS Working Group
TGNP	Tanzania Gender Network Program
T-MAP	Tanzania Multisectoral Project
TOMSHA	Tanzania Out put Monitoring System for HIV/AIDS
UNAIDS	United Nations Program on AIDS
UNDP	United Nations Development Program
WOFATA	Women Fighting AIDS in Tanzania

II: Foreword by chairperson of the board of trustees

The current work of NGOs particularly in this changing environment in funding modalities is considerably challenging when partners in development prioritize their main focus of financial support to government. Inadequate funding is mainly felt when we are trying to overcome these challenges as we build our new organization while at the same time addressing both quality and magnitude of interventions in the areas that we focus.

However, our dynamic team of staff made the board's strategic decisions a reality in their efforts to put in practice the plans and programmes that we had developed and endorsed for the year 2006. We thank the organisation's management and staff for their good work and ensure of my personal support and that of the entire board of trustees as we strive in achieving results.

This report presents the activities done in 2006, highlights the lessons learnt in the course of implementation; and documents major programmatic challenges and achievements, all of which are paramount in programme development. We recognise and support partners who supported us in the course of the year and we envisaged our continued collaboration in the years to come.

The Audited financial account report is also presented to share with our partners on how we comply with the financial standards.

In the next three year HDT will continue to implement projects encompassed in the three pillars of our operational framework namely Capacity Building, Policy Advocacy and Community Development. We will prioritise three regions of Mbeya, Kagera and Dar es Salaam. Our work in Kijitonyama will continue with planned innovative project to improve the livelihood of old people caring for MVC. Our engagement in policy and budget process through out next year will continue in the working group and probably bolstered by being the secretariat of Tanzania AIDS Forum.

Finally I would like to take this opportunity to thank all partners who supported us in the course of the year and call for more concerted efforts as we implement our three years strategic plan.

Christine Mwanukuzi Kwayu
Chairperson,

Board of Trustees, February 2007

III: Message from the Executive Director,

Dear Stakeholders,

I'm delighted to share the 2nd Annual Organizational Report.

Without your support and encouragement we would not have made it and we could not have registered the achievement articulated in this report. This second Annual Report continue to evidence not only growth of the organization but commitment of the organization as a whole.

In this year, we were challenged with availability of funds not only to recruit competent human resource but also to implement community programs set forth. The research and Training section has continued to be resourceful in generating un restricted funds which covered the overhead cost of the organization and part of program cost.

First I want to take this opportunity to thank the board of trustees for the guidance, encouragement and support through out the year. The staff and volunteer who worked tirelessly in such a constrained resource setting to realize the achievement stated.

On the second place, recognition is also extended to the partners who supported us in the course of the year. In particular recognition goes to TACAIDS, VSO, Africa Bridge, Oxfam International, UNADS and UNDP

The year 2006 was also used to reflect and develop a strategic plan for three years 2007 to 2009 which is underpinned by the National Multisectoral Strategic Framework. It prioritizes three regions of Dar Es Salaam, Mbeya and Kagera. It encompasses both service delivery and policy advocacy and governance in HIV and AIDS.

Finally, I would like to request partners and readers of this report to give us constructive comments on both programmatic and strategic issues which will help us to reflect and grow. In particular the business plan which is an extract of our strategic plan. The strategic plan is available from our HDT offices upon request.

I would like to take this opportunity to thank you for your continued support

Dr. Peter Bujari
Executive Director

1. INTRODUCTION

The year 2006 was an important year as it was mainly used to under go internal reflection and decide what we want to achieve in the next three years. The board of trustees approved the Strategic plan for the next three years and it starts to be implemented in 2007. This is a major achievement. Parallel to this was also to develop and strength internal procedures including financial manual and regulation. Hitting the ground in operation, the challenging aspect was also to plan and at the same time undertake fund mobilization to implement the programs which were achieved.

This report intends to inform our stakeholders on activities made in 2006 and summarizing plans for year 2007. We also intend to communicate lessons accrued in the period which are useful for HDT and other stakeholders. These lessons have been instrumental to our strategic planning and business plan. Beyond what HDT performed and using its network in wider civil society policy work and civic engagement, we also present context analysis and trend which we feel is also paramount for planners and actors in the sector in HIV and AIDS.

Activities reported in this report covered a range of geographical areas. With exception of work place programs, other activities were conducted in Dar Es Salaam and Mbeya. HIV workplace program extended beyond these areas and responded to the needs of partners. This work was crucial in learning and differentiates the context of private and public sector.

Finally, we present the Audited financial report which is consistent with financial standards and compliance with International Financial Reporting Standards (IFRSs). This report also shares the approved governance and organizational structure.

Planning meeting with Ngara District

2. CONTEXT ANALYSIS AND MAJOR TRENDS IN 2006

The interventions in the country has continued to be strong, with more challenges becoming eminent including lack of effective coordination among actors, more funding available but not readily accessible to for users. The Public Expenditure Review report for 2006 reports an estimate of 226.8 billions for the year 2005/6 and further that although the government expenditure was expected to double, it only increased to less than half. The percentage of spending as extracted from annual revenue in the year decreased from 14.12% t 11.0% from 2005 to 2006.

Funding mechanism in the country in HIV and AIDS have remained diverse, with TACAIDS, RFE, FCS, RFA,PEPFAR to mention a few disbursing funds to actors. Funding to CSO have remained a challenge, both at local and district level. While there is no sustainable formal mechanism to fund CSO at national level, at district level CSO and CBO are funded by RFA, which is challenged by its high operation cost [$1 to $ 1 disbursed]. CSO and LGA also challenge the scope and sustainability of this funding through CARF and more importantly the capacity building to LGA which has to date fallen short of what is expected.

Operation at district and council level has continued with some district receiving financial support predominantly from GFATM and T-MAP. The PER report 2005/6 estimate that approximately a third did not receive funding and that the both the timing and amount could not be determined by the LGA them selves. This challenge seems to be addressed in 2006/7 budget by introducing formula based allocation to HIV and AIDS. Governance issues in council AIDS committee [CMACs] visited remained to be a challenge where effective representation was not registered. A third of CMACS had no specific meeting dates. Issues of coordination, monitoring and evaluation and outstanding strength of the committee were among the challenges. It is of interest to note was that the monitoring and evaluation is to be addressed by TACAIDS through TOMSHA.

Coordination of CSO has been weak for years, with each working independently. This could easily lead to duplication, weak learning and sharing, poor networking and partnership. With internal inspiration, and through a wide consultative process a forum of CSO working in HIV, Health, Gender and or policy was formed in this year (Tanzania Aids Forum). This ends a long history of weak partnership among CSOs and opens more opportunities to work together, to act as a conduit of voices of CSO both in programmatic and policy issues.

Lastly the NMSF is becoming to an end and process to review the existing and develop a new one have began. CSO have positioned them self at a strategic position to input into the process and content. They have held their first consultative meeting to inform the process on the strategic and implementation strength and weakness of NMSF.

3. SUMMARY OF ACTIVITY BASED OUT PUT IN 2006

In this section, a synopsis of achievement registered in 2006 will be given and its from which the main report is based.

Strategic objective 1. HIV and RH school based program.
Focusing in Mbeya, Rungwe district, we have trained 42 primary school students, 15 secondary school students and 23 teachers and ward leaders. Support visit was done twice and refresher training done.

Strategic objective 2. To Undertake innovative HIV program linking care and treatment centers, VCT and community.
No intervention done in this area due to lack of funding. Planned and budgeted for 2007.

Strategic objective 3. To work with partners and institutions to design and implement HIV/AIDS program including workplace intervention.
Focusing on private and public institutions, 13 CSO were supported in implementing HIV work place program, 2 private sector institutions and 3 government departments. A tool to monitor progress of work place program was also developed and pre tested.

Strategic area 4. To strengthen human capacity and resource within HDT
We developed a three year strategy, which have been approved by the board of Trustees. Financial manual and regulation was also developed and approved by the board. Head office expanded to create a conference room, with creation of wider Area Network [WAN] and electronic equipments to facilitate internal communication. Thee volunteers were brought on board one independent another with support from VSO and other an intern from Mzumbe University.

Strategic objective 5. Strengthen partnership and net working to influence policies and budget processes.

HIV budget analysis was done and policy implications developed and presented to members of parliament. A study on functioning of CMAC was also done and summarized policy implication. We have facilitated CSO consultation to inform the process for review of current NMSF. Finally we were active in the formation of CSO coordination forum [Tanzania AIDS Forum] which are secretariat.

Strategic objective 6. Undertaking HIV/AIDS internal mainstreaming within the organization

Staff sessions have been done consistently, HIV mainstreamed in other staff development programs and a minimum of one session was done monthly. Condoms continued to be available at work place.

4. ORGANIZATIONAL ISSUES

4.1. VISION AND MISSION

Our vision is a society where health is a priority and where rights of children, youth, women, men and old people are respected in all understandings. [Health is defined as a state of well being and not merely the absence of disease or infirmity.]

To achieve the above vision;

Our mission is to pioneer new standards of substantive equality for men, children, youth and older people throughout the country through working with communities and their organizations.

4.2. OBJECTIVES AND FUNCTIONS

1. In partnership with communities, design and implement projects that target youth, children, women, men and older people to improve their quality of life including but not limited to, those which facilitate greater coherence and connections between political and economic considerations, human rights, social justice and development.

2. To build the capacity of community groups and organizations of PLHIV in the fields of advocacy, partnership and HIV/AIDS programming.

3. To influence the creation of policies, programs and legislation at local, regional and national level that advances the role of human development in creating a better, fairer and more equitable society.

4.3. CULTURE AND VALUES

At HDT we will seek to address poverty and HIV/AIDS, by seeking in all our undertakings to be:

1. Collaborative
2. Accountable
3. Innovative
4. Cost effective
5. A conduit to empowerment for communities and their families in striving for sustainable development
6. An agent of social change
7. Linking and leaning

4.4. COMMITMENT OF HUMAN DEVELOPMENT TRUST

1. We commit to and listen to the people we serve, ensuring that their voices are heard, this also contributes to continuous learning for HDT and its staff members and enables us to feed this into our overall programs and priorities.

2. Women and youth are particularly vulnerable to both poverty and HIV, we are therefore committed to devising methodologies that will remove gender inequalities and economically empower them.

3. We are committed to pioneering the rights and quality of life for older people, including but not limited to social-economic, legal and health endeavors.

4. We are committed to advocating for the health and education of children, old people and youth throughout Tanzania.

4.5 PROJECT MANAGEMENT GUIDELINES

All programs and work under Human Development Trust is guided by nine core questions as part of being accountable and assessing impact of the work in the life of people. These questions are:

1. What significant changes have occurred in people's life as a result of our work?
2. Have the interventions addressed the equity and inclusion of children, youth, women and old people? And how will we measure this?
3. What changes have happened as a result of HDTs interventions in the policies that infringe the rights of vulnerable groups and civic engagement.
4. What changes are there in cultural beliefs (towards our target audience/s) that can be attributed to our work?
5. Have we involved and empowered the stakeholders in the project cycle including planning, implementation, Monitoring and Evaluation.
6. Have we built the capacity of the communities we work with to sustain the interventions?
7. Are these interventions cost effective?
8. To what extent have we learnt from our work and how have we have adopted and shared the experience as well as lessons learned?
9. Have we documented our experience and good practice and disseminated to our partners both national and internationally?

5. ACHIEVEMENT TOWARDS STRATEGIC OBJECTIVES IN 2006

Achievements in this year are structured on the strategic objectives which form the strategic plan for next three years. This format is adopted to ensure consistency and comparison of performance in subsequent years.

5.1. HIV and Reproductive Health school program.

5.1.1. Project set up and running:

Through 2006, HDT, Africa Bridge and Rungwe district agreed to implement a school HIV and reproductive Health program, to begin with seven primary schools and two secondary schools. Approaches used by HDT are to work together with the district authority and prepare for phase out from the beginning. HDT provided technical expertise and some overhead cost, Africa Bridge provided program cost while district provided hosting and follows up in schools. We sat for a planning meeting, which included ward leadership, teachers, students' representatives, representative from district education department, HDT and AB to discuss roles and responsibilities and process of selection of participants.

Participants in a group discussion

HDT provided two trainers who were paired with two district staff, with back ground in peer education. HDT developed training guide which was shared with local trainers to feed in local perspective, and after which it was adopted to be used in the district. The manual can be accessed at www.hdt.or.tz/resources.

Desegregations of participants was done into primary school, secondary school and teachers and ward leaders in separate groups. A Five days training was done to each groups covering a range of topics ranging from basic facts on HIV, Reproductive Health into life skills. There was also information filtering as trainers moved from primary school participants to adults.

Upon graduation, work plan was developed on what students will be doing and how teachers will guide them. These served as monitoring tools for the district and on the side HDT and AB. In total we trained forty two primary school children

from standard five to seven from seven schools. Fifteen secondary school students were also trained from two secondary school. It was imperative to bring together ward leaders and teachers for support purposes and ownership. Twenty three teachers and ward leaders were then trained and in addition to the general training they also discussed supportive roles.

Students were allowed to run session on weekly basis and teachers were supportive as deemed necessary. District team as part of supervision and inspected if peer education was going on and provide advisory role where necessary. Although it was made clear that those who will do well will be awarded during the follow up visit it was noted that much depended on the leadership of the school.

Formal peer to peer education in school

Support visit was done two times in a period of ten months where students were allowed to run sessions. During visit, weak areas were rectified and where strong commented. All the peer educators after eight months were brought together for refresher training where experience sharing was done and they were provided with update information in HIV and RH.

5.1.2. Key issues through out the trainings:

Knowledge on HIV and Reproductive Health:
Trainers observed that, majority of the trainees had only little knowledge which is contrary to the perceived national awareness of over 90%. The noticeable gaps included basic facts on HIV/AIDS & STIs including transmission and prevention, (difference between HIV and AIDS), basics on Reproductive Health, Care and Support, VCT, Life Skills as well as impacts of HIV/AID & STIs. It was also clear that, participants had different levels of understanding.

Understanding and possible sex among students:

Anecdotal information and deduction from discussion with participants indicated that, some of pupils do practice sexual intercourse, although it was insisted to abstain. Surprisingly there were many questions related to the use of condoms, partly implying that that, pupils are either practicing unsafe sex or they have been denied information.

For example one STD V boy said;

> *"It is not difficult to get a place to practice sex. One can go to the forest, in the fields while pretending playing" .*

Another STD seven girl said;

> *"Disclosing when one being raped is shame, and if a teacher is a culprit then excessive punishment will always follow you wherever you go.*

Of importance to mention here is that it was noted that students are often assigned duties at teachers' residence and this was used as a trap and it was difficult to disclose this.

Discussion indicated that sex most likely takes place in areas including maize fields, forests, homes, houses under construction, teachers' houses and even in guest houses. They mentioned that, the practice is done between pupils themselves, pupils and teachers particularly for girls, pupils and relatives, e.g. Aunt, uncle etc.

One boy of STD V said

> *"Girls are assigned domestic tasks at teachers' residents with pre determined aim, and the reality is that, they do sex with teachers!", this was evidenced by a girl of STD VII who said "A teacher can coerce by saying, if you will disclose this I will teach you how to keep quite"*

Effect of tradition practice:

It was noted that the use of alcohol some times is practiced since infancy among the citizen of the area. The pupils said that, infants are given, up to one cup of local brews which is known as "hombwa". This makes children to get used to alcohol hence going to bars them selves which in turn can becomes a risk factor for HIV transmission. Of importance to note was also that pupils were often told that once they reach puberty, they have to do sex and that if they don't, then they

will not be functioning in later years.

5.1.3. Major achievements

1. The knowledge of participants on HIV/AIDS, Reproductive Health and Life Skills was increased at the end of the training, and was consolidated when students were allowed to practice at school. Evidence indicated that student self confidence has increased mainly attributed to this project. There are also indication from testimonies that there is behavior change on both students and teachers who acknowledge to adhere to the ethics.
2. A number of myths and misconception were demystified which includes that; one has to do sex to prove his/her puberty and or frequent sex would shed off the virus from the person infected. Also being healthy does not mean one is free of HIV, STIs can be treated and that it is better to be treated early. TB infection is not synonymous to being HIV positive. This information is vital to prevention of HIV and STI as well as taking care of those infected.
3. Working with the district has been an outstanding achievement, on one hand acting as a catalyst and on the other hand building the capacity of local facilitators. HIV was adopted into the school supervision list items and as we plan to phase out the district has planned to take over the program into other schools.

Students in search of information

5.1.4. Lessons learnt during project implementation

In this section we highlight lessons from this project, which are useful for our programmatic response and could be useful to our stakeholders too.

Lesson 1: Although awareness on HIV/AIDS according to national data is above 90%, knowledge about HIV/AIDS in the community is still low.

During the pre training assessment, it appeared that participants' understanding on basic facts on HIV/AIDS was very low (below 50%). Ways on how HIV is and not transmitted was still unclear. Similarly perception on personal risks are still very low, implying that although awareness may be high, knowledge base is still narrow and may not effect behavior change. The fact that ways in which HIV is not transmitted are not entirely known probably explain why stigma continues. Condoms for instance had not been seen by many participants, and were even much less among women. Only two participants out of 23 adults had seen and used condoms which is less than 1%.

Knowledge on life skills and in particular decision making and consequences associated with the choices made were imperceptibly low. Assertive skills were rare to find especially when related to sexual matters.

Lesson 2 : Communities are still in the denial wave hence ignoring realities of HIV/AIDS and need to challenge traditions fueling HIV transmission.

Experience from this training showed that HIV had not been perceived to be present and the effect it was posing to the livelihood and social systems. To put this in perspective, the house is not yet burning, hence expectation of community response will continue to be low. Even when signs and symptoms were evident, it was still attributed to witchcraft, a fact which stigmatizes and prevents those who are living positive to come out. Health center statistics would indicate the number of people is high but this was contrary to the perception of village leaders.

Lesson 3: The impact of AIDS is now felt in many areas including schools being overburdened with caring for orphans

Although communities deny the presence of HIV, its effect is felt but there is shame to acknowledge its effect. For example, Idweli Primary School which is one of the seven schools trained has a total number of 438 pupils. 210 (47%) of these are orphans, and 58(27%) being double orphans and others being single orphans,

most of them have lost their fathers. In such a community, its important to develop projects to help them acknowledging the impact and develop comprehensive community support as institutionalization seems not to be effective.

Lesson 4: Development of effective interventions requires comprehensive sustained program and not segmental short lived projects.

Our intervention in school project was bound not to be fully effective, given that it was not complemented with community interventions. When we preached and explained the reason for abstinence in school, at home they were told the opposite. This in a sense confuses a child in terms of which information to trust. To be effective, HDT has secured funding for the community comprehensive project which will then complement the school program.

5.2. Strategic engagement in policy and budget processes and advocacy at national level and local level.

In 2006, HDT continued to work with other organizations to contribute to the policy and budget processes in HIV and AIDS. Extending on achievement of 2005, HDT facilitated partnership among CSO to form a forum through which voices and lessons could be shared. In addition, high level engagement with parliamentary committee was made on budget session and local level governance. CSO have contributed to the process and content of the new NMSF and will continue to so in a series of consultations to happen in 2007.

5.2.1. Engagement in local level governance [CMACs]

Working with a group of CSO, we did a research on the performance of CMACs, to identify their strength and weakness and make recommendation for improvement. This study covered 26 district councils in 12 administrative regions. Our report titled: The Implication of Participation: The development of robust state and non state partnership and role of CMACs addressed two research questions which were:

- Are the operations of CMACs suitably developed in order to coordinate a robust multisectoral response at district level?
- What lessons can be leant from those performing better and conversely, those perceived to be performing less well?

Key findings:

About 35% of CMACs studied were meeting on ad hock basis with almost a similar number meeting quarterly. 15% were meeting on monthly basis and about 5% meting biannually. About 85% of councils reported to have compiled comprehensive plan, but about 20% of CMAC members interviewed had not participated and were not aware of the plan. Less than half of councils visited [46%] reported to have received funds more than once. There was overall feeling that CMAC lacked outstanding authority and in most cases not embraced by the councils. Co opted members [Including CSO, FBO, representatives of groups] felt that they were not being perceived as equal partners.

Policy implications:

Given the above, CMAC may not afford to undertake its functions and HIV will continue to be business as usual. It is recommended that CMAC be given status like other standing committee including budget for the same.

To have effective participation and build strong public-private partnership, the local government needs to allow representation of stakeholders and not selecting on their behalf. CSO and community groups themselves need to be educated to effectively engage at that level. CSO working at district level will need to work together and build strong networks through which their representation can be fostered.

5.2.2 Engagement in budget process

Where as we know that HIV was announced to be national disaster seven years ago, and policy framework available, we sought to understand the extent at which the budget allocation matches the policy recommendations. To do this, we analyzed the HIV budget for 2005/6 using TACAIDS budget, Ministry of Health budget and Ministry of Finance budget digest. Acknowledging that HIV allocation could be allocated else where, it stood to reason that sectoral budget present a prime proportion to be evaluated. Below is a summary of analysis for discretionary expenditure

	2005/6		2006/7	
	Allocation in billion Tsh	% Total discretionary expenditure	Allocation in billion Tsh	% Total discretionary expenditure
TACAIDS	23.6	0.70	30.4	0.67
MoH	66.9	1.97	69.4	1.52
Total HIV	90.5	2.67	99.8	2.19
Total discretionary expenditure	3,388.7		4,562.8	

Overall findings:

The government allocated 2.67% of its available money to spend to HIV and AIDS for year 2005/6. It also allocated 2.19% of its available funds to HIV and AIDS in year 206/7. Although the government had more money to spend in 2006/7 an increase of about 1174 billions, this did not match the allocation to HIV. This information was useful and appreciated by members of parliaments when we made engagement session with them. Both the information on budget and local level governance was important to help them influence the budget and follow up in their constituency.

Engagement session on budget analysis with members of parliament

5.2.3 CSO coordination and partnership.

The establishment of the Tanzania AIDS FORUM (TAF) on 30th May 2006 marked another milestone for CSOs working on HIV/AIDS within Tanzania. The formation of the HIV/AIDS CSO FORUM was the output of some six months work by eight national organizations namely the HDT, ACORD, BAKWATA, CCT, TNW+, CHAWATA, TGNP, Care International, with support from TACAIDS. The aforementioned organizations held a series of meetings culminating in the consultation of 27 CSOs in early 2006. The outcome of which highlighted the clear need and willingness for a national forum, and the establishment of an interim committee to spearhead the process.

A draft Memorandum of Understanding for the FORUM was prepared by the interim committee, chaired by the Human Development Trust. This draft was intensively discussed in a two day meeting bringing together 37 organizations in May 2006. The meeting set a precedent for CSOs in Tanzania by the establishment of a forum lead by organizations themselves, from the ground-up. It was agreed at that meeting that a FORUM should coordinate the work of CSOs and should also act as a conduit for information exchange and lessons learned. Furthermore the MOU was agreed and a decision was taken by the group that leadership of the FORUM (referred to as the Executive Committee) be pooled from the initial interim committee with the Human Development Trust elected in an anonymous vote as Secretariat for the first period of operation.

The forum was established in May 2006 and was set to accomplish the followings:

- Facilitate learning, knowledge update and information and experiences sharing among members at community, at national and international level;
- Serving as a high level organ for strategic engagement and dialogue with government and other actors in the HIV/AIDS field;
- Develop and implement a comprehensive well-resourced capacity building programme for the members;
- Set up and regularly update mechanisms for coordination and linkage among CSOs

HDT as a secretariat has since then taken up the role of sharing information and presentation in various fora. TAF had been embraced and supported by TACAIDS, UNAIDS, UNDP and even with DPG AIDS. TAF members have engaged quite well

in formulation of NMSF and will continue to do so including reviewing the draft when time comes.

Participants during TAF Inagural AGM

5.3. To work with partners and institutions to design and implement HIV work place program.

Developing specific response at the work place remains crucial as most of time of workers is spent at the place of work. HDT continues to provide support to a number of partners including Government Agencies, Non Governmental Organizations and Private companies. Using experience gained in the area for some time, HDT developed a Visual analogue scale to help work place managers and focal person to measure their stage in comparison to what is desired as good work place program. This program continued to generate un restricted income for the organization some of which financing programs and other covering administration cost for the organization.

5.3.1. HIV workplace program in Non Governmental Organizations.

This year we supported 13 Non Governmental Organizations, twelve funded by Oxfam International, which prioritized mainstreaming amongst its work in Tanzania. In our opinion, this is a model which may be adopted by other development partners. To mention these organizations they are: KIWAKKUKI, KINNAPA, Ujamaa CRT, Maarifa ni Ufunguo, Haki Kazi Catalyst, Oxfam GB Ngorongoro office, TMDWO, TIP, PINGOS Forum and SAIPRO Trust Fund, MIFPRO.

Another organization which we worked with during the period MEDA. During this period, we noticed a change in attitude among partners on the program as initially they had not perceived themselves to need the program.

Partners on Management of HIV workplace program

5.3.1.1. Lessons Leant

In the course of this work, few lessons were drawn which are worth sharing, as internal mainstreaming become an agenda in both private and public sector.

Lesson one: Management support seems to be a determinant factor to have a sounding work place program.

We noted that, management support was crucial to have the internal mainstreaming moving forward. In other words only organizations where leaders believed that their house was burning and they needed to act and protect their employees were able with time to develop and manage a quality work place program. Support to partners during this period, documented paradigm shift among those who initially did not consider work place program as part of their work. We further noted that training of management is certainly a starting point, but was by no way enough on its own. Where managers seem lukewarm to act either due to their personal perception or other wise, horizontal learning seemed to work where managers were brought together for sharing and learning.

Lesson two: Work place program can be made to succeed; the nature of the business not withstanding.

We noted that both AIDS specialist and non AIDS Specialist can do well in this program. Certainly the AIDS specialists have advantage in terms of the cost of hiring human resource as they have them readily available. In terms of performance and leadership, we found no significant difference between specialist and non specialist organization. The critical step we found was to mainstream work place program into organizational business plan, appraisal system and human resource management. Even after the whole year support some partners were still reluctant to have it mainstreamed. It was not clear why this took time, but we hypothesize it could be to cost implication where donors are yet to see this as aspect they can fund and other being denial. Development partners funding civil society organization needs to do policy shifts to accommodate this new phenomenon.

Lesson three: Across the board, work place program has been perceived to be more seminars than considering minimum package interventions.

Where as continuous education is important in the work place program, other components have been suffering. We noted for example that very few partners considered mitigating impact of HIV at work place either born by the workers or the organization. Care and support was minimally done in many organizations. In many cases, structures required to have work place functioning were not prioritized and where they were there they remained toothless. As a result, follow up and command remained weak hence a program which is not monitored or evaluated. Where work place policy was developed, it remained in English despite of the fact that many of their staff would not comprehend English very much.

5.3.2. Work with Ministry and Government Agencies.

The work with Ministry and Government departments was to largest extent un structured and with exceptional of Immigration department, Prime minister's office where the environment have been open and supportive. Immigration department in this year was reviewing their work place program, by undertaking KABP survey, developing Monitoring and evaluation framework to implement their strategic plan. This work will continue being done in year 2007. It was also leant with concern that most of plans in the MDA were not implemented as planned, reasons ranging from slow approval to lack of funds from TACAIDS. Across the board, the

system of monitoring, measuring out puts and seeing the impact remains weak.

Staff session with Ministry of Labour

5.3.3. Work with other institutions.

During this year, we also worked with BP Tanzania limited and PPF. BP Tanzania being one of the institutions with innovative and ambitious policy which covers treatment of their staff, partners and children for the rest of their life except if they are employed and can afford. The work with PPF was to supply condoms at their work places, which was not matched with other relevant information at work place. Internal review of the program did not show evidence of embedment and success of which was documented to be hampered by prejudice among the staff which was not addressed yet. Challenging phenomenon in all institutions is the balancing between their core business and the time to invest in the work place program.

6.0 Organizational development

6.1. Development of strategic plan for 2007-2009

This year we have made organizational commitment by developing a three year strategic plan covering 2007-2009. A time frame for the planning process was agreed, starting with the review of current trends and characteristics of the national response. Then they were coupled with the generation of strategic issues from staff and trustees using the HDT objectives and operational framework as well as a staff planning day using participative techniques. A meeting comprising Board members and staff was held which resulted in an initial list of strategic issues proposed. Following which a SWOT analysis was undertaken and issues discussed at length, after which prioritization of four strategic issues was decided upon. Strategic change objectives and SMARTS profiling was used to further narrow the development of program activities and action plan.

Staff during strategic planning session

The Annual Business Plan (Operating Plan) for 2007 has been developed based on a objectives of the strategic plan and projected funding. A summary of which is annexed to this report as 8.1. The planning process looked both retrospectively at what HDT has achieved in its short-life as well as projecting forward to where we would like to be in the future. This Strategic Plan will be implemented over a three year period but reviewed on an annual basis through the business planning process and development of the reflective annual report undertaken by key-stakeholders, staff and the board. It is a result of this latter process, which will inform the business planning for the following year and milestones and target progress checked against this longer-term Strategic Plan.

6.2. Staff development and organizational capacity.

In 2006, staff capacity was enhanced in the areas of policy advocacy, data management[TSED] and organizational development. Highlighting the critical need for organizational growth and the current achievements, Research and Training Program Officer Mrs. Yovitha Mrina says;

Research and Training Program Officer Ms. Yovitha Mrina

"From the time I joined HDT, I have witnessed organizational transformation both the size of organization, human resource, funding base and programs. Joining from university, I have practically leant many things including, presentation skills, data analysis, report writing and participatory approaches to community development.

I have been motivated by the leadership and commitment of the team made of eight staff whose work can be attributed to over ten staffs. My work through this organization has touched the lives of Tanzania mainly students in schools, workers at work places and beyond all it has made positive spin off effect to my life, relatives and neighbors.

I remain committed and motivated to grow with the organization and use my skills and knowledge to serve this country through this organization....."

HDT continued to strength it self, to secure enough space for efficient running of its business. The office expanded to cater for the office of Executive Director and conference room. The conference room in particular was a major achievement in the event that we are the secretariat for TAF and our engagement in HIV working Group.

In this year there were also purchasing of computers and linking them through WAN, a system which has enabled efficient delivery of work. Lack of power in the year 2006 was a major obstacle to operations, and not only that we were forced to purchase a generator, but the running cost was particularly higher than anticipated.

6.3. Work place policy implementation within HDT

Implementation of work place has remained a challenge where there are few resources and staff as well. Nevertheless, progress was made in this area and more programs are anticipated next year. To make staff sessions part of organizational business, HIV staff sessions were included in staff development program done on weekly basis. HIV session is at least covered once a month. Condoms are available in the office for staff use.

HDT Staff Session on HIV/AIDS

6.4. Staff and volunteer worked with HDT in 2006

We would like to sincerely thank staff and volunteer below who worked tirelessly to deliver the programs described in this report.

1. Dr. Peter Bujari	Executive Director
2. Malanilo J. Simon	Program Manager
3. Mayra White	Management Advisor
4. Yovitha Mrina	Program Officer Research and Training
5. Felix Sukumsi	IT Officer
6. Saidi Kivinza	Office Assistant
7. Asha Mweke	Program Assistant
8. Patrick Kanyamwenge	Policy & networking Assistant
9. Ellihaika Kessi	Program Assistant

7. Audited financial report for year 2006

We present audited financial account for the year 2006, with slight changes from 2005 to comply with International Financial Reporting Standards (IFRSs), where we have moved from cash basis audit to include the assets. Financial audit was done by MEKONSULT, certified Public accountant located at 2nd Floor, Harbours View Towers, Samora Avenue Telephone +255-22-2124383 Fax: +255-22-2124383 Email:mekonsultcpa@yahoo.com

7.0 To the board of trustees of human development trust

We have audited the accounting financial statements of Human Development Trust which comprise the Balance Sheet, the Statement of Income and Expenditure and the Cash flow Statements for the year ended 31 December 2006.

7.1 Management's Responsibility for the Financial Statements

The Human Development Trust management team is responsible for the preparation and fair presentation of these financial statements in accordance with the International Financial Reporting Standards. This responsibility includes: designing, implementing and maintaining internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

7.2. Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgments, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error.

In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control system. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements give a true and fair view of the financial position of Human Development Trusts as of 31 December 2006, and of its financial performance and its cash flows for the year then ended in accordance with International Financial Reporting Standards.

7.3. Statement of income and expenditure year 2006

	NOTE	2006 TZS	2005 TZS
INCOME			
Revenue grants	2	26,890,030	24,950,000
Release of deferred grants	7	18,953,641	-
Consultancy income	3	8,416,000	32,707,000
Other income	4	140,000	204,500
Total income		**54,399,671**	**57,861,500**
EXPENDITURE			
Advertisement and networking		4,275,000	1,682,000
Audit fees		1,320,000	530,000
Capacity building		24,303,490	20,969,930
Communication		3,639,020	1,881,100
Depreciation		1,169,998	756,880

Office rent	1,595,000	1,620,000
Other expenses	2,912,838	2,560,245
Personnel expenses	18,954,199	12,098,620
Renovation and maintenance	1,555,880	1,692,650
Non expendables: office equipment	-	316,100
Stationeries	1,725,790	1,088,460
Total expenditure	**61,451,215**	**45,195,985**
(Deficit)/ Surplus for the year	**(7,051,544)**	**12,665,515**

7.4. Balance sheet at 31 december 2006

	NOTE	2006 TZS	2005 TZS
ASSETS			
Non-current assets			
Property, plant and equipment	5	4,369,563	3,068,020
Current assets			
Prepayments and advances		2,130,000	300,000
Cash and bank balances	6	41,942,072	11,486,649
Total current assets		**44,072,072**	**11,786,649**
Total assets		**48,441,635**	**14,854,669**
EQUITY AND LIABILITIES			
Equity			
Accumulated surplus		7,273,563	14,324,669
Total equity		**7,273,126**	**14,324,669**

Current liabilities			
Deferred grants	7	39,719,509	-
Accounts payable		1,449,000	530,000
Total equity and liabilities		**48,441,635**	**14,854,669**

7.5. Cash flow statement for the year ended 31 december 2006

	2006 TZS	2005 TZS
Surplus for the year	(7,051,544)	12,665,515
Adjustments for non-cash items:		
Depreciation charge	1,169,998	756,880
Operating income before working capital changes	**(5,881,546)**	**13,422,395**
Changes in working capital		
Increase in prepayments	(1,830,000)	(300,000)
Increase in deferred grants	39,719,509	-
Increase in creditors and accruals	919,000	530,000
Net cash flows from operating activities	**32,926,963**	**13,652,395**
Cash flows from investing activities		
Acquisition of property, plant and equipment	(2,471,540)	(2,806,400)
Net cash utilized in investing activities	**(2,471,540)**	**(2,806,400)**

Net increase in cash and cash equivalents	**30,455,423**	**10,845,995**
Cash and cash equivalents at 1 January	11,486,649	640,654
Cash and cash equivalents at 31 December	**41,942,072**	**11,486,649**

7.6. NOTES TO THE FINANCIAL STATEMENTS

7.6.1. Statement of Compliance with IFRS

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRSs) and its interpretations adopted by the International Accounting Standards Board (IASB). These are the Trust's first financial statements prepared under the IFRSs and IFRS has been applied.

An explanation of how the transition to IFRSs has affected the reported financial position and financial performance of the Trust is provided in note 9.

7.6.2. Basis of preparation

The financial statements have been prepared on accrual basis under the historical cost convention, and in accordance with International Financial Reporting Standards.

The preparation of financial statements in conformity with IFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

7.6.3. Income

Revenue grants
Revenue grants received from the donors to fund activities of the Trust are recognized in the Income & Expenditure statement upon receipt.

Deferred grants
Funds received to finance specific activities are recognized initially in the deferred grant account for each donor. Such deferred grants are released to the statement of income and expenditure to match the specific expenditure incurred in accordance with the agreements during the year.

Other income
Other income is recognized in the statement of income and expenditure when received.

Currency translations

These financial statements are presented in Tanzania Shillings (TZS). All the transactions and closing balances are in TZS.

7.7. NOTES TO THE FINANCIAL STATEMENTS (Continued)

1 REVENUE GRANTS

	2006 TZS	2005 TZS
Africa Bridge	5,795,000	-
Christine Mwanukuzi	50,000	-
D. Kasongi	30,000	-
Dr. Peter Bujari	2,295,030	-
Fabian Ndezako	50,000	-
Feddy Mwanga	50,000	-
Samaritan 1	600,000	-
Samaritans 2	600,000	-

TACAIDS	17,420,000	24,950,000
Total grants received	**26,890,030**	**24,950,000**

2 CONSULTANCY INCOME

	2006 TZS	2005 TZS
BP (T) Limited	2,000,000	500,000
PPF	2,885,000	-
OXFAM	3,531,000	13,233,000
Tanga Deanery	-	1,800,000
4H Tanga	-	8,934,000
Vodacom Tanzania	-	1,020,000
Ireland Group	-	1,200,000
Concern Worldwide	-	500,000
Kiwakuki	-	3,200,000
Tanga Aids WG	-	2,320,000
	8,416,000	32,707,000

3 OTHER INCOME

	2006	2005
The Northern College of Utalii	125,000	-
Interest income	15,000	-
	140,000	-

4 PROPERTY, PLANT AND EQUIPMENT

	Computer and electrical equipment TZS	Furniture and fittings TZS	Total TZS
Cost			
At 1 January 2006	3,374,400	656,000	4,030,400
Additions	1,389,000	1,082,540	2,471,540

At 31 December 2006	4,763,400	1,738,540	6,501,940
Depreciation			
At 1 January 2006	814,880	147,500	962,380
Charge for the year	952,680	217,317.5	1,169,997.5
Disposals	-	-	-
At 31 December 2006	1,767,560	364,817.5	2,132,377.5
Net Book Value:			
At 31 December 2006	2,995,840	1,373,723	4,369,563
At 31 December 2005	2,559,520	508,500	3,068,020

5 CASH AND BANK

DESCRIPTION	31 DECEMBER 2006	31 DECEMBER 2005
NBC	41,913,143	10,562,860
TWIGA BANCORP	28,789	894,389
Cash in hand	140	29,400
Total	41,942,072	11,486,649

6 DEFERRED GRANTS

DONOR	At 1 January	Receipts	Released to income	At 31 December
Global fund - AMREF	-	58,673,151	18,953,641	39,719,509

Annex 8:1: Summary of 2007 Business plan
Direct Programe Cost

STRATEGIC OBJECTIVE		PROJECT ACTIVITIES	INDICATORS	Source	Budget
6.1.1	To strengthen approaches to HIV and STIs prevention work that effectively address gender and sexuality issues, with a particular focus on men	2. Rungwe HIV/RH school program Capacity Building to LGA, schools Mentoring Supporting LGA budgeting process	Rungwe district competent to handle the program by August 07 Education budget including HIV/RH budget	HDT/AB	1,000,000
6.1.2	To Undertake innovative HIV and AIDS care, support with emphasis on cross referral system	1.GFATM – 4 Community Support Groups in Rungwe	150 needy PLHIV supported in nutrition 10 support groups supported and 3 theatre groups supported 102,423 people mobilized	GFATM	40,575,499
6.1.3	To undertake community based and sustainable support to orphans and vulnerable children	Pilot project to comprehensive Support to MVC through foster families in DSM & Kagera	Forty foster families supported on income generation activities	HDT	8,400,000

6.2.1	To advocate for favorable policies in HIV, health and poverty reduction as a strategy to ensure health in the community.	FCS: Youth Policy engagement in Kagera and Mbeya[Rungwe, Kyela, Biharamulo and Ngara	Youth network established in 4 districts 100 youths trained in policy	FCS	27,105,000
		TMF/VSO and HDT: Policy engagement through HIV working Group in collaboration with VSO	Budget analysed & popularized and desseminated by policy makers	VSO	7,500,000
6.2.2.	To foster coordination of CSO in Tanzania working in HIV, health, gender and poverty reduction through TAF	TAF coordination: Hosting secretariat for TAF Representing and feedback to CSO Organizing AGM	AGM held in 2007	HDT	1,000,000
		Host, attend and substantively contribute to the PER and budget cycle processes. Refer TMF project	WG plan pending	HDT	Refererble 6.2.1

6.3.1.	Foster partnerships with institutions to design and implementation of HIV/ AIDS programs including work place intervention	Oxfam International – Partners - Technical support on implementation of HIV/AIDS workplace program Mobilizing new partners in work place program	9 OI Northern Zone Partners supported At least 6 new partners supported	OI	1,800,000
6.3.2	To assist and support organizations of PLHIV	HDT/VSO capacity building to PLHIV organizations in Mtwara, Kagera & Dar	Atleast 10 PLHIV organizations trained 5 of them receiving grants	VSO	32,702,000
6.4	Capital Investment for HQ and field offices	5 laptops, Motor vehicle, 2 printers, video camera, photocopier, air conditioner, office vehicle & fax machine	Improved organization performance		24,120,000
TOTAL DIRECT PROGRAM COST					127,850,000
SUPPORT COST					103,737,000
Annual Organizational cost for 2007					255,707,000
TOTAL FUNDS PROJECTED					249,398,000
ANNUAL BUDGET DEFICIT					6,309,500

8.2. Annex II: HDT governance and Organizational Structure