Human Development Trust

ACHIEVEMENT REPORT

January 2009 - December 2010

This Achievement Report for 2009 – 2010 has been prepared by:
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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AIHA	American International Health Alliance
AMREF	African Medical and Research Foundation
ART	Anti-Retroviral Therapy
ARV	Anti-RetroViral drugs
AWITA	Association of AIDS Widows in Tanzania
BAKWATA	Muslim Council of Tanzania / Baraza la Kuu la Waislamu Tanzania
CCT	Christian Council of Tanzania
CD4	Cluster of Differentiation 4 (host cells that aid HIV replication)
CEGAA	Centre for Economic Governance and AIDS in Africa
CEPA	Campaign to End Paediatric AIDS
CHAWATA	Chama cha Walemavu Tanzania / Association for People with disabilitity
CHBC	Community Home Based Care
CSO	Civil Society Organization
CTC	Care and Treatment Care
DBS	Dry Blood Sample
DHS	Demographic Health Survey
EANNASO	Eastern Africa National Networks of AIDS Service Organizations
EJAF	Elton John AIDS Foundation
FBO	Faith Based Organization
FDC	Fixed Dose Combination
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HBC	Home Based Care
HDT	Human Development Trust
HIV	Human Immunodeficiency-Virus
HRM	Human Resource Management
ICASA	International Conference on AIDS and STIs in Africa
IEC	Information, Education and Communication
IGA	Income Generating Activity
IMF	International Monetary Fund
JAST	Joint Assistant Strategy
LGA	Local Government Authority
MDA	Ministry Department and Agencies
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kupunguza Umasikini na Kukuza Uchumi Tanzania / Poverty reduction Strategy
MSH	Medical Science for Health
MVC	Most Vulenrable Children
NGO	Non-Governmental Organization
NAAP	National Advocacy Action Plan
NACOPHA	National Council for People living with HIV/AIDS
NMSF	National Multi-sectoral Strategic Framework
OD	Organizational Development
OCA	Organizational Capacity Assessment
PLHIV	People Living with HIV
PPO	Positive People's Organization

RUDEF	Rungwe Development Forum
R2L	Right to Life
STI	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TAF	Tanzania AIDS Forum
TGNP	Tanzania Gender Network Program
TNCM	Tanzania National Coordinating Mechanism
UNGAS	United Nations General Assembly Special session on AIDS
USAID	United States Agency for International Development
VSO	Voluntary Services Organization
VCT	Voluntary Counseling and Testing
WAD	World AIDS Day

FOREWORD TO 2009-2010 REPORT

The Human Development Trust (HDT); a Tanzania not for profit, non-government national organization has been operating since 2004. It was to partner with communities to develop interventions that improve health of poor families in Tanzania, including taking care of Most Vulnerable Children. In addition to national level intervention in advocacy, HDT operates at grass root level in three priority regions: Dar es Salaam, Mbeya and Kagera. The programmatic focus on Service Delivery is in health, HIV, education to MVCs and income poverty reduction. That of Policy Advocacy focuses on HIV, Family Planning, governance and general health. The Capacity Development focuses on community based organizations and supporting privately run pre-nursing schools (KCMC, Bugando and St. Gasper) to become model of excellence.

In 2009 and 2010, HDT implemented a number of projects whose results are summarized in this report. HDT would like to express sincere gratitude to our donor partners (not in order of priority) including Voluntary Service Overseas (VSO), Futures Group, AMREF, Elton John IDS Foundation, Results Education, Center for Governance of AIDS in Africa, Global AIDS Alliance, Egmont Trust and Elton John AIDS Foundation. We are indebted for their generous support in enabling HDT to accomplish the results presented in this report. We would also like to thank the Government of Tanzania especially TACAIDS and Ministry of Health and Social Welfare who provided valued partnership during implementation of the interventions in the said period. Lastly, we would like to recognize the support from the local government authority in the districts of Ngara, Biharamulo, Rungwe, Kyela and Kinondoni. Their support was very valuable and contributory to the results presented herein.

On behalf of the board of Trustees of Human Development Trust, I would like to take this opportunity to thank all partners and staff who contributed to the achievement of the results presented here. I would like to recognize the support from Mrs. Christine Mwanukuzi-Kwayu (Chairperson), Ms. Feddy Mwanga (Member), Reginald Miruko (Member) and Dr. Millembe Panya (Member). I would like to thank the Senior Management team composed of myself (Dr. Peter Bujari), Director of Programs (Simon Malanilo) and Director of Finance and Administration (Geofrey Isack) for their leadership. Finally I would also like to thank all staff for their good, tireless work and more important putting more time than they are actually compensated for. The staff includes Agnes Kisala, Violet Mathew, Jackline Jema, Jaliath Rangi, Asna Mshana, Emmanuel Makwaya, Andrew Katemi, Dickson Mbita, Henry Siwale, Moses Kabogo, David Bukozo, Mixcus Buzoya and Halifa Juma.

I hope this report will be used by partners to learn more about the work of HDT and engage more in areas of mutual interest. It should also be used by staff to learn how best we can improve our work.

Sincerely yours,

Dr. Peter Bujari
Executive Director

ABOUT HUMAN DEVELOPMENT TRUST

The Human Development (HDT) is a not for profit, non-government organization (NGO) operating at both grassroots and national level. HDT is registered under society ordinance 1954 (Rule5) with registration number SO. No. 12060 of February 2004.

HDT 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 Children. HDT operates at both grass root and national level and in three priority regions: Dar es Salaam, Mbeya and Kagera.

The head office is located in Dar es Salaam and with two field offices where one is in Mbeya (Rungwe) and the other one is in Kagera (Ngara). The Mbeya office was opened in January 2007 and the Kagera in March 2007. On its sixth year, HDT has presence in three regions having a steady partnership with Voluntary Service Overseas (VSO) working in Mtwara region under the Capacity Building Program. In partnership with AIHA, it has interventions in Botswana under capacity building program. With its celebration of the 6 years in service, HDT is a potent and vibrant organization that continues to learn, succeed with strong drive, and in so doing, expanding its intended impact to better serve its target beneficiaries – people living with HIV/AIDS, old people and vulnerable household caring for most vulnerable children. HDT is in Partnership with Elton John AIDS Foundation (EJAF) to support vulnerable groups including most Vulnerable Children (MVC); People Living with HIV (PLHIV) and Care givers.

OUR VISION AND MISSION

HDT's vision is for society where health is a community priority, where rights of children, women and old people are respected in all undertakings. The mission is to pioneer and develop new standards of substantive equality for men, children, youth, and older people throughout Tanzania.

In our pursuit of the vision, we define health as a state of well being and not merely the absence of disease or infirmity and in this mission, HDT will be a conduit to empowerment for communities in striving for sustainable development. Furthermore, HDT will network and collaborate with other organizations to be that agent of change.

OUR AREAS OF WORK

All projects that are implemented by HDT are in line with three strategic pillars. Capacity Building, Policy Advocacy and Service Delivery.

The work of each pillar complements each other and supports the impact and results of our work.

The HDT's interventions are primarily linked to National Policies. Interventions classified as service delivery are in line with MKUKUTA Cluster I and II. The interventions in Policy Advocacy Program

address Cluster III, Joint Assistance Strategy and International Declarations of Commitment such as MDG and Universal Access.

Our Work in Capacity Building

HDT engages in Capacity Building because several partners and allies in HIV&AIDS and development have low capacity in areas of organization and project management for progressive development. By improving the capacity of our stakeholders, they are able to provide high quality service and efficient output to the communities where they work, In this engagement, HDT defines capacity building as working with institutions and communities to help manage their resources and/or program better as an effective means to deliver high quality services. More so, quality program delivery is dependent on the capacity to manage the institution as well as planning and implementing programs. Thus, Capacity Building is therefore a means toward a productive and impact-driven end.

In this area, the strategic objectives are:

1. Support organizations in implementing HIV Workplace Programs and develop appropriate policies and strategic interventions to better care for staff.
2. Support the PLHIV partner organizations and those working in the area of HIV to collectively improve organizational and project management practices.
3. Build Capacity of partner organizations in policy analysis and encourage engagement in policy processes to make its policies effective.

Our Work in Service Delivery

Our Service Delivery work is done to make sure the interventions address the actual needs of the communities, which leads to greater sense of ownership and guarantees strong support for sustainability. HDT's Service Delivery work involves working in partnerships with stakeholders to provide locally and culturally acceptable support services to the community members and groups.

In so doing Vulnerable groups such as people living with HIV (PLHIV), Most Vulnerable Children (MVC) and old people are supported with immediate services such as nutritional Packages, school needs, as well as sustainable projects so that sustainable support is available even when the support has come to an end.

In this area, the strategic objectives are:

1. Build up approaches to HIV and STI prevention work that effectively address gender and sexuality issues with particular focus towards men.
2. Pioneering HIV and AIDS care and support with importance on cross referral system and to form support groups that have strong functional foundation and ownership.
3. Care for Orphans and Vulnerable Children (MVC) through and by community based interventions with specific interest towards care families.

Our Work in Policy Advocacy

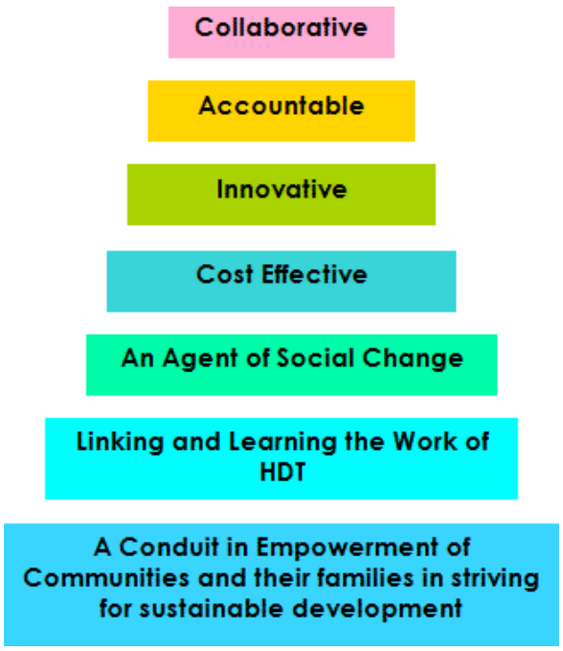
HDT is working in Policy Advocacy to ensure the CSOs are engaging in policy making through effective coordinated strategic advocacy work. We define our Policy Advocacy as engaging with policy makers, with and on behalf of civil society organizations to influence policy and practice. Understanding that policy is the stated framework guiding actions, it is important to ensure that favorable policies are made and implemented.

In this area, the strategic objectives are:

1. HDT and other actors engage in policy advocacy related to HIV, health and poverty reduction. Under these strategic objectives we envisage to have strong involvement in formulation, implementation and review so as to instill ownership, and create accountability of actions.
2. CSOs that are working in HIV, health, gender and poverty reduction are well-coordinated as a team through the Tanzania AIDS Forum (TAF) to share its best practices in the engagement in the policy and budget processes.

OUR VALUES

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



OUR COMMITMENT

The commitment of Human Development Trust expands to these five areas with utmost dedication and passion towards achieving a sustainable mark for the nation. Our commitment hopes to shed inspiration and support, here as follows:

1. We commit to listen to the people we serve by ensuring that their voices are heard and understood, and will try our best to bring the best appropriate action. This also contributes to continuous learning for HDT and its staff members and enables us to feed this into the overall programs and priorities.
2. We commit to bring the welfare of women and youth into a priority. Women and youth are particularly vulnerable to both poverty and HIV; we therefore want to exemplify our commitment by devising methodologies that will remove gender inequalities and to economically empower them.
3. We commit to pioneer new standards of representation and civic engagement in public policies, planning and implementation to improve quality of life for vulnerable groups, including but not limited to social-economic legal and health endeavors.
4. We commit to advocate for the health and education of children, old people and youth throughout Tanzania and where there is greater need.
5. We commit to network and work in partnership with other actors in the country both state and non state. In particular, we will work towards coherent and valuable partnership between CSOs working in HIV, Health, Gender, and/or policy and budget processes.

CAPACITY BUILDING:

Achievements, Lessons Learnt and Challenges 2009-2010

HDT's WORK IN CAPACITY BUILDING

Capacity building is one of the programs among the three interrelated pillars of HDT. It deals with building the capacities of community based organizations in organizational management, program management and deliver better services. In addition this program provides specialized services at user fee for the intention of generating unrestricted income to support operations that are not donor funded.

Objectives and strategies of the program have been designed consistently to meet the needs expressed in Cluster two of MKUKUTA (improvement of quality of life and social well-being). Most of interventions are linked to cluster 1 and 2 as indicated below.

Key Results in the Capacity Building program 2009 - 2010:

Key Results in the Capacity Building program 2009 - 2010:

- Twenty Partner organizations have improved skills and knowledge to manage themselves and their projects
- More than 99 million were disbursed as grants to small Community Based Organizations (CBO's).
- HDT staff has improved knowledge of HIV&AIDS to protect themselves, support each other and provide their services better to their beneficiaries
- Improved capacity of six HPI partner organizations in managerial process, human resource and finance
- 12 organizations established sustainable projects under Right to Life (R2L) Projects.
- 5 Organizations receive more funds from other donor/partners amounting to 20 million By the end of 2010.

Linkage with MKUKUTA
Cluster 1: Growth and reduction of income poverty.
Goal 2: Promote sustainable and broad based–growth
Cluster strategy 2.1.7 develops programs to fight spread of HIV and AIDS in workplaces in all MDA, CSO, LGA and private sector.
Cluster 2: Improvement of quality of life and social well being
Goal 2: Improved survival, health and well being of all children and women and of especially vulnerable group.
Operation target 2.8 increased knowledge of HIV /AIDS transmission in the general population and reduce HIV/AIDS stigmatization.
Cluster strategy: implement and support a program of continuity of care for PLHAs including community based initiatives, for example, HBC, nutrition support, psychosocial support, promotion of women support programs, elderly support and family headed by children.

Our approach towards capacity building for CSOs is unique. It is a seven stage model, which imparts both knowledge and develops skills. It starts with identifying organizations and determining their capacities with regard to organizational design and function using Organizational Capacity Assessment OCA tool . Afterwards the first training course known as Basic Organizational Development (OD1) is delivered, followed by project management (OD2), the mentoring and coaching to give hands-on support in proposal writing skills, office arrangement and setting necessary ground rules follows. Having assessed and evaluated the outcome of the training and support, small grants are provided which extends the practical relationship of partners and HDT. At this stage the participating CSOs implement projects with guidance and coaching from HDT. This approach enables partners to gain confidence and experience in managing projects and funding, hence opening opportunities to seek grants elsewhere. All participating CSOs which successfully pass through the first four stages are selected to attend Strategic Planning and Advocacy workshops so that these organizations will learn to be sustainable.

The diagram below summarizes stepwise the capacity building process:

Participants in the Right to Life project posing in a group photo after the regional sharing workshop that took place in Dar

1 Is the tool which helps to categorize the organization's capacity in accordance to scores attained. The organizations score may be classified into Nascent stage meaning organization being at earliest stage of development with no proper management components or emerging or development stage where structures for governance, managerial functions and service delivery are somehow existing, or Expanding stage where such structure would need reshaping or Sustainable stage where by this stage an organization is fully functioning and sustainable with diversified resource base partnership and networks in place and the organization has a track records of achievement which is recognized by the constituency, government or other stakeholders

RESEARCH AND TRAINING

Research and Training is one of the projects under Capacity Building program. Under this project, we primarily provide support to the development and implementation of quality HIV programs particularly at the workplace settings to all companies, both in the private and public sector, which are legal institutions here in Tanzania. The strategy for the program is to build in-house capacity for institutions to implement HIV/ AIDS Workplace programs on their own.

On the other hand this project was established by HDT to help generate unrestricted fund, as we work on consulting basis, of which a great part of it is ploughed back to support priority project which have not received funding from any donor. From unrestricted funds HDT has procured two project vehicles. Our workplace program on HIV and AIDS supports partners to mainstream HIV and AIDS in their organizations and make employers aware of their responsibilities together with opportunities to respond to the HIV and AIDS Pandemic at their workplace. HDT provides technical support to build in house capacity to implement the programs and can be contacted at anytime!

LESSONS LEARNT AND RECOMMENDATIONS

- Many organizations have vision, mission and even plan for having better life, but what matters is having skills in management and have source of funds.
- The way the organization partners uses their skills and knowledge to different activities especially on IGA gives a great hope that they can improve their development.
- The exchange and study visit activities are seen to be very important because they give a chance to different organization members to share their experience on organizational development and learn from each other.
- Face to face support is very important because the need and the problems among the organization differ that is why mentoring is key in Capacity Building Program.
- There are some organizations which perceive themselves as capacity building organizations which they provide one workshop. We have learnt that this is not Capacity building so can therefore adopt HDT's model of Capacity Building.

CHALLENGES IN THE CAPACITY BUILDING WORK

Inadequate funds for training: Participants needed more time to discuss and learn in depth but due to lack of funds training is only for one week.
Lack of veterinary experts for their animal husbandry as they experience death many times after getting sick and no direct help from public officers. In Ngara and Kyela the district veterinary officers helped some of our beneficiaries to access treatment of their animals.

Lack of agreed capacity building model adopted by the nation. There are many stakeholders who provide "Capacity Building" in different ways. Some between one day to five days as a one off activity while HDT have a different approach described in this report. The experience of HDT in Capacity building program can be accessed at our website www.hdt.or.tz

High demand for financial resources than HDT can provide: HDT would wish to provide sizable grant to partners to enable them to manage the office and provide services for a year or so. Unfortunately the grant which we provided was small due to limited funds from our donors. As a result less of overhead cost is covered and the impact to beneficiaries was not very significant.

PROGRAM OUTLOOK

The major task ahead include persuasive advocacy aiming at influencing other development partners to adapt our capacity building approach. The current partners will be maintained and efforts made to mobilize resources for more grant.

SUCCESS STORIES

AWITA was identified among partners for capacity building in 2007. During capacity assessment, AWITA had scored 56 marks out of 344 which is level one meaning starting stage or nascent stage.

HDT provided Organizational Development trainings in two phases, organizational management and project management. The capacity of AWITA improved and won a small grant that enhances the organization to implement what they have learned. Their income generating project was on soap making.

HDT provided frequent mentoring and coaching support. The soap making project

progressed well and for the second time AWITA won grant worth 5 million to purchase soap making machine.

Left picture, taken during mentoring session to AWITA's secretary. Right picture, Mama Mhando receives a grant cheque worth 5 million to purchase soap making machine.

SERVICE DELIVERY:

Achievements, Lessons Learnt and Challenges 2009 - 2010

HDT's WORK IN SERVICE DELIVERY

Like the whole organization, service delivery is result oriented, which is in sync with outcomes based in MKUKUTA. Most of the interventions in the program address the second cluster *(improvement of quality of life and social wellbeing)*. The results below address three goals (1, 2 and 4) of MKUKUTA cluster two.

Key Results in the service delivery program:

- *Support and meetings with MVC attending school:* 1,272 pupils are attending school well and are still benefiting from scholastic materials given earlier. Attendance for pupils in schools where the project is implemented has increased. Most MVC pupils interviewed are aware of HDT support.
- *Nutritional support to PLHIV:* Nutritional support to PLHIV helped them to recover their health. The support also increased self-confidence of PLHIV who feel more supported and become Productive.
- *IGA support to PLHIV and MVC caring families:* IGA groups have helped more than 150 PLHIV increase their income. IGA support to 250 caring families has also increased support for MVC. Through regular mentoring visits the projects are sustainable and as a result PLHIV and MVC are benefiting.
- *CHBC providers and PLHIV support groups:* This has reduced stigma in the community by increasing the number of CHBC providers who are supporting PLHIV and providing the service in the communities. Bicycles have helped CHBC work easier and reach new clients. The CHBC kits have supplemented the deficit of opportunistic infection medication, as well as providing CHBC with education and instruments to care for patients at community level. Furthermore, CHBC providers facilitate formation of PLHIV support groups.
- *Expert Patient support:* These are PLHIV who assist in CTC to reduce the workload by health providers.
- *VCT and referral support:* CHBC refered about ….. to nearby health facilities for HIV testing, ARV adherence counseling as well as treatment of opportunistic infection and other counselling.
- *Community HIV/AIDS education:* with the theatre performances, interior villages have been reached with HIV education and VCT services which were deprived of. A total of …. Have been reached with HIV testing out of them …. Were found positive and …… reached with IEC materials.

Linkage with NMSF

Thematic 1: Prevention: Strategic objective for reduction of risk of infection among those vulnerable due to gender inequality, sexual abuse, socio cultural factors etc.
Also addresses thematic area 3: care and treatment, sub theme 1 on continuum of care, treatment and support.

Linkage with MKUKUTA

Cluster 1: Growth and reduction of income poverty.
Goal 1: Equitable access to quality primary and secondary education for boys and girls, universal literacy among men and women and expansion of higher, technical and vocational education.
Goal 2: Improved survival, health and well being of all children and women and of especially vulnerable group.
Operation target 2.8 increased knowledge of HIV /AIDS transmission in the general population and reduce HIV/AIDS stigmatization.
Cluster strategy: implement and support a program of continuity of care for PLHIV including community based initiatives, for example, HBC, nutrition support, psychosocial support, promotion of women support programs, elderly support and families headed by children.
Goal 4: Adequate social protection and rights of vulnerable and needy groups with basic needs and services

The Kagera Regional AIDS Coordinator Mr. Mafwimbo giving the bicycle and kit to one of the CHBC in Kagera Region in early 2010

Summary Results for Service Delivery

Plan	Achievements
Grants provision, training and mentoring to 400 MVC caring families (1,308 MVC)	Some of the IGA projects are doing very good. Most families have IGA activities.
	Through regular mentoring visits the projects are sustainable and as a result MVC are benefiting.
School bursar and scholastic materials support to MVC	Among 1,308 MVC identified, 200 have received school bursar and scholastic materials support. Others to be sponsored in 2011
	Pupils are well attending school and are still benefitting from scholastic materials provided. School attendance where the project is implemented has increased.
	Most MVC pupils interviewed are aware of HDT support.
Nutritional support followed by IGA to 300 PLHIV	Nutritional support to PLHIV helped them to recover their health. The support also increased self-confidence of PLHIV who feel more supported.
	IGA groups have helped more than 300 PLHIV increase their income.
Support groups	Support group has managed to reach 888 people on the community.
Expert patients	By using 14 expert patient located at 7 Health Centres, number of people who attend CTC has increased from 13,763 before intervention up to 14,162 after intervention of 4 months.
	By using expert patient has reduced stigma among PLHIV because for now they are being trained by their fellow PLHIV on the use of ARVs.
	Confidence among PLHIV has increased.
CHBC support: Training of 100 CHBC providers; provision of 100 Kits and 100 Bicycles for the CHBC	This has reduced stigma in the community by increasing the number of CHBC who are supporting PLHIV and providing service at community level.
	Bicycles have helped CHBCS work easier and reach more and recruiting new clients.
	The CHBC kits have supplemented the deficit of opportunistic infection medication, as well as providing CHBC with education and instruments to care for patients at community level.

Plan	Done
VCT and referral support	More people in villages are willing to test when counselors are closer to them, rather than going distant clinics and being unsure of counselors elsewhere
	VCT of RUDEF has managed to test 1,004 people out of them 40 were found positive.
Community HIV/AIDS education: 54 theatre performances; 42,000 IEC materials	With the theatre performances, interior villages have been reached which were deprived of VCT services and HIV education.
	With distribution of IEC materials, people are more willing to opt for VCT and have better awareness on stigma reduction.
	During theatre performance total of 9,980 attended, 4,562 were counseled and tested for HIV and 194 were found positive.
	35,000 people received the message of HIV/ AIDS and stigma through IEC materials.

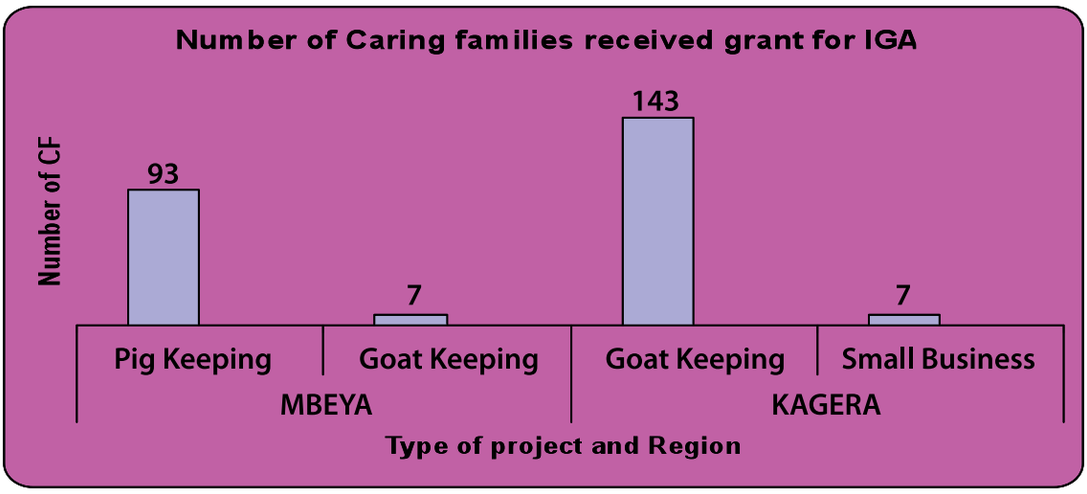
The following are the details of activities under service delivery:

Support to MVC through caring families

HDT's philosophy is that the best way to support MVC is to strengthen the capacity of the family rather than providing materials to children alone. The main aim is to improve livelihood of caring families leading to sustainable support of the children. HDT's approach is to support MVC by building the capacity of the family in terms of livelihoods and skills to address immediate and long term needs. These families are provided with grant to carry out income generating activities. This way, sustainability of the family is ensured and families are empowered rather than providing readymade materials only to the children.

Entry point: The family identification starts with a meeting at the ward level where village/ hamlet leaders are informed about the project and their responsibility during the project. This is followed by meetings with community members mainly to introduce the project and kind of support that the organization intends to provide. HDT staff in collaboration with MVC coordinators and village leaders identifies MVC and assess the needs for immediate and long term support. The reason behind convening the meeting with community members lies behind the challenges arising from community members blaming the selection procedure being biased. HDT reconfirms the family's status and source of livelihood through a methodology called transit walk, whereby families are visited and asked the kind of project would like to operate in their localities.

Output result: As a result of supporting MVC through caring families, most of the families now have sustainable projects. Projects like animal husbandry (goat Ngara and pig in Rungwe) have been reliable and are able to support the children any time. Other projects implemented by supported families include selling sorghum, maandazi and banana. Most of the caring families doing small business have started gaining the profit and use it to carter for basic needs while animal husbandry projects are support the families through selling of the sibblings. Cumulatively 400 caring families have received grant for IGA and 1,308 MVC are identified, 200 MVC have received school material support while the rest will receive school material in 2011.



People Living with HIV (PLHIV) Support Groups

Understanding the concept of positive health, prevention and dignity, HDT has continued to facilitate meetings for 10 PLHIV support groups in 10 wards of Rungwe district. The aim of support groups was to provide psychosocial support to PLHIV, raise their self esteem, confidence and restoring their dignity. It also aims at helping them undertake HIV education sessions and testimonies in their community.

Entry Point: HDT staff joined the meeting at initial stage to guide the groups, organizing them and trying to ensure that they understand their roles. In these initial meetings, each of the 10 groups discussed what should be their roles and responsibilities under the guide of HDT staff. They agreed to meet monthly and one of their roles was to share their experience on how those who have been on treatment or have lived with virus for years managed. They also agreed that once a week, they will be going out to the community and educate them on HIV and advice individuals to test for HIV. This activity has increased the number of people who are going for VCT services.

Output Results: 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 infected and affected. PLHIV now have confidence and can communicate openly to the public. Support groups have done a good job in mobilizing community using existing avenues like community meetings to avoid added cost. Furthermore, the groups cater for both infected and affected. A total of 888 people received service through support groups.

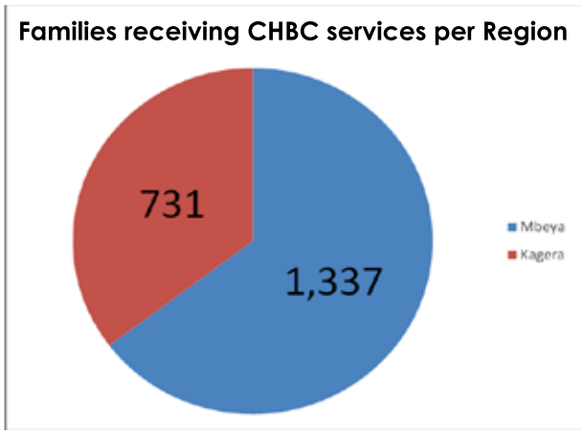
Community Home Based Care (CHBC) providers

Chronically ill HIV patients are mostly cared by family members particularly women and children who usually lack inadequate training, skills and support. Due to the increased number of patients especially with HIV, the gap continues to widen between the demand and availability of health care services. Due to the low number of health worker to support patients at community, HDT identified the need to train CHBC providers to serve in Ngara, Biharamulo, Kyela and Rungwe. The aim CHBC activities is to support all bedridden and chronically ill patients at their localities, providing referrals to the seriously ill patients, provide technical skills to support groups and community in large

Entry point: Due to high stigma in the society PLHIV groups are advised to train themselves on care among the member as the way of reducing stigma and restoring dignity. Meetings were held with PLHIV groups in the wards of operation with HBC providers from health facilities.

In each group, a discussion was made around the criteria for CHBC provider including; s/he must be PLHIV, CD4 count above 250, able to read and write, spirit of volunteerism and ability to help others. All identified CHBC providers were trained according to National guideline of CHBC. After the training they were linked to CTC and health facilities at their localities to provide services. HDT provided HBC kits and bicycles, and the kits are posted in the health facilities.

Output Results: Selecting PLHIV to be community Home Based care has reduced stigma in a society as well trust and confidentiality among PLHIV. A total of 2,068 patients including PLHIV have received services through 100 CHBC providers and most of them improved their health. Bicycles are very useful to reduce workload and facilitate movement while attending client at their homes. HBC kits were provided for provision of services and drugs for opportunistic infection. The skills in care, kits and bicycle empower them and subsequently help them regain strength and recognition among the communities. It has been realized that, they do not only serve PLHIV but other chronic eg. those with TB, Cancer illnesses and those in need of home based care services especially where health facilities are at distance.



Expert Patients

The acute shortage of health care workers in sub-Saharan Africa including Tanzania is well documented, but little attention has been paid to those who have human resource management (HRM) responsibilities, tasked with developing and leading a productive, motivated, and supported health workforce capable of delivering quality, accessible health services (AMREF,USAID and MSH 2009).

Since the rise of HIV/AIDS pandemic, clinicians and nurses have spent a large amount of time educating patients on HIV and ART, initiating ART, monitoring and recording side effects of HIV – positive patients as well as dealing with clinic tasks like cleaning and managing patients' flow. However, the overwhelming volume of HIV positive patients seen each day in the clinic makes this unsustainable technique and the morale declines daily.

Due to this problem, the number of people requiring medical attention greatly overweighs the number of skilled health workers. As a result health professionals work under stress and yet with increasing dissatisfaction reports from clients they attend. This is where task shifting could prove to be a solution with lower cadres of health workers taking over basic administrative tasks, ART education and counseling.

To fill the gaps, HDT adopted task shifting techniques to utilize lower cadres of health for basic health duties. As an example of task shifting, HDT developed expert patients' intervention to reduce the workload of nurses and clinicians at the CTC in Rungwe district.

Entry point: 14 expert patients from 7 CTC (2 from each CTC) were given a two days training. The objectives of the training were to make sure that the expert patients are able to train other PLHIV who are at the stage of starting using ARV and adherence counseling, referrals and services provided at the CTC, ARVs use and, nutritional education to PLHIV, basic knowledge about HIV and AIDS, mode of HIV transmission and STIs, and preventive measures of HIV. After training, they were given a task to train their fellow PLHIV who are eligible to start ARVs. After the training, they were assigned to the respective CTCs in order to perform their roles.

Output results: The use of expert patients at CTCs has reduced stigma to PLHIV themselves and the number of people attending education sessions has increased. The workload to health workers has been reduced because records indicate reduced time PLHIV spend in the clinic from five hours to less than two hours. The attendance to clinic has increased from 13,763 before intervention to 14,162 after intervention of four months.

Nutritional support to PLHIV in need

Nutritional support was focused to needy PLHIV preferably on ARVs. The aim of the support was to improve their health so that they can resume their normal daily activities.

Entry Point: In support of district health facilities, CHBC providers, PLHIV groups and CTC identify PLHIV in need of nutrition support. The criteria include; those on ARVs, chronically ill, below 200 CD4 count and bedridden patients. Following identification nutrition support is provided for four months. A total of 150 are recruited and continue receiving the support. Nutrition is provided in from of fortified nutrients (e'pap) imported from South Africa. *For more information about E'pap can be found in the following website www.epap.co.za.*

This way of supporting was the major transformation of nutritional support since the product is well packaged, has long shelf life and easy to use. E'pap is used as porridge taken twice a day with a standard number of spoons mixed with water every day. Because of its formation and instruction on use, it is communicated and perceived as medication thus restricting the rest of the family members to use it. Once the health of the individual under nutrition improves, they are provided with IGA-training session followed by grant for them to set up and run their livelihood projects. PLHIV on nutrition support are monitored both clinically and with physical measurements to document any change for the purpose of learning and possibly influencing policy.

Output Results: A total of 300 PLHIV received nutritional support and grant for establishment of IGA in Rungwe district and most of them have resumed their health. HDT has the experience that once people reach AIDS stage, the functional capability declines and they have problem in affording even a single meal. As such when ARVs are provided and instructions provided to consume balanced diet becomes impractical. HDT found out that, during illness support from neighbours and friends often decline and almost all livelihood activities stop. Some PLHIV believe that they are no longer productive due to the infection. HDT has managed to change the mindset of some PLHIV by supporting them for recovery from illness and building up the possibility for production through IGA.

Community Mobilization for HIV Prevention, Testing and Stigma Reduction

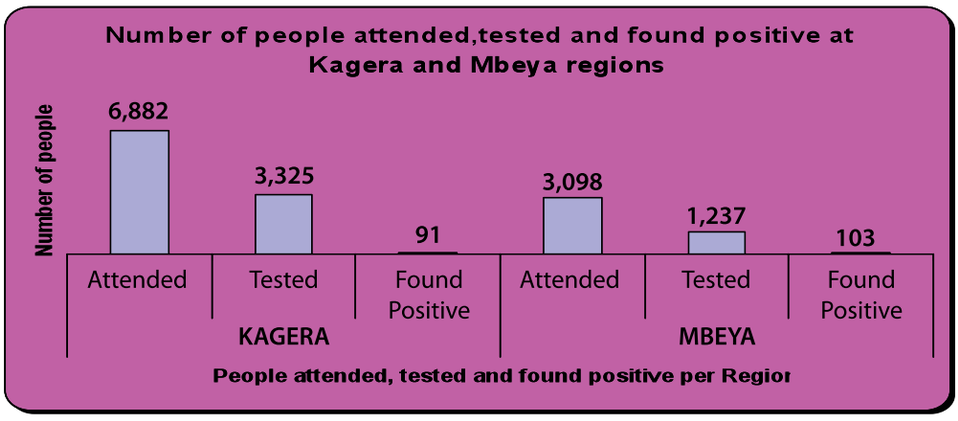
HDT is supporting five theatre groups to undertake community mobilization through methodology of Theatre for Development. Theatre performance is frequently used as a tool for communicating information across a range of sector, particularly health, to bring about

attitudinal and behavior change and changes in life style. Theatre for development is also used to analyze, discuss and identify problem and seek for solution with the participation of the community affected by the specific problem. Through the dialogue, the level of awareness is raised and contributed to the empowerment of all involved. These also mobilize people to take action and support them in the process of social and political change.

Entry point: Existing theatre groups were identified within the district where intervention is going to take place. The groups are organized and prepared for 5 to 7 days training. Normally the training comprises of theory in class and practical in the village/field. Understanding the above methodology, HDT supports and work with five theatre groups (total number of artist is 75; 15 per groups) who were trained for theatre for development. Three groups in Rungwe and two groups in Ngara district. Performances focus on risk behaviors, sexual practice, stigma reduction and increased VCT uptake. Performance is developed around a specific theme and performance is done. Community members then discuss the performance on what issues is being presented whether the issue is depicted are the problem in the community. Once they agree that is a problem, discussion is conducted on why it's a problem and what should be done to alleviate the problem. Role for each side is discussed. During the performance community is allowed to ask question on various issues of HIV/AIDS.

Output Results: A total of 9,980 people participated in the theatre performance which took in rural village of Ngara and Rungwe district. In the course of this performance, 4,562 (45.7%) tested for HIV and receive the results, out of those who were tested 194 were found positive. Theatre performance is an effective tool for mobilizing community. During theatre performance people come for entertainment and education and others are convinced to test

Success story: During theatre performance which was held at Mpandapanda, a group of five pupils attending class 5 requested to make a drama show concerning HIV/AIDS and Mafataki "sugar daddies". Their confidence and high capacity of managing the stage attracted many people.



Printing and distribution of IEC materials

The main aim of IEC is to promote and support appropriate change in behavior, especially among population with high-risk behavior. IEC materials were developed using both swahili and vernacular language for Ngara and Rungwe districts. This was done as an attempt to localize and maximize the impact of IEC materials. Distribution was done during the implementation of the project while some posters were displayed in areas where many are gathered or visit often within a ward or village. Other IEC materials were provided during theatre performances, stakeholders meeting etc.

Output results: IEC materials are useful in ensuring the message goes across the age groups. Local language is very useful. Even for those who do not know to read and write, when someone reads for them no translation is needed because it's in their mother tongue. IEC material were also used to mobilize the community to HIV test whereby while theatre performance was conducted the first 10 people in the queue for HIV testing were provided with T-Shirts, the second ten were caps and the rest were leaflets. This attracted many people for HIV testing. In the course of printing and distribution of IEC material 35,000 people were reached with HIV and stigma reduction messages.

Establishment of VCT center

Voluntary Counseling and Testing (VCT) for HIV allows individual to know their HIV status and serve as the gate way for both HIV prevention and for early access to treatment, care and support. Knowing ones status provides for the choice to: for those who are negative remain negative and those who are positive seek access to treatment, care and support and to reduce the risk of HIV transmission to future children and partners.

Low coverage of the service: There is very low number of VCT in Rungwe district compared to the total area. In the district there are 31 VCT sites whereby the government owns 28. The VCT sites have been built in the average of 1 VCT per ward. This has become difficult to community members to attend the VCT services because some villages are distantly located within a ward and people need to walk a significant distance towards VCT. This was a driving force which made HDT in collaboration with Rungwe Development Forum (RUDEF) to establish a VCT which is supervised by RUDEF.

Entry point: A meeting between HDT, RUDEF and other stakeholders including the Government and other organizations took place in order to see the relevance of the intervention. All stakeholders supported the idea of the intervention and the preparations began. RUDEF provided a site while HDT facilitated its renovation and including equipment and administration. For six month (January – June) the VCT has managed to test 352 people, among them 14 were HIV positive.

CHALLENGES IN SERVICE DELIVERY

1. Scarce for Medicine for CHBC kits

We operates in partnership with Local Government, we agreed the government to refill the HBC kits after ours finished. More often there is stock out of medicine which hinders smooth performance of CHBC providers.

2. Low support from district health facilities

There is low support by districts health workers to CHBC providers especially those trained by non state actors. Some of the health workers assume that CHBC providers are there to replace them.

3. Head of family

Many of the Caring families are headed by female, this was due to the some of the men have passed away due to various diseases like HIV/AIDS, some of them due to poor economic condition their husband decide to run away from their homes and leave the women with children and other men decided to marry other women and some of the men abandoned their families without any reason.

4. The demand of services was less than the supply of the same

During implementation of our work we found the demand of the service is very high compared to the support. There more required to be done than what we could afford. The program had little funding which was not able to meet the demand on the ground.

5. Unreliable projects

From mentoring visits to IGA projects it was noted that some projects are doing poorly, mainly crop growing projects. IGA projects which rely on crop growing are not bringing the needed income due to poor harvest (lack of rain), therefore not meeting the goal of supporting the MVC.

6. Delay of funds

Could not extend project to other families in 2009 due to delayed of funds. None of the planned support to support groups meetings was done in 2009 due to delayed funds. For existing support groups, there is a need to strengthen support group to be more proactive in their areas also by providing new information about HIV/AIDS and conducting various trainings.

7. Multiple Support

Some of the parents and MVC have a tendency of hiding information if they are supported by another NGO, for example one secondary student was discovered to also be getting support for school fees with another NGO, but was later addressed.

LESSONS LEARNT AND RECOMMENDATIONS

Involvement of LGA; in the project encourages their participation and simplifies implementation.

Care for PLHIV; is mostly preferred if undertaken by their fellow PLHIV.

Nutritional support; to PLHIV on ARVs treatment outcomes are more favorable than when ARVs are given alone;

Theatre for Development; is an effective tool for community mobilization. People come for entertainment and education. Others are convinced to test for HIV;

CHBC providers; play great role in caring patients. The service has benefited many people than those that are heath facility based;

MVC can be supported in a sustainable way through caring families; HDT has learnt that through empowering caring families MVC can be supported beyond the project life. This approach increased confidence to caring families before children and allows children to receive the support sustainably. Also we learn that provision of readymade material can serve to address immediate needs, but should be given by parents.

Rural based families are more disadvantaged than urban areas; HDT noted that on average, a family in urban cares for 2 MVC and that of rural about 4.7. There were also less support in rural areas than an urban and family planning was less considered in rural as compared with urban. These findings are confirmed with DHS 2005 where use of contraceptive methods for family planning in urban was 34 and 16% in rural areas. This would mean to further priorities rural based interventions.

Female headed household and rural based families tend to do better when supported than male and urban counterpart; HDT has established that families which were headed by women did better in projects they were implementing and compared to male counterpart. Furthermore, rural base families do better that those in urban in terms of generating profit and being honest to consult when they did not know what to do. HDT have not scientifically established the reasons for some of these, but we will continue monitoring the performance and possible factors and they experience will inform further placing for better result.

PLHIV can be active and be meaningful if given a chance and support to act; To overcome some of the challenges above, HDT worked and involved PLHIV in its intervention. Some of their support groups were reinforced to become community based organizations and some are registered by now. PLHIV after gaining their health back, they were given money to start IGA, which became care kits and now operational and productive. To further reduce

stigma, PLHIV were trained to be community home based care providers and when they successfully completed the course, they were then given home based care kits.

Care and treatment complemented with nutrition supplement registers health improvement quite outstandingly; Working with Rungwe district hospitals, we have monitored PLHIV who are on ARVs and provided them with nutrition. Parameters being monitored include CD4, weight, frequency of hospital attendance, frequency of opportunistic infections. So far evidence show that there is general improvement with critically ill PLHIV resuming work between four to six months. The documented work on the study can be requested from HDT.

PROGRAM OUTLOOK

The program future starts from the current achievement, the challenges above and lessons learnt too. Broadly however, in programmatic perspective this program will:

- Continue working with communities to design and implement projects leading to sustainable development leading to healthy communities;
- Continue targeting PLHIV, MVC, the elderly, youth and women in interventions that increase their dignity and power in the society;
- Enhance collaboration with partners including local government, development partners and fellow community based groups; and consolidate the interventions in the five districts (Kinondoni, Rungwe, Kyela, Ngara and Biharamulo) given resource are available to expand further.
- Continue investing in health and Education related projects so as to have healthy educated and responsible communities.

POLICY ADVOCACY:

Achievements, Lessons Learnt and Challenges

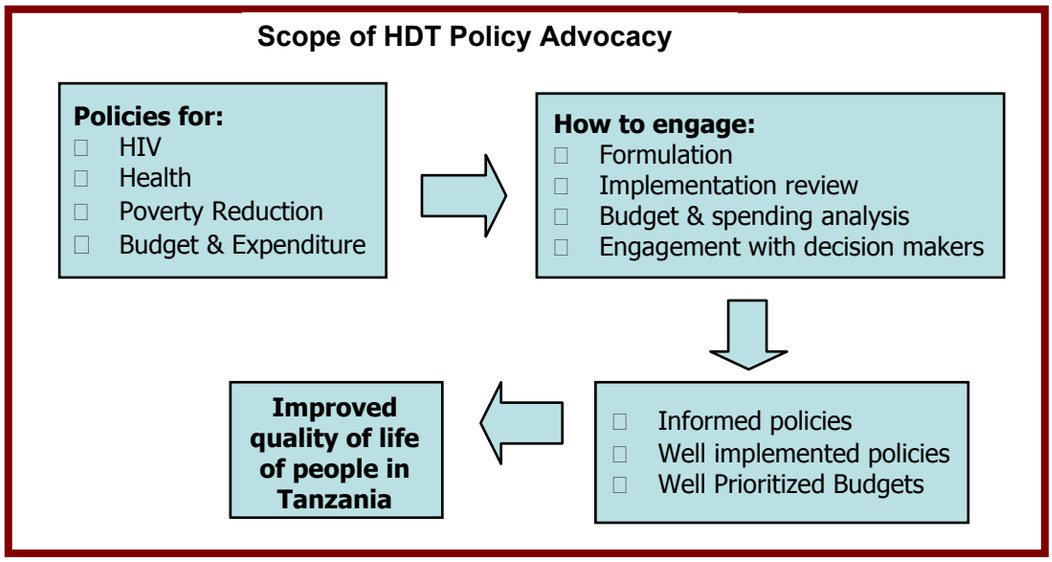
HDT's WORK IN POLICY ADVOCACY

HDT's work in policy advocacy focuses on influencing the policy both at the local and the national level. This work is strongly linked with MKUKUTA, the Second National Multisectoral Strategic Framework (NMSF II) on HIV/AIDS 2008-2012 and the Joint Assistance Strategy (JAST). By so doing they facilitate mutual accountability of government and development partners and making them accountable for themselves based on their actions and public resource utilization. In addition, CSOs engage in dialogue with the government and development partners and consolidate and present community views to the government and development partners. (JAST 2006)

The policy advocacy interventions address thematic area one of the NMSF which focuses on Cross Cutting Issues related to the Entire National Response (i.e. enabling environment).

Key Results in the Policy Advocacy program:

- From its engagement in Macro Economic Policies (including participation at significant meetings): the IMF mission now consults CSO's and MPs.
- HDT has been able to expand its networking with other development partners like the Centre for Economic Governance and AIDS in Africa, RESULTS Educational Fund and Ifakara Health Institute, the Parliament, Civil Societies, Media and also participates in Regional Workshops, e.g. ICASA, Dakar, etc.
- From its lobbying for development of minimum capacity development packages (including participation at significant meetings): The partnership framework between the Government and CSO's has changed. all TNCM approved proposals must include capacity building of CSO's, US based institutions request to partner with local CSO's.
- NAAP developed for CEPA and Bottlenecks report: HDT was chosen as lead country partner and made a presentation before the guest of honor at the pre-launching summit in Johannesburg (October 2009). Bottlenecks analysis is available at HDT's website.
- From its networking HDT joined the Policy Forum in April 2009.



CHALLENGES IN THE POLICY ADVOCACY WORK

There is limited transparency in budget processes and macro policy formulation
There is limited access to information on budget and limited stakeholders' participation in budget processes. Macro policies formulation is limited to finance Ministry and lacks participation of Parliament and Sectoral Ministries. Opening up of more participation to enable use of expansionary policies and access to information will enhance the policy formulation process and its end results.

There is limited capacity and interest of CSOs to work in policy advocacy
Many CSO are formed to work on service delivery and their capacity to analyze policy and hold government accountable is limited. CSOs need capacity building in policy areas to realize that lack of appropriate policies and/or deficiency in their implementation can limit them to achieve their vision. The Government also needs to perceive CSOs as equal partners than as junior brothers as it is the case.

Lack of funds/support and lack of high level skills
In general challenges for advocacy are lack of high skills and extensive knowledge (especially keeping updated on changing scenes), lack of support from others who expect to see tangible results and lack funds. Some activities were not implemented well due to lack of funds and skills, for example:

- Budget Analysis: Did not work well due to lack of funds and lack of officers to sustain the interventions.
- Expansionary Policies: Did not work well due to limited funds, lack of government support and limited skills.

PROGRAM OUTLOOK

In the future HDT looks forward to work more strategically to become a think tank where we will be providing well-founded researched information on policy formulation options and what can work on the ground. We look forward to creating more strong partnership both at international and national level to build a mass of CSOs prioritizing in policy work and who have the capacity to analyze policies, be accountable and hold the government accountable. For this to happen, HDT will invest in CSOs capacity building, coordination both nationally and internationally as well as critical engagement with decision makers at different levels of decision making.

ACHIEVEMENTS in 2009-2010

Policy advocacy activities in 2009 were not project related, except in 2010 when the Campaign to End Pediatric AIDS (CEPA) project was launched. The activities were mainly:

- Documentation of the benefits of the use of expert patients in establishing **Family Centred Care and Nutrition for PLHIVs.**
- Meetings conducted with UNICEF and UNAIDS on the adoption of WHO guidelines by the government of Tanzania.
- A meeting with the PCR Specialist at MoHSW on the development of guidelines for time bound transportation of DBS for **Early Infant Diagnosis and Treatment.**
- Advocating for the inclusion of child development parameters in the CTC 2 Form which turned to be the MCH Card to be used for both HIV positive and negative clients. The final draft was presented to the MoHSW for final modifications, adoption and use.
- Discussions and Media training on **Access to Appropriate Medication and Commodities** during WAD commemorations were conducted. As a result, in December 2010 the government ordered the first bunch of FDCs for infants. The FCDs were expected to be in the country within six months.
- Budget Analysis was done and it was found that there was no budget line for PMTCT to achieve **Full Funding for PMTCT** which makes it difficult to know how much the government had allocated for PMTCT.
- **Resource mobilization for CEPA:** initiatives to leverage funds for CEPA included going for Global Fund under the support of TACAIDS were done. Unfortunately Round Ten for Tanzania did not go through.
- In addressing **Stigma and Discrimination** TAF followed up closely with UNAIDS who was funding the National Council for PLHIV (NACOPHA) to undertake Stigma Index in a number of administrative Regions.

ACHIEVEMENTS in 2009-2010

Plan	Done
Macro Policy Research and Advocacy	Research done, printed, used for Breakfast Debates and dialogue with MPs and Senators
	Issued Press Statement co-authored by the Executiv Director for HDT and RESULTS
	Held parallel meeting of CSOs with IMF in DSM in March 2009
Weblinks on HDT's work	http://www.habarileo.co.tz/biasharaFedha/index.php?id=16025 http://www.forbes.com/2009/06/17/congress-budget-investment-opinions-contributors-imf.html
Lobbying for development of minimum capacity development packages for CSOs	The partnership framework between the Government and CSOs has changed: all proposals approved by the TNCM must include capacity building of CSOs; US based institutions required to partner with local CSOs
Networking	Joined the Policy Forum in April 2009
	Participated in significant meetings including the a Breakfast Debate on IMF policies (February 2009); the CSO workshop on IMF policies (March 2009); and the US Senate meetings on GFATM funding (April and June 2009).
CEPA	Bottleneck Analysis available at www.hdt.or.tz HDT chosen as lead country partner NAAP developed Tanzania team presented before guest of honor

Linkage with the NMSF

This work is linked with the NMSF through thematic area 1: *Cross Cutting Issues Related to the Entire National Response* (i.e. **Enabling Environment**)

Indicator: National Composite Policy Index
Sub-theme 1: Advocacy and Political Commitment

Linkage with MKUKUTA

This work is also linked with MKUKUTA Cluster Three on Governance and Accountability
Goal: Equitable allocation of public resources and effective control of corruption.
Targets: *(i) Public resources are allocated, accessible and used in an equitable, accountable and transparent manner; (ii) Institute effective regulations and mechanisms regarding petty and grand corruption.*

POLICY ENGAGEMENT

MACRO ECONOMIC POLICIES (2008 – 2009)

Through working in partnership with the Centre for Economic Governance and AIDS in Africa, RESULTS Educational Fund and Ifakara Health Institute HDT participated in conducting a study on the Impact of IMF policies to developing countries. This research was conducted in three countries i.e. Kenya, Tanzania and Zambia as part of a multi-country effort to explore the relationship between Macroeconomic policies and government spending for health in general and in particular HIV/AIDS and TB.

These factors limit the size of National Budget, Sectoral Budget and hence impact on the adequacy and quality of services. The IMF support policies favor aid "absorption" (increasing imports) rather than "spending" (increasing expenditures on domestic goods, services and human resources). This has limited the government's use of aid to upgrade the health system leading to:

- Poor health infrastructure and inadequate human resources for health.
- Stock out of drugs for opportunistic diseases and lack of nutrition especially among infants weaned due to AIDS
- Low absorption capacity of funds in particular development funds
- Corruption in the health system
- Poor incentives to attract workers in rural areas
- Poor health infrastructure
- Weak human resource capacity

Achievements in 2009 from engagement in Macro Economic Policies:
HDT has been able to expand its networking with other development partners like Centre for Economic Governance and AIDS in Africa (CEGAA), RESULTS Educational Fund and Ifakara Health Institute, the Parliament of Tanzania, Civil Societies, Media and has also been participating in the regional workshops, e.g. Breakfast Debates in Dar es Salaam.

Linkages with NMSF

This work is linked with the NMSF in the Financial, Human and Technical Resources framework of the national response.
Goal: Provide the necessary and appropriate financial and human technical resources for the implementation of the national response to the HIV epidemic through combined, coordinated and sustained efforts by the government of Tanzania, the private sector and civil society and development partners.

Indicator: Domestic and international AIDS spending by categories, financing sources and level of government.
Development using gender responsive approach and to develop relevant interventions.

CIVIL SOCIETY ORGANIZATIONS' COORDINATION (2006-09)

HDT together with ACORD, BAKWATA, CCT, TNW+, CHAWATA, TGNP, Care International, and Concern Worldwide with support from TACAIDS initiated the formation of the Tanzania AIDS Forum (TAF). The forum is a network of NGOs, FBOs, and International Organizations aiming to strengthen the voice of non state actors and improve the programming on HIV and AIDS. With its strong capacity of lobbying and advocacy in policy, HDT was elected as the secretariat and coordinates all TAF activities for two years. TAF was chaired by the Executive Director of HDT (Dr. Peter Bujari) and led by the board, which comprised of ten (10) member-CSOs.

Achievements in 2009 with the facilitation and establishment of TAF:

- The forum contributed to the revision of the current National Multi-Sectoral Strategic Framework for 2008 to 2012.
- Currently, the forum consists of 41 Members with signed MoUs in 10 Regions of Tanzania (i.e. Dar es Salaam, Arusha, Kilimanjaro, Mwanza, Dodoma, Rukwa, Tanga, Shinyanga, Kagera, Mbeya).
- TAF participated in several outstanding activities including the review of the AIDS Bill, capacity building to members on the UNGASS, condom programming, Male HIV and AIDS prevention program of UNAIDS, National HIV and AIDS thematic area technical working committee meetings (new dialogue structure), Joint thematic committee planning meetings and Coordinators Planning meetings organized by EANNASO. TAF organized and coordinated the CSOs' representation in the technical working group.
- HDT was elected as one of the two representatives in TNCM.

Linkage with NMSF

This work is linked with the NMSF thematic area 1: Cross Cutting Issues related to the Entire National Response (i. e. Enabling Environment)

Indicator: % of coordination structures at national, regional and district level that provide services according to their mandates in a satisfactory manner.

Linkage with MKUKUTA

Cluster three: Governance and Accountability:
Goal 5: reduction of political and social exclusion and intolerance
Target: develop political and social systems and institutions which allow for full participation of all citizens including the poor and vulnerable groups

LESSONS LEARNT AND RECOMMENDATIONS

- The advocacy on partnership with local institutions worked well: Reason being the high level lobbying done
- Changes in US policy worked well: Coincidence on presidential change
- Expansion of consultations of IMF worked well: The reason for this was the high level & strategic pressure.
- Budget analysis did not work well: Reasons being lack of sustained interventions (funds and officer).
- Expansionary policies did not work well: Reasons being limited funds, lack of government support and limited skills
- Advocacy can uplift image very quickly if done well. Can also damage if not done well
- Sustained interventions are required with multiple and strategic partners
- Advocacy needs high level skills and extensive knowledge including constant updates
- It is important to raise resources for advocacy, the area is not clouded yet.

HDT PARTNERS

HDT would like to take this opportunity to thank development partners who has worked with HDT for the last years. We would also like to thank those who have expressed interest to work with HDT and more importantly those communities whose life have been touched by our interventions and they have appreciated that. In the following, we provide list of partners who have supported the work of HDT, not in order.

AMREF/GFATM
AMREF being principal recipient for global fund, provided funds to HDT to implement a project in Mbeya. With significant results, AMREF increased the grant to HDT from about Tsh. 40 million in 2006 to about 400 million in 2009. We are indebted to this support and envisage showing more results hence increase of grants.

Voluntary Service Overseas (VSO)
Voluntary Services Overseas has worked with HDT since 2007 with annual grant of about 55 million and now up to 90 million. VSO has also supported about five volunteers to HDT at different times and different duration. We would like to thank them for this support

Egmont Trust
Egmont trust started its second year relationship with HDT supporting capacity building project. Including year 2009, Egmont trust has funded HDT over 70 million.

Other donors
We would also like to acknowledge support from Good Samaritan who contributed to HDT work. Other none individuals include Africa bridge, CEGAA, TACAIDS and Result Education Fund. We would also like to acknowledge support from partners who offered work to HDT and subsequently pay for it, money which supported non-donor funded projects and operation. These include Immigration Department, Marie Stopes International, Zanzibar AIDS Commission, Medicos Del Mundo, Oxfam International, Tanga AIDS Working Group, BP Tanzania Ltd and Vodacom.

Local Governments
We would like to express our heartfelt gratitude to leadership of the following districts for their support in the entire period. Rungwe, Kyela, Ngara, Biharamulo, Kinondoni, Muleba, Bukoba Rural, Mikindani and Mtwara District Councils.

Elton John AIDS Foundation (EJAF): We partner in implementing a project to improve the livelihood and community support to PLHIV and most vulnerable children (MVC).

HAT: We partner to improve access to Medical services and education to Rural Communities.

JOHNS HOPKINS UNIVERSITY: We partner to reposition family planning through increased political and financial commitment.

AMREF: We partner in projects related to HIV and AIDS and Gender Based Violence.

TMARC: We partner in implementing projects project that support parents and guardian to improve their communication skills.

HUMAN DEVELOPMENT TRUST

REPORT OF THE MANAGEMENT TEAM
FOR THE YEAR ENDED 31 DECEMBER 2010

5 RESULTS

Human Development Trusts income is derived from grants and donations and also from different consultancy services offered by the staff to other organizations/ institutions. Summary of funds received during the year ended 31 December 2010 is presented on page 10. The use of these funds in the year ended 31 December 2010 and the state of financial position on that date is shown in the Statement of Income and Expenditure and Statement of Financial Position on pages 4 and 5 respectively.

6 STATEMENT OF DIRECTORS AND MANAGEMENT'S RESPONSIBILITIES

It is the management team's responsibility to prepare financial statements for each financial period that gives a true and fair view of the state of affairs of the Trust as at the end of the financial period and of its surplus or deficit for that period. The management team is also responsible for keeping proper accounting records, for taking reasonable steps to safeguard the assets of the organization and for preventing and detecting fraud, error and other irregularities.

The Directors and Management accept responsibility for the annual financial statements, which have been prepared using appropriate accounting policies supported by reasonable and prudent judgements and estimates, in conformity with International Financial Reporting Standards. The Directors and Management are of the opinion that the financial statements give a true and fair view of the state of the financial affairs of the company and its operating results. The Directors and Management further accept responsibility for the maintenance of accounting records, which may be relied upon in the preparation of financial statements, as well as adequate systems of internal financial control.

The financial statements were prepared on an accruals basis and in conformity with the International Financial Reporting Standards.

Nothing has come to the attention of the Directors' and Management's to indicate that the organization will not remain in going concern for at least the next twelve months from the date of this statement.

7 AUDITORS

MEKONSULT were appointed auditors of the Trust's financial statements for the year ended 31 December 2010. The auditors MEKONSULT have expressed their willingness to continue in office and are eligible for re-appointment. A resolution proposing the appointment of auditors of the organization for the year ending 31 December 2011 will be put to the Annual General Meeting.

On Behalf of the Management Team

.....
Executive Director

Date: 30-06-2011

.....
Director of Finance and Administration

Date: 30-06-2011

MEKONSULT
Certified Public Accountants

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Website: www. mekonsult.co.tz

AUDITORS' REPORT
TO THE BOARD OF TRUSTEES OF HUMAN DEVELOPMENT TRUST

We have audited the accounting financial statements of Human Development Trust which comprise the Statement of Financial Position, the Statement of Comprehensive Income, Statement of change in Equity, and the Statement of Cash Flows as at 31 December 2010 then ended and a summary of significant accounting policies and other explanatory notes.

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.

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 2010, and of its financial performance and its cash flows for the year then ended in accordance with International Financial Reporting Standards.

MEKONSULT
MEKONSULT
Certified Public Accountants
DAR ES SALAAM

Signed by: Elinisaidie K Msuri
Partner

Date: 30/06/2011

HUMAN DEVELOPMENT TRUST

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 DECEMBER 2010

INCOME	**Notes**	**2010**	**2009**
		TZS	TZS
Grants revenue	**3**	941,788,467	287,997,767
Release of capital grants		14,367,910	13,725,609
Release of deferred grants		363,745,352	60,360,678
Consultancy income	**4**	52,000,000	67,877,828
Other income		800,362	4,883,060
Total income		**1,372,702,091**	**434,844,941**
EXPENDITURE			
Policy advocacy		83,564,329	57,444,060
Service Delivery		698,052,995	146,706,682
Capacity building		226,783,602	122,058,261
Depreciation		41,339,601	27,048,581
Loss on Assets disposal		-	69,625
Anniversary		-	19,029,700
Loss on TAF split		-	4,716,000
Loss on stolen items		-	808,000
Central costs		95,276,924	63,666,837
Overhead costs		45,038,462	31,833,418
Total Expenditure		**1,190,055,913**	**473,381,164**
Surplus for the year		**182,646,178**	**(38,536,223)**

The Statement of Income and Expenditure is to be read in conjunction with the notes to and forming part of the financial statements set out on pages 8 to 12.

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HUMAN DEVELOPMENT TRUST

STATEMENT OF FINANCIAL POSITION
AT 31 DECEMBER 2010

	Notes	2010 TZS	2009 TZS
Non-current assets			
Property and Equipment	5	73,257,640	50,638,392
Current assets			
Prepayments and advances		51,070,326	48,716,508
Accounts receivable		2,581,875	2,671,875
Cash and bank balances	6	207,206,823	309,983,096
Total current assets		**260,859,024**	**361,371,479**
Total assets		**334,116,664**	**412,009,871**
Equity and Liabilities			
Capital and reserve			
Accumulated Surplus		214,485,449	31,839,271
Capital grants	7	8,550,716	16,418,626
Equity		**223,036,165**	**48,257,897**
Current liabilities			
Deferred grants	8	56,802,314	363,745,352
Accounts payable	9	54,278,185	6,622
Liabilities		**111,080,499**	**363,751,974**
Total equity and liabilities		**334,116,664**	**412,009,871**

The Statement of Financial Position is to be read in conjunction with the notes to and forming part of the financial statements set out on pages 8 to 12.

.....
Executive Director

Date 30-06-2011

.....
Director of Finance and Administration

Date 30-06-2011

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HUMAN DEVELOPMENT TRUST

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 31 DECEMBER 2010

Details	Accumulated surplus TZS	Capital Grant TZS	Total TZS
At 1 January 2009	74,099,299	30,144,235	104,243,534
Release to income statement	-	(13,725,609)	(13,725,609)
TAF's Portion of Income Statement	(3,723,805)	-	(3,723,805)
Surplus/(Deficit) for the year	(38,536,223)	-	(38,536,223)
At 31 December2009	**31,839,271**	**16,418,626**	**48,257,897**
At 1 January 2010	31,839,271	16,418,626	48,257,897
Addition for the year	-	6,500,000	6,500,000
Release to income statement	-	(14,367,910)	(14,367,910)
Surplus during the year	182,646,178	-	182,646,178
At 30 December 2010	**214,485,449**	**8,550,716**	**223,036,165**

The Statement of movement in Reserves is to be read in conjunction with the notes to and forming part of the financial statements set out on pages 8 to 12.

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ANNEXES

I. FOUNDERS, BOARD AND STAFF

THE FOUNDERS

John Simon Malanilo

Dr. Peter Bujari

Ms. Hawaa Nashivai Mollel

Dr. Millembe Panya

BOARD MEMBERS 2009 - 2010

 Ms. Christine Mwanukuzi Kwayu	 Mrs. Halima Shaliff	 Dr. Millembe Panya
 Mr. Reginald S. Miruko	 Dr. Peter Bujari	

II. STAFF OF HDT IN 2009 – 2010

Name & Position	From/to	Name & Position	From/to
DSM Office			
 Dr Peter Bujari **Executive Director**	2006-todate	 Agnes Kisala **Finance & Administration Officer**	2007-todate
 John Simon Malanilo **Director of Programs**	2004-todate	 Felix Sukums **IT Officer**	2009-todate
 Geoffrey Isack **Director of Finance & Administration**	2007-todate	 Violet Mathew **Program Assistant**	2009-todate
 Jaliath Rangi **Program Officer-Capacity Building**	2009-todate	 Halifa Juma **Driver**	2009-todate
 Jackline Nusurupia **Program Officer-Advocacy**	2009-2010	 Emanuel Makwaya **Office Assistant**	2010-todate

Kagera Regional Office			
 David Bukozo **Regional Program Manager**	2007-todate	 Moses Kabogo **Regional Program Officer**	2008-todate
 Mixcus Buzoya **Driver**	2010-todate		
Mbeya Regional Office			
 Dickson Mbita Regional Program **Manager**	2009-date	 Henry Siwale **Driver**	2007-date
 Alice Edwin **Office Assistant**	2010-date		

Volunteers/Part-time Support			
 Elaine Sammarco **Dar Es Salaam**	2008-2010	 Noumi Oosterwijk **Dar Es Salaam**	2009-2010
	2010-date	 Riziki Benjamin **Mbeya**	2010-date

III. ORGANOGRAM