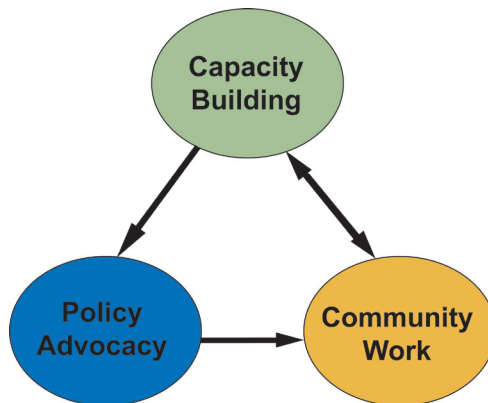




HUMAN DEVELOPMENT TRUST (HDT)

2005 ANNUAL REPORT

HDT's Operand Module



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The list of Acronyms

AB	Africa Bridge
ABC	Abstain Be faithful and Condom
AIDS	Acquired Immune Deficiency Syndrome
CMAC	Council Multisectoral AIDS Committee
CSOs	Civil Society Organizations
DAC	District AIDS Coordinator
DFID	Department for International Development
DOTs	Direct Observed Therapy
HBC	Home Based Care
HDT	Human Development Trust
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activities
NEPHAK	National Empowerment of People Living with HIV and AIDS in Kenya
NPF	NGO Policy Forum
MDA	Ministry Department Agency
MKUKUTA	Mkakati wa Kupunguza Umasikini na Kukuza Uchumi Tanzania
MOU	Memorandum of Understanding
OD	Organizational Development
PEs	Peer Educators
PRSP	Poverty Reduction Strategy Paper
SIPAA	Support for International Partnership Against AIDS in Africa
SRH	Sexual Reproductive Health
TACAIDS	Tanzania Commission for AIDS
TAYOPA	Tanzania Young Positive Ambassador Living with HIV
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
WOFATA	Women Fighting AIDS in Tanzania

Views from the Chairperson of the Board



Dear readers,

We have faced some challenge in the past year, which we want to turn into opportunities in 2006. I am delighted that most of them have been addressed in our three year strategy. I predict and I see the year 2006 to be quite involving, in which quality assurance, documentation and sharing can not be over emphasized.

Indeed I want to commend for the development of three year-organizational strategic plan because it leads our organization to be more organized, coherent and focused. We will prioritize three districts in three regions of Dar Es Salaam, Mbeya, Kagera, and strength our national engagement.

I also see quite some innovation in the approach we are taking, which I believe needs to be tested, proved and shared. To cite a few, they include HIV/AIDS programmatic focus to men, economic support to foster families as a strategy to help most vulnerable children, land inheritance for orphans, CSO coordination and engagement in MKUKUTA implementation and review.

For Human Development Trust to be able to achieve what is planned, it requires substantial financial support. I call for development partners, the government and private sector to support us in these initiatives.

Finally, I call for concerted efforts to support HDT to realize development for all.

Sincerely yours,

A handwritten signature in black ink that reads "Mwanukuzi".

Christine Mwanukuzi –Kwayu
Board Chairperson

Message from the executive Director



Dear partners in development work,

Greetings from HDT!

Starting an organization and having it fully functioning requires a not only rigorous work but also innovation. And indeed this annual report exemplify that HDT family (the board, staff and partners) have been able to do it. It is a testimonial that HDT is growing with more potential in future.

I am happy to join this organization as Executive director, a position I feel offers more opportunities and challenges to excel in being among the best innovative, transparent and serious organization to serve this country. It is another opportunity as a co-founder realizes my dreams.

Special recognition goes to the HDT family which made funds available to run programs and the organization. In particular, I salute TACAIDS and DFID through their SIPAA program. I want to recognize the partnership with Oxfam International for the work to support their 12 partners to develop and implement work place HIV/AIDS program.

As an organization, we are looking the year 2006 as a year of challenges and opportunities. We foresee more partnership with different stakeholders both in the implementation of current interventions and forthcoming innovative programs set out in the 2006 annual plan which is drawn from the three year strategy.

Lastly but not list, the lessons we registered in 2005 will form the basis of our action to remedy. Our programmatic response draws from serious reflection and appraisal of the current interventions and therefore requires support. Kindly join us in these endeavors.

Sincerely

A handwritten signature in black ink, appearing to read 'P.S. Bujari'. The signature is written in a cursive style with a horizontal line under the first name.

Dr. P.S. Bujari
Executive Director

ORGANIZATIONAL BACKGROUND.

1.1. Preamble:

Human Development Trust is a registered national non-government organization operating both at grass root and at national level. The experience of local and national context bolsters the capacity of HDT to articulate relevant issues as well as supporting the arguments. HDT is spearheaded by competent staff and managed by committed board of Trustees all of which exemplify its capacity and credibility. We have external pool of consultants with interest to avail their expertise to contribute to the organization which strengthens our organization to step up our un restricted funds.

1.2. Human Development Trust's Strategic Commitment to HIV, policy process and poverty reduction.

From a development perspective, the fight against poverty can be thwarted, given the relationship between HIV/ AIDS and poverty. This is because HIV is intimately linked to poverty, and this relationship is bi-directional. HIV/AIDS has impacted on all aspects of development in Tanzania, affected all classes of people and all regions of the country including government ministerial workers private sector, business sector leading into reduction of productivity, increase medical expenditures, reduction of household savings and assets, reduced labor availability and increase the burden on carers.

There is an estimation of over 1.8 million adult living with the virus (the majority of them unaware of their status) and over 1.5 million orphans in Tanzania¹. Yet behind all of these statistics, the grim reality is of individuals and families who face death, bereavement and poverty as a result of this silent pandemic.

The burden of caring for infected individuals and for orphaned children falls disproportionately on women. Understanding this,

HDT is committed to explore and develop project that link poverty and HIV as well as reduction of its impact to the livelihood of children in difficult circumstances especially those cared by old people. Policy analysis and advocacy for favorable policies related to poverty, HIV, children, women youth and old people's rights remains the core business of the organization.

HDT's contribution to implement MKUKUTA cluster one, is evident through its support to institutions to develop work place program. The seven teen institutions supported so far is projected to increase in the course of next year. Through out next year, we will invest in developing a tool to guide institutions to develop sustainable work place program.

1.3. Vision and Mission

Our vision is a society where healthy is a priority, where rights of children, youth, women, men and old people are respected in all undertakings². To achieve the above vision, our mission is to pioneer the new standards of equity for women, children, youth and old people through out the country by working with communities and their organizations.

1.4. Objectives of HDT

- 1.4. 1. To design with communities and implement projects targeting youth, children, women and old people to improve their quality of life.
- 1.4.2. To build the capacity of community groups and other organizations in areas including Organizational development, advocacy, partnership and HIV/AIDS programming.

¹ THIS: *The Tanzania HIV/AIDS Indicator Survey, key findings; Dar Es Salaam April 2005*

1.4.3. To work with other organizations and networks to contribute to the creation of favorable policies for human development in and outside Tanzania.

1.5. Human Development Trust's Values and culture

To address poverty and HIV, we seek to be:

1. Collaborative
2. Accountable
3. A change agent
4. Innovative
5. Cost effective
6. And empowering communities and families for sustainable development

1.6. Commitment of Human Development Trust

1. We commit to listen to people we are serving and make their voice not only heard, but also feeding into the 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 pioneer the rights and quality of life for old people, including but not limited to social-economic, legal and health endeavors.
4. We are committed to advocating for the health of children, women, old people and youth through out Tanzania, particularly those in difficult circumstances.

² Health is defined as a state of well being and not merely the absence of disease or infirmity.

ACHIEVEMENT IN 2005

2.0. CAPACITY BUILDING

2.1. Organizational Development, Advocacy and Partnership.

Capacity building undertaken by HDT is a means to an end than an end to its self. In partnership with TACAIDS/SIPAA program, we undertook capacity building to CSO on Organizational development, Advocacy and partnership to 30 CSOs. Low capacity for CSO as appreciated by many stakeholders is among the obstacle for CSO to undertake strategic HIV/AIDS interventions. Other factors includes the shortage of highly skilled human resource to implement the HIV/AIDS programs, limited experience and expertise in building program partnerships, duplicated efforts, pressure from development partners who sometimes request for delivery of unrealistic targets, and cultural conflicts issues.³

CSO trained came from Dar Es Salaam, Cost, Morogoro, Dodoma and Kilimanjaro. The main focus was on Organizational Development, Advocacy and Partnership.

The objectives of training included enabling participants to analyze and acknowledge the levels of organizational complexity, understand source of vision and mission, undertake SWOT analysis for their organization, understand basics of advocacy and principles as well as the tradeoffs for partnership and networking.



Participants during CSO training at Njuweni hotel

During the workshop evaluation, participants acknowledged that the training was useful to them as individuals and as an organization. It was also acknowledged that this served as introductory because there were many important topics to be covered in a short span of time. It was recommended that on site support to organizations would be more useful.

I feel now knowledgeable on how to manage my organization, but I am sure I need more to do betterSays N.M from Kilimanjaro

I did not know advocacy was important to what my organization is doing, but now I know its importanceSays J.J of Dar Es Salaam.

I have learnt that my staff should know what my organization is doing to better support it to reach its target I will not hide documents for staff any moreSays J.H of Kibaha

During this assignment a number of lessons were acknowledged which are worth sharing in this report. They include that: CSO works individually and do not share information both within the organization with similar minded organizations. There is noticeable weakness in governance, setting up systems and structures. In many cases the systems of management are closed type which more often than not does not allow growth.

As an organization we have learnt to ensure transparency within the organization and making sure that we all move as a team.



On site support to CSO in Iringa

3

Action Aid Int: Dar Es Salaam 2004, Factor limits CSO to access in country funding

The second part of capacity building suffered in some ways inadequate funding. Nevertheless, we provided on site support to CSOs on one hand to verify what has been their experience since training and new challenges. The priority this time was on strengthens partnership and advocacy among CSO.

Through this mode of operation, we managed to support 43 CSO (16 Iringa, 10 Kibaha and 17 Dar Es Salaam) which was beyond the target of supporting 30 CSO. This was 140% of what was expected.

We noted key observation which again requires sharing as they present challenge and needing support. Most of CSO were unable to acknowledge how advocacy can contribute to their mission, meaning that they mostly serve as relief organization. Partnership among CSO at local level was indeed weak and forum for coordination does not exist.

On their side, they called for continuous support as capacity building could not be achieved in a day. They also recommended for HDT to follow up and assess the result of the work done, which could not be done for the reason aforementioned.

2.2.HIV/AIDS, Sexual Reproductive Health and skills building

A number of interventions in this area has been done including support institutions to develop and implement HIV/AIDS work place program, training of Peer Educators, undertaking school health program on HIV/AIDS, Sexual Reproductive Health and Life skills.



Participants at Peer Educator Refresher training in Arusha

2.2.1. HIV/AIDS work place program.

This program has been implemented in partnership with different institutions and Charging user fee. This is done for two main reasons, on the first hand is to show institutional commitment and on the other hand this fund is used to run the organization and implement community programs. Through out the year, we worked with seventeen institutions. This program has brought on board new partners including Oxfam International⁴ and TAWG. Maintenance of the existing partners such as BP Ltd and Voda com certainly exemplifies our strength in the area and we will aspire to be much more professional. Training and supporting institutions has created opportunity to learn that there is still high denial among institutions in terms of how they are affected by HIV/AIDS. This is exemplified by the fact that institutions focus the neighborhood than them selves. This area requires advocacy, leadership and emphasize for leaders to by in.

We also leant that it was not clear what and how a work place program should look like, steps and how do one measure. Lack of such guideline may have contributed to institutional focal person not knowing what they should do.

HDT pledges to work around this area to produce a tool for work place programs to be used by institutions. It will enable institutions to gauge where they are and where they should aspire to reach. We are optimistic that the tool will be available in the course of 2006.

2.2.2. Sexual Reproductive Health and HIV program in schools

There are debates on whether school children should be taught HIV/AIDS or not. The community presenting mixed views, some

⁴ OI supports its partners to develop and implement work place program and HDT was selected as service provider. We support 1 partners located in Northern zone (Kilimanjaro, Arusha and Manyara

feels not and others feel it should be. Using available studies and experience, we feel that they should be taught, but the information should be filtered for age and is should bank on the life skills than ABC.

Working in partnership with Tanzania 4H organization⁵ we trained 129 (64% being females) schools children as peer educators in HIV/AIDS, Reproductive Health and Life skills. Mechanism was designed to ensure that these peers have opportunity to disseminate and establish dialogue among them selves. Since the school children are organized in clubs, we also trained 79 (30 males and 49 females) club advisors to be able to support children when they need guidance.

The main objective of the training was to provide peer educators with basic knowledge and facts on HIV/AIDS, Reproductive Health and Life skills. The following topics were covered; The concept of Sexual Reproductive Health, Reproductive Organs, Changes during adolescence, Facts on HIV/AIDS and STI and Life skills.

The facilitation technique employed participatory problem solving approach, exploring what school children knew, demystifying the misconception and giving the facts. To assess the achievement of the training, post training evaluation was done and we concluded that the training objectives were met as 84% of participants scored above 50%. Testimonial from participants below exemplify the usefulness.



Participants in one of the group discussion

I was once told that once I start getting wet dreams I should get a girl, but now I know that they are normal signs of growth...Says M.J a participant in the training.

I had asked all these questions to my aunt but she did not tell me, now I know how STI and HIV are transmitted... I will prevent myself... Says J.B one of the participant.

I have now realized that as a teacher I am a risk for HIV infection, I will take care of myself and mobilize my fellow teachers...Says Z.H one of the teacher.

As an organization, we learnt that although this was retraining; some participants were new, which inform us to ensure continuity for quality programming and program memory. We noted some difficulties due to age differences and big number of participants. In future we will check these factors as they affect the quality of program.

2.3. Support to partners

HDT has been providing technical support to organizations of PWHA. We have so far established partnership with WOFATA and TAYOPA. The former being an organization of women living with HIV and the latter HIV/AIDS youth ambassadors. Our support to TAYOPA has been demand driven and more often hands off to allow growth.



HDT Africa Bridge signing Partnership agreement

Working with NEPHAK, we supported the strategic process and development of the same for WOFATA covering 2006-2009. This was a learning exercise especially where HDT was preparing to do one.

⁵ 4H stand for Head, Hands, Heart and Health. 4H is a Tanga based organization which works with school children in IGAs

Support to TAYOPA has been on and off mostly when they need technical input in issues of organizational development and or project management.

HDT has signed a Memorandum of understanding with Africa Bridge, to work together in improving lives of children in difficult circumstances in Tanzania.

The year 2006 will form a year of challenge for HDT to define precisely the partnership concept and levels of engagement. More partners will be identified for mutual benefit.

2.4. Documentation and publication

Documentation of lessons from year 2005 was a challenging among the reasons being lack of equipments. This section will require attention across program management. Documentation was done during advocacy training and culminated into development of advocacy training manual for CSO which is available at www.hdt.or.tz/resources. Other resources developed are also available in this section.

A number of resources has also been developed and shared through the website and link above. HDT will aspire to produce more document and share. As an attempt to formalize our work and share our experience, the Peer Educator manual adopted in Kiswahili has been developed and tested. Final testing will be done in 2006 and sharing done using available links and networks.



3.0. POLICY ADVOCACY

Policy formulation and implementation is an important part of CSO work. It is arguable that CSOs working on policy influence and implementation are likely to register success than those focusing on service delivery only because they are able to forecast and adjust accordingly. HDT is building on this to work on policy issues related to HIV and or poverty as there is a bidirectional relationship between these.

3.1. Strategic engagement in PRSP review and AIDS mainstreaming in MKUKUTA ⁶

HDT recognized the importance of engaging in policy advocacy from its inception. Working in the framework of NGO Policy Forum, through the PER Working Group⁷, we contributed to the voice of CSO in the review of poverty Reduction Strategy one through a series of workshops.

Unlike the PRSP 1 which had priority sectors, the PRSII, popularly known as MKUKUTA is outcome oriented categorized in three clusters. Our main role was to ensure that HIV is mainstreamed into the strategy as a means to reduce poverty.



Participants during a workshop to mainsteam HIV in PRSP

Through a series of advocacy and lobbying meetings and support from TACAIDS and UNDP, HIV is mainstreamed in cluster one and two. Cluster one address the economic growth while two focuses on social well being. We noted with concern that cluster three (governance and accountability) did not include HIV/AIDS issues which in our opinion we feel that HIV is yet to be perceived as development, governance issue but social well being. In any case we and as a group were proud of what has been achieved because we believe is a good beginning. We will in the course of 2006, engage partners in demystifying MKUKUTA and working with them to identify areas they should engage in at local level.

3.2. Engagement with HIV/AIDS PER working group of Policy Forum

This group has expanded the scope and focus and has started focusing much more strategic business including fact findings as a basis of advocacy. In the year 2005, We have been active into voicing CSO views, reviewing the HIV/AIDS Public Expenditure report and disseminating the same to the our partners.

In an attempt to undertake effective advocacy work on participation and decision making of CSO and community groups at district level, this group undertakes an evaluation of 26 Council Multisectoral AIDS Committee. Where as the findings is still a draft, few issues needs to be highlighted. On the first place, 33.8% of the committee meet quarterly and 35.2 % meet on ad hock basis. 24.4% of respondent reported that their CMACs had no out standing authority (mostly from Singia, Dodoma and Pangani). Of interest to mention is that up to 50% of the council interviewed indicated to disclose the HIV/AIDS budget to

⁶ MKUKUTA is a popular name for the National Strategy for Economic Growth and Poverty Reduction where CSO did input heavily on integration on cross cutting issues including HIV and AIDS.

⁷ Members of this group include: Oxfam Ireland, Tanzania Gender Networking Programme (TGNP), Concern, CARE International, ACORD, Save the Children, Research on Poverty Alleviation (REPOA), PACT, Voluntary Service Organization (VSO), Action Aid, Youth Action Volunteers, Kuleana, Transparency International, Amani ECCD, Human Development Trust, Shinyanga Foundation Fund, TADESO, Youth Empowerment for Sustainable Development and Youth Partnership Countrywide.

stakeholders⁸ Reflecting on this, one could argue probably the fundamental reason is that CMACs do not have the full status of a standing committee and this explains why unlike the other three Council Standing Committees; they are not provided with adequate funds for their needs. We have also learnt that CMACS do not get full support from the councils (from the chairperson and director)

Through the PER working group we have contributed our voice into the policy options for consultation from the ministry of finance on financial framework. We will still engage in this through engagement in budget cycle process and General Budget Support discussion.

⁸ *PER working group: CMAC evaluation report draft 3, January 2006*

4.0 Organizational issues

4.1. Board of Trustees' Commitment

The founders of the HDT felt that expansion of the board will benefit the organization in many ways. The board of Trustees therefore expanded from four to eight, bringing in diverse professional background. The founder members are acknowledged to be Dr. Peter Bujari, Mr. John Malanilo, Dr. Millemebe Panya and Ms. Nash Hawaa Mollel. The board became strong when was joined by new trustees namely Dr. Fabian Ndenzako, Mrs. Christine Mwanukuzi-Kwayu, Mrs. Feddy Mwanga and Dr. Ann May.

The contribution of the board has been outstanding as they managed to meet both during their statutory meetings and extraordinary. Temporary movement of the trustees out side Tanzania has to some extent weakened their participation and contribution to the organization matters, though they remain committed. We salute the leadership of Mrs. Christine Mwanukuzi-Kwayu for leading the team.

4.1.1. Chairperson of the board Ms. Christine Mwanukuzi-Kwayu, (mnyamizi@hotmail.com)

Mrs. Kwayu is currently the national programme officer responsible for gender and HIV/AIDS with the United Nations Population Fund (UNFPA) in Tanzania. She has worked with local and International Organizations with task ranging from training, advocacy, SMEs, human rights and natural resources.



4.1.2. Board Secretary and Executive director,

Dr.Peter Bujari

(dr_bujari@hdt.or.tz)



Dr. Bujari is a co-founder of the organization and has been supporting the organization since its inception including set up and subsequent advising on strategic direction. His commitment leads to the board confirming him as executive director from February 2006 as he moved from Oxfam.

4.1.3. Dr. Ann May PhD,

(amaydar@yahoo.com)



Is a social anthropologist who has conducted research in Tanzania since 1992. Her research has focused on the circumstances of rural-urban migrant youth known as wamachinga; the engagement of pastoralists in tourism in northern Tanzania and its effects on Maasai culture; and the recent large-scale migration of Maasai to cities for wage labor.

4.1.4. Ms. Feddy Mwangi

([mwangaf@tz.afro.who.int.](mailto:mwangaf@tz.afro.who.int))



Ms. Mwangi a medical anthropologist who currently works as national program officer with WHO on HIV/AIDS community care. She has a diverse work experience both in clinical and non clinical work. Her experience and expertise ranges from training in colleges to more challenging development work related to health and management.

4.1.5. Mr. John Malanilo, a co founder

(j_malanilo@hdt.or.tz)

A teachers by profession, with over eight years in managing programs related to children in difficult circumstances. He was the first full time volunteer as he moved from being center manager for Tuamoyo Family Children Center in Kigamboni.



4.1.6. Ms. Nash Hawaa Mollel, a co founder

(nash_mollel@hdt.or.tz)

Nash is a dynamic and committed young lady with diverse skills in counseling, youth life skills and Information technology. Her motivation lies mainly in women empowerment with particular emphasis on removing the bondage of traditional customs affecting Maasai women as well as economic emancipation.



4.1.7. Dr. Millembe Panya, a co founder.

(millembepanya@yahoo.com)

Dr. Panya is a medical doctor with specialty in child health. She is motivated to advocate for community child health as well as their rights. She has a special training in care for patients with AIDS including ARVs.



4.1.8. Dr. Fabian Ndenzanko,

(ndenzako@yahoo.com)

A Medical Doctor (MD, MPhil) specialized in International Community Health. He has vast experience in the field of public health at Community, National and International level. He is currently working with WHO country office in New Papua Guinea leading the Universal access initiatives for ARV's



4.2. Staff expansion and development.

Beginning 2005, HDT had one full time volunteer who became the first staff for the organization. The number of staff increased from one to three in the course of the year. We also worked with five different volunteers with different specialty who in many ways needs to be recognized for their contribution. Special thanks goes to Dr. F. Manase, Ms. Felista Mbwana, Ms. Asha Mweke, and Dr. Tatizo Waane who volunteered to work with HDT in the course of 2005.

A special thanks also goes to staff namely Mr. John Malanilo, Rose Kabuje and Yovitha Mrina. Dr. P.S. Bujari is acknowledged to have provided technical advice for the organization who have now joined the team as executive director.

Although capacity building to our own staff is our culture, we have been constrained by our resources. Even though, we managed to sent one staff for advocacy training at Mapambazuko Arusha, skills we believe are core to the business of our organization.



4.3. Communication and Public relations

This area has started receiving attention. The challenge is how do we share what we are generating which may be of interest to others. We developed communicating material in form of leaflet and has been distributed widely. Development of the website (www.hdt.or.tz) for the organization forms a point of departure for HDT to post information which may be useful to other stakeholders. See section 2.3 on resources available. We are taking this opportunity to invite stakeholders to visit our website and join us.

Human Development Trust (HDT)



5.0 KEY LESSONS IN 2005.

Lesson one: Sexual, Reproductive Health and life skills training in school should aim to lead children to plan for their future life.

We noted that school children were aware of sexual matters and often information which had been provided to them in many ways was not banked on the life skills. The approach we recommend is one which give the facts then instill life skills and decision making process for the children to be able to look ahead. Half backed information on HIV and STI can be as distractive as the disease them selves.

Lesson two: Civil Society Organizations needs to be supported to improve their capacity as a means to the end not as an end.

The capacity of CSO to articulate programs will heavily depend on their capacity. Although there is high commitment, the capacity to facilitate communities to articulate relevant interventions is lacking. The support provided by HDT, was of small magnitude and suffered shortage of funds. Many of CSO are crying of no funds despite increased in country funding for HIV, which in 2004/5 about 148 billion was made available in Tanzania. Strategic thinking is required to break through the stratum and reach the community.

Lessons three: Civil Society Organizations have not acknowledged how policy advocacy can help them achieving their mission.

We have experienced that many CSO feels that they have been formed to provide services to the community and not to occupy the third sphere of society left by state and private sector. By occupying this sphere, they are charged with holding the government responsible while at the same time complement its efforts. We

feel that CSO in Tanzania needs to be supported individually and in groups to engage in policy dialogue to demand transparency for the allocation, judicial use of government resources. This notwithstanding, CSO themselves should start cleaning their house before they go out.

Lesson four: There is poor coordination among CSO and engagement with government.

Although at district level, CMAC is supposedly the forum where CSO can engage with the government, current reports indicate that they have limited voices. See section 3.2. Coordination among CSO themselves is weak and in many areas does not exist. At National level, there is no coordination and working with other stakeholders, HDT will in the course of 2006 invest into having this national coordination being fostered.

Lesson five: HIV/AIDS interventions require partnership between medical and non medical personnel.

Defining the thematic areas in the National Strategic Framework, has opened doors for different stakeholders to engage in different activities, therefore noting importance of other specialties in the struggle. Our medical and non medical staff have worked together with success to train communities on HIV/AIDS, Reproductive Health and Life skills. Many of interventions on prevention, care and support and impact mitigation are now being carried out by non medical people. We encourage all Tanzanian to acknowledge that HIV is every ones problem and each should define what they can do starting with themselves.

6.0 NEW AREAS OF ENGAGEMENT FOR YEAR 2006

In order to be more strategic and effective, HDT has developed the three year strategy covering 2006 to 2008. The strategy evolves from a quick scan, review and reflection by HDT family on the trend and current focus of HIV/AIDS intervention and poverty reduction. This strategy prioritizes work both at national and local level , and this is because we believe that they all feed into each other. Regional wise, the strategy priorities Kinondoni in Dar Es Salaam, Rungwe in Mbeya and Ngara in Kagera. At national level it prioritizes the work in policy analysis and advocacy, Networking and coordination among CSO and HIV/AIDS work place programs.

6.1. Strategic HIV/AIDS interventions

6.1.1. Prevention.

Our strategy in prevention prioritizes men both in and out of school without excluding women. A particular emphasis on men is employed so that men can be responsible for their decision. The hypothesis behind the approach is that if men become at the centre of epidemic and responsible then the risk to women will decrease.

6.1.2. Care and Support.

Our approach in this will be innovative.

We will provide Home Based Care in collaboration with health facility. We will link VCT, community DOT⁹, health facility so as to have comprehensive program. Unlike many of the VCT, we will have community counselors who will be giving supportive counseling. Approaches to work with those taking care AIDS patients will be strengthened as efforts to reduce stigma while emphasizing for the formation of support groups.

⁹ *DOT stands for Direct Observed Therapy for Tuberculosis*

6.1.3. Impact Mitigation.

This area will support affected families particularly those fostering orphans in more holistic way. Old people supporting orphans will be prioritized. The focus will be on improvement of the economic level for the foster families. MVC committee will be established and funds generated through community contribution which will be matched with support from external source. Approaches to support orphans psychosocially will be done to increase their self esteem and feel belonging to the community. We will work with local government to ensure that orphans inherit land which will make them feel that they are important part of the community.

6.2. Capacity building.

The capacity building program will work beyond the prioritized regions. We will support local organizations on organizational development and advocacy. We will catalyze the CSO coordination at local level. Another priority area will be building the capacity in HIV/AIDS programming. Supporting institutions to develop work place programs will be a priority as well as developing tools for the same.

6.3. Policy analysis and advocacy.

This will be central to the work of HDT. The engagement with Public Expenditure Review Group of NPF will be continued. With Executive Director leading this work, we will join the membership of Policy Forum, through which the main engagement will be on PER, budget cycle and MKUKUTA. In Rungwe and Ngora district, we will facilitate CSO to acknowledge how policies are important for them to operate smoothly as well as how advocacy can help them or frustrate them to achieve their vision. Discussion will be facilitated at local level on role of LGA and CSO in implementation of MKUKUTA.

6.4. Partnership and networking.

HDT will strive to develop its partnership strategy and levels of engagement. The Memorandum of Understanding with Africa Bridge will be implemented for the mutual benefit. We will seek and strengthen partnership with other actors with similar mission. Of particular priority are the development partners and government through TACAIDS and other government departments.

6.5. Institution strengthening.

HDT will strengthen in terms of capital items and human resource. To be able to deliver the strategy, HDT expects to have nine staff in the course of 2006.

7.0. FINANCIAL STATEMENT

HUMAN DEVELOPMENT TRUST

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2005

Statement of accounting policies

The following accounting policies have been applied consistently in dealing with items which are considered material in relation to the financial statements of Human Development Trust.

Basis of preparation

The financial statements have been prepared on a cash-basis of accounting in accordance with the accounting policies as set out below, which have been approved by the Board of Trustees.

In relation to the accounting treatment of the acquisition of property, plant, equipment and stocks, the organisation's policy is to expense these immediately to the statement of income and expenditure at acquisition. This is deemed to be a more appropriate accounting treatment than the treatment normally afforded to such transactions to be recorded as assets subject to annual depreciation charges as these assets are utilised or consumed. However, control measures are in place to safeguard the fixed assets including maintenance of Fixed Assets Register.

Income

Incoming resources are recognised by inclusion in the statement of income and expenditure only when received in the form of cash or of other assets, the ultimate cash realisation of which can be assessed with reasonable certainty.

Expenditure

Expenditure is recognised and recorded on a cash basis.

Fixed Assets

All items of property, plant and equipment are expensed to the statement of income and expenditure in the year of acquisition.

Stocks



All items of property, plant and equipment are expensed to the statement of income and expenditure in the year of acquisition.

Registration

The Trust was incorporated under the Trustees' Incorporation Ordinance (Cap.375) with Certificate of Incorporation no.2860 on 16 July 2004.

**HUMAN DEVELOPMENT TRUST
STATEMENT OF INCOME AND EXPENDITURE
FOR THE YEAR ENDED 31 DECEMBER 2005**

	Note	2005 Tzs
INCOME		
TACAIDS Grants	1	24,950,000
Consultancy income	2	32,707,000
Other income		204,500
		57,861,500
EXPENDITURE		
Capacity Building		20,969,930
Non-expendables: office equipment		3,122,500
Staff salaries and wages		12,098,620
Communication		1,881,100
Advertisement and networking		1,682,000
Office rent		1,620,000
Renovation and maintenance		1,692,650
Stationeries		1,088,460
Other expenses		2,560,245
		46,715,505
Surplus for the year		11,145,995
Surplus at the beginning of the year		640,654
Surplus at the end of the year		11,786,649
Represented by:		
Balance at bank and cash		11,486,649
Staff loan		300,000
		11,786,649
On behalf of management of Human Development Trust:		



 Dr. Peter Bujari
 Executive Director
 Box 65147
 DAR ES SALAAM
 TANZANIA
 HUMAN DEVELOPMENT TRUST
 Mr. Malanilo Simon
 Programme Development Coordinator

1st February 2006
 Date

February 1, 2006
 Date

Auditor's Report

To the Registered Trustees of Human Development Trust

We have audited the financial statements of Human Development Trust as set out on pages 5 and 6, which have been prepared in accordance with the accounting policies and basis of preparation set out on page 4. We have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purposes of our audit and to provide a reasonable basis for our opinion. The financial statements are in agreement with the accounting records.

Respective responsibilities of management and auditors

As described on page 2, the management of the organisation is responsible for the preparation of financial statements. It is our responsibility to form an independent opinion, based on our audit, on those statements and to report our opinion to you.

Basis of opinion

We conducted our audit in accordance with International Standards on Auditing. Those Standards require that we plan and perform our audit to obtain reasonable assurance that the financial statements are free from material misstatement. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by management in the preparation of the financial statements,

and of whether the accounting policies are appropriate to the organisation's circumstances, consistently applied and adequately disclosed.

In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements. We believe that our audit provides a reasonable basis for our opinion.

Opinion

In our opinion, proper books of account have been kept by the organisation and the financial statements give a true and fair view of the state of affairs of organisation as at 31 December 2005 and of its operations for the year the ended in accordance with the accounting policies and basis of preparation set out on page 4.