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INTRODUCTION

This report summarizes the projects implemented in the course of five years and their results. It is worth mentioning that none of the projects have been there for five years. The longest project has been there for two years and others were short lived depending on the funding duration or whether they were considered strategic or not.

For many years, there have been concerns that capacity of local organization is low and this is in some ways true. The reason is that those who work with local organizations and become able, move to international organizations where they have better package. This becomes vicious cycle and as a result; local organizations despite the added advantage of being local, hence they miss a number of opportunities which are then taken by foreign organizations.

HDT was then founded due the above fact and intended to work towards challenging the paradigm hence its strategies to work with communities, community based organizations and creation of strong partnership. To achieve this, HDT employs qualified staff and work through a continuous learning environment through staff capacity building, review and reflection process called DIRA, which happens three times a year.

To further ensure that there is multicultural and multi-skilled staffing, HDT employees both national and international staff through volunteer scheme with supports from VSO. This helps local staff to learn some new ways of working and vice versa.

To ensure that HDT is placed among high competitive firms in its services and product, it has in its fifth year turned into result based planning and result based management. Under this philosophy, HDT focuses on what results will be achieved and how that change lives of vulnerable groups than actual interventions to be done. We hope this change opens more doors for HDT to further grow in quality and standards.

We are grateful to donors who have provided funds to HDT to make this happen. These are VSO, Egmont trust, American International Alliance, Foundation for Civil society, Result Education Fund, Center for AIDS and governance in Africa, Support partnership against AIDS in Africa, Oxfam international, Marie stopes, Immigration department, Abbot fund, Zanzibar AIDS commission, AMREF, PPF, VodaCom, Accenture Netherlands and Good Samaritan who made contribution to HDT.

HDT is happy to celebrate its five years of service to communities in Tanzania. I am happy to be part of this young, energetic and result-focused team. The organization's guiding principles has been results, quality-based and people-oriented services. This report summarizes the history, the achievements, challenges, lessons learned and future outlook of HDT. With early years being difficult in terms of building experience, credibility and trust of both communities and partners, HDT has to date recorded partners in and outside the country.



Where we work (Mbeya, Kagera, Mtwara and Dar Es Salaam) our partnership with district, ward, village leaders and communities has continued to be strong. We have trained over 300 peer educators who have reached over 3,000 people. Through theatre for development HDT has mobilized, over 7,000 people and about 200 tested for HIV in the process. HDT has also supported over 300 PLHIV on ARV with nutrition and exploration of innovative mechanism to improve their livelihoods. Over 100 care families for MVC have been supported to take care of over 360 most vulnerable children. Although these numbers may be small but feedback from our partners and those who benefited from the programs indicate that lives have really been changed!

To strengthen partnership with other community based organizations, HDT has been supporting over 90 community based organizations in organizational development and project management and grants. HDT has continued to provide support to other organizations in HIV mainstreaming, KAP survey and in project monitoring and evaluation; areas which generates unrestricted funds for the organization.

At policy level, HDT has continued to work with other organizations and government in policy design. Our participation in community based survey of THIS-2 and review of the (NMSF) further informed our planning. Our work on ensuring that budget allocations are in sync with policies has contributed to the motivation for members of parliament to effectively participate in budget process.

I am happy to also mention that as HDT commemorate its five years anniversary, the organization is conducting organization review. This entails both organizational policies and programmatic achievements which will then inform our next strategic plan. I salute development partners who have been supporting HDT to achieve its mission and those who are coming on board. I also thank all those partners who have given us ideas and advice with out forgetting my fellow board members who have continued to support HDT in its growth. The staff, who have made the ideas, the advices and the resources speak to the communities and change lives. To them I say, "Keep on the good work". Lastly, to thank the founders whose passion has now come into reality to improve the quality of life of the people of Tanzania.

Ma. Christine Mwanukuzi-Kwayu
Chairperson of the Board



ABOUT HUMAN DEVELOPMENT TRUST

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 in 2004 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 3 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 fifth year, HDT has presence in three regions and with steady partnership with Voluntary Service Overseas (VSO) it has also work in Mtwara region under the Capacity Building Program. With partnership with AIHA, it has interventions in Botswana under capacity building program.

With its celebration of the 5years 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.

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

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 Work in Capacity Building

HDT engages in Capacity Building because several partners and allies in HIV&AIDS and development have low capacity towards in 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 the 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 Community Development

Our Community Development 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 defines Community Development as working in partnerships with stakeholders to provide locally and culturally acceptable support services to the community members and groups

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 VALUES

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

Collaborative

Accountable

Innovative

Cost Effective

An Agent of Social Change

**Linking and Learning the Work of
HDT**

**A Conduit in Empowerment of Communities
and their families in striving for sustainable
development**

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.

Through the Years in Policy Advocacy

Policy Advocacy

2005 - 2009





HDT IN POLICY ADVOCACY

OUR SUCCESS: Key Facts

HDT experience and capacity in policy advocacy has been enriched and our networking has increased.

Our outstanding results in this program include:

- *Supporting decision makers to understand the significance of thematic allocation on HIV funds and to influence the allocation as well as judicious use of the money through HIV budget analysis and results dissemination*
- *Enhanced understanding of the impact of macro policies on sectoral budget and education of non state actors on the same.*
- *100 youth were trained as ToT on youth policy, and governance and 34 youth groups were formed for this advocacy*
- *Led the CSO forum for HIV and health was establishment, hosted by HDT and now graduated into independent secretariat with its strategic plan and website.*
- *Influenced the mainstreaming of HIV in MKUKUTA to mainstream HIV as well as influencing the focus of NMSF*

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 Multi-sectoral Strategic Framework on HIV/AIDS 2008-2012, Joint assistance strategy. By so doing they facilitate mutual accountability of government and development partner and making them accountable for themselves based on their actions and public resource utilization. In addition CSO engages 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 addresses the thematic area one of the NMSF which focused on Cross Cutting Issues related to the Entire National Response (i.e. enabling environment)

OUR UNIQUENESS IN POLICY ADVOCACY

Constitutionally, each citizen has a right to express her/his opinion. Since CSO occupy the third sphere of society, it's the responsibility of CSO to ensure accountability among themselves on one hand and of the government on the other hand. The policy advocacy done by HDT is informed by our work on the ground in community development and capacity building. This enables us to present well founded opinion on policy statement.

Relation to MKUKUTA

Third Cluster (governance and accountability).

Goal 2: Effective public service framework in place to provide foundation for service delivery improvements and poverty reduction. These are regarded as entry points in the implementation of the policy advocacy work.

Relation to NMSF

Goal: create a political and economic and cultural environment for the national response to HIV based on human rights and gender responsive approach with transparency and accountability at all levels, broad public participation and empowerment of PLHIV, women and youth.



HDT BUDGET ANALYSIS FOR HIV EXPERIENCE AND ACHIEVEMENT (2005- 2009)

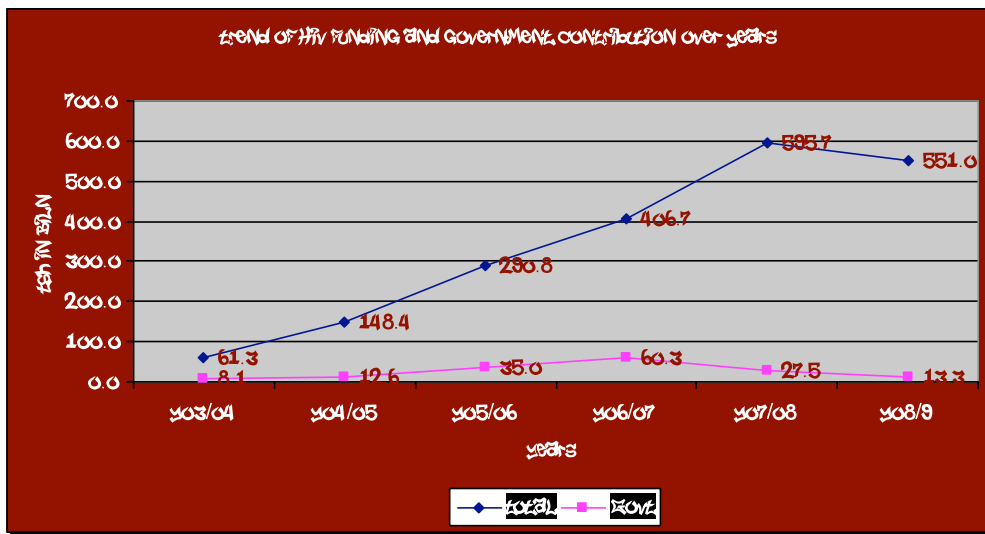
Cluster three of MKUKUTA goal 2 emphasizes on equitable allocation of public resources with corruption effectively addressed. It further commits to ensure that public resources are allocated, accessible, and used in equitable and transparent manner (page 50). Section 4.5 of joint assistant strategy for Tanzania of 2006 stipulates the role of CSO... "They thus facilitate mutual accountability of the Government and Development Partners as well as domestic accountability of the Government. In turn, they are themselves accountable for their actions and public resource utilization to their constituents and to the Government. The NMSF (2008-2012 page 104) states the dual roles of CSO where on one hand they complement public services and on another hand they play a role of watch dogs. This part therefore highlights HDT experience and achievement in contributing to the above policy statement.

Uniqueness Of The Project

This project is unique because it analyze the policy statements, the money allocated for implementation and engages both decision makers (members of the parliament) and civil society organizations. This work is also informed by other work in community development and capacity building experience on the ground.

Achievements Under HIV Budget Analysis

A number of facts have been established, communicated and warning sign given to decision makers along side with alternative way of budget allocation. The figure below summarizes the trend of HIV funding in the country, with notable decrease in funding both in total and from government contribution.



According to information available, all sector had budget decrease except NACP. The President's Emergency Plan for AIDS Relief (PEPFAR) budget fell by 1% between FY2007/8 and 2008/9 and is likely to decrease further due to un favorable exchange rates and, possibly, the impact of the current global economic recession. A number of other acts have been established and communicated to decision makers including:

- There is lack of public budgetary information availability, contrary to MKUKUTA commitment, and this affects good governance, transparency, coordination and planning.
- Significant amount of HIV funding comes from PEPFAR (over 65%) and yet is 'off-budget' and not open to detailed analysis.



- Significant funding was not open for functional classification
- Contrary to policy statement prioritizing local response, budget analysis show that it is not adequately reflected as regional administration and district in 2008/9 for example shared only 10% of approved budget.
- Even when small amount allocated to districts, what reaches varies and can be as low as 14%.
- The amount of funding allocated to prevention seems to be low, this is also true for impact mitigation.

Some notable achievements have been registered including:

- There is formula based allocation to local government which was not the case in the last three years
- The relationship with some government agencies have improved, thus facilitating access to information in some ways
- The relationship with members of parliament, in particular the standing committee for HIV and social services have also improved
- Members of parliament have used some of the information we provided from the analysis during the debate in the parliament.

Relation to NMSF

This work is linked with the NMSF through the thematic area 1 Cross Cutting Issues related to the Entire National Response **(i. e enabling environment)**

Strategic objective: Maintain and strengthening political commitment , transparency, accountability and popular support for HIV interventions using human right and gender responsive approach as well as deepen public awareness acceptance and understanding of the needs and concerns of the of PLHIV and other vulnerable and marginalized groups through sustained advocacy at all levels

Relation to MKUKUTA

This work is also linked with MKUKUTA cluster three 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;



POLICY ENGAGEMENT

MACRO ECONOMIC POLICIES (2008 – 2009)

HDT through worked in partnership with the Centre for Economic Governance and AIDS in Africa, RESULTS Educational Fund and Ifakara Health Institute which conducted 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 a part of a multi-country effort to explore the relationship between macroeconomic policies and government spending and in particular for health in general, HIV/AIDS and TB.

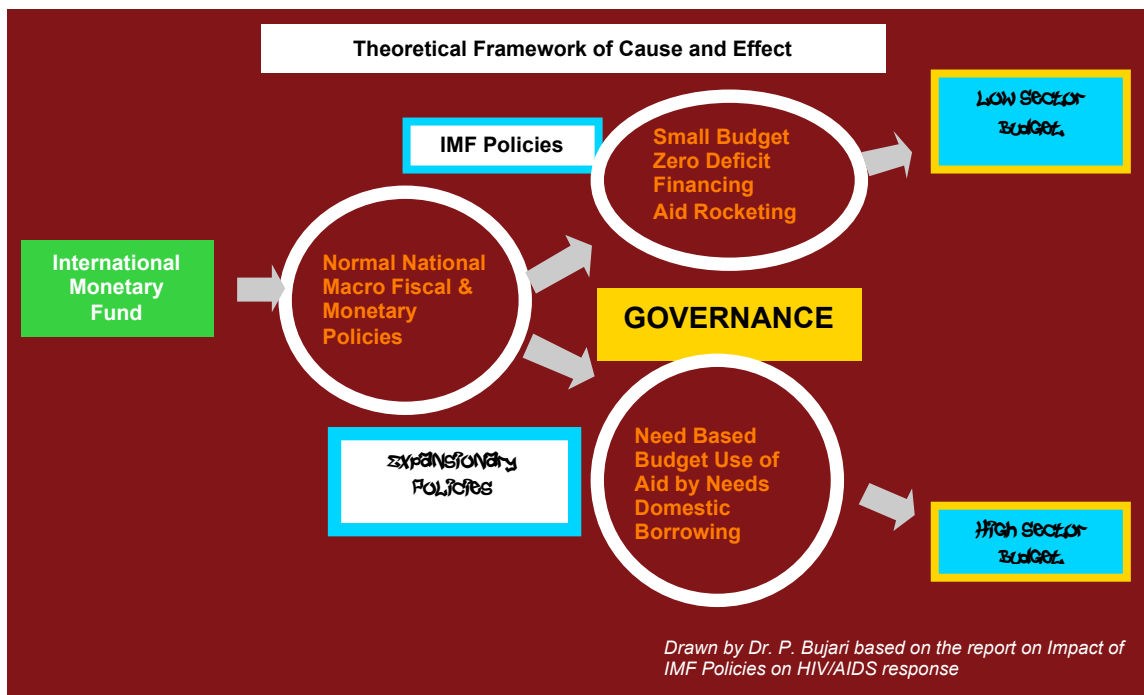


Figure 1 provides a summary of the cause and effect of IMF supported policies. It does show that due to conditions and framework provided by IMF, Tanzania macro policies prioritize cash budgeting, zero domestic financing and Rocketing of aid .

These factors limit the size of national budget, sectoral budget and hence impact on adequacy and quality of services. The IMF support policies favors

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. This leads to:

- Poor health infrastructure and inadequate human resources for health.
- Out of stock of drugs for opportunistic diseases, 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
- Lack of human resource capacity

Achievements With Engagement In Macro Economic Policies



Presentation of findings to MPs

- HDT joined hands with other organizations and presented the findings to the Members of the Parliament in November 2008. The objective was to educate the decision makers, and on the impact of IMF supported Policies on health sector in Tanzania.
- HDT has been able to expand its networking with other development partners like Centre for Economic Governance and AIDS in Africa, RESULTS Educational Fund and Ifakara Health Institute, parliament, civil societies, media and also participating in the regional workshops. E.g. Dakar meeting.

¹Cash budgeting means that countries spending depends entirely on domestic collection and no domestic borrowing is allowed, even if it may have future gain. Rocketing of aid means building foreign reserve to finance the deficit between import and export, hence the aid is not used to support any social sector.

Relation to 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



**YOUTH ENGAGEMENT WITH POLICY AND GOVERNANCE
(2007-2008)**

HDT provided education to youth on youth development policy and good governance. The Organization has been provided training on the current youth development policy, group dynamics, partnership, networking and promotion of good governance for the purpose of informing youth to take active participation in the development plans and networking within their localities. A total of 100 youth groups were trained and 34 youth groups have been established. Nine in Ngara, 3 in Biharamulo, 10 in Rungwe and 12 in Kyela. Youth aged between 14 -24 were selected from 5 wards in each district.

Achievements in Youth Engagement with Policy and Governance

- Dialogue platforms have been formed and this included some officials from the district council and wards like the Community Development Officer and youth themselves. As a result of training and formation of the dialogue platform, the youth started demanding their rights of participation in various activities including decision making. This trend is however seen as confusion to some leaders at local level, who lack experience in participatory decision making.
- Established collaboration between HDT and other CSOs. In this effort there are six (6) CSOs working with HDT **Ngara -Rulenge Youth for Development and Rulenge Forum for development,; Biharamulo (Accord), Kyela (Kyela Theatre Troupe) Rungwe (Tukuyu Youth Group and Africa Bridge)**
- The mixture of out-of-school and in school enabled youth to appreciate the needs of each group and chart out the mutual shared needs.
- Four task forces were formed through youth organizations and these serves as mechanism and structure through which youth can be reached. In addition to that leaders recognized that youth policy was not wholly pro them and that implementation of the same was challenging
- 1,301 youth have been trained on youth policy, group dynamics, partnership, networking and governance for the span of five years.
- Evidently, the self esteem of these young men and women were developed and currently most are confident to face their problems and positively demand inclusion in govern



Relation to MKUKUTA

This work is linked with MKUKUTA cluster three i.e. governance and accountability

Goal: Structures and systems of governance as well as the rule of law are democratic, participatory, representative, accountable and inclusive

Target: to ensure representative, inclusive (poor and vulnerable) and accountable governance institutions operating at all level



ENGAGEMENT IN PRSP (MKUKUTA) AND NATIONAL MULTI-SECTORAL STRATEGIC FRAMEWORK AND AIDS BILL (2005-08)

HDT worked with the NGO policy forum through the PER working group on a series of workshops. Through the workshops, it served as a venue to contribute their views during the review of the Poverty and Reduction strategy I. The aim was to make sure that HIV/AIDS is mainstreamed into all clusters in the PRSII popularly known as MKUKUTA for poverty reduction. Despite all efforts HIV was only mainstreamed in cluster I and II. It was not perceived as a governance issue.

The AIDS bill is one of the policy legal documents which gives rights and responsibility and enforce a number of policy statement including penal code where necessary. On Dec 2007, the CSO through the TAF and the support from HDT (the secretariat of TAF), Concern World Wide and Oxfam coordinated the stakeholders' workshop amongst which 17 CSO participated and provide written submission for inclusion in the AIDS law.

Some of the issues raised by the participants include:

- **Mandatory testing**
Every person residing in Tanzania may on his own consent volunteer to undergo HIV testing.
- **Government responsibility**
The ministry shall quantify the requirement of condoms, ARVs and accompanied drugs in Tanzania by espousing different stakeholders, mobilizing resources required for procurement of condoms generally with a view to ensuring availability of condoms of standard quality in Tanzania.
- **Ensuring access to services and product to PLHIV**
PLHIV have the right to have access to maximum use of resources available to them and for stakeholders providing HIV services must ensure that the aid/support materials are used for the purpose required.
- **Judicial use of aid**
Every NGO, CBO, FBO, private organization, public institution and any person receiving aid and assistance for the purpose of providing preventive, treatment and care for Persons living with HIV and AIDS,

widows, orphans, shall ensure that aid and assistance so received is used for that purpose.

- **Establishment of court for family/ marital rape**
Establishment of the family courts that deals with the marital case
- **Criminalization of HIV transmission**
Criminalization of the HIV will infringe human rights and undermine public policy specific criminal legislation can further stigmatize persons living with HIV, provide a disincentive to HIV testing, create a false sense of security among people who are HIV negative, and impose women on the burden and risk of discrimination and violence. The priority must be given to increasing access to comprehensive and evidence informed prevention methods in the fight against HIV/AIDS.
- **Inclusion of non health forums**
HIV/AIDS should be perceived as a social, economic and health issues and not a health issue alone.

Achievements with This Project

- HIV/AIDS is mainstreamed into the cluster one and two of the MKUKUTA. Cluster one address the economic growth while two focuses on social well being.
- HDT is one of the major representatives on the joint technical committee on Finance and audit.
- Some of the recommendations provided by the CSOs were incorporated to the New AIDS BILL which is already passed and signed by president.

Relation to MKUKUTA

This work is also linked with MKUKUTA cluster three governance and accountability
Goal 3: Effective public service frameworks in place to provide foundation for service delivery improvement and poverty reduction.

Target: Administrative systems of public institutions are managed transparency in the best interest of the people they serve



CIVIL SOCIETY ORGANIZATIONS' COORDINATION (2006-09)

HDT together with ACORD, BAKWATA, CCT, TNW+, CHAWATA, TGNP, Care International, concern worldwide with the 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 & AIDS. With its strong capacity of lobbying and advocacy in policy, HDT was elected as the secretariat of TAF for two years and coordinates all TAF activities. TAF is chaired by the Executive Director of HDT (Dr. Peter Bujari) and lead by the board, which comprises of ten (10) member-CSOs.

Achievements With This Facilitation And Establishment Of TAF

- The forum had 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 MoU in 10 regions (i.e. Dar es salaam , Arusha, Kilimanjaro, Mwanza, Doodma, Rukwa, Tanga, Shinyanga, Kagera, Mbeya) of Tanzania.
- TAF participated in 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 meeting (new dialogue structure), Joint thematic committee planning meeting, Coordinators Planning meeting organized by EANNASO, TAF organized and coordinated the CSO's representation in the technical working group.
- In 2007 HDT and TAF participated in various fora for information and experience sharing in different countries like Kenya, Uganda, and Ethiopia etc.
- HDT elected as one of the two representative in TNMCM

Relation to 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*

Relation to 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 provides services according to their mandates in a satisfactory manner.

LESSONS OF EXPERIENCE IN POLICY ADVOCACY

Stakeholder Participation is essential in the development issues for collective voice

Stakeholder participation is vital for any development agenda. We have learnt that Programs and plans must be implemented focusing on the public interest for better success. We have learnt that the voice of NGOs are somewhat heard as the government has started allocating money for the Local government HIV/AIDS activities, though inadequate. A lot still desired on prioritizing local response and strategic use of funds.

Persistence can result into actual changes regardless of bureaucracy

Working with the government requires patience and institutional commitments. The bureaucratic nature of the government may demoralize the activeness of the CSOs, even if they are presenting sound evidence. TO succeed persistence and courage is required.

Lack of information dissemination of public policies and strategies hampers implementation of the same.

Dissemination of information remains to be the most critical issue. Policies are prepared at the higher-ministerial level while the implementation is done at the grassroots level. Dissemination of information to the communities on their rights and responsibilities needs to be addressed by every stakeholder with the support from the government.

There is a gap between policy statement and practical situation; hence a need to walk the talk.

The promotion of good governance was often negatively perceived by local leaders. The perception of the training provided to youth on the youth development policy and promotion of good governance was different in some district, while others viewed it as provision of knowledge to the community to demand their rights others perceive it as chaos. The policies emphasize on participatory planning and accountability, this still has a long way to be realized.

CHALLENGES IN THE POLICY AND ADVOCACY WORK

There is limited transparency in budget process and macro policy formulation

There is limited access to information on budget and limited stakeholders' participation in budget process. Macro policies formulation is limited to finance ministry and lacks participation of parliament and sectoral ministry. Opening up of more participation to enable use of expansionary policies and access to information

There is limited capacity and interest of CSO to work in policy advocacy

Many CSO are formed to work on service delivery and the capacity to analyze policy and hold government accountable is limited. CSO need capacity building in policy areas to appreciate that lack of appropriate policies and or their implementation can limit them to achieve their vision. Government also needs to perceive CSO as equal partner than as junior brother as it the case.

PROGRAM FUTURE OUTLOOK

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

Through the Years in Capacity Building

2005 - 2009

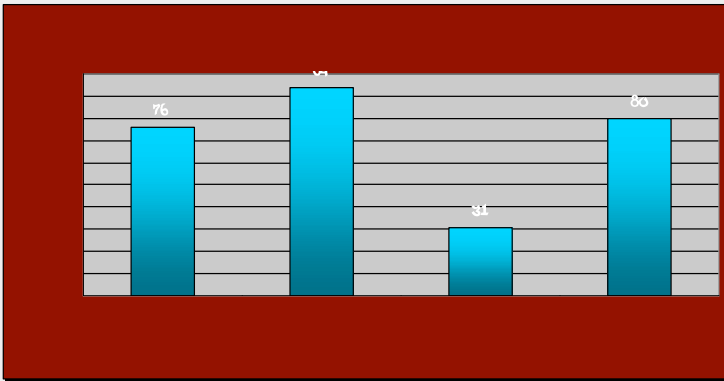


Capacity Building



OUR SUCCESS: Key Facts

This program has expanded from one off training started in 2005 into systematic and focused interventions ranging from capacity assessment, training, mentoring, granting and verifying use of knowledge, skills and financing. Some of mentoring organizations did not require capacity assessment because they were based on HIV work place program.



- **76** organizations were assessed through HDT organizational capacity assessment methods
- **94** organizations trained on Organizational design and development, project management and programming and quality service delivery.
- **31** organizations received grants
- **80** organizations are currently in the mentoring loop for organization development
- **209** people trained on organization development, advocacy and networking and technical skills on management of HIV and AIDS programs.
- **8** regions involved in the capacity building of CSO (Mtwara, Kagera, Dar es Salaam, Mbeya, Botswana-Gaborone, Kilimanjaro, Dodoma and Iringa)
- **5** Umbrella organizations were given Organization Development Training on how to strengthen their capacities on coordination, resource mobilization, advocacy and communication and M & E for HIV and AIDS programs (ZAPHA +, ZIADA, ABCZ, UWAKUZA and ZANGOC) under Zanzibar AIDS Commission (ZAC)
- **2** Program Evaluation done: Sexual Reproductive Health Services Project of Marie Stopes in 14 Districts in Tanzania.
- Conducted Situational analysis and design of M&E framework for HIV/AIDS Workplace program for Immigration department, Ministry of Home affairs.
- Developed the Baseline survey (KABP) among the Tanzania Police Force under Marie Stopes Tanzania

HDT 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 to manage organizations, program 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 has 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 Goal 1 and 2. The table below show the relation ship of projects and MKUKUTA Goals

Capacity Building

HDT PROJECT NAME	GOAL CONTRIBUTED TO IN MKUKUTA
workplace programs under research and training project	Cluster 1. growth and reduction of income poverty. Goal 2. promote sustainable and broad based –growth Cluster strategy 2.1.7 develop programs to fight spread of HIV and AIDS in workplaces in all MDA, CSO, LGA and private sector.
Capacity building of CSOs	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, Food support , psychosocial support, promotion of women support programs , children and PLHIVs Elderly support and family headed by children.

Capacity Building



This program is dichotomous, as on one hand focuses on developing tailored interventions to build the capacity of community based organizations in organizational and program management. On another hand it focuses on creating partnership with able institutions to provide expertise in research, program management and training.

The program started building the capacity organizations of People Living with HIV and AIDS, and expanded to include Non PLHIV organizations. Today, it has gone further to become a stop center for Organizations Development and a fore front consulting wing for both several influential institutions in the private and public sector both in Tanzania and in the international setting.



Our Uniqueness in Capacity Building

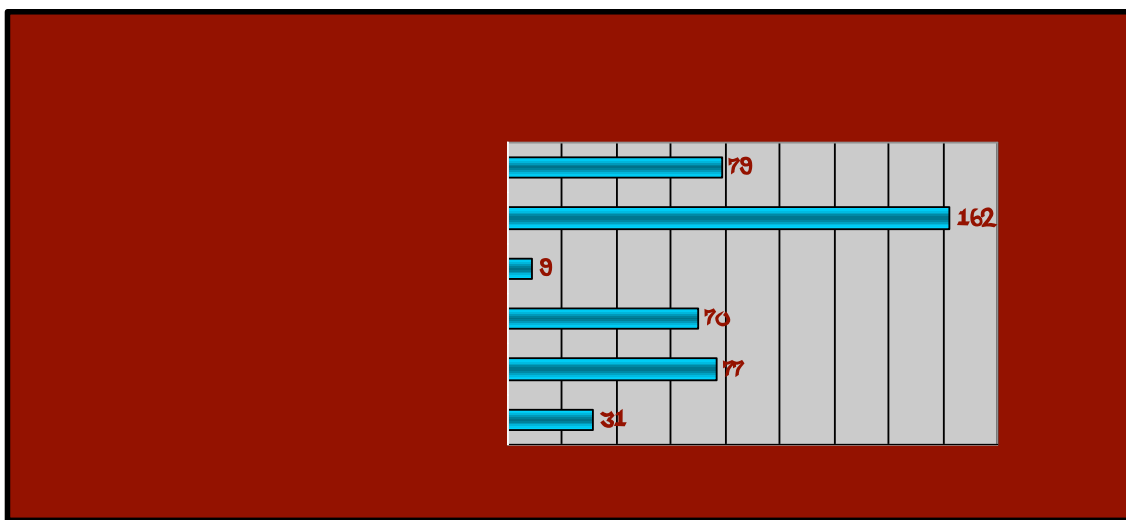
Our approach towards capacity building for CSOs is unique. It is a six stage model, which imparts both knowledge and develops skills. It starts with identifying organizations and determining their capacities with regard to organizational design and function using OCA tool. Afterwards the first training 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. 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 else where. 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:



*OCA tool: 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.

Achievements In Organization Development Of CSOs Project



The figure above summarizes the achievements of the capacity building of CSOs project.



In 2005, started its capacity building to CSO and built the capacity of 30 CSOs on Organizational development, Advocacy and Partnership. CSO that participated in the training were from Dar Es Salaam, Cost, Morogoro, Dodoma and Kilimanjaro. HDT also provided on site support to CSOs to verify what has been their experience since training and new challenges.

- 43 CSO (16 Iringa, 10 Kibaha and 17 Dar Es Salaam have were provided with on site support on advocacy networking and strategic partnership between 2006-2008.

Since 2007, HDT capacity building program became more structured with long term relationship. The six stage model above was put in place aiming to get better results which are measurable. AT this time, capacity assesment was formalized as an important stage in capacity building and addition of hand on mentoring and granting came into being.

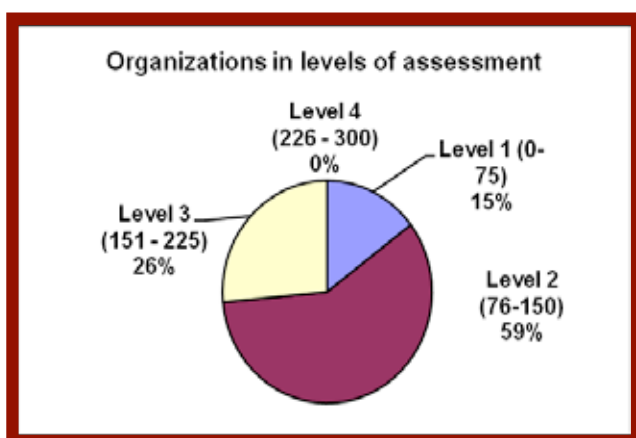
36 organizations have participated in the training on Organizations governance, managerial functions; financial management, Human resource management, office management, and networking and communication, out of them 28 (77%) are of PLHIV. This improves their confidence to manage their organizations, improve their life and hence reduce stigma.

After a series of training and coaching and granting to these organizations the positive spin off effect from these organizations' members includes:

- Improved livelihoods of PLHIV and their beneficiaries through Income generating activities
- Home based Care to PLHIV and those with chronic illness as well as MVC supported as a result of grant received
- Improved confidence on fighting with stigma and social discriminations
- Improved welfare of the Most Vulnerable Children, such as the attendance to schools has increased as a result of supplemented educational materials, support through psychosocial guidance and counseling, social protection and food support accorded to MVCs.

These have been made possible because organizations are starting to be capable in addressing the community needs which was reinforced further after receiving OD1 and OD2 training.

Capacity Building of CSOs Outside Tanzania



This project is being conducted in Botswana in partnership with Marang Child Care Network.

The major goal of this project is to build the capacity of the secretariat and its member organizations in order to manage organization and program better hence efficiently support orphans and vulnerable children.

This project started in April 2008, to date we celebrate the following achievements:

34 out of 60 organizations have passed through Organization capacity Assessment exercise. The findings were as appear in the diagram

Created and authored the training manual that addresses capacity gaps identified during capacity assessment. The training addressed issues on organization management, Monitoring and Evaluation, Governance, Human resource management, and planning for effectiveness. This was done through one tailor made - training for the above capacity gaps has been conducted to 11 organizations.

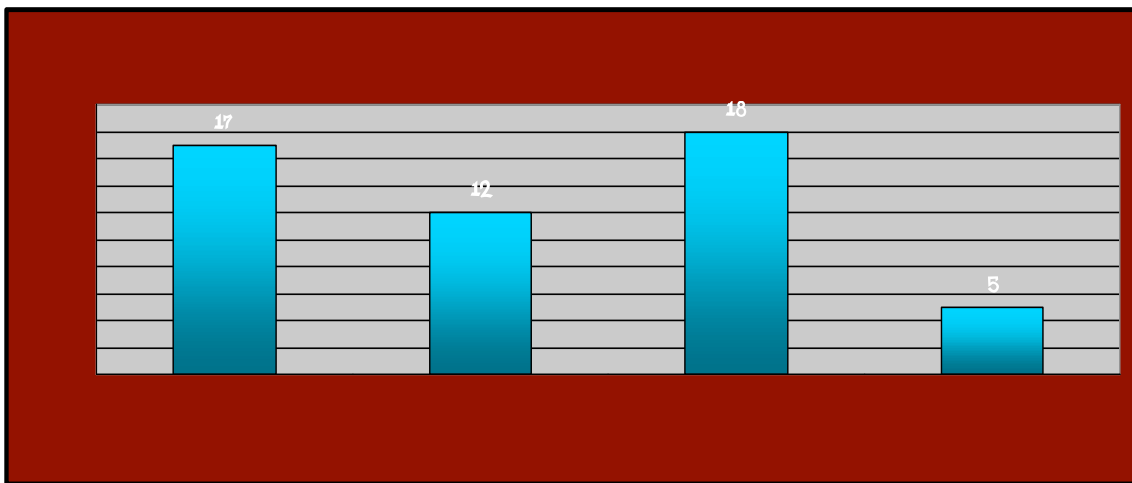
Two physical verifications done to ascertain whether financial management are in accordance and comply to stipulated financial regulations, policy and procedures.



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 which great part of it is ploughed back to support priority project which have not received funding from any donor. For over a year now, HDT unrestricted funding have supported a project on most vulnerable children and procured two project vehicles. It operates largely on consulting bases for the under shown areas of focus.



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 on which the Research and Training Unit takes the lead.

Amongst these programs lend supports on the following:



- Management training on roles and their responsibilities towards HIV and AIDS response
 - Situation and response analysis before, during and post establishment of specific workplace program.
 - Development of workplace policies or guidelines
 - Development of strategic plans
- Facilitation of the formation of HIV committees and train them on roles and management
 - Training of peer educators
 - Development of monitoring and Evaluation frame works and tailor made support.
 - Provision of Information Education and communication materials
 - Performing Monitoring and evaluation of the Programs for partners and clients implementing HIV and AIDS projects
 - Training on national and international policy and opportunities for advocacy

Achievement Under The Research and Training

A number of organizations have benefited from our service in different years:

In the year 2007:

- 9 organizations were supported in developing and managing HIV/AIDS programs at the work place; These include KIWAKKUKI, PINGOS forum, SAIPRO, MIFPRO, TIP, KINNAPA, Ujamaa CRT, Maarifa ni Ufunguo and MEDA.
- 4 Ministries were supported in developing HIV/AIDS programs in the work place. These are Immigration department, Ministry of Home affairs, Ministry of Labor, Employment and youth development and ministry of higher education.

In the year 2008:

- In partnership with Marie stopes Tanzania we performed a situational analysis for Tanzania police force with regard to Knowledge, attitude, behavior and practices (KABP survey), whose results would help the department to establish appropriate HIV and AIDS interventions.
- Mid term Review for Sexual and Reproductive Healthy (SRH) project implemented by Marie Stopes Tanzania in northern regions of Tanzania and Lake Zone, whose findings and recommendations would be potential informing data for decision making and further improvement of the project

- Remarkably 5 Umbrella organizations in Zanzibar working in the field of HIV and AIDS underwent Organizational Capacity assessment subsequently tailored - training to addressing capacity gaps on coordination, resource mobilization and financial management, good governance, advocacy, networking and communication
- Training on HIV/AIDS sensitization to Policy department, Ministry of Labor
- Training on HIV/AIDS sessions to Employment Department, Ministry of Labor



Through the research, recommendations and training provided under this department, organizations have been able to restructure their interventions and used this information as data to establish their own projects that address their needs at workplaces.

Stakeholders' discussion during Annual Evaluation of capacity building project of CSOs in Dar es Salaam.

- Strengthened Marang Secretariat through exchange visits and correspondences to properly manage the network and development of appropriate support to members.
- Contributed to the Marang annual General Assembly with regard to principles of networking and partnership.

Relation to MKUKUTA

Cluster 1. Goal 2 cluster strategy 2.1.7 develop programs to fight spread of HIV and AIDS in workplaces in all MDA, CSO, LGA and private sector

Indicators:
Number of private and public institutions supported with workplace programs.

Relation to NMSF

Goal: to reduce HIV Prevalence in the country under the following sub themes:

- Expansion of workplace interventions
- Education on prevention of STIs
- Promotion and distribution of condoms

Indicators: Number of organizations supported with workplace programs and services.



LESSONS OF EXPERIENCE IN CAPACITY BUILDING

Low level of education among partners staff affects the quality and pace of training in Organizational Development

Many of participants in level one organizations had low levels of knowledge and this affects the pace at which training can be done. Comprehension was also slow with potential language barriers, making it relevant to have all sessions in local Kiswahili for Tanzania and Setwana in Botswana. To overcome this, HDT staff also provided more supportive sessions after the training. Mentoring visits are used to continuously coach the Organizations, especially the ones that showed weakness in some areas eg financial recording after receiving grants

There are multiple reasons for starting organizations and care has to be taken when supporting them if communities have to be served

During the identification process, HDT found that some of the local organizations are willing to receive resources but not to learn. This indicates that the purpose of forming the organization was for their gain rather than for supporting communities. This was exemplified when many organizations were complaining about the small allowances issued to them during the training. In providing support therefore, clear separation has to be made between those who form a support group to support themselves and those who form institutions to support others. These two groups have different needs and therefore should be treated differently

Training for HIV positive people needs to be adjusted to suit their needs and circumstance

We noted that when giving workshops where PLHIV are attending there should be enough time for breaks in the schedule. They often need time off either for rest or taking medication. The timetable needs to take this into consideration. Sensitivity on the nutrition provided can not also be over emphasized.

Reliable transport is needed to enable efficient support to partners especially in hard to reach areas

In Kagera and Mbeya, the wards where the project beneficiaries are scattered and there are poor roads to their areas of operation, reliable

means of transport is a pre requisite. Absence of reliable transport makes the identification process, implementation, monitoring and evaluation, time and resource consuming. Development partners, including those who fund the project, need to allow resources to be invested in the purchasing vehicles (car, motorcycle) if the project is to be implemented efficiently and effectively.

Partnership sustainability depends on understanding cultural differences and forbearance

Understanding that each organization is different and people are different and have different cultures is essential for partnership working. Some are hard working and time bound while others like to work in closed systems, in bureaucratic ways and with no time pressure. The lesson we learnt was importance of understanding the operating context by clear communication so that the needs and expectations are known by both sides from the outset.

CHALLENGES IN CAPACITY BUILDING

Inadequate Financial Resources for Partners

The demand for financial resources is higher 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.

Some development Partners do not support overhead costs.

While some partners prefer not to finance core cost but direct project cost and they forget the other aspect of infrastructure which is pertinent for institutional growth, motivation and support of Human resources carrying interventions. Mentoring and coaching is required for partners to supplement the training and this requires both significant human resources and reliable transport which are often not available. When ToT are used to provide coaching, commitment and funds are required to ensure that it done effectively and efficiently.

Poor response on workplace programs by companies

Although it's the policy (MKUKUTA, National HIV policy and NMSF) that private and public institutions need to develop interventions at workplaces, a lot more are desired than is happening. Often the challenge is the cost associated with services (preventions and care) as compared with the profitability of companies. The government will have to enforce its policies.

PROGRAM FUTURE OUT LOOK

Capacity Building to CSOs.

The first phase of training will be completed encompassing: strategic

planning, training on Advocacy and partnership and networking. 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 increase the size of grants these partners can get for meaningful work. Linkages of this program and that of policy advocacy (none state actors capacity in advocacy) so that capacity issues are dealt comprehensively.

Research and Training Unit

The unit hopes to explore doing evaluations, baseline surveys and assessments with regard to HIV and AIDS and other health related issues as well as social and economic, community development projects and programs. It will continue doing workplace programs for both public and private institutions with regard to HIV and AIDS response at work places.

The unit will also conduct specialized training on Organization development in the areas of governance, management structures and functions, financial management, Human resource management, office administration, programming and resource mobilization, monitoring and evaluation.



Through the Years in Community Development

2004 - 2009



Community Development

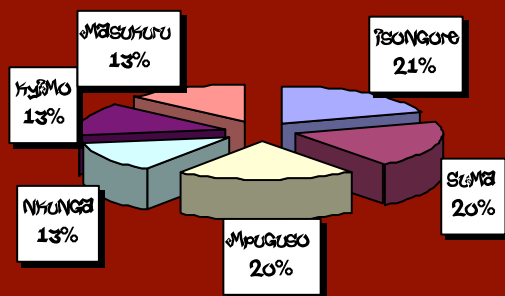


OUR SUCCESS: Key Facts

In the last five years, community development worked to support most vulnerable children through care families, school and out of school reproductive health and HIV project. The other project is community based HIV prevention, care and stigma reduction. The chart below summarizes cumulative results per project in community development.

- **6,692** community members engaged in theater for development

Proportion of People participated in theatre for development per ward; N=6,692



- **310** peer educators were trained
- **3,110** pupils were reached through the peer educators
- **357** Vulnerable Children are being supported
- **312** PLHIV received nutrition support and support groups
- **104** people voluntarily tested for HIV after the theater shows about anti-stigma and discrimination

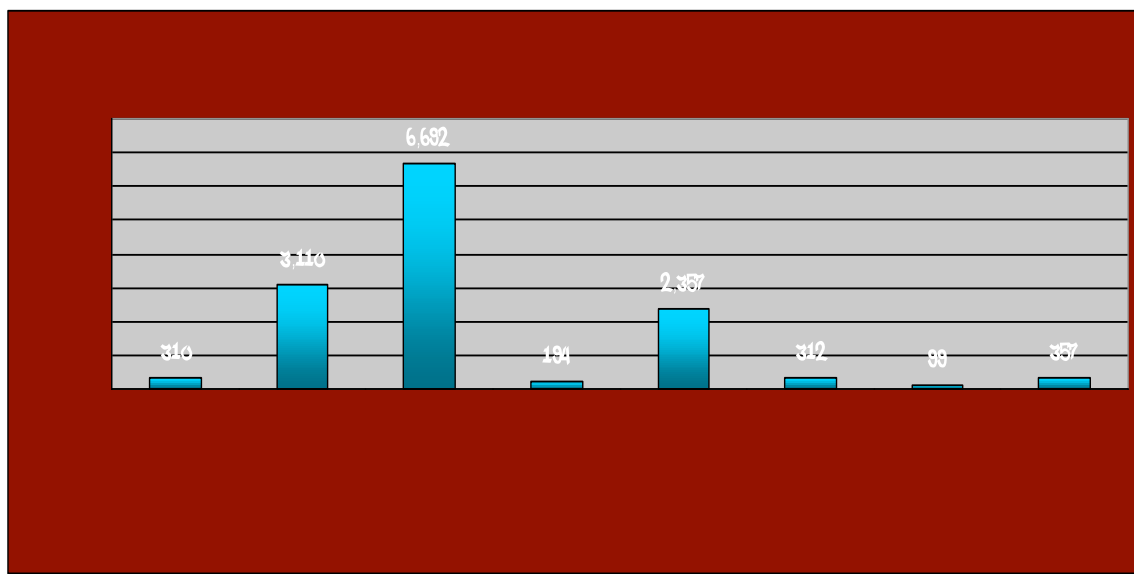
HDT IN COMMUNITY DEVELOPMENT

Like the whole organization, community development program is result oriented, which is in sync with outcome based in MKUKUTA. Most of the interventions in the program address the second cluster (improvement of quality of life and social wellbeing). The overarching results above address three goals (1,2 and 4) of MKUKUTA cluster two. The table below shows the Relations of the project implemented and goals contributed to in MKUKUTA.



HDT PROJECT NAME	GOALS CONTRIBUTED TO IN MKUKUTA
Support to most vulnerable children in Ngara & Kinondoni	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.
School and out of school HIV and SRH project Tanga, Ngara and Rungwe	Goal 2: Improved survival, health and wellbeing of all children and women and especially vulnerable groups
Stigma reduction through community education, support groups and livelihoods for PLHIV in Rungwe (GFATM)	Goal 4: Adequate social protection and rights of vulnerable and needy groups with basic needs and services

The figure below summarizes quantitatively the number of beneficiaries reached by HDT in the last five years.





SUPPORT TO MOST VULNERABLE CHILDREN (2007-2009)

MKUKUTA under its cluster II envisages minimizing the disparities between poor and rich, and rural and urban. Under its operational target 5.3.2.1 (B) it envisages to increase the proportion of orphans and vulnerable children in schools from 2% in year 2005 to 30% in 2010. It also plans to increase the number of OVC and children with disabilities completing secondary school. Other targets include increasing attendance rate in primary school.

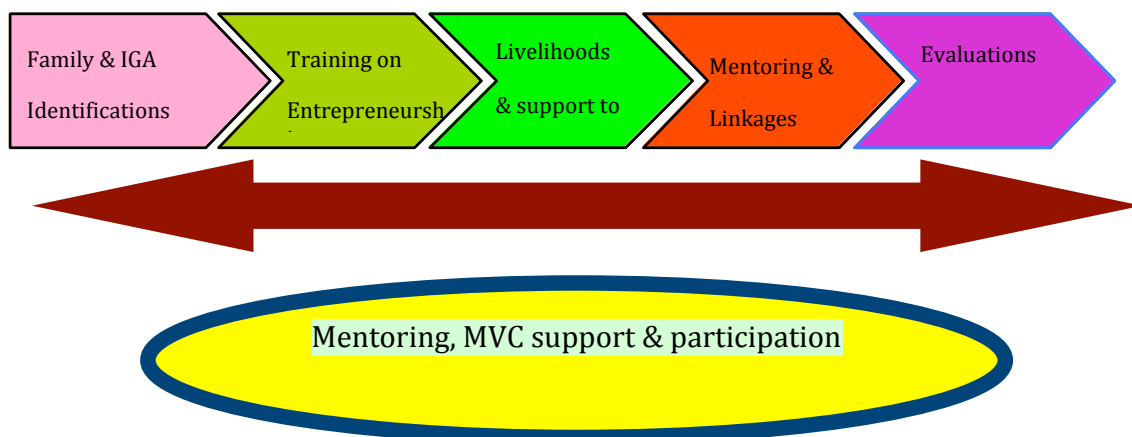
The National Costed Plan of action [NCPA 2007-2010] prioritizes that family **to be strengthened so that core needs of MVC and youth are met to ensure their current and future wellbeing**. The plan intends to comprehensively support children by provision of psychosocial support where the emphasis is on reducing/eradication of fear, grief, trauma and stigma. The plan further commits to track the implementation, quality and effectiveness. HDT work in supporting most vulnerable children have been developed to contribute to the targets of MKUKUTA above and to contribute to the targets in National Plan of Action.

Uniqueness of this Project

HDT's philosophy is that the best way to support MVC is to strengthen the capacity of the family to better provide than providing materials only to children from out side. We believe that families have some thing to contribute on each day that MVC lives and thus this is what we need to improve. The approach we use to support MVC prioritizes the capacity of family in terms of livelihoods and skills to address psychosocial issues. We therefore strengthen the source of livelihood for the care takers them selves to provide the support in their own context than us as foreigner. This way, sustainability of family livelihoods is ensured and families are empowered rather than providing ready made materials only to vulnerable children. When immediate materials are needed, HDT staff works with care takers to go and procure materials and the care takers themselves handles the materials to children. This way maintains the dignity and respect between children and care takers.

Project Methodology

This project to support MVC started as pilot project in Kinondoni municipal and Ngara district where in both projects, HDT's own funds was used since March 2007. Family identification started with meeting between hamlet leaders and HDT staff, where families were provisionally identified, later HDT reconfirmed the family's status and source of livelihood through a methodology called transit walk. The figure below summarizes the steps we use in this project.



Achievements In MVC Projects

With unrestricted funds of HDT, 99 families supporting 357 most vulnerable children were supported broadly. The table below summarizes quantitative results to date.

Age groups	Dar es Salaam		Kagera Region		Overall total
	Male	Female	Male	Female	
0 to 4	0	7	20	16	43
5 to 8	5	6	37	17	65
9 to 13	13	11	49	34	107
14 to 17	9	12	34	29	84
18 to 21	7	4	18	21	50
22 to 25	2	0	5	1	8
Others	0	0			0
Total	36	40	163	118	357

A number of projects are being implemented by supported families including selling charcoal, items in a small shop, live chicken, live goats and agricultural farming. Most of the children supported are in 9-13 age 30% followed by 13 to 17 years (24%). Approximately 73% of female headed families are recorded to be doing well as compared to 27% of male counterpart. HDT will be studying social cultural issues determining the success of the family and this will form part as an important data in the future planning of the project. The figure below summarizes family performance using visual analogue scale of three levels.

Performance in IGA and Care for MVC				
	Very good	Good	Poor	Total
Dar es Salaam	9	25	5	39
Kagera	9	43	8	60
Total	18	68	13	99
Percentage	18%	69%	13%	100%

Mentoring to families and visiting schools have shown significant improvement in children general wellbeing, school attendance, self esteem, school performance etc. Nearly all families supported have provided to the MVCs with basic needs such as uniforms, shoes, exercise books, pens and school fees and health care costs.



Mrs. Amina Yusuph who lives at Ali Maub, Dar Es Salaam, takes care of four orphans. During mentoring visit, she said:

“I used the grant to increase my small scale business in baking and selling maandazi (small bites for tea). Every day I bake maandazi and sell them to a shop close to my house. With this business I am able to make a net profit of Tsh. 1,000 per day, which is enough to support 4 children with daily food, school fees, uniforms and books”.

Amina feels that she is better supported than before. She mentions that before she was selected for this project, she could not afford school fees and was always in debt. She says: “Now I am able to cover my debts and pay for the school fees of this year. I also hope to increase my business and I try to save some money every week, so my children can also go to secondary education. I had never possessed a bank account, but now I have one with NMB and I have a balance, which is good for me”.

There has been a number of positive by-product and derivative effects to HDT as a result of the achievement and methodology used by HDT. Below we summarize some of these:

1. Working with local leaders, there has been exemption on tuition fee to MVC paid by pupils of standard 4 and 7, though this is not yet permanent.
2. The time to show video in some places has been moved to evening hours after pupils are from school to reduce temptation to MVC
3. HDT received recognition the Government of Tanzania as one of the innovative service providers to vulnerable groups. We received a letter to this effect and we are proud to share it.

JAMHURI YA MUUNGANO WA TANZANIA
WIZARA YA AFYA NA USTAWI WA JAMII

Anuani ya Simu "USTAWI"
Simu Nambari 2184631.
Unapojibu tafadhali taja:



IDARA YA USTAWI WA JAMII,
S. L. P. 1949,
DAR ES SALAAM.

Kumb. Na. GA.112/291/02/23

25/06/2008

Mkurugenzi Mtendaji
Human Development Trust,
P.O. Box 65147,
DAR ES SALAAM

HUMAN DEVELOPMENT TRUST
RECEIVED

DATE: 17/7/08

**Kuh: KUSAJILIWA KAMA MTOA HUDUMA KWA MAKUNDI
YALIYO KATIKA MAZINGIRA MAGUMU ZAIDI.**

Kwa niaba ya Wizara ya Afya na Ustawi wa Jamii nachukua fursa hii kukupongeza, kuipongeza taasisi yako NGO kuhusu huduma kwa makundi yaliyo katika mazingira hatarishi (Makundi maalum). Taasisi za kidini na kijamii, mashirika, na taasisi yako ikiwa mojawapo mmeonyesha moyo wa kuguswa kuisaidia serikali pale ambapo pana mapungufu kwa kushirikisha jamii kutoa misaada mbalimbali ya kifedha, mitaji midogo, watoto kupatiwa vifaa vya shule, uniform kule jamii walipo wakishirikiana na viongozi wa kata, vijiji na familia.

Aidha kwa mujibu wa sheria, miongozo na kanuni za utoaji huduma hizo kwa makundi maalum. Idara ya Ustawi wa Jamii husajili kwa sheria ya Childrens Home Act pale tu taasisi inapotaka kuanzisha na kuendesha makao ya watoto wenye shida, wa mitaani, wenye ulemavu. Hapo Kamishna anayo mamlaka kisheria kusajili na kusimamia uendeshaji wa makao ya watoto.

Mtizamo wa serikali ni huduma hizi zitolewe kule jamii walipo na Shirika lako Human Development Trust (HDT) limekidhi hitaji hilo.

Wizara inatoa tamko rasmi la kutambua huduma ya taasisi yako ni za Ustawi wa Jamii na Taasisi hii ni mdau mmoja wapo kwa utoaji huduma kwa makundi maalum kwa kuchangia jitihada za serikali na jamii kwa kutoa misaada mbalimbali.


G.A. Kameka

KAMISHNA WA USTAWI WA JAMII



REPRODUCTIVE HEALTH and HIV/AIDS IN SCHOOL (2005 – 2007)

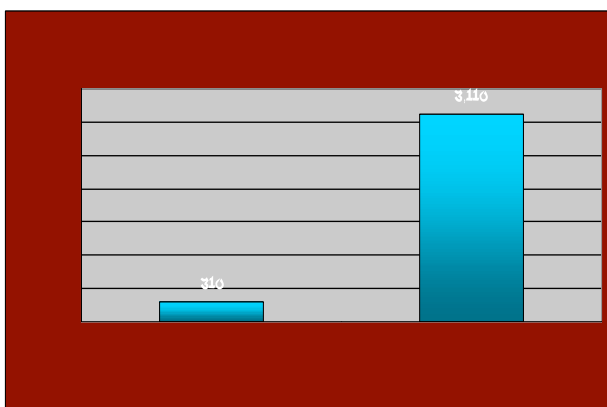
MKUKUTA cluster II goal 1, cluster strategy C6 and E2 envisages to provide life skills and gender sensitive trainings in both primary and secondary schools. It further commits to undertake reforms in primary and secondary teachers curricula to incorporate gender and HIV/AIDS (pg 15-16 annexes). This project was therefore developed to contribute to the targets under this area. The main objective of the project was to provide peer educators with basic knowledge and facts on HIV/AIDS, Reproductive Health and Life skills.

Uniqueness of This Project

Unlike other project which focuses students only, this project also included teachers and school committee. The philosophy behind was to ensure that teachers on one hand to provide backstopping and school committee provide advocacy with parents who resist such session in schools. Students were given sessions in their schools and received backstopping from their teachers with support from school committee. Six months later, refresher training was conducted with the aim of sharing the experience and collective address the challenges faced during the period.

Achievements In Reproductive Health, HIV/AIDS In School Project

The knowledge of participants on HIV/AIDS, Reproductive Health and Life



Skills was increased at the end of training, and was consolidated when students were allowed to practice at school. Evidence indicate that student self confidence increased mainly attributed by this project. Also there are indications from testimonies that there is behavior change on both students and teacher who acknowledge adhering to the ethics.

I was once told that when 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 participants.

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

Says Z.H one of the teachers.

This project was taken as a model in Rungwe, where we worked with district education department. As a result, the department continued to budget and plan for school HIV and RH sessions and this was included in the list of areas requiring supervision.

Relation to NMSF:

Thematic area 1; Prevention: In particular sub theme: Promotion of abstinence, delayed sexual debut, partner reduction and consistent condom use among young people in and out side school. It address the strategic objective: empowering young people with knowledge and skills to dialogue about sexuality, adopt attitude and practice that protect them against HIV infection and access to reproductive health services.



HIV/AIDS INTERVENTIONS PROJECT (2007 – 2009)

MKUKUTA cluster II, goal 2 operational target D articulated a number of measurable and non measurable targets. D (2.8 and 2.9) specifically was addressed by this project. Interventions addressed operational strategy D1, D4 and D5 which are summarized below.

OPERATIONAL TARGET	INTERVENTION PACKAGE
1. Reduce HIV prevalence from 11% to 5% in 2010 between 15-25 age bracket	Support community based initiatives for PLHIV
2. Increase knowledge of HIV/AIDS transmission in general population	Support for food, water, housing and gloves, psychosocial support to PLHIV
3. Reduce HIV/AIDS stigmatization	Community care of chronic illness including AIDS
	Support PLHA care takers with focus on elderly care givers, widows and child headed households

To implement this, HDT became sub recipient in GFATM round four which was granted two years ago that had an onset start last October 2006. Interventions started in Rungwe district with ten wards and now expanding to five more making a total of 15 wards. In line with above interventions package, this project does community mobilization for prevention and stigma reduction, provides nutrition to PLHIV, provide income generating activities to PLHIV, support groups, renovation of VCT, supports community home based care and worked closely with care and treatment and VCT.

Uniqueness of This Project

This project is managed by steering committee which is composed of stakeholders in the district. Chaired by District executive director, the committee is made by government representative representatives, care and treatment centers, VCT, TB and HBC coordinator, NGO and FBO representatives in the district. The committee makes strategic decision such as geographical areas to focus, important strategies and makes recommendation on the progress of the project. This set up has helped HDT to work closely with government and not only to receive adequate support from the government, but also minimize duplication.

The other uniqueness of the project is that it uses theatre (KIHAWIRU, HURUMA and YOUTH ALIVE) to help communities think of the risk behavior and practice and allow them to discuss and agree on collective and individual measures. The community home based care aspect has adapted an approach of using PLHIV them selves to further reduce stigma. Nutrition also being provided is closely being monitored as longitudinal study to show the effect of nutrition on treatment. The results will then be used to influence policies and practice in Tanzania and beyond.



Achievements under The Community Education On HIV/AIDS

Cumulatively, a total of 6,692 people participated in the theatre groups, in the last TWO years of the project. The district networking and partnership has now been reduced and referral system are somewhat working. The quality of life for PLHIV has improved with reduction in hospital attendance, improved general health and continuation of normal duties. Acceptance for PLHIV at family level is anecdotally said to have been improved.



The three theatre groups (45 members) have been trained in basic facts, theatre for development, life skills in order to improve the messaging.

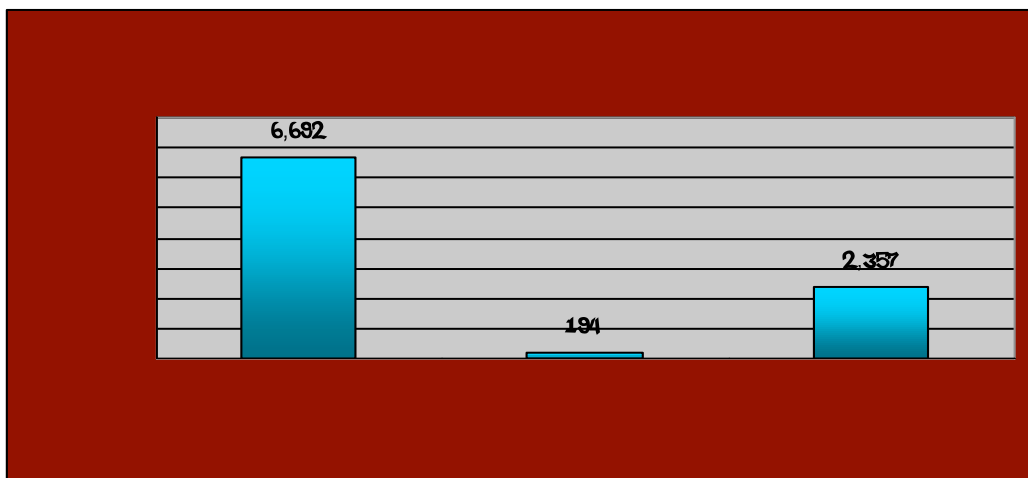
Ten (10) support groups were formed and supported in the ten wards of Rungwe. Each ward it with 10 members, 8 PLHIV and 2 HBC. The main role of support groups includes to provide psycho-social support to PLHIV and to raise awareness to community in order to avoid new infections, reduce stigma.

The picture (right) shows PLHIV receiving locally grown food which they receive monthly. We have been providing with Peanut Butter, Sugar, Lishe Flour, Vegetables, Fruits and Dagaa. In 2009, the nutrition package will change into food supplement (e-pap) to be used by the patients only.]



Cumulatively, a total of 321 PLHIV have been supported with nutrition through their support groups.

e'Pap is a pre cooked fortified food which delivers in a food portion 28 nutrients in a bio-available form. The contents of e'pap includes vitamin a, B1,2, 3,5,6,12, vitamin C,D,E, folic acid and biotin. The mineral content includes calcium, chromium, copper, iodine, iron, magnesium, manganese, molybdenum, selenium and zinc. In 100 grams for adults and 50 for children, it provides the daily required allowance.



Local based interventions have been done, including development of IEC materials that are in local language to allow easy understanding of messages. One of the IEC was the poster on stigma which was developed in Kinyakyusa. As a result of this and other interventions, there is more acceptance of PLHIV at family level and more people going for testing.



Relation to 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.

LESSONS OF EXPERIENCE IN COMMUNITY DEVELOPMENT

Rural based families are more disadvantaged than urban areas.

We 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 un 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.

We have established that families which were headed by women did better in projects they were implementing and compared to male counterpart. When looking at rural Vs urban, those in rural areas tended to 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 cut down 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 quite soon. We hope that when the study is completed, it will be useful for policy and program people.

CHALLENGES IN COMMUNITY DEVELOPMENT

The above results notwithstanding, a number of challenges were faced, which also formed part of the lessons of experience:

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

Across the three projects we implemented, there more required to be done than what we could afford. The program had little funding, some of which being generated by HDT itself and this was not able to meet the demand on the ground.

There is resistance for service providers to change from short lived interventions to long term interventions.

HDT aspiration to pioneer the most vulnerable support project was because most of interventions were short lived and we did not get money for any of long term interventions. Most of development partners support project that creates dependence and more interest on numbers than what can be behind the numbers in terms of quality.

The attitude of some beneficiaries makes it difficult to reach self sustaining.

A number of times some community members expect to be recipient than contributing into their own development. A grant for example given would be used (by some families) without thinking of the future expecting more support. Some PLHIV for example feeling that they need to be provided with and that they could never be productive any more.

PROGRAM FUTURE OUTLOOK

The program future takes departure from the current achievement, the challenges above and lessons too. The current organizational and programmatic review in addition to above will inform the strategic plan to be developed by July 2009. Broadly however in programmatic perspective, this program will:

- Continue to work with communities to design and implement projects leading to sustainable development hence health communities
- Continue targeting PLHIV, MVC, old people, youth and women in interventions that increase their dignity and power in the society
- Enhance collaboration with partners, being local government, development partners and fellow community based groups
- Consolidate the interventions in the five districts (kinondoni, Rungwe, Kyela, Ngara and Biharamulo) and given resource availability expand further



WORKING TOGETHER TOWARDS GREATER IMPACT

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 in 2009. We are indebted to this support and envisage showing more results hence increase of grants.

VSO: Voluntary Service Overseas

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.

American International Health Alliance/Twinning center

AIHA started working with HDT on a cross boarder capacity building project in Botswana since beginning of 2008. AIHA has to date funded HDT to a tune of Tsh. 100 million.

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.

Foundation for Civil Society

Working on youth policy in four districts, FCS funded HDT for a nine month project worth about 34 million. Further relationship is likely to be explored to continue this important work.

Other donors

We would also like to acknowledge support from good Samaritan who contributed to HDT work. Others 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 none donor funded projects and operation. These include Immigration department, Marie stopes international, Zanzibar AIDS commission, Medical Delmundo, Oxfam international, Tanga AIDS working group, BP Tanzania Ltd and vodacom.

Local Governments

We would like to express our heart felt gratitude to leadership of the following districts for their support for the entire period. Rungwe district, Kyela, Ngara, Biharamulo, Kinondoni, Mulaba, Bukoba rural, Mikindani and Mtwara district

FINANCIAL REPORT



The importance and even the indispensability of a transparent and accurate financial information is very important for HDT. The evidence of accountability has attracted many donors and partners to work with us and the number has been increasing year after year.

HDT was able to present an audited financial statements in the year 2005 and since then HDT strives to perform substantially good to comply with International Financial Reporting Standards (IFRS) each year. These in turn have proved that HDT's financial accounts are prepared and audited, complete with clean auditor's report.

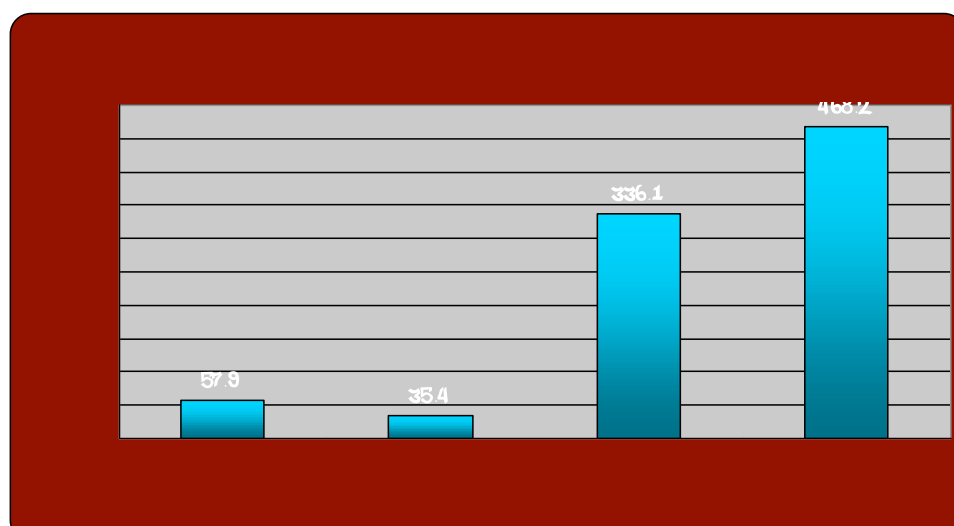
Our main sources of income include the following:

- Grants from partners and other donors
- Income from consultancy work which is unrestricted
- Other income from sources other than those mentioned above like bank interest, membership fees and charges for use of our assets.

This table below summarizes the Income trends for the past four years (2005-2008)

	2008	2007	2006	2005
	TZS	TZS	TZS	TZS
Grants received	378,316,910.00	157,273,487.00	26,870,030.00	24,950,000.00
Consultancy Income	87,150,260.00	178,837,896.00	8,416,000.00	32,707,000.00
Other income	2,723,914.00	-	140,000.00	204,500.00
Total income received	468,191,084.00	336,111,383.00	35,426,030.00	57,861,500.00

Graphical presentation of income trend for years 2005-2008:



Expenditures

Expenditures as per statutory cost categories have been as shown in the table below:

YEAR	2008	2007	2006	2005
Program Percentage of total utilization	56%	66%	49%	51%
PROGRAM				
Capacity building	156,475,045	154,044,528	29,898,490	23,182,930
Community development	52,071,250	33,032,640	0	0
Policy advocacy	36,752,887	48,614,573	0	0
Total program cost	245,299,172	235,691,741	29,898,490	23,182,930
Support and governance cost	192,002,984	123,916,347	31,552,725	22,014,055
GRAND TOTAL	437,302,156	359,608,088	61,451,215	45,195,985

From the above figures, program costs as a percentage of total costs were just about 50% for the first two years and increased considerably in subsequent years. Due to required organizational investment in capital items to allow smooth running of the interventions, the cost in 2008 was about 56%. Partly this was also due to discontinuation of some funding for which fixed cost had to be incurred.

PEOPLE BEHIND THE ACHIEVEMENTS

THE FIRST BOARD MEMBERS OF HDT

Ms. Christine Mwanukuzi Kwayu	Dr. Milleembe Panya
Ms. Hawaa Nashivai Mollel	Dr. Fabian Ndenzako
Ms. Ann May	Mr. Reginald S. Miruko
Mr. Deogratius Ntukamazina	Dr. Peter Bujari
Mr. John Simon Malanilo	

THE STAFF OF HDT

Dr. Peter Bujari 2006 to date	
Isack Geoffrey 2007 To date	John Simon Malanilo 2004 To date
Ildephonce Mabamba 2008 to date	Nasim Losai 2008 to date
David Bukozo 2007 to Date	Shahada Kinyaga 2008 To date
Nicholous Dampu 2007 To date	Asna Juma Mshana 2008 to Date
Agnes Kisala 2007 To date	Hemedi Abdala 2008 To date
Henry Siwali 2008 to date	Moses Kabogo 2008 to date
Saidi Kivinza 2006 – 2008	Yovitha Mrina 2005 – 2007
Rose Kabuje 2005 – 2006	Robina Atugonza 2008
Titus Lugendo 2007	David Ngirangwa 2005

VOLUNTEERS WHO ARE PART OF HDT

Marga Jesse 2007	Agnes Minja Christopher 2007
Sandra Van Marseveen 2007 – 2008	Christopher M. Reyes 2008 to date
Elaine Sammarco 2008 to date	Violet Mathew 2008 to date
Felix Sukumsi 2006 to date	Mwanaidi Msuya 2008 to date

ANNEXES

LIST OF ABBREVIATIONS

ABCT	AIDS Business Coalition Tanzania
ABCZ	AIDS Business Coalition Zanzibar
ACORD	Agency for Cooperation and Research in Development
AIDS	Acquired Immune Deficiency Syndrome
AIHA	American International for health Alliance
AMREF	African medical Research Foundation
ART	Anti Retro Therapy
ARV	Anti Retro Viral Drugs
BAKWATA	Baraza la Waislam Tanzania
CBO	Community Based Organization
CCT	Christian Council of Tanzania
CHAWATA	Chama cha Walemavu Tanzania (Association for Disabled)
CHBC	Community Home Based Care
CRT	Community Resource Trust
CSOs	Civil Society Organizations
EANNASO	Eastern Africa National Networks of AIDS Service Organizations
FBO	Faith Based Organizations
GFATM	Global Fund to fight AIDS, TB and malaria
HBC	Home Based Care
HDT	Human Development Trust
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activity
IMF	International Monetary Fund
JAST	Joint Assistance Strategy Tanzania
KABP	Knowledge, Altitude Behavior and Practices
KINNAPA	Kibaya, Kimana, Njoro, Ndaleta, Namelock and Partimbo
KIWAKKUKI	Kikundi cha Wanawake Kilimanjaro Kupambana na UKIMWI
LGA	Local Government Authority
M &E	Monitoring and Evaluation
MDA	Ministerial and Department Agencies
MDG	Millennium Development Goal
MEDA	Mennonite Economic Development Association
MIFPRO	Mixed Farming Improvement Project
MKUKUTA	Mkakati wa Kukuza Uchumu na Kupunguza Umaskini Tanzania which is "National Strategy for Growth and Reduction of Poverty (NSGRP)
MKUZA	Mkakati wa Kukuza uchumi Zanzibar
MVC	Most Vulnerable Children

NACP	National AIDS Control Program
NCPA	National Costed Plan of Action (for MVC)
NGO	Non Government Organization
NMSF	National Multi-Sectral Strategic Framework
OCA	Organizational capacity Assessment
OD1,2	Organizational Development (level 1,2)
PEPFAR	President's Emergency Plan for AIDS Relief
PINGOS	Pastoralists Indigenous Non Governmental Organization
PLHIV	People Living with HIV
SAIPRO	Same Agriculture Improvement Trust Fund
SRH	Sexual reproductive Health
STI	Sexual Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TAF	Tanzania AIDS Forum
TB	Tuberculosis
TGNP	Tanzania Gender Networking Program
TIP	Traditional Irrigation and Environmental Development Organization
TNCM	Tanzania National Coordination mechanism
TNW+	Tanzania Network of Women Living with HIV and AIDS
ToT	Trainer of Trainers
UWAKUZA	AIDS Coalition for Members of the House of Representatives
VCT	Voluntary Counseling and Testing
VSO	Voluntary Service Overseas
ZAC	Zanzibar AIDS Commission
ZANGOC	Zanzibar NGO Cluster
ZAPHA +	Zanzibar Association for People Living with HIV/AIDS
ZIADA	Zanzibar Interfaith Association for Development and AIDS



ORGANO CHART

HDT ORGANIIZATIONAL CHART

