Human Development Trust [HDT]

2007 Annual report

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II: List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ACODE	Agaupe Upendo and Development
AMREF	African Medical and Research Foundation
AMWAVU	Akina Mama Wanaoishi na Virusi Vya Ukimwi
ARV	Antiretroviral therapy
AWITA	Association of Women Living with HIV & AIDS
BP	British Petroleum
CASEC	Community Aid & Small Enterprises Consultancy
CD4	Cluster Designation 4
CHAKUPAU	Chama cha kupambana na athari za UKIMWI
CHBC	Community Home Based Care
CHOGAM	Commonwealth peoples forum
CRT	Community Resource Trust
CSO	Civil Society Organization
CTC	Care and Treatment Centers
DAC	District AIDS Coordinator
DSW	District Social Welfare
FBO	Faith Based Organisation
FCS	Foundation for Civil Society
FIHATA	Fighting HIV & AIDS in Tanzania
FVN	Furaha VVU Network
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HBC	Home Based Care
HDT	Human Development Trust
HEDEA	Heath and Development for PLHIV
HIV	Human Immunodeficiency Virus
HOSPHA+	Hope Star for People Living with HIV & AIDS
IEC	Information, Education and Communication
IGA	Income Generating Activities
INGO	International Non-Governmental Organisation
IT	Information Technology
KINNAPA	Kibaya, Kimana, Njoro, Ndaleta, Namelock and Partimbo
KIWAKKUKI	Kikundi cha Wanawake Kilimanjaro Kupambana na UKIMWI
M&E	Monitoring and Evaluation
MEDA	Mennonite Economic Development Association
MIFPRO	Mixed Farming Improvement Project

MoU	Memorandum of Understanding
MVC	Most Vulnerable Children
NACP	National AIDS Control Program
NEBUMWO	Network of Bukoba Municipal Women with HIV & AIDS
NGO	Non-Governmental Organisation
NMSF	National Multisectoral Strategic Framework
NPF	NGO Policy Forum
NYP+	National Young Living Positive
PER	Public Expenditure Review
PINGOS	Pastoralists Indegenous Non Governmental Organization
PLHIV	People Living with HIV
PPF	Public Pension Fund
R2L	Right to Life
RH	Reproductive Health
SAIPRO	Same Agriculture Improvement Trust Fund
SHAFA	Shangwe na Faraja
STI	Sexually Transmitted Infection
SWD	Social Welfare Department
TACAIDS	Tanzania Commission for AIDS
TADEPA	Tanzania Development AIDS Trust
TAF	Tanzania AIDS Forum
TAYOPA	Tanzania Young Ambassadors living with HIV & AIDS
TIP	Traditional Irrigation and Environmental Development Organization
TMDWO	Tanzania Mineworkers Development Organization
TOCHA+	Tanzania Orphans and Children with HIV & AIDS
TOT	Training of Trainers
TWIHA	Tanzania Women Infected with HIV & AIDS
UMULA	Umoja katika Mpambano ya UKIMWi ni Lazima
UNAIDS	United Nations Program on AIDS
UNDP	United Nations Development Program
UVIBO	Umoja Vikundi Biirabo
UWAVUBU	Umoja Wa Wanawake wanaoishi na Virusi vya Ukumwi Bukoba
VCT	Voluntary Counseling and Testing
VSO	Voluntary Service Overseas
VVU	Virusi ya Ukimwi (HIV)
WAMATA	Walio katika Mapambano ya ukimwi Tanzania
WOFATA	Women Fighting AIDS in Tanzania

III: Foreword by the Chairperson of the board of Trustees

Another year of hard work, challenges and good results has come to an end and we are happy to celebrate each moment we have worked with our partners and friends. In the year 2006 we shared with you the achievements, which we have realized together, without forgetting the challenges we faced and which makes the organisation stronger each day. Without our partners' support we wouldn't have been in this position now. We can't forget our key partners, the community with whom we are proudly sharing with you the fruits of their commitment towards development.

Each one of you has supported HDT in overcoming the challenges that were experienced in 2006, the main one being funding. Commitment of our key partners and the hard work of our staff team have made it possible to count the achievements that we are happy to share with you.

Partnerships have been one of our key strategies in realizing results, which include that with Egmont Trust, Foundation for Civil Society, GFATM through AMREF, VSO and Abbot fund.

In the first year of implementing our Strategic Plan, we have grown in many ways: our staff number has increased from 6 to 13, HDT opened field offices in Kagera and Mbeya, more volunteers with multicultural orientation are brought onboard, we developed a new website for HDT (see www.hdt.or.tz) and consolidated our interventions.

We have continued with our programmes in the 3 areas of interventions namely; capacity building, policy and advocacy and community development. Key to mention here is that we noted that each area is dependent on the others, hence the need for strengthening the inter linkage.

In 2008 we will continue to work on our interventions in Dar es Salaam, Mbeya and Kagera. We anticipate to expand our work within communities in 2008. The Most Vulnerable Children program will expand to Rungwe district (Mbeya) and we will support 14 more organizations in Organizational Development. HDT also got the unique opportunity to start a twinning project with Marang Child Care Network in Botswana. A summary of the planned 2008 interventions is presented in the last chapter.

I would like to present my gratitude to our member of staff and the leadership that takes charge on the day-to-day management, our esteemed partners and family in development for their support and collaboration. I finally call for your continued cooperation for achieving the results we have planned for the year 2008.

Christine Mwanukuzi-Kwayu
Chairperson of the Board of Trustees

IV: Message from the Executive Director

Dear Partners,

HDT is just about to celebrate its fourth year anniversary, with a strong foundation and substantial successes. In these four years, HDT presents its third annual report which highlights development within the organization and the progress and achievements registered in the three pillars. However, for these successes to have a wide effect, we need a functioning governance system at both national and subsequent levels.

Problem tree analysis of Upendo Group during the OD II training in Rungwe district (Mbeya)

As will be presented later in this report, our work in 2007 was supported by many partners. I salute GFATM through AMREF, VSO, Egmont Trust and Foundation for Civil Society in that order. A special thanks goes to the Immigration Department where HDT, through partnership in the HIV work place program, made services available within the department. In turn HDT generated some unrestricted funds, of which some other projects are funded directly.

I would also like to thank our partners under capacity building, who have demonstrated that, if given appropriate and tailored support, they can deliver the results. The capacity building program to CBOs has been tailor made to ensure that community based organizations can better manage their organization and projects they run.

I also thank my Board of Trustees for their support and encouragement throughout the year, for without them the achievements stated in this report would not have been achieved. Another pivotal group I would like to salute is the staff and volunteers of HDT who worked tirelessly, often long hours without any additional remuneration. I wish also to thank VSO for supporting volunteers, who have been instrumental to the work of HDT.

For the third year, funding hasn't been easy and mechanism for the same remains obscure. I call for relevant authority to work on the framework and mechanism for transparent and harmonized mechanisms for funding and partnerships with Civil Society Organizations. This will build a strong Civil Society in the country.

Sincerely,

<signature>
Dr. Peter Bujari
Executive Director

V: Executive summary

In 2007, HDT has started implementing the strategic plan 2007-2009. According to this plan, HDT has worked in three regions namely Dar es Salaam, Mbeya and Kagera. The two field offices were opened in 2007; in January 2007 in Mbeya (Rungwe) and in March 2007 in Kagera (Ngara).

In 2007 HDT has grown from a small office in Dar es Salaam with 6 staff members to an organisation with 13 staff members, including two volunteers. HDT's projects are aligned along 3 strategic pillars; Capacity Building, Policy Advocacy and Community Development.

In the area of Capacity Building, HDT is building the capacity of PLHIV organisations in Dar es Salaam, Kagera and Mbeya. This project started in April 2007 with the aim to strengthen the capacity of PLHIV organisations to enable them to become more sustainable and have more impact in their interventions. To build the capacity of these organisations, a series of Organizational Development workshops were conducted and small grants were disbursed to qualified organisations. HDT is also supporting organisations and institutions to implement a HIV & AIDS workplace policy.

On Policy Advocacy, HDT has implemented a Youth Policy project in Mbeya and Kagera to educate youth on youth policy and good governance. This included the formation of youth groups at village level and networks at ward and district levels. The program also entails training in life skills and reproductive health in order for youth to be able to be more responsible and make the right choices. Furthermore, HDT has worked with other organizations on the HIV and AIDS budget analysis and HDT is the secretariat to Tanzania AIDS Forum from May 2006 to May 2009. Although the forum is in its young existence, it has already contributed to the revision of the current NMSF, the consultative meeting on UNGASS report and the AIDS Bill.

Within Community Development, HDT has implemented a project for Most Vulnerable Children and their foster families in Kinondoni and Ngara districts. The project aims to improve the livelihood of foster families that support MVCs by giving small grants to establish small but sustainable projects. The profit of the projects is used to support MVCs with basic needs (e.g. school uniforms, exercise books, school fees etc.). Under Global Fund, HDT implements a project on community education in the areas of prevention and stigma reduction through theatre for development. HDT also promoted and supported the formation of groups for PLHIV and supported nutritional needs for needy PLHIV. In addition, a school HIV and RH project is implemented in Mbeya, training students and teachers as HIV and AIDS Peer Educators.

In 2008 HDT will continue with the implementation of most of these projects and some will be expended to other regions. Beside project implementation, the focus will also be on developing a strong system for monitoring and evaluation and improving the communication of our work to stakeholders. The later already started with the launch of the new HDT website in September 2007.

1. HIV & AIDS context analysis and major trends in 2007

Tanzania, like many other Sub-Saharan African countries, has continued to face the challenges of the AIDS pandemic, with women and old carers absorbing the blunt of the pandemic. Major progress has been registered particularly in the area of promotion of VCT uptake countrywide, which was lead by the President of the United Republic of Tanzania the Excellence Jakaya Mrisho Kikwete. The world AIDS Day in 2007 concluded the long and stepwise participatory process to develop a new National Multisectoral Strategic Framework for 2008 to 2012. Development of robust response in the country has been hampered by many factors, among them being poor coordination and low resources at district level, creating AIDS budget support through the government decreasing the funding flow to the Civil Society, weak coordination among CSO to effectively engage in policies and planning wholesome as a sector. Poor and late accounting of funds by either government and/or civil society in public and private partnership schemes such as Global fund, lead to late release of funds and sometimes reduction of funding at different phases. This has immeasurably affected the continuity and smooth provision of services.

The funding mechanisms in the country on HIV and AIDS have remained diverse, with RFE, FCS, GFATM, RFA, PEPFAR and TACAIDS to mention a few institutions disbursing funds to actors. The framework to access funding in such a large country has remained uncoordinated with more funding reported available for the country than is physically accessible. Many actors therefore have continued to starve in abundance. HDT for example, had a deficit in its 2007 annual budget of up to 40 million, which was never raised despite a number of attempts to increase funding. HDT partners who we have regular contact (10 in Dar es Salaam and 7 in Kagera) have the same cry. We expect TACAIDS will conclude the study on framework and mechanisms for CSO to access funding early in 2008 and that the results will be used to develop efficient funding mechanisms in the country.

Across the country and in many areas, programmatic interventions have continued to be strong. Community groups, mainly of women, shoulder the bulk of the work, especially in Home Based Care, with little or no skills to cope. Old cares have continued to be forced to provide for their grand children. Many interventions are being implemented with a priority to numbers rather than the quality of the work and or sustainability of projects. Monitoring, reporting and evaluation frameworks are documented to be weak and the same can be said about strategic information use in programmatic responses. These are areas that need to be worked on to strengthen the response to the pandemic.

The preparation of NMSF (2008 to 2012) was for the first time open for input by wide stakeholders though participation excluded non state actors towards the end. This and the fact that the MoU for implementation is signed between Government and Donors reflect an inherent perception that CSO are perceived as junior brother. The paraphrasing of the vision of NMSF into more a realistic one probably indicates the better understanding of the pandemic and preparedness to register results if some of the above issues are addressed. The priorities of NMSF were prevention, provision of sustainable and quality services and locally based interventions indicate further strength pending implementation of the same.

2. About Human Development Trust

2.1 The organisation

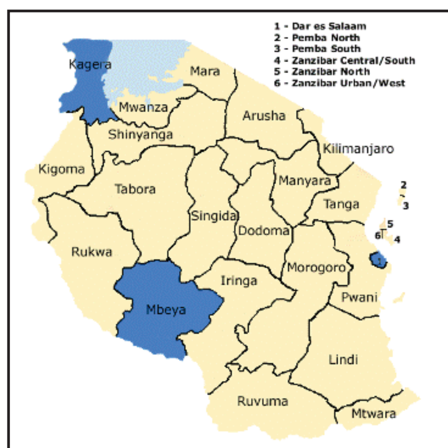
The Human Development Trust (HDT) is a not for profit, non-government organization (NGO) operating at both grassroots and national level. We are registered under society ordinance 1954 (Rule 5) with registration number So. NO 12060 of February 2004.

HDT was founded four years ago with the intention to partner with communities to develop interventions that improve health of poor families in Tanzania including taking care of Most Vulnerable Children.

The head office is located in Dar es Salaam and HDT has 2 field offices; one in Mbeya (Rungwe), which was opened in January 2007 and another in Kagera (Ngara) which opened in March 2007. HDT has presence in three regions now, which are Dar es Salaam, Kagera and Mbeya. In partnership with VSO, we also work in Mtwara region under Capacity building. For 2007, HDT worked with an enthusiastic staff of 13 team members, including two volunteers (one from VSO and one from UN). This number is projected to increase to 15 in 2008.

Opening of the HDT office in Kagera in March 2007

HDT is an organization that is continually learning, driving to succeed and in doing so, helping to better serve its target beneficiaries – people living with HIV & AIDS and the community.



The three HDT priority regions of operations

2.1. Vision and mission

HDT's vision is for a society where health is a community priority, where rights of children, women and old people are respected in all undertakings.

The mission is to pioneer and develop new standards of substantive equality for men, children, youth and older people throughout Tanzania.

2.2. Areas of work

All the projects that are implemented by HDT are in line with the 3 strategic pillars: Capacity Building, Policy Advocacy and Community Development. Although Community Development is the core business appreciated by many actors, the other two areas of work are essential to enable community development to be effective.

2.2.1. Policy Advocacy

HDT is working in Policy Advocacy to ensure that CSOs are engaging in policy making through effective coordinated strategic advocacy work.

HDT defines 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 (formulation, implementation and review) as a strategy to improve ownership, seeking accountability and ensuring health in the community.
2. CSOs (working in HIV, health, gender and poverty reduction) are coordinated through Tanzania AIDS Forum (TAF) to effectively engage in the policy processes and budget processes.

2.2.2. Capacity Building

HDT engages in Capacity Building because several partners and allies in HIV & AIDS have a low capacity. By improving the capacity of our stakeholders, they are able to provide high quality services to the communities where they work.

HDT defines capacity building as: working with institutions and communities to help manage themselves and/or program better as a means to delivering high quality services. Quality Program delivery is dependent on the capacity to manage the institution as well as planning

and implementing the programs. Capacity Building is therefore a means to an end.

In this area, the strategic objectives are:

1. Support organizations in implementing HIV work place programs and develop appropriate policies, strategic interventions to better care for their staff.
2. Support PLHIV partner organisations and those working in the area of HIV to collectively improve organizational and project management.
3. Build capacity of partner organisations in policy analysis and effectively engage in policy processes.

Capacity building workshop in Dar es Salaam

2.2.3. Community Development

Community Development work is done to make sure interventions address the actual needs of the communities, create a sense of ownership and the results are sustainable.

HDT defines Community Development as: working in partnership with stakeholders to provide support services to the community.

In this area, the strategic objectives are:

1. Strengthen approaches to HIV and STI prevention work that effectively address gender and sexuality issues, with a particular focus on men.
2. Innovative HIV and AIDS care, support with emphasis on cross referral system and support groups are formed and functional in operational areas.
3. Orphans and Vulnerable Children (MVC) are cared for by community through community based interventions and foster families.

2.3. HDT values

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

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

2.4. Commitment of Human Development Trust

1. We commit to and listen to the people we serve, ensuring that their voices are heard, this also contributes to continuous learning for HDT and its staff members and enables us to feed this into 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 pioneering 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 are committed to advocating for the health and education of children, old people and youth throughout Tanzania.
5. We are committed to network and work in partnership with other actors in the country both state and not state. In particular, we will work towards coherent and effective partnership between CSOs working in HIV, Health, Gender and/or in policy and budget processes.

HDT head office in Dar es Salaam

2.5. Project management guidelines

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

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

2.6. The staff and volunteers who worked with HDT in 2007

Below you find a list of all the staff members and volunteers who worked tirelessly to deliver the programs described in this report.

Dr. Peter Bujari MD, MBA
Executive Director

Simon J. Malanilo
Program Manager Community Development

Geofrey Isack
Finance and Admin Manager

Marga Janse
Management Advisor (volunteer from VSO)

Sandra van Maarseveen
Management Advisor (volunteer from VSO)

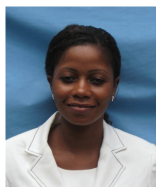
Titus Lugendo
Regional Program Officer Mbeya

Yovitha Mrina
Program Officer Research and Training

Neema Mhada
Portfolio manager TAF (volunteer from UN)

David Bukozo
Regional Program Assistant Kagera

Nicholous Dampu
Program Officer Capacity Building



Agnes Kisala
Finance and Admin Assistant

Felix Sukumsi
IT Officer

Henry Siwale
Driver

Agnes Christopher
Program Volunteer (intern from the Institute of Social work)

Shamim Bayona
Finance and Admin Trainee (intern from Tumaini University)

Saidi Kivinza
Office Assistant

3. Achievements in 2007

Achievements in this year are structured on the strategic objectives that are introduced in the strategic plan 2007 – 2009. This strategic plan is being implemented since January 2007 and is expected to undergo a midterm review in July 2008 and will end in December 2009. This format is adopted to ensure consistency and comparison of performance in subsequent years.

3.1. Achievements on strategic issue 1: to promote and implement strategic HIV & AIDS interventions

HDT is implementing 2 projects under this strategic objective in three priority regions.

3.1.1. Global Fund (GFATM) project

Introduction

Under the Global Fund, a project is implemented aiming for community education on prevention and stigma reduction in the community through theatre for Development and support groups. Theatre for development is both educative and entertainment, allowing communities to identify local risks and discuss possible ways to minimize them including institutionalization of local by laws as deem necessary. This project is run from the HDT regional office in Tukuyu and is being implemented in collaboration with Rungwe district. It is funded by Global Fund through AMREF as a lead recipient.

Entry en set-up

The project started with a meeting held between LGA leaders and other stakeholders to discuss the project objectives and decide the best approach and the wards to be included. After this meeting, the ward leaders of the chosen wards were informed about the start of the project and the support it would provide. It was also agreed with them how they would be supporting the project. To reinforce the partnership, the District Director was the chair of the steering committee for the project.

Former District Director Mr. Buliga chairing the stakeholder meeting. On the left is Mr. Lugendo, the Regional Program Officer for HDT in Mbeya.

Formation of Community Theater groups

The methods being used for community education is Theatre for Development. The aim of the project was to work with existing theater groups where possible, so that local resources could be strengthened. Where theater groups did not exist, HDT worked with local leaders to identify artists that would be good model in the community. In total 3 groups and 45 artists were trained in Theatre for Development Methodology as well as on how to act and create a message for Community Theater. After the training, the theater groups were left to practice under the guidance of the Project manager and Project Officer to improve their skills. The groups have been the cornerstone for the community mobilization.

Community education through Theatre for Development

The three theatre groups were supported with an honorarium to undertake community mobilization. The performances were focusing on risk behavior, sexual practices, VCT and stigma reduction and were allowing community discussion afterwards. A total of 10 theatre performances in 10 wards and a minimum of 5,415 community members were reached. Twining the theatre and VCT team started late (from July), but in due course 55 people tested during the campaign and out of those, 23 were found to be HIV positive.

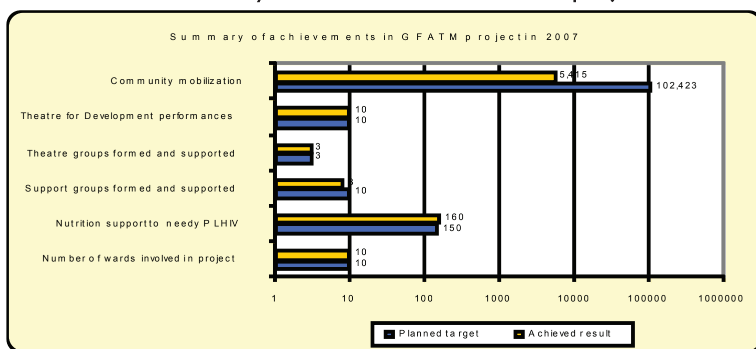
Provision of nutrition including health education

HDT promoted the formation of 8 support groups for PLHIV, with the aim to provide psychosocial support to PLHIV and to undertake a community HIV education program. HDT provided support in the formation of these PLHIV groups by conducting monthly meetings. Funds were also set aside to provide nutrition to needy PLHIV, preferably on ARVs, so that their health could improve and they could resume their normal function. A total of 160 people were given nutrition, which is 10 more then expected.

Achievements

This project among other success has managed to revive the referral and networking among implementers in the HIV and TB. The partnership between actors in the district has also been strengthened. Needless to say is the improved quality of life to patients on ARV who have admittedly reported to be healthy now and being able to undertake their duties. Study also showed that their CD4 counts have increased with an average of 65%.

The graph below shows a summary of the achievements in this project:



Targeted support to PLHIV can also lead to personal growth and independence, as is shown by a case study from Kamba Segela Mbeya:

Nickson Mwagomba tested positive three years ago, when he was admitted for Tuberculosis. He was on Septrin for over a year, before his CD4 counts were down to a level that requires to start with ARVs. This was about 18 months after he got tested. However, his condition didn't improve substantially when on ARVs. Until late 2006, when HDT in collaboration with Tukuyu CTC identified PLHIV on ARVs who needed nutrition. The HDT Regional Program Officer by then Mr. Lugendo met Nickson when he was in a bad shape: "I was on bed, had no energy to work and my fiends were not caring. I received some food from HDT and subsequently supportive counseling through our group. When I gained energy, I started mobilizing others to join together and now we have a strong group called Furaha WAVIU NETWORK which has up to 23 active members now" said Nickson, who is the chair of Furaha Network.

Nickson, one of the project beneficiaries and chair of Furaha Network

Nickson is one of the beneficially of the project that was supported with food along side with others. But he came out strong as a leader to mobilize and support other people who are sick.

Through HDT's Capacity Building Program, Furaha Network has been trained on Organizational Development and project Management and will receive a grant to develop their group and support PLHIV. Nickson has been supporting Home Based Care in Kambasegela ward and HDT is considering training him as Community Home Based Care Provider next year.

3.1.2. Most Vulnerable Children (MVC) Project

Introduction

HDT implements the MVC project with the philosophy that old people and women shoulder the burden of care, thus they should be supported to cope. The objective of the project is to improve the livelihood of those foster families that support MVCs. This improvement is realized by giving the families small grants, so they are able to meet immediate needs and scale up their existing source of livelihood for sustainability. The philosophy is that when the income of the family improves, care takers will be in position to cater for the basic needs (for example

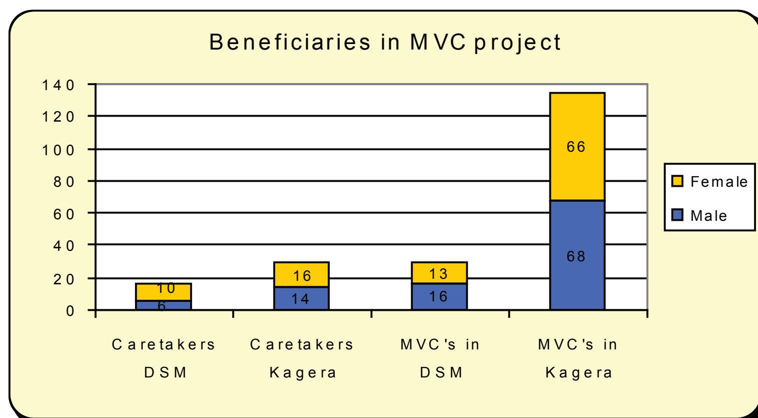
school uniforms, medical needs, exercise books and pencils) of their children and they will be able to sustain the services beyond the life of the project. This approach differs from other projects supporting Most Vulnerable Children in a way that it strengthen the families to improve their livelihood and capacity to better care for their children and the children they foster. This way the project ensures sustainability of family livelihoods and empowers them rather than providing ready made materials to vulnerable children. To ensure that children's self esteem is improved, children meeting addressing their involvement in projects and psychosocial needs are conducted.

Entry en set-up

HDT started the project as a pilot in Dar es Salaam (Kinondoni municipal) in March 2007. The start was a meeting with local authorities (mtaa leaders and Ward Community Development Officer) where HDT introduced the idea on how the community could support MVCs. During this meeting it was also decided to start the project in hamlet 'Ali Maua B' in Kinondoni. Once the pilot with 10 foster families proved to be successful, HDT expanded the project with the use of its unrestricted funds acquired from capacity building programs. In May 2007, HDT started implementation of the project in Kagera (Ngara district), where the same methodologies were used as in Dar es Salaam, with some minor changes in activities due to lessons leant in the pilot.

Identification of foster families

For the pilot project, HDT identified 10 foster families in Kijitonyama Ward in Dar es Salaam. The identification was done in collaboration with local authorities and a priority was given to caregivers of age 55+. In May 2007, another 30 foster families caring for 123 MVCs were identified in Kagera (Ngara district). Among these families there are also two child headed families. In July 2007, 6 new families were identified in Dar es Salaam. In total, 46 families that are caring for 163 MVC's participated in project in 2007. About half of the beneficiaries are female and half are men and most of the MVC's are in the age between 6 and 18.



Training of foster families and provision of grants

After identification, the families were brought together to discuss their source of livelihood and to think how they can expand their income. Once it is clear how they think they could be best supported, they learn the general principles of entrepreneurship and managing a business. They are also taught basic recordkeeping and how to support their children on immediate and long term needs. This also includes training on psychosocial support. Once the families were trained, they were provided with small grants and/or materials, depending on the nature of the livelihood they would like to undertake or strengthen. In Dar es Salaam the minimum grant was Tsh. 100,000 while the maximum was Tsh. 140,000. The grants provided to each family in Kagera ranged from Tsh. 75,000 to 150,000. In some cases, the project invested in improving the housing of the carers when it was deemed necessary.

Income Generating Activities

With the small grants and/or materials that HDT provided, the families were able to establish small income generating projects. Examples of these projects are selling charcoal, starting a small shop or keeping chicken or goats. 40% of all the families are very successful with their business and have been making profit already. The rest of the families are still improving their business.

Family in MVC project

Support to MVC's

Through the project we have been able to improve the livelihood of most families that are participating. Almost all families have been able to support the MVCs with basic needs such as uniforms, shoes, exercise books, pens and school fees or have been covering health costs. School attendance of MVCs has significantly improved. This was also due to the fact that in collaboration with the hamlet leader, HDT managed to change the starting time of the local video show (now the video show is scheduled in the evening instead of in the morning). Some older children are also involved in family business after school. Linking with ward education team, HDT has been able to address the tuition issues where some pupils who can not pay are chased out of classes.

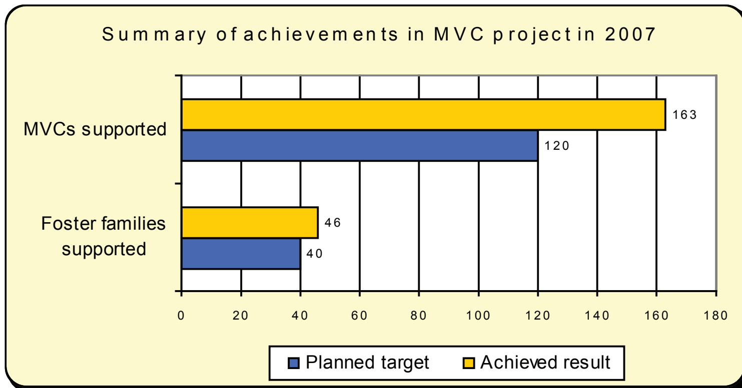
Mentoring

Weekly monitoring visits to the individual families were conducted to support and mentor them. These visits were also meant to check the progress of the business, the record keeping and spending to meet the needs of the MVCs. A one day evaluation at Mtaa was done with all families to share experiences and the challenges they faced, not only during implementation of project but also on their family transformation.

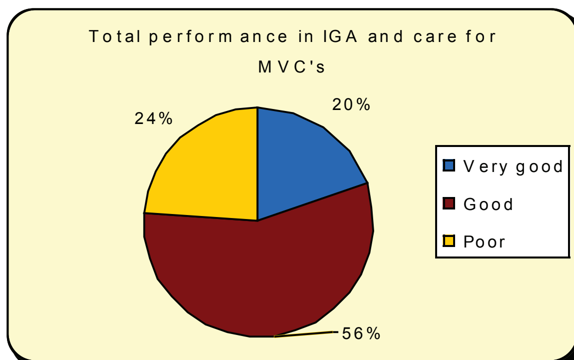
Achievements

Due to the much appreciated work, HDT has been engaged in the Children's Bill in December 2007. This work will continue in 2008 and it intends to operationalize the Child Development Policy. HDT also managed to obtain a recommendation letter from SWD Kinondoni, recommending HDT to be a MVC service provider.

The graph below shows a summary of the achievements in this project:



As shown below, we have leant through this project that some families are successful and others not. We have identified some of the bottlenecks in the same and we will be addressing a number of them in 2008.



As described above, HDT funds the MVC project in Dar es Salaam and Kagera, whose expansion is limited due to the lack of available funding. We believe however that the support we provided has immeasurably improved the life of Most Vulnerable Children. This is exemplified by the short story from Mrs. Amina Yusufu, resident of Kijitonyama below.

Mrs. Amina Yusuph, care taker of 4 orphans said: *"I used the grant to increase my low scale business in baking and selling maandazi (small bites for tea). Every day I bake maandazi now 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 supported enough financially for now. 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".*

Mrs. Amina Yusuph with two of her children

3.1.3. Lessons learnt during project implementation

Lesson 1: Although the knowledge on HIV is reportedly to be high, we noted that its still low in many areas we work in.

In some of the areas where we implement projects, there is still low knowledge on HIV and AIDS (e.g. the 2 districts in Mbeya region). This leads to high denial and stigma, with some community members even arguing that PLHIV should be in jail or killed. Projects that aim for stigma reduction and community mobilization remain very important and sufficient funds should be allocated to this, as behavioral change takes a long time.

Lesson 2: ARV use combined with good nutrition is most effective

ARV use without good nutrition is not very effective because the health of AIDS patients often deteriorates. In the GFATM project, HDT supported nutritional needs for PLHIV that were also on ARV's, with only a few exceptions. The combination of starting ARV's and good nutrition shows good results. We recommend that the government recons with us and considers having nutritional support as a package to those that are critically ill, rather than drugs alone. See also the example of Nickson that is described earlier in this chapter.

Lesson 3: the well-being of project beneficiaries depends on releases of funds by donors and delays in funds often compromise the livelihood and even security of providers.

Some of the funds that HDT received from donor were released later then anticipated. For example, funds from GFATM stopped completely in June 2007 till December and it was hard to respond to patients. This causes delays or even stops the implementation of project activities, that are lifesaving and as a result we lost three people to AIDS. In Rungwe for example, some PLHIV have lost hope and some of them have even immigrated to other places. HDT is strategically planning to minimize these risks by ensuring donor funds are used in interventions that are sustainable. For example, supporting PLHIV is planned to be more sustainable by given nutrition in combination with training on IGA and bookkeeping. This way, as soon as their health improves, they are able to provide for themselves.

Lesson 4: most project beneficiaries have little entrepreneurship skills, and some have lost hope of breaking the cycle of poverty.

When implementing projects that include training on IGA, it was recognized that most project beneficiaries have little entrepreneurship skills. This means that in the training extra attention should be given to topics such as how to set up and run a profitable business and how to promote your business and generate customers. After the training, this also should be given extra attention in supervision and mentoring. Some beneficiaries believed that the grant they received for starting up or up scaling their business was a gift and that HDT should not follow them up or guide them on how they can improve their business in the best way. The aim and guidelines of the projects will in the future be communicated well to ensure beneficiaries understand, are committed and are actively involved. The problem of commitment might also be solved by practical solutions, such as giving out non-interest loans instead of grants.

Lesson 5: there is a difference in performance by men and women

In the MVC project we have found that the families we support that are led by women are doing much better than men-headed families. We noticed that the likelihood of female supported family to do better was about two times higher than that of men headed household. The scale of assessment isn't bid enough to be representative, but this needs further study. In 2008, we will conduct more research to find out what are the reasons for this situation and take further action on the outcomes of this research.

Lesson 6: If local leaders are involved in the work, they can be instrumental in the support to PLHIV

Working in Kambasegela ward in Mbeya, HDT was keen to involve ward councilor and other local leaders. When they understood the concept and how those infected should be valued and supported, the ward meeting agreed that those who have disclosed their status will be exempted to contribute to school development program. The money they would have used was then redirected to cover their own need. This practice was recognized and acknowledged by HDT as appropriate leadership to be exemplary. This act mobilized further disclosure and subsequent establishment of support group which grew to be a community Based Organization as we present this report. We have leant that involvement of local leaders is instrumental to the local success of the project.

3.2. Achievements on strategic issue 2: to engage and undertake strategic advocacy work

HDT has 3 projects under this strategic objective.

3.2.1. Youth Policy project

Introduction

According to the 2005 review, it was discovered that most of the youth have neither the idea of what is contained in the national youth policy, nor having a copy of it. The review further showed that existing groups in communities of Mbeya and Kagera did not undertake policy advocacy in their locality. Where youth groups existed, they had no networks and were not organized, which made it difficult to engage at district level. To address these issues, HDT started a nine months Youth Policy project, which would educate youth on youth policy and good governance. The program also entailed training in life skills and reproductive health in order for youth to be able to be more responsible and make the right choices. This project is funded by the Foundation for Civil Society.

Entry and set-up

HDT conducted inception meetings with district officials to introduce the project in four districts (Rungwe and Kyela in Mbeya region; Ngara and Biharamulo in Kagera region). In these four districts a total of 10 wards were identified to participate in the project, in collaboration with the District officials. This was followed by the formation of a task force in each district. HDT, with the assistance of the District Community Development Officer, selected 5 members from each district to form the task force, which included in and out of school youth, one LGA, one CSO representative and one district official who would provide the guidance.

Establishment of youth groups

Once the task forces had been establish, youth groups were identified by the taskforces. Where groups did not exist, the task forces helped to identify about fifty youth (both male and female and in and out of school) to form youth groups at village level. A total of 40

youth groups have been established. These groups are supported by HDT with onsite support during the whole project.

Identification and training of youth

The aim was to identify and train a total of 100 youth in the age between 18 and 25 in the four districts. The youth groups facilitated to select 25 representatives per district who were trained and in return facilitated dialogues on youth issues in the district. The first training of two days targeted youth group formation & dynamics, youth policy, partnership and networking. This was followed by a second workshop of three days on good governance, advocacy, youth development policy and life skills. During the training, participatory approaches are employed to make sure the youth is fully engaged.

This project suffered lack of continuity as the donor would not remit funds in the appropriate time frame. Started six months later, the project has been on going for eight months and just two quarters have been funded. This has caused considerable inconvenience to HDT and youth them selves as neither HDT not youth could predict next step and when to start.

Training of youth on youth policies

Provision of onsite support

The youth that was trained conducted meetings at their wards to discuss with their peers on youth policy, group dynamics, partnership, life skills and networking. The same trained youth attended quarterly meetings to discuss governance, policy and life skills. HDT assisted in problems that youth encountered during onsite support. Youth have now started demanding their rights of participation in various activities in local areas. This trend is seen as chaos to leaders at local level, who have no experience in involving youth in decision making.

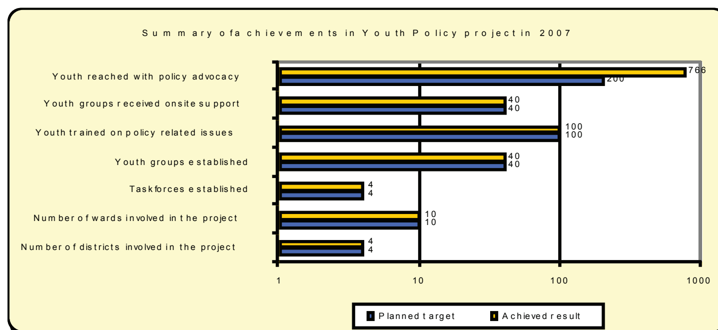
Achievements

In Katoke (Kagera region) a youth group known as Umoja wa Vijana Katoke (UVIKA) was established after the training. The group already has 21 members now (5 girls and 16 boys), prepared a constitution and submitted the registration to the DCDO office. They also opened a bank account at NMB bank, where the entrance fee is Tsh. 10,000 for every member is

saved.

Almost in all districts youth felt that the Youth Development Policy was made without their consult and that the Youth development Committees in the policy are made-up of adults only. Youth need to be included in those committees and therefore they made alternative committees which are to be submitted to the Ministry of Labour and Youth Development.

The graph below shows a summary of the achievements in this project:



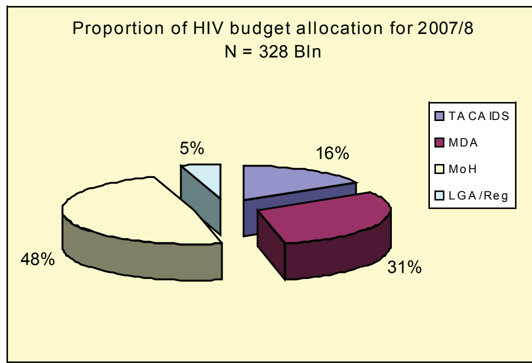
3.2.2. HIV budget analysis

Introduction

Tanzania has been experiences a rapid increase in AIDS funding in the last years. However, the infection rate has not been reduced and spending is reported to be skewed towards care and treatment. Whereas the total expenditure on HIV and AIDS in Tanzania is known, it is not known where the money is being spent and on what programs. To that effect, HDT has worked with other organizations on the HIV and AIDS budget analysis for 2005/6 to determine the amount of funds allocated to HIV. The actions under this section happen in Dar es Salaam, but the effect of the same reaches the whole country in terms of budget allocation.

HIV Budget analysis

To do the budget analysis, all budget guidelines and Medium Term Expenditure Framework from respective ministries are collected and analyzed. Through thorough checking and cross checking it was determined how HIV funds were allocated as a total and by administrative classification. It also determined central and regional allocation. This information was presented to the members of parliament to make a better contribution to the budget speech. It is also being used to engage with decision makers to influence allocations.



Currently HDT is working with other NGO's on the budget analysis for 2007/8. Brief findings are presented above. The findings of that analysis will be used to influence the next Tanzania Government budget cycle in terms of prioritization, equity and efficiency. It will also be used to engage policy makers in debates on how HIV/AIDS spending can be improved to achieve national and international commitments.

Engagement with parliamentary Committee on Constitutional, Legal and Public Administration

3.2.3. Secretariat of Tanzania AIDS Forum (TAF)

Introduction

HDT has been leading an advocacy group of NGO's and has in this role registered a number of policy changes. These factors contributed to the recommendation of HDT becoming the secretariat of the Tanzania AIDS Forum (TAF). TAF is the newly visionary CSO network consisting of NGOs, FBOs and INGOs aiming to strength the voice of non state actors and improve programming on HIV & AIDS. In the role of secretariat HDT coordinates and takes lead in all TAF activities. TAF is chaired by Dr. Peter Bujari (director of HDT) and lead by the executive committee, which comprises of nine national CSOs . The Tanzania AIDS Forum held its inaugural Annual General Assembly in February 2007.

The work of TAF

Although the forum is in its young existence, it already contributed to the revision of the current National Multisectoral Strategic Framework for 2008 to 2012 and continues to be active in the finalization process. TAF also mobilized the members to undertake a number of advocacy campaigns, e.g. on the review of the AIDS bill. Furthermore, TAF contributed to capacity building to members on the UNGASS reporting process and Indicators, provided technical assistance to TACAIDS on the 2008 UNGASS reporting and participated in condom programming of TACAIDS as well as male HIV and AIDS prevention programme of UNAIDS. For the purpose of sharing experiences with other countries (e.g. Kenya, Uganda, Ethiopia etc.), TAF participated in the 2007 Commonwealth peoples forum CHOGAM and the Eastern Africa Regional Consultative Meeting. To this date, TAF has 30 members who signed the MoU.

TAF members discussing draft of NMSF supported by UNDP May 2007

3.2.4. Lessons learnt during project implementation

Lesson 1: it is essential that the involvement of local leaders is well managed and leaders assisted to know their role in community development

The involvement of local leaders in HDT's projects must be well managed. Although local leaders are not always concerned with the project itself, they are often the key people we depend on to arrange meetings or to contact the beneficiaries. Due to different policies, some actors provide allowances and others do not. It become difficult to handle that, as local leaders often feel that they need to be paid to support the project. At different levels the issues of allowance needs to be addressed and not becoming motivator.

Lesson 2: Interruption of funding not only overburdens the implementing organization, but also affects the out put of the project.

The fact that the donor for the Youth Policy project did not give funding continuously for internal reasons, affected grossly the budget of HDT. The effect was mainly on overhead cost

and staff cost which can not be stopped, once they are under contract. Beneficiaries could also not predict next steps and it even created mistrust between HDT and the beneficiaries. Dissemination of knowledge to fellow youth under this project was affected and it may be likely that the target may not be reached. Even worse was that HDT did not know when funding would come and the communication with donor was weak. HDT feels that such projects should be discouraged as they affect the image of the organization and become burden to the organization affecting budget performance of the organization.

Training of youth on youth policy and good governance in Biharamulo

Lesson 3: TAF lacks sufficient resources and strategic plan

TAF lacks a strategic plan, which makes it difficult to focus on activities and be a conduit of change. Networking and sharing resources and experiences are also still a challenge, which is mainly due to lack of resources. As HDT is the secretariat of TAF, we also have to encourage other organisations to join TAF to make a strong network. This involves looking into ways to involve and advocate TAF to non-TAF members in certain activities.

Lesson 4: TAF members are not very active yet

Currently, most of TAF's members are not very active in policy advocacy. As HDT is the secretariat, we have to encourage other organisations to join TAF to make a strong network. HDT also needs to look for ways to involve and advocate TAF to non-TAF members in certain activities. Most of the members of TAF would benefit from an advocacy training, which should also help to encourage partners to engage in policy advocacy more.

3.3. Achievements on strategic issue 3: to strengthen the capacity of partners and allies in HIV & AIDS

HDT has 2 projects under this strategic objective.

3.3.1. Capacity Building for CBO's

Introduction

People living with HIV and AIDS are increasingly forming support organisations to meet their social, political and economic needs and to ensure their opportunities for improved health and well-being are maximised. The majority of these organisations has a low capacity in planning, fundraising and project management and very few are actively involved in sustained advocacy at national and/or local levels. However, if supported to develop their capacity, such organisations could play a vital role in tackling the HIV epidemic, eroding the stigma surrounding the disease in Tanzania and reaffirming the rights of positive people to life. To build the capacity of CSOs working in HIV, HDT started implementing a project called "Right to Life" (R2L), in collaboration with Voluntary Overseas Services (VSO). This project is an initiative of VSO the Netherlands and is funded by the Dutch government. Currently, the capacity building program is supported by 2 donors; VSO and Egmont Trust. The scope of the project under financial support of VSO focuses on Dar es Salaam, Kagera (Bukoba and Muleba districts) and Mtwara. That of Egmont Trust focuses geographically in Mbeya (Rungwe and Kyela districts) and Kagera (Ngara and Biharamulo districts).

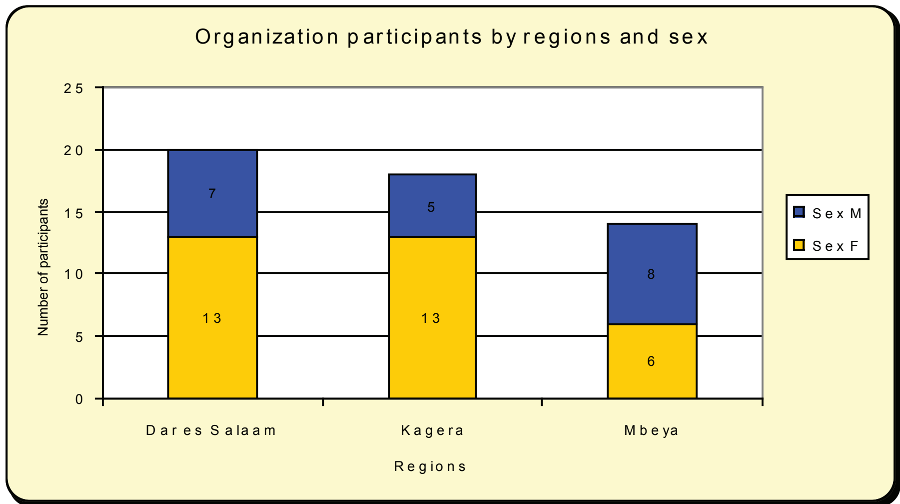
AWITA, one of the participating NGO's from Dar es Salaam, makes soap as income generating activity

Entry and set-up

The project started in Dar es Salaam in April 2007 with the aim to strengthen the capacity of 10 Positive People's Organizations and those working in the area of HIV and AIDS. The participating organisations were selected through a careful identification process. After the selection, Capacity Assessment was done to see their strength and weakness. They were then offered training in Organizational Development to enable them to become more sustainable and create more impact in their interventions. The experience gained in the pilot in Dar es Salaam was used in the further expansion of the project.

Identification of CBO's

HDT selected organisations carefully, in order to get credible organizations to participate in the trainings on Organizational Development. The identification was done using the Organizational Capacity Assessment (OCA) tool. This tool includes questions on the organization registration status, working experience, capacity in terms of management, human resources, financial resources and administration and relationship with partners and other stakeholders. The final selection of organizations was done based on the score on the Organization Assessment tool, as well as observations made by the assessors and discussions with organization members. To participate in the project, HDT chose the organisations that had a mediocre score on the assessment, because organisations with a high score are not our target beneficiaries. In 2007, HDT has identified 10 organisations in Dar es Salaam, 6 organisations in Kagera and 7 organisations in Mbeya.



Capacity building trainings

To build the capacity, a series of workshops are conducted with the selected CBOs. Two or three of the representatives of these organisations received two Organizational Development trainings. The first workshop dealt with how to run a healthy and transparent organisation, how to check if the constitution is reflecting your organization, how to write a vision and mission, what organisation principles and values are important and how to identify strategic issues. The second workshop was designed to understand and implement project cycle management, financial management and how to write a comprehensive report. After each training, organization got assignments that they had to work on before the next training or mentoring visit. This could include the development of an organization profile or organization chart or the revision of their constitution. All the organisations that were identified in 2007 have completed the first training and the 16 organisations from Dar es Salaam and Kagera have also finished the second training.

HDT uses participatory approaches in the training; Aisha Felix working with a colleague on a problem tree for their organisation

Provision of small grants

After the 2 Organizational Development trainings the participants had to show that they could utilize what they had learned through writing a proposal. The organisations that qualified received a small grant of Tsh. 1,500,000 to use for activities. In 2007, the organisations from Dar es Salaam already succeeded in doing this.

Monica Simba, the chairperson of TWIHA from Dar es Salaam receives a grant from the Committee, which are: Dr. Peter Bujari (executive director of HDT), Mercy Ndekano (Kinondoni DAC) and Deo Ntukamazina (member of the Board of Trustees of HDT)

Mentoring and coaching

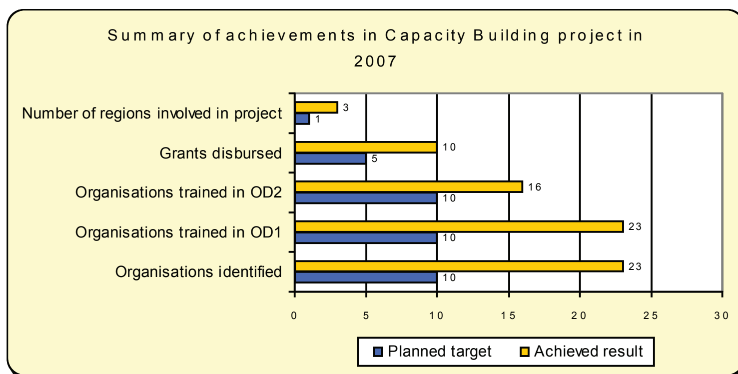
All the participating CBOs were coached and mentored by a team from HDT to ensure that sustainable growth was registered. Some were supported to write proposal to source other funding and two organizations have received funding else where. To give sufficient coaching in the Kagera region, HDT trained two people as TOT, one from TADEPA, Bukoba and another from WAMATA Rubya in Muleba. HDT did physical verification to partners after receiving the reports which included checking the systems, documentation both in finance and in program. This has enabled them to be serious and grow beyond how they were.

Achievements

Participants of this project appreciated the trainings very much, as is exemplified by the comments below:

"The approach used was very friendly, this training has opened my eyes and now I know why we formed our organization AMWAVU. I also know what to do next and probably use the knowledge to educate my fellow members" says Victoria Mutagaywa, one of the participants during workshop evaluation in Bukoba. Another participant, Mr. Saidi Nshaija from UWAVUBU said "Really I appreciate to get this kind of training and it means a lot to my organization."

The graph below shows a summary of the achievements in this project:



3.3.2. Workplace Program on HIV and AIDS

Introduction

Developing a specific response at the work place remains crucial as workers spent most of their time at the place of work. HDT assist organisations to mainstream HIV and AIDS and make employers aware of their responsibilities and opportunity to respond to the HIV and AIDS pandemic at their workplace. This program generated an unrestricted income for HDT, which is used to cover project costs of several programs and to cover administration costs for the organization. In 2007, HDT generated about Tsh. 64 million, from which a vehicle for Dar es Salaam has been bought. Other funding was used to fund MVC projects in Dar es Salaam and Kagera. In addition to that, this fund covers overhead costs which are not covered by donors.

Entry and set-up

To promote workplace programs and get support in HIV and AIDS mainstreaming, HDT focused on establishing rapport with institutional leadership, a HIV and AIDS focal person and peer health educators in partner organization.

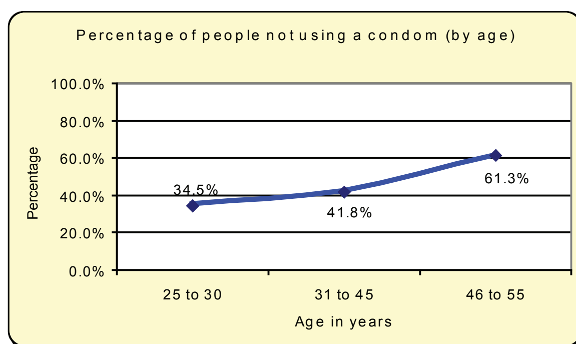
Implementation of Workplace Programs

The organisations that requested HDT's assistance in implementing an HIV and AIDS workplace program were supported through the development of customized programs. HDT also provided technical support to build in house capacity to implement the programs. This included the following:

- Management training on roles and their responsibilities
- Situation and response analysis to Immigration
- Development of workplace policy or guidelines
- Facilitation of the formation of an HIV committee and train them on roles and management
- Development of a monitoring and evaluation framework and tailor made support

HDT supported 13 NGOs (KIWAKKUKI, PINGOS Forum, Haki Kazi, CASEC, Oxfam GB Ngorongoro, SAIPRO, MIFPRO, TIP, KINNAPA, Ujamaa CRT, TMDWO, Maarifa and MEDA) and three ministries (Immigration department, Ministry of Labour and Ministry of Higher Education) in developing their HIV workplace program. HDT also supported two companies (BP Tanzania, PPF) to implement their workplace program on HIV and AIDS at different levels.

The effect of education which is reportedly to be high is yet to impact on lives of the Tanzania. In one of the KABP survey we did, we noted that the practice of people was not reflective of the knowledge.



As can be seen from the above, it seems that there is a direct relationship between not using a condom and age. As the age increase, the likelihood of not using condoms increases. Programmatically, there is a need to develop targeted interventions to address some of these issues.

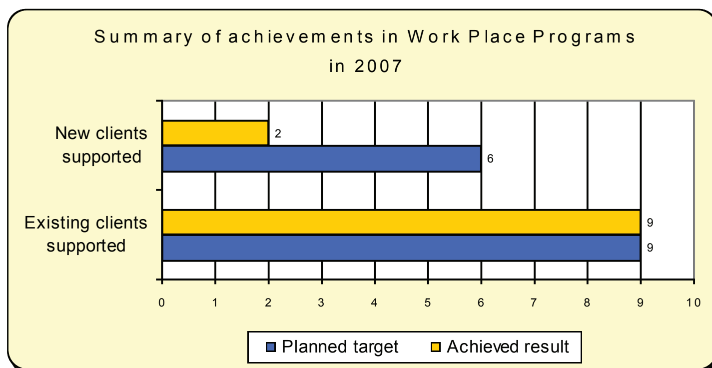
Mentoring and coaching

HDT provided regular support in the form of mentoring and coaching through a quarterly two days support and supervision visit to each partner. During this visit HDT reviewed the progress of the implementing of their HIV and AIDS mainstreaming plan. When additional support was needed, HDT conducted coaching via telephone and e-mail communication. Extra visits were done to partners who were in more need. In general the support depended on the needs of the partner, with more engagement occurring with Immigration Department and Oxfam partners.

Session with Ministry of Labor

Achievements

The graph below shows a summary of the achievements in this project:



3.3.3. Lessons learnt during project implementation

Lesson 1: Low level of education among partner staff affects the quality and pace of training in Organizational Development

The level of education and understanding among the participants of Organizational Development training is very low and the content of the training is very new to them. The pace and content of the trainings had to be adjusted to suit the level of understanding. To overcome this, HDT

staff also provided more supportive sessions after the training to partners that needed this. During the mentoring visits, HDT continuously coached the organizations, especially the ones that showed weak financial records after receiving grants.

Lesson 2: 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 of PLHIV are willing to receive resources but not to learn. An assessment may indicate that the purpose of forming the organization was rather to gain themselves than supporting the communities. This was exemplified when many organizations were complaining about the small allowance they got during the training. In sustainable support therefore, clear separation has to be made between those who formed a support group to support themselves and those who formed institutions to support others. These two groups have different needs and will therefore be treated differently.

Lesson 3: Trainings for positive people needs to be adjusted to suit the 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 time table needs to take this into consideration. Sensitivity on the nutrition provided ca not also be over emphasized.

Lesson 4: Reliable transport is needed to enable efficient support to partners especially in regions (Mbeya and Kagera)

In Kagera and Mbeya, the wards where the project beneficiaries from the capacity building project are located are scatted and far away from each other, sometimes even 60 km. This makes the identification process, implementation, monitoring and evaluation time- and resource-consuming. Also, some of the beneficiaries do not speak Kiswahili. E.g. during the identification process of PLHIV in Mbeya, some people were only talking Nyakyusa and the questions had to be translated. Development partners, including those who fund the project, need to allow resources to be invested in the purchasing vehicles (car, motorcycle) if the project has to be implemented in quality.

Lesson 5: Some employers do not consider it their role to care for their staff and develop a supportive environment and policies to that effect

Although the government has included the development of an HIV workplace program at the work place as mandatory in the policy, only a few institutions have taken this serious. As such, HDT's attempt to mobilize new partners was not successful. Even where it was successful, companies were selective as to what interventions should be done. For example, one company wanted only condom to be supplied. When assessment was done, the level of knowledge turned out to be low and there was a high level of stigma towards those who used condoms. The management was in denial and thus HDT decided not to continue with this partnership. In others, they would only allow one session which does not have continuity, hence is ineffective.

3.4. Achievements on strategic issue 4: to strengthen institutional quality control in Governance and Management

3.4.1. Strengthening human resource capacity through staff development program

In 2007, the human resource capacity of HDT is strengthened by conducting 3 dira meetings; in April, in August and in December. During dira meetings, the achievements, challenges and plans for the next period are discussed by HDT's staff. There are also capacity building sessions for the staff. In 2007, capacity building topics included:

- Documentation of HDT's work
- Effective communication
- Motivation and assertiveness
- Financial Regulations
- Computer skills, such as Microsoft Office products
- Monitoring and Evaluation methods and tools
- Data collection and quality
- Ethical dilemma's

HDT staff in the dira meeting

3.4.2. Strengthening Management Information System

The biggest challenge HDT identified during the dira meetings was the lack of effective monitoring and evaluation of its projects. Especially defining clear goals and objectives, selecting indicators, collection reliable information from beneficiaries, measuring improvements and reporting and documenting results has been difficult in the past. In September 2007, a volunteer from VSO was assigned to help HDT set up a thorough system for monitoring. This includes providing M&E guidelines, tools and reporting formats.

To share HDT's work with stakeholders and other interested people, we have launched a new website in September 2007. The new website contains more information on the organisation

and the projects that are implemented. Also, there is a part dedicated to Tanzania AIDS Forum, which will likely be transferred to the new TAF website in 2008.

3.4.3. Strengthening partnerships and networking

HDT works with different partners according to the mission. We categorize partners in program partners and core partners. Program partners are institutions and/or individuals who give grants or donation to HDT. Core partners are the partners who we work together with to achieve a certain objective. They include those partners which we have supported to build their capacity and those in networks for policy advocacy. Sometimes the partnership may overlap into more than one category.

The current program partners are:

- AMREF
- GFATM
- Voluntary Service Overseas (VSO)
- Egmont Trust
- Foundation for Civil Society
- Abbot foundation

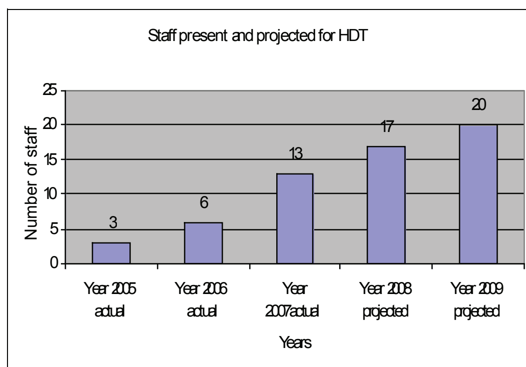
The current core partners include:

- Capacity building: there are several partners in the regions:
    - Dar es Salaam: Tupendane group, TOCHA+, HOSPHA+, CHAKUPAU, AWITA, TAYOPA, NYP+, UMULA, FIHATA and TWIHA.
    - Bukoba district (Kagera): AMWAVU, NEBUMWO, UWAVUBU and TADEPA.
    - Muleba district (Kagera): UTULIVU, TWEYEMEMU, UVIBO and WAMATA RUBYA.
    - Rungwe district (Mbeya): THAMINI, FVN, ACOUDE, Upendo Group and KIHAWIRU.
    - Kyela district (Mbeya): SHAFA, Mkombozi Group Tanzania and HEDEA.
- Networking: Members of Tanzania AIDS Forum, which include the government TACAIDS, DSW and NACP, who we work together with in policy formulation and implementation reviews.

To support long term investments in communities there is still a lack of donors and implementation partners. Long term investments are needed to ensure that communities support them selves in a sustainable way. To be able to run all the projects, they are often funded by several different partners. This makes accounting and reporting very complicated and time-consuming. HDT will be working to address this lack of harmonized funding and will be sharing its work to attract more partners on sustainable community support.

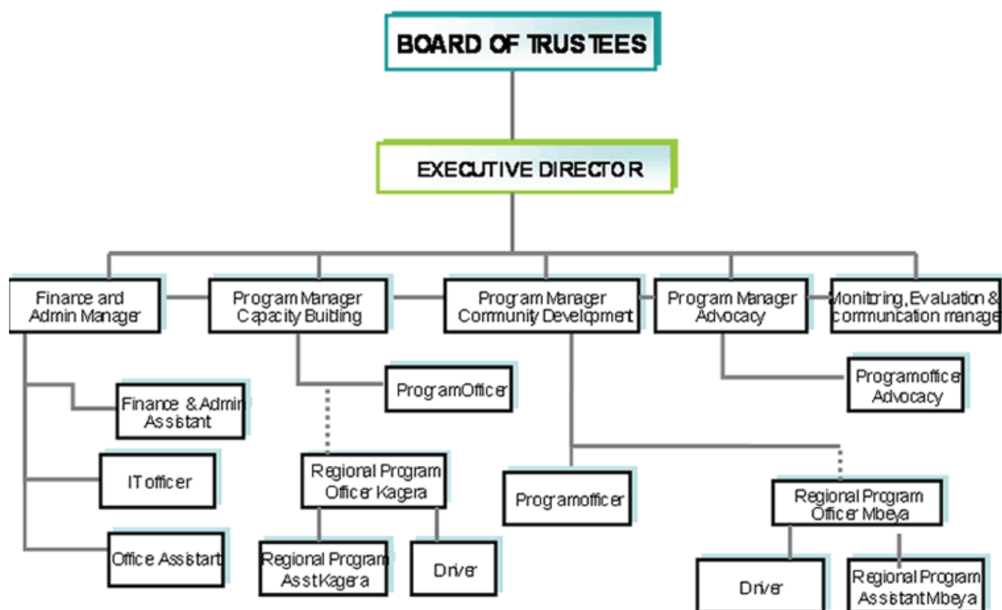
4. Organizational development

4.1. Staff development



In 2007 HDT has grown from a small office in Dar es Salaam with 6 staff members to an organisation with 13 staff members, including two volunteers (one from VSO and one from UN). In addition to contract full time staff, HDT also works with volunteers both on programs and admin tasks. These include full time volunteers and those on intern placements.
For 2008 we expect to continue to grow to 17 staff members, mainly adding more staff in the regions of Kagera and Mbeya.

Due to the growth of the organisation, the Board of Trustees has approved a new organization structure. This stipulates roles, levels and line reporting to ensure that the organization improves its efficiency in service delivery, governance and administration. More importantly, this new structure is also more in sync with the strategic plan and the areas of work. Currently, HDT works under the following new structure:



4.2. Organizational capacity

HDT is an organization that is continuously learning and growing, using former experience to strengthen itself. HDT is working to achieve its strategic objectives with an open mind, looking for challenges and innovative ideas in order to improve the impact of our activities. On occasion, HDT also draws on a pool of expert consultants to attract expertise and assist in the strengthening of organizational structures, design and processes.

In 2008 we will continue to build the capacity of our organisation by conducting dira meetings and do individual capacity building wherever needed.

With the increasing staff at HDT's head office, it had to be expanded to secure enough space for efficient running of the business. The conference room was therefore build into office space, where there are now 4 desks for our Capacity Building and Policy Advocacy staff members. HDT has managed to hire extra office space in the building behind the headquarter office, which is made into a conference room and resource center.

In 2007 HDT also purchased several capital items for the office, including furniture, technical equipment and vehicles. This was also due to the opening of 2 field offices; in Mbeya and Kagera. On furniture, HDT bought 8 office chairs, 9 chairs for the conference room, 2 tables and 4 filing cabinets and shelves and a bench. There were also 2 houses (1 in Dar es Salaam and 1 in Mbeya) equipped with furniture, as these are rented by HDT for office staff and volunteers. The technical equipment that HDT purchased included 6 laptops, 2 air conditioners, a photocopy machine, 2 cameras, a printer and a fax machine. For the conference room, a flipchart stand and television with video deck were purchased and the finance department got a safe for office security. Due to the geographical spread areas of operation (Dar es Salaam, Mbeya and Kagera), it is often hard to reach these areas and operate in them effectively, especially with no reliable transport available. Therefore, HDT purchased a motorcycle for the regional office in Kagera and is looking into ways to purchase other HDT vehicles. This will improve the implementation of activities and monitoring and evaluation of programs.

The instability of power and internet connection remained a problem in 2007. Running costs of the office becoming higher than expected especially when we had to use the generator for energy supply.

4.3. Work place policy implementation within HDT

HDT's work place program on HIV and AIDS continued with sessions where staff was together. Information on HIV was continuously availed at the work place, as well as condoms that are available at the work place. Staff confidentiality continued work where one staff was HIV positive with internal disclosure done. Consciously support was provided to this staff including flexibility as deem necessary.

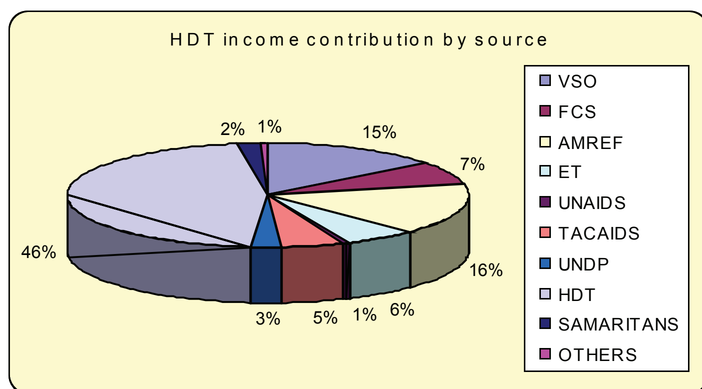
Condoms and IEC materials available at HDT

5. Audited financial report for year 2007

5.1 Financial information and context

Total income for year 2007 amounted to Tzs. 388,778,483 of which Tzs. 207,665,587 was received as donations and grants, Tzs. 178,837,896 as income from consultancy done by HDT and the remaining Tzs 2,275,000 from other small funding as per details below:

SOURCE	CONTRIBUTION (Tzs)	PERCENTAGE
VSO	56,533,487.00	15%
FCS	2,047,500.00	7%
AMREF	61,480,000.00	16%
ET	10,385,000.00	6%
UNAIDS	27,835,000.00	1%
TACAIDS	18,975,000.00	5%
UNDP	22,740,000.00	3%
HDT	178,837,896.00	46%
SAMARITANS	7,669,600.00	2%
OTHERS	2,275,000.00	1%
TOTAL	388,778,483.00	100%



5.2. Audited Financial report

6. Summary of the 2008 business plan

Below a brief summary will be given of the 2008 business plan per strategic issue and objective.

Strategic objective	Project activity	Main indicators and targets	Source	Budget
Strategic issue 1: to promote and implement strategic HIV & AIDS interventions				
To strengthen approaches to HIV and STI prevention work that effectively addresses gender and sexuality issues, with a particular focus on men are strengthened in regions where HDT works	Phasing out of Rungwe HIV & RH in school program	Phasing out successfully done	RDC-EDU	-

Strategic objective	Project activity	Main indicators and targets	Source	Budget
To undertake innovative HIV and AIDS care and support with emphasis on cross referral system	Conduct Community theater performances for stigma reduction in Mbeya	4 theater performances in 4 wards, reaching 1,200 people	GFATM	10,800,000
	Produce and distribute IEC materials and CHBC kits in Mbeya	1000 posters, 3000 leaflets, 500 T-shirts and caps and 30 CHBC kits distributed	GFATM	10,500,000
	Train Community Home Based Care providers in Mbeya	10 CHBC providers trained	GFATM	4,525,000
	Support monthly meetings of support groups and conduct stakeholders meeting in Mbeya	10 PLHIV groups supported	GFATM	3,282,000
	Support PLHIV on ARV with nutrition and loans for IGA in their PLHIV groups in Mbeya	150 PLHIV supported with nutrition 4 times, CD4 counts increased	GFATM	18,000,000

Strategic objective	**Project activity**	**Main indicators and targets**	**Source**	**Budget**
To undertake community based and sustainable support to orphans and vulnerable children	Support MVC through training and provision of funds to foster families in Dar es Salaam and Kagera	46 existing families and 45 new families supported on IGA	HDT	17,6345,000
	Support MVC through MVC Committees in Mbeya	MVCC formed and supported and 3,285 MVC supported in 2 years	Abbott Foundation through Africa Bridge	68.2 million
Strategic issue 2: to engage and undertake strategic advocacy work				
To advocate for favorable policies in HIV, health and poverty reduction as a strategy to ensure health in the community	Support and strengthen youth groups and networks to participate in policy process in Kagera and Mbeya	Youth groups supported	FCS	4,000,000
To foster coordination of CSOs in Tanzania working in HIV, health, gender and poverty reduction through TAF	Facilitate learning and sharing knowledge, lessons and experiences among members at community, national and international through formation of national directory for HIV and AIDS CSOs	1000 brochures and flyers will be developed and distributed. 4 interactivities learning and sharing sessions meetings	HDT funds for coordination of CSOs	2, 200,000

Strategic objective	**Project activity**	**Main indicators and targets**	**Source**	**Budget**
	1) Engage in policy and legal processes related to social, cultural and economical issues	Stronger regional networks	To be determined	To be done under TAF
	Establish comprehensive mechanisms for capacity building among members	Formation of thematic groups	To be determined	To be done under TAF
	2) Strengthen strategic engagement on HIV/AIDS work of CSO's with national and community based priorities	Quarterly membership drive to 11 TAF members, 10 new regional networks formed	To be determined	To be done under TAF
	3) Provide conducive atmosphere that will facilitate appropriate coordination and linkage among CSO's	Website for information, training in advocacy and networking	To be determined	To be done under TAF
	4) TAF development	Strategic plan, TAF website and branding & logo	UNAIDS UNDP	To be done under TAF
Strategic issue 3: to strengthen the capacity of partners and allies in HIV & AIDS				
To support partners to mainstream HIV and AIDS individually and collectively at work place and in core business	Develop effective communication and advertising plan and through this mobilize new partners in work place program	6 organizations or institutions supported in implementing HIV work place programmes	HDT	9,500,000

Strategic objective	Project activity	Main indicators and targets	Source	Budget
To assist and support organisations of PLHIV	Train PLHIV organisations from Dar es Salaam, Kagera, Mbeya and Mtwara on Organizational Development, Strategic Planning and Policy Advocacy	24 PLHIV partner organizations trained	VSO and Egmont Trust	40,368,000
	Disburse grants to qualified NGOs from Kagera, Mbeya and Mtwara	24 grants disbursed	VSO and Egmont Trust	24,000,000
	Mentor and coach the participating organisations, evaluate the project and conduct regional linking meeting	Support PLHIV organizations in strategic planning and linking	VSO and Egmont Trust	28,550,000
Strategic issue 4: to strengthen institutional quality control in Governance and Management				

Strategic objective	Project activity	Main indicators and targets	Source	Budget
Capital investment for HDT offices	Purchase goods and services to improve organisation performance	1 car, 2 motorcycles, 6 laptops, 1 wireless point, 1 back server, 2 printers, 1 fax, 1 AC, 2 file cabinets, 1 water filter, 2 TTCL hand set, 12 office chairs, 10 conference chairs, 3 modem, 2 HDD/MMR, 2 copiers, 3 electronic accessories, 3 digital camera's, 2 generators, office premises/ land/building	HDT	97,670,000.00
	Train HDT staff, both individually and collectively	Staff training and dira meetings	HDT	8,000,000.00
Total direct program costs				211,100,040.00
Program support costs				280,333,160.00
Annual organizational costs for 2008				491,433,200.00
Total funds fund confirmed				366,553,740.00
Annual budget deficit				(124,879,460.00)