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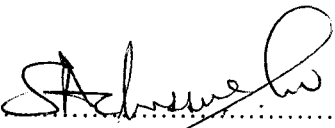
**Project Title: Establishing Community Based and Managed Saving and Credit
Group Systems to People Living with HIV/AIDS in Marumbo Ward in Kisarawe
District**

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**‘A PROJECT SUBMITTED IN PARTIAL FULFILMENT OF REQUIREMENTS
FOR THE MASTER OF SCIENCE IN COMMUNITY ECONOMIC
DEVELOPMENT SOUTHERN NEW HAMPSHIRE UNIVERSITY AT THE
OPEN UNIVERSITY TANZANIA’, 2007.**

SUPERVISOR'S CERTIFICATION.

I, Dr, Simon C.A. Waane, certify that I have thoroughly read this Project Report and found it to be in a form acceptable for review.

Signature.....

Date.....24. 08. 2007

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DECLARARTION BY THE CANDIDATE

I, Angela Egidio Shija , do hereby declare to the Senate of the Southern New Hampshire University at The Open University Tanzania, that this Field / Project Report is my own original work and declare that it had not been submitted for a similar degree award at any other University.

ABSTRACT

This project is about establishing community managed saving and credit groups system to the people living with HIV/AIDS (PLWHA) for improving the family's income. According to the study findings, most of the PLWHA had improved their health status after receiving home based care services from Jipeni Moyo Women and Community Development Organization (JIMOWACO). 68% of the PLWHA said their health statuses improved and were able to work. For their family livelihood, 50% depended on small business and farming, but the size of these activities are small due to lack of financial capital. The majority (71%) do not have cash savings for expanding their business capital base, hence what they earn, just from hand to mouth. The project was planned to start in six villages of Marumbo Ward in Kisarawe district.

The project so far had managed to identify a development partner who is willing to support the training sessions to community saving and credit group members through covering the costs for buying working kits and facilitation expenses. The community mobilization sessions had started whereby the end of January 07, three community interest groups were formed and they were waiting for the training sessions to begin.

Home based program programs have proven to support the well being of PLWHAs, but the interventions needs to ensure supporting strategies to improve family livelihood .The increase in family income will have a significant impact on improving the food intake to meet their highly nutrition requirements, which almost doubles with HIV/AIDS and utilization of the antiretroviral drugs.

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List of Abbreviations

BAMITA –Baraza la Misikiti Tanzania.

CED-Community Economic Development Program.

CBH-Community Based Care.

IGA-Income Generation Activity.

JIMOWACO-Jipeni Moyo Women and Community Organization.

NACP – National AIDS Control Program.

OVC-Orphans and Vulnerable Children.

PLWHA- People living with HIV/AIDS.

UNAID-Joint United Nation Program on HIV/AIDS

URTZ –United Republic of Tanzania.

VCT-Voluntary Counseling and Testing.

VSHP-Voluntary Sector Health Program.

WAMATA-Walio Katika Mapambano na AIDS Tanzania.

WHO-World Health Organization.

EXECUTIVE SUMMARY

This project is about establishing community managed saving and credit groups system at Marumbo ward in Kisarawe District. The Marumbo ward has six villages namely Kikwete, Mfuru, Marumbo, Chang'ombe A, Kitonga and Palaka villages. The six villages are among the 39 project villages covered by the Home based care support program implemented by JIMOWACO (project host organization) to PLWHAs in Kisarawe District.

The project main activities includes mobilization of resources for funding the project activities, mobilization of communities to form community managed saving and credit groups and training them on how to manage the group's saving as well training the group members on selection, planning, management (SPM) of small businesses. The main target groups for the project are the registered PLWHAs under JIMOWACO home-based care project, which includes people living HIV/AIDS (PLWHA) and Orphans and Vulnerable Children (OVC) families.

The project is trying to address the problem of inadequate business capital and skills to manage small income generating activities, which are important for the livelihood of PLWHAs. As per the research findings, the major means for livelihood for most PLWHA families (50%) was both small business and farming, and others (18%) small businesses alone due their health status. 56% of PLWHAs, takes care of themselves, thus some are family bread winners, hence expanding their small businesses capital is important for the family's well being, as most lost former economic activities as a result of frequent illnesses.

Currently most of the PLWHAs, about 71%, don't operate any kind of cash saving due to the poor income they gain, hence meeting family emergencies like medical care and school material for the children have been so difficult, thus many depend on assistance from the donor project and relatives. Most of them operates very small businesses whereby they can not individually save to expand their capital base, hence group cumulative saving, is important source of financial capital to them. Therefore, through operating of community managed and saving system, the group members will be able to pull their resources together and generate capital bases for expanding their small businesses and taking small loans to meet house hold emergency at their convenient time.

The main project purpose was to establish community managed saving and credit groups to people living with HIV/AIDS (PLWHA) and the family for improving family livelihood, with the following specific objectives:

- (i) To identify development partner like minded to support the training of PLWHAs groups in saving and credit by October 2006
- (ii) To identify 3 trainers for the community saving and credit to the formed PLWHA groups by the December 2006
- (iii) To mobilize 10 PLWHAs families interest groups for saving and credit associations by September 2007
- (iv) Training of the 10 organized PLWHAs groups in community managed saving and credit association model by September 2007

(v) Training of the community managed saving and credit groups on Selection, Planning and Managements (SPM) of income generating activities.

The first and second objectives have been fully accomplished as planned. The third objective has been implemented partially, and the activities are still going on. The fourth and fifth objectives are not yet accomplished, but plans have been made by the host organization (JIMOWACO), to accomplish them.

The home based care programs are very important for improving the well being of the PLWHA and their families at large, but the program are costly and depends so much on donor funds, hence their sustainability is questionable and as well increases dependency syndrome.

Communities are willing to save no matter how poor are they, but they need to be supported with technical skills. Start-up capital support for establishing small income generating activities are very important for PLWHA's livelihood, as many lost their business capital/jobs as result of long period sickness. Home-based program should have family livelihood improvement intervention so as to assist those with a significant health improvement. Small business improvement support will reduce dependency on food supplements from the home based project and as well increasing their capability to solve other family's social-economic issues like school material for children, medical care and other household demands.

HIV affects individual's immune-status, food intake and metabolism, hence affects nutrition status of the affected one, therefore investments in medical programmes to

support PLWHA should also be completed with efforts to ensure a minimum level of nutrition is obtained through livelihood improvement measures.

CHAPTER 1: COMMUNITY NEEDS ASSESSMENT

HIV/AIDS has become one of the major social-economic problems in the country. Recently, an estimate suggests that more than 2 million people are living with it today. HIV/AIDS is a major development crises that affect all sectors and people in all walks of life and is decimating the most productive segments of the population particularly women and men between the age of 20-49 years.

It has been well established that poverty significantly influences the spread and impact of HIV/AIDS. In many ways it creates vulnerability to HIV infection, cause rapid progression of the infection in the individual due to malnutrition and limit access to social and health care services. HIV/AIDS causes impoverishment as it leads to death of the economically active segments of society and breadwinners, leading to reduction of income or production.

Therefore, the community need assessment was conducted so as to find out, the real needs of people living with HIV/AIDS (PLWHA) basing on social-economic information collected and analyzed to find alternative ways to improve their means of livelihood.

1.1. Kisarawe District Profile

Location and size:

Kisarawe District is situated between latitudes 50° and 35° S and between longitudes 38° 15° E and 39° 30° E. The district borders are Mkuranga District in the east and Morogoro

District in the west, Ilala Municipality of Dar-Es-Salaam City to the northeast, Kibaha District to the north and Rufiji District to the south.

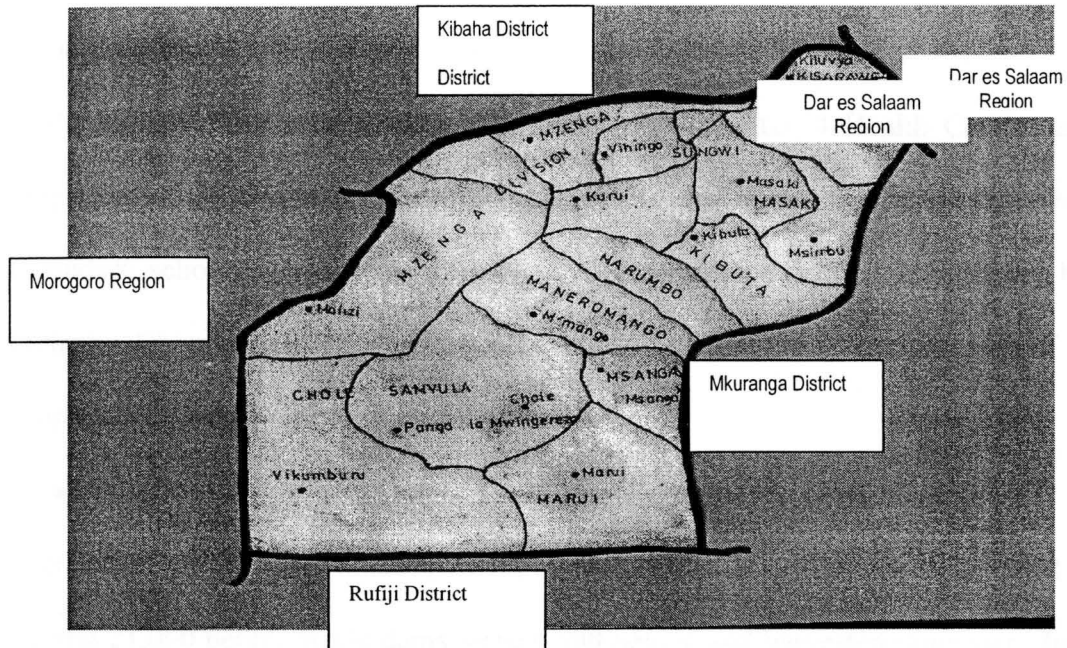
Administration:

The Council has four Administrative Divisions namely Mzenga, Chole, Sungwi and Maneromango which comprises a total of 15 Wards with 74 registered villages and 226 hamlets and 22,949 households.

Climate:

The District has temperatures that vary between 28⁰C and 30⁰C, with a mean temperature of 29⁰C. There are two main rainy seasons; the short rains, popularly known as 'Vuli', start from October to December while the long rains, 'Masika', start from March to May. The average rainfall range from 1400mm to 1600mm in the eastern part of the district, which covers Sungwi division, while in the western part covers of Chole and Mzenga Division which receive an average rainfall of 1000mm.

THE KISARAWE DISTRICT MAP



LOCATION AND SIZE:

Kisarawe District is situated between latitude $6^{\circ} 50'$ and 35° and between longitude $38^{\circ} 15'E$ and $39^{\circ} 30'e$. It borders Mkuranga District in the east and Morogoro district in the west, Dar-Es-Salaam City to the north-east, Kibaha District to the north and Rufiji District to the south. Kisarawe District has area of 3535 square and 1000m.

Social Welfare Services

• Education

In 2006, Kisarawe district had 74 primary schools with 598 teachers (299 Females and 299 Males) and 23,276 pupils (12,101 boys and 11,175 girls). The District also had 9 secondary schools, whereby 1 is owned by Government, 6 own by communities, 1 by

Lutheran Mission and 2 are privately owned. These schools had 91 teachers and 1,691 students.

- **Health**

In the Health Sector, the district has one District Hospital, 4 Health Centres and 16 Dispensaries. Out of the 16 dispensaries, 11 are Government owned, 1 owned by Minaki secondary school, 2 owned by Tanzania Peoples Defence Force and 2 owned by the Lutheran Church. District Hospital is having total of 150 beds and average of 5,882 people serve at each dispensary each year.

- **Water**

There are different water sources within the district. These sources include piped water serving 21,000 people while dams serve 6,500 people and harvested rainwater. In total, water services delivered covers 48% of the population demands.

- **Roads and Railway line**

The Kisarawe District Council is serviced with road network of a total km.661.4. Out of that 202 km are regional road, 65.8 km are Council roads and 403.6 km are feeder roads serviced by the communities. The roads are passable almost throughout the year except for a few feeder roads, which makes easy transportation of charcoal, fire wood, oranges and cassava and to the larger market in Dar-es-Salaam.

There are 2 railways with 50km passing through the district, which are Central line and Tanzania and Zambia Railway (TAZARA) line. TAZARA connects communities of Mzenga village especially the Gwata ward to Dar-es-Salaam, since there is no public transport to serve the wards, due to very poor roads.

Economic activities

The Agriculture Sector employs almost (87%) of the district population, followed by business operations (6%), formal employment (3%) and other informal occupation (3%) (Kisarawe District 2004, Report, National census report, 2002).

The major cash crops include cashew nuts and coconuts. There are also tropical fruits such as mangoes, oranges, pawpaw, jackfruits and pineapples. Food crops grown include cassava as staple food, maize, paddy, sorghum and sweet potatoes.

The other sources of district's revenue are from natural resources like forest reserves, on-timber and forest products including timber, firewood. Charcoal, building poles, taxes as well from licensing fees collected from hunting activities.

Poverty levels

Kisarawe district is among the bottom ten poor districts in Tanzania; with over 50% of population living bellow basic need poverty line of Tsh262/- per day that is approximately US\$0.33 (Tanzania Human and Development Report 2005). Per-capital income of the Kisarawe population is minimum, as compared to that of the coast region, which is Tsh268, 944/- per annum. (See section 1.3.Graphic content-Attached-Map of Tanzania showing the poverty level by district in Tanzania.)

HIV/AIDS Status in Kisarawe District

The prevalence of HIV infection among blood donors in Kisarawe district was 11%, which is higher than that of the Coast region (7%) and the nation (8.8%) in 2003 (National HIV/Aids/STI Surveillance Report of 2004). According to the District HIV/AIDS Report of 2004, the attendance in the Out Patient Department (OPD) services

within the district in 2004, indicates that 41% of the attendees were HIV positives, with the following percentages: 15-19years (4.4%), 20-24years (7.9%) and above 24years was 28.6%.

1.2. The Research Methodology

The methodology for identification of community needs involved the following techniques: Administering survey questionnaire to PLWHA (JIMOWACO home-based care project beneficiaries); conducting interview to the District officials and JIMOWACO staff; focus group discussion with Village HIV/AIDS committee and home-based care community volunteers and Review of HIV/AIDS reports.

The reasons for selection of data collection tools where as follows:

- Administering survey questionnaires: the method was used because it is a quick and/or easy way to get more information from many people in a friendly environment.
- Personal interviews: the method was used so as to get a full understanding of someone's impression or experiences and depth of information
- Focus Group discussion: the method was used so as to explore the topic in depth through group discussion e.g. experiences, challenges, suggestions etc.
- Reviews of HIV/AIDS reports and JIMOWACO's project progress reports: this method was used so as to get the status of HIV/AIDS in the district and historical dimensions of the project, lessons learnt and challenges.

1.2.1. The survey

1.2.1.1. Goal and Purpose of the Survey

The main goal of the survey was to assess the impact of JIMOWACO Home Based Care (HBC) Program to the life of the people living with HIV/AIDS (PLWHA) and to find ways of improving their means of livelihood.

The specific survey objectives were:

- To assess the impact of Home based care and supported services provided by JIMOWACO to the life of PLWHA in Kisarawe district
- To identify means of livelihood activities for PLWHA and alternative income opportunities which they can manage in Kisarawe district
- To identify financial sources for improving family livelihood in Kisarawe district.

1.2.1.2. Research Questions

This survey intended to answer the following questions:

- What is the impact of home-based care services provided by JIMOWACO to the lives of PLWHA in Kisarawe District?
- What are the sources of income for PLWHA livelihood in Kisarawe district?
- What are the alternative sources of livelihood of PLWHA in Kisarawe district?

- What are the financial sources for PLWHA income initiatives in Kisarawe district?
- What are the saving methods used by PLWHA in Kisarawe district?
- Are the PLWHA willing to join saving and credit associations?
- What is the loan size required by the PLWHA and preferable loan collection period for their income generation initiatives?
- What more support do PLWHA require from the JIMOWACO home-based care project support?

Hypotheses to be tested

- Home based care services improve the quality of life of PLWHA
- PLWHA and their families have limited access to financial resources for their livelihood
- PLWHA/care takers and their families have limited saving capabilities
- PLWHA and their families are able to save if guided and given opportunities and space.

1.2.1.3. Characteristics of the Survey

Contents of the Survey Instruments

The content of the survey instrument mainly covered the following key areas:

- Type of services offered and received from the JIMOWACO home-based project and their impact to the life of PLWHA and the family

- Main sources of income and capital for PLWHA and family livelihood; Suggestions regarding alternative ways to improve livelihood of PLWHA and the family
- Challenges facing home based care services in Kisarawe District and suggestions to improve them in Kisarawe District.

For details see appendix 7: The Survey Questionnaire.

Psychometric Characteristics

The research applied standard methods in the selection of sample size, data collection and analysis. Both measures assure reliability of the research results and the findings obtained from the field survey. The research results were then compared to the similar research, which have been conducted in the Home Based Care project of the same nature in Iringa region in Tanzania.

Validity and Reliability of information collected

Pilot testing of the questionnaire and appropriate selection of data collection tools to suit the purpose of the study was done to ensure that valid and reliable data are collected. Interviews with project staff and district officials prior visiting the community was conducted so as compare the validity of the information. The use of more than 3 tools (i.e. triangulation of survey questionnaire, personal interview, focus group discussions) and review of HIV/AIDS report interviews were considered in order to crosscheck the reliability and validity of the information collected. The methods used to collect

information revealed almost similar and relevant information, hence the information collected are valid and reliable (Hardo et al., 2001).

Administration

The study was participatory and involved the project home based care field staff, which comprised a clinical officer, a research assistant (Advanced Diploma in Community Development) the CED student (BSc. Home Economic and Human Nutrition) and project community volunteers from selected villages.

A one-day discussion meeting with JIMOWACO project staff, community volunteers and the research assistants were done to introduce the purpose of the survey, sample selection and to pilot test the questionnaire to the selected clients.

The focus group discussion with the four JIMOWACO Home Based care community volunteers and eight village AIDS committee members took about one and a half hours. Personal interviews with two community leaders (Ward Executive Officer and Ward Councillor), District Social Welfare Officer, District Aids Coordinator and completing of questionnaire to the 72 PLWHA all took about 30 minutes each.



Photo: CED student (left) accompanied by the Home Based Care volunteer, interviewing the PLWHA at her home in Homboza village-Kisarawe District.

1.2.1.4. The Research Design

This study is descriptive as it involves the systematic collection and presentation of data to give a clear picture of a particular situation. It is concerned with the description of the characteristics of each particular group of people. Therefore this study examines only those benefiting from the Home Based Care Project, the People Living with HIV/AIDS. (Hardo et al., 2001).

1.2.1.5. Internal and External Validity

- **External validity**

The choice of more than two appropriate data collection methods and pilot testing of the survey questionnaire were undertaken to ensure the collection of valid information since there is no single data collection method that can give out valid information than other

method. Pilot interviews were conducted to PLWHA and a community volunteers so as to crosscheck the appropriateness of the designed questions with a view to improving them (Hardo et al., 2001).

- **Internal validity**

Pre-testing of the questionnaire among respondents was done to check the reliability and ensure its internal validity. The interview guide questions and questionnaire were also given to my colleague for review to ensure internal validity (Hardo et al 2001).

1.2.1.6. Sample

- **Sampling Method Used**

The sample selection method used was stratified sampling so as to get enough information required from the population selected. The method involves dividing the sample into study units/groups/strata with specific characteristics based on the information required by the study, then the group representatives were selected randomly or systematically to enable the researcher to get valid information for the study.

For this study, the stratification of the population grouped the sample into 4 categories: project staff, community members (which included the volunteers), community leaders, village AIDS committee members, the patients (PLWHA) and district leaders/officials. In each category purposive sampling or random selection was done depending on the category and the role played by the personnel selected. The patients were randomly

selected from based on the accessibility of the location, availability of the respondents and willingness of the respondents to participate in the survey.

- **The Sample Size**

The sample size selected was 80 individuals out of the 669 PLHWA registered as receiving home-based care services, determined by their similarities in nature, resources available and the time constraints. Out of these 72 people responded. These were 62 PLHWA, 2 project staff, 4 community HBC volunteers, 2 community leaders, 1 District AIDS Coordinator, 1 District Social Welfare Officer. (3 selected PLHWA died, 3 were absent during the visit and 2 were not willing to be interviewed after requesting their consent).

1.2.1.7. Appropriate Analysis

Data were coded and analyzed using the SPSS descriptive statistics, which includes frequency distribution tables and cross-tabulation between the current sources of income and alternative/more available opportunities for income for PLHWA.

1.2.1.8. Summary results of Survey Questionnaire

Table 1: PLHWA activity status before and after HBC services (Msimbu, Kisarawe, Marumbo Wards).

Status	Before		After	
	Freq.	(%)	Freq.	%
Can work	4	7	42	68
Able to walk	32	51	18	29
Sleeping	26	42	2	3
Total	62	100	62	100

The HBC services provided by JIMOWACO to the PLWHA has helped to reduce the number of respondents who were completely sleeping in bed by 39% and increased the number of those who can do some work by 61%.

Table 2: PLWHA caretakers

Description	Frequency	Percentage
Care taker present	27	43.5
No care taker	35	56.5
Total	62	100

Almost half (56%) of the PLWHA had no one to take care of them and depend on themselves for their well-being. This implies that most respondents are either family breadwinners or family heads.

Table 3: PLWHA Current Sources of Income

Activity	Frequency	Percentage
Farming	15	24.2
Small business	11	17.7
Small business and farming	31	50
Other	5	8.1
Total	62	100

Almost half of the PLWHAs families depended on small business and farming for their daily lives though they are living in rural areas, where is believed that more that 75% are farmers. This implies that, PLWHA cannot do much of cultivation for their survival. Consequently they need alternative means of survival.

Table 4: Alternative Income Sources (i.e. more opportunities for income)

IGA	Frequency	Percentage
Local chicken rearing	13	21
Gardening	2	3.2
Crops cultivation	2	3.3
Small business	40	64.5
Chicken and gardening	5	8.1
Total	62	100

More than half of the respondents (64%) indicated that, due to their health status the best option for their livelihood is small business. Thus support of small business is crucial for their wellbeing.

Table 5. Cross tabulation

Alternative income sources (more opportunity for income) and current income sources

		Source of income				Total
		Farming	Small business	Farming and small business	Others	
Alternative/ more opportunity for income	Local chicken rearing		2	6	5	13
	Gardening	2				2
	Crops cultivation	2				2
	Small business	11	9	20		40
	Chicken rearing and gardening			5		5
	Total	15	11	31	5	62

The cross tabulation of the collected information, shows that more than 60% of the respondents depend on small business and farming as sources of income, although the only alternative source of income suggested by the majority is small business.

Table 6: Addition Support Requested From the Project

Support	Frequency	Percentage
Deceases prevention skills	6	9.7
Business skills	15	24.4
Business capital/loan	29	46.8
Other	12	19.4
Total	62	100

The majority of the respondents (46%), when asked what additional support they need from the HBC project, indicated the need for financial capital /loans for expanding their small business.

Table 7: PLWHA Savings Methods

Types	Frequencies	Percentages
No savings	44	71
Buying materials	6	9.7
Ascas (Upatu)*	5	8.1
Saving & credit union	2	3.2
Bank account	5	8.1
Total	62	100

*'Upatu' in KiSwahili means 'merry-go-round', and is an informal means of micro-saving scheme (not registered with the government system).

The majority of the respondents (71%) indicated of not having any cash savings, this implies that, what they earn from their small business and farming activities is just enough for their survival (i.e. hand to mouth).

Table 8: Source of Financial Capital for Income Generation Initiatives

Source	Frequency	Percentage
Selling of crops	9	14.5
Given by spouse/relative	21	33.9
Small saving	9	14.5
Others	23	37.1
Total	62	100

The majority of the respondents (50%) depended on small business and farming (Table 3). About 33% of the respondents were given the financial capital to start the businesses by relatives or spouses, and 14% through small cash savings. This implies that there are no credits and saving services/micro-financing services provided in their communities.

Table 9: Is Individual Financial Capital Enough?

	Frequency	Percentage
Yes	2	3.2
No	60	96.8
Total	62	100

Almost all the respondents (96%) declared that they were not completely satisfied by the size of their business capital; hence they need more support in that area.

Table 10: Range of Additional Loan/Financial Support Required

Capital range (Tsh)	Frequency	Percentage
10,000-20,000	5	8.1
21,000-50,000	23	37.1
51,000-100,000	13	21.0
101,000-150,000	10	16.1
Above 150,000	11	17.7
Total	62	100

Due to the nature of their small business, the range of capital required by the majority (37%) ranged from Tsh21, 000/- to Tsh50, 000/- and for some from Tsh50, 000/- to Tsh150, 000/-. The small amount of capital required by the majority is not the preferred amount by most micro-financing institutions due to subsequent high administration cost of follow-ups which make it unprofitable. This information calls for the need to establish community based/ managed saving and credit group system for expanding the capital base.

Table 11: Willingness to Join Saving and Credit Groups

	Frequency	Percentage
Yes	53	85.5
No	9	14.5
Total	62	100

About 85% of the respondents showed willingness to join community based / managed saving and credit group system if training and support will be given to them.

Table 12: Recommended Loan Recovery/collection Period.

	Frequency	Percentage
Weekly	0	0
Monthly	43	69.4
Above 1 month	19	30.6
Total	62	100

More than half (69%) of the respondents indicated willingness to take loans if provided, on condition that the loan recovery period will be on monthly basis. The loan condition suggested is due the nature of their business and their unstable health condition. However, most micro-financing institutions operating in Coast Region like PRIDE and FINCA prefer weekly loan collection periods. This indicates the need to establish community based/managed saving and credit group system in the study area where loan conditions are determined by the group members.

1.2.2. Individual Interview with Key Informants.

Personal Interview and discussion with key informants were conducted to District Social Welfare Officer, District HIV/AIDS Coordinator, JIMOWACO's Project Manager and one field staff. The interviews aimed to collect information regarding the contributing factors to HIV transmission in the district, effort done within the Kisarawe District to mitigate the impact of HIV/AIDS, challenges and ways to improve Home Based care services for improving the livelihood of PLWHA and their families.

1.2.2.1. Individual Interview with key informants Results.

With regard to the HIV transmission, the District Social Welfare Officer revealed that, since Kisarawe is adjacent to Dar-es-Salaam city, there is an influx of people coming and out for business like charcoal collection and other social gathering especially the routine traditional dances, thus increasingly sexual interaction with the community members. However, the people of Kisarawe district are more than 90% Muslim, which allows their males to have multiple partners. The existing cultural behavior within the district is adding to the increasingly number of divorces and re-marriages which contribute much to unsafe heterosexual behavior and as well increase the risk of HIV infection. As a cultural norm in Kisarawe, there are a lot of traditional dances in the communities almost every weekend which brings a lot of Kisarawe citizens, who are town dwellers in Dar-es-Salaam city, together with the “ngoma” troupes. The traditional dances are accompanied by large amounts alcoholism, which reduces sexual self-control; hence increase the chances of unsafe sex.

The District AIDS Coordinator said, the District council is trying to ensure counseling, and testing services are obtained free to PLWHA at the closes health centers ,however, for treatment the district has one counseling and treatment centre (CTC) at the district hospital. Due to limited funds, very few personnel from existing health facilities have been trained on home based care services who work closely with village health workers to offer treatment of opportunistic infection to PLWHA. The districts haven’t done much on provision of direct support to PLWHA and depend on the works of NGO support, especially JIMOWACO and BAMITA who are funded by Care International.

JIMOWACO has been providing tangible home based care services in the district, which have helped a lot of PLWHAS, to improve their health. Most of PLWHA are coming from poor families, hence the food support given was of help especial to those under medication ARV drugs, and however, the support is not enough to meet the families demand. Other support that they offered to them, are bedding and school materials, which were highly the needed by the affected one, as majority are poor. We real appreciate the works of NGO and we call for many others to assist PLWHA in mitigating the effects of HIV/AIDS.

The JIMOWACO Project Coordinator reported of conducting a study in 32 villages in the district where by they had identified and registered 669 people with HIV/AIDS related illnesses within the community who need support. Through providing home based care services to them, which included such services as medication for opportunistic infection, food supplements, paying for transport cost to attend ARV clinic services, and supply of school material to OVC, a lot of PLWHA health status improved. Homes based care services provided are very costly and depend highly on donor funds; therefore is difficult to address all the basic needs for PLWHA and orphans. To reduce over dependency on food supplement from the project, income generating activities support to PLWHA have started by local chicken rearing project to families, but the significant results takes time to be observed. Training and supply of cockerel to 60 PLWHA and orphans families have done, and more will be reached in the near future.

JIMOWACO field staff insisted that, the home based care services provided to PLWHA and OVC, have real helped many. Some of PLWHA after they had received medication

for opportunistic infection and those in ARV medication can now do some work and the orphans who dropped school, went back to school soon after they got the school material (i.e. uniform, shoes, exercise books and text books).

1.2.3. Focus Group Discussions

Two focus group discussions were conducted to HIV/AIDS committee of Msimbu Village and JIMOWACO's Home Based Care Community volunteers. The discussion aimed at collecting information regarding the Home based care services provided by in terms of their impact, challenges and ways to improve them.

1.2.3.1. Focus group discussion results.

The focus group discussion with home based care volunteers revealed that, Home Based Cares (HBC) services provided by JIMOWACO, have played a significant change to their clients (PLHAs and OVCs) and is the only organization providing the HBC services to their communities.

The Ant Retro Viral (ARV) referral services support provided by JIMOWACO in terms of transport costs refunds to PLWHAs and community volunteers to attend the ARVs /counseling treatment centre (CTC) clinics have helped PLWHAs to access the services easily. At first the ARV services were obtained from near by districts of Dar-es-salaam (Ilala and Temeke Districts) and Kibaha district in the coast region before the Kisarawe district started providing them in 2006. In addition, with the medical support given to PLWHAs for curing the opportunists infection, many who received the services, their health have improved and are now able to do small cultivation and small business. The

orphans and vulnerable children (OVC), who received school material and uniforms support are now attending school and those who had dropped out from school and with poor attendance , have gone back to school.

Most of them, congratulated JIMOWACO for the new initiative of local chicken rearing project to support PLWHAs families, and hope to have a significant result since can be kept even by children (OVC) and have large market at Dar-es –salaam. However the previous milk goat project supported to the few PLWHA families, but didn't bring expected results, since the Kisarawe communities by culture are not livestock keepers. Most of them died due to poor husbandry.

The village HIV/AIDS committee appreciated good services provided by JIMOWACO though are not sufficient, especially the food support. However, the little food support provided, but had helped. The majority of PLWHA are poor and with ARV drug use, the body energy and nutrients requirement increases. The had also acknowledged for the few bed nests supplied but more nets are needed, since many PLWHA are not sleeping under bed net, hence are prone to Malarial infection.

All agreed that, there is very minimum community support to PLWHA and in most cases is observed during funeral ceremonies. There is great need to do community sensitization meetings so as reduce stigmatization and increasing community support to PLWHA and OVC. The HIV/AIDS committee members insisted the need of collaboration between NGO providing services to PLHAs, especially OVCs with community leader, so as to avoid duplication of services /support provided to them while living other with nothing.

In improving income of PLWHA, the suggestions given were as follows: -PLWHA to form groups and join their effort to start group business like a shops ,tailoring mart and grocery; Supporting of farming activities like local chicken rearing, milky goats husbandry and gardening activities. Communities need to be sensitized to support PLWHA with some domestic cores like fetching water, cultivation and establishing community fund for supporting PLWHA with basic social needs like bus fare to attend medical check-ups/clinics.

1.2.4. Review of HIV/AIDS reports.

The District HIV/AIDS report of 2004 and National HIV/AIDS /STI Surveillance report of 2004 were reviewed in order to understand the HIV/AIDS status of the Kisarawe District.

1.2.4.1. Review of HIV/AIDS Reports Results.

Kisarawe district is among the most highly affected districts with HIV transmission in the Coast region with a prevalence of 11%, whereas that of the Coast Region is 7%. The leading cause of HIV/AIDS transmission, is about 80% is heterosexual relationships. (National HIV/AIDS/ STI 2004 Surveillance Report). Adults with HIV/AIDS related symptoms occupy more than 50% of the inpatients wards in Kisarawe. The productive age groups are most affected, i.e between 20-24(7%) and above 24 yrs (28.6%)(Kisarawe District report 2004).

1.3. Discussion of Results and findings.

About 65% of the respondents were female and 36% were males. The age of the respondents were (8.%) 11-20 years, (18%) 21-30years, (34%)31-40years and (40%) above 41years.57% of the respondents are taking care of themselves, thus the majority are family heads while, 43% were having somebody to care off, which includes parents, children and relatives. This implies that, however they are suffering from AIDS, still they need to provide for their families too, hence they need to have an active means of livelihood for them to survive and access basic social services like food, medical care and education for children.

The impact of home based care services provided by JIMOWACO to PLWHAs

The home based care services provided by JIMOWACO to PLWHAs, which includes medical care, nutritional/food support, beddings, school material and psychosocial support services have shown significant improvement to the life of PLWHAs. At the beginning of the home based services, 7% of the responds were able to perform their work, 29% could just walk and 26% were bed ridden, but after the intervention (Table 1) 68% of them were able to work, 29% just walking and only 3% where bed ridden. This implies that, home based care services are important to the well being of the HIV/AIDS affected individual and the family, however are very expensive to be undertaken. I.e.. Most depends on donor funds.

The sources of income for PLWHA's livelihood.

About 50% of PLWHAs depend on small business and faming for their livelihood; 24% only on farming activities and 18% on small business (Table 3). This implies that,

despite their health status the majority of the respondents do small business and small farms for their livelihood. However, farming activity is a major means of livelihood in Kisarawe district (87%) population, but is hard work to most PLWHAs due their health status. Therefore, there is great need to support PLWHAs with simple and best-improved agricultural practices, techniques and small business in order to improve their family well being.

Alternative sources of livelihood of PLHAs.

The research findings (Table 4 and 5) shows that, small business (65%) is the most attractive means of livelihood for the life of PLWHAs in Kisarawe which comprises of food vending, small shops, selling of second hand clothes and charcoal. The second option was local chickening rearing, since they are easy to keep and have high market demand and good price at the adjacent Dar-es-salam city. The third option was gardening in combination with local chicken rearing. Therefore upgrading small business is important for the livelihood of the PLWHAs.

Sources of financial capital for PLWHAs income initiatives.

The majority of the PLWHAs had lost their business and their livelihood means after suffering from AIDS. Having improved their health status, most of them started small business as a means of livelihood. About 34% of them, their start up capital was given by their relatives, 15% from selling of crops, 15% accumulated small cash saving and the rest other sources (Table 8). However, 97% of them said, the financial capital they have, is not sufficient for expanding their businesses (Table 9). Therefore there is a need

to find a sustainable solution for obtaining funds for business start up capital in terms of soft loan or small grants

Saving method used by PLWHA.

Most of the respondents indicated that they earned less to the extent of failing to accumulate any savings (71%). Thus, what they earn is just good for their survival; 10% indicated that they do save through buying other materials for selling to expand their small businesses; 9% said they do save through 'marry go round' (Upatu in Kiswahili) and 8% are the retired Civil Servants who enjoy previous saving in the form of pension, they use bank accounts to keep some cash (Table 7). This information is compatible with the fact that, Kisarawe district has more than 50% of its population living below basic needs line of 262 Tsh (US\$ 0.33) a day and is among the bottom 10 district as poverty head count in the country (Tanzania poverty and human development report of 2005). Therefore there is a need of establishing community managed saving and credit services, as means of solving family immediate problems by using saving reserves.

PLWHA willingness to join saving and credit association/groups.

Most of the respondent (86%) (Table 11) indicated willingness to join community managed saving and credit groups system if they will be trained and guided. However, although they earn little, the truth is, most poor people can and do save given a choice and opportunity. Collectively, poor communities have substantial resources that can be utilized more optimally if pooled and organized into a transparent and efficient financial system.

Financial support/loan range required and loan collection period by PLWHA.

The majority of PLWHA's have small business and farms for their livelihood. More than one third (37%), indicated a need of 21,000-50,000Tsh for the start-up capital while (21%,) 51,000-100,000, (16%) 101,000-150,000, (17%) above 150,000 and (8%) below 20,000/= sh (Table 10). The range of the financial resources most of them need, does not fit in most micro-financing services providers working in the Coast region like PRIDE and FINCA since the minimum amount of the credit they can offer is 50,000/=. However, the formal micro-financing institution operate on the principle of financial sustainability through cost recovery and makes loan based on pre-established loan criteria, in which those who needs small loan of below 50,000/ do not fit. Most of the formal micro financing institution operates in semi urban centers; they work with poor household that are relative economically active and stable rather than the poor of HIV/AIDS affected household. However, the majority of the responded PLWHA indicated the need for more financial support/loans. But 69% (Table 12) of them recommend for a period of at least one month and above (30%) for the loan recovery/collection period rather than on weekly basis. One of the main obstacles to self-employment is access to start-up capital. Therefore community managed saving and credit system is the best approach for improving PLWHA livelihood. They can allow group capital base accumulation through small saving and group members can take small loans to protect assets. They use their savings to send children to school and pay for medical expenses at agreeable flexible time.

More support request by PLWHA from the JIMOWACO Home based care project.

As the majority of the PLWHA's health status have been improving since they started receiving the home based care services from JIMOWACO's project, most of the them had requested for business start-up capital/loans (47%), since by being suffering from AIDS, they had found themselves loosing their former income generating activities. Most of them depend on small business and farming for survival, they can no longer do heavy cultivation; hence, they request business skill training (table 6). It is important to considered for skill upgrading for exploring new marketing opportunities.

1.3.1. Findings and Recommendation.

Most of the Home Based Care projects are costly and donor dependent. The project operates in poor communities where they support PLWHAs and OVCs with food, school material like uniforms, textbooks and other basic services, but these are not sustainable after the end of donor fund period. Community capacity building for sustainable livelihood after their health status has improved is paramount for sustainability of the program.

Hence therefore, improving PLWHA's family livelihood to access basic social economic activities basing on the findings is important. It is recommended that; -

1. PLWHAs be organized to form interest groups for income generation activities;
2. Upgrading the capacity of PLHWAs on management of small businesses.
3. Community managed saving and credit model be promoted to the vulnerable groups like PLWHAs and widows, so that they can collectively accumulate their capital base for expanding their small business and save for emergencies like medical care and school fee rather than depend on donors.

4. Promoting gardening and local chicken rearing as these can easily be managed by the PLHAWs and have a large demand in Dar-es-sallam.

1.3.2. Comparison of the findings with other surveys.

There are few studies conducted and published in Tanzania on home-based care programs except for a similar program in Iringa region. The findings in Kisarawe and that of Iringa are almost the same. For instance, lack of food and income was the cry of the families visited; this calls for more support for income generation activities so as to solve immediate household social –economic needs like food and school expenses. Also, there has been minimum community education/ sensitization, which is helpful in reducing stigma, discrimination and enhanced family and community supports to people living with HIV-AIDs in both.

1.4. Graphical contents

Map of Tanzania showing the poverty level by District in Tanzania. (See attached map).

ASILIMIA YA WATU WANAOSHIRIKIWA KATIKA UMASIKINI, KIWILAYA TANZANIA BARA 2000-2



CHAPTER 2: PROBLEM IDENTIFICATION

Jipeni Moyo Women and Community Organization (JIMOWACO), is implementing a home-based care program (HBC) to people living with HIV/AIDS (PLWHA) and orphans and vulnerable children (OVC). Various interventions have been carried out to improve their well being, but according to the findings of the needs assessment reported in Chapter 1, still more support is required by them for improved sustainable family livelihood. With the limited resources JIMOWACO received from donors to implement the program, it is not enough to address all the problems facing PLWHA/OVC and their families.

Therefore from the community needs assessment conducted, prioritization was given to address the real problems of the community, particularly families affected by HIV/AIDS, so as to take advantage of the scarce resources obtained from donor support for obtaining sustainable achievements.

2.1. Problem statement

Situation to be changed

The 11% prevalence rate of HIV/AIDS infection in Kisarawe District has increased the demand for health, social and economic services to the communities than was the case before. Thus services such as Voluntary Counseling and Testing (VCT), community health education, antiretroviral services and life skills education are highly required by communities than the government can provide.

HIV/AIDS have a negative impact to the family household income, since the active working group including families' breadwinners has been affected. The small family earnings are used for medical care hence increased household poverty. Household poverty reduces the capacity of the family to access quality basic social services such as education, health and social security for responding to the threats of the epidemic. Therefore, there is a need to improve household means of livelihood for the development and wellbeing of the families particularly for the people living with HIV/AIDS.

Who is affected by the problem?

HIV/AIDS has most affected the productive age group and mostly bread winners, hence resulting in the decrease of the household income. The attendance records in the Out Patient Department (OPD) services within the district in 2004, indicates 41% of the attendees were HIV positive. The distribution was 15-19 years (4.4%), 20-24 years (7.9%) and above 24 years was (28.6%). In comparison, the national HIV prevalence among blood donors in 2004 was 4.7% (15-19 years), 5.7% (age 20-24 years), 7% (25-29 years), and for the overall national prevalence was 7.7% as per the national surveillance report of 2004.

Therefore, as the most productive age group is affected with increasing HIV/AIDS infection, it implies reduction in household income and increasing family poverty. Not only that, but also the community and the nation as well is also affected directly as the human resource is attacked by the pandemic, hence government expenditure has increased to fight the epidemic and to meet the demand for increasing social services, especially medical care services.

Contributing Factors to HIV Transmission

According to the National HIV/AIDS/STI Surveillance Report of 2004, the predominant mode for HIV transmission is heterosexual sex, which constitutes up to 78% of those affected; mother to child transmission 4.6% and blood transfusion 0.5%. Other transmission routes like intravenous drug use, accidents or through traditional skin practices are rare. Despite prevention efforts in the last 16 years, there has been slight sexual behavioral change and most people do not feel the risk. However many have been affected in one way or the other by HIV/AIDS. A collective effort is required to fight the pandemic, since the underlying factors contributing to the pandemic are mostly poverty related and bad personal behaviors.

Traditional male-dominated gender relations and due to income poverty, the capacities of girls and women to determine their sexual relations are reduced. Thus making them more vulnerable to HIV infection transmission. Income poverty, especially to vulnerable groups like poor single women, widows, orphans, street children increases the risk of contracting HIV. Information gathered from interviews with local key informant's shows that the social-cultural practices, which contribute indirectly to the spread of HIV, are drunkenness, overnight traditional ceremonial dances (Ngoma), divorces and remarriages and cultural initiation ceremonies.

The increasing HIV/AIDS pandemic has resulted in inadequate medical services, especially for inpatients since more than 50% of hospital beds in Kisarawe District are occupied by AIDS patients. Increasing income poverty as a result productive age group being affected by the pandemic, has reduced the ability of households to pay for the cost

of accessing basic social services like health, education, housing, sanitation, hence household poverty dramatically increases.

The Magnitude of the Problem

The study done by Jipe Moyo Women and Community Organization (JIMOWACO) in 32 villages out of the 75 in the district identified 669 AIDS patients who needed support. The District Hospital is having a total of 150 beds and averages of 5,882 people are served at each dispensary in the district per year. This implies that there is a huge demand for care and hospital supplies than the district and community can afford. The situation calls for alternative ways of providing care and social economic support to all communities in the district. The district has started to implement a home based care services program, but the coverage is still minimal because of inadequate trained health personnel, community health workers and care givers, few VCT centers and health center, inadequate supply of medication for home based care and antiretroviral services to meet the increasing demand.

What will happen if nothing is done?

If there are no measures taken to support PLWHA and OVC, both with basic needs like food, medical care, and other social services-economic service like education and income generating activities, there will be an increasing death rate of the PLWHA, malnutrition, street children, child labor, school dropouts and more risks to these vulnerable groups for more HIV transmission.

Efforts Undertaken Within the District

The Kisarawe district council has done many things to combat HIV/AIDS in community including establishing Home based care services by conducting training to community home based care volunteers, home based care supervisors, HIV/AIDS for school peer educators. It has undertaken training of care takers and widows on skills needed for income generating activities, and has supported OVCs with food, school fees and uniforms. It has organized condom promotion events, established village orphan committees, AIDS Committees at all levels and voluntary counseling and testing (VCT) units in some dispensaries and health centers.

Blood screening prior to donation is conducted regularly at the District Hospital and establishment of HIV/AIDS/Sties forums (Women Network, Faith Based Organizations Networks, Non-governmental Organizations (NGOs) and Government Sector collaborations. The district also has called for collaboration with other NGOs, Community Based Organizations (CBOs) and Civil Society Organizations (CSOs) to support care for widows, PLWHA and OVC.

Efforts Undertaken by the Government

Tanzania, in collaboration with various partners, is intensifying its efforts in fighting the epidemic. To date, the HIV/AIDS epidemic ranks among the top priorities in Government plans. In response to HIV/AIDS epidemic, the Government since the first patient was identified in 1983 formed the National HIV/AIDS Control Programme (NACP) under the Ministry of Health. NACP formulated Short Term Plan 1985-1986, which was followed by Medium Term Plans in three phases, which covered the period between 1987 to 2002. The Government is also incorporating HIV/AIDS issues in the

Poverty Reduction Strategy Paper (PRSP) of October 2000 and prepared the National HIV/AIDS Policy of Sept 2001. In December 2001, Tanzania Commission for AIDS (TACAIDS) was established for the purpose of providing leadership and coordination of multi-sectoral responses. Hence in January 2003, TACAIDS prepared the National Multi-Sectoral Strategic Frame for HIV-AIDS 2003-2007. Not only that, but also in February 2005, NACP established the National Guidelines for Home based care services to ensure PLWHA receives appropriate services.

However, the response has not had as much impact on the progression of the epidemic as expected. The national response initiatives were constrained by a number of factors including, inadequate human and financial resources, ineffective co-ordination mechanisms and inadequate political commitment and leadership. Some of these constraints are now being addressed. There is strong political commitment and leadership from the highest level. HIV/AIDS has been declared a national crisis and is now one of the top priorities in the Government agenda, along with poverty alleviation, and improvement of the social sector services.

Efforts by International Agencies

The United States President's Emergency Plan for Aids Relief is supporting Tanzania's efforts to combat HIV/AIDS. Under the Emergency Plan, Tanzania received \$70.6 M in FY2004 to support comprehensive HIV/AIDS prevention, treatment and care programs. In FY2005 Tanzania received nearly \$108.8M and FY2006, US has committed approximately \$112.9 M to support Tanzania.

2.2. The Project Target Community

Phase one of the implementation of project will cover six (6) selected villages of Marumbo Ward, in Maneremango Division (out of 39 villages covered by the Host organization JIMOWACO). These villages include Palaka, Kitonga, Marumbo, Chan'gombe, Kikwete and Mfuru. The remaining villages will be considered in Phase Two during the scaling up of the project by JIMOWACO.

The registered people living with HIV/AIDS (PLWHA) and orphans and vulnerable children (OVCs) and their family members /caretakers under the JIMOWACO Home Based Care are the target group of the project. The interested family members/care takers will be organized in groups of 15-25 people and trained on community managed savings and credit group system.

2.3. Stakeholders Analysis

Stakeholder	Participation	Evaluation	Impact of participation	Rate	Plan
Registered PLHA/OVC's family/care takers and interested community members	-Project beneficial and active group members of saving and credit groups	High	- Active participation in the saving, credit and loan recovery to form the capital base.	+ve	Involving them in all project stages.
Home based care project volunteers	Community mobilization, collecting groups monitoring forms and linking the groups with trainers and project staff	High	Overseer of the general progress of the project and monitoring of the health status of the PLWHAs.	+ve	Involving them in all project stages and monitoring of the health of PLWHA
Community leaders	Community mobilization and general overseer of the community groups.	Medium	Harmony and peace with community and intended beneficially to benefit from the services.	+ve	Involving them awareness meeting, training and giving them feedback of the progress.
District Social welfare department.	Information sharing and technical assistance in other social-economic issues. .	Medium	Liking the groups with other support services from the government and other donors.	+ve	Giving them feed back report and monitoring
Trained community members on Community managed and saving groups model (Community own resource person.).	Identification of project beneficiaries /clients and supervision during distribution of supplies to clients.	High	Smooth running and self managed saving and credit groups.	+ve	Community awareness, groups' formation, groups training and monitoring.

JIMOWACO project staff-home based care project staff.	Planning, organizing, implementing, monitoring of all activities and financial support.	High	Smooth running and self managed saving and credit groups.	+ve	Community awareness, group's formation, groups training and monitoring and evaluation.
CED student	Technical advices, identification of trainers and donor for the project support, orienting the JIMOWACO staff on the community managed, Saving, credit operation	High		+ve	Participation on the early preparation of project planning, trainer's identification, community mobilization and group's formation.
Plan Tanzania – Kisarawe program Unit.	Technical advice and financial support	High	Smooth undertaking of mobilization, training and kits supply.	+ve.	Information sharing, feedback, reports.

2.4. Project Goals

The main purpose of the project is to establish community managed savings and credit groups system to people living with HIV/AIDS (PLWHA) and their families.

2.5. Project Objectives

The project specific objectives are as follows:

1. To identify a like minded development partner to support the training of PLWHA groups in saving and credit management by October 2006
2. To identify the 2 trainers for the community saving and credit training to be offered to PLWHA groups formed by December 2006
3. To mobilize 10 PLWHA family interest groups for saving and credit associations by September 2007
4. Training of the 10 organized PLWHA groups in community managed saving and credit association model by September 2007
5. Training of the community managed saving and credit groups on selection, planning and management of income generating activities by December 2007.

2.6. The Host organization

The JIMOWACO Organization.

The host organization is known as Jipe Moyo Women and Community Organization (JIMOWACO). JIMOWACO is a registered organization under the Society Ordinance Act (Registration No.12250 in January 2004). This is a non-profit making, autonomous,

membership organization. The Project Office is located in Kisarawe district, with a mailing address of P.O Box 28040, Kisarawe, Pwani.

JIMOWACO Project Description.

The main project activity implemented by the organization is Home based Care and support for people living with HIV/Aids (PLWHA) as a sub-grantee of the 'Tumaini program'. The 'Tumaini' program is formed by alliance partners coordinated by CARE International and is funded by President's Emergency Plan for AIDS relief through USAID. The alliance partner of 'Tumaini' program includes Care International, Family Health International, Muhimbili University College of Health Sciences, HEIFER International, Health Scope and Centre for Counseling, Nutrition and Health Care (CONSENUTH.)

Project History

Before the start of the Care and Support project to PLWHA and OVC in June 2004, the organization was dealing with community education on HIV/AIDS and encouraging voluntary testing, but no other support was given to communities. By then, JIMOWACO was assisting 110 registered PLWHA, and was working with community health workers and peer educators in educating the communities and encouraging them to go for testing (VCT).

In 2002, CARE International came in the district with the idea of implementing Voluntary Sector Health Program (VSHP) for one year. CARE started by conducting a workshop with interested organizations, which was followed by organization assessment and proposal writing. JIMOWACO was among the 8 organizations that got the funds.

The success of the VSHP project as implemented by JIMOWACO, made them to be selected again among the 2 (ie. BAMITA and JIMOWACO) who won the assessment and they were given funds to implement the care and support project to PLWHA and OVCs under the Tumaini Alliances Project in Kisarawe District.

The project is operating in 39 villages in 8 wards of Sungwi, Maneremango and Mzenga Divisions in Kisarawe District-Coast region. (See Appendix 8 for list of villages). The Project works with People Living with HIV/Aids regardless of their age. The services or support given to the beneficiaries varies with age group or social group. All clients are entitled for medical care, food support and counseling, but school children are given additional support. A school pupil is supported with school uniforms and exercise books

JIMOWACO's Project Goal and Objectives

The main goal of the project is: People Living with HIV/ADS to have good health, to be able to resume their daily activities through Home Based Care and Antiretroviral services.

The project objectives are as follows:

1. To strengthen home based care services to 500 People living with HIV/Aids (PLWHA) in 5 ward of Kisarawe district by 2006
2. To improve nutrition care and support to 500 PLHA and Orphans and Vulnerable Children (OVC) in 5 Wards of Kisarawe district by 2006
3. To improve income to 100 PLHA and 100 OVC households in 5 Wards of Kisarawe district by 2006

4. To enable active primary school attendance of 1200 OVC in 5 Wards of Kisarawe district by 2006

5. To formulate networking for continuum of care with other stakeholders.

The Care and support project for people living with HIV/AIDS provides home based care services and support with the following main activities:

- Nursing care services, through community health workers and nurse supervisors;
- Treatment, through referral system and home care;
- Food support to the sick ones, which includes peanut butter, power food flour, maize flour, beans and cash for fruits and vegetables
- Shelter improvement through support of mattress and bed sheets
- Home based care education to community home based care volunteers (CHBCV), nurse supervisors and JIMOWACO staff
- Training on income generating activities
- Counselling /guiding services on legal matters, spiritual an psychological issues
- Bicycle support to CBHCVs and nurse supervisors
- Supporting access to counselling treatment and care services for antiretroviral drug services.



Photo: JIMOWACO Home based field staff distributing food supplement support to home based care volunteers in Homboza village for redistributing to PLWHA.

Personnel Involved in the Project

10 members formed the organization and employed 6 full-time staff that are paid by the Home Based Care Project for implementation of the project activities i.e. project coordinator, accountant and 4 field officers.

The home based care field staff are in the frontline in the implementation of the project in day-to-day activities. They supervise community volunteers who are close to the patients and conduct regular home visit as the feedback they receive from community volunteers or continues monitoring visits. The project manager who links the organization to the development partners and also manages the funds and prepares project progress reports assists the field workers.



Photo: JIMOWACO home-based care field staff distributing medicine kits to home base care volunteers of Msimbu ward (ie.at Homboza Dispensary).

PARTICIPATION OF EACH GROUP

JIMOWACO Stakeholders Analysis

Stakeholder	Participation	Evaluation	Impact of participation	Rate	Plan
People living with HIV/Aids (PLWHA)	-Project beneficial -Peer - education	High	Addressing their felt needs and active participation, willingness to change behavior is success the project.	+ve	Involving them effectively in all stages and them.
Orphans and vulnerable children (OVC)	-Project beneficiaries. -Active participants in income generating activities i.e Poultry keeping.	High	Active participation e.g in schooling and poultry keeping reduces the magnitude of the problem.	+ve	Involving them effectively and train them
Family member of the PLWHA/OVC	Care taking for the PLWHA and OVC, participating in income generating activities.	High	If not ready to take part, the magnitude of the problem will be increasing.	+ve	Educating them and involving them in project activities.
Community volunteers/ Community health workers.	-Educating the communities, identifying clients, follow-up of clients and delivery of supplies to clients. Linking the communities and the project and monitoring of the project activities.	High	If are not active the objectives of the project will not be met especially in home based care services	+ve	Involving them and supporting them with working tools and capacity building
Supervisor-Health post personnel	Treatment of the PLWHA, custodian of the medicines, giving referral and monitoring of the project activities.	High	If are not active the objectives of the project will not be met especially in home based care services	+ve	Involving them and supporting them with working tools and capacity building.
Community leaders. /ward executive officers.	Identification of project beneficiaries /clients and supervision during distribution of supplies to clients.	Medium	Intended beneficially might not be access the project benefits/services, hence project objective not met.	+ve	Involving them at all stages of the project and information sharing.

Stakeholder	Participation	Evaluation	Impact of participation	Rate	Plan
District Social welfare department.	Information sharing and technical assistance. Linking with other stakeholders.	Medium	Needs of some beneficiaries might not be addressed and lacking of Government support.	+ve	Involving them at all stages of the project and information sharing.
District medical department.	Treatment of the PLWHA, attending referral cases and supplying of medicines and supplies.	High	If are not active the objectives of the project will not be met especially in both hospital and home-based care services.	+ve	Information sharing and feedbacks.
District agricultural department	Technical assistance in agriculture activities especial poultry and goat keeping	Medium	Lack of their supervision might affect poultry and goat keeping activities.	+ve	Information sharing and feedback
BAMITA	Recipient of funds from the same donor to implement same activities. Information sharing.	Low	Poor implementation of the project might affect the implementation of the other partner organization in the same area.	+ve / -ve	Information sharing and feedback.
Care International	Large Project fund, supervision and capacity building of staff.	High	Lack of funds can affect implementation of some project activities. Skilled staffs are crucial for the success of the project.	+ve	Feed back and progress reports both narrative and financial report.
Pact Tanzania.	Part of the project funds and capacity building to staff.	High	Lack of funds can affect implementation of some project activities. Skilled staffs are crucial for the success of the project	+ve	Feed back and progress reports both narrative and financial report.
Family Health International	Technical support in identification of appropriate medicines for PLWHA-home based care. (Joint member of the 'Tumaini project')	Medium	Their long-term experience in home based care is required for learning to the success of the project.	+ve	Information sharing and feedback.

Stakeholder	Participation	Evaluation	Impact of participation	Rate	Plan
Muhimbili University	Technical assistance in fight against stigma and discrimination. . (Joint member of the ‘Tumaini project’)	Medium	Their experience in technical skills in fighting against stigma and discrimination is required for the success of the project.	+ve	Information sharing and feedback.
CONSONUT	Technical assistance in Nutrition issues for PLWHA and determining type of food to be supplied. . (Joint member of the ‘Tumaini project’)	Medium	Their technical assistance is important for nutrition support for the PLWHA for meeting the project objective.	+ve	Information sharing and feedback.
Heifer International	Technical assistance and purchasing of the milk goats (Joint member of the ‘Tumaini project’)	Medium	Their technical know how is crucial for the success of milk goat keeping activity.	+ve	Information sharing and feedback.
Health scope Tanzania	Technical assistance in monitoring and evaluation of the project activities. (Joint member of the ‘Tumaini project’)	High	If monitoring and evaluation of the project activities is done properly, might lead to donor dissatisfaction	+ve	Information sharing and feedback.

My Role in the JIMOWACO Project

The main project roles assigned to me were as follows:

- a) Assessing and suggesting the support for income generating activities for improving family livelihood and which are relevant to the life of Kisarawe communities
- b) Assisting the organization in the project planning for the year 2006
- c) Assisting the organization in the formulation, monitoring and evaluation of the system
- d) Assisting the organization in data analysis.

Major Responsibility.

My major responsibility in the project was to facilitate the establishment of community managed and saving model to the project communities. The purpose being to improve the means of livelihood of PLWHA and OVC in order to access basic-social services at community level and reduce over dependency on the project.

CHAPTER 3: LITERATURE REVIEW

The literature review was carried out in order to enrich this project, in terms of understanding theories regarding home based care service and learning from other implemented home based care programs so as to find best practices, challenges and ways to improve home based care services for improving the wellbeing of PLWHA. The project needed to contribute towards the national goals and objectives, therefore policy review was also conducted so as to shape the project to the already established guidelines.

PLWHA are among the vulnerable poor people in the country, therefore their access to micro-finance services offers the possibility of managing household small business resources more efficiently and provides protection against risks, provision for the future and taking advantage of investment opportunities for economic returns.

Saving services are among the most beneficial financial services for low-income people. Nearly all households need to save to protect themselves against periods of low income or specific emergencies and to cover large anticipated expenses like school fees. Small enterprises also need to store the value accumulated from their profit until they can invest them to earn higher returns.

3.1. Theoretical Literature

Home Based Care Services

Home and community-based care takes many forms, but typically it is provided by relatives, friends, or community volunteers working for non-governmental organizations, and is supported to a greater or lesser extent by health professionals, mainly nurses. It is

generally holistic care that offers treatment and psychosocial support to patients, as well as support to care takers and relatives, including orphaned children. Community-based programmes also do important work in raising awareness, challenging stigma and teaching HIV prevention. They are expected to be the foundation on which national antiretroviral treatment programmes are built. However, they will require tremendous support to enable them to carry the extra burden: most such programmes work in isolation from one another and from the health services, and their funding is precarious (UNAIDS, 2004).

The main components of the home based care as per the National Guideline for Home Based Care Service (URTZ, 2005a) includes: physical care, such treatment of opportunist deceases, nutrition care and support, antiretroviral management and hygiene; emotional support to reduce fear and worries; social support to reduce loneliness and neglect by involving ensuring maximum interaction such as in recreational activities; spiritual support to address spiritual needs; legal support in order to get legal aid and economic support so as to reduce financial burden to the family for extra medical care and address other basic social services such as children's education.

Palliative care services

World Health Organization (WHO, 2004) defines palliative care as an approach that: affirms life and regards death as a normal process, does not hasten or postpone death, provides relief from pain and other symptoms, offers a support system to help patients live as actively as possible right up to their death, integrates psychological and spiritual

care, and provides a wider support to help the family cope during the patient's illness and their own bereavement after death.

Palliative care is intended to relieve the suffering of people who are living with incurable illness. The aim of palliative care is to provide the best quality of life for individuals, many of whom will be approaching death, and to offer comfort and support to their families and caretakers as well. It is a holistic approach to care and support, and takes into account emotional, psychological and spiritual needs as well as physical needs. Pain control is central to the concept of palliative care. Freedom from pain allows people to come to terms with their approaching death and enables them to make arrangements for the future of others who depend on them, as well as to live as fully as possible for as long as possible. (UNAIDS, 2004).

Palliative care ideally combines the professionals of an inter-disciplinary team, and includes the patient and the family. It is provided in the hospital and community, when patients are living at home. This care should be available throughout patients' illness and during the period of bereavement. (UNAIDS, 2000).

Support for caregivers is an essential part of palliative care, whether they are family members or professional careers. For professional careers, an integral part of providing palliative care is to work with families and friends to ensure effective communication. It is an essential part of a comprehensive health care system, which is missing in many developing countries, and must not be neglected in the efforts to provide greater accessibility to more technical drugs and therapies (National Institute of Child Health and Human Development, March 2001).

One of the most neglected aspects of HIV care is palliative care, which is treatment to relieve pain and other distressing symptoms in people who are incurable and often terminally ill. It is estimated that at least half of all people with HIV will suffer from severe pain in the course of their disease (WHO, 2002).

Levels of Delivering HIV /AIDS Care

According to UNAIDS guidelines HIV/AIDS care is delivered at four levels, which frequently work independently, in ignorance, or in distrust of each other. These four levels are: clinic-based service providers (doctors, nurses, counselors); community-based service providers (village health workers or AIDS community workers); home-based caregivers (relatives or friends); self-care by persons living with HIV/AIDS (UNAIDS, Sept 2001).

Challenges Facing Home Based and Palliative Care Services

Experience shows that palliative care can relieve the intensive broad suffering of people living with HIV/AIDS. However, HIV/AIDS has challenged the ideas of palliative care because of its dimension as follows: the disease is complex since it is highly variable, with a wide range of potential complications, rate of progression and survivals as well the patients varies in their emotional responses to the infection, this again complicates the planning and delivery of palliative care. Complex treatment as of now, a wide range of treatment for HIV/AIDS patients is currently available. Antiretroviral drugs (ARV) have been shown to be highly effective in controlling the progression of HIV diseases, but their high cost means they are not readily available to most patients in development countries. Stigmatization and discrimination faces people living with HIV/AIDS

(PLWHA), since many have specific set of psychosocial problems, even in high prevalence countries where HIV affects nearly every member of the population. Complex family issues occur as a result of HIV/AIDS especially in areas of high prevalence and where most PWLHA are young and partners in a relationship may be infected, and results in increasing financial problems when the bread winner becomes ill. Role reverse can also occur in families, since HIV care often involves older people looking after their younger relatives, without financial contribution from these children. This result in hard economic and social consequences (UNAIDS: Technical update, 2000).

Many home care projects are unable to provide the pain relief and treatment of symptoms that are needed to prolong life and ease dying and death. Projects have limited funds as many depends on donor funds, hence they cannot meet high administration costs involved to hire qualified personnel, transport cost to visit the families and salaries hence affects the quality of services provided and their sustainability. The other obstacles are minimum understanding and training in the palliative care approach to health care services providers. Further, the success of the community/home based care services also depends on commitment of community leaders to mobilize communities and facilitating different activities, as per the field experience of WAMATA (Walio Katika Mapambano na AIDS Tanzania). WAMATA found minimum commitment of both local government and community leaders, which increases difficulty in services delivery. Not only that but they had also uncouncted minimum HIV/AIDS awareness in

rural communities which increases stigmatization and so affects smooth delivery of the home based care services to the HIV/AIDS affected ones.

3.2. Empirical Literature

Different strategies and interventions have been used in implementing home based care activities. The basic principle of its approach to care and support projects is the belief that home and community care are fundamentally important for persons living with HIV/AIDS for psychosocial, spiritual, social-economic support and nursing care services. There is also a strongly held view that there is a need to mobilize those directly affected (PLWHA, family and friends) and the immediate community (e.g. neighbors, members of same parish, etc.) of the persons living with HIV/AIDS in planning and implementing activities. The following are some of interventions used in community and home based care initiatives in other countries.

- **Basic supports for needy clients**

The Diocese of Kitui HIV/AIDS program in Kenya assisted very needy clients with their food needs such as beans, maize, flour, eggs, and milk. This assistance is assessed at the individual level in order not to encourage dependency. During famine, seeds were given to people living with HIV in each area (UNAIDS: Case Study, 1999).

WAMATA (Walio Katika Mapambano na AIDS Tanzania) support PLWHA under the Home Based Care services with foodstuffs that include maize flour, rice, cooking oil, sugar and beans and clothes to those with great need. School-going orphans are supported with uniforms, school materials and fees, especially those with great need.

- **Support for groups and income-generating activities**

The high death rate among the young and adults is the cause of a rising number of families headed by young children or very old persons, who not only have to do the myriad tasks needed to run a household but also have to care for the sick. Given the prevailing reality of extensive poverty, people living with HIV/ AIDS and children in distress require special support and methods through which they can generate an income. Income-generating activities (IGAs), such as building of houses, food-related activities, farming, and other micro-enterprises, can be supported at the home based care centre or to community interest group in terms of skills and capital. For example, in Côte d'Ivoire and the choice of IGA is identified through a research process by the Centre for Social and Medical assistance (CASM). A similar process is used in Kariobangi in Kenya, and both show the kind of efforts that can be made to reach out to AIDS-affected families in resource poor settings (UNAIDS, 2001).

In Tanzania, WAMATA under the home based care project is supporting PLWHA with training in small business management and small grants ranging from Tsh50, 000/- to Tsh100, 000/- for running small businesses. However, the grant is supposed to be recovered within a period of 10 months, without interest. In the case of failure to pay the loan due to sickness and other unavoidable circumstance, one is not obligated to pay it after the 10 months period. For the PLWHA whose businesses have expanded and require more cash than Tsh100, 000/-, they are advised and linked to credits services providers.

- **Use of community managed saving-based financial systems**

Community managed saving-based financial systems, have been found to assist poor communities to improve their livelihood as compared to formal microfinance institutions. The formal microfinance institutions operate on the principle of financial sustainability through cost recovery and give loans based on pre-established criteria. As a result they tend to work with poor households that are economically active. They consider most HIV/AIDS affected households are poor credit risks.

The Kupfumu Ishungu microfinance program in Zimbabwe, had reached more than 15,000 participants at the end of 2002, using 'SIMBA' microfinance project. The basic approach used by SIMBA project was to promote community based, self-managed and saving based microfinance services and to provide basic business management training. The evaluation of Kupfumu Ishungu revealed that, the saving-based program approach has been very effective in improving household livelihood security. Participants regularly accessed small and flexible loans to meet basic household needs like school fees, pay for medical expenses and to expand their income opportunity, thereby avoiding assets sale and destitution (Jain, year unknown).

- **Training of the community managed saving and credit groups of and vulnerable groups including PLWHA, in selection, planning and management of income generating activities**

The Kupfumu Ishungu microfinance program had incorporated the training of Selection, Planning and Management (SPM) of income generating activities into community managed and saving based system to vulnerable groups including people living with HIV/AIDS. The SPM training module was designed and implemented to impart basic

business literacy training and sound business practices. The training sessions helped the participants to map and identify appropriate business opportunities in the market environment, manage cost, fixing prices and market products. (Jain, year unknown).

- **Involvement of people living with HIV/AIDS**

It is believed that the most constructive way to improve HIV-positive people's quality of life lies in home and community care, and the participation of infected and affected family and community members. The field experience by the Centre for Social–Medical assistance (CASM) in Côte d'Ivoire found out that direct involvement of persons living with HIV/AIDS in counseling, prevention, support, fund-raising, income generation and care can directly alleviate the immediate effects HIV/AIDS such as stigmatization.

Also, in the Diocese of Kitui HIV/AIDS program in Kenya used PLWHA as community volunteers, which had helped to reduce denial and stigma and has been an effective way to educate communities (UNAIDS 2001, UNAIDS 1999).

- **Use of community volunteers**

The Bambisanani Eastern Cape South Africa project, takes seriously the widely confirmed experience that volunteers working in poor communities remain active, and function best, when they are provided with some form of incentive. Therefore the project provides volunteers with incentives in the form of transportation reimbursement, volunteer T-shirts, record keeping materials, and token payments (UNAIDS, 2001).

However, in Tanzania WAMATA as well, do use community volunteers like the Bambisanani Home based care project, which have proven to be a good link between the project and the PLWHA .The community volunteers are also are given small incentive

which includes transport /lunch allowance to motivate them to work for the sick ones, since due stigma and discrimination, many community member are not willing to interact and support PLWHA in their localities.

- **Use of peer educators**

The Centre for Social–Medical assistance (CASM) in Côte d'Ivoire, in collaboration with peer education efforts, has helped to increase AIDS awareness at clinic level. For example, peer support groups have aided problem-solving on psychosocial issues that may inhibit behavioral change. The use of peer counseling has made AIDS education more acceptable to patients who visit the clinic. Also the use of trained teenagers who are used to give training session regularly in classes to schools were found to be useful in approach as used by the Programme for AIDS Initiative in Ecuador (UNAIDS, 2001). WAMATA similarly uses peer group /individual counseling especially to school youth and at places of work which are accompanied with experience sharing which were found to be useful in educating people and encouraging them to visit other services like Voluntary Counseling and Testing (VCT) services and to join groups and post test clubs.

- **Prevention program through AIDS awareness**

More people have been reached through the use of different methodologies including group discussions, community conferences, slide shows, theatre, personal testimonies, media support and other strategies to achieve the greatest possible impact have further promoted AIDS awareness. Many of these interventions apart from collaborating with other partners, the participation of people living with HIV/AIDS in their design and execution was considered in Centre for Social–Medical assistance (CASM) activities in

Côte d'Ivoire .The use of personal testimonies by HIV positive persons in prevention work has both humanized and personalized the AIDS epidemic. Visibility of persons living with HIV/AIDS within communities and schools has promoted more open discussion on AIDS and sexuality (UNAIDS 2001).

In Tanzania, WAMATA conducts HIV /AIDS prevention campaigns whereby HIV/AIDS awareness is conducted through outreach to schools, work places, discussion forums with communities with the great involvement of PLWHA, especially in high transmission areas.

- **Community capacity building**

In order to create an environment conducive to home-based care and support for children in distress, community capacity-building was among the strategies used by Bambisanani Eastern Cape South Africa Project for the success of the project (e.g. community leaders, such as church leaders and traditional leaders, women's and youth groups, traditional healers, and community structures such as Community Health Committees), (UNAIDS, 2001).

- **Training of care takers**

Holistic care involves not only the staff and volunteers at the centre, but also the care-givers (mostly family members of patients) at home, who are recognized and valued as the main source of most patients' care. The Midway Centre for palliative HIV/AIDS Care in Uganda organized workshop on such topics including: simple nursing techniques, bed bathing, care and prevention of pressure sores, mouth care, patient toileting, lifting and handling of patients, feeding techniques, diets suitable for

HIV/AIDS patients, drug administration, will-making, issues of death and dying, handling a difficult patient, communicating with children, modes of HIV transmission, positive living, and income-generating activities (UNAIDS, 2001).

- **Support for HIV-positive young people**

Children are now living longer with HIV/AIDS, occasionally up to 16 years of age. Some, who are suffering from chronic disabling conditions, have special care needs that families and communities have great difficulty meeting. Since the HIV-positive individuals fall sick often, some have left school, or are orphans; their needs are very rarely recognized and planned for. In addition, the transition from childhood to adolescence is a difficult time, during which the HIV-positive adolescent is undergoing exactly the same social and emotional stresses as those who are HIV-negative. To assist these young people, Mildmay in Uganda has formed an adolescents' club called Our Generation Mildmay Adolescent Club (OGMAC). It teaches adolescents how to improve or cope with various aspects of their lives (e.g. nutrition, reproductive and sexual health, positive behavioral change) and to encourage them to seek health services (UNAIDS, 2001)

- **Partnerships and alliances**

Partnership and alliances were found to be important in the success for the Bambisanani project in Eastern Cape South Africa since it is built on cooperation between different organizations that apply their specific expertise or comparative advantages. The partnership's experience, to date, confirms the significant potential benefit of cooperation between existing services, each contributing its own expertise and practical

experience, and the feasibility of doing so without creating new levels of bureaucracy. It also provides a continuum of care linked with a referral system, spanning home to hospital (UNAIDS 2001; UNAIDS 1999).

- **Utilizing the existing community resources with sustainable support mechanisms**

Use of local resources, as much as possible, has proven significant advantages, but the approach depends very much on the relative wealth of the community and country. In the poorest settings, the most important local resource is people, and therefore volunteer labor is a key input (often this is achieved with the assistance of local religious authorities). The Bambisanani Project, Eastern Cape, South Africa in contrast, has been successful in gaining the financial and material support of industry, with participation by both the mining and pharmaceutical sectors. In Ecuador, many of the AIDS efforts supported by the Programme for AIDS Initiatives have achieved notable resource mobilization successes, gaining funding or material support from sources such as municipal governments and church groups (UNAIDS, 2001).

- **Community mobilization.**

Project Hope in Brazil benefits from a great deal of community support, which is often expressed in contributions of materials or services. Fundraising or recreational events often receive free food from local businesses. For instance, local people with cars or trucks donate their time to do whatever driving is necessary, including driving patients to medical check-ups or treatment and delivering donated food and clothing to people unable to come to the centre (UNAIDS, 1999).

- **Lessening the burden on women**

Ways to ease women's disproportionate care burden in AIDS-affected households are available and many are similar to those used for more generalized gender inequalities. In many places, informal women's support groups have developed. Some fulfill an important advocacy function such as providing a platform for demanding health resources for communities. Still, these support groups have serious limitations: they are voluntary, make even more work for already overworked women and do not change gender attitudes or men's care responsibilities. As per UNAIDS Global AIDS Report of 2004, possible options suggested for resolving problems related to the care economy include:

- Cooperative day care and nutrition centre that assist women with their workload
- Nutritional and educational assistance for orphans
- Home care for people living with or affected by HIV, including orphans
- Labor-sharing and income-generating projects
- Savings clubs and credit schemes for funeral benefits
- Improving rural households' access to labour, land, capital, management skills and improved technologies to make the best use of available resources.

In low and middle-income countries, income-generating initiatives are an integral component of the AIDS response. Access to these initiatives should be increased. Recent innovations include death insurance for terminally ill patients, flexible saving arrangements and emergency loans (UNAIDS, 2004).

Lessons learned from the case studies discussed above in implementation of Home Based care programs for PLWHA.

1. The HBC project aims at reaching the most vulnerable people, i.e., the poorest households with PLWHA. Although this has proved difficult, it has been more effective in urban areas where HIV testing is available and needs assessments are carried out by social welfare departments. In rural areas, however, testing was not available but selection was based on clinical symptoms, even though this had to be done in the absence of a clinical personnel.
2. Many home care programmes have focused on addressing the immediate needs of PLWHA but there is need to identify strategies that target the medium to long-term food security of other household members. For example, OVC are often left without the knowledge and skills base to work the land in order to grow food and crops at a time when labour is in increasingly short supply for such work.
3. Less time is available for agricultural production, including animal husbandry, due to the time spent on caring for the ill. Production methods, which are less labour intensive but which produce food that is just as nutritious, therefore need to be developed.
4. Poor households are very often unable to find paid employment, which would enable them to purchase the food they need. In fact, they often deplete their assets in attempting to buy medicines and services to help PLWHA. Increasing access to income could play a key role in improving food security.
5. Most poor can and do save, given a choice and place for secure saving. Community managed and saving-based financial system can provide much more needed services

to these highly vulnerable populations at low costs, allowing participants to take small flexible loans to protect assets, send children to school and pay for medical and funeral expenses.

3.3 Policy Review.

The Tanzania National Policy on HIV/AIDS (URTZ, Sept 2001).

The Tanzania National policy on HIV/AIDS, stipulates that, all members of the community have individual responsibility to actively participate in prevention and control of HIV/AIDS epidemic. National response shall be multi-sectoral and multi-disciplinary. The implementation of the HIV/AIDS policy is guided by a number of principles, to mention but a few:

- Strong political and government commitment and leadership at all levels is necessary for sustainable and effective interventions against HIV/AIDS epidemic
- The objectives in the National response will be most effectively realized through Community Based Comprehensive approach which includes prevention of HIV infection, Care and support to both infected and affected by HIV/AIDS and close cooperation with People Living with HIV/AIDS (PLWAs)
- HIV related stigma plays a major role in influencing the spread of HIV infection
- Combating stigma must be sustained by all sectors at all levels
- PLWHAs have a right to comprehensive health care and other social services including legal protection against all forms of discrimination and human right abuse

- Given the viscous circle between HIV/AIDS and poverty, intervention for the control of the epidemic should be simultaneously related by the poverty alleviation initiatives.

The HIV /AIDS Policy have provided some specific objectives regarding care for PLWHAs which includes:

- To provide counseling and social support for PLWHA and families
- To combat stigma and strengthening living positively
- To provide adequate treatment an medical care through and improve health care system which aims at enhancing quality care
- To establish a system of referral and discharge that link hospital services to community services in a sustainable complementary relationship while ensuring that the quality of supervision for hospital care is comparable to that of home care
- To ensure availability of essential drugs, the treatment of opportunistic infections. In the case of High Active Anti-Retroviral Drug (HAATD), PLWHA will be required to meet the cost
- To ensure that the cost of counseling and home care is reflected in the National and Local budgets for health Care and social warfare services
- To involve and support community in the provision of community based and home based care services.

The policy under section 7, also insisted on Community Based Care and Support Services as a comprehensive response to HIV/AIDS have since shown to be effective in

the control of the epidemic. This includes prevention, care and support to patients with HIV/AIDS in the communities including home based care. However, it must be appreciated that at the household level, caring for an AIDS patient is very costly in human, time and financial terms. The need for support from the community is paramount. Therefore, to achieve this:

- The Government shall establish cooperation and collaboration with interested individuals, organizations, agencies or bodies in promoting community based care for AIDS patients and orphans.
- The Government shall encourage the collaboration of religious communities in providing spiritual care and material support for PLWHA. Spiritual care is a component of holistic care.
- All public claims of cures for HIV/AIDS by traditional and faith healers or other care providers shall be discouraged until such claims are authenticated and approved by government agencies. All importation and manufacture of modern and traditional remedies for HIV/AIDS shall be promoted and approved by relevant government agencies.
- The Government shall expedite rapid drug trials and registration of efficacious modern and traditional remedies.
- Modalities for establishing a special trust fund for complementing community initiatives in supporting and caring for those infected and affected by HIV/AIDS shall be developed.

National Multi-Sectoral Strategic Framework on HIV/AIDS, 2003 – 2007 (URTZ, 2003)

The National multi-sectoral strategic framework on HIV/AIDS (2003 – 2007) has identified one among the thematic areas of concern is Home/Community-based care and support. The biggest challenge in Tanzania with Home/Community-based care and support programme is that they are still in early and often experimental stages. Experiences have yet to be documented and discussed and network of learning to be established. Stigma and discrimination of HIV /AIDS still erects barriers to expansion of programmes.

With the objective of “Increase the proportion of PLWHA having access to adequate community-based care and support”, the following are the suggested strategies:

- Develop guidelines on provision of Home/Community care and support
- Promote and expand community and home-based care programme
- Support NGOs/CBOs and Faith-based organizations in care and support projects
- Strengthen referral systems for patients in need to ascertain continuum of care from home – community to hospital level
- Increase advocacy and education in communities to make them receptive and responding to the needs of PLWAH and their families
- Promote greater involvement of PLWHA in planning and implementation of Home/Community care and Support.

The National Guidelines for Home Based Care Services (URTZ, 2005)

Home Based Care (HBC) services aim at improving the quality of care for chronically ill patients within the health facilities and at their homes. These Guidelines aim at providing guidance to the planning, implementation and evaluation of Home based care in Tanzania.

Community programmes supporting PLWHA need to be closely linked with HIV/AIDS Care and Treatment Clinics (CTC) at the facility level. Care and treatment plans should ensure that activities for primary attention by community based programmes are implemented and these include: prevention programmes, access to VCT, basic support, such as food and housing, promotion of PLWHA support groups, psychosocial support, community education in ART fundamentals and secondary support for adherence.

Guiding Principles for Successful HBC Services given were as follows:

- Care should be comprehensive (holistic), including medical and nursing care, counseling and psychosocial support, spiritual care, material and social support (welfare, legal advice and care for survivors), and referral
- Care should be along a continuum. Home care is an essential component in a continuum of care for people with chronic illnesses including PLWHA, but at certain stages, cannot substitute the role of other health institutions such as hospitals and clinics. Referral systems and links between services along a continuum are necessary
- Care and prevention may be most effective if fully integrated

- Home care should target all people that are chronically ill to avoid stigmatization of people with chronic illnesses including PLWHAs and discrimination of patient categories (equity). Resources permitting, home care should also provide support not only to the patient but also to the entire affected family
- Home care should be pursued, not as a way to divert the burden of chronically ill including AIDS patients on hospitals to the community, but to provide the same kind of care in a different environment
- Home care programs are more sustainable and feasible if they are community initiated and fully owned.

Essential Intervention Package for Quality HBC should include the following key components:

- Physical care for treatment of opportunistic diseases and nutritional support
- Emotional support for patient suffering from chronic or terminal illnesses
- Social support to reduce loneliness and neglect
- Spiritual support to address spiritual needs
- Legal support to inform patients to get legal aid
- Economic support to reduce financial burden.

The HBC roles and responsibilities are also located at different levels - from the central level, health facilities and community level. This section intends to address the roles and responsibilities at each level. Standardization of roles and responsibilities is mandatory to ensure the delivery of highest possible quality of HBC services.

In order to get optimum benefits from HBC services, each of the players will be required to perform their respective roles and responsibilities. These key actors include family, community HBC provider, HBC services organization (FBO, NGO, CBO) and religious leaders.

The National Strategy for Growth and Reduction of Poverty (MKUKUTA) (URTZ, 2005)

The National Strategy for Growth and Reduction of Poverty has focused on three main clusters, namely:

- Growth and reduction of poverty
- Improving the quality of life and social well being
- Governance and Accountability.

One of the goals in improving the quality of life and well-being is to ensure adequate social protection and rights of the vulnerable and needy groups with basic needs and services. To archive this goal there must be increased support to poor households and communities to care for vulnerable groups targeting older people, orphans, other vulnerable children and people living with HIV and AIDS.

National Micro-Financing Policy (URTZ, 2000)

Micro-finance addresses the financial needs of major sectors of the Tanzania population. They are primary facilitators rather than creator of the underlying economic property. The Government considers micro-finance system as an integral part of the Financial Sector that falls within the general framework of its Financial Reform Policy Statement of 1991.

- **Objective of the Policy**

The overall objective of the this policy is, therefore, to establish a basis for the evolution of an efficient and effective micro-financing system in the country that serves the low-income segment of the society, thereby, contributing to economic growth and reduction of poverty.

- **The Policy Coverage**

The policy covers the provision of services to households, smallholder farmers, and small and micro-enterprises in rural areas as well as in the urban sector. It covers a range of financial services, client use of these services and financing of all types of legal economic activity.

A wide range of institutions will be involved in the provision of services, including specialized and non-specialized banks, non-bank financial institutions, rural community banks, cooperative banks, SACCOS and NGOs.

- **Importance of Micro-financing in Tanzania population**

For the majority of Tanzanians, whose incomes are very low, access to financial services offer the possibility of managing scarce household and enterprises resources more efficiently, protection against risks, provision for the future and taking advantage of investment opportunities for economic return. For the household, financial services allows high standard of living to be achieved with the same resources base, while for enterprises and farmers, financial services can facilitate the pursuit of income growth.

- **Saving services**

Saving services are among the most beneficial services for low-income people. Nearly all households need to save to protect themselves against periods of low income or specific emergencies, and to cover large anticipated expenses like school fees. Enterprises also need to store the value they accumulate from their profit until they can invest them to earn a higher return. Moreover, saving in financial form provides funds for investment by others. Thus, saving services can have a very broad outreach and value.

- **Credit services**

Credit services can perform some of the same services as saving services and can allow enterprises and families to take some important investments sooner. Enterprises use credit as a source of short-term working capital and longer-term investment capital. Households use it to meet consumption needs, particularly during periods when income flows are low, such as during the off-season before crops are harvested, and to make investment, such as housing improvements.

- **Roles and responsibilities**

Under the law, the responsibilities have been assigned to the Government, thus Ministries, Bank of Tanzania and other Government entities, and to the providers of micro-financing services, which includes Banks and Non-Banks Financial Institution, SACCOS, NGO and Donor communities.

NGOs are particularly important in reaching difficult to serve clients and in developing and testing innovative products and services delivery mechanisms. It is the responsibility of NGOs to learn and apply best practices in micro-finance, and to structure their

operations so as to reduce and eliminate their dependence on subsidies and donor funds, to the maximum degree, but compatible with reaching their targeted population.

The donor community is the main sources of capital; particularly start up capital for provision of micro-financing services to NGOs. It also provides funds for capacity building .The Government expects all donor programmes supporting micro-finance in Tanzania to comply with this policy. Care needs to be taken by donors to ensure that the NGOs that they support develop sustainable operations so as to ensure the latter's existence after donor support ends.

CHAPTER 4: IMPLEMENTATION

Proper project planning is important for the success of the project; however the planning exercise is time consuming. Analysis of what the project wishes to deliver, inputs required to meet the outputs planned to be delivered, and proper allocation of the scarce resources available, needs to be considered carefully before starting implementation of the project.

Projects results need to be sustainable so as to ensure there is long-term community economic development, therefore capacity building and participation of project beneficiaries in the project planning, implementation, monitoring and evaluation should be considered through out the project cycle.

All project implementing partners need to know their roles and responsibility for smooth implementation of the project to meet planed project objectives.

4.1. Project Planning

The project is intended to be implemented in two phases. The first phase covers 6 villages (out of 39 project villages) in Marumbo ward, Maneremango division. Phase two, scaling up of the project (depending on available donor fund) include the remaining project villages in which the community managed saving and credit system has not been introduced by any other organization.

Selected trained facilitators, will be used to sensitize community to form community managed saving and credit groups and will also train them for once a week for seven weeks. After the training, weekly follow-up visits will be conducted in the first 6 months

to assess the group progress and do necessary adjustments. Occasional visits or upon group demand, will be done in the second six months, to the trained groups to solve arising issues.

The training on Selection Planning and Management (SPM) of small business will be conducted to all trained groups in community-managed saving and credit group system. Afterwards the group has to qualify in record keeping of all saving and loan disbursement and collection transactions (this will occur during the six months of follow up visits).

JIMOWACO field staff in the project respective ward will work hand in hand with the facilitators during the sensitization sessions, training and monitoring of groups performance and as a way of learning and building their capacity.

Plan Tanzania as the development partner, will prepare a memorandum of understanding with JIMOWACO for disbursement of the funds.

4.2. Project Implementation Plan

Objective	Activity	Outputs	In puts	Responsible	Time
1To identify development partner to support the trainings on Community managed saving and credit.	1.1 Identifying list of development partners and discussing with them.	One dev. partner to be Identified.	Transport, stationeries,	CED student and JIMOWACO coordinator.	Sept-Oct2006
	1.2. Identifying type of support from the agreed dev. partner.	Commitment of funds available for support	Transport, stationeries,	CED student and JIMOWACO coordinator.	Sept-Oct2006
2To identify the trainers for the community saving and credit groups	2.1.To identify organization implementing the community managed saving and credit model in Kisarawe District	One to be identified.	Transport, stationeries,	CED student	Nov-December 2006
	2.2.Identifying potential facilitators	- 2Facilitators to be identified	Transport, stationeries, Lunch allowance	CED student and JIMOWACO coordinator	
3To mobilized PLWHA families interest groups for saving and credit associations	3.1.Conducting sensitization meeting with village leaders	a) 6community leaders meetings	Transport, stationery, Lunch allowance	CED student Home based care field officer, and facilitators.	Jan-Feb 2007 and July –Sept07
	3.2.Conducting sensitization meeting with PLWHA families and community	6community meetings to be conducted.	Transport, stationery, Lunch allowance.	CED student Home based care field officer, and facilitators.	Jan-Feb 2007 and July –Sept07

	3.3. Community managed saving and credit group formation.	10 saving groups to be formed	Transport, stationery, Lunch allowance	CED student Home based care field officer, facilitators.	Jan-Feb 2007 and July –Sept07
4.Training of the organized PLWHA groups in community managed saving and credit association model	4.1. Training logistical preparation. Stationary, handout, timetable	Stationary purchased, handouts prepared and kit purchased	Transport, funds for purchasing stationeries, photocopying and group kits.	JIMOWACO field officer	February and August
	4.2. Conducting training on saving and credit model	10 Groups to be trained on community managed saving and credit	Transport, stationery, Facilitator allowance	Home based care field officer, facilitators	March-April 2007 and Sep-Oct07
5.Training of the community managed saving and credit groups on Selection, Planning and managements of income generating activities	5.1. Training logistical preparation. Stationary, handout and timetable.	Stationeries and training materials and kits prepared.	Transport, funds for purchasing stationeries, photocopying and trainer's kits.	Home based care field officer., facilitators	May and oct07
	5.2. Conducting training on selection, planning, management of small business.	9 Groups trained on selection, planning and management of small business	Transport, facilitator allowances stationeries, handout and trainer's kit.	Home based care field officer. facilitators	May –June 07 and Nov –Dec07

4.3 Staffing pattern.

Description of personnel	Key roles	Skills/Training required.
JIMOWACO project Manager.	<ul style="list-style-type: none"> -Linking JIMOWACO and the development partner. -Reviewing the project report and copy it to the development partner 	<ul style="list-style-type: none"> -Training on project management. -Literacy on community managed and saving model
Home based care Field officer.	<ul style="list-style-type: none"> -Community mobilization and facilitation formation of the group. -Linking community groups with the facilitators. -Preparation of training material, kits and training logistics 	<ul style="list-style-type: none"> -Community mobilization skills and group formation -Training on operation of the community managed and saving model.
Selected trained facilitator	<ul style="list-style-type: none"> - Community mobilization and facilitation formation of the group. -Preparation of training material. -Preparing progress report Training and monitoring of the trained groups. 	<ul style="list-style-type: none"> -Knowledge of community managed and saving model. -Facilitation skills. -Report writing skills.
Home based care project volunteer	<ul style="list-style-type: none"> -Community mobilization especially PLWHA to join the groups. 	<ul style="list-style-type: none"> -Community mobilization.
CED student	<ul style="list-style-type: none"> -Identifying development partner who deals community managed and saving model in Kisarawe. -Identifying training facilitator available in Kisarawe. -Orienting JIMOWACO staff with community managed and saving model. 	<ul style="list-style-type: none"> -Knowledge of community managed and saving model. -Micro-enterprise development skills. -Facilitation skills. -Community mobilization skills.

4.4. Budget

The budget has been prepared and attached in Appendix 1.

4.5. Project Implementation Report

In January 2007, when project was partly handled over to JIMOWACO staff, the planed activities for phase one were still going on. Only objective one - identifying the development partner to support the group's trainings, and objective two - selection of facilitators, were fully accomplished. The third objective of community mobilization has started to be implemented in two villages where by 3PLWHA family interest groups were already formed. Mobilization meeting for the third village was to be accomplished by early February 07, in order to cover first 3 villages' groups planned to be trained for the period of January –June 2007(see table 4.2 implementation plan). The objectives for the training for community managed saving and credit system and the selection, planning and management of small business were not yet to be implemented. (See summary timetable below for more details).

Summary of the Project Implementation Report (covers implemented objective only)

Objective	Activity	Outputs Planed	Output deliver	Time frame	Reason for deviation
1. To identify development partner to support the trainings on Community managed saving and credit.	1.1 Identifying list of development partners and discussing with them.	One dev. partner to be Identified.	One development partner identified (Plan Kisarawe Program Unit.)	Sept 06	Not applicable
	1.2. Identifying type of support from the agreed dev. partner.	Commitment of funds available for support	5.500Milion T.Sh committed	Oct 006	Not applicable
2.To identify the trainers for the community managed saving and credit group system	2.1.To identify organization implementing the community managed saving and credit model in Kisarawe District	One organization identified to be identified	Plan Tanzania Kisarawe Program Unit	Nov- 2006	Not applicable
	2.2. Identifying potential facilitators.	2Facilitetors to be identified.	3 Facilitator Identified (i.e. one id resave)	Jan2007	Not done since Plan was conducting training of trainers for the community managed saving model
3To mobilized PLWHA families interest groups for saving and credit associations	3.1.Conducting sensitization meeting with village leaders	a) 6community leaders meetings	3 communities - Kikwete, and Mfuru	Jan 2007	Marumbo village will be covered in February and remaining 3 villages July to Sept as planned.
	3.2.Conducting sensitization meeting with PLWHA families and community	6community meetings to be conducted.	2community meeting done.	January 2007	Marumbo village will be covered in February and remaining 3 villages July to Sept as planned.
	3.3. Community managed Saving and credit groups' formation.	10 saving groups to be formed	3 groups formed.	Jan2007	Marumbo village groups to be formed February and remaining villages groups July-Sept

4.6. Project Implementation Chart/Timetable

The project implementation timetable was developed and is attached in Appendix 2.

CHAPTER 5: MONITORING, EVALUATION AND SUSTAINABILITY

For the project to meet the intended objectives, monitoring of the project through out the project cycle is very important. Monitoring needs to be considered during project planning, by establishing indicators for the success, allocation of time and resource whenever needed which will help to keep the project on track. When monitoring takes place during the project cycle, evaluation also should be done along with it so as to ensure all planned activities are archived and to make necessary revision and re-planning on time so as to reach the indeed project objectives.

The project results needs to last for a long time, therefore, during project planning, all measures which will ensure the project results are sustained after the donor funding ends, have to be considered before the starting of the project. Building the capacity of the project beneficiaries, use of local available resources and participation of the beneficiary in the project cycle with economic advancement needs to be considered before hand.

5.1. Monitoring

5.1.1. Management Information System (MIS)

- **Monitoring questions.**

The following are the key questions to be asked during monitoring of the project activities:

- Has a supporting development partner for the training been obtained?
- What kind of support the development partner willing to commit?

- Have the training facilitators been identified?
- How many community mobilization meeting have been conducted?
- How many community members have joined community managed saving and credit system groups?
- How many community managed, saving and credit groups have been formed?
- How many group members attended the training (saving and credit management training, selection, planning and management of small business training)?
- How much capital base has been accumulated for each group at the end the month?
- What new income generating activities have been established after the training?
- What has been the socio-economic impact of community managed saving and credit system to the group members? E.g. in education, in increasing income and solving other immediate family problems.

- **Monitoring data collection system.**

Monitoring of community managed saving and credit groups will be conducted on monthly basis for assessing the groups' progress. The training facilitators, under the supervision of JIMOWACO field staff, will conduct visits to each specific group on a monthly basis in the first six months and on group request in the second six months.

Monthly monitoring forms and MS-Excel database for monthly field visit data collection will be designed for assess group's progress of capital accumulation and credit services. Each community managed saving group will use designed forms/books to record their weekly savings and credit group's meeting activities. Also, each group member will have his/her own passbook for personal saving and loan records.

5.1.2. Data Collection Methodology

General monitoring of all group activities information will be conducted by:

- Reviewing of records which includes meetings minutes, training reports, and group saving and credit record books
- Interviewing saving and credit group members and leaders
- Discussion with community managed saving and credit group members

Training will be conducted by the facilitators and JIMOWACO field staff, of each group leadership committee on how to use various data collection forms. The JIMOWACO field staff will also be trained on how to use the excel database to store the progress information of all groups.

5.1.3. Monitoring results

Review of meetings records, had shown a good attendance of more than 70% of the PLWHA families in the first 2 villages where the community mobilization meeting started. In the same day, three groups started to organize themselves. When some of the newly group members were interviewed, most said, we need the training as soon as possible, because we need to save for our own family benefit. They appreciated for the

plan to train them on community managed saving and credit system, believing they will access small loans to attend family issues and business expansion.

Discussion with community saving and credit group members was not done, by January, since the training for the groups were not yet done.

5.1.4. Monitoring Table

Description	Indicators	Method of data collection	Who collect information	Planned time	Actual time
Objective1. To identify development partner to support the training	-# Of development partner identified. -Amount/type of support committed by the development partner.	Review of meeting minutes/agreements signed/memorandum of understanding.	Project manager and CED student	Sept-Oct06	Sept 06
Activities 1. Identifying development partners and requesting for support. 2. Identifying type of support from the ready to support development partner.	-List of names of the identified ready to support dev, partner Amount of money/support committed for the support	Review of visit/meeting reports, review memorandum of understanding	JIMOWACO Project manager/field staff/CED student	Sept-Oct06	Oct 06
Objective 2. To identify the trainers for the community saving and credit groups.	-# /names of trainers identified and sign agreement	Review of meeting records/memorandum of understanding.	JIMOWACO Project manager/Field staff and CED student	Nov-dec06	Oct 06
Activities. 1.To identify organization implementing the community managed saving and credit model. 2. Preparation of training terms of reference. 3.Identifying potential facilitators	-List of potential facilitators identified. -Names of facilitator identified and agreed to facilitate trainings.	Review of meeting reports, review memorandum of understanding/facilitation agreement.	JIMOWACO Project manager/field staff and CED student	Nov-dec06	Nov 06
Objective 3. To mobilized PLWHA families interest groups for saving and credit associations	# Of saving and credit groups formed	-Review of meeting minutes and attendance. -Review list of group members.	Facilitators, Field staff, community volunteer.	Jan-Feb07	Dec 06

Activity. 1. Conducting sensitization meeting with village leaders 2. Conducting sensitization meeting with PLWHA families. 3. Saving and credit groups formation	-# Of sensitization meetings with leader/PLWHAs families conducted. -Number of groups formed.	- Review of meeting minutes and attendance. -Review list of group members	Facilitators, Field staff, community volunteer	Jan-Feb07	Dec 06
Objective 4. Training of the organized PLWHA groups in community managed saving and credit association model	# Of PLWHA groups trained on saving and credit	-Review of training report. - -Discussion meeting with group members.	Field staff and training facilitator	Feb and oct07	not yet
1. Training logistical preparation. 2. Conducting training in 3 phases@ 3 groups.	-Logistic prepared timely as per project schedule. -Number of training session conducted. -Number of PLWHA group trained on saving and credit	-Review of training report -Discussion meeting with the Group members	Field staff and training facilitator	Feb and August March-April & Sept-Oct	Not yet
Objective5. Training of the community managed saving and credit groups on Selection, Planning and managements of income generating activities	-# Of training session conducted. -# Of PLWHA groups trained on SPM.	-Review of training report. -Discussion meeting with the Group members	Field staff and training facilitator	May and Dec.	Not yet
1. Training logistical preparation. Stationary, handout, timetable 2. Conducting training in 3 phases@ 3 groups	-Logistic prepared timely as per project schedule. -# Of PLWHA group trained on saving and credit	Review of training reports, discussion with trainees. Discussion meeting with the Group members.	Field staff Field staff and facilitator	May and Nov May-June and Nov-Dec	Not yet

5.2. Evaluation

5.2.1. Performance Indicators

To assess the performance of the project, both formative and summative evaluation will be conducted.

- **Formative evaluation.**

The formative evaluation will look at the outcome of the project, by assessing the following indicators: number of active saving and credit groups, percentage increase of each group's capital base, number of group members receiving loans, repayment rate of individual members' loans, number of new income generation business formed and number of existing income generation business expanded. The formative evaluation will be done after the completion for phase one of the project, in order to assess the success of the project.

- **Summative evaluation**

Summative evaluation also will be conducted after a period of one year to 18 months, on completion of the project to assess its impact. The impact assessment will look at the social-economic changes to the lives of group members. Such indicators to be assessed include: number children going to school, number of houses improved, number of new assets acquired, percentage of family members accessing proper medical care and percentage decrease of malnourished family members.

5.2.2. Methodology for Data Collection

Formative evaluation will be done at the end of December 07, using participatory methods, which will involve a team from JIMOWACO. This will included the Project

Coordinator, JIMOWACO Field Staff, Assigned Training Facilitator, and the community-managed savings credit group members.

For the formative evaluation the following data collection tools will be used:

- Focus group discussions with community managed saving and credit group members to assess the groups' progress.
- In-depth interviews will be conducted with key informants from community managed saving and credit group members to see the individual progress and benefits gained such as development of new /existing small business.
- Review of records for the community managed saving and credit/ to assess the increase of group's capital accumulation, loans disbursement and collection. Also, loan request forms will be assessed to find out if loan requested are for income generation initiatives

Summative evaluation also will be conducted to assess the impact of the project by:

- Administering questionnaires to community managed saving and credit group members
- Observation of community managed saving and credit group members' activities
- Focus group discussions with community managed saving and credit group members

Information to be collected will focus on assessing the social-economic changes / impact on the life of group members after a period of time after the completion of the project.

5.2.3. Data Analysis

The data collected will be analyzed using prepared Ms-excel sheet database to determine the percentage (%) increase /decrease of group's saving/credit services. The qualitative information collected will be coded as per variables identified to answer the evaluation research questions.

5.2.3. Formative Evaluation Results.

As of January 2007, the project had managed to meet first, second and part of third objective. One development partners, Plan Tanzania-Kisarawe program unit, shown willingness to support the trainings sessions for the community managed saving and credit group system to PLWHA .The organization had similar project in other communities in the district .The organization planned to give a support of Tsh 5.5million, which will cover costs for the facilitation and saving and credit group kits, which includes recording keeping books and cash box. Yet, the fund was not yet disbursed by January 07.

Three training facilitators were already obtained and started community mobilization sessions in the 2 villages and had already managed to form 3 interest groups to be trained. All training session were not yet started hopes to be conducted, as the funds are disbursed from the development partner.

See table 5.2.4 summary of evaluation table for details.

5.2.4. Summary of Evaluation Table (Formative evaluation).

Objective	Performance indicator	Target/expected output	Achievement to date/outcome
1.To identify development partner to support the training	-# Of development partner identified. -Amount/type of support received from a development partner. .	One development partner	Plan Tanzania-Kisarawe program unit, promised to support with 5.5m Tsh for PLWHA groups initiative.
2.To identify the trainers for the community saving and credit groups	-# Of facilitator actively facilitated the training and making group follow-up. -#Of monitoring visits conducted.	2trainers	3 trainers who have been received refresher training from Plan support on community based saving and credit.
3. To mobilized PLWHA families' interest groups for saving and credit associations.	-# Active group in community saving and credit system.	10 pilot groups	3 groups have been formed and the process is on going.
4.Training of the organized PLWHA groups in community managed saving and credit association model	-#Of group members trained in community managed, saving and credit system. %Increase of group's capital accumulated. -# Of group members received loans. -%Increase of loans disbursement/recovery rate.	10 pilot groups	Not yet done
5.Training of the community managed saving and credit groups on Selection, Planning and managements (SPM) of income generating activities	-# Of groups members trained on SPM -# Of new business initiatives developed. -# Of new/expanded business opportunities developed.	10 pilot groups	Not yet done.

5.3. Sustainability

5.3.1 Sustainability Elements

Home based care services depend much on donor funds, therefore good strategies to ensure sustainable availability of funds is important. Community leaders, political leaders and government officials need to be involved in planning, implementation and evaluation of the project since they have power over the people and can influence decision making.

Stigma and discrimination have been hindering blocks to the success of the project, therefore, all cultural and traditional beliefs need to be addressed during early stages of project set up. Capacity development of the project staff and community group members is very crucial for the efficiency and effective management of the project.

5.3 2. Sustainability Plan

Sustainability Element	Plan/Measure taken
Financial	<ul style="list-style-type: none">-The Community saving and training model is self manage, no inject of funds.-Members' contribution to be collected in the normal meeting to cover for the facilitator cost during on going follow-up visits.-Writing more proposals to seek for other interested donors.
Political	Involving community leaders and communities from the start of the project, implementation and evaluation
Socially	<ul style="list-style-type: none">-Conducting community public meeting before start of the project.-Use of existing community volunteers during mobilization of communities.-Involving community leaders at all stages
Technical	-Training of the whole group and 14 weeks follow-ups visits after training.

	-Train and use of available trained community members as facilitators for saving and credit training for future facilities. -Involving project staff in all project activities including participating in the training.
Institutional	Linking the groups with community own resource facilitator who can facilitate the groups to formal credit and saving cooperatives.

5.3.3. Institutionalization of the Suitability Plan

The host organization has been advised to use the trained community members (i.e. those who attended training of trainers conducted by the partner organization Plan Tanzania, (Kisarawe program unit), who are available within the district, for easy follow-up and are low cost, rather than to use external facilitators who are expensive.

Continuous partnership with the existing donors is important and can be strengthened by giving them progress and evaluation reports, so that they can be encouraged to give more support for scaling up of the project. Involvement of project staff, community leaders and government officials at all levels during project scaling up is important for their commitment and accountability towards project success.

Lastly, JIMOWACO was advised to look for more funds by writing funding proposals to donors so that they can have sufficient resources for continuing to offer home based care services to PLWHA and OVC. For example, a funding opportunity that is available is the Rapid Fund Envelope (RPE), which supports initiatives to mitigate the impact of HIV/AIDS in Tanzania.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

Throughout the project cycle a lot of learning took place, which needs to be shared with others who wish to implement the same project, as well as for improving future project implementation. Documentation of lessons learnt and challenges faced during project implementation are important for future implementation of projects by JIMOWACO, or by other organizations wishing to implement similar projects.

Therefore recommendations are suggested for the implementation of future community home based programmes to people living with HIV/AIDS, to encourage the success of these programmes and ensure they significantly improve the wellbeing of PLWHA.

6.1. Project Results

The project has already identified a development partner (Plan Tanzania-Kisarawe program unit) that was willing to support the training sessions of the PLWHA on community managed saving and credit system, with approximately Tsh5.5million, for the financial year 2006-07. Plan Tanzania has already been implementing a community managed saving and credit group system in other villages within the Kisarawe district.

By the end of January 2007, community mobilization meetings were held in two communities out of six as per the plan and were very successful. Soon after these meetings, three communities managed saving and credit system groups were formed in two villages.

Thereafter, the implementation of project activities were handed over to JIMOWACO field staff and facilitators who were proceeding with the remaining community

mobilization meetings to the rest of planned project villages, as per planned timetable (3 villages were to be covered between January to June and 3 villages from July to December 2007, for the phase one of the project). The remaining project activities were not yet started by January 2007 (when the project was handed to JIMOWACO as per the planned time table), which includes training on the community managed saving and credit system as well the training on selection, planning and management of income generating activities. However, preparations to accomplish the remaining activities were in progress and soon after the disbursement of the funds, the trainings were to start.

The planned project activities were expected to be accomplished because the trained trainers were already obtained and the development partner was still committed to support the project.

Since January 2007, JIMOWACO, the organization implementing the project, has been engaged to a new donor, Family Health International (FHI) for continued support of the Home Based Care program activities, after the phase out by the former donor, Care International. The new donor (FHI) is neither willing to support direct income generation activities through grants nor food support to PLWHA as Care International did, but instead is looking at linking PLWHA groups with micro-financing institutions for accessing loans to upgrade their small businesses. Therefore the community managed saving and credit system to be implemented has been a good starting point for successfully linking PLWHA with micro-financing institutions. JIMOWACO is eager and ready to implement the community managed saving and credit system to support PLWHA and their families, since this will assist them in the future implementation of

the home based care program, as per the conditions of the current donating organization (FHI).

6.2. Recommendations

Home Based Care programs are very important for improving the life of the PLWHA and their families. They need to be promoted due to their significant positive impact on the life of people affected by HIV/AIDS and their communities. However, the programmes are costly and depend very much on donor funds. Hence their sustainability is questionable due to increased dependency syndrome. At the same time, unexplored funding/resource opportunities still exist within the Kisarawe District for supporting PLWHA, like fundraising from the business people and existing non-governmental organizations that support efforts against the HIV/AIDS pandemic but are not yet utilized.

For improving the wellbeing of PLWHA and reducing donor dependency syndrome, there is a need to support PLWHA with financial capital and technical skills for establishing and expanding small income generating activities for their livelihood development. Many lost their business capital/jobs as result of long periods of sickness. The community managed saving and credit group system is an important strategy for collective saving to accumulate capital base for PLWHA to establishing and expand business opportunities for income generation.

Therefore recommendations for successfully implementing Home Based Care programmes to PLWHAs include:

1. Support income generating activities, including training on small business skills; agriculture production, agricultural implements/inputs, simple improved techniques and best practices, credit facilities and marketing strategies. However, the option for the suggested interventions should be specific to local settings and availability of opportunities, which can be backed by technical support.
2. HIV/AIDS affects an individual's immune system, food intake and metabolism, resulting in poor nutrition status. Investment in medical programmes to support PLWHA should be completed with efforts to ensure that a minimum level of nutrition is obtained. Therefore, Home Based Care programmes should consider family livelihood interventions using local based resources to improve family nutrition.
3. Give high priorities to community education and sensitization prior to other support of PLWHA for the sustainability of activities.
4. Home Based Care programs should be linked to micro-financing service providers, so that as the health status of an individual with HIV/AIDS improves, they can access business capital to run a small enterprise/business for earning income to improving family livelihoods.
5. A community based managed saving and credit group system, has proven to assist people of low income including PLWHA. Groups need to be organized to form SACCOs so that they can easily access large loans/capital from micro financing service providers like the National Micro-Financing Bank (NMB) and the Co-operative and Rural Development Bank (CRDB).

6. Civil society organizations and institutions implementing community based care programmes and support to PLWHA in Tanzania need to develop funding proposals to make the most of the available opportunities of grants for supporting PLWHA. These grants, for example, from the Rapid Funding Envelope for HIV/AIDS (RFE), can be used as start-up capital and for capacity building training to manage small business. The RFE is an initiative to enable organizations to participate in the national multi-sectoral response to AIDS. It enables organizations to provide assistance in areas such as the care, support and treatment of people with HIV/AIDS and its related opportunistic infections. Such interventions mitigate the impact of the effects of the epidemic, and include assistance to orphans and vulnerable children.

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