Towards a model of ADP staff for Multisectoral response at community level.

The case of World Vision Tanzania

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Dedication

To

My wife

Graides Katabaro.

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List of Abbreviations

ADP	Area development Program
AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organization
CCC	Community Care Coalition
CDP	Community Development Projects
CoH	Channel of Hope
FAO	Food and Agriculture Organization
FBO	Faith Based Organization
AAHAPCO	Addis Ababa HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
IOM	International Organization for Migration
MoEC	Ministry of Education and Culture
MTEF	Medium Term Expenditure Framework
MTN	Mosquito Treated Nets
NACP	National HIV/AIDS Control Program
NMSF	National Multisectoral Strategic Framework
OVC	Orphans and Vulnerable Children
PER	Public Expenditure Review
PLWHA	People Living with HIV/AIDS
PRSP	Poverty Reduction Strategic Paper
TACAIDS	Tanzania Commission for AIDS
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNDESA	United Nations Department of Economic and Social Affairs
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Education Fund
URT	United Republic of Tanzania
WV	World Vision
WVI	World Vision International
WVT	World Vision Tanzania
ZMT	Zonal Monitoring Team

Abstract.

The study seeks to improve WVT community level response to HIV/AIDS epidemic through a Multisectoral approach. The study focuses on area development program (ADP) by considering the strong connection existing between ADP staff and the community. The selection of respondents was guided by the information needed for the research. The respondents include ADP staffs, community representatives in the ADP, people living with HIV/AIDS group and World Vision staffs. In summary, 37 ADP staffs were interviewed, 4 focus group discussion and 6 WVT staff.

The result revealed that the impact of AIDS in development work is recognized by both groups of respondents. The impacts of AIDS in agriculture and education sector were mentioned frequently by all categories of respondents. However the ADP staffs who work with HIV/AIDS department were found to have better knowledge of AIDS impact compared to ADP staffs dealing with other development sectors.

The study shows that, the current competences of ADP staff to deal with development issues in the era of HIV/AIDS are not promising. Further the study suggests the need to equip ADP staff with adequate knowledge, altitude and skills so that they overcome the challenges in the field posed by HIV/AIDS. According to the results, the respondents proposed the areas of gapes in their competences which are; knowledge about HIV/AIDS in general, communication skills, networking skills, advocacy and lobbying skills.

From the research, it was apparently that there is a lot of strength in the organization which can accelerate the indirect response to the epidemic through Multisectoral approach. The communal culture of the organization makes people to be connected to each other hence fuelling the Multisectoral response. Also there is potential factors like communication among staff within the organization helps people to collaborate; which is the road map for Multisectoral response.

Also the study shows the organization structure which limits the room for creativity to ADP staff. This is identified in this study as the hindering factor for Multisectoral response to the epidemic. It was found that the room for staff to make decision is limited due to the bureaucracy of the organization. Most of what staff does, comes from top as an instructions. Therefore this study comes up with recommendation that; for Multisectoral response to be effective, we need ADP staff involvement in all steps of program cycle.

Further the study recommend that, the department of HIV/AIDS, health and Malaria should make sure that the linkage between AIDS impact and developmental work are well known to all WVT staff to the level of individual ownership. This will help every staff to respond to the epidemic from the perspective of his/her sector. Further the department were reminded that, people knows about the impact of AIDS in the developmental work with the perspective of assuming that the department of HIV/AIDS is there to respond.

1.0 Introduction and Background Information

The thesis describes the results of a study on assessing Multisectoral response to reduce AIDS impacts at community level in World Vision programs.
The study was conducted in King'ori Area Development Program (ADP), Ruvu Remiti ADP and Nakombo ADP based on Arumeru, Simanjiro and Same district respectively.

The document is build up as follows. In section one the situation is described that lead to proposing this study and its objective and research questions that the study is trying to answer. In section 2 important concepts and related literatures to the subject to be study is outlined. In Section 3 an explanation is given of how the study was conducted. Findings and discussion is presented in section 4 and finally the paper end by giving conclusion and recommendations for actions.

1.1 Tanzania HIV/AIDS Situation

Tanzania is one of the countries hard hit by HIV/AIDS epidemic in sub-Sahara Africa. Recent reports from the Ministry of Health indicate that since the first 3 cases were reported in 1983 a total 1,400,000 cases have been reported from health facilities in the country by the end of the year 2007(UNICEF, 2008). It is facing a 'generalized[1] epidemic of HIV. The national HIV prevalence rate among the sexually active population (defined as the population between 15 and 49 years of age) is 5.8 %, with females having a slightly higher rate (6.8%) than males (4.7%). Based on this prevalence analysis, it is estimated that 1.05 million people including adults and children are living with HIV or AIDS. (SOS[2], (2008) & TACAIDS, (2008)). The prevalence rate varies from one region to another. The highest prevalence rate is from Iringa (18.2%) region followed by Mbeya (15.9%) and Dares salaam (10.9%). The smallest figure is found in Kigoma region (3.5%).
For detailed information about prevalence rate see appendix6.1.

The literature shows the higher infection rates to urban than rural areas. The highest infection rates are found in women of the age-group 30 -39 years and in men of the age-group 35-44. The infection between young women (19-24 years old) and young men of the same age group is (4% and 3% respectively) (TACAIDS, (2008)). According to TACAIDS, (2008); the leading mode of transmission is heterosexual contact, constituting about 80% of all new infections. Mother to child transmission is reported to account for about 18% of new infections.

In Tanzania the reports shows that, for both men and women, HIV prevalence increases with level of education. Adults with some secondary education are more likely to be infected with HIV than those with no education (i.e. with no education, males 4.2% and females 5.8%, while with some secondary education the rates are 7.3% for males and 9.3% for females. HIV prevalence among separated/divorced/ widowed is significantly higher (men 15% and women 19.8%) than among those currently in union/married (men 7.8% and women 6.9%) and those never in union (men 3% and women 3.8%). HIV prevalence also seems to increase with wealth (prevalence rates among the poorest men 4.1% and women 2.8% while among the richest men 9.4% and women 11.4%)

[1] Generalized" in the classification of the HIV epidemics of UNAIDS means "HIV prevalence consistently over one percent in pregnant women. Moreover the epidemic was identified as for commercial sex workers but now is for the whole society.
[2] SOS Children's Villages is an independent, non-governmental international development organisation which has been working to meet the needs and protect the interests and rights of children since 1949

TACAIDS also report that; there are cases of transmission through anal sexual intercourse (heterosexual or among men who have sex with men) as well as HIV infection through drug abuse. This occurrence is important factors for the further spread of HIV. However the dimension of these infection routes is not known.

1.2 Impact of AIDS in Sectors

This section is describing the impact of AIDS in Tanzania by focusing on sectors which World Vision Tanzania is dealing with. The impact per sector as described below indicates the linkage between HIV/AIDS and multiple sectors; hence showing that AIDS is impacting all sectors in a society and should be dealt with in all those sectors. The fact that World Vision is dealing with some sectors gives it the potential to respond in a multi-sectoral way. In general, the organization deals with agriculture, Community Based organization(CBO), education, water and sanitation HIV/AIDS, malaria and health.

1.2.1 Impact of AIDS in pre-primary and primary school education

AIDS affects the education sector in a number of ways such as:

- The supply of experienced teachers will be reduced by AIDS-related illness and death; Increase in teacher attrition and drain is expected as other sectors seek personnel to replace those lost to AIDS, as the teaching profession can serve as a preparation for many other professional careers in society. Moreover, there are increased losses in productivity in the education system due to AIDS-related sickness and absenteeism of teachers and major problems of finding replacement for qualified teachers and other staff (MoEC, (2007)).

- Many children who are enrolled are not able to maintain school attendance when they become too sick or are pulled out of school to attend sick family members or engage in petty business to support other family members, too often as household heads in their teen-age years children may be kept out of school if they are needed at home to care for sick family members or to work in the fields (Henry, J. (2007);

- Children may drop out of school if their families cannot afford school fees due to reduced household income as a result of an AIDS death.

- Death of parents will result in an increased number of orphans who often have no one to provide them with care or support. Carr-Hill,R; et al, (2002) in their work on the impact of HIV/AIDS on education; and institutionalizing preventive education revealed that; many orphans are failing to attend school or have miserable school lives because of wide spread stigma and discrimination which affects their performance. All these are likely to result into lower achievement among the affected children and the schools.

- The impact of AIDS in the education system presents a serious challenge for the planning of education and training. Apart from taking into account the change of client like orphans, dropout children, teacher attrition and their personal needs as a result of HIV/AIDS also it will consider the role, process and the content of education and training.

1.2.2 Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. According to studies done in Tanzania and other have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income (Bollinger, L. Et al 1999). The loss of a few workers at the crucial

periods of planting and harvesting can significantly reduce the size of the harvest. In communities where there is a traditional division of labor by gender between agricultural tasks and household work, the domestic labor burden of women increases disproportionately. Women have to take up additional burden of taking care of the sick, orphans and attend frequent funerals. The increased workload may greatly reduce their time to participate in agricultural activities, leading to a decline in agricultural production in areas where females are the major agricultural producers. In Tanzania, women spent 60 percent less time on agricultural activities because of their husbands' illness (Rugalema, 1999). Because they are overburdened, women no longer have time for non-farm activities such as artisan crafts, market gardening, food processing and others, activities that previously contributed to the family budget. This also negatively impacts on their livelihood.

In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops (UNDESA, (no date)).

Thus, AIDS could affect the production of cash crops as well as food crops. In the Kagera region of Tanzania, although short-term impacts on agricultural production have not been felt yet, medium- and long-term impacts will occur. Soil fertility is being affected because labor is not available to mulch bananas or clear new areas, resulting in decreasing yields and over cropping. According to the literature, this increases pressure on the subsistence agriculture system that exists (ECA, (2006).

The overall effect of HIV/AIDS is to accelerate the process of impoverishment. Poor farmers caring for family members and falling ill themselves and eventually dying will inevitably reduce the amount of time spent in the fields (FAO, (2003). The labor force in the agricultural sector will be diminished and weakened, which will results in a decrease in food or cash crop production. The increasingly attendance to funerals adds to this tendency. At the same time costs increase for drugs, treatment and care of AIDS patients as more persons fall ill. Expenses related to funerals are equally increasing. The end results are that less food and cash crops are produced resulting in less available food and less money not only to buy food but also to buy other essential goods and services (Liberatus L, (2003)).

1.2.3 Impact of AIDS on Health.

AIDS affects the health sector for two reasons:

- it increases the number of people seeking services and
- Health care for AIDS patients is more expensive than for most other conditions.

Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

1.2.4 Impact of AIDS on Water.

Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Furthermore, Barnett,T. and Whiteside, A., (2006) in their work pointed out that the need of water for AIDS patient is five times the need of water to another person.

The sectoral impact of AIDS is felt differently from individual to National level. For the purpose of this study, the focus will be deal with the impact of AIDS at individual, household and community level.

1.3 Impact of AIDS at different levels

In WV, the main focus of development is from individual level, followed by household level and we end up with community level. For that reason, this study considered the sectoral impact of AIDS in relation to these three levels.

1.3.1 Impact of AIDS at Individual level

At individual level, the infected person can experience frequency illness and the excess cost for treatment which will lead to erode resources at his/her disposal. According to Barnett,T. and Whiteside, A., (2006) and Karuhanga, B; (2008): the impact of AIDS is felt sharper for the economic weak person that the wealth one due to the different access to health services. The impact of HIV/AIDS at individual level also varies in respect to the following factors;

- Whether you fit in the society or you don't fit; if you fit in the community, very likely you're going to receive care and support in excess than the person who doesn't fit. Or you will not experience stigma.

- Who you are in terms of status and gender; the richer or/and royal person is having minimum chance to feel the impact than the poor and oppressed person. Furthermore the literature shows that women in either category (rich or poor/ royal or oppressed), they experience more impact compared to men.

- Where do you live; the place someone live can either increase the sharpness of impact or reduces. If a person is living in town, within a fenced house and all important needs are found inside the house is likely to get little impact that the poor person living in the village.

- To whether your replaceable in the society or not; the person in the community who is playing a big role to help people due to the wealth he/she have is seems to experience minimum impact than the person whom no body bother about.

The personal/indidual impact of HIV/AIDS is also found in travel restriction; such that, the person affected by HIV/AIDS is not eligible to entire into some countries (UNAIDS/IOM, 2004). Another impact to the affected person is the situation of being emotional, hopelessness, stress, social isolation and psychological problem (www.areyouhivprejudiced.org).

1.3.2 Impact of AIDS at household level

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses. The effect of illness and death in the household depend on a number of factors like;

- The number of cases the household experiences
- The characteristics of deceased individual. E.g., age, gender, income and cause of death
- The household composition and asset present
- Community social cohesion
- Community structure in accessing services from government or/and civil societies organizations

Bollinger, L. Et al 1999 analyses the impact in terms of the loss of income of the patient (who is frequently the main breadwinner), household expenditures for medical expenses may increase substantially and other members of the household, usually daughters and wives may miss school or work less in order to care for the sick person. When the death happen, it may result in a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

Many studies in Tanzania shows that when husbands die from AIDS, their widows suffer from a lack of cash, since men are the main cash income earners in Tanzania (Mwakalobo,A. 2003).

1.3.3 Impact of AIDS at community level

As HIV/AIDS deepens, increasing the mortality and morbidity rates at the household level, the socioeconomic impacts widen to affect the whole community, resulting in an adverse long-term effect on community structure and function. Community problems that arise as a result of HIV/AIDS include the need to support an increasing number of orphans, reduced participation of the community in neighborhood and community structures, increased homelessness and increased crime. In other words, social cohesion is threatened, a situation that in turn increase the risk of HIV transmission (Mwakalobo,A. 2003).

The number of orphans, homeless children and children living on the street is increasing due to the HIV/AIDS epidemic. The high mortality of prime-aged adults due to AIDS has left behind orphaned children in households with fewer or no breadwinner to support them.

The socioeconomic impact of HIV/AIDS expands from household to community to Different parts of the country. The increasing mortality and growth of the number of orphans pose unprecedented social welfare demands for countries already burdened by huge development challenges. AIDS overburdens social systems and hinders health and educational development. The epidemic increases the strain on state institutions and resources, while undermining the social systems that enable people to cope with adversity. As parents and workers succumb to AIDS related illnesses, the structures and divisions of labor in households, families, workplaces and communities are disrupted, with women bearing especially heavy burden (Rugalema, G. (1999))

1.4 Tanzania Response to HIV/AIDS.

Tanzania recognizes the severe threat posed by the HIV/AIDS epidemic on social and development efforts and has taken the necessary steps to respond. The national response to HIV/AIDS receives strong commitment from the government and international community. In

recognition of the threat of HIV/AIDS to social and economic development, the Government of Tanzania has declared HIV/AIDS as a national disaster, requiring intensive action by stakeholders. The need to address HIV/AIDS features prominently in all of the Government's main development frameworks and strategies, including Development Vision 2025, the Poverty Reduction Strategy Paper (PRSP) and sector program financing arrangements through the Public Expenditure Review (PER) and Medium Term Expenditure Framework (MTEF).

The major HIV/AIDS programs that are in place in the country among others include the National Multisectoral Strategic Framework (NMSF) established in October 2002. Currently we have the second phase of the framework which covers for the year 2008-2012. This NMSF guides the approaches, interventions and activities which will be undertaken by all actors in the country by translating the National policy on HIV/AIDS and by providing strategic guidance to the planning of programs, projects and interventions.

In June 2001 Tanzania, joined 189 countries under the program of action to fight the HIV/AIDS pandemic through adoption of the United Nations General Assembly Special Session (UNGASS) declaration in its national HIV/AIDS. The goal of the declaration is the national response, placing priority on UNGASS targets for reduction of HIV infection among infants and youth adults, improvements in HIV/AIDS prevention, health care and treatment, and increased support to children and communities affected by HIV/AIDS.

The National HIV/AIDS Control Program (NACP) was established since 1988, under the Ministry of Health, with the responsibility to combat the spread HIV/AIDS in the country. In order to strengthen the institutional and organizational framework for HIV/AIDS coordination, the Government established the Tanzania Commission for AIDS (TACAIDS) in December 2000. The institution is mandated to provide strategic leadership and to coordinate and strengthen efforts of all stakeholders involved in the fight against HIV/AIDS with the main emphasis on Multisectoral approach. This is to make sure the that there is the link of HIV/AIDS programs with community development activities targeting households with infected and affected groups, especially women, children and AIDS orphans; (TACAIDS, 2008-2012).

From the brief information about the struggle of Tanzania government to respond to the epidemic, motivates other stakeholders to act up on the situation. The National Multisectoral Strategic Framework shows the commitment of the government to respond to the epidemic through Multisectoral way. WV being among the stakeholders who plays a role of fighting against the epidemic is obliged to adapt the government strategies.

1.5 Poverty in Tanzania

In Tanzania, the majority of the population lives in rural areas, about 80 percent are engaged in subsistence agriculture for their livelihood and lives under poverty line. Karuhanga, (2007) pointed out that poverty as per definition of poor people is more than just living below one dollar per day: it is also the lack to satisfy basic and social needs as well as feeling of powerlessness to break out of cycle of poverty.

Common features of poor household in Tanzania include; few assets for production, insufficient foods, inadequate income to health care and education costs and to obtain basic household necessities; many dependants, susceptibility to HIV infection and vulnerability to AIDS impacts, poor health or lack of social support.

Poverty in Tanzania like any other third world country is a rural phenomenon as basic needs rural poverty incidence is estimated at 57 and the food poverty incidence is about 32 percent (URT, (2000)). Poverty, increases susceptibility to infection of HIV and vulnerability to the impact of AIDS and HIV/AIDS exacerbates poverty the latter increases social exclusion of already poor groups. (Muller, T. 2005).

Economic status of the household determines which competence of development worker should be applicable so that there is equal benefit among the client towards support given by WVT. During implementation of WVT program, the most active people are those of at least sufficient economic status (*experience from my former work*) hence leaving behind the most needy people. Furthermore, the HIV/AIDS affected households are not likely to attend meetings, trainings and another development projects due stigma and discrimination. This situation fuels the practicalities of limited resources and narrow option (UNAIDS 2003).

This sub-chapter alerts the study that poverty and HIV/AIDS thrive on each other; WV to deal with poverty among the communities which is facing HIV/AIDS problem might stuck if proper approach is not applied. Therefore addressing development in the country like Tanzania, which is hard hit by the epidemic require multi-sectoral approach.

1.6 World Vision Tanzania Overview.

1.6.1 Organization mission

The mission of World Vision is to follow our Lord and Savior Jesus Christ in working with the poor and oppressed to promote human transformation, seek justice and bear witness to the good news of Kingdom of God. For more information about the mission of the organization see appendix 2.

1.6.2 World Vision Tanzania and development work

World Vision is a Christian releif, development and advocacy organization dedicated on working with children, families and communities to overcome poverty and injustice. Apart from its' Christianity, the organization serves all people regardless of religion, race, ethnicity or gender.

In Tanzania WV started in 1981 as a program with the head office from Nairobi Kenya. At this time the operations were done through the system called Community Development Projects (CDP). In 1988 Tanzania got the status to have National office and the head quarter become Arusha. Four years later (1992) World Vision Tanzania changed the system of operation from CDP to Area Development Program (ADP) which is the system until to date. One ADP is supposed to have the population of 20,000 – 100,000 people. The organization has implementations in twelve regions in the mainland of Tanzania. Within the ADP the following sectors are implemented;

Education;

- The ADP is networking with the government in order to facilitate school structure through constructions and establishing teaching resource centers and materials.
- Also the establishment of centers of excellence in primary education in each zone and mobilizing communities to replicate best practices.
- Advocating for all children of school age to be enrolled in pre-primary school and primary school classes.
- Conducting refresher course to teachers so as to improve quality of primary school education.

Water;

- Encourage the establishment and strengthening of community-based water management systems.
- support the construction and development of water sources and sanitary facilities.

Health;

- Focus on promoting the use of Mosquito Treated Nets (MTN); breast and hygienic child feeding practices and insisting on the construction and use of latrines and utensils drying rakes.
- Training of community change agents like village health workers, traditional birth attendants and traditional healers on suitable skills as recommended by Tanzania Ministry of Health.
- Support outreach immunization services.

HIV and Malaria;

- Further the ADP collaborate with HIV/AIDS and Malaria response department for better programming/integration of HIV/AIDS and Malaria control promising /best practices in the ADP master plans.
- Collaborate with HIV/malaria response department to develop relevant tools to plan implement and monitor the relevant behavioral changes more effectively

Livelihood;

- In agriculture the ADP deals with promotion of drought resistant/tolerant varieties in drought prone locations, while promoting micro-irrigation schemes in all potential areas.
- In collaboration with extension service personnel from research institute the ADP promote seed multiplication and storage initiatives.
- Either the ADP promote appropriate technologies for processing and storage of perishable food staffs and assist farmers create market linkage systems for their produce, through development of marketing information network and supporting the construction and renovation of storage facilities.
- The ADP also facilitate to promote new cash crops (such as sun flower, vanilla and paprika), bee keeping and livestock for processing to add value, while establishing and strengthening farmers' associations.

Alongside there are Six cross-cutting issues which are implemented; Christian commitment, disability, environment, gender, peace building and conflict resolution and protection.

1.6.3 Responding to HIV/AIDS by World Vision Tanzania

WVT through its mission of helping the poor and oppressed, recognize the threat posed by HIV/AIDS in the community. To join the international efforts of fighting against HIV/AIDS, the organization have the department dealing with HIV/AIDS, Malaria and Health. The department is structured from national office where we have the manager, followed by zonal coordinators for HIV/AIDS, malaria and health. At the ADP level we have Program facilitator who is representing the department. The staffs from national office to zonal office have the background of health and at the ADP they are not necessary to have health.

In dealing with the epidemic, WVT have the budget each ADP which is 15% of the total ADP annual budget. Further, the organization implements short term HIV/AIDS projects which arise

according to the need of either the community or the donor[3]. The organization's struggle to fight against the epidemic is focusing on the following areas;

- Community Care Coalition (CCC): this is the model used to mobilize community-led care and support for Orphans and Vulnerable Children (OVC)
- Channels of Hope (CoH): this is the model used to mobilize and equip Churches/faith based organization for HIV/AIDS response.
- Prevention activities for children under the age of 18 years: the program uses the Scripture Union Curriculum (Adventure Unlimited) and/or other age-appropriate values-based life skills training. The curriculum is selected by the national office in consultation with the regional HIV/AIDS team.
- To integrate advocacy approaches with CCC's, CoH, and prevention work for children under the age of 18 years.
- Ensuring integration of HIV/AIDS with other core areas such as, food security, education, etc.
- As HIV and AIDS programming entails direct HIV/AIDS specific interventions like rolling out of the core models as well as Multisectoral approaches focusing on Mainstreaming of HIV/AIDS, ADPs and projects are needed to consider the needs of the most vulnerable in their sectoral project planning.
- Staffing: Ensuring a minimum of one full time HIV/AIDS staff person per ADP (taking into account who in the ADP will work with CCCs and churches and prevention). (WVI, (2008)).

More details about the organization response to the epidemic, monitoring and supervision are found in appendix 3

1.6.4 World Vision Tanzania community development approach

Community development in WVT and elsewhere is about helping to empower those who are poor. Good development tackles the interrelated causes of poverty and is led by those who live in poverty. It encourages people to resolve issues and work for change in their own communities. It is about long-term solutions, not quick fixes.

At the heart of World Vision's community development work are the Area Development Program (ADPs). Each ADP usually covers several communities with which World Vision partners to improve lives. ADPs are initiated in both rural and urban areas in response to specific community needs in education, health, nutrition, water and sanitation child care and other program sectors. Virtually all of World Vision's ADPs and related projects share a single underlying purpose: to improve the lives of children.
In the community WVT starts with need assessment; this is done by special consultation with community leaders, government and any other stakeholders existing within and outside the

[3] There is a situation where the donor sends a request of HIV/AIDS proposal to the community through World Vision with the condition of project location and the target group. In this research is regarded as donor driven need. There are cases where the community identify need and write a proposal to seek fund. This is regarded as community driven need.

targeted community. This step is followed by signing the memorandum of understanding between the community and WVT. There after the work starts with sensitization in which World Vision (WV) introduce the vision and mission of the organization, sharing the organization core values, explaining in depth what WV do and what not to the community at household level. The process takes two years before the start of implementations.

Through this approach, WV intends to bring about the sense of ownership to the clientele by encouraging full participation in the partnership.

1.6.5 World Vision Tanzania ADP category and composition

The advisable ADP size recommended by World Vision International must have the population not less than 20,000 people and the maximum population should not exceed 100,000. This is a size equivalent to two up to four wards[4] in districts. In the ADP there is two category of staff namely community staff and World Vision staff. Community staff are those recruited by the ADP management, they are coming from the same community where ADP operates, they report to ADP chairperson administratively and they report to program coordinator technically, their work is based in the community of their residence . This category comprises more than 90% of staffs at ADP level. The second category is World Vision staff which comprises only two staffs namely program coordinator and program accountant. These two staffs are recruited by WVT under human resource manual and they report to World Vision management. The ADP management therefore; is the combination of community staff, WV staff and ADP committee[5].

1.7 Problem Statement.

The goal of WVT is to contribute to improve life of the poor and oppressed groups in rural communities. As shown about AIDS impacts in all sectors at different levels, calls for reviewing current approaches so as to develop the communities.

The representation of staff in different sectors within the Area Development Program (ADP) gives the organization's strength to deal with HIV/AIDS by involving all staff in their respective sectors to respond to the epidemic indirectly. Also the Tanzania Commission for AIDS (TACAIDS) gives WVT a conducive environment to respond to the epidemic through Multisectoral approach[6].

The current practice in the organization focuses the interventions per sector, which limits the room for staff collaboration among sectors. This can be observed through lack of common forum during planning period, inadequate interaction between staffs and the absent of common program during the implementation time.

Due to wide range of AIDS impacts in rural communities calls for community development approach which is Multisectoral.

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[4] This is the political administration which is obtained from dividing the district into divisions and divisions into wards.

[5] ADP committee is formed through two representatives from each village within the ADP. The two members (must be gendered), from each village, come together and select their ADP chairperson and ADP secretary.

[6] The institution (TACAIDS) is mandated to provide strategic leadership and to coordinate and strengthen efforts of all stakeholders involved in the fight against HIV/AIDS with the main emphasis on Multisectoral approach

Objective:
To find out on how to improve WVT community level response to HIV/AIDS epidemic through a Multisectoral[7] approach.

Main Question:
How collaboration among ADP staff can be enhanced in order to get a more comprehensive Multisectoral response to HIV/AIDS?

Sub - Questions:

1. What are organization's changes required in order for ADP staff to collaborate so as to enhance Multisectoral response to HIV/AIDS epidemic?
2. What are the limiting factors for the changes to take place?
3. What are facilitating factors for the changes to take place?
4. What are competences required by ADP staff for responding to HIV/AIDS epidemic?
5. Do ADP staffs recognize the impact of AIDS in their work?

1.8 Definitions of Concepts.

1.8.1 Multisectoral Response to HIV/AIDS

Multisectoral approaches to HIV/AIDS are those seeking to reduce HIV prevalence, provide care and treatment to persons living with HIV/AIDS (PLWHA), and mitigate the impacts of the epidemic on affected populations by employing an appropriate mix of health- and non-health-based interventions and involving a broad array of stakeholders in their design and implementation. Further it involves all sectors of society, governments, business, civil society organizations, communities, PLWHA at all levels in addressing the causes and impact of HIV/AIDS. It requires action to engender political will, leadership and coordination, develop and sustain new partnerships, strengthen capacity of all sectors to make an effective contribution. It has to be dynamic, flexible, strategic and coordinated (Gillespie, S; (2006) & Lule, E; (2007))

1.8.2 Collaboration

Collaboration is a self-repeating process where two or more people or organizations work together in an intersection of common goals; for example, an intellectual attempt that is creative in nature by sharing knowledge, learning and building consensus. Collaboration is defined as "a process through which parties who see different aspects of a problem (or issue) can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (Borden, M. & Perkins, D; (1999)).
For the purpose of this research, collaboration is looked at the way staffs at ADP level work together since the WVT goal is the same.

1.8.3 Rural Development Competences

Competencies are meaningful clusters of knowledge, skills and attitudes that are neither explicitly nor externally obvious, but become apparent in concrete actions in specific contexts (Mulder, 2001). In www.businessdictionary.com; competence is define as the cluster of related abilities, commitment, knowledge and skills that enable the person to act effectively in a job or situation.

[7] Multisectoral response to HIV/AIDS in this research refers to the joint efforts of all sectors in WVT at ADP level to respond to the epidemic; it is not the joint effort with outside organization.

For the context of rural development competences to deal with developmental issues in the era of HIV/AIDS; refers the knowledge on HIV/AIDS (the sources of infection, how it spreads, methods of prevention, its impacts and the tragedy that there is no known cure for it), rural development staff altitude (for this case ADP staff) towards the epidemic and skills to deal with complicated issues posed by the epidemic.

1.8.4 Vulnerability to AIDS impact

Vulnerability is defined with different people at different context. In respect to Karuhanga, (2008) vulnerability is defined generally as inability to cope with stress or adversity. It describes those features of a society, social of economic institution or processes that makes more or less likely excess morbidity and mortality associated with disease will have negative impacts (Barnett,T; Whiteside, A; 2006).

In this study, vulnerability means being without adequate protection open to physical or emotional harm, extremely susceptible, easily persuadable or liable to give in to temptation, physically or psychologically weak thus unable to resist illness, debility or failure, open to attack or possible damage.

1.9 Conceptual Framework.

The conceptual framework presented below gives an illustration of the thoughts in linking the rural development professionals and the impact of AIDS in the community. It brings the theoretical thinking of the relation between rural development professionals' competences, collaboration and Multisectoral response to the epidemic. The idea behind the concept is; bringing together rural development competences, organizational change and collaboration will lead to Multisectoral response to HIV/AIDS. Then the result is community development. Without putting emphasis on Multisectoral response to the epidemic is certainly that there will be no development in the community hence vulnerability to the impact.

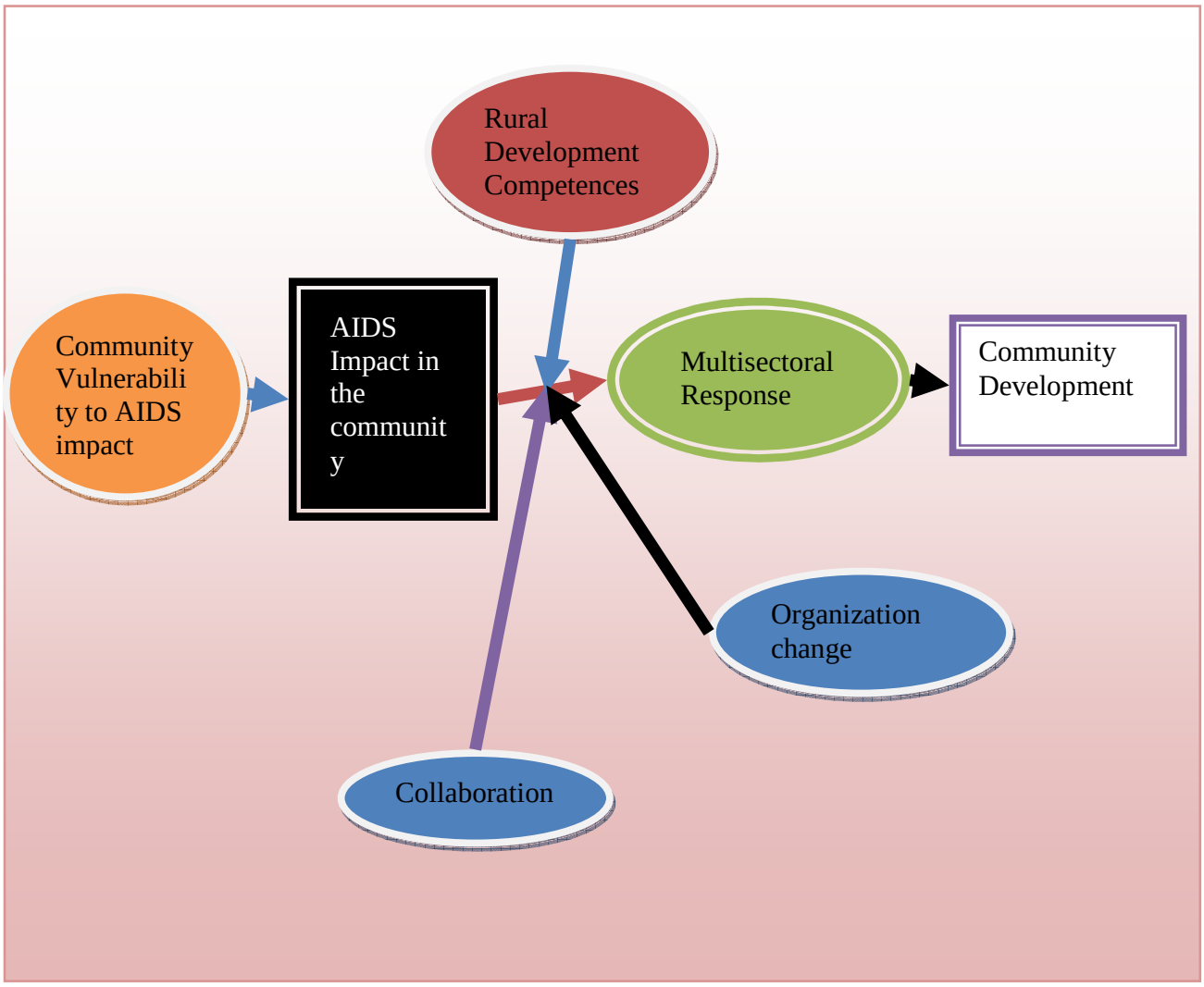

Fig. 1 Conceptual frame work

2.0 Literature Review

Within the previous chapter the background of the study, problem definition and objective of the study was highlighted.
This chapter starts with a literature review on theoretical approaches that explain the concept of; Multisectoral response, collaboration and vulnerability of AIDS impact competences. It tells the application of these concepts in this study.

2.1 Why Multisectoral Response?

The impact of AIDS in agriculture and food security, education, health, infrastructure transport and mining, private sector and economic impact impose the new challenge to development worker. Lule, E; 2007 in his work (ACTafrica) pointed out that the drivers of epidemic like;

- poverty and social exclusion,
- gender inequalities,
- conflict,
- violence,
- culture and social norms/practices and
- Labor mobility and transport/trade corridors; bring about HIV/AIDS to be Multisectoral issue hence need Multisectoral response (Gillespie, S. 2005)

Multisectoral approaches to HIV/AIDS are those seeking to reduce HIV prevalence, provide care and treatment to persons living with HIV/AIDS (PLWHA), and mitigate the impacts of the epidemic on affected populations by employing an appropriate mix of health- and non-health-based interventions and involving a broad array of stakeholders in their design and implementation. Further it involves all sectors of society, governments, business, civil society organizations, communities, PLWHA at all levels in addressing the causes and impact of HIV/AIDS. It requires action to engender political will, leadership and coordination, develop and sustain new partnerships, strengthen capacity of all sectors to make an effective contribution. It has to be dynamic, flexible, strategic and coordinated (Gavian, S.et al . . . & Lule, E; 2007)

In this study Multisectoral response to HIV/AIDS is looked at the contribution of different sectors like agriculture, education, water & sanitation, health and HIV/ADS operating within the same ADP.

The previous study suggests that the crucial problem is that staff who are working outside the health sector; they are often uncertain about what should be done. Even individuals who have been allocated budgets openly aimed at tackling the impacts of HIV/AIDS on either agriculture or/and education are often uncertain about how best to use such funding. This raises the question as to whether current knowledge concerning effective means of addressing the social and economic impacts of HIV/AIDS is sufficient (Commonwealth Countries, (2003)). At the same time, however, many local initiatives are now tackling the effects of the epidemic on rural communities. A key problem appears to be that information about such interventions is not widely disseminated. Personnel have limited time and resources to analyze and write up their work so the lessons learned from project successes and failures are not shared, and experiences at grassroots level do not reach key decision makers. (White J; & Morton,J; 2005)

> *As can be deduced; the main reason we need to shift our thinking when coping with HIV/AIDS is because we now need new solutions, mental frameworks and tools for these old problems (Hemrich, G. & Topouzis, D (2000))*.

It is not to undergo different strategies or implement different interventions, but rather to address them in a different fashion; how will these efforts not only impact you and your sector immediately, but in addition, how will they impact others in society (directly and indirectly). Shifting our sectoral and institutional thinking and behavior will be working towards the same goals as listed above (AAHAPCO & UNDP (no date)).

The success of development actors in the community depends much on the knowledge transfer. The knowledge transfer is believed to be more effective if the recipient is prepared to receive and is able to apply the received knowledge. In the era of HIV/AIDS most of the affected households are not able to attend even normal village meetings due to lack of time (more time they spent to take care the sick person) and stigma. Elsey,H; & Kutengule,P;2003 in their work on HIV/AIDS mainstreaming, pointed out that badly affected people and households can become invisible to development interventions, as they do not participate in many activities.

Furthermore, Multisectoral response does not end up at the level of involving all sectors (in this case ADP sectors) to respond to HIV/AIDS; rather it goes beyond to the level of do no harm. This is due to the fact that the presence of the epidemic can lead into some development activities to cause susceptibility to infection of HIV and leading into more vulnerable to the impact of AIDS. When exploring HIV/AIDS mainstreaming Elsey,H; & Kutengule,P;(2003), looked at some intervention in agriculture and education which can cause the community more susceptible to HIV infection and vulnerable to AIDS impact.

In case of agriculture they argued that, increased agricultural output, particularly for cash crops can increase vulnerability as cash is spent on drinking, entertainment which may result in un-safe sex. Men's control of cash exacerbates this situation and leaves women vulnerable to exchanging sex for commodities/services, as they don't have enough cash themselves. In case of education, combining primary and secondary schools exposes younger children sexually active pupils hence susceptible to HIV infection and lack of adequate sex education in the school curriculum, especially on self-esteem pupils not equipped to say no to unwanted sex or have safer-sex.

2.2 Collaboration

Collaboration is a self-repeating process where two or more people or organizations work together in an intersection of common goals; for example, an intellectual attempt that is creative in nature by sharing knowledge, learning and building consensus. Collaboration is defined as "a process through which parties who see different aspects of a problem (or issue) can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (Borden, M. & Perkins, D; (1999)).

Technically, collaboration is a process of participation through which people, groups and organizations work together to achieve desired results. Most of collaboration requires leadership, although the form of leadership can be social leadership within a decentralized and classless group. The literature point out that; teams that work collaboratively can obtain greater resources, recognition and reward when facing competition for finite resources. The goal of collaboration is to improve performance in current and future programs

For the purpose of this research, collaboration is looked at the way staffs at ADP level work together since the WVT goal is the same. The present of epidemic in the community call for

collaboration among sectors in the organization which is dealing with community development work like WVT. It should be noted that a multi-sector collaboration is a partnership formed by representatives of sectors to solve problems that impact the whole community. According to the literature, multi-sector collaboration efforts emerged in response to complex issues where conventional approaches were not working (Borden, M. & Perkins, D; (1999)). Further the literature pointed out that, many individuals and groups recommend working together to form strong problem-solving collaborative relationships to improve the present status and future well-being of children, families, and the communities in which they live. Moreover, many local, state, and federal children, youth, and family initiatives now require collaboration among multiple sectors (Borden, 1998 and IBM, (2008)).

Table: 1.The level of relationship which lead to collaboration.

The levels of relationship which lead to Collaboration			
Levels	**Purpose**	**Structure**	**Process**
Networking	Dialog and common understanding: Clearinghouse for information and Create base of support	Loose/flexible link: Roles loosely defined and Community action is primary link among members	Low key leadership: Minimal decision making, Little conflict and Informal communication
Cooperation or Alliance	Match needs and provide coordination: Limit duplication of services and Ensure tasks are done	Central body of people as communication hub: Semi-formal links, Roles somewhat, defined, Links are advisory and Group leverages/raises money	Facilitative leaders: Complex decision making, Some conflict and Formal communications within the central group
Coordination or Partnership	Share resources to address common issues: Merge resource base to create something new	Central body of people consists of decision makers: Roles defined, Links formalized and Group develops new resources and joint budget	Autonomous leadership but focus in on issue: Group decision making in central and subgroups and Communication is frequent and clear
Coalition	Share ideas and be willing to pull resources from existing systems: Develop commitment for a minimum of three years	All members involved in decision making: Roles and time defined, Links formal with written agreement and Group develops new resources and joint budget	Shared leadership: Decision making formal with all members and Communication is common and prioritized
Collaboration	Accomplish shared vision and impact benchmarks: Build interdependent system to address issues and opportunities	Consensus used in shared decision making: Roles, time and evaluation formalized and Links are formal and written in work assignments	Leadership high, trust level high, productivity high: Ideas and decisions equally shared and Highly developed communication

Source: Adapted from Community Based Collaborations- Wellness Multiplied 1994, Teresa Hogue, Oregon Centre for Community Leadership.

In order for collaboration to take place, the following factors are very essential (Borden, M. & Perkins, D; (1999);

Note; according to literature, these factors were meant for community collaboration, however, for the purpose of this study many of them were adapted and suited for ADP staff collaboration while some were not.

- Leadership: Staff collaboration requires effective leadership. The leadership for successful collaborations is broadened to include those who impact change within group and/or organization.
- Communication: Collaborative efforts are dependent upon open and clear communication. Norms of communicating must be established which assure "language usage" which is acceptable to all members.

- Research and Evaluation: Obtaining and utilizing information is essential for collaborative groups. The effect of meeting the desired outcomes is the primary objective of a collaboration evaluation. Data must be collected which establishes benchmarks for future impact and outcome analysis.

- Sustainability: In order for collaborative efforts to be sustainable, it is essential that systems be instituted to provide sustained membership, resources, and strategic program planning.

- Connectedness: Connectedness refers to the linkages between individuals, groups, and organizations. That is, how people know each other or how they are connected to one another.

- Policies/Laws/Regulations: Solving problems collaboratively means transforming and changing Policies, Laws and Regulations. Collaborations are more likely to succeed when supportive Policies, Laws and Regulations are in place.

- Catalysts: Catalysts get the collaboration started. The existing problem(s) or the reason(s) for the collaboration to exist must be viewed by potential collaboration members as a situation that requires a comprehensive response.

2.2.1 Foundation for collaboration.

There are four foundation of collaboration namely Vision, Commitment, Leadership and Action.

- Vision: This refers to what the collaborators want to accomplish and how they will use the collaboration to get there.

- Commitment: there should be pledge to attain specific goals and benchmarks and to enhance the collaboration.

- Leadership: the quality leader should include personal commitment, enjoyable involvement and determination to achieve the goals and benchmarks vital to the development and operation of the collaboration

- Action: there should be a plan to accomplish these goals and benchmarks, including responsibilities, resources and deadlines

2.2.2 Challenges for Collaboration

According to the literature there are Eight challenges for collaboration which are resources, commitment, turf, conflict, respect, diversity, communication and facilitator;

- Capital: Lack of ready funding resources and skill in creating new financial resources
- Dedication: Resistance to involvement and commitment from key community sectors
- Turf: Turf issues, often stemming from a lack of trust
- Conflict: Personality conflicts within the collaboration
- Respect: Building respect, understanding and trust
- Diversity: Gaining an appropriate cross section of partners
- Communication: Maintain open and frequent communication
- Facilitator: Insuring a skilled facilitator is engaged with the group

2.3 Vulnerability of AIDS impact

Vulnerability is defined with different people at different context. In respect to Karuhanga, (2008) vulnerability is defined generally as inability to cope with stress or adversity. It describes those features of a society, social of economic institution or processes that makes more or less likely excess morbidity and mortality associated with disease will have negative impacts (Barnett,T; Whiteside, A; 2006). In this study, vulnerability means being without adequate protection open to physical or emotional harm, extremely susceptible, easily persuadable or liable to give in to temptation, physically or psychologically weak thus unable to resist illness, debility or failure, open to attack or possible damage. It looked at in line of social and economic position of clientele in the present of HIV/AIDS.

In this study, vulnerability is basing on the ability of households to cope with the effects produced by HIV/AIDS. The ability to cope depends on the household's or individual's capacity to deal with the crisis (Barnett,T; Whiteside, A; 2006). The magnitude of vulnerability to impact of AIDS can easily be amplified by the presence of other shocks in the community like earthquake floods and drought.

Karuhanga (2008) in his work pointed out that the level of vulnerability to HIV/AIDS impacts to household characteristics like; household size, age of household member infected, household asset base, nature of support net work engaged, community characteristics (that is socio-economic and socio-political factors). Therefore, it can be said that household resource-based status, existing social support/cohesion networks, prevailing socio-economic and political environment as well as government non-government and private institutional support are important determinants of capacity respond to a given crisis and consequently the ability to recover (bounce back from shock). The vulnerability caused by the impact of AIDS can be felt differently at different category of society composition. FAO, 2004; in the article with title; Addressing HIV/AIDS through Agriculture and Natural Resource Sectors pointed out that the following category of groups are feeling more impact of AIDS;

2.3.1 Individuals and households level

Those most vulnerable to the impact of AIDS include:

- resource-poor men and women with few resources or social networks to fall back on in times of crisis and few livelihood alternatives;
- households that have already lost at least one key family member to the disease and have had to sell household assets to care for them, and are compromised in their ability to care for another;
- orphans without anyone to care for them;

- women who have to give up their usual livelihood to care for the sick;
- widows with weak control of household resources and who risk losing them to other family members;
- The elderly who are caring for sick children or orphaned grandchildren.

Furthermore, HIV/AIDS vulnerability is more gendered because of the gender hierarchies in the development processes that result in a differential ways in which women experience marginalization and discrimination compared to men. Also it causes breakdown in social ties, lack of protection against hardship created by divorce, desertion, widowhood (World Bank, 2000; Karuhanga, 2008). HIV/AIDS induce changes by creating large number of orphans, child and female headed households and inter-household labor system are of particular importance since this influence household labor availability for agricultural production and other income generating activities for sustainable livelihoods.

2.3.2 Community level

Factors that make communities more vulnerable to the impacts of AIDS include:

- weak social cohesion and an absence of social networks and labor exchange between households to provide support to each other in times of crisis;
- limited opportunities to substitute between labor intensive livelihood activities and activities requiring fewer labor inputs;
- limited opportunities to diversify livelihood activities into non-farm employment;
- regular experiences of food insecurity;
- insecure land tenure and weak system of property rights;
- widespread poverty;
- limited access to external support such as information, home-based care, food for work, school feeding program;
- weak infrastructure which makes many aspects of rural living very labor intensive, requiring household members to travel considerable distances – often on foot – to collect water, seek health treatment etc;
- Advanced state of the epidemic which has exhausted any tradition of welfare assistance within the community.

Thus, this is a framework for the study to determine the capacity/level of competence of community development worker (in this case ADP staff in WVT) to address development in the crisis of HIV/AIDS.

The main impact of AIDS induced morbidity and mortality can be described as the disruption of the household productive domestic labor interface, which in rural income, which is mostly, dominated by agriculture, primary affect women (White; & Morton, J; (2005)). For example, in Sub Saharan Africa, eighty percent of economically active women work in agricultural sector and the share of female agricultural labor is increasing rapidly (World Bank, (2002) & Karuhanga,.(2008)).

Traditional (stereotype) gender roles have resulted into HIV/AIDS producing differential impacts with women experiencing the heavier burnt. Because women are traditional care providers, the burden of care for AIDS patients and AIDS orphans automatically fall on them (Karuhanga,B; (2008)). In a study carry buy UNDP, 2002; showed that 85% of single parents' orphan households were headed by female. Time spent in care provision also means time foregone in participating in income generating activities with consequences of increased household poverty, food insecurity and possibly of engagement in risky behavior hence vicious cycle of HIV/AIDS and poverty (Barrnett, T & Whiteside, A (2006)).

3.0 Research Methodology

The chapter give description of study area, explains about the study design, discus the criteria for selection of respondents and tells about data collection and analysis methods. At the end, it discusses the limitation of the research

3.1 Study area.

The research was conducted in three (3) ADPs located in three different districts, three different regions within World Vision Tanzania - Northern Zone;

- Kingóri ADP found in Arumeru district – Arusha region
- Nakombo ADP found in Same district – Kilmanjaro region
- Ruvu Remiti ADP found in Simanjiro district – Manyara region

3.1.1 Criteria for selecting these districts.

The three aforementioned ADPs are located in northern regions of Tanzania where the districts were sampled. The inhabitants of the three districts are of different tribes/ethnic groups (maasai - simanjiro, meru - Meru and pare - kilimanjaro). They speak different local language and practicing different livelihood strategy. The rationale for the selection was guided by the distance of the ADP from the head office, the age of the ADP, the accessibility of the ADP from head office and the number of staff for the ADP. It has been the traditional that most of the ADPs near head office are the one cared more compared to those very difficult to access them. For the purpose of this research, the author focused to found out if the criteria have any relation with the competences of ADP staff to address development issues in the present of HIV/AIDS. Ruvu Remiti ADP is the most difficult program to be accessed by visitors hence being in a risk to be forgotten followed by Nakombo ADP; while Kingóri is very close to head office.

The three ADPs are aging between 6 years to 11 years which in WVT they are called matured ADPs. All programs in these ADPs are taking place, thus the staffing is at maximum level i.e. all department have adequate staff. The ADPs of at least that age must have HIV/AIDS budget which is 15% of the program total budget. The age criteria was chosen in this methodology because of the assumption that being in the community for a long time helps to internalize the community socially and economically. Also for staffs being in the program for many years is assumed that they accessed enough on job trainings hence their competences to deal with development issues in the presence of HIV/AIDS is good.

3.2 Research Design

A qualitative case study was conducted in Kingóri, Nakombo and Ruvu Remiti ADPs. The study focused mainly on ADP staffs who live close to the community. This is because the author would like to use the opportunity for them being close with community as the strength of the ADP to address HIV/AIDS related issues in the entire community.

The research initially was planned to sample the interviewee as follows;

- 15 customer relation service secretaries from each ADP
- 3 nurses from three ADPs
- 3 community facilitators from each ADP
- 3 program coordinators from three ADPs
- 3 focus group discussion from three ADPs
- 1 key informant from zonal office; this is the HIV/AIDS, Malaria and Health zonal coordinator, hence for the purpose of this research, it is assumed that this person is in the

position to explain HIV/AIDS issues in the zone and to have the answers on the strategies of the zone to deal with the epidemic through indirect response.

- 2 informants from national office. One is the manager for HIV/AIDS, malaria and Health hence being able to explore the strategies at national level on how to mitigate the impact of AIDS through indirect response. The second one is the operation director; all ADPs are under the control of the director. This was sampled to share the ideas of collaboration among staffs at the ADP level. The purpose was to know whether there is the formal structure at the ADP which can lead to collaboration among staffs hence responding to the epidemic through Multisectoral approach.

During the familiarization time it was noticed that there are some staff does no longer exist in the ADP due to re-structuring process of the organization. Below became the real plan for my research;

- 9 customer relation services secretaries from each ADP because the number was big, not to be affordable with time limit
- 1 nurses from one ADP because in two ADPs their nurses got redundancy
- 2 community facilitators from each ADP because one facilitator got redundancy
- 3 program coordinators from three ADPs
- 4 focus group discussion from three ADPs because during the discussion I found interested to interview the group of PLWHA so as to know the type of support they got from the ADP
- 4 key informant from zone office because when I interviewed the planned informant, gave me answers which refers to other zone staff; and after interviewing the second informant I got contradicting information; thus I was forced to go for the next two.
- 2 informants from national office

3.2.1 Selection of respondents:

Random selection of 15 customer relation services secretaries from each ADP were done in collaboration with the program coordinators. Key informants were selected due to the category of their responsibilities and focus group discussion considered the fair representation of whole area within the ADP.

3.3 Data Collection

The data was collected in four stages: staff interviews, key informant interviews, observation and focus group discussion. Before data collection a check list of unstructured questions was developed. I took 5 days (one week) to do the following activities;

- The first and second day I went to WVT national office to seek permission for doing research in the organization and also to make an appointment with key informants.
- The third, fourth and fifth days I did pre-visit to the research ADPS to meet the program coordinators in order for them to arrange for me the focus group discussion and to inform their staff about my interview.

3.3.1 Semi-structured interview

The sampled customer relation services secretaries, nurses, PFs and program coordinators were interviewed through semi-structured interviews using pre-formatted check lists. The interview included;

- Personal work responsibilities
- Overall knowledge of HIV/AIDS
- Overall knowledge of AIDS impact in the community they work with and how it affects their work.

- The strategy they use to deal with the impact
- The gape in their competences and
- The organization room for change

The detailed interview checklist see appendix 1

3.3.2 Key informants.

Interviews were also administered to 4 key informants from zone office and 2 key informants from national office. From zone I interviewed Sustainability Coordinator (the position is there to make sure that all programs should continue running even after ADP phase out), Zone coordinator for HIV/AIDS, health and malaria (the position is there to address all issues related to aforementioned sectors), the zone customer relation services secretaries officer (the post is there to supervise all sponsorship issues at zone level) and zone monitoring and evaluation coordinator. The most interesting thing is that; these four informants together form one committee namely Zonal Monitoring Team (ZMT). Furthermore, the two key informants from national office were HIV/AIDS, Health and Malaria manager (the position is there to manage all aforementioned sectors in the whole country) and Operation Director (the in charge of all ADPs in the country). Interviews with key informants focused mainly on;

- Overall knowledge of AIDS impact in the community they work with and how it affects their programs.
- The overall knowledge on HIV/AIDS mainstreaming and Multisectoral response
- The strategy they use to deal with the impact in the community
- The gape in the staff competences to deal with HIV/AIDS issues
- The type of trainings they provide to ADP staff to build their competences on dealing with the epidemic when they do their field work
- The organization room for change

3.3.3 Focus group discussion

Three ADP committees were interviewed through focus group discussion to know their mandate during planning of the program activities, monitoring and evaluation. The criteria used were their representation of the whole community within ADP operations, their knowledge about ADP work and the great experience they have in the community. One group for PLWHA was interviewed form Ruvu Remiti ADP. This was not planned but due to the feedback I got from focus group discussion (on the assistance the ADP provide to PLWHA groups) I decided to sample the group. The information I looked for, were the type of support they have already received, their opinion about that support and what further should be done by the ADP in order for them to stay independent.

Table: 2. Summary of Respondents, category and method of data collection

Number of respondent	Category of respondent	Method of data collection
27	Customer relation service secretaries. They monitor the data of sponsored children.	Semi-structured Interview
3	Program Coordinators. They are the in charge of all programs in the ADP	Semi-structured Interview
6	Community facilitators. They are the implementers of programs per sectors in the ADP	Semi-structured Interview
1	ADP nurse. Responsible for sponsored children health	Semi-structured Interview
4	Focus group discussion. Responsible for planning, implementation and evaluation of the program.	Focus group discussion guide.
6	Key informants.	Checklist

3.4 Data Analysis

Data collected was analyzed using 12 - boxes framework and Matrix tools of data analysis. 12–boxes framework is the tool used to analyze the organization and programmatic strength and limitation on HIV and AIDS from gender perspective. Further it priorities for action to respond to and manage HIV/AIDS in the workplace and in the program work. The analysis leads to more commitment, understanding and energy for staff. Among 12-boxes, only three were used in this analysis which is boxes 10, 11 and 12. The choice of these boxes was guided by the nature of the research; which is external mainstreaming of HIV/AIDS. These boxes analyses the ADP in terms of program design, decision making and actions taken in the program (ADP) and the staff beliefs and behavior towards the community.

3.5 Limitation

The period was within the last quarter of the year according to WVI calendar, hence everybody was busy to finalize the activities. Actually this time is where a lot of queries are coming from donors. This situation made my work to be accomplished later than what I planned.

The procedure to get permission to do the research took me four days instead of two days as I planned. This is due to the absence of some officers and bureaucracy of the organization itself. This led to have short time in the field as I planned.

Another limitation was the period given for the data collection and report writing for this thesis, it did not cater for 4 days (to and from Netherlands) involve in travels.

4.0: Results and Discussions

Introduction

This section presents findings from the study with discussion. It is presented as follows: it starts with the ADP labor and processes. This sub-chapter discusses the issues of planning procedures; recruitment and trainings; the link between the epidemic and ADP sectoral work; the criteria applied for selection of clients per sector and the room to maneuver for ADP staffs. The sub-chapter finalizes with ADP staff and work organization. The chapter ends with the competences of ADP staff in terms knowledge, altitude and skills in the aspect of AIDS impact as the challenge in development work. It explains what the staffs have and what they do not have by picking their opinions.

Findings presented in this chapter are responses from ADP staff (N=37), discussion group and key informants. If the information is from either of the aforementioned category will be indicated.

4.1 ADP labor and processes.

4.1.1 ADP planning procedure

The respondent from focus group discussion said, they have five year plan which they are following, thus their committee meet few month before the starting of the following year to check if there is some variation to be made in the annual implementation plan. All sector heads (program facilitators and customer relation services in charge) responded that; they participate in this period of checking the suitability of the plan although their level of participation varies. From customer relation services department they responded that; their participation is not very live because their work are standardized from partnership[8] office so they just follow the instruction.

> *It is true that the program coordinator want me to participate in the planning period but I feel like I am wasting time because everything in our department is planned by partnership office. I wish they could leave me to continue with other duties (said one of the staff).*

Staffs continue to speak out that, their participation is to give their opinions in respect to their sector need. Further they urged that, there is no guarantee for their opinion to be taken which gives them less motivation to participate. This implies that, heads of sectors are implementing things in the field which some of them they did not participated to plan or/and to check the plan. The literature explains that, multi-sectoral response should be done by partnering and/or collaborating among sectors. For that reason, if the participation of implementers is questionable, alerts the difficulties in implementation through multi-sectoral approach.

This case was different for one ADP whereby community facilitator for HIV/AIDS and community facilitator for agriculture responded that, during the planning period they are fully involved step by step. All of them come together to make sure that they share plans from each sector. Further they urged that; this is done to reduce repetition of work hence minimizes the cost of operation. Respondent from the ADP (HIV/AIDS facilitator) said;

[8] Partnership office is the World Vision international office coordinating all organization issues in the world.

If I have a plan to train farmers on nutritious crops and the head of HIV/AIDS sector is planning to train the community on importance of nutrition to build body immunity for PLWHA; we normally decide to combine the training which I hope reduces the cost.

Coming together during planning period can be regarded as a road map to multi-sectoral response of AIDS impact mitigation. What is happening in this ADP is the result of connectedness which according to Borden, M. & Perkins, D; (1999), refers to the linkages between individuals, groups, and organizations. In order for this situation to happen, there should be who are connected and know each other. However the system of planning at this ADP was found to be informal. Further the literature revealed that; the lack/absence of policy mandate is among the constraints for multi-sectoral approach (Hemrich, G. & Topouzis, D (2000)). It was the desire of sector heads to meet and discus thus there is no binding regulations to the sector head who does not want to collaborate. This was verified by other ADPs where they are not doing the way that ADP do.

4.1.2 ADP Staff Recruitment and Trainings.

The focus group discussion revealed that the employment criteria for ADP staff are academic qualifications, working experience, the status of Christianity and being residence of the ADP area (being residence in the ADP area is due to the fact that the employee of the ADP are supposed to come from the same area where the program is operating). After recruitment they undergo orientation[9] which they said they do not know for how long the orientation took place. When there is a vacancy, the ADP chairperson advertises the post and the qualified candidates apply. After recruitment the new staff report to the ADP and the head of the specific sector is responsible for orientation (said in group discussion). The interview with staff shows that, the time for orientation is too short compared to the specific responsibility of the new staff. This implies that there are a lot of errors in the field being done by new staffs. If the staff is customer relation services secretaries, he/she will be introduced to issues related to customer relation services secretaries and in very rare cases the organization mission, vision and core values will be introduced as well. The result shows on how it is difficult for the staff from one sector to know the happening in another sector. One staff said that;

Sometimes it is very shameful when we are in the community because when a community member asks me about agriculture sector I cannot provide any information.

To have staffs at the community level seems to be among the strengths of the organization by assuming that all staff can play the role of bringing the good news of development in the community. This was witnessed by staff themselves during the interview where they declared that the community members face them frequently seeking for advice. The direct contact with the community is the great potential for them to disseminate good news to the target group. But if the ADP staff have not equipped with the proper knowledge about the epidemic, they will fail to deliver/educate the community appropriately. This might lead to the confusion in the community or/and loss of trust to the organization. Thus the good package of knowledge about any issue therefore can be more helpful to both the ADP staff and the community. Out of 37 staffs, 23 (62%) suggested that, it is better for a new staff to be passed through all programs in the ADP so that in case something happen, she/he will not be empty minded.

More over this can be the good start of multi-sectoral response in the era of HIV/AIDS. A lot of literatures wrote about the wide impact of AIDS, which is imposing the new demand of

[9] Orientation in world vision is the relation training offered to new employee immediately after employment

personal and organizational competences to handle. For example UNAIDS (2004e) brings together five strategic pillars as the way of addressing the issue of AIDS orphaned children. The pillars are strengthening family capacity, mobilizing community-based responses, providing essential services improving policy and legislation, and advocating for a supportive environment. Note that, there is no pillar which can stand on its own, they depend each other, so we need ADP staff that can collaborate with other sectors to respond to the epidemic, by equipping him/her the capacity to integrate others capacity in his/her work. This can be built up during the orientation period/ recruitment period.

In response to recruitment procedure, three key informants at zonal level declared to have no formal package for orientation to new staff at ADP level. Also they urged that; the training provided during the orientation and on job training is more specific to the sector and not multi-sectoral. The table below summarizes the type of trainings conducted for ADP staff in respect to their category.

Table: 3. Type of training in respect to staff category.

Number of Staffs (N=37)	Category of staffs	Type of training attended in 3 years time.
19	Customer relation service secretaries	Introductory letter writing, step exercise and photo taking techniques. (All these trainings are customer relation service secretaries issues) and cross-cutting themes[10].
3	Customer relation service in charges	Introductory letter writing, step exercise and photo taking techniques. (All these trainings are customer relation service secretaries issues) and cross-cutting themes.
1	Nurse	Immunization procedures, top ten diseases, refresher course on symptoms of malaria and cross-cutting themes.
2	Community Facilitators for agriculture, community based organization, village community bank	Principle of organic farming, formation of community based organization, formation of village community bank and community entry point strategies and cross-cutting themes.
3	Community facilitator for HIV/AIDS, health and malaria.	How to deal with stigma in the community, channel of hope, HIV/AIDS basic knowledge and cross-cutting themes.
3	Program coordinators	Budgeting procedures, new format on report writing, proposal writing and all mentioned to other staff they are also attended

Note: six (6) staffs reported to attend no training/ workshop because they are just employed (less than six month in job).

[10] To the context of WVT cross-cutting themes are emergence and relief disaster mitigation, Christian commitment, gender, advocacy and environmental conservation.

From the table above, it can be noted that there is no training which was aimed to cut across other sectors except for cross-cutting issues. If the training is about HIV/AIDS, they would like to see HIV/AIDS facilitators only. This seems to limit the chance of collaboration among staff since they are more equipped in their individual sector and there is no room for integration with other sectors.

Hemrich, G. & Topouzis, D (2000) in their work, constraints and opportunities for technical co-operation, pointed out that sector based structure and donor sectoral funding plays a big role to hinder multi-sectoral response. For example one of the staff said; *I am very lucky because I attended the workshop of Channel of Hope*[11]; she said the workshop made her capable to deal with issues related to HIV/AIDS. On following the content of the workshop, the study noticed that the material is suitable for all ADP staff, thus to enroll them is of important. The key informant from zonal level explain that, there is no clear follow up on how to make sure that the people who are trained, they go and train others.

> *The cost to train all ADP staff is quiet big to be affordable by the organization, what we usually do, we select and train some of the staff so that they go and train others' (the key informant said)*.

4.1.3 The link between HIV/AIDS and sectoral work

The ADP staffs (respondents) were required to explain the linkage between HIV/AIDS and their sectoral work. PFs for agriculture revealed that agriculture require labor while HIV/AIDS erode labor by killing people at their productive age (15-49yrs). They continue to speak out that there is a change of their client from household head by male to household headed by orphans, teenagers and widows. These groups are playing an increasingly critical role in heading households and securing livelihoods. It should be noted that these social groups were excluded from agricultural support services, including government extension services. Also, young people, particularly orphans, are less likely to have benefited from hands-on training in agricultural methods from their parents and may not have considered farming to be a viable income-generating activity. The presence of the epidemic brought a new challenge which demand careful linking of ideas between agriculture sector and HIV/AIDS. Therefore the planning of any agriculture related service requires the great understanding of the link between the sector and HIV/AIDS. The literature shows that up to 80 percent of the population in some African countries depend on subsistence agriculture; crops, livestock and other natural resource products are the mainstay of economy and export earnings; and agriculture, forestry and fisheries provide vital safety nets (FAO, 2004 & Commonwealth Countries, (2003)).

> *When we sensitize the formation of Village Community Bank*[12] *(VICOBA) in the community we put emphasis on voluntary formation of groups with members not exceeding 30 people and not less than 15 members. Further we tell the community*

[11] Channel of Hope is the training or module which is provided to faith leaders so as to change their perspective and help PLWHA in the will of God. Also the module carters for those who are not leaders but they have negative perspective to PLWHA. It is intended to help PLWHA even if he/she denies himself/herself. To know how HIV is transmitted and how not; in such workshop among the output is to make people know that HIV/AIDS is for every person. To know the truth the vision of God about vulnerable people like widows, orphans and PLWHA.

[12] Village Community Bank is the financial institution located in villages and controlled by community. This is the initiatives of Tanzania government to help the poor and oppressed people in rural areas. The guarantee to join is the personal historical efforts in development work.

criteria for formation of groups so that they select a partner who is proactive in development issues, hard worker, physically and mentally fit, he/she is not a drunker, accepted in the community. In this kind of groups there is no possibility to accommodate PLWHA due to the fact that the community regards them as ghost and due to existing stigma they are not accepted in the particular community. Also due to their death sentence they will join the group and die immediately thus causing burden to the remaining members. The fellow members feel wise to leave them aside when forming VICOBA groups as the way to avoid the risk which should happen after their death. Moreover the affected household or individual normally do not come for such kind of meeting due to existing stigma against them. (The staff explains).

On response to the question; what action do you take when you see the situation like that, he said "I real do not know because I came to know this situation after you asked me those questions". Haddad, L. & Gillespie in their work in effective food and nutrition policy responses to HIV/AIDS: what we know and what we need to know pointed out that; even when the epidemic is in its early stage the infected family is less able to avoid default and hence is less attractive to group-based liability schemes. Further Steely, J. (2002) in her work, thinking with the framework in the context of the HIV/AIDS epidemic revealed that; access to credit for PLWHA is something NGOs are now seeking to address. She further continues to say, like insurance and investments, who would lend money to someone who has an illness with a death sentence? Access to credit has never been easy for the poorest sections of communities, and seldom has it been easy for women.

One CRS responded that; within the community, they believe that we are there to provide help to the vulnerable group such as PLWA. When you go to collect child information, the house hold brought problems to you with expectations that you will solve them. If you fail to solve (especially those requires material support) you become the enemy of the household. They normally assume that because you know that they are affected by HIV/AIDS that is why you discriminate them. One ADP staff reported that he has been visiting the sponsored child without even knowing that the child is affected with HIV/AIDS. He said the community was not able to disclose the situation because they believed that if I know the situation I might stop visiting the child due to the myth that she is a ghost. I came to know that the child was suffering from AIDS related illness after her death. That is the time I realized the girl was left by their parents three years past due to AIDS related death. These findings gives the clear indication that there might be a number of orphans within the community whose their parents died from AIDS related diseases; and they are not disclosed due to stigma. This is adding another challenge in dealing with orphans due to AIDS.

4.1.4 Targeting criteria in sectoral work.

As indicated in WVT mission statement, the focus group discussion revealed that the targeting criteria for sectoral work are the level of vulnerability of the community. The vulnerability according to their definition is the poor and oppressed people in the community of which HIV/AIDS affected people are most likely to fall under this category. The literature shows that the death of household members for HIV/AIDS increases the probability of a household falling below poverty. The explanation for that is; as soon as one or more member become infected with HIV/AIDS-related conditions income falls as family members' ability to work diminishes, household living expenses increase due to increased costs on medical expenses, and funeral and mourning costs when the patient dies (Mwakalobo,A. (2003)). On how this targeting criteria impact PLWHA, all focus group discussion were explaining the work done by HIV/AIDS department for care and support to affected people. During the discussion, one member

argued that; the PLWHA have their own money, so it will not sound better for them to be accommodated in the budget for other sectors. This kind of statement implies the little knowledge prevailing among the community members about Multisectoral response of HIV/AIDS because when you talk about the epidemic they associate directly with cost involvement. In literature we found that Multisectoral does not require undertaking new activities, rather it should continue to focus on its core business but view it through the lens of HIV/AIDS (Gillespie, S. 2005). Moreover PLWA should not be reorganized as anonymous images on leaflets and poster, or people who only receive services but they can contribute to provide the useful feedback (renewing our voice: code of good practice for NGOs responding to HIV: edited by David Wilson, 2004).

There was no clear answer on how the agriculture sector for example plans their target to impact PLWA. In the interview with program coordinators, they revealed that; the entire community where ADP operates is regarded as the area with poor and oppressed people; there is no any special targeting for PLWA rather than the way department for HIV/AIDS is doing. All issues related to HIV/AIDS are directed to the responsible person (the person within the department), the same for issues related to my sector are directed to me (PF for agriculture said). Respondents from HIV/AIDS declared to work with affected household for care and support. They said "the type of support to the PLWA is mostly determined by the donor and not the people affected". One of the HIV/AIDS PF explains that last year the donor brought money for dairy cows for women living with AIDS while in literature it shows on how it is difficult for PLWA to take care dairy cow. Holden, S. (2004) explains that women affected with AIDS prefer quick return projects like gardening, poultry and small ruminants. On discussion with one of the beneficiaries of the support she said;

> *I thank God to bring ADP in this village because they gave me the diary cow and I am expecting to start milking soon. But it is very difficult for me to take care this cow especially in this dry season since there is no grasses nearby; thus I have to take care the cost of buying grasses for Tsh.15,000/- (equivalent to 7.5 euro) per week (one trip of land rover pick up). My opinion I could prefer more chicken because I will not suffer to collect grasses but do not tell them because something is better than nothing (she whispered to me).*

According to these results, implies that the set up of programs does not allow the Multisectoral planning hence becomes very difficult to target for HIV/AIDS. Further we learn that the targeting in the department of HIV/AIDS is not seen to be more effective especially for the donor driven projects.

4.1.5 ADP work organization

At the ADP work is organized per sector. The sector for agriculture for example is responsible to make sure the set objectives are achieved. All respondents in three ADPs declared to have their own specific sectoral goals. They responded that; if your sector is agriculture, you're responsible to make sure that at the end of the year you finish all activities as per budget. The supervisor (in this case program coordinator) makes his/her supervision in respect to sector. If the issue is related to a specific sector like education, the PF for education will be answerable. In all three ADPs they are dealing with similar sectors; which are agriculture, education, water and sanitation, health, HIV/AIDS and Malaria. Due to this sectoral structure, every staff is obliged to fulfill a certain objective. On collaboration issue the program coordinator responded that; the situation in World Vision Tanzania is very difficult to accommodate the freedom of staff to collaborate. The collaboration checklist results show that more than half of the staff

said they disagree with collaboration factors (19 in average). This implies that the factors for collaboration are not in the ADP. The results in the table show that there are 13 in average, people who reorganize the factors of collaboration within the ADP. This can be taken as the strength for collaboration in the ADP hence the road map for collaboration. The factor like goals found to have only three people; this is due to the fact that goals are developed mostly with World Vision staff hence being difficult for ADP staff to declare the goals. The three appeared in the results are program coordinators.

Table: 4. the checklist results for three ADPs on collaboration.

A collaboration situation in the sampled three ADPs					
Factors	Strongly Agree 1	Somewhat Agree 2	Neither Agree or Disagree 3	Somewhat Disagree 4	Strongly Disagree 5
Goals	3	6	0	10	18
Communication	30	3	4	0	0
Sustainability	0	0	0	0	37
Research and Evaluation	0	0	0	7	30
Political Climate	30	7	0	0	0
Resources	37	0	0	0	0
Catalysts	0	0	0	0	37
Policies/Laws/ Regulations	0	0	0	0	37
History	2	0	3	1	31
Connectedness	33	2	1	0	1
Leadership	1	0	3	5	28
Community Development	NA	NA	NA	NA	NA
Understanding Community	NA	NA	NA	NA	NA
Total & average	143/11=13	18/11=1.6	11/11=1.0	23/11=2.0	219/11=19.9

The results tell that the work to be done by individual staff is big to the level of not giving the room to spend time for other extra duties from other sectors. ‘sometimes you can afraid of taking the leave just because you want to make sure that your allocated budget is finished timely’ he said. Also as program coordinator, the frequent/main question my supervisor asks me is how are you going to do so that to finish the budget at the end of the year. All three program coordinators declared that there is no forum which gives chance for ADP staffs to share their works although there are some cases where community facilitator shares their duties, but that is not mandatory. The findings reflect that; ADP staff can get difficulties in coordinating their work hence failing to respond to HIV/AIDS indirectly.

Out of 37interviewee, 32 argued that the system of being specific to their sectors is good because the system makes everybody responsible to the assigned goals. Nobody should be answerable to somebody’s weakness. Among the remaining 5 respondents, one staff said; this system makes everybody to look for his/her own budget. When we fight to finish our budget sometimes we tend to overlook the actual impact needed to the community. That is why most

of the time our report at the end of the year is full of quantity than quality e.g. number of classrooms rather than the impact of having classrooms (said the respondent).

4.1.7 Room to maneuver for ADP staff.

The interview was aimed to know whether the ADP staff has room to maneuver at their work place. The result shows that the chance to maneuver is quiet limited due to the process supposed to follow. On answering the question on how emergence issues are handled when, happen to the field, all responded declared difficulties on handling them. We just present the issue to higher authority for them to respond because in some cases money is needed to solve a certain problem, if you attempt by using your own money, the procedure for refund will make you regret your decision (said one of the respondent). The focus group discussion revealed that whenever obstacle happens we advocate to the management so that they take action. The result shows that the presence structure in the organization limits the chance for maneuver. All informants argued to have no chance for maneuver due to the demand of procedures from top to grassroots. According to the literature, if the chance for maneuver is limited implies that the possibility for innovation and change is limited. The existing limitation of maneuver within the organization is called structure inertia as discussed in Rollinson, (2005) which says that;

> *'The structure of an organization gives it a strong element of stability which establishes regular patterns of behavior that go unquestioned in the minds of organizational members. Thus, they often become the way that things should be done. They also give people a feeling that things are predictable and create a strong force to maintain matters as they are'.*

Key informants agreed that the structure of the organization has a lot to contribute to the limited innovations and maneuver. World Vision Tanzania is a partner with World Vision International hence, everything to be done must be aligned with partnership requirements. Here is where challenges comes because the organization is working within the great variation of community nature worldwide; thus the procedure to make any change should consider the protocol from partnership office. This reflects that, the need to innovate a number of issues during the implementations like reorienting our programs in the glass of HIV/AIDS need consultation from partnership office. This becomes very smooth in operation if and only if the desire comes from top to the bottom.

4.2 ADP staff competence in terms of knowledge about HIV/AIDS.

4.2.1Transmission

The result shows that all were knowledgeable about the transmission methods with some little variation. All of them declared that transmission can be through unprotected sex with an infected person; contact with contaminated blood or other bodily fluids (such as semen and vaginal secretions) (for example, by sharing contaminated skin piercing instruments such as injecting needles, razor blades and safety pins, or open cuts and wounds, or by transfusion with infected blood); or from mother to child (during pregnancy, at delivery or during breast-feeding).

During the interview, all respondents mentioned unsafe sex as the main source of HIV transmission in Tanzania. According to literature, HIV is transmitted from one person to another mainly through heterosexual intercourse which accounts for about 80 per cent of all infections followed by mother to child which account to 18% (TACAIDS, 2008). The

knowledge was found to be different between the staffs dealing with HIV/AIDS as the sector and other development staff. The staffs dealing with HIV/AIDS were able to explain more clear about the epidemic facts than the rest. It should be noted that these staffs are only one in the ADP (PF for HIV/AIDS). The reason is the staff dealing with HIV/AIDS has access to training than other staffs.

Other ADP staff argued that the understanding they have about HIV transmission is coming from what they trained in schools, what they read in leaflets, pamphlets, seeing in television, radios and very few in internet. This was verified by key informants from zonal office where they showed not to have clear direction for training of HIV/AIDS to ADP staff.

4.2.2 Method of Prevention

The results revealed that the best way of prevention is to surrender the life to Jesus Christ. They explain that, being committed Christian you will be able to abstain and also being faithful in your marriage. About 6 staffs out of 37 staffs were able to talk about the use of condom as the prevention approach. These 6 staffs are those with access to attend HIV/AIDS trainings conducted by WVT.

The clear information about prevention to commercial sex worker couldn't come out because only 3 people were able to talk about supplying them with condoms. Others said nothing rather than being scared to talk about the issue (personal observation). Furthermore, the issue of prevention for men to men sex (homosexual) practice, nobody was able to explain anything except one staff said;

> *If a men sex with other men biblically is the greatest sin, I think they deserve punishment; so I wonder, why should we bother to prevent them? On my opinion, is better to preach them the word of God so that they change their lifestyle.*

According to this result, it seems there are some topic related to HIV is very difficult to be discussed in the organization. This is due to organization culture (the culture of Christianity which refers affected people with the epidemic as sinners). Failure to talk about HIV/AIDS openly is the great obstacle to multi-sectoral approach.

4.2.3 AIDS impact

The findings revealed that the impact of AIDS is well known to ADP staff to the extent that they took it as part and parcel of the community. Out of 37 interview 33 (89%) were able to explain the impact of AIDS at individual, house hold and at community level. Answers were checked by using the prepared checklist for the impact of AIDS in aforementioned three areas (See appendix 6)

Also they explored the way in which the impact of AIDS affects their daily activities. For example one staff (customer relation services secretaries) explains that;

> *When I go to the village, I am no longer comfortable because there are some people who are affected by the epidemic and once they see my motorbike they come and asking for assistance in terms of money or food. That is because they know that we are Christian organization therefore we must have sympathy for them. My opinion is to help them but the organization cannot give me the package of goods to give them, and if I fail to give them what they demand, they start saying bad thing to the organization. The*

*created bad image of the organization contributes to bring back the spirit of community contribution in development work which is supported by the organization***.**

On response to the interview, the respondent suggested to be equipped with counseling skills so that he will be able to talk with affected people in either circumstance. On deep interview with staff, the counseling referred in their context was more or less communication skills than the actual counseling skills. This was revealed by asking them on how they will apply their skills to the community.

The key informant at zonal level revealed that there is a great change in composition of ADP clients related to presence of HIV/AIDS in the community. There is an increase in number of children who head their house due to death of their parents through HIV/AIDS. This brought a big challenge in our sponsorship philosophy since we used to sponsor a child under the guardian and not a child heading a house. Moreover she argued that the impact of AIDS in sectors like agriculture, education, health and environmental protection made the work of the organization more difficult such that every year we perform under target. This happen because HIV/AIDS causes death to teachers for example, hence being not possible to achieve the goal of improving education.

Furthermore there is increasing cases of school dropout due to pressure in family resources. As a result of their shortened education, these young people were being left with limited means to support themselves, which increased the likelihood of their vacation to high-risk behavior, such as transactional sex, to secure basic goods and cash.

Most of respondents revealed that women, especially widows and grandmothers, are the caring for people living with AIDS (PLWHA). This becomes very challenging to them since they are responsible for securing household food and income. The key informants explain that, this group is the primary target of our work therefore our staff in ADPs should focus on this group. He could not provide the clear answer on the competence needed by the ADP staff to deal with such kind of people. However, the interview with staff, reviewed that, this group is facing critical resource and information needs so that to sustain their living.

The literature explain that, as a consequence of being widowed, women lacked the knowledge and resources needed to sustain the production of cash crops which had previously provided a vital source of income. In addition, their lack of access to credit, a long-standing constraint, had been exacerbated by the loss of male relatives who had had wider access to sources of financial support that had benefited the whole family (White, J. & Morton, J. April, 2005)

The zone informant continues to speak out that; the epidemic affects government officials such that, when they take care for their relatives, they normally not concentrate on fulfilling their responsibilities of serving the community. When answering the question on the specific strategies in place to address those challenges, the informant declared to have no clear strategy apart from what is done by the department of HIV/AIDS and malaria. It should be kept on mind that HIV/AIDS department is dealing only with AIDS work as per Holden, (2004) definitions.

The staff interview further revealed that their work is being disturbed due to the presence of the epidemic in the community. One of the staff explains that “it is very difficult to visit sponsored children in the presence of the disease”. Just imagine you find the house hold member is AIDS patient, and you want to know the data of the child; in actual situation you just postponed the activity hence you start the way back to the office or you decide to go to another family.

The focus group discussion revealed that HIV/AIDS is causing a lot of program to stack. That is because the big amount of money is located for HIV/AIDS hence reducing the budget to other programs. In the meeting one member said;

> **"***Now days our priorities are no longer implemented because of this disease. You found during planning the PC come with instruction from above that HIV/AIDS should be budgeted 15% of the total ADP annual budget. In the absence of the epidemic, that money could be able to construct two to three classrooms or one teacher's house which can accommodate two families".*

4.2.4 Knowledge on HIV/AIDS terminologies.

For the ADP staff to be model towards multi-sectoral response to HIV/AIDS, it is expected to have suitable competence not only in prevention, care and support but also the appropriate usage of HIV/AIDS terminologies. If the staff does not know the proper meaning of the terminology, it is very likely that he/she will not put into action the whole subject matter. Furthermore, by knowing the meaning of the terminologies put or/and will put the staff in a position to understand what they know and what they do not know. This reflected in my personal experience through the use of HIV/AIDS mainstreaming terminology while the work being done is HIV/AIDS work.

Moreover few ADP staff was able to explain the difference between HIV and AIDS (41%). Knowledge about the difference between HIV/AIDS is very important to ADP staff. Knowing such kind of terminologies helps an individual (in this case ADP staff) to think about HIV/AIDS in a wider range i.e. a person should take precautions in whatever cases without depending up on the symptoms of the infected person. Furthermore the staff could be able to deliver the proper message to the community as an alert for susceptible situation for new infection by explaining all phases of HIV and ADIS.

All key informants, program coordinators and community facilitators for HIV/AIDS were able to explain the difference with little variation to the sense that those dealing with HIV/AIDS as their core responsibility were able to explain better than those from other sectors. This aforementioned group is the once accessing workshops, trainings and seminars frequently than the rest. It should be noted that staffs who are not competent with such kind of terminologies are the once very close to the community (customer relation service secretaries) and their number is bigger (wide spread to the community).

The 8% of staff who know nothing, most of them are new employee, thus it is assumed that through the experience at work they will become aware about the terminology. This was due to the fact that the people dealing with HIV/AIDS are expected to have more knowledge due to their access to trainings compared to the other group. From these results we saw the direct picture on how the epidemic is dealt departmentally. The HIVAIDS in the organization is the business of the HIV/AIDS, malaria and health department people and not for all staff. For that view it becomes very difficult for some to talk about the epidemic while he/she is not coming from the HIV/AIDS department.

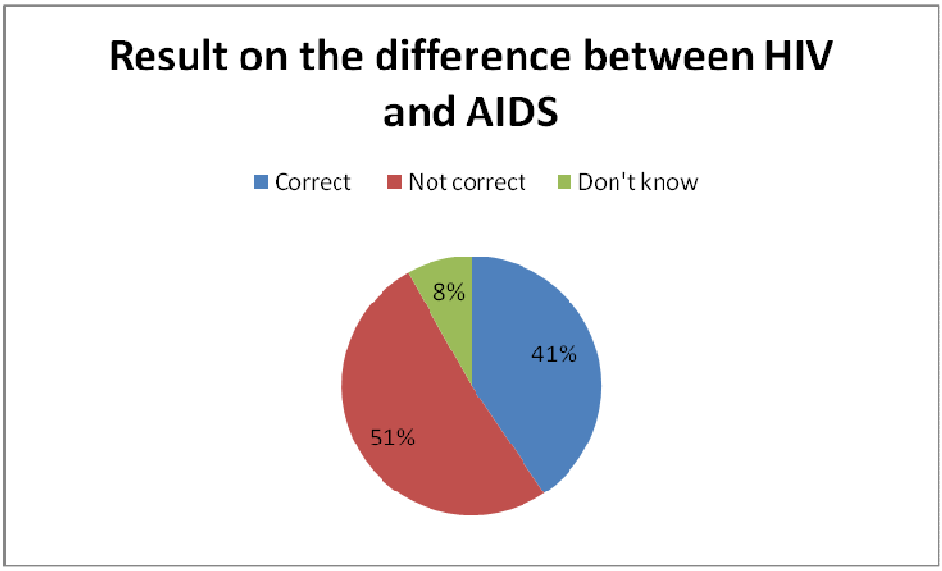

Fig: 2 Result on the differences between HIV/AIDS

The findings from all respondents shows that there is mixed understanding of terms used in the era of HIV/AIDS. Most of the respondents were using HIV/AIDS work and HIV/AIDS integration as the same thing. In responding to the interview, the respondent said; “during the sharing with staff dealing with HIV/AIDS he/she give me the names of affected people and it taken into consideration during the distribution of agricultural inputs”. Further the respondent said is due to fact that they were told from head office (here refers to Zone Office) to integrate HIV/AIDS and gender during implementations of our programs. One informant explains that, the purpose of the organization to have HIV/AIDS department is to integrate HIV/AIDS in its programs through prevention, care and support. Some of the work being done in the field are awareness creation, promoting ABC, facilitating PLWA to collect ARVs, supporting PLWA groups with income generating activities and sponsoring orphans. Having different meaning for the same terminology in the era of HIV/AIDS can bring the whole team of staff in a wrong direction hence bring constraints for Multisectoral response.

The literature shows that, these implementations to be HIV/AIDS work since they are being channeled within its own department and they are direct addressing the affected person through prevention, care and support (Holden, S. 2004). No respondent were able to explain the meaning of HIV/AIDS mainstreaming. It should be noted that the Multisectoral approach is found to be the more proper way to mainstream HIV/AIDS externally (NMSF, 2008). Therefore, to a staff responding through Multisectoral approach should be equipped with the knowledge of important HIV/AIDS terminologies as per aforementioned. (personal opinion).

However during the interview with key informants there was some strategy just put in place by the organization which gives elements of HIV/AIDS external mainstreaming. The informant explains that, currently they have Zonal Monitoring Team (ZMT). Among the functions of this team is to make sure that during ADP planning period, they pass through the annual operation plan to see how the activities are set in order to address the issue of HIV/AIDS susceptibility and vulnerability, gender and advocacy. Further she said they go through every sector like water and sanitation, agriculture, education etc. Without altering the primary purpose of the sector, they make sure that the aforementioned issues are covered.

To adapt development work in order to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS; which focuses on core program work in the changing context created by AIDS; ensuring that new and existing projects are relevant to that context and that they contribute positively to the wider response to HIV and AIDS and this is what Holden, S. (2004) define as external mainstreaming of HIV/AIDS. However the idea presented by this informant was not supported by any of the other respondents. For this research I failed to speak whether the idea is from personal knowledge or other people do not have access to such kind of information. To verify this idea I interviewed other three members of zonal monitoring team where I got no related results. For my opinion, this requires more findings for better conclusion.

4.3 ADP Staff competence in terms of altitude about HIV/AIDS

The result shows that apart from the knowledge staffs have in respect to HIV/AIDS, it didn't change much on their altitude towards the epidemic. This was found where the staffs were able to explain well about the means of HIV transmission but still afraid to visit the affected household. One of the staff explains that "it is very difficult to visit sponsored children in the presence of the disease". Just imagine, you find the house hold member is AIDS patient, and you want to know the data of the child; in actual situation you just postponed the activity hence you start the way back to the office or you decide to go to another family. Another staff shared the event which says;

> "One *day I visited the household in order to collect child information's. In my arrival I found the child outside the house and they told me that parents are inside. When I asked him to call them for me he replied that her mother is totally sick on the bed. In our conversation the father of the boy came out and he welcomed me to see his wife. When I got inside, what I saw is my secret. It was the first time to see a person who is seriously suffering for AIDS related diseases. I could not say anything rather than saying bye. As a result I have never visited that house up to date and in order to get the information about the child, I just go to school and if I miss him then I forge so as to secure my job".*

This information was cemented by community facilitator for HIV/AIDS who showed how difficult it was to work in the community before the training of channel of hope. The respondent said;

> *You know my background is community development; when I got employment to be the community facilitator for HIV/AIDS in this ADP I was so scared. Actually my thinking was as if I am sacrificing my life because I knew that at any time I might get infection of HIV as well. In two month afterward I went for CoH training. Real from my heart this training opened me about HIV/AIDS and now I am working comfortably. If I could be having power, I could let all ADP staff to undergo that training (said the staff).*

Further results were obtained in staff altitude by using 'test your organization with the 12-boxes framework' figure 9 checklist.

Table: 5. ADP staff altitude towards HIV/AIDS.

scenario	Agree	In between	disagree
I will support an HIV-positive person decision to have children	1	0	36

HIV-positive people should not be recruited for senior positions that have many key responsibilities	37	0	0
I will let my children/my young brother play with football with a HIV-positive child.	0	4	33
We should employ HIV-positive people in our office as it gives a good image to donors.	9	20	8
I feel that HIV –positive person should not marry a HIV-negative person	30	3	4
I think that every staff member should know who is HIV-positive within the organization so that they can protect themselves and support the HIV-positive staff	1	30	6
Every staff member should be tested for HIV so that their treatment, care and support can be started early	10	3	24
I will employ a HIV-positive staff to cook for the staff	1	3	33

In the table above, it is clear that the altitude of staff towards the epidemic is not promising. Also the analysis made by using box 12 in the assessment of staff altitude and behavior towards the community, it reflected the altitude of stigmatizing the HIV/AIDS affected people by isolation and staying away action (for more detailed analysis see appendix 5). To refer one example all interviewed staffs were not able to support the HIV-positive staff to be given the higher position in the organization. The result gives the clear indicators for stigma for many staffs; which is among the strong constraints for Multisectoral response (Hemrich, G. & Topouzis, D (2000)).

4.4 ADP Staff competences in terms of Skills to deal with HIV/AIDS challenges.

This study provides evidence that due to HIV/AIDS there is a clear shift needed from ADP staff being responsible for solely sector in the ADP to more 'social skills' persons. The result shows various skills are needed for the staff to address development issues in the era of HIV/AIDS. According to Commonwealth Countries, (2003), one of the constraints for multi-sectoral approach is lack of skills. ADP staffs suggested that they would like to have counseling skills. The explanation for that is; having counseling skill they will be able to communicate to the affected people thus there will be no fear any more. Further they claimed that, the skills will help them to advice people to go for testing their status. The respondents continue to say, the skills will help them to talk about HIV/AIDS easily in the community; to communicate with the target group; to inform infected people about coping strategies; to suggest ways on how to deal with stigma in the community; to develop an ability to handle shocks;
However from the definition of HIV/AIDS counseling by FAO (2002);

> *HIV/AIDS counseling is a dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions relating to HIV/AIDS. The counseling process includes the evaluation of personal risk of HIV transmission and the facilitation of preventive behavior.* From that perspective, the literature suggests that, instead of counseling skills there should be facilitation and communication skills.

Other skills the staff mentioned was strategies and techniques of interventions for mitigation and cure with limited resources and the power they have at their disposal. This was elaborated as the constrain because there are some cases where they are willing to address the situation out of their job description but nobody especially higher authorities is willing to support the staff

resource wise. Further they explain that, the power they have for decision making, limits them to utilize their creativity.

Networking skills and interactive skills was also mentioned as the keys for staff to respond to the epidemic. We might be lacking resources as ADP but within the area there is an organization with that capacity. Therefore if we network with them, our problem can be handled.
Conflict solving skills; one respondent explain that;

> *One day during my child visit routine I found in a house hold a husband chasing away the wife and children. My arrival was the relief for the woman and she started to explain the situation so that I should provide the solution. The issue was the woman went to test for HIV and found she is positive. On informing the husband, then he decided to chase her away by blaming as she brought the disease at hope*.

The responded declared to face two times such kind of situation in the field with the note that the community believes that since they are working with ADP they know everything. From this case it is clear that the issue of HIV/AIDS skills is coming in but it involves other skills like advocacy and lobbying. For Multisectoral response, all these skills are important to the staff because the staff cannot continue working in the field while the house hold are fighting and dissolving. For better Multisectoral response we need stabilized society/community (personal view).

5.0 Conclusion and Recommendations.

From the study the main conclusion is that, there are organizational changes required in order for multi-sectoral response to take place at the community through ADP. Shifting from looking HIV/AIDS as departmental issue to organizational and tackling HIV/AIDS in both perspective of developmental and health aspect found to be the main challenge of the organization. The structure of the organization seems to be the potential obstacle to undermine changes to take place. Further the altitude of ADP staff can hinder the changes because it shows to stigmatize[13] the HIV/AIDS affected people in the community. The limited opportunity to maneuver for ADP staff gives the narrow chance to creativity and innovation which could be the advantage of the organization for better achievement.

Further it can be concluded that, there is recognized conducive environment/atmosphere in each researched ADP to adopt a more[14] multi-sectoral response. The following factors which exist in the organization revealed the good start of multi-sectoral response.

- Communication: The ADP staffs use languages which are acceptable to all and they have clear and open communication. The language used is full of modesty and harmony; for example before the starting of the sentence the ADP staff starts with '*mtumishi wa Mungu' (*the Swahili words meaning the servant of God*)*.

- Connectedness: at ADP level there is promising linkages between individuals, groups and organization. This strength makes people to know each other hence easily collaborate, which is the road map for multi-sectoral response.

- Christianity culture: WVT is dominated by communal culture, where by Christianity values are the key direction of every individual. Through this culture there is strong mutual supportive way among ADP staff. This forms the strength part of the organization to respond the AIDS impact through multi-sectoral approach.

- Community based: WVT is among the organizations which works very close to the rural community. This factor gives the strength to ADP staff to internalize with the community, knowing their need through informal and formal ways and targeting according to the needy in the community.

- HIV/AIDS department: the presence of the specific department for HIV/AIDS gives strength for the organization to respond to the epidemic through multi-sectoral approach due to the assumption that if the department will be equiped enough it can play a role of leadership in the whole processes of making sure that ADP staff are collaborating.

[13] Staying at a distance and isolating is one of the act of stigma (sub-chapter 4.4)
[14] This statement means, to a certain extent the approach is being applied in the organization, but not to the promising level.

- Resource capacity: WVT has good reputation which makes them no difficulties to access financial resources.

All these factors when the organization utilizes them effectively will end up with a good strategy for multi-sectoral response to the epidemic hence reducing the impact of AIDS in the community.

Furthermore, the study concludes that, ADP staffs are not having enough competences in terms of knowledge about HIV/AIDS, altitude and skills to deal with developmental issues in the presence of AIDS impact in the community. This can be observed in sub-chapters 4.2 to 4.4.

The ADP staffs recognize the impact of AIDS in the community and how it affects their work. Also there is great linkage between AIDS impact and their sectoral work. The study conclude that, the recognition of staff to the impact of AIDS in sector wise smoothen the way to multi-sectoral response to the epidemic.

Recommendations

The recommendations below are ranked important for the ADP staff to be model for multi-sectoral response:

- First, the research revealed the tendency of top down approach which limits the creativity of ADP staffs. Staffs are implementing what the higher authorities said to be implemented and whenever there is new demand in the community, the procedure to change the plan is extremely long. This study recommends that, WVT leaders should build a tendency to share and utilize the program information in collaboration with ADP staff.

- Secondly, this study recommends that, there should be establishment of AIDS impact database in respect to each ADP office which will help the organization to have clear targeting criteria. This will be used as well to inform donor the appropriate support needed in the community.

- Thirdly, the HIV/AIDS trainings should be conducted to all staff at the ADP level and not in selection like what happened for CoH training. Or, if the organization find difficult in terms of financial resources to train all staff, the technique should be to train the trainers in each ADP with clear note that there must be a clear follow up to whether the training is enrolled.

- Fourth, there is a need for the department of HIV/AIDS to make use of the facts that; the epidemic should be dealt not only from health perspective but also from developmental and humanitarian assistant perspective. Thus the whole team of staff at the ADP is responsible to fight against the epidemic; which can be taken as among the potentials in the department. And through that perspective, we will be responding to the impact of AIDS through multi-sectoral approach.

- Fifth, during the budgeting period, zonal monitoring team should make sure that there is indication for multi-sectoral response to the impact of AIDS in every sector. This should be done by preparing the checklist for areas of response, and sending them to the ADP in advance before the commencement of planning period. This process can be simplified if the database for AIDS impact is in place.

Sixth, capacity building should be planned for HIV/AIDS department staff to be updated with the recent wave of fighting against HIV/AIDS. The organization must avoid to send just directives from partnership/Africa region office to Tanzania National office by assuming that they will follow the instructions and implement accordingly. The live example is that, in 2008 the mainstreaming of HIV/AIDS was among the directives from Africa Region office, but nobody during the study were able to explain the meaning of the terminology and the application of it.

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7.0 Appendices

Appendix 1: Interview checklist.

1. Focus group discussion
   a) General ADP information
      - When was the ADP started?
      - What was the purpose of the ADP?
      - Are there any changes in the purpose of the ADP? (explanation)
      - What is the structure of ADP leadership?
      - How are you involved in decision making of the ADP?

   b) ADP activities related to the community

Activity	**How is done by the ADP**	**Problems experienced in last three years.**
Sensitization		
Structure		
Structure constructions		
Trainings and workshops		
Community mobilization		
Program designing		

   c) What do you do during the implementation of your activities if the problem associated by chronic illness and absenteeism happens?
   d) How do you reorganize the impact of AIDS in your community?
   e) What the ADP do to address the issue of HIV/AIDS in the community?
   f) What can you comment about the participation of a person suffering from AIDS related illness in the program activities?
   g) What approach the ADP has to make sure that the AIDS affected household is benefiting from the program?
2. The checklist for the dip-interview to ADP staff
   a) Personal data:
      - Job profile,
      - Job content,
      - Educational background.
   b) How the work at ADP is organized?
   c) What do you understand about the following terms;
      - HIV & AIDS
      - HIV/AIDS work
      - HIV/AIDS integration
      - HIV/AIDS mainstreaming
   d) What changes, due to HIV/AIDS, do you notice with regard to contacts with your clients?
   e) What changes, due to HIV/AIDS, do you notice with regard to your sectoral work practices in your working area?
   f) Any other changes you have noticed in your work practice/fieldwork that is the consequence of HIV/AIDS?
   g) What are the consequences of HIV/AIDS within your organization?

- Contacts with colleagues.
- Content of work.
- Other.

h) What are important competencies in your job, in your opinion?
- Knowledge.
- Skills.
- Attitude.

i) Are these competencies related to dealing with HIV/AIDS within your job?

j) What are important/required competencies in the context of HIV/AIDS, according to you?
- Knowledge.
- Skills.
- Attitude.

k) How do you collaborate with other sectors during the implementation of your activities?

l) What is your room for maneuver/change in respect to your job description?

3. Checklist for key informants

a) Zonal monitoring team
- Zonal coordinator for HIV/AIDS, malaria and health
- Zonal customer relation services officer
- Zonal monitoring and evaluation coordinator
- Zonal sustainability coordinator

Information of interest from them will be;
- The role of their team to support ADP performance;
- Their opinion about the impact of HIV/AIDS in development programs;
- Their room to bring changes in the ADP
- The current strategies for the zone to make sure that the programs are sustainable in the era of HIV/AIDS
- The opinion of the team on the competences of ADP staff to deal with developmental issues in the presence of the epidemic.
- The criteria used to identify the training need for ADP staff.

b) National manager for HIV/AIDS, malaria and health: deals with all issues of HIV/AIDS in the organization.

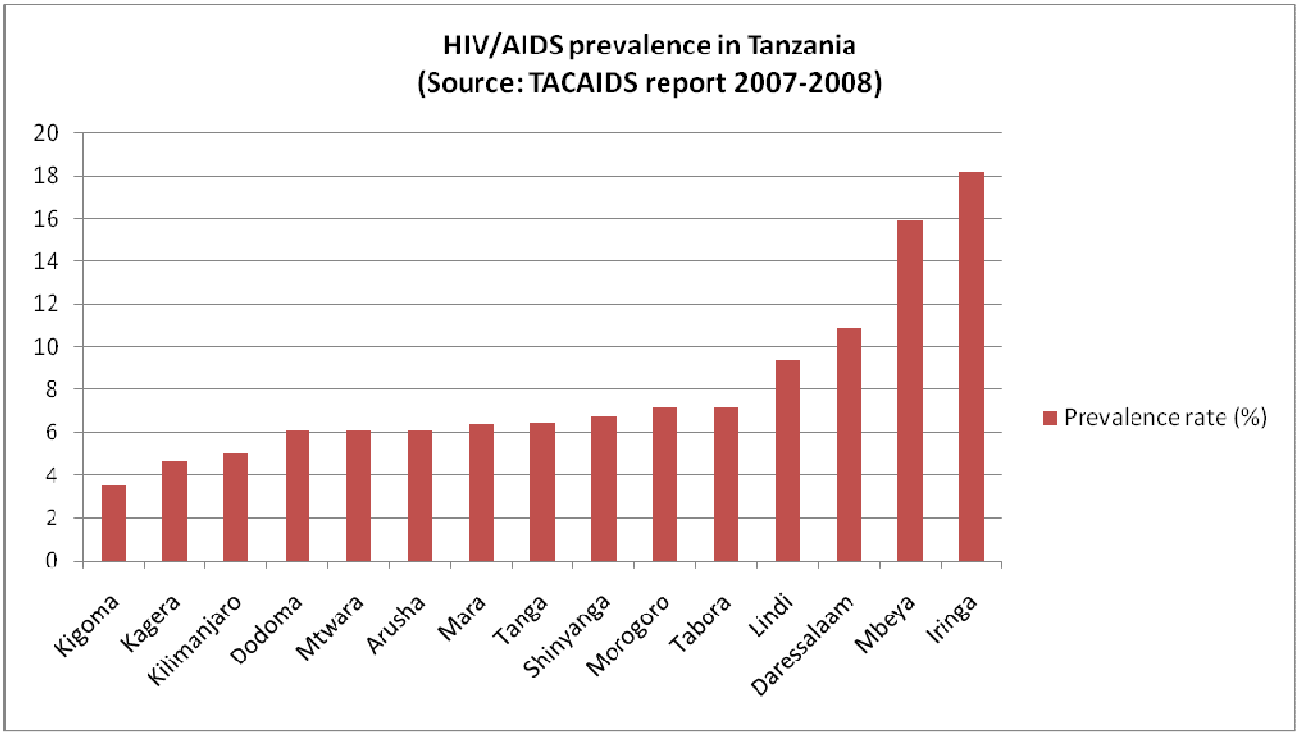
The information or interest will be;
- The overview impact of AIDS in WVT development work
- The linkage between HIV/AIDS department and other department at the ADP level
- The overview of HIV/AIDS external mainstreaming in ADP community work
- The role of the department to facilitate changes in the organization
- The opinion of the department in respect to the competences of ADP staff who are dealing with developmental programs in the era of HIV/AIDS.

c) Operation director, WVT: all ADPs in Tanzania are under this directorate.

The information of interest will be;
- How the current approach of ADP can fit in the era of HIV/AIDS
- How changes in the organization are taking place
- The role of the office to facilitate changes

- The personal opinion on the competence of ADP staff to address developmental issues in the era of HIV/AIDS

Appendix 2: HIV/AIDS prevalence rate in Tanzania.



Appendix 3: World Vision Overview and ADP structure.

This mission of WVT is being pursued by putting the focus on three fundamental elements which are Christianity, Child focused and Community based. This is done by integrated holistic commitment to transformational development that is community based and sustainable, focused especially on the need of children, emergence relief that assists people afflicted by conflict or disaster, promotion of justice that seeks to change unjust structures affecting the poor among whom we work and strategic initiatives that serve the church in the fulfillment of its mission. Public awareness and witness to Jesus Christ by life, deed, word and sign are encouraged so that people should respond to the gospel

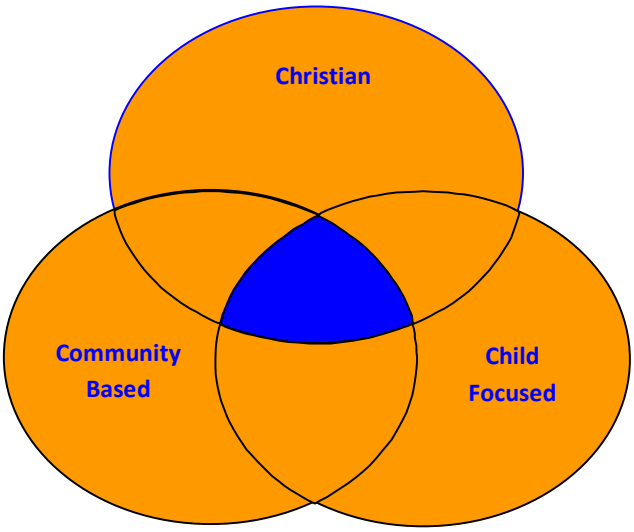


Fig 3:Three areas World Vision focuses in its implementationssource : World Vision Africa region integrated ministry guideline, 2009

Organizational structure of ADP

In order to ensure that collective efforts in the organization is directed towards specified goals a structure has been designed , through which activities of the Organization are allocated, controlled ,integrated and coordinated. The organization hierarchy is from the national board to the national director followed by five divisional directors. Further it lower down to zonal managers, program managers and at last community staff. In order to be more precise, for the purpose of this research, the drawn structure is considered only one ADP which represents others (they have homogeneous structure)

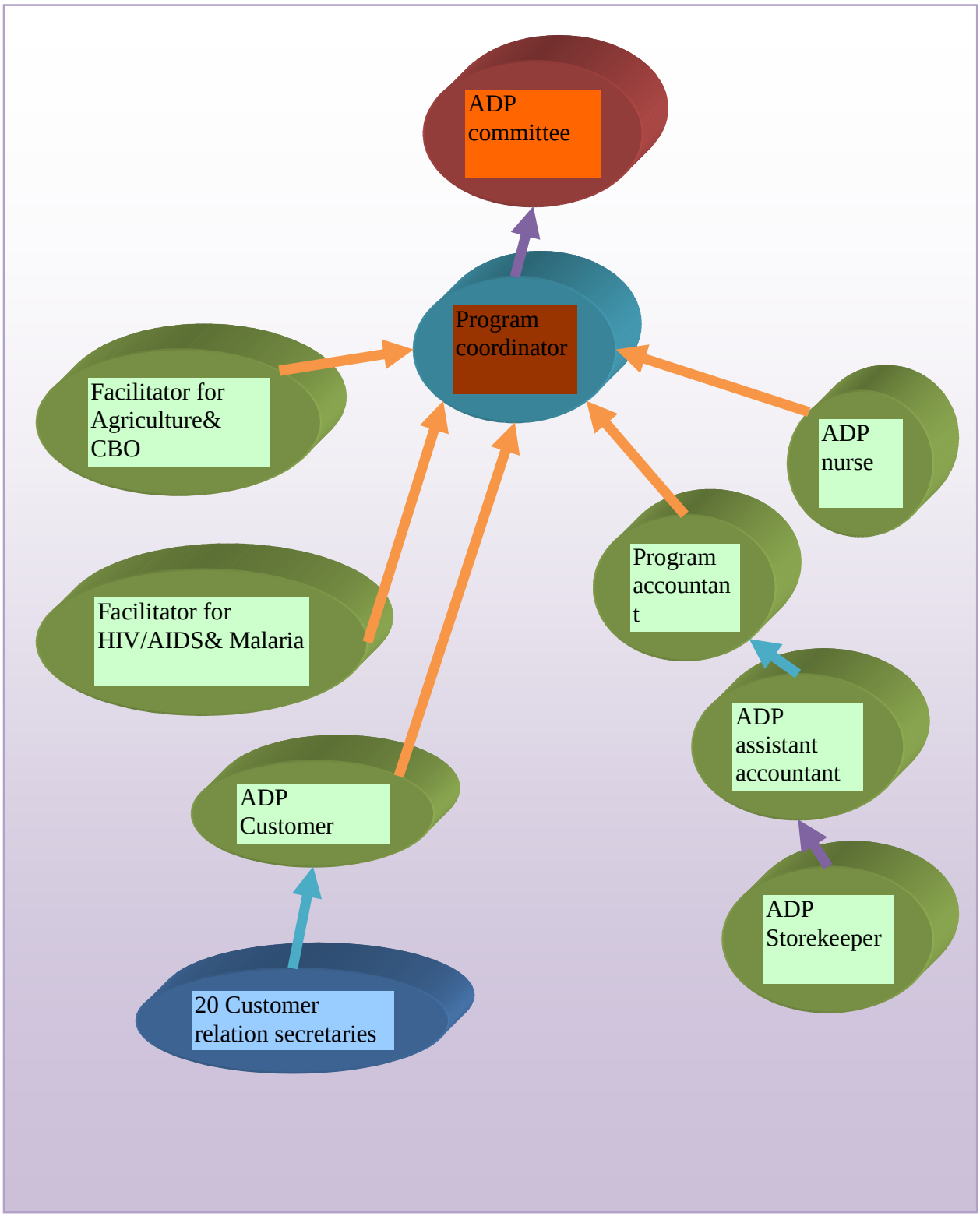


Fig: 2 World Vision Tanzania organization structure at ADP level

Appendix 4: World Vision Tanzania Response to HIV/AIDS.

1 HIV & AIDS PREVENTION AMONG CHILDREN UNDER 18	
FY 08 OBJECTIVES / INDICATORS Measured by CHARMS	ACTIVITIES
# and percent of primary school students (girls/boys) under 18 years who receive age appropriate, values-based education and life skills training, either directly from WV or through government and civil society partners # and percent of out school girls/boys under 18 years who receive age-appropriate, values-based education and life skills training or reached through peer education or other prevention approaches through WV or partners # youth clubs formed in and out of school # parents involved in parent groups	↓ Training of primary school teachers and others in each ADP to train school going and out of school, pupils/students in values-based life skills including HIV prevention, using age-appropriate, value-based life skills curricula that are consistent with WV's values-based approach (i.e. Scripture Union's Adventure Unlimited)or other curricula as identified by NOs. ↓ Other related activities and curricula including "sports for life" and "community conversations" to be implemented in some NOs and ADPs based on experience and capacity. ↓ Training peer educators among under 18 year old children ↓ Forming and supporting children's clubs to promote healthy living and HIV prevention ↓ Training for parents and ADP communities ↓ Regular supervision and monitoring of training activities and follow-up

2. HIV&AIDS Care and Support (Community-led care utilizing the CCC guide)	
FY08 Objectives/Indicators	**Care and Support for OVC/PLWHA**
# and percent of orphans and vulnerable children (girls/boys) identified receive community-led care # and % of these OVC (boys/girls) that have the following: ↓ Education – are either in school or in appropriate vocational education ↓ Nutrition – have either: a. Adequate nutrition according to national standards (where it is possible to measure this), or b. At least as much food	↓ Mobilization and training of CCCs (CCC Guide) ↓ Strengthening of CCCs using the Organizational Capacity Building guide) ↓ Monitoring of CCC functions and ongoing capacity building ↓ Establishment of linkages between CCC and potential sources of assistance (technical, financial, material) at local or district level (e.g. government and nongovernmental institution, businesses, etc.)) ↓ Training/ equipping Home Visitors to provide care and support for OVC (and/or people living with AIDS) including on-going and refresher training & incentives ↓ Training of ADP development facilitators on CCC and other HI core models ↓ Provision of small-scale financial and/or material resources that CCCs manage to benefit OVC ↓ Nutrition and livelihoods programming to improve food

as the norm for children in the community - Care – are being visited regularly by a caring community member who monitors and assists the child and family - All of the above # of PLWHAs receiving care and support (home-based or palliative care, treatment adherence and support, participation in support groups)	availability, accessibility, and utilization (e.g. MED and Savings Schemes, Home and school vegetable gardening, Livestock Schemes, Fish ponds, Nutrition education, Nutrition supplements, etc) - Training of MED and MFI staff on the CCC model and integration of HIV /AIDS and Med. - Provision of short-term food only where situation is dire (in collaboration with NO relief or commodities team) - Shelter support (e.g. renovation of OVC shelter, provision of construction materials, mobilization of community to assist in provision of shelter to OVC) - OVC rights protection (e.g. local advocacy, payment of legal fees to secure OVC property rights birth registration, community UNGASS monitoring activities, rights of the elderly as caregivers, etc.) - Advocacy and CCC reflection, learning and sharing, including community to community exchanges and learning - Provision of educational support to OVC - Improving health care for OVC (e.g. immunizations, urgent care, provision of treated bed-nets, hygiene education, clean water, early seeking of medical assistance, etc.) - Support to people living with AIDS (PLWHA) with care, support and advocacy activities that promote positive living

3. Psycho-Social Support	
FY08 Objectives/Indicators	**Psycho-social Support, including Inter-personal psychotherapy for groups (IPT-G)**
- No of pss workshops/sessions held with local &church leaders, OVC, Youth and adult care givers - Psychosocial status of ovc and number and/or % of OVC struggling with psychosocial challenges in community - No. of group volunteer facilitators and trainers trained to provide IPT-G intervention. - On group sessions/number of OVC participating in groups - No. of debriefing /supervision sessions held - % of OVC/care giver no longer indicating with signs and symptoms of depression/psychosocial problems	- Provide Psychosocial awareness raising/sensitisation workshops to local church,CCC & CBO leaders ,OVC and their care givers . - Carry out ethnographic assessment and screening of psychosocial status of OVC/care givers - Hold IPT-G sessions - Training Interpersonal Group Therapy (IPT-G) volunteers - Hold monthly debriefing sessions with all IPT-G volunteers - Train CCCs and home visitors (HVs) in child psycho-social support - Monitor IPT-G participants and refer clients needing additional support

▪ No. of OVC referred for further help /counselling ▪ No. of home visitors and CCCs trained in basic child psychosocial support skills ▪ Type and frequency of recreational/cp/camp activities organised for OVC ▪ No. of Youth/Adolescent mentors trained to provide peer support to OVC	▪ Organize camps and other recreation/child play(CP) activities OVC psycho-social support ▪ Train older adolescent mentors to provide psycho-social support to OVCs

4. Churches/Faith based Organization Partnerships (Channels of Hope)	
FY08 Objectives/Indicators	Activities
# of formal and informal partnerships established with churches and FBOs to address HIV&AIDS at ADP level (track nat'l level through signed Memoranda of Understanding) # of faith leaders (e.g. pastors or imams) (women/men) who attended church/FBO mobilization workshops # and percent of individual congregations in the ADP represented at the church/FBO mobilization workshops held # and percent of congregations that formed CHAT teams (HIV&AIDS leadership teams) # of congregational CHAT team members active in prevention, care, and advocacy in the ADP # of congregations that sent members to join a CCC	▪ Sent at least one person/staff member to be trained as CoH facilitators for each ADP or cluster of ADPs ▪ Budget for mentoring of the trained facilitators from ADP ▪ Market the CoH to faith leaders at various levels in the ADP ▪ Present Channels of Hope (CoH) mobilization and sensitisation workshops for faith leaders from churches and FBOs within the ADP area ▪ Monitor and follow-up faith leaders ▪ Present congregational Hope Team workshops ▪ Support CHAT Teams as they implement their strategic plans ▪ Facilitate linkage between CHAT teams and CCCs ▪ Build capacity of volunteers from congregations (in collaboration with CCC where applicable) ▪ Build capacity of the CHAT teams (e.g. program management, strategic planning, financial management) Use adapted CoH curricula for Muslim context and leaders (when available)

5. Advocacy	
FY08 Objectives/Indicators	Activities
Y/N: Did the ADP engage with HIV&AIDS-focused district-level agencies and networks?	a. Produce an HIV&AIDS advocacy strategy: ▪ Conduct situational analyses to analyse and monitor the rights and needs of OVC and their care givers, especially to combat stigma and discrimination

Y/N: ADP/non ADP project has undertaken advocacy on one or more of the following issues 1 = Mobilizing and strengthening care for OVC and chronically ill 2 = Reducing gender-based effects of HIV and AIDS 3 = Increasing access to continuum of care 4 = Mobilizing resources for HIV&AIDS response # of ADP/non ADP project staff trained on HIV&AIDS-related advocacy # of community members trained in the ADP/Non-ADP project on HIV/AIDS related advocacy # of in school and out of school children who participated in ADP/Non-ADP HIV and ADIS advocacy activities # Community members who participated in ADP/Non-ADP HIV and ADIS advocacy activities /N: Did the ADP engage with HIV&AIDS-focused district-level agencies and networks? Y/N: ADP/non ADP project has undertaken advocacy on one or more of the following issues 1 = Mobilizing and strengthening care for OVC and chronically ill 2 = Reducing gender-based effects of HIV and AIDS 3 = Increasing access to continuum of care 4 = Mobilizing resources for HIV&AIDS response # of ADP/non ADP project staff trained on HIV&AIDS-related advocacy # of community members trained in the ADP/Non-ADP project on HIV/AIDS related advocacy	▪ Facilitate discussion between CCC and local leaders about advocacy issues identified in OVC situational analysis and where appropriate work with other organizations in coalitions ▪ Whenever possible involve children in the child rights advocacy activities ▪ Lobby civil servants and politicians to have OVC given greater priority in PRSPs national AIDS strategies and national development plans ▪ Be actively involved in the design and implementation of the OVC national plans of action, especially through UNICEF and other key stakeholders. b. Advocacy for strengthening care for orphans and vulnerable children through: ▪ Training CCCs and home visitors to protect OVC rights ▪ Using the legal system to promote justice for OVC in cases of abuse, exploitation, and/or loss of inheritance ▪ ADPs engaging with district level government agencies and HIV&AIDS focused networks • c. Advocacy for reducing the vulnerability of girls and women to HIV&AIDS through: ▪ Supporting campaigns on the girl child and their right to education ▪ Supporting legal representation for women/girls in cases of abuse, exploitation, and/or loss of inheritance ▪ Providing training that motivates and equips men and women to become more gender-sensitive and change harmful behaviours ▪ Utilize and promote “community conversations” model to enable communities to discuss and address issues related to the vulnerability of girls and women to HIV ▪ Support campaigns on harmful practices and early marriage • d. Advocacy for increasing access to continuum of care through: ▪ Improving communities’ awareness of their health rights and the existence of affordable medicines • e. Advocacy for mobilizing resources for HIV&AIDS response through: ▪ Empowering communities, CBOs, and FBOs to lobby for increased funding for HIV&AIDS and to access available funding • Empowering communities including PLWHAs to monitor expenditure of

# of in school and out of school children who participated in ADP/Non-ADP HIV and ADIS advocacy activities # Community members who participated in ADP/Non-ADP HIV and ADIS advocacy activities	government, donors, and NGOs at the local level

6.Core HIV&AIDS Response Monitoring System (CHARMS) & Monitoring and Evaluation	
FY08 Objectives/Indicators	Activities
# of on time and complete CHARMS reports submitted # of SMT meetings where CHARMS data analysis is discussed	- Carry out a baseline assessment or survey that includes HIV&AIDS information (both qualitative and quantitative) - Identification of CHARMS point person at NO and ADP level - Training of CHARMS point persons and NO M&E staff - Training of Volunteer Partners (e.g. CCC home visitors, CoH Hope Team Visitors) in community-based data collection, tools, analysis and interpretation of data - Establishment of CHARMS reporting systems - Bi-annual analysis and feedback of CHARMS data to staff and partners - CHARMS results from previous year, utilized to set ADP or project targets for this year Carry out follow-up evaluations including HIV&AIDS according to LEAP program/project timetables

Appendix 5: 12-boxes framework (for boxes 10,11 & 12).

10. Program design	**11. Decision making and action taken in programs**	**12. Staff beliefs and behavior towards community**
Strength: - There programs addressing HIV/AIDS directly to promote prevention, care, support and treatment - Advocating when happen violence or any bad act to women and children - The evaluation/ assessment is done after every three years Limitations: - No assessment of the need for prevention of HIV, treatment care and support. - The situation analysis does not include gender specific issues that influence susceptibility to HIV infection - No indirect approach to tackle the epidemic - There is no formal partnership with organizations which are engaged in HIV/AIDS and gender. - Monitoring and evaluation system does not consider the impact of AIDS	Strength: - There are financial resources allocated for prevention, treatment and support. - The system of disseminating information is good. Limitations: - Decisions are made from the top with no consideration to susceptibility to HIV infection and impact to AIDS. - No enhancement of indirect response to HIV/AIDS - No consultations with ADP staff on issues of HIV/AIDS and gender.	Strength: - ADP staffs believes the important of removing stigma and discrimination - HIV/AIDS staff works to reduce stigma. - ADP staff demonstrate empathy to the PLWHA Limitations: - ADP staffs do not work to reduce stigma except the staff for HIV/AIDS department - ADP staff members are not willing to involve PLWHA except the one dealing with HIV?AIDS - The knowledge about gender inequalities in relation to HIV/AIDS is not clear to ADP staff

Appendix 6: The impact of AIDS at individual, household and community level

Impact at Individual level	**Impacts on Household**	**Impacts on communities**
- Frequency illness - the excess cost for treatment which will lead to erode resources at his/her disposal. - Whether you fit in the society or you don't fit; - Who you are in terms	- Loss of labor - Loss of capital - Decline of asset base - Change of the farming system - Downgraded crops and loss of livestock - Loss of income - Decrease in Remittances	- reduced labor - increased poverty - inability to maintain infrastructure - loss of skilled labor, including health workers and teachers - loss of agricultural input and credit

of status and gender; - Where do you live; - To whether your replaceable in the society or not; - Travel restriction; Another impact to the affected person is the - situation of being emotional, - hopelessness, - stress, - social isolation - Psychological problem.	- Food and livelihood insecurity increases - Loss of opportunities - Increased household expenditures - loss of farm management resources and skills - inability to earn income - forced migration - dissolution - stress - inability to parent and care for children - increased number of multigenerational households lacking middle generation - change in family composition and adult and child roles - diminished productive capacity - development of bad behavior among children	- reduced access to health care - increased morbidity and mortality - loss of tradition and indigenous knowledge - increased widow-, orphan and elderly-headed household - psychological stress and breakdown - inability of marshal resources for communitywide funding schemes or insurance - disruption and breakdown of social bond and support network - increased dependency - loss of market opportunities - wider social impacts marginalization of youth - loss of usufruct farming rights - problems of extension services