CIVIL SOCIETY ORGANISATIONS AND HIV/AIDS:

A CASE OF IRINGA DISTRICT, TANZANIA.

BY

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ABSTRACT

This study was designed to determine the role of Civil Society Organisations (CSOs) in combating HIV/AIDS in Iringa District. Non Governmental Organisations (NGOs), Faith Based Organisations (FBOs) and Community Based Organisations (CBOs) were selected for the study. Specifically, the study aimed at identifying the HIV/AIDS thematic areas in which the CSOs were engaged; the institutional management structure of CSOs; the CSO's achievements; the challenges faced by CSOs and at determining people's attitude towards CSOs addressing HIV/AIDS. A cross sectional survey was employed where by both structured and non-structured interviews were used to collect data. Purposive sampling method was used to obtain CSOs that implemented HIV/AIDS interventions whereas stratified sampling method was used to get 18 NGOs, 6 FBOs and 6 CBOs to constitute the sample of 30 CSOs that were interviewed. The collected data were analysed using SPSS computer software where descriptive statistics and cross tabulation were used in presenting the study results. HIV/AIDS interventions implemented by CSOs were in four thematic areas namely awareness raising, impact mitigation, capacity building and HIV voluntary counselling and testing. HIV/AIDS impact mitigation was the intervention implemented by most of the sampled CSOs (41.8% of responses). However CBOs unlike FBOs and NGOs engaged mostly in HIV prevention through awareness raising. Despite of limited monitoring of CSOs' activities by the government, community members have positive attitude towards CSOs addressing HIV/AIDS issues with the views that the government could not manage to implement all aspects of HIV/AIDS. CSOs' interventions were affected by limited funding whereby 41.5% of sampled CSOs' responses indicated that they relied on external funding. It is recommended that the government (both central and local government authorities) has to formulate an integrated programme of implementation together with a monitoring and evaluation system of

HIV/AIDS interventions for effective multisectoral approach towards combating the epidemic.

DECLARATION

I, Suzana Samson do hereby declare to the Senate of Sokoine University of Agriculture that this dissertation is my own original work and it has not been submitted for a higher degree award in any other University.

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19/11/2008
Date

The above declaration is confirmed

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20/12/08
Date

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DEDICATION

This dissertation is dedicated to my lovely parents Samson Nyanda and Mariam Musuka who laid the foundation for my studies. It is also dedicated to my lovely husband and daughter; and above all to the Almighty God.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

LIST OF ABBREVIATIONS

AFNET	Anti-Female Genital Mutilation Network
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical Research Foundation
ARVs	Antiretroviral drugs
CBOs	Community Based Organisations
CSOs	Civil Society Organisations
CTC	Care and Treatment Clinic
ECA	Economic Commission for Africa
ELCT	Evangelical Lutheran Church of Tanzania
FBOs	Faith Based Organisations
FHI	Family Health International
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IMPACT	Implementing AIDS Prevention and Care
KIWOHEDE	Kiota Women Health and Development organisation
LGAs	Local Government Authorities
MOEC	Ministry of Education and Culture
MOEVT	Ministry of Education and Vocational Training
MoH	Ministry of Health
NACP	National AIDS Control Program
NGOs	Non Governmental Organisations
OVCs	Orphans and Vulnerable children
PANTIL	Programme for Agricultural and Natural resources Transformation for Improved Livelihoods
PLHAs	People Living with HIV/AIDS

RFA	Regional Facilitating Agency
SPSS	Statistical Package for Social Science Software
SPW	Students Partnership Worldwide
SRH	Sexual Reproductive Health
TACAIDS	Tanzania Commission for AIDS
TAHEA	Tanzania Home Economics Association
TV	Television
UMATI	Chama cha Uzazi na Malezi bora Tanzania
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisations
URT	United Republic of Tanzania
VCT	Voluntary Counselling and Testing

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Tanzania is among Sub Saharan African (SSA) countries that have been hit by the AIDS epidemic. The first incidences were reported from Kagera region in 1983, by then only three cases were reported. Within a period of twenty years (1983/03) the number of HIV incidences increased to about 1 820 000 and a total of 176 102 reported AIDS cases (TACAIDS, 2005). Findings from the Tanzania HIV/AIDS Indicator Survey conducted in 2003-04 indicated that Mbeya region had the highest HIV/AIDS prevalence cases (14%) followed by Iringa (13%) and Dar es Salaam region (11%) (TACAIDS, 2005).

In Tanzania civil society organizations (CSOs) and private institutions contribute to government efforts in fighting against HIV/AIDS. According to Marche and Ruvuga (1994), civil society organizations (CSOs) have been playing major role in areas including civil welfare, agricultural extension and basic health education. Government and civil society organizations are implementing a variety of intervention measures in fighting against the epidemic (ECA, 2006). A study conducted by economic commission for Africa (ECA) in Southern African countries (Malawi, Zimbabwe, Mozambique, Lesotho and Swaziland) found that there is a lack of coordination between the different actors. A multi-sectoral approach involving a combination of prevention, treatment, care and mitigation to implementing HIV/AIDS interventions demands the cooperation of all stakeholders to minimize repetition and to ensure sharing of information (ECA, 2006). Recognition of the role played by each actor is very vital in enhancing such coordination, this study therefore focuses on identifying the role of CSOs in combating HIV/AIDS.

1.2 Problem Statement

Recent years, have witnessed the rapid increase of civil society organizations (CSOs) working against the spread of HIV in Tanzania. Despite the fact that today there are several non governmental organisations (NGOs), community based organisations (CBOs) and faith based organisations (FBOs) in the country that direct their activities in both urban and rural areas in the efforts to combat HIV/AIDS, yet the role of these CSOs have not been clearly recorded. This might be contributed by a limited number of research studies that have been conducted to assess the role of CSOs in combating HIV/AIDS.

1.3 Problem Justification

NGOs, CBOs and FBOs can make important contributions towards mobilization of communities; they create space for people to engage themselves in activities they perceive as important. These organisations also provide a room for discussion of critical issues that are of concern to people, thereby linking them together and creating shared values (Kiondo, 2000). Effective responses to HIV/AIDS are based on the capacities of people living in communities to assess their own vulnerability and plan their own responses. Civil society organisations' interventions in combating HIV/AIDS are the responses towards the identified community vulnerability (Kiondo, 2000). Despite tireless efforts and dedicated leadership from both the community and government levels and a visible stakeholder involvement, the HIV/AIDS epidemic has continued to be a disaster on communities worldwide (URT, 2003a). Millennium Development Goal number six has also emphasized on the efforts to combat HIV/AIDS (UN, 2006). The Tanzania national policy on HIV/AIDS provides the general framework for the collective and individual response to the epidemic (URT, 2001a). Among other things, the policy mentions the roles of various sectors in the prevention, care and support in HIV/AIDS. This study is therefore relevant in identifying the role played by Civil Society Organizations. This information will be

useful to the government in coordinating CSOs activities; CSOs in planning and implementing their interventions and other sectors involved in the fight against the epidemic.

1.4 Objectives of the Study

1.4.1 General objective

To determine the role of Civil Society Organisations fighting against HIV/AIDS in Iringa District.

1.4.2 Specific objectives

Specifically, the study aimed at:-

i. Identifying the HIV/AIDS thematic areas in which the CSOs are engaged.

ii. Identifying institutional management structure of CSOs.

iii. Identifying CSO's achievements in combating HIV/AIDS.

iv. Identifying challenges faced by the existing CSOs addressing HIV/AIDS.

v. Determining people's attitude towards CSOs addressing HIV/AIDS.

1.5 Conceptual Framework

HIV/AIDS comprise of different issues which have to be addressed in totality so as to combat the epidemic successfully. Civil society organisations address various HIV/AIDS themes through the implementation of various interventions. People's attitude towards the interventions may have influence on the achievements of these organizations. Not only that but also institutional management of the organisations may also affect their role since these organisations work under the government rules and regulations. The institutional management structure may have influence on the HIV/AIDS thematic areas to be addressed by CSOs and people's attitude towards CSOs interventions and may as well pose challenges to the overall working environment of these organizations. The study

anticipates that, civil society organisations may face other challenges which are also considered to affect their role in combating HIV/AIDS. Therefore, this particular study will identify the role of civil society organisations in combating HIV/AIDS. Their role will be determined basing on the achievements of the CSOs' set objectives, geographical area covered and /or number of people reached by CSOs (Fig. 1).

1.6 Research Questions

This study intends to answer the following questions:

1. What are HIV/AIDS thematic areas that CSOs engage in?
2. How are CSOs fighting against HIV/AIDS managed?
3. What are the CSO's achievements in combating HIV/AIDS?
4. What are the challenges faced by CSOs addressing HIV/AIDS issues?
5. What are the people's perceptions towards CSOs addressing HIV/AIDS issues?

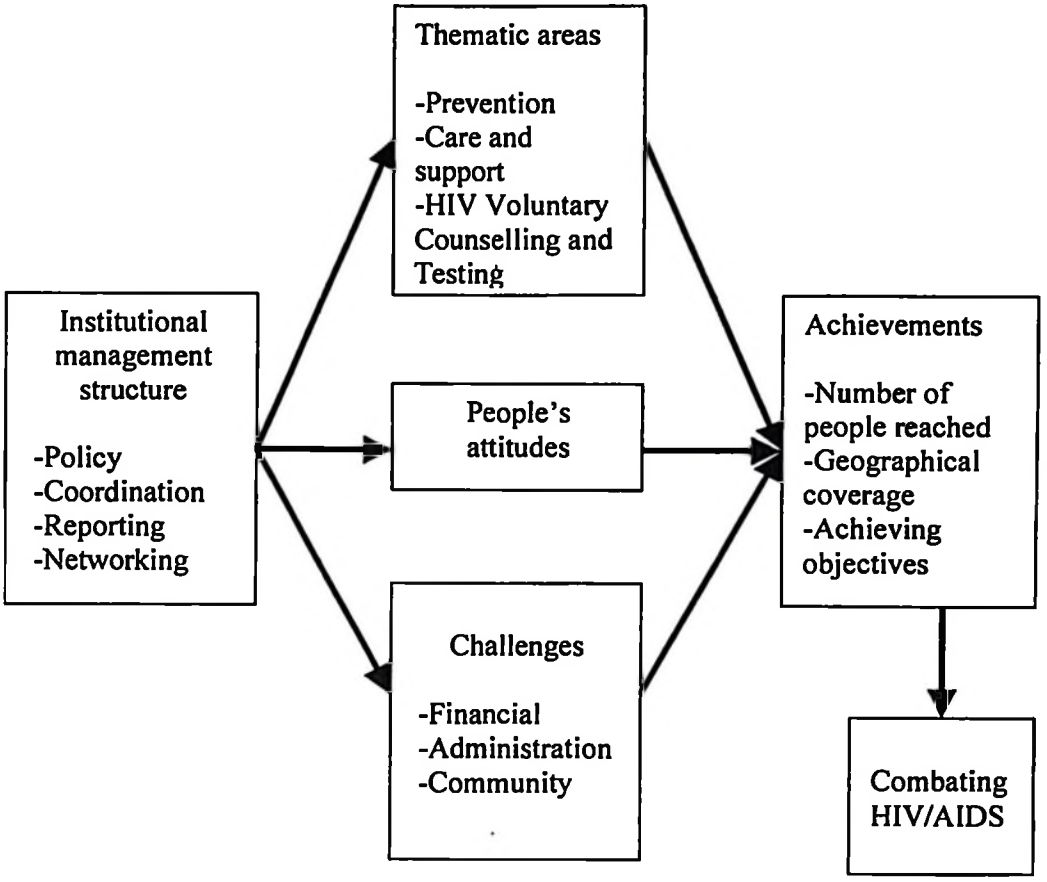

Figure 1: Conceptual Framework

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Overview

This chapter describes literature related to this study. Section 2.2 gives definition of concepts. The overview of HIV/AIDS situation is explained in section 2.3 while section 2.4 describes the civil society organizations. Section 2.5 discusses the civil society organizations and HIV/AIDS whereas the last section (section 2.6) explains the institutional management structure of civil society organisations.

2.2 Definition of Concepts

2.2.1 Non governmental organisations

Turner and Hulme (1997) define Non Governmental Organisations (NGOs) as "associations formed from within civil society bringing together individuals who share some common purpose". Hulme (2001) characterizes them (as well as civil society) as "people organizations [that] are both not part of the state structures, are not primarily motivated by commercial considerations or profit maximization, are largely self-governing, and rely on voluntary contributions (of finance, labour or materials) to a significant degree".

2.2.2 Faith based organisations

The term "faith-based organisation" (FBO) typically suggest religious congregations, whose primary missions are worship and religious education (Chaves, 2004). A general term used to refer religious and religious-based organizations, places of religious worship or congregations, specialized religious institutions, registered and unregistered non-profit

institutions that have religious character or missions. These institutions implement HIV/AIDS interventions as their contribution in the efforts towards combating the epidemic.

2.2.3 Community based organizations

According to the Centre for African Family Studies (CAFS, 2001), community based organisations (CBOs) are local community initiatives, covering limited geographical areas. They are usually registered under a relevant government department and operate on a limited budget, relying heavily on voluntary work.

2.2.4 Human Immuno-deficiency Virus

Human Immunodeficiency Virus (HIV) is the virus that causes AIDS (Hubley *et al.*, 1995). HIV destroys part of the human immune system. Specifically, it affects a type of white blood cells in the blood that help the body fight off all kinds of germs and diseases. When HIV invades the body; it damages or kills the white blood cells and other cells, weakening the immune system and leaving the person vulnerable to various opportunistic infections and other illnesses (Dowshen, 2007). When the viruses damage many cells, the person's body can no longer fight against diseases and it is at this point the person gets sick and develops AIDS.

2.2.5 HIV antibody positive and AIDS

A person who is infected with the virus is called HIV positive the status which can be known through undertaking a HIV test only. The HIV positive person has been tested and found to have signs of the human immunodeficiency virus in the blood (Hubley *et al.*, 1995). The amount of time it takes for symptoms of AIDS to appear varies from person to

person. Some people may feel and look healthy for years while they are infected with HIV. It is still possible to infect others with HIV, even if the person with the virus has absolutely no symptoms.

As time goes by, it comes a point when a person who has been infected with HIV becomes ill due to the continuous damage of the immune system. As the immune system fails, symptoms develop. Initially many of the symptoms are mild, but as the immune system deteriorates the symptoms worsen to the point when the person becomes seriously ill with a number of severe illnesses. This is the point in the stages of HIV infection that the HIV positive person is said to have AIDS (Dowshen, 2007).

Acquired immunodeficiency syndrome (AIDS) is a condition caused by a deficiency in the body's immune system, the condition diagnosed when there are a group of related symptoms that are caused by severe HIV infection. AIDS makes the body vulnerable to life threatening illnesses called opportunistic infections, because they take advantage of the opportunity offered by a weakened immune system (Hubley *et al.*, 1995). These infections cause illness or death in HIV positive individuals and not the virus itself. Most people do not develop symptoms for 10 to 12 years and others remain symptom free for much longer. This average is based on a person having a reasonable diet; someone who is malnourished may progress to AIDS and death more rapidly (Dowshen, 2007).

As with most diseases, early medical care can help prolong a person's life. Antiretroviral medication can prolong the time between HIV infection and the onset of AIDS. Modern combination therapy is highly effective. Theoretically, someone with HIV can live for a long time before it becomes AIDS. Combinations of antiviral drugs and drugs that boost the immune system have allowed many people with HIV to resist infections, stay healthy

and prolong their lives. Apart from not being a cure, these medications are very expensive and they are not available to everyone in the world (Dowshen, 2007).

2.3 HIV/AIDS Situation

HIV/AIDS is a global disaster that has attracted attention all over the world. In 2007 a total of 33.2 million people were living with HIV around the world out of which 30.8 million were adults (UNAIDS, 2007). The same report found that, over 6800 persons become infected with HIV every day because of inadequate access to HIV prevention. Children under 15 years who were reported to be living with HIV were 2.5 million.

According to UNAIDS (2007), a total number of deaths were 2.1 million; out of which adults were 1.7 million and children under 15 years were 330 000. Over 5700 persons were also reported to die from AIDS every day mostly because of inadequate access to treatment services. Sub-Saharan Africa remains the most seriously affected region, with AIDS remaining the leading cause of death of its people (UNAIDS, 2007).

2.4 Civil Society Organisations

Shariff and Albee (2000) defined civil society organizations (CSOs) as organized groupings which occupy the public space between the state and the individual citizen. People across the globe are re-discovering and attaching more importance to civil society (Shariff and Albee, 2000). This realm includes NGOs, but extends well beyond them to encompass people's organizations, trade unions, human rights bodies, religious groups, community based organizations, policy activist bodies, associations of business and professional people's organizations and others. All may be found in the domain termed civil space, and thus are called civil society organizations (Shariff and Albee, 2000).

Cornman *et al.* (2005) mentioned that there is a variety of terminology used to describe entities in the non governmental and civil society sector; this includes private voluntary organizations (PVOs), non governmental organizations (NGOs), civil society organizations (CSOs), community-based organizations (CBOs) and faith-based organizations (FBOs). The author also pointed out that local NGOs are those working in multiple countries, national NGOs working on countrywide issues and community based NGOs, FBOs or CBOs are focused on local stakeholders and issues (Cornman *et al.*, 2005). CAFS (2001) classified NGOs into three categories: First, Community based organizations; local community initiatives, covering limited geographical areas. The second category is NGOs that cover a larger area and which are registered under the relevant legal framework for NGOs. The third category is international NGOs that have set up local affiliates that may or may not have a significant level of autonomy.

The above information shows that different authors use different terminologies to represent organisations that are not governmental entities. The terminologies are context based that is, there is no standard categorisation of CSOs. Their classification can be done according to various categories; including their organizational structure (formally organised/registered or informal associations of collective action; their functional interests (development, policy advocacy, human/civil rights and governance, and watch-dog functions); their levels of operation (at grassroots, local/municipal, national, regional, and international levels); and their funding sources (membership supported, locally/nationally financed, and dependent on international donors). It should be noted, however, that the distinction between these categories is not always clear or rigid, and many CSOs fit into more than one category (CCSO, 2001). In this particular study where not specified, CSOs will mean a collective term for NGOs, FBOs and CBOs studied. These three categories of CSOs will be considered in this particular study because they are involved most in addressing HIV/AIDS issues with NGOs being the largest category.

2.4.1 Emergence of civil society organizations in Tanzania

The liberalization of the Tanzanian economy and politics in the 1980s led to an unprecedented proliferation of civil society organisations that are now being recognized as constituting a special sector (Mogella, 1999). Externally, the current NGOs boom in Tanzania corresponds with the proliferation of NGOs around the world due to the recent focus by international development institutions on involving civil society in development programmes. Development agencies are increasingly channelling funds through NGOs as efficient and cost effective method of partnering with civil society. This substantial new source of funding has resulted in a tremendous growth in the NGO sector and an expansion of NGO programmes around the world (Arielle, 2002). Whereas Kajimbwa (2006) pointed out that the government's inability to provide high-quality public services to citizens is the internal cause for NGOs to step in with new approaches to enhance efficiency and effectiveness in providing public services and infrastructure. NGOs have also filled a crucial role in enabling people to organize themselves and share responsibility for governance (Kajimbwa, 2006).

2.4.2 Non Governmental Organizations Profile in Tanzania

The number of NGOs operating in Tanzania is not clear; there is no exact number of NGOs operating in the country. The Tanzanian Vice President Office NGOs Calendar prepared in 2000 showed that Tanzania had 8499 registered NGOs in 1998. The calendar also showed that the country had more than 10 000 registered NGOs in 2000. The Tanzania NGO Policy of 2001 claimed that there were about 3000 local and international NGOs in the country (URT, 2001b). Whereas the Ministry of Community Development, Gender and Children (MCDGC) that was given the responsibility of NGOs coordination in 2006 stipulated that there were over 4000 NGOs out of which 3600 were local and 400

international (MCDGC, 2006).

The registration of NGOs is decentralized and delegated to the regional and district administration levels for NGOs operating in single districts or single regions. International NGOs and those operating in more than one region are registered at the national level (URT, 2002a). Having these levels of registration; limited coordination of registration activities might result into poor records of NGOs working in the country at a given time hence difficulties in recognizing the role they play.

2.5 Civil Society Organisations and HIV/AIDS

A report prepared by Haapanen (2007) on civil society in Tanzania shows that, HIV infections had shown a declining trend during the last few years due to efforts from different sectors of the society. The author also mentioned that, there were also signs that the stigma around people living with HIV was gradually decreasing as attitudes towards these people were becoming more positive; the successes which emanated not only from the government initiatives but also from the awareness raising and advocacy work of various CSOs throughout the country. CSOs have been involved in running clinical and home based care for HIV/AIDS patients, which have a very important complementary role together with governmental efforts (Haapanen, 2007).

A study conducted by Family Health International (FHI) through its Implementing AIDS Prevention and Care (IMPACT) Project on partnering with faith based organizations to address HIV/AIDS, found that the faith based groups have the opportunity both to have a very strong role in preventing HIV/AIDS by teaching their own faith orientation and rules of living as well as providing compassionate care for those infected with HIV/AIDS. Faith based organizations around the world are dedicated to promoting safer behaviors to avoid

HIV transmission, particularly among young people. For example, IMPACT in Rwanda launched several community based prevention projects for youth in partnership with Catholic organizations and dioceses in the nation's capital of Kigali and throughout the country. Those FBOs were among the strongest community based organizations in Rwanda and had considerable success in reaching youth and other audiences with behavior change interventions (Dadian, 2004).

According to Barnette *et al.* (2001), the NGO community has played a critical role worldwide in response to the HIV/AIDS epidemic. In many countries NGOs were providing basic prevention, education and care for those infected with HIV/AIDS before the government acknowledged that it was a national problem. Many governments and international agencies recognize that NGOs are uniquely capable of reaching populations affected by HIV/AIDS. Jamil and Muriisa (2004) found that NGOs work hand in hand with government health officials who handle referrals from NGOs. Both NGO and government officials acknowledged that they needed each other for their effectiveness. The authors further found that much of responses towards combating HIV/AIDS at the local level were contributed by NGOs. In Uganda, NGOs were found to be dominant players in the fight against HIV/AIDS; they were involved in the control, care and sensitization programmes related to HIV/AIDS where almost all NGOs included fighting HIV/AIDS on the list of their activities. However, various approaches used by CSOs in addressing HIV/AIDS issues have caused them to have comparative advantages in reaching the population. The following are comparative advantages NGOs and FBOs have over other actors in the fight against HIV/AIDS.

2.5.1 Non governmental organisations and HIV/AIDS

In responding to the HIV/AIDS pandemic, NGOs bring a collection of experiences, technical capabilities and connections that make them indispensable (Comman, *et al.*, 2005). NGOs often have a comparative advantage in responding to the complex and evolving landscape of HIV/AIDS. The strengths NGOs contribute significantly to their successes and the sustainability of their activities can be derived in one way or another from the close connection that the organizations have with the populations they serve (Sethna, 2003).

2.5.1.1 Cultural competency and innovation

Most NGOs have a thorough understanding of their local communities; they know the details of local constraints and issues and can effectively prioritize problems within their context (Sethna, 2003). NGOs know how HIV/AIDS is understood and viewed in a particular community, they initiate actions in ways that are understood by the community and deemed appropriate and acceptable. In addition NGOs emphasize experiential learning by doing. NGOs' employees often learn from people they work with, they have a belief that beneficiaries know better what affects them. Jamil and Muriisa (2004) mentioned that, only the poor can change their own lives when provided with necessary resources.

2.5.1.2 Community mobilization

Many NGOs use their strong connections with beneficiary populations to obtain community investments for interventions being undertaken. NGOs are among the strongest supporters and practitioners of methodologies that encourage local participation (Wandwalo, 2004). According to Sethna (2003), NGOs are often created and staffed by community members. This gives them credibility with the communities they serve. Thus,

NGOs are more likely to attract community participation for HIV/AIDS prevention and care efforts.

2.5.1.3 Responsiveness and flexibility

Based on their size, operating structure and connection to the communities they serve, most NGOs are in a better position than government bureaucracies to respond quickly to identified needs and opportunities at the community level. These characteristics also allow NGOs to respond flexibly to the complex and rapidly evolving HIV/AIDS epidemic, make mid-course adjustments as necessary and tailor existing programs to local realities (Comman *et al.*, 2005).

2.5.2 Faith based organisations and HIV/AIDS

Many FBOs have been deeply engaged in providing services and programming around HIV/AIDS for years and are often the only genuine non governmental organizations in many rural parts of poor countries (Green, 2003). FBOs have the ability to provide expanded coverage, given that they are community focused and have a wide population reach, particularly to underserved populations and rural communities. Faith based groups can be more effective in offering holistic support, including protection and economic, psychosocial and spiritual support (Comman *et al.*, 2005; Dadian, 2004).

2.5.2.1 Reducing Stigma and Discrimination

In several areas, FBOs have provided the bulk of services or have been extremely effective in influencing public policy and reducing stigma. For example, service delivery NGOs that partner with faith based groups for psychosocial care are reporting that the involvement of religious organizations is helpful in reducing stigma and discrimination

and in increasing the delivery of services (Green, 2003).

2.5.2.2 Providing care and support

Religious organizations are involved in the provision of care and support to individuals and families affected by AIDS. FBOs provide care, support and counselling for people living with HIV/AIDS, including care for AIDS orphans, income generation projects for people living with HIV/AIDS and their dependents (Green, 2003). FBOs often play a substantial role in HIV/AIDS clinical and home based care, particularly where public health services are insufficient. FBOs have been involved in expanding access to antiretroviral drugs (ARVs) and supporting other sectors in the administration of treatment (Liebowitz, 2004).

2.6 Institutional Management Structure for CSOs

Tanzania Commission for AIDS (TACAIDS) is an independent department under the office of the Prime Minister. Monitoring and evaluation of all on going HIV/AIDS activities is among other functions of TACAIDS. TACAIDS Act includes creation of district and Village HIV/AIDS committees to lead the planning, resource mobilization and coordination of local responses (URT, 2003a). At all levels of these committees, one of the invitees is the representative from a network of NGOs that are involved in the fight against HIV/AIDS (URT, 2003b). This mode of CSOs representation in the committees might be a limiting factor in expressing the roles they play in the fight against HIV/AIDS especially in areas where there is no network of CSOs.

While TACAIDS coordinates all HIV/AIDS activities, the Ministry of Community Development, Gender and Children oversees all NGO matters through NGO Coordination Board which operates under the NGOs Act (URT, 2002a). This means that, the role of

CSOs involved in combating HIV/AIDS have to be clearly recognized by both offices, that is, the Ministry of Community Development, Gender and Children through the NGOs Coordination Board and the Prime Minister's Office through TACAIDS (See Appendix 2 and 3 for more reference on CSOs Coordination).

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Area Description

This study was conducted in Iringa District which is among the six districts of Iringa Region, other districts being Kilolo, Njombe, Ludewa, Mufindi and Makete. Administratively, Iringa District comprises of both Iringa Rural and Municipal areas. The district is bordered by Dodoma Region in the North, Morogoro Region to the East, Mufindi District to the South and Mbeya Region to the West. According to URT, (2002b), Iringa District has a population of 1 495 333 with 346 815 total number of households and an average household size of 4.3. The main ethnic group in Iringa District is the Hehe with their major occupation being farming while livestock keeping is practiced on small scale.

3.2 Sampling and Data Collection

3.2.1 Sampling

Iringa Region was purposively selected because it is among the most affected regions with the HIV prevalence rate of 13% being the second to Mbeya Region which has prevalence rate 14% in Tanzania (TACAIDS, 2005). Iringa District was selected because it comprised of Iringa Municipal and rural, so the District was thought to have substantial number of CSOs to be studied. Purposive sampling procedure was employed in selecting CSOs for the study, only CSOs that were involved in combating HIV/AIDS constituted the sampling frame. Three categories of CSOs were involved namely non governmental organisations (NGOs), faith based organizations (FBOs) and community based organizations (CBOs). The number of organisations from each category was selected using stratified sampling through which the total number of organisations found in each category determined the number of organisations to constitute the sample. Simple random sampling was employed

in each stratum to get representative organisations to constitute the required sample.

Furthermore, purposive sampling technique was applied in selecting villages and 'Mitaa' from which members for focus group discussions were obtained. Villages and 'Mitaa' in which more than one organisation involved in combating HIV/AIDS operated were selected. Members were purposively selected to constitute the mixed group of community members. The group included the Village or Mtaa Chairperson, Village or Mtaa Executive Officer, Primary School Headteacher, two Religious leaders (one Christian and one Muslim), two youth (one male and one female), two elders (one male and one female) and one influential person for example the Ward Councillor if was found to live in the Village or Mtaa that was selected for focus group discussion. People living with HIV/AIDS (PLHAs) for focus group discussion were also purposively selected from the post test clubs from both Iringa rural and municipal. Whereas three District Council officials as key informants were selected basing on their roles in the district council. These were the Council HIV/AIDS Control Coordinators (CHACC) from both Iringa Rural and Municipal District Councils and the District Administrative Secretary (NGOs Assistant Registrar) (Appendix 3).

3.2.2 Sample size

Lists of all NGOs (30), FBO (10)and CBOs (10) involved in combating HIV/AIDS were obtained from the District Council Office where by eighteen NGOs, six FBOs and six CBOs were selected for the study; making a sample size of 30 CSOs from which one organisation's spokesperson was interviewed on behalf of the organisation.

3.3 Sources of Data

3.3.1 Primary data

A cross-section survey was employed for primary data collection where questions to a representative sample of the population were asked at single point of time. Structured interview using an interview schedule with standard set of questions (Appendix IV) was done to key personnel from CSOs dealing with HIV/AIDS in Iringa District. The interview schedule was pre-tested before embarking on the full-scale fieldwork. Three organisations were involved in the process: KIWOHEDE (NGO), Shalom Centre (FBO) and Mapambano Group (CBO). The purpose of pre-testing was to test the relevance of the questionnaire and questions to the study. The study considered interventions conducted in 2006/2007 for consistency among all organizations.

Unstructured interview using lists of general questions (Appendix 5, 6 and 7) was also employed to key informants from district council representatives and for focus group discussions. Focus group discussions (FGDs) were used to gather information on the attitudes of community members towards CSOs involved in combating HIV/AIDS. Eight focus group discussions were conducted; six were groups of mixed community members from three 'mitaa' (municipal) and three villages (rural) communities while two were groups of people living with HIV/AIDS one from rural and the other from municipal post test clubs (PTCs). Each focus group had at most 10 members for effective discussion where by discussions were recorded for easy retrieval of information. This was made possible because members for focus group discussions accepted the researcher's request for recording the discussions.

3.3.2 Secondary data

Secondary data were gathered from various documents from the organizations that were included in the study and from Iringa district council as well. In addition data was also sought from published documents from various sources such as Sokoine National Agricultural Library (SNAL) and internet search.

3.4 Data Analysis

Quantitative data were analysed using the Statistical Package for Social Science (SPSS) and the results are presented in the form of tables and charts. Most of the study findings are based on multiple responses hence numbers of responses were used instead of frequencies. Qualitative data was analysed using content analysis (Stewart and Shamdasani, 1990).

3.5 Data Limitations

The following are some of problems encountered during data collection activity

- Organisations were unable to provide quantitative data during the time of the face to face interviews which required intensive follow ups. Five CSOs did not provide the quantitative data on their intervention even after that intensive follow ups resulting into underreporting on the number of people reached;
- Postponements of interviews with spokespersons due to other commitments for their organisations were common;
- The researcher was forced to be specific to interventions conducted in 2006/07 for maintaining consistency because some organisations mentioned to have implemented various interventions since their establishment by following the funding blow, hence difficulties in tracing back information from the previous years' interventions;

- Report from the district council on activities conducted by CSOs in combating HIV/AIDS was limited to those organisations and/or activities funded by the government making difficult in crosschecking information obtained from other individual organisations under the study;
- Data analysis was challenging because there was no any thematic area in which all the interviewed CSOs implemented interventions.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSIONS

4.1 An Overview

This chapter describes the results of the study; it is divided into seven sections. Section 4.2 presents the general information of organizations studied. Section 4.3 explains the organisational focus of CSOs whereby section 4.4 summarises HIV/AIDS thematic areas addressed by the studied CSOs. Section 4.5 summarises the approaches used by CSOs in combating HIV/AIDS. Section 4.6 describes institutional management of civil society organisations (CSOs) while section 4.7 presents community members' attitude towards CSOs' interventions. Section 4.8 presents challenges faced by CSOs.

4.2 Civil Society Organisations Studied

In this particular study civil society organisations (CSOs) were considered to be organised groupings that were not governmental. Out of many organized groupings comprising the civil society, only three groupings were involved in the study these are Non Governmental Organisations (NGOs), Faith Based Organisations (FBOs) and Community Based Organisations (CBOs). The study involved 60% NGOs while FBOs and CBOs were 20% each. A total number of 30 CSOs were involved in the study which was a combination of representative organisations from all the three grouping of the civil society organisations. The number of organisations in each group was based on the information obtained from Iringa District Council office showing that there were a total of 30 NGOs, 10 FBOs and 10 CBOs that were actively implementing HIV/AIDS interventions.

4.3 Organisational Focus of CSOs

Basing on their organisational focus, Civil Society Organisations studied were further classified into international, national and local organisations. In this particular study, international organisations meant those working worldwide while national organisations referred to those originated in Tanzania but operated national wide and local organisations referred to organisations established in Iringa region and operated in the whole region or parts of the region. This study comprised of 10% international organisations while 20% and 70% were national and local organisations respectively.

Some of international and national organisations had other operations in the study area, they implemented HIV/AIDS interventions as a cross cutting issue in line with their primary projects as efforts to combat the epidemic. These organisations are AMREF and CARE (international organisations); and Tanzania Home Economics Association (TAHEA) and Chama cha Uzazi na Malezi bora Tanzania (UMATI) being national wide organisations. AMREF for example, its projects revolved around poverty alleviation through community involvement, sustainability and gender balance. The emergence of HIV/AIDS epidemic caused the organisation to have HIV/AIDS as one of the priority intervention areas because of its relation with poverty.

4.4 HIV/AIDS Thematic Areas Addressed by CSOs

The fight against HIV//AIDS is diverse; various interventions were implemented by CSOs in the efforts to combat the epidemic. Study results in Table 1 show that, CSOs interventions revolved around four thematic areas namely impact mitigation (41.8%), HIV prevention (30.9%), voluntary counselling and testing (16.4%) as well as capacity building (10.9%). Increased HIV/AIDS incidence resulted into increased number of people living with HIV/AIDS (PLHAs) and HIV/AIDS related deaths both resulted into

increased number of orphans and vulnerable children.

Impact mitigation activities implemented were visiting PLHAs for moral support; awareness raising especially on stigma and discrimination; care and support for PLHAs, orphans and vulnerable children. Despite the fact that other HIV/AIDS thematic areas were addressed more than the other, thematic areas are interrelated hence organisations implemented interventions in more than one thematic area for better achievements.

Table 1: HIV/AIDS thematic areas addressed by CSOs

HIV/AIDS thematic area addressed	Civil Society Organisations			
	NGOs	FBOs	CBOs	Total
HIV/AIDS Impact mitigation	15(40.5)	5(45.5)	3(42.9)	23(41.8)
HIV Prevention	11(29.7)	2(18.2)	4(57.1)	17(30.9)
HIV Voluntary testing and counselling	6(16.2)	3(27.3)	0(0.0)	9(16.4)
Capacity building	5(13.5)	1(9.1)	0(0.0)	6 (10.9)
Total	**37(67.3)**	**11(20.0)**	**7(12.7)**	**55(100.0)**

Results are based on multiple responses.
Figures in parenthesis are the percentage of responses from the sampled CSOs.

Table 1 show that there were variations in the HIV/AIDS thematic areas addressed within the categories of CSOs studied. Forty six percent of responses from the studied FBOs indicated that they engaged mostly in impact mitigation followed by HIV testing and counselling services (27.3%). HIV/AIDS impact mitigation fits well within the overall mission of the faith based organisations (Corman *et al.*, 2005). The power of FBOs lies in providing services for people. For instance, they run orphanages and dispensaries, and their role in providing health services remains strong.

Responses from the community based organisations (CBOs) studied showed that they mostly addressed HIV prevention (51.7%) followed by HIV/AIDS impact mitigation (42.9%) as indicated in Table 1. Community based organisations (CBOs) being locally

based they were involved in HIV prevention because they were aware of the risk behaviours their community members were involved in; hence they were in the best position to address them than other people who were not staying in that community. On the aspect of impact mitigation, these organisations were aware of the needy people in particular the PLHAs and orphans hence they provided them with the right support needed. These organisations were not involved in HIV voluntary counselling and testing (VCT) services and capacity building due to limited skills in health issues.

NGOs studied were involved across all the HIV/AIDS thematic areas identified in the study. Study results show that 40.5% of responses from the studied NGOs indicated their involvement in HIV impact mitigation whereas 29.7% of NGOs responses indicated that they were involved in HIV prevention activities (Table 1). This shows that, NGOs are relatively capable of implementing diverse HIV/AIDS interventions because they have high interaction with various donors better able solicit fund from various sources and they are flexible to accommodate various interventions through scaling up provisions they have (Haapanen, 2007). They can scale up through expanding geographical coverage or implementing interventions in more than one HIV/AIDS thematic area depending on fund availability. Not only that but also international NGOs studied were the key players in capacity building of other local civil society organisations and source of funding to other local CSOs.

4.5 CSOs Approaches in Combating HIV/AIDS

Civil Society Organisations (CSOs) have played a significant role in AIDS programmes from an early stage of the AIDS epidemic. Interviews with the key informants revealed that, CSOs' interventions have lead to reduced stigma as the result community members are going for HIV test, HIV positive people are joining post test clubs (PTCs), presence of

community initiatives such as contributions for travel costs for people living with HIV/AIDS (PLHAs) to attend care and treatment clinics (CTCs) and provision of basic needs for PLHAs, orphans and vulnerable children. This section will explain the approaches used by CSOs and their achievements basing on the four HIV/AIDS thematic areas identified in the study.

4.5.1 HIV/AIDS prevention approaches

HIV/AIDS prevention is the only hope for overcoming the epidemic in the absence of any treatment. Hung *et al.* (1998) contended that, the key to preventing AIDS is to stop the transmission of the HIV virus before it enters the human body. The sampled CSOs indicated that, HIV/AIDS prevention was done through awareness raising. Twenty two percent of responses from the sampled CSOs indicated that they created awareness through seminars, 17.1% of CSOs' responses indicated the use of school sessions and 17.1% of CSOs' responses showed the use of performing arts (Table 2). These CSOs were educating the community members on HIV/AIDS issues including ways of HIV transmission; ways of preventing HIV infections (like, abstinence, faithfulness, reducing number of sexual partners, safe sex, and condom use) and life skills education.

Performing arts were mostly used to address HIV/AIDS prevention issues; the method was effective at gathering people due its education through entertainment nature thus community members were entertained and educated at the same time. The performing arts used were poems, songs, drama, story telling, traditional dancing and comedies. Theatre arts groups were surveying the target area prior to the performance to know the problems existing there so that they can be addressed in the arts. Drama and story telling were made participatory where the audience discussed what has been seen or heard and how the

issues related to them and to the community. Through situation analysis prior to performance, most of the situations addressed were existing in the respective communities. Thereafter, community members were involved in the discussion on how to tackle the problem addressed in the arts. This was done in such a way to encourage community initiatives in addressing problems basing on their community environment (UNESCO, 2006).

Table 2: HIV/AIDS prevention activities by CSOs

Activities for HIV prevention	Civil Society Organisations			
	NGOs	FBOs	CBOs	Total
Seminars	7(25.9)	2(25.0)	0(0.0)	9(22.0)
Performing arts	3(11.1)	0(0.0)	4(66.7)	7(17.1)
School sessions	5(18.5)	2(25.0)	0(0.0)	7(17.1)
Sports	3(11.1)	0(0.0)	0(0.0)	3(7.3)
Production of newsletters	1(3.7)	0(0.0)	0(0.0)	1(2.4)
Condom distribution	1(3.7)	0(0.0)	0(0.0)	1(2.4)
No any activity implemented	7(25.9)	4(50.0)	2(33.3)	13(31.7)
Total	**27(65.9)**	**8(19.5)**	**6(14.6)**	**41(100.0)**

Figures in parenthesis are the percentage of responses from the sampled CSOs.

Performing arts was the methodology used by all four CBOs (66.7%) involved in HIV/AIDS prevention through awareness raising (Table 2). Different from other approaches like seminars and school lessons that required personnel that received some training on how to address HIV/AIDS issues, performing arts used talented community members to come up with arts that were used to educate the community.

Seminars and school sessions were mainly conducted to in and out of school youths respectively; more emphasis was on life skills education. This education was important because youths were at high risk of contracting HIV; it intended at making them act on the HIV prevention information as pointed out by Hubley *et al.* (1995). With life skills education, messages like 'say no to sex' (abstinence), condom use negotiations and how to use condoms were taught. Non formal education techniques like role plays, story telling

were used during the sessions in order to encourage youth to participate. Learning by practicing such as demonstrating how a person particularly a female can say no to sex was also done. This was done in order to make them confident to act on their own decisions. The study also found that, abstinence was highly emphasized to primary and secondary school students and unmarried out of school youth while faithfulness was for married couples. On the other hand safer sex and condom use were also encouraged for people who can neither abstain nor be faithful for example young people beginning adult life who may not get married for several years or more (Hubley *et al.*, 1995).

4.5.2 Achievements in HIV/AIDS awareness raising

The study found that about 60 169 community members were educated on HIV/AIDS through awareness raising activities while out of school and in-school youth reached were about 28 216 and 8477 respectively (Fig. 2). Results also show that about eleven (11) CSOs reached community members (out of school youth and adults) as opposed to two (2) CSOs operated in both schools and community. Few organisations worked in schools because school settings are not flexible, presence of fixed number of sessions per year limits external interferences. CSOs conducting HIV/AIDS education in schools were those able to conduct HIV/AIDS sessions as substitute to the HIV/AIDS sessions allocated in health or science subjects, there was no provision for extra sessions allocated to CSOs' interventions. Furthermore, HIV/AIDS is not taken as a separate subject in the schools curricula instead it is a topic in Civics, General Studies and Biology subjects for Secondary schools and in Science subject for Primary schools (Sayi, 2007).

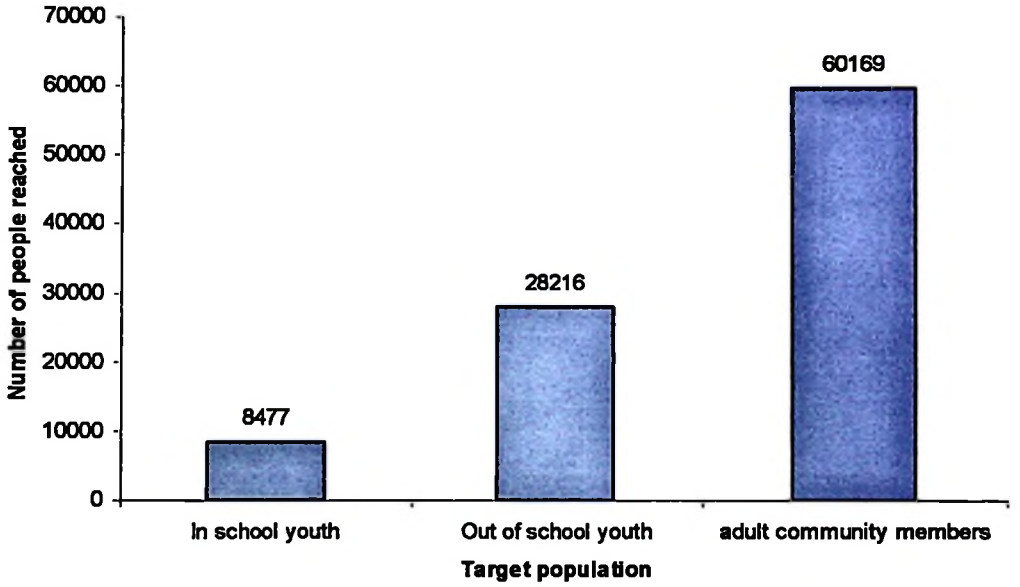

Figure 2: Sampled CSOs and HIV/AIDS awareness education in 2006/2007

4.5.3 HIV/AIDS impact mitigation approaches

HIV/AIDS epidemic has posed a lot of challenges in the communities and a nation as a whole. There are adverse effects of the epidemic everywhere in the country; people infected and affected by the epidemic face a lot of life challenges ranging from social to economic. CSOs are doing a range of interventions in mitigating the impact. In this particular study, impact mitigation was subdivided into care and support of people living with HIV/AIDS (PLHAs) and support of orphans and vulnerable children (OVCs).

4.5.3.1 Care and support for Orphans and Vulnerable Children

In this context, an orphan was considered to be a child under age 18 years who has lost one or both parents while a vulnerable child was the one under age 18 years, with one or both parents being very sick unable to provide the child with basic needs. This study found that 36.7% and 16.7% of sampled CSOs provided support to OVCs through their care givers and caring them at the centre respectively (Table 3). This kind of OVCs'

support was also pointed out by URT (2003b) that, support activities should be sustained in close relation with the existing traditional family and community systems (extended families) which are unable to absorb the challenge of increased number of orphans. Therefore this kind of support provided by CSOs helped the families to provide the orphans with basic needs. Among the basic needs provided were food, cloth, school uniforms, exercise books, pens and money for school fees and other school contributions.

Table 3: Impact mitigation activities by CSOs

Activities for OVCs support	Civil Society Organisations			
	NGOs	FBOs	CBOs	Total
Basic needs through care givers	8(44.4)	2(33.3)	1(16.7)	11(36.7)
Caring them at the centre	3(16.7)	2(33.3)	0(0.0)	5(16.7)
Staying with them	0(0.0)	0(0.0)	1(16.7)	1(3.3)
No any activity implemented	7(38.9)	2(33.3)	4(66.7)	13(43.3)
Total*	**18(100.0)**	**6(100.0)**	**6(100.0)**	**30(100.0)**
Activities for PLHAs support				
Provision of basic needs	7(30.4)	3(33.3)	2(22.2)	12(29.3)
Home visits	5(21.7)	1(11.1)	3(33.3)	9(22.0)
Opportunistic infections drugs	1(4.3)	1(11.1)	1(11.1)	3(7.3)
ARVs provision	0(0.0)	1(11.1)	0(0.0)	1(2.4)
Income generating activities support	1(4.3)	1(11.1)	0(0.0)	2(4.9)
No any activity implemented	9(39.1)	2(22.2)	3(33.3)	14(34.1)
Total**	**23(56.1)**	**9(22.0)**	**9(22.0)**	**41(100.0)**

*Results are based on respondents. **Results are based on multiple responses.
Figures in parenthesis are the percentages.

4.5.3.2 Care and support for People Living with HIV/AIDS

Care and support for People Living with HIV/AIDS (PLHAs) is important not only for making infected people live longer but also for reducing the transmission of HIV. According to Dowshen (2007), most people do not develop AIDS symptoms for 10 to 12 years and others remain symptom free for much longer. However, Hubley *et al.* (1995) pointed out that, a person dies 1-2 years after showing AIDS symptoms when no care provided. With proper care support system a person can live longer. Results in Table 3 show that, 40% of responses from the interviewed CSOs indicated that they provided

basic needs while 30% and 10% of responses indicated that CSOs visited them and provided drugs for opportunistic infections treatment respectively. This was in line with Dowshen (2007) and Hubley et *al.* (1995) findings that, treatment of AIDS consists of providing drugs to treat the different opportunistic infections. This, together with maintaining good nutrition, can lead to apparent recovery hence making the infected person to live longer.

Civil society organisations reported that home visits were done regularly in order to provide moral support to the sick person and family members; assess their needs in physical and meet those needs through practical measures such as drugs and other basic needs provision. Needs identification was mentioned to be useful because needs were not only met by organisations that conducted home visits but also other organisations that provided support through referral services. Provision of drugs was done at home of the sick person while basic needs provision was done at the Village or Mtaa government office. PLHAs or their representatives for those beds ridden PLHAs collected basic needs from the village office. This shows transparency on support provided to PLHAs and ensuring that the support reaches the intended beneficiaries. On the other hand the situation limited some of PLHAs to get support due to confidentiality attached to them hence those who were open received support from many organisations.

4.5.4 Performance in impact mitigation

4.5.4.1 Orphans and Vulnerable children reached

Results in Figure 3 show that, provision of basic needs was a kind of support given much priority for OVCs with about 4949 children reached. The number of OVCs supported for secondary education (134) was relatively lower than those supported for primary

education (423) because the costs for secondary education are much higher than that of primary schools such that CSOs can not afford to support a large number of students. Government primary school education costs were minimised, for example the removal of school fees so as to meet universal primary education for all (UN, 2006), hence CSOs can afford to support a substantial number of primary school students.

About 508 OVCs were cared for at the centre (Fig. 3); this number is also relatively low. However it is greater than those supported for secondary education; this is because intervention needs a very reliable funding and more commitment. Funding is needed for providing them with basic needs (shelter, cloth and food), education and health services support. It was further reported that, OVCs who were at the age of primary school education attended nearby schools for easy access. Once passed for secondary schools, they were also supported to pursue the studies. It was further found that 108 OVCs were supported to attend vocational training of their choice.

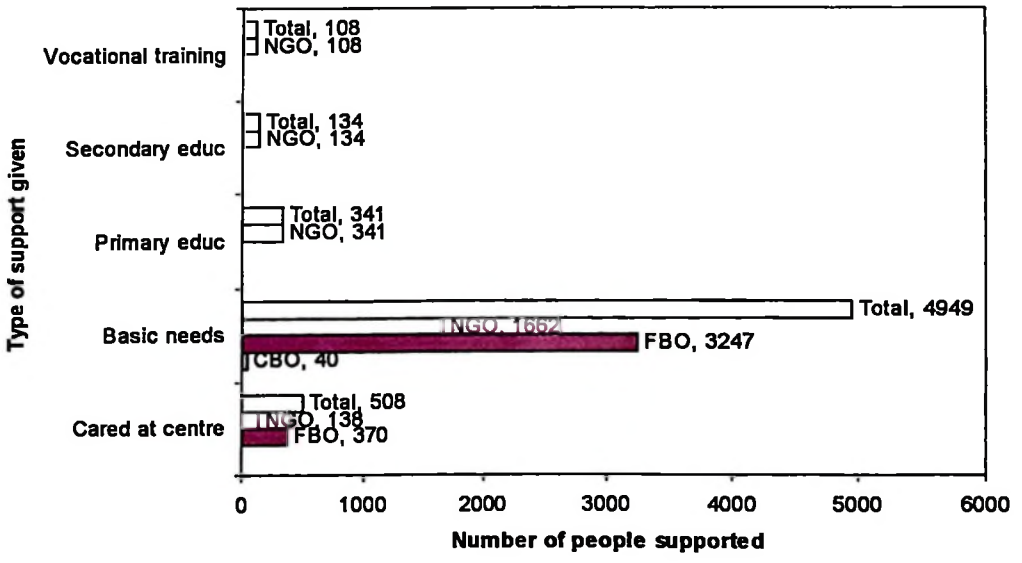

Figure 3: Sampled CSOs and orphans and vulnerable children support in 2006/2007

Selection of OVCs to be supported was based on the level of the requirements, amount of materials and/or type of support the respective CSO can offer. In most cases 'worse off OVCs' were considered more than the 'better off OVCs'. Information on the number of orphans to be supported was found from school head teachers for school pupils and/or Village or Mtaa government offices. This was the commonly used way of identifying OVCs to be supported especially in the support of basic needs through care givers.

On the other hand, selection for OVCs to be cared in the orphanage centres unlike the selection of OVCs for other support was through application letter written by relative of the prospective beneficiary and endorsed by the respective Village/Mtaa government leaders. Close assessment visits were also conducted by the orphanage centres staffs in the respective Village/Mtaa to ensure that the support was given to the right person. Since orphanage centres costs were relatively high compared to other kinds of support for OVCs found in the study, all orphanage centres studied reported to consist of 'worse off OVCs'.

4.5.4.2 People Living with HIV/AIDS reached

Evidence has shown that a person with HIV can live productively when provided with proper care and support (Dowshen, 2007; Hubley *et al.*, 1995). The interviewed CSOs indicated that by the time of the survey they had visited about 4789 PLHAs for moral support and awareness raising, 3869 PLHAs were provided basic needs support and 443 PLHAs were provided with drugs for opportunistic infections treatment (Fig. 4). Home visits were done by HBC volunteers as well as community based organisation members. The visits were intended to help not only the patient but also the other family members in making them cope with their own feelings and reactions.

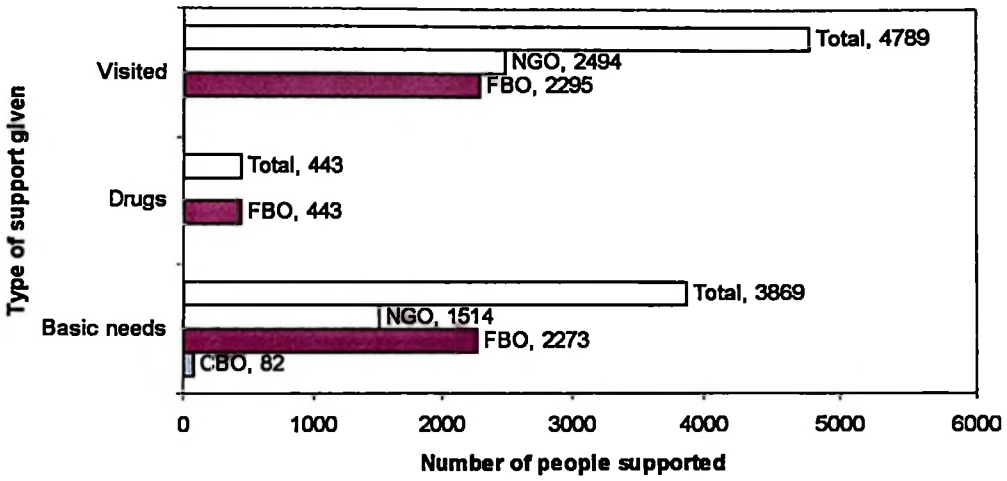

Figure 4: Sampled CSOs and people living with HIV/AIDS reached in 2006/2007

About 660 people were provided with IGAs support (Fig. 5), the support was given to both infected and affected people to assist them to raise their income status. Income generating activities mentioned were keeping chicken, goats and pigs. Among organisations studied only two organisations were involved in the provision of income generating activities support. The number of women supported was 367 while that of male was 293. More women than men were supported because women were more responsible for taking care of orphans and vulnerable children more than men, the aspect that was also reported by TACAIDS (2005). For instance, Anti-Female Genital Mutilation Network (AFNET) reported to consider widows living with HIV/AIDS more than widowers living with HIV/AIDS because widows faced a lot of challenges including their family properties being taken by their late husbands' relatives the aspect that lead them to a poor standard of living.

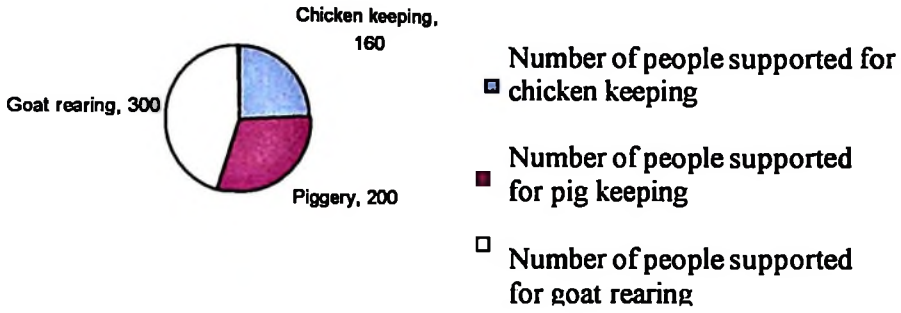

Figure 5: Income generating activities support by sampled CSOs in 2006/2007

4.5.5 Voluntary HIV Counselling and Testing

Voluntary HIV counselling and testing takes two facets (Hubley *et al.*, 1995); the first is when a person goes for HIV screening willingly without being forced in anyhow. This testing is associated with pre and post test counselling. The second component of this aspect is for a person who is found infected during the test, the counselling provided to this person is not the same with that during the test. This second component of counselling is continuous such that a person is counselled on how to accept the situation and live positively with that HIV status. The organisations interviewed were conducting both facets of counselling. Interventions in this HIV/AIDS thematic area were only done by eight NGOs and four FBOs no any CBO among those studied had VCT interventions and this might be due to limited skills these organisations have (Table 4).

From the study findings shown in Table 4, counselling and referral services were both indicated by 12.1% of responses from the sampled CSOs. It was further found that these activities were done by CSOs implementing home or community based care services. The services were provided by local volunteers who received basic training on counselling. Referral services were done on complicated cases beyond their knowledge and skills. Among the referral cases mentioned were medication complications, counselling services, legal issues and support services. URT (2003a) mentioned that, home or community based

care service is important because health-care system especially on hospital care is limited in a developing country like Tanzania. This system is also important in mobilising the communities and promoting compassion for those infected and affected by the epidemic. Mobilising people for VCT was reported by 6.1% of responses all being from NGOs; FBOs did not mobilise people for VCT (Table 4).

Further investigation show that mobilisation of people was done by NGOs that were implementing HIV/AIDS prevention through awareness raising in which FBOs involvement was also found to be relatively low (Section 4.4). Organisations implemented HIV prevention addressed the issue of VCT as another measure for HIV/AIDS prevention, then community members who were interested in testing for HIV were mobilised. The mobilising organisation was responsible to seek for other organisations with those services to provide mobile VCT services to those mobilised community members. This was also noted during focus group discussion that mobile VCT service was helpful to the community members because they were far from the VCT centres located in town that demanded them to incur travel costs.

Results in Table 4 show that, 6.1% of responses from the sampled CSOs indicated that they operated HIV voluntary counselling and testing centres. These CSOs had professional personnel in counselling and testing. Apart from the need of skilled personnel, the establishment of centre have to pass through different authorities for approval the aspect that limited CSOs involved in that service delivery. In the interview with the Council HIV/AIDS coordinator (CHACC), it was noted that VCT services especially the component of testing and ARVs provision is mostly done by the government due to medical ethics attached to the service.

Table 4: HIV voluntary counselling and testing activities

Activities for VCT	Civil Society Organisations			
	NGOs	FBOs	CBOs	Total
Counselling services	2(10.0)	2(28.6)	0(0.0)	4(12.1)
Referral services	3(15.0)	1(14.3)	0(0.0)	4(12.1)
Mobilising people for VCT	2(10.0)	0(0.0)	0(0.0)	2(6.1)
Centre for VCT	1(5.0)	1(14.3)	0(0.0)	2(6.1)
No any activity conducted	12(60.0)	3(42.9)	6(100.0)	21(63.6)
Total	**20(60.6)**	**7(21.2)**	**6(18.2)**	**33(100.0)**

Figures in parenthesis are the percentage of responses from the sampled CSOs.

4.5.6 Performance in HIV voluntary counselling and testing

Table 5 shows that, about 1724 and 1798 people were counselled and tested respectively. People counselled and tested were from the two (2) CSOs that had centre for VCT services as shown in Table 5. The number of people counselled is exclusive of those received pre and post HIV test counselling; this shows that other people attended the centres for getting counselling services only.

Table 5: Voluntary counselling and testing services by sampled CSOs in 2006/2007

VCT services	"N"	Minimum	Maximum	Total
People Counselled	2	518	1280	1798
People tested	2	518	1206	1724

"N" Number of organisations involved in VCT services

4.5.7 Capacity building

The results indicated in Table 6 show that, 15.2% of responses from the sampled CSOs showed that they trained local volunteers while 9.1% and 3% of CSOs' responses indicated that they trained other CSOs and community leaders respectively. The major aim of training local volunteers was to equip them with knowledge and skills in implementing the required services. Among the aspects taught were home based care services, basic counselling principles, facilitation skills, communication skills and life skills. Training of other CSOs was specifically done by international organisations in order to enable local

organisations to implement quality programmes. This situation shows that CSOs provided training to people that worked in delivering the intervention at the grassroots level. It was noted that civil society organisations that implemented interventions through the use of volunteers ensured that their volunteers were well equipped with knowledge and skills relevant to the intervention.

Table 6: Capacity building activities conducted by sampled CSOs in 2006/2007

Activities for capacity building	Civil Society Organisations			
	NGOs	FBOs	CBOs	Total
Training of local volunteers	4(19.0)	1(16.7)	0(0.0)	5(15.2)
Training of other CSOs	3(14.3)	0(0.0)	0(0.0)	3(9.1)
Training of community leaders	1(4.8)	0(0.0)	0(0.0)	1(3.0)
No any activity implemented	13(61.9)	5(83.3)	6(100.0)	24(72.7)
Total	**21(63.6)**	**6(18.2)**	**6(18.2)**	**33(100.0)**

Figures in parenthesis are the percentage of responses from the sampled CSOs.

4.5.8 Performance in capacity building

Despite the fact that this thematic area needed a good resource base, sampled CSOs indicated that about 421 volunteers were trained (Table 7); out of this 361 volunteers were for home based care provision. It was indicated during the interviews that HBC volunteers served a minimum number of ten PLHAs; from this data it implies that volunteers served a total of about 3610 people that could have been admitted in the government hospitals. Limited space and number of medical doctors in the government hospitals could have been a challenge in attending those people in hospitals (URT, 2003a). This was also noted in the focus group discussions that HBC services reduced the number of patients in hospitals and medical doctors' workload.

Only two organisations (AMREF and Nuru CARE) trained other four (4) CSOs (Table 7), these were international organisations having health professional personnel the fact that made training of other CSOs possible. According to Haapanen (2007), international NGOs

play an important role as the 'capacity builders' of civil society. About 82 community leaders were also trained. Training of community leaders was done to facilitate effective implementation of HIV/AIDS interventions through providing supportive working environment for CSOs in their respective communities.

Table 7: Training conducted by CSOs in 2006/2007

Training	"N"	Minimum	Maximum	Total
Volunteers trained	5	40	200	421
CSOs trained	2	4	5	9
Community leaders trained	1	82	82	82

"N"- Number of organisations conducted training

4.6 Institutional Management of CSOs

This section discusses the institutional management of CSOs involved in combating HIV/AIDS. Major focus is on the national response on HIV/AIDS; organisational structure of CSOs; institutional and legal framework for CSOs; government – CSOs relationship and institutional management challenges.

4.6.1 National response on HIV/AIDS

The Government of Tanzania responded to HIV/AIDS epidemic since 1985 through the implementation of various programmes aimed at combating the epidemic. National AIDS Control Program (NACP) was established in 1986 under the Ministry of Health (URT, 2003a). This program perceived HIV/AIDS as a health problem and the campaign to deal with it involved the health sectors only (TACAIDS, 2005). The response did not have much impact on the progression of the epidemic as was expected (Appendix 8). Then, the government declared the epidemic to be a national disaster as a strategy towards comprehensive efforts in combating the epidemic (TACAIDS, 2005). Tanzania Commission for AIDS (TACAIDS) was therefore formed in December 2000 being

instituted under the Prime Minister's Office to coordinate and intensify the national multi-sectoral response (URT, 2003a). TACAIDS also spearheaded the establishment of the National HIV/AIDS Policy in 2001 (URT, 2003a).

In 2003, TACAIDS produced the National Multi-sectoral Strategic Framework on HIV/AIDS (2003-2007) which stipulated that Local Government Authorities (LGAs) were needed to play a crucial role in planning and Coordinating HIV/AIDS interventions that are implemented by various organizations and communities in the districts in order to ensure sustainability, coordination and ownership of the interventions (URT, 2003a). Following this, District and Village HIV/AIDS committees were created under TACAIDS Act of Parliament to lead the planning, resource mobilization and coordination of local responses (URT, 2001c). The formation, composition and responsibilities of these committees are stipulated in Appendix 8. These efforts included a call of all sectors to take new measures to respond to the epidemic. This call caused various actors including civil society organisations to implement HIV/AIDS interventions in the efforts to combat the epidemic (URT, 2003a).

4.6.2 Organisational structure of civil society organisations

Despite the efforts placed by the government during the early stages of the epidemic, the presence of the disease was denied by the community because HIV positive persons do not show any evidence of infection for some years and will look and feel healthy (Hubley *et al.*, 1995). It took twenty years (1983-03) for the government of Tanzania to declare the HIV/AIDS epidemic as a social problem since the first AIDS cases were reported in Tanzania (TACAIDS, 2005). This indicates that, HIV/AIDS interventions implemented by civil society organizations gained prominence in the late 1980s with the realisation that HIV/AIDS was no longer just a health problem but also a social problem (Small, 1997).

The findings of this study indicate that 50.0% of CSOs interviewed started in 2000-05 and 26.7% started in 1995-00 (Table 8).

Table 8: Year of start of civil society organisations

Year of start	Civil society organisations			
	NGOs	FBOs	CBOs	Total
Before 1985	2(11.1)	1(16.7)	0(0.0)	3(10.0)
1985 - 1990	0(0.0)	1(16.7)	0(0.0)	1(3.3)
1990 - 1995	2(11.1)	0(0.0)	0(0.0)	2(6.7)
1995 - 2000	5(27.8)	1(16.7)	2(33.3)	8(26.7)
2000 - 2005	9(50.0)	3(50.0)	3(50.0)	15(50.0)
After 2005	0(0.0)	0(0.0)	1(16.7)	1(3.3)
Total	**18(100.0)**	**6(100.0)**	**6(100.0)**	**30(100.0)**

Figures in parenthesis are the percentages of CSOs interviewed.

4.6.3 CSO's legal framework

Civil Society Organisations are legally recognized entities which operate under the national laws. Registration of CSOs is the mechanism through which organisations are provided with regulations to follow including the reporting procedures, the process also provides information for monitoring and oversight of organisations involved in combating HIV/AIDS in order to ensure that organisations do not generate profit for their owners; if a profit is generated it is used back into the organisation (Barr and Fafchamps, 2005). Not only that but also holding the organisations accountable to the state, donors and clients. Registration of civil society organisations in Tanzania have been through different legislations.

According to Faisal (2004), most NGOs and CBOs in Tanzania were registered under the Societies Ordinance of 1954. Other legislations giving legitimacy to civil societies in the country are Trustees Incorporation Ordinance of 1956, the Companies Ordinance of 1935, National Sports Council Act of 1967, Trade Unions Act of 1991, Political Parties Act of 1992 and the Cooperatives Act of 1991. Different from other entities of the civil society

organisations, NGOs position in Tanzania is well established, guaranteed by law and well acknowledged in the NGOs Act of 2002 (URT, 2002a; Appendix 9).

Study results show that (30%) of the interviewed CSOs were registered under the Ministry of Home Affairs. Another 6.7% of the CSOs were registered under three ministries/departments, that is, Ministry of Health, Sports Council of Tanzania and Vice President Office (Table 9). Four (22.2%) NGOs reported to be registered but spokespersons were not aware of the ministry under which their organisations were registered. The spokespersons were either not involved in the registration process or registration was done at the head office located out of Iringa District. Only one NGO was not registered, this was the orphanage centre established in 2005. When further investigation was done, it was noted that application for its registration was done but the registration certificate was not yet provided by the time the survey was conducted.

Investigations on the legal framework of CSOs also found that, the Vice President's Office was responsible for the coordination of NGOs activities (URT, 2001b; Appendix 9) before the responsibility was shifted to the Ministry of Community Development, Gender and Children in 2006 (MCDGC, 2006). However, the NGOs policy explains the presence of contact officers in the 'sector ministries' (URT, 2001b). The contact officers' role is to enhance relations with NGOs having common interest with the Ministry. During the study, it was observed that CSOs lack clear understanding on matters relating to the registration and actual implementation of their interventions the aspect that make them fail to differentiate between the line ministries, legislation bodies and the Ministry coordinating NGOs matters. Societies Ordinance and Sports Council of Tanzania were mentioned to be the office of the registrar (Table 9) while these are legislation bodies guiding the registration process of civil society organisations (Faisal, 2004). Other CSOs

mentioned that they were registered by sector ministries including the Ministry of Education, Ministry of Home Affairs and Ministry of Health (URT, 2001b).

Table 9: Registration of Civil Society Organisations

Ministry for registration	Civil society organisations			
	NGOs	FBOs	CBOs	Total
Vice President Office	2(11.1)	0(0.0)	0(0.0)	2(6.7)
Home Affairs	7(38.9)	2(33.3)	0(0.0)	9(30.0)
Ministry of Health	2(11.1)	0(0.0)	0(0.0)	2(6.7)
Sports Council of Tanzania	0(0.0)	0(0.0)	2(33.3)	2(6.7)
Ministry of Education	1(5.6)	0(0.0)	0(0.0)	1 (3.3)
Societies Ordinance	1(5.6)	0(0.0)	0(0.0)	1 (3.3)
Do not know	4(22.2)	0(0.0)	0(0.0)	4(13.3)
Not registered	1(5.6)	4(66.7)	4(66.7)	9(30.0)
Total	**18(100.0)**	**6(100.0)**	**6(100.0)**	**30(100.0)**

Figures in parenthesis are the percentages of CSOs.

Results in Table 9 indicate that 13(72.3%) NGOs were registered but only 2(33.3%) FBOs and CBOs interviewed were registered. This is because NGOs are coordinated by the central government, they have well structured registration procedures and they are issued with registration certificates. HIV/AIDS interventions conducted by religious organisations were projects within the already existing registered religions hence there was no separate registration done to those interventions rather than working under the umbrella of the religious institutions. Separate registration was done for interventions like orphanage centres and voluntary counselling and testing (VCT) centres because of the ethics attached to those interventions. The two CBOs reported to have registered were the theatre arts groups registered under the Sports Council of Tanzania. They were registered because they aimed at conducting their performances beyond Iringa Region. The study regarded them as community based organisations because they were found to be community members' initiatives and they had not started to operate national wide when the survey was undertaken.

Community based organizations (CBOs) and faith based organizations (FBOs) introduced their HIV/AIDS interventions to the local government authorities by writing application letters requesting for formal recognition. The application letters were endorsed by the Village/Mtaa government leaders and the Ward community development officer in which CBO of FBO operated. The Community development department at the district level establish file for each organisation that applied for formal recognition and tracking their progress. The low number of HIV/AIDS interventions undertaken by FBOs and CBOs is partly a result of the application procedures for formal recognition. Lack of a well defined registration procedure limits the recognition of their exact numbers as pointed out by Haapanen (2007). The author mentioned that, CBOs usually operate at grass roots level, particularly with the poor, disadvantaged and marginalized people; their number is not known because they are not officially registered.

4.6.4 Institutional framework for CSOs

Institutional framework provides a basis for coordination of CSOs. The NGO Act (URT, 2002a; Appendix 9) stipulated the aspect of NGOs accountability that, each Non Governmental Organization shall for every calendar year: Prepare a report of its activities to be made available to the Public, the Council, the Board and other stake holders; prepare an annual audited report and submit copies to the Council and the Board. The study found that, 90% of responses from the sampled CSOs those submitted both operational and financial reports to the Local Government were funded by the district council through RFA. Thirty one percent of the sampled CSOs responses indicated that they did not submit financial reports to the District Council; these CSOs obtained funds from external donors and other sources (Table 10).

One CSO reported to have no any source of funding (Table 10); this was the post test club (PTC) started in January 2006 by people living with HIV/AIDS (PLHAs). This CSO was addressing HIV prevention through awareness raising using performing arts. Further investigations on this CSO found that, they decided to speak out about their infection status in order encourage other people to come forward for testing. It was also mentioned that, their openness can change the image of HIV/AIDS from illness, suffering and death to living positively with HIV. This CSO reported to have not received any funding, they worked on voluntary basis the situation that was reported to be challenging to them regarding the financial constraint PLHAs face (Jamil and Muriisa, 2004). The club submitted its operational reports to the government as efforts to be recognised by the government for due consideration on government HIV/AIDS funding.

Table 10: CSOs source of funding and reporting to government

	Type of report submitted to the local government		
CSOs source of funding	Operational report	Both operational and financial reports	
External donors	5(55.6)	16(80.0)	21(72.4)
Tanzanian government	3(33.3)	18(90.0)	21(72.4)
Own contributions	1(11.1)	4(20.0)	5(17.2)
Church donations	0(0.0)	2(10.0)	2 (6.9)
Community contributions	1(11.1)	0(0.0)	1(3.4)
No any source of funding	1(11.1)	0(0.0)	1(3.4)
Total	**9(31.0)**	**20(69.0)**	**29(100.0)**

Figures in parenthesis are the percentages of CSOs.

Interviews with the key informants revealed that, it was difficult to obtain reports from CSOs that were not funded by the government this was due to the fact that their operations were independent from government interventions. This sometimes made CSOs not to be accountable to the government system. Although the NGO Act of 2002 stipulated the reporting mechanism, none of the NGOs studied mentioned to have reported to the National Council of NGOs and/or the Coordination Board of NGOs as par registration

guidelines (URT, 2002a). Since the NGO Act does not cover other CSOs such as religious organizations or community based organizations, reports from these organisations were submitted to the district council only. This can be said that, poor reporting of CSOs activities limit the recognition of the role they play in combating HIV/AIDS.

4.6.5 Government-CSO partnership

As the government recognizes the important role and contribution of NGOs in society, the NGO policy urges the government to consider NGOs as important partners in the development process by creating a conducive and enabling environment to ensure that NGOs' potential is utilized. In this particular study, government-CSO partnership was investigated in terms of how they collaborated; how CSOs get funds from the government and how government monitored and evaluated CSO activities.

4.6.5.1 Government and CSOs collaboration

Government and CSOs collaborated in various ways. When asked their views on the level of collaboration, the responses in Table 11 show that 73.3% of the sampled CSOs said that the level of collaboration was high. The type of such collaboration was described as government support and expertise in running the organization's activities as indicated by 60.5% and joint activities as indicated by 39.5% responses of the sampled CSOs. The support was mostly needed by CSOs on more technical issues beyond the organisations' capacity for example training on issues like home based care and counselling. While joint activities mentioned were major events like world HIV/AIDS and women's days; and mobilising people for the national HIV testing campaign. This is because CSOs have the comparative advantage in mobilizing community members.

Government and CSOs activities are complimentary to one another, that is, they both need each other for their effectiveness in combating HIV/AIDS (Jamil and Muriisa, 2004). The study further found that, during the last financial year HIV/AIDS interventions were mostly done by CSOs. In Iringa Rural District Council for example; it supported school fees for 88 secondary school orphans, 444 orphans were provided food, organised two stakeholders meetings and visited 16 wards to monitor HIV/AIDS interventions. On the other hand Iringa Municipal Council did not implement any HIV/AIDS activity because it did not get funding.

Table 11: Government-CSO partnership information

Level of collaboration	Responses	Percent
High	22	73.3
Moderate	8	26.7
Total	**30**	**100.0**
Collaboration Ways		
Joint Activities	15	39.5
Government staff's support and expertise	23	60.5
Total	**38**	**100.0**

4.6.5.2 Government funding to CSOs

Government funding support to CSOs helps the Local government Authority to take on the role of planning and coordinating HIV/AIDS interventions while benefiting from the efforts of CSOs. Government funding is coordinated by TACAIDS which has contracted Regional Facilitating Agencies (RFAs) to manage the funds in regions or zones (combination of regions). The interview with the key informants on how TACAIDS money was channelled to CSOs indicated that action plans of CSOs were submitted to the District Council; the regional facilitating agency (RFA) together with the District Council Officials selected the plans that were worthy to finance. The selection process was based on the areas of operations and HIV/AIDS thematic areas given priority by the District

Council.

Despite the fact that TACAIDS contracted RFAs to manage funds; the funding channel reduced the amount of money supposed to be invested in HIV/AIDS interventions. RFAs being intermediary actors, they used part of the fund to cover their operational costs. This amount of fund could otherwise be invested in the interventions if the existing government or civil society's structures were used instead of the RFAs. This shows that HIV/AIDS government funding has fundamental limitations in meeting the needs of the target community.

4.6.5.3 Monitoring and evaluation of CSOs activities by government

Monitoring and evaluation of CSOs activities is very important in order to assess their contribution in the fight against HIV/AIDS. Key informants interviewed noted that, the action plans submitted for government funding request were used as a tool for monitoring their activities. District council officials conducted field visits in the area of operations of CSOs to monitor the implementation of activities. Monitoring was done through interviews with the target beneficiaries and the community leaders. Government officials also conducted end of intervention evaluations to CSOs received government funding. However, during focus group discussions it was noted that, there was limited monitoring of CSOs' activities by the government, other CSOs implemented the interventions contrary to those originally introduced to the community members.

4.6.6 Institutional management challenges

4.6.6.1 Lack of formal networks

Networks facilitate some form of collaborative action, they provide a structure for members to establish and maintain essential communications with each other (Barr and Fafchamps, 2005). In Iringa district there were no any formal network of CSOs, these organisations lack communications with each other as the result some of them happened to work in the same place with the same target population. Key informants interviewed also mentioned that, lack of networks limits the government efforts towards coordinating CSOs activities. It is through networks where working in collaboration with CSOs can be enhanced. Lack of networks forced the district council officials to arrange meetings with them on quarterly basis in order to share information.

4.6.6.2 Lack of fundraising skills

During the interview held by District officials, it was also found that local NGOs lack competence in areas of fund raising and proposal writing. Information obtained from the office of Assistant Registrar of NGOs indicated that 64 NGOs were registered to operate in Iringa District with the aim of combating HIV/AIDS out of that only 43 NGOs were mentioned to be implementing interventions. After seeking further information from the District Council HIV/AIDS Coordinators (CHACC), about 30 NGOs were mentioned to be actively involved in combating HIV/AIDS in the district. Key informants also mentioned that other organisations that solely expected fund from the government had not implemented any activity since their registration due to limited funding from the government. CSOs were expected to compliment the district council activities through their own funding initiatives. Lack of skills in fundraising and proposal writing have caused them to implement interventions on behalf of the government rather than

complimenting government efforts because most of them (40.4%) mentioned the government as another source of funding.

4.6.6.3 Lack of transparency

Transparency in the context of this study entails openness of CSOs on their income and expenditure aspects. In the efforts towards combating HIV/AIDS, transparency is important because it is where achievements can be measured against resources committed into the efforts. During the study it was noted that sampled CSOs were not transparent both to the government and to the communities they served. In the interview with the key informants, it was observed that organisations did not share their work plans with the government except when they were seeking government funding. The government was not aware of organisations' interventions implementation at a particular time. Failure to submit reports to the NGOs Coordination Board and the National Council of NGOs also indicates lack of transparency.

During the focus group discussions with PLHAs it was also noted that, PLHAs believed that they were receiving less than it was planned. Due to lack of transparency PLHAs tend to believe that the co-founders of the organisations were benefiting more than the PLHAs. One of the members mentioned that "I *have to receive whatever I am given, I can not question because I did not know what was planned*". This situation shows that, community members can not question CSOs accountability because they fear the support will be withdrawn from them (Alnoor, 2003). Lack of transparency between CSOs resulted into duplication of efforts in some cases. However the results of the study show transparency between CSOs that lead to complementing each other and sharing of activities.

4.7 Community Members' Attitude Towards CSOs' Interventions

This section presents results on how CSOs implemented their interventions in the community and how community members viewed those interventions. It includes target groups reached; geographical area coverage; expected outcomes; activities monitoring and evaluation; inter-organisational linkages and community involvement.

4.7.1 Target groups reached by CSOs

Civil Society Organisations implemented various interventions; other interventions were specific to certain groups of community members. The study identified four major groups targeted, 31.7% of responses from the interviewed CSOs show that they targeted orphans and vulnerable children while all community members, PLHA and youth were targeted by 29.3%, 26.8% and 12.2% of responses from the studied CSOs respectively (Table 12). These results are based on multiple responses thus most organisations studied had more than one target group. These results conform to focus group discussion results that the mostly targeted groups were PLHAs and OVCs. They further said that, they knew that they targeted them because some of the discussants were staying with those beneficiaries (Table 12).

Table 12: Target population reached by CSOs

Target group	Civil Society Organisations			
	NGOs	FBOs	CBOs	Total
Orphans and Vulnerable children	8(33.3)	2(28.6)	3(30.0)	13(31.7)
All community members	7(29.2)	2(28.6)	3(30.0)	12(29.3)
People Living with HIV/AIDS	5(20.8)	3(42.9)	3(30.0)	11(26.8)
Youth	4(16.7)	0(0.0)	1(10.0)	5(12.2)
Total	**24(58.5)**	**7(17.1)**	**10(24.4)**	**41(100.0)**

Figures in parenthesis are the percentage of responses from the sampled CSOs.

4.7.2 Geographical coverage

Ward was identified to be a basic unit of operations for 83% of civil society organisations interviewed. With the exception of VCT and orphanage centres (17%), NGOs covered relatively large number of wards than FBOs; while five out of six CBOs studied each covered only one ward. When asked on the wards they were working, Nzihi and Ifunda wards in Iringa rural district had 10.3% and 7.5% of responses from CSOs working in respectively (Appendix 10). On the other hand Mwangata (5.6%) and Kihesa (5.6%) had more than one CSOs working for the case of Iringa Municipal (Appendix 10). All wards of Iringa district were reached by CSOs addressing different themes on HIV/AIDS. On the other hand, focus group discussions results noted that CSOs are free entities they have operated even in areas where the government could not have reached. This is also supported by information obtained from the district councils; for example in 2006/07 financial year Iringa Rural District Council provided HIV/AIDS education in 11 wards out of 20 wards while Iringa Municipal Council did not implement any HIV/AIDS intervention.

Incidence of the problem was mentioned by most organizations (75.9%) to be the influencing factor for the choice of location. The incidence of the problem was attributed by highways, congested settlements (slums) and economic activities undertaken in the place. Economic activities as the cause of the growing incidence of the problem were also mentioned during the focus group discussions conducted in Nzihi ward. The ward is exposed to new comers due to growing of tomatoes and the presence of Africa drinking water production factory. Many business people stayed there and engaged in unsafe sex with the community members leading to the increased rate of HIV infections, the aspect which influenced many CSOs to work in that Ward.

4.7.3 Community involvement

Community involvement in the CSOs' interventions was investigated. All CSOs interviewed said to have involved the community members. When asked on the stage of the project cycle at which community members were involved the results show that 43.6% and 28.2% of CSOs' responses showed that they involved community members in all stages and project implementation respectively while 17.9% of CSOs' responses indicated that they involved them in monitoring and evaluation of the project and 10.3% of responses from the studied CSOs revealed that they involved them in planning and designing of the project (Table 13). Furthermore, results show that community involvement in intervention implementation was through the use of local volunteers. All home based care volunteers were coming within the respective community, this was also noted during focus group discussions as members mentioned that HBC volunteers come within the village/mtaa. The use of local volunteers enhances the sustainability of intervention impact, skills equipped to volunteers are very useful even when the operations of the organisation cease.

Table 13: Community involvement in the project by CSOs

Project stage	CSOs Responses	Percent
All stages of the project cycle	17	43.6
Implementation stage	11	28.2
Monitoring and evaluation stage	7	17.9
Planning and designing stage	4	10.3
Total	**39**	**100.0**
Source of baseline information		
Considered what was happening in the community	21	61.8
Baseline survey	10	29.4
District Council	3	8.8
Total	**34**	**100.0**

Contrary to the findings on the involvement of community members in all stages, focus group discussions revealed that community members' involvement was very minimal. The CSOs' leaders introduced the CSOs to the community leaders then the latter organised

community members to attend meetings through which CSOs introduced their interventions to the intended community. This situation shows that community members were only informed on the presence of CSO and its work in their community the aspect that Alnoor (2003) mentioned it to be participation that involves consultation with community leaders and members but decision making power remains with the project planners. These CSOs go to the respective community assuming that they know what to implement and therefore they do not ask community members' problems to be addressed through implementing relevant interventions. Therefore community members accepted each and everything already planned by the organisation, which is a top down and supply driven approach (Kajimbwa, 2006).

Furthermore, focus group discussion with PLHAs revealed that, CSOs targeting them do not involve them in identifying their needs prior to supporting them as the result they received the same kind of support while other needs that required support remained untouched. Only 29.4% of responses from the sampled CSOs show that they conducted baseline survey for their interventions while 61.8% of CSOs' responses indicate that they designed the interventions basing on the considerations of what was happening in the community (Table 13). This shows that as much as CSOs conducted an assessment of community needs new needs were not adequately addressed. Frequent (at least once a year) reviews and assessment of PLHAs needs is useful in designing of interventions that address immediate priority needs of the intended beneficiaries.

4.7.4 Expected outcomes

Outcomes are short term results of an intervention. Investigation of the expected outcomes of the interventions implemented by CSOs show that 33.9% of the sampled CSOs' responses expected to see high level of awareness on HIV/AIDS issues (Table 14).

Twenty two percent of CSOs expected to see improved life for PLHAs while 20.3% of CSOs expected to see improved life for OVCs. Increased number of people going for HIV test was another expected outcome indicated by 15.3% of CSOs' responses and community ownership of interventions was an expected outcome indicated by 8.5% of CSOs' responses. When asked on whether the expected outcomes were achieved; most of CSOs (43.3%) reported to achieve the expected outcomes while 40% and 16.7% of the sampled CSOs reported partly and no achievement of the expected outcomes respectively (Table 14).

Table 14: Expected outcomes from CSOs interventions

Expected outcomes	CSOs Responses	Percent
HIV/AIDS awareness raised	20	33.9
Improved life for PLHAs	13	22.0
Improved life for OVCs	12	20.3
Increased number of people going for HIV test	9	15.3
Community ownership of intervention	5	8.5
Total	**59**	**100.0**
Achievement of expected outcomes		
Achieved	13	43.3
Partly achieved	12	40.0
Not achieved	5	16.7
Total	**30**	**100.0**
Reasons for partly/not achieving expected outcomes		
Long term objectives	8	47.1
Limited resources	7	41.2
Lack of community understanding	2	11.8
Total	**17**	**100.0**

Results in Table 14 also summarises the reasons for partly or no achievements of the expected outcomes which are long term objectives (47.1%), limited resources (41.2%) and lack of community understanding (11.8%). Results show that most of CSOs which achieved the expected outcomes were those that addressed HIV/AIDS prevention through education. This shows that presence of various methods used in awareness raising such as programmes in media like radio and TV that were not necessarily done by the CSOs

studied also contributed highly to HIV/AIDS awareness raising.

Sustainable improved life for people living with HIV/AIDS (PLHAs), orphans and vulnerable children (OVCs) outcome are long term objectives as well as resource demanding interventions. With the nature of support provided to these target groups, it is true that the outcome can not be realised within a short period of time. Despite the limited assessment of beneficiaries' needs priorities by CSOs, results from focus group discussions show that organisations were very helpful especially in the provision of support to PLHAs and OVCs; family and the community members were already overburdened. The support provided by CSOs was of significant help to the target groups and the community as a whole. The same response was obtained through discussions with PLHAs that the support provided was of great importance to them because most of them had no substantial source of income hence facing difficulties in getting their daily needs. Provision of food was importantly mentioned because the use of (Antiretroviral drugs) ARVs has to be accompanied by good nutrition.

4.7.5 Self monitoring and evaluation of activities

Monitoring and evaluation of activities is important for any intervention to track progress and to measure performance. Table 15 summarises ways through which the CSOs studied monitored and evaluated their activities. The ways mentioned include visiting of the beneficiaries and working in collaboration with the government each indicated by 24.5% of responses from the interviewed CSOs. The use of activity reports was showed by 20.8% of responses from the CSOs studied (Table 15).

Table 15: Monitoring and evaluation of CSOs' activities

Ways of activities monitoring and evaluation	CSOs Responses	Percent
Visiting the beneficiaries	13	24.5
Collaboration with government	13	24.5
Activity reports	11	20.8
Staff field supervisions	9	17.0
Donor visits	4	7.5
Day to day feedback	2	3.8
Meetings	1	1.9
Total	**53**	**100.0**

Civil society organisations interviewed had more than one way of monitoring and evaluating their activities. Working in collaboration with government officials was mentioned to be important especially on making close follow up on activities implemented at the grassroots since they are the one staying within the community. The aspect of providing support to PLHAs and OVCs through government offices was the mechanism to ensure close monitoring of that support. It was also found that, head of schools and community leaders at Ward and Village/"Mtaa" levels were asked to endorse reports on activities conducted in their locality especially on prevention through education which had no any confidentiality before they get to CSOs coordinating offices for compilation.

4.7.6 Inter-organisational linkages

In this study, every organisation mentioned to have other CSO (s) involved in combating HIV/AIDS in its operation area(s). When further investigation was done on how they collaborated, it was found that 39% of responses from the sampled CSOs showed that they shared expertise. Information sharing was indicated by 37% of responses from the sampled CSOs while 23% of CSOs' responses indicated that they collaborated through implementing joint activities (Table 16). Expertise sharing was mostly reported in the aspects of voluntary counselling and testing through which one organisation referred its clients to other organisations for cases it cannot handle. Farrington and Bebbington (1993) also mentioned that, NGOs often lack adequate money, personnel and can not afford

different specialist in one organization.

Economic Commission for Africa (2006) pointed out that, sharing of information is important within CSOs and is critical to the success of efforts to combat HIV/AIDS. In this particular study, various channels were mentioned to be used for sharing and disseminating information which include printed media, national events such as launches, AIDS day and the internet. For example Iringa Press Club is the organisation that provides HIV/AIDS education and information through newsletters; its work depends entirely on information from other CSOs implementing various interventions on the epidemic.

Table 16: Inter-organisational linkages

Variable	Responses	Percent
Collaboration among CSOs		
Expertise sharing	23	39
Information sharing	22	37.3
Joint activities	14	23.7
Total	**59**	**100.0**
Things in common among CSOs		
Same target population	26	49.1
Same thematic area	12	22.6
Same type of activities	10	18.9
Same donor	5	9.4
Total	**53**	**100.0**

Partnership between CSOs was not only observed through the above referral system and information sharing but also through, implementation of joint HIV/AIDS programmes. In this respect, one CSO contracted another to help implement its programmes. For example, Nuru CARE a programme under CARE international an organisation involved in providing HBC to HIV/AIDS/TB patients contracted other CSOs (St Vianey and ELCT) to provide the service on its behalf (Jamil and Muriisa, 2004). Other CSOs mentioned to conduct joint activities when coincided to operate in the same area, with same target group and same type of activities. Under this scenario, activities were shared partly so that the

intended activities were accomplished jointly.

The study also investigated things in common for CSOs happened to operate in the same area. Forty nine percent of responses from the CSOs studied indicated that they had the same target population while 22.6% and 18.9% of CSOs responses showed that they had same thematic area and same type of activities respectively (Table 16). As already seen on the target population, most of CSOs targeted OVCs and PLHAs, this resulted into duplication of efforts in some areas thus same type of support was provided to same people. This was also noted in the focus group discussion that PLHAs and OVCs were provided the same type of support by each organisation that targeted them while leaving other needs untouched. An example was given where a standard five orphan was given primary school uniforms by different organisations such that he has completed standard seven while other uniforms are not used at all.

4.8 Challenges Facing Civil Society Organisations

Civil Society Organisations mentioned to face some challenges in their interventions. Responses from the interviewed CSOs showed that the challenges faced were funding challenges (58.5%), administration challenges (17.1%) and lack of community understanding (12.2%) as shown in Table 17. Funding challenge was mostly indicated by responses from the sampled NGOs (69.2%) and FBOs (57.1%) whereas 50% of CBOs' responses indicated that they faced what CSOs termed administration challenge meaning office based facilities that limited their performance (Table 17).

Table 17: Challenges faced by Civil Society Organisations

Challenges faced	Civil society organisations			
	NGOs	FBOs	CBOs	Total
Funding challenges	15(68.2)	4 (57.1)	5(41.7)	24(58.5)
Administration challenges	1(4.5)	0(0.0)	6(50.6)	7(17.1)
Lack of community understanding	3(13.6)	1 (14.3)	1(8.3)	5(12.2)
No challenges faced	3(13.6)	2(28.6)	0(0.0)	5(12.2)
Total	**22(53.7)**	**7(17.1)**	**12(29.3)**	**41(100.0)**

Figures in parenthesis are the percentage of responses from the sampled CSOs.

4.8.1 Funding challenges

Local and national CSOs faced the challenge of funding; when asked on the sources of funding responses were as shown in Table 18. Major sources of funding for most of CSOs was external donors and Tanzanian government showed by 41.5% and 39.6% of responses from the sampled CSOs respectively. Responses also show that all FBOs studied reported to receive funding from external donors whereas most of NGOs studied received funds from both Tanzanian government (47.1%) and external donors (44.1%). Tanzania government and own contributions were major sources of CBOs funding each indicated by 37.5% of responses from the interviewed CBOs (Table 18). Community based organisations' access to external donors funding was limited by lack of skills in fundraising especially in proposal writing and lack of link with external donors.

Investigation on the external donor funding channels to CSOs revealed that, external funding was received through direct transfer of funds from donor to the organisation (56%) and from donor through international NGOs (recipient) then to the sub recipient organisation (44%). Since the government of Tanzania had no reliable funding for HIV/AIDS issues the only remaining funding source for CSOs was from external donors.

Table 18: Civil Society Organisations funding

Sources of fund	Civil society organisations			
	NGOs	FBOs	CBOs	Total
External donors	15 (44.1)	6(54.5)	1(12.5)	22(41.5)
Tanzanian government	16 (47.1)	2 (18.2)	3(37.5)	21(39.6)
Own contributions	2 (5.9)	0 (0.0)	3(37.5)	5(9.4)
Church donations	0 (0.0)	3(27.3)	0(0.0)	3(5.7)
Community contributions	1 (2.9)	0(0.0)	0(0.0)	1(1.9)
No any source	0(0.0)	0(0.0)	1(12.5)	1(1.9)
Total	**34(62.2)**	**11(20.8)**	**8(15.1)**	**53(100.0)**
External donors funding influence				
Choice of project activities	7(25.9)	3(33.3)	0(0.0)	10(27.0)
Choice of location	7(25.9)	3(33.3)	0(0.0)	10(27.0)
Project duration	6(22.2)	2(22.2)	0(0.0)	8(21.6)
Choice of beneficiaries	1(3.7)	1(11.1)	0(0.0)	2(5.4)
No influence	6(22.6)	0(0.0	1(100.0)	7(18.9)
Total	**27(73.0)**	**9(24.3)**	**1(2.7)**	**37(100.0)**

Figures in parenthesis are the percentage of responses from the sampled CSOs.

External donors have their own priorities in HIV/AIDS interventions to be funded, thus it is fund that sets and dictates the priority of interests and therefore control of the programme actions (Corman *et al.*, 2005). External funding was reported to influence CSOs in various ways. Twenty seven percent of sampled CSOs' responses indicated to be influenced on the choice of project activities and location (Table 18). The external funding influence on the project duration was showed by 21.6% of responses from the sampled CSOs as indicated in Table 18. The effects reported to be emanated from these influences were: limitations on addressing the problem as was originally planned, some objectives were not achieved and other target groups were not reached. Corman *et al.* (2005) also contended that local and national NGOs change from project to project, frequently with different objectives and approaches, to keep the revenue flowing. This situation can limit their ability to focus and concentrate on becoming institutions of excellence in a particular service delivery area.

Furthermore, it was noted that the organisations did not have own sources of funding. Only three out of five orphanage centres mentioned to have income generating projects.

Projects undertaken were farming where by the produce were used for consumption at the centre thus reducing expenditure on food. Apart from donor funding received, the farming undertaken were considered as income generating projects because fund that was served from purchasing food was allocated for other purposes hence improving the financial situation of the orphanages.

4.8.2 Administration challenges

Administration challenges in this case refer to limitations in the CSOs' offices that affected CSOs' performance in their interventions. Only two CBOs out of six investigated had their own office premises, others were using the government premises. On the side of local NGOs, most of them had limited office spaces while some were sharing the office premises. Lack of working facilities like computers was also reported to be a challenge to local CSOs. This situation shows that, donors were funding activities and not the office running costs. Corman *et al*; (2005) pointed out that many donors do not invest in improving administrative procedures when scarce resources are prioritised to relieve suffering in the community.

4.8.3 Lack of community understanding

The CSOs operations were limited by misunderstanding on the side of communities. During the study some community members including community leaders indicated that they would wish if their contribution in terms of time would be renumerated by CSOs. Community members had the notion that organisations had a lot of money for HIV/AIDS interventions and that failure to renumerate them was due to misuse of that money. This was further noted during focus group discussions where participants indicated that they had a feeling that CSOs had a lot of money. They thought that the fact that offices are located in town hence a lot of money was used as running costs in monitoring the

activities conducted in rural areas. Focus group discussion participants indicated that the purchase of vehicles, fuel costs and allowances paid to CSO employees during the visits were among the costs incurred by CSOs at the expense of meeting the needs of the target groups.

However, findings from the CSOs studied show that, community members' views that CSOs had a lot of money limited CSOs' operations because community members had higher expectations than what CSOs' can offer. Further more, community members had what the CSOs termed as 'allowance syndrome' meaning that community members expected to be paid allowance for participating in CSOs' activities. The CSOs viewed this aspect as the limiting factor to the implementation of their interventions in respect to limited funding they had. It can be said that, lack of community members' awareness on how CSOs get and utilize funds from donors as well as lack of transparency of CSOs to community members is attributed by lack of linkage between CSOs and community members they serve. Clear guidelines by the central and/or local government authorities' on how CSOs should implement HIV/AIDS interventions in the communities could have created harmony between CSOs and community members. The problem of lack of CSOs transparency to community members and lack of community understanding could have been well addressed.

CSOs interventions also faced community challenges that resulted from minimum community involvement as pointed in the preceding section. Community members viewed the involvement in CSOs interventions through introductory meetings was low level of involvement. Community members expected to be involved by CSOs in identifying their problems prior to the implementation of interventions which in turn could result into the CSOs being implementing interventions that respond to community problems. It can be

said that low level of support from the community that was experienced by CSOs was due to the community members' views that were least involved in the interventions. This was also found by Alnoor (2003) that, although each CSO claimed 'community involvement', their various failures showed that they did not consider community needs, strengths and conditions prior to design and implementation of interventions.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

Civil society organisations (CSOs) contribution in fighting the epidemic was through implementing interventions in four HIV/AIDS thematic areas identified in the study which are HIV prevention through awareness raising, HIV/AIDS impact mitigation, capacity building and HIV voluntary counselling and testing (VCT). Approaches used by CSOs varied across those HIV/AIDS thematic areas; the variation was contributed by the category of civil society organisations. The general conclusion is that, none of the CSO implemented intervention in all the four identified thematic areas. The frequently implemented interventions include HIV/AIDS impact mitigation and HIV/AIDS prevention through awareness raising were the themes addressed most by the studied CSOs.

HIV/AIDS impact mitigation was frequently addressed because the impact of HIV/AIDS in the community was already high that is, large number of orphans and PLWHAs as well. On the other hand, HIV/AIDS preventions in the form of awareness creation was also highly addressed in order to serve community members from being infected and those already infected from not getting new infections and not infecting others. The other two interventions: HIV/AIDS voluntary counselling and testing as well as capacity building were not frequently implemented. This was mainly due to limited human resource capacity (trained professionals) among CSOs.

A single CSO can not address all HIV/AIDS thematic areas; therefore coordination among the actors involved in combating HIV/AIDS is inevitable. There are several organisations

participating in the initiatives to combat HIV/AIDS, although the different civil society organisations (CSOs) have different mandates they all have a common goal of combating HIV/AIDS. The study findings indicated that there is a lack of coordination between the different actors, yet a multisectoral approach to implementing HIV/AIDS interventions demands the cooperation of all stakeholders to minimise repetition and to ensure sharing of information.

There was limited data management systems with the CSOs studied. The number of people reported to have been reached by the CSOs was underestimated because 5(16.7%) organisations were unable to provide quantitative data on the number of people reached and others did not provide information on all the interventions implemented.

Limited funding was reported to be the challenge faced by CSOs showed by 58.5% of responses from civil society organisations (CSOs) studied whereas 41.5% of CSOs' responses indicated that they relied on external donors funding. However, the Tanzanian government was mentioned as the main source of funding for the local CSOs due to their limited skills in fundraising. However the government funding channel to CSOs, the use of RFAs had limitations because part of that funding was used as operational costs rather than being committed into the interventions.

Community members appreciated the contributions made by CSOs; the only limitation was lack of linkage between them and the CSOs operated in their areas. Central government and/or local government authorities have the role to play in order to create harmony among CSOs and community members they serve.

5.2 Recommendations

Based on the results, discussion and conclusions the present study recommends the following:

- TACAIDS in collaboration with the Ministry of Health has to compliment the civil society organizations (CSOs) efforts in HIV voluntary counselling and testing (VCT). The government has to establish VCT centres or provide mobile VCT services especially in rural areas;

- Networking has to be improved among the CSOs, the foundation for civil society organisations and the National NGOs Council have to work on this from the district level up to the national level. The Local Government Authorities together with these self regulatory organs for CSOs and NGOs should encourage community involvement in the interventions in order to enhance the community members' trust to CSOs especially on the proper utilisation of funds;

- TACAIDS should formulate an integrated programme of implementation together with a monitoring and evaluation system for enhanced coordination of actors involved in combating HIV/AIDS;
- Civil society organisations should keep records of the interventions conducted. The information is very useful not only to their donors but also to the wider community. It is through statistical information where the role they play can be well determined;

- The government funding for HIV/AIDS should consider most the local community based initiatives in combating HIV/AIDS in order to encourage and sustain them. Community members residing with the needy people particularly people living

with HIV/AIDS (PLHAs), orphans and vulnerable children are the one aware of the right support those people need. The community members also know the HIV/AIDS risky behaviours their community faces, hence they are in the best position to address them in order to prevent the spreading of the epidemic.

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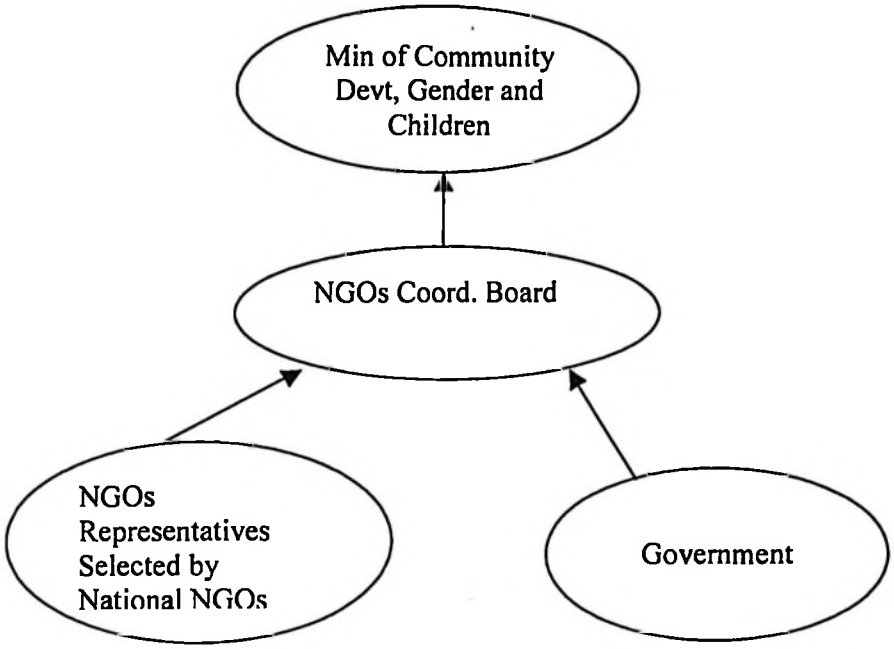
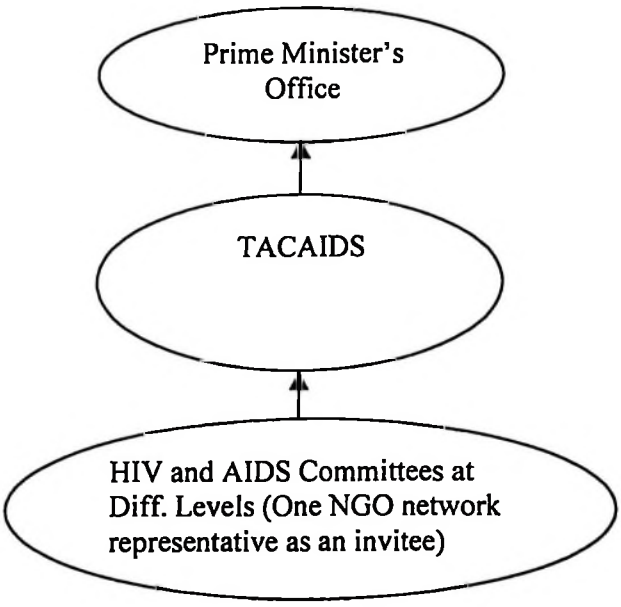
APPENDICES

Appendix 1: NGOs Activities Coordination through NGOs Coordination Board



Appendix 2: NGOs Activities Coordination through TACAIDS



Appendix 3: Sampling technique, sample size and data collection method

Category	Sampling method	Reason	Sample size	Data collection method
Iringa region	Purposive	High HIV prevalence	N/a	N/a
Iringa Rural District	Purposive	Number of CSOs	N/a	N/a
CSOs	Purposive	Dealing with HIV/AIDS	30	Structured interview
District authority representatives	Purposive	Their responsibility	3	Key informants
Focus group discussant s at district level	Purposive	PLWHA Availability	20	Focus group discussions
Villages/Mitaa	Purposive	More than one CSO	6	N/a
Focus group discussants at village level	Purposive	Sex , age, leaders	60	Focus group discussion

Appendix 4: The Interview Schedule for CSOs staff

A: CSO's Background information

CSO Name.....

Category (NGO,FBO,CBO).....

Respondent Name.....

Position.....

Reg No.....Ministry/Department.....

Date of the interview.....

B: CSOs Strategies, Approaches and Methods

1. When did this CSO start?.....
2. What is your target population?
    1. Orphans and Vulnerable children
    2. Youth
    3. PLWHA support
    4. All community members
    5. Combination of the above (specify)
    6. Others (Specify).....
3. Which HIV/AIDS thematic area does your organization address?
    1. Prevention
    2. Impact mitigation
    3. Institutional strengthening/capacity building
    4. Others (Specify).....
4. How did you come to the decision of that thematic area?
    1. Incidence of the problem
    2. National priority theme
    3. Demand by the community members
    4. Donor influence
    5. Others (Specify).....
5. How did the organization get information on the target group and thematic area to be addressed?
    1. Baseline Survey
    2. District Council

3. Village/ street council
4. Considered what was happening in the community
5. Others (Specify).....

6. What are the organization main activities in relation to the thematic areas?

1.....
2.....
3.....
4.....

7. How did you come to decide that type of activities in relation to the target population?

1. Easy implementation, monitoring and evaluation
2. Donor influence
3. Government influence
4. Mostly favored by the target group
5. Others (Specify).....

8. How are project activities monitored and evaluated?.....

9. What is the organization coverage? (Villages, ward, districts and/or regions).....

10. What influenced the choice of location?

What influenced choice of location	How it influenced

C: Project Details and Performance

11. Who initiated the intervention idea?

1. Government
2. Villagers
3. My organization
4. Others (Specify).....

12. What was the intervention target (population/ area coverage)?.....

13. What are the achievements so far basing on the set target?.....

14. What were the expected outcomes of the organization?

1.....

2.....

3.....

15. Have they been achieved?

1. Yes

2. No

16. If no in question 15 above, what are the reasons for less than desired performance?

1. Political acceptability problem

2. Lack of community understanding

3. Wrong community expectations

4. Lack of clear direction, faulty objectives and methods

5. Lack of experience and skills

6. Lack of adequate and reliable fund

7. Others (Specify).....

17. Do you involve beneficiaries in the project?

1. Yes

2. No (Go Qn number 19)

18. If yes in question 17 above, at what level of the project cycle is the target population involved?

1. Planning and designing

2. Implementation

3. Monitoring

4. All of the three above

19. What limits the beneficiaries' participation in the project?

1.....

2.....

3.....

4.....

20. What does the community contribute to the intervention?

1. Financial

2. Labor

3. Ideas in project design, implementation or evaluation activities

4. No contribution

5. Others (Specify).....

21. How does organization to ensure the sustainability of its service?

1.....

2.....

3.....

4.....

22. What type of support your organization provides to the target community?

1. Financial
2. Material
3. Training
4. Others (specify).....

D: CSOs and Inter-institutional Relations with the Government

23. What did you experience in the whole process of registration of your organization?

Duration of the process(whether quick or slow)	What were the reasons	If it was slow, what are the solution for such a short fall (if any)

24. What is the level of collaboration between your organization and the government?

1. High
2. Moderate
3. Low

25. What do you think are the reasons for the response in question 24 above?

1.....

2.....

3.....

4.....

26. In what ways does your organization collaborate with the government?

1. Joint activities
2. Governments' staff support and expertise in running the activities
3. Both 1 and 2
4. Others (Specify).....

27. Under what arrangements do this happen?

1. Through HIV/AIDS committee
2. Inviting government officials during the intervention big events
3. Representative of the organization during District Council meetings
4. Others (Specify).....

28. Do you know any local committee that is involved in combating HIV/AIDS?

1. Yes
2. No

29. Is your organization having representative in that committee?

1. Yes
2. No

30. If yes in Qn 28 above, how often does this committee meet?

1. Once every month
2. Twice every month
3. Quarterly
4. Others (Specify).....

31. Is there any government authority that needs your organization report?

1. District Council
2. Respective ministry or department
3. TACAIDS through HIV/AIDS Committees
4. Others (Specify).....

32. What kind of report(s) needed?

1. Operational
2. Financial
3. Both 1 and 2
4. Others (Specify).....

33. What are the challenges faced with that reporting structure(s) if any?.....

E: CSOs and Inter-institutional Relations With other CSOs dealing with HIV/AIDS

34. Are there other CSOs dealing with HIV/AIDS in the area of your operation?

1. Yes
2. No (Go to Qn 36)

35. If yes in question 34 above, what do you have in common?

1. Same target population
2. Same thematic area
3. Same type of activities
4. Same donor
5. Others (Specify).....

36. Does your organization co-operate with other CSOs?

1. Yes (Go to question 37 and 38)
2. No (Go to Qn 39)

37. What form does that relationship take?.....

1. Joint activities
2. Information sharing
3. Expertise sharing
4. Others (Specify).....

38. What are the benefits of such relationships?

1. Better use of resources
2. Minimizing duplication of efforts
3. Have common say
4. Others (Specify).....

39. What are the reasons for not cooperating with other CSOs?

1. Different objectives
2. Individualism
3. There are no incentives to join us together
4. Others (Specify).....

F: CSOs Sources of Fund

40. What are the sources of funding on which your organization depend?

1. Tanzanian Government
2. External donors
3. Others (Specify).....

41. What are the modalities for funding your organization?

1. From donor Through international NGO
2. Directly Donor country governmental agencies
3. From donor agencies Tanzanian government

4. Others (Specify).....

42. What kind of influence do the funding agencies or organizations have on your organization?

1. Influence on the choice of project activity
2. The objectives to b e pursued
3. Location of the project
4. Beneficiaries
5. Project duration
6. Management of the CSO
7. Others (Specify).....

43. How is the performance of your organization affected with that funding agencies influence?

1.....

2.....

3.....

Thank You for Your Cooperation

Appendix 5: Interview Checklist for the Council HIV/AIDS Control Coordinator

1. What HIV/AIDS thematic areas are mainly addressed by those CSOs?
2. How are the CSOs' plans integrated with the district council plans?
3. How these CSOs' activities are monitored and evaluated by the government?
4. What are the achievements gained from that monitoring and evaluation?
5. What are the challenges faced when monitoring and evaluating CSOs activities?
6. Is there any network of CSOs dealing with HIV/AIDS in your district? Can you comment on its presence or not?
7. What are your views of CSOs' representation in the HIV/AIDS committees at different levels within your district?
8. As an important government official, what role does the government have in ensuring the smooth running of CSOs in combating HIV/AIDS intervention measures?
9. What can you comment on the role of CSOs in combating HIV/AIDS?

Appendix 6: Interview Checklist for Assistant Registrar of NGOs

1. How are CSOs registered at district level and how long does the process take?
2. What is the role of the government in assisting the CSOs to select the area of operation and the target group to be served?
3. How these CSOs' activities are monitored and evaluated by the government?
4. What are the achievements gained from that monitoring and evaluation?
5. What are the challenges faced when monitoring and evaluating CSOs activities?
6. As an important government official, what role does the government have in ensuring the smooth running of CSOs in combating HIV/AIDS intervention measures?
7. What can you comment on the role of CSOs in combating HIV/AIDS?

Appendix 7: List of Questions for Focus Group Discussions

Name of the village/District.....

1. Is there any CSO dealing with HIV/AIDS in this village/District?
2. What are the thematic areas addressed by these CSOs?
3. Which population segment is mostly targeted?
4. Do the activities implemented respond to the HIV/AIDS problems you are facing?
5. Do the CSOs involve you in their HIV/AIDS interventions?
6. In your own opinion, who owns the interventions or projects?
7. In your own opinion what can you comment on the role of CSO in combating HIV/AIDS?

Appendix 8: National response on HIV/AIDS

The Government of Tanzania responded to HIV/AIDS epidemic since 1985 through the National AIDS Control Program (NACP) of then Ministry of Health (URT, 2003a). This program perceived HIV/AIDS as a health problem and the campaign to deal with it involved the health sectors only (TACAIDS, 2005). The response did not have much impact on the progression of the epidemic as was expected due to various constraints. NACP efforts were constrained by structural factors (URT, 2003a): low implementation rate; lack of human and financial resources; inadequate capacity of implementing institutions; excessive bureaucracy and centralization; insufficient coordination and limited integration of development partner activities. The government's declaration of the epidemic to be a national disaster was a strategy towards comprehensive efforts in combating the epidemic (TACAIDS, 2005). Efforts included a call of all sectors to take new measures to respond to the epidemic. This call caused various actors including civil society organisations to implement HIV/AIDS interventions in the efforts to combat the epidemic (URT, 2003a).

Formation of TACAIDS

The presence of various actors in the efforts towards combating HIV/AIDS, coordination of those actors was required for success. The Tanzania Commission for AIDS (TACAIDS) was formed in December 2000 instituted under the Prime Minister's Office to coordinate and intensify the national multi-sectoral response (TACAIDS, 2005). TACAIDS spearheaded the formation of the National HIV/AIDS Policy in 2001. The overall goal of the policy is to provide for a framework for leadership and coordination of the national multisectoral response to the HIV/AIDS epidemic such as formulation of appropriate interventions effective in preventing transmission of HIV and other sexually transmitted diseases; protection and supporting vulnerable groups; and mitigating the

social and economic impact of HIV/AIDS (URT, 2003a).

In 2003, TACAIDS produced the National Multi-sectoral Strategic Framework on HIV/AIDS (2003-2007) which stipulated that Local Government Authorities (LGAs) were needed to play a crucial role in planning and Coordinating HIV/AIDS interventions that are implemented by various organizations and communities in the districts in order to ensure sustainability, coordination and ownership of the interventions (URT, 2003a). It basically translated the national HIV/AIDS policy by providing strategic guidance to the planning of programmes, projects and interventions by various stakeholders in the fight against HIV/AIDS. It further stipulated that, the success of the national response resides with the competence of communities to live up the challenges and threats of the epidemic and develop appropriate responses. Mobilization of communities can be easily done by CSOs which need to be supported by the government this is because it is in the wards and villages where services are needed for the population (URT, 2003a). In order to achieve this, District and Village HIV/AIDS committees were created under TACAIDS Act of Parliament to lead the planning, resource mobilization and coordination of local responses (URT, 2001c)

Formation of HIV/AIDS committees

HIV/AIDS committees are ways through which the District Councils under the Local Government Authorities (LGAs) can be effectively involved in the fight against HIV/AIDS. These committees were formed at various levels of the government that is Sub-village, Village council, "Mtaa", "Mji mdogo", Ward, District, Town and City Municipality. Commonly, the committees comprise of chairperson and secretary of respective level, one representative from the network of NGOs that are involved in combating HIV/AIDS, two religious representatives (one Christian, one Muslim), two PLHAs representatives (one male, one female), two youth representatives (one male, one

female), two prominent citizens (one man, one woman), one representative teacher and all experts working within the respective level.

The subsequent committees also include representatives from their immediate lower levels. URT (2003b) further shows that, the committees' composition at higher levels, that, is from the District to City level changes to constitute members and invitees. Members are the respective level chair person and secretary, all selected members of parliament from constituencies within the respective level and two Ward Councillors selected by the respective Council. Whereas the invitees are AIDS Coordinator, two youth representatives (one male, one female), two religious representatives (one Christian, one Muslim), two PLHAs representatives (one man, one woman), a representative from a network of NGOs working in combating HIV/AIDS (URT, 2003b).

Responsibilities of HIV/AIDS committees

Among other responsibilities, HIV/AIDS committees were tasked to evaluate stakeholders' activities on issues of HIV/AIDS including CSOs capabilities and interests, the aspect which is achieved through evaluating the implementation of the intervention plans. Committees are also required to prepare quarterly and annual reports to be presented to TACAIDS (URT, 2003b). These functions can be achieved through the committees' regular meetings. The same source stipulates that, committees at all levels are required to meet once per month in order to track progress on the efforts towards combating the epidemic.

Interviews with key informants found that, committees were expected to be trained from the higher down to lower levels through succession training approach, that is the higher level committee after been trained was supposed to train its immediate low level the

strategy that was not successfully implemented down to the lower levels due to lack of finance. This shows that HIV/AIDS committees especially from ward level down to sub village level were there by names but not active resulting into limited responsibility in evaluating the activities conducted by CSOs. It can be further said that Councils involvement in combating HIV/AIDS is still low because the HIV/AIDS committees at lower levels (Ward to Sub-village) where HIV/AIDS interventions are implemented are not active and are not undertaking the undersigned responsibilities.

Appendix 9: The National NGO policy

The formulation of NGO policy in 2001 and passing of NGO Act in 2002 were efforts to improve the working environment of NGOs. NGO Policy was formulated in order to guide the operations of NGOs in Tanzania as many laws governing the registration and operations of NGOs were a course of confusion and that collaboration between the Government and NGOs was inadequate (2001b). The policy aimed at improving the internal coordination and self regulation within the NGOs themselves (URT, 2001b).

The NGO Act (URT, 2002a) established a position of a director for NGOs as Registrar and a link between the government and NGOs but working under the NGO Coordination Board. The Act also provided for the establishment of the National Council for NGOs as a self-regulatory mechanism for the NGOs. The members for the Coordination Board include representatives of the NGOs as recommended to the responsible minister by the NGO Council. The National Council of NGOs is to be composed of thirty members appointed by non governmental organizations to represent their respective interests. The Council is a collective forum of non governmental organizations for the purposes of co-ordination and networking of all non governmental organizations operating in the nation. Whilst the activities of NGO Coordination Board include NGO approval and coordination of NGO registration and activities, directing the cancellation or suspension of NGOs, the examination of NGOs' annual reports and providing advice to the government (URT, 2002a).

The registration of NGOs is done by the Registrar in the ministry/office responsible for the registration of NGOs. In order to simplify the registration process, decentralization sought to be the best way where by registration of NGOs was done at regional and district levels for NGOs operating in one region or district respectively. International NGOs and local NGOs operating in more than one region are registered at the national level. There

are requirements for registration of NGOs (URT, 2002a); among others a copy of constitution of the organization is a very important requirement. During the interview with the Assistant Registrar (Iringa District Administrative Secretary), it was noted that NGO's constitution was delaying the registration process when it was done centrally because people were spending much time and money in making follow ups. With decentralization of the process, the Assistant Registrar is tasked to ensure that the constitution together with other documents required are clear before are forwarded to the Registrar for issuing registration certificates.

Appendix 10: Wards covered by CSOs in Iringa District 2006/2007

Name of Wards	CSO responses	Percent
Mseke	3	2.8
Ifunda	8	7.5
Lumuli	3	2.8
Maboga	7	6.5
Kihorogota	5	4.7
Maguliwa	5	4.7
Mgama	4	3.7
Nduli	4	3.7
Nzihi	11	10.3
Izazi	3	2.8
Mwangata	6	5.6
Kihesa	6	5.6
Mtwivila	5	4.7
Gangilonga	3	2.8
Kalenga	5	4.7
Ruaha	5	4.7
Mlandenge	3	2.8
Kitwiru	5	4.7
Idodi	2	1.9
Ilolompya	4	3.7
Itunundu	3	2.8
Tungamalenga	1	0.9
No any ward covered	6	5.6
Total	**107**	**100.0**

Results are based on multiple responses.