FINAL PROJECT NARRATIVE REPORT

You will need to refer to your Project Application Form and the Agreement with WACC. Please answer the questions as fully and concisely as possible to help us learn about your completed project. The report should not exceed 15 pages, excluding appendices. Please return the report with any supporting documents and materials to WACC. We welcome stories about how individuals benefited from the project, with photos. We also welcome case studies. Please place stories and case studies, if any, in an appendix.

1. GENERAL INFORMATION

1.1 Project Title: (as in the Agreement)	**HIV/AIDS & Stigma Cutback**
1.2 Project Reference Number: (as in the Agreement)	**1800**
1.3 Full Name of Organisation:	**Anglican Church of Tanzania**
1.4 Country:	**Tanzania**
1.5 Full Postal Address:	**P.O. Box 899, Dodoma, Tanzania**
1.6 Physical Address:	**7th street, Plot no. 3, Dodoma**
1.7 Contact Person:	**Frank Mathew Haji**
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1.10 E-mail:	**frank@anglican.or.tz**
1.11 Website:	**www.anglican.or.tz**
1.12 Period the project was implemented: (from month/year to month/year)	**March 2012 – February 2013**

2. OUTCOMES AND IMPACT

2.1 What was the project's long-term goal?
Communities within Anglican Church of Tanzania Parishes to be HIV & AIDS competent by empowering congregational and community level responses to stigma reduction through Strategic Behaviour Communication (SBC)
2.2 What was the project's immediate purpose and to what extent was it achieved?
The purpose was to increase access for key populations to comprehensive VCT and HIV services free from *Stigma* and *Discrimination*. • Access to friendly VCT and HIV services increased for over 200% over the previous year, 64% of whom are People Living with HIV/AIDS. • Number of school days attended by orphans who lost one or both parents due to HIV/AIDS is now increasing because stigma is alleviating in schools. • Some PLHAs are now engaging again into community through small income generating activities like gardening.

2.3 To what extent were the expected outcomes and outputs achieved?	
Expected outcomes and indicators	Achieved outcomes (disaggregated by sex)
1. A total of 15 Church and Community leaders including PLHAs as TOTs are in forefront implementing Behaviour Change Communication Strategies to increase community awareness of the harm done by stigma and discrimination against people living or affected by HIV and AIDS. *(Indicator: Documented reports of the meetings and sensitization events)*	1. Reports show that all 15 TOTs conducted a total of 150 meetings for 10 months. 1,650 people *(916 male and 734 female)* attended these meetings. Two Community Sensitization events were held; a total of approx. 800 people *(500 male & 300 female)* attended the events.
2. A total of 5 Church and community groups incorporate HIV/AIDS & Stigma reduction strategies in their plans *(Indicator: HIV/AIDS competence plans that include stigma are in place)*	2. All 5 groups, one from each parish, developed HIV/AIDS competence plans that include stigma.
Expected outputs and indicators	Achieved outputs (disaggregated by sex, if applicable)
1. A total of 15 Church and Community leaders including PLHAs have been empowered with knowledge, skills and communication strategies and equipped with resources to increase community awareness of consequences of HIV-related stigma and discrimination *(Indicator: Increased number of people speak out about their health status and seek care and treatment services)*	1. Reports from 1 VCT centre and during Mobile VCT shows increased number of referrals for PLHAs and newly diagnosed to District/Regional hospital for further managements in 2012. 21 people were referred *(14 Female and 7 Male)*
2. A total of1000 people empowered with HIV/AIDS and stigma knowledge *(Increased number of people seeking VCT Services through data collected from our local VCT sites)*	2. For 10 months; March through December 2012, Mobile VCT and 1 VCT site recorded a total of 421 clients *(199 female and 222 male)* seeking VCT services. This is an increase of over 400% comparing to previous year, 2011.
3. Experience gained to scale up in second phase to cover larger community mostly in need. *(Prepared scaled up version Document).*	3. Project Scaling-up version documents is underway.

2.4 What other observations did you make? Please mention anything that may illustrate the benefits arising from the project.
Through the course of this project we observed that most of the people in targeted communities were keen to fight HIV/AIDS and related stigma, but they were lacking proper education and strategies on how to come about talking HIV/AIDS and how to fight the stigma around.
2.5 If you observed any unintended positive outcomes arising from the project, please describe.
We focused in 5 Parishes only, but people from neighbouring Parishes and Communities attended sensitization meetings and we trained 3 TOTs from untargeted communities whom they now lead cascading training to their areas.
2.6 If you observed any negative outcomes arising from the project, please describe.
At the beginning some critics were telling people not to adhere with this project because it is belongs to Christians only. But with time they recognise that the project is for all members of the community and that everybody was entitled to board and benefit.
2.7 Did you observe any long-term impact (positive or negative) in the wider context that might be related to the project interventions?
If we scale-up this project countrywide with the efforts undertaken by the government and other Civil Society Organisations, in a very near future HIV/AIDS related Stigma and Discrimination will be things of the past.
2.8 What methods did you use for assessing outcomes and impact?
2.9 Please describe the actual direct beneficiaries and indicate the number of women and men. Please also mention any indirect beneficiaries.
2.10 What is the likelihood that the project outcomes will be sustained over the medium and long term? Please explain.
No doubt that achieved outcomes will be sustainable in both medium and in long term because community members are the ones who own this project as they now see the benefits not only for them but for their upcoming children and generations to come if they'll properly address/use the resources already developed i.e. HIV/AIDS competence plan that include Stigma already incorporated in their congregational and community plans, the cascading training on HIV prevention and Stigma cutback and the National Policy Manual for the right of People Living or affected with HIV.
2.11 What has been the most important change brought about by the project and what is the key evidence for this change?
The most important change brought by this project is the desire for people to know their health particularly HIV/AIDS status. You can prove this by looking on the number of people seeking VCT services which has increased in 5 parishes for 10 months only. In 2011 only 97 people attended VCT, 85 of them being pregnant mothers because it is routine. But from March to December 2012 a total of 421 people were offered VCT services; 199 were females including 107 pregnant mothers.

3. ACTIVITIES

3.1 Please provide a summary of the major activities carried out in comparison with those planned. In the case of significant changes, please explain the reasons. If applicable, please report on specific activities for women and men respectively.		
Planned activities	Actual activities (*state if they were specifically for women, for men, or for all*):	Explanation of change
1. TOT on behavioural communication strategies focusing on HIV prevention, stigma and discrimination to PLHAs, community members, Church and Community leaders.	1. A total of 15 people *(10 men & 5 women)* attended TOT training on behavioural communication strategies focusing on HIV prevention, stigma and discrimination to PLHAs.	1. None
2. On-going cascade training on the same, focusing local community members and congregations especially Youths.	2. Cascading training Involved both Male & female *(as per 31 Dec. 2012 about 10 youth groups were already formed with a total of 215 members, 125 male and 95 females)*	2. None
3. Assessment of community knowledge of HIV related stigma through questionnaires.	3. About 600 questionnaires were used in the assessment *(389 male and 211 female were reached and interviewed)*	3. None
4. Discussions and role plays during community sensitization events and annual review meetings.	4. Drama and Acrobatic groups with HIV/AIDS message and speeches in between, perform to over 800 people attending 2 events. *(both male and female were involved in discussions and role plays)*	4. None
3.2 How did the beneficiaries react to the programme activities?		
They accepted all the activities and were very cooperative during project implementation.		
3.3. If the project is primarily purchase of equipment, please describe what kind of impact / change the equipment is bringing to the beneficiaries.		
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3.4. If the project included a workshop, seminar, or consultation, please attach the list of participants, the themes/topics of their speeches/papers, and any statement, declaration, or other material published.		
See attachment		

4. CHANGES IN THE ORGANISATION

4.1. Please note any important changes or events that took place that directly affected the project. These can relate to management, planning, staffing, or other matters.
Nothing happened that affect our project implementation.

5. CONTEXT

5.1 Please note any important changes in the following contexts since the project began and summarise the implications for the relevance of the project.	
Political:	None
Social:	None
Natural environment:	None
5.2 To what extent is the project still relevant in the present-day context? Please explain.	
Although the prevalence rate for HIV transmission is retarding in Tanzania, we are still among countries with high transmission rate in Sub-Saharan Africa. So does the need to fight HIV/AIDS and related Stigma.	

6. YOUR ORGANISATION'S LEADERSHIP ROLE AND NETWORKING WITH OTHERS

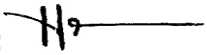
6.1 Has the project and the support from WACC helped your organisation be in a better position to provide leadership for further initiatives of your own or of others? If so, please explain.
Exactly! The project itself put Anglican Church of Tanzania among forefront fighters of HIV/AIDS and Stigma. According to Dodoma Urban District commissioner's speech as guest of honour in our first Community sensitization event, he hails the Church for his efforts to fight this pandemic and call for other NGOs to learn from what the Church is doing.
6.2 In what ways has your organisation articulated and shared good practices, lessons learned, and/or resource materials with other organisations working on similar or related concerns? If you have not done so, do you plan to do so? How can WACC assist?
We managed to work with Christian Council of Tanzania (CCT) especially in sensitization meetings where we shared costs on printing T-shirts and producing Flyers with HIV/AIDS messages. We also distributed copies of Living with Hope and Stepping Stones Books to CCT and two other Civil Society Organisations who are promoting fight against HIV/AIS and Stigma here in Dodoma Region. The only part WACC can offer us more support is the area of resource materials e.g. Books and fryers, after training or sensitization meetings and the on-going cascading training people need such materials to keep reading and become more expert. But the cost for printing such supplies is high.

7. CONCLUSIONS

7.1 What lessons and good practices have emerged from this project?
Once people are strategically mobilised and sensitized to engage themselves in any challenge facing their communities, they will always come up and do something positively to overcome the challenge but if and only if they own the strategies used.

7.2 What challenges and difficulties were encountered, and how did you address them?
Some critics told people that this project belongs to Christians and not people of other faith, but during our sensitization meetings we refer before communities what projects we did in the past that benefited people of all Faith and believes in Tanzania and in their areas in particular i.e. Schools, Dispensaries and other community development projects.
7.3 Did the project have any impact on gender equality issues?
Definitely, because the number of girls and women including married ones increases because they now have the power to discuss with their partners and decide for their own fate and go for VCT instead of waiting for the permission from their partners or caretakers as it has been a tradition before.
7.4 What further work needs to be carried out or follow up steps taken, if any?
Supportive supervision is key factor in maintaining the on-going cascading training.
7.5 Other comments, if any.
We are convinced to scale-up this project to more Parishes and enable more community members to have skills and resources to alleviate HIV/AIDS related stigma.
7.6 We would like to receive digital copies of materials produced such as manuals, training materials, and other products to share them with others. We would also appreciate digital copies or internet links to photos, video or audio recordings produced by or about the project. Please indicate below what you are sending us.
• Photos

Name and position of person submitting the report.
Dr. Frank Mathew Haji Provincial Health Officer Anglican Church of Tanzania

Signature:  **Date: 18.01.2013**

APPENDIX 1 – T.O.T Training

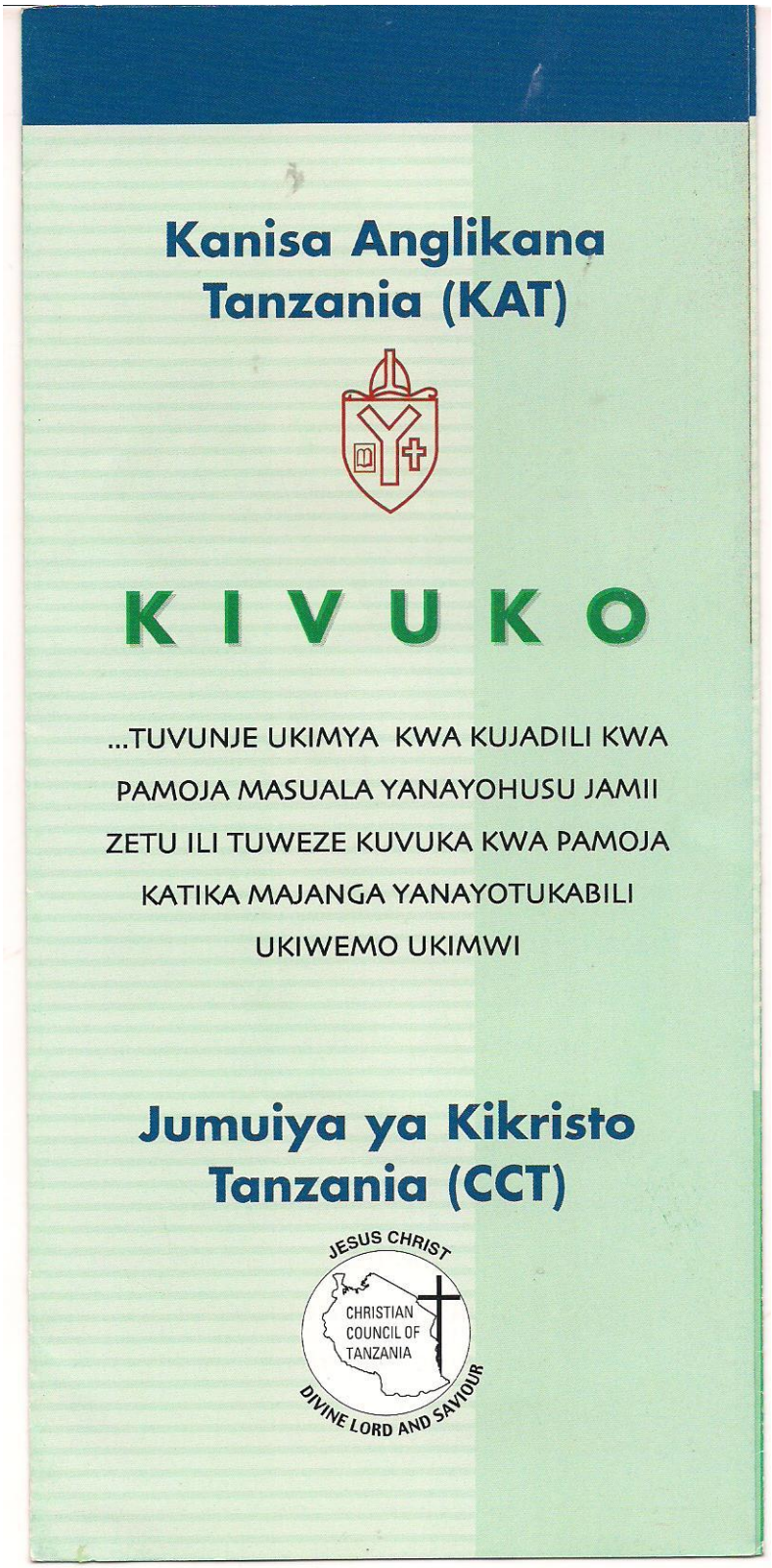
1.1: Participants of T.O.T course during training above and at group discussion below.

1.2: T.O.T training in progress

1.3: T.O.T s demonstrates a role play “stepping stones”.

APPENDIX 2 – Community sensitization event

2.1: A Muslim cleric airs his views during the event.



2.2: Front page of a flyer printed in collaboration with the Christian Council of Tanzania (CCT) with the message "let us break the silence on issues surrounding our communities through dialogue in order to overcome those including HIV/AIDS"