Lessons from KIWAKKUKI: The importance of "The Human Network" in Sub-Saharan Africa and how to use it in HIV Prevention and Local Development

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Description of Research

The political and economic policies set forth by institutions like the World Trade Organization, the World Bank, and the International Monetary Fund are aimed partly to aid in the development of nations. As a consequence, there is an inherent pressure place on countries to ascribe to the ideologies of these organizations in order to pursue development. Less Developed Countries (LDCs) are oftentimes forced to adopt strict policies that promote free trade, and will face repercussions for deviations from this determined regime of global trade and finance. Despite all of these policies, practices, and institutions that promised to usher in a new era of globalized growth, progress has not been as we had hoped. Many development markers have suggested improvement, but a stark contrast persists between the livelihood of the developed world and LDCs (Milanovic 2011), and there is also a growing gap between the rich and the poor in developing countries. Essentially, development has been largely unequal both between and within nations. Development of the "third world" appeals to values of global equity, and ideally, also pursues a more equal distribution of wealth within developing societies. (Kenny 2011).

Economist Amartya Sen, a highly acclaimed Nobel Laureate, presented a new way to examine development through the abilities and access of individuals within a particular society. In his "capabilities approach", he acknowledges new components that had been previously neglected to his discussion of development economics and its outcomes for the welfare of a society. He cites an individual's freedom to economic access, a balanced lifestyle, and pursuit of happiness to be of significant importance to their capability to pursue economic, political, and social growth. His capabilities approach was applied with the help of political philosopher Martha Nussbaum to create Ten Central Capabilities that need be fostered in order to sustain political stability, economic growth, higher quality of life, and increased global equity. The first

and second Central Capabilities both call for the widespread ability of people to 1) live a life of normal span that is 2) healthy, including reproductive health and adequate nutrition and shelter (Nussbaum 2011). These health-related capabilities have become a focal point in the discussion of development, as the status of citizen health in a country has an incontrovertible relationship with development under Sen and Nussbaum's theory of capabilities.

The United Nation addressed the global need for "third-world" development with its Millennial Development Goals with some emphasis on improving health-related capabilities in several of its targets. Its sixth target of eight to be (hopefully) reached by 2015, addresses the issue of tropical and infectious diseases with added focus on HIV/AIDS (UNAID 2010). Human Immunodeficiency Virus is a sexually- and blood-transmitted virus that jumped from primates to Humans in the early 20th century, and has since become an epidemic worldwide amongst at-risk populations (IV drug users, sex workers, men who have sex with men). In Sub-Saharan Africa, however, the disease has had more severe consequences, reaching the status of a generalized epidemic not statistically limited to niche populations (Green and Ruark 2011). A myriad of factors have contributed to the widespread nature of the HIV virus in Africa, including a culture of misinformation about the disease and its transmission and a lack of dialogue about sexuality, sexual practices, and the impact of gender roles on sexual dynamics (Dowden 2010). The result of these factors is a stigmatization of HIV/AIDS across much of Africa, though the level of stigma surrounding the virus varies based on regional differences and a multitude of other sociological factors (Dowden 2008). Some scholars also suggest that over-emphasis on condom use as a prevention strategy creates a "sexual moral hazard" where a sense of safety encourages people to engage in riskier sexual practices (Green and Ruark 2011).

In the broader discussion of global development, it is clear that economic, political, and social measures dominate the policy landscape. However, because of the Millennial Development Goals and the acknowledgement of health outcomes as related to growth and prosperity, public health is one of many fields now linked to the conversation of LDCs and their development. The literature on the relationship between health and the other indicators of development has been broad, but largely inconclusive. It is still largely up for debate amongst development scholars what exactly the nature of the connection is between health and development at the fundamental level. Some scholars cite poor health outcomes as a result of a floundering economy and a failing state, while others suggest that existing public health crises cause people to be underproductive and politically disengaged (Grimm 2011). Because of the validity of both of these perspectives, other development scholars suggest that the relationship between health and development is far too intertwined and complex to be separated and for one to accept the blame for inhibited growth. Scholars refer to this theory as "bi-directional causation", where health and economic/political growth have an interplay that makes it inefficient and unhelpful to discuss one as independent from one another (Ukpolo 2004).

My research was an attempt to understand, in the context of one specific community, how HIV prevention efforts interact with other aspects of the economic, political, and social development of that community. As with most topics in International Political Economy, this particular question is complex and impossible to answer without examining the dynamics between several disciplines that rely on each other in an almost symbiotic way. Because of this, my research took a more anthropological form, and most of my research methods centered on qualitative observations and interviews that gave me insight into the issues at play, rather than a quantitative approach which would quickly become entangled by many variables.

In order to carry out this research, I sought the help of a third-party volunteer coordinator to place me with an HIV prevention organization in Tanzania. Global Crossroads, LLC linked me to Kikundi cha Wanawake Kilimanjaro Kupambana na UKIMWI, henceforth referred to as KIWAKKUKI, an HIV prevention organization that approaches pandemic HIV through a lens of women's empowerment. Global Crossroads also provided me room and board in a house with other volunteers working on various projects in Moshi, a large town in the greater Kilimanjaro region of Northern Tanzania. During my first week in Tanzania, I partook in a weeklong crash course in Kiswahili, the local language, in order to have a baseline understanding of basic Swahili conversation. After this course, I began a 7-week stint of working with KIWAKKUKI on various different projects the women of the organization have started. The organization, which was founded in 1995, now commands a membership of over 5,000, mostly consisting of women that populate seven districts in the greater Kilimanjaro region. Projects focus primarily on spreading prevention messages and providing resources to women and children in the area. KIWAKKUKI utilizes connections with countless schools in the area, and works to provide income-generating projects for women both in Moshi's urban center and the more far-flung rural areas of the Kilimanjaro region.

As a volunteer for KIWAKKUKI, I was fortunate enough to get to experience many of the different projects and partnerships the organization operates. At the beginning of each week, I would work with the women in KIWAKKUKI's main operational office in the center of Moshi town to devise a weekly schedule of activities. Because of the flexibility the coordinators gave me, I was able to travel to rural districts to see town and village meetings, tour a wide variety of schools in all areas of the region, work with organizations that partner with KIWAKKUKI to provide services to the handicapped, go on home visits to speak with patients living with HIV

about their experiences and stories, observe HIV voluntary counseling and testing (VCT) sessions in their Moshi office, and deliver "life skills" lessons to local children on assertiveness, empowerment, ambition, and good health.

On a typical day in a rural district, my guide and translator, Riziki, would pick me up at the Moshi offices and we would ride by dala dala (a small, vastly over-crowded minibus) to our destination to meet a KIWAKKUKI representative, who would take us to see some of their community. This would usually involve a visit to a local partner school or a patient living with HIV. We would then attend a town meeting with a sampling of the members of KIWAKKUKI who live in the area, and Riziki would translate during pauses in the action as business was conducted nearly exclusively in Kiswahili. Some of the more rural areas we visited, like Hai, Siha, and Boma were more than 1 hour away from Moshi's center. On these kinds of visits, I would occasionally interview people, but most of my information from these trips came in the form of observation.

Many days were spent visiting various different schools and seeing their partnerships with KIWAKKUKI. A majority of the schools visited were private, primary schools. As part of the tour, we would introduce ourselves to each class, and we would meet individually with students whose school fees were paid by KIWAKKUKI. At some of the schools, we would observe "club meetings", where some older students who participated in "KIWAKKUKI clubs" sponsored by the organization would perform dramatic skits or songs that expressed HIV prevention messages like the reduction of stigma or promoting good and safe behavior. Several of these performances were video recorded with the consent of the students and teacher, which was very easy to obtain, as the children loved to see themselves on photo or video.

Home visits to KIWAKKUKI members living with HIV gave me some particularly interesting insight into how living with HIV impacts a person's ability to participate in the community. Home visits were conducted all over the region, both in rural and urban areas, and men and women from various socioeconomic and cultural backgrounds and ages were visited. Upon arrival, Riziki and I would present the client with a gift, typically sugar to sweeten tea or a bar of laundry soap to wash clothes. We would then sit and talk with the client about their history with HIV. Conversations were almost entirely in Swahili, and I relied heavily on Riziki to translate both my questions into Swahili and the client's answers into English. The dialogue between the client and I usually resembled an interview format, though I almost never followed a prescribed set of questions or had the client sign a consent form. I recorded paraphrased responses in writing after the interviews so as to not interrupt the flow of the conversation or make the client feel uncomfortable.

Voluntary counseling and testing (VCT) sessions were very similar in their structure to home visits. The counselor that I would be working with for the day would ask if the client was comfortable with someone conducting research being in the room for their VCT session, and if the client agreed, I would simply observe the session. Only a few sessions were conducted in English, so I would often just watch for body language while the session was taking place. While the counselor would be taking the blood for the test, he or she would explain what they talked about and give me background information on the client regarding what they knew about HIV, what their reason was for getting tested, and what their plan was in order to minimize their risk of becoming HIV+. They would then ask if I had any questions they could relay to the client, giving me the opportunity to ask more specific questions. I would only record any information or findings from the interview once the client had left.

Occasionally, I would also be asked to deliver a "life skills" lesson to some of the local children. In order to draw in children to the main office to relay prevention messages, KIWAKKUKI allows people to take advantage of on-site computers free of charge, and only requires them to listen to a speaker for a short amount of time. I, along with other volunteers, was occasionally called upon to give lessons on "life skills", which is an intimidatingly broad term. KIWAKKUKI recommended that helping young people to gain proficiency in English, talking to them about good values like ambition, respect, and compassion were good things to discuss with the children. Because the students have varying levels of English comprehension, I tried to keep things simple and more hands-on. Some examples of activities and topics included playing card games to learn the numbers in English and a sharing activity where the kids would talk about what they wanted to be when they grew up and what school subjects they would need to do well in to achieve those career goals.

Over the course of my stay in Tanzania, I was able to speak with most people that worked in the KIWAKKUKI office, but I rarely did so in a formal interview setting. I obtained several interviews with people in a sit-down manner, but most of the information I gained was from listening to people in the field and making a quick note of it in a pocket notebook or waiting until returning to my hostel to write it down, rather than taking notes while people were talking. In many cases, it felt as though it would be disrespectful to disrupt someone's story with writing it down. Because of the more friendly and personal nature of business and interactions in African culture, I decided to forego note-taking in most situations, leading to most of my information being logged in a daily log.

I initially went into my project looking to examine the intersection of public health and community development outcomes, with a hypothesis that the relationship between the two

would be bi-directionally causative, both acting as inputs into the outcome of the other. While carrying out my research however, my thesis evolved to include a new finding. I observed that the importance of a person's access to "human networking", the daily face-to-face interaction between people, is paramount in promoting not only HIV prevention AND economic development, but other development outcomes like political access and social inclusion.

Budget

The $4,000 stipend allotted to me by the department was relatively sufficient in funding with a bit of personal supplement. I was fortunate to plan my program and room and board before arriving in Tanzania, so there was no uncertainty about my accommodations or their cost when I departed. I paid the application fee ($200), program fee ($1,600), and airline tickets ($1,600) months before my departure. I hadn't included medical expenses in the form of vaccines and anti-malarial prophylactics into my budget because I thought I was up-to-date on vaccinations because I traveled to Tanzania in 2010. Unfortunately, I needed a new Typhoid vaccine and Hepatitis boosters in addition to anti-malarials which my insurance provider would not cover, setting me back over $300 when all was said and done.

Upon arrival, I was met with immediate financial challenges when I realized that I was going to have to pay an extra $50 for my tourist visa and residence volunteer permit because the Tanzanian government will not issue $50 single-entry visas to US citizens, who are forced to buy a $100 multiple-entry visa because of ill feelings toward the US for high-cost travel visas for Tanzanian nationals. I had budgeted to purchase a single-entry visa, so this caused my in-country expense allowance to be lessened. Fortunately, I didn't have to purchase all of my own water like I had expected to since the water is glacial run-off and completely safe once boiled.

Transportation also was not as much as I had expected within Moshi, as all of our bus fares to the rural areas were paid by my program fees and dala dala fare between my hostel and the main KIWAKKUKI offices was a mere 300Ts per ride, equivalent to about $0.20. The only large expense was a long weekend trip to Zanzibar, an island territory in the Indian Ocean, where transportation to and from proved to be expensive. As I gained little information relevant to research on this trip, I treated it as a vacation and paid for it outside of my grant allotment.

In total, I went over-budget by about $350, not including my own trip to Zanzibar, and covered all of these expenses personally. Weekly spending varied depending on the activities, including how often I needed to utilize Internet cafés for research or personal purposes as well as weekend trips. And of course, the inevitability of "mzungu price" made it so that any food not provided to by my hostel or souvenirs cost more if our hostess, Rosie, wasn't involved in the transaction.

Preliminary Findings

My primary objective through this research was to better understand the relationship between public health crises, such as the HIV/AIDS crisis in Sub-Saharan Africa, and development in small, local communities. I found that, based on my observations in the Kilimanjaro region of Tanzania, the health outcomes of people have an impact on their ability to foster community development through their involvement in community projects, but also that poor health outcomes are heavily biased toward those with lower economic, political, and social access in the community. These observations support the theory of "bi-directional causation" purported by several development scholars.

Through my time working with KIWAKKUKI, I saw this relationship played out in a variety of different ways, exemplifying how difficult it is to separate development from the capabilities of its people.

On my first two home visits to patients, it became obvious that their health had incredible effects on their ability to participate in the community in a productive way. The first woman I met was an HIV+ mother to 5 children who had been on anti-retroviral drug therapies (ARVs) provided by the government for a number of years. Her husband, who had left, infected her and she had become too sick to work at many times, causing her incredible hardship in feeding her family. KIWAKKUKI helped her to establish an income-generating activity, which in her case meant selling small fish in the local market. Her illness makes it difficult for her to travel, and she has little money to afford bus fare, which means that she often does not make it to market and also stopped receiving ARVs from a dispensary out of town in January of 2013. A man who I met in the same week was one of the first diagnosed cases of HIV in Tanzania when he became diagnosed in 1988. He was a civil engineer who worked away from his wife for much of the time, building roads between Dar es Salaam and Kilimanjaro. He contracted HIV and stopped being able to work, as ARVs were unavailable at the time of his infection. He now lives in poverty outside of Moshi with his wife, whom he infected in the 1990s.

The socioeconomic status of individuals has an inherent effect on their likelihood of contracting HIV. Young women who are raised in poverty have a greater chance of engaging in prostitution as a means to make money to support themselves and, often, siblings and/or children of their own. If the families of these girls had had the financial means to pay their school fees and keep them well-fed enough to concentrate in school, then their chances of ending up in such a high-risk situation would be much lower, and they would be at a decreased risk of contracting

HIV+. There is also a link between poverty and agency, and women who are poorer often feel less able to insist on condom use, even if the sex is consensual with a boyfriend or husband, as well as less likely to leave a partner who is being unfaithful. One of the women I met on a home visit had a similar story. Her annual school attendance depended on if her single mother could afford school fees and she ultimately couldn't continue on to secondary school. In order to provide for herself, she began a relationship with an older man who left her pregnant and HIV+. It is clear that had her situation been one of more opportunity, she would not have felt as though she needed to engage in sex for financial security.

In addition to bi-directional causality between economic growth and health outcomes, I noted that in developing and implementing effective projects for both economic development *and* HIV prevention, there is enormous reliance on what I am choosing to call for the intention of this paper, "the human network". "The Human Network" refers to the strong reliance on face-to-face, daily interactions between people that the "developed world" utilize less of as globalization connects us *virtually* to an increasing number of people. In the developing world, where access to technology is still far sparser, globalization has had much less time to have a sociological impact on the way people interact with one another. The amount of time a person in Africa spends on face-to-face interactions means that for things to get done, they need to be arranged and implemented in person. It is true in African culture that it is expected that you will prioritize the request of someone who is speaking face to face with you. During a Swahili lesson with our teacher, Joseph, he would frequently answer phone calls from people about the orphanage he ran, but his priority was always clearly our lesson, because we were sitting in front of him. Likewise, plans were never formally made with our coordinator, Deo, unless he came to see us in the flesh,

and though this frustrated many of the volunteers at first, it became accepted as "part of the culture".

In order to set in motion a project in the community in Moshi, one needed to pool resources from many sources and talk to many people to get the ball rolling. A person looking to get something done needs to have friends all over to help make it happen; people buy things from their friends to get the best price they can, and people trust in their friends to spread word and advertise for a cause or project. The volunteers often joked that Deo was "the mayor of Moshi", and he could never walk very far without having to stop to talk to a friend. In reality, this is how he was able to set community projects in motion and help the volunteers to have such great experiences working on projects. While in Moshi, we watched as Deo set up a number of projects for the local "street boys", who were for myriad reasons not living at home and instead on the street, not going to school or being provided for by a guardian. Deo also was able to set me up with a visit to Kilimanjaro Christian Medical Center (KCMC), the largest hospital in the region through a friend who is a doctor at the hospital. Deo's success in implementing projects in Moshi came from his involvement in the community and his access to a network of friends and contacts.

This concept of accessing "the human network" was equally important in my work in KIWAKKUKI. Part of the reason why this organization has been so successful in implementing programs is the number of women who are members. Over 5,000 women in the community are members of KIWAKKUKI, and this creates an instant connection for women in the organization who try to implement projects to not only fellow KIWAKKUKI women, but also friends and family of these women who can lend a helping hand. I would say that having this many KIWAKKUKI members who are engaged in the greater community is reason why the

organization has such great involvement with local schools. KIWAKKUKI women are mothers, they are teachers, and they are students themselves, and they take their message and share it with their colleagues and friends. These women form relationships with other women, and their message spreads organically through the community through people who care for one another. People trust the message more when it comes from within their "human network" and they are more likely to be receptive and communicate that message to others. Other HIV organizations led by foreign organizations seem to garner less investment from members of the communities simply because these organizations are not inherently plugged into the community's "human network".

Unfortunately, "the human network" is not purely used to improve the community and start projects that can improve the conditions of a community. People in African culture are constantly using their connections to others to gain something, and while these friendly arrangements can and are used to work toward a community goal, they are also often used to the community's detriment. Political corruption is an ideal example of how "the human network" can be systematically misused to stunt community development. Nepotism and shady deals between community officials can stunt community development projects or make them more expensive or ineffective. During a return journey from Zanzibar, I experienced first-hand how "the human network" can be used to exploit when we were charged "mzungu price", *mzungu* being Swahili for foreigner or tourist. Fellow volunteers and I were grossly overcharged for bus tickets from Dar es Salaam back to Moshi. When we boarded to bus and realized we had been charged about 50% more than everyone else for our bus fare, we were "lucky enough" to have a government official on the bus with us. He led us off the bus where he talked to the police about our situation. After about 25 minutes of stalling the bus, it was determined that the man who had

sold us our tickets did not work for the bus company and had ran off with the extra 15,000TSH he stole from us. The police sent a colleague to search for the man, and the government official arranged for us to get 9,000TSH back per ticket, meaning each of us had still been overcharged 6,000TSH. We determined when we boarded the bus that the police and government official had agreed to give us back most of our money, but pocket the rest for themselves.

"The human network", despite its importance in the prevention of HIV, can be abused, which caused the spread of pandemic HIV to begin with. As sexual contact is the mode of transmission in almost all cases of HIV in Sub-Saharan Africa, it can be inferred that "the human network" in a sexual context is the root of the problem. There are cultural expectations about masculinity being connected to sexual prowess and less social stigma around non-monogamy than in Western societ, both of which have contributed to African people having a particularly difficult battle with preventing HIV. The importance of remaining favored in your network is what motivates the stigmatization of HIV; people are afraid of being disowned by their family and friends because of misinformation about HIV, which is still a problem despite improved access to accurate prevention information. One of the misconceptions about HIV that still seems prevalent is that people in faithful, monogamous relationships cannot become HIV+. While sitting in on VCT sessions, I heard this idea expressed by clients multiple times. People also informed me that in rural areas, stigmatization of HIV is higher, and this can be correlated with a lower degree of connection to "the human network" of urban areas, which generally have easier access to the facts about HIV and its transmission.

"The human network" is a powerful tool in African society. The nature of its use can determine the success of development projects. If people spread incorrect information about HIV or fear knowing their HIV status because of the potential alienation they may feel by testing

positive, then HIV will continue to be a problem. On the other side of the coin, though, if people talk openly to one another about how HIV is spread and how to protect yourself, then people will be more aware and less ignorant and afraid of the disease, and this will undoubtedly prevent countless people from becoming HIV+. If people ask for help in starting a community project rather than attempting to use favors to gain unfair advantages in local politics, then we can repurpose "the human network" to be a mechanism for organic and beneficial social change. I believe that the women of KIWAKKUKI are promoting this idea through promoting character education to children in schools and empowering women to get involved in their communities.

I found that not only are HIV prevention and community development linked, but they are part of a more broad set of connections that tie community development and economic growth to a variety of sociological factors such as; education, tribal affiliations and family backgrounds, vulnerabilities such as orphanhood, disability, and gender, and rural versus urban lifestyles. I was impressed by KIWAKKUKI's ability to observe these relationships and respond with programs that attempted to address these issues through effective programming. I feel inclined to attribute this success to the strong leadership of the organization and the large and diverse membership base, which maximizes KIWAKKUKI's access to a vast "human network" and thus, a wealth of ideas and resources with which they can organize programs that respond to the demands of their community.

The success of KIWAKKUKI as an organization and the fact that it started almost 20 years ago by a small group of women was astounding to me. The entire growth of the organization seemed organic from my perspective; the organization took on more and more local women, and then received attention from foreign donors, and with outside funding continues to expand in size and scope. I found that this was an ideal way for an NGO to grow sustainably,

maintaining strong community ties and local legitimacy while avoiding mission drift. I found that organizations with more apparent relationships to foreign NGOs seemed to be less utilized and less well-known amongst local people. KIWAKKUKI is a Swahili acronym, and it is a local organization founded by almost entirely local women, with a wealth of respect from local people. Rather than foreign NGOs going into an area and setting up their own sites and providing their own services, I now see much more merit in a foreign NGO or government simply sponsoring an organization with some exhibited potential.

Reflections

There were several aspects of my research that I would have improved upon had I had more time or resources with which to work. Primarily, there were a multitude of things that I would have had the opportunity to do with the organization had I simply known about them earlier into my research or had more time in Africa to carry them out successfully. Unfortunately, with only 7 weeks spent at KIWAKKUKI, I didn't have ample time. I am satisfied with the data that I collected and feel that it provided a cohesive thesis and some interesting and useful findings, but I left Africa with just as many questions as I had before my departure, and wishing I could have done more.

KIWAKKUKI carried out a study of number of years ago in partnership with Duke University and their School of Public Health around the topic of HIV prevention and home-based care. Duke still has a large presence in the greater Moshi area as a donor to KIWAKKUKI and through a working partnership with Kilimanjaro Christian Medical Center (KCMC), the largest hospital in the region. Once looking at the abstract for the research in the main offices, I inquired about their partnership with Duke and wanted to know more about what they were still working

on in the region. A week before departing, I finally arranged a trip to KCMC through a contact I made via my volunteer coordinator, Deo. We visited the hospital, however, unfortunately, the Duke representative I was to talk to, was not in the hospital that day, and I never heard from them via email or my local phone before leaving Tanzania. Had I had the opportunity to speak with someone from Duke, I would have likely talked to them about their current research projects to see if any of them were at all related to my own topic of community development and HIV prevention.

Additionally, one of the leaders in KIWAKKUKI, who we affectionately called Mama Matechi, approached several of the other volunteers, including myself, about the possibility of submitting a proposal for a new project that the women could implement. She explained that KIWAKKUKI was in the process of shifting its primary focus from the prevention of HIV to countering the negative impact that HIV has on their community, which follows a broader movement in the issue of HIV in Africa that is less optimistic about eliminating the virus completely, and instead wants to alleviate some of its detrimental side effects to inputs to community development, like the economy and local governments. I was initially very excited about this proposition, but became all too aware of how difficult it is to find an idea for a good, sustainable project as someone who has very little access to a "human network" in the region. As a volunteer from an entirely different part of the world, my fellow volunteers and I had difficulties in assessing what the greatest needs in the community were; we had only been there for a few weeks at most. Additionally, I found the idea of presenting a cohesive proposal to be challenging to synthesize in the 3-4 weeks I had from the time the idea was presented to us until the day I was to leave for the US. Had I had more time to get a more in-depth understanding of

the community, I would have definitely taken this opportunity, but feeling unable to speaks volumes for the importance of ideas coming from within the community itself.

Many new questions and concerns arose during my time in Tanzania on which hope research has or will carried out. Experiencing the nature of HIV and community development in person brought to light many concerns I hadn't even thought about before coming to carry out my own research. Working with KIWAKKUKI and knowing many of the things that they have experienced in recent years make me curious of the consequences of these events for other organizations.

KIWAKKUKI has had a long-standing relationship with the World Food Programme (WFP) for years, and until 2011, WFP was directly providing food to the organization to be dispensed at their main offices as well as in more rural areas to members in need as well as people living with HIV/AIDS (PLWHA). Then, the WFP as a whole shifted its focus from providing food to providing opportunities for people to sustain themselves through agricultural and economic programs. The idea follows a popular adage; "give a man a fish, he eats for a day; teach a man to fish, he eats for a lifetime", and seems like an ideologically sound plan of action. The problem, though, is that the WFP has, to date, not began any sort of agricultural programs in the region, but swiftly cut the food aid that was being delivered to organizations like KIWAKKUKI. Leaders in KIWAKKUKI have spoken to representatives from the WFP, and even have met with them since the end of food provision, but there is still no programs in progress, and worse yet, no signs to the community or KIWAKKUKI that there are even programs in development. I'm interested in what kind of accountability the WFP does or should have to organizations like these in a transitional period such as this. How can large-scale organizations like this provide services to smaller organizations with which they partner in a

transitional period. Additionally, should there be organizations that are exempt to the overarching shift from food aid to agricultural assistance? Organizations dealing with possibly-debilitating diseases like HIV are likely to resist these programs because, simply put, the cripplingly sick can hardly farm to feed themselves.

I am also interested to see how organizations such as KIWAKKUKI handle an influx of new donors, many of who are NGOs or government programs with their own goals and objectives. In the case of KIWAKKUKI, I thought that their mission was clear and that their projects worked toward meeting their goals, but I am curious, for KIWAKKUKI and other locally-based NGOs with international funding, if their mission or goals have changed when this new money comes in. If a donor wants the local NGO to change its size via expansion or modify their goals and projects, how does the NGO reconcile accountability to donors and accountability to their local constituency?

One of the most shocking and upsetting comments I heard while in Tanzania was when a member of KIWAKKUKI told me that many people felt that they would rather contract HIV than become a diabetic. This seems backwards and ignorant to anyone who lives comfortably in the US but, sadly, this mindset has a degree of logic to it. For a number of years now, antiretroviral drug therapies (ARVs) have been provided by the Tanzanian government to anyone who presents a CD4 T-cell count of under 250, which is a relatively high threshold for how "sick" a person must be in order to receive the drugs. Almost no one can afford the drug without its free provision by the government, but people do receive ARVs and can live relatively normal lives with diligence and a lot of effort to remain healthy. Type II Diabetes, however, is becoming more and more prevalent in much of Africa because of shifts in diet toward more refined sugars, and has no treatment provision by the government. People are still going blind and losing entire

limbs due to diabetes in Africa, and in a hypothetical circumstance where they were given a choice, HIV almost seems like the wise one. Because of this, I am very interested in observing how prevention of a particular disease measures in developing countries impact perception on other diseases. I also have to question what should the responsibility be of health-related NGOs, like KIWAKKUKI and others, in this matter. Should we continue the pattern of specific NGOs dealing with a limited number of diseases, or should we perhaps change gears toward having health NGOs be more all-inclusive in promoting health and preventing all diseases?

Overall, I am incredibly pleased with the outcome of my research and to have lent my time by working with KIWAKKUKI. Carrying out this research has been incredibly beneficial for my studies, and I plan on using the information I gained in my Senior Thesis in International Political Economy. I gained valuable foresight into what it is like to carry out field research, and exercised a variety of research techniques that I hope to use in the future on other projects. My ability to take my observations and channel them into a thesis that sums up my findings is a skill that I expect to utilize in pursuance of a Master's Degree in Public Health in the future.

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