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Community-driven development: understanding the interlinkages between individuals, community-based workers and institutions.

CDD Working Paper Series

Working Paper No. 2

Policy Overview: A review of policy and practice in relation to water and HIV/AIDS in Tanzania

By
Comfort Mfangavo
with Frances Cleaver, Anna Toner, and Jelke Boesten

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Community-driven development: understanding the interlinkages between individuals, community-based workers and institutions.

The purpose of this research is to identify the potential and constraints of community-driven management and service delivery by tracking the evolution of participation, in selected projects as shaped by the interface between individuals, community workers and institutions.

Pro-poor community-driven development is both enabled and constrained by individual identities, the actions of community workers and the workings of institutions. The positive aspects can be enhanced through a greater understanding of individual motivations, institutional processes and improved monitoring techniques. However, the limitations of such models must also be recognised.

This research has three objectives: (1) to understand individual participation in collective action; (2) to understand the contribution of community-workers to participatory processes; and (3) to understand the possibilities of 'getting institutions right' for pro-poor development.

The research analyses case studies of community-driven development activity in relation to water and HIV/AIDS in Tanzania and South Africa.

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This Working Paper Series is dedicated to the memory of

Comfort Mfangavo

enthusiastic research partner in Dar es Salaam.

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Abbreviations

AA Tz	Action Aid Tanzania
AMREF	African Medical Research Foundation
AWEC	Annual Conference of Water Experts
CBO	Community Based Organisation
DAS	District Administration Secretary
DWST	District Water and Sanitation Team
FBO	Faith Based Organisation
FGM	Female Genital Mutilation
GoT	Government of Tanzania
ILO	International Labour Organisation
ITV	Independent Television network
LGAs	Local Government Authorities
NGO	Non Governmental Organisation
MoH	Ministry of Health
MoW	Ministry of Water
NSGRP	National Strategy for Growth and Reduction of Poverty (formerly PRSP)
OVC	Orphans and Vulnerable Children
PLHA	People Living With HIV AIDS
RFAs	Regional AIDS Facilitating Agencies
TMAP	Tanzania Multi-Sectoral Aids Projects (Of the World Bank)
SDC	Swiss Development Cooperation
URT	United Republic of Tanzania
VCT	Voluntary Counselling and Testing
VWC	Village Water Committee
WAMATA	Walio katika Mapambano ya ukimwi Tanzania (Those who are in the fight against AIDS)
WFP	World Food Programme

Key Findings

CDD in the water sector

- The water sector in Tanzania shows an increasing emphasis on community participation in the management and supply of water, often in partnership with private sector management. The 2002 Tanzanian water policy emphasises a demand-responsive approach.
- There is no regional and district level strategic planning in relation to the extension of improved water supplies, with much of the existing activity being undertaken by NGOs, International Agencies and local communities.
- A wide range of interventions emphasise that community participation is essential if water supplies are to be properly valued at the local level. Community engagement is sought through community mobilisation to supply labour, raise capital funding and administer ongoing revenue collections for operation and maintenance.
- Three problematic issues are evident: a) in the majority of cases coverage of improved water supplies is patchy and depends on the ability of a community to organise and to be visible; b) the difficulties of effective and inclusive community participation receive very little attention (with the exception of WaterAid) and the benefits of participation are often assumed; c) there is no discussion about the need to ensure access for the poorest either through subsidy or pricing.

CDD in combating HIV/AIDS

- The Tanzanian State designed a comprehensive multisectoral framework to combat HIV/AIDS in 1998. However, despite revisions and amendments, actual policy-design is slow and implementation hardly visible.
- The institutional and legal framework with regard to gender equality and violence on the one hand, and with regard to HIV-positive status and access to services, protection, and labour, is weak.
- Increasing availability of foreign resources to combat HIV is positive, but is also in need of stronger government regulation and coordination. The UN is attempting to support TACAIDS in this task.
- At community-level, little governmental intervention is noticeable. NGO presence is more apparent, well-resourced, and well-focused, but scattered. Non-governmental intervention lacks local, regional, and national coordination to streamline needs and services.

Issues for research

- What are the possibilities for improved coordination and regulation of both governmental and nongovernmental development interventions?
- How can policy and legislation contribute to protection and access to services for vulnerable groups (women, PLHA, very poor)?
- How can local government be more effective in the implementation of CDD?
- What is meant by and targeted as ‘community-based’ and ‘participatory’ interventions with regard to water supply HIV/AIDS and how effective are such approaches?
- How can community-based workers (volunteers) be supported more effectively in their efforts to deliver services?

1. Introduction- Background to research

Community-driven development promises much: it offers the possibility of the sustainable, equitable and effective provision of services and the reduction of poverty. In common with similar approaches, such as livelihoods, asset-based community management, it aims to put the people at the centre of development. The assumption is that the people know their own situation better than experts do and that they can make choices about what they want to make life better.

People's willingness and ability to participate in development projects are critical factors in the success of community-driven development approaches to reduce poverty, but are little understood. This research aims to further our understanding of the gaps in current practice and to identify both the potential and limits of participatory approaches in promoting social inclusion through community-based management and service delivery. This is expected to contribute to DFID's specific objective to promote policies and actions that support sustainable livelihoods.

This research aims to explore a number of case study interventions in Tanzania and South Africa which have as their unifying feature a commitment to community-driven development. Through detailed ethnographic research we aim to shed light on the interactions of individuals, community-based workers and institutions in community-based development, in order to respond to current gaps in knowledge (see Boesten 2005)

1.2 Structure of this paper

As a preparatory resource for this research, it is essential that our case studies are contextualised through a consideration of the policy contexts to which they relate. It is also important in research such as this, in which a limited number of case studies are subjected to detailed qualitative analysis, that those case studies are placed in terms of their significance to the broader range of practice in a particular sector.

This paper therefore reviews changing policy in Tanzania with regard to water supply and HIV/AIDS. As such, it tracks the development of policy approaches towards these two issues, it outlines the governmental frameworks in which community-driven interventions are embedded, and it reviews the activities of the major international and national actors in providing community-driven water and HIVAIDS interventions on a national scale.

The study is based on semi structured interviews with key informants in the field, such as government representatives and selected representatives of major organisations and institutions. Nevertheless, opinions of the key informants are not necessarily the opinion of the organisations and institutions they represent. Therefore, where available, policy and evaluation documents of the different institutions under review have been examined as well.

Not all major actors were prepared to be involved in this study. For example, the governmental coordinating body for HIV/AIDS policy and implementation, TACAIDS, has not granted us an interview. Although this could be a major shortcoming to our study, we believe that this rejection in itself says something about the organisation. TACAIDS' reputation of inefficiency and possibly corruption was enlarged by media coverage during the first years of its existence. Although the veracity of such accusations should be questioned – in 2005 an international assessment committee concluded that the confusion was rather the result of wrong expectations and uncertainty about TACAIDS' tasks than of corruption-[1], it might have led to reluctance on the part of TACAIDS to be 'questioned' by us. Grass roots organisations were probably the most critical towards TACAIDS' performance, making us, researchers concerned with the views and capacities of community-based organisations and the links they maintain with the institutional environment, perhaps not the most desirable interlocutors.

Most institutions have, however, kindly granted their permission to talk about their activities (interviewed persons are listed in annex A) and provided available documentation. We are grateful for their participation.

The paper is divided in two sections: first we discuss the policy background for water provision, and than we do the same for HIV/AIDS prevention and care. Both sections are structured along the same lines and include sections on a) problem definition, b) outline of policy development, c) community-driven development approaches, and d) an outline of activities by non-governmental organisations. A concluding section draws the two thematic sections together by identifying some common possibilities and constraints in community-based development processes in Tanzania and by placing these in the national and international institutional context discussed throughout the text.

[1] This was a UNDP assessment carried out by H. de Knocke, James M. Guwani and Henry Meena, 'The 'Three Ones' principles: Assessing progress in their application in the United Republic of Tanzania', Unpubl. June 2005.

2. Water Policy in Tanzania

2.1 Introduction: from state as provider to state as facilitator

The evolution of water policy in Tanzania is necessarily mirrored in the evolution of the Tanzanian state. Policy in the water sector reflects changing political ideology as can also been seen in the evolution of agricultural policy in Tanzania (Ponte 1999). The broad thrust of this change is explored in table 2.1 below.

Box 2.1 Evolution of water policy in Tanzania

Period	Water Policy
Colonial Period (1890s-1961)	Reliance on improvement of indigenous systems Some large-scale irrigation projects(Hyden 1980)
Ujamaa (1961-1980s)	Water as a public good State took responsibility for capital investment Improved access to water from 12-47% (Hyden 1980; Kapile 2003)
Transition (1990s)	State continues as provider in partnership with donors-(Therkildsen 1988) 1990/01 Access to protected water source- 46%(Hyden 1980; Maganga et al. 2002; URT 2002a; Kapile 2003)
Liberalisation (1995-2005)	State as facilitator and regulator. Civil societies and communities to deliver services in partnership with private sector Integrated water management approach echoing international 'consensus' 2000/01 Access to protected water source- 55% (URT 2002a; Sokile et al. 2003; URT 2004b)

Following the Arusha Declaration in 1967, there was heavy investment in the water schemes during the 1960/70s, which resulted in the proportion of the population with access to improved water supply rising from 12 to 47% in the period from 1971-80. Water was recognised as a public good and the government undertook to cover all capital costs of investment (Maganga et al. 2002; Vavrus 2003)) However these early investments could not be maintained and many schemes fell into disrepair. The failure of such schemes is not placed on a lack of government investment but tends rather to be blamed on a lack of community participation in design and management.

Since the 1990s Tanzania has attempted to implement an integrated approach to the management of water resources (Sokile et al. 2003; Sokile et al. 2004). The 1991 policy aimed for the provision of safe, clean water to all the population within 400 metres by the year 2002. However by 2002, only 50% of the rural population had this access. The 2002 water policy (URT 2002a) sought to rectify gaps in the 1991 National Water Policy, which framed the state as the main investor in and manager of water projects. The revised policy, in common with most policy reform of this period, reorients the state away from service provision and towards facilitation, co-ordination and the formulation of policy. This document views water as an integrated component of Tanzania 2025 Development Vision which aims at 'achieving a high quality livelihood for its people, attain good governance through the rule of law and develop a strong and competitive economy. Universal access to safe water is viewed as one of the central features of a quality livelihood[2].

The 2002 policy argues that the present water acts (1974 and amendment in 1981) are insufficient to deal with the current management challenges. Water in Tanzania is managed through a river basin approach and is divided into nine hydrological zones, and this policy makes a case for integrated water resources management at basin level. Integrated management approach seeks a participatory, multi-sectoral and multi-disciplinary management that views water as a scare resource and makes linkages between water, land-use and the importance of water ecosystems in the national economy (URT 2002b)

In line with international agreements on water resource management (for instance the Dublin statement on water and sustainable development,) current policy recognises the importance of a

[2] see Http://www.tanzania.go.tz. Last accessed 26/1/05

sufficient supply of water and an adequate means of sanitation as basic human needs and, in addition, institutional mechanisms that operate through community user organisations and the private sector. The measure of this right to water is given as 25 l of potable domestic water per day at a distance of 400m and serving 250 people per outlet(URT 2002a). However this is a target to be aimed at, rather than a recognised legal right as it is in South Africa (Sokile *et al.,* 2004).

Key issues in the 2002 Tanzanian water policy are:

- Community Participation – communities to legally own, manage and sustain water supply facilities
- Private Sector Participation – private sector to complement public provision of water
- Integration of water supply, sanitation and community health education
- Redefinition and Clarification of roles and responsibilities of various water stakeholders
- Demand Driven Approach – water services to be provided to communities based on community initiative, preparedness and willingness to pay

Considerable emphasis is placed by the 2002 document on participation of water users and local communities in managing water and in driving projects/programmes, in cost-bearing by communities, in working with NGOs, private sector and other external agents, decentralisation of decision-making (Sokile et al. 2003; WaterAid 2004; Kyessi 2005). Community ownership is seen as a means of achieving sustainability through community investment and commitment to their schemes and specifically through the mechanism of village water committees. Communities are expected by the policy to pay a portion of capital costs (in cash and in kind) for rehabilitation and extension of existing schemes. Communities are also expected to pay the full costs of operation and maintenance. Thus water has become reframed as an economic good (Winpenny 1994; Rogers et al. 2002; URT 2002a; Vavrus 2003)

There appears to be a contradiction between the emphasis on a demand-driven approach in the 2002 Water Policy and the stated aim in the Government Vision 2025 to reduce poverty through minimum basics access criteria. Whilst the Tanzanian government recognises water as a basic right, it lays out no specific means of addressing the needs of the poorest and most vulnerable groups. Communities appear to be homogenous and equally able to pay. There is a disconnect in the policy that on the one hand seeks to ensure efficient and equitable use of water, but stops short

of suggesting any means of doing so, and passes the responsibility for water management to independent water user entities and stresses their accountability. However, specific mechanisms are undefined. Sokile *et al.,* (2004) maintain that this is a general weakness in integrated water resource management as an approach formulated through the iteration of general principles (such as Rogers and Hall, 2003). These approaches, appropriated entirely by the 2002 Tanzanian water policy, tend to ignore the contextual specificity of management and say little about issues of equity and sustainability at the micro-level (Cleaver 2004). Further, they overestimate the capacity and commitment of private sector providers to the delivery of public services(Tendler 1997; Beall 2004; Kyessi 2005). Further more, the current programmes and policies of the Ministry are themselves ideals and are largely dependent on securing the necessary funds (from donors) to implement them (Kapile 2003).

Truly integrated water management relies on strategic management of resources at a number of levels. This requires an appropriate institutional framework. At present, in Tanzania, water is increasingly being managed through a complex matrix of water user entities (WUE) including private companies, co-operatives, and water users associations. Legal rights to water can be granted through these organisations. Whilst in the future it is proposed that a rationalised institutional framework relying on water user associations as the bottom-level in water basin management will be applied (URT 2004b) it is necessary to reflect on the limitations of the current mix of government, private enterprise and donor-funded projects.

In a recent review of strategy the MOWLD themselves recognise the limitations of private sector participation and community participation, in particular they emphasise that a substantial majority of the population cannot afford the high prices of private water supply. Additionally, the broad ownership and participation by communities in water management is restricted by prevailing local norms and the differential inclusion of certain social groups (URT 2004a). This is further supported by a detailed ethnographic case study in Kilimanjaro Region, which shows local elite empowered through the opportunity to manage a Village Water supply with the consequence that pricing moved in favour of private taps and disadvantaged the poorest who were not represented in the local Water User's Association and whose needs were not locally recognised (Toner 2005)

2.2 Approaches used for community-driven water projects

This paper seeks to provide an overview of a range of current interventions in water supply which emphasise community-driven management. Table 3.1 summarises the interventions considered in this review. They include a range of interventions from small-scale single community engagement to large scale demand responsive government funding streams.

One of the objectives of this paper is to create an information package for stakeholders on existing practices in community-driven water projects (CDWP). This will help to inform other stakeholders about what others are doing, and will contribute to a reflection on current water policy and practices in Tanzania.

Data was gathered from the organisations through interviews with personnel, and through the collection and review of documentation relating to specific interventions. The questions asked of the data relate to the scale and scope of the interventions, the mechanisms they use to facilitate community participation and an assessment of their impact and sustainability. Such a review is of course limited but we hope that it will provide a sufficient overview of the range of approaches taken in this area; and will therefore provide a substantive contribution to assessing both the strengths and weaknesses of community-based service delivery and management of water supply.
This will assist this research in contextualising our analysis of specific case study data in future outputs.

In this particular paper our focus is on examining the policies formulated at the macro-level which define certain roles for communities in delivering services and then in comparing such policies with the actions being taken by different agencies within the sector.

Table 2.1 Summary of interventions reviewed

Intervention/Organisation Name	**Agencies Involved**	**Activity & Scale**	**Community Contribution/participation**	**Impact & Sustainability**
Village water Supply Project (Uchira Village) (1999-present)	GTZ MOWLD	Rehabilitation and extensions of existing scheme with new intake. Technical advice and works funded by GTZ, implement by local contractors/consultants 1 Village (5000 inhabitants)	Communal labour, financial contributions to construction, payment for water, community management board through legal constitution as 'water user's association'.	Water supply much improved. Necessary evolution away from community management to bureaucracy Contested & partial community ownership Questionable sustainability given small scale
Hai District Water Supply project (Early 90s-present)	KfW Hai District Council MOWLD	Rehabilitation and extension of water supply across Hai District in several phases	Communal labour and payment for water. Community representation through Village Council on 'Local Water Management Trusts'	Good balance between community representation & effective management Self-sustaining system with good and increasing coverage.
Rural Water Supply since 2002 - 06	Ministry of Water, GoT	Medium scale project, covering Shinyanga Region only. Funded by the Netherlands Embassy (About 8million USD)	Water users contribute at least Tshs 100,000 for initial investment for shallow wells and are advised to keep Tshs 60,000 for O&M in their bank account before the project commence. Community identify, plan, and execute the project, with minimum supervision from the District Water Engineer. Public Private Partnership is emphasised	Improved water supply in the dry-land of Shinyanga. Communities provided training on management of water schemes and hygiene aspects of water schemes.

Intervention	Agency Involved	Activity & Scale	Community Contribution/Participation	Impact/Sustainability
Community water supply projects since 1991	Plan International in Tanzania	Community Development interventions with children as a focus of development. A Canadian originated international NGO working a few districts	Communities contribute labour, locally available raw materials, and a percentage of capital cost, which varies from 3% to 5%. Some communities contribute Tsh 300 per month, while other communities use pay-as-you-use system	Improved water supply. Government official much involved in O & M of schemes. Once-off intervention. Large coverage in terms of districts, but few people benefit from each district (patchy).
Community Driven Development projects including water supply since 2003 – 2008	Tanzania Social Action Fund (TASAF)	Joint government of Tanzania and World Bank initiative for community driven development initiatives. Covers the whole country – depending on the interest of the community to participate	Community contribution varies from place to place but normally Tshs 80,000 per well and labour. Communities do major works for O&M, with some minor advisory technical support from District water engineer	The rule is that 70% of communities have to participate for the project to be approved. Sustainability is possible, although community capacity on management of water funds is still weak
Rural Water Supply	Water Aid	Support to community water projects in few districts	Community water committees organise collection of contribution and labour to access inputs of technology and capacity-building	
Rural Water Supply since 2002 - 08	Ministry of Water, GoT	Joint World Bank and GoT funded Demand Driven water projects. Started in 2002 with 5 Regions but has expanded to all Districts in 2005. Large scale (About 4.7 million USD for five years)	Communities contribute 5% as a condition for water scheme to be granted. District council also contributes 5% although this varies between Districts. O&M system vary between villages, but in all cases, the project generates funds for O&M through user charges. Public Private Partnership is emphasised	Improved water supply at community level. Emphasis is put on improving District Water offices in terms of equipment and staff training

2.3 Overview of approaches taken (agencies, activities and scale)

The CDD approach is heavily promoted in the national water policy, although implementation of the policy takes a variety of forms in different projects. Basically in the country, there are effectively three broad types of institutional arrangement for management of water schemes; government management (the old supply-driven approach), management by communities through WUAs, and public/private partnerships (trusts, public companies, private operators). This review will concentrate on the latter two as our focus is on the ideas and practice associated with community participation, engagement and management.

The range of approaches used to facilitate community involvement in community-driven water projects is similar in all of the surveyed interventions. All of the projects start with a process of community sensitisation and engagement often followed by PRA exercises (and other participatory techniques) for identification of the water problem and planning a response. Community committees are commonly used to coordinate construction of water schemes and to organise the collection of a cash contribution from local residents. Their responsibilities also include organising for community physical participation in construction works and solving logistical problems. In TASAF[3] projects, for example, committees are given more authority in controlling project activities and finances, and in the selection of contractors, although here the issue of capacity of the committee in practically dealing with those issues is questionable.

Apart from the shift in practice towards increased community participation, In general the current range of interventions shows little difference from the pattern illustrated in table 2.1 that emerged from the 1980s onwards. It shows a significant stream of intervention in the sector by government using donor funds. The origins of donor funds are multiple and each follows a different approach which suggests a lack of harmonisation in the sector at the macro level, or a continuation of the strategy of donors in previous decades to adopt a district/region (Therkildsen 1988). However as table 3.1 in terms of method at the local level there is a surprising degree of unity as to how to mobilise a community, to create a demand for water and to institute a community-based system for the payment of user fees. Schemes supported by International

[3] Tanzania Social Action Fund for community initiated development projects. The fund is contributed by World Bank and the government of Tanzania. While launching TASAF II in July 2005, President Mkapa announced that TASAF II contain a village fund of Tshs 120bn, which shall be used for community driven development initiatives such as water, rural roads, etc. He further clarified that for water component, local community shall be required to contribute 5% of the investment cost

NGOs such as WaterAid and Plan follow similar patterns of community engagement but operate on a significantly smaller scale.

2.4 Stakeholder partnerships

Public-private partnerships

As described above the water sector is predominantly a government domain (through donor supported projects), although there are few NGOs which engage in this venture. Public-private partnerships are considered to be a central component of the current Tanzanian water policy but the capacity of private sector to deliver what is expected by clients and the government is still low. Most contributors to this research claimed that commonly, private water contractors did not have the appropriate machines and equipment, necessary for geo-physical surveys and drilling water sources, thus those companies fail to give proper advice to communities on where to locate their water source, resulting to some water sources drying up immediately after construction.

The objective of making people participate in community-driven water projects is to enable them to 'own' and sustain the project after the project has been phased out. Private operators when given water management authority may be mostly interested in making profit. Thus there is greater possibility of over utilising the scheme (thus reducing its life span) and denying other special groups of vulnerable people from accessing the service, even if this is outlined in regulations. When private operators are involved in tariff setting, there is great possibility of setting higher price to acquire maximum profit

There are mixed feelings about how the government operates in water sector. PLAN Tanzania acknowledge that the government is making efforts to ensure that communities get safe water at affordable prices, and that there has been an improvement in government efforts to engage CSOs in policy processes and decision-making at the national level. However, Binamungu (2001) states the government doesn't give enough protection to water users from tariff hikes where private operators are contracted; this increases household costs for water and increases poverty. This situation is not only confined to operations by the private sector; the poorest can also be left out when community-management is in operation (Toner 2005).

GoT/WB funded project representatives argued that there is a mixture of success and failure with regard to private sector participation in water scheme management. In their opinion private water

operators have proved to be effective in tariff collection for water services. However, under such schemes, poor and vulnerable people are normally subjected to difficulties in getting water, because of the business motive of private operators. This is confirmed in Water Aid / MoW (2001) documents in which community members report that old people in their village (where a private operator operates the water scheme) are not exempted from paying for water services, and that they are only excused from queuing for water. That is contrary to the village government agreement with the said private operator. They further argue that effective government policy may influence private operators by setting tariff and subsidy structures, which can help in solving the conflict between cost sharing and poverty reduction, and similar arguments are used elsewhere (Toner 2005). Nevertheless, the degree of extent of effective government influence on water schemes is debatable.

Water Aid/ MoW (2001) indicate that another controversial area where private operators operate water scheme is the issue of accountability, i.e. 'who are they accountable to?' Although by-laws indicate that private operators are supposed to operate under village water committees, in practice some private operators by-pass village water committees. In general interviewees considered that cost-sharing systems are difficult to implement in Tanzania because of levels of poverty in communities. High levels of poverty cases delay of contributions (and therefore delay of projects) and/or selection of low quality technology. This impacts sustainability. Binamungu (2001) comments that because the concept of cash contribution is new to communities, people are adopting it slowly and sometimes people refuse to contribute arguing that water services should be free to all. However, some studies also show that poor people can and are willing to pay for water services, provided that they are assured of regularity of the service (Binamungu, 2001).

Community water user entities

Possibilities of partnership between communities, private sector and NGOs in provision of water services have been emphasized in the 2002 policy because of a growing recognition of the important contribution of NGOs and private sector in development activities (URT 2002).

One issue of significance for contributors to this study is the legal registration of community-level water user entities charged with managing water schemes. Some assert that legally constituted water entities are relatively powerless and may be influenced by government authorities (MoW representative). A similar opinion is expressed in Water Aid/MoW (2001), where water committee members complain that the village government leaders interfere with water funds by

forcing the committee members (which are considered un-official) to give them money from water fund to be utilised for other village activities. This they claim demoralises people and make them unwilling to contribute for water services. However, the reverse situation is different in some cases (Uchira water supply project for instance) where the water users entity is more powerful than the village government in terms of resources and in effect is able to treat the Village council as an executive arm to mobilise village labour (Toner 2005)

In cases where community-based committees are given the mandate to choose contractors and to manage the procurement of water scheme items, Plan Tanzania suggest that most of the members have neither the capacity to analyse competence of the contractors, nor sufficient experience with complicated procurement processes. The one-week project management training provided to the committee, in their projects, does not provide enough knowledge for the committees to be able to handle procurement and contractors issues, hence most committees end up being manipulated by both private contractors and sellers of scheme items.

The linkage between communities and other institutions is normally through District government support teams as per the national policy. Normally, the teams are comprised of the district water engineer, health officer, environmental officer, and community development officer. These teams are created by projects to enable smooth operations and technical support when the project phases out. Some projects (e.g. PLAN Tz) offer means of transport to district teams (community workers) to enable them to follow-up the project after phasing out. The GoT/WB funded project offers equipment such as computers to District water authorities to enable project operations and customer tracking. However, a significant issue for District/Regional Government staff is the number of individual water entities that they may have to oversee. Such staff therefore have very limited capacity to plan strategically for their area unless they happen to be in a location which receives a district-wide input of resources such as the KfW funded project in Hai District.

2.5 Community contributions: A necessary or sufficient condition for successful water projects?

Community participation is the heart of current water policy. Participation of communities in planning, implementation, operation and maintenance of water facilities is considered as the main approach to ensure sustainability of water supply to the society.

Interviewees from PLAN Tanzania assert that it is much easier to mobilise people in communities to participate in water projects due to the importance of water as a commodity, and due to high demand for water services in many places. Discussion with various stakeholders in the water sector concludes that community participation is considered fundamentally necessary for the success of water projects because it gives people an opportunity to choose the type of technology they prefer and the location of the water points, as well as management of schemes, thus ensuring sustainability. The major problem in community participation arises during operation and maintenance of the scheme, when communities have to supervise all activities on their own. These problems range from lack of experience and expertise in managing and maintaining water schemes to domination of few people of the decision-making power over water usage as was discussed in the previous section.

Information from MoWLD indicates that the more the number of households participating and contributing towards capital investment of the project in the village, the more likelihood of having a more appropriate water scheme, high speed of implementation and the possibility of customer satisfaction. Participation of communities promotes the development of management and organisational skills to communities; it strengthens local organizations, and gives people a sense of ownership of the project, and it is claimed promotes individual and community empowerment (Mwendahacha, 2001). However, we would suggest that there is little evidence from the interventions in this review to substantively support this claim.

This study indicates that community participation in water projects varies between communities - from representational community water users committees to domination by leaders and elites in communities. Communities also participate through direct involvement in construction of water schemes and through supervision of contractors and private operators. It was suggested by an interviewee at the MCDGC that effective participation depends to a large extent on whether or not formal and informal community leadership is developed among the poor people. Effective participation is explained differently in different projects, but commonly in water projects it is said to be about people taking control of rules and regulations that gives them access to water. Genuine participation therefore requires water users (the community) to have appropriate knowledge and information on water related issues. However, it is not possible in most cases to assess the depth of community ownership. Evidence from detailed ethnographic research shows that in the GTZ-funded project in Uchira only a few people in the community dominate decision making on water use, despite a heavy project emphasis on broad community ownership, and that

a majority of village residents consider that the water has been privatised by a village elite (Toner 2005).

Commonly in World Bank funded projects, water committees are formed with 8 – 10 members chosen by the community. In most cases women occupy about 30% to 50% of the committee. Committees are given necessary training on bookkeeping and organising for operation and maintenance. Following completion of construction of the scheme, committees start managing the schemes using tariffs collected from user charges. A representative of TASAF explained that in some water projects, communities are allowed to contribute labour only, instead of labour and cash; even though, the labour is not normally provided for free. This was also confirmed during discussion with Moshi District water authority.

Participation of women is particularly influenced by their social role of managing domestic water for the family. Although women are identified as important stakeholders in water issues, nevertheless, few projects prove to have a high level of involvement of women. In most rural settings, women face many constraints to participation including lack of general development knowledge & exposure and cultural constraints. The PRA processes that are normally used as an entry point to water projects are too short to enable an ordinary woman to have the capacity to participate effectively, thus the claimed participation of women has not much influence on decision making in water projects (MCDGC representative).

2.6 Impact of community-driven water management on poverty

The broader objective of water policy is poverty reduction through improved access to adequate and safe water (URT, 2002). However, reports show that only 50% of the rural people have access to adequate and safe water, while in urban areas only 68% of the households are connected to the main government water supply system (Mwendahacha, 2001:18). This indicates a high possibility of eruption of water-bone diseases such as cholera and bilharzias, thus increasing poverty. Similarly, the long distance and long waiting time used by mostly women in fetching water is a wasted time for other economic activities, which could have improved the level of incomes in poor families.

Poor people are more likely to buy water from unsafe sources; this increases their cost of life because they need to boil the water before consuming – which means high cost in energy. Not boiling means more diseases and vicious cycle of poverty continues. In urban areas, Lupuga

(2001) comments that the urban poor pay a higher unit cost for water than their rich counterparts. This is because the higher and middle income earners are more likely to be connected in the government main water system – which charge less expensive flat rate, while the urban poor mostly buy water from vendors, who sell water at a higher rate than the rate charged by the government.

The government acknowledges the existence of vulnerable people in communities and it aims to identify those who are to be given water for free (URT 2002). These issues however are governed in water by-laws of individual communities and are varied. For instance, a respondent from the GoT/WB funded project reported that in their project, vulnerable people are identified by the water committee and are provided water for free / excluded from contributions but are given a specific number of buckets (8) per day, and when it happens that they need more than eight buckets they have to pay for all the buckets including the first eight buckets. Experience shows that the issue of who is in the water committee can be a major determinant of who among vulnerable people gets water and who doesn't. This brings in another difficult area in pro-poor water by-laws, that is 'who' identify the vulnerable poor in the community and who are 'the vulnerable', this is of concern to the NGO WaterAid and is supported by (Toner 2005). Identification of the vulnerable is normally left with the village water committee and village authority. Logically this may seems to be a good practice, but in some cases personal attitudes and perceptions may influence committee's decisions on who should be subsidised, thus leading to wrong/unfair targeting for subsidies, and therefore minimising the impact of water in poverty reduction (MoW representative)

2.7 Possibility of scaling-up community-driven water projects

It is unlikely that resource intensive and spatially-isolated interventions can be significantly scaled up. PLAN Tanzania operates in several districts within the country, using more or less the same approach in all areas, but scaling is limited by resource inputs. This is also the case for the GTZ-funded intervention in Uchira, which invests heavily in one village and therefore is unreplicable, as a model of water provision, in the absence of significant donor funding (Toner 2003). Since most of projects are donor funded, scaling-up is difficult given the constraints of donor funding in terms of time and resources for replication of projects.

Logically it would follow that demand-driven projects are driven by external factors and therefore scale themselves up at a pace determined by that demand. For instance, TASAF started in 2001

with 42 Districts, and in February 2005 it has expanded to the whole country. However, the result of this is that the scaling-up itself is patchy and without strategy. The result is then a lack a strategic management of water resources as a whole, and the bypassing of the poorest and most isolated communities.

2.8 Conclusion

It is claimed that community-driven water projects will result in the enhanced sustainability of water schemes because they put communities at the centre of planning and managing schemes. Substantive evidence to support such claims is lacking in practice and this review has revealed a number of critical issues which need to be addressed.

- The processes needed for CDD assumes relatively high levels of experience and skills, which are lacking in most of communities. To be effective strategies are required to 'empower' communities to gain the knowledge necessary for making informed choices, and the skills necessary to understand the implications of their choices so that they take control of their development process. It is evident that limited project time, lack of enough funds and appropriate skills leads development agencies to take a lead role and thus control of the project. In addition, community empowerment and capacity-building are amorphous and expensive (in resource terms) enterprises and thus may not be cost-effective in relation to the reduction of poverty.

- The argument for community driven projects is the need to empower communities to be able to control and sustain their projects. However, in most cases, empowerment is not a perceived priority of the communities that are desperate to getting the end product - water. That means there is a tension between the immediate need for water service, and the slow empowerment processes that are undertaken to start water schemes.

- Clearly, participation of communities alone is not sufficient particularly in marginalised communities - with limited skills. Limited capacity of communities leads to domination of powerful people in the community who make decision on behalf of others. There is a possibility that the claimed community-driven projects might be vehicles for strengthening of the domination of powerful people, thus the poorest in communities might be further marginalised

- In most of projects, there is no specific system for exempting the vulnerable from paying for water although the 2002 policy states clearly that those people are to be exempted. Exemptions mostly rest on the discretion of the village government. Commentators increasingly argue for a stronger system of state subsidy and regulation in relation to ensuring water access for the poor.

- As it is currently practiced CDD may lead to patchy and incoherent service delivery and lead to problems in the strategic management of natural resources. It may also further increase demands on local government staff who have to try and coordinate an increasing diversity of partnerships and microprojects; and the attendant conflicts that result.

3 HIV/AIDS Policy in Tanzania

3.1 Introduction

Tanzania is among 14 African countries with high prevalence rate of HIV/AIDS. Over two decades of HIV/AIDS in Tanzania, the pandemic has become one of the leading killer diseases in the country, as indicated in the Tanzania HIV/AIDS indicator survey (THIS) of 2004. The survey estimates that 7% of the population in the country is HIV/AIDS positive. The THIS, which focused on the age group 14-49 showed that women have a higher rate of infection than men (TACAIDS 2004:23). Additionally, the Ministry of Health community-based surveillance shows that AIDS is the leading killer disease for adults in both urban and rural areas while it acknowledges that under reporting of the epidemic is likely to be as high as 80% (URT, 2004).

In 1999, the President of Tanzania declared HIV/AIDS a national disaster. HIV/AIDS has a major impact in Tanzanian lives and has retarded development efforts of the nation. The disease affects much of the young generation, thus leading to a decrease in life expectancy and slowing down the pace for poverty reduction. Other immediate impacts are visible in family income, whereas Garbus (2004) reports that families with chronically sick persons (including AIDS patients) in Tanzania loose between 30-35% of income while taking care of the sick. AIDS takes away the educated population thus affecting the national workforce. An ILO study of 1995 claims that in Tanzania, on average, organisations loose workers at a rate of 0.5 to 1.5 per year due to AIDS related deaths (Bollinger, et al 1999). Although all economic sectors are affected, Forsythe (2002) indicates that tourism, mining and transportation sectors are adversely affected. New research found that HIV/AIDS increases the costs of doing business at firm and/or sector level, and increasingly affects the health care and education sectors, further drawing communities into circles of poverty, ill-health, and lack of treatment and prevention strategies (Veenstra and Whiteside 2005).

Clearly, AIDS is not only a health problem but also a socio-economic and cultural problem, which needs a holistic approach in addressing it. Socially, HIV/AIDS has changed the roles of people within families; adults have become care takers of the AIDS infected young adults and orphans, while in some communities, children have become heads of families (Dayton and Ainsworth, 2002, HelpAge, 2004:14). Gender relations are redefined and renegotiated, sexual

behaviour is overshadowed by accusation and blame, and cultural practices are questioned, reaffirmed by some and discarded by others.[4]

3.2 HIV/AIDS policy in Tanzania

The government of Tanzania started efforts to combat HIV/AIDS in 1985 (two years after the first case of HIV/AIDS was reported), when a Task Force for HIV/AIDS was formed. This Task Force developed a short term plan (1985-86). This resulted, with the technical support of the WHO, in the establishment of National AIDS Control Program (NACP) in 1987, and a Medium Term Plan (MTP 1987-91) (Garbus 2004; URT 2001; World Bank 1992). Three five year MTPs followed. The NACP was essentially a medical organisation, directed, managed, and monitored by the health sector. In the 1990s, the community concerned with HIV/AIDS prevention in Tanzania realised that a broader approach was necessary. The third MPT was therefore designed as a multisectoral framework which was supposed to cover all relevant sectors and ministries. In 2001, the Tanzania Commission for Aids (TACAIDS) was set up to coordinate the activities from the Prime Minister's Office (instead of the Ministry of Health). The NACP was maintained to deal with the medical side of HIV/AIDS (interview #).

*Development of national HIV/AIDS response***.**

Period	**Action**	**Policy**
1983	**Three cases of diagnosed HIV/AIDS**	
1985	**National Task Force** **Short Term Plan**	**1) Track the epidemic** **2) Medical research**
1987	**National AIDS Control programme, NACP**	**1) Information, Education, Communication, 2) Laboratory, 3) Clinical, 4) Epidemiology/ research; 5) Counselling and Support**
1987-1991	**Medium Term Plan (MPT) I :** **US$ 11 million**	**1) Prevention of transmission; 2) Monitoring and research; 3) coping and care**
1992-1997	**MTP II**	**1) Prevention of transmission; 2) Monitoring and**

[4] This is, for example, the case with FGM: AIDS gave campaigners against FGM a new argument: that of unsafe practices. Similarly, the role of traditional healers, herbal medicine, and ritual is questioned and/or affirmed.

		research; 3) coping and care
1998-2000	**MTP III**	**Multi Sectoral Framework planned and prepared, increased emphasis on involving all relevant sectors**
1999	**President B. Mkapa declares HIV a 'National Disaster'**	
2001	**Tanzania Commission for Aids, TACAIDS: first year US$ 8 million**	**All relevant strategies under TACAIDS coordination, incl NACP.** **National Policy**
2002 -present	**Rapid Funding Envelop**	**Funded by international funding agencies, coordinated by TACAIDS, distributed among Civil Society Organisations**
2003-2008	**World Bank Multi-Country AIDS Projects (MAP)**	**US$ 70 million for interventions.**
2003-2007	**TACAIDS**	**National Multi-Sectoral framework on HIV/AIDS: policy framework from which TACAIDS will facilitate and coordinate HIV/AIDS interventions; strong emphasis on Community-based responses and decentralisation.**

Adapted from: World Bank, (1992) *Tanzania AIDS Assessment and Planning Study*, p. 137 ; URT (2001), *National Policy on HIV/AIDS*; Interview with the director of the NACP, Dr Somi, Dar es Salaam, 11-10-05.

The increased magnitude and impact of the pandemic on Tanzanian society urged the government to formulate a policy in 2001 and a multi-sectoral strategy in 2003. These were directed at the coordination of HIV/AIDS interventions and the provision of strategic guidance for HIV/AIDS initiatives. The multi-sectoral framework also emphasises poverty reduction, improvement of health, education and other social services and is linked to the Tanzanian Poverty reduction Strategy Paper. The national HIV/AIDS strategy is meant to go beyond awareness creation by addressing other factors that precipitate the spread of the disease such as poverty, unequal gender relations and violence against women (TACAIDS, 2003).

TACAIDS is the institution responsible for the coordination of HIV/AIDS related work in all sectors, and is increasingly responsible for mobilising funds. International funding for HIV/AIDS programmes comes from the Global Fund, the World Bank, and USAID, amongst others (annex c). Whereas TACAIDS allocates funds to government institutions, it is not responsible for the allocation of funds to CBOs. This has been shifted to district councils for local organisations, and to a Rapid Funding Envelope which allocates funds for defined NGO interventions on a local and/or national scale.

Major Issues in National HIV/AIDS Policy

- Developing and supporting effective and appropriate strategies to reduce and mitigate the impact of the epidemic
- Reinforcement and promotion of community inclusion and cohesion with infected and affected people
- Increasing awareness of PLHA and OVC on their rights and strengthening their capacity in negotiation, dialogue, and advocacy for realisation of their rights
- Coordination of efforts to fight the disease

URT (2001b)

3.3 Legal Framework, customary issues, and gender relations

Despite the existence of policy and strategy framework, the Tanzanian justice system does not sufficiently integrate legal issues with regard to HIV/AIDS. A major debate is what should be the punishment for those who intentionally spread the disease. This is related to laws against sexual violence; the sexual offence act of 1998 outlines rape and sexual assault as criminal offence, but it does not outline aspects of HIV transmission as a result of rape and sexual violence. The question if and when people should legally be held responsible for transmitting HIV after consented though unprotected sex while consciously HIV-positive is even more difficult to answer and is currently also debated in the UK (Weait 2005). In addition, some customary practices (such as wife inheritance, widow cleansing, polygamy, FGM) promote the spread of the disease (Rwebangira & Tungaraza, 2000). The continuing practice of wife inheritance in some sectors of society contributes to the rapid spread of HIV infection - when a husband dies of AIDS and his wife is inherited by another man who is also married, the disease spreads from one family to another.

The subordinate position women have in relation to men endangers them (and their sexual partners) disproportionally. A majority of women are economically as well as socially dependent on men, they are solely responsible for raising and maintaining their children and often other dependents (such as chronically ill family members) while they have less means to do so properly. Sex often serves to make money, to retain a partner, or to diversify the dependency over various men. In addition, women seem to have little power to negotiate safe sex in these sexual relationships. Women's sexual, economic, and social subordination reinforces their poverty and their vulnerability to contracting HIV (Tungaraza 2005).

For example, there is a strong relationship between women's HIV status and sexual violence incidences – research has shown that women who were found to be HIV positive were found to have experienced sexual violence more frequent than women who were HIV negative (Garbus 2004). Domestic violence also impedes women from doing HIV tests or telling their sexual partners if they are found HIV positive. Research found that HIV positive women are at increased risk for partner violence (Maman et al 2001). Customary and religious practices do not favour women's empowerment in such matters. Additionally, some faiths insist on unprotected sex in marriage –based on the assumption of trust and faithfulness among couples-, which, in reality, leads to further incapacity for women to control their sexual bodies faced with an unfaithful husband. Lack of tolerance towards divorce condemns married couples to further transmission.

A further issue in which national legislation should intervene is labour discrimination of people living with HIV/AIDS (PLHA). Forsythe (2002) reports that the workplace law with regard to PLHA is weak, and that in some cases, employers exercise discriminative practices to PLHA, such as firing employees who are tested HIV positive and/or demanding HIV test certificate as a pre-requisite for being employed. Norms and legislation concerning HIV/AIDS, the workplace, and labour are currently under investigation and are increasingly under public discussion. This is strongly related to the general need for the formulation and regulation of the human rights of PLHA in national laws to enable PLHA to demand their rights to treatment, care, support and reduction of stigmatising behaviours (POLICY 2002; URT 2003, Garbus 2004).

Important Statistics of HIV/AIDS in Tanzania (as of 2004)

. At least 7% of Tanzanians are infected . Women's infection rate is 7.7% as compared to men 6.3% . The age group 15-49 is the most affected . Mbeya Iringa and Dar es Salaam are the most affected regions with 14%, 13% and 11% rates of infection respectively . Kigoma, Manyara and Singida are the least affected regions . HIV Prevalence in Pregnant Women is 9.6% . Estimated Number of AIDS Orphans is 1.1 million

Source: TACAIDS (2004b) and (OUSGAC, 2004)

3.3 Community-driven HIV/AIDS activities in Tanzania

The idea that the community is the basis of the solution to challenges in development has led to widespread adoption of community-based interventions methods by both NGOs and the state. The major international funding agencies encourage such an approach and, as a result, large national NGOs increasingly re-allocate their money to local community-based organisations (CBO). The state, in turn, has designed a framework in which decentralised policy-making, funding, and implementation are central. While these changes are meant to give more ownership to the community, increase accessibility to basic services, be cost-effective and improve cultural effectiveness of service provision, there are many obstacles before achieving these ideals (Boesten 2005 WP.1).

Government interventions

TACAIDS has divided its activities in five main departments: Finance, Administration and Resource Mobilisation; Policy, Planning and National Response; Advocacy, Information, Education and Communication; District and Community Response; and Monitoring, Evaluation, Research and Management Information System. HIV interventions in Tanzania are subdivided in three categories – bio-medical interventions, Preventive measures, and Care & Support for the infected and affected. TACAIDS supposedly facilitates the establishment and strengthening of PLHA constituencies that bring together PLHA to express their views, concerns and aspirations on effective interventions and influencing policy (TACAIDS 2004:18). This involves mobilisation of PLHA associations and building their capacities on how to manage their organisations and advocate for their rights. This is, however, a relatively new strand to governmental interventions and its success cannot be evaluated as yet. Up until now, the

government engaged more in bio-medical and preventive interventions, while NGOs engage mostly in care and support work.

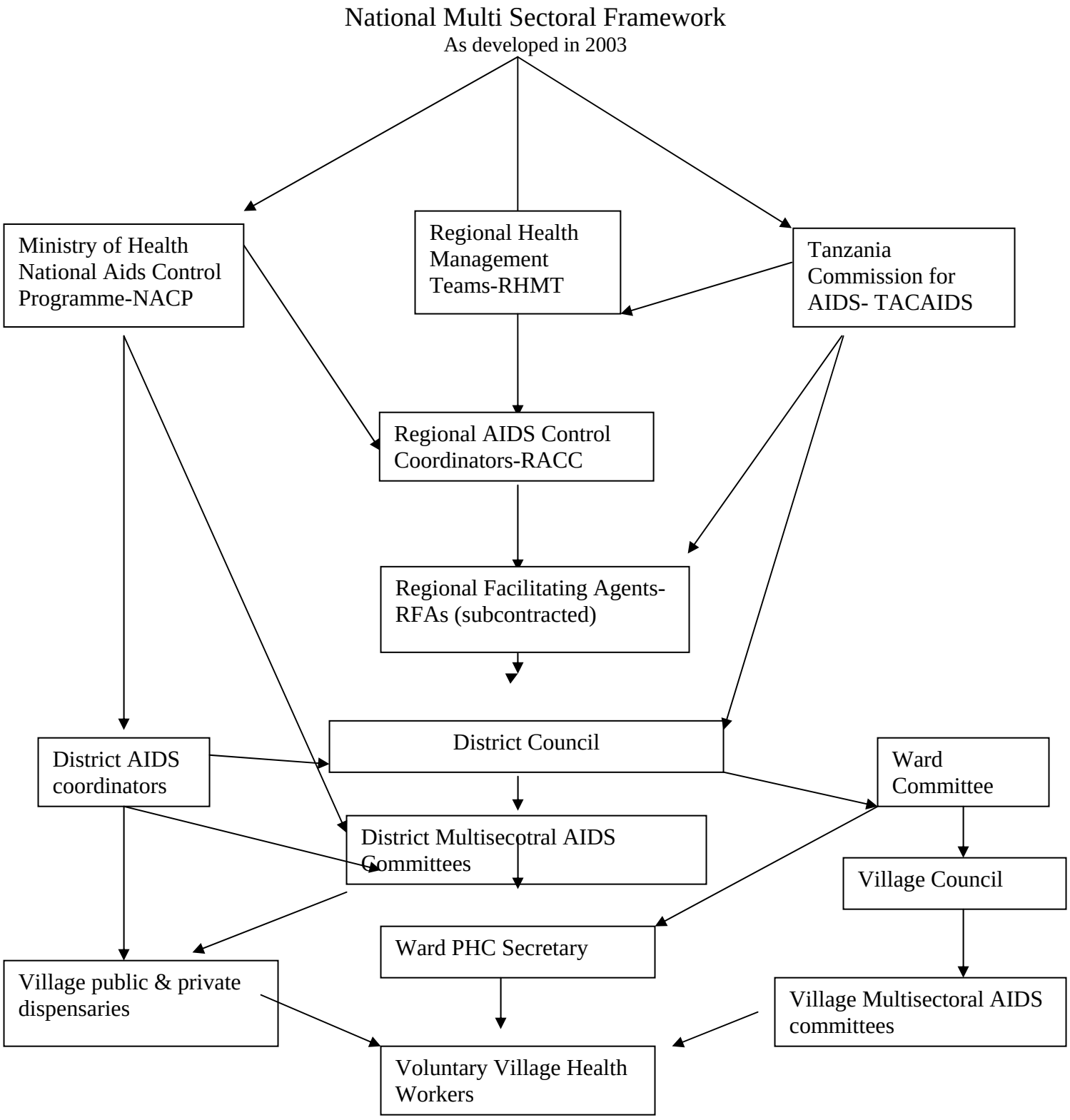
The government concentrates mostly on hospital-based interventions such as treatment of opportunistic diseases and administration of Antiretroviral drugs (ARVs) and prevention of mother to child transmission (PMTCT). According to the Ministry of Health budget speech of 2005/06, about 3,000 PLHA will benefit from free ARV treatment throughout the country in this financial year (3,000 of an estimated 2 million PLHA). The government claims to prepare a 'conducive' environment for other players to undertake HIV/AIDS initiatives by laying-down rules, policy, strategies, and standards and collaborates closely with other sectors, especially on issues of prevention (URT 2003b).

Community initiatives are supported through two decentralised strands: a coordinating string supervised by TACAIDS and a medical support string under supervision of the NACP. The district AIDS coordinators have prepared HIV/AIDS plans in all Districts in the country, but these are only recently put in place. However, reports suggest that the supporting link is strong between the different bodies, but that access to funds, knowledge and materials on a local level is still a problem.

The Regional Facilitating Agent (RFA) are supposed to provide technical and managerial support to District-based CSO, and district and local councils (URT 2003b). The RFAs are contracted out to non-governmental organisations that are perceived to have the appropriate technical knowledge and political distance to be able to support and coordinate the district and local level bodies effectively (interview with dr. Somi). The RFA allocates the funds for interventions in the region while they are, in turn, financed by the government through the five-year US$ 65 million World Bank project (TMAP). US$ 14 million of this is allocated for community responses in a Community AIDS Response Fund (CARF) (TACAIDS, 2004c). Some of this money has reached the communities through the district council in the form of training for teachers and health care workers, leaflets, condoms, and awareness raising campaigns (Same District Council 2005).

The first screening for funding from the RFA is carried out by the district council as they know their local organisations, needs, and existing activities. The district AIDS coordination office compile bio-data and funding proposals for AIDS interventions from CBO/NGOs within their district and carry out an initial selection of organizations which are potential recipients of funding

from RFA. As this is a relatively new initiative it is difficult to measure the outcome of RFAs activities at regional level. However, if the system works out, then it will be the first successful allocation of funds and technical support to communities through the state bureaucracy.


National Multi Sectoral Framework
As developed in 2003
Ministry of Health National Aids Control Programme-NACP
Regional Health Management Teams-RHMT
Tanzania Commission for AIDS- TACAIDS
Regional AIDS Control Coordinators-RACC
Regional Facilitating Agents-RFAs (subcontracted)
District Council
District AIDS coordinators
Ward Committee
District Multisecotral AIDS Committees
Village Council
Ward PHC Secretary
Village public & private dispensaries
Village Multisectoral AIDS committees
Voluntary Village Health Workers

Besides the allocation of funds and technical support to CBO, village councils are also expected to develop a plan against HIV/AIDS. Village councils are instructed to form HIV/AIDS committees which include local politicians, Village Health Workers, PLHAs, youth and other influential members of the community. This committee is supposed to conduct a situational analysis of their village and submit the report and mitigation plans to TACAIDS through local government authority (LGAs) and regional facilitating agencies (RFAs) for financial and technical support (URT 2004). The success of this scheme depends on the capacity of the community to assess their situation and take opportunities to mitigate the negative impact of the pandemic as they come.

Discussions in the Moshi-Rural District office and in various communities indicated that not all communities have such committees or are aware of their existence; some village council leaders did not seem aware of its supposed function, urgency and use; and other existing committees were not perceived as effective. In the Same District office, responsible officials confirmed that such AIDS committees work at village level and that their members had received training from the international NGO World Vision. Whereas this sounds hopeful, interviews we held with relevant community members and village leaders in rural areas of Same suggested that the districts' judgement might have been too rosy.

Despite the major efforts made by the government in fighting the disease, there are concerns about the role of the government in the fight against HIV/AIDS. Personnel of the important HIV/AIDS advocacy organisation WAMATA commented that there is a general perception among NGOs that the government is slow in its response to the pandemic and often too bureaucratic. A general complaint was that the government failed to close the gap between policy and grass roots initiatives; however, as we saw above, new governmental initiatives might change this. WAMATA, however, observed that the majority of government support went to bigger organizations/institutions (such as Muhimbili National Hospital), which sometimes neither had the capacity to serve the population nor to follow-up on people tested HIV positive. Similarly, local government officials in Moshi Rural District indicated that national government support is very low, quoting only one incidence where the District had received money from the national government for HIV/AIDS works. These complaints are fuelled by the invisibility of the government's activities on HIV/AIDS as TACAIDS is mainly meant to coordinate (but not necessarily redistribute!) donor funds (Garbus 2004). On the other hand, another NGO worker commented that the government has improved the way it associates with CSOs, referring the

recent experience of invitations for CSOs in formulating HIV/AIDS strategy. In sum, despite the criticism, the relationship between the government and CBOs seems to be improving, albeit slowly and arguably, late.

3.4 Civil Society Initiatives

Civil Society Organisations (CSOs) and NGOs are vital to HIV/AIDS initiatives in the country as they provide support to community-based responses such as home-based care networks, public awareness campaigns, income generating activities and mobilisation of people around HIV/AIDS issues. Other common services that were almost exclusively offered by CSOs and NGOs (the government has recently set up a nation-wide campaign) include prevention programmes through provision of basic HIV/AIDS information, counselling for voluntary testing, and training in topics such as reproductive health, gender inequity, and stigma reduction. In this section we will briefly introduce the main actors among national and international NGOs who contribute to the fight against HIVAIDS in Tanzania.

One of the most popular and longstanding local NGOs engaging in HIV/AIDS in Tanzania is WAMATA, an organisation established in 1989 (Detaf 2005). WAMATA perceives education as the most significant strategy in prevention of spread of HIV and focuses on changing attitudes, behaviours and norms of the society. HIV/AIDS awareness creation activities aim at enhancing consciousness about HIV/AIDS within communities and promotion of active community participation and involvement in fighting against the epidemic. WAMATA uses multiple approaches for community mobilization and support for PLHA. They mobilise PLHA and provide information about the disease in the areas of transmission, prevention and care and, in doing so, intend to dispel myths surrounding HIV/AIDS. This normally involves person-to-person counselling, display of posters, and drama group performances. WAMATA also mobilises infected and affected women to come together to build self-help support groups to enable them to deal with social and economic problems, and strengthen their organisational capacity. Such self-help groups receive training on how to identify and initiate income-earning activities that can help them to improve their living conditions and that of their families. Educational support to orphans is hoped to expand children's future employment possibilities. An important component of WAMATA is training directed at improving advocacy skills and empowerment of PLHA, so that they can take a more active role in reducing social stigma and discrimination. Within their programme area WAMATA offers home visits and care support for

those who are seriously sick or have no money to travel to the WAMATA offices.[5] The organisation works together with the African Medical Research Foundation (AMREF, see below) in the training of home-based carers.

Common HIV/AIDS works undertaken by NGOs and the Government in Tanzania

- Mobilising people living with HIV/AIDS and strengthening their organisations
- Information, Communication and Educational campaigns
- Mainstreaming HIV/AIDS into development programs and policies
- Prevention of mother-to-child transmission and treatment of opportunistic diseases
- Promotion and Protection of human rights of those infected and affected
- Innovative, user friendly, prevention and life-skills education programmes
- Counselling for pre and post testing
- Home-based care and support for orphans, the affected and infected

CARE Tanzania is an international NGO, financed by USAID, which supports local NGOs/CBOs/FBOs and institutions which engage, amongst other activities, in HIV/AIDS work. Their core activities aim to provide support and care to people affected by HIV/AIDS through providing training to networks of local volunteers, linking PLHA with voluntary counselling and test centres (VCT), and supporting the health sector to cope with the ever increasing number of people known to be infected. Many people with HIV in Tanzania have no access to even basic drugs, which can help them to treat opportunistic diseases. Through their strategic local partners and their networks of volunteers, CARE supports people by availing access to ARVs, basic medicines, palliative care, and a range of other HBC activities (CARE 2005). CARE's interventions are intended to strengthen the capacity of people infected and affected to be able to meet their basic needs and realise their rights to health, economic security and education, in line with those proposed in the National Multisectoral Strategy for fighting against the disease. They actively work with local and district councils and provide a forum for various authorities working on HIV/AIDS at District level to be able to meet and discuss challenges. As such, the activities CARE develops are those of an external facilitating agent to the meso and local levels.

ActionAid Tanzania is also an international NGO which deals with HIV/AIDS issues. ActionAid emphasises institutional capacity building and strengthening policy. ActionAid works on advocacy of the rights of PLHA by contributing to national policy formulation, implementation (by organising zonal stakeholder workshops) and strengthening of local networks and alliances of NGOs, CBOs & FBOs involved in HIV/AIDS work. The organisation supports local organisations through technical support, capacity building on developing & implementing

[5] This includes Dar es Salaam, Kagera, Mwanza, Arusha and Pemba Regions

HIV/AIDS interventions, and mainstreaming of HIV/AIDS issues in development work, as well as providing resources needed to carry out the work.

On a local level, ActionAid emphasises the full participation and responsibility of individuals and communities to find solutions to their problems, they use a so-called 'stepping-stone' methodology in order to break the 'culture of silence' and promote communication and information sharing within families and among peer groups on issues of HIV/AIDS. In interactive exercises with groups in communities, the organisation hopes to capacitate and empower people to improve their own lives (ActionAid 2003). Such innovative participatory approaches can also positively contribute to the reduction of stigma.

The international organisation Help Age International works with elderly people who are affected by HIV/AIDS. The national HIV/AIDS Indicator Survey narrowly focuses on the age group 14-49, and does not consider effects of AIDS to the old people (above 49 years of age). Nevertheless, besides the fact the older people also might be infected with the virus, the also experience specific problems related to the epidemic. AIDS has increased the burden for older women in taking care of the increased number of orphans (Bonnerjee cited by Garbus 2004). Help Age International helps older people by working with community-based organisations to provide support for betterment of homesteads and domestic environments. Help Age also emphasises education, nutrition, and health care for orphans and the sick by focusing on the capacities of their elderly caretakers. The organisation has also observed that in some regions, older women are often blamed for the presence of the epidemic in the community because of their supposed relationship with witchcraft. Awareness raising campaigns have to reduce these patterns of blame. Community interventions organised by Help Age facilitate experience sharing and interaction amongst sero-positive and sero-negative people, intended to reduce social stigma and discrimination and to increase tolerance. The organisation started a campaign for the installation of a solid pension system in Tanzania to carter for the destructive impact that AIDS has on many aged and orphans (Help Age 2004).

The complexity of HIV/AIDS policy and strategy and the language used for writing it (English) make it sometimes difficult for local communities and institutions to understand and implement. In 2005 Concern (an Irish NGO) and Femina produced a simpler policy document in Kiswahili to be distributed among local communities and CBOs. This has contributed substantially to the capacity of communities to act upon their problems within the policy framework. Femina also

hosts a talk show on national television, a website, and a magazine in which issues related to sexuality are discussed.

The use of local 'traditional' healers for treating opportunistic diseases is becoming quite common, as observed by Garbus (2004).[6] Likewise, the Global Health Council (2004) documented that increasing numbers of people appreciate the work of traditional healers. We have to keep in mind, however, that the use of traditional healers for treating opportunistic diseases seems especially common among people with low incomes as this is cheaper and closer to home than bio-medical care usually is. Whether resorting to traditional medicine is an issue of income or effectiveness of traditional medicines is an area of concern. Increasingly, there are calls for improved control over healers and collaboration with them. In response to such trends, the Tanga AIDS working group collaborates with traditional healers in providing medical support for AIDS infected people (TAWG 2002; UNAIDS 2002).

Considering the importance of a balanced diet for the chronically ill people and the simultaneous loss of income in families caring for AIDS patients and/or AIDS orphans, the World Food Programme of the United Nations (WFP) provides food baskets to vulnerable children and PLHA who are supported by home-based carers, and to poor patients who uses ARV therapy (WFP, 2005). Linking up to the idea that interventions should be decentralised and supported by the local community, WFP works with regional NGOs or CBOs to coordinate and implement the programme. These organisations, in turn, are responsible for selecting beneficiaries, distributing and monitoring the intervention through their networks of grass roots organisations and with collaboration of village and district councils. These volunteers are trained by WFP to do so and some receive a food basket to encourage their voluntary participation. The expectation of WFP was that this activity would not only support the poorest in their daily survival, but that it would also enhance the communities' institutional networks, care giving capacities and human resources (WFP 2002; see also our case study on Community Action in Hedaru, forthcoming

[6] In how far 'traditional' actually means a form of healing used by large groups of people and passed on by generations is open for discussion. Some people we interviewed argued that 'traditional' means reinvented, or even altogether invented. It seems clear that is increasingly popular among the poorest people who are increasingly chronically ill and have little to no access to medical services. Paul Farmer gave similar critique referring to Haïti (Farmer 1999)

Table 3.1 Summary review of discussed interventions

Organisation / Institution	**Main Activities undertaken**	**Scale**	**Community participation**	**Impact & Sustainability**
CARE (T) – Tumaini Project	Variety of development activities including sub-granting to CSOs engaging in AIDS works Leadership in Strategic partnership with other organisations	Large scale, covering Coast, Iringa, Arusha, Mwanza and Dodoma regions. In 2005 the plan is to support 25,000 orphans and 12,000 PLHA	Local village health care workers are trained, supported and supervised to deliver HBC. Activites are contracted out to CBOs, CBOs, FBOs	Direct impact to PLHA, Orphans, and the affected. At least 25,000 OVCs to be supported in 2005
ACTION AID	Variety of development support including Lobbying and Advocacy at national level on issues of HIV/AIDS			National wide – policy and advocacy
WAMATA	VCT services, Youth drama campaign group, Income generating Activities for PLHAs	Covers Dar es Salaam, Mwanza, Arusha and Pemba regions	Community-based HBC managed together	With AMREF Direct impact to PLHA, OVC and affected women
UNAIDS	Strategic planning, M&E, surveillance, advocacy, networking with other donors	Country wide – Policy level	No	Working with the government to influence policy, Donor

				coordination
Swiss Agency for Development and Cooperation	Bilateral Donor Agency	Country wide – Policy level and financial support to the government through SWAp	No	Direct impact to the government budget
Maria Stopes – Same	Counselling and Testing services	Same District	Training, support and supervision of community-based VHW who provide family planning and AIDS advise	Small scale. Increased awareness of HIV/AIDS at community level, and willingness for voluntary test
Ministry of Health - National AIDS Control Program	Surveillance, bio-medical services	National wise – Bio-medical, blood safety and research	No	Nationwide surveillance and research
Help Age International	Support to the aged on variety of age related issues, including HIV, age policy, research	Throughout the country	Participatory methods of communication, education and information	Large scale
AMREF	Medical research, service provision, training community carers and counsellors, counselling,	Throughout the country	Local village health care workers are trained, supported and supervised to deliver HBC	Large scale

WFP	Provision of food assistance for PLHA, OVC and their families. Training for community-based carers	Various parts of the country.	Local CBO/NGOs are partners in distribution, community-based volunteers select beneficiaries and distribute baskets. Village councils are involved	Large scale. About 35,000 people assisted

3.5 Scaling-up HIV/AIDS initiatives

Most respondents in this study recognised the problem of scale. Of course, the country might benefit from the scaling-up of successful interventions. However, many interventions are successful because of their small-scale and geographic and thematic boundaries. Given the spread and impact of HIV/AIDS in Tanzania, one could argue that the small scale of most interventions limits the level of achievement of the fight against the disease on a national scale. Thus, expansion of activities is fundamentally important for success of the efforts. Nevertheless, scaling-up involves higher costs which can not always be covered. In addition, scaling-up through collaboration is often obstructed by the different perspectives and approaches to the problem that organisations, institutions, and funding bodies might have. Therefore, scaling-up is also limited by a lack of coordination between funding bodies, the government (on both local and national levels), NGOs and CBOs.

Some NGOs do scale up by slowly extending their services to regions where there are high infection rates (WAMATA), whereas others extend their activities from their urban headquarters to the surrounding rural areas (KIWAKKUKI, see case study Hedaru, forthcoming). International NGOs such as CARE and ActionAid increase their impact by building partnerships with potential NGO, CBO, and FBOs that play strategic roles in fighting the disease. Mostly, the partnership is made with FBO, CBO and NGOs which already have HIV/AIDS related activities in communities and the ones which have a potential to expand the scale of their operations. In such a manner, these organisations also contribute to coherence and coordination of the fight against HIV/AIDS.

As the impact of HIV/AIDS increases, so does the number of NGOs working in that area. Most NGOs work with participatory methods in order to set up community-driven HIV/AIDS projects. However, as some interviewed critics observed, most NGOs operate in a programmatic manner with scarce resources and limited time, thus making it difficult to scale-up their activities. There seems to be an increase in the number of NGOs working on small scale and irregular HIV/AIDS interventions. Although these activities should be welcomed, the resulting diversification of HIV/AIDS interventions does not contribute to coherence and coordination of the fight against AIDS. On the other hand, organisations with greater organisational capacities and resources such as CARE and AMREF have expanded their areas of operation. CARE recently included the

districts of Rufiji, Mufindi, Kondoa, Karatu and Ukerewe, in its programme area and encourages and supports community sub-guarantors to scale-up their initiatives as well.

Many NGOs train community volunteers to deliver services to PLHA and to organise for community actions. The organisations seem to hope that community volunteers can ensure sustainability when the project is phased out by carrying-over the project activities and by using the skills acquired during the project to take care of sick people. However, the quality of services provided by volunteers and their capacity to do so is debatable. Levels of training, support and supervision provided differ considerably between facilitators. The effectiveness of training in the longer term is, however, understudied.

3.6 Challenges of Community-Driven HIV/AIDS work in Tanzania

Allocation of funds

Between year 2000 and 2005, the donor community has put increasing effort in supporting HIV/AIDS initiatives in Tanzania. This support is necessary for the country to be able to increase prevention strategies and the scale of services to PLHA and orphans. Coordination and allocation of funds, is, however, a difficult and contested field. Some argue that a rapid influx of huge amounts of donor funding may weaken creativity of local organisations and encourage rivalries between organisations in competing for funds, thus weakening the effort in fighting the disease. The accountability of small organisations is also disputed. For example, local organisations such as religious groups could do well on community-level. However, although FBOs are commended for their credible job on fighting the pandemic – especially in care and support, some interviewees observed that their accountability on financial matters is weak, which limits their potential strength and links to other activities and organisations.

Most donor funds are disbursed in short-term bases - normally one year, which is practically too short a time to influence any change of behaviour, attitude and perception of the society towards HIV/AIDS infections, or, for that matter, to set up any sustainable service delivery scheme. Rapid donor funds with limited time for disbursement might lead to funds ending-up in wrong organisations because of limited scrutiny of organisations that qualify for the fund. Generally, Tanzanians seem to think that in spite of the increased donor allocations for HIV/AIDS in the country, few resources reach the target group (the sick and affected people). Such an observation also raises the question of who the carers of the affected are and who they should be, i.e., which

carers should be supported? In a discussion with one of our respondents about difficulties encountered with CBWs at the grass roots the suggestion was made if we did not appointed the 'wrong' people to deliver home-based care. Perhaps, instead of training selected community representatives to provide HBC, it is more effective to train and support the family members of AIDS patients who are dealing with the chronically ill on a daily basis. Thus, the question of who should receive financial support through which channels is not at all clear, obvious, or solved.

Institutional environment

Problems with the allocation of funds and the coordination of interventions (including scaling-up) are strongly related to the weakness of Tanzanians institutions. Whereas Tanzania is politically well-organised, reasonably stable, and democratically ruled, its political effectiveness and institutional capacity are limited. The political and institutional organisation maintains and reproduces an existing status quo of a powerful minority, an authority that is shared with a range of regional, district and local networks which, in turn, maintain and reproduce local status quos. Political accountability and civil monitoring are low. This, in light of emphasis on community-based strategies and the reliance on the participation of the population in finding solutions, does not encourage actual interventions. Local political elites are strongly tied to the regional and national political networks, but are not necessarily prepared to stand up for –or be accountable to- their local constituency. In addition, as we saw above, the multi-sectoral HIV/AIDS policy framework is dependent on strong collaboration between the different administrative levels and bodies and the different sectors, including the non-governmental sectors and funding bodies. Lack of transparency, accountability and public monitoring mechanisms might obstruct the effectiveness of such collaboration. The institutional environment and its workings in practice, at the grass roots, is further examined in the case studies.

Stigma

Banteyerga et al (2003) observe that social stigma and fear of isolation are the major causes for people refraining from disclosing their HIV/AIDS status to the community, or for even going for a test. Others suggest that the decision to be open about one's HIV status or not might depend on whether the disclosure would help people to cope with the results (in terms of care and support), or, on the contrary, would only decrease people's possibilities to earn a living. Stigmatisation of AIDS as a disease and the people who live with it make them and their families more vulnerable than they already are through the illness. In addition, the stigma attached to HIV/AIDS prevents

people from changing behaviours/actions which can prevent infecting others, thus limiting the effects of prevention campaigns and knowledge.

Several actors in the field have observed that efforts for prevention of HIV are hindered by some religious messages that prohibit the use of condoms, as condoms are associated with immoral behaviour. This increases stigma, as such arguments emphasise a link between 'promiscuous' behaviour and AIDS. Of course, faith-based organisations play a significant role in offering psychological, spiritual and care support to PLHA and their families. The fact that these institutions emphasise solidarity, love and care might help to reduce stigmatisation in society. Nevertheless, their strong influence on society and the lack of other sources of information in many rural areas limits local understandings of safe-sex –as it is clear that people do not abstain, nor are they faithful.

Medical care

Another challenge to HIV/AIDS interventions is the accessibility of drugs to enable PLHA to live longer (ARVs), given the fact that majority of those who are sick are also poor. ARVs are introduced only recently and then only on a very limited scale. According to the NACP, the procurement of ARVs is done through an international bidding system. The fact that the drugs are imported makes it difficult for the government to influence the price in favour of the poor. As a result, few people have access to ARVs (apart from pregnant and breastfeeding mothers). During the 2005/06 budget session, the Deputy Minister of Health pointed out that the complexity of administering ARVs (it requires complicated test equipment and qualified specialised staff) make it impossible to extend the services to rural health centres, considering the lack of appropriate equipment and personnel required. Existing drugs that are easier to manage, used in other regions of the world, are not available as yet. Some limited numbers of people receive free drugs, while patients with a better socio-economic position can buy them. Interviews in the rural areas showed that the level of information on use, effect and availability of drugs is low, thus contributing to the lack of access to ARVs for the majority of the poor (WAMATA).

Community sensitisation on HIV/AIDS helps to strengthen participation of communities in fighting the disease, as well as encouraging voluntary testing and fighting social stigma. This however is constrained by lack of financial capacity of the people to pay for VCT services. According to Maria Stopes Same district, many people are not able to pay the Tshs 1000/-

charged (US$ 1,-) for VCT services.[7] Marie Stopes provides testing services free of charge when they, occasionally, receive testing supplies from the government district hospital.

Poverty

The HIV/AIDS pandemic is a social, cultural and economic problem that has propelled poverty in Tanzanian society – the pandemic depletes family resources for care and treatment of the sick, and it takes away labour-power which could have helped families to produce more and earn more income. Wandwalo et al (2005) report that the World Bank estimates that by 2015, the country will loose about 15-20% of the GDP because of AIDS pandemic.

All social classes in Tanzanian society are affected by HIV/AIDS. As the TACAIDS HIV/AIDS indicator survey of 2004 shows, the pandemic does not discriminate against levels of income of people. Nevertheless, poorer people are more vulnerable to get AIDS because of their insufficient access to health care, food and daily income (Help Age, 2004). Poverty (and gender inequality) affects the way people make a living (women in prostitution) but also people's attitude towards risk and disease (people who find malaria or hunger as much a daily threat as is AIDS). To worsen the situation, chronic illness in a family worsens existing poverty. AIDS patients need decent health care and well-balanced diets, making the already poor more vulnerable to the vicious cycle of poverty and AIDS. Recent research has demonstrated, for example, how the lack of access to clean water in dry areas disproportionally disadvantages the chronically ill (Hutchings and Buijs 2005). The circle of poverty in which many households end up when one or more family members fall ill is worsened by the lack of water. Logically it is difficult to mobilise communities on the fight against HIV/AIDS when such a community has such unmet basic needs. At the same time, less poor groups such as teachers are increasingly dying of the disease, thus affecting the education sector (Garbus 2004). These can also be seen as circles of decline into poverty: both the education and health care sectors are affected by HIV, decreasing their capacities as sectors to manage the situation. Therefore, the fight against poverty should be (and is, at least on a discursive level) central to the fight against HIV/AIDS.

[7] Marie Stopes is an American based International family planning & health organisation. See also AMREF 2005.

3.7 Conclusion

The outline of policy concerning HIV/AIDS in Tanzania shows that although on paper most important issues are included, implementation is still weak. At a governmental level decentralisation of the multi-sectoral policy proves to be a problem. In many districts and villages government intervention lacks. This is related to weak institutionalisation parallel to a strong personalised political organisation. One could argue that in Tanzania, this combination results in a partial paralysation of policy implementation. The increased efforts of donor funding for HIV/AIDS have helped the government and NGOs to provide urgently needed services to the people affected and infected, and, on a discursive level, there is a high level of political commitment towards combating the epidemic. Policy strategies have been written down, monitoring systems set up, partner's recruited, regions and districts informed. Nevertheless, the government's financial commitment towards HIV/AIDS is not very visible and little has reached the recipients as yet. At the same time, the governments efforts to solicit funds from donors and the receipt of millions of foreign money is clear, creating suspicion and resentment among civil society organisations, local politicians and the general population.

Although the government recognises the necessity for a holistic approach in addressing HIV/AIDS, the institutional and legal frameworks to do so are still weak. For example, whereas gender inequality is seen as central to the continuous spread of the disease, and thus in urgent need of change, the national legislation does not sufficiently support such a transformation. Practices that disadvantages women, and influences their vulnerability to contracting or transmitting HIV, such as widow inheritance, FGM, or land inheritance laws, are still largely supported by national legislation. The sexual offence act (1998) has improved the legislation against rape and sexual abuse, but remains silent about HIV/AIDS and rape**.**

Perhaps there are considerably more interventions against HIV/AIDS in Tanzania which are initiated, designed, funded and managed by NGOs than there are by the government. Most NGOs seem to be well focused - in terms of quality of their services- but pay little or no particular attention to issues of coverage. This results in limited impact of their interventions as interventions are or too localised, or too short-term. It is often a big challenge to expand levels of services and keep quality at the same time. In addition, HIV/AIDS in Tanzania is related to particular cultural practices and social relations in communities. Given the diverse cultures in

Tanzanian society, it might be difficult (in some cases inappropriate) to scale-up locally initiated HIV/AIDS initiatives. If initiatives were designed at a specific locality (community level), scaling-up to other areas means imposing what is possible in one community to another community – where the initiative might not be appropriate.

External funding can also be a problem in itself: the increased influx of donor funding in HIV/AIDS might create competition among NGOs on chasing for donor funds, and thus the likelihood of enmity among NGOs that should be allies in efforts in fighting the disease. Likewise, there is a general concern in Tanzanian society that the increased donor commitment towards rapid funding envelopes for HIV/AIDS initiatives might outweigh the capacity of NGOs and the government. Rapid and huge donor funding is also feared to encourage new malicious NGOs to be formed for the sake of accessing donor funds.

On the content level of HIV/AIDS interventions, we observed that the emphasis among both government and non-governmental efforts is on prevention.[8] Few people have access to medicine, and even fewer to ARVs. Access to ARV is strongly related to location (urban/rural) and socio-economic position. In rural areas, few people even know about the existence of ARVs. Access to ARVs is growing though, and with the help of bio-medical research projects of US universities, more people seem to be able to participate in antiretroviral therapy. The lack of actual medicines for PLHA also obstructs adequate and useful home-based care programmes. HBC programmes are often well-defined on paper, and non-clear at the grassroots. Without concrete support such as medicines or food supplements, HBC easily becomes an empty shell –or merely neighbourly palliative care. Another important issue which does not seem to be effectively combated is the social stigma attached to HIV/AIDS. Fear associated with stigma contributes to further spread of the disease and reluctance to HIV/AIDS testing. Therefore, organisations intend to provide people with accurate practical knowledge and skills to care for the sick and for orphans to help reduce stigma at community level. Nevertheless, such initiatives are in need of strong support on local, meso and national levels.

Whereas both the State and the relevant NGOs claim to be committed to community-driven strategies to combat HIV/AIDS, few interventions are really bottom-up. Often, participatory

[8] Considering the limited results these measures have showed, this is surprising. Whereas AIDS awareness seems to be as a high as 90 %, this has not led to major behaviour change. On the other hand, the prevalence rate does not seem to increase either.

processes used for initiating externally designed projects are referred to as community-driven. Such misconceptions of what ‘community-driven’, ‘community-based’ and local ‘participation’ mean should be scrutinised, questioned and debated. There is a strong need to revisit what are supposed to be community-driven initiatives, and what practices could give communities a stronger voice in defining and shaping the directions and priorities of HIV/AIDS interventions.

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APPENDICES

A. List of individuals interviewed

Name	Institution/Organisation	Title/Position
Mr Daudi Makamba	Plan Tanzania	Water and Sanitation Advisor
Ms Evelyne	WAMATA	Counsellor
Mr G. P. Sangana	Ministry of Community Development, Gender and Children	Assistant Director
Eng. E. C. Mziray Eng. J. A. Mukumwa Eng. Lwakabare	Ministry of Water and Livestock Development Ministry of Water and Livestock Development Ministry of Water and Livestock Development (World Bank water project)	Assistant Director - O&M (rural water & sanitation) Assistant Director – Construction Monitoring (Rural) Project Manager (WB/MWLD)
Mr Steve Power	CARE International in Tanzania	Chief of Party
Ms I. Ilaria Dali	Swiss Agency for Development and Cooperation	Deputy Country Director
	Action Aid	
Mr F. Maro	Tanzania Social Action Fund (TASAF)	Projects Engineer
Mussa Mgata	Help Age International	HIV/AIDS Coordinator
Dominic DeWaal Rehema Tukai	Water Aid Water Aid	Policy Analyst
	Action Aid	
	Moshi Rural District	District HIV/AIDS coordinator
	ACTION AID	HIV/AIDS Advisor
Dr Somi	Ministry of Health - National AIDS Control Program	Head – Epidemiology Department
	Moshi-Rural District	District Administrative Secretary District AIDS Coordinator
Mr. Mfuru	Same District Council	District AIDS Coordinator
	Maria Stopes – Same	
Dr H. Meena	UNAIDS	
Dr P. Waibale	AMREF	Country Director

B. Participants by institution type

Local NGOs	1
International/Affiliated NGOs & Bilateral donors	6
Public sector / Government of Tanzania	5

C. Bio data of organisations involved in the study

Organisation	What they do
Plan International in Tanzania	Community Development interventions with children as a focus of development. A Canadian originated international NGO
WAMATA	A Local NGO. One among the few popular NGO delivering HIV/AIDS support at grassroots level. The organisation is internationally and locally funded
Ministry of Community Development, Gender and Children	Ministry responsible for community development and gender
Ministry of Water and Livestock Development	Ministry responsible for water and livestock development
CARE International in Tanzania	An international NGO (USA origin) which undertakes variety of development interventions, including HIV/AIDS. Currently they are major recipients of US Presidential fund for AIDS activities
Swiss Agency for Development and Cooperation	Swiss Government development cooperation department of the Switzerland Embassy in Dar. The department is one of the largest contributors in the Rapid Funding Envelop for HIV/AIDS initiative
Action Aid	UK origin NGO which provide variety of development support including Lobbying and Advocacy at national level on issues of national interest
Tanzania Social Action Fund (TASAF)	Joint government of Tanzania and World Bank initiative for community driven development initiatives.
Help Age International	UK origin NGO which support the aged on variety of age related issues, including HIV
Water Aid	UK origin NGO which supports community water projects
AMREF	Medical Research, Community Development works, Voluntary HIV/AIDS counselling and testing, Development of quality standards manuals/curriculum
UN (AIDS)	Joint United Nations programme on HIV/AIDS. Supports/Advise the government and other donors on AIDS matters

D. HIV/AIDS Financing in Tanzania

Name of Agency	Type of Agency	Main programs	Budget in US$
Tanzania Commission for AIDS (TACAIDS)	Multi-sectoral semi-autonomous commission (under Prime Minister's office)	Strategic leadership, policy guidance, resource mobilisation, coordination of the national response	$19 million (2002-2003)
National AIDS Control Programme	Government (under Ministry of Health)	Technical leadership for surveillance monitoring, blood safety, clinical and support standards, supervision and oversight including guidelines, curriculum, monitoring, evaluation	$8.1 million (FY 2002-2003)
Ministry of Education	Government	Technical leadership for introduction of information and education on reproductive health, HIV/AIDS and TB into the primary and secondary school curriculums and peer groups for students, teachers	n/a
UNAIDS	Multi-lateral	Strategic planning, M&E, surveillance, advocacy, networking, human rights, district response. Coordination of Development Partners Group (DPG) on HIV/AIDS	$1 million (2002-2003)
UNICEF	Multi-lateral	Vulnerable youth activities and orphan support	$11 million (2003-2006)
UNDP	Multi-lateral	Capacity strengthening for mainstreaming HIV/AIDS in national development, formulation of national strategic plan, and strengthening coordination of the multisectoral response.	$3.3 million (2002-2006)
DFID	Bilateral	Basket funding and PER/MTEF support	$3 million (2002)
GTZ	Bilateral executing agency	Comprehensive AIDS Control in 4 regions (Tanga, Mbeya, Lindi, Mtwara)	$3 million (2002-2004)
Italian Cooperation	Bilateral through Italian executing agencies (CUAMM, LVIA, CMSR)	STD control, Prevention and containment strategies for HIV/AIDS	$2.2 million (2003-2005)
USAID	Bilateral	♦ Voluntary Sector Health Program 3 years through 9/2003) ♦ Angaza – Scaling up VCT (three years through 9/2003) ♦ Policy activities (advocacy, legislation, institutional arrangements) (funded on annual basis)	$28 million (2003-2005)

		♦ Development of logistics management systems within MOH for HIV/AIDS commodities (two years through 9/2003) ♦ Condom social marketing (1992 through 9/2003) ♦ Behavior change communication (national HIV/AIDS campaigns and BCC activities in support of refocused antenatal care for presumptive treatment of malaria in pregnancy) ♦ Impact mitigation – Social Action Trust Fund (support for education for children orphaned by HIV/AIDS) ♦ PMTCT in collaboration with MOH and CDC	
Irish AID	Bilateral	Basket Funding, ISHI IEC Campaign, Strategic planning for HIV/AIDS	$4.9 million (2003-2005)
World Food Programme	Multi-lateral	Food supplementation for affected families	$2.8 million (2002-2006)
Canadian CIDA	Bilateral	Strategic planning and limited support in 1 district	$750,000 (2002-2005)
Belgium	Bilateral	Support for home based care and syndromic management of STIs	$3.5 million (2002-2006)
World Health Organization	Multi-lateral	HIV/AIDS: STI, TB, VCT, HBC, blood safety and surveillance	$5 million (2002-2004)
JICA	Bilateral	HIV test kits and other commodities and Malaria works	$9 million (2003-2005)
Finnish Aid	Bilateral	Limited support for HIV/AIDS	$200,000 (2002-2003)
Swiss Agency for Development Cooperation	Bilateral	Support for programmes in Zanzibar and 1 district on the Mainland, Basket funding	$1.5 million (2002-2003)
U.S. Centers for Disease Control and Prevention	Executing agency for bilateral	HIV/AIDS: technical and financial support of surveillance testing and blood safety	$4 million (2002-2003)
Royal Netherlands Embassy	Bilateral	Social marketing of condoms; significant support for tuberculosis treatment	$11 million (2002-2004)
World Bank[9]	Multi-lateral	Not earmarked for specific intervention	$70 million (2003-2007)
Source: adapted from Garbus (2004) <http://www.theglobalfund.org/search/docs/3TNZHT_747_0_full.pdf>			

[9] The World Bank's Multi-Country Aids Program (MAP) in July 2003 approved an IDA credit of US$70 million scheduled to run through September 2008 to provide for funds for the national HIV/AIDS programs

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