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Social Policy Regime, Care Policies and Programmes in the Context of HIV/AIDS

Tanzania

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Section 1: Social Policy Regimes: an Overview

The evolution of social policy debates and regimes in Tanzania has been influenced by the historical colonial system, efforts to de-colonize the colonial social policy regimes, the socio-economic crisis of the 1970s and 1980s, and the conditions imposed by the International Monetary Fund (IMF) and World Bank through structural adjustment programmes (SAPs).

This paper identifies three major post-colonial phases of policy regimes in Tanzania. The first phase is the immediate post-colonial period from 1960 to 1967, the second spans the period from the Arusha Declaration of 1968 until 1986 and, finally, the third spans the structural adjustment and liberalization era from 1986 to date.

The colonial policy regime had excluded the majority of people on the basis of race, geographical location, gender and social class. Investment in the social sector during the colonial era was based on this hierarchy, and driven by the goal of supporting the colonial economy. State institution provided selective services to a few government officials and medical and educational facilities were provided in a few geographical locations by faith-based institutions. However, the majority of citizens depended upon traditional support systems including traditional healers and family and social network. This colonial legacy influenced the social policies of the independent state of Tanganyika¹.

Social Policies under the Modernisation Era (1961-67)

Although the post-colonial leadership declared poverty, disease and ignorance enemies of the post-colonial state, from 1961-1967 the country did not formulate a comprehensive social policy to fight the declared three 'enemies'. The social policy regime of this period can be categorised as a conservative/residual model based on exclusionary principles inherited from the colonial regime. The government provided a few selected services, anticipating that the market-driven economic policies of modernisation would have a 'spill-over' effect for the majority of citizens. Gender differences were not considered in the formulation of economic policies and hence the gendered social impact of the policies of the modernisation approach was ignored.

The immediate focus in the social sector was abolishing racial segregation in education and health services by banning racially segregated services. Investment in education, health, urban housing and water was linked to the contributions of these services to the growth of the economy rather than to citizens' rights to social services. The institutions involved in the provision of care continued to encompass faith-based institutions, traditional healers, and state institutions as well as households. The majority of citizens in rural areas continued to depend upon family and social support networks, while urban people depended on these as well as burial associations and workers' social welfare networks. The market had a limited role in social service provisioning due to pervasive poverty and resultant inability of the majority of the people to pay for services (Mchomvu et al, 2002).

¹ Before the country united with Zanzibar, in 1964, it was known as Tanganyika. After Union, it was renamed Tanzania.

The Arusha Declaration: Socialism and Self Reliance (1967-1986)

In 1967, Tanzania declared “Socialism and Self Reliance” as the philosophy which was to guide both economic and social development of the country. The Ujamaa philosophy, as it was known, stressed the concept of equal rights and opportunities for all members of society. It aimed to create a system in which all members could live in peace with their neighbours without suffering or imposing injustice, being exploited, or exploiting, and in which all would have a gradually increasing basic level of material welfare before any individual lived in luxury (Nyerere, 1968). This approach arose from the concern that development during the first phase of independence had led to, or sustained, social differentiation, inequality and disparities in national development. In addition to raising the standards of living of the people, the Ujamaa philosophy aimed at empowering people to participate in decision-making processes in order to enable them to take control of their own lives.

During the Ujamaa era, the country witnessed a paradigm shift from the exclusionary model to a stratified universalistic social regime model in which the state took over the primary responsibility for service delivery. Social equity rather than economic growth provided the rationale for social service delivery. A primary health programme, universal compulsory primary school education, mass literacy campaigns, as well as maternal and child health (MCH) programmes were launched. These programmes made basic social services accessible to the majority of Tanzanian citizens but did not do so in respect of secondary and tertiary services.

For example, primary school was compulsory and free for all children, but secondary school and tertiary education were offered to a small proportion of the children who completed primary education. Those who completed university were able to enter the formal labour market which had various social security schemes. However, the majority, who remained in subsistence farming or the informal sector, were excluded from such schemes. In health, the primary health care programme was provided through village posts staffed by less skilled people, while the higher skilled staff was concentrated in the less widely accessible secondary and tertiary services.

While the socialist regime attempted to deal with some of the inequalities inherited from the colonial state, it perpetuated some of the conservative elements which had been inherited from the colonial state. The Marriage Act of 1971, for instance, provided for paid maternity leave for formally employed women for up to four children. Women employed in subsistence agriculture and the informal sector did not have access to maternity leave. Similarly, all labour laws were directed at protection of formal sector employees who constituted the minority of the labour force. Tax relief was provided in respect of children but was only available to the small minority who earned enough to pay tax. In addition, while there was no rule restricting the tax relief to women, in practice this relief was paid primarily to fathers. Formal sector employees were also entitled to paid annual leave of 28 days and a package covering transport costs of a spouse and four children under the age of 18 years from the employee’s urban residence to their rural place of birth. Again, in theory this was available to both women and men, but in practice child travel allowances were mainly paid to fathers, and to mothers only upon submission of written letter from the spouse’s employer indicating that the husband had not claimed a travel allowance for the children. A similar letter was not required from male employees. Paid sick leave was granted

for six month, after which a panel of doctors was to determine the ability of the employee to continue with formal employment. Again this was limited to formal sector employees.

Although there were attempts to minimize the role of the market in social service provision, the private sector continued to provide services under the guise of not-for-profit. Thus in 1977, when the government banned private practice, it allowed private providers to practice on a fee-for-service basis on condition that they affiliate with faith-based institutions. The government did not put in place mechanisms to control the fees charged by these providers. The majority of private providers did so without necessarily changing the fee structure and profit margins. The household, particularly women, continued to shoulder the bulk of the care work on an unpaid basis. This included child care, fetching water and firewood for domestic energy consumption, food preparation, and the care of sick persons.

The socialist regime did not address the gendered inequalities embedded in the patriarchal social system. The customary laws, and particularly those related to personal law, which were recognized in Tanzania's legal regime, discriminated against women and girl children in respect of ownership and inheritance rights. This has had a serious impact on women's welfare particularly when widowed, divorced or separated. These limitations notwithstanding, government involvement as a primary provider of social services facilitated access to social services such as education, health, and water and made it possible for the majority of citizens to improve their living conditions.

Structural Adjustment and the Market Economy (1986-2000)

As a result of the socio-economic crisis discussed in Report I, in the 1980s the Tanzania government experienced serious difficulties in financing the social services it had developed in the 1970s. In the education sector, government resources were insufficient to pay teachers' salaries, buy text books and other teaching materials and maintain the school buildings. Similarly in the health sector, government resources were not sufficient to supply the necessary medical equipment and drugs, pay salaries and maintain the physical infrastructure. As a result, the infrastructure crumbled, schools went without books, adult classes could not be sustained, literacy levels relapsed, health indicators deteriorated, and rural water infrastructure could not be maintained. The situation was worsened by the implementation of IMF austerity measures which forced the government to play a minimal role in the provision of social services, and attempted to transfer part of the cost to the users through various mechanisms including the introduction of user fees.

Deteriorating availability and quality of health services meant an increase in the burden of care borne by households and, in particular, by their women members. In terms of childbirth, for example, the majority of deliveries took place in private households with care provided by a traditional midwife in the community, mother-in-law, grandmother, mother or sister. The care that follows after birth care was also largely provided by women.

The reform programmes of the crisis period transformed the universalistic social service regime into a 'dual' model, in which limited services were to be offered universally, but in partnership with the private sector. So, for example, in 1991 the government legalised private clinical

practice, ending the 1977 prohibition. This resulted in a rapid increase in private facilities, but concentrated in urban areas. While religious organisations continued to provide services in some parts of the country, the private sector proper felt no obligation to address the welfare of poor citizens. The state continued to provide social services but at the same time encouraged the private sector and private households to share costs, and contribute to the financing of these services.

To mitigate the impact of user fees on the poor the government introduced exemptions and waiver systems. The exemptions involved a statutory entitlement to free health care services automatically granted to individuals falling under categories specified in the cost-sharing operational manual. These categories were MCH, including immunization of children in all Grade 111 services, children under 5 years of age, patients suffering from TB, leprosy, paralysis, typhoid, cancer and HIV&AIDS, cholera, meningitis, plague and long-term mental disorders (Burns & Mantel, 2006). In contrast, a waiver would be granted to those patients who did not automatically qualify for the statutory exemption but were classified as “unable to pay.

Waivers and exemptions were supposed to protect the poor from the negative effects of cost sharing and user fees in vital services such as health and education. In health, for example, children under five, pregnant women, and people suffering from chronic diseases were theoretically entitled to free medical care in all public health institutions. Institutions were expected to exempt those classified as poor. However, exemptions of the above categories did not necessarily benefit the poorest, while waivers were unsystematically implemented. In particular, there were difficulties in defining who was poor, and should thus enjoy a waiver, in a situation of pervasive poverty. Further, health facilities were not reimbursed for losses incurred through waivers and exemptions, resulting in reluctance to implement them. Mamdani & Bangser (2004) argue that “health care charges have placed financial burden on the poorest households who are often excluded from using health facilities when they most need them.” The authors further observe that, in addition to paying user charges, the poor incur other costs including transport, time spent, as well as unofficial costs such as bribes and payment for drugs and supplies.

The cut-backs in provision of social services and government’s role more generally resulted in large-scale retrenchments of government and para-statal employees. These retrenchments reduced the size of the already small formal sector. This resulted in an increase in the number of poor households. It also reduced the number of people and households with access to the social protection measures available to those in the formal sector.

The crisis and related austerity measures impacted women and men differently. Feminist critiques of the austerity packages argue that the SAPs tended to pay too much attention to relations of exchange and directed very little attention to social relations. Furthermore, human resources, which are largely produced by unpaid care work, were considered as a costless “non-produced factor of production”. It was assumed that the social reproductive tasks performed primarily by women would continue to be done because of social obligations, their costs notwithstanding. As a result, as in other countries, women in Tanzania acted as “shock-

absorbers" of the impact of the austerity packages implemented during the crisis and post-crisis period (Meena, 1991).

The current period

The current period can be seen as a continuation of the previous period. Recent years have, however, seen the development of a number of overarching development policies that envisage more comprehensive provision of social services that would reach all citizens, including the poor, alongside healthy economic growth.

Vision 2025, launched in 1999 and still regarded today as the long-term vision for the country, envisages that by 2025 Tanzania would have graduated from the status of a least developed country to a middle-income country, with much higher levels of human development. The document envisages that by 2025 Tanzania should have the following attributes: high quality of livelihood, peace, stability and unity, good governance as well as a well educated and learning society; and a competitive economy capable of producing sustained growth and shared benefits. Vision 2025 is based on the creation of a market-driven economy which balances growth and distributive elements.

Tanzania was one of the first countries to draft a poverty reduction strategy paper (PRSP) as part of the World Bank-led process of qualifying for Highly Indebted Poor Country status and the related debt relief. The country's first national poverty eradication strategy document was launched in 1998, and became the basis for the PRSP published in 2000. The overall aim of PRSP was to halve absolute poverty, i.e. the percentage of the population living under the official poverty line, by 2010 and eliminate poverty by 2015. The PRSP provided a basis for increasing public resources to poverty-related sectors. The PRSP identified seven priority sectors, among which were the health sector and the fight against HIV&AIDS.

In the year 2005 a National Strategy for Growth and Reduction of Poverty (NSGRP) popularly known as "Mkukuta²" was launched. MKUKUTA, represents the second-generation Tanzanian PRSP, was approved in April 2005, and covers the period 2005-2010. MKUKUTA aims at achieving "faster, more equitable, and sustained growth." Instead of the previous sectors, it introduced three thematic 'clusters' namely: (i) growth and reduction of income poverty; (ii) improved quality of life and social well-being; and (iii) good governance and accountability. MKUKUTA recognizes strategies for ensuring provision of social services (mainly health, education, water and sanitation for all) and controlling the HIV&AIDS pandemic as critical inputs towards improving livelihoods and promoting sustainable growth and development. Furthermore, MKUKUTA acknowledges the multi-faceted nature of poverty, giving specific attention to income poverty and employment as well as to non-income poverty and issues related to vulnerability and the need for stronger social protection. In terms of non-income poverty, the focus is placed on education and illiteracy, health, survival and nutrition, HIV&AIDS and water and environment. The links between the three clusters are generally weak.

² MKUKUTA is a Swahili term which stands for " *Mpango wa Taifa wa Kukuza Uchumi na Kufuta Umaskini* or National Strategy for Growth and Poverty Reduction

The basic tenet of MKUKUTA is that growth is necessary but not sufficient for poverty reduction. MKUKUTA thus emphasises the need to pay attention to equity issues as well as equitable growth which focuses on reducing inequalities and enhancing livelihood opportunities for the poor. Within the MKUKUTA framework, equitable growth is supposed to entail improving access to and use of productive assets by the poor, addressing geographical disparities and ensures equal and universal access to public resources.

The universal principle spelt out in MKUKUTA provides a foundation which obliges the state to assume primary responsibility for providing social services without discrimination. This should include providing services that do not discriminate against people with chronic diseases including those living with the HI virus. It should also imply ensuring that the burden of care for those with the disease is not disproportionately shared. However, while MKUKUTA recognises the effect of HIV&AIDS on poverty, the effects of HIV&AIDS on households and families are not adequately factored into the MKUKUTA.

Within the MKUKUTA framework, the market is recognised as the engine of growth, but public resources will be provided to protect citizens from market imperfections. The main direction of the social service sector policies from the late 1990s to date has been to attempt to bring about a different balance between private and public provision of social services. The envisaged shift will not revert to that of the Ujamaa period, with government as near-universal provider. It will, however, attempt to redress some of the negative effects of the severe cut-back in social services in the SAP period. In this regard, various sector policies have been developed and modified to include private/public partnerships in social service provisioning.

The sector-wide policies which have a direct impact on the care diamond include those related to health, water, nutrition, and education. All these policies are also of direct relevance from a HIV&AIDS perspective, which is the main focus for Tanzania within the UNRISD project. These policies are discussed further in section 3 below. Before discussing these policies, we summarise the findings of Research Report II in respect of the contribution of unpaid care work done in the home and community to addressing the care needs of the society.

Section 2: The significance of unpaid care carried out within the household

One way of gaining a sense of the size of unpaid care work done in a society is to compare the value of the work done with other macro-economic measures. Because most macro-economic measures are expressed in monetary terms while unpaid care work is, by definition, unpaid, one first needs to convert the time amounts used to measure unpaid care work to their monetary equivalents. In Research Report II, two approaches are used when assigning a 'wage' to the hours spent on unpaid care work. The median earnings approach estimates what might have been earned if the time spent on unpaid work had been spent, instead, on paid work. The generalist approach estimates what it would have cost if the household had paid someone else to do the unpaid care work. In absolute terms, the value of unpaid care work is estimated at between Tshs 5,887bn and Tshs 10,521bn in 2006. The value of person care, the sub-set of unpaid care work that involves more direct services to persons and excludes activities such as housework, lies somewhere between Tshs 898bn and RTshs 1,601bn. As explained in Budlender (2007), the

median earnings approach uses sex-disaggregated earnings and thus provides sex-disaggregated results, while the median generalist approach – which estimates how much it would cost to buy in services – is not sex-disaggregated in this way.

Table 1 Unpaid care work and person care as percentage of Gross Domestic Product: Different approaches

	UCW			Person care		
	Male	Female	Total	Male	Female	Total
Median earnings all earners	17%	46%	63%	2%	7%	10%
Median generalist wage			35%			5%

Source: Budlender, 2007b

Table 1 shows that unpaid care work is equivalent to somewhere between 35% of the value of GDP in 2006 when using the median generalist wage and 63% when using median earnings of all earners. This large difference between the two percentages reflects the very low wages paid to domestic workers which form the basis for the generalist estimate. Yet even the lower estimate suggests that the value of unpaid care work is equivalent to more than a third of total GDP. For the narrower measure of person care, the value is equivalent to between 5% and 10% of GDP. For both unpaid care work and person care, the male and female columns show that the female contribution is far larger than that of males, even though each hour of female work is given a lower value than an equivalent hour of male work. Thus for the median earnings approach, 46 of the 63 percentage points represent unpaid care work done by women while only 17 represents unpaid care work done by men. The relative size of unpaid care work shows clearly that policies that ignore unpaid care work are blind to a large part of the production that occurs in the society.

The estimated value of unpaid care work can also be compared with the amount that government spends on its core care-related services, namely health and education. For this comparison, we use the allocations for the education and health sectors for 2006/07. These stood at Tshs. 891.2 bn and Tshs. 427.4 bn respectively if one includes the allocations to districts. (These allocations include off-budget support which, as discussed below, makes up a large proportion of HIV&AIDS expenditure.) The estimated value of unpaid care work using the first approach is close to eight times as large as government health and education expenditure, while the second approach gives an estimate more than four times as large as government expenditure on these services. This comparison suggests that households are making a far larger contribution to meeting the care needs of the society than government is doing.

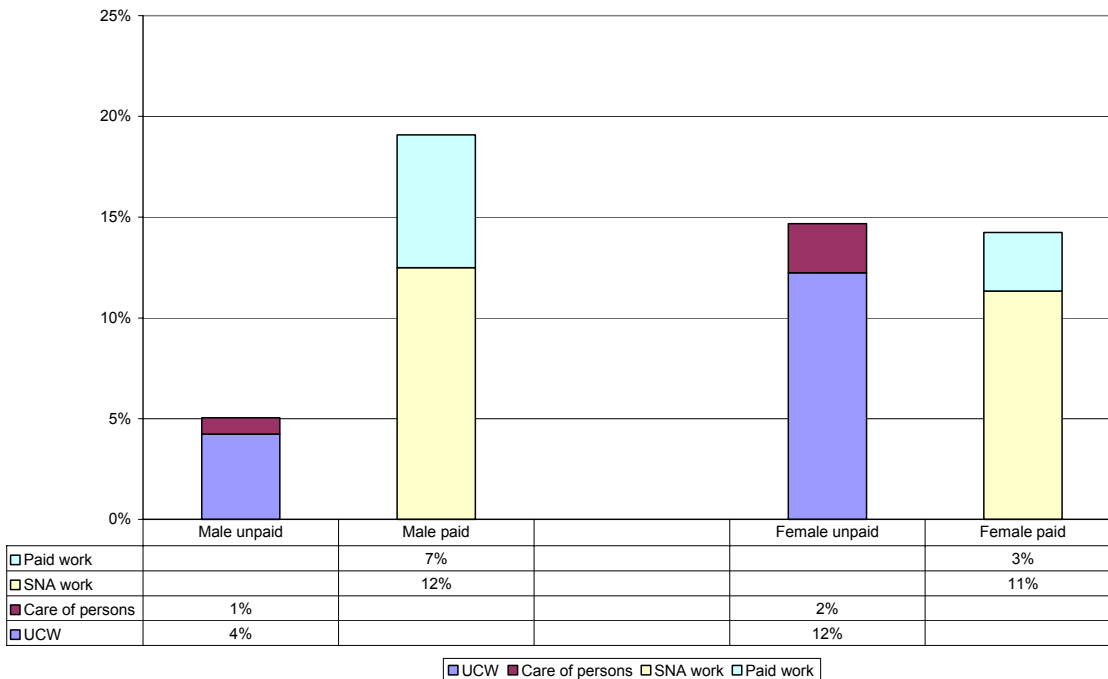
The burden of unpaid care work is very unevenly distributed. Above we show the gender imbalance, but there are further imbalances. Thus analysis of the time use survey data also reveals that household maintenance time spent by females rises from 59 minutes for the age group 5-9 years to a peak of 230 minutes for the age group 25-34 years, after which it declines but does not go below 130 minutes. For males, the trend start at 40 minutes for the youngest group, peaks at 59 minutes for the age group 15-24 and remains within the lower 50 minutes range throughout the remaining age groups (National Bureau of Statistics, 2006: 91-92). These patterns suggest the greatest burden falls on young women when they are in their prime reproductive years as well as, potentially, in prime income-earning years. The unpaid care burden has implications for their ability to participate in education, as well as their ability to effectively contribute towards improved well being and welfare of the household members.

Marital status tends to increase females' participation in unpaid household activities while having a reverse impact on males. The time use survey revealed that married males spent less time on unpaid care work than all women and than men with other marital status. Single women tended to spend less time on unpaid care work than married females, but much more time on unpaid care work than single males.

In Tanzania, most of the adult women and men who engage in unpaid care work do this work alongside work that is included in calculation of GDP i.e. paid work, unpaid work in a family business, or work in subsistence agriculture. (We refer to work included in GDP calculations as "SNA work" as it is the System of National Accounts (SNA) that provides the rules that determine what is included in these calculations

Figure 1 below reveals that, among the Tanzanian population aged five years and above, males spend approximately 19% of an average day on SNA work and 5% of the day on unpaid care work, while females spend 14% of the average day on SNA work and 14% on unpaid care work. Combining both forms of work, males spend close on a quarter (24%) of their day working, while females spend 28% of their day working. These percentages are almost certainly an estimate as internationally it is recognised that time use survey respondents tend to under-report time spent on care of persons, particularly when this work is done simultaneously with other activities and does not involve direct personal interaction with the person being cared for. The fact that women tend to bear more responsibility for person care, and probably particularly for indirect care and supervision of persons, probably means that the under-reporting is more severe for women than men. The amount of time spent on both forms of work would also tend to be lower because of the inclusion of children from age five in the calculations, whereas many other countries calculate time use for the population aged ten and above or even higher age cut-off.

Figure 1 Time spent on paid and unpaid work by sex



The figure also under-represents the burden borne by particular women (and men) in that it refers to averages over the full population aged five years and above. If analysis is restricted to the 18-49 year age group, men spend 6% of their day on unpaid care work and 39% on SNA work, while women spend 24% of their day on unpaid care work and 24% on SNA work. The gender imbalance remains in terms of total work, with men spending 45% of their day working compared to the 48% - close on half of the average day, weekends included – spent by women.

In respect of care of persons – where the burden would be particularly affected where there is an ill person in the household – the averages are biased downwards by the fact that a significant proportion of the population does not do this work at all. Among men and women aged 15-64 years, the time use survey found that only 36% of men and 64% of women reported doing any care of persons over the preceding week. The averages quoted above would be much higher if calculated only for those reporting some care of persons. For men aged 15-64 years, the average number of minutes spent on person care increases from 13 to 35 when the calculation changes from the full population to only those doing this activity. For women the increase is from 47 to 74 minutes. One in fifty (2%) of women do six hours or more of unpaid care of persons on an average day.

In addition to increasing care needs, the existing literature on the impact of HIV&AIDS on households reveals that HIV&AIDS increases the consumption needs and depletes household's assets, while reducing available labour as well as available income. The reduction in income is caused, among others, by fewer people being able to work either because of their own illness or because of needing to care for others. Where there are ill people in the household, there are also increased demands for time spent collecting water and fuel to be used in caring. (TGNP, 2005 Budlender, 2007a) The strain in terms of meeting consumption needs is increased by the fact that

a large proportion of Tanzanian workers do not have cash earnings. Of those aged five years and above who report employment-related work, 64% are reported to be working on their own (non-commercial) farm, and a further 16% working unpaid in family businesses or agriculture. The households of these workers have limited ability to assume the cash-related burden of care for sick persons.

Section 3: The Care Diamond: Multiple institutions producing the welfare/care matrix

For the UNRISD project, the Tanzania case study has its focus on care in respect of HIV&AIDS. Most immediately, then, the research needs to look at health-related care needs. This focus will seem self-evident given that HIV&AIDS is a disease which generates need for treatment and care. However, the HIV&AIDS pandemic generates and affects a range of care needs that goes far beyond health. Further, in attempting to provide for HIV&AIDS-related care needs, provision for other types of care can be affected either negatively or positively.

This section of the paper looks at policies, budgets and provisions in relation to health and infrastructure. Within infrastructure, it focuses on aspects of particular relevance in the context of the HIV&AIDS pandemic. The paper explores government's role as policy maker, regulator, funder and provider. It also explores the role of other players, such as the private sector and faith-based and non-governmental organizations in respect of provision, and donors in respect of funding as well as how they shape policy. The paper thus complements the analysis in Research Report II which focused on the role of households in providing care.

Before exploring the areas of infrastructure, health and education some general observations on the legal framework in Tanzania and how it operates in the context of the HIV&AIDS pandemic are appropriate.

Tanzania has multiple legal systems in that statutory, Islamic, Hindu, and customary laws operate side by side. These laws regulate the day-to-day lives of citizens, and are hence relevant to prevention, care and mitigation in respect of HIV&AIDS. Some of the customary practices have discriminatory elements which affect women's rights in matters of sex and sexuality, inheritance rights, succession and the right to own and dispose land. These affect women's ability to refuse sex and increase their vulnerability to infection, as well as their economic entitlements when family members die. Customary practices such as female genital mutilation, polygamy and wife inheritance also create conditions which make women vulnerable to HIV&AIDS infection (Rwebangira & Tungaraza, 2000). These laws and practices tend to increase the demand for care by increasing the number of infected people. The laws and practices also, by limiting women's access to economic resources, limit their ability to cope with the care and other consequences of HIV&AIDS.

Most of the existing pieces of statutory legislation were enacted before the spread of the HIV&AIDS pandemic. Even some of the laws which were enacted after the first HIV case was discovered in 1983 have not provided legal protection to individuals living with the virus. In 2004, the government therefore initiated a process of revising laws to protect the rights of people living with HIV&AIDS. The government revised Employment Ordinance, Cap. 366 to provide

that every employer shall at his /her own expense provide medical aid for the employees and members of their families' in accordance with a prescribed scale. The extent to which employers are adhering with this ordinance was not assessed in this study. However, even if there were full adherence, there would be limited impact given the small percentage of the population in formal employment. Thus, the ILFS 2006 suggests that only 3% of currently employed people were in government or para-statal, and only 9% in the formal private sector (National Bureau of Statistics, 2007).

The policies and government programmes described below must also be understood against the background of an ongoing decentralization programme. The Local Government Reform Programme (LGRP) which was launched in Tanzania in 1997 provides that local government should bear the main responsibility for social development and public service provision within the area of their mandate. The LGRP thus transferred duties, and to some extent financial resources, from the central level to the local governing structures in areas such as health, education and water. A decentralised structure was considered facilitative of the redistributive function of the state, and it was hoped that local governments would have better knowledge than central government of local needs and that there would also be greater accountability and participation in decision-making. A decentralised approach should, theoretically, assist in ensuring a continuum of care for people living with the AIDS virus. In practice, insufficient resources at local level combined with capacity problems can mean that decentralisation does little to reduce inequalities and address needs. The inequalities can be exacerbated when donors choose to focus on certain districts leaving others with minimal services. This danger is particularly acute in an area such as HIV&AIDS where much of the donor funding happens off-budget and where there is heavy reliance on donor funding.

Infrastructure

It might seem unusual to include a focus on infrastructure in a study on care. However, several studies have revealed that there is a direct relationship between water requirements of households and HIV&AIDS. Thus, for example, one study (TGNP, 2004/05) revealed the significant amount of additional water needed by a household caring for an AIDS patient on top of other family water needs. The additional requirements reflect, among others, the need for regular washing of the patient and carers and the equipment used, as well as the fact that those who are AIDS ill generally suffer from severe vomiting, diarrhoea and skin disease.

There is a close link between water supply, sanitation and hygiene practices and the household workload in households containing people living with HIV&AIDS. As with water requirements, the diarrhoea and vomiting that are associated with opportunistic infections as well as with some of the treatments require access to decent toilet facilities.

Access to safe water has appeared as a government priority in most of the national policy frameworks. The Tanzania Development Vision 2025 aims for universal access to safe water by 2025. MKUKUTA targets include increasing the proportion of the rural population with access to clean and safe water within 30 minutes from the dwelling from 53 per cent in 2003 to 65 per cent in 2010 in rural areas and from 73 per cent in 2003 to 90 per cent in 2010 in urban areas. Similarly, MKUKUTA targets improving access to sanitary facilities from 17 per cent in 2003 to

30 per cent in 2010 in both urban and rural areas. It further envisages that 100 per cent of all schools should have basic sanitation by 2010.

Within the sector itself, the overall objective of the 2002 National Water Policy (NAWAPO) is to facilitate provision of an adequate clean and safe water supply and sanitation services so as to improve the health and nutrition of both rural and urban population. NAWAPO identifies the Government of Tanzania, development partners, NGOs, user fees, community contributions and private sector investments as the main contributors of finance for this provision.

While NAWAPO identifies water supply for the poor as a priority, studies reveal a gap between policy statement and actual practices. The substitution of public provision of water by private providers is seen by many critics as posing a threat to the well-being of the poor, and especially to women who shoulder the bulk of the burden of supplying domestic water when it is not readily available (TGNP: 2004, REPOA: 2008). Unlike in other sectors, there are no waivers or exemptions within the water policy to assist poor households.

Poverty monitoring progress reports indicate that there has been some improvement in access to improved water supply. As of June 2003 for instance, 53% of households had access to safe water compared to 42% in 2000. There are however, inequalities in access. Thus in 2003, approximately 42% of rural households had access compared to 88% in Dar es Salaam and 84% in other urban areas. The poverty monitoring report of 2004 (RAWG: 2004) further indicated that 50% of rural households had no toilet facilities.

Availability of fuel is another aspect which impacts women's workload generally, and could alleviate both the time and money burden of providing care. In terms of time, ready access to nearby sources of fuel would mean that it no longer needed to be fetched over long distances. In terms of money, ready access to nearby and cheap sources would save the money currently spent on purchasing charcoal and paraffin oil.

It is estimated that wood fuel accounts for 92 per cent of total household energy supply in Tanzania, with a further 2 per cent from hydro-electricity and 7 per cent from oil-derived products (REPOA, 2008). Investment in electricity has been heavily biased in favour of urban dwellers, in that 10 per cent of urban households have access to electricity compared to less than 2 per cent of rural household.

Health services

With regards to policy, the Government of the United Republic of Tanzania has put in place several policies and plans which impact the care of people living with the AIDS virus. Some of the policies are summarized in the following section.

General Health Sector Policies

The 2001 National Health Policy aimed to deliver equitable and quality health services to the Tanzanian society. Additionally, the policy aimed at empowering communities and engaging them in health service delivery.

In 2007, the government issued a new Health Policy which instructed local governments (LGs) to establish dispensaries in every village, a health centre in every ward, and a district hospital in each district. The physical proximity of a well-equipped health facility to people living with HIV&AIDS (PLWHAs) would help to reduce the time taken by both patients and their carers to visit the facility for treatment of opportunistic infections (OIs) or obtaining anti-retrovirals (ARVs).

The Policy was introduced in tandem with the Primary Health Sector Development Programme (PHSDP) (2007-2012). The PHSDP was intended to address the many constraints facing the health system and preventing access, quality and efficiency of district-based services. These constraints included poor infrastructure at the primary level; shortage of skilled human resources; short supply of essential equipment, pharmaceuticals, and medical supplies; a poorly functioning referral system; and inadequate financial resources. The PHSDP has seven programme areas, namely: District Primary Health Care System, Human Resources for Health; Maternal Health; HIV&AIDS; Tuberculosis; Malaria; and Institutional Arrangements. In addition to the HIV&AIDS programme area virtually all of the others have strong links with HIV&AIDS. For example, PLWHAs will not have good access to care unless the district health system works efficiently, the care will be of poor quality unless the necessary skilled human resources are available, and those who are HIV-positive have increased vulnerability to tuberculosis and are also more likely to die in childbirth and/or to infect their children. In terms of HIV&AIDS specifically, the plan was to scale up treatment, and especially prevention of mother-to-child transmission, with a simultaneous emphasis on home-based care for those infected given the inability of the public health system to cope with the increased demand within its own facilities.

A National Health Strategic Plan (NHSSP) for 2007-2010, thus covering more or less the same period, identified priority areas for resourcing by the Ministry of Health and Social Welfare (URT/MHSW: 2007). Priority areas were defined as those that were core to the mandate of the Ministry, that were expected to have greatest impact, and that were in line MKUKUTA and other national frameworks. The question here is whether areas like home-based care will be seen as a priority.

All the above policies and planning frameworks hence emphasis on improving access to health facilities. However, existing data reveal that current health facilities include 4,679 dispensaries, 481 health centres and 95 district hospitals. The shortfall is 5,162 dispensaries, 2,074 health centres and 48 district hospitals, implying that more than half of the needed dispensaries are not yet available, and only about a fifth of the needed health centres are currently in existence. Further restricting equal access is the fact that the government owns 61.3% of the health facilities, (which are ideally accessible to the majority of citizens) while voluntary agencies account for 15.5%, the parastatals own 4.1% while for profit companies own dispensaries 19.6% (HERA:2006:pg.20). More generally, even though physical access has improved, especially to primary facilities, for many people access is hampered by cost, the unequal distribution of available facilities across districts, and transport difficulties (REPOA, 2008). Worse still, government expenditure on health has fluctuated as a percentage of total government expenditure over recent years, increasing from 8.1% in 2002/03 to 10.6% in 2005/06, but then falling back again to 9.7% in 2007/08 (Economic and Social Research Forum, 2007).

Health sector provisioning

As noted above, during the SAP era the government instituted cost-sharing policies in order to contribute to health funding. User fees were introduced in Tanzania at the hospital level in 1993, as part of the broader package of reform referred to as the Health Service Fund. Further charges were introduced in 1999 through the drug revolving fund at hospital level with subsequent rolling out of the Community Health Fund (CHF). Currently, user fees are charged in practically all public hospitals and have also been introduced at lower levels of facilities, namely health centres and dispensaries. As discussed further below, the rolling out of user fees in primary facilities is happening in tandem with the rolling out of the CHF.

A range of studies have examined the impact of user fees and the CHF on the access of poor households to health services (Tibandabage & Mackintosh, 2005; HERA: 2006; Save the Children: 2005; Euro Health Group (2006) RAWG: 2004). In addition to these direct costs, there are a range of other costs which patients or their carers have to bear. These include transport, purchase of medicine, and provision of items such as gloves for women who are delivering as well as, in some cases, bribes and similar under-the-counter payments. These costs have the potential of inhibiting access by the poor to health facilities. Several studies confirm that cost is not the only barrier to access to quality health services. Additional barriers include inadequate information, health care seeking practices where people do not seek care as soon as they should, or turn to non-quality sources of health care and lack of trust (ibid.).

The exemptions and waiver policies regarding fees described above in respect of the SAP era have remained, as do the problems with implementation. Above it was suggested that the exemptions are implemented more readily than waivers. However, even with the former, there are problems. Thus, for example, a recent evaluation (Health Research For Action (HERA), 2006) revealed that faith-based organisations (FBOs) were reluctant to give exemptions to patients in the specified categories because they were not reimbursed for the foregone income. This disadvantaged rural Tanzanians living in areas served by the FBOs. There are also problems in identifying the aged given lack of proof as well as lack of support from health staff.

The Views of People Survey (REPOA: 2007) revealed that nearly half (48 percent) of all the elderly surveyed were not aware that they were entitled to free medical treatment in government facilities. Furthermore, of those who sought medical treatment during the months preceding the survey, only 10 percent received free medical treatment. Reasons given for not receiving free services included lack of money to pay for services (18%) and lack of proof of their age (13%). In some cases these elderly people are themselves care givers, which doubly disadvantages them if they fail to get access to free medical care for themselves.

The waiver system is even more problematic. The criteria to be used for waiving of the user fee are left to the discretion of the health facility or community leadership. There have been problems of defining the poor in a context of widespread poverty. Additionally, many of the poor are not aware of their rights to free services.

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The review of exemptions and waivers done by the Euro Health Group in Tanzania (2006) made the following observations:

- Exemptions might benefit the better off more often than the poor, most of the exemptions are for children under five, chronic diseases and pregnant women which are the highest cost items; many of those exempted belong to households which would be able to pay the public services fees or for community health fund (CHF).
- The poorest who are not able to pay often do not have access to waivers; either due to lack of information and /or denial of the waiver by a provider
- Waived patients experience stigmatization and are disadvantaged while attending health services compared to those who pay for services.
- With the introduction of user fees and CHF at primary level of care, there is the risk that access of the poorest to essential health care is substantially decreasing
- Identification/application procedures and screening criteria for waivers are unclear
- The exemption and waivers procedures have loopholes that allow the misuse and sometimes abuse of the system.
- There is a potential conflict between the attempt to generate revenue and protection of the vulnerable (Euro Health Group (2006) pg.8.

Health insurance schemes

The

above discussion has focused on financing of government expenditure on health care. Another angle is to consider how households cover the financial costs associated with health care, and the extent to which the various forms of cover are subsidised by the state, employers or other actors i.e. who ultimately bears the costs. This section thus examines the National Health Insurance Scheme, the CHF and micro-insurance schemes.

National Health Insurance

In the early 1990s, the Ministry of Health (MOH) started exploring possibilities for the development of health insurance as a long-term health care financing mechanism for Tanzania. This resulted in the establishment of a mandatory National Health Insurance Scheme for formal sector employees starting with the government sector. The scheme started operations in 2001.

When the NHIF was introduced it was, amongst others, envisaged that it would improve the revenues from cost sharing in government facilities by providing a channel for formal sector employees to contribute to the financing of health care services. At the same time it was envisaged that it would provide a conducive environment for the growth of the private health care sector as those covered by the scheme would be better able to afford private services. It was also seen as a mechanism for enhancing equity among formal sector employees by increasing access to private facilities and through channelling increased funding to rural facilities to increase access to quality services. As a spin-off other users would also benefit from increased quality (Ramadhan 2006).

In reality, the scheme has had limited success in achieving these goals. The National Health Insurance scheme still covers civil servants only. By the end of 2004, the Fund had registered over 240,000 public servants as contributing members including 900,000 dependents. This means that the Fund is catering for only just over 1.1 million beneficiaries in the country. It thus covers about 3% of the total population but has a target of eventually enrolling 15% to 20% of the total population (HERA, 2006).

The total contribution per employee amounts to 6% of gross salary, equally shared by the employer (government) and the employee. These contributions have given the NHIF a large surplus. In the financial year 2004/05, contributions collected amounted to Tshs 24 bn, with claim reimbursement totalling 4.9 billion – only about a fifth of total contributions. There is currently no mechanism to use surplus funds to meet the challenges which the health sector is facing.

The payments made by the fund for services should, in theory, increase the funds available to government facilities when the fund covers the user fees at these facilities. However, the Annual Joint Review of the Health Sector (2005) notes that the NHIF is a negligible source of funding at dispensary level. This is likely due to the fact that dispensaries provide only limited services and appear especially hard hit by the lack of resources in the sector including lack of qualified personnel (Annual Joint Health Sector Main Review 2005). Because of these limitations, most NHIF members prefer to use other health facilities. NHIF reimbursements are therefore predominantly made to hospitals, suggesting considerable bypassing of lower level health facilities which are more accessible to the general populace and, if adequately funded, would contribute more than hospitals to equitable access to care and treatment.

The civil service members of the fund, over half of whom are teachers, have a range of complaints about the fund. The scheme covers up to four children or dependents and members complain that those with more than four dependants therefore have to pay user fees for each additional dependent. The scheme also does not extend cover beyond three months after the date of retirement, after which the individual must take care of her/his own health cost and those of dependent members of the households. Members also report delays in issuing of membership cards thus delaying access to care and inequities in the type of facilities that can be accessed due to lack of specialised services in rural areas.

In reality, however, the NHIF members are privileged compared to their counterparts in the private formal and informal sectors as well as compared to those in subsistence agriculture as government, their employer, is in effect subsidising the health care of government officials through their part of the contribution. Upon retirement however, the individual does not enjoy these rights, and hence might easily fall under vulnerability in the cases of those who occupy low status in the government service. Ex members of the funds are hence likely to be a burden to their households in the event that they contract the HIV&AIDS related disease and are forced after a long illness to quit formal employment.

Community Health Fund

The Community Health Fund (CHF) is a decentralised voluntary health insurance (pre-payment) scheme which was first tested in Igunga district in 1996. Membership benefits cover the cost of accessing basic health care services in the existing facilities. Benefits do not cover access to referral national hospitals. The membership fee covers only a fraction of the cost of this benefit as the government through the local councils is supposed to provide a matching fund in order to cover the rest of the needed cost.

The Ministry of Health aims to set up CHFs in all 124 districts, but as of 2007, only 68 funds were operational (REPOA, 2007). The scheme targets members from the formal and informal

sectors, and is designed to include the poor. Village councils are supposed to enroll poor members of the community and waive contributions by them, seeking compensatory funding or sponsorship from other sources and with district councils subsidising the poor members of the community. In practice, subsidisation has not been functioning.

In districts where the CHF operates, citizens are given two choices. If they choose not to join the CHF, they must pay an out-of-pocket (user fee) flat rate per each episode of illness for which they attend a public facility. Alternatively, they can pay membership fees for the CHF and not have to pay the user fee. The level of the fee varies from one district to the next, and at times also within a district, with a typical fee being Tshs. 1,000. Under the CHF option, each district identifies a flat rate premium, which ranges from Tshs 5,000 to Tshs. 10, 000 or more per annum, to cover a specified (but varying across districts) maximum number of members per household. The district determines the levels of contribution, maximum number of members to be covered and other modalities.

The district council is also supposed to put in place mechanisms to identify community members who deserve a waiver or exemptions. CHF guidelines are very clear on waivers and exemptions, which mirror those for public facilities. Thus pregnant women, under five year-old children, senior citizens over 60 and HIV&AIDS patients are supposed to be exempted from CHF and user fees. The waiver is applied using a poverty index established by the district council. Ideally, the CHF could thus provide an alternative mechanism for cost sharing without compromising the well being of the poor and vulnerable. However, the CHF exhibits the same problems in respect of waivers and exemptions as described above for user fees.

A study conducted by Mushi (2007) in Iringa revealed that majority of people preferred the user fee to the CHF because of the cost of the latter and the fact that it requires a once-off lump sum payment. Under the CHF scheme in Iringa and Kilosa, households that join the fund pay a fixed annual premium of Tshs. 5,000 for free access to health services for a maximum of 10 members of households. Alternatively, individuals who are non-CHF have to pay a fixed amount of Tshs. 1,000 per visit in public health institution for each episode of illness. The study revealed that the scheme was found to be too expensive for the poor as they were unable to come up with the lump sum required for the CHF payment. In some cases this meant that by the end of the year they had paid more than they would have if they have paid the lump sum, but were more able to do this because the costs were spread throughout the year. Other reasons for not becoming members related to quality of care and choice of facility. To address the lump sum issue, some districts have experimented with flexibility in mode and time of payment. The fact that the membership fee is the same for all members rather than calculated as a percentage of income might be thought of as regressive. This is, however, probably less of a problem than it might be in other situations in that in most communities there would not be the significant differences in income found elsewhere, and the poorest should, at least theoretically, be able to access the waiver system.

A study conducted by Partners for Health Reform^{plus} (PHR^{plus}: 2005) revealed that, except in respect of dispensaries, CHF members who were HIV-positive incurred a higher cost per admission than HIV-positive non-members, as illustrated in the table below.

Table 2: Average Cost of Care for PLWHA per Visit and per Admission by Care Setting and CHF Membership Status

	CHF members		Non-CHF members	
	Tshs.	N	Tshs.	N.
Out-patient costs				
Dispensary	1,835	323	1,900	309
Health centre	2,680	215	2,116	309
Hospital	7,714	2	2,525	22
Average total cost per visit	2,193	540	2009	538
In-patient cost per admission				
Dispensary	N/A		N/A	
Health Centre	6,348	33	6,399	39
Hospital	4,530	3	3,655	50
Average total cost per admission	6,195	36	4,858	89

Source: RHRplus, 2005:16)

Although the differences between non-members and members for out-patient cost per visit are small, the difference in average cost for in-patient care is large, although based on relatively small samples and without any indication in the table of the length of in-patient stay. Overall, CHF members incur a higher cost per admission than non-members – at Tshs. 6,195 as opposed to Tshs. 4,858. The disparity is largely a result of the type of facility where the in-patient care takes place in that non-members were far more likely to report using a hospital rather than the more costly health centres. The cost patterns are counter-intuitive in that hospitals usually have better resources than health centres. The patterns cannot be explained by length of stay because, as seen below, non-members tended to have longer stays than members.

Access to health facilities is also influenced by cost of the drugs, as well as availability and cost of transport to and from the health facility. The *PHRplus* (2005) study found that the average cost of drugs per admission for HIV patients was lower for the CHF members than for non-members at the health centre and hospital. This was largely because the average length of stay for CHF members was 8.9 days compared to 10.5 days for non-members. The lower cost was also attributed to lower consumption of drugs in that CHF members tended to receive care at an earlier stage in the disease's progression much earlier than the non CHF members and hence required less expensive intervention. However, the inability of the majority of community members to afford the CHF premium meant that they had to accept the short-term gain of saving on this expenditure and suffer the long-term effect of delayed access to services.

Such delays probably also explain the fact that CHF members accessed out-patient services on average 2.5 times per year while non-members did so 2.1 times. CHF members also used out-patient services 19% more often than non-members. This difference in utilisation was statistically significant. Members and non-members also used out-patient services differently: the average number of revisits was 1.8 for members versus 1.6 for non-member. These findings suggest that the CHF facilitates access. If, however, it remains unaffordable to the majority of people, it cannot make significant inroads in addressing the care needs associated with HIV&AIDS and other illnesses.

Government is keen to scale up the CHF. At present the scheme to some extent aggravates inequities in that better-off districts tend to have more CHF members, perhaps because citizens are more able to afford the upfront payment and because facilities are better able to provide

quality care. The inequity comes in because it is these better-off districts that are currently benefiting from government support through the matching grants discussed in the previous sections of this report

All in all, the CHF scheme which was conceived as a scheme to facilitate poor people's access to health facilities has not realized its initial goals despite the potential which it has. Membership rates are still very low in most of the districts where the scheme has been operating. This is attributed to a number of factors. In the first place, the modality of payment of a lump sum is not affordable for the majority of the people and especially women who control fewer resources at household level. Secondly, CHF membership does not cover referral level where costs are higher and it is needed most. Thirdly, in some instances, there are cumbersome and bureaucratic procedures for accessing benefits (Uro Group, 2006). Finally, the poor quality of services at lower levels discourages community members who can afford to contribute to the fund from joining the scheme because they have possibility of accessing better-resourced facilities owned by voluntary agencies or private for profit organisations.

Micro-Insurance Schemes

In addition to the CHF, there are several micro health insurance schemes which are run by faith-based organizations, informal groups and associations. One example of such schemes is VIBINDO, which is registered under the Societies Act, and is an umbrella organisation of informal sector operators based in Dar es Salaam. Other similar schemes are emerging among farmers' associations and cooperatives.

The micro health insurance schemes aim is to expand coverage to include the working poor, particularly those working in informal sector, as they are not covered by formal insurance schemes. However, the coverage of these schemes is limited, there is as yet no regulatory framework in place, and there is no government oversight to ensure minimum protection of the members. The schemes also do not have the benefit of accessing public funds in the same manner as the formal schemes.

Social Security Schemes

In addition to schemes with a direct focus on health, there are a number of other social security schemes that could assist some of those affected by HIV&AIDS in monetary terms, and could be of assistance to far more people if they were extended beyond government employees and the formal sector. In addition to the National Health Insurance Fund, there are a further six social security institutions, namely the National Social Security Fund (NSSF), Parastatal Pension Fund (PPF), Public Sector Pension Fund (PSPF), Local Government Provident Fund (LAPF), Government Employees Provident Fund (GEPF) and Zanzibar Social Security Fund (ZSSF) (Ramadhani, 2006: 3). Together, these schemes are estimated to cover only 4.8% of the labour force and less than 1% of the population. And it is only the NSSF that has offices in all regions of the country. The rest have offices only in Dar es Salaam or Dodoma.

The National Social Security Fund (NSSF) covers (formal) private sector employees, except those owned by para-statals and organized groups such as cooperatives. Domestic workers are also excluded. Benefits are provided for old age, survivors, invalidity, maternity, funeral costs, health care and employment-related injury (www.nssftz.org/member/rights). The levels of

benefits vary according to the amount contributed by the member. The survivors, invalidity, funeral and health care benefits could conceivably be of assistance to those affected by HIV&AIDS.

In 2001, the NSSF conducted a research study whose primary objective was to ascertain how social security could be extended to the informal sector (URT: 2003 a) The study revealed that 91.9% of workers in the informal sector knew of the existence of the NSSF scheme, and 54.8% were willing to join the scheme. Furthermore, more than half had income equal to or above the minimum statutory wage, and 21.8% were willing and able to contribute an amount equal to 20% of the statutory minimum wage or more. This suggested that there is a real potential for increasing coverage of the workers in the informal sector. The study pointed out that there is a wide spectrum of social security demand ranging from old-age benefits to social protection extension in the education sector. The latter would include school fees for orphaned children or those unable to meet all the cost of education including food aid, uniform, and basic needs. The study recommended that workers in the informal sector be registered on a voluntary basis with a pre-condition that the members are able to meet their obligations. To date, this recommendation has not been implemented.

In the absence of such extension, the majority of Tanzanians are not covered by social protection. The small proportion covered and their families have access mainly to short-term benefits because most benefits cease when employment ceases. In particular, for those offering health insurance, this ceases once the member retires or leaves work for another reason, including ill-health.

HIV&AIDS Policy

In 2001 the Government of Tanzania issued the National Policy on HIV&AIDS. This policy aimed to promote early diagnosis of HIV infection through voluntary testing, with pre- and post-test counselling (VCT) as well as prevent infection through PMTCT. The policy openly admits that government cannot alone address the issue: “It is beyond the capacity of the Government to provide adequate funds for the National Response Programme. Therefore the development partners and the private sector also share the responsibility and moral obligation to complement the government” (URT, 2001: 11). This formulation does not, however, acknowledge the unpaid work and monetary contributions of households

In December 2002, the Tanzania National AIDS Commission (TACAIDS), in collaboration with the Ministry of Health, developed the first National Multisectoral Strategic Framework on HIV&AIDS 2003-2007 (NMSF). The NMSF translated the National HIV&AIDS policy into concrete programming. The NMSF identifies gender equality in access, care treatment and support as a cross-cutting theme. It emphasises the right to health protection stressing the rights of the PLWHAs. It urges the public and private sectors and local and international NGOs to initiate interventions aimed at addressing four themes, namely: prevention, care and treatment, impact mitigation and enabling environment.

In 2003, the Ministry of Health elaborated the Health Sector HIV&AIDS Strategy for 2003-08, which became the basis for the design of the National Care and Treatment Plan for People Living

with HIV&AIDS (URT: 2003 b) . The plan has the following aims: to provide quality, continuing care and treatment to as many PLWHAs as possible, to contribute to health system strengthening efforts (through expansion of health care personnel, facilities and equipment and comprehensive training in the care and treatment of PLWHAs); to foster information, education and communication (IEC) efforts focused on increasing public understanding of care and treatment alternatives, reducing the stigma associated with HIV&AIDS and providing ongoing prevention campaigns; and to contribute to strengthening social support for care and treatment of PLWHAs through home-based care (HBC), local support groups and treatment partners.

The second NMSF (2008-2012) builds on the first NMSF but adds some new priority areas. The new priority areas include the Most at Risk Populations (MARPs), which are defined as those vulnerable due to gender inequality, sexual abuse, socio-cultural factors, women engaged in commercial sex, sexually abused children, widows, and divorcees, men having sex with men, prisoners, refugees and displaced people, people with disability and intravenous drug users. Compared to the earlier NMSF, the second NMSF has a greater focus on prevention, and stresses the need to achieve a balance between treatment, care and prevention.

In all the policy frameworks, HIV&AIDS is considered as a cross cutting issue which must be mainstreamed in all sector policies in line with a multi-sectoral approach.

Provision of Resources for HIV&AIDS Interventions

The Government of Tanzania has mobilised resources from its own central budget as well as from development partners to support HIV&AIDS-related activities in four main areas, namely: combating HIV&AIDS, preventing the spread of the HIV&AIDS infection, care and treatment, and economic and social support to HIV&AIDS-affected. Each of these areas is relevant from a care perspective. Effective prevention, for example, will reduce the need for care, while equitable access to care and treatment will reduce the amount of unpaid care that must be provided in the home as well as the costs associated with accessing care. Availability of testing and counseling will encourage people to test early, and thus avoid their becoming too ill before accessing treatment. Economic and social support will strengthen the ability of families to provide for the care and other needs.

The NMSF 2008-2012 draws on the Multi-Sectoral HIV&AIDS Public Expenditure Review to show patterns in HIV&AIDS funding. The analysis reveals that government recurrent spending on HIV&AIDS nearly doubled between 2004/05 and 2005/06. The development partners accounted for nearly 90 per cent of total public expenditure on HIV&AIDS in 2005/06 if off-budget spending was included. The total expenditure on HIV&AIDS including donors off-budget spending was nearly 5 per cent of total government spending.

The table below shows total government and donor expenditure increasing almost ten-fold over a period of four years, from Tshs 47.06 bn in 2002/03 to 406.67 bn in 2006/07. The percentage attributable to donors fluctuates somewhat from year to year, but is more than 84% throughout the period. HIV spending as a percentage of total government spending reaches a peak of 7.5% in 2005/06, decreasing slightly to 5.63% in 2006/07. Mamdani & Omondi (2008) note that these figures represent an under-estimate of total expenditure in respect of HIV&AIDS as they do not

include significant spending on HIV&AIDS financed from the health basket fund, as well as expenditure funded from local government's own revenues. The estimates also exclude the 40% share of health personnel costs estimated to be accounted for by HIV&AIDS and related hospital and medicine costs.

Table 3: Trends in Source of Public Expenditure on HIV&AIDS (Tshs.billions)

	Actual 2002/03	Actual 2003/04	Actual 2004/05	Actual 2005/06	Budget 2006/07
Total govt. and donor expenditure	47.06	61.3	148.43	290.84	406.67
Government	7.1	8.1	12.6	35	60.3
Donors	39.96	53.2	135.83	255.84	346.37
Donor spending as % of HIV spending	84.9	86.8	91.5	88.0	85.2
HIV spending as % of total govt. spending	2.47	2.91	4.56	7.52	5.63

Source: NMSF (2008-2012): 23

What is not shown in the table is the division within donor spending between on-budget and off-budget expenditure³ Despite international statements about new aid modalities such as budget support, as elsewhere in the world a large proportion of the HIV&AIDS funding is off-budget. The percentage off-budget also seems to be increasing over-time. In 2005/06, 47% of expected aid was included in the government budget produced by the Ministry of Finance. For 2006/07 the percentage was only 23% (Mamdani & Omondi, 2008). The fact that much of the HIV&AIDS funding is of US origin, and the US's resistance to the new aid modalities, partly explains this pattern.

The donor contribution is dominated by a small number of development partners, namely the Global Fund for HIV&AIDS, TB and Malaria, the World Bank Tanzania Multisectoral AIDS Project (TMAP) and the Presidents Emergency Plan Fund for AIDS Relief (PEPFAR). Together these three sources account for 86% of donor support in 2007/08 with the percentage expected to reach 90% of the total for 2008/09. Further analysis show that care and treatment account for 64% of combined US and Global Fund spending in 2006/07, prevention was just 15% of total expenditure, and economic and social support about 8%. Spending on care and treatment by these two donors alone represents 55% of all expenditure on HIV&AIDS in 2006/07.

The concern here is that donors have not made long-term commitments, and that they could change priorities in funding at any time in line with their own national priorities and funding policies. This creates challenges for sustainability. It is of particular concern given the long-term nature of HIV&AIDS and the fact that much of the support is for ARV therapy. Stated bluntly, once a person is receiving ARVs, stopping the treatment constitutes a death sentence – and would quickly impose a care burden on the household.

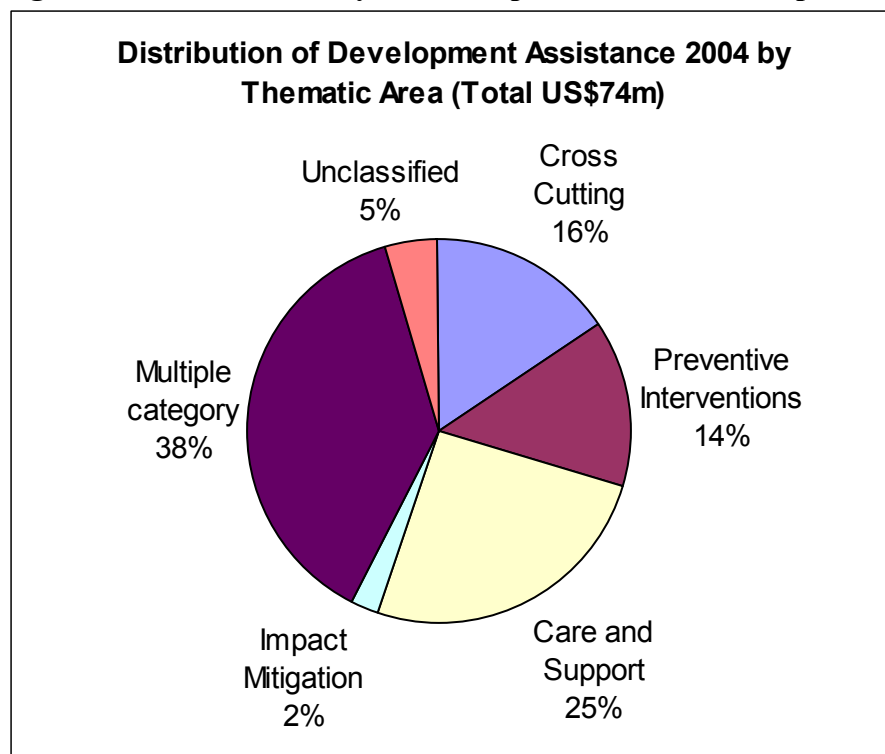
Donor dependency also poses a problem in terms of government accountability for addressing the HIV&AIDS pandemic. Practically, it is difficult for a government to be accountable for allocation and expenditure if the bulk of money is coming from external sources, and much of this is not directly channelled through the government budget.

³ on-budget expenditure refers to the budgetary expenditures mainstreamed in the core government budget, while off-budget expenditure refers to expenditures which were not revealed in the core government budget.

Functional analysis of money allocated for 2005/06 reveals that more than half (56%) of the Tshs. 68.3 bn was marked as “multi-purpose”. This is unhelpful as it gives no real sense of how this money will be used. In addition, 35% of the total is allocated for care and treatment, only 8% for prevention, and a paltry 1% for mitigation (URT/NMSF, 2007). A further concern from our perspective is that while care and treatment are allocated over one-third of the resources, this category does not necessarily include home-based care. It relates to more conventional types of care provided in hospitals and health centres.

Functional analysis of donor funding for 2004/05, as shown in figure 2, shows 25% going for care and support, 14% for prevention and 2% for impact mitigation. As with overall funding, large amounts are allocated for amorphous categories – namely 38% for “multiple category”, 16% for “cross-cutting” while 5% was unclassified.

Figure 2: Functional Analysis of Prospective HIV Donor Spending FY 2004/5



Source: URT/NMSF, 2007

Large allocations to categories such as “multi-purpose” and “cross-cutting issues” leave room for diverting such resources to non-priority activities. They also reduce accountability of government and donors.

Analysis of sectoral distribution of HIV&AIDS money reveals that approximately 90% of government expenditure on HIV&AIDS is accounted for by only three agencies: Health (49%), TACAIDS (30%) and the Ministry of Education and Culture (11%). For aid resources captured in the budget the pattern is similar. The same three agencies combined account for 97% of aid captured in the Accountant General’s System. (URT/NMSF: 2007).

The fact that the Ministry of Health gets the lion's share of the resources allocated for HIV&AIDS could undermine the multi-sectoral approach to the pandemic as well as undermining efforts to mainstream HIVAIDS in all sectoral activities. It also over-emphasises the medicalisation of HIV&AIDS intervention approaches. This could hamper initiatives to address the non-medical factors contributing to the spread of the HI virus.

However, even with this concentration, the resources are insufficient to meet the health and medical needs. Of the health allocation, the largest portion is for strengthening referral hospitals. The priority accorded to referral hospital is not in line with the observations made in the Poverty and Human Development Report of 2005 about the under-resourcing of primary health care and the need for urgent measures to arrest further deterioration of these services (Health Equity Group 2006/07). The primary health facilities are the most accessible for communities and, if properly resourced, can contribute significantly to the continuum of care for PLWHAs.

A further problem, not reflected in the aggregate statistics, is inequitable geographical distribution. For example, the Global Fund's money is allocated to only 40 of the 126 districts in the country. Further, very little is allocated to local government; despite statements that it is there that activities should be concentrated.

As noted above, the current NMSF 2008-2012 places greater emphasis on prevention, naming it as priority number one. The NMSF notes that prevention efforts will be targeted to the younger generation (10-24 years old) with emphasis on keeping young people free from HIV&AIDS. Targeting young people is likely going to reduce number of new infections, a factor which will likely reduce the number of people needing care at household level. However, prevention efforts will need to encompass a range of interventions, including making condoms freely available at accessible outlets, life skills programmes in schools, making schools a safe place especially for young girls, effective control and management of sexually transmitted infections, and addressing gender-based violence and inter-generational sex.

The above paragraphs focus on financial resources. In terms of human resource for HIV&AIDS, the most recent NMSF (2007) notes that there are approximately 19,696 workers in the various central government agencies and local government with some skills in HIV interventions. These workers are considered as the potential drivers of the HIV&AIDS interventions in the agencies. Furthermore, the private and informal sectors have been implementing workplace programs while civil society organizations (CSOs) and FBOs located in villages and communities have community-based interventions. While some human resources thus exist, the NMSF notes that overall there are insufficient personnel skilled in HIV interventions.

The HIV&AIDS Care and Treatment Plan (2003-2008) estimated the specific staffing needs of the ARV programme plan (2003-2008) through tracking the number of patient contact minutes for each member of staff. Staff included in the calculations were prescribing clinicians, evaluating clinicians, treatment counsellors, lifestyle counsellors, pharmacist, phlebotomist and laboratory technicians, with lifestyle counsellors accounting for 35% of the total and evaluating clinicians for 27%. The full-time equivalent (FTE) total (new) need across all categories

combined was estimated to increase from 459 in year 1 of implementation to 3,014 in year 5. The cumulative FTE total in year 5 stood at 9299.

The model was based on the premise that all staff work 200 days per year, and that prescribing and evaluating clinicians would see patients for four hours per day, while the remaining staff would see patients for 8 hours a day. During the first year, an infected and symptomatic person with CD4 count less than 200 would require 90 minutes for prescribing clinician, 150 minutes for evaluating clinician, another 150 minutes for treatment clinician, 480 minutes for lifestyle counsellor, 155 minutes for pharmacist, 35 for phlebotomist and 65 for lab technician, giving 11,125 total minutes for the year. Similar estimates were derived for those with higher counts.

The estimates indicate the size of the extra demand for professional staff created by ART. This area of treatment is especially important given, on the one hand, its ability to effect radical improvements in the health of infected people and, on the other hand, the extent to which the treatment is dependent on donors' continuing to provide aid in this area.

The NMSF (2007) notes that the projected number of staff needed over the five-year period for treatment plan is more than the number of medical officers, pharmacists, medical laboratory technicians and registered nurses produced over the period 1999-2003. The estimates are based on the assumption that staff with the corresponding skills and qualifications is available. In practice, however, the majority of facilities have neither the required number of staff nor the required specialisations. The few available workers then become responsible for all tasks and are often forced to work over time without the additional remuneration. The HERA (2006) evaluation revealed that there had been an increased work volume in laboratory services and counselling in particular, with counsellors doing an average of 45 minutes of unpaid overtime every day, and paying approximately US\$7 a month out of their own pockets to help patients.

More generally, the HIV&AIDS pandemic places enormous stress on a health sector which would have serious workforce and other resource problems even in the absence of the pandemic. The NMSF (2007) notes that the projected costs of ART are many times higher than current per capita expenditure in health. It notes further that the budget for ARVs has increased to almost the same size as the MOHSW budget for drugs.

In terms of human resources, while the HIV&AIDS pandemic creates ever-increasing demand for health services, the total health workforce declined by 28% from 67,600 in 1994/95 to 48,500 in 2000/01, and by a further 10% to 43,640 in 2005/06 (ibid). Increasing demand for HIV&AIDS-related services in a situation of decreasing human resources is likely to result in poor quality services and bad treatment of patients and their families by staff operating under severe strain and with unmanageable workloads. The shortfalls in professional skilled staff shift the burden further onto the shoulders of household members, particularly women.

The increasing demand for HIV&AIDS-related services also places pressure on delivery of basic general health services. This is not helpful for the general health and well-being of the population, and the sustainability of health infrastructure and services. It is not helpful in terms of the pandemic's progression, in that a person's susceptibility to infection and prognosis once infected is heavily influenced by general health status. Decreased resources for primary health

care also means that care for non-HIV-related illnesses is likely to be increasingly shifted onto the household.

The HERA (2006) evaluation found that the wards most affected by HIV&AIDS were medicine, paediatrics, surgery and psychiatry in that order. Medical and other wards found that at least half of their patients were admitted for HIV-related conditions, while some medical staff were themselves affected by HIV. Hospital budgets are meanwhile overstretched, with the financial burden exacerbated by the fact that HIV patients are often exempted from payment. Available resources for care for patients are further reduced when hospitals have to pay for ill staff and funerals. The result is inevitable a reduction in the quality of care.

Delivery of HIV&AIDS Services and Interventions

The Tanzania Service Provision Assessment Survey (TSPA) (National Bureau of Statistics, 2006) collected data on health services, including HIV&AIDS-related services, from a representative sample of 611 health facilities throughout Tanzania. The sample covered all levels of facilities, from dispensaries to hospitals, and included facilities operated by different managing authorities, including government, private for-profit, para-statal, and faith-based organizations. The results thus provide a useful picture of service provision.

One of the objectives of the survey was to assess the strengths and weaknesses of the infrastructure and systems supporting the various health services.

In respect of HIV&AIDS, the TSPA study revealed that workers in government, private and faith-based institutions were exposed to “hospital acquired infection” due to lack of infection control facilities. One of the least available infection control facilities was running water. Additionally adequate waste disposal systems for infectious waste and sharps waste were available in only about a third of all facilities, and in about half of private for-profit and faith-based institutions (NBS, 2006: 8). In facilities which do not have running water, health workers sometimes demand that relatives of patients bring water for the use of the patients.

The survey revealed that only a quarter of all health facilities, and only one-fifth of government facilities, could conduct HIV tests on-site or in an affiliated laboratory, or had some other system of obtaining test results so as to follow up with the patient. The report notes further that only 15% of men and women in Tanzania have ever had an HIV test. These patterns must be read against the NMSF’s (2007) report that 1,027 voluntary testing and counselling (VCT) sites had been established such that each district had a minimum of three VCT services.

ART has the potential to significantly reduce the care burden. Although the medication does not “cure” AIDS or remove the HIV infection, it generally allows the infected person to remain healthy for an extended period of time. ART was first introduced in Tanzania in 2004, yet by 2006 only 4% of all facilities prescribed ART, and 70% of these were hospitals. Faith-based facilities were more likely to offer ART than government and private facilities. The National AIDS Control Programme (NACP) of the Ministry of Health and Social Welfare has plans to make ART to all in need by 2012. The number of patients to be reached with ART is expected to increase to 600,000 by 2012, and the expansion would include 500 primary health care facilities,

health centres and dispensaries. The NMSF of 2007 records a total of 200 clinics providing ART, 1,427 health care workers trained on ART management, and 125,139 PLWHA receiving the drugs.

The most recent TACAIDS progress report (TACAIDS, 2008:25) indicated that by end 2007, about 20 per cent of adults and children with advanced HIV infection were receiving ART. This leaves 80% of seriously ill people who are likely to be a burden to household carers.

As noted above, many Tanzanians rely on traditional healers for health care. Some of these healers claim to be able to improve the health of those who are HIV-positive, including increasing the CD4 count. In a discussion with healers, they said that it could take up to six months before the CD4 count improved and that the cost of the full treatment was between Tshs. 300,000 and 400,000. Because of the cost, the traditional healers admitted that they have few clients who are able to afford the treatment whether paying in cash or in kind.

The Joint Evaluation of the Health Sector in Tanzania 1999-2006 (COWI, 2007) summarises the key challenges facing HIV&AIDS interventions as follows:

- Coverage of HIV&AIDS services is low compared to the needs. Although services appear to have increased over the past five years, most of the services are urban-based, and rural areas remain largely uncovered by prevention, care and treatment services.
- Poor health infrastructure compounded with poor management and planning result in service bottlenecks for laboratory, logistics and patient referral.
- Skilled human resources to deliver the services are in short supply;
- There is low participation of male users in HIV&AIDS services. The reasons for this are not explained in the report, but could include the fact that women would be automatically tested when presenting themselves for antenatal services, while there is no equivalent automatic testing for large groups of men. Lesser utilization of men has also been found in other countries such as South Africa and could relate to men's willingness to acknowledge that they might be infected and need assistance.
- Stigma and discrimination prevent uptake of the available testing and counselling services.
- Coverage of PMTCT services is low, in part due to low rates of hospital delivery.

These observations suggest that individuals and their immediate household members are carrying a heavy burden of the impact of the HIV&AIDS pandemic. At household level, the burden falls disproportionately on women who constitute the majority of care givers.

Home Based Care (HBC) Services

Home-based care is of particular interest for the UNRISD project as it represents an interface between “external” provision of care and the care that is provided by the household. In addition, the people “employed” as home-based carers or community health workers by organizations and sometimes by government are generally ordinary community members. Finally, these workers often work unpaid or, where they are paid, receive small amounts or items such as uniforms and equipment rather than full wages. In this way, too, their work falls somewhere in between unpaid care work and professional paid care on the care continuum.

From the government perspective, HBC is important because of the inability of the formal health care system to cope with the additional burden of HIV&AIDS when it was unable to cope with basic health needs even without the pandemic. While government strongly advocates home-based care, it does not provide funding for actual delivery beyond, perhaps, referral and linkage to existing services. The costs are borne instead by the non-governmental, faith-based and community organisations that provide these services, as well as by community members who do the work, generally on an unpaid basis or for low allowances. For government, then, HBC seems a cost-effective option that relieves facilities and staff and reduces costs.

HBC will be one of the foci of Research Report IV, and this report therefore does not go into great detail on the topic.

In 1999, the Ministry of Health in collaboration with TACAIDS put in place Tanzania's National Guidelines for Home Based Care. According to these guidelines, PLWHAs are entitled to: (i) referral to care facilities, provision of drugs and equipment, (ii) care by community health workers (CHWs) and (iii) support for primary care givers within the family. Later guidelines of 2005 list the following components as the minimum package of services for the HBC programme: (i) access to counselling and testing, (ii) all elements of palliative care (iii) a functional referral system, (iv) ensuring the patient's medical adherence, (v) psychological support, (vi) nutritional guidance and food support, (vii) care of primary care givers, (viii) a reporting system, (ix) prevention through information and communication, and (x) PMTCT and access to condoms.

The HBC is premised on an assumption that the referral system, communication and resources will be available to and reach individual households with PLWHA. The central level is charged with policy making and providing guidelines to ensure quality of care, development of a monitoring and evaluation mechanism and ensuring pre-service training. The regional level is charged with interpreting the HBC guidelines, linking the district and central level, and facilitating efforts for improving nutrition and care and support for the chronically ill. The district level is supposed to implement the HBC policy guidelines, integrate the HBC activities in council activities, conduct the required training and support activities to improve nutrition, as well as monitor and evaluate. The national level consultancy hospitals are to handle complicated cases emerging from medical-related problems. Finally, the family level is charged with the main responsibilities of care, through identifying caregivers, and providing emotional and material support, including taking patients to hospitals and clinics. This assumes that the family will have sufficient resources needed including human resource for the care of people living with the virus.

The HBC program receives very limited resources from either central government allocations or donor funding. Between 1% and 2% of total government and donor funding is allocated to the HBC programme activities. None of this is allocated to individual households.

A mapping study of community HBC services in five regions of the Tanzania mainland by Pathfinder (2006) identified several challenges. While the majority of the ill people interviewed in the study reported having a person to care for them, a third of the respondents did not have caregivers. There were some reported cases of relatives and spouses giving up on a patient after a

prolonged period of sickness. Other cases involved patients who had been forced to relocate from their original family homes and hence relying upon neighbours. There were extreme cases of patients who were reported to be desperate as they did not have place to sleep, food and anybody to care for them. Poverty was identified as one of the main reason for lack of caregivers.

In terms of services, 40% of the organizations covered in Pathfinders' study provided HBC, while 53% provided services that were supportive to HBC. The range of services provided was extensive. Just over a third (35%) of the organizations provided HIV&AIDS information, income-generating activities and VCT. About one tenth offered food to PLWHA and their families. Fewer organizations provided ARVs and fewer still offered training on how to write a will.

The study established that faith-based organisations provided significant support to PLWHA, beyond the traditional spiritual support. This was particularly the case in Arusha and Kilimanjaro where church-related women's groups provided significant support to PLWHA, while in Tanga the Anglican Church and Mosque women's groups provided regular support to PLWHA through providing them with food, clothing, as well as support for schooling of orphans.

Support to PLWHA preparing for death was found to be limited in the five regions. The referral system, even where it worked, was complicated by lack of money to cover transport costs. Time, money and opportunity costs were increased by the fact that patients referred to hospitals generally had to be escorted by a family member, CHWs, or relative. The challenge of transport costs was confirmed in the focus group discussion the author had with some nurses in one of the VCT facilities in Dar es Salaam.

Pathfinder found that in some cases PLWHA had been trained to provide HBC. This phenomenon was also confirmed in an interview with the organization Service Health Development and Education for People Living with HIV&AIDS (SHDEPHA). Problems repeatedly mentioned by care providers within the family included lack of training, lack of emotional support, the workload, and the expectations from the rest of the family.

In their annual report for year 2007, TACAIDS claim to have trained 6,800 community health workers, including 5400 community-based and 1400 HBC workers (TACAIDS: 2007). This number is small compared to the needs and TACAIDS acknowledges that caregivers are few and under-capacitated.

In a focus group discussion conducted by the author with care providers of SHDEPHA home-based care providers indicated the time taken to offer care as being an issue. The Tumaini HBC project notes the same problem. According to reports from Care International, Tumaini's care is generally provided by volunteers who are accompanied by a staff member for technical support. HBC volunteers typically carry a caseload of 10-15 households and report spending 15 minutes to one hour per visit, with a frequency of visiting households of one to two times per week. The frequency and length per visits are driven by the sick person's needs. The Tumaini volunteers estimate spending approximately eight hours in a typical week on this work without any compensation for their time. They do this in addition to carrying their own domestic workload.

In a few cases the HBC workers are given a small token payment which hardly covers the fare to and from their home to the homes to be visited under the programme.

A study conducted by TGNP (2004) in two districts revealed that HBC interventions did not significantly reduce the caregiver burden of household members. The study found that most of the household caregivers had not received basic training on the rudimentary skills of how to care a PLWHA and how to take care of themselves when caring. Most of the volunteers were either paid very little money in order to cover transport costs, or were not paid at all.

The NMSF report (2007) acknowledges that HBC services at community level are limited and that there had been insufficient support to HBC from hospitals and district teams. It notes additionally that those facilities which had attempted to offer HBC faced problems of skilled personnel as well as transport costs. The roles and responsibilities of various actors in HBC services will be discussed in report no. 4. But all in all, the family and community members have been given more responsibility for the care than other actors.

Vulnerable children

The majority of the HIV *infected* are adults, although some babies and young children are also infected, primarily through mother-to-child infection occurring at birth or through breast-feeding. Much larger numbers of children are *affected* by HIV&AIDS, for example, when their caregivers and the breadwinners in their families become ill reducing available care and money and sometimes requiring care to be given by the child, as well as when caregivers and breadwinners die.

Internationally these children are commonly known by the term “orphans and other vulnerable children (OVC)”. Tanzania has coined the alternative term “most vulnerable children (MVC) in acknowledgement of the fact that the majority of the country’s children are vulnerable, especially given high poverty rates – regardless of whether directly affected by HIV&AIDS, and that not all orphans are among the most vulnerable. Thus Mamdani (2008) quotes estimates based on the Demographic & Health Survey that suggest that about half of all destitute are not orphans. Conversely, 89.9% of 10-14 year olds who had lost one or both parents attended school, while other evidence suggests that there is no significant difference in primary school attendance between orphaned and other children. Where studies do find differences between orphans and other children, these are generally small. The MVC term is thus intended to focus attention on those who are most vulnerable, with a recognition that death of parents is likely to increase vulnerability. However, while this term is now used for national interventions such as those described above, critics question the sense and ethics of identifying and targeting a proportion of vulnerable children in this way.

Quoting data from the 2005 Tanzania Demographic & Health Survey, Leach (2007) notes that 11% of the Tanzanian population under 18 are orphaned, having lost one or both parents. Quoting a 2007 REPOA expenditure gap analysis by Lindeboom et al, Leach reports that orphans and vulnerable children together constituted 16% of the child population. (Vulnerable is defined here as those with one or both parents very sick for at least three months in the 12 months prior to the survey plus those living in a household with no adult between the ages of 18

and 49 years.) One in twenty children could be considered to be “most vulnerable” in the sense of living in households with expenditures 30% below the poverty level where food is a major problem. Using data from the population census of 2006, Lindeboom et al.’s analysis projects the number of MVC in Mainland Tanzania to be 929,000 where an MVC is defined as a child living in a child-headed or elderly-headed household with no adults 20-59 years, children with both parents deceased, rural children with one parent (the ILFS data put the total number of children under 18 years in Tanzania at 18.5 million in 2006). The numbers in the various categories of vulnerability making up the “most vulnerable” are shown in table 4 below.

Table 4. Estimated Number of Children by Different Vulnerability Criteria, 2006

Vulnerability Criteria	0-6years	7-14 years	15-17	Total
Poor children	3,126,362	2,645,657	841,304	6,613,324
Children in child-headed households	39,910	62,282	72,008	174,201
Children in elderly-headed households	69,445	163,671	59,765	292,882
Double orphaned children	24,820	110,085	70,579	205,484
Maternal orphaned children	79,723	216,980	115,420	412,123
Paternal orphaned children	257,779	591,556	291,920	1,41,255
Total orphans	362,322	918,621	477,919	1,758,862
Disabled children	56,977	99,277	37,729	193,982
Most vulnerable	181,689	481,439	265,815	928,944

Source: Leach, 2007: 6.

In terms of services for those directly affected, the most recent NMSF (2007) (2008-2012) reports that paediatrics AIDS accounted for 5% of all reported AIDS cases in 2004. A recent paper by Leach (2007) reports, that only 12% of eligible pregnant women received an ARV course to reduce transmission to their children. This suggests an improvement in coverage over a few years earlier, but it is still only a small proportion of those who need it who receive the medication. The failure to offer PMTCT services in all cases where deliveries take place under medical supervision is attributed, among others, to insufficient trained staff and lack of needed drugs. Thus, as at October 2006, only 66% of hospitals, 38% of health centres, and 7% of dispensaries were offering PMTCT services (NMSF, 2007: 117). The low percentage of dispensaries offering this service is particularly worrying given that this is the facility most easily accessible to rural communities. Where PMTCT is not offered, the family is likely to be burdened with an additional sick member.

In terms of those affected, the Tanzania HIV Indicator Survey (THIS) of 2003/04 indicated that care and support services for children, and particularly orphaned children, were not widespread in Tanzania. Thus only 4-6% of orphans and vulnerable children lived in households that reported receiving various types of external support. Support services were more prevalent in urban areas, but there was no clear pattern across wealth quintiles. (NBS 2004). Support was generally ad-hoc rather than ongoing.

Traditionally, orphans would have been absorbed into extended families. With numbers increasing, this absorption process cannot be relied on in the same way as before. The Tanzania government has recognised the problem through, among others, an OVC Rapid Country Assessment, Analysis, and Action Planning (RAAAP) conducted in 2003, a National Plan of Action (NPA), and a proposal to establish a national MVC database. The THIS would have reflected the position before implementation of interventions in terms of these initiatives.

The NPA was developed under the leadership of the Department of Social Welfare (DSW), with support from Family Health International. As with the NMSF, the plan is multi-sectoral and imposes responsibilities beyond government. Guidelines on Community Care for MVC, training manuals and packages to support the training of the MVCCs have been developed. By 2010, the aim is to reach a million MVCs across the mainland.

Mamdani (2008) reports that the MVC database suggests that the programme has been extended to at least one ward in 62 of the 126 districts in the country, 410,000 MVC have been identified through the standard identification process, and 160,000 of these children have received some form of support. This is nowhere near the numbers estimated by Lindeboom et al, but is nevertheless a significant achievement over a short period.

UNICEF was among the first to support these activities, the ultimate aim of which is to build the capacity of communities to provide (unpaid) care, support and protection to their most vulnerable children. The process involves establishment (through election or appointment) of Most Vulnerable Children's Committees (MVCCs) at ward and village level; training of district and ward facilitators; and definition of vulnerability criteria for children by the community. The MVCCs are then required to utilise these criteria to identify the most vulnerable children and coordinate the response, including identifying an adult to take (unpaid) responsibility for checking that each of the identified children and their caregivers receive essential services from identified international and national non-governmental, faith-based or community-based organisations.

The approach is based on an expectation that community members will assist unpaid. UNICEF's pilot programme includes provision for a village MVC Fund, but this fund places an added burden in terms of contribution of labour or cash on the community. The funds are intended to assist with providing for essential needs such as shelter, bedding, clothing, health, food and educational expenses. The money is to be made up of contributions by citizens and local government, which will be matched by UNICEF. Matching funds will be based on the number of MVC and the poverty level of the district concerned. The community contribution can be given in kind if this is preferred to a cash contribution.

In addition to UNICEF, other key HIV&AIDS funders have supported MVC interventions. The Global Fund has allocated a total of US\$58 million over the period 2005-2010 for economic and social support, which consists essentially of MVC interventions. PEPFAR disbursed about US\$18.3 million (less than 10% of total PEPFAR support) in 2006/07. The heavy reliance on donor funding makes this programme – like other aspects of Tanzania's HIV&AIDS interventions – very vulnerable to donor shifts in priority. The danger is exacerbated by the fact that the programme is generally seen as donor-conceived and donor-driven, with very little financial and other support from within the country.

Leach (2007) notes, quoting Lindeboom et al, that the cost of providing assistance to vulnerable children for the financial year 2006/07 would have been less than 11% of the total HIV&AIDS budget for that year, and less than 1% of the total government budget. She notes that Tshs. 30.7 billion was needed for food and Tshs.7.1 billion for non food. This suggests that it would be

possible to provide essential basic assistance to the most vulnerable children if the budgeting and planning processes adopt a child-centred approach.

The UNICEF pilot worked through district authorities, while subsequent roll-out is happening through networks of civil society organisations under the direction of the Department of Social Welfare. Local governments nevertheless continue to have a key role, for which they do not have adequate funding. Mamdani (2008) quotes the 2006/2007 HIV&AIDS Public Expenditure Review (PER), in which year local government had a shortfall of TShs. 10.5bn, as follows: “2006/7 was the second year in a row in which LGAs were encouraged to prepare ambitious plans that could not then be implemented due to lack of funding”

The Community HIV&AIDS Response Fund (CHRF) of the World Bank-funded Tanzania Multisectoral AIDS Project (TMAP), and the Global Fund have provided some funding to local government. However, the Global Fund money reaches less than half of all districts (ibid).

In terms of achievements on the ground, Mamdani (2008) reports that a 6-district assessment of the MVC programme suggests that while some components are in place, they are not yet functioning reliably. Thus MVCs were being identified, but the impact – while positive – was small. Overall, MVCs received more support from family members not living with them than from the programme. Education and food were the most commonly provided forms of assistance by the Programme, but the support was inadequate, and inconsistent. Another study quoted by Mamdani found that not all MVCs in the area had been identified, and not all children received all needed forms of assistance. Organisations assisting with the programme reported problems with funding, such as late interrupted payments. MVCCs had irregular contact with NGO or government service providers, and expended most of their effort raising funds and food from their own communities. The fact that the MVC committees were not established as statutory bodies may have limited the extent to which they can expect financial support from local government. The lack of supervision and defined lines of accountability lays the programme open to the possibility of the chairperson and committee abusing their powers.

From the observations made on MVCCs, it goes without saying that households which have an MVCC and an HIV&AIDS person has a greater burden of care than those without MVCCs, a factor which underscores the need for a more holistic approach in supporting the poor resource households in coping with the pandemic.

Non-State Service Delivery for HIV&AIDS

The discussion above has referred at times to service delivery by non-state actors. These include traditional healers, faith-based organizations, other civil society organizations, and the private sector.

Not-for-profit organizations

The contribution of not-for-profit organizations is particularly noteworthy in the HIV&AIDS arena, but the range includes everything from large international NGOs down to small community-based organizations. The wide range and the fact that some of the organizations are

very small and might have short lives makes it difficult to present a good picture of the full contribution. However the available literature as well as field visits, observations and discussions with actors in the field suggest that most of their activities are ‘gap filling’ and most of the organizations are, like government, highly dependent on donor funding. As a result, most of the programmes are not sustainable, and low levels of funding make it unlikely that they will have significant individual impact on the problems they are trying to address. Nevertheless, their collective capacity to deliver services should not be underestimated. Further, some of the voluntary organizations have also been able to extend their support to areas which government and donor resources have not reached and which would therefore remain unattended without the non-profit services.

The organizations choose different foci for their work. For example, SHDEPHA focuses (among others) on supporting orphans by advocating for their enrolment and retention in primary schools and helping them pursue further education, particularly vocational training. Since 2000, the programme has supported over 13,000 children in the Dar es Salaam, Coast and Shinyanga regions with uniforms and school. Several orphans who received SHDEPHA support to complete their education have offered to volunteer with the organisation, thus giving back to those who are in situations similar to their own. At the time this study was being conducted, SHDEPHA had, however, stopped its HBC services due to lack of funding. A few Home base care workers, the majority of who were PLWHA continued to make home visits but without the previous support from the organisation in terms of transport and the HBC kit.

The Comprehensive Community-Based Rehabilitation in Tanzania (CCBRT) provides legal support to PLWHAs. Legal issues addressed include those resulting from cultural practices which exclude women and girls from inheritance rights. The CCBRT legal aid programme started in 2001 handled 1,005 cases in the first year. By 2004, the number of cases had increased to 2,645. The programme offers clients information, representation and financial support to take their grievances through formal legal channels. Services are delivered through three legal aid units which are located within the three municipal hospitals in Dar es Salaam where CCBRT partners with local health authorities to provide HIV testing, counselling and ARV treatment. The organisation has also established a number of initiatives to provide emotional support to children orphaned by AIDS. These include a network of community-based ‘orphan mediators’, who annually visit more than 1,500 children who have been reintegrated into new homes and schools around Dar es Salaam city. CCBRT also help PLWHA prepare legally for their deaths, and help widows and orphans to protect their rights and social security. The cost-free services include the preparation and declaration of wills, the filing of inheritance cases, marriage and divorce cases, labour conflicts, issues arising from the custody and care of children, guidance on land and property issues, violations of human rights, and cases of child abuse.

Both of these organisations are to some extent doing care-related work. In particular, the work in respect of orphans fills the gap caused when the “natural” caregivers of these children dies. SHDEPHA’s HBC work was also directly concerned with care although, as noted above, this has come to an end due to funding problems. The wide range of services offered by NGOs means that some are more directly working on care than others. But even organisations such as those working on awareness raising and other prevention activities, while not directly providing care can be said to be influencing the care burden if they reduce the numbers who become ill.

Government, in its statements about the multi-sectoral approach to HIV&AIDS and the need for all actors to play a role, includes the non-profit sector. If this sector is to play an effective role, more attention needs to be paid to it in terms of improving information on its size, shape and distribution geographically, and ensuring the financial and other support that will allow it to provide effective and sustainable services.

The Private for Profit Sector

The household budget survey of 2000/1 suggested that the public health sector accounted for over half (55.1%) of utilisation of health care services. The contribution of the private sector was also substantial, at 38.5% for the “modern” private health sector and 15.0% for traditional healers. About 11% of informants said that they consulted more than one type of provider (Ministry of Foreign Affairs/Danida, 2004). In terms of ownership, the “modern” private sector includes voluntary organisations, most of which are faith-based, and private for-profit operators. As seen below, the two groupings tend to emphasise different types of services.

In terms of facilities, in 2000 the private sector proper, i.e. excluding voluntary and faith-based institutions, accounted for 16 (3%) of the 479 health centres in the country, 663 (17%) of the 3955 dispensaries, 22 (22%) of the 101 specialised clinics, and 20 (23%) of the 86 “other” hospitals (i.e. hospitals other than those classified as specialist, regional or district). The private sector proper further accounted for two-thirds (228) of the 340 “other” health facilities. While the numbers are impressive, these facilities are very unevenly distributed in geographical terms. Meanwhile voluntary and faith-based organisations accounted for 2 of the 8 specialised hospitals, 13 of the 68 district hospitals, 56 “other” hospitals, 48 health centres, 612 dispensaries, 4 specialised clinics, and 15 “other” facilities.

These figures suggest that the private sector plays an important role in health care provision, but with a difference in emphasis between the voluntary/faith-based and the private sector proper. In general, organisations in the former grouping focus on lower level services while the latter is less evident at the basic level of health centres. These patterns reflect the greater extent of integration of the voluntary/faith-based services into the public health system, which includes recognition and funding of some of their hospitals. In contrast, there is at present very little integration of for-profit and public facilities. In theory, the for-profit providers are subject to regulation by the Ministry of Health through the Private Hospitals Advisory Board. In practice, there is very little effective regulation and no regulation at all over issues such as fees.

In contrast to earlier periods (see above), government policy now professes strong support for a private sector role in health care provision. Both the first and second Health Sector Strategic Plans (the second covering the period 2003-2008) have public private partnerships as the seventh of eight strategies. Government strategy and donor support also spans the private as well as public sectors in areas such as capacity building and construction. For example, donor funding mechanisms include a multi-donor Joint Rehabilitation Basket that is intended for improvement of primary health care facilities in both public and private sectors. The guidelines for the District Basket Fund also emphasise the private sector role. Saying something in policy does not, however, mean that it will automatically happen effectively.

Conclusions

The current social policy regime in Tanzania can be categorized as a ‘dual’ model, which is attempting to combine elements of limited universal coverage, with programmes and services which exclude the majority of the poor population. The dual model is premise on two dialectically opposed theoretical frameworks. On the one hand, the neo-liberal model demands minimal state invention in the provision of services, while on the other hand, social equity policies demand state intervention in re-distributing public resources. In the Tanzanian context, redistributive policies seem to be undermined by the neo-liberal forces which demand commoditisation of social services. In the health sector, in particular, the burden of care is gradually shifting to individuals through user fees, mandatory contributions such as health insurances and Community Health Funds, as well as direct out-of-pocket expenses in both public and private for-profit health services.

Safety nets introduced by the state to protect people from risks and vulnerability have failed to protect the poor. Social security funds are only available to a small proportion of the population who are by far not the most vulnerable. Waivers and exemptions are not working effectively to enhance equity in accessing services. Community-based funds such as the CHF are not providing alternative safety nets for the poor, and particularly PLWHAs. The CHF is simply too expensive for the poor as currently structured. (Euro Health Group (2006)

Donor dependence seriously threatens the sustainability of some services. Donor dependency is particularly acute in relation to HIV&AIDS-related services. Further, the emphasis on HIV&AIDS and the added stress on existing general services has undermined the capacity of these existing services.

The voluntary sector has some potential to fill gaps in service delivery, but their dependency on donor funding makes then unsustainable as reliable alternative channels for service delivery.

The private sector has two contradictory aspects. On the one hand, excessive pursuit of profit and commercialization of service provision threatens the quality of life of the poor and particularly women. It promotes inequalities in access to health care services, and thus adds to the burden of poor households and particularly poor women. The drive to commoditize service provision negates the principles of universalism in service provision. On the other hand, the private sector providers of health services can complement public service providers if the government is able to regulate and control quality and fee structure. In addition, through progressive taxation regimes, government can generate resources from the private sector to be re-invested in the public social services.

Inequalities in accessing social services, including those for PLWHAs and affected children, place an additional burden on the unpaid care economy. When the poor are forced to “choose” not to use a health facility due to the costs involved, the burden of care is borne by a household member, usually female. When preventive measures are undermined due to prioritisation of cure and treatment, it imposes a future burden of care in respect of those who will become infected. Failure to provide adequate support for children made vulnerable by HIV&AIDS exacerbates the

financial and care burden placed on those who are generous enough to take on the care of these children.

Lack of access to ARVs at an early stage exacerbates the severity of opportunistic diseases which required 24-hour care. Inequalities in accessing PMTCT create a double burden, where the household must care for the sick mother, a sick baby as well as, in many cases, a sick male adult.

The HBC policy recognises the link of unpaid household care that is missing from some other policy framework. However, the HBC policy and programmes provide very minimal assistance to caregivers within the home.

The result of the dualist social policy regime is that the bulk of care is shouldered by individuals (predominantly female) through their own unpaid labour, assisted by friends and family.

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