BILATERAL DEVELOPMENT: ASSESSING THE STRENGTHS AND WEAKNESSES OF THE CANADIAN-TANZANIAN PARTNERSHIP THROUGH HIV/AIDS INDICATORS

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Abstract

In recent years, access to HIV prevention and treatment services for women, including the prevention of mother-to-child transmission (PMTCT) have received increased attention at all levels, particularly under the internationally-driven *Millennium Development Goals* (MDGs) and *Paris Declaration on Aid Effectiveness* (Paris Declaration). It is widely accepted among international bodies (e.g., UNAIDS and UNICEF), that the number of infections among women are on the rise; consequently, more children are being born to HIV-positive women. In response, governments now have the responsibility to integrate international consensus into their national HIV/AIDS strategy plans.

Undoubtedly, new approaches to development are influenced by agreements such as the MDGs and the Paris Declaration, and the ensuing movement towards strengthening bilateral partnerships for aid effectiveness; through its program-based or "balanced approach", the Canadian International Development Agency (CIDA) serves as an apt example of this process. Therefore, the agency's bilateral partnership with the Government of Tanzania (GoT) is examined in this thesis for its commitment to, and achievement of, the following key outcomes: 1) decreased number of HIV-infections among women; 2) increased access to the prevention of mother-to-child transmission services; and 3) decreased number of HIV-infections among children.

By examining improvements in the key-outcomes listed above, this study highlights the strengths and weaknesses of CIDA's bilateral program-based approach or "balanced approach" to development and HIV/AIDS responses. CIDA's balanced approach is characterized by short-term, agency-supported, local projects that complement medium- to long-term development programming. These projects are instrumental in achieving the key outcomes listed above, especially in the short-term.

This study shows that CIDA's balanced approach to development helped to stabilize the number of HIV-infections among women and children in Tanzania, and improved access to PMTCT services. However, universal access to HIV-prevention and treatment services for women, including the prevention of MTCT, is yet to be realized. This shows that, although bilateral partners are working more effectively, results in the short-term are mixed. Furthermore, there is still a heavy reliance on local organizations by those seeking HIV-related services, demonstrating the continued importance of local efforts beyond national health care strategies.

This study provides a snap-shot of development and HIV/AIDS mitigation in 2009, and is enhanced by the knowledge and insights of CIDA staff interviewed for this thesis. However, as development modalities related to HIV/AIDS mitigation inevitably continue to evolve, this study can be used to complement future research. I recommend that the effectiveness of program-based approaches and their effects on HIV/AIDS responses, including the prevention of MTCT should be continuously reviewed for successes in the long-term.

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List of Acronyms

AIDS – Acquired Immunodeficiency Syndrome
ART – Antiretroviral Treatment
ARVs – Antiretrovirals
CBOs – Community Based Organizations
CIDA – Canadian International Development Agency
CMA – Critical Medical Anthropology
DFID – United Kingdom Department for International Development
FHI – Family Health International
GAVI – Global AIDS Vaccine Initiative
GDP – Gross Domestic Product
GEDS – Government Electronic Directory Services
GoT – Government of Tanzania
HDI – Human Development Index
HIV – Human Immunodeficiency Virus
HSR – Health Sector Reforms
IPU – Inter-Parliamentary Union
MDGs – Millennium Development Goals
MSI – Marie Stopes International
MST – Marie Stopes Tanzania
MTCT – Mother-to-Child-Transmission
NGO – Non-Governmental Organization
NMSF – National Multi-sectoral Strategy Framework on HIV and AIDS
NSGRP- National Strategy for Growth and the Reduction of Poverty
ODA – Official Development Assistance
OECD – Organization for Economic Cooperation and Development
OVC – Orphaned and Vulnerable Children
PBA – Program-Based Approach
PEPFAR – Presidential Emergency Plan for AIDS Relief
PMTCT – Prevention of Mother-to-Child-Transmission
PRSP – Poverty Reduction Strategy Paper
RFE – Rapid Funding Envelope for HIV/AIDS
SAPs – Structural Adjustment Programs
SIDA – Swedish International Development Agency
STI – Sexually Transmitted Infection
SWAPs – Sector-Wide Approaches
TACAIDS – Tanzania Commission on AIDS
TOMSHA – Tanzanian Output Monitoring System for HIV/AIDS
UN – United Nations
UNAIDS – United Nations Joint Programme on HIV/AIDS
UNDESA – United Nations Department of Economic and Social Affairs
UNDP – United Nations Development Programme
UNGASS – United Nations General Assembly Special Session on HIV/AIDS
UNHCHR – United Nations High Commission on Human Rights

UNICEF – United Nations Children's Fund
UNPFA – United Nations Population Fund
USAID – United States Agency for International Development
VCT – Voluntary Counselling and Testing
WHO – World Health Organization

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Chapter One – Introduction

1.1 Introduction

The magnitude of the global HIV/AIDS pandemic is well-known, as is the complexity and extent to which it infects and affects women and children.[1] With this knowledge, issues concerning women's vulnerability to HIV, within the larger political and socio-economic context, have become increasingly prioritized by the international community, especially in the last several years (UNICEF 2007:4; UN 2000). As such, policymakers at both the international and national levels have been forced to design and implement programming which targets these issues. International bodies, most notably the United Nations system (e.g., UNAIDS and UNICEF) have produced clear recommendations, goals and targets deemed necessary to reduce HIV-infection among women and to decrease rates of mother-to-child transmission (MTCT). With this international consensus, governments now have the responsibility to develop and implement national HIV/AIDS action plans through bilateral partnerships, and are encouraged to focus on women and the prevention of MTCT (PMTCT) as a means of improving child health.

The commitment to integrating international consensus (e.g., the *Millennium Development Goals* (UN 2000) and the *Paris Declaration on Aid Effectiveness* (OECD 2005)) into development programming and HIV/AIDS responses currently characterizes

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[1] Although there are competing definitions, it is generally accepted that children range from infants to the age of 18. This is the age of "children" infected and affected by HIV/AIDS accepted by UNAIDS and UNICEF, and is clearly defined in Article One of the *Convention on the Rights of the Child* (UNHCHR 1989). Obviously the range in age requires that a variety of prevention and treatment strategies are designed and implemented for this cohort, as children are infected and affected by HIV/AIDS in varying and unique ways. Further disaggregation of children infected and affected by HIV/AIDS into sub-groups (e.g., children infected through MTCT, sexual abuse, and voluntary sexual activity) demonstrates the critical need to develop and focus prevention and treatment initiatives that target this cohort specifically.

the bilateral partnership between the Canadian International Development Agency (CIDA) and the Government of Tanzania (GoT). The *Millennium Development Goals* (MDGs, UN 2000) not only clarify important goals and targets for development (see Appendix A), they focus the efforts of UN Member States and, consequently, national aid agencies, such as CIDA. Similarly, the *Paris Declaration on Aid Effectiveness* (OECD 2005), signed in 2005, serves to reinvigorate the efforts made by its signatories (e.g., donor and recipient countries, multilateral aid agencies) in order to make progress towards, and to achieve, the MDGs by the target date of 2015.

Drawing from these international agreements, CIDA programming evolved from a "project-based" approach to the current "balanced approach" to development. The balanced approach is most simply defined as multi-sectoral development programming. By following the balanced approach for development, CIDA supports initiatives at the multi-lateral, bilateral, and local level, insofar as local initiatives directly support objectives defined at the bilateral level. With these recent changes, questions concerning the effectiveness of CIDA's bilateral programming model arise. Therefore, the central research objective of this thesis is to identify the strengths and weaknesses of CIDA's bilateral programming model in its ability to decrease rates of HIV-infection among women and children, and improve access to the prevention of mother-to-child transmission services in Tanzania. The exploration of the CIDA/GoT case study provides evidence as to whether or not there are any appreciable gains towards reducing HIV-infection among women and instances of MTCT through CIDA's balanced approach. This thesis presents changes in the number of HIV-infections among women and

instances of MTCT in Tanzania in order to assess the strengths and weaknesses of CIDA's bilateral aid model.

If the number of HIV-infections decline, it suggests strengths within the bilateral programming model for development. Alternatively, if numbers stagnate or increase, it suggests weaknesses, or areas for improvement, within the bilateral programming model. However, before these links can be made, external factors that exacerbate rates of infection must first be determined and considered, as they also influence the overall success of development programming. The information presented in this thesis, therefore, includes key issues regarding HIV-infection among women and children infected via MTCT in Tanzania.

To fully demonstrate the scope and complexity of HIV-infections among women in Tanzania this thesis highlights various political and socio-economic determinants of health, thereby, connecting macro- and meso-level forces to the number of HIV-infections at the individual level. Similarly, this study connects aspects of aid effectiveness, resource flows, and international consensus, to changes in the number of HIV-infections and access to PMTCT services (Campbell 2008:249). These linkages demonstrate that development policy and practice is an ideal arena for anthropological research "in an attempt to understand policy implementation...and analyze the interconnections among beneficiaries, local organizations, and donors" (Campbell 2008:250). This study follows this reasoning,[2] as it first discusses international consensus for development and HIV/AIDS mitigation and broadens the understanding of HIV/AIDS in Tanzania. It then analyzes the interconnection between rates of infection among

[2] This approach is seen in the work of John Campbell (2008) who completes a similar analysis of bilateral programming in Kenya. A study on the impact of state HIV/AIDS policies on women in South Africa was also reviewed for similarities to the Tanzania example (James 2006).

women, instances of MTCT, and the role of CIDA and Marie Stopes Tanzania in mitigating HIV-infection. This demonstrates the contributions anthropologists make towards the study and practice of development. They may do so by, first, characterizing the broader context of development planning and implementation, and, second, demonstrating the effect these programs have on beneficiaries.[3]

As the primary and secondary research in this paper is largely grounded in development theory[4], it broadens the understanding of the socio-economic and political factors that exacerbate rates of HIV exposure in specific local and cultural contexts. Development practitioners and policymakers at every level can then apply this understanding in order to respond appropriately to the challenge of HIV/AIDS through targeted programming. This study examines the relationship between the Government of Tanzania and foreign aid agencies, in this case CIDA. Furthermore, it analyzes CIDA's development discourse as well as its partnership with Tanzania for its ability to reduce HIV/AIDS in that country (Campbell 2008:250).

1.2 Rationale and Focus of the Study

International organizations such as UNAIDS and UNICEF continue to make significant headway in defining HIV/AIDS treatment and prevention objectives,

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[3] It is recognized that this study is limited, as it only includes qualitative interviews with national level actors, and does not include any ethnographic research from the community level (e.g., HIV patients, NGO workers, health care providers, etc.). However, the strength of this study comes from its engagement with national level actors, and the process of "studying up". The information collected in this study is valuable for future research, as it provides a broader political-economic context for development programming and implementation, and can then be used to understand the effect that national level initiatives have on communities and individual patients.

[4] Similarities exist between development theory that advocates for a multi-sectoral approach to development, and the critical medical anthropology (CMA) approach (Hanson 2000:342). The CMA approach provides a relevant link between anthropological and development theory as it seeks to broaden the political and socio-economic context in which individual are left vulnerable to disease and disease outcomes, such as HIV-infection and death due to AIDS.

generally, and specifically for women and the prevention of MTCT. In turn, international consensus pressures national governments to set corresponding treatment and prevention targets for their populations, and encourage bilateral partnerships to ensure that these goals are met. However, development targets remain unmet for many populations. According to one CIDA representative interviewed for this study, these targets are failing most often in relation to the needs of women and children (Participant #4, 2008[5]). In fact, it is widely accepted that many countries, particularly in sub-Saharan Africa, are at risk of not achieving MDG 4 (reduce child mortality), MDG 5 (improve maternal health), and MDG 6 (combat HIV/AIDS) by the target date of 2015 (Hecht *et al.* 2006:1992; UNDESA 2007:4; UNDPI 2007:1). This concern heavily influences and motivates this thesis, as this study seeks to reveal why HIV continues to disproportionately infect and affect women and children. More importantly, this thesis seeks to reveal the role that bilateral development initiatives play in promoting the needs of HIV-infected women and reducing rates of MTCT. Therefore, women are given specific attention in this thesis, given their unique vulnerability to HIV/AIDS. The level of dialogue surrounding MTCT at the international level also warrants attention in academic literature.

This study is concerned specifically with children who are HIV-infected via MTCT, as they account for 90 percent of HIV-infections among children (Ross *et al.* 2006:2; UNAIDS 2008c: 37). Critics suggest that focusing primarily on the prevention of MTCT negates the needs of children HIV-infected as a result of other modes of transmission. While recognizing the importance of the "missing face"[6] of the epidemic,

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[5] Refer to Appendix B

[6] In 2005, UNAIDS and UNICEF teamed up to spearhead the *Unite for Children, Unite Against AIDS* (2005) campaign demonstrating that, despite their pressing needs, children remain a "missing face" within responses to the HIV/AIDS pandemic. CIDA's Child Protection Unit, in conjunction with UNICEF,

this paper does not address the complete spectrum of issues that infect and affect children beyond MTCT. Rather, it focuses on the ways that individual governments, including the Government of Canada, respond to the challenge of HIV-infection among women and the prevention of MTCT.

1.3 Research Objectives

This thesis reviews existing literature and data, and includes primary research material collected from CIDA staff. The purpose of this thesis is to identify and highlight the strengths and weaknesses of CIDA's balanced approach to development in improving rates of HIV-infection among women and reducing instances of MTCT in Tanzania.

The approach used is a case study analysis of CIDA's bilateral programming model, influenced by new international development modalities (e.g., the MDGs and *Paris Declaration for Aid Effectiveness*). This analysis demonstrates the link between international and national approaches to development (e.g., including health system strengthening and national HIV responses), persistent barriers to HIV/AIDS prevention and treatment, and rates of HIV-infection among women and instances of MTCT. By highlighting political and socio-economic barriers that exacerbate the spread of HIV among women and children infected via MTCT, this study helps to illuminate why HIV and MTCT rates improve, decline, or stagnate.

This thesis also contributes to a better understanding of new development modalities, as implemented by CIDA, including their effectiveness on the ground. This is relevant, as "Canadian aid policy has been the focus of a long tradition of scholarly

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produced their own set of recommendations outlined in the *Enhanced Protection for Children Affected by AIDS* (2007), highlighting priority areas to decrease the vulnerability to HIV among the world's most marginalized children, beyond the prevention of MTCT. "Orphaned" and otherwise vulnerable children, children vulnerable to sexual exploitation and abuse, voluntarily sexually active youth, and youth who are forced or coerced into sexual activity are given special attention in these reports.

analysis and debate" (Black 2007:183). However, the level of engagement with this important issue declined since the start of the new millennium, even though the Canadian government and, subsequently, CIDA have re-invested in and renewed efforts towards development and aid effectiveness (Black 2007:184). Studies that evaluate the strengths and weaknesses of bilateral programming for development, in general, and HIV-mitigation, specifically, are limited in the academic literature (Black 2007:184; Campbell 2008:250). More importantly, an anthropological approach (e.g., "studying up") provides insight into the complexity of development policy and the uncertainty of development outcomes, due to the socio-economic, political, and cultural contexts in which development is negotiated and implemented (Campbell 2008:249).

In sum, the core research objectives of this study are: Firstly, to review the information gathered from CIDA staff and secondary sources to determine the strengths and weaknesses of the agency's balanced approach to development; and, secondly, to critically examine the partnership between CIDA and the Government of Tanzania in terms of improving the following key HIV-outcomes: 1) decreased number of HIV-infections among women; 2) improved access to the prevention of mother-to-child transmission (PMTCT) of HIV services; and 3) decreased number of HIV-infections among children.

This thesis will, therefore, assess the outcomes of CIDA's bilateral programming model. Firstly, CIDA's partnership with the Government of Tanzania, as an example of new development modalities, may have resulted in a decreased number of HIV-infections among women, and increased access to PMTCT services. Alternatively, it could be demonstrated that the partnership has not had a significant effect, with the number of

HIV-infections among women and instances of MTCT remaining static or increasing. In the second case, it is also possible that CIDA's partnership has laid the foundation for effective HIV/AIDS mitigation in Tanzania, but actual improvements remain a long-term objective.

1.4 Key Themes

Women, HIV-infection and MTCT

This study examines the linkages between political, economic, and social institutions and their influence on the health of "unequally positioned members of society", including women (Baer *et al.* 2003:53; Brown *et al.* 1998:15; Farmer 1999:5). Creating these linkages exposes the macro- and meso-level forces that exacerbate disease burdens and outcomes, constrain individual autonomy, and reduce access to, and the quality of, health care systems (Brown *et al.* 1998: 16; Farmer 1999: 6; Singer 1998: 226). This thesis also acknowledges the fundamental importance of income inequalities in determining individual exposure to disease, access to health care, and disease outcomes. No less important are gendered inequalities and their impact on the health and well-being of women (Baer *et al.* 2003:34; Farmer 1999: 52; Singer 1998:226).

In order to understand the reality for women infected by HIV, and, subsequently, children infected via mother-to-child transmission, this study contextualizes HIV/AIDS within sub-Saharan Africa. This serves as a basis for understanding rates of infection in Tanzania. In sub-Saharan Africa, approximately 22 million individuals were infected with HIV at the end of 2007 (UNAIDS 2008c:4). It is widely accepted that, due to the feminization of the disease in sub-Saharan Africa, at least 60 percent of those infected in the region are women (UNAIDS 2008c:8). In 2007, approximately 370,000 children

under the age of 15 were newly infected with HIV globally; the total number of children infected with HIV increased from 1.6 million in 2001 to 2.0 million in 2007. In 2007, approximately 290,000 children died due to AIDS-related illnesses. Experts estimate that 90 percent of children newly infected, or who succumbed to AIDS-related illnesses lived in sub-Saharan Africa (Kaiser Foundation 2008; UNAIDS 2008a; UNAIDS 2008c: 33). Additional relevant statistics are presented in the table below. Table 1.1 shows that women are infected at a rate of 50 to 60 percent of the total number of adults HIV-infected – an alarming trend consistent at the global, regional, and country level.

Table 1.1 – Total Number of HIV-Infections (2007)

	Adults (age 15-49)	Women (age 15-49)	Children (age 0-15)
Global	33, 000, 000	15, 500, 000	2, 000, 000
sub-Saharan Africa	22, 000, 000	13, 200, 000	1, 800, 000
Tanzania	1, 300, 000	760, 000	140, 000

(source: Global Coalition on Women and AIDS 2009, UNAIDS 2008c, UNAIDS 2008f)

In order to elaborate on these statistics, this thesis addresses the key concerns regarding HIV-infection among women. Specific attention is paid to factors that increase vulnerability among women, as the highest instances of HIV-infection among children are attributed to MTCT (UNAIDS 2008c:33). In 2007, approximately 1,800 infants became infected with the virus by way of MTCT every day (UNAIDS 2008b). With these numbers in mind, it is important to understand how the international community is responding to concerns faced by women and children vulnerable to HIV/AIDS.

International and National Consensus Concerning Women, Children and HIV/AIDS

This section includes an overview of international documents such as the *Millennium Development Goals* (MDGs) (UN 2000, 2006) and the *Paris Declaration on*

Aid Effectiveness (OECD 2005). The overview of key international documents aims to demonstrate that not only has an international consensus been reached with respect to preventing and treating HIV/AIDS among women and children, but also, goals have been articulated with respect to development, generally (see Chapter Two). As a signatory to the MDGs, Canada is committed to building and maintaining global partnerships for development (MDG 8), improving child (MDG 4) and maternal health (MDG 5), and the reduction of HIV/AIDS (MDG 6). These objectives are reinforced by the *Paris Declaration on Aid Effectiveness* (OECD 2005), to which Canada is also a signatory. Briefly, the Paris Declaration is an international agreement that promotes the coordinated and effective use of aid for development; national ownership; and capacity building at all levels. UN Member States and respective national governments (e.g., Canada and Tanzania) have demonstrated their commitment to the MDGs and the Paris Declaration. The upcoming analysis examines the viability of shifting international agreements, as seemingly lofty and unattainable goals to operationalized programmes for targeting improvements in key outcomes at the national level. Conversely, the analysis also considers if these agreements simply increase the dialogue at the national level without producing tangible results.

CIDA Programming and the Balanced Approach

Multilateral organizations, such as the United Nations, have had substantial influence on the priorities of donor agencies; CIDA is not exempt from this influence. In the past, policy shifts, inspired by international consensus, were achieved rather informally, through the dissemination of research and consultation. However, throughout the 1990s, the degree of donor consensus and policy harmonization steadily deepened,

culminating in the release and endorsement of the MDGs and Paris Declaration (Black and Tiessen 2007:200). This consensus is clearly seen in the programming priorities of CIDA, and a range of new program-based approaches. CIDA's balanced approach to development is one such example.

Development modalities now operate under the assumption that local level planning should complement strategies at the national level (James 2006:203). Research in this area suggests that the work of NGOs, where isolated, has failed. Therefore, new modalities seek to enrol actors from all levels in partnerships for development (Campbell 2008:251). Furthermore, the goals and objectives of national and local level planning should be harmonious, as articulated by the *Paris Declaration on Aid Effectiveness.* Therefore, CIDA's balanced approach to development is premised on coordinated donor involvement in multilateral, bilateral, and local development planning. Although it is not within the purview of this paper to explore each of these topics in full, CIDA's partnership with the Government of Tanzania and local partner, Marie Stopes Tanzania, illuminates the strengths and weaknesses of CIDA's balanced approach in reducing HIV-infection among women and reducing instances of MTCT.

The Partnership between CIDA and the Government of Tanzania

Consistent with the MDGs and Paris Declaration, the Government of Tanzania has increasingly prioritized the issue of HIV/AIDS treatment and prevention through the *National Policy on HIV/AIDS* (United Republic of Tanzania 2001); the *National Strategy for Growth and the Reduction of Poverty* (United Republic of Tanzania 2005), and the first and *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2003, 2007). This reveals that the GoT, like CIDA, is responding to the

challenges of development and HIV/AIDS by producing strategy plans and frameworks. Furthermore, it shows that the GoT is not dependent upon the contributions and insights of Canadian organizations; rather an exchange of ideas is taking place in multilateral, bilateral and local fora. The history and motivation of the partnership between CIDA and the GoT is critical, and is influenced by the principles of the *Paris Declaration on Aid Effectiveness* (OECD 2005).

Finally, this study considers how historical political relationships between and within countries influence contemporary disease distribution and national mitigation strategies (Baer *et al.* 2003:34; Brown *et al.* 1998: 16; Singer 1998: 226). The exploration of Tanzania's partnership with CIDA serves as a useful entry point for investigating rates of HIV-infection among women and instances of MTCT, as well as whether they are improved by the partnership with CIDA. Understanding the limitations of development programming and HIV-mitigation in Tanzania are important to this thesis. Such barriers are seen to exist due to the implications of post-colonial political and economic processes, structural adjustment programs (SAPs), poverty, and debt burdens (Poku 2005:37-39; Oppong and Kalipeni 2004:48). As a result, ineffective or non-existent health care facilities continue to characterize Tanzania, leading to and/or exacerbating rates of HIV/AIDS infection among women and children (Poku 2005:38), or limiting the scope of treatment and prevention programs outlined within the national strategy plans. For this reason, health system strengthening has become a priority area for both CIDA and the Government of Tanzania.

By exploring the key themes outlined above, this thesis, first, highlights the influence of international discourse and the terms of bilateral partnerships, and situates

the process of development programming within the broader socio-economic and political context. Secondly, it provides a better understanding of Canada's contributions to HIV-prevention strategies that target women and children (through the prevention of MTCT). CIDA's commitment to strengthening Tanzania's health care system, as part of its overall HIV/AIDS strategy, is also reviewed. Finally, this thesis summarizes the strengths and weaknesses of CIDA's balanced approach, and its ability to reduce the number of HIV-infections among women and instances of MTCT, thereby reducing the number of infections among children in Tanzania. Linkages can then be made concerning the strengths and weaknesses of bilateral aid modalities, more generally, and whether or not national governments and development agencies should continue to "stay the course" when it comes to defining and implementing HIV/AIDS mitigation strategies.

1.5 Methodology

This thesis consists of two modes of inquiry. Firstly, it draws upon the work of others, in the form of an academic literature review as well as grey literature found on international and national agencies' websites (e.g., UNAIDS, UNICEF, Marie Stopes International, GoT and CIDA). Secondly, primary research was conducted in the form of interviews with key informants at the Canadian International Development Agency (CIDA). CIDA was selected for this study as a representative of the Government of Canada due to the agency's commitment to gender, maternal health, child health, HIV/AIDS, and its role as an international donor. As discussed more thoroughly in the chapters that follow, Canada, as a UN Member State, is obliged to uphold international commitments that the country helped to develop and signed. CIDA draws its current development strategy from the *Millennium Development Goals* (UN 2000), and the *Paris*

Declaration on Aid Effectiveness (OECD 2005), giving specific attention to HIV, women and the prevention of MTCT for the promotion of child health.

Prior to conducting primary research it was unclear which CIDA partner country would take precedence within this thesis. However, after speaking with several CIDA staff (described below) a comprehensive overview of bilateral programming was collected and Tanzania was selected as an example of CIDA's current balanced approach to development. Relevant information was collected from staff members working in the Mozambique and Malawi Program, in addition to the Tanzania Program, highlighting the consistencies within the Geographic Programming Branch, and CIDA's approach to bilateral programming generally. The information was reinforced, not only among staff members, but also on the agency's publicly accessible website, and CIDA's internal *Policy Statement on Strengthening Aid Effectiveness* (CIDA 2002).

CIDA staff and CIDA's website provided a variety of primary research materials and literature concerning bilateral programming in Tanzania, with additional information gathered from the Government of Tanzania's official website, and additional academic sources. Interviews with CIDA staff revealed that bilateral programming in Tanzania is characterized by one of the agency's highest budgets in sub-Saharan Africa (at a rate of 80 million dollars in 2006/2007); its commitment to HIV/AIDS and health system strengthening; a national commitment to good governance; and the production of an updated *National Strategy for Growth and the Reduction of Poverty* (United Republic of Tanzania 2005) and their first and *Second National Multi-sectoral Strategic Framework on HIV/AIDS* (TACAIDS 2003, 2007).

A review of Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2007), with respect to its commitments and program priorities (including women's vulnerability to HIV-infection, MTCT, and children), helped to determine whether, and to what extent, these issues are prioritized in national strategy plans. Information collected through primary research interviews with CIDA staff members, and statistics gathered from publications released by international organizations (e.g., WHO, UNAIDS and UNICEF) served as useful material for comparison with national strategy plans in Tanzania.

I conducted a series of semi-structured interviews from May 2008 to October 2008. The purpose of the interviews is to gain insight into the finer points of CIDA programming and HIV/AIDS responses that are not necessarily included on publicly accessible websites or academic literature. The decision to interview CIDA staff is clear, as participants with experience working in the field of HIV/AIDS have much to offer in the analysis of academic literature. The contributions made by the research participants proved to be useful for several important reasons. Their insights reiterate the influence of the MDGs and the Paris Declaration on CIDA's current balanced approach to development. The information collected from CIDA staff complements my analysis and critique of bilateral programming in Tanzania, including the identification of areas for improvement such as increasing the focus on women infected by HIV, and reducing instances of MTCT, thereby reducing rates of HIV-infection among children in Tanzania. Next, as all but one of the research participants are Senior level employees, their familiarity with their own programs, as well as their "corporate memory" proved very useful, as they were able to raise and discuss a broad range of ideas relevant to my

research that I may not have initially considered. Finally, engaging with current professionals working within Canadian organizations, such as CIDA, broadens the Canadian perspective on HIV/AIDS within the academic literature, and provides an opportunity to relate these insights and experiences to others working towards the goal of eliminating HIV/AIDS.

The first research participant interviewed was a personal contact, a Junior Policy Analyst, in the Social Policy and Planning Branch; the second participant, contacted through a colleague was a Senior Health Advisor at CIDA, also in the Social Policy and Planning Branch. These interviews laid the groundwork for my primary research, as additional participants were recruited using a "snowball" approach, in that another member within the organization referred them to me. In the end, a total of 24 individuals were contacted, 11 interviews were completed (see Appendix B), and in lieu of an interview, three participants (a Senior Analyst in the Integrated Social Development/Africa Branch, an Analyst from the Health and Education Directorate, and a Senior Analyst from the Multilateral Programming Branch) forwarded electronic documents (e.g., PDFs) that they thought to be of use. A total of 10 individuals declined, referred me to another staff member, or did not respond after several emails and telephone calls. In all instances, interviews took place in person at the CIDA headquarters in Gatineau, Quebec. I contacted one participant, a Senior Development Officer from the Tanzania Program, via Skype, as she was working in the field. Prior to conducting the interviews, there was no consideration given to the gender of research participants, as this is not relevant to this study. It was assumed, however, that the majority of research participants would be women given their primacy in the NGO and development industry.

In the end, this assumption was confirmed; overall 13 of 24 participants contacted, and seven of eleven participants interviewed, were women.

The second interview conducted with the Senior Health Advisor was indeed the most crucial for this study, as he identified a list of three countries (Mozambique, Malawi, and Tanzania) as having large program budgets, and a focus on health care and HIV/AIDS within sub-Saharan Africa. Once these countries were identified, it was then possible to explore the Government Electronic Directory Services (GEDS) database. By using the GEDS system, I was able to contact specific country Program Managers and narrow my search for relevant participants. Program Managers in Mozambique, Malawi, and Tanzania referred me to the individuals working in health and HIV/AIDS in those countries. Meetings were scheduled, and interviews conducted with several Senior Development Officers from the Mozambique, Malawi and Tanzania Program, Senior Policy Analysts from the Social Policy and Programming Branch, and Senior Team Leaders from the Child Rights and Protection Unit. I also contacted additional participants, including CIDA's Health and Education Specialists from the Social Policy and Programming Branch, the Multilateral Programming Branch, and the Health Programming Division, although no interviews were conducted with these individuals.

The individuals interviewed[7] had specific connections to programming that involves HIV/AIDS and/or children. These individuals have various responsibilities, including the management of the health and HIV/AIDS portfolio, and assessing the agency's overall contributions to HIV/AIDS and other health issues (Participant #1,

[7] The dates for all interviews are included in Appendix B - List of Participants. Reference to the information gathered during the interviews is generalized, and no individuals are identified. Participants are referenced according to a number (e.g., Participant #1, 2008), which can be linked to their position in the agency only.

2008). They are also responsible for ensuring that internal policies are coherent with international commitments, and that the agency is represented in international fora such as WHO and UNAIDS meetings (Participant #1, 2008, Participant #2, 2008, Participant #5, 2008). Others integrate HIV/AIDS into programming through program management (Participant #3 2008; Participant #4, 2008; Participant #6, 2008; Participant #7, 2008), and help to develop CIDA's internal policy on HIV/AIDS (Participant #8, 2008); some represent CIDA in the field with regard to health and HIV/AIDS support given to Tanzania (Participant #6, 2008; Participant #9, 2008). Staff also support programming to offer a better perspective on health issues in Africa (Participant #8, 2008). Finally, some are responsible for reviewing programming for gaps, and facilitating research to develop a better understanding on the needs of children (Participant #11, 2008), providing leadership to the agency on the issue of child rights and protection (Participant #10, 2008).

The structure of the interview questions aimed to identify and discuss the elements of bilateral programming in relation to health and HIV/AIDS involving CIDA and the Government of Tanzania, and were organized according to several key themes (see Appendix C): program objectives; partnerships; area of emphasis (such as treatment, prevention, and/or support); international discourse; funding; program accountability; successes and challenges; and most importantly, if women, and the prevention of MTCT are genuinely included in these areas. The information collected on these thematic areas was then compared to official HIV statistics to determine whether changes in development programming (i.e., CIDA's shift to bilateral programming, known as their balanced approach) have helped to improve key outcomes related to rates of HIV-

infection among women and the prevention of MTCT, thereby reducing rates of HIV-infection among children in Tanzania.

1.6 Conclusion

This thesis contributes to the larger dialogue surrounding bilateral programming and HIV/AIDS responses in several ways. Firstly, this study highlights the challenges faced by women infected and affected by HIV/AIDS in sub-Saharan Africa, and more specifically in Tanzania. Secondly, it considers key international agreements that include women and the prevention of MTCT, and reiterates the important role they play in influencing bilateral aid modalities. This study also examines the relationship between CIDA and the Government of Tanzania, and demonstrates their capacity to develop and influence HIV/AIDS strategy plans and programming for reducing HIV-infection among women and children. Finally, the thesis provides an apt case study that demonstrates the contributions anthropologists make to the study of development policy and practice. By conducting semi-structured qualitative interviews among bilateral level actors, this thesis reveals the ways in which international consensus informs national programs and policies, and whether or not current approaches to development should be continued for success on the ground. While literature surrounding the effectiveness of bilateral programming for development and HIV/AIDS mitigation does exist, it remains somewhat limited in academic literature. Therefore, this thesis contributes toward this growing body of literature through a case study on the Canadian-Tanzanian partnership.

1.7 Chapter Outlines

This thesis first introduces key themes and issues, as well as the rationale and focus of the study. The literature review, included in Chapter Two, provides an overview

of the political and socio-economic context in which women are vulnerable to disease, such as HIV-infection. Background information on the risk of infection, as it relates to HIV/AIDS among women is provided, including factors that exacerbate rates of mother-to-child transmission. This chapter also demonstrates risk factors faced by women, such as economic and gender-based inequalities, that serve to increase their vulnerability and reduce access to essential services, such as health care and education, which further exacerbates the number of women and children infected with HIV.

Chapter Two also provides a comprehensive review of key international agreements and discourse that deal explicitly, or in part, with women, children, and HIV/AIDS. These include the *Millennium Development Goals* (2000) and the *Paris Declaration on Aid Effectiveness* (2005), to which Canada is a signatory. A review of these agreements is essential, as they highlight the continued priority given to women's specific vulnerability to HIV and the prevention of MTCT. Importantly, they serve as reminders of the commitments governments have made to those infected and affected by HIV/AIDS. By highlighting the key commitments and recommendations, it is possible to demonstrate their importance in defining current bilateral aid modalities and partnerships such as the partnership between CIDA and the Government of Tanzania. This chapter also introduces CIDA's balanced approach to development.

With an understanding of bilateral aid modalities in place, Chapter Three continues to contextualize the motivation for and the nature of the partnership between CIDA and the Government of Tanzania. Chapter Three also raises important issues of health system strengthening in Tanzania, as health has been defined as a key priority area by the partnership. The current health system in Tanzania is unable to satisfy the basic

health needs of the population, as well as the specific needs of HIV/AIDS patients. It is shown that inadequate health care, and barriers to health care access faced by women are key factors in perpetuating the spread of HIV/AIDS among women, and limit their access to MTCT prevention services.

With this context in mind, Chapter Four demonstrates the strengths and weaknesses of CIDA's balanced approach, which is the agency's current development strategy. Chapter Four presents the case study of the CIDA and Government of Tanzania partnership, and highlights CIDA's contributions to the national HIV/AIDS strategy in Tanzania. This chapter also reviews Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2007), as the framework identifies priority areas set by the Government of Tanzania that are supported bilaterally by CIDA. Finally, Marie Stopes International (MSI) and its local partner Marie Stopes Tanzania (MST) are presented as part of the CIDA/GoT case study. MST provides 20 percent of reproductive health care services in the country including: family planning; pre- and post-abortion counselling; maternal health; sexual health; male circumcision; and HIV/STI services. Reviewing the organization's role provides further insight into the effectiveness of CIDA's balanced approach. CIDA's contributions to health system strengthening, and support to Marie Stopes Tanzania are highlighted, as they are linked to changes in HIV-infection rates among women and instances of MTCT.

Finally, Chapter Five offers an analysis of bilateral programming and CIDA's balanced approach. Conclusions are drawn concerning the strength and significance of bilateral programming, and whether or not agencies should maintain the current approach to development when defining HIV/AIDS mitigation strategies. By creating a link

between CIDA's program-based approaches, and improvements in rates of HIV-infection among women and the prevention of MTCT, this study contributes to the growing body of academic literature on the effectiveness of bilateral programming, which, so far, remains limited. This chapter concludes by summarizing the thesis, discussing its strengths and weaknesses briefly, and offering suggestions concerning the inclusion of women and the prevention of MTCT into CIDA's bilateral HIV/AIDS programming, as well as areas for future study.

Chapter Two – Background to the Study: Situating Women in the Broader Meso- and Macro- Socio-Economic and Political Context

2.1 Introduction

Within the field of medical anthropology, the documentation of larger political and socio-economic processes which exacerbate the spread of HIV has gained momentum, especially by those who adhere to the critical medical anthropology (CMA) approach. Therefore, the purpose of this chapter is to, firstly, document the political and socio-economic processes that leave women vulnerable to HIV-infection, and subsequently, children, vulnerable to MTCT of HIV. This will also clarify why political and socio-economic factors are emphasized over cultural reasoning, which is a more common approach to anthropological inquiry.

Next, the chapter provides a concise timeline for international and national HIV/AIDS responses. This includes an overview of the *Millennium Development Goals* (UN 2000) and the *Paris Declaration on Aid Effectiveness* (HLF 2005). A review of these documents focuses not only on their inclusion of international HIV/AIDS goals and targets, but also on their ability to galvanize national efforts through new development modalities. One such example is CIDA's approach to bilateral programming, known as the "balanced approach" to development. The agency's adherence to the MDGs and the Paris Declaration heavily influences CIDA's balanced approach, which combines national level planning with complementary CIDA-supported, locally designed and implemented projects. CIDA currently favours this approach over its traditional "project-based approach", and the rationale for this shift is discussed in relation to the agency's Geographic Programming Branch (Hanson 2000:347).

With these frameworks in mind, this chapter concludes by examining the range of structural and contextual determinants of health, such as inequality and discrimination, poverty, and economic and political instability that make women, and consequently, their children more susceptible to HIV-infection via MTCT. Children who are infected with HIV most often acquired the disease during their mothers' pregnancies, delivery, and/or through breastfeeding (Ross *et al.* 2006:2; UNAIDS 2008c:37). This chapter contextualizes HIV/AIDS by using current statistics from sub-Saharan Africa, generally, and then specifically within Tanzania. The chapter also provides an overview of the political and economic climate in Tanzania as background to the analysis.

2.2 Critical Medical Anthropology (CMA) and Socio-Economic Determinants of Health

This section reviews the critical medical anthropology (CMA) approach in order to better understand the political and socio-economic context that leaves women vulnerable to HIV-infection. The literature review includes the works of Brown *et al.* (1998), Baer and Singer (1998; 2003), Farmer (1999; 2004), and Poku (2005), among others. Through examining the work of these authors, it is clear why socio-economic and political determinants of health are favoured over cultural or behavioural determinants in this thesis. The CMA approach postulates that cultural beliefs or practices that may influence individual behaviour or circumstance cannot be studied in isolation from the political and socio-economic determinants of health. It is understood that although cultural understanding cannot be eliminated from anthropological inquiry, as it is the discipline's classic approach, more often cultural reasoning should be used to enhance the CMA approach rather than relying solely on cultural reasoning for analysis, which fails to

address the root causes of poverty (Campbell 2008:256). This thesis reiterates the belief among critical medical anthropologists that the root cause of disease in developing countries and impoverished communities is poverty and inequality: as such these factors must be understood before development programming can be designed and implemented (Farmer 1999:xxiii; Singer 1998:225).

Critical medical anthropology forces the deeper examination of regional disparities through global political-economic influences, thus avoiding the artificial separation of local settings from the wider political context. This includes exposing the macro-level forces that exacerbate disease burdens and outcomes, constrain individual autonomy, and reduce the quality of, and access to, health care systems (Brown *et al.* 1998: 16; Farmer 1999: 6; Singer 1998: 226). Therefore, the critical medical anthropology approach aptly considers how historical political relationships between and within countries influence contemporary disease distribution and national mitigation strategies (Baer *et al.* 2003:34; Brown *et al.* 1998: 16; Singer 1998: 226). CMA focuses on the "political economy of health," as exemplified by the writings of Poku (2005), Baer *et al.* (2003) and Oppong and Kalipeni (2004). Poku notes that although the idea of linking health to political and economic forces is not new, he feels that the documentation of these linkages remains rare (Poku 2005: 2). He further suggests that few researchers have examined how the "course, direction, and impacts of the [AIDS] epidemic have been affected by the continent's ubiquitous poverty, the continually pervasive prescriptions from international financial agencies or Africa's marginalization in the globalization process" (Poku 2005:2). His writing connects the implications of post-colonial political and economic processes, structural adjustment, poverty, dependency,

and underdevelopment to the spread of HIV, and the treatment of AIDS. These processes are reflected by the current health system reality in Tanzania, explored below (Poku 2005:17; Oppong and Kalipeni 2004:48).

Proponents of the CMA approach also claim that prior research on HIV/AIDS misrepresents Africa through cultural stereotyping and largely ignores the impacts of HIV/AIDS on social, economic, and political stability in favour of documenting sexual or "deviant" behaviour in relation to HIV (Oppong and Kalipeni 2004:48; Poku 2005:2). These authors are critical of the latter approach, as they strongly believe that sexual "behaviour" alone cannot explain the high HIV- prevalence rates in sub-Saharan Africa. Furthermore, they reject assumptions that Africans are more sexually active and that "exotic" African kinship and marriage patterns contribute to high rates of HIV-infection in the region (Oppong and Kalipeni 2004:50; Poku 2005:2). Sexual norms, such as chastity and monogamy, are found in many African sub-cultures, just as they are across the globe (Oppong and Kalipeni 2004:51-2). Oppong and Kalipeni (2004) also draw attention to the fact that individual autonomy, societal norms and gender relations also influence sexual behaviour. In short, sexual behaviour should be viewed within the context of socio-economic factors (e.g., poverty and gender inequalities) and these factors should be adequately included in HIV/AIDS mitigation strategies (Oppong and Kalipeni 2004:50).

It is, therefore, critical to recognize that in the past many mitigation strategies focused primarily on HIV-prevention, targeting behaviour modification and condom use, rather than on restructuring the socio-economic and political conditions that leave individuals vulnerable to HIV. This is particularly relevant to this study, as current

strategies are increasingly comprehensive and balanced, emphasizing that prevention and treatment strategies must not exist in isolation and must engage actors from all levels in order to design and implement effective HIV/AIDS responses. Factors that limit access to treatment and prevention need to be concurrently addressed in relation to women's exposure to HIV and the prevention of MTCT. As articulated by Farmer, issues such as gender inequality and poverty need to be dealt with in conjunction with local HIV/AIDS prevention and treatment programs in order to facilitate long-term change (1999:xxv). By leaving these inequalities unchallenged, it is inevitable that diseases will continue to persist among marginalized populations, including poor women and children.[8]

Finally, Farmer suggests that populations at risk of HIV/AIDS remain vulnerable when signatories and policymakers fail to uphold commitments made at the international level (Farmer 2004:8). Farmer contends that, in order to achieve international conventions and agreements, such as international treatment or prevention targets, implementation must be concurrent with poverty reduction and development strategies and the promotion of social equality (Farmer 2004:11). This point is especially pertinent to the discussion on HIV-responses in Tanzania. International commitments, including those reviewed in this chapter, are included in the development of national HIV/AIDS

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[8] Farmer, although not explicitly, furthers the CMA approach through his application of the "structural violence" perspective. According to Farmer, structural violence is the process of socio-economic and political inequality at the international or national level, which serves to undermine health care systems, as well as HIV/AIDS prevention and treatment initiatives at the national or local levels (Farmer 1999:149). To illustrate his claims, Farmer often points to the high rates of infection that persist among women within the developing world. These women are burdened by both inadequate health care systems at the national and community levels, as well as social inequalities at the household level that limit their access to health care, education and preventative services, and increase their risk of HIV-infection (Farmer 1999:78-9), resulting in higher rates of infections among children through mother-to-child transmission (MTCT). This is especially true in low-income settings, where children are exposed to HIV-infection because of the lack of medications, and inadequate pre- and post-natal care and education among their parents (Farmer 1999:141). The knowledge and technology to prevent MTCT are available, although they remain unevenly distributed across regions.

strategy plans, and define the conditions of bilateral agreements between CIDA and its partners, such as Tanzania. With Farmer's contention in mind, this thesis discusses the effectiveness of bilateral aid modalities, influenced by consensus at the international level. This thesis also considers whether or not national governments and agencies should continue with their approach to bilateral programming, when defining HIV/AIDS mitigation strategies or, conversely, if such strategies should be reconsidered in light of them failing to decrease the number of HIV-infections among women and instances of MTCT. With the CMA approach outlined above, it is clear why the political and socio-economic factors that exacerbate the number of HIV-infections among women, and increase instances of MTCT are discussed in this thesis. Furthermore, the number of HIV-infections among women and instances of MTCT in Tanzania serves as a relevant background to the upcoming case study analysis.

2.3 Factors Affecting Women's Health Status and the Prevention of Mother-to-Child-Transmission (MTCT)

Women now account for at least half of all people infected with HIV globally. In 2007, UNAIDS estimated that 15.4 million women worldwide were living with HIV (UNAIDS 2008c: 14; UNAIDS 2007a: 1). In fact, in some regions, women face a risk of infection three times higher than their male counterparts. In sub-Saharan Africa, where the total number of adults living with HIV is highest, over 60 percent are women (UNAIDS 2007a:8). This section provides a broad overview of the unique HIV-related concerns faced by women. In general, there are a variety of cultural and socio-economic determinants that exacerbate infection rates among women, which may also increase the number of children infected via MTCT (James 2006:195). It is important to note that it is impossible to make universal statements concerning women's experience with

HIV/AIDS. Factors increasing vulnerability are not static. They are not faced by all women, and are felt more or less by individual women, depending on their class, age, ethnicity and level of autonomy in the home.

Economic marginalization, including poverty at the household level, serves as a barrier to health care and education for women in several important ways. When financial resources at the household level are exhausted, women are often the first to be deprived of health care services. In this scenario, women are less likely to seek or receive medical care and treatment, as their needs may be overshadowed by the needs of male family members (Esplen 2007:8). In such low-resource settings, women also face higher rates of malnutrition compared to their male counterparts, as they may be forced to skip meals or eat less to feed others in the family. This is especially dangerous as HIV-infection can progress more rapidly to the AIDS stage without treatment and care, which includes proper nutrition (Esplen 2007:8).

Women's unequal access to education may limit their understanding and ability to prevent HIV-infection in the first place. Compounding this problem is the fact that girls, living in a household infected and affected by HIV/AIDS, are twice as likely to be withdrawn from school with detrimental consequences (Badcock-Walters 2003; UNAIDS 2008d:14). Studies (IPU 2007; Ross *et al.* 2006) reveal that the adoption of behavioural changes, such as the promotion and practice of safer sex, are more effective if initiated at an early age. Where the spread of HIV has been stopped or slowed, it has been largely connected to the availability of tools (e.g., condoms) and information that young people need to protect themselves (IPU 2007:160). Young people, especially young women, who have access to education, are more likely to delay sexual début, and, subsequently, reduce

their number of sexual partners, thereby decreasing the chance of HIV-infection due to unsafe sex, or complications during pregnancy (IPU 2007:161). However, the promotion of strict abstinence-based education unnecessarily jeopardizes the health of young people, and undermines their right to information and education about sexual health by emphasizing sexual morality, instead of accurate information about sexual and reproductive health.[9]

Access to health care services is directly linked to levels of education (Habib *et al.* 2008: 622; James 2006:196). Surveys conducted by the World Health Organization (WHO) reveal that many young people, especially women, simply do not know where to obtain sexual and reproductive health care, including voluntary counselling and testing for HIV and other sexually transmitted diseases. In 25 of 39 countries surveyed by WHO, less than 50 percent of women (aged 15 to 24 years) knew where to go to obtain testing and counselling, however, women with higher levels of education were more likely to know where to go to obtain these services (Ross *et al.* 2006: 30). Prevention and education programs that target sexually active youth can be especially useful in curbing the future of the pandemic. Adolescents must learn about the risk of sexually transmitted infections before becoming sexually active and/or reach their child-bearing years; they must also learn about the relationship between HIV-transmission and social forces, such as poverty and gender inequalities (Farmer 1999:89).

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[9] By dollar value, USAID represents the largest contributor to funding HIV/AIDS prevention programs in the developing world. However, the hundreds of millions of dollars spent by USAID were directed by former President George W. Bush and his administration to focus almost exclusively on abstinence-based prevention and pro-life programs (Davis and Fort 2005:146). The current administration led by President Barack Obama, has reversed this order, lifting what is known as the "global gag-rule" which previously barred US federal funding to comprehensive family planning initiatives (Rovner 2009). The "global gag-rule" has been criticized, for limiting access to family planning and contraceptives that are vital in preventing the spread of HIV (Halloran 2009; James 2006: 204). Family planning organizations in the United States and abroad commend Obama's decision to lift the ban, as it is largely recognized that young people continue to engage in sexual relationships despite the message to abstain (IPU 2007:160).

Related to the issue of poverty is economic dependence (James 2006:1996). Fear of rejection, stigma, and violence, coupled with economic dependence on their husbands, intimate partners, and families prevents women from seeking testing, counselling, and treatment for HIV and HIV-related illnesses, even if these services are economically feasible (Habib *et al.* 2008:617). Furthermore, requesting funds to pay for antiretroviral treatment (ART), utilizing options like powdered milk to prevent mother-to-child transmission, or insisting on condom use to reduce repeated exposure are "obvious" indicators to their partners or families that a woman is HIV-positive (Esplen 2007:7). At the root of this issue are the sexual double standards faced by women. In many contexts, the social and cultural value surrounding female "purity" means that women living with HIV/AIDS are subjected to greater discrimination than men. Cases where women are "blamed" for their infection can lead to heightened levels of domestic abuse, abandonment by spouses or in-laws, or to dismissal from paid employment (Esplen 2007:1). Oftentimes, women lack the ability to negotiate safer sex in the home or demand fidelity; this is due to socio-cultural and historical patterns, which continue to subordinate women (James 2006:197). Internalized stigmas may also affect a woman's confidence to leave a physically or sexually abusive relationship (Esplen 2007:2). Not only does this undermine individual autonomy, but it also increases the risk of HIV-infection among women.

Beyond the household, in situations where health care services are unreliable and confidentiality is not respected, and, as indicated above, women face the risk of abandonment if their HIV status is revealed to their partners or family. Women who are found to be HIV-positive during pre-natal testing may face discrimination, coercion, or

forced sterilization at the hands of health care providers (Berer 1993:93; Habib *et al.* 2008:617). Young women, in particular, may not seek medical attention, even if they suspect HIV-infection, because they may feel embarrassed, guilty, or fear that their privacy will not be respected (Ross *et al.* 2006:30). Openly discussing issues of sexuality and contraception may still be considered taboo among older generations (Baylies 2004:76). As such, young women who attempt to protect their sexual health may face unfriendly attitudes from health care workers and peers when accessing services (Baylies 2004:73). Again, this can limit the likelihood of women being voluntarily tested and treated for HIV, sexually transmitted infections, and opportunistic infections, which ultimately exacerbates rates of death due to AIDS among women (Berer 1993:93; James 2006:197).

It is important to note that while women voluntarily engage in sexual activity, they may also become victims of sexual exploitation and abuse. There are a number of factors that may account for this, including gender-based discrimination, which increases the risk of sexual abuse and violence among women and girls (CIDA/UNICEF 2007:15-17). Young women who are expected to earn an income are particularly vulnerable to trafficking and sexual abuse (Ross *et al.* 2006:34). In the worst cases documented, girls as young as 10 years old were forced to engage in prostitution (CIDA/UNICEF 2007:17). For many young women, the onset of sexual activity does not happen by choice. Studies show that 10 to 20 percent of young women aged 15 to 19 years were forced or coerced into their first sexual experience. In many societies, people turn a blind eye to sexual abuse and gender-based violence, both of which have implications for HIV-transmission (Ross *et al.* 2006:33-4). Limited legal safeguards may also leave crimes such as sexual

abuse and assault unreported, and, consequently, perpetrators go unpunished (CIDA/UNICEF 2007:17). Legal frameworks need to be continually strengthened and enforced, particularly at the local level. Women and men are equally recognized in Tanzania under the law, but systemic gender biases against young women and girls undermine the law's effectiveness (CIDA/GGI 2004:4).

Intergenerational sexual relationships also compromise the health of women. These relationships act as barriers to safer sex for young women, especially, who are not able to negotiate sexual relationships on an equal basis with their partners, which further exposes them to sexually transmitted infections (STIs), including HIV (CIDA/UNICEF 2007:18; Smith 2002). Girls may also "willingly" form relationships with older men, commonly known as "sugar daddies", who are prepared to give money or goods in return for sex (Ross *et al.* 2006:34; Smith 2002). Poverty often influences a woman's decision to accept these intergenerational relationships as a means of survival. An in-depth analysis of data from five sub-Saharan African countries, including Tanzania, found a clear association between young women infected with HIV, and the number and age of her partners (UNICEF 2008a:17). Young women aged 15 to 24 were more likely to be infected when they had multiple partners, or partners that were older. In Tanzania, a woman was 3.3 times more likely to be infected if she had three or more partners in her lifetime compared to a woman with only one partner, and 2.4 times more likely to be infected if her partner was 10 or more years older (UNICEF 2008a:17). The inability of young women to negotiate safe sex also compounds this problem. This point reiterates the importance of understanding and preventing transactional and/or intergenerational sex.

In some scenarios, cultural beliefs support the misconception that condom use is emasculating. It is thought that the use of condoms has implications for the male psyche, as a man may feel that this limitation challenges his notions of manhood, as condom use interferes with the ability to conceive (Tober 2001:158). In her article, Tober explores the reproductive health and sperm donor industry, and the cultural interpretations of genetic inheritance related to sperm. She suggests that semen is not only a vehicle for genetic transmission, but also carries various historical, cultural, and sexual meanings (Tober 2001: 138). These culturally held notions influence men's perception and preoccupations with sperm. To support her claim, Tober draws upon the work of Emily Martin, who problematizes reproductive metaphors that view sperm as the "aggressor" and the egg as the "passive recipient", based on stereotypical male-female relations (Tober 2001:139). This medical rhetoric is said to reinforce sexual dominance of men over women, and the notion that men have sexual rights over women's bodies (James 2006:196) – and is often related to the number and timing of children. However, this is not the only issue surrounding condom use, as condom use, as an HIV-prevention strategy, is incompatible with the desire for children and pregnancy by both women and men.

The symbolic value of conception and childbirth is immeasurable not only for men, but also for women, as the perpetuation of genetic and economic inheritance, and continuation of culture, all relate to the desire to have children (Davis-Floyd 1994: 1). As with men, rituals of conception and childbirth have implications for a woman's conceptualization of herself and her role within society (Davis-Floyd 1994:2). The desire to have children is also linked to economic security within the home, not only because children can be economically productive, but also because children will care for parents

in old age. Clearly, HIV undermines both sexual and cultural reproduction, however, technologies that can help manage the spread of HIV, while also preserving cultural and sexual reproduction, are not equally accessible. Similarly, when planned-parenthood is desired, poverty limits the ability to purchase contraceptives such as condoms, a challenge faced by both men and women. Ultimately, the desire for children or the inability of women to negotiate decisions about their reproductive and sexual health, are both a cause and complication of HIV-infection (Piot *et al.* 1999:869).

Regardless of HIV status, women in sub-Saharan Africa are at risk during childbirth; early or complicated childbirth and abortion further increase the rates of HIV-infection (Berer 1993:96; Habib *et al.* 2008:616). In sub-Saharan Africa, over half a million women continue to die each year from treatable or preventable health complications of pregnancy and childbirth (UNDPI 2007:2). In resource poor settings, complications, such as traumatic delivery or blood loss, might mean a blood transfusion is required; this can be very risky if blood supplies have not been adequately tested for HIV (Berer 1993:46). In the past, the privatization of health care and declines in the public health care spending, influenced by structural adjustment programs (SAPs), [10] led to an increase in privatized blood banks and health care facilities. Such decentralized control made it more difficult to regulate or screen the supply of blood suitable for transfusions (Berer 1993: 59). In many parts of the world, blood transfusions are no longer a significant source of HIV-infection, in fact, Tanzania claims that 100 percent of donated blood is now screened prior to transfusion (UNAIDS 2008f:15). However, the

[10] Structural adjustment programs (SAPs) are characterized by reduced government expenditure, typically in the health care and education sector. The World Bank and the International Monetary Fund (IMF) were responsible for designing and encouraging SAPs in the late 1980s and 1990s as a pre-requisite for development loans. This process is explained more fully in Chapter Three.

importance of continued vigilance of blood supplies cannot be overstated (UNAIDS 2009).

An additional problem encountered in resource poor settings is that health services may still face a limited supply of sterilized or obstetric equipment (Kruk *et al.* 2009:280). There are a number of reasons for this: equipment used for sterilization may not be available, or may simply break down, and there is often no funding or expertise to repair it. Consequently, non-sterile or inadequate surgical tools may be used, thereby increasing the chance of HIV-infection among patients (Berer 1993:65; Kruk *et al.* 2009:280). A serious detrimental effect of externally driven structural adjustment programs, that reduced funding and support to the health sector (see Chapter Three), is witnessed today in the inadequacy and inability of the health care sector to provide safe and reliable services to women and their infants (Campbell 2008: 256).

With the risks faced by women so clearly outlined, it is not difficult to connect rates of HIV-infection among women to rates of HIV-infection among children. As previously mentioned, MTCT accounts for 90 percent of all children infected with HIV (Ross *et al.* 2006:2; UNAIDS 2008c:37). The need to prevent mother-to-child transmission has gained increased attention within the international community. MTCT can occur in various stages of pre- and post-natal care, including pregnancy, delivery, and breastfeeding (Poggensee *et al* 2004:477). However, transmission can be significantly reduced with interventions at all three stages. With the administration of treatment during pre- and post-natal care, and the provision of alternative feeding options (as opposed to breast milk), mother-to-child-transmission of HIV can be significantly reduced to less than 2 percent (UNAIDS 2008c:7). However, without these interventions, the risk of

MTCT of HIV-infection remains as high as 20 to 45 percent during pregnancy and delivery alone; an additional risk of 20 to 40 percent is added if non-infected children are breastfed by HIV-positive mothers (Esplen 2007:15; Poggensee *et al.* 2004: 477).

Limited access to testing and treatment among women, as well as limited pre- and post-natal counselling, are clearly reflected in the current statistics of children infected by MTCT. Unfortunately, less than 33 per cent of pregnant women worldwide are currently offered services needed to prevent mother-to-child-transmission of HIV (UNAIDS 2008b) and in 2007, only 18 per cent of women in low- and middle-income countries knew their HIV status, or had ever received an HIV test (Poku 2004:40; UNICEF 2008a:4). In Tanzania, only 16 per cent of HIV-infected pregnant women had been tested for HIV (Habib *et al.* 2008:617). However, even when a woman's HIV status is known, globally, only one in 25 children born to an HIV-positive mother receives the prophylaxis needed to prevent opportunistic infections and the onset of AIDS (UNICEF 2007:3). Unfortunately, limited access to testing and treatment among women (for reasons previously discussed), increases the risk of MTCT. Limited pre- and post-natal counselling are also reflected in the current number of children infected in this way (Poku 2004:40; UNAIDS 2008c:3).

Breastfeeding accounts for high rates of mother-to-child-transmission, as the majority of African women breastfeed (Poggensee *et al.* 2004:484). It is now known that breast milk contains high levels of the virus, increasing the risk of HIV-infection among infants (Esplen 2007:15; Piot *et al.* 1999:869). In order to mitigate these challenges, women must be guaranteed equal access to education and health care in order to increase their awareness of mother-to-child transmission; post-natal counselling must also be

provided to both partners (Poggensee *et al.* 2004: 478; Poku 2004:40). Interfering with the process of breastfeeding also has cultural implications, as breastfeeding is conceptualized in culturally specific ways. Although the relationship between motherhood and maternal milk is not static, the connection is undeniable (Millard 1990:211). Aside from cultural factors, breastfeeding can be connected to economic circumstance, such as the unavailability or prohibitive costs of formulas that may leave women with no other option than to breastfeed (Poggensee *et al.*2004:483). This is especially important to the discussion of MTCT, as one of the most widely accepted methods to avoid MTCT is to provide formula to the infant exclusively. According to UNAIDS, no medically validated prophylactic treatment regimen exists to completely eliminate the risk of HIV-infection due to breastfeeding. Ideally, early weaning is recommended to reduce the risk of infection among children who are breastfed by HIV-positive mothers (Poggensee *et al.* 2004: 478; UNAIDS 2008c: 121). Research reveals that when women receive antiretroviral treatment, breastfeeding is a viable HIV prevention option, but breastfeeding must be limited to the first six months (UNAIDS 2008c: 243). New technologies are being developed to prevent mother-to-child-transmission via breast milk, such as a nipple shield that disinfects breast milk as it leaves the breast or bottle (BBC 2008). Developers are hopeful that this technology can have positive effects for HIV-positive mothers who are reliant on breast milk, as the shield is quick, simple to use, and relatively inexpensive (BBC 2008; EWB 2009). However, more research needs to be done to improve this technology, to make it both safe and marketable (EWB 2009).

Clearly, breastfeeding adds yet another dimension to the issue of reproductive health and HIV. The dependency on formulas or other technologies in order to protect the child from HIV may lead to increased economic burden on the household, or may not be adopted at all if it is economically unfeasible, leading to transmission of HIV to the child. Furthermore, breast milk replacements become complicated, as formulas require clean water and timely preparation as does breast pumping for bottle feeding, rather than the mother's natural lactation that is available on demand (Millard 1990:219). This could lead to complications such as malnutrition in the child, or high risk of HIV-infection if women resort back to breastfeeding (Poggensee *et al.* 2004:483). Safe and reliable alternatives (such as formulas, boiling breast milk, or nipple shields) concurrent with post-natal counselling, need to be made available to women, however, these alternatives are constrained by household income, as well as access to clean drinking water needed to prepare formulas and fuel to boil breast milk (UNAIDS 2008b). Again, women's awareness of these options require adequate access to health care and educational services, which may be unavailable to them for the myriad of reasons previously discussed.

As a final consideration, the prevention of MTCT is burdened by economic constraints and the inadequate amount of funding devoted to the health care sector at the national level. Despite arguments which suggest that the universal provision of zidovudines (antiretrovirals specific to the prevention of MTCT) is not economically feasible, it is argued that, compared to the long term costs associated with the loss of

future economic growth and cost of other treatment options for newly infected children, zidovudines are relatively inexpensive (Poku 2005:133).[11]

Taking a step in the right direction, Tanzania is demonstrating its commitment to the issue of MTCT through the implementation of a national monitoring and evaluation framework for the prevention of mother-to-child-transmission (PMTCT), as part of its national health system strengthening strategy (Ministry of Foreign Affairs, Denmark 2007:115). However, the extent to which facilities and resources are adequately distributed needs to be closely evaluated and improved. In 2006, only 66 per cent of hospitals, 38 per cent of health centres, and 7 per cent of dispensaries that perform deliveries provided adequate PMTCT services. This is largely attributed to inadequate training among staff and the lack of antiretrovirals (ARVs). More integration of HIV/AIDS services is needed in anti-natal care settings to reduce the number of missed opportunities to prevent MTCT (Ministry of Foreign Affairs, Denmark 2007:117).

2.4 International and National Consensus on HIV/AIDS and Development

Within the health community, the prevalence of international declarations, consensus, and discourse surrounding HIV/AIDS is overwhelming. Countless documents and seemingly endless commitments that have been drafted and signed, are continuously evolving to reflect changing needs and newly emerging epidemics. With the vast amount of documentation devoted to the issue of HIV/AIDS, it is not possible to review them all. Therefore, the purpose of this section is to highlight two crucial documents important to this study, the *Millennium Development Goals* (MDGs) and the *Paris Declaration on Aid Effectiveness* (Paris Declaration) and to situate them in their historical context. These two

[11] Other issues such as treatment delivery, adherence and dosage for children are prevalent in literature about paediatric HIV/AIDS. However, it is not within the purview of this paper to discuss these concerns.

documents are selected above all others, as they are the basis for CIDA's current approach to development, and reinforce the inclusion of women, MTCT and HIV/AIDS in the agency's programming. Furthermore, CIDA interviewees repeatedly referred to them as having the utmost importance in the agency's understanding of development goals, and in CIDA's relationship with its bilateral partners. With this understanding in place, it is critical, at this juncture, to discuss the effectiveness of new bilateral aid modalities, and their influence on rates of HIV among women and instances of MTCT.

From the 1980s, HIV/AIDS was troubling the minds of the international health community, however, it became increasingly apparent that HIV/AIDS could not be contained by the efforts of the health sector alone (Barnett and Whiteside 2002:274; Gordenker *et al.* 1995:1). A concerted effort was needed from those working in the political, economic, and development spheres, as well as, in what is now commonly known as multi-sectoral responses. The year 1987 marked the beginning of the World Health Organization's (WHO) Global Program on AIDS, which provided national governments with internationally agreed upon guidelines and coordinated HIV/AIDS strategies locally and internationally (Gordenker *et al.* 1995:1). With the support of national governments, WHO ambitiously planned to prevent new infections, reduce sectoral impacts, and unify international efforts (Gordenker *et al.*1995:1). These themes continue to characterize many international HIV/AIDS responses today.

In the last 20 years, international consensus has come a long way, although policymakers, development practitioners, civil society, and individuals continue to struggle with skyrocketing rates of HIV-infections and emerging epidemics among increasingly marginalized cohorts (especially women, and children infected via MTCT).

For the purpose of this chapter, it is not necessary to provide an entire history of HIV/AIDS responses; even those that are relevant to Tanzania, specifically, are far too many to describe in detail. A brief listing of the most relevant events follows in Figure 2.1:

Figure 2.1 - Timeline for International and National HIV/AIDS responses

1987: Global Programme on AIDS launched by WHO;
1989: The Convention on the Rights of the Child signed by 190 Member States (including Canada and Tanzania);
2000: Millennium Declaration and launch of the Millennium Development Goals;
2000: Global AIDS Vaccine Initiative (GAVI) Alliance formed;
2001: UN General Special Session on HIV/AIDS (UNGASS), 189 Member States sign the Declaration of Commitment;
2001: Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Infectious Diseases endorsed (African Regional Declaration);
2001: Tanzania Commission for AIDS (TACAIDS) established;
2001: National Policy on HIV/AIDS (Tanzania);
2002: National Health Policy (Tanzania);
2002: The Global Fund to Fight AIDS, Malaria, and Tuberculosis created;[12]
2003: National Multi-sectoral Strategic Framework on HIV and AIDS (Tanzania);
2003: The Presidential Emergency Plan for AIDS Relief (PEPFAR) launched (USA);
2003: Tanzania receives first round of funding from Global Fund;
2004: The "Three Ones" principles for coordination of national AIDS responses launched;[13]

[12] The Global Fund is a multilateral initiative that partner governments, civil society, the private sector and communities affected by HIV/AIDS, tuberculosis, and malaria. Similar to the "Three Ones" principles, the Global Fund was borne from the recognition that disease responses must be made increasingly effective and coordinated. It was first endorsed by G8 countries in 2000, then by African leader at the Abuja Summit in 2001, and, finally, at a UNGASS special session in 2001. By 2002, the Global Fund was distributing funds in over 36 countries, including Tanzania. It is important to note that the Global Fund operates as a financial instrument, attracting, managing, and disbursing financial resources - but it is not an implementing entity. In other words, the Global Fund does not design health programming, rather, the Global Fund works in close collaboration with bilateral and multilateral organizations to supplement their existing efforts for dealing with disease. The Global Fund is committed to Paris-principles, as funding is distributed to support national health plans and priorities, and requires that representatives from all levels are involved in the planning process. Comprehensive and balanced programming, that includes both prevention and treatment initiatives, according to local needs, is also considered. The Global Fund also finances health system strengthening initiatives, for example, infrastructural improvements and improving human resources for health care delivery.

[13] Despite the enormous amount of funding available for HIV/AIDS prevention and treatment, rates of new HIV-infections and deaths due to AIDS continue to rise. The UN suggests that this is due to an inadequate use of funding, resulting from a lack of coordination between the international, national and community based responses to the pandemic. The "Three Ones" were developed as an attempt to coordinate multi-sectoral initiatives and responses to HIV/AIDS, build capacity among national and regional leaders, and to improve the inadequate use of funding observed by the United Nations. Endorsed in 2004, the "Three Ones" principles commit signatories to developing ONE agreed upon AIDS action framework that provides the basis for coordinating; ONE national AIDS coordinating authority, with a broad-based multi-sectoral

2005: G8 commitment to Universal Access to Treatment;
2005: Launch of "Unite for Children, Unite Against AIDS" campaign by UNICEF/UNAIDS;
2005: Signing of the Paris Declaration on Aid Effectiveness by 123 Countries (including Canada and Tanzania);
2006: UN General Assembly Political Declaration on Universal Access to Prevention, Treatment, Care and Support;
2007: Second National Multi-sectoral Strategic Framework on HIV and AIDS (Tanzania)
2007: Launch of "Enhanced Protection for Children Affected by AIDS" by CIDA/UNICEF;
2008: 147 Member States submit UNGASS Country Progress Reports (including Tanzania).

(source: Ministry of Foreign Affairs, Denmark 2007:34; UNAIDS 2008a:12)

From this lengthy (although not exhaustive) list, two important internationally agreed upon documents can be highlighted, as they influence the CIDA's "balanced approach" to development. Reinforced by the signing of the *Millennium Development Goals* (2000), the needs of women (MDG 3 and MDG 5) and children (MDG 4), and HIV/AIDS (MDG 6) are recognized as global priorities. The signing of the *Paris Declaration on Aid Effectiveness* in 2005 ushered in a new era of unified poverty-reduction strategies, including HIV/AIDS action plans across countries and regions. These two documents are recognized as the cornerstones of CIDA's program-based approaches, which define their bilateral partnership with the Government of Tanzania. They are the basis of CIDA's four-point strategy on HIV/AIDS, which clearly prioritizes HIV/AIDS in relation to women and children: 1) health system strengthening at the national and community level to provide adequate basic health care services to people living with HIV/AIDS; 2) research for a vaccine; 3) the promotion of gender equality due to the feminization of the disease; and 4) the promotion of children's rights and protection of children infected and affected by HIV/AIDS (CIDA 2007:1). By

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mandate for all partners; and ONE agreed country-level monitoring and evaluation system (Parliamentary Centre/WBI 2009: 25). The Government of Tanzania signed on to the "Three Ones" and aims to achieve "coordinated, effective, transparent, accountable and sustainable leadership and management structures...at central, regional and local levels" (TACAIDS 2007: xx).

highlighting the frameworks that inform CIDA's current HIV/AIDS responses, this section provides a basis for the analysis that follows. Chapter Four focuses on whether or not CIDA has contributed to any appreciable gains towards the goal of reducing the number of HIV-infections among women and the prevention of MTCT through its bilateral programming model.

2.5 The Millennium Development Goals

In brief, the Millennium Development Goals (MDGs) are derived from the United Nations Millennium Declaration. In the year 2000, 189 (of 192) UN Member States, including Canada, adopted the MDGs. The objective of the eight goals is to produce meaningful, achievable, time-bound development goals aimed at: 1) eradicating extreme poverty and hunger; 2) achieving universal access to primary education; 3) promoting gender inequality and empowering women; 4) reducing child mortality; 5) improving maternal health; 6) combating HIV/AIDS, malaria, and other diseases; 7) ensuring environmental sustainability; and 8) developing a global partnership for development – all by 2015 (UN 2005). Each goal is further defined by its own set of qualitative and quantitative targets (see Appendix A).

The Millennium Development Goals are extremely influential in informing CIDA's poverty-reduction and HIV/AIDS mitigation strategies, a point articulated by several CIDA staff members included in this study. Much of CIDA's work, such as funding, programming, and area of emphasis, coincides with the objectives of the MDGs. Such widely accepted goals have reinvigorated countries around the world by providing a framework for development, and, as reiterated by CIDA staff, have galvanized unprecedented efforts to meet the needs of the world's poorest (UN 2005, 2006:3). Not

only do the MDGs have implications for overall poverty reduction and development, but they are also interconnected with effective HIV/AIDS responses (UNAIDS 2008a:14). Indeed, there are a multitude of socio-economic factors linked to HIV-infection among women that exacerbate instances of MTCT and the number of HIV-infections among children, as discussed in the first half of this chapter. Although only one goal (MDG 6) specifically addresses the epidemic, the successful achievement of the MDGs is threatened by the progression of HIV/AIDS, and, inevitably, HIV/AIDS responses are dependent upon the overall success of the MDGs (UNAIDS 2008a:14).

Although reports indicate that there are gains towards achieving the MDGs by 2015, the extent to which the eight development goals are "on-track" is highly variable between countries and regions (UNDESA 2007:3). Currently, at the approximate midway point between their adoption in 2000 and the 2015 target date, sub-Saharan Africa is not on-track for achieving any of the Goals (Hecht *et al.* 2006:1992; Perkins *et al.* 2009:290; UNDESA 2007:4; UNDPI 2007:1). The tone of recent reports indicates that recent progress seen outside of sub-Saharan Africa "should provide the incentive to keep moving forward", however, there is still a long way to go in order to meet the objectives outlined in the MDGs (UNDESA 2007:3). Overall, successes demonstrate the importance of firm commitment by developing countries and their partners. Reports reveal that without committed political leadership many millions of people will not see the promise of the MDGs affect their lives positively, and some argue that the MDGs are nothing but "buzzwords" used to overshadow "business as usual" (Cornwall and Brock 2005:3; UNDESA 2007:3).

The importance of applying the MDGs to HIV mitigation strategies is clear, and the role of bilateral partnerships (e.g., CIDA and the GoT) in effectively achieving such targets at the country level is explored in the upcoming chapters. Similarly, Cornwall and Brock argue that the MDGs can only be achieved by harmonizing donors, and ensuring that development assistance is delivered in accordance with partner country priorities, including poverty reduction and HIV/AIDS (Cornwall and Brock 2005:12). This assertion is critical in understanding the importance of the *Paris Declaration on Aid Effectiveness* (2005) and its adoption by CIDA, discussed below.

2.6 The Paris Declaration on Aid Effectiveness

As international and national responses, inspired in part by the MDGs, are now broader and stronger, access to financial resources for development and HIV/AIDS mitigation is equally impressive. Contributions from the Global Fund, the World Bank, donor countries, as well as increased commitments by affected countries themselves have led to an unprecedented level of funding for a singular objective. In 2004, $6.1 billion USD was available specifically for HIV/AIDS programming in developing countries, and in 2007 approximately $10 billion USD was available (UNAIDS 2008e). However, the need to develop efficient strategies to mobilize these financial resources has become increasingly apparent.

The Paris Declaration (2005) is an international agreement among development officials from 91 countries, 26 donor organizations and partner countries (including those from Canada and Tanzania), and representatives from civil society and the private sector. More than 100 signatories committed to making aid more efficient for the promotion of widespread development (OECD 2005). The *Paris Declaration on Aid Effectiveness* is

the outcome of a series of high-level meetings (2002 Monterrey, Mexico; 2005 Rome, Italy; 2005 Paris, France) held to address the issue of aid and aid effectiveness. In Paris, the international community reached a consensus, which aims to encourage ownership of development strategies by partner countries; harmonize efforts among multilateral, bilateral, and local agents; build capacity among national and regional leaders; and improve the inadequate use of funding observed by the United Nations (APRN 2008:2; OECD 2005:1). The Paris Declaration is "a well-intentioned and ambitious agreement" to aid delivery, as it calls for mutual accountability on the part of both donors and recipients, and redefines indicators for monitoring aid effectiveness (APRN 2008:1; OECD 2005, 2008).

The Paris Declaration was well received by CIDA, and research participants from CIDA consistently claim that the agency is very "Paris-friendly". In fact, the Paris Declaration forms the basis of CIDA's current development strategy – that is, bilateral programming. Furthermore, the Paris Declaration builds on the recognized need for increased aid and aid effectiveness through support to partner countries and good governance, clearly outlined in MDG 8 (APRN 2008:2; UN 2005).

The Paris Declaration is an extensive document based on "five mutually reinforcing principles" (APRN 2008:2). The five principles, and the implications of the Paris Declaration for HIV/AIDS mitigation, are outlined below. Briefly, the spirit of the Paris-principles emphasizes the importance of: national ownership and locally-driven priorities; donor alignment and cooperation; joint monitoring and evaluations; results based management; and mutual accountability among donors and partners.

1) Ownership

The Paris Declaration is important to HIV/AIDS mitigation as it allows for priority areas to be defined by the partner country, rather than by the donor (APRN 2008:2; OECD 2005:3). In the case of Tanzania, the country has been successful in defining the needs of the population through the production of several key strategy plans related to women, HIV/AIDS, and the reduction of MTCT (see Figure 2.1). Similarly, CIDA is committed to respecting the leadership demonstrated by the Government of Tanzania, and to help strengthen their capacity to establish their own priorities and objectives (OECD 2005:3).

2) Alignment

Donor countries, in this case, Canada, have committed to basing their overall support on the Government of Tanzania's national development and HIV/AIDS mitigation strategies (APRN 2008:2; OECD 2005:4). According to CIDA staff, and recognized in the most recent HIV/AIDS strategy plan, Tanzania looks to its donors for feedback when re-evaluating national systems, institutions, and procedures for managing aid to ensure that the process is effective, accountable, and transparent. As noted by a Senior Development Officer, the Government of Tanzania called upon donors to participate in the drafting of its second national HIV/AIDS mitigation strategy in the hopes of improving and addressing priority areas that fell short in the past (APRN 2008:2; OECD 2005:4; Participant #4, 2008).

3) Harmonization

Through the Paris Declaration, donors have committed to making actions more harmonized, transparent, and collectively effective (APRN 2008:2; OECD 2005:6).

According to Senior CIDA staff, this decreases the burden on partner countries by reducing the number of reports they have to produce by coordinating the specific indicators that partner countries are expected to monitor (Participant #6, 2008; Participant #7, 2008; Participant #9, 2008). Moreover, it minimizes the instances of duplicate HIV/AIDS mitigation strategies, thereby maximizing resources and ensuring far-reaching benefits (OECD 2005:6). Indeed, this process is demonstrable in Tanzania through the management of pooled-funding. Multilateral and bilateral donors contribute to a centralized fund, managed by the government and individual sectors including health care. Civil society can also access funds through an application process. Proposals are assessed and approved by CIDA staff according to the extent to which they are in line with the priorities in the Tanzania national strategy framework. A similar process is implemented if civil society organizations (in both Canada and Tanzania) wish to apply to CIDA, directly, in order to fund local projects.[14] However, these projects are often approved on the basis that they contribute to HIV/AIDS strategies defined at the national level. Senior CIDA staff in the Tanzania Program claim that the number of isolated projects is beginning to decline, as CIDA moves more towards the balanced approach to development (Participant #3, 2008; Participant #4, 2008; Participant #8, 2008; Participant #9, 2008).

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[14] CIDA contributes to a coordinated fund for local initiatives in Tanzania, called the Rapid Funding Envelope for HIV/AIDS (RFE). Established in 2002, the RFE was designed to support local initiatives through a central fund. Most recently, CIDA contributed $3 million CAD to the fund (Participant #9, 2008). The RFE was designed to support NGO projects for HIV/AIDS prevention, treatment, care and support. Its design centers on the recognition that local projects must be maintained, while larger, long-term programs are being organized and strengthened at the national level (RFE 2009). The RFE provides grants to Tanzanian non-profit civil society organizations, academic institutions, and civil society partnerships for short-term projects, insofar as they are aligned with the *Second National Multi-sectoral Strategic Framework*. RFE sponsored projects must lead into, contribute towards, or be complementary to long-term efforts in the national response (Participant #4, 2008; Participant #8, 2008; RFE 2009). The purpose of the RFE is to enable local institutions in Tanzania to participate in the national multi-sectoral response to the AIDS epidemic.

4) Managing for results

Donors are also committed to harmonizing their monitoring, evaluation, and reporting requirements by using a results-oriented reporting system designed by the partner country as far as possible (APRN 2008:2). In return, partner countries commit to strengthening the linkages between their national development strategies and budgetary processes (APRN 2008:2; OECD 2005:8). In line with this, as noted by Senior Development Officers, Tanzania submits annual narrative reports to donors, showing the connection between development activities and spending (Participant #3, 2008; Participant #4, 2008).

5) Mutual accountability

Finally, donors have committed to providing timely, transparent, and comprehensive information on aid flows, so that partner countries can present comprehensive budgets to their legislatures and citizens, taking projected development assistance into account (APRN 2008:2; OECD 2005:8). According to one CIDA staff member, there are obvious benefits for the partners when donor funding is more predictable, as long-term goals are more likely to be set and achieved (Participant #3, 2008).

This brief overview highlights some of the impacts that the Paris Declaration has had on bilateral partnerships, such as the partnership between CIDA and the Government of Tanzania. A better understanding of the Paris Declaration allows for a more critical analysis of CIDA's bilateral programming, discussed in the coming pages. Questions concerning the efficacy of these frameworks are discussed, alongside CIDA's decision to complement national level planning with small-scale, time-bound projects – known as

CIDA's "balanced approach". The agreements highlighted above (e.g., the Millennium Development Goals and the Paris Declaration) take international commitments to child health (MDG 4), maternal health (MDG 5) and HIV/AIDS (MDG 6) into account. Overall, both policy documents are characterized by a general approach to development and building partnerships for effective programming (MDG 8). The influence of these frameworks on CIDA programming, in particular, are discussed in the next chapter.

2.7 Conclusion

This chapter highlights the interlocking relationships between various cultural, political and socio-economic structures connected to women's vulnerability to HIV/AIDS and instances of MTCT, which subsequently increase the number of HIV-infections among children. Social inequalities, influenced by culturally defined gender-roles and responsibilities, also play a role in exacerbating rates of infection (James 2006:196).

The frameworks outlined above (e.g., MDGs and the Paris Declaration) are relevant as they are the basis of CIDA's current approach to development and HIV/AIDS, discussed in Chapter Three. These documents reinforce one another in several important ways. First, the *Millennium Development Goals* (2000) highlight important areas for development relevant to this study, particularly MDG 3 (eliminate gender inequality) MDG 4 (improve child health), MDG 5 (improve maternal health), MDG 6 (combat HIV/AIDS), and MDG 8 (improve partnerships for development). However, it is increasingly recognized that, without concerted effort among multilateral, bilateral and local partners, the realization of these goals is a long way off. In some countries it seems unlikely that the MDGs will ever have any significant impact on the quality of life for

millions of individuals. This is especially so in sub-Saharan Africa, which has failed to make any considerable progress on any of the Goals.

The endorsement of the *Paris Declaration on Aid Effectiveness* (2005) stems from the need to improve the quality and use of aid, particularly relevant in an era where resources are abundant, yet real gains fail to meet the expectations of donors and partners. Furthermore, the Paris Declaration was embraced as a mechanism for realizing and accelerating progress towards the MDGs. Most clearly, the Paris Declaration reinforces MDG 8 that aims to develop and strengthen a global partnership for aid, which, in turn, makes the achievement of the other goals more likely.

CIDA has been thorough in its application of the MDGs and Paris Declaration. What remains to be discussed are the strengths and weaknesses of CIDA's bilateral programming and CIDA's "balanced approach" to development in reducing rates of HIV-infection among women, and the prevention of MTCT. Chapter Three provides additional background on the partnership between CIDA and the Government of Tanzania. A discussion of the influence of international aid modalities on programming designed and implemented at the bilateral level, generally, leads to the investigation of the CIDA/GoT partnership specifically.

Chapter Three – The Canadian-Tanzanian Partnership: Background to the Case Study

3.1 Introduction

With an understanding of international development modalities outlined in Chapter Two, the purpose of this chapter is to introduce the specific partnership between CIDA and the Government of Tanzania. First, this chapter illustrates how CIDA has integrated the MDGs and Paris Declaration into its new bilateral programming model – the "balanced approach" to development. As part of CIDA's balanced approach to development, the agency is committed to building partnerships with local organizations to supplement to development programming at the national level. Therefore, CIDA's support of Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF) and Marie Stopes Tanzania are introduced.

Secondly, this chapter discusses the rationale for CIDA's partnership with the Government of Tanzania. Seen below, Tanzania fulfils a number of important criteria that CIDA uses to assess potential development partners. Information on the socio-economic and political conditions in Tanzania are presented and situated into their historical and contemporary context. Most importantly, this understanding contextualizes the current health care system in the country. It shows that the ineffective health system in Tanzania exacerbates instances of HIV/AIDS in the country. To create these linkages, statistics on HIV-infection among women and children infected via MTCT in Tanzania are also included.

Ultimately, the background information provided in this chapter serves as a useful entry point for reviewing the strengths and weaknesses of bilateral programming, using declines in the number of HIV-infections among women in Tanzania and access to

prevention of mother-to-child transmission services as indicators for success (see Chapter Four).

3.2 CIDA, the Millennium Development Goals, and the Paris Declaration

Established in 1968, CIDA's role is to manage the majority of Canada's official development assistance (ODA) overseas (CIDA 2009a). Although CIDA was once heavily engaged in designing, funding, and implementing "project-based" development in numerous countries,[15] in recent years CIDA's focus shifted towards program-based approaches (PBAs), also known as bilateral (government-to-government) development assistance, with fewer key partners (Brown 2007: 213; CIDA 2002:29). This shift in focus stems from the agency's internal *Policy Statement on Strengthening Aid Effectiveness* (CIDA 2002) as well as the *Paris Declaration on Aid Effectiveness* (OECD 2005).

The significance of CIDA's *Policy Statement on Strengthening Aid Effectiveness* (CIDA 2002) is two-fold: first, it demonstrates the agency's internal assessment of the effectiveness of its aid programs (CIDA 2002:i); second, it is "set against the backdrop of an emerging international consensus on the goals and principles of development cooperation" (Brown 2007: 219; CIDA 2002:1). According to a Senior Development Officer:

> Canada is quite active at the international level and that always filters down to the agency. For example, Canada is a signatory of the *Paris Declaration on Aid Effectiveness*, and this has definitely filtered down to the level of CIDA country programming. You can see the evolution of our program over the last several years, as we have moved away from projects towards aligning with other donors and buying into government programming. (Participant #3, 2008)

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[15] CIDA funding to local projects reached an all time high of $320 million CAD in 1991, however, this figure has dropped in the past decade to $195 million CAD in 2005, clearly reflecting CIDA's shift away from "project-based" development (Black and Tiessen 2007:204).

In order to facilitate a comprehensive development model, the agency is now divided into three branches: the Multilateral Branch, the Geographic Programming Branch, and the Partnership Branch (CIDA 2002:1). By taking a multi-sectoral approach, the agency believes it is better able to address "the political, economic, social and institutional dimensions of development" (CIDA 2002:2). CIDA's 2002 policy statement stresses the importance of: good governance; coordinated sectoral reforms; the need for capacity building[16] in public and private sectors; sustainability; and the role of civil society. Although this model applies to all aspects of CIDA programming (i.e., Partnership, Geographic Programming, and Multilateral Program Branch), the *Policy Statement on Strengthening Aid Effectiveness* specifically addresses the agency's approach to bilateral aid, with a special focus on low-income countries that are committed to development (CIDA 2002: 2). As this thesis is concerned primarily with bilateral programming, the role of CIDA's Multilateral Branch is only highlighted briefly, and this is followed by a more in-depth review of the Geographic Programming Branch.

Key Distinctions Between Multilateral and Bilateral Programming

CIDA's Multilateral Programs Branch aims to "strengthen the ability and effectiveness of multilateral organizations to reduce poverty and to meet the MDGs in health, education, gender equality, and environmental sustainability" (CIDA 2009a). In order to achieve this objective, the Branch participates in discussions that influence development agendas and good governance at the international level. The Branch also

[16] Capacity building is aimed at improving the ability to design, manage, and achieve stated objectives within an organization or agency (Campbell 2008:257). "Capacity building" emerged in the mid- to late 1990s through the provision of organization development training to local NGOs and community groups (Campbell 2008:258).

influences the "rules for international conduct" and ratifies objectives such as those found in the MDGs and the Paris Declaration (CIDA 2009a). The agency also offers financial support to multilateral agencies (CIDA 2009a).

One-third of Canada's ODA goes to multilateral organizations, including the World Health Organization (WHO), UNAIDS, UNICEF, and the Global Fund to fight AIDS, Tuberculosis, and Malaria (CIDA 2009; Participant #7, 2008; Participant #8, 2008; Participant #9, 2008). Speaking with Senior Health and Policy Advisors revealed that the majority of CIDA funding used specifically for HIV/AIDS mitigation is managed by the Multilateral Programs Branch (Participant #2, 2008; Participant #8, 2008; Participant #9, 2008). Multilateral development assistance is unique, as it offers financial support, through the international system, to countries where donors are reluctant to engage at the bilateral level. This is particularly the case where partner countries do not meet the criteria for bilateral funding (described below).

Another important distinction between multilateral and bilateral aid is that, at the international level, CIDA has the ability to earmark funds for HIV/AIDS mitigation strategies. For example, CIDA made significant financial contributions to WHO specifically for maternal health and the prevention of mother-to-child-transmission. The Global Fund does not allow for funds to be earmarked in this way, however, CIDA can still help to influence the use of funds for a specific area. As explained by a Senior Policy Analyst:

> The Global Fund does not allow earmarking of funds. The way that we would work in that situation is through dialogue with the Global Fund...and working with countries in putting forward proposals [to the Global Fund] that include maternal and child health. (Participant #9, 2008)

Although there is some flexibility in the use of multilateral funding, CIDA's approach to bilateral assistance is not defined in the same way.

The move towards bilateral assistance was initiated from the observation that earmarking funds for "project-based" development was too difficult to coordinate, slow to disperse, and unpredictable in volume. Through discussions, the GoT, CIDA, and other donors decided that coordinated pooled funding, at the bilateral level, would be the most efficient manner of channelling resources for HIV/AIDS, therefore, enabling the GoT to achieve the goals within their national HIV/AIDS strategy plan (CIDA 2006b:12). Therefore, at the bilateral level, funding can no longer be earmarked for a particular priority area. For example, CIDA will support the reduction of HIV-infection among women and the prevention of MTCT through bilateral funding, insofar as the GoT identifies these priority areas in their first and *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF) (TACAIDS 2003, 2007). By committing to support the GoT through bilateral aid, CIDA must "buy-into" the government's national strategy plans, as a whole. CIDA cannot "ring-fence" an issue and ask that the agency's contribution be earmarked for a particular area (Participant #3, 2008; Participant #4, 2008; Participant #8, 2008; Participant #9, 2008).

However, CIDA can bring issues that they feel are being overlooked to the table, by engaging in dialogue with partners and other donors. As explained by a CIDA Development Officer from the Tanzania Program:

> The role that CIDA plays is to facilitate... If it's clear that a program target is not being met, there are discussions among the donors whether capacity building is needed. Or there is a discussion if there needs to be particular emphasis on an activity that is not currently taking place.... [However], our funds just go towards the entire program, and we debate and deliberate with the government so that it

> adjusts its allocation criteria, so that funding can go to towards a particular area. (Participant #4, 2008)

What this process shows is that, in line with Paris-principles,[17] goals and targets are not prioritized by CIDA, but rather they are identified and prioritized jointly by the partners. The partner country ultimately decides what areas should, or should not, be included, thereby making the strategies nationally owned in both the planning and budgeting stages (CIDA 2002:4).

Regional Programming

In 2005-2006, 78 per cent of Canada's ODA was managed by CIDA, and 46 per cent ($1.3 billion CAD) went to regional programming in sub-Saharan Africa (CIDA 2009). There are reasons for this regional focus: CIDA determined that sub-Saharan Africa has enormous potential for development, however, this potential has been undermined by several gaps in progress related to the *Millennium Development Goals*, a fact confirmed by multiple UN reports (UN 2006; UNDESA 2007; UNDPA 2007). Canada, as a United Nations member state, has committed itself to the *Millennium Development Goals* (2000), and as indicated above, reinforced this commitment by signing the *Paris Declaration on Aid Effectiveness* (2005). As articulated by a Junior HIV/AIDS Policy Analyst:

> We [Canada] have committed ourselves along with other UN member states to eradicating diseases, tackling child mortality, and improving maternal health – which are best outlined through the MDGs. Those guiding principles and international commitments that Canada has chosen to pursue, and which Canada had a role in developing at the international level, get [integrated into the work of] . . . the agency [CIDA]. (Participant #1, 2008)

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[17] As noted in Chapter Two, Paris-principles are characterized by the commitment to: 1) national ownership and locally-driven priorities; 2) donor alignment and cooperation; 3) donor harmonization, joint monitoring and reporting; 4) results based management; and 5) mutual accountability.

As can be seen in this statement, the MDGs are paramount within CIDA, and they play an extremely important role in the daily operations of the agency; they are strongly linked to the agency's rationale for funding projects and programs (Participant #1, 2008; Participant #3, 2008; Participant #6, 2008; Participant #9, 2008).

Indeed, an institutional integration has taken place, because, "agency funding, programming, internal policy, and priority areas synchronize with the Goals" (Participant #1, 2008). As one Senior Development Officer explained, when looking to approve a bilateral program or project, there is "always reference to the MDGs". This statement is reinforced by others in the agency (Participant #1, 2008; Participant #3, 2008; Participant #7, 2008; Participant #8, 2008). Related to the MDGs for health, specifically, it was further explained by a Senior Director in the Policy and Programming Branch: "Most everything that we do at CIDA is related to the MDGs. As you know the MDGs are related to maternal and child health, so they are core areas or priorities from the MDG perspective" (Participant #8, 2008). As another explained in direct relation to HIV/AIDS:

> I think what the MDGs have done is focus attention on, and highlight the severity of the HIV/AIDS epidemic. Whether it would have been better to take a different approach, or whether the targets were set too high or too low, I don't know. But I think certainly the MDGs give clear international commitments. CIDA can't say it supports the MDGs and not give attention to HIV/AIDS. (Participant #7, 2008)

From these comments, it is clear that the Geographic Programming Branch is committed to upholding the MDGs as a route to development in sub-Saharan Africa, particularly by focusing on child health (MDG 4) and maternal health (MDG 5). HIV/AIDS (MDG 6) and gender (MDG 3) remain "crosscutting" themes, and CIDA is committed to reducing gender-based inequality in all of its programming (CIDA/GGI 2004:7; CIDA 2009a; Participant #6, 2008). CIDA's priority areas are clearly drawn from all eight MDGs;

these priority areas are not only identified on the agency's website, but their impact on CIDA's current development strategy is easily recognized by staff members interviewed for this thesis. By making clear reference to the MDGs and by consistently referring to Paris-principles, international discourse has, at the very least, influenced the corporate understanding of development among CIDA staff members. In turn, this understanding affects the way that CIDA staff interact with partners and other donors through their balanced approach to development.

3.3 A "Balanced Approach" to Development: Program-based Approaches and Complementary Projects

Drawing from the MDGs and the Paris Declaration, CIDA continues to move towards strengthening and implementing program-based approaches. However, projects (i.e., time bound efforts and activities implemented by local level organizations) continue to play a crucial complementary role in the short-term – this is known as the "balanced approach". In general, CIDA staff believe that the agency is doing a "moderate job" and is "par for the course" in terms of its model of development (Participant #1, 2008; Participant #2, 2008). What this means is that CIDA's balanced approach (i.e., supporting multilateral, bilateral, and local partnerships) is similar to other development agencies operating under the influence of the Paris Declaration (Brown 2007:214). As with other donors, CIDA supports multilateral initiatives such as the Global Fund, UNICEF, and WHO. They also support the GoT's national HIV/AIDS strategy plan, such as the *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF) (TACAIDS 2003, 2007), and contribute to local initiatives, such as the activities of Marie Stopes Tanzania (MST), that are aligned with national priorities. One Senior Development Officer described the strength of this balanced approach:

> I think that one of our strengths is that we use a balanced approach, between the pooled fund and having complementary projects on the side that fill in some of the niches where Canada can have some value-added...It gives us a nice position in the country, as we are [not only] putting effort into strengthening the government structures, but we are also remembering that CIDA can also have a positive role as well [through projects]. (Participant #3, 2008)

A Senior Director in the Policy and Programming Branch reiterated this idea:

> We don't deal exclusively through program-based approaches. We do still see the role of projects, even though we have been focusing on new modalities. There ...[is] still a value-added to having a project that might focus on a particular area to complement what we are doing at that national level...I think bringing together these two modalities is a good way of maximizing the smaller resources that we have. (Participant #8, 2008)

Finally, as noted by a Senior Policy Analyst:

> There has certainly been a shift from projects to programs...there is still a lot of value in projects, not just quick fixes. A project does allow you to do things quickly, and to learn lessons quickly, and then apply those lessons to the scale of program-based approaches. Within CIDA, there is not an absolute shift from projects to programs; there is a balance. Whether or not CIDA achieves that perfect balance remains to be seen, but we are constantly trying to determine what ... the best use of our resources [is]. (Participant #9, 2008)

From these statements, several conclusions can be drawn. Firstly, despite the influence of internationally agreed upon modalities for development, CIDA is not abandoning projects in an absolute way. Secondly, continuing to support projects allows CIDA, as a small donor, to make a "value-added" contribution, by financing local initiatives in niche areas. Next, CIDA's movement towards programs must include lessons drawn from the project-based model to foster success in the long run. Ultimately, CIDA recognizes that projects play an important complementary role, meeting the needs of the population where national level services are unable to deliver services. Although CIDA is currently in the process of phasing out project-based approaches, Senior Development Officers and Policy Analysts recognize the continued role that local initiatives play in the interim.

Therefore, these should continue to be integrated into bilateral strategies in a coordinated way. CIDA support to Marie Stopes Tanzania (MST) illustrates this point, discussed below.

3.4 The Rationale for the CIDA and GoT Partnership

The first half of this chapter reveals the influence of the MDGs and the Paris Declaration on CIDA's balanced approach to development. In line with CIDA's bilateral aid model, partner countries are also reviewed for their commitment to, and progress towards, the MDGs, as expressed through their national strategy plans for development and HIV/AIDS mitigation. As stated by a Senior Health Advisor: "As the Goals become more entrenched in national strategy plans, and if CIDA is supporting the national strategy plan through financial and technical assistance, then CIDA is supporting the achievement of the MDGs in the best possible context-specific way" (Participant #2, 2008). This approach ensures that countries are not only setting their own priorities for development in line with Paris-principles, but that they also reflect the MDGs. In Tanzania, the MDGs are clearly prioritized in national plans such as the *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF) (TACAIDS 2003, 2007). According to two CIDA Senior Officers in the Tanzania Program:

> The MDGs are always one of our reference points when we are taking about programming in Tanzania. When you are looking at the program approval documentation you must ask; where does Tanzania lie in terms of meeting the MDGs on HIV or maternal health? That's a particular emphasis - as we recognize that maternal health is moving the most slowly. (Participant #4, 2008)

> In terms of Tanzania, this is why we [CIDA] support them. The Government of Tanzania has its own national strategy plan, and the strategy is built on the MDGs...certainly within the health sector. (Participant #6, 2008)

Indeed, the MDGs are central to the Tanzania program, justifying CIDA's involvement in the country.

As previously discussed (see Chapter Two), in 2002 CIDA began the process of phasing-out traditional projects, moving towards country-led development. This decision came from internal policy, international discourse concerning aid effectiveness (CIDA 2002; OECD 2005), and criticisms that CIDA projects were not effectively contributing to long-term development objectives found in the MDGs (CIDA 2002:5). In line with CIDA's *Policy Statement on Strengthening Aid Effectiveness* (2002), a total of six African countries of concentration were selected, including Tanzania, Mozambique, Ethiopia, Ghana, Senegal, and Mali (CIDA 2006a:2; Participant #4, 2008; Participant #9, 2008). In 2005, the *Paris Declaration on Aid Effectiveness* was released, solidifying CIDA's commitment to bilateral programming in the aforementioned countries, adding Benin, Burkina Faso, Cameroon, Kenya, Malawi, Niger, Rwanda and Zambia to the Geographic Programming roster. In the latter grouping, country budgets are smaller, approximately $10-20 million CAD, whereas the former group have budgets ranging from $60-80 million CAD. As noted by a Senior Development Officer, $80 million CAD (spent on bilateral programming in Tanzania in 2006/2007) is considered "medium-high" in terms of annual country budgeting. This is compared to Afghanistan and Haiti, which have the two highest program budgets within the agency at a rate of $280 million CAD (2006/2007) and $92.5 million CAD (2006/2007) respectively (CIDA 2009; Participant #3, 2008).

The inclusion of countries in sub-Saharan Africa is important in the history of program-based approaches at CIDA, however, this focus has continued to evolve. As of

February 2009, CIDA Minister Beverley J. Oda announced a new list of partner countries solidifying Canada's shift in focus from Africa to the Americas. Eight African countries (Benin, Burkina Faso, Cameroon, Kenya, Malawi, Niger, Rwanda, and Zambia) were removed from CIDA's list of countries of concentration (see Appendix D), however, the Tanzania Program remains unaffected by the policy shift (Berthiaume 2009a:1-2).[18]

To date, CIDA's involvement in Tanzania has spanned 40 years, and in that time CIDA has contributed more than $1 billion CAD to a broad range of development initiatives across the transportation, agricultural, education, and health-care sectors (CIDA 2009b; High Commission of Canada 2006). From 1997 to 2004 CIDA funded over 200 projects or interventions in Tanzania, totalling $120 million CAD. Bilateral, multilateral, and local level programming was employed, although the majority of this funding (69 per cent) went towards bilateral aid (CIDA/GGI 2004:6). This shows that CIDA has a history of bilateral programming in the country, prior to formalized program-based approaches. According to a Senior Development Officer in the Tanzania Program,

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[18] Described as an evolution in the "Aid Effectiveness Agenda," Oda suggested that focusing bilateral programming on the Americas would yield better results and increase accountability (Berthiaume 2009a:1). Opponents claim that this clandestine decision merely benefits a "trade effectiveness agenda", with more attention on Canada's foreign policy and trade objectives in the Americas, and has less to do with poverty reduction (Berthiaume 2009a:1; Howard 2009:1). While some countries knew they would be affected by the policy shift in advance, diplomats from Rwanda and Zambia said they were only made aware of the decision after the fact through media reports (Berthiaume 2009b:1).

The Government of Canada justifies the shift with a need for focus, Oda claimed: "I couldn't see any indication of concentration...and Canada has not got enough focus in its international assistance," adding, "it tries to do too much in too many places" (Berthiaume 2009a:3; Howard 2009:1). While the last comment holds some validity in reference to CIDA's project-based model of development, in general, Oda's statement contradicts previous reports produced by the agency. As previously discussed, reports clearly justify why Africa was selected as a regional focus, primarily due to socio-economic constraints to meeting the MDGs. Many of the African countries losing CIDA support are still struggling to achieve the MDGs, and remain low on the Human Development Index. Poverty is one of the key criteria for bilateral partnerships (Berthiaume 2009b: 1; UNDP 2009). Oda maintained, however, that Canada is not "abandoning" any countries, and that CIDA will continue to work with countries through multilateral avenues, local partnerships, and humanitarian assistance. However, this announcement did not come with any promises of additional funding for development (Berthiaume 2009a:3).

in order to be considered for CIDA funding at the bilateral level, partners are assessed against the following criteria:

> The distinction between geographic programs and the level of funding they receive is the status of the countries based on their level of governance. Canada wants to feel assured that the national partner believes in democracy, that corruption levels are lower than other countries, and we can rely on their financial mechanisms. (Participant #4, 2008)

Typically, countries with historic and diplomatic relations with Canada are more likely to be absorbed into CIDA's geographic programming, as well those with a demonstrable commitment to poverty reduction (Participant #3, 2008, Participant #4, 2008). Similarly, the country must also have an "obvious" need in terms of poverty and be a least-developed country (Brown 2007: 220; Participant #4, 2008). Tanzania satisfies these criteria.

Since CIDA and the Government of Tanzania have maintained a long-standing partnership for development, Tanzania became, and continues to be, a good candidate for bilateral aid. As stated above, good governance is also an important vetting tool for the agency. The agency believes that good governance and political stability are the most important determinants of aid effectiveness and development progress (CIDA 2002:5). Where countries demonstrate corrupt, one-party "vindictive" governance, CIDA has withdrawn bilateral aid or simply not offered funding, as an incentive for political reform (Campbell 2008: 252; Participant #7, 2008). In these scenarios, funding is kept out of government control, and CIDA replaces bilateral aid with direct funding to non-governmental organizations (NGOs) and/or humanitarian assistance through the Partnership Branch, or initiatives implemented by multilateral agencies (CIDA 2002:5; Participant #3, 2008; Participant #7, 2008). Similarly, there are differences in country

programming depending on whether CIDA is engaged in development programming compared to what CIDA does in conflict and post-conflict situations, otherwise known as "countries in crisis" (Participant #8, 2008). Countries in crisis are defined by low governance capacity, usually due to ongoing civil war or because they have just emerged from such a crisis. When countries have demonstrated little effort towards political reform, or mitigating corruption, CIDA support is linked to well developed, civil-society organizations with strong capacity and a good reputation in the community (CIDA 2002:10). However, critics suggest that focusing on countries that already have "good governance" in place, ignores the cause of "bad governance". It is argued that bad governance is symptomatic of underdevelopment, therefore, continually denying aid perpetuates a state of underdevelopment and does not promote capacity building at the national level (Brown 2007:220).

Nevertheless, Tanzania has demonstrated strength in the area of good governance with a stable, multi-party democracy (Participant #9, 2008). Furthermore, its role as a moderator in the region has positioned Tanzania favourably in relation to the donor community (Black and Tiessen 2007:196). Tanzania's first multi-party election was held in 1995, with little incident. Although some political upset occurred after the second-term election of President Benjamin Mkapa, CIDA and other donors were involved in a timely reconciliation process, aimed at reducing political tensions (CIDA/GGI 2004:4). Overall, former President Mkapa is well regarded and has been praised by the Tanzania Commission for AIDS (TACAIDS) for his active involvement in HIV/AIDS mitigation. He was heavily involved in the launch of the TACAIDS in 2001, and the first *National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2003). With regard to

HIV/AIDS, TACAIDS has attributed secure bilateral and multilateral funding in the country to President Mkapa's strong political leadership (TACAIDS 2007:14). In addition to the country's strong political leadership, the Government of Tanzania remains committed to poverty reduction.

Tanzania is ranked among the poorest countries in the world and income distribution remains disparate, however, Tanzania has demonstrated a clear commitment to poverty reduction (CIDA/GGI 2004:4; TACAIDS 2007:1; UNDP 2009). According to CIDA, the development context in Tanzania has changed considerably over recent years, and in a positive direction (CIDA 2006a:1). Since 1995, Tanzania has endured a variety of economic and political reforms (see Figure 2.1 – Timeline for International and National HIV/AIDS Responses). The results have been varied, but overall the country's commitment to growth and poverty reduction has yielded concrete results in terms of macroeconomic growth, as well as progress toward a number of development goals (CIDA 2005a:2), redistributing robust macro-economic growth toward social development programming at the community level (CIDA/GGI 2004:4; CIDA 2009). In 2008 Tanzania was ranked 159th out of 177 countries in terms of GDP, compared to 174th in 2002; Tanzania was ranked 152nd in the UNDP's Human Development Report (2008), compared to 162nd in 2004 (CIDA/GGI 2004:4; UNDP 2009). Although these rankings are broad, and do not account for the distribution of income in the country, generally, they point to improvements in terms of overall national growth and development. However, Tanzania still has a very high level of poverty due to unequal income distribution, and steady economic growth has not translated into improved living conditions among the poor (CIDA 2005a:2).

In response, the *National Strategy for Growth and Reduction of Poverty* (United Republic of Tanzania 2005) has entered its second phase, highlighting broad strategies for development, with an emphasis on poverty reduction and the achievement of the MDGs (CIDA 2006a:1). In fact, the recent NSGRP ambitiously aims at reducing poverty by a rate of 50 per cent by the year 2010 (TACAIDS 2007:1). Because Tanzania has demonstrated its commitment to the issues of poverty reduction and development, CIDA has continued to work with the Government of Tanzania in the hopes of facilitating long-term socio-economic reform (CIDA 2009b). As the partnership between Canada and the Government of Tanzania was already established, the agency was comfortable scaling-up financial contributions under the new banner of program-based approaches, assessing the country as a "low fiduciary risk" (Participant #4, 2008).

It was noted by a Senior Development Officer that CIDA is more inclined to partner with countries where other donors are also involved, or where CIDA can demonstrate their "value-added" to a program (Participant #3, 2008). As a small donor, CIDA is not in the position to offer bilateral assistance alone, or to usurp the contributions of donors that are heavily involved. In terms of volume, Canada is a minor actor in terms of foreign aid. In 2003 Canada provided less than 3 per cent of the total bilateral aid from OECD countries, comparatively the United States provided 29 per cent, Japan 13 per cent, and European Union member states 48 per cent (Brown 2007:223). Simply put, the level of CIDA funding available is not adequate enough to address multi-sectoral reform. In Tanzania, multiple donors are now engaged in bilateral programming in the country, including the UK Department for International Development (DFID), the

Swedish International Development Agency (SIDA), Irish Aid, and USAID, to name a few (DFID 2009; SIDA 2009; Irish Aid 2009; USAID 2009).

Currently, CIDA provides bilateral support to Tanzania in four key sectors that, again, reiterate the MDGs: education, good governance, private sector development, and health (Brown 2007:221). These are sectors prioritized by the Government of Tanzania through various national strategy plans. During the 1997 to 2003 period, 70 per cent of the total bilateral investments were in these four sectors, with approximately $22.8 million CAD allocated to health in Tanzania (CIDA/GGI 2004:8). As with all CIDA programming, gender equity and HIV/AIDS are "crosscutting" themes (CIDA 2009a; High Commission of Canada 2006). It is important to note that CIDA does not offer support to all sectors in all countries; national and sectoral support is determined according to the needs of the partner. For example, not all country programming will have a focus on health and/or HIV, whereas Tanzania does have this focus (Participant #8, 2008).

3.5 An Overview of HIV/AIDS in Tanzania

Across sub-Saharan Africa, national prevalence rates, that is the percentage of adults HIV-infected, are highly variable. Some countries report that HIV-infection rates are stabilizing or showing signs of decline. In Tanzania, rates of infection among adults (aged 15 to 49 years) are relatively unchanged from 2001 to 2007 statistics (see Table 3.1 below).

As with most countries in the region, Tanzania is experiencing a mature, generalized epidemic, meaning that HIV is not contained within a small enclave of the country, or within a particular sub-group. The primary method of transmission is

unprotected heterosexual intercourse, which accounts for 80 per cent of new infections in the country (PEPFAR 2008; UNGASS/TACAIDS 2008:5). Among adults, data suggest that the basis of the epidemic is higher-risk sexual activity, including unprotected intercourse, intergenerational sex, and multiple and/or concurrent sexual partners (UNGASS/TACAIDS 2008:5).

At the end of 2007, the adult prevalence rate of HIV/AIDS reached 6.2 per cent (CIA 2009; UNGASS/TACAIDS 2008) of the total population (41, 048, 532 individuals). This translates into approximately 1.4 million adults living with HIV in Tanzania in 2007 (UNAIDS 2008d). In the same year, approximately 140,000 children were HIV-infected in Tanzania (UNAIDS 2008f:4). Eighteen per cent of new infections were among children, who were infected via mother-to-child transmission (UNGASS/TACAID 2008:5). Seen below, Table 3.1 shows an increase in the number of children infected with HIV from 2001 to 2007 that corresponds with an increase in the number of women HIV-infected. It is clear that with such high rates of HIV-infection among women in the country, children face a correspondingly high burden due to mother-to-child transmission. Death from AIDS-related illnesses remains a long-term development challenge due to the need to scale up treatment initiatives. In Tanzania, limited access to health care and treatment led to the death of approximately 96,000 people (UNAIDS 2008d).

Table 3.1 HIV-Infections in Tanzania (2001 and 2007)

	2001	2007
Rates of Infection (% Total Population)	7.0	6.2[19]
Adults (15-49)	1, 400, 000	1, 400, 000
Women (15-49)	740, 000	760, 000
Children (0-14)	120,000	140,000

(source UNAIDS 2008f:4)

3.6 Historical, Political and Economic Context

Faced with these numbers, it is crucial to understand why the region, and, consequently Tanzania, is burdened by HIV/AIDS. In order to develop this understanding, it is imperative to illuminate the historical processes that influence current HIV-prevalence rates in the region. Historical relationships between and within countries can be used to clarify contemporary disease distribution as well as the existence or effectiveness of current mitigation strategies (Baer *et al.* 2003:34; Brown *et al.* 1998:16; Singer 1998:226). This is also useful in understanding why investment in areas such as health care and education, that are crucial to HIV prevention and treatment, has been limited in Tanzania.

As outlined above, it is critical to understand the historical, political, socio-economic and cultural structures that exacerbate the spread of disease, especially among

[19] In 2001, HIV prevalence was estimated at 7.0 percent of the adult population, affecting women at a rate of 7.7 percent compared to their male counterparts for whom the rate was 6.3 percent (PEPFAR 2008; UNAIDS 2008f:4; UNGASS/TACAIDS 2008: 5). In 2007, estimates showed instances of infection at a rate of 6.2 percent, however, the report clarifies that these declines represent a change (i.e., monitoring and reporting is currently more accurate) in statistical methodology over the years, as opposed to an actual decline in infections (UNGASS/TACAIDS 2008:5).

vulnerable populations – in other words, the interaction between the macro-level political-economy and the individual experience of health and disease (Singer 1998:225). The poor political-economic conditions that characterize most of sub-Saharan Africa have been influenced by the legacy of colonialism, and more recently, exacerbated by IMF and World Bank policies. To understand this issue, a brief explanation of the role of structural adjustment programs (SAPs) is necessary.

In the late 1980s and early 1990s many countries were encouraged to adopt SAPs (characterized by a process of fiscal "belt tightening" and reductions in sectoral expenditures) as a prerequisite for development loans. SAPs resulted in higher prices for agricultural inputs, food and other basic necessities, which were incurred by the household (Bezruchka and Mercer 2005:11). Persistently high levels of national indebtedness, coupled with reduced government expenditure on health and education programs, also transferred rising health care and education costs onto the individual.

Although the World Bank no longer implements structural adjustment programs, the legacy of these programs has undermined the socio-economic security of civilians, as the continued burden of debt has led to higher levels of debt servicing and deteriorating health care and education sectors. CIDA, among other donors, has addressed financial burdens by channelling debt relief into priority sectors such as education and health care, however, this has not been enough to lead to any appreciable change, as Tanzania's current external debt is 5.3 billion USD (CIA 2009; CIDA 2005a:4)

Economic mismanagement, corruption, and indebtedness also have a role to play in the contemporary state of African affairs (Hanson 2004: 344; Poku 2005:16), and, despite donor concern for transparency and accountability (e.g., to be considered for

bilateral support partners must demonstrate *lower* levels of corruption compared to other countries), corruption continues to plague the health sector in Tanzania. According to the country's Economic and Social Research Foundation, the health care sector in the second most corrupt sector in the country (PEPFAR 2008). One feature of this, is that spending, including HIV/AIDS funding is often "off-account," that is, not channelled through the exchequer, or incorporated into financial reporting (The Ministry of Foreign Affairs, Denmark 2007: 113). Donors have acknowledged these risks and more attention has been given to improving low institutional capacity (particularly at the local level), reducing corruption, and strengthening systems for democratic accountability (CIDA 2005a:3). Addressing corruption through capacity building is one important way that development partnerships can help to challenge economic mismanagement at the national level, and capacity building has implications for the quality of services delivered at the local level.

3.7 The Health System in Tanzania

As with other sectoral reforms which took place in the 1990s, the GoT sought to improve health care management through the decentralization of health services, through health sector reforms (HSR). HSR were promoted based on the idea that public health care facilities were inefficient compared to services provided by the private sector. External pressure from the World Bank can also be linked to investments in privatized health care, decentralized government control over health care facilities, and the introduction of user fees. This trend was seen in Tanzania among other countries in sub-Saharan Africa (Hanson 2000: 341; Verdugo 2005:57).

Prior to the introduction of health sector reforms, the GoT had banned privatized hospital care under the Private Hospitals Regulation Act (1977). However, "major

economic and social" challenges in the early 1990s led the Government of Tanzania to re-evaluate the previous ban on privatized health care, and it looked "more favourably on the role of the private sector" (United Republic of Tanzania 2008). They also initiated financial reforms through user fees in government hospitals and the introduction of health insurance, and encouraged the private sector to complement public health (Ministry of Foreign Affairs, Denmark 2007: 333; The United Republic of Tanzania 2008). However, the results could not have been further from the intention of the reforms.

Currently, the consequences of health sector reforms are seen in several negative outcomes. First, by reducing government investment in public health care facilities, patients are increasingly required to directly pay "out-of-pocket" in order to receive private health care services. These out-of-pocket costs include official registration fees and patients cards, laboratory costs, care, bed stay, drugs and supplies, transportation, food, and accommodations for accompanying family members. Direct costs may also include informal or unauthorized fees charged by staff for care (Perkins *et al.* 2009:290). In one study, women reported paying out-of-pocket costs for facility-based deliveries. Officially, maternal health care services, provided by the government, are offered free of charge in Tanzania, however, studies show discrepancies between official policy and the real costs (Perkins *et al.* 2009: 290-1). In Tanzania, 91 per cent of women reported paying fees for obstetric services. In the study, patients estimated that out-of-pocket costs for maternity care constitute approximately 6 per cent of monthly household income (Perkins *et al.* 2009:296). This can push a household into poverty, or deepen existing poverty (Perkins *et al.* 2009:298).

It is recognized that increasing the number of skilled birth attendants is an effective

strategy for reducing maternal mortality, and the prevention of MTCT. However, costs are an important barrier to women's use of private health care facilities, generally, and for reproductive care (Perkins *et al.* 2009:290). Furthermore, the quality of care individuals receive is limited if they are unable to pay for private health care services (Hanson 2000:344; Ministry of Foreign Affairs, Denmark 2007: 33-34). More than 40 per cent of women choose to deliver in government or local facilities, due to the high costs of private facilities, despite differences in the quality of care (Kruk *et al.* 2009:279).

While cost-sharing mechanisms are in place, the inability of staff to manage special waivers that exempt low-income patients from paying fees, resulted in these individuals shouldering the cost of health care, where they should not have (Ministry of Foreign Affairs, Denmark 2007:124). Without government subsidization, low-income families did not pay significantly less than high-income families (Perkins *et al.* 2009:289). Other studies show that individuals are less likely to seek treatment due to higher costs, resulting in reduced utilization rates of both public and private health care facilities (Verdugo 2005:57).

Locality also has a role to play, especially in rural areas. In Tanzania, 44 per cent of women deliver outside of both private and public health facilities, simply due to the inability to reach a health care facility (Ministry of Foreign Affairs, Denmark 2007: 112; Perkins *et al.* 2009: 292). Overall, coverage of HIV/AIDS services are low compared to the population's needs; despite some service increases, remote areas remain largely unserviced by prevention and care services (Ministry of Foreign Affairs, Denmark 2007:116).

Local health care services are characterized by severe shortages of essential drugs,

equipment, supplies and deteriorating infrastructure resulting from poor management and a lack of staff incentives. Health care workers report feeling "demoralized" because they are both poorly paid and unable to provide the services their patients require (Hanson 2000:344). Overall, hospital care is stagnant and deteriorating, and there is a lack of coordination between public and private facilities (Ministry of Foreign Affairs, Denmark 2007: 33-34). Improving coordination between public and private facilities is important, not only for the treatment and care of patients, but also for collecting and sharing epidemiological and technical information (Hanson 2000:348). Skilled human resources needed to deliver health interventions are also described as being in "short supply" (Ministry of Foreign Affairs, Denmark 2007:116).

One of the greatest challenges within the Tanzanian health sector today is inadequate human resources to deliver services (PEPFAR 2008). While some services may be currently available in Tanzania, coverage is low compared to the needs of the population, as are the skills, training, and physical resources required. These issues must be addressed in order to provide a better quality of care, roll out appropriate treatment and prevention services for women, and manage the spread of mother-to-child transmission (Ministry of Foreign Affairs, Denmark 2007:116; PEPFAR 2008). Due to the current health system reality, health sector strengthening continues to be one of the primary focuses of the Government of Tanzania, and is supported by donor agencies such as CIDA, as the health sector remains central to HIV/AIDS mitigation (CIDA 2005a:3; The Ministry of Foreign Affairs, Denmark 2007:112).

3.8 Conclusion

Consistent with the CMA approach, this chapter highlights the linkages between international and national level planning and local realities. These processes are demonstrated in two thematic areas – firstly, this chapter links the internationally agreed upon *Millennium Development Goals* and the *Paris Declaration on Aid Effectiveness* to new bilateral aid modalities operationalized by CIDA. This connection is important, as it serves for a basis of understanding CIDA's rationale for programming in Tanzania. Secondly, documenting historical socio-economic and political processes in Tanzania allows for a clear understanding of the current health care system in the country. It is accepted that inadequate health care systems at the national level, due to health sector reforms in the 1990s, exacerbate poor health and rates of HIV-infection in the country. CIDA's partnership with Tanzania aims to improve the situation through health system strengthening initiatives, to be discussed in the following chapter.

The goal of this chapter is to improve the understanding of CIDA's programming model generally, and its "balanced approach" to development, underway in Tanzania. With this background in place, the next chapter discusses CIDA's various contributions to national HIV/AIDS strategies in Tanzania. Following this, Chapter Five concludes with an analysis of the strengths and weaknesses of CIDA's involvement in Tanzania, using rates of HIV-infection among women and instances of MTCT as indicators.

Chapter Four – Case Study: CIDA's Balanced Approach to HIV/AIDS in Tanzania

4.1 Introduction

Chapters Two and Three provide both the international and national context for the analysis of the upcoming case study. As indicated previously, CIDA's bilateral programming model, known as the balanced approach, is influenced by international consensus, including the *Millennium Development Goals* and the *Paris Declaration on Aid Effectiveness*. These documents were important to explore not only for their impact on bilateral programming models, but also for the attention they give to women, children (infected via MTCT) and HIV/AIDS. As a result, these priority areas are included in national HIV/AIDS strategy plans.

Factors that exacerbate rates of infection among women and instances of MTCT are discussed in Chapter Two, generally, and with specific reference to Tanzania. Concerns such as the weak and deteriorating health care system in Tanzania are also illuminated. In order to determine if CIDA has contributed to any appreciable gains in the reduction of HIV-infection among women and the prevention of MTCT the following four programmatic areas are highlighted: 1) CIDA's contributions to national level planning, including the *Second National Multi-sectoral Strategic Framework for HIV and AIDS*; 2) CIDA's contributions to Marie Stopes Tanzania; 3) CIDA's Health System Strengthening Initiative; and 4) progress towards joint monitoring and evaluation through the design and implementation of the Tanzanian Output Monitoring System for HIV/AIDS (TOMSHA), funded exclusively by CIDA.

Each of these elements are designed and implemented with the explicit aim of combating HIV/AIDS in Tanzania, and reducing the number of HIV-infections among

women, and the prevention of MTCT. This chapter presents data on the number of women HIV-infected, women's access to MTCT services, and number of children HIV-infected. These data are useful to discuss whether or not CIDA has contributed to improvements in these key outcomes. The strengths and weaknesses of CIDA's programmatic areas are the focus for further discussion in Chapter Five.

4.2 CIDA's Contributions to HIV/AIDS Mitigation Strategies in Tanzania

CIDA first contributed a "modest sum" of approximately $5 million CAD to HIV/AIDS mitigation directly to the "Quick Start" initiative in 2003 (Participant #6, 2008). Implemented by the American NGO Family Health International (FHI), "Quick Start" provided pre-selected health care facilities with the financial and technical support needed to administer antiretroviral treatment to their patients (FHI/USAID 2007:15). According to one Senior Field Staff, the funding for this project was released prior to the country receiving assistance from the Global Fund (Participant #6, 2008). With inadequate funding for treatment, the country struggled to meet the demands for antiretrovirals among the HIV-positive population (Ministry of Foreign Affairs, Denmark 2007: 34). One CIDA staff member in the field noted: "As a small donor, CIDA saw the opportunity to provide direct funding to the Government of Tanzania, and the government was able to use the funds specifically for treatment as it saw fit to do at the time" (Participant #6, 2008).

CIDA's contributions to HIV/AIDS mitigation in Tanzania has evolved from its initial one-time contributions made through the "Quick Start" initiative, to CIDA's support to national level planning and the balanced approach. CIDA support currently comes not only through financial contributions, but also through technical support,

feedback, and recommendations regarding national programming, seen clearly in the support given to the *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF). Through this process, CIDA is ensuring that national HIV/AIDS strategy plans are country-driven, meaning that countries are setting their own agendas and not simply complying with what CIDA or other donors want them to do. As a Senior Health Advisor explained:

> Countries identify what goals are pertinent to them based on their country context (e.g., HIV-infection rate, the status of their health system, what the child-mortality rate is, the safety and efficacy of child birth). All of these indicators help countries establish what goals they set and what they need to do to achieve those goals from their perspective. CIDA will review that within a strategy – but it is not up to CIDA to identify those goals in the strategy. The country has to identify what their goals and needs are, and CIDA supports that. And that's the main approach that CIDA takes; development is country-driven, country-initiated, country-led … and that's all entrenched in the Paris Declaration. (Participant #2, 2008)

As part of CIDA's balanced approach to development, the agency will "buy-into" national and sectoral strategy plans by contributing a pooled fund alongside other donors. As one Senior Development Officer explained:

> Countries [such as Tanzania] have a broad poverty reduction strategy or national HIV/AIDS strategy plan, and the ministries all develop sectoral strategies that feed into the national strategy. The national strategies also inform the sectoral strategies – so they support each other in a sort of co-relationship. (Participant #3, 2008)

CIDA also supports its partners by providing assistance to develop and strengthen the goals (Participant #8, 2008; Participant #11, 2008), and ensure that the national and sectoral strategies are "realistic, costed, audited, and followed-through" (Participant #3, 2008). According to CIDA Field Staff, Senior Health Advisors and Development Officers in the Tanzania Program, CIDA is "heavily engaged" in developing national strategy plans for development and HIV/AIDS mitigation, such as the NMSF (TACAIDS

2003, 2007), and helps the Government of Tanzania to promote and implement these frameworks (Participant #6, 2008; Participant #8, 2008). The Senior Director in the Policy and Programming Branch explained that:

> Tanzania is a country where we are heavily engaged in HIV/AIDS and health programming....through coordinated pooled funding and sector-wide approaches (SWAPs). So we [CIDA] buy-into government plans with other donors and partners to support national programs in health and HIV/AIDS. (Participant #8, 2008)

Through this process CIDA can also help to monitor the use of funding, share its managerial expertise with program planning and implementation, and influence best practice. As explained by a Senior Development Officer:

> Our job as a donor to the pooled fund is to monitor two things: 1) we have to identify the problems in implementing the activity; and2) we have to recommend how to effectively use and distribute money, and on a realistic timeline. So there are controls that make sure that the process is smooth and realistic... What CIDA typically tends to do is work with other donors to develop consensus on pooled fund management so that the managers of the pooled fund aren't faced with competing interests among donors. CIDA is generally very good about getting the donors to make agreements about the pooled fund. (Participant #7, 2008)

This consultative process is acknowledged in the most recent NMSF, and thanks are given to development partners for their financial and technical contributions (TACAIDS 2007: xv).

As with any issue, HIV/AIDS must be addressed from a multiplicity of angles; institutionalized responses at the country level must "trickle-down" to the community level and community based responses must "trickle-up" to complement the national and sectoral level. Finally, sectors must "trickle-laterally" to support each other through sectoral partnerships.[20] Therefore, CIDA's current approach to development, is concerned with fostering multi-sectoral solutions in the long-term. As a result, CIDA reduced its

[20] An example of a lateral partnership is the health care and education sectors partnering to develop HIV-prevention programs in schools (Participant #3, 2008).

support to "project-based" development, which is increasingly criticized for being ineffective in the long-term. As explained by one Senior Development Officer:

> CIDA traditionally funded projects, which were very distinct units of activity. It's not that they are bad, per se, but it was sometimes leading to isolated activities – which were not necessarily linked or sustainable. So a lot of country programs have shifted to program-based approaches, and this stems from the *Paris Declaration on Aid Effectiveness.* (Participant #3, 2008)

It is important to note that while CIDA is working towards integrating traditionally isolated projects into national strategy plans, it is not abandoning local initiatives in an absolute way, as evident in Tanzania. A Senior Development Officer explained:

> Some country programs have begun supporting program-based approaches entirely, and a large percentage of their budgets are dedicated to supporting government plans. At CIDA we have what we call the "balanced approach"...Within the agency, each country program has flexibility to decide how they are going to implement their funding in the country. Country programs (e.g., Mozambique, Tanzania) have chosen to support common funds, but also continue with some project funding which complements where the national plan has a gap or needs extra emphasis in a certain area. (Participant #3, 2008)

This was reiterated by a Senior Director in the Policy and Programming Branch:

> Tanzania is one country that is quite consistently going ahead with program-based approaches...There is still some project-based activity remaining... But we are moving more in the direction of coordinated, multi-donor support. And Tanzania is one country where the coordination is really strong. I know we have also supported civil society initiatives in a coordinated way. In other words, donors have come together to support civil society through a program-based approach. (Participant #8, 2008)

By strengthening the forum in which local organizations can engage in national planning, it can be argued that CIDA is helping to build capacity among local actors and ensure that their perspective is included in national strategy plans. Furthermore, local organizations benefit from funding and capacity building that may otherwise have been unavailable. Through this process, projects are better integrated into comprehensive national strategies. Integrating projects into bilateral programming allows project implementers to

become increasingly involved in policy dialogue with donors and national governments with whom they are operating (CIDA 2002:6). Looking specifically to the health system, sectoral support helps to finance the delivery of services, and builds the capacity of the entire health system. Ultimately, the aim of integrating projects into bilateral programming is to allow local organizations to benefit from capacity building and human resource development, necessary for sustainable self-reliant development (CIDA 2002:6).

What can be seen from the description above, is that CIDA is actively involved in HIV/AIDS programming in Tanzania both financially, and also through offering technical support and recommendations during the development and implementation of national strategy plans. Therefore, CIDA supports HIV/AIDS mitigation strategies through bilateral programming, which in turn supports programs that reflect the *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2007), described in more detail directly below.

4.3 Tanzania's Second National Multi-sectoral Strategy Framework on HIV and AIDS (NMSF)

Through CIDA's balanced approach to development, the agency supports Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF 2008 to 2012). The NMSF outlines the country's current HIV mitigation strategy, building upon the achievements and strengths of the first NMSF (2003 to 2007). CIDA contributed $20 million CAD in support of the recent NMSF (Participant #6, 2008). The new strategy is regarded as effective, as it was developed through an "extensive review and consultation process under the guidance of national and international consultants" (TACAIDS 2007:xvi). It is further recognized that achievement of the NMSF requires engagement of actors from the multilateral, bilateral, and local levels (TACAIDS 2007:

xvi).

The NMSF proposes indicators, goals, and recommendations to overcome past barriers to effective program implementation, and to achieve progress towards the strategy's thematic areas. Additionally, the MDGs and targets (see Appendix A) were incorporated into the new NMSF, thereby replicating international consensus in the Tanzanian HIV/AIDS framework (TACAIDS 2007:6). As stated in the framework, the achievement of the NMSF is dependent upon progress made towards each goal, which is measured by the proposed indicators (TACAIDS 2007:40). The thematic areas focus on creating a political, socio-economic, and cultural environment that enables comprehensive, gender responsive prevention, treatment, care, and support (TACAIDS 2007:xiv, 40). This approach is further endorsed by CIDA.

According to CIDA staff members, the agency supports a comprehensive approach to HIV/AIDS mitigation, ensuring that bilateral programming is holistic, and targets a "broad spectrum" of priority areas, including treatment, prevention, care and support (Participant #6, 2008; Participant #9, 2008). According to a Senior HIV/AIDS Policy Analyst:

> Canada recognizes that a comprehensive approach is needed to address HIV/AIDS. Whether or not Canada needs to fund all of those areas is a different question. But Canada needs to be a part of the dialogue on all of those areas, and to ensure that national strategies address HIV/AIDS through a comprehensive approach, addressing all of those areas [prevention, treatment, care and support]. Strategies must focus on prevention but also ensure that the millions of people infected are receiving the treatment that they need. (Participant #9, 2008)

Regarding HIV/AIDS as a social issue, as opposed to simply a health issue, is also important to CIDA. This includes taking the broader socio-economic context into account for example, gender and income disparities into account. In order to achieve this goal,

CIDA's current approach to HIV/AIDS can be summarized by four priority areas: 1) health system strengthening at the national and community level to provide adequate basic health care services to people living with HIV/AIDS; 2) research for a vaccine; 3) the promotion of gender equality due to the feminization of the disease; and4) the promotion of children's rights and protection of children infected and affected by HIV/AIDS.

It is also important to note that CIDA's commitment to a comprehensive approach is not simply dictated internally, but, rather, it also reflects a two-way exchange of ideas between donors and partners. According to a Senior Health Analyst, the decision to support holistic programming is influenced by the fact that national HIV/AIDS strategies (e.g., the NMSF in Tanzania) also include these elements (Participant #2, 2008). Therefore, by supporting national strategies through the balanced approach, CIDA is inevitably agreeing to support comprehensive HIV/AIDS mitigation.

Local context is also taken into consideration when developing national HIV/AIDS strategies. In countries where prevalence rates are low, a focus on prevention may emerge; where disease burdens are high, treatment, care and support may take precedence. In effect, HIV/AIDS mitigation strategies, at the bilateral level, are not bound by CIDA-driven priorities; rather they reflect the needs of the partner countries and the priorities outlined in their national HIV/AIDS strategies. As for all elements of bilateral programming, CIDA raises concerns during the consultation process if they feel one or more HIV/AIDS priority areas (prevention, treatment, care and support) have not been given adequate attention in national strategy plans, although, ultimately, it is up to the partner to determine focus areas. Guided by the specific country context,

comprehensive sexual and reproductive health services are central to Tanzania's most recent NMSF (TACAIDS 2007). Despite the country's best efforts, reproductive health and HIV/AIDS remain a major challenge, and negatively influence rates of HIV-infection among women, rates of MTCT and, consequently, the number of children infected by HIV. The overview of the most recent NMSF (TACAIDS 2007), outlined below, details strategic recommendations regarding women's vulnerability to HIV/AIDS and the prevention of MTCT.

4.4 The Inclusion of Women and Children infected via MTCT in the NMSF

As discussed in Chapter Two, women's HIV-status is intrinsically linked with rates of HIV-infection among children, via MTCT. The NMSF outlines several targets and indicators regarding HIV-infection and gender inequalities that may exacerbate rates of infection among women. Also included are issues surrounding children infected via MTCT. These issues, discussed below, are identified as high-priority areas in the NMSF.

The NMSF proposes targets and measures to reduce HIV transmission via MTCT by 2012. Achievement of this goal should be evident in the decreased number of HIV-infections among men and women, and a subsequent decrease in the number of infants who are born HIV-positive from 2006 to 2012 (TACAIDS 2007:40). Although heath care provisions have been scaled-up from 2003 levels, the prevention of mother-to-child transmission (PMTCT) services were scaled up to more than 12 per cent of national health care facilities in 2006. This translates to a total of 710 hospitals and clinics offering PMTCT services (TACAIDS 2007: xviii, 19). With the expansion of services, 87 per cent of pregnant women admitted into clinical care, accepted HIV-testing as part of their pre-natal care. However, only 53 per cent of women found to be HIV-positive had

access to the needed antiretroviral care, due to frequent drug shortages and the weak and deteriorating health care system in the country. Extrapolated to the entire country, it is estimated that only 12 per cent of HIV-positive pregnant women received the treatment needed to prevent mother-to-child-transmission of HIV, clearly highlighting an unmet need (TACAIDS 2007:65).

Similarly, maternal mortality rates are very high and skilled birth attendance has remained at 45 per cent from 2003 to 2007. Overall, access to quality sexual and reproductive health services, such as PMTCT during pregnancy, delivery, and/or breast-feeding and access to care and treatment for mothers and infants, is particularly constrained in rural areas (CIDA 2006a:2, TACAIDS 2007:xxiii). In fact, women in rural areas are four times less likely to be offered HIV testing and counselling than their urban counterparts (TACAIDS 2007:63). Ultimately, it is hoped that the percentage of pregnant women receiving antiretrovirals for the prevention of MTCT will increase from 12 per cent, reported in 2006, to 96 per cent in 2012 (TACAIDS 2007:70).

Tanzania is presently "off-track"[21] with MDG 4, MDG 5, and MDG 6, child health, maternal health, and HIV/AIDS respectively (CIDA 2006a:1). In terms of post-natal services, the NMSF proposes that follow-up treatment and care be improved in order to reduce instances of MTCT. The NMSF suggests that although effective antiretroviral treatments are now available for the prevention of MTCT, they need to be made increasingly available (TACAIDS 2007:64). In addition, the Government of Tanzania has appealed to parents to ensure that the next generation is HIV-free by knowing the HIV status of the *mother* before conception (TACAIDS 2007:xiv, emphasis added). Although

[21] This terminology is often used in literature concerning progress towards the MDGs, it is assumed to mean that if current progress towards the goal is sustained, without significant increases, then the MDG will not be achieved by the target date.

this strategy is well intended, this statement is problematic as it removes responsibility from the father (i.e., male partners). Compounding this problem is the fact that male participation remains low in sexual health and PMTCT services, as health care facilities are not considered "male-friendly" (TACAIDS 2007:20). Men are simultaneously excluded from the prevention message, and are not held responsible for their health, or the health of their female partners and children. This is a serious challenge that needs to be addressed.

As discussed in Chapter Two, this issue remains complex, as a woman may also face violence or rejection by disclosing her HIV status, making it unlikely that she would willingly include her male partner in pre- and post-natal care (TACAIDS 2007:20). The NMSF suggests that health and education services are increasingly built upon the principle of dismantling prevailing gender norms, and discouraging male aggression and female submissiveness in the home and in sexual relationships (TACAIDS 2007:53). The promotion of open dialogue and awareness at the local level is important both to empower women and girls to negotiate safer sex, and also to enhance knowledge of sexuality, reproductive and sexual health for both partners (TACAIDS 2007:56).

The need to reduce the risk of infections among vulnerable groups due to gender inequalities, violence, and sexual abuse is also highlighted in the NMSF (TACAIDS 2007:xxii). As discussed in Chapter Two, young women are increasingly withdrawn from school in order to look after ill relatives, denying them opportunities to become economically independent. In these cases, women might become engaged in transactional and intergenerational sex, which increases their risk of HIV exposure (TACAIDS 2007:55). As a result, the NMSF gives special attention to those involved in commercial

and transactional sex recognizing the negative impact of poverty on rates of infection (TACAIDS 2007:10). To combat this, the NMSF recommends that special attention should be given to alleviating poverty among female-headed households, thereby breaking the cycle of poverty and the consequent risk for HIV-infection (TACAIDS 2007:12).

The NMSF also recommends the development and strengthening of laws and legislation needed to protect women from socio-economic insecurity. For example, it advocates for a revision of land tenure laws, to allow women greater land security, thereby increasing their control over resources and agricultural productivity (TACAIDS 2007:4). Similarly, the NMSF suggests that marriage laws must also be amended to protect women from early marriage (before the age of 18), and to give legal recognition to gender-based violence and marital rape as punishable offenses, and to widely enforce these laws. Counselling and legal support must also become widespread (TACAIDS 2007:57). Overall, the NMSF makes several important recommendations with regard to gender-based discrimination, which negatively affects women and exacerbates rates of infection among women and instances of MTCT.

In general, the NMSF addresses the need to balance two dimensions that are specific to HIV in Tanzania: measures must concurrently address the 7 per cent of the sexually active population (aged 15 to 49 years) who are HIV-infected, and the 93 per cent that are not and who should be protected from infection. Thus, prevention efforts need to be increased (TACAIDS 2007: xxi). According to the NMSF, this includes an emphasis on behaviour change, the provision of voluntary counselling and testing (VCT), and effective and timely treatment of sexually transmitted infections (STIs) and HIV.

Prevention is continuously highlighted, even though surveys record that the population is highly knowledgeable about HIV/AIDS and the ways to avoid infection. However, the NMSF suggests that rates of new infections in the country are disturbing. The NMSF attributes the 400,000 reported cases of STIs in 2005/2006 to the "apparent complacency" among the general population of Tanzania, highlighting the urgent need to intensify prevention efforts to curb new STIs and HIV (TACAIDS 2007: xiii). However, the statement "apparent complacency" is misguided, suggesting that if/when prevention services are available individual behaviour will automatically shift. What this statement fails to recognize is that there are socio-economic factors, such as poverty, locality, gender inequalities, and intergenerational concerns (i.e., services that discriminate against young women, or intergenerational relationships that leave young women more vulnerable to infection) that may undermine prevention efforts.

Although STI treatment has increased, from 223,000 patients in 2003 to 400,000 patients treated in 2006, evaluations of these programs reveal low utilization. Furthermore, those who do access these services are likely to face frequent drug shortages and inadequate counselling on condom use and the benefits of HIV testing (TACAIDS 2007:18). Although services are available, they do not meet the needs of STI patients, and are inadequately promoting the message of prevention, testing, and treatment among young women and men. The Government of Tanzania has reported increased coverage of STI treatment to all hospitals and 60 per cent of dispensaries, and the number of voluntary counselling centres has been increased more than three times (TACAIDS 2007: xvii). These successes, however, do not lessen the urgent need for increased prevention (TACAIDS 2007:xvii). Ultimately, preventing new infections is

identified in the NMSF as being the key to curbing the epidemic in the country (TACAIDS 2007: xiv).

The need to increase national prevention efforts is highlighted not only within the NMSF, but also by Development Officers and Field Staff from CIDA's Tanzania Program. Trends show that when treatment initiatives begin to take precedence over prevention, it negatively affects the rate of HIV-infection. While those who are already infected are being treated, those who miss out on the prevention message are at risk, and may add a burden to the health care system. With this assertion, a few CIDA staff offered a strong opinion on the matter, making it clear that the development community "cannot treat its way out of the pandemic," and individuals in Tanzania must "start taking some responsibility for their behaviour" (Participant #2, 2008; Participant #6, 2008). However, statements such as these are problematic, as they, again, negate the importance of socio-economic and political factors that lessen access to health care and education among marginalized women.

The overview above highlights a selection of goals included in the NMSF that are specific to the prevention and treatment of HIV among women and the prevention of MTCT. The NMSF document, being as broad and detailed as it is, addresses nearly every aspect of HIV/AIDS mitigation, and, therefore, it should provide an adequate framework to counter the pandemic for women (James 2006:204). Yet, the criticism remains that there is no clear plan of action. The NMSF is essentially a raw strategy plan that local and sectoral initiatives can draw from in the hopes of contributing to the overall national plan. One such example is seen in the initiatives implemented by Marie Stopes Tanzania.

4.5 The Role of Marie Stopes Tanzania

In 2005, CIDA contributed $3,950,000 CAD to Marie Stopes Tanzania (MST) for its Reproductive, Maternal and Child Health and HIV/AIDS Services Project (CIDA 2005b; High Commission of Canada 2006). According to the Canadian High Commissioner, Marie Stopes is regarded as a key partner in Tanzania's efforts to achieve the MDGs of improving maternal and child health and combating HIV/AIDS. Reports confirm the idea that NGOs have an important role to play in addressing issues that have not been adequately handled at the national level (Black and Tiessen 2007: 203; CIDA/GGI 2004:5). In Tanzania, local organizations are acknowledges with the NMSF for the important role they have in providing services that address poverty, gender inequality, and health care, and consequently HIV/AIDS mitigation.

Marie Stopes Tanzania currently offers 20 per cent of the country's total reproductive and sexual health services, including family planning, HIV/AIDS testing and counselling, and the prevention of MTCT. Second only to the GoT, Marie Stopes Tanzania is the largest health care provider and manages 86 per cent of long-term and permanent family planning facilities in the country (CIDA/GGI 2004:15). Marie Stopes operates in 24 Districts in Tanzania, and offers 18 full-service static centres and over 120 regularly serviced outreach sites that operate separately from publicly run clinics (High Commission of Canada 2006).

In all 18 health care facilities, voluntary counselling and testing (VCT) services are offered, and as the organization expands, these services are being rolled out to the outreach sites. STI testing and treatments are also available in all permanent facilities, and at many of the outreach sites. The fact that MST has 18 fully equipped facilities

makes them the largest VCT provider in the country, surpassing the capacity of the national health care system (Marie Stopes Tanzania 2002: 6). MST also carries out antenatal and maternal and child health activities in all its health care facilities, and through rural outreach programs it provides medical intervention to prevent mother-to-child-transmission. MST treats opportunistic infections among women and children, and provides post-natal care and nutritional counselling to prevent transmission via breastfeeding (Marie Stopes Tanzania 2002: 6). In 2002, Marie Stopes Tanzania provided services to 253,000 Tanzanians, and recent reports show that MST services reached 534,277 individuals in 2008, particularly women in rural areas (Marie Stopes International 2009).

Although Marie Stopes Tanzania is a non-profit organization, it operates on a "cost-recovery" basis, with the exception of family planning contraceptives and condoms, which are distributed free of charge (High Commission of Canada 2006). According to a CIDA Senior Development Officer in the Tanzania Program, donor contributions help to alleviate the costs shouldered by the user. She explained:

> We are funding the Marie Stopes directly, but we are also funding the government with the intention of developing a public-private partnership (i.e., The Government of Tanzania and Marie Stopes Tanzania). In turn, Marie Stopes Tanzania will be a part of the planning at the district level (meso), it will be the implementer providing the specific health services [at the micro-level], and the government [macro-level] will reimburse the organization for the health services Marie Stopes Tanzania has provided. (Participant #4, 2008)

By supporting Marie Stopes Tanzania, CIDA has also reinforced and drawn attention to the importance of reducing the number of HIV-infections among women, and the prevention of MTCT. Secondly, it has provided financial support for the organization to implement its activities, all while fostering a relationship between Marie Stopes and the

Government of Tanzania. The rationale for this comes from the obvious principle that "development means that CIDA will no longer have to provide funding to the Government of Tanzania in the future" (Participant #4, 2008). Through its balanced approach, CIDA is trying to promote "public-private"[22] partnerships for development, so the Government of Tanzania will eventually choose to support an executing agency, such as Marie Stopes Tanzania, to provide health care directly to the marginalized and underserved population in Tanzania (Participant #4, 2008).

This case study is interesting, as it demonstrates the complementary role that local organizations can play while national level planning is designed and implemented (High Commission of Canada 2006). As the MST broadens its reach throughout the country, CIDA hopes that the GoT will continue to strengthen its relationship with the organization, as an additional aspect of the Paris Declaration is the harmonization of efforts between the government and local organizations. Along with its own organizational objectives, MST acknowledges the role that they are able to play in expanding local-level interventions efforts against HIV/AIDS, by offering a local perspective to the *Second National Multi-sectoral Strategic Framework on HIV and AIDS*. MST also works in close collaboration with the District Health Sector, to establish areas of needs and to prevent the duplication of efforts and wasted resources (Marie Stopes Tanzania 2002: 6). This provides a positive example of the ways in which coordination between local, national and sectoral responses can be adequately facilitated. It must also be noted, though, that due to the size of the organization, Marie Stopes

[22] Although Marie Stopes Tanzania is an NGO, its partnership with CIDA is described as "public-private". Although this terminology is not typically used to describe public partnerships with NGOs in other academic literature, I will be using this term consistent with the terminology used by CIDA staff.

Tanzania has the technical capacity and management experience to handle large-scale donor funding efficiently, allowing them to take on this level of coordination effectively (Marie Stopes Tanzania 2002:6).

4.6 Health System Strengthening in Tanzania

As discussed in Chapter Three, economic reforms in the early 1990s served to undermine the national health care system in Tanzania. These effects continue to be felt today. In Tanzania, health care services are constrained by the lack of hospital equipment, essential drugs, trained personnel, and technical capacity. Adding to this challenge is the fact that HIV/AIDS services absorb 30 per cent of all health-dedicated resources. Addressing this issue, one Senior Director from CIDA suggests that:

> When there are so many needs in the health sector...the challenge is to change the way the whole system operates, allowing the whole system to benefit, not just a particular disease area...It's not wrong to put money in those areas, but you need to ensure than the whole health system benefits. (Participant #9, 2008)

Arguably, more funding must be dedicated to capacity building and improving human resources in the health care sector to supplement the funds being directed toward HIV/AIDS services. However, this is a difficult balance to achieve. As seen in the statement, below, there is a tension between some CIDA staff, as different members believe that funding to HIV/AIDS service delivery should be increased, while others feel that it continues to divert funds away from other disease areas, and the health sector generally. As explained by a Senior Field Staff working in the Tanzania Program:

> Research has shown that when money is used for HIV, it draws money and human resources away from other areas to ensure that people are getting the HIV services and medicines they need. Meanwhile, you are depleting the much-needed resources from other areas of the health care system. In Tanzania, more people are actually dying from malaria than AIDS. So, as a donor, if you already have limited resources, why would you put your limited resources on paediatric HIV/AIDS specifically?...I don't think there has been enough research on the

> opportunity cost of favouring one disease area at the expense of another. (Participant #6, 2008)

What these two statements suggest is that, while health system strengthening is vital, other disease areas, above and beyond HIV/AIDS mitigation, must be given increased attention (Ministry of Foreign Affairs, Denmark 2007:118). According to a Senior Development Officer in the Tanzania Program:

> Our colleague in the field is actually the focal point for that issue [health sector strengthening], so there is a technical working group that just focuses on this issue, and she has been successful in gaining momentum on this issue, since it is now recognized as a crisis in the country...the shortage [of human resources for health care delivery] is approximately 60-70 per cent. The strategy to improve the health sector and human resources was released in January 2008, but this has not yet been implemented or operationalized...So my colleague and some other donors have been working with the government and trying to develop varying ways to engage the Government [of Tanzania] and the private sector in the implementation of this plan. (Participant #4, 2008)

Speaking on this issue, a CIDA Senior Officer working in the field confirms the fact that Tanzania is facing a 60 to 70 per cent deficit in human resources related to health care delivery, adding:

> At the end of the day, I don't believe that you are going to make progress on controlling and managing epidemics unless we start looking at the human resource crisis. I don't know how you make progress on HIV/AIDS, maternal and child health unless you deal with the human resource issue. If you don't have trained individuals, how do you deliver your programs? (Participant #6, 2008)

This last statement clearly highlights the need to address the socio-economic barriers that continue to disadvantage individuals in need of care: first, in terms of developing the capacity and skills of individuals; and second, by improving the scope of quality health care services. However, the issue remains as to how CIDA can ensure that marginalized individuals gain access to these services once they become available.

4.7 Joint Monitoring and Evaluation of the NMSF

Aside from identifying specific HIV/AIDS strategies and indicators, another important feature of bilateral programming includes joint monitoring and evaluation. In order to monitor progress towards the NMSF, the Tanzanian Commission for AIDS (TACAIDS) has developed the Tanzanian Output Monitoring System for HIV/AIDS, commonly known as the TOMSHA, funded by CIDA. The TOMSHA, like other Paris-driven strategies, aims to coordinate HIV/AIDS activities at the community level. Facilitated by TACAIDS, community-based organizations (CBOs) are invited to participate in training workshops, and learn how to use the TOMSHA. If all CBOs report on the indicators outlined in the NMSF simultaneously, the objective is that the TOMSHA is a means to coordinate the monitoring and evaluation system across sectors and organizations. Secondly, the TOMSHA could serve as a useful tool for "rolling-up" indicators from the local level to the national level, monitoring local contributions towards the NMSF and in future, minimizing duplicate efforts (Participant #4, 2008). However, initial reports show that the TOMSHA has not had the desired results. According to the NMSF, although the monitoring tool was successfully developed, TACAIDS is "overburdened" as a national coordinating structure and is unable to fully implement the TOMSHA (TACAIDS 2007: xviii); this concern was also raised by two Senior Staff in the Tanzania Program (Participant #4, 2008, Participant #6, 2008). It is not difficult to ascertain why TACAIDS is overburdened, as it is attempting to cope with the multiplicity of indicators outlined in the NMSF, and the fact that a number of local organizations are submitting reports concerning their contributions to these indicators.

As noted by CIDA Senior Field Staff and Development Officers in the Tanzania

Program, the TOMSHA is a relatively new tool, and CIDA and TACAIDS have yet to determine how effective it will be for monitoring progress. To determine the efficacy of the tool, in October 2008 Development Officers from the Tanzania Program met with a selection of CBOs who attempted to implement the TOMSHA to determine what indicators TACAIDS is asking them to report on, and where there are discrepancies between the TOMSHA and reporting (Participant #4, 2008). One staff member in the field explained:

> We are going to be evaluating the TOMSHA through field visits. First, we are going to look at the transfer of funding from donors to partner organizations. Secondly, we are going to find out what they did with the funds and what kinds of monitoring mechanisms they have, and review how they report on what they've been doing. Once you get down to the local level you are dealing with some really small initiatives and there is no mechanism to collect all this data. So I think it's going to show us that we have a lot of work to do to focus our attention on how to strengthen those mechanisms. (Participant #6, 2008)

If this monitoring tool can be improved and successfully implemented, it is hoped that it will strengthen the ability of the national government to collect data about small-scale, community initiatives, including the use and effectiveness of funding, and results that may have otherwise gone unreported. With proper implementation, the TOMSHA could have an immensely positive impact on coordinating national and local responses, as well as providing a clear, comprehensive snap-shot of HIV/AIDS and HIV/AIDS-related activities in the country. However, until these problems with planning and implementation are dealt with, donors will be hesitant to put further resources into developing this tool. Currently, CIDA, who piloted this tool, is the only donor (Participant #4, 2008). Once the results of the TOMSHA are released, this will be an interesting area for further research, as the TOMSHA model could potentially be pioneered in other countries looking to improve their understanding of the pandemic

nationally.

4.8 Data and Analysis

The Government of Tanzania has built its *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2007) upon the MDGs, which reflects a comprehensive approach to HIV/AIDS mitigation. In line with Paris-principles, CIDA supports Tanzania's national strategy through bilateral programming, thereby also supporting progress towards the MDGs and HIV/AIDS mitigation. Ultimately, as CIDA supports the national strategy plan, they are subsequently supporting the reduction of HIV-infections among women, and the prevention of MTCT, but actual outcomes of these programs need to be explored.

Table 4.1 provides relevant statistics concerning the number of women HIV-infected and instances of MTCT in Tanzania. Statistic from the years 1990, 2001, 2007, and goals for the year 2015 are included. The year 1990 serves as a baseline for the achievement of the MDGs for health. The year 2001 represents the most comprehensive data, after the signing of the Millennium Declaration. Finally, 2007 is the midway point to reaching the 2015 target date for the realization of the MDGs. Demonstrating changes in numbers over this timeline sheds some light on the gains in key outcomes related to women's health and children's exposure to HIV.

Table 4.1 – HIV-Infection Among Women, MTCT services, and HIV-Infection among Children in Tanzania (1990, 2001, and 2007)

	1990	2001	2004	2005	2006	2007	Goal (2015)
Women (15-49)	**300,000**	**740,000**		760,000	760,000	**760,000**	**Halted or reversed the spread of new infections (MDG6)**
PMTCT services (%)	**N/A**	**N/A**	2%	6%	15%	**35%**	**Achieved universal access to HIV treatment and prevention (MDG 6), including reproductive health care (MDG 5)**
Children (0-14)	**N/A**	**120,000**				**140,000**	**Halted or reverse the spread of new infections (MDG 6), reduced by two thirds under five mortality (MDG 4)**

(source Habib *et al.* 2008: 616; UNAIDS 2008c; UNAIDS 2008f)

On the surface, the rationale for a balanced approach to development is very compelling, however, as seen in the table, results have yet to be fully demonstrated in the short-term. What the data show is that in Tanzania the number of HIV-infected women, and, subsequently, children has stabilized, but has yet to decline. If the Government of Tanzania can stay on top of its prevention efforts and improve the way it systematically addresses socio-economic inequalities faced by women, at the very least, the number of women infected will remain stable by the year 2015. Gains in the prevention of MTCT have been made have also been made, most notably from 2004 to 2007. However, urban-rural disparities, poverty, and gender-based discrimination continue to be barriers to women's access to PMTCT services (see Chapter Two). As with other prevention initiatives, the delivery of MTCT services must be coupled with initiatives that improve women's access to these services.

To highlight the value of CIDA's balanced approach, this chapter reveals the complementary role that local organizations such as MST can play in the short term, as program-based approaches are established and strengthened over the long-term. As one Senior Development Officer explained, development initiatives at the community level, such as MST, are valuable, as they support the immediate health and well-being of community members. However, long-term bilateral programming is fundamentally important for creating "systemic changes" for meaningful development. This same Development Officer stated:

> You can have development projects that are the community level and it will support the overall health and well-being of the community, but it won't have any systemic changes. You can also have a project that is at a very high level, such as changing the function of a ministry, but it won't trickle down to the community. And then you can also have a project at what we call the "meso" (e.g., sectoral) level, which can influence in both directions. But to have a change you have to work systemically and challenge the way the country does things overall. (Participant #3, 2008)

Essentially, to create long-standing change, CIDA must work to challenge the way that Tanzania currently operates. While these institutional changes are taking place, CIDA must also make sure that people on the ground are being taken care of and are active participants in creating solutions. Steps are being made in this regard through direct financial support given to MST by CIDA. However, CIDA's involvement with MST must also facilitate the participation and inclusion of patients and other program beneficiaries to ensure individual needs and concerns are raised and considered around a donor table. As an established health care provider, MST has the unique ability to represent the communities they serve, and bring these concerns to the forefront. Therefore, MST should continue to participate in stakeholder negotiations.

As outlined in the NMSF, local initiatives are vital as they complement national HIV/AIDS priorities. Therefore, the Government of Tanzania is committed to capacity building within local organizations that provide quality services that are consistent with the national priority areas outlined above (TACAIDS 2007:xxvi). The public-private partnership between bilateral actors and Marie Stopes Tanzania exemplifies this objective in the NMSF. Marie Stopes Tanzania, funded in part by CIDA, complements the nationally-provided health care services by offering comprehensive, sexual and reproductive health services, through a gender-sensitive approach (Marie Stopes 2009).

By implementing its balanced approach to development, CIDA is able to support HIV/AIDS mitigation at the sectoral, national, district, and local levels. However, it is difficult to claim success or "positive impacts" where CIDA has contributed to strengthening country programming, policy-making, and monitoring and evaluation, since these cannot be monitored numerically. The example above reveals that CIDA is committed to improving national and local level planning with the aim of decreasing the number of HIV-infections among women and the preventing MTCT. However, this is identified as an area for continued improvement.

4.9 Conclusion

This chapter outlines the ways in which bilateral aid modalities permeated national strategy plans developed by CIDA partners, as demonstrated through Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2007). This strategy plan reflects the context-specific needs of the country, and, in turn, is supported by CIDA, in line with Paris-principles that encourage nationally-drive strategies for development. With the inclusion of Paris-principles into CIDA's current

development strategy, the "project-based" model of development is given less attention by the agency. CIDA now integrates local initiatives into national strategies; one example is the support given to Marie Stopes Tanzania. This organization is supported by CIDA with the aim of fostering a public-private partnership with the Government of Tanzania, and integrating local projects into program-based approaches. However, questions remain about the efficacy of this model, as CIDA's balanced approach cannot be clearly linked to any gains in reducing the number of HIV-infections among women and preventing MTCT. Chapter Five offers some insights on these issues by reviewing the strengths and weaknesses of these approaches. Suggestions are made about how HIV-infection among women and the prevention of MTCT can be made a more prominent focal point in bilateral programming, so that we may begin to see improvements in these key outcomes.

Chapter Five – Analysis, Conclusions and Suggestions

5.1 Introduction

This chapter provides insights and suggestions responding to the content and data presented above. Before doing so, it is important to review the contributions of the previous chapters, and to reiterate the central research objective of this thesis. Finally, the chapter addresses important issues surrounding the strengths and weaknesses of CIDA's "balanced approach" to development.

Chapter One highlights the central thrust of this thesis, which is to review the findings gathered from CIDA staff and secondary sources to determine strengths and weaknesses of the agency's balanced approach to development and HIV/AIDS mitigation strategies. Chapter One also highlights key themes: to introduce the socio-economic factors that exacerbate rates of HIV-infection among women and children; to demonstrate that, undoubtedly, consensus at the international level (e.g., MDGs, Paris Declaration) influences CIDA programming, and their relationships with partners abroad; and, to examine the partnership between CIDA and the Government of Tanzania in terms of their ability and commitment to reducing the number of HIV-infections among women, and instances of MTCT.

Chapter Two outlines the critical medical anthropology (CMA) approach as it relates to understanding the number of HIV-infections among women and children. This background allows for better understanding of political, socio-economic, and historic processes that exacerbate rates of HIV-infection, in this case, within the sub-Saharan Africa context, generally, and specifically in Tanzania. This chapter then highlights the complex factors that affect rates of HIV-infection among women, and children. It is

widely accepted among international bodies (e.g., UNAIDS and UNICEF), that the increased number of HIV-infections among women lead to the increased number of children infected with HIV, via mother-to-child-transmission (MTCT). Although there are countless prevention and treatment initiatives underway, at all levels, the effectiveness of these activities is largely determined by their ability to decrease individual vulnerability to HIV-infection by simultaneously reducing poverty and gendered-based discrimination and abuse. Chapter Two demonstrates a variety of factors that affect women, including, but not limited to, socio-economic inequality such as poverty and gender discrimination; unequal access to health care and education, particularly in poor households; social and economic marginalization; intergenerational relationships, which exacerbate rates of infection among women; and discrimination faced by women, especially young women, in health care settings.

Chapter Two also demonstrates that, while offering prevention and treatment options is important, this does not inevitably lead to a decreased number of HIV-infection and/or death due to AIDS. Rather, prevention, treatment, support and care offered at the national level must be coupled with strategies that reduce poverty; increase access to health care and education among socially and geographically marginalized groups; and challenge gender discrimination. These processes are outlined and prioritized by international discourse (see Appendix A), namely, the *Millennium Development Goals* (UN 2000) and the *Paris Declaration on Aid Effectiveness* (OECD 2005).

The review of these internationally agreed upon development goals and targets and aid strategies demonstrates the pervasiveness of development consensus surrounding women, and the prevention of mother-to-child transmission (PMTCT) and HIV/AIDS.

Chapter Two highlights the importance of the Paris Declaration as both a stimulus for the realization of the MDGs, as well as the influence of Paris-principles on CIDA's program-based approach to development. CIDA's balanced approach is being increasingly favoured over traditional short-term projects, especially so in the Tanzania Program, which is managed by CIDA's Geographic Programming Branch.

In responding to these issues, the effectiveness of CIDA's bilateral approach needs to be constantly reviewed. Chapter Three, therefore, explores bilateral aid modalities for development programming and introduces the specific partnership between CIDA and the Government of Tanzania (GoT). Chapter Three illustrates that CIDA's new bilateral programming model integrates the MDGs and Paris Declaration into its balanced approach to development. As part of CIDA's balanced approach to development, the agency is committed to building partnerships with local organizations to supplement to development programming at the national level.

Finally, Chapter Three discusses the rationale for CIDA's partnership with the Government of Tanzania, as it fulfils a number of important criteria used to assess potential development partners. The current health system is described and situated in its historical and contemporary context. Chapter Four demonstrates CIDA's specific contributions to national planning in Tanzania, including its support of: Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF); the TOMSHA; health system strengthening; and Marie Stopes Tanzania. Ultimately, the background information provided in this chapter serves as a useful entry point for Chapter Five's review of the strengths and weaknesses of bilateral programming, using

the decreased number of HIV-infections among women in Tanzania and prevention of mother-to-child transmission as indicators for success.

Building upon the previous chapters, Chapter Five satisfies the critical research objective of this thesis: to identify and highlight the strengths and weaknesses of CIDA's "balanced approach" to development in decreasing the number of HIV-infections among women and reducing instances of MTCT in Tanzania. It concludes that because the number HIV-infections among women has stabilized, and not declined, and because access to MTCT services have improved, but is not universal, that the results of bilateral programming in the short-term are mixed. Furthermore, the findings support the contention that bilateral programming has laid the foundation for programmatic success, however, there are still areas for improvement required in order to achieve the key outcomes in the long term. To support this conclusion, the strengths and weaknesses of CIDA's balanced approach to development are discussed below.

5.2 The Strengths and Weaknesses CIDA's Balanced Approach

Strengths

The aim of bilateral programming is for donors to assist partner governments in the achievement of national strategy plans for development through the provision of funding, technical feedback, support, and capacity building. Drawing from the Paris-principles, program-based approaches are based on the following elements: country-driven priorities and leadership; alignment of programs and budgets; donor coordination and harmonization; and joint monitoring and evaluation (CIDA/GGI 2004:10; OECD 2005). In Tanzania, CIDA, alongside other donors, is engaged in the development and implementation of national health care initiatives, including the *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2003, 2007), complemented

by CIDA's support to Marie Stopes Tanzania. CIDA staff identified several strengths and weaknesses of this approach as discussed below. By characterizing areas for improvement, it is possible to offer some suggestions for improving bilateral programming and increasing the ability of bilateral partnership to achieve key outcomes (e.g., decreased number of HIV-infections among women, and reduced instances of MTCT).

1) The phasing out of traditional "project-based" development promotes local ownership and the achievement of long-term, coordinated development

In the past, CIDA mainly funded short-term projects as a means of development assistance. CIDA's Partnership Branch supported local initiatives and public-private partnerships (private can include both for-profit and non-profit organizations), funding projects designed and implemented by organizations including research institutions, domestic and international non-governmental organizations, (NGO) programs, and volunteer projects (Participant #7, 2008). While individual projects may have successes in the short-term, they may fail to have long-term benefits within a community or country once the project ends. Research indicates that projects were "often developed and implemented with insufficient regard for the broader context which could affect, or undermine, their impact" (CIDA 2002: 5-6).[23]

Furthermore, donor funding, directed to hundreds of isolated projects in a particular sector, actually increases the strain on the administrative capacity of partner countries. Each project has its own reporting mechanisms, systems, and methodologies.

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[23] For example, a project could be developed to provide antiretrovirals to a particular community, however, the project may overlook the capacity of health care workers and clinics to actually distribute these drugs. The project might also fail to foresee that antiretroviral treatment, once started, must be continued for the entire lifetime of the patient. In this example, the lack of provision of treatment could have a devastating impact on people's lives, if the project cannot be renewed over the long-term.

As it is the responsibility of the partner country to oversee reporting, coordinate development initiatives and minimize the number of reports that need to be written (i.e., integrating projects with national plans), this removes the excess burden from the national government (CIDA 2002:6). Finally, over-reliance on projects can foster a "lack of ownership, direction, and control" of the development process at the national level, thereby violating the spirit and principles of the Paris Declaration (CIDA 2002:6). For these reasons, CIDA's movement toward "phasing-out" short-term projects in Tanzania is considered a strength of the agency's new approach to development.

2) Bilateral programming better coordinates financial resources for HIV/AIDS

Under program-based approaches, various financial arrangements are available, two of which are currently operationalized in the Tanzania Program (i.e., pooled sectoral funding, coordinated funding for projects). First, CIDA contributes to a pooled fund, alongside other donors. These funds are used by the Tanzanian Government to support national HIV/AIDS programming, which is designed, budgeted and agreed upon by all partners. Activities supported through this coordinated donor funding aim to achieve broad-based results in a given sector or thematic area, such as HIV/AIDS (CIDA/GGI 2004:10). In Tanzania, this type of funding is currently used to support the *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2007), and is preferred by partners over general budget support.[24] As explained by a CIDA Senior Development Officer in the Tanzania Program:

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[24] General budget support can be implemented, whereby donors fund the national budget of the recipient country (CIDA/GGI 2004:10). General budget support has no pre-determined limits or thematic areas (e.g., HIV/AIDS) on which these funds are actually spent. However, this means that different departments and sectors are competing to access general budget support, and have different interests and demands about where the money should go, thereby causing additional delays. Currently, there is no general budget support in Tanzania, although this is an area that CIDA is hoping to develop, as "CIDA recognizes that

> When you speak with officials within the government you will find that they are happy to have sectoral support [pooled funding], because if donors provide money directly to the sector it can be accessed and distributed more quickly. (Participant #4, 2008)

In terms of funding, CIDA also makes financial contributions to local organizations that are integrated and coordinated within the overall bilateral program, with an emphasis on local ownership (CIDA/GGI 2004:10). Direct support to NGOs, such as MST, is considered to be more efficient and effective, promoting local ownership of service delivery, and is better capable of meeting local needs (Black and Tiessen 2007:204; Hanson 2000:355). This funding has been further advocated by NGOs and civil society coalitions that argue pooled sectoral funding, being top-down in nature, is less likely to reach to the poor. CIDA's move towards pooled sectoral funding, combined with direct support by CIDA to organizations such as MST,[25] therefore, reflects the agency's responsiveness to international aid modalities, as well as balancing the needs of individuals and community-based organizations (Black and Tiessen 2007:207; Campbell 2008:253). Nationally driven strategies, coupled with locally developed programs and projects for development, are identified as key to the promotion of national "ownership", outlined in the Paris Declaration (OECD 2005:3).

3) Internationally, CIDA maintains a reputation as a respected moderator

In general, other donors appreciate the leadership role that CIDA plays in harmonizing efforts (CIDA/GGI 2004:12). Study participants from CIDA reinforced this statement, and identified CIDA as a moderator and leader, stemming from its well

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Tanzania needs to have funding at all levels (i.e., general budget support, pooled sectoral funding, and coordinated funds for projects) to try to allow these systems to mature" (Participant #4, 2008).

[25] Although Marie Stopes Tanzania is part of the Marie Stopes International Partnership, a high level of autonomy and decision-making is given to the local partners, making them "local" in practice, with support of their international partners.

received presence internationally. A Senior Policy Analyst suggested: "CIDA has a good reputation...on average we have a good relationship with our partners and donors, we try to foster these relationships, we bring in principles of aid effectiveness, and try to make things as simple as possible" (Participant #9, 2008).

As a small donor, CIDA must make full use of the resources that it has, which is the agency's strong voice and moderator role. Dialogue with partners and other donors is one of the critical ways that CIDA is able to highlight the agency's key areas of concern directly. For example, CIDA is committed to raising gender concerns, due to the feminization or the disease. By lobbying with other donors and partners, CIDA can advocate that gender concerns are adequately included in national level planning (e.g., the NMSF). A joint-evaluation of the Tanzania Program found that CIDA has an impressive degree of influence at the table, relative to its financial contributions (i.e., its promotion of policy and discourse is well respected and integrated, while financial contributions remain low (CIDA/GGI 2004:17)). As noted by a Senior Director in the Policy and Programming Branch:

> We [CIDA] don't always bring as much money as some of the other donors, but when we engage, we engage. We really work in partnerships with others, and that is appreciated in the way that Canada works with other countries around the table, and on the ground. Some other countries come into the partnership with a lot of money, but they don't back up the use of that money, or help [to] build capacity. (Participant #8, 2008)

Similarly, a Senior Development Officer described CIDA's role in the following way:

> We are seen as a balanced partner. We are not extreme in different ways, therefore, I think that CIDA embodies Canada's reputation as a middle power, negotiator...Other donors have that approach, as well, but I think, internationally, partners generally appreciate CIDA's role as a moderator, where other donors can have a very specific, or extreme approach linked to a particular issue [such as HIV/AIDS]. (Participant #3, 2008)

In general, CIDA is commended for the constructive leadership role played by its staff (CIDA/GGI 2004:17). CIDA's role as a moderator not only reflects "Canadian values" (Brown 2007:216), but also demonstrates the steps CIDA has taken to integrate Paris-principles fully into bilateral, multi-donor, programming.

4) CIDA is strong in its commitment to raise gender concerns

As development specialists, the general consensus among CIDA staff is that the agency also raises gender concerns wherever possible, although there are some areas for improvement (Participant #2, 2008; Participant #6, 2008; Participant #7, 2008; Participant #8, 2008, Participant #10, 2008). When questioned about CIDA's role in targeting concerns related to gender inequality, and its connection to HIV/AIDS, participants spoke confidently about the strength of the agency to bring gendered issues to the table:

> Gender equality is at the core of the epidemic...and women's inability to control their own sexuality and access the services that they need to protect themselves and get treatment. So we really take on that gendered perspective into what we are doing, and ensuring that women and girls are included into what we are doing and ensuring that we have targeted programming. I would say that is one of CIDA's strengths. (Participant #9, 2008)

According to a Senior Director in CIDA's Policy and Programming Branch:

> The new modality [balanced approach] ensures that priorities and programming are defined at the country level, which is *de facto*, their political, socio-economic, and cultural circumstances. Although some of the priorities emerge incidentally, CIDA also has individuals assess the different determinants of health that are cultural and social in nature. To complement national planning and priorities, from CIDA's policy perspective, the agency promotes a gendered perspective on HIV/AIDS.... (Participant #8, 2008)

Finally, one respondent spoke directly to gendered issues and children:

> One of the things that CIDA is known for, and have in the past been quite prominent leaders on, is on gender equality. And certainly some of the research [under the Child Protection Research Fund] really did focus on girls and the

> gendered dimensions of various issues. I think around a donor table that is something that we can speak to with some authority, and I think something that would be quite relevant to a discussion on paediatric HIV/AIDS, the differential concerns, vis-à-vis boys and girls. (Participant #10, 2008)

What is seen in these responses is that CIDA's Development Officers and Health and Policy Advisors are informed about gender issues, and take a gendered perspective quite seriously. Furthermore, they suggest that the program-based approach is an effective forum for the promotion of gender concerns, although the agency is still working to improve gender mainstreaming. However, it is difficult to directly link CIDA's recommendations to specific areas within national frameworks, in terms of gender, or otherwise.

Although several strengths of CIDA's bilateral programming are illustrated above, it is also critical to describe its weaknesses, so that suggestions for improvement can be offered.

Weaknesses

1) The coordination of donor interests works in favour of small agencies such as CIDA, but may not work in the best interest of development partners.

According to the Paris Declaration, program-based approaches are implemented "as a way of engaging in development cooperation, based on the principles of coordinated support for locally owned programs" (OECD 2005:11). Typically, donor coordination is achieved through donor negotiation. As explained by a Senior Development Officer, "donors first discuss everything as donors, and then go to the government with a unified position" (Participant #3, 2008). In these negotiations, donors discuss and identify areas that need more attention in national strategy plans, before consultation with the partner country. This ensures that donors are entering agreements with the partner country with a

unified approach as much as possible. Typically, decision-making, in and between bilateral agencies, is often complicated by internal disagreements and debates (Campbell 2008:253). As described by a Senior Development Officer at CIDA, sometimes donors "just need to agree to disagree" (Participant #7, 2008).

As a small donor, CIDA is somewhat limited in terms of its influence, and appears to be reliant on aligning itself with other donors that have similar viewpoints. It was noted by one CIDA staff member that CIDA is able to have greater influence when other donor priorities are in line with their own, as this gives the agency a better chance of promoting its own priorities, which may be contrary to those of large donors, such as USAID and DFID. According to a Senior Director in the Policy and Programming Branch:

> A recent challenge of aligning with Paris-principles is when different players come around the table. We are not a big player, so when we have the Global Fund and PEPFAR coming into a country, our challenge is that if we don't find a way to collaborate with them, there is a possibility of skewing what goes on at the country level. Since they [PEPFAR and the Global Fund] come in with such large financial contributions, it can have a way of influencing the way that the national level perceives its health care and HIV/AIDS priorities, and that affects the country and the role CIDA can play as a donor. (Participant #8, 2008)

A Junior Policy Analyst argued that the "bilateral decision-making process gives CIDA a stronger voice" when dealing with other, larger donors as opposed to making decisions unilaterally (Participant #1, 2008). She gave the following example:

> Unfortunately, money talks, so when abstinence-based education [for HIV/AIDS prevention] was promoted by the United States, it was hard for CIDA to present a competing strategy (e.g., condom distribution). However, when CIDA is beside other donors who support the same strategy, it gives the strategy and the agency more validity. It also gives the issue more momentum in international fora and in bilateral programming than CIDA would be able to achieve on its own. (Participant #1, 2008)

This is an important strength of program-based approaches, as donor coordination gives CIDA, as a relatively small donor, a stronger voice as the agency "lacks political clout" (Brown 2007:223).

While this negotiation process helps to mediate competing donor interests, giving a stronger voice to agencies such as CIDA, it may skew national health priorities within the partner country, therefore, it is not a flawless system (CIDA/GGI 2004:12). Speaking generally on the issue, a Senior Health Advisor made the following statement: "One weakness of the program-based approach is that you have to work in an environment where different donors have different things to offer, and different areas that they might want to focus on" (Participant #2, 2008). A Senior Development Officer in the Tanzania Program reiterated this statement, explaining that donor coordination is still an area in need of improvement, although steps are being made towards this goal through the negotiation process among donors and development of national strategy plans (Participant #4, 2008). While some donor interests may be lost throughout the negotiation process, the benefit of this is that donors are not placing individual demands on the partner, because donor interests and expectations are coordinated. However, one potential drawback of this system, is that while the Government of Tanzania is left out of the discussion that take place among donors, if a donor, such as CIDA, raises an issue that doesn't make it into the final set of priority recommendations, then the Government of Tanzania will not have the chance to consider it. This is a detriment to all donors, not just CIDA, who may develop an innovative approach that is not ratified by the group of donors, and these ideas may be lost.

2) The Government of Canada needs to fulfil its promise to contribute 0.7 per cent of GNP to foreign aid, and renew its interest in development and HIV/AIDS

Development aid has continued to decline almost universally since 2006, despite renewed donor commitment to increase aid at the Monterrey Conference on Financing for Development in 2002 (UN 2007: 28). According a UN MDG Progress report, if the development community is going to make any appreciable gains towards the MDGs, including improving maternal health, child health, and the eradication of HIV/AIDS, development programs will have to triple their level of funding, not decrease it (UN 2007:28). The Government of Canada is especially guilty of this. In terms of the overall development assistance (ODA)/GNP ratio, Canada's aid spending declined from 0.49 per cent of GNP in 1991-92 to 0.3 per cent in 1998 at a time when agencies were embracing wider aid effectiveness and development objectives (Black and Tiessen 2007:193; Campbell 2008:252). More recently, the Conservative Government did not commit new resources to foreign aid in the 2006 budget (Brown 2007:222). The degree to which the current economic climate affects the Government of Canada's decision to withhold resources from foreign aid remains another point of debate. However, the fact remains that given the economic uncertainty faced by donors worldwide, other donors are still willing to commit their share to development initiatives. While CIDA strives to be an influential player in multi-lateral and bilateral initiatives, Canada will not come close to meeting the UN recommended amount of 0.7 per cent of GNP, compared to European and Scandinavian countries where foreign aid spending has reached or surpassed 0.8 – 1 per cent (Black and Tiessen 2007:195).

3) CIDA needs to better communicate its use of funding to the Canadian public

Domestic budgetary concerns also have a role to play. CIDA staff from the Tanzania program feel that in the past not enough attention was given to raise the level of

the Canadian public's understanding of program-based approaches, and the use of funding, an issue that persists today (CIDA/GGI 2004:17). It is no surprise that the Canadian public knows little about aid spending, "as CIDA's budget cuts to development education since the 1990s have been significant" (Black and Tiessen 2007:193). CIDA needs to improve its ability to communicate results to the Canadian public, not just by presenting "sexy" tangible results that Canadians are looking for, but also by communicating the process-results made in terms of achieving goals, such as fiscal monitoring and evaluation, within partner countries (Participant #3, 2008). As stated by one Development Officer: "Individuals are far more interested in knowing how many antiretrovirals were distributed, rather than how a country has developed [a] strong reporting mechanism" (Participant #3, 2008).

This is a concern, as the agency must answer to Canadian taxpayers, first, and, therefore, CIDA needs to communicate its roles, responsibilities and program outcomes effectively to the public. When questioned on CIDA's roles and responsibilities in responding to HIV/AIDS, the following response was given:

> In any area of government, the responsibility is [to] the Canadian taxpayers to ensure that we are spending their money in a way in which the elected government has allowed us to spend it. But that's where the responsibility stops to a degree. However, as a responsible international actor, the Government of Canada has given the agency the mandate to participate in international fora, and to uphold its commitment to the MDGs. So, essentially, the agency has a secondary level of responsibility to HIV/AIDS and I would argue that Canada has been good at honouring those commitments…Have we done all that we could do? No. Has the world done enough generally on HIV/AIDS? Again, no. (Participant #9, 2008)

This statement presents two issues: first, that the agency is interested in clear and accountable reporting to the Government of Canada and taxpayers; and second, that

CIDA needs to communicate its secondary role, being committed to HIV/AIDS, in international fora.

4) The Government of Tanzania has a high level of accountability to its donors and less to its own citizens

As donors have their own domestic accountability issues to manage, this justifies the demands placed on donor countries to report on the use of funding, and activities through narrative and budget reports. Conversely, the Government of Tanzania is concerned that they are more accountable to donors rather than to their own citizens. This is shown by the fact that reports and policy documents are often shared with donors before parliamentarians and citizens see them (CIDA/GGI 2004:18). Donors and governments must be able to manage these competing interests effectively, but this is a difficult balance to achieve, as giving partners more ownership and decision-making power are key elements of the Paris-Declaration. According to one CIDA evaluation, "This presents a paradox of program implementation, where competing accountability agendas favour donor agencies such as CIDA, to the detriment of the partner countries they are trying to help" (CIDA/GGI 2004:19). As such, it can be argued that CIDA must be more flexible in terms of the demands it places on partner countries.

5) The shift towards "balanced" development, may have detrimental effects on local organizations

As CIDA undergoes policy and priority shifts, NGOs must also respond to these changes. Research shows that, as development modalities shift, local organizations must also reinvent their goals, programs, and mandates. For example, local organizations may be required to invest more time and money in project planning and proposal writing to ensure that they align their work with national strategies, which reduces the time and

energy they are able to spend reaching out and serving communities. As such, NGOs become increasingly constrained in their day-to-day activities (Campbell 2008:249).

No doubt, local organizations play a pivotal role in the effective management of program-based approaches, as they are not only able to act as health care service providers, they can also play a "watchdog or accountability role". NGOs and other local organizations are also expected to "act of a counterweight to state power – protecting human rights, [and] opening channels of communication and participation" (Black and Tiessen 2007:204; Campbell 2008:250). However, it is recognized that, in general, Tanzania has an under-developed civil society, which, in turn, poses an accountability problem (CIDA/GGI 2004:17). Often, the monitoring role given to NGOs that are also engaged in government-funded delivery (e.g., Marie Stopes Tanzania), thereby puts the organization in the position of having to challenge the government upon whom they rely for funding (CIDA/GGI 2004:17). The ability of NGOs to pressure donors to re-evaluate program priorities is compromised by their dependence upon CIDA funding (Black and Tiessen 2007: 208). For this reason, local NGOs (both domestic and international) are critical of CIDA's programming shift, and have lobbied for poverty reduction and basic needs to take precedence over adherence to bilateral aid modalities. It is, therefore, increasingly important to consider the wider policy environments in which NGOs operate, and for donors to enable environments conducive for NGO operations and equal participation (Campbell 2008:249). This raises questions around the integration of local organizations, such as Marie Stopes Tanzania, into national aid channels, an issue that remains an important area for further research.

6) CIDA does not have a formal policy framework on HIV/AIDS. This limits the extent to which CIDA can contribute to HIV/AIDS responses at the international level

In order to increase funding, programming, or efforts to combat HIV/AIDS, CIDA needs support from the Government of Canada. The current minority Conservative government has not yet ratified a national HIV/AIDS policy. In fact, Canada's International Policy Statement (IPS), which includes a draft HIV/AIDS policy, is described as "uncertain at best", as it is not clear how development goals will be achieved by federal agencies (Black and Tiessen 2007:196). Furthermore, the IPS was never officially adopted, yet is used by CIDA as a reference tool in the absence of other new policy directions (Brown 2007: 214; CIDA 2009). As explained by two Policy Analysts and a Senior Team Leader in the Child Rights and Protection Unit, in an environment of political instability, with considerable political turnover (e.g., at the federal level in Canada), one does not get a lot of policy change (Participant #1, 2008; Participant #9, 2008; Participant #11, 2008).

CIDA remains weak and vulnerable within the larger political environment, and, therefore, weak in its ability to define and assert clear objectives and priorities (Black 2007:184; Brown 2007: 226). Also speaking on this issue, one Senior Development Officer states: "Canada has the ability to devote more resources to HIV, but that depends on where the Government wants to put its emphasis. It depends on that government of the day, and what it feels the priorities are" (Participant #4, 2008). To reiterate this point, one Senior Policy Analyst claims: "The reality is [that] we've had a lot of turnover, both at the political level and internally, so it's hard to maintain momentum with these issues (e.g., HIV/AIDS) from time to time" (Participant #8, 2008).

Although there is a gap in national HIV/AIDS policy in Canada, CIDA staff draw from the agency's internal four-point HIV/AIDS strategy plan, and frameworks identified

under the former Liberal Government, such as CIDA's *Policy on Meeting Basic Needs* (CIDA 1997) and Canada's International Policy Statement (2005), using these as *de facto* policies (Participant #1, 2008; Participant #2, 2008; Participant #8, 2008). This indicates that internal policy is not absent, per se, but, rather, is outdated and non-specific.

One Senior HIV/AIDS Policy Analyst reveals that:

> Sometimes it is difficult not to have one specific policy document to refer to when you are trying to develop an HIV/AIDS program or project. If someone comes to you with a proposal and you are unable to say that, "yes, that fits in exactly with our policy", or "no, it doesn't", it might be a weakness. But on the flipside, we have more flexibility, so you evolve to changing needs and be open to new ideas and approaches. There are plusses and minuses. (Participant #9, 2008)

Despite the flexibility that comes from an absence of policy, this argument is not completely convincing. As previously discussed, without concrete and specific HIV/AIDS strategy plans at the federal level, Canada (and CIDA) is limited in terms of its level of influence in international fora, thereby limiting positive contributions to HIV/AIDS mitigation and the reduction and HIV-infection among women and the prevention of MTCT. Nevertheless, it is recognized that, for better or worse, the lack of policy is a reflection of the current Government of Canada, and their limited interest in promoting an HIV/AIDS policy and related development agenda, more so than a reflection of CIDA's commitment to the issues. Internally, CIDA remains committed to the issue of HIV/AIDS, and it is self-evident that CIDA is continuing to promote its HIV/AIDS and development agenda, despite the lack of formal policy. Therefore, the agency has not allowed its commitment to the issue to be overshadowed by the complacency of the current minority Conservative Government.

5.3 Analysis and Conclusion

This study reveals that the emergence of new development modalities,

operationalized by CIDA, are influenced by the *Millennium Development Goals* (UN 2000) and the *Paris Declaration on Aid Effectiveness* (OECD 2005). It is evident that, although donors and partners jointly determine priority areas for development through negotiation and discussion, it remains unclear to what extent donor influence dictates priorities within the Tanzanian national development and HIV/AIDS strategies. At the center of CIDA's development strategy are, undoubtedly, the MDGs – a focus shared by most donors. However, agreeing on the centrality of the goals "says little about the means adopted to achieve them" (Brown 2007:217). Critics further argue that current socio-economic paradigms do not necessarily promote the achievement of the Goals (Brown 2007:217). As such, challenging socio-economic inequalities must be made a permanent focus of development programming, not only for the achievement of the Goals, but also for the reduction of HIV-infection and MTCT.

Similarly, under the influence of the Paris Declaration, it is assumed that the relationships between donors in the global "North" and partners in the "South," are equal, and that this partnership reflects the needs and priorities of Tanzania. However, what this study shows is that, while steps are being made to address this concern with equality, donor priorities still have the ability to skew the goals and targets of the partners, who are dependent on donors for funding and support. Similarly, the relationship between CIDA and local organization Marie Stopes Tanzania, may be little more than a mutual acceptance of the term "partnership", as it is argued that donor support can reduce the autonomy of local organizations, and their own goals and objectives risk co-option by larger bilateral strategies (Black and Tiessen 2007:205). Therefore, the rhetoric of "partnerships" being equal under the guidance of the Paris Declaration may not be

entirely borne out in practice.

Without actually observing the process of donor-partner negotiations and dialogue, there is no clear way to conclude how closely the *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (TACAIDS 2007) actually reflects the priorities of the Government of Tanzania. Furthermore, there is no clear way to conclude how the mandate of Marie Stopes Tanzania is similarly influenced by the GoT and CIDA. However, what is clear from the interviews with CIDA staff, and through a review of the literature, is that this process still favours the priorities of donor countries, as they are the ones holding the purse strings (i.e., they still hold power and influence, despite the rhetoric of North-South equality and partnerships promoted in the Paris Declaration and MDG 8). Ultimately, recipient governments have few real choices in how they allocate foreign aid, as they are pressured to conform to donor priorities (Black and Tiessen 2007:207). As stated by one author, "national ownership of development strategies is not truly possible when recipient governments know that they need to say certain things to obtain donor assistance or when donor funded consultants are writing national strategies" (Brown 2007:218). This is not to say that donors, such as CIDA, are ill-intended; rather, as pointed out by CIDA staff, they have a high level of accountability to Canadian taxpayers, before they are accountable to the Government of Tanzania, or the citizens of Tanzania (Brown 2007:218). Furthermore, discussions surrounding the level of donor coordination and alignment (i.e., donors agreeing to areas to support before meeting with partners) suggest that donors are as concerned with having their voices and priorities well represented, as are the partner country governments.

Situated in a historical context, there is no doubt that foreign aid is continuously

evolving. Program-based or balanced approaches are yet another new form of externally-driven development modalities, similar to structural adjustment programs (SAPs) and health sector reforms (HSR) (Parpart and Veltmeyer 2004:40). As a result, CIDA's programming priorities have been prone to frequent changes. Like other donors, and perhaps more enthusiastically, CIDA has associated itself with new development modalities and policies which have changed multiple times since the birth of the agency (Black and Tiessen 2007:194). It has been said that Canadian foreign aid policy has followed "the new fashions and policy thrusts, rather than forging its own path" (Brown 2007:226). Drawn from the brief history of development and health programming outlined above, it is clear that CIDA's health care and development priorities are highly influenced by multilateral influences.

Similarly, Tanzania's health and development priorities are influenced by bilateral donors, upon whom the Tanzanian government depends for ongoing funding and support. Throughout the years, the Government of Tanzania has been pushed and pulled by a variety of international policies, with various outcomes; adherence to the MDGs is no different. However, given the short time frame that the development community has been given to achieve the MDGs, national level planning must certainly be scaled up – as the efforts of private and community-based organization are insufficient in providing health care, and HIV-related services needed to achieve the MDGs in health (Brown 2007:217). As seen with structural adjustment programs (SAPs) and health sector reforms (HSR), which were once seen as effective routes to development, health care delivery was actually destabilized, rather than improved. Although it is now widely accepted that these strategies were misguided, program-based approaches may be assessed, in future, as yet

another Northern-driven modality that failed vulnerable people in the global South. This remains an area for future study.

The fact remains that partnerships for development are convoluted and complex. This study shows that the partnership between CIDA and the Government of Tanzania does not exist in isolation from multilateral influences, competing donor interests (at home and abroad), and locally implemented strategies. This insight contributes to the larger body of literature which seeks to understand and improve health care programming by improving the understanding of the interaction between international, national, and local modalities, as well as the influences these modalities have on reducing individual vulnerability to HIV-infection, consistent with the works of Brown *et al.* and Singer (Brown *et al.* 1998:10; Singer 1998: 225). Ultimately, as a new development modality, program-based approaches represent partner countries' ongoing dependence on donors, as the partners endeavour to advance their own development agendas. Thus, despite the rhetoric of change that is implied by the Paris-principles and the MDGs, it is very difficult to ascertain if there are any long-term *transformative outcomes* emerging from program-based approaches and development partnerships. Similarly, it is argued that "despite the changing thematic language of aid, it is not altogether clear how much these changing fashions have altered the substance of aid practices on the ground" (Black and Tiessen 2007:194).

For example, the number HIV-infections among women and children have begun to stabilize, however, it appears that bilateral programming in Tanzania has not made an impact on the overall statistics (James 2006:206). Granted, time may be a factor here, but as long as power and decision-making remains largely in the hands of donors, as

indicated in this study, the promise of substantive change remains somewhat elusive. Furthermore, it is evident that CIDA's ability to support the Government of Tanzania's strategy plan, regardless if it genuinely reflects the local context in Tanzania, is dependent on the wavering support to women and the prevention of HIV/AIDS and MTCT, as exhibited by the current Conservative minority Government of Canada.

This study reveals that CIDA must maintain its focus on, and increase its funding to, gender concerns, as gender relations influence rates of infection among women, and children via MTCT. Although CIDA is adamant in its claim to promote gender concerns, in terms of improving rates of infection among women and children, which CIDA identifies as a priority, this thesis finds that while CIDA's commitment to gender has improved, the inclusion of gender concerns within the balanced approach to development has mixed results. Internal evaluations reveal that, in the past, gender equality was not adequately addressed through program-based approaches during the 1997 to 2004 period (CIDA/GGI 2004:15). Critics also suggest that the overall lack of gender mainstreaming, and the lack of attention given to women with HIV is a persistent problem in bilateral programming and implementation (James 2006: 207). In the past, CIDA lacked the institutional capacity to coordinate and develop a responsive gender program, as gender advisors were undervalued and underutilized (CIDA/GGI 2004:15). However, CIDA has taken steps to prioritize gender in its current planning, demonstrating that the agency seriously considered and integrated the recommendations found in the evaluation. For example, the agency's commitment to gender is demonstrated through its support of Marie Stopes Tanzania (MST). CIDA's continued support to MST furthers gender-related issues, and is having a positive effect on the lives of women in Tanzania through

the provision of reproductive health care services. Further research would allow us to have a better understanding of these issues, and could serve to inform CIDA (and others) about opportunities for advancing these concerns more effectively and achieving key outcomes (related to HIV-infection among women and the prevention of MTCT).

By giving attention to gender, CIDA has improved its reputation as an agency, and is now known for its commitment to this important issue. Similarly, gender equality is addressed in Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* (NMSF). As discussed in the previous chapter, several elements of the NMSF address the needs of women, including legal safeguards that protect women from domestic violence, sexual abuse, and loss of property and inheritance. The framework also identifies intergenerational sexual relationships as an area for further study. While NMSF highlights these target areas, more research is needed to determine how effectively these goals are met, and what role CIDA actually has in promoting these target areas.

The inclusion of children infected via MTCT in bilateral programming does occur through the promotion of CIDA's four-point strategy plan on HIV/AIDS and other "think-pieces" developed by the agency.[26] Through dialogue with partners and other donors, CIDA raises issues related to maternal and child health, emphasizing the need to

[26] In addition to the four-point strategy plan the *Enhanced Protection Paper* outlines recommendations for protecting affected children from increased vulnerability to, and problems exacerbated by, HIV-infection (CIDA/UNICEF 2007:5). The *Enhanced Protection Paper* has an important role to play within CIDA operations, as well as in international forums. Internally, the paper is regarded as a "think piece," and should be more thoroughly integrated into bilateral programming, by engaging Development Officers in a more formal way, and by promoting child rights and protection within CIDA and across all sectors (Participant #10, 2008).

address the broad effects of HIV/AIDS on children. As explained by a CIDA Senior Policy Analyst:

> The agency looks at the effects of HIV/AIDS on children in a broad way, for example, rates of HIV-infection among children related to mother-to-child-transmission, as well as the broader effects of HIV/AIDS on children who have been marginalized as a result of, and are vulnerable to, HIV. This includes orphaned children, HIV-infected children, or children living in child-headed households...these are all issues related to child protection and rights, which are part of CIDA's four-point strategy on HIV/AIDS...However, it's probably the area where we need to improve the most. We need to do more explicit work in that area. (Participant #9, 2008)

This statement draws attention to the fact that Senior Officials are well versed in the specific vulnerability of children to HIV, as well as the need to improve targeted programming for children, infected via MTCT, and otherwise. Actors at the international and national levels believe that, as the prevention of mother-to-child-transmission services are made increasingly available, there will be positive effects on the number of children HIV-infected. As explained by a Senior Policy Analyst:

> There has been a concern that there hasn't been enough focus on paediatric HIV/AIDS globally, however, we are seeing some progress using the prevention of mother-to-child-transmission as a marker. A few years ago, there was only 12 per cent coverage of prevention of mother-to-child-transmission services globally, now it's approximately 33 per cent. I think that's indicative that countries are realizing the importance of the issue. I think we will also see the same trends emerge as more information is released around paediatric treatment, coupled with continued support given to the issue of universal treatment. (Participant #9, 2008)

Although this statement offers some optimistic insight into reducing the number of children HIV-infected in Tanzania, there are still troubling gaps in the quality and scope of prevention of mother-to-child-transmission services. As outlined in Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS* only 12 per cent of HIV-positive pregnant women have access to health care services needed to prevent infection throughout pregnancy, delivery, and post-natal care (TACAIDS 2007: xvii). As

discussed, this will have an effect on the improvement of HIV-infection rates among children, as 90 per cent of children are infected via mother-to-child-transmission. Arguably, if maternal health is addressed effectively in the long run (i.e., women are protected from HIV-infection in the first place), then the need to provide prevention of mother-to-child-transmission services and to develop targeted programming for children, after the fact, will be drastically reduced.[27]

The current reality is that women continue to make up more than half of new HIV-infections globally, coupled with the fact that maternal health services continue to lag, and mother-to-child transmission persists, children are subsequently HIV-infected. Ultimately, CIDA, and the development community at large, is not effectively addressing the needs of women and children infected via MTCT, nor tackling the broader issues that leave women vulnerable to HIV-infection in the first place. I would further argue that the provision of mother-to-child-transmission services is a short-term solution, while factors such as gender discrimination, and violence must be improved in the long-term. In other words, CIDA is not adequately addressing meso-level factors that influence maternal and child health at the individual level.

For example, CIDA staff interviewed for this study point to initiatives that promote either condom distribution, or the improvement of maternal health care services, as successes within bilateral programming. However, what this fails to recognize is that while these services are valuable, concerns remain related to barriers to access, as well as the fact that these strategies do not alter the barriers to access faced by women.

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[27] Individuals in CIDA's Child Rights and Protection Unit problematize this approach, suggesting that more attention and autonomy be given to children, and that their health care needs must be separated from maternal health care. What this suggests is that children are being included in bilateral programming, however, their inclusion is *assumed* and linked to CIDA's broader strategy plan and targeted programming that address maternal health issues.

Prioritizing the needs of women, through the promotion of safer sex (e.g., condom distribution) and sexual and reproductive health, do not, in and of themselves, address HIV-infection among women and the prevention of MTCT. As discussed in Chapter Two, if women are denied access to these services due to household poverty, locality, or abusive interpersonal relationships, simply *providing* these services is not an effective response. It is critical to monitor and evaluate service utilization and impact using both qualitative and quantitative indicators.

Finally, a compelling argument by CIDA staff members in the Tanzania Program is for the need to improve health system delivery more generally. Supporting in-country health system strengthening is an important way that CIDA can improve the health system and services in Tanzania, thereby decreasing the number of HIV-infections among women and rates of MTCT.

As the discussion above demonstrates, development priorities, a renewed aid effectiveness agenda, and the growing HIV/AIDS epidemic are instrumental in influencing CIDA's current approach to development. These factors have set the parameters in which the agency can work, and determined how "partnerships" for development are operationalized (Black and Tiessen 2007:209). While CIDA has undergone a shift to bilateral programming, priorities such as HIV mitigation and the prevention of MTCT have been overshadowed. This is not to say that these issues will not be adequately addressed in the long-run, however, short-term planning is not effective.

As seen in the case of Tanzania, the number of HIV-infections among women and children, infected via MTCT have not declined. The limitations of this study, similar to

other studies on bilateral programming, are linked to the fact that it is impossible to disaggregate CIDA contributions to HIV-mitigation from the contributions of other donors (Campbell 2008:260) and other influencing factors. It is possible, however, to demonstrate specific programmatic contributions (e.g., the TOMSHA, and support to MST) as being unique to CIDA.

In sum, the efficacy of CIDA's balanced approach to HIV/AIDS remains contested, as improvements in key outcomes (e.g., the number of HIV-infections among women and access of MTCT) are mixed. CIDA's partnership has laid the foundation for effective HIV/AIDS mitigation in Tanzania, but actual improvements remain a long-term objective. Since the inception of the new bilateral aid modalities, influenced by the signing of the Millennium Development Goals (2000) and reinforced by the Paris Declaration (2005), rates of infection among women first increased from numbers seen in 2001 and then stabilized in 2007. Access to the prevention of MTCT services has improved from being non-existent in 2001, to a rate of 35 per cent coverage in 2007. However, the goal of universal access is not yet achieved, and it is unclear whether it will be by the year 2015. Interestingly, while access to MTCT services increased in this time period, the number of children HIV-infected increased. This would suggest that MTCT services are not having the desired results, to prevent new infections among children, although they are being made increasingly available. It could also suggest that data regarding the number of children infected by HIV is increasingly available, as a result of better reporting of statistics. Thus, results are mixed, demonstrating that bilateral programming has had some gains in the short-term, but the achievement of the key outcomes (defined by the MDGs and targets) remain a long-term endeavour. These

results will need to be re-evaluated in 2015 in order to determine the true success of bilateral programming models.

Overall, program-based approaches are still a relatively new modality within the international development community, and one that CIDA is still learning about (CIDA/GGI 2004:15-6). Therefore, as a new development modality, it is difficult to conclude at this point if CIDA's balanced approach to HIV/AIDS will have the desired outcome. However, by comparing the findings in secondary literature to the data collected from CIDA staff, this thesis reveals that the balanced approach has had some positive gains, although there are still some areas for improvement. The reality is that while CIDA's balanced approach is grounded in the so-called "right" or correct principles (i.e., internationally agreed upon modalities such as the Millennium Development Goals; Paris Declaration), its effectiveness in terms of poverty alleviation, maternal and child health, and HIV/AIDS is a longer-term prospect (CIDA/GGI 2004:16). Furthermore, partnerships must work hard to ensure that partner interests (e.g., Government of Tanzania, Marie Stopes Tanzania, HIV/AIDS patients) are not being overshadowed by the priorities of the donors that they rely on for funding. More importantly all stakeholders must ensure that women and children infected and affected by HIV/AIDS are included in the decision-making process. A way to achieve this is for local organizations, such as Marie Stopes Tanzania, to present the concerns and needs of patients to donors. MST is well established and respected in the communities they serve, and are also directly engaged with the patients they offer services to. Therefore, they are in touch with the needs of the community, more so, than national level planners. Acting

as a representative of the community, MST is in a unique position to raise concerns and challenges faced by the community that may otherwise overlooked around a donor table.

When programs follow the priorities of the partner, in accordance with its national strategy plans, donor coordination is improved, and stronger partnerships are built between donors and partners (CIDA/GGI 2004:16). Tanzania is recognized as a country where donor coordination and aid effectiveness have progressed further than is the case with most other development partners (CIDA/GGI 2004:16).

Donor coordination continues to improve as donors continue to solidify their roles and responsibilities (CIDA/GGI 2004:16). Through negotiations and deliberation, donors and partners are better able to define the areas to be supported, and what donors will provide in terms of funding, technical support, and capacity building. However, according to one CIDA staff member, donors need to continue to work on providing more stable funding, so that partners are able to allocate and implement budgets over the long-term (Participant #3, 2008). Campbell suggests that, "it is important not to overemphasize the power of bilateral agencies...whose limitations are demonstrated by their inability to cooperate with each other and by internal tension with their organizations" (2008:265-6). Although this is an important consideration, ultimately, donors are still able to present a unified approach to development partners. The extent to which all donor interests are represented remains an important area for further research. Similarly, the extent to which "unified" donor interests overshadow partner priorities, needs to be continuously evaluated.

While the current development agenda is rightly intended (i.e., CIDA no longer controls the in-country issues and results that are targeted, or how programming is carried

out), attention to CIDA's priorities, such as poverty reduction, the improvement of maternal and child health, and HIV/AIDS mitigation is not guaranteed (CIDA/GGI 2004:18). As previously discussed, by supporting Tanzania's overall national strategy plans CIDA may be supporting these issues indirectly, but only insofar as the Government of Tanzania has made them its priority focus. Therefore, it remains unclear as to whether or not CIDA's efforts in Tanzania can be linked to improvements in key indicators.[28]

The successful advancement of HIV/AIDS mitigation, which includes a focus on women's vulnerability to HIV/AIDS and the prevention of MTCT is dependent on the strength of partner/donor relationships and the ability of the Government of Tanzania to develop a strong position in particular areas (CIDA/GGI 2004:18). However, CIDA's ability to contribute effectively to the HIV/AIDS agenda is weakened by the fact that the current Government of Canada has not fostered an environment in which HIV/AIDS policies can be advanced. This lessens the legitimacy that CIDA has in bilateral partnerships and in international fora.

In this environment, CIDA's ability to promote these issues is dependent on their continued credibility among other donors and partners, as well as their ability to dialogue and negotiate effectively (CIDA/GGI 2004:18). As indicated above, CIDA does maintain a positive, well-respected position in international fora. If this reputation can be maintained, CIDA will continue to have a positive role in promoting the needs of women and children in policy and programming dialogues at the bilateral and multilateral levels.

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[28] In fact, studies on the policies of developing countries have not yet yielded a predictable, consistent relationship between policies and outcomes related to HIV/AIDS incidence rates (James 2006:199). It should be noted that the proactive governmental response and resulting decline in HIV incidence in Uganda has been well documented, serving as one contrasting model (James 2006:200).

However, CIDA's influence must not override local priorities; as, in a true partnership, effective negotiation is paramount.

Successful program implementation has been linked to the level of financial and technical resources that CIDA and other donors are willing to invest (CIDA/GGI 2004:18). As discussed, despite its somewhat limited resources, CIDA endeavours to maximize its "value-added" to a particular program by offering financial assistance to specific niche areas, such as maternal health and the promotion of a gendered perspective in bilateral programming. By taking a more "balanced approach" to development, CIDA highlights the efficacy of "projects" in the short-term, while long-term strategies for program-based development are being built and strengthened.

Additional concerns, such as the fear that program-based approaches may be replaced by yet another new modality, must also be acknowledged. As indicated in Chapter Three, CIDA has already shifted its regional focus, by pulling out of several African countries that were previously deemed to fit the criteria of program-based approaches. This shows that CIDA programming and funding are uncertain and, as argued above, are subject to the short term, strategic and somewhat self-interested priorities of the Government of the day. Furthermore, this undermines the spirit of international agreements, particularly the Millennium Development Goals and the Paris Declaration. Where basic needs and essential services, such as education and health care, are out of reach, I argue that Canada has a responsibility to maintain its partnerships for development, and not to abandon countries that are struggling to realize the MDGs. However, it is recognized that this is more of a failure of the policies of the Government of Canada, rather than of CIDA.

What this study demonstrates is that partnerships for development are complex, and do not exist in isolation. As partners and donors continue to carve out their own unique roles, responsibilities, and niche areas, individuals vulnerable to HIV-infection including women and children *remain vulnerable*. What is concluded from this discussion is that, unless development partners begin to look critically at factors that exacerbate rates of HIV-infection, the status quo of development modalities and subsequent HIV/AIDS mitigation will be remain ineffective, despite the banner of "partnerships" that Paris-principles promote. To attempt to address this issue, in the section below I present six suggestions.

5.4 Suggestions for Continuing Program-Based Approaches

The suggestions offered below are made based on a review of the academic literature and the insights and knowledge shared by CIDA staff members interviewed for this thesis. They also take into consideration the following issues: HIV-infection among women and the prevention of MTCT; international development modalities; and the strengths and weaknesses of CIDA's balanced approach to development. By exploring these issues, it is argued that although internal dialogue (e.g., among CIDA staff) does include the needs of women and the prevention of MTCT, bilateral programming has yet to meet the goals of reversing the number of HIV-infections among women (MDG 5, MDG 6), and providing universal access to MTCT services (MDG 6) for the promotion of child health (MDG 4). Despite the rationale that CIDA's limited resources could be better used to address other disease areas and health issues, this argument is not entirely convincing. CIDA is recognized as being a well-respected and vocal partner in areas

concerning women's health and gender. Therefore, I believe that CIDA can maintain its influence on these issues, which does not require an increase of financial resources.

CIDA should continue to strengthen the program-based approach modality, as the strategy has yielded some gains in the Tanzania Program. As indicated in this thesis, the production and implementation of several instrumental strategy plans (i.e., *National Strategy for Growth and the Reduction of Poverty* and the *National Multi-sectoral Strategic Framework*) are a testimony to the achievements made in Tanzania, as other countries in sub-Saharan Africa continue to lag in this regard. However, these strategy plans are broad and do not offer a structured plan on when and how activities should be implemented in order to achieve the targets. In many cases, local organizations are instrumental in offering services and demonstrating results in line with national strategy plans, and meeting the needs of marginalized populations. The importance of this is highlighted within the Paris-Declaration, and is embedded in the Tanzania Program. Although it is difficult to link CIDA's direct contributions to the national level planning, CIDA's support to Marie Stopes Tanzania can be most clearly connected to the achievement of Tanzania's *Second National Multi-sectoral Strategic Framework on HIV and AIDS.*

Local projects still have validity, particularly when they are connected to the realization of national strategy plans, known as the "balanced approach". Therefore, in the short term, CIDA's support to local projects plays a valuable and complementary role to program-based approaches, while the partner country continues to develop economically and politically, and continues to build human and technical capacity (CIDA/GGI 2004:20). Until the Government of Tanzania can successfully finance and

deliver health and HIV/AIDS services at the national level, or can afford to fund local initiatives on its own, CIDA will have a role to play alongside other donors.

In the same way, CIDA should continue to offer support to local organizations through the promotion of public-private partnerships (e.g., Marie Stopes Tanzania). Through these avenues, CIDA should continue to invest and advance the prevention of mother-to-child-transmission agenda, and continue to promote gender issues. Yet CIDA needs to scale up its contributions to these areas, as this is identified as an area for improvement by not only CIDA staff, but also by actors at the international level (e.g., UNAIDS).

From the content and analysis presented above, it is appropriate to present the following six observations and suggestions with regard to bilateral programming, known as the "balanced approach" in Tanzania. These suggestions first address bilateral programming, generally, and then give special attention to women and the prevention of MTCT.

1) Since CIDA is not a major financial player, the agency's ability to bring issues to the table and to engage equally with other donors and partners is CIDA's most notable strength. CIDA must maintain its reputation as a vocal and engaged donor.

2) If CIDA is to have more validity and credibility in international fora, the Government of Canada needs to address the current policy void with respect to HIV/AIDS and fulfil its 0.7 per cent commitment to foreign aid.

3) CIDA should maintain a "balanced approach", as opposed to phasing out traditional projects absolutely in the short-term. When implemented correctly (i.e., through the application of Paris-principles), program-based approaches have the potential

to improve macro- and meso-level structures (e.g., institutions that perpetuate income and gender based inequality), improving access to quality health care services, education, and HIV/AIDS prevention and treatment. However, this is a long-term endeavour. While bilateral programming is being developed, strengthened and implemented, short-term projects (designed and implemented locally) have a continuing role to play, filling in for gaps in progress in the interim. This is observed through the support given to Marie Stopes Tanzania. These initiatives are instrumental in reducing the number of HIV-infections among women and children by delivering MTCT services and promoting reproductive and sexual health education and services. Questions concerning the dwindling support given to local initiatives should be reassessed in the long-term, and this presents an additional topic for future research.

4) CIDA should continue to promote health system strengthening as a focal area in Tanzania. This supports capacity building, and has the potential to reduce barriers to access. Historically, the health care system in Tanzania has suffered from externally driven economic reforms (e.g., structural adjustment plans, introduction of user fees). By redressing these concerns, and offering high-quality, universal health care, the ability of the country to provide essential services needed to mitigate the HIV/AIDS epidemic will be improved. Developing human resources and capacity in the health care sector is considered vital for the effective realization of the *Second National Multi-sectoral Strategic Framework on HIV and AIDS.*

5) CIDA has considerable strength in promoting and bringing gender-related concerns to the forefront through bilateral programming in Tanzania. Building on this strength, CIDA must also continue to push for the advancement of prevention of mother-to-child-

transmission services, as these services have obvious implications for reducing HIV-infection among children. Equalizing access to health care and education between women/girls and men/boys should remain a top gender priority for CIDA, in line with achieving the MDGs.

6) CIDA must continue to develop and promote child health and protection, not only through the promotion of the prevention of MTCT, but also by broadening the scope of its interventions. Although steps have been taken to address this area through the promotion of the *Enhanced Protection Paper* as well as identifying children as a priority area in CIDA's four-point HIV/AIDS strategy, more work needs to be done to ensure that this issue is more thoroughly integrated into its bilateral programming. Children's health and protection from HIV-infection must not be incidental, and must not be connected exclusively to services provided to their mothers (e.g., PMTCT services). This latter approach limits the level of autonomy given to children as actors, and does not adequately address the needs of the 10 per cent of at-risk children and youth who are not reached by these services. Services that tackle gendered inequalities affecting young girls vis-à-vis young boys must also be highlighted.

By and large, new development modalities such as program-based approaches can be effective in strengthening the capacity of partner countries to achieve development, generally, and to contribute towards HIV/AIDS mitigation. What is clear, however, is that this is a long-term investment. This study also reveals that increased attention needs to be given to programming, by making the needs of women and children infected via MTCT a more prominent focal point. By investing in women, and protecting children by the prevention of MTCT, countries are taking a forward-looking approach to

development. Similarly, challenging external forces that leave women vulnerable to HIV in the first place will undoubtedly reverse the number of women infected, which has stagnated in recent years. It is only after implementing a multi-sectoral and comprehensive development model that women will be universally protected from HIV-infection. Furthermore, by protecting children from MTCT will ensure that the next generation remains "HIV-free" in Tanzania.

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Appendix A: Millennium Development Goals and Targets

MDG 1: Target 1 - Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day. Target 2 - Achieve full and productive employment and decent work for all, including women and young people. Target 3 - Halve, between 1900 and 2015, the proportion of people who suffer from hunger;

MDG 2: Target 1 - Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling;

MDG 3: Target 1 - Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015;

MDG 4: Target 1 - Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate;

MDG 5: Target 1 - Reduce by three quarters the maternal mortality ratio. Target 2 - Achieve universal access to reproductive health;

MDG 6: Target 1 - Have halted by 2015 and begun to reverse the spread of HIV/AIDS. Target 2 - Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. Target 3 - Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases;

MDG 7: Target 1 - Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources. Target 2 - Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss. Target 3 - Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation. Target 4 - By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers;

MDG 8: Target 1 - Address the special needs of least developed countries, landlocked countries and small-island developing states. Target 2 - Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Target 3 - Deal comprehensively with developing countries' debt. Target 4 - In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries. Target 5 - In cooperation with the private sector, make available benefits of new technologies, especially information and communications.

(source : www.un.org/millenniumgoals)

Appendix B: List of Research Participants

Participant #1 (Junior HIV/AIDS Policy Analyst). June 10th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #2 (Senior Health Advisor). July 18th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #3 (Senior Development Officer). August 21st, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #4 (Senior Development Officer, Tanzania Program). August 25th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #5 (Senior Manager Multilateral Programs Branch). August 28th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #6 (Senior Development Officer/Field Staff, Tanzania Program). September 2nd, 2008. Dar es Salaam, Tanzania.

Participant #7 (Senior Development Officer, Malawi Program). September 9th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #8 (Senior Director, Policy and Programming Branch). September 16th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #9 (Senior HIV/AIDS Policy Analyst/ Senior Development Officer Tanzania Program). September 18th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #10 (Senior Team Leader Child Rights and Protection Unit). September 19th, 2008. CIDA Headquarters: Gatineau, Quebec.

Participant #11 (Senior Team Leader Child Rights and Protection Unit). October 7th, 2008. CIDA Headquarters: Gatineau, Quebec.

Appendix C: Discussion Questions

Background Questions:
Can you tell me about your role and responsibilities within the agency? What do you do?

Bilateral Program Objectives:
Which partner countries (in sub-Saharan Africa) has CIDA been the most involved with in terms of health? Can you tell me a bit about these programs and the key objectives?

1) What programs or projects exist within CIDA (multi/geographic/partnership branch) that address child and maternal health?
2) To compare, UK and Irish Aid agencies have dedicated 2% of its total funding to children? Has CIDA demarcated funding to this specific area of child health and HIV? If so, which age groups (infants/children/teenagers) receive the most attention and why? If not, why do you think this area was not given as much attention?
3) How do the programs/projects address the vulnerability of children? Is there a focus on reducing the risk of HIV transmission (MTCT/ sexual exploitation/sexual activity)?
4) Are the programs/projects involved in strengthening national responses of the partner countries? How so? Is there a focus on structural improvements such as infrastructure, training, education, gender equality, economic development, etc?
5) Research on HIV/AIDS often points out that there are social, cultural, political and economic frameworks (such as debt burden, national spending), which can disadvantage individuals and lead to the spread of HIV and/or exacerbate disease outcomes such as AIDS among vulnerable groups. Does CIDA address these broader structural issues as part of its HIV/AIDS program? If so, how are these concerns approached? If not, why not? What do you feel are the pros and cons of approaching such structural issues?
6) Can you tell me about the *Enhanced Protection Paper for Children Affected by HIV/AIDS*? What was CIDA's role in developing it? How is it used?
7) Are there any other health policies specific to maternal and child health that exist within CIDA?

Partnerships:
Now I would like to talk about the relationship between CIDA and its partners. Can you tell me a bit about the relationship between CIDA its partners in sub-Saharan Africa?

1) How are the countries/projects chosen?
2) How does CIDA work with its partners to strengthen the national responses to child health and HIV? How does CIDA and its partners strive to protect children vulnerable to HIV/AIDS?
3) Can you tell me about the relationship CIDA has with the partner organization?
    a) What are the strengths of CIDA's role internationally?

b) What are the weaknesses of these partnerships?
c) In what areas have the partner organizations improved CIDA's understanding of, and responses to, HIV?

4) Overall, what roles and responsibilities do you feel CIDA has to play in the fight against paediatric HIV/AIDS abroad? How is CIDA organization fulfilling that role alongside the partner countries?

5) How is CIDA supporting front line HIV/AIDS organizations and NGOs?

Prevention and/or Treatment:
What are the agencies areas of emphasis?

1) What is the major emphasis of the agency? a) Is it treatment? b) support? c) prevention OR, d) something else? Why this emphasis?
a) Why has the organization decided to put more emphasis on this area/areas?
b) Why is it important to this organization to provide a more comprehensive approach by focusing on more than one area? (treatment, prevention and support)
2) Why did this become the focus of the agency? What and who influenced the decision to focus on this issue? Do you anticipate that this focus might shift over time, or has it already shifted? If yes, what might (or did) cause that shift?
3) How does CIDA attempt to integrate cultural or social context into its HIV/AIDS responses?

International Policy: My study is also focused on the application of international policy and guidelines, namely the Millennium Development Goals among others. Can you comment on the importance of the MDGs?

1) Does CIDA aim to integrate the MDGs? Is so, how so? If not, why not? How could this be improved?
2) Why does CIDA focus on these goals?
3) Has a focus on paediatric HIV emerged within the agency? Was it influenced by a specific international document? What first initiated the shift in focus for the organization?
4) Do you feel that CIDA has genuinely integrated global consensus, such as the MDGs?
5) Could you also comment on the Paris Declaration and why this is an important document to CIDA?

Governmental Approaches: Can you tell me about the international or national policy statements CIDA incorporates into its HIV/AIDS responses?

1) No doubt, there are both strengths and weaknesses in the way the Canadian government responds to paediatric HIV/AIDS. How would you characterize the strengths?
b) How would you characterize the weaknesses?
c) If you had the opportunity to address a major weakness, what would you focus on? How would you go about doing this? Why this issue?

2) Overall, if you could improve Canada's response to paediatric HIV/AIDS what would you do?

Funding Issues:

1) In what way does CIDA support partner countries via funding?
2) Does this organization interact with the partner organization strictly through funding?
   a) If so, how is the funding monitored?
3) As a small donor, do you think we are making the best use of our resources when it comes to HIV/AIDS and health?
4) How much does CIDA contribute to multilateral initiatives such as UNAIDS, the Global Fund, or GAVI?

Program Accountability/Indicators:

1) How does CIDA measure program success when re-evaluating funding criteria? What indicators are used? Is there a consistent framework for all projects?
2) How does CIDA ensure that these program indicators are met?
3) What steps are taken to improve programs if indicators are not being met?

Successes and Weaknesses:

In your experience with CIDA can you comment on the greatest strength of its approach? Its greatest weakness?

1) What do you see as the biggest challenge in responding to the HIV/AIDS epidemic?
2) Can you provide any examples of challenges faced in your experience and how these were resolved?
3) What is unique about the CIDA approach compared to other donors in your experience? Is there anything specific you like compared to other approaches?

Conclusion:

Are there things I've forgotten to ask you that you think would be important for me to understand? Any other comments?

Do you have any additional contacts in mind who might be useful for me to speak with?

Appendix D: CIDA's "Countries of Concentration" 2009

IN	OUT
Afghanistan	Benin
Bangladesh	Burkina Faso
Bolivia	Cambodia
Caribbean	Cameroon
Columbia	Kenya
Ethiopia	Malawi
Ghana	Nicaragua
Haiti	Niger
Honduras	Rwanda
Indonesia	Sri Lanka
Mali	Zambia
Mozambique	
Pakistan	
Peru	
Senegal	
Sudan/Darfur	
Tanzania	
Ukraine	
Vietnam	
West Bank/Gaza	

(source: Berthiaume 2009a)