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

Tanzania

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Section 1: Social Policy Regimes: an Overview

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

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

The colonial policy regime had excluded the majority of people on the basis of race, geographical location, gender and social class. Investment in the social sector during the colonial era was based on this hierarchy, and driven by the goal of supporting the colonial economy. State institution provided selective services to a few government officials and medical and educational facilities were provided in a few geographical locations by faith-based institutions. However, the majority of citizens depended upon traditional support systems including traditional healers and family and social network. This colonial legacy influenced the social policies of the independent state of Tanganyika[1].

Social Policies under the Modernisation Era (1961-67)

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

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

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

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

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

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

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

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

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

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

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

Structural Adjustment and the Market Economy (1986-2000)

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

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

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

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

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

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

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

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

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

The current period

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

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

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

In the year 2005 a National Strategy for Growth and Reduction of Poverty (NSGRP) popularly known as "Mkukuta[2]" was launched. MKUKUTA, represents the second-generation Tanzanian PRSP, was approved in April 2005, and covers the period 2005-2010. MKUKUTA aims at achieving "faster**,** more equitable, and sustained growth." Instead of the previous sectors, it introduced three thematic 'clusters' namely: (i) growth and reduction of income poverty; (ii) improved quality of life and social well-being; and (iii) good governance and accountability. MKUKUTA recognizes strategies for ensuring provision of social services (mainly health