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POLITICAL AND SOCIAL ECONOMY OF CARE: TANZANIAN PROPOSAL

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Background

The Political and Social Economy of Care project of UNRISD encompasses comparative research on the provision of care by households and families, government, markets and the voluntary/'community' sector – which the study refers to as the 'care diamond' – across two countries in each of four continents. The emphasis in the study is on the multiplicity of sites where care takes place, and the mix of institutions involved. Of special interest is analysis of how unpaid care is articulated with the commodity economy from a gender perspective – the 'labour/care regime', and how responsibility for unpaid care shapes the carer's paid work profile, access to income and poverty (and vice versa).

It is proposed that Tanzania be included in this comparative research, alongside South Africa as the other African case. Many of the key issues are similar in the two countries. In particular, both countries have been severely affected by the AIDS pandemic, which is proposed as a key focus for the Tanzanian case study. Although the prevalence rate is substantially higher in South Africa than in Tanzania, in both countries it has moved beyond being concentrated in obviously high-risk groups and spread throughout the general population. At the same time, the political economies of the two countries are very different, thus providing scope for interesting comparisons.

Some of the differences include the significantly higher levels of infection in South Africa, different distribution patterns and levels in terms of poverty and inequality, different levels of wealth and availability of resources (in particular, differences in government resources and thus extent of dependence on donors), and differences in levels of urbanisation. These factors have an impact on vulnerability to HIV infection, and the ease or otherwise of access to health services, as well as on women's employment patterns and access to the cash economy. The two countries also differ markedly in their social policy history. This is true in terms of both general social policy and, more specifically, health-related policy. In respect of the latter, Tanzania was one of the earliest and strongest proponents of the primary health care approach, including community-based health workers. Later, however, the country's health services were very negatively affected by the structural adjustment programmes of the 1980s. This legacy continues to affect the availability of public health services, and thus the extent to which those affected by HIV&AIDS are expected to rely on their own resources (including, in particular, the unpaid work of women and children). Finally, the countries differ significantly in the commitment shown by the two governments to addressing HIV&AIDS, with Tanzania showing strong commitment (albeit dependent on significant outside support) while the South African government, at least until recently, vacillated between a denialist and luke-warm position.

The particular focus of this study in terms of types of care would be the provision of care for those infected by HIV or AIDS-sick. The study would focus, in particular, on care provided in the home by household members as well as by community home-based care services, but will also look at linkages between these types of care and the care and treatment provided in public and private (for-profit and not-for-profit) health facilties. These linkages are important because the extent of need for household-provided care (the care provided by primary carers in the home) and community home-based care is heavily determined by access to other forms of care and treatment. The latter, in turn, is heavily influenced by levels of poverty, gender and other axes of inequality. The study would thus look at the extent to which the burden of care for the ill is falling on households and their members as a result of weaknesses in, lack of accessibility of, and 'over-burdening'

of other parts of the 'care diamond'. In particular, it would look at what care was being provided by the public and private health services and by community home-based care, and the extent to which this might relieve the burden on family members. In order to contain the ambit of the study, it would not examine care for others affected, such as orphans, although this is likely to emerge as a related issue at various points in the study, including where the overall burden to affected families is considered.

The study is important because unpaid care work – of which care provided by family members (mainly women) in respect of those who are infected is part – underlies many of the gender disparities in Tanzania, as it does in other countries. Transforming gender relations thus requires that this issue is addressed. The burden borne by households and women in Tanzania has been exacerbated by the burdens of poverty and underdevelopment which have, in turn, been exacerbated by neo-liberal macro and meso policies. Policy discussions in respect of HIV&AIDS relatively often refer to the possibility that the extended family is stretched to breaking point now that HIV&AIDS has been added to the existing poverty-related and other burdens. Policy discussions rarely mention that "wifely", maternal, grandmotherly, sisterly and daughterly love might similar be stretched to breaking point. This research thus has as starting point a sense that governments home-based care strategy assumes a continuation of patriarchal social relations to ensure an ongoing supply of unpaid care work in the home.

Tanzania seems a good country for the study because of the work that has already been done in this area, and the significant interest that Tanzania Gender Networking Programme (TGNP), in particular, has in continuing work and advocacy on the topic of AIDS-related care. This context will mean that the research is likely to be utilised to a greater extent than would be the case in which there was less activist feminist interest. Previous activities in this area which show evidence of TGNP's particular interest include the following:

- ♀ TGNP previously carried out research on care provided by household members for those who are HIV-infected or AIDS-sick (TGNP. 2005 *'There are too many empty promises'*).
- ♀ TGNP did extensive advocacy and awareness raising which resulted in the National Bureau of Statistics adding a time use module to the Integrated Labour Force Survey (ILFS) conducted during 2006, and government agreeing to fund this effort. TGNP has provided technical and other support to the time use component. As a result of TGNP's expressing its especial concern around HIV&AIDS-related care, the activity classification used for the time use module is unusual internationally in distinguishing care for adults who are ill from care for adults who are disabled or elderly.
- ♀ TGNP is currently involved in the preparation up of the new National Multi-Sectoral Strategic Framework (NSMF) for HIV&AIDS. (The current strategic framework covers the period 2003-2007, hence the review and planning process for a new one.)
- ♀ TGNP is in the process of finalising a position paper on home-based care.

The study would be done in close collaboration with Research on Poverty Alleviation (REPOA). This organisation is regularly commissioned to do research for government and donors, including research related to monitoring of implementation of health-related policy and MKUKUTA (Tanzania's current poverty reduction strategy paper) more generally. REPOA is also the secretariat of the Gender Macro Policy Group, consisting of

representatives of government, donors and civil society organisations, which will be in a strong position to follow up the policy implications of the study's findings.

The proposed research team consists of two researchers who have close links with TGNP. Professor Ruth Meena is currently chairperson of the organisation, and has participated in TGNP-commissioned research of relevance to the study, including the household care research. Debbie Budlender has worked with TGNP since 1997, was also involved in the household care research project, and has assisted the National Bureau of Statistics with the design, implementation and analysis of the time use module. The team would be supported by two academic advisors: Marjorie Mbilinyi of TGNP, and Masuma Mamdani of REPOA. TGNP would also organise four quality assurance sessions at strategic points in the research. These sessions would serve both to provide feedback to the research team and to interest and inform a larger group of people who could take the research findings further. They would be held at the completion of Research Report 2 (this meeting would discuss Reports 1 and 2), Research Report 3, Research Report 4, and the consolidated report.

The study would follow the approach used in other countries in consisting of four focused reports which are then consolidated and summarised into a fifth report. The proposed focus and possible methods and sources to be drawn on are described below.

Research Report 1: Historical context: economic, demographic and social structures and trajectories (desk study)
Due date: 31 July 2007
The proposal is to cover the period from the early 1990s to the present. This period makes sense politically, in that it was in the early 1990s that Tanzania shifted to a multi-party system. In macro-economic terms, the period occurs post structural adjustment which began in the mid-1980s, but with the impact of the 'adjustment' still very evident. Moreover, implementation of privatisation and liberalisaton policies deepened and became widespread, in the early 1990s. The choice makes sense in terms of the HIV&AIDS epidemic, in that the first HIV&AIDS case in Tanzania was reported in 1983, and by the early 1990s the epidemic had reached serious proportions. It also makes sense in terms of available data sources, in that a labour force survey was conducted in 1991, with the next such survey in 2000/1 and the most recent one in 2006. There is also a range of other data and studies available for the latter part of the period reflecting the development of the poverty reduction strategy papers and associated monitoring activity from 2000 onwards.

The first sub-section of this report would deal with political transformation, including the constitution, women's political presence in parliament and in government and women's machinery) and macroeconomic and macro political strategies. This sub-section would draw, among others, on the Gender Profiles which TGNP has produced over the years. This began with the first, self-generated profile in 1993, and includes two further profiles that were produced in partnership with the Swedish International Development Cooperation Agency. The most recent one was produced in 2006. This sub-section would also discuss the role of donors in shaping policies and government reforms.

The second sub-section would cover socio-demographic changes, including household and family structures; fertility, mortality, age structure, changes in marriage practices, educational levels, and prevalence and other aspects of HIV&AIDS. This would draw,

among others, on the Gender Profiles, Tanzania's Demographic and Health Survey, the Tanzania HIV&AIDS Indicator Survey and Tanzania's report to the African Gender and Development Index.

The third sub-section would cover economic structures and labour force changes, including economic policies and labour force characteristics. For the statistics, this section would draw on the various labour force surveys. For other elements it would draw, among others, on the Poverty and Human Development Reports and MKUKUTA and its associated reports. Especial emphasis will be placed on the macro-economic indicators, given their impact on overall policy directions, as well as on the dependence on donors.

The final sub-section would cover poverty and inequality and would again draw on MKUKUTA and associated studies and reports, such as the Household Budget Survey, Poverty and Human Development Report and the Status Report 2006 recently produced by REPOA for the Ministry of Planning, Economy and Empowerment (previously the Ministry of Planning and Privatisation!).

In all sub-sections, the report would highlight implications for care and, in particular, implications in respect of HIV&AIDS-related care.

Research Report 2: The analysis of time use data on work/care regimes and macro data on the care diamond

Due date: 30 July 2007 [depending on availability of time use data]

The final approach of the analysis of the time use analysis will need to be shaped by what the data will throw up. Initial steps in exploring the data will include:

- Tabulations in respect of the distribution of people's time between paid work and unpaid care work. For this analysis, categories of people will be defined in terms of sex, age group, marital status, whether there are young children in the household, employment status, location (Dar es Salaam, other urban, rural), personal income level, household income level, and the composition (in terms of three age-defined groups) of the households of which they are a member. These tabulations will be performed in respect of unpaid care work as a whole (e.g. including general housework) as well as unpaid care work more narrowly defined (i.e. the work that is done more directly with and for people).
- Tabulations in respect of the different sub-categories of unpaid care work. At a broad level, the classification system distinguishes between (a) household maintenance, management and shopping for own household; (b) care for children, the sick, elderly and disabled for own household, and (c) community services and help to other household. This set of tabulations will focus, in particular, on category (b) and on the sub-categories of (c) that relate directly to care of persons. The tabulations will also focus in on activities specifically targeted at ill adults.

The findings from the above tabulations will inform further analysis. Where, for example, clear patterns are found between particular groups, these will be further investigated through methods such as further disaggregation or simple statistical analysis. The extent to which these more in-depth investigations can be done will be limited by the sample size for particular sub-groups and the number of records for a particular activity.

The analysis will deal explicitly with simultaneous activities by including analysis using the 'full' minute (not adjusted to fit the 24-hour day) and the 24-hour minute. For determining how long different categories of people spend on particular types of care, the 'full' minute will usually be the most meaningful, while distribution of time between paid work and unpaid care work is more usually presented in terms of 24-hour minutes.

Some macro measures
At a macro level, the team will examine labour force and other data to describe the overall patterns of paid care work in the economy. In addition, the team will attempt a series of valuation exercises to give a sense of the relative sizes of the paid and unpaid (care) economies.

- ♀ Calculating the value of total paid work in the economy vs value of total unpaid work, including the sex breakdown for the total paid and unpaid, with broad sub-categories within both paid and unpaid.
- ♀ Calculating the value of unpaid care work compared with different types of tax revenue, differentiating between care narrowly defined and broader notions of care.
- ♀ Calculating the value of unpaid care work compared with different types of government expenditure on salaries, such as in schools and hospitals.
- ♀ Calculating a measure of care produced by care workers falling within the SNA production boundary. This is described above.
- ♀ Calculating the value of unpaid care as a percentage of gross domestic product.

Research Report 3: Institutions and Policies for care
Due date: 10 December 2007
While there are no strict boundaries between the various "points" or institutions that constitute the "care diamond", the categories are nevertheless useful in highlighting particular characteristics that are common at or near the different "points". The research will encompass all the institutions, but the research material and analysis may not be organised primarily in terms of these categories.

For the purposes of this study, the 'community' point of the diamond will be understood as including both non-profit organisations (including faith-based, and including both local and international) and 'the community' beyond the ill person's immediate household/family, both nuclear and extended.

Donors constitute a further group of important actors, or 'institution', in Tanzania. They should probably not be considered as a fifth point of the diamond as they generally do not provide services directly. They do, however, have a strong influence on policy and on what is done by other actors and will thus need to be covered in the report. In particular, sources such as the President's Emergency Plan for AIDS Relief (PEPFAR) the Global Fund to Fight AIDS, Tuberculosis & Malaria and the World Bank's Multi-country HIV/AIDS Programme (MAP) have influenced the focus of the response to HIV&AIDS.

For this report, we propose a combination of documentary, interview and possibly focus group discussion sources. Those to be interviewed or used as sources of documents include CARE International, the Business Coalition (in respect of anti-retrovirals), African Medical and Research Foundation (AMREF), Family Health International, Pathfinder, National Institute for Medical Research (Mwanza), London School of Hygiene & Tropical Medicine and Tanzania AIDS Commission (TACAIDS), Women's

Dignity Project (WDP), Tanzania Food & Nutrition Council, National AIDS Control Programme, WAMATA, PASADA, the Tanzanian Social Action Fund, Economic and Social Research Foundation, Human Development Trust, and Muhimbili College of Health Sciences (MUCHS: for nutrition study).

State

Of relevance here is public policy in respect of health services, HIV&AIDS and home-based care. Policy in respect of nutrition will also be covered to the extent that this is increasingly seen as a necessary element of support to those infected and affected. In some of these areas, the state plays a significant role as provider. In many it plays additional roles, for example as regulator or funder, and the examination of public policy will therefore also provide information on other institutions of the care diamond. This aspect will draw, among others, on a recent cross-country comparison prepared by Debbie Budlender for Social Sciences Research Council of whether and how government policies provide for household care and home-based care in respect of HIV&AIDS. It will also draw on the soon-to-be-finalised National Multi-sectoral Strategic Framework to the extent that this document includes a review of what has happened to date. For health systems issues more generally (i.e. not specific to HIV&AIDS), it will draw on work by Maureen Mackintosh and Paula Tibandebage. (The study will focus primarily on the past and current situation rather than on what is planned for the future.)

This research will attempt to obtain information both on policy and on actual implementation. The latter information may be available, among others, in various monitoring reports, including the HIV&AIDS Public Expenditure Review and Health Public Expenditure Review, and the budget reviews carried out last and this year by the HIV&AIDS Working Group and the Health Equity Group, in both of which TGNP is actively involved. These reports will need to be supplemented from other documentary sources and through interviews.

The market

The size and shape of the "market" in respect of health services will be described. The interaction between household spending in the public and private health sectors, and, within private, between allopathic and traditional will also be described to the extent that this information is available from household surveys, public expenditure reviews, work of researchers such as Mackintosh, and elsewhere. In these descriptions particular attention will be paid to the profile of beneficiaries and users of the different services and, in particular, patterns of usage by poor people. The research will also look, if the data are available, at the distribution of health care staff (and nurses, in particular) between public and private. The work in this area will involve secondary research. Both here and in the discussion of the state, attention will be paid to the relative emphasis given to provision of anti-retrovirals ('treatment') in comparison to that given to care.

The 'community'

The time use survey will provide some indication of the time household members spend providing unpaid care to people outside their households. This is the more informal end of community care. A major element of home-based care constitutes 'community' provided care, alongside the care provided by family members; and this community-provided care is sometimes provided through organisations and sometimes more informally. The care ranges from fetching water for the sick when the demand for water increases, through actual care for the sick, to helping to arrange burials. We will attempt

to find key informants who can cover different forms of home-based care and will draw on the experience of groups such as WOFAT+, a network of positive women. This aspect of the study will also draw, among others, on recent research on home-based care in five districts done by Pathfinder as well as the earlier research done by TGNP.

All sub-sections of this report will have as a key focus the implications of provision (or lack of provision) by these different 'points' of the diamond for the care burden of household and family members.

Research Report 4: Non-household care providers (e.g. nurses, community-based carers etc.)
Due date: 1 May 2008
Two case study foci will be included in respect of non-family provision of care. For each of these significant categories of worker the research team will explore both how they give care and how they receive care/organise care of self:

Nurses: Tanzania, like many other countries, has a nursing crisis. This has been exacerbated by the HIV&AIDS pandemic, which has led to incapacity, death and emigration of nurses, but the pandemic is by no means the sole cause of the problem. The focus will be on nurses both as carers of patients at work, voluntary/informal carers and advisors in respect of ill people in their own communities, and (possibly) carers of ill family members at home on the one hand, AND as people needing care in that they are not immune from being infected and affected by the pandemic on the other hand. The Nursing Association will be one source of information in this area. Other sources, including possible focus groups and life histories, will also be explored.

Home-based care: This is seen by the government, like many other governments in developing countries, as a key strategy for addressing care needs and reducing the burden on the health care system. Conceptually this area is interesting because of the widespread activities of 'volunteers' across the spectrum of groupings undertaking this work (ranging from formal welfare organisations to small women's and church groups), with some of the 'volunteers' paid (poorly) and some of them unpaid. As with the nurses, in addition to investigating the care provided by these workers, the research team will attempt to explore how their own care needs are satisfied.

There is some general literature and research available on home-based care that could be useful for the purposes of this study, such as the studies mentioned above by TGNP and Pathfinder, and others done by Care International and AMREF. WOFAT+ might also be able to assist in this area. These will, however, need to be supplemented by further research that focuses on the core questions of this project. The interfaces between these different types of work and methods of obtaining care will thus need to rely primarily on new, mainly qualitative, methods.

Research Report 5: Main findings of research
Due date: 1 August 2008
This final research report will draw together the main findings, which have appeared under the various Research Reports, providing an analytical and substantive account of the research.