

Analysis of the National Tanzanian Policy on HIV/AIDS from a Sociocultural Perspective: Reading Policy as a "Cultural Text" in Light of the AIDS Crisis

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Introduction

HIV/AIDS is a major development crisis that affects all sectors. During the last two decades the HIV/AIDS epidemic has spread relentlessly affecting people in all walks of life and decimating the most productive segments of the population particularly women and men between the ages of 20 and 49 years [sic].

Every one of us has a role to play and must be fully involved in the struggle against the HIV/AIDS pandemic....We must break the silence on HIV/AIDS....We must seriously and openly discuss the social, cultural and economic environments that fuel the spread of HIV infection...We must also discuss ways to support those affected and infected by HIV/AIDS, as well as orphans in our communities. Together we must fight the scourge of stigma. (Mkapa, 2001, in the National Policy on HIV/AIDS, 2001)

These powerful words from the President of Tanzania in the National Policy on HIV/AIDS highlight the complex issues that surround the AIDS pandemic. To echo these sentiments, U.S. Secretary of State Colin Powell declared AIDS "a national security problem....It is a devastating problem especially in Africa" (Reuters News Media, February 4, 2001).

At first glance, President Mkapa's aforementioned statements seem to allude to a new way of looking at policy as a response to a crisis--from a holistic, *sociocultural* perspective--instead of the detached, top-down and routine laundry-list of policy recommendations that tend to permeate current approaches to developing national policy documents. However, as one takes a closer look at the HIV/AIDS policy, one sees the traditional and general way that the policy is laid out. As an example, the policy lists the *social, cultural and economic* phenomena that currently influence the spread of HIV/AIDS in Tanzania, but they are never expanded upon or explained. These fundamental issues that are essential to understanding the local life of a Tanzanian living in the Kilimanjaro region in the midst of this emergency situation are thrown out on the printed page with lists of policies, leaving the reader to decide for themselves what these sociocultural elements might mean.

What does it mean to reconceptualize educational policy through a sociocultural perspective, utilizing the Tanzanian HIV/AIDS policy as a point of reference? Why is it important to engage in policy analyses of complex emergency situations, such as the AIDS epidemic? According to scholars Levinson and Sutton (2001), in order to reexamine policy from its most basic level, policy should be seen as "a complex social practice, an ongoing process of normative cultural production constituted by diverse actors across diverse social and institutional contexts...[and] to explicate policy as a practice of power" (p. 1). Or, as social scientists Shore and Wright (1997) have posited, government agencies should move towards an *anthropology of policy*, a qualitative, multifaceted inquiry where all sectors of society are taken into account in developing laws and ordinances that treat all constituencies equitably and fairly. In this paradigm, "policy communities' are not just rhetorical, but contested political spaces" (Shore & Wright, 1997, p. 15) and policy documents are analyzed as "cultural texts" (Shore & Wright, 1997).

Stephen Ball (1994) complements the work of the above authors by describing the critical and post-structural notion of "policy-sociology" (Ozga, 1987, 1990; Ball, 1990, as cited in Ball, 1994). Policy-sociology "suggests that it is important to 'bring together a structural, macro level analysis of education systems and education policies and micro level investigation, especially that which takes account of people's perception and experiences'" (Ozga, 1990, p. 359, in Ball, 1994, p. 14). Additionally, Ball highlights the importance of a comparative approach to sociocultural policy analysis by stating that, "Sometimes when we focus analytically on one policy or one text we forget that other policies and texts are in circulation, and the enactment of one may inhibit or contradict or influence the possibility of the enactment of others" (Ball, 1994, p. 19). Using Ball's discourse on "policy as text" as a point of reference, "multisited ethnographies" that study the "interconnected cultures of policy" (Sutton & Levinson, 2001) are critical to understanding how policies are put into practice across geographic localities.

Throughout the course of this paper, I will examine sections of the national Tanzanian HIV/AIDS policy from a sociocultural and anthropological lens, incorporating personal ethnographic data gleaned from visits to local community-based organizations in the Kilimanjaro region of Tanzania during a Teachers College course taken in the summer of 2003, as well as works of Africanist scholars who currently conduct research in northern Tanzania. These examples will illustrate how this national policy--as a response to an ongoing social, cultural and economic crisis--has been translated by various levels of society, namely the Kilimanjaro Christian Medical Centre, KIWAAKUKI (a local NGO whose acronym means "Kilimanjaro Women's Group Against AIDS" in Swahili), the Mkombozi ("liberation" in Swahili) Regional Training Centre, and the primary school setting in the town of Old Moshi.

Furthermore, I will discuss the ways in which the current HIV/AIDS policies are put into practice in local communities and organizations in Kilimanjaro, and how such actors might adapt these current policies to better address their local needs in light of the development crisis that threatens to

"decimate the most productive segments of the population" (United Republic of Tanzania, 2001, Ch. 1). I will end this paper with recommendations for how the national HIV/AIDS policy could be adapted or modified based on the way it is experienced at the local level in the Kilimanjaro region today.

Now we turn to how the National Policy on HIV/AIDS was developed in Tanzania.

Justification for the National Policy on HIV/AIDS

At the outset of the AIDS epidemic in Tanzania in the early 1980s, it was initially treated as purely a health issue, and the health sector was brought on board to combat the disease through the national AIDS Control Programme (National Policy on HIV/AIDS, 2001, p. 3). Until the year 2000, the national response to HIV/AIDS centered on "developing programs to prevent, control, and mitigate the impact of the HIV/AIDS epidemic, through health education, decentralization, multi-sectoral response and community participation" (p. 3). However, the Tanzanian government, despite their best efforts, did not see a decline in the rate of HIV transmission, and realized that it was not a disease that could be treated in isolation. All sectors of society have to be involved to tackle this nefarious illness. It has now been declared a national crisis and complex emergency (as of 2001), and is now one of the top priority items on the socioeconomic development agenda for the Tanzanian government. Moreover, HIV/AIDS has become the leading cause of death among adults in many parts of Tanzania (Setel, 1999, p. 1). How does the health sector, such as the Kilimanjaro Christian Medical Centre, translate HIV/AIDS policy into practice in Kilimanjaro?

Kilimanjaro Christian Medical Centre and Local HIV/AIDS Policy

Health care providers of all cadres shall be trained in order to acquire the necessary knowledge and skills for prevention, early diagnosis and case management of STIs. (United Republic of Tanzania, 2001, p. 17)

A visit to the Kilimanjaro Christian Medical Centre (KCMC) in June of 2003 helped to illustrate how HIV/AIDS is currently being researched, treated and taught about in the region by health care providers from a sociomedical perspective. According to the top hospital administrator of KCMC, there are 10 main sociocultural factors why HIV/AIDS policy has largely been unaddressed across the nation, and why the rapid rate of HIV continues unabated in sub-Saharan Africa and Tanzania in particular (personal communication, June 4, 2003):

- 1) *Food taboos*--people believe that certain foods can cause HIV (i.e., the Maasai do not believe in eating fish or eating little during pregnancy), so individuals may not have a balanced diet and therefore a weakened immune system
- 2) *Poor latrines*--leads to unsanitary conditions

- 3) *Poverty*--leads women to engage as sexual workers, men to travel far in place of work
- 4) *Polygamy*--multiple spouses resulting in multiple sex partners
- 5) *Ignorance and high illiteracy*--men and women do not know enough about HIV/AIDS
- 6) *Gender inequalities*--girls and women do not feel empowered to say 'no' to sex
- 7) *Witchcraft*--belief that witchdoctor can prevent HIV--so people neglect seeing a doctor
- 8) *Inheritance rights*--widows often do not have any rights and have multiple sex partners
- 9) *Low acceptance of family planning and high fertility*--can lead to HIV and mother-to-child transmission (MTCT)
- 10) *Local herbs*--similar to witchcraft--people neglect seeing the doctor because they believe these herbs can cure HIV/AIDS

In a subsequent meeting with the community health nurses at KCMC about HIV/AIDS, various local approaches were outlined with regard to Sexually Transmitted Infections (STIs) and HIV prevention education that appear to have a direct correlation to the aforementioned pre-2001 national health sector policy. For example, the nurses spoke extensively about prevention of MTCT of HIV, which is highlighted in a few different sections in the policy document. The community health nurses described their concern of the local, sociocultural community tradition of employing midwives over going to the hospital during pregnancy. This tradition has led to higher rates of MTCT of HIV and even death during childbirth, and the nurses are slowly trying to change this widespread practice (personal communication, June 4, 2003). Furthermore, the nurses relayed some of the challenges to their work such as lack of transportation and local healthcare facilities in the villages, and cultural taboos (some of which are mentioned above) that have been reiterated as "inadequate human and financial resources" (United Republic of Tanzania, 2001, p. 3) in the National Policy on HIV/AIDS. The nurses declared that the best way to curb the rate of STIs and HIV was through *behavior changes* in individual and collective sociocultural practices, which is one of the guiding principles of the National Policy on HIV/AIDS (2001):

Transmission of infection is preventable through changes in individual behaviour, hence education and information on HIV/AIDS, behavioral change communication as well as prevention strategies are necessary for people and communities to have the necessary awareness and courage to bring about changes in behaviour at the community and individual levels. (p. 5)

It is interesting to note that there was little to no mention of condom distribution and usage in this individual behavior change in KCMC's approach to treating HIV/AIDS (though their approach otherwise is quite comprehensive), even though the national policy clearly states that "there is overwhelming evidence about the efficacy and effectiveness of condoms when used correctly and consistently in the prevention of HIV transmission (National Policy on HIV/AIDS, 2001, p. 17). This seems to be a case where the local faith

community has decided to not employ a national policy due to deeply ingrained religious beliefs, which has its own set of policy-related challenges. This ethical dilemma--the way local faith groups respond to the HIV/AIDS pandemic--although fundamental to the way local life is practiced in the Kilimanjaro region, is beyond the scope of this paper. Nevertheless, it is important to include that Vavrus (2003) sheds light on the condom/church dialectic in her research in Kilimanjaro by pointing out that many ministers believe that "condoms are the devil" and that "AIDS is a big problem and that it is God's punishment for immoral behavior" (p. 65).

Some of the most innovative attempts at fostering individual change in behavior have been through local Tanzanian community-based (CBOs) and non-governmental organizations (NGOs) such as KIWAAKUKI, an NGO created by women in the Kilimanjaro region that provides a range of AIDS-related services, including education, care for AIDS orphans, and hospice care for individuals that are living with AIDS.

KIWAAKUKI and Local HIV/AIDS Policy

Being a social, cultural and economic problem, prevention and control of [sic] HIV/AIDS epidemic will very much depend on effective community based prevention, care and support interventions. The local government councils will be the focal points for involving and coordinating public and private sectors, NGOs and faith groups in planning and implementing of HIV/AIDS interventions, particularly community-based interventions. (United Republic of Tanzania, 2001, p. 9)

Since its inception more than a decade ago, KIWAAKUKI is one of the leading grassroots HIV/AIDS organizations in Moshi and arguably the entire Kilimanjaro region. Setel (1999) states that "KIWAAKUKI has been unique in Tanzania as a democratic form where women of diverse economic, educational, and social backgrounds have joined together to set an agenda for local AIDS activism" (p. 86). Their numerous community-based outreach services such as AIDS education, voluntary pre-and-post HIV testing and counseling, free condom distribution, life skills training, support to local villages through the formation of KIWAAKUKI chapters, etc. have assisted thousands of men, women, youth and children who have been "infected and affected by the epidemic including widows and orphans" (United Republic of Tanzania, 2001, p. 9).

To illustrate, "Mama Orphan," the coordinator for AIDS orphans, explained to us that out of approximately 50,000 AIDS orphans in the region, KIWAAKUKI has serviced about 2,130 to date (personal communication, June 6, 2003). Through local, national and international fundraising efforts, income-generating activities, and partnering with organizations in other countries, this NGO has been able to pay school fees and provide uniforms for these orphans who attend primary and secondary schools, many of whom would be out of school otherwise. The issue of AIDS orphans as an emerging emergency situation has extensive and far-reaching policy implications, but it is only treated

peripherally in a few sections in the policy document. In fact, to date, there is no comprehensive policy on the AIDS orphans crisis.

In response to a discussion of national HIV/AIDS policies and how they are implemented at the local level, one of the KIWAAKUKI directors stated that "policy is a high sounding nothing" (personal communication, June 6, 2003). In conversations with many CBOs and NGOs, the common sentiment was reiterated time and again that the national government was not doing enough in the area of HIV/AIDS and that the local community would have to find their own creative and innovative solutions in combating the deadly disease. Another local CBO that was formed by a powerful and inspiring individual to work with youth in several areas of their lives, including HIV/AIDS prevention, is the Mkombozi Vocational Training Centre.

Mkombozi Vocational Training Centre and Local HIV/AIDS Policy

The ministries responsible for youth development affairs, in collaboration with Local Government Councils, NGOs and Faith Groups shall develop participatory HIV/AIDS, sexual and reproductive health education programmes for the out of school youth. The youth should be given correct information including prevention strategies and promotion of correct and consistent use of condoms, abstinence and fidelity, and voluntary counseling and testing...Having been empowered with information, the youth should be encouraged and supported in developing their own strategies. (United Republic of Tanzania, 2001, p. 16)

The motto of the Mkombozi Vocational Training Centre (MVTC) is "Quality Education for Self-Reliance" (personal communication, June 6, 2003). Mrs. Mshana, the founder and director of the Center, saw a great need to provide a local vocational center for out-of-school youth because, in her opinion, young people have been largely ignored and even forgotten by local and national Tanzanian government policies. She believes that this education for self-reliance through small income-generating activities and job skills will help to liberate youth from a life of poverty and idleness. As affirmed in the MVTC brochure, "members work together to cultivate skills toward liberation from all kinds of oppression, social, economic or political towards the creation of positive social change" (Vavrus, 2003, p. 140). The MVTC also has a HIV/AIDS education unit. The youth facilitator explained the three main components of the AIDS education program (personal communication, June 6, 2003):

- 1) Poverty largely contributes to the spread of HIV because young people cannot work--Mkombozi gets the youth off of the streets and into a place where they can learn job skills, which will most likely reduce the spread of HIV through casual sex;
- 2) Young people still do not know much about how HIV is spread; the AIDS education program discusses HIV transmission in great detail;
- 3) The youth in turn educate the community and their peers through approaches such as drama, music, and videos.

In accordance with the national HIV/AIDS policies, the youth at MVTC are seemingly empowered to develop their own strategies in combating the AIDS epidemic. They work with local youth groups, such as the Kilimanjaro Arts Group, to travel and disseminate information about HIV/AIDS prevention.

Another area of analysis for local HIV/AIDS policy is in the primary school setting.

Primary Schools and Local HIV/AIDS Policy

The education sector is among the sectors that have been seriously affected by the HIV/AIDS epidemic. The Ministries responsible for education...in collaboration with TACAIDS and NGOs shall develop appropriate intervention strategies to accelerate AIDS information in schools. These include provision of non examinable HIV/AIDS information in primary and secondary schools...Reproductive and sexual health should be incorporated in the school curricula. (United Republic of Tanzania, 2001, p. 15)

From our visits with various primary schools in the Kilimanjaro region, it became apparent that the local villages are hesitant to incorporate HIV/AIDS curricula into the lower primary grades. At almost every school we visited, the common answer to when HIV/AIDS is introduced is at 12 years of age (personal communication, June 3, 2003). Could this be because of strong evangelical religious beliefs, the stigma surrounding AIDS, or a combination of both? This dilemma of when to introduce HIV/AIDS into the curricula at the primary level appeared to be common issue for the primary school administrators in the Old Moshi district of the Kilimanjaro region. Additionally, Vavrus (2003) points out various cultural, economic and linguistic challenges that arise when young people are introduced to sex or family life education in primary school, such as the lack of textbooks and curriculum only taught in English, when the overwhelming majority of students speak, read and write in Swahili.

Furthermore, the increasing numbers of AIDS orphans that attend these primary schools was another area of local HIV/AIDS policy that the local communities were struggling to implement, most likely because there are limited services for the orphans and families that care for them. For example, in the primary school of Kisaseni on the slopes of Mt. Kilimanjaro, there are approximately 59 AIDS orphans in a school of 430 (personal communication, June 3, 2003). When asked how these orphans are cared for, the response from the village chairman was that the orphans are taken care of by the local clans of the families or by the churches. An AIDS committee was started at Kisaseni to help provide services such as food and materials for these children, but it had only begun to function as of June 2003.

Since there is no formal national policy on how to care for AIDS orphans over the long-term, the local community has to find innovative, sociocultural solutions to care for the increasing numbers of children and young people who are living without one or both of their parents. One of the obvious challenges for

these primary schools and the local villages that house them is how to fund the services of these orphans. With the drop in the price of coffee in Tanzania, the majority of the families that live in the villages of Old Moshi can barely afford to send their children to school, even though school fees have been almost entirely abolished at the primary level (personal communication, June 3, 2003). The problem is compounded when another child, such as an AIDS orphan, moves in with relatives in their clan, most often with their grandmother or an uncle and his family. The family cannot adequately afford to care for an extra child, so these children often are left at home, or take to the streets in search of work, food and shelter. The issue of the number of street children is increasing in the Kilimanjaro region, but the majority of them appear to be out-of-school males from impoverished families with relatively few AIDS orphans in that particular demographic mix (personal communication, June 5, 2003). Dr. Joseph Lugalla, a Tanzanian sociologist who has done extensive research on street children in this Eastern African nation, has remarked that the street children phenomenon has increased at an alarming rate--during the last decade in Tanzania due to an ongoing social and economic crisis (Lugalla, 1999, p. 1).

At the international level, the World Bank (Deininger, Garcia & Subbarao, 2003) gives further credence to the urgent and pressing necessity to pursue research about AIDS orphans and other vulnerable young people. These authors state that the dramatic increase in the number of AIDS orphans in sub-Saharan Africa is a critical issue for policymakers for two main reasons:

- 1) Many countries in Africa have not yet reached the peak of the AIDS epidemic. As a result, the number of AIDS orphans will increase significantly for a long time even after rates of new AIDS infections have been brought under control in some countries.
- 2) According to USAID, by 2010, there will be 35 million AIDS orphans in Africa. Failure to provide adequate education and health care for this large segment of the population is likely to have long-term impacts on social and economic infrastructures as well as on productive capacity (human capital) for the foreseeable future. (p. 1202)

These authors point out areas for further research in the arena of AIDS orphans and other vulnerable children. They declare that the AIDS orphan phenomenon will have long-term policy implications and pose formidable challenges for these government actors. According to the World Bank, the dramatic rise of African AIDS orphans that are being fostered by extended-family households "may adversely affect broader social systems and human development in African countries" (p. 1217).

After the brief above examination of how national HIV/AIDS policy has been experienced at the local level in Kilimanjaro on a daily basis, I would like to now offer some recommendations for how this policy could be adapted and modified to better reflect the way of life in this northern Tanzanian region on the slopes of Mt. Kilimanjaro, using the aforementioned organizations as a point of reference.

Recommendations for Adapting and Modifying the National Policy on HIV/AIDS in Kilimanjaro from a Sociocultural Perspective

At the Kilimanjaro Christian Medical Centre, I would recommend that the community health division be further trained by local CBOs and NGOs to be more open about condom usage and distribution, as well as to discussions about the on-going stigma surrounding AIDS, the issue of homosexuality, etc. KCMC, as essential and valuable as it is to the Kilimanjaro region, is still seemingly operating under pre-2001 national health policy by not being more holistic in its approach to HIV/AIDS education. The national policy does not go into detail about how the health sector could be more well-rounded, so KCMC might still be reliant on a more traditional and conservative religious approach based on abstinence and monogamy. The issue of faith groups and HIV/AIDS was only mentioned once or twice in the national policy document, so it is not surprising that many faith groups are doing what they have always done--based on the church doctrine.

From a personal perspective, KIWAAKUKI is doing some of the best HIV/AIDS prevention education and care for people living with AIDS in the region. However, they could still do more, if they had more funding and staff. For example, they seem to be at the forefront of assisting AIDS orphans, but reaching 2,130 out of 50,000 is only a proverbial drop in the bucket. Since the national HIV/AIDS policy does not adequately address the issue of orphans--it is not given its own section, but is instead lumped together with AIDS widows--KIWAAKUKI could request to meet with their regional government to re-write this particular policy so that more money goes towards the services and care of AIDS orphans.

The Mkombozi Vocational Training Centre does valuable work with young people with very few financial resources. I would recommend that they meet with the Regional Health Officer for Kilimanjaro to discuss how CBOs and NGOs could become a bigger part of the national HIV/AIDS policy mandate since they are essential to the success of community-based efforts for out-of-school youth. I would also take a Freirian approach, and recommend that MVTC work with the youth to empower them to write their own curriculum, thereby creating more services for the youth of the local community.

The primary school setting is challenging, because it is a multifaceted organization and directly under the auspices and control of the local government. The primary schools are in dire need of financial assistance, which is most likely an on-going policy issue. However, the issue of primary schools and AIDS orphans appears nowhere in the national HIV/AIDS document, so a lot of work could be done in this area. For example, the primary school headmasters could meet with the Regional Education Officer for Kilimanjaro to discuss the issue of AIDS orphans and support for these children. Also, the primary schools should be encouraged to begin teaching HIV/AIDS education when children are around nine years of age, which is when these young pupils are becoming fully aware of their bodies.

Finally, on a general level, I would recommend that all of these organizations request a bi-annual regional meeting or conference with their representatives from the Ministries of Education and Health to discuss all of these issues surrounding HIV/AIDS. Together, everyone could draft new and updated local HIV/AIDS sociocultural policies that better meet the needs of all constituencies in Kilimanjaro. These policies could include real-life examples of policy in practice, and they would have different sections for the health sector, AIDS orphans, faith groups, out-of-school youth, CBOs and NGOs, etc., instead of lumping them all together, as they currently exist in the 2001 edition of the National Policy on HIV/AIDS.

Conclusion

Democratization of policy processes calls for a retreat from purely technocratic, top-down approaches. In some cases, the best thing a researcher may contribute to democratizing policymaking is to advocate consultative alternatives to research. Such alternatives may in the end be more cumbersome or time consuming, but they can always be more effective in yielding beneficial and broadly endorsed outcomes. (Levinson & Sutton, 2001, p. 16)

As a policy researcher, I realize that the Tanzanian government is not yet at a point where the local community is able to move towards an anthropology of policy, where it can assist in re-writing national policy, although it surely can influence what is included in current policy. As an educational researcher interested in pursuing a dissertation on HIV/AIDS policies surrounding AIDS orphans, I might be able to assist local Tanzanians in finding the sociocultural language to modify these current HIV/AIDS policies through longitudinal, multi-site ethnographies (Shore & Wright, 1997, p. 14). Since Tanzania and many other developing nations are still under the strong influence of multinational lenders and donors such as the World Bank and the International Monetary Fund, it is going to take some time to infuse a truly sociocultural or democratic approach to policymaking, as Levinson and Sutton have described. Reading policy as a sociocultural text may be a good place to begin, especially in light of the on-going AIDS crisis in Tanzania and other parts of sub-Saharan Africa that has already claimed millions of victims.

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