HIV/AIDS+WORK

HIV/AIDS, work and development

in the United Republic of Tanzania

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Acronyms

AIDS	Acquired immunodeficiency syndrome
AMREF	African Medical & Research Foundation
APPCs	AIDS Prevention Planning Communities
ARV	Antiretroviral (medication)
ASSA	Actuarial Society of South Africa
DHS	Demographic and Health Survey
EAMAT	Eastern Africa Multidisciplinary Advisory Team (ILO)
ESRF	Economic and Social Research Fund
FAO	Food and Agricultural Organization of the United Nations
GDP	Gross domestic product
GTZ	Deutsche Gesellschaft Technische für Zusammenarbeit (German Technical Cooperation)
HIV	Human immunodeficiency virus
ILO	International Labour Organization
IPEC	The ILO International Programme on the Elimination of Child Labour
LFS	Labour Force Survey
NACP	National AIDS Control Programme
OTTU	Organization of Tanzania Trade Unions
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PRSP	Poverty Reduction Strategy Paper
SIDA	Swedish International Development Agency
STI	Sexually transmitted infection
TACAIDS	Tanzania Commission on AIDS
TANESCO	Tanzania Electricity Company
TCC	Tanzania Cigarette Company
THA	Tanzania Harbours Authority
TB	Tuberculosis
TRCHS	Tanzania Reproductive and Child Health Survey
TTU	The Tanzania Teachers' Union
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
VTC	Voluntary testing and counselling
WHO	World Health Organization

Contents

Executive summary

This paper reviews the demographic and socio-economic impact of HIV/AIDS in Tanzania. It describes the effects of HIV/AIDS on labour supply and skills and on the demand in key occupations. It identifies current and potential shortages in human resource capacity that will significantly affect economic growth and development in Tanzania. It also presents policy implications and provides recommendations for interventions in the world of work.

Section A looks at the recent economic and labour market situation and reviews current epidemiological trends. It presents estimates of the impact of the epidemic on demographic structure and on the labour force. HIV has advanced relatively rapidly since the first cases of AIDS were reported in 1983. According to the most recent data, national HIV prevalence is just under 9 per cent in the age group 15 to 49 years, with some variation that can be observed on the basis of sentinel surveillance data for women seeking antenatal care, studies of blood donors, and some population-based surveys. Although the epidemic in Tanzania today is characterized as generalized, the prevalence level is lower than in the neighbouring countries of Malawi, Mozambique and Zambia. Tanzania is also bordered by two countries – Kenya and Uganda - that have lower HIV prevalence rates, Uganda after a decade of determined efforts to control HIV. Consequently, all indications point to the need and the potential for Tanzania to address HIV/AIDS forcefully in order for it to achieve lowered - rather than succumb to increased - prevalence. For that purpose, all efforts must focus on the causes of the epidemic and the means to prevent further transmission.

Among the socio-cultural and behavioural factors contributing to the transmission of HIV are the increasing gap between initiation of sexual intercourse, which continues to occur at a young age, and age at marriage which is rising; the high number of sexual partners; population mobility; gender inequalities; lack of knowledge and the persistence of misinformation; low condom use; and the presence of sexually transmitted infections (STIs) that are potential co-factors.

Section B describes the macroeconomic and microeconomic impact of HIV/AIDS as a result of its effects on the labour force, and on human capital accumulation in various sectors. Within the limits of available data, the paper assesses the impact on business, agriculture, health, the public sector, the informal economy, and education. It also examines the microeconomic impact of HIV/AIDS on households and the consequences of a large number of orphans with inadequate schooling entering the labour supply.

Section C discusses the national response to HIV/AIDS by the Government of Tanzania in the newly-implemented multisectoral AIDS strategy and the Ministry of Health's initiatives to counter HIV/AIDS. The review shows that these initiatives have not taken the workplace sufficiently into account, and that the socio-economic impacts of the epidemic have not yet been fully considered. HIV/AIDS continues to be widely considered a health issue, despite national and international efforts to increase awareness about the multisectoral dimensions of the epidemic. Section C identifies policy options and offers recommendations to promote awareness of the socio-economic impact of HIV/AIDS and steps to make prevention, treatment, care and support programmes available for workers living with HIV/AIDS.

A. Situation overview

1. Recent economic trends and labour market background

Tanzania is a large country comprising three geographic regions—the islands and the coastal plains to the east; the inland saucer-shaped plateau; and the highlands. Dodoma is the country's political capital, and Dar es Salaam its commercial capital. The economy is dependent on agriculture, which accounts for half of the country's GDP, and provides 85 per cent of exports. Topography and climatic conditions, however, limit cultivated crops to only 4 per cent of the land area.

The Real GDP of Tanzania was estimated by the World Bank to be US$513 per capita in 2002, which indicates that it is one of the poorest countries in Africa, and in the world. Approximately half of the population lives in extreme poverty. Real GDP growth nevertheless remained steady at 7- 8 per cent per year for the four years 2000-2003. At the same time, overall health-care spending (public, private and non-profit) is increasing rapidly, and household expenditures for health services are estimated to have more than doubled since 1991[1]. Some gains in real growth have been and continue to be cancelled by the HIV/AIDS epidemic. The ILO estimates that an average 1.2 per cent of growth of Real GDP was lost due to HIV/AIDS every year over the 11-year period 1992-2002[2]. This growth shortfall is expected to continue; the World Bank estimates that Tanzania's future GDP will be 15–20 per cent lower in 2010 than it would have been in the absence of HIV/AIDS. Many sectors of the economy, such as transport, education and mining, are experiencing a loss of skilled labour due to HIV/AIDS, which entails increased recruitment costs, sick leave costs, reduced profits and reduced government revenues. The situation is exacerbated by population growth, the generally poor health status of the population (life expectancy is estimated by the United Nations in 2002 to be currently in the mid-40s), the low levels of education of the population, unsustainable use of natural resources, and weak physical infrastructure.

The United Nations projected in 2002 that the population would reach about 38 million in 2005, with some four-fifths living in the rural areas. The growth rate of the population was high – at over 3 per cent - until the mid-1990s, but growth is estimated to be now below 2 per cent because of a decline in fertility from 6-7 children per woman that prevailed until the mid-1990s to 5 children in 2000; a fertility rate of 4.5 children is projected for 2005. The population will remain young for some time, however; it is estimated that about 44 per cent of the population will be under 15 years, and 66 per cent under 25 years, in 2005.

The Government of Tanzania launched a National Population Policy (NPP) in 1992, with the broad objective: "to reinforce national development through developing available resources, in order to improve the quality of life of the people". This policy was intended to place particular emphasis on lowering the population growth rate while improving health and welfare.

2. Trends in HIV/AIDS prevalence

The first cases of AIDS in Tanzania were reported in 1983 in Kagera. By 1987, all regions reported cases. UNAIDS estimates that about 1.5 million persons aged 15 to 49 were living with HIV/AIDS in Tanzania at the end of 2003. Surveys of blood donors and the results of antenatal clinic surveillance show variation around the national prevalence in older adolescents and adults aged 15 to 49 estimated at 8.8 per cent.

1. National Bureau of Statistics Tanzania, 2002.

2. International Labour Organization, 2004.

(i) Factors contributing to the transmission of HIV

A number of socio-cultural and behavioural factors help explain the HIV prevalence level: early sexual debut for both men and women that, together with later marriage, gives rise to a long gap between first sex and first marriage; a high number of sexual partners in and out of marriage; lack of knowledge and widespread misinformation worsened by low, inconsistent or incorrect use of protection during sexual intercourse; and the background prevalence of sexually transmitted infections (STIs) in the population.

Age at first intercourse: According to a 'Knowledge, Attitudes and Practices' (KAP) study, one in three boys and one in five girls had first sexual intercourse by age 14. The 1999 Tanzania Reproductive and Child Health Survey (TRCHS) confirmed that one in five women had first intercourse by age 15, and found that seven in ten women had first intercourse by 18, the legal age of marriage, whereas only half of women this age were already married[3]. Among both male and female students, nearly eight in ten had first intercourse by 17[4].

Age at marriage: Early first sex is followed by rising age at marriage for both men and women. In combination with low condom use this increases the risk of exposure to STIs and HIV as well as unwanted pregnancies. The latter often results in young women discontinuing their education, which may, in turn, increase their risk of exposure to STIs and HIV.

Lack of knowledge: Surveys indicate that most men and women have heard of AIDS and more than 95 per cent of the population know it is possible to protect oneself from HIV. Nevertheless, the number of men and women actually using condoms has remained low for a number of reasons, including insufficient knowledge, inaccessibility of condoms, religious beliefs, and a dislike for the method. In fact, quite a large number of men and women do not consider themselves to be at any degree of risk of transmission.

Gender norms: Unequal gender relations and norms of sexual behaviour are at the root of much of the transmission of HIV in Tanzania. Considerable HIV transmission occurs in association with sex work, and clients transmit the virus in the general population. Prevalence rates among sex workers have been reported at levels of 42–50 per cent in Dar es Salaam.

Migration: There has been unequal economic development among regions and between urban and rural areas for many decades. As a result, regions such as Kagera have long been a source of outmigration to other parts of the country (a fact that partly explains the high rates of inward remittances that have supported families affected by HIV/AIDS in Kagera in the past decade). In addition, there are regions with intense internal population movements, as for example the Mbeya region, situated at the borders between Tanzania, Malawi and Zambia. A highway and a railway line connecting the Tanzanian capital with neighbouring countries have contributed to high HIV prevalence in this region. Furthermore, Tanzania is a poor country by South African Development Community (SADC) and international standards, and therefore tends to suffer from the outmigration of those with internationally valuable skills and qualifications. As in other countries in the region, the losses due to HIV/AIDS in Tanzania seem to be high in areas such as nursing and teaching, where skills and qualifications are transferable[5]. Although data on such labour losses to Tanzania are not easily compiled, it is apparent that these losses are taking place, and that they further exacerbate the country's diminishing human resource capacity.

3. Demographic Impact[6]

(i) Trends in population structure

Tanzania has a youthful population; according to the 2002 census, people under 15 now make up 46 per cent of the country's population. The 2000–2001 Labour Force Survey (LFS) showed that 80 per cent of the labour force lived in rural areas, and agriculture continues to be the main occupation of the work force. Many workers (43 per cent of the labour force) have only had access to primary education; a quarter of the workforce has never attended school, and another quarter has attended but did not complete primary school. Data show that there are more women and girls who have never attended school than men and boys.

(ii) Impact on the labour force

In a country such as Tanzania, where labour is fundamental to agricultural production, the impact of both morbidity and mortality is severe. This has already started to result in increased dependency ratios, decreased agricultural production and, thus, an increase in poverty. HIV/AIDS mortality has resulted in a reduction of the number of people in their productive years. This has given rise to progressively fewer earners to provide for a wider base of dependants. The composition of the population and workforce is changing, and

3. Demographic and Health Surveys (DHS) and United Republic of Tanzania, 1999.

4. Tanzania Ministry of Education and Culture (MOEC) and UNFPA, 2001.

5. Cohen, 2003.

6. This section relies on data from the 1990/1991 and the 2000/2001 Labour Force Survey (LFS) and labour market projections carried out by ILO.

Table 1: Projected cumulative losses to the labour force (15-49 years) due to HIV/AIDS, Tanzania, 2005, 2010 and 2015 (number and per cent of labour force by that year)

Year	2005		2010		2015	
	Total number	percent	Total number	percent	Total number	percent
Loss	1,322,600	6.3	2,080,200	8.8	2,858,300	10.6

Source: ILO, 2004

there is a rising number of young people who had to become the breadwinners at younger ages. The World Bank already projected in 1997 that the workforce would become younger (with a projected average age of 29 instead of 31 years by 2010), less experienced, and less educated and trained as a result of HIV/AIDS.

The United Nations has projected the impact of HIV/AIDS on the population of Tanzania, taking into account changes in fertility. UNICEF, in collaboration with others, has looked at the projected number of orphans for different countries.

There are significant declines in the labour force already taking place due to HIV/AIDS, and these will become larger over the next decade. The ILO has projected that Tanzania will have lost 9 per cent of its labour force to AIDS by 2010 (see Table 1), which, in absolute terms, represents a loss of 2 million persons[7]. Life expectancy is estimated to have reached the low level of 43 years in 2000–2005, representing a loss of 8 years compared to 1980-1990[8].

The labour force is still expected to grow significantly, but increased mortality due to AIDS will result in fewer persons of working-age than would be the case in a no-AIDS scenario. The ILO estimates that by 2015, Tanzania will experience cumulative labour force losses of nearly 11 per cent as a result of HIV/AIDS[9].

However, the loss is even greater considering the quality of the workforce lost as a result of AIDS. There will be fewer qualified workers in terms of education, skills, experience and health status. Policy-makers need to take account of these changes when formulating policies and programmes for social and economic development in the coming decades, since the size and quality of the labour force in terms of human capital accumulation are important determinants of economic growth. The demographic impact of HIV/AIDS on different industries, and in both formal and informal economies, must also be assessed for a better understanding of exactly what changes are taking place within various sectors, levels and geographical regions of the country's labour force.

Projected labour force by sex: Mortality due to AIDS is now rising faster for women than for men. Whereas mortality losses due to HIV/AIDS of women were below those of men in 1995, in the year 2015 the losses of women will be 25 per cent greater. Cumulatively, in the absence of treatment, Tanzania will lose an estimated 1,483,000 female workers to AIDS, compared to 1,375,000 male workers by 2015[10].

4. Health provision and social security

Since 1995, Tanzania has been undergoing restructuring based on decentralization and local government reform. The role of the government as sole provider of health services is being modified to involve voluntary and private sector providers. The Ministry of Health promotes this 'public-private mix' of health-care provisions under Strategy Seven of the Health Sector Reform[11]. Most private sector health institutions are owned by faith groups operating as non-profit organizations, for example the Anglican Church of Tanzania, the Evangelical Lutheran Church of Tanzania and the Roman Catholic Church, in addition to NGOs.

Previously free health-care services, subsidized by the government (including maternal health care) are now subject to charges. Most Tanzanians are unable to afford consultation fees, diagnostic tests and medicines. However, some measures to provide equitable access to services have been adopted, and older persons, those who are very poor and people living with HIV/AIDS are, in principle, exempted from user fees.

Antiretroviral treatment is not yet available within the public health-care system except in a very small number of prevention of mother-to-child transmission (PMTCT) sites. Even though the price of treatment fell from US$12 000 a year per person in 1998 to US$500 in 2002, it remains well beyond the means of most. As a result, it is the goal of governments to develop ways of financing the provision of antiretrovirals (ARVs). Some have been made available through funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Ministry of Health is approaching other

7. *ILO, 2004.*

8. *United Nations, 2003.*

9. *ILO, 2004.*

10. *ILO, 2004.*

11. *Barker et al.,2003.*

donors to help ensure greater provision. They will probably be offered free of charge, but it is not clear whether the clinical services required to monitor and manage treatment will also be free. Nor have any arrangements been made as yet to make donated ARVs accessible to private (non-profit) providers.

To address the problem of rising costs and to empower communities and households in health-care decision-making, the government piloted a Community Health Fund (CHF) in 1996. This was designed to provide rural residents with access to a basic package of health services through the purchase of a health card.

The National Social Security Fund (NSSF) was established in 1997. It began operations in June 1998 and absorbed and replaced the National Provident Fund created by law in 1964. It is the goal of the NSSF to offer health-care benefits to 400,000 members and their families (up to five dependants per primary insuree), but the ILO has advised it to delay the introduction of benefits until a system of delivery and payment is in place. Two private insurers exist in Tanzania—African Air Rescue (AAR), registered in Kenya, and Medical Express Tanzania Limited (MedEx), registered in South Africa. AAR provides medical insurance to both corporate and individual clients. It has been active in Tanzania since 1998 and currently provides coverage to 7,000 members. According to Tanzanian law, employers must meet employees' medical expenses but may shift this burden by ensuring that their workers contribute to the NSSF.

The Factories Rules, 1985, specifically address occupational health. Although the employer is primarily responsible for health and safety of the employees at the place of work, a suitable organization may be permitted to provide occupational health services. This includes compulsory periodic examination of workers in establishments where workers are exposed to special occupational hazards.

In terms of sick leave and termination of employment, the employer is obliged to provide leave with full pay for three months and with half pay for up to an additional three months; after six months of sickness the employer is entitled to terminate the services of the sick worker on medical grounds after obtaining a medical report.

B. The economic impact of HIV/AIDS

1. Macroeconomic impact

Tanzania is one of many countries experiencing a reversal in economic and in human development due to the HIV/AIDS epidemic. The annual loss of 1.2 per cent in the rate of growth of GDP between 1992 and 2002 is equivalent to lost production worth US$177 million per year[12]. The World Bank has estimated that Tanzania's GDP will be 15–20 per cent lower in 2010 than it would have been without AIDS.

About 48 per cent of the population lives in absolute poverty, and the national Poverty Reduction Strategy Paper (PRSP) considers HIV/AIDS a central challenge. Work performance and productivity are being undermined by absenteeism, increasing health-care costs, additional recruitment and training costs, and burial expenses. The production of goods and services has been disrupted in maritime activities, civil aviation, road and rail transport, utilities, and postal, telecommunications and meteorological services[13]. The principal effects on the economy of increasing sickness are due to a reduction in labour productivity, an increase in health-care expenditures, a reduction in human-capital investment, and losses of income and savings.

2. The impact of HIV/AIDS in the workplace[14]

Productive sectors of the economy are experiencing a loss of skilled labour, increasing recruitment costs, sick leave costs and reduced revenues. Certain economic sectors, including transport, education and mining, are experiencing mortality rates such that employers are losing many of their more experienced personnel, and facing shortages of skilled workers. Industries that attract large numbers of migrant workers, such as mines, are particularly challenged by the transmission of HIV, both among the workforce and in the surrounding communities.

As in other developing countries, qualified personnel are in short supply and the time it takes to train physicians, teachers, engineers, social scientists and other specialists makes the substitution of such skills a major development challenge. This area has been one of the least researched so far and studies are urgently needed—all the more so because of the time lag between the loss and the replenishment of human resources, during which a great deal of inefficiency will be experienced by the sectors involved.

(i) The private sector

Impact costs

Businesses have felt the impact of the epidemic on production and profits, and enterprise closures have occurred in many sectors due to HIV/AIDS. The impact on personnel and management has been reported by the Tanzania Chamber of Commerce and Industry and by the Government of Tanzania. The private sector of Tanzania currently employs about 350,000 persons. Many companies offer health benefits to their employees and, in most cases, to at least some of their dependants. For a variety of reasons, however, employers are dissatisfied with current methods of offering employee health-care programmes. They are also increasingly concerned about the likely direct impact of HIV/AIDS on their companies, and see a need to develop programmes targeting prevention and mitigating the effects of the disease.

Little empirical or quantitative evidence on the impact of HIV/AIDS has been collated in Tanzania on businesses; in the few studies that have been conducted, different researchers have used different methodologies, making it difficult to determine the impact of HIV/AIDS overall. It is also hard to obtain prevalence rates for the productive labour force because of issues of confidentiality and the reluctance of persons who are HIV-positive or relatives of deceased persons to release information on the cause of death. Finally, it is difficult to distinguish the impact of HIV/AIDS from other factors that influence morbidity and mortality, such as government economic policies that ultimately affect health.

Some studies show that larger enterprises, for example the Tanzania Electric Power Supplies (TANESCO), have experienced high death rates among their employees. About 597 workers died due to AIDS in two years. In addition to the number of deaths, there is evidence of other costs that have to be borne by organizations. Health costs for the Tanzania-Zambia Railway increased by 64 per cent in one year due to AIDS[15]. A survey of six firms revealed that the annual average medical and burial costs per

12. ILO, 2004.

13. Result of a recent ILO field mission to mining areas.

14. The results of an ILO field mission to Tanzania (June 2003) provided much of the information on HIV/AIDS-related losses felt in the private and public sectors, as well as in health, education, households and the informal economy.

15. Eastern Africa Multidisciplinary Advisory Team (ILO/EAMAT),1995.

employee increased 3.5 times and 5.1 times respectively between 1993 and 1997.

Seven companies of 15 interviewed by the ILO in 2003 said they perceived the effect of HIV/AIDS on their personnel, or knew of specific employees who had died or become ill as a result of AIDS. The other eight said that they were aware that HIV/AIDS was a problem but had not yet perceived its impact on their workforce. In general, employers had difficulty estimating when the impact would be felt, or how severe it would be, due to the general lack of accurate, consistent HIV-prevalence data. Two companies, Brooke Bond and TANWAT, have data on worker HIV prevalence from voluntary anonymous in-house testing. Other companies rely on information from District Health Officials or local NGOs but find it inconsistent and inadequate to warrant expenditure on HIV/AIDS programmes.

The situation with respect to HIV prevalence is thus unknown in most enterprises and will become known only to those few employers who insist, unethically and illegally, on mandatory testing of their workforce. Mandatory testing is not permitted by the Government of Tanzania, but this regulation is ignored by certain producers. Information should only be gained through voluntary disclosure or anonymous testing based on informed consent (see Section 8 of the *ILO Code of Practice on HIV/AIDS and the world of work*). It is unclear how many firms actually carry out mandatory testing, but Standard Chartered Bank admitted in 2002 that it tested all employees, and Tanzania Breweries (a subsidiary of South African Breweries) is reported to test all employees every three to six months. The repercussions for employees and their dependants in these situations are not known[16]. Cases have been reported of employers screening job candidates for HIV without their knowledge and of some organizations with in-house medical facilities screening employees who are frequently ill or who look ill.

Enterprise policies and programmes

Organizations such as Tanzania Harbours Authority (THA), Tanzania Electricity Company (TANESCO), and Tanzania Cigarette Company (TCC) have already started rigorous HIV/AIDS intervention campaigns targeting their workforces. TTCL (Tanzania Telephone Company Limited) has had a workplace HIV/AIDS policy for several years. A memorandum of agreement has been set up with the African Medical & Research Foundation (AMREF) for implementing a workplace programme package. The approved medical budget for 2003 included funds for workplace activities. Programmes were initiated in Dar es Salaam in early 2003, including the training of Peer Health Educators, distribution of condoms, and free access to voluntary testing and counselling (VTC) for all employees and dependants. These activities were extended to other regions by June 2003, reaching about 21,000 employees and dependants. The company is currently paying for ARVs for 30 employees.

Brooke Bond Tanzania reports that 60 per cent of deaths in the company hospital are due to AIDS-related illness, and that 60–70 employee deaths per year are due to HIV/AIDS. Its HIV/AIDS programme includes peer education, cultural community activities and VTC, with an approximate yearly uptake of 600 clients. All employees and dependants are tested free of charge, but others from the local community pay a small fee for VTC services. The ARV nevirapine is administered free to pregnant HIV-positive clients during labour and to their children after delivery.

The African Medical and Research Education Foundation (AMREF) is an NGO that has helped establish HIV-prevention activities at the workplace. AMREF has also carried out a number of studies of the impact of HIV at the workplace, finding, for example, that the prevalence of HIV in selected businesses was already 21 per cent of the workforce in 1992 and 24 per cent in 1994. It is believed that such statistics, together with the mounting costs of absenteeism, medical insurance and funerals, are beginning to demonstrate the benefits of workplace programmes, and of establishing AIDS Prevention Planning Communities (APPCs) to coordinate activities and advise management.

AMREF is currently providing about 35 private companies in Tanzania with Health Programme Packages for the workplace. All programmes are designed to build in-house capacity by training peer educators, and by mobilizing supervisors. Another component of AMREF workplace programmes entails the creation of service-provision networks linking STI treatment, VTC, and home-based care and support.

Coca Cola Kwanza[17] covers all its employees through a private insurance programme that bears the full financial risk in exchange for a monthly premium. TANESCO would like to develop a different health-care scheme and has explored options among providers in Tanzania: costs are a concern, given the 6,500 employees they have on their books. In November 2002, a number of private sector organizations in Tanzania identified a common need to develop new health-care benefit approaches and HIV/AIDS programmes for employees. Fifteen private companies representing 70,000 employees and 283,000 dependants agreed to collaborate in a feasibility study to identify options for providing better care at a reasonable cost[18].

Other companies do not currently have programmes and are reluctant to hire additional personnel who would be responsible for managing company programmes[19]. Most companies want their employees to be

16. Cohen, 2003.

17. Barker et al., 2003.

18. Barker et al., 2003.

19. Barker et al., 2003.

educated about HIV/AIDS in order to be able to protect themselves, but would prefer if outside parties implemented programmes. Williamson Diamonds' managers said that as HIV/AIDS is a "taboo" issue, attempting to address it at work by introducing voluntary testing would have a negative effect on worker morale, and decrease productivity. The view that a comprehensive workplace intervention programme is very expensive deters many companies. This is a sensitive issue for employers, many of whom are attempting to cut costs while increasing production. Companies such as Kilombero Sugar and Security Group are concerned that implementing programmes might disrupt work schedules because of the need to relocate employees for education.

Trade unions have increasingly expressed their willingness to support the development of workplace policies and programmes, and have contributed through the training of shop stewards as peer educators.

(ii) The public sector

The ministries interviewed by the ILO explained the impact that HIV/AIDS is having on government departments generally. They reported an increase in the number of workers who are ill and who have died, and in the number of days that workers take off to visit the bereaved and to attend burials. The Ministry of Agriculture has shown how the epidemic, in combination with current Civil Service reforms and staff reductions, has resulted in the loss of substantial numbers of skilled and experienced staff, although exact numbers are unavailable[20]. Qualified agricultural practitioners are reaching retirement age while those in the middle age ranges are dying and not being replaced.

The ILO team was informed that there were significant differences in the impacts on and needs of the various ministries concerned – the workforce in the Ministry of Foreign Affairs, for example, is urban-based and accessible, but that in the Ministry of Agriculture is dispersed across the rural areas. The lack of statistical data, however, was general. Firstly, ministries are under no instructions to compile HIV/AIDS morbidity or mortality data; secondly, workers do not have to reveal their HIV status; thirdly, ministries do not have the resources, the skills or the mandate needed to compile such statistics.

Whereas every ministry had recently established a committee charged with handling all matters relating to HIV/AIDS in the workplace, including information and training, only a minority appear to have convened a meeting. Activities to mitigate the effects of HIV/AIDS were geared towards educating the workforce on how to prevent the transmission of the disease. The macroeconomic impact of HIV/AIDS and, therefore, the impact on human resource capacity, were not yet on the agenda. The government has declared its intention of providing care and treatment for the public sector workforce.

Health

Strained by limited resources, the scaling-up of access to ARVs, and the great number of HIV/AIDS patients, physicians and nurses are under extreme pressure. The Tanzania National Institute for Medical Research reported in 2001 that the workload had dramatically increased, and the number of staff was insufficient to meet the increased demand. The health sector workforce had been reduced in the course of the 1990s as a result of structural adjustment: there were 19,000 fewer staff in 2001/2002 than in 1994/1995. The current workforce numbers just under 50,000. Further strains on the sector are caused by funeral attendance, care of sick relatives, or illness and death of staff members themselves[21]. A high level of stigma associated with the virus was reported by HIV-positive patients who complained about neglectful and poor services. In response, health workers protested that the lack of protective gear meant that they could not assist the patients safely; it is clear that information and in-service training on HIV and AIDS are also inadequate.

Data from the Economic and Social Research Fund (ESRF) 2003 report show that lack of record-keeping in the Ministry of Health makes it impossible to obtain an accurate measure of how the epidemic is affecting its human resource capacity. Where the ILO team was informed of the death of health-care workers, it was also told that only about half the workers had been replaced. At the same time, there are ambitious plans for scaling up staff numbers to meet the demand for administration of ARVs. The Tanzania care and treatment plan has estimated that more than 1,200 new (full-time equivalent) health workers are required to deliver ARVs to 65,000 new patients. A recent study has estimated that the delivery of treatment to those who need it would require the full-time services of nearly half the health workforce[22].

Education

The education sector is one of the largest employers in the country and also one of the sectors worst affected by HIV/AIDS. In 2000/2002 there were 1,045 deaths of teachers. Of these, more than half (57 per

20. Teskey and Hooper, 1999.

21. Teskey and Hooper, 1999.

22. Kurowski et al., 2003, in Wys,2004.

Table 2: Deaths of teachers by age group (2000, 2001, and second half 2002)

Region	Number of deaths by age group				Total number of deaths
	<31 years	31 - 40 years	41-50 years	51 years+	
Arusha	1	4	19	7	31
Dar es Salaam	9	21	48	6	84
Dodoma	1	7	34	8	50
Iringa	4	39	48	10	101
Kagera	2	12	38	7	59
Kigoma	4	6	11	3	24
Kilimanjaro	1	10	27	3	41
Lindi	5	12	35	8	60
Mara	5	11	19	9	44
Mbeya	5	21	46	8	80
Morogoro	0	5	23	10	38
Mtwara	0	5	23	10	38
Mwanza	7	22	41	17	87
Pwani	4	6	23	5	38
Rukwa	3	3	27	6	39
Ruvuma	2	2	32	5	41
Shinyanga	4	14	32	11	61
Singida	4	5	34	10	53
Tabora	7	10	22	3	42
Tanga	3	4	20	7	34
TOTAL	**71**	**219**	**602**	**153**	**1045**

Source: the Tanzania Teachers' Union.

cent) were male and more than two-fifths (42 per cent) were reported to be AIDS-related. TACAIDS reported in 2002 that about 100 primary-school teachers were dying each month due to HIV/AIDS-related diseases. Their report stated that it would cost the government US$40 million to replace them.

The Tanzania Teachers' Union is one of the very few organizations to have collated evidence of the impact that HIV/AIDS has been having on the teaching profession. In an interview with the ILO, the General Secretary of the Union acknowledged that the most challenging task faced daily by the organization has been that of dealing with HIV/AIDS. This includes advising two to three teachers a day who visit their headquarters to seek financial assistance for medical treatment; counselling the families of teachers who have died; and helping teachers discuss HIV/AIDS in the classroom, including the feelings they express of inadequacy faced with this expanding task.

The union believes that the capacity of the country to deliver education is being severely affected by HIV/AIDS at a time when enrolment of pupils has been increasing due to the implementation of universal primary education. It estimates that 45,000 trained teachers will be needed by 2006 to make up for the numbers lost to AIDS. In addition, the union recognizes the difficult working conditions that teachers face, including a severe shortage of teaching material, training and skills to teach pupils about HIV/AIDS.

Table 2 above shows the number of teachers who died in 2000, 2001 and the second half of 2002. Although not certified as being related to AIDS, the causes of deaths relate to diseases associated with HIV infection, such as cancer, Kaposi's sarcoma, pneumonia, persistent diarrhoea.

These data on teachers' deaths reveal:

- The heaviest burden of deaths in absolute terms fell on a small number of regions. A disproportionately high number of deaths of teachers occurred in districts close to the main highways linking the major cities, especially Dar es Salaam and the provincial capitals.
- The largest number of teachers who died were in the 41–50-year age group, those with high levels of skills and experience.

(iii) The informal economy

Virtually all persons of working age – women and men from about 15 to 65 years – are productive, even if not employed in a job as conventionally defined: they undertake activities that produce food or bring in some

sort of income. Without education and formal job opportunities, working-age adults are left to their own devices, and their work comprises the informal economy.

In Tanzania there are a few industries that formally employ a workforce, mostly in the retail trade of agricultural and other products, stationery, photography, processed foods, and the tourist industry of restaurants and hotels. The majority of Tanzanians, however, earn their livelihoods informally. Furthermore, household surveys conducted at intervals confirm that the proportion of households relying on informal work is increasing in both urban and rural areas. Observers note in this regard the increased difficulty of finding formal employment, the associated economic hardship, and the need to have recourse to a survival strategy. For a proportion of persons who do have formal employment, an additional informal activity may be necessary to augment the household income in order to meet the family's needs.

The ILO Office in Tanzania recently commissioned an enquiry to ascertain the impact of HIV/AIDS on the informal sector. Respondents were asked a series of questions designed to gain information on the impact of HIV/AIDS on their work, as well as questions on behaviour, beliefs and practices regarding their sexual health. The report concluded that factors of risk for workers in the informal sector include multiple partnerships; inadequate knowledge of HIV transmission (only 48 per cent of respondents believed that it was not possible to get infected with HIV by working with an HIV-positive person); reluctance to undergo HIV testing (though three-quarters of all respondents could mention at least one place where they could get tested); economic motives for sexual relations; and reluctance to use condoms as a method of protection against transmission. Seventy-four per cent of respondents declared that they never used (male) condoms, despite the fact that the majority—80 per cent —expressed fear of becoming HIV-positive. A higher percentage of male respondents expressed this concern than did female respondents (85 vs. 77 per cent respectively). Forty-one per cent of respondents knew at least one colleague who was HIV-positive, and half of these reported having discriminated against them. Almost 25 per cent of respondents said that there was little sympathy for those were HIV-positive, as they were seen to be morally weak and incapable of self-control.

The impact of HIV/AIDS on informal sector enterprises is severe because they are small, labour-intensive and with little or no access to social protection. The impact is felt not only in terms of the sickness and death of workers, but also in relation to employment security, privacy and discrimination, issues that are particularly hard to handle in small and micro enterprises. Confidentiality is hard to maintain, and legislation – where it exists – hard to implement.

3. Microeconomic impact

(i) Households

The declining productivity of HIV-positive individuals is first felt within the family. The loss of adults in their productive prime then reduces the capacity of communities, and the collective effects radiate to the national and macroeconomic level. In addition to increased expenditures when a family member becomes sick, households experience a loss in income. In order to cope with the pressure on households, children are taken out of school either to assist with household chores and the care of sick household members, or to generate income; girls are most likely to be the ones held back. Young girls who have no education or skills and are orphaned are far more likely to find themselves pressured into early marriage, marriages with older men, or having recourse to sex work.

(ii) Orphans

It is estimated that Tanzania had close to a million orphans under age 18 as a result of HIV/AIDS by the end of 2003. Children who are orphaned due to AIDS account for half of all orphans, and between 12 and 13 per cent of all children. As a consequence, there is a growing number of households headed by children, without adult supervision, guidance, or skills transmission. The child heads of households and their younger siblings are all less likely to attend school and to have access to either the formal learning or the social behaviour and skills training available to children who are schooled.

Whereas in most of Sub-Saharan Africa, fostering within the extended family has been the primary recourse in case of parental loss, in Tanzania as in other countries affected by AIDS, the systems are now overwhelmed, and relatives now either refuse to take in children or are unable to care for them adequately[23]. As has been found in Thailand and Uganda, whereas grandparents are the most likely to take in orphans, they are also likely to be poor and unable to offer substantive material support to their grandchildren. The changes taking place may or may not be symptomatic of change in the concept of family and evidence that family responsibilities are increasingly confined to nuclear rather than extended relations, but they are clearly a response to economic pressures related to HIV/AIDS and other systemic factors.

23. Rau, 2001.

C. Policy options

1. Response to the HIV/AIDS epidemic

(i) National response

The head of state of Tanzania, President Benjamin Mkapa, declared HIV/AIDS a national disaster in 1999. HIV/AIDS is now discussed as a major obstacle to development and is among the government's top challenges. From 1985 to 2000, HIV/AIDS intervention programmes were coordinated and directed by the National AIDS Control Programme (NACP) under the Ministry of Health. The country response took the form of a Short-Term Plan (STP, 1986–1987), followed by the formulation of three five-year Medium-Term Plans (MTPI, II, and III) that ended in mid-2002. These plans approach HIV/AIDS principally as a health challenge, with little emphasis on addressing HIV/AIDS through other sectors. The NACP concentrated mainly on monitoring, research and prevention.

A new National HIV/AIDS Multisectoral Strategy Framework was recently formulated in line with the Tanzania National Policy on HIV/AIDS of 2001. Its objectives are to strengthen a multisectoral approach, ensure political and government commitment in the prevention of transmission, encourage voluntary HIV testing, increase care for persons living with HIV/AIDS and their families, enhance research efforts, and ensure the revision and creation of legislation on HIV/AIDS. The Tanzania Commission on AIDS (TACAIDS) became operational in the Prime Minister's office in 2000, when it took over from the NACP. Its role is to facilitate strategic leadership and multisectoral coordination, monitoring and evaluation of national responses, and it has the task of assisting every sector in planning, budgeting, and mobilizing financial and human resources for its own programmes to mitigate and control HIV/AIDS. This involves government and the private sector, the bilateral and multilateral donor community, and NGOs, as well as local government councils who in turn coordinate local activities.

Despite these efforts and the large numbers of people concerned, addressing HIV/AIDS has so far been very much a Ministry of Health responsibility. The Ministry has acknowledged that shortages of trained staff hinder policy implementation. It has concentrated efforts on raising additional resources for health care and preventive measures to ensure that the ministry labour force is protected from HIV transmission while carrying out health-care duties. Workplace options, including comprehensive HIV/AIDS programmes designed to address the need to maintain human capacity and to retain skilled and experienced workers have not yet been introduced. Few efforts have been made by government to inform and inviolve the private sector (business and labour).

Non-governmental organizations have played an important role in organizing civil society in addressing issues of prevention, stigma, discrimination and orphanhood.

Ministry of Health HIV/AIDS Strategy, 2003–2006

The Ministry of Health (MOH) has developed a comprehensive strategy for HIV/AIDS. As AIDS has become the major cause of adult morbidity and mortality in Tanzania, its impact on health services has seriously affected the quality of care and led to an attrition of the health workforce. The Ministry states that the implementation of a comprehensive health sector strategy will assist in future priority-setting and resource mobilization. As in the past, the priority HIV/AIDS interventions planned are in the areas of prevention, care, support and impact mitigation. Most of the activities planned are in areas such as training, home-based care, counselling, psychological support and palliative care, management of opportunistic infections, nutrition support and integrated HIV/AIDS/TB care.

As part of its comprehensive approach Tanzania aims to put 65,000 patients on ARVs by 2005. Data from state hospitals indicate that up to 50 per cent of all beds are occupied by patients with HIV/AIDS-related illnesses. Whereas activities such as workplace programmes on HIV/AIDS are also planned, these receive very little attention and a much smaller proportion of the funds to be disbursed. For example, in the current budget US$200,000 is set aside for fighting stigma and discrimination, but only US$85,590 is earmarked for workplace interventions.

Other than the Ministry of Education and Culture (MEOC) and the MOH, no ministry visited by the ILO team had a strategy for tackling AIDS, despite creating Ministerial Technical

AIDS Committees (TACs) following a call from the Ministry of Health for more multisectoral collaboration. The obstacles to the effective functioning of TACs relate to structure, policy, and inadequate perceptions of the threat of the disease. Some sectors have very fundamental problems. The agricultural sector reported that HIV/AIDS remained "more or less a one-person and no-budget scenario". Lack of knowledge, weak political commitment, denial and silence about the epidemic contribute to the limited multisectoral response to the epidemic. Nonetheless, the new strategic plan on HIV/AIDS is under way and awaiting approval. TACAIDS is charged with coordinating initiatives in all sectors, though its programmes are mostly in the early stages of assessment and planning.

Ministry of Education programme

The Education and Training Policy of 1995 guides the provision of education in Tanzania and focuses on increasing enrolments, quality improvement, equitable access and optimum utilization of available resources. This policy, however, does not take HIV/AIDS into account. The absence of HIV/AIDS issues in the Education and Training Policy poses a big challenge to the Ministry of Education and Culture (MOEC). Currently, HIV/AIDS activities are based on two non-formal policy documents supported by the National Policy on HIV/AIDS of 2001 that focus on school youth and adults, and MOEC guidelines on AIDS Education and Life Skills. MOEC has, however, compiled an AIDS Education Programme divided into six components—Strengthening the HIV/AIDS Management Structure, School HIV/AIDS and Life-Skills Education, School Peer Education, School Guidance and Counselling Committees, School Guidance and Counselling Services, and MOEC Headquarters Peer Education.

The implementation of the AIDS Education Programme is carried out at three levels. At the central level, activities include the formulation and design of interventions, management, coordination, supervision, monitoring and evaluation. The implementation of interventions related to the programme is done at the district and institutional levels. HIV/AIDS education has been now incorporated into the guidelines for secondary schools, including church schools, which has facilitated open discussions about HIV/AIDS among school staff. Before the introduction of HIV/AIDS into the secondary-school curriculum, openly talking about it at church-owned secondary schools (seminaries) was not acceptable.

The MOEC collaborates with a number of stakeholders in areas of education and of HIV/AIDS. The partners include TACAIDS, the President's Office for Regional Administration and Local Government (PORALG), the National AIDS Control Programme of the Ministry of Health (NACP/MoH), the World Bank, UNESCO, UNAIDS, UNDP, UNICEF, the Christian Social Services Commission (CSSC), the International Federation of Red Cross and Red Crescent Societies, the Aga Khan Foundation, the Muslim Council of Tanzania (BAKWATA), the Tanzania Parents' Association (TAPA), the Tanzania Teachers' Union (TTU) and the Teachers' Services Commission (TSC).

(ii) International and NGO response

Activities relating to workplace programmes have been supported by USAID and GTZ since the early 1990s, as well as NGOs such as AMREF (see page 7).

The ILO, UNAIDS and the World Bank, together with some local NGOs, have also carried out work in this area. There are activities intended to develop policy frameworks and to support prevention programmes in specific sectors, such as transport, where the ILO is helping strengthen responses in eight countries of the region, including Tanzania. Progress in workplace action has been slow, but organizations such as the Tanzania Chamber of Commerce, the Private Sector Foundation and the Confederation of Tanzanian Industries can, with appropriate donor and government support, provide a framework for moving forward with workplace policies and programmes.

Several national and international NGOs have HIV programmes for the general population that are accessible to workers. WAMATA (*Walio Katika Mapambano na AIDS Tanzania*, meaning people in struggle against AIDS in Tanzania) is involved in disseminating information, facilitating education and communication, providing counselling, and support and care for people living with HIV/AIDS. SHDEPHA+ (Service Health & Development for People Living with HIV/AIDS) is an association to help people live positively with HIV/AIDS. Besides peer group support, SHDEPHA+ provides information, education, counselling, home-based care, advocacy for legal and human rights, and training for income-generating activities. AIDSSET in Washington DC has begun providing registered SHDEPHA+ members with ARVs.

D. Recommendations

The main finding of this report is that HIV/AIDS is still overwhelmingly regarded as a health challenge, managed through the Ministry of Health, with little discussion of its impact on the economy. It took about 20 years from the reporting of the first AIDS case for the government to establish a coordinating body for a multisectoral approach. Nevertheless, it is clear that the government is now keen to actively involve a range of sectors and partners, and is giving high priority to a strategy for the world of work. The following recommendations are therefore intended to help the implementation of effective policies for the world of work, through collaborative action between the government of Tanzania (HIV/AIDS authorities and the Ministry of Labour), the ILO, the social partners, and others with a stake in the world of work.

The specific objectives are:

(a) to gain greater political support for a comprehensive and multisectoral approach to the epidemic, involving all ministries and taking on board its socio-economic and human capacity implications;

(b) to ensure the implementation of a strategy for the world of work through the national AIDS plan, the involvement of the social partners in national AIDS structures, and the inclusion of the world of work in Global Fund proposals and Country Coordinating Mechanisms;

c) to strengthen the capacity of the tripartite constituents to contribute to national efforts separately and in collaboration, focused on workplace programmes for prevention, care and the protection of rights;

(d) to ensure a tripartite approach to the development of public-private partnerships for the provision of care, support and treatment, making full use of the potential of occupational health services.

The implementation of these objectives would involve the following specific activities:

- The provision of technical support by the ILO and other partners for the collection of data on the impact of HIV/AIDS on key productive sectors, with particular reference to labour losses and human resource needs, and the particular implications of the epidemic for the informal economy.

- The provision of technical support for a survey of enterprise policies and programmes, and how these address issues of employment, retention of employees, and maintenance of required outputs; this can draw on the Rapid Assessment methods used by UNICEF and by the ILO's Programme on the Elimination of Child Labour (IPEC).

- The facilitation of a tripartite agreement mobilizing government, employers and trade unions to contribute to national efforts on HIV/AIDS, and help sustain human resource capacity through workplace action programmes for prevention, support and access to treatment. Now that the cost of ARVs has dropped, there is a strong argument for increasing general access to antiretroviral and other drug therapies for all employees.

- The provision of policy guidance and technical assistance to support the expansion of workplace programmes in both public and private sectors. These should include all components of a comprehensive workplace policy, covering prevention, care and the protection of rights, as set out in the *ILO Code of Practice on HIV/AIDS and the world of work*.

- Advocacy with employers and donors, and the development of structures and capacity to expand access to treatment, care and support for workers, their families and communities, in collaboration with the WHO/UNAIDS '3 by 5' initiative.

- The mobilization of and support for a range of partners to develop and implement a strategy for the informal sector and small and medium-scale enterprises, ensuring they are included in all relevant activities, and drawing on other ILO programmes that support employment and social protection in the informal economy.

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