UNITED REPUBLIC OF TANZANIA

THE PRESIDENT'S OFFICE-

PUBLIC SERVICE MANAGEMENT

REPORT ON THE MANAGEMENT OF HIV/AIDS PANDEMIC IN THE PUBLIC SERVICE

JUNE 2005

LIST OF TABLES

LIST OF ABBREVIATIONS

ARV	Anti Retroviral
HBC	Home Base Care
LGA	Local Government Authority
MCDGC	Ministry of Community Development Gender and Children.
MDA	Ministry, Department and Agency
MEM	Ministry of Energy and Minerals
MLYDS	Ministry of Labour Youth Development and Sports
MNRT	Ministry of Natural Resource and Tourism
MOEC	Ministry of Education and Culture
MOF	Ministry of Finance
MOH	Ministry of Health
NACP	National AIDS Programme Control
NMSF	National Multi-sectoral Strategic Framework
OI	Opportunistic Infections
PLWA	People Living With AIDS
PMTCT	Prevention Mother to Child Transmission
POPSM	President's Office, Public Service Management
PORALG	President's Office, Regional Administration and Local Government
RAS	Regional Administrative Secretariat
TACAIDS	Tanzania Commission for AIDS
VCT	Voluntary Counselling and Testing

EXECUTIVE SUMMARY

Background

The improvement of quality of service in the public service is largely dependent upon availability of human resources capacity to carry out the various functions bestowed upon the government. The fast encroaching scourge of HIV/AIDS is threatening available human capital and imposing a huge burden on the government budget The loss of professional personnel, the escalated costs, reduced labour productivity, and associated organizational problems are directly affecting public service delivery for the poor as well as the capacity of the productive and non productive sectors in augmenting government service.

1. Pursuant to the above, it is important that the Government identifies interventions/options for mitigating the impact of HIV/AIDS related attrition on its capacity and capability as part of its ongoing Public Service Reform Programme.

2. Against the above background, the President's Office, Public Service Management has thought it essential that a study on the management of HIV and AIDS pandemic in the public service be undertaken, as part of the Public Service Reform Programme implementation in order to assess the impact of the pandemic on human resources, assess the interventions and support mechanisms that are in place, the problems MDAs and LGAs face in dealing with the impact of HIV and AIDS pandemic, and recommend favoured options for government policy response.

The Terms of Reference (TORs)

3. The terms of reference requires the study to focus on the following issues, namely:

- To compile a profile of the magnitude and general impact of HIV/AIDS on the public service and related attrition within public service in Tanzania
- To assess the number of staff who left service with a focus on HIV/AIDS related attrition.
- Assess problems encountered by all levels of government in dealing with human capital planning.
- To assess the HIV/AIDS intervention currently in place at all levels of government, and the extent to which the government has networked with external institutions to access available services.
- To assess the extent to which workplace characteristics fuel the spread of HIV/AIDS
- To identify areas requiring policy considerations basing on the findings and the assessments done.

5. The study looked at eight Ministries (POPSM, MEM, MOEC, MNRT, MOF, MOH, MLYS, MCDGCL), ten Councils (Hai, Iramba, Mbeya MC, Songea Urban, Mbinga, Singida TC, Morogoro MC, Kilosa, Kinondoni, Rungwe) and six Regional Administrative Secretariats (Dar Es Salaam, Kilimanjaro, Mbeya, Morogoro, Songea, Singida). Data collection to address the above TORs covered the period 2000/01 - 2003/04.

Key findings:

(6) Attrition in the MDAs, Councils and RAS

(a). General Attrition

Overall, findings from the sampled MDAs, Councils and RAS showed that attrition during the four years of study was predominantly due to deaths. The deaths attrition to total labour force in the respective levels of government ranged between 0.77% to 1.19% in MDAs; 1.20% to 1.37% in Councils; and 0.46% to 1.1% in RAS. The councils have the highest attrition rates, and one could speculate that this is due to the concentration of public service workforce in councils compared to other levels (primary school teachers, nurses and extension officers).

i. In the MDAs, deaths accounted for about 75% of the total attrition. Attrition due to causes other than deaths contributed, but insignificantly, especially during the period 2000/01 to 2002/03. Nevertheless, normal retirement started to feature as cause of exit in 2003/04.

ii. In the councils sub-sample attrition of the staff during the four years (2000/01- 2003/04) was predominantly due to deaths of generalised causes. In the sample of 10 Councils exits due to deaths of all causes was lowest at an average of 1.2% of total workforce in 2000/01 and highest at 1.4% (average) of total workforce in 2002/03.

iii. In the RAS, deaths stand out predominantly in all the years. The deaths in relation to total attrition, accounted for more than 75% in the four years. The rate of attrition due to death increased steadily between 2000/01 and 2002/03 although there is a sign of reversal in the last year 2003/04.

(b). Attrition due to HIV/AIDS

Overall the deaths occurring attributable to AIDS are high. In the ministries the average attrition rate of AIDS deaths to total employees were in the range of 0.37% and 0.53% of total workforce, in the Councils the range is 0.68% to 0.81% of total workforce, and in the RAS the range is 0.15% to 0.55% of total workforce. Again the rates for the Councils are much higher than those of the other levels of public service. Moreover the deaths from AIDS have a growing trend in the four years. The possibility of erosion of the already accumulated experiences, skills and tacit knowledge among workforce is evident

(c). HIV/AIDS deaths by age

The findings in the sampled MDAs, Councils and RAS show that those dying due to AIDS related factors were in age group 30 to 50 years. That most deaths occur in the ages 30 to 50 years in the workforce is not surprising given that the infection incubation period is about 10 years and contraction most probably occurred in the ages of 20-30 years.

(d). HIV/AIDS deaths by gender (sex)

The incidence of AIDS deaths by gender differs among the three levels of government. In the MDAs and RAS the male gender has a higher death occurrence than female gender. In the councils more female staff died compared to males staff.

i. In the MDAs, analysis of the attrition further showed that more AIDS deaths occurred among the male employees than among the female, except for the Ministry of Education and Culture (MOEC). A point of caution here is that this analysis is not based on the proportion of deaths to total employees in the particular gender.

ii. In the councils the findings show that, except for the year 2002/3, more AIDS and AIDS related deaths occurred among the female gender than their male counterparts. The female average rate of exit due to AIDS death was highest at 0.45% of total workforce in 2000/01 but declined to 0.29% of total workforce in 2002/03. The rate of exit among the male gender in councils remained more or less unchanged, at approximately 0.32% of total workforce.

iii. In the RAS, The magnitude of staff exits caused by AIDS deaths is on the increase in both female and male set-ups. For the female sub-group, the RAS' average rate of exit due to AIDS death is reported as 0.03% of total workforce in 2000/01 rising sharply to the highest of 0.19% in 20003/04.

The more interesting feature in the gender-segregated attrition in RAS is that the male exit rate is higher and somehow parallel to that of female.

(e). HIV/AIDS deaths by education

The findings show that staff attrition due to AIDS deaths in the ministries is concentrated among those with ordinary diploma level education. In the Councils, highest attrition rates due to AIDS deaths (0.30% - 0.43% of total workforce) are observed in the workforce with standard 5-8 levels of education. In the RAS, workforce with level of education of standard 5-8 were more affected than the rest.

i. In the MDAs, over the four years (2000/01 – 2003/04) staff attrition due to AIDS deaths has been rising among those with ordinary diploma level education. Again as in the case of gender analysis above, this is because the majority of the workforce in the ministries are a diploma holder.

ii. In the Councils, over the four year period (2000/01 – 2003/4) highest attrition rates due to AIDS deaths (0.30% - 0.43% of total workforce) are observed in work force sub-group with standard 5-8 levels of education, followed by the subgroup with form 1-4 level of education and next by those with form 4 plus certificate training. Again the concentration of primary schools teachers and nurses with low education qualifications appear to account for the observed situation.

iii. In the RAS, although the majority of exits in RAS are those with standard 5-8 level of education, there are exits of personnel with Masters level of education that must be recognized. And given the limited number of professionals at this level, it is quite obvious that the departure of a graduate might leave a certain sector without an expert.

(f). HIV/AIDS deaths by profession

Our general findings indicate that in the MDAs there were more professional staff exits due to AIDS deaths over the four years compared to the support staff, most likely because the workforce structure in the MDAs is composed of more professionals than support staff. In absolute terms[1] in the sample of eight MDAs the total AIDS deaths over the four years were 119 professionals and 18 support staff.

In the councils there are more exits due to AIDS deaths in the support staff category than the profession cadre in the administration, excluding those in education, health, agriculture and livestock accounted for under attrition by sector. Again mostly likely because the latter cadre is thinner than the support staff cadre

(g). Attrition by sector

i. The analysis of HIV/AIDS deaths by sector focused on the Councils. Our findings reveal higher AIDS and AIDS related attrition, in absolute terms, among schoolteachers than any other group. Records from the Teacher Education Commission in the year 2001/2002 showed that there were 1,096 deaths of teachers, with 517 deaths for the first half of year 2002/2003. Of the 1096 deaths of teachers reported in 2001/2002, more than two fifths (42%) are estimated to have died of HIV/AIDS related diseases, tuberculosis, long term fever, cancers, etc.

ii. Basing on percentages, however, the administration ranks highest in the rate of exits due to the HIV/AIDS deaths over the four years; (lowest of 1.20% in 2000/01 and highest of 1.78% in 2001/02).

(7). Current main activities used to manage the HIV/AIDS catastrophe in the public service sector:

i. The public service sector lacks sector specific policy on HIV/AIDS intervention. Though providing guidance to the public sector, the broader national policy on HIV/AIDS response does not address the specific requirements of employer, employees and their families in the sector.

[1] Since we don't have the total workforce figures by profession, it is not possible to compute rates of exits by profession.

ii. Mainstreaming of HIV/AIDS activities in the MDAs/Councils and RAS is on-going in so far as establishment of HIV/AIDS management structures is concerned though not to a satisfactory level. But development of HIV/AIDS strategic plans within the institutional medium or long term plans of development is very rudimentary in the councils and RAS. In all three government levels HIV/AIDS activities are being done within functional lines, but have not received due priority in resource allocation. A 'focal point' was found in all ministries but this was additional to his/her normal duty.

iii. HIV/AIDS related problems have undermined human resource planning in the public service. Vacancies are being created through exits due to AIDS deaths but the replacements take long to be completed. There are problems of getting the lost skills.

iv. There is no change in the mind-set of the officials in the public service on how to make better use of special skills. The use of existing manpower is still traditional, and has not taken on board the potential threats posed by the HIV/AIDS scourge at workplace.

v. Government's interventions in the thematic areas of prevention, care and support, advocacy has remained rather superficial, characterised mainly by sensitisation seminars and workshops. Limited activities take place in the area of care and support. Sensitization through workshops has covered only the top cadre (in most MDAs). Many workers reported not to be aware of the interventions.

vi. The level of financial support to these interventions is indeed low. All the levels of government are yet to make a serious level of financial commitment to the HIV/AIDS course.

vii. Management of information on employees very weak in all levels of the government, A lot of the information kept is partial, fragmented or does not flow over time frame or its management is so unorganised that data access is next to impossible. The gaps in information at all levels of Government pose a serious obstacle towards making good decisions on capacity building, replacements, multi-skills development and resources allocation.

viii. A number of workplace characteristics were found to fuel the spread of HIV/AIDS. The most popular practices mentioned included:

- Workers behaviour at work places that connote sexual relationship.
- Staff transfers without consideration of its implications on marriage bonds and family obligations or on personal retirement commitments.
- Long separation of couples due to transfers of spouse.
- Inadequate Salaries and allowances that cannot fully support monthly normal living.
- Long waiting time for placements for teachers or transfers that fuel sexual corruption.

(8). RECOMMENDATIONS AND POLICY ISSUES

Our study has made a number of observations for which policy considerations are need. These are summarised in table below together with their urgency and responsibility.

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
Legal and Policy framework	1. The public service sector lacks sector specific policy on HIV/AIDS intervention. It is guided by the broader national policy on HIV/AIDS response, which does not address the specific requirements of employer and employees in the sector	Draw up a policy for the public service sector to address the specific work conditions in the sector. The policy paper should be supported by a guideline which helps the sectors in its operationalisation. It has been noted in the text that the guideline which was issued by PORALG has to a large extent helped the Councils in putting together the structures for dealing with HIV/AIDS at that level.	Policy issue	Immediate (Within 1 year)	POPSM
	2. There is lack of a Legal framework covering issues of HIV/AIDS at workplaces leading to negative effect on the management of HIV/AIDS	Develop Legal Framework covering issues of HIV/AIDS at workplaces. The law will be instrumental in enforcing the interventions which will be put in place. For example, a law that makes non-protective sexual activity (PLWA having unprotected sex) in workplace a criminal offence will go a long way in curbing the spread of HIV/AIDS through negligence.	Legal framework issue	Long-term (within three years)	POPSM/Ministry of Justice Constitutional Affairs

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
Human Resources Management (HRM)	1. There is ample evidence that the public service is losing it most valuable workforce due to HIV/AIDS in all the three level of government MDAs, Councils and RAS). This makes the public service more vulnerable given that the deaths are occurring in the most prime age of between 31- 50 years.	1. Develop a formal system for allocating and monitoring the effective use of resources. Human resource planning, implementation and monitoring must be practiced. Due diligence should be exercised on the HRM to encompass human resource planning, recruitment, training, motivation and monitoring.	Operational issue	Immediate (Within 1 year)	POPSM/PORALG/MOF
	2. Vacancies are being created and the replacements take long to be completed. 3. Bureaucracy in approving replacements is a major concern of authorities particularly the Councils	2. The system in use for approving replacements by POPSM should be revisited. First let an assessment be done to check on the magnitude of the problem. The internal audit department could do this. 3. A more effective monitoring of staff replacement should be adhered to.	Operational issue	Immediate (Within 1 year)	POPSM
	4. There is problem of getting replacement for the rare skills. 5. No institution has thought of making use of multi-skills approaches for purposes of optimising on available skills.	4. POPSM should institute a policy that will provide incentive to staff to move away from single to multiskills, as a way of reducing the severity of the impact of HIV/AIDS scourge. 5. Ensure mechanisms for conservation of the skills and work experiences acquired are in place by encouraging young people to understudy the more experience people.	Policy issue Operational issue	Immediate to long-term (within 3 year)	POPSM/PORALG/Council/RAS
Information Management	1. A major shortfall in the public service, from the	1. Government should put in place comprehensive information system to ensure	The problem of IMS is a policy	Long-term (within 3 Years)	POPSM/PORALG

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
	Centre (POPSM) down to the regions, districts etc is the lack of efficient information systems. 2. Information kept on employees is poor quality measured in terms of completeness, accuracy, consistency, and timeliness. A lot of the information kept is partial, fragmented, does not flow over time frame	capturing of such data. Such data should be disaggregated by education, gender, age, level, profession, training level achieved etc. 2. Deliberate efforts should be made to computerize such data throughout the public service 3. Indicators for monitoring purposes should be identified and agreed upon in collaboration with TACAIDS 4. Frequency in Monitoring and evaluation should be established as a matter of policy. 5. Gender should be mainstreamed in the HIV/AIDS related IMS. 6. Guidelines should be in place to identify the type of information to be recorded, types of reports, and their timing. For example, data and information intended for economic and social analysis could be identified which allow for the following reports to come out: • Time utilisation and the cost of lost time. • The burden of HIV/AIDS in terms of Treatment, funerals, terminal benefits, replacement costs etc. • Opportunity costs of lost production or service due to HIV/AIDS related problems. • The status of families affected by HIV/AIDS in terms of orphans left behind and how they are taken care of; whether those affected have access to housing, education, health;	issue Operational issue		

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
		• How many of those affected have been counselled, have left behind a will and to whom did the terminal benefits go to. • A study to measure the economic impact of HIV/AIDS should be undertaken.			
HIV/AIDS management at Workplaces • Mainstreaming • Interventions • Budget allocations • Networking	1. Government's interventions in respect of prevention, care and support, advocacy have remained rather superficial, characterised mainly by seminars and workshops. 2. Mainstreaming of HIV/AIDS activities in the MDAs/Councils and RAS is on course. 3. Structures in MDAs, Councils, and RAS currently being introduced to manage HIV/AIDS are weak. Typically, the appointment of a 'focal person' to coordinate the HIV/AIDS programmes on a part-time basis underline the weakness. 4. In some MDA's there are divisional committees that are yet to become fully	1. HIV/AIDS programmes aimed at the workers must be articulated in a manner that distinguish activities that target the workers from those that target the public. Activities to be implemented for the workforce should be identified along the thematic areas of prevention; care and support; and advocacy. The activities should also be selected on a prioritized basis. For example, • **Prevention:** (i) a strategy for making condoms available to all workers should be worked out; (ii), activities to re-enforce ethical matters should be identified and be programmed for implementation. Etc. • **Care and support:** a system for providing anti-retro viral drugs to those infected should be instituted. • **Advocacy:** again the activities to be implemented should be worked out and be programmed for implementation. 2. The activities identified above under prevention, care and support; and advocacy should be allocated sufficient resources through the institutional budget.	Policy issues	Immediate (Within 1 year).	MDAs/RAS/Councils (Overseeing by POPSM/PORALG)

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
	functional. 5. In councils, the committees formed to oversee HIV/AIDS activities focus more on district/community interventions rather than workplace interventions.	3. Clarify on the structures or institutional arrangements which will ensure that established HIV/AIDS programmes and plans for THE workforce will be implemented. As of now, the roles and responsibilities of the various parties involved in the management of HIV/AIDS at place of work are not clearly stipulated. For effective management; the future should see the following: • An officer to work on HIV/AIDS matters should be appointed and this should constitute the principal responsibilities and duties. Among other things, he should take charge of planning, implementation, monitoring and reporting of HIV/AIDS matters along the lines of prevention, care and support, and advocacy. And the capacity of the individual should be enhanced through training. • Create an office under PS officer/DED/RAS to take charge of HIV/AIDS issues viz. policy, planning, implementation and monitoring. • Provide clear terms of reference to the office as well as the committees. • The office created should be well resourced with qualified personnel and facilities. • The participation process of the workers should be identified clearly. • Finally, the overseeing/advisory			

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
		committee to work with the officer should be identified. 4. There are many organisations which are offering valuable services on HIV/AIDS pandemic. The councils should continue with the already demonstrated pro-activeness in accessing available services offered by other institutions. The MDAS which have lagged behind on this matter on networking should move from their passivity. Also worth noting is the fact that the networking does not need to be confined to Civil Society Organisations/NGOs alone, The private sector, especially the enterprises with multinational setting, could provide valuable experience on how to deal with the HIV/AIDS issues at workplace. (Tap the international practice of firms operating in Tanzania).			
Health of workers	1. Existence of opportunistic diseases e.g. TB which pose a danger to the health of other workers.	1. Routing health checks for workers to be regularized and annualised by making it compulsory. Organizations should develop programmes for ensuring safe health among the existing workforce. 2. On new recruitments, there should be guidelines emphasizing clean certificate of health with a focus on the opportunistic diseases, but also with an understanding that HIV/AIDS is not a disease.		Immediate	All Chief Executive Officers/personnel officers in MDAS, Councils and RAS
Information education and	1. Workers are not informed enough of what the	1. When the policy/guidelines on HIV/AIDs in the public services are prepared, the issue of		In the next one year	POPSM, all

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
communication	employer is doing on HIV/AIDS pandemic.	IEC should be part of it. 2. Each MDA/Council/RAS should then prepare an IEC strategy. The IEC is an important tool for passing information to and from workers/management.			MDAs/Councils and RAS.
Work place Characteristics	1. Workers behaviour at work places connotes sexual relationships. 2. Sexual corruption was observed to an issue when seeking placement or transfer especially in the case of teachers.	1. Standing orders should be revisited for purposes of bringing on board behavioural/ethics issues pertaining to HIV/AIDS. 2. Assess the effectiveness of operationalisation of the standing orders, the code of ethics in public service and other control measures instituted for purposes of identifying loopholes to be addressed. 3. Transparency in the management of transfers, relocations, and placements should be enforced.		Immediate (within 1 year)	POPSM
	3. Staff transfers without consideration of its implications on family obligations or on personal retirement commitment	4. The issue should be studied further in relation to national gender and employment policies.		Long-term (within 3 years)	POPSM

1.0 INTRODUCTION

1.1 BACKGROUD

The improvement of quality of service in the public service is largely dependent upon availability of capacity to carry out the various functions bestowed upon the government. The motto of the Public Service Reform Programme (PSRP) is "Pursuit of Quality Public Service under Severe Budgetary Constraints". This implies best use of available human and non-human capital resources to achieve the cherished goals within very stringent budgetary conditions. However, the fast encroaching scourge of HIV/AIDS is threatening available human capital. Attrition due to HIV/AIDS is having a serious impact on the capability of Sub Saharan African Countries Institutions. Many studies on AIDS impact point to the looming danger of depletion of capacity in developing countries, with Sub-Saharan Africa (Tanzania included) being among the most badly affected regions. The loss of professional human resource, the escalated costs, reduced labour productivity, and associated organizational problems are affecting public service delivery for the poor as well as the capacity of the productive and non productive sectors in augmenting government service. UNAIDS (1998) advocate that the impacts of HIV/AIDS in the work place include loss of experienced personnel, increased recruitment and training costs, increased labour turnover productivity, lower productivity of new recruits and increased health care costs due growing ill-health status of staff, medical and insurance costs, death benefits, disability and pension payments.

Pursuant to the above, it is important that the Government identifies interventions/options for mitigating the impact of HIV and AIDs related attrition on its capacity and capability as part of its ongoing Public Service Reform Programme..

Against the above background, the President's Office, Public Service Management has thought it essential that a study on the management of HIV and AIDS pandemic in the public service be undertaken, as part of the Public Service Reform Programme implementation in order to assess the impact of the pandemic on human resources, assess the interventions and support mechanisms that are in place, and problems MDAs and LGAs face in dealing with the impact of HIV and AIDS pandemic. The Public Service needs to ensure that its human resource planning and management/development policies, its services delivery systems and procedures are designed to take into account the deleterious changes caused by HIV/AIDS, and that mechanisms are put in place to monitor and combat the pandemic and to monitor the effectiveness of intervention programs. It is important also to note that this initiative is consistent with the objectives of the National Multi-sectoral Strategic Framework on HIV/AIDS, which requires each sector to monitor and assess the impact of HIV/AIDS on its operations. The results of the study are a major input in the implementation of PSRP.

This report presents findings of the study in line with the Terms of Reference (TOR) appended in annex 5.

The outline of this report is as follows. Section 1 is the introduction to the study, while section 2 presents an overview of the magnitude and general impact of the HIV/AIDS problem in the public service. Section 3 presents the findings of the study, while section 4 presents the conclusions and recommendations of the study.

1.2 METHODOLOGY

The study involved a number of stages; first a review of documentation on the magnitude and impact of HIV/AIDS in the public Service and related attrition, as well as its impact globally was undertaken. Then structured and unstructured survey instruments were designed, and tested in one Ministry and one local

council. Revised instruments were then administered in 8 MDAs, Local councils and Regional Administration Secretariats offices with the help of research assistants. Data on death cases and establishment and recruitment figures was obtained by interviewing the Directors of personnel, heads of departments + document review (going through files to get information on deaths etc). Data collection covered the period 2000/01 – 2003/04

Stratified selection of the workplace population for interview included the employer, employees in the groups senior, middle level and support staff.

Sample institutions

The sample of institutions to work with comprised of eight MDAs, ten councils and six Regional Administrative Secretariats. The selected institutions are as follows:

i) List of Ministries

Presidents office, Public Service Management; Ministries of: Labour, Youth Development and Sports; Health; Education and Culture; Natural Resources and Tourism; Finance; Community Development, gender and Children; and Energy and Minerals

i) List of Councils

Hai, Mbinga, Songea, Mbeya, Tukuyu, Singida, Iramba, Kinondoni, Morogoro, and Kilosa

ii) List of RAS

Kilimanjaro, Dar es Salaam, Morogoro, Mbeya, Ruvuma, and Singida

1.3 INFORMATION MANAGEMENT SYSTEMS AND STUDY LIMITATIONS

Some tools for collecting data from central sources were developed and approved by the client, based on the assumption that the consultant would get information kept centrally to enable profiling of the general magnitude and impact on public service. On application of the tools, it was discovered that there was no centrally kept data that showed attrition by reason/cause. First, information kept by the Central Establishment at POPSM was incomplete in regard to monitoring attritions in the public sector, and secondly, data maintained by the Directorate of Management Information Systems (DMIS) is payroll driven and does not maintain records which indicate attrition by cause. We also found out that the data kept by the DMIS was similar to that in the Ministry of Finance since they use the same database. Also in the case of health insurance fund, the data kept does not have detailed information about the illnesses of employees.

In some MDAs, RAS offices and local councils, researchers had problems getting cooperation. Either some of the officials were too busy or were not in a position to provide the required information. Some personnel officers had recently been employed or transferred to the current department. Coupled with poor record keeping in the MDAs, RAS offices and local councils, the exercise took longer than expected.

Specifically the data inadequacies had the following effect:

(i) Data from central sources, e.g. POPSM, Treasurer, Health insurance fund etc. cannot provide for profiling the HIV/AIDS impact problem in the public service.

(ii) Data records available on personnel at POPSM have no information on causes of exit. Even records kept by the MIS Directorate at POPSM are more-or-less payroll driven.

(iii) There is a significant number of personnel records with unclassified gender in records at POPSM which limits the use of centrally kept information as original planned and tools developed.

(iv) Data management in the MDAs, Councils and RAS is not organized for efficient data access –e.g. periodic reports (annually, quarterly, monthly) or computerized personnel records are non-existent. Accessing such information is cumbersome.

(v) Personnel data are not centrally kept but are scattered in the various departments/sections. In the Councils the heads of sections keep their employee details, but also in the MDAs information such as absenteeism, or excuse duty etc are not centrally monitored.

(vi) In the council and MDA, we found out that responsibility for fighting HIV/AIDS was vested with the coordinator. These are newly appointed officers. These new officers do not have the memory of the death characteristics of staff that exited before her/his appointment.

(vii) The quality of data in MDAs, Council, and RAS records have problems also. Records concerning death are available but the specific employment data are not centrally available especially where employees work in the field. For example, date of employment is not available; characteristics of death not known; lack of a detailed reporting system, it is quite likely the numbers given as exiting are incomplete and therefore unreliable.

(viii) Information concerning death characteristics is not documented, and therefore one had to rely on recall of the respondent. This being the case, it means to get that information you need to have someone who has been in the section/department and who knew the health status of the staff before he/she died.

2.0 AN OVERVIEW ON THE MAGNITUDE AND GENERAL IMPACT OF HIV/AIDS

1. Globally the HIV/AIDS is on the increase and the number of people living with HIV/AIDS has reached alarming level. By 2001, almost 22 million people had already died of HIV/AIDS, while more than 40 million adults and children were living with the disease (UNESCO, 2002). Recent estimates by UNAIDS and WHO (2002) indicate that by end of 2002, 42 million people were living with HIV/AIDS (PLWHA), of whom 38.6 million were in their most productive years (between 15 and 49 years), and 3.2 million were children aged 15 year or younger.

2. Approximately 95 percent of the global number of PLWHA live in developing countries (Amani, 2003). Lyon (2004) reports that over 90 percent of all people infected with HIV since the beginning of the pandemic are from the developing world. This proportion is expected to increase given the widespread poverty, poor health systems and the limited resources available for prevention and care. The number of deaths due to HIV is also expected to increase. The spread of the disease will particularly accelerate in Asia and Africa over the next decade, with an estimated 75 million PLWHA by 2010 in five of the world's most populous countries (i.e. China, India, Russia, Ethiopia and Nigeria (Gordon, 2002).

3. In Sub Saharan Africa where two thirds of the world's infection has occurred, more than 7.4 percent of the population between 15 and 49 is estimated to be infected with HIV/AIDS.

4. Nationally, there is a high level of HIV/AIDS infection in Tanzania, which is threatening all poverty alleviation initiatives in the country. The rate of infection has been accelerating since the first case was diagnosed in 1983 in a village on the Ugandan border in Bukoba district. Recent NACP reports (show a two-fold increase in HIV prevalence among blood donors from 7.2 to 13.3 percent during the last ten years (1991-2000), and that 13.3 percent of women who delivered in health care facilities in the year 2000 were HIV positive (NASP Surveillance report no 15). In 2002 it was reported that HIV prevalence among persons of 15 years and above who donated blood was 9.7%. The prevalence among females stood at 12.3% and that for males was 9.1%. Currently adult HIV prevalence rate is 8.8%

5. Information on the impact of HIV/AIDS in the public Service in Tanzania is scanty. Concrete data on the infection and its impact on the public service is also not available or not systematically kept. A Study on the impact of HIV/AIDS on the education sector in Tanzania has shown that there are critical information gaps in the literature with regard to the pandemic. The situation is a little bit better in some countries such as Malawi.

6. With HIV/AIDS affecting the most productive age group (15-49), the pandemic is having great impact on the labour force and within the work place. Experienced workers are being lost through death or early health retirement. UNAIDS (1998) advocate that the impact of HIV/AIDS in the work place include loss of experienced personnel, increased recruitment and training costs, increased labour turnover productivity, lower productivity of new recruits and increased health care costs (medical and insurance costs) and increased death benefits, disability and pension payments. Nsemwa (1999, 2000) reported that the major cause of deaths among beneficiaries of Parastatal Pension Fund (PPF) pension payment was HIV/AIDS (54%), followed by malaria and others (22%), and Tuberculosis (18 %), and cancer (6%) for the period January to September 2000. In 1999, HIV accounted for 71% of all deaths, followed by tuberculosis (15.1%). Nsemwa further reported that 75% of all deaths of their members are caused by AIDS or AIDS Related Complexes (ARCs).

UNESCO's (2004) study on the impact of HIV/AIDS on the education sector in Tanzania has shown the vulnerability of the sector to HIV/AIDS. Being the largest employer in the country, the sector is perhaps more vulnerable to HIV/AIDS than other sectors. Epidemiological reports show that the 15-24 age group is highly vulnerable to HIV, while demographic surveys indicate that HIV/AIDS is the greatest cause of mortality amongst adults in mainland Tanzania. One of the causes for teacher attrition is death. In the year 2001/2002 there were 1,096 deaths of teachers, with 517 deaths for the first half of year 2002/2003. Of the 1096 deaths of teachers reported in 2001/2002, more than two fifths (42%) are estimated to have died of HIV/AIDS related diseases, tuberculosis, long term fever, cancers, etc. Deaths of teachers may have resulted in

disruption of schooling, especially given that those teachers cannot be replaced speedily. Similar situations have been reported in Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

3.0: THE IMPACT OF HIV/AIDS PANDEMIC IN MDAs, COUNCILS AND RAS

3.1: INTRODUCTION:

Attrition of public service staff was studied in 8 ministries (MDAs), 10 local government authorities (LGAs/Councils), and 6 regional administration secretariats (RAS) covering a four-year period (2000/01-2003/04. Information on six potential causes of exit were used to disaggregate the attrition levels by year, death, acute/chronic illness, normal retirement, voluntary/early retirement, dismissal, or redundancy. Gender (herein after used in the context of sex), age, profession, and education level is used to disaggregate attrition.

Availability of data/information

As observed in the methodology section systematic record keeping was a major problem in all sampled MDAs, Councils and RAS. Centrally maintained human resources data related to the current study was also non-existent. It was evident that a directive from above and other incentives to maintain employees records were missing. Efficient information management systems are critical in human resources planning and management, especially at this stage when the impact of HIV/AIDS on workforce needs to be monitored on a continuous basis. The absence of systematically generated information makes it difficult for the government to assess and forecast the magnitude of the impact of the pandemic on public service for effective intervention strategies. Essentially therefore, the Presidents Office, Public Service Management (POPSM) should be able to give directives on the need to maintain HIV/AIDS related data. POPSM itself should provide some guidelines and relevant tools to generate such information. Furthermore, a management information system that will require POPSM to maintain such data centrally should be instituted.

3.2: ATTRITION IN SAMPLE MINISTRIES, COUNCILS AND RAS

In this section we analyse attrition by general causes and HIV/AIDS cause. The information is then analysed further in terms of age, gender, education, profession and infectious diseases. The findings are presented below.

3.2.1: Attrition by General Causes: Selected Ministries, Councils and RAS

Overall, findings from the sampled levels of government showed that attrition during the four years of study was predominantly due to deaths. The percentages of deaths to total attrition in MDA were on the average about 75%. It is however important to mention that during this period of study that normal retirements appear to be minimal after the extension of the retirement age to sixty years. The deaths attrition to total labour force in the respective levels of government ranged between 0.77% to 1.19% in MDAs; 1.20% to 1.37% in Councils; and 0.46% to 1.1% in RAS. The Councils have the highest attrition rates, and one could speculate that this is due to the concentration of lowly paid staff (teachers, nurses and extension officers) and who are probably more exposed to risky work conditions due to the social-economic environment under which they work. The findings in the each level of government are as follows;

(a). Magnitude of staff attrition due to general causes of exits of personnel in ministries.

There is adequate evidence from the information obtained from the sub-sample of ministries that attrition of personnel during the period 2000/01- 2003/04 was predominantly due to deaths (See Table 3.1 and Figure 3.1). The deaths in relation to total attrition, accounted for more than 75% in the years 2000/01 to 2002/03, while in 2003/04 the ratio was 63.24. The fall in the last year could be due to an increased number of exits due to normal retirements which accounted for 11.97% of the total attrition.

Table 3.1: staff attrition by general causes of exit: selected ministries

Cause		2000/01 N=6250	2001/02 N=7011	2002/03 N=6203	2003/04 N=6999
Deaths	**No**	52	54	74	74
	%	0.83	0.77	1.19	1.06
Normal retirement	**No**	2	1	4	14
	%	0.03	0.01	0.06	0.20
Sickness	**No**	1	2	4	3
	%	0.02	0.03	0.06	0.04
Resignation	**No**	4	5	4	22
	%	0.06	0.07	0.06	0.31
Dismissal	**No**	8	4	8	3
	%	0.13		0.13	0.04
Redundancy	**No**	1	1	1	1
	%	0.02	0.01	0.02	0.01
Total attrition	**No**	68	67	95	117
	%	1.01	1.11	1.53	1.67
Deaths to total attrition	**%**	76.45	80.59	77.89	63.24

NB: Percentages are based on the actual workforce total in the sample ministries in the indicated year.

This analysis excludes two ministries in the sample (MNRT, MLYS) due to lack of complete data in these ministries.

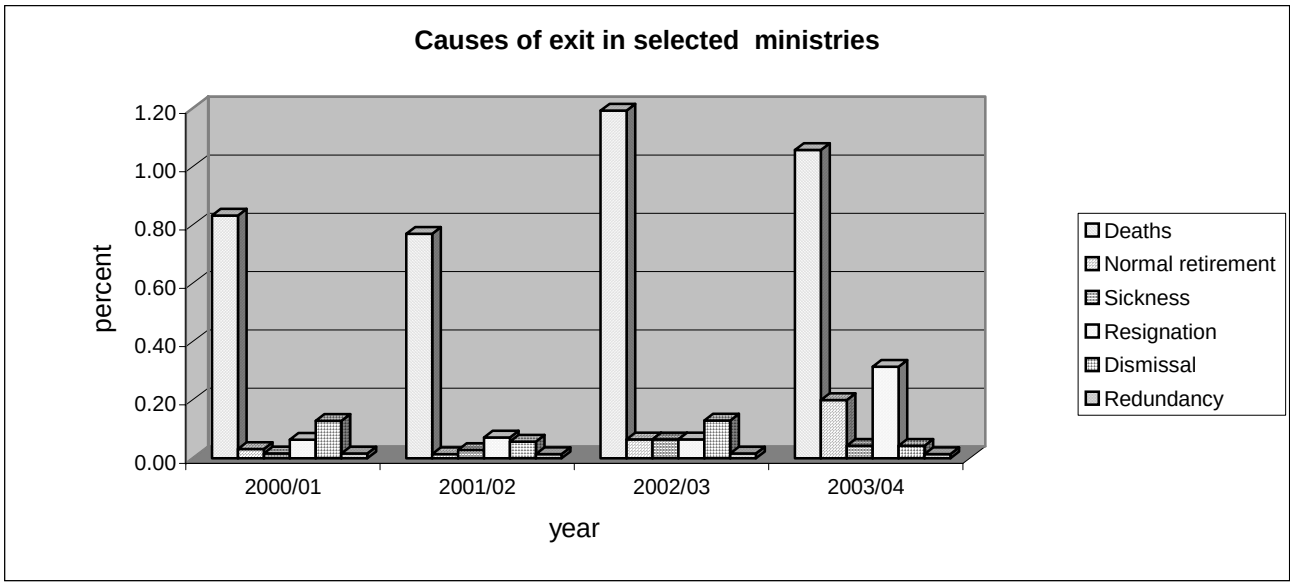

Figure 3.1: Profile of staff attrition by General causes of exit in selected MDAs.

Attrition due to causes other than deaths contributed, but insignificantly, especially during the period 2000/01 to 2002/03. Nevertheless, normal retirement started to feature as cause of exit in 2003/04. This cause can be explained by the fact that most of the public servants who benefited from the elevated retirement age (55-60) Act of 1998 started to exit in 2003/04. Analysis of the deaths by causes reveals HIV/AIDS or AIDS related complexes to be the main cause. This means therefore that the major cause of personnel attrition in MDAs is attributed to the HIV/AIDS catastrophe.

(b). Magnitude of the staff attrition due to general causes of exits of personnel in Councils

Generally in the Councils sub-sample attrition of the staff during the four years (2000/01- 2003/04) was predominantly due to deaths of generalised causes. In the sample of 10 Councils exits due to deaths was lowest at 1.2% of total labour force on average in 2000/01 and highest at 1.4% on average in 2001/02 (see Table 3.2, Figure 3.2). The deaths in relation to total attrition, accounted for more than 75% in the years 2000/01 to 2003/04.

Exits due to causes other than deaths contributed but minimally to the attrition levels. Of the other causes, redundancy featured highest especially in 2003/2004 perhaps due to the ongoing local government reforms.

Table 3.2: Staff Attrition By General Causes: Selected Councils

	2000/01 N=16153		2001/02 N=16790		2002/03 N=17321		2003/04 N=18336	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Deaths	195	1.207	231	1.376	211	1.218	244	1.331
Normal Retirement	2	0.012	1	0.006	12	0.069	16	0.087
Sickness	3	0.019	1	0.006	6	0.035	1	0.005
Resignation	21	0.130	29	0.173	43	0.248	23	0.125
Dismissal	13	0.080	15	0.089	10	0.058	10	0.055
Total attrition	234	1.448	277	1.65	282	1.628	294	1.603
Deaths to total attrition (%)		83.33		83.39		74.82		82.9

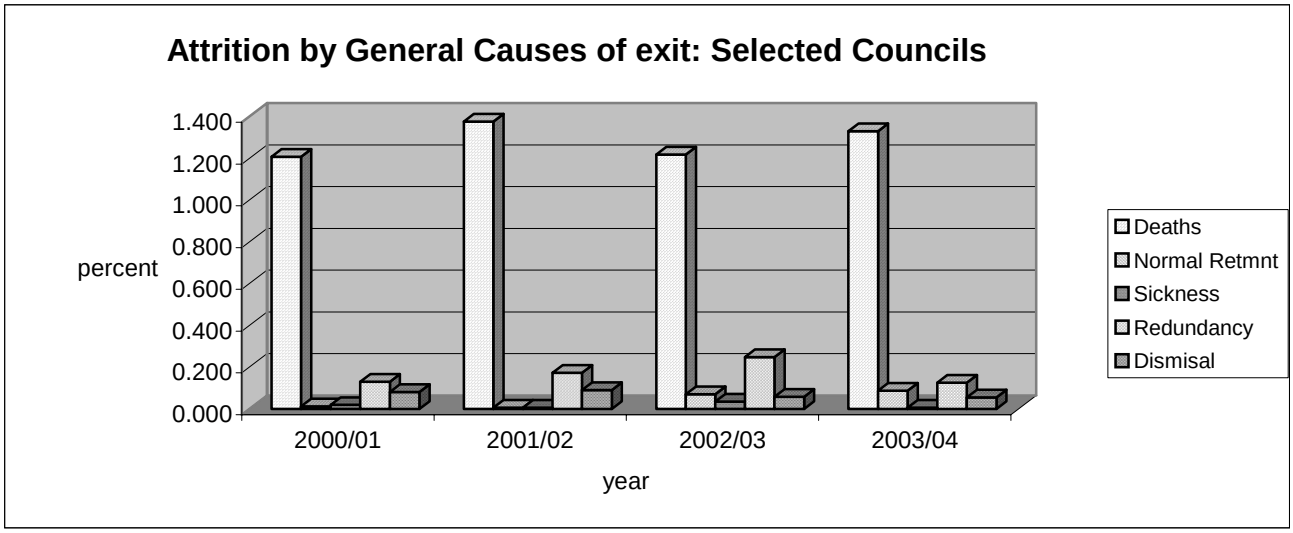

Figure 3.2: Graph of staff attrition by general causes of exit in Councils

The fact that over the four years the exits due to deaths remained more or less constant is an important indication that whatever interventions (if any) were in place in the period before 2000 in the Councils to contain the causes of death no effect was registered as yet. This logical observation is supported by a further analysis that looks into the causes of death among the reported deaths in the sample (see section 3.2.2.(b) below).

The mere magnitudes of exit due to deaths by all causes (1.2% -1.4%) can hardly be used to make conclusions since there has to be a benchmark against which to measure how serious a figure such as 1.2% or 1.4% is. It would make sense if government established a benchmark value above which an attrition level due to deaths can be said to call for priority concerns.

Further analysis of attrition resulting from HIV/AIDS deaths by age, gender, education level, profession, is more revealing in respect of the critical factors in human resource management, that may need to be taken on board in targeting intervention effort at workplaces workforce. These analyses are in sections 3.2.3 (b) on age; 3.2.4 (b) on gender and 3.2.5(b) on education level.

(c). Staff attrition due to general causes of exit in selected RAS.

It's generally observed that the RAS are organized into functional clusters rather than departments. The workforce in most of the sampled RAS ranges from 119 (DSM RAS) to 670 (Mbeya RAS).

Among the various causes of exit of staff in the RAS death stand out predominantly in all the years. Rate of attrition due to death increased steadily between 2000/01 and 2002/03 although there is a sign of reversal in the last year 2003/04. The deaths in relation to total attrition, accounted for more than 75% in the years 2000/01 to 2003/04.

Table 3.3: Attrition By General Causes in selected RAS

	2000/01 N=3047		2001/02 N=2708		2002/03 N=2721		2003/04 N=2534	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Death	14	0.46	17	0.63	30	1.1	23	0.91
Normal retirement			1	0.04			1	0.04
Sickness			1	0.04				
Resignation	4	0.13	2	0.07	2	0.07	4	0.16
Dismissal			1	0.04			2	0.08
Total attrition	18	0.59	22	0.82	32	1.17	30	1.19
Deaths to total attrition (%)		77.78		77.27		93.75		76.67

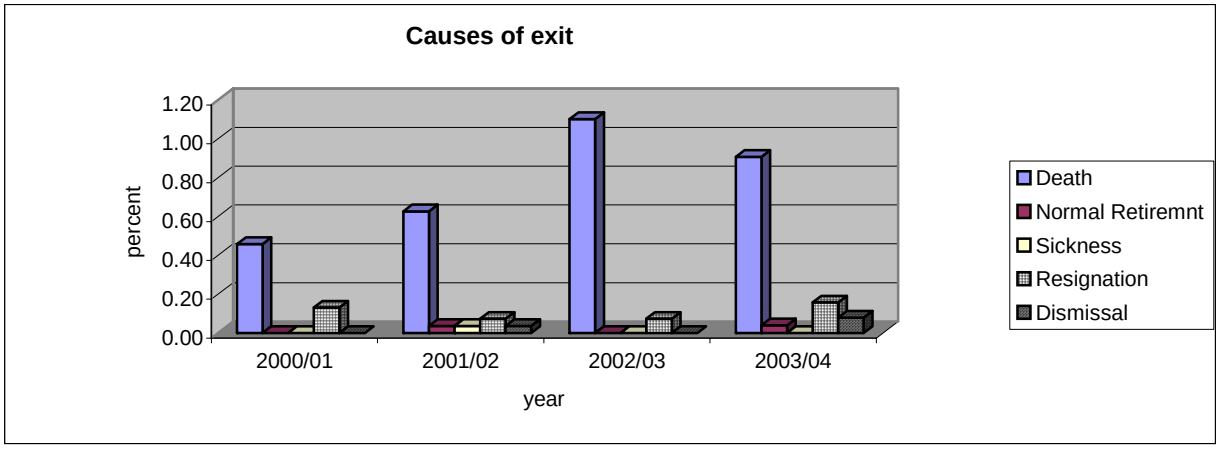

Figure 3.3: Profile of Attrition by General cause of staff exit inn RAS

The implications of deaths on service productivity in RAS, as is the case in MDAs and Councils, are obvious. The lost investment in human capital which is certainly difficult to replace, will disrupt the delivery of services. And taking care of those affected will certainly lead to diversion of resources from the core functions of the institution. Besides, the employment gap created increase stress on those who have to take

over the responsibilities of the exiting staff which impact upon the delivery of services. And finally the fear that is created leads to desperation that may affect the morale to work.

3.2.2: Attrition due to AIDS deaths and other cause of exit in MDAs, Councils and RAS

Where the reason of attrition was reported to be due to death researchers went further to establish the cause of death. In the case where the cause was not directly specified to be AIDS or ARC, a proxy technique was used to establish the cause by combining two or more sickness symptoms that characterised the illness before death. Common sicknesses that are related to HIV/AIDS are well known, and occurrence of several of them on a person is good indication of HIV/AIDS case.

Overall the deaths occurring attributable to AIDS are high. In the ministries the average attrition rate of AIDS deaths to total employees were in the range of 0.37% and 0.53%, in the Councils the range is 0.68% to 0.81%, and in the RAS the range is 0.15% to 0.55%. Again the rates for the Councils are much higher than those of the other sectors. AIDS related deaths appear to dominate. Moreover the deaths from AIDS have a growing trend in the four years. The possibility of erosion of the already accumulated experiences, skills and tacit knowledge among workforce is evident. This makes the three sectors vulnerable as it will lead to reduced productivity hence poor service delivery.

(a). Attrition due to AIDS in the selected Ministries.

Staff attrition due to HIV/AIDS deaths in the four years in the selected ministries was in the range of 0.37% and 0.53%, with a simple average of 0.43% of total employees. If we accept the rule of thumb that AIDS deaths occurring at a given year are due to HIV infection about 10 years earlier, the above findings mean two things: one, that in ministries HIV infection had made in-roads ten years ago and now the outcome is that AIDS deaths are depleting the workforce at a rate almost equal to that of all other causes. This should be a point of alarm. Second, that any intervention program (if any) that have been put in place have not shown recognizable effect, otherwise there would have been a noticeable decline in AIDS related deaths.

Table 3.4 and Figure 3.4 present the profile for attrition due to AIDS deaths and to other causes in ministries.

Table 3.4: Summary Attrition due to Causes of Deaths in Selected Ministries

	YEARS							
CAUSE OF DEATH	2000/01		2001/02		2002/03		2003/04	
	No.	%	No.	%	No.	%	No.	%
HIV/AIDS	23.00	0.37	37.00	0.53	26.00	0.42	28.00	0.40
Other causes	29.00	0.46	17.00	0.24	48.00	0.77	46.00	0.66

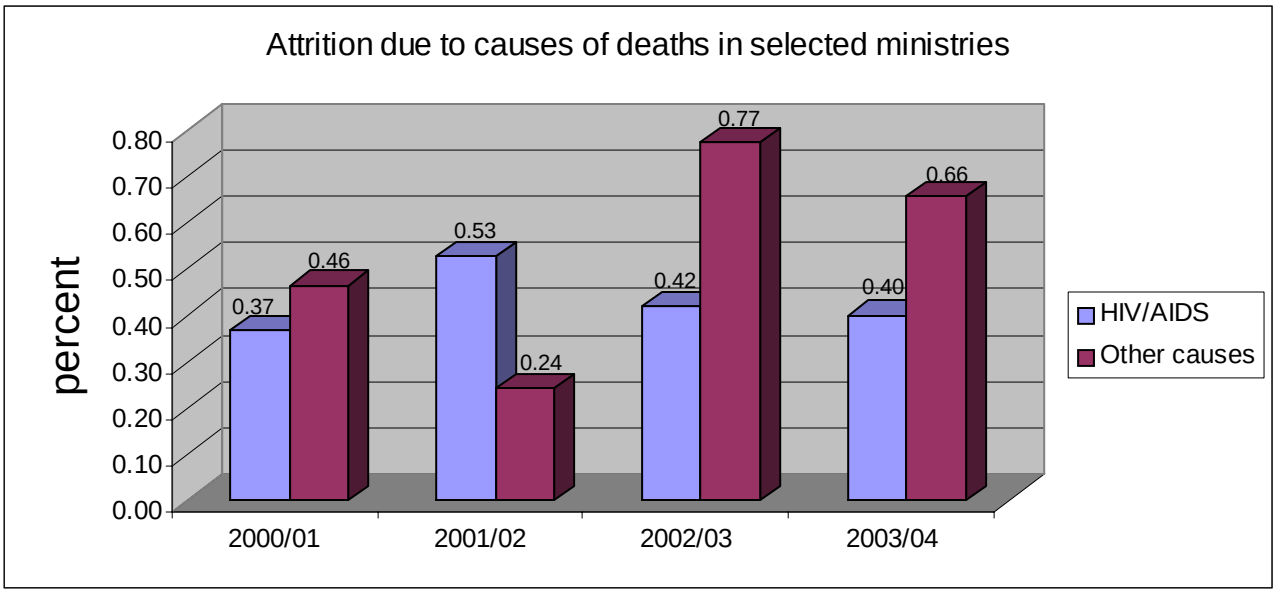

Figure 3.4: Profile of Attrition due to AIDS deaths and others Causes of Death in Ministries:

(b). Attrition due to aids deaths and other causes in the councils

In Councils, unlike in MDAs, attrition due to AIDS deaths, compared to other causes is even more alarming. In 2000/01 rate of attrition due to AIDS deaths were twice that due to other causes where as in the subsequent year there is no significant sign of decrease and yet the other causes also almost equally depleted the workforce.

Table 3.5 and Figure 3.5 present the profile of attrition due AIDS deaths differentiated from other miscellaneous causes in Councils.

Table 3.5: Attrition due to AIDS Deaths and Other causes: Selected Councils

	YEARS							
CAUSE OF DEATH	2000/01		2001/02		2002/03		2003/04	
	No.	%	No.	%	No.	%	No.	%
HIV/AIDS	132.00	0.8172	123.00	0.7326	117.00	0.68	131.00	0.71
Other causes	63.00	0.39	108.00	0.6432	94.00	0.54	113.00	0.62

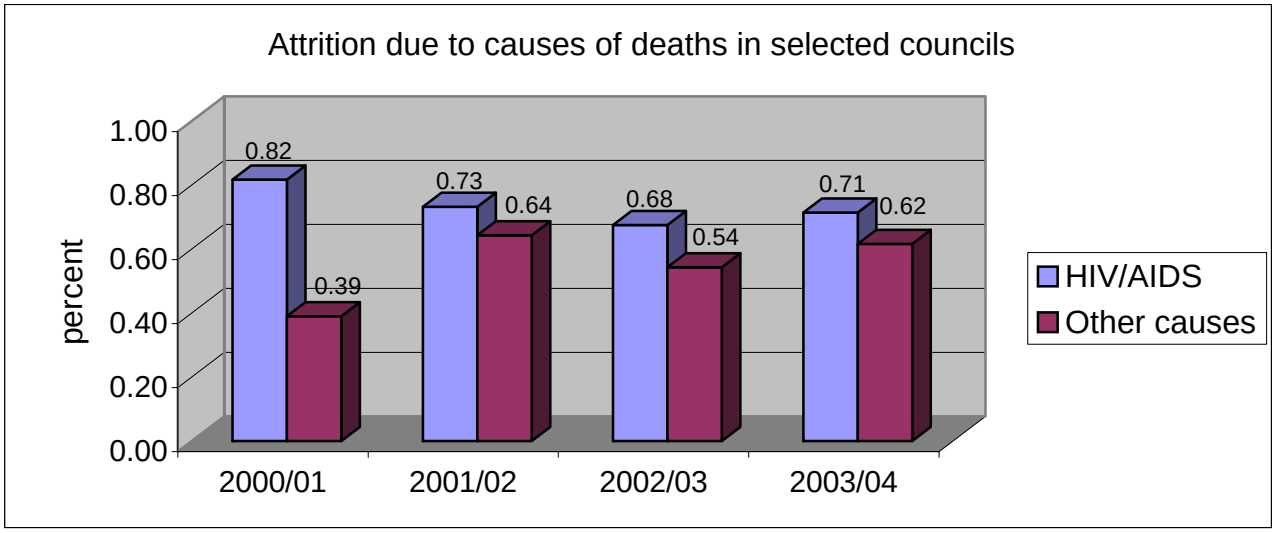

Figure 3.5: Profile of staff attrition due to AIDS deaths and Other Causes: selected Councils.

(c). Attrition due AIDS deaths and other causes in RAS

In RAS, the rate of attrition due to AIDS causes to total workforce remained low and constant in the first two years (2000 – 2002) at around 0.15% to 0.16%, but more than tripled in the following two years to reach a level of 0.55% in year 2003/04. Worth-noting is the fact that attrition due to other causes were double that due to HIV/AID in the first three years (2000- 2003), but declined to a lower level in the last year.

Table 3.6 and Figure 3.6 present the profile of attrition due AIDS deaths differentiated from other miscellaneous causes in RAS.

Table 3.6: Attrition due AIDS deaths and other causes in RAS:

	YEARS							
CAUSE OF DEATH	2000/01		2001/02		2002/03		2003/04	
	No.	%	No.	%	No.	%	No.	%
HIV/AIDS	5.00	0.16	4.00	0.15	9.00	0.33	14.00	0.55
Other causes	9.00	0.30	13.00	0.48	21.00	0.77	9.00	0.36

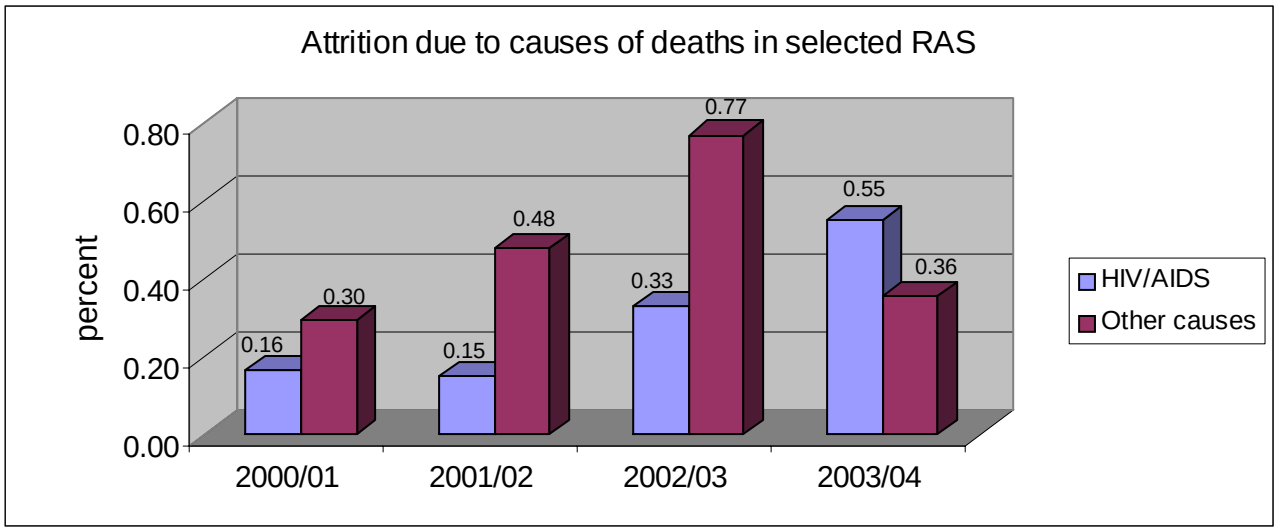

Figure 3.6: profile of Attrition due to AIDS deaths and other Causes: Selected RAS

3.2.3: Attrition due to AIDS deaths by age category in MDAs, Councils and RAS

In this section we present findings on staff attrition due to AIDS deaths by age as reported in the sampled ministries, councils and RAS. As explained earlier, deaths that were caused by HIV/AIDS were indicated as such or as ARC (AIDS Related Complex) otherwise they were established to be so by a method of proxies based on combining at least two symptoms known to be commonly associated with AIDS.

The findings show that those dying due to AIDS related factors were in age group 30 to 50 years. That most deaths occur in the ages 30 to 50 years in the workforce is not surprising given that the infection incubation period is about 10 years and contraction most probably occurred in the ages of 20-30 years (NACP Report no. 17, 2003).

(a). Attrition due to AIDS deaths by age category in the selected MDAs

Our findings reveal that a significant proportion of the ministries staff who exited service in 2000/01 to 2003/04 because of AIDS or AIDS Related Complex (ARC) is concentrated in the age group 30 to 50 years. (See Figure 3.7 and Table 3.7 for details). This finding is consistent with previous studies on the impact of HIV/AIDS in the Education sector. Also it is consistent with the reports of AIDS cases for the general population (see National AIDS Control Programme (NACP) report no. 17, 2003). The situation is alarming given that majority of personnel in the ministries is of average age of 43.3 years, (according to reports from POPSM). Coupled with an aging current workforce population in most MDAs as a result of freezing of recruitment that was enforced during the period 1992 to 2000.

Table 3.7: Summary Attrition due to AIDS Deaths by Age: Selected Ministries.

DEATHS	YEAR

AGE CATEGORY	2000/01 N=6250		2001/02 N=7011		2002/03 N=6203		2003/04 N=6999	
	No	%	No	%	No	%	No	%
20-30 years	1	0.02	1	0.01	0	0.00	4	0.06
31-40 years	11	0.18	11	0.16	10	0.16	11	0.16
41-50 years	7	0.11	17	0.24	10	0.16	6	0.09
51-60 years	2	0.03	6	0.09	2	0.03	1	0.01
>60 years	0	0.00	2	0.03	0	0.00	0	0.00
Not indicated	2	0.03	0	0.00	2	0.03	0	0.00

NB: Percentages are calculated from the total workforce of the indicated year in the sample MDAs

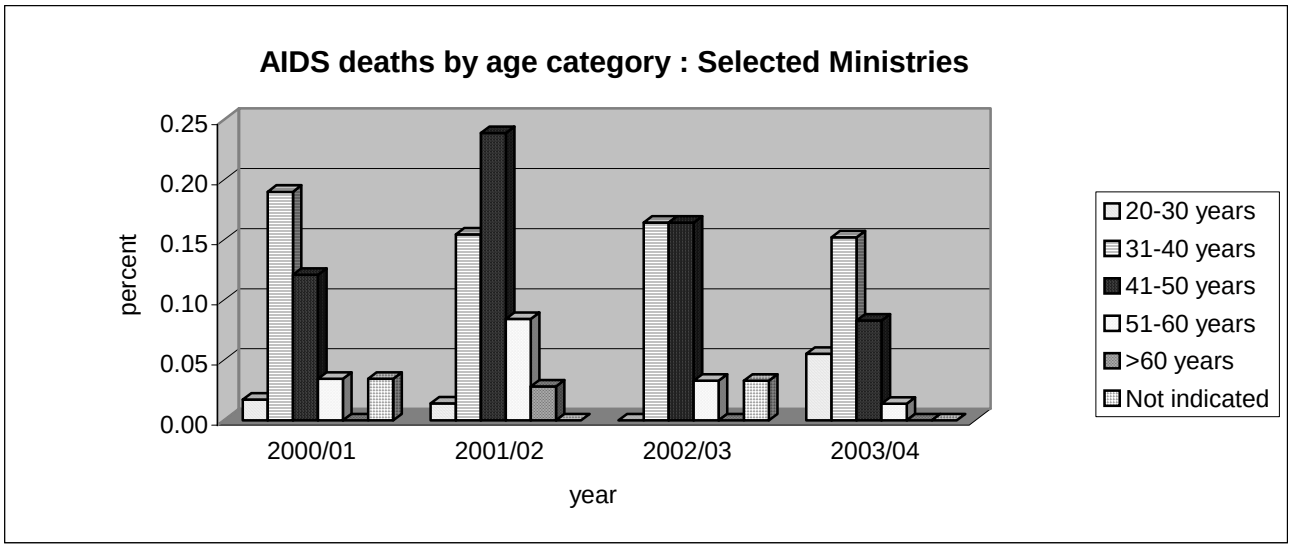

Figure 3.7: Profile of Staff exits due to AIDS in Ministries

Further detailed analysis of our findings in respect of employees attrition by age indicate that, with an exception of year 2001/2002 (where majority of the deaths were from the age group 41-50 years), most HIV/AIDS deaths in the sampled ministries occurred in the age group 31-40 years. This finding is consistent with the general population scenario as reported by NACP (Report no. 17 of 2003). Attrition rates in the age group 41-50years were also high. This situation is depriving the public service quality leadership considering that the age group 31-40 is most likely to take up leadership/senior positions in the immediate future. At the same time the age group 41-50 is where current leaders, skilled and experienced personnel are concentrated. This phenomenon increases the vulnerability of the public service in respect of human resource capacity considering the significant investment in terms of resources that have gone into developing this cadre. Vulnerability is also compounded by the loss of tacit knowledge that cannot be easily developed through the conventional training programmes. The main concern here is the erosion of human resource capacity that the ministries have achieved in many years.

(b). Attrition due to AIDS deaths by age category in the selected Councils

Usable data for analysis of deaths by age was obtained from eight sampled councils except for Kinondoni and Singida.

Like in the case of ministries, results of our analysis reveal that a significant proportion of the councils' staff who exited service in 2000/01 to 2003/04 because of AIDS or AIDS Related Complex (ARC) is concentrated in the age group 30 and 50 years. (See Figure 3.8 and Table 3.8 for details). Again this finding is consistent with previous studies on the impact of HIV/AIDS in the Education sector, which found out that about 80 percent of HIV/AIDS deaths among teachers in Tanzania were from the age bracket 31-50 (MoEC & IIEP-UNESCO, 2004). The situation is alarming given that majority of personnel in the public service fall in this age category. Given that the current workforce population is aging, and public service recruitment was frozen during the period 1992 to 2000, this situation makes the councils particularly vulnerable in addressing the effects of HIV/AIDS related attrition.

Further analysis of the findings indicate that, throughout the four years there were more deaths in the age group 41-50 years than in any other age bracket. The age group of 31-40 years is similarly affected though the rate is slightly lower. The effects for the councils are as argued under the MDAs.

Table 3.8: Attrition Due To Aids Deaths By Age Category: Selected Councils

DEATHS AGE CATEGORY	YEAR							
	2000/01 N=16153		2001/02 N=16790		2002/03 N=17321		2003/04 N=18336	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
20-30	4	0.025	8	0.048	5	0.029	8	0.044
31-40	53	0.328	41	0.244	38	0.219	48	0.262
41-50	63	0.39	78	0.465	61	0.352	64	0.349
51-60	11	0.068	15	0.089	21	0.121	18	0.098
>60	1	0.006	0	0	0	0	0	0
Not indicated	0	0	0	0	0	0	0	0

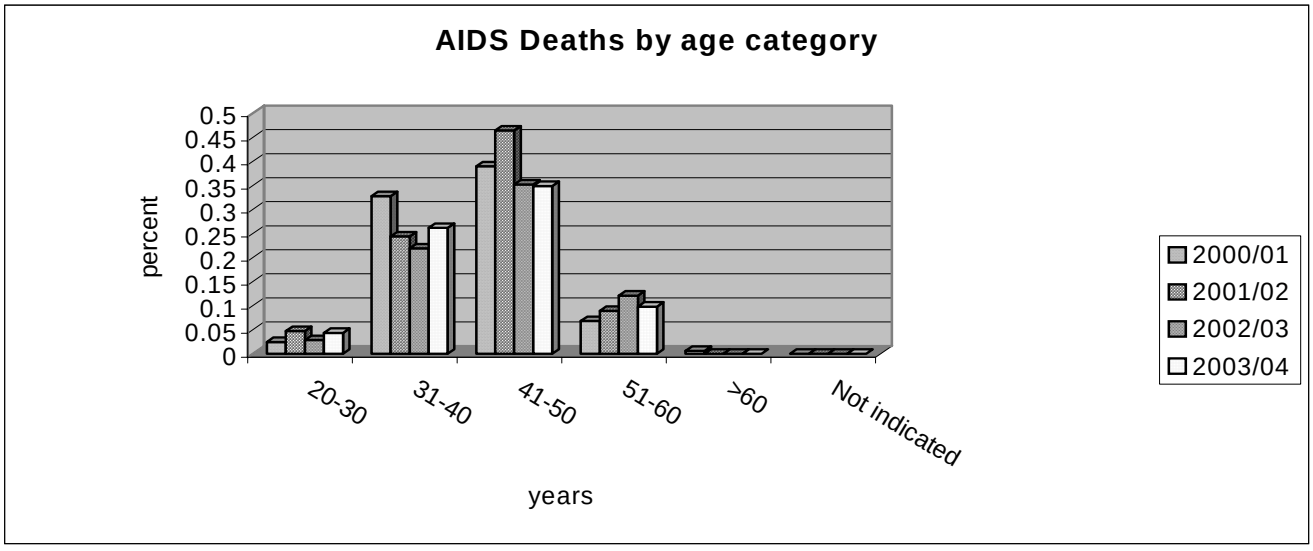

Figure 3.8: Attrition Due to AIDS Deaths by Age Category: Selected Councils

(c). Attrition due to AIDS deaths by age category in RAS

The reported deaths in the RAS sub-sample are generally fewer than in the Councils. But even here, where the reason of exit is death further probing was done to establish, to the extent possible, the cause of the death. In many RAS, available data on personnel deaths is silent (or incomplete) as to whether the cause was AIDS

or indicated as due to ARC (AIDS Related Complex). The same method of proxies was applied to establish the cause of death.

Table 3.9: Attrition Due To Aids Deaths By Age Category in RAS

DEATHS AGE CATEGORY	YEAR							
	2000/01 N=3047		2001/02 N=2708		2002/03 N=2721		2003/04 N=2534	
	No	%	No	%	No	%	NO	%
20-30 years	0	0.00	0	0.00	0	0.00	0	0.00
31-40 years	2	0.07	0	0.00	2	0.07	6	0.24
41-50 years	3	0.10	3	0.11	4	0.15	6	0.24
51-60 years	0	0.00	2	0.07	3	0.11	0	0.00
>60 years	0	0.00	0	0.00	0	0.00	0	0.00
Not indicated	0	0.00	0	0.00	0	0.00	0	0.00

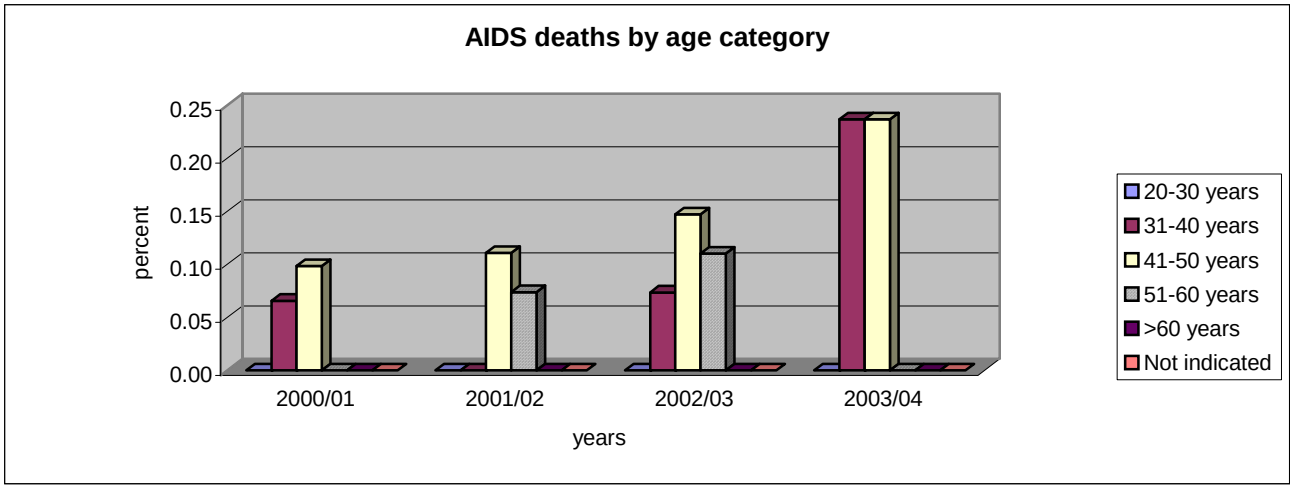

Figure 3.9: Attrition of staff due to AIDS deaths by Age Category in RAS.

On the other hand, the scantiness of the data in the RAS could mean two things. One, the staff information management system is in not traditionally maintained to provide such data, and second, because there are very few deaths due to AIDS. But again whatever the case, AIDS death preventions should be an important agenda in all public service units.

3.2.4: Attrition due to AIDS deaths by gender: selected MDAs, Councils and RAS

The incidence of AIDS deaths by gender differs among the three levels of government. In the MDAs and RAS the male gender has a higher death occurrence than female gender. In the councils more female staff died compared to males staff.[2] The findings in the individual sectors are presented below

[2] The interpretation of these findings should be taken with caution because the analysis done is not based on the proportion of deaths to total employees in the particular gender. The death by gender figures were analysed in relation to the total employment.

(a). Attrition due to AIDS deaths in the gender structures of workforce in Ministries

Analysis of the attrition showed that more AIDS deaths occurred among the male employees than among the female, except for the ministries of Education and Culture (MOEC). In view of the caution raised above (see footnote) about the limitation of the analysis, it is therefore dangerous to conclude at this stage that women employees were less affected than their male counterparts. The finding could be a result of gender imbalances in the workforce to the disadvantage of the female subgroup in these ministries.

Table 3.10: Staff Attrition due to AIDS deaths by gender: Selected Ministries.

MINISTRIES		YEAR							
		2000/01 N=6250		2001/02 N=7011		2002/03 N=6203		2003/04 N=6999	
		M	F	M	F	M	F	M	F
MOH*	No	0	0	0	0	3	0	0	0
	%	0.00	0.00	0.00	0.00	0.11	0.00	0.00	0.00
MEOC	No	4	7	14	6	9	5	11	7
	%	0.24	0.41	0.66	0.28	0.82	0.45	0.64	0.41
MEM*	No	0	0	0	0	0	2	4	0
	%	0.00	0.00	0.00	0.00	0.00	0.34	0.70	0.00
MOF	No	1	2	2	1	1	0	0	0
	%	0.24	0.49	0.55	0.27	0.30	0.00	0.00	0.00
MCDGC	No	3	1	5	3	3	0	1	0
	%	0.24	0.08	0.43	0.26	0.24	0.00	0.08	0.00
POPSM	No	0	0	1	0	1	0	0	0
	%	0.00	0.00	0.43	0.00	0.39	0.00	0.00	0.00

* NB For these ministries data was incomplete in the senses that they did not avail the causes that underlay the deaths they reported.

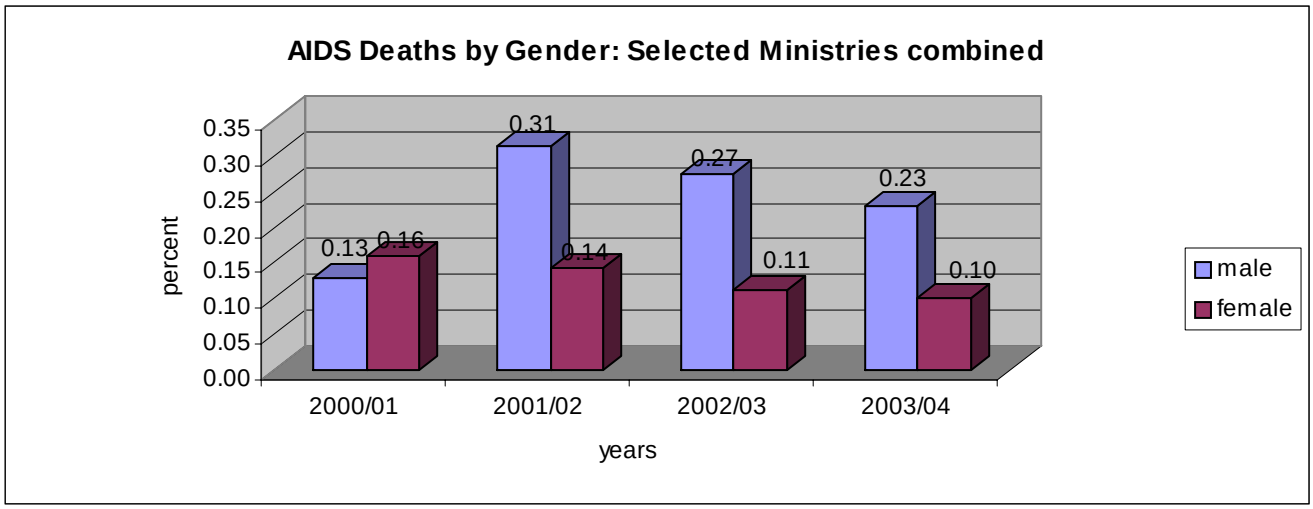

Figure 3.10: Profile of staff attrition due to AIDS deaths by Gender: selected MDAs

Gender imbalance in public service employment notwithstanding, the results point to the possibility of erosion of the already accumulated experiences, skills and tacit knowledge among the dominant male gender in the public service workforce. Accepting this situation, the effects of vulnerability discussed elsewhere equally apply.

Detailed ministries' profiles of staff exit due to death by gender (sex) structures are presented in Annex.1.

(b). Attrition due to AIDS deaths by gender in the selected Councils

Results of our analysis in Councils reveal that except for year 2002/3, more AIDS and AIDS related deaths occurred among the female gender than their male counterparts The female average rate of exit due to AIDS death was highest at 0.45% in 2000/01 but declined to 0.29% in 2002/03. (Row 1; Table 3.11). Further analysis shows that the attrition rate of the female workforce was highest in Morogoro municipal Council with rate 0.66% and 0.63% in 2000/01 and 20003/04 respectively followed by Songea (0.53% in 2002/03) and Mbinga (0.5% in 2000/01).

Table 3.11: Attrition due to Aids Deaths by Gender: Selected Councils

		YEAR							
CAUSE OF DEATH		**2000/01 N=16153**		**2001/02 N=16790**		**2002/03 N=17321**		**2003/04 N=18336**	
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
HIV/AIDS	**No.**	52	80	51	72	61	56	55	76
	%	0.3	0.5	0.3	0.4	0.4	0.3	0.3	0.4
Other causes	**No.**	31	46	51	67	39	70	50	49
	%	0.2	0.3	0.3	0.4	0.2	0.4	0.3	0.3
Not indicated	**No.**	6	19	10	20	20	23	101	81
	%	0	0.1	0.1	0.1	0.1	0.1	0.6	0.4

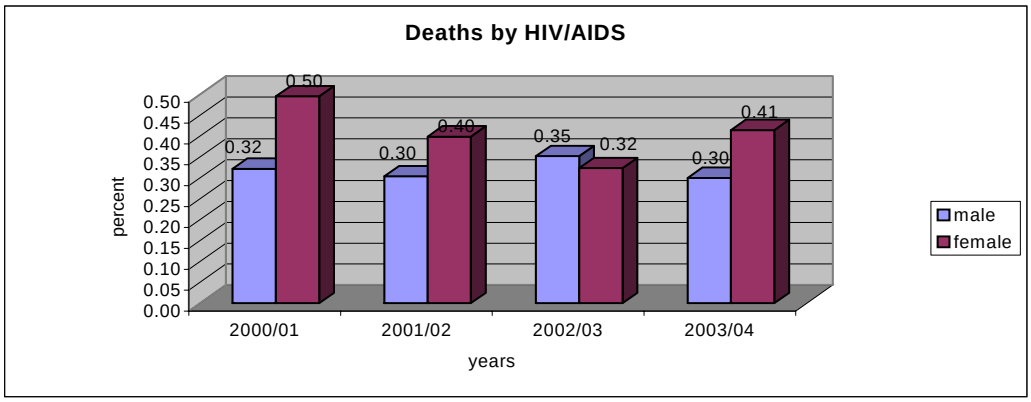

Figure 3.11: Rate of staff exit due to AIDS deaths by Gender: selected Councils

The rate of exit among the male subgroup remained more or less unchanged. As alluded to earlier, it may be dangerous to make conclusions at this stage given that this analysis is not based on the proportion of deaths to total employees in the particular gender.
Whatever the explanation, this is an area of concern for policy and strategic intervention. Mainstreaming gender in HIV/AIDS interventions should be a matter of priority in the Councils. For instance, is condom distribution as a preventive measure targeting both male and females at work places? Are both male and female personnel assured of un-interrupted supply of both male and female condoms?

Councils' profiles of AIDS deaths by gender are presented in Annex.2.

(c). Attrition due to AIDS deaths by gender in RAS

The magnitude of staff exits caused by AIDS deaths is on the increase in both female and male set-ups in RAS. For the female sub-group the RAS' average rate of exit due to AIDS death is reported as 0.03% of total workforce in 2000/01 rising sharply to the highest of 0.19% in 20003/04. The more interesting feature in the gender-segregated attrition in RAS is that the male exit rate is higher and somehow parallel to that of female. With a record of 0.13% in 2000/01 to 0.36% in 20003/04 this trend presents a challenging scenario where the female workforce generally are considered to be more affected. Table 3.12 and the attached Figure 3.12 present a summary of these trends.

Table 3.12: Attrition due to Aids Deaths by Gender in RAS

		YEAR							
Cause of Death		**2000/01 N=3047**		**2001/02 N=2708**		**2002/03 N=2721**		**2003/04 N=2534**	
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
AIDS	**No**	4	1	3	1	5	4	9	5
	%	0.13	0.03	0.11	0.037	0.184	0.147	0.355	0.197
Other Causes	**NO**	3	7	8	5	14	9	3	12
	%	0.1	0.23	0.3	0.185	0.515	0.331	0.118	0.474
Not indicated	**No**	1	0	1	2	2	1	2	0
	%	0.03	0	0.04	0.074	0.074	0.037	0.079	0

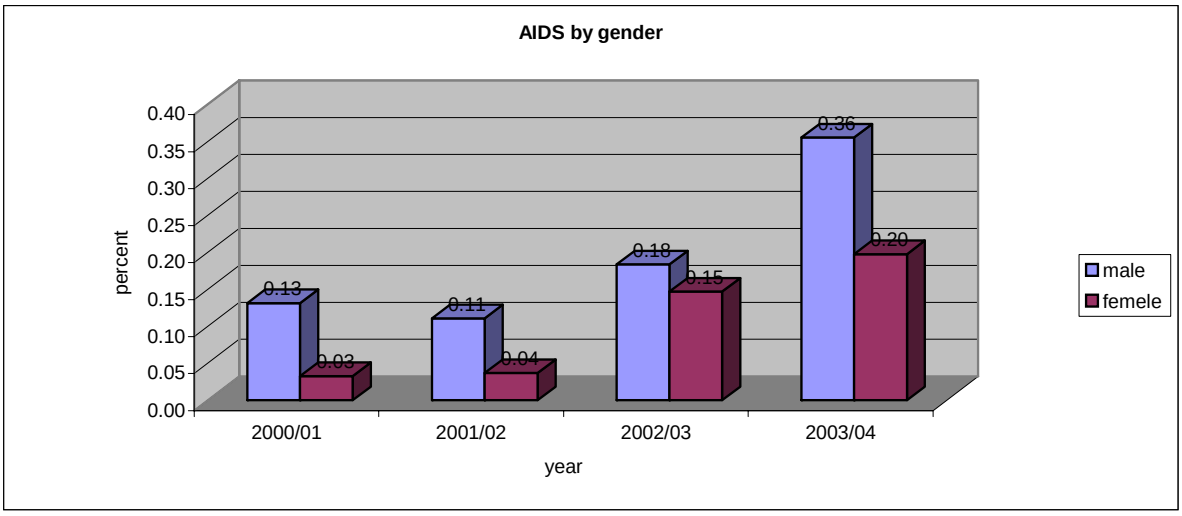

Figure 3.12: Profile of AIDS deaths by Gender in selected RAS.

The uphill trend in attrition rates due AIDS deaths in RAS raise a danger flag. One is tempted to ask: "Are there any serious interventions for the fight against HIV/AIDS in the RAS?" This question gets partly answered in a latter section of this report. But even if they exist "how effective are they?"
RAS risk loosing the workforce on account of HIV/AIDS if serious efforts to fight epidemic are not made

3.2.5: Attrition due to AIDS deaths by level of education in MDAs, Councils and RAS

Level of education in workforce is an important factor in human resource planning and development. Education level structure in workforce partly determines the maturity and performance capability of any organization to carry out the core functions for which it was established. When the organisation suffers losses of its educated personnel due to HIV/AIDS deaths its capacity to perform is reduced and quality of service is water down.

Therefore, education as an attribute of workforce performance is equally important in studying staff attrition since it provides knowledge as to which of the various education level set-ups in the workforce is most affected by the HIV/AIDS catastrophe.

The findings show that staff attrition due to AIDS deaths in the ministries is concentrated among those with ordinary diploma level education. In the Councils, highest attrition rates due to AIDS deaths (0.30% - 0.43% of total workforce) are observed in the workforce with standard 5-8 levels of education. In the RAS, workforce with level of education of standard 5-8 were more affected than the rest.

(a). Staff attrition due to reported AIDS deaths by level of education in the ministries:

Table 3.13: Profile of AIDS deaths by level of Education in the Ministries

Education level	Year							
	2000/01 N=6250		2001/02 N=7011		2002/03 N=6203		2003/04 N=6999	
	No	%	No	%	No	%	No	%
Standard 1-4	0	0.00	1	0.01	0	0.00	0	0.00
Standard 5-8	5	0.08	8	0.11	9	0.15	2	0.03
Form 1-4	0	0.00	7	0.10	0	0.00	2	0.03
Form 5-6	8	0.13	3	0.04	13	0.21	2	0.03

Form 4+certificate	0	0.00	1	0.01	0	0.00	0	0.00
Form 6+certificate	1	0.02	3	0.04	0	0.00	0	0.00
Ordinary diploma	22	0.35	30	0.43	33	0.53	42	0.60
Advanced diploma	2	0.03	0	0.00	0	0.00	4	0.06
Bachelors degree	0	0.00	0	0.00	3	0.05	10	0.14
Post graduate diploma	1	0.02	0	0.00	0	0.00	0	0.00
Masters degree	0	0.00	2	0.03	1	0.02	2	0.03
Doctorate	0	0.00	1	0.01	2	0.03	0	0.00
Unknown level	0	0.00	2	0.03	0	0.00	1	0.01

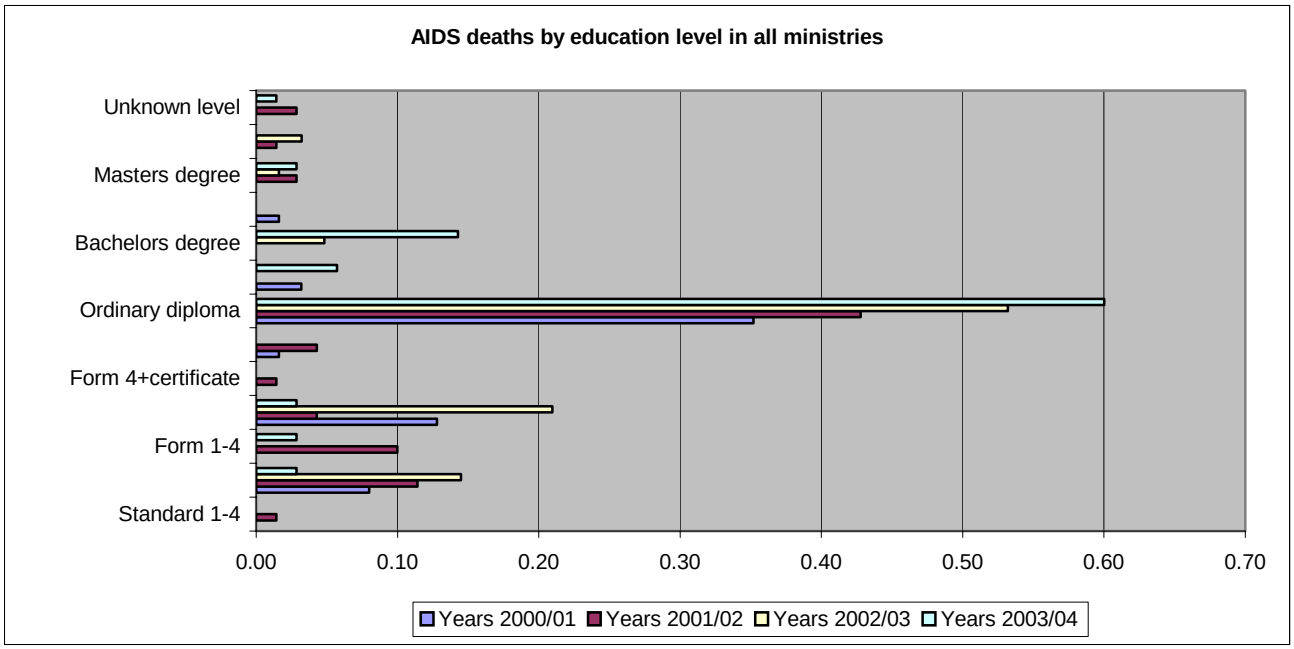

Figure 3.13: Profile of AIDS deaths by level of Education in the Ministries.

Viewed together with the profile of attrition due to AIDS deaths by age category (Table 3.13, Figure 3.13), the profile above shows that the majority of the personnel in the ministries are diploma certificate holders and form four plus certificate holders. (See also POPSM Paper). Very few are direct employees after completing 6 and few (6%) have advanced diploma and first degree.

Over the four years (2000/01 – 2003/04) staff attrition due to AIDS deaths has been rising among those with ordinary diploma level education. Again as in the case of gender analysis above, this is because the majority of the workforce in the ministries is a diploma holder. Due to limited data proportion of deaths to total labour force in the particular education category could not be worked out. Such a proportion could be more revealing than basing our conclusion on absolute numbers. Effective monitoring of the impact of HIV/AIDS would require maintenance of such important indicator.

For the staff with other levels of education the attrition trends are fluctuating over the four years (see for the example the trends for the staff with form 6 level of education).

(b). Attrition due to AIDS deaths by level of education in selected Councils

Most of the council workforce is populated by personnel with standard 5-8 education (especially the health sector and support staff in administration), and with form 4 and form 4 plus certificate education levels (especially in the education sector). Hardly any of the personnel have education less that standard 4 and very few have education more that form 6. Over the four year period (2000/01 – 2003/4) highest attrition rates

due to AIDS deaths (0.30% - 0.43% of total workforce) are observed in the LGAs work force sub-group with standard 5-8 levels of education followed by the subgroup with form 1-4 level of education and next by those with form 4 plus certificate training.

Given the educational composition of the workforce in Councils, the above rate of attrition due to AIDS deaths provides direction to which effort should be focused in confronting HIV/AIDS within the Council set-ups.

Table 3.14 and Figure 3.14 presents the staff attrition due to AIDS deaths by education structures in Councils.

Table 3.14: Attrition due to AIDS Deaths by Level of Education: Selected Councils

	2000/01/ N=16153		2001/02 N=16790		2002/03 N=17321		2003/04 N=18336	
	n	%	n	%	n	%	n	%
Unknown	0	0.00	5	0.03	1	0.01	0	0.00
Standard 1-4	2	0.01	4	0.02	3	0.02	2	0.01
Standard 5-8	68	0.42	62	0.37	53	0.31	57	0.31
Form 1 -4	31	0.19	32	0.19	24	0.14	28	0.15
Form 5-6	1	0.01	1	0.01	0	0.00	2	0.01
Form 4+certificate	19	0.12	17	0.10	26	0.15	25	0.14
Form 6 +certificate	3	0.02	1	0.01	1	0.01	1	0.01
Ordinary diploma	6	0.04	3	0.02	6	0.03	5	0.03
Advanced diploma	0	0.00	0	0.00	0	0.00	3	0.02
Bachelors degree	0	0.00	0	0.00	2	0.01	0	0.00

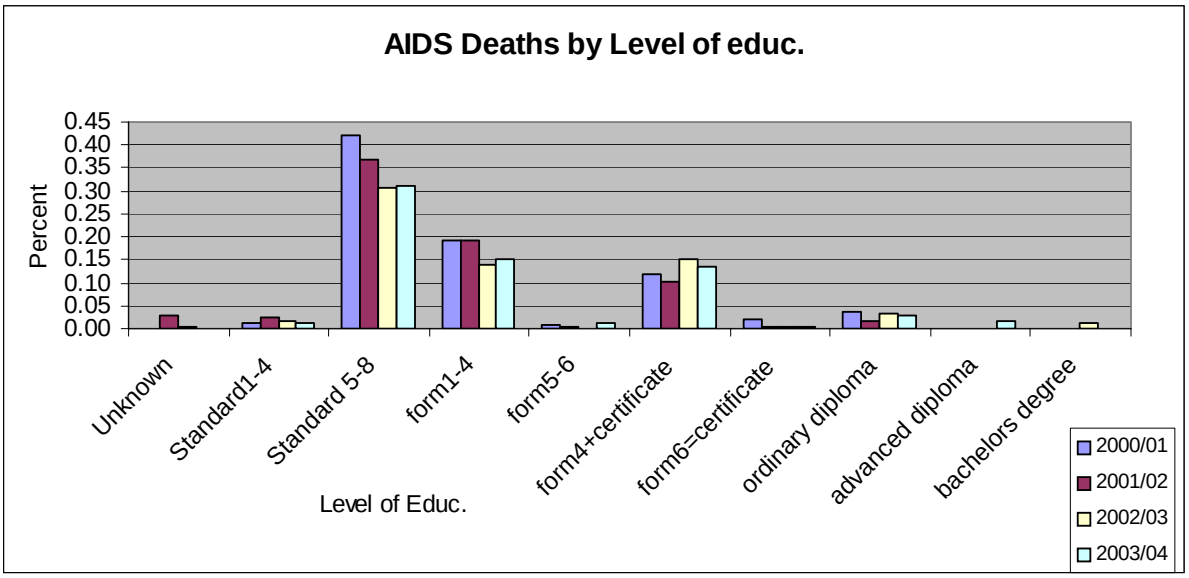

Figure 3.14: Attrition Due to AIDS Deaths by Level of Education: Selected Councils

(c). Attrition due to AIDS deaths by education in RAS

Education level structures in workforce in RAS have not been exception in the wave of impact of HIV/AIDS. RAS suffer losses of educated personnel due to death and this is a threat to their service performance and existence. Although the majority of exits in RAS are those with standard 5-8 education, also there are exits

due to personnel with Masters level of education. Loss of Masters level personnel, even though few, leave the organisation at a more serious vulnerable situation, than where the loss were lower level education employees. Needless to mention, the RAS staff work as advisors to the councils and therefore the death of an expert undermines that role or function.

Table 3.15: Attrition due to aids deaths by education in RAS

	2000/01 N=3047		2001/02 N=2708		2002/03 N=2721		2003/04 N=2534	
	No.	%	No.	%	No.	%	No.	%
Not indicated								
Standard 1-4								
Standard 5-8	1	0.03	1	0.04	3	0.11	7	0.28
Form1-4					1	0.04		
Form5-6							1	0.04
Form4+Certificate							1	0.04
Form6=Certificate	2	0.07	1	0.04				
Ordinary Diploma	1	0.03			1	0.04	1	0.04
Advanced Diploma	1	0.03			2	0.07	1	0.04
Bachelors Degree			1	0.04			1	0.04
Post Grad. Diploma							1	0.04
Masters Degree			1	0.04			2	0.08
Doctorate								
Other Qualification								

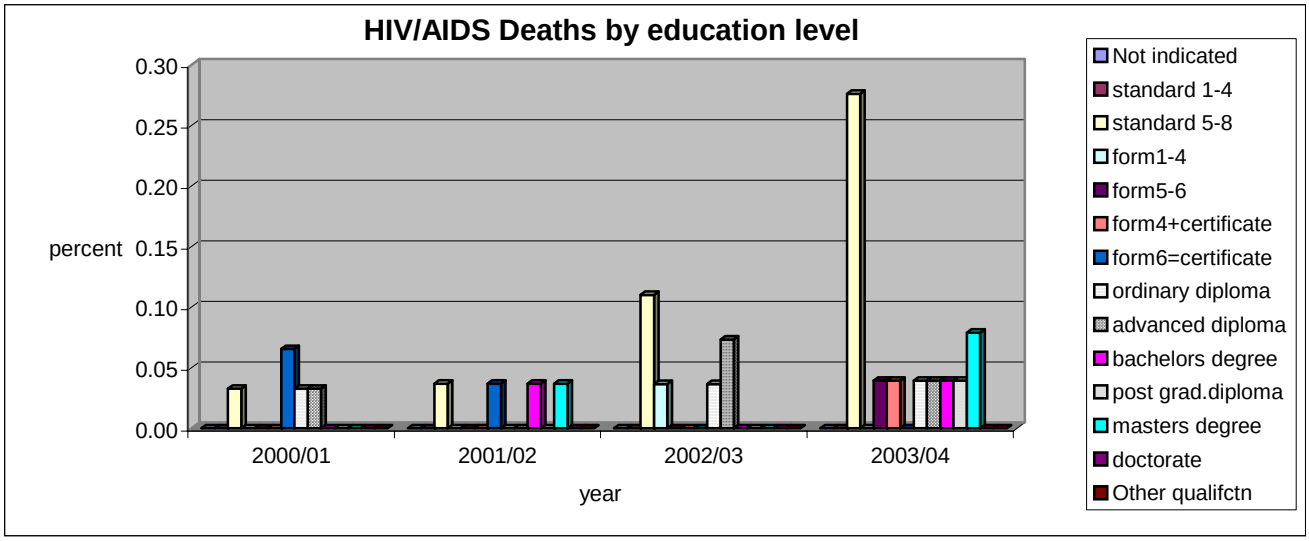

Figure 3.15: Profile of Staff Attrition due to AIDS Deaths by Level of Education in RAS

The sub-section of the RAS workforce with level of education of standard 5-8 exited service is larger number than in all other subgroups. Personnel of this level of education could be concentrated in the districts and division level of RAS functions. But also if this category of workforce is not protected there is danger of RAS services at those levels becoming hopeless.

3.2.6: Attrition due to AIDS deaths by profession in MDAs and Councils

Attrition due to AIDS deaths have been analysed by profession in the two levels of public service, namely MDAs and Councils. In the councils the analysis is focused on the administration staff which include sectors other than education, health, agriculture and livestock.
Our general findings indicate that in the MDAs there were more professional staff exits due to AIDS deaths over the four years compared to the support staff, most likely because the workforce structure in the MDAs is composed of more professionals than support staff. In absolute terms[3] in the sample of eight MDAs the total AIDS deaths over the four years were 119 professionals and 18 support staff.

However, in the councils there are more exits due to AIDS deaths in the support staff category than the profession cadre in the administration. Again mostly likely because the latter cadre is thinner than the support staff cadre. In absolute terms, in the sample of ten councils, the total AIDS deaths in the administration over the four years was 14 for the professionals and 34 support staff. It should also be pointed out that the death of a professional, for example a legal officer or an economist or accountant, could leave the council without an expert of that type for a long time because in most cases they are not employed in multiple numbers. The impact is that the roles that the expert played are suspended until a replacement is found.

The details are attached as annex 5.

3.2.7: Other Profiles of attritions in MDAs, Councils and RAS

TB has been identified to be an opportunistic disease highly associated with occurrences of HIV/AIDS cases. Because it is dangerously airborne, its presence in workplaces poses a high risk to affecting the health of the personnel working around the infected. It is in this connection that the researchers felt it important to profile the staff attrition rates in where the reason exit was reported to be TB caused death among other causes. This would allow establishing the imposing risk of TB as a second epidemic at workforces. In view of the latter, the health practice of routine medical check-ups should be intensified. Secondly, there is need to establish the root cause of the increasing TB cases.

(a). Attrition due to TB cases in reported deaths in selected ministries

TB as cause of death among the reported deaths as reason of exit is minimal in comparison to other causes. However, because of the contiguous nature of TB it should not be allowed to exist in the workforce. It reduces productivity, as TB victims have to be assigned less workload or excuse duties for long periods. When it is a complex of TB and HIV/AIDS, normally TB recurs, meaning the PLHIV who is also TB enters chronic syndromes of ill health thus interfering with performance.

Table 3.16 and Figure 3.16 presents the profile TB cases among the reported exits due to deaths in the sample ministries.

Table 3.16: Attrition due TB deaths in Reported Deaths: Selected Ministries

DEATHS	YEAR							
CAUSES	2000/01 N=6250		2001/02 N=7011		2002/03 N=6203		2003/04 N=6999	
	No	%	No	%	No	%	No	%
TB	6	0.10	12	0.17	5	0.08	13	0.19
Other causes	56	0.90	59	0.84	81	1.31	86	1.23

[3] Since we don't have the total workforce figures by profession, it is not possible to compute rates of exits by profession.

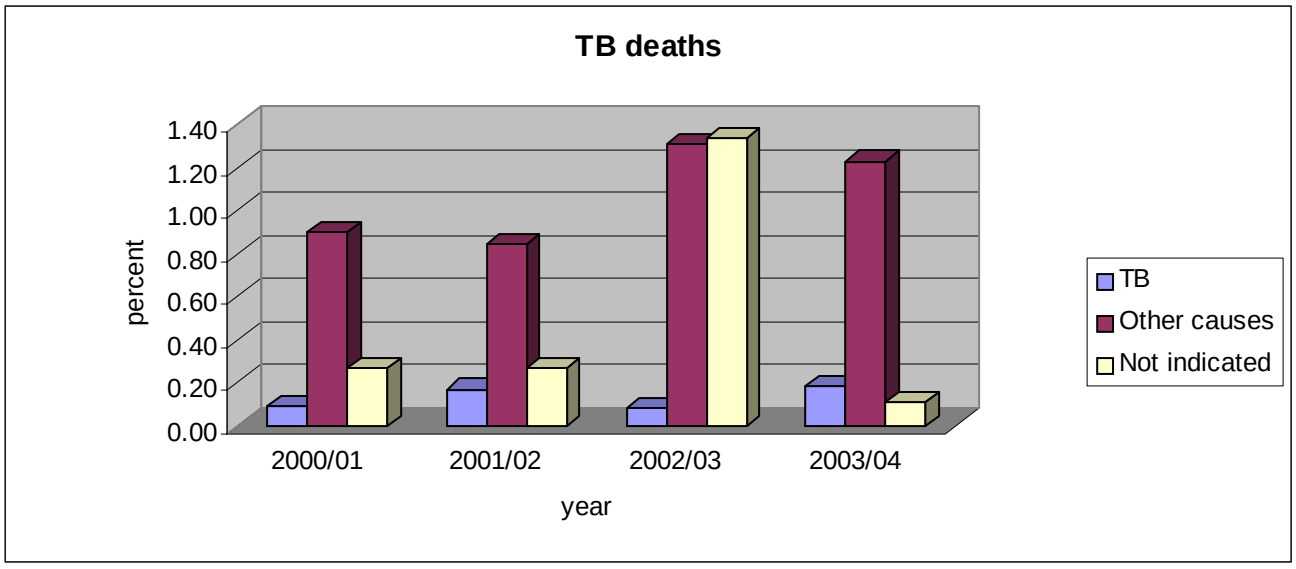

Figure 3.16: Profile of TB cases in Reported Deaths in Ministries

(b) Attrition due to TB cases in AIDS deaths in selected Councils

TB as cause of death among the reported death as reason of exit is slightly higher in Councils than in ministries. As argued for the ministries the contiguous nature of TB puts Council workers at higher risk of a second epidemic.

Table 3.17 and Figure 3.17 present the data on attrition due to TB in deaths.

Table 3.17: Attrition Due to TB in Deaths: Selected Councils

DEATHS CAUSES	YEAR							
	2000/01 N=16153		2001/02 N=16790		2002/03 N=17321		2003/04 N=18336	
	No	%	No	%	No	%	No	%
TB	39	0.24	39	0.23	33	0.19	30	0.16
Other causes	159	0.98	195	1.16	189	1.09	217	1.18
Not indicated	31	0.19	44	0.26	60	0.35	182	0.99

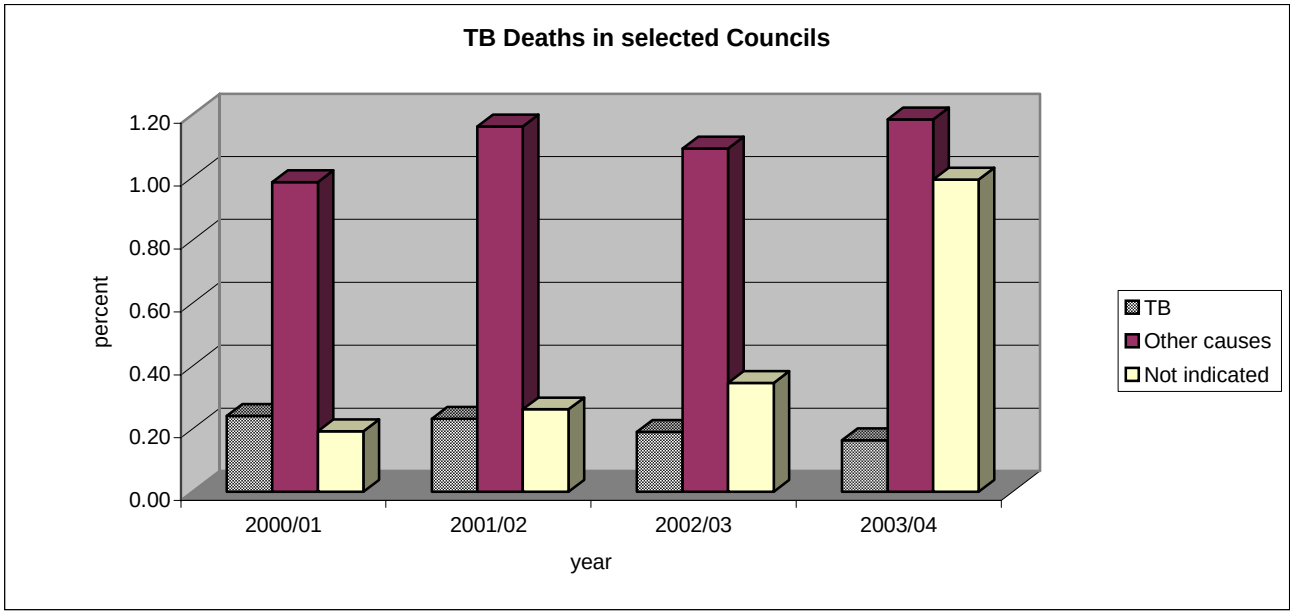

Figure 3.17: Profile of TB Cases in Reported Deaths in Councils

3.3 ATTRITION DUE TO AIDS DEATHS BY SECTOR/DEPARTMENT

This analysis is done to establish the magnitude of AIDS related deaths by functional sectors. The focus has been on the Councils where the separation or marking of sectors is clear, i.e. education, health, agriculture and livestock, and administration etc. it is in these sectors where professionals are concentrated. Nonetheless, within the Councils, there are sectors with rare professionals that really are not big enough – size-wise, to warrant separate study. In carrying out the data collection and the analysis, such sectors were grouped together under 'administration.' Therefore 'administration' encompasses all functional units that are not in the mainstream sectors of Education, Health or Agriculture and Livestock development. Except for the Agriculture and livestock clusters the administration is small compared to the other sectors.

Consistent with other findings, our findings reveal higher AIDS and AIDS related attrition among schoolteachers than any other group. Records from the Teacher Education Commission in the year 2001/2002 showed that there were 1,096 deaths of teachers, with 517 deaths for the first half of year 2002/2003. Of the 1096 deaths of teachers reported in 2001/2002, more than two fifths (42%) are estimated to have died of HIV/AIDS related diseases, tuberculosis, long term fever, cancers, etc. This has a major implication of disrupting schooling, especially given that those teachers cannot be replaced speedily. Also given that many of the deaths occur in the age group 31-50, makes the Councils vulnerable to loosing highly experienced teachers. The 42% loss and just in one sector is a serious form of brain drain.

Table 3.18: Attrition Due To AIDS Deaths By Sector: Selected Councils

	YEAR											
SECTOR	2000/01			2001/02			2002/03			2003/04		
	No.	WF	(%)	No.	WF	(%)	No.	WF	(%)	No.	WF	(%)

Health	18	2096	0.86	24	2307	1.04	22	2466	0.89	30	2729	1.10
Education	90	10031	0.90	76	10082	0.75	69	10492	0.66	71	11447	0.62
Ag & livestock dev.	8	490	1.63	2	510	0.39	6	459	1.31	3	481	0.62
Administration	13	1014	1.28	18	1009	1.78	14	1014	1.38	14	15731	1.30

1.WF= Workforce
2.Percentages are based on the actual workforce of the year indicated in the sector in all Councils

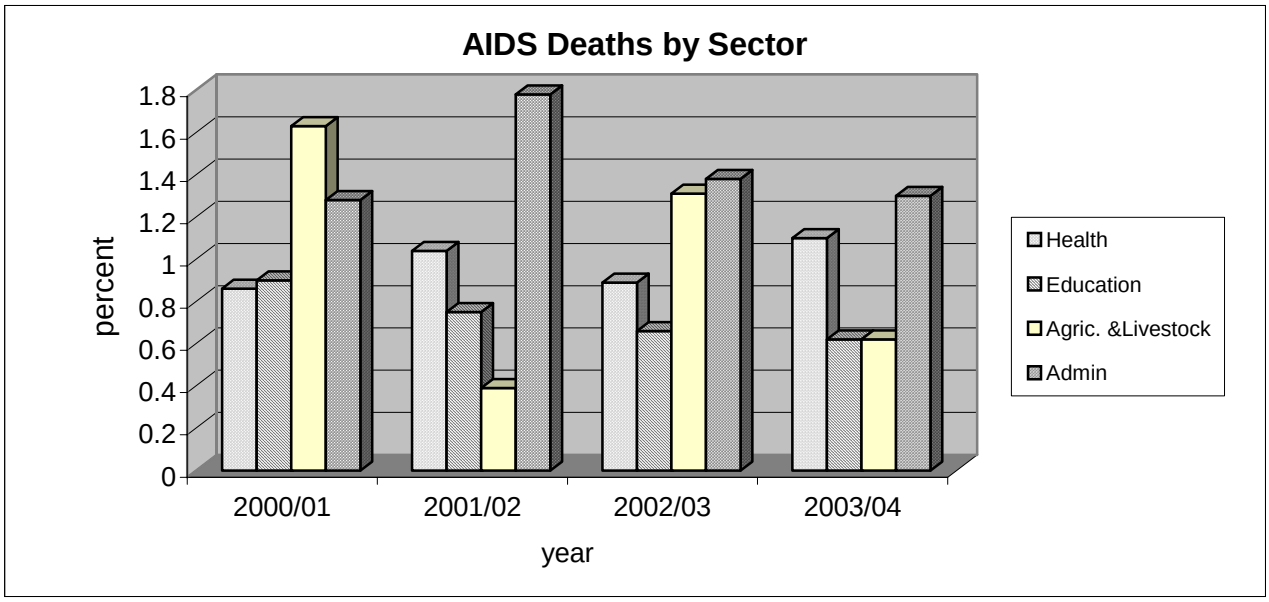

Figure 3.18: Attrition due AIDS deaths by Sectors/departments in Councils;

Similar to findings of other studies, results of our study indicated that although deaths due to HIV/AIDS or to AIDS related complexes (ARC) occurred in all sectors, there were more deaths in the education sector than in others. (See also the Malawi study). The agriculture sector recorded the lowest number of deaths. This difference, however, is expected given the large numbers of teachers in the councils compared to other sectors.
Basing on percentages, the administration ranks highest in the rate of exits due to the HIV/AIDS deaths over the three years – 2001/02 to 2003/04; (at low of 1.20% in 2003/04 and highest of 1.78% of total workforce in 2001/02). The education sector, though showing a declining attrition rates due to AIDS deaths (0.9% in 2000/01 to 0.6% in 2003/04) the fact that the teachers' workforce is a large group in Councils is a cause for priority and targeting in both HIV/AIDS interventions and human resource planning.

3.4. TOTAL ATTRITION PERSPECTIVE

The preceding analysis on attrition in sections 3.2 to 3.3 is based on sampled MDAs Councils and RAS. A broader picture can be inferred by applying the various levels of attrition rates on the total workforce in the three levels of public sector.

Table 3.19 below summarises the inferred total attrition due to deaths of all causes in the three sectors. On the other hand, Table 3.20 summarises the inferred total attrition due to HIV/AIDS deaths in the three sectors. These tables are supported by Figures 3.19 and 3.20.

As far as the MDAs are concerned, during the last three years total attrition due to deaths of all causes depicted a slight upward trend as reflected in figure 3.19. In the case of Councils, the trend on total attrition due to deaths of all causes is oscillating. As for the RAS, the trend on total attrition due to deaths depicts a slight upward trend especially in the last three years. Given that these inferred trend patterns are related to deaths of all causes, it is difficult to make meaningful conclusions because there are no interventions to stop deaths generally.

However, trends in total attrition due to HIV/AIDS deaths are important. From Table 3.20 and Figure 3.20 the trend in attrition for the MDAs is that of stagnation or slight increase over the years. In the case of the Councils, one sees a slight decline in the first year, there after a slight upward trend. As for the RAS, the pattern is one of increase over the four years.

The trends observed have implications. The fact that trends observed show either a stagnation or upward trend is by itself an issue of concern. First, these deaths are related to infections that occurred ten years ago. If there have been no effective intervention programmes to control infections, obviously infections will have occurred and deaths will continue to deplete the workforce for at least another ten years. Secondly, in absolute terms, the inferred total annual attrition for all the sectors ranges from 1,605 to 1,720 (table 3.20 last column). These figures present a serious problem in human resource management as already alluded to above, hence the need for a concerted effort to have effective interventions in place to control the spread of HIV/AIDS.

Table 3.19: Inferred attrition due to deaths in the three levels: all causes

	Public service sectors			
Year	MDAs	Councils	RAS	Total
2000/01	714	2009	46	2769
2001/02	685	2973	61	3719
2002/03	1035	2196	111	3342
2003/04	954	2461	91	3506

Source: Computed using information on annex 4

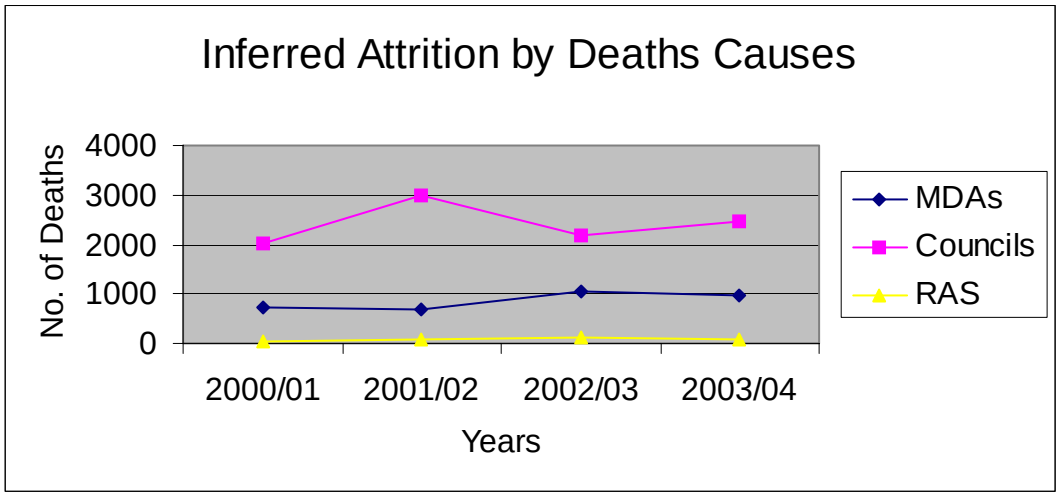

Figure 3.19: Inferred attrition due to deaths in the three levels: all causes

Table 3.20: Inferred Attrition due to HIV/AIDS Deaths in the three levels

	Public service sector			
Year	MDAs	Councils	RAS	Total of all sectors
2000/01	310	1361	16	1687
2001/02	463	1219	15	1697
2002/03	348	1224	33	1605
2003/04	351	1314	55	1720

Source: Computed using information on annex 4

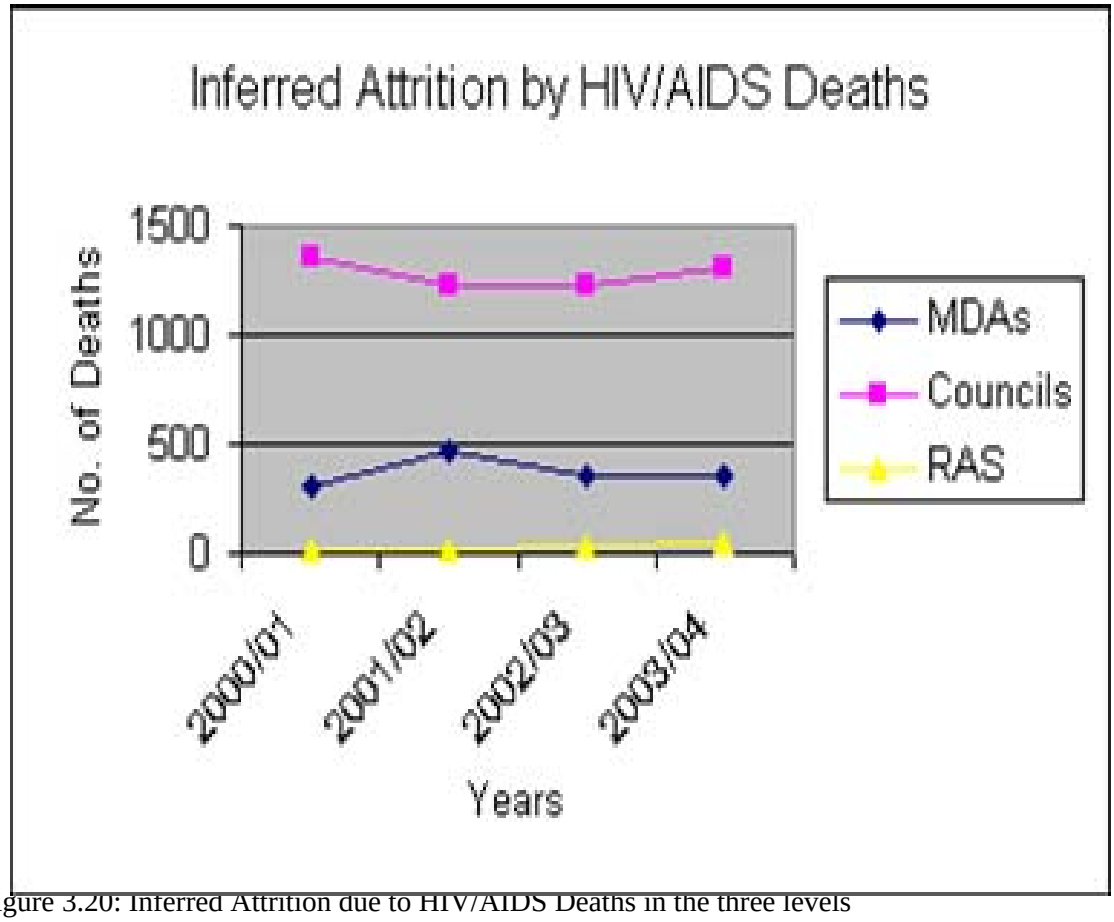

Figure 3.20: Inferred Attrition due to HIV/AIDS Deaths in the three levels

3.5 POLICY AND LEGAL FRAMEWORK

The fight against HIV/AIDS initially was coordinated through the National Aids Control Programme (NACP) which was formed in 1985. This programme was implemented through short-term plans whose focus was on identification of responses to be guided and coordinated by the health sector. Besides, some of the plans drawn under NACP called for the wider participation of both the public and non-public institutions including the private sectors and the civil society organisations.

The worsening of the HIV/AIDS situation in the country was a clear testimony of inadequacy of the NACP to deal with the pandemic and also to coordinate multi- sectoral programmes. Hence the need for a more inclusive policy to deal with the pandemic.

In 2001 the Government formulated and launched a National Policy on HIV/AIDS. The policy provides the framework for managing and responding to the epidemic. To ensure smooth implementation of the policy, the government formulated the national multi-sectoral strategic framework (NMSF). The NMSF calls for all sectors, public and non-public to formulate appropriate programmes aiming at prevention, control and mitigation of the impact of HIV/AIDS. The various sectors are urged to prepare action plans, which become the basis for coordinating implementation.

In immediate past the management of HIV/AIDS in the public sector has been driven principally by such policy.

The specific objectives of the policy include, among others:

- To prevent the transmission of HIV/AIDS
- To promote HIV/AIDS testing
- To provide a framework of care for people living with HIV/AIDS
- To stipulate sectoral roles and financing mechanisms
- To promote HIV/AIDS research
- To advocate for HIV/AIDS legislation, and
- To stipulate cross-cutting issues of national interest

The leadership and coordination of the national policy on HIV/AIDS is vested in the Tanzania Commission for Aids (TACAIDS), which has the legal mandate to do so. TACAIDS was established in 2001. To ensure that it became a strong coordinating body, it was placed under the Prime Minister's Office.

TACAIDS has been working with the various sectors, public and non-public, to develop interventions to address the pandemic.

The local government authorities, through the President Office, Regional Administration and Local Government (PORALG), has gone a step further to ensure that the Councils and the regional administrative secretariats deal appropriately with the pandemic. PORALG has issued a communiqué/circular letter of 8 January 2003 to the Councils instructing them on how to move forward with the issue of HIV/AIDS. Among other things, the Councils shall;
Form a 'HIV/AIDS Coordination (kuratibu) Committees' (at all levels of local government –Council, ward, village, mtaa or kitongoji)[4].

[4] The composition and the roles of the Committees are spelt out as well and include among others (i) collaboration with stakeholders to widen contribution of ideas, (ii) to oversee the creation of subcommittees responsible for HIV/AIDS, (iii) to deal with management of HIV/AIDS (planning, implementation and control aspects), and (iv) Evaluate actual situation of HIV/AIDS in the work place etc.

Appoint HIV/AIDS Coordinators,

- Have the Director be overall responsible for HIV/AIDS coordination in the Council
- Plan financial and other resources requirements for HIV/AIDS activities following the systems in practice.
- Have action plans for HIV/AIDS interventions approved by Councils machinery, and reports prepared every quarter.
- Funds to be provided on the basis of plans.
- That the fight against HIV/AIDS shall remain a priority activity in the Councils.

The communiqué has played a vital role in directing the activities of the Councils in managing HIV/AIDS.

The government is yet to enact a law that provides a framework for managing the HIV/AIDS pandemic. The fact that HIV/AIDS management impact upon social, economic and ethical issues makes it imperative that there should be a legal framework for dealing with the problem. At the workplace the law should protect the interests of the employer, the employee and the families of the employees. Besides, the enactment should take into consideration existing international law(s) on human rights.

3.6 MAINSTREAMING HIV/AIDS ACTIVITIES IN THE PUBLIC SERVICE

Four factors are used to evaluate the extent to which HIV/AIDS management has been mainstreamed in the public service. One is the availability of a plan (action plan) that is part of the organisation's strategic plan. Secondly is the existence of a unit (focal point) in the organisation which is responsible for managing HIV/AIDS activities, thirdly is the existence of committees responsible for coordination purposes, and finally is the level of resource commitment through the budget for HIV/AIDS activities.

3.6.1: Observations in Ministries

All the 8 ministries have action plans addressing the HIV/AIDS. The ministries also have assigned responsibility to a unit (focal point) which is responsible for managing HIV/AIDS activities. The ministries have also set up committees for coordinating such activities. The committees draw representatives from different departments. The problem is, the coordinator for HIV/AIDS works alone, and secondly he has other responsibilities as well, thus making this role ineffective.

As regards financing of the activities, six out of eight ministries have been allocating resources for the purpose. The allocations in last four years have varied from ministry to ministry. About half of the ministries allocated funds in the last one or two years, while the rest have been allocating funds through out the four years. The funds allocated have been increasing over the years, but still low in relation to total ministerial annual budgets. The budget allocations are less than 1.5% of the budgets of the ministries concerned. In absolute terms, few ministries have allocated amount exceeding Tshs. 40 million per year. Table 3.19, summarises the information pertaining to the eight MDAs.

Table 3.19: Summary of institutional and financial arrangements for HIV/AIDS management in MDAS

	Name of ministry	Ministry has HIV/AIDS Plan. Insert 'yes'	Ministry has a Unit for coordinating HIV/AIDS. Insert 'Yes'	Unit has clearly defined responsibilities.[1] Insert 'yes'	Unit has committees for overseeing HIV/AIDS activities. Insert 'yes'	Is there budget in all 4 years? Insert 'yes'
1	POPSM	yes	yes	Yes	yes	None
2	MLYDS	yes	yes	yes	yes	Yes

3	MOH	yes	yes	yes	no	yes
4	MOEC	yes	yes	yes	yes	Last 1 year
5	MNRT	yes	yes	yes	yes	yes
6	MOF	yes	yes	Not indicated	yes	-
7	CDGD	yes	yes	yes	yes	yes
8	MEM	Yes	yes	Not clear	Yes	Last 2 years

3.6.2: Observation in the Councils

All Councils have been handling HIV/AIDS activities at least in line with the guidelines issued by PORALG. The Councils have prepared action plans, but in some cases ,the quality of the plans is questionable. Some plans cover a period of six months. Others are very sketchy without adhering to the basics of preparing an action plan. In line with the PORALG communiqué, the Councils have formed committees and the roles of such committees are clearly articulated. Coordinators for the HIV/AIDS activities have been appointed in nine Councils out of the ten Councils studied. But this coordinator works without assistants, and secondly he has other responsibilities to perform in the council.

The presence of the guideline has tended to give priority to HIV/AIDS activities which target the public (their clients) more than they do for the employees of the Councils. The activities listed by the management which cover prevention, care and support, and advocacy subsequently target the community rather than the employees.

As regards funding of HIV/AIDS activities, five Councils out of ten (equal to 50%) have been allocating funds. Out of the lot that has been allocating funds, three of them have allocated funds in the last two or three years. Only two Councils had funds allocated in all the four years covered by the study. Seriousness in allocating funds coincides with the issuing of the circular, and to a less extent, the issuing of the national policy on HIV/AIDS and establishment of TACAIDS. The amount allocated are still low in absolute terms, and neither do the allocations appear to be increasing. It is only in two Councils out of the five allocating funds depicted an upward trend. Table .3.20 summarizes the observations made on the different Councils.

Table 3.20: Summary of institutional and financial arrangements for HIV/AIDS management in Councils

	Name of Council	**Council has HIV/AIDS Plan.**	**Council has a Unit for coordinating HIV/AIDS.**	**Unit has clearly defined responsibilities.[1]**	**Council has committees for overseeing HIV/AIDS activities.**	**Is there budget in all 4 years?**	**Is the budget stagnant, increasing, or dwindling over the past four years?**

1	Hai	yes	yes	yes	yes	yes	Increasing
2	Mbinga	yes	yes	yes	yes	yes	increasing
3	Songea	yes	yes	yes	yes	none	-
4	Mbeya	yes	Yes	Not indicated	yes	Last 2 yrs.	stagnant
5	Tukuyu	Yes (draft)	yes	yes	yes	Last 3yrs	dwindle
6	Singida	none	none	none	none	none	-
7	Iramba	yes	yes	yes	yes	no	-
8	Kinondoni	yes	yes	yes	yes	no	-
9	Morogoro	Yes (draft)	yes	yes	yes	Last 3yrs	stagnant
10	Kilosa	yes	yes	yes	yes	No (money from TACAIDS only).	no

3.6.3: Observations in the RAS

The five regions studied indicated that they had action plans for implementing HIV/AIDS activities. Only Dar did not provide information on action plans for HIV/AIDS. The RAS are also covered by the communiqué from PORALG. In lieu of the latter, those who were found to have action plans were also found to have persons to coordinate and committees to overseeing the implementation of HIV/AIDS activities. The roles of the committees were also clearly articulated.

Most of the RAS did not have budget allocations for purposes of HIV/AIDS. In the absence of budgets it is difficult to see how the implementation of the action plans can take place. The RAS response towards HIV/AIDS pandemic remains rhetoric and the more important area of care and support for example, which calls for real support to those infected and affected, will not get any attention in the absence of budgetary allocations. Table 3.21 below summarizes the experience of the RAS.

Table.3.21: Summary of institutional and financial arrangements for HIV/AIDS management in RAS

	Name of Regional Administrative Secretariat	**Regional administrative secretariat has HIV/AIDS Plan.**	**Regional administrative secretariat has a Unit for coordinating HIV/AIDS.**	**Unit has clearly defined responsibilities.[1]**	**RAS has committees for overseeing HIV/AIDS activities.**	**Is there budget in all 4 years?**	**Is the budget stagnant, increasing, or dwindling over the past four years?**
1	Kilimanjaro	Yes	Yes	Yes	yes	None	-

2	Dar es Salaam[5]	-	-	-	-	-	-
3	Morogoro	Yes	Yes	Yes	Yes	-	-
4	Mbeya	Yes	Yes	Yes	Yes	-	-
5	Ruvuma	Yes	Yes	Yes	no	-	-
6	Singida	Yes	Yes	Yes	no	Yes	Increasing

3.7 HUMAN RESOURCE PLANNING AND MANAGEMENT

The HIV/AIDS pandemic has high negative impact on the stability of the most important resource in the public service. Depletion of the human capital has serious consequences on the provision of public service.

It is argued that mortality, morbidity and absenteeism attributable to HIV/AIDS pandemic erode human resource capacity to deliver the required quantity and quality of services.

3.7.1: Effects of HIV/AIDS attrition on vacancy levels

Mortality and morbidity attrition have contributed to the existence of vacancies in the MDAS, Councils and RAS as summarized below.

(a) Vacancies in the MDAS

The deaths and retirements caused by HIV/AIDS related problems have left some vacancies in the MDAS. The terminated cases expressed as a percentage of the occupied positions in the respective ministries, for the four years studied, indicated the following;

- The vacancy rates during the four years have ranged between 0.16% to 3.54%. In 2000/01 the range was between 0.17 to 1.59 percent; in 2001/02 it was 0.43 to 1.55 %; in 2002/03 it was 0.16 to 3.54%; and in 2003/04 it was 0.16 to 2.74 %.
- The majority of the ministries have rates below 1% over the four years, namely POPSM, MLYS, MOF and MCDGC. The only ministry that appears an out layer is MOEC which in 2000/01, 2001/02, 2002/03 and 2003/04 the rates were 1.59%, 1.55%, 3.54% and 2.74% respectively.

In absolute terms, the number of vacancies created among the ministries studied over the four years ranged from 1 to 49 persons. Some ministries had an average of 1 vacancy per year, while others posted a slightly bigger figure, as for example the Ministry of Education and Culture which has a range of 27 to 49 persons between the four years. The information is summarized in the following table 3.22.

Among the eight ministries, the alarming case is that of MOEC where the number of vacancies has been going up. At this juncture it is difficult to establish the reasons for this rather exceptional situation. The observed trend is likely to affect the delivery of services very negatively in deed.

Table 3.22: Staff whose employment was terminated due to HIV/AIDS

	Name of	**Number of Exiting staff.**							
		2000/2001		**2001/2002**		**2002/2003**		**2003/2004**	
		No.	**%Tage**		**%Tage**		**%Tage**		**%Tage**
1	POPSM	-	-	1	0.43	1	0.3	1	0.4
2	MLYS	2	0.17	3	0.25	2	0.16	2	0.16
3	MOH	-	-	-	-	-	-	-	-

[5] Regrettably information could not be obtained from the HIV/AIDS Coordinator because he was not around most of the time, in spite of several visits. And no body else was ready to answer our questions on this item.

4	MOEC*	27	1.59	33	1.55	39	3.54	49	2.74
5	MNRT*	7	N/a	7	N/a	6	N/a	9	n/a
6	MOF	2	0.48	3	0.85	1	-	1	0.26
7	CDGD	3	0.24	8	0.68	-	-	1	0.08
8	MEM	-	-	-	-	3	0.52	6	1.05
	Total for all	40		55		49		65	

Note: * The number of approved positions provided during the interview appear unrealistic.

- Information not available

(b) Vacancies in the Councils

The deaths and retirements caused by HIV/AIDS related problems have left some vacancies in the Councils. The terminated cases expressed as a percentage of the occupied positions in the respective Councils for the four years studied, indicated the following;

- The vacancy rates during the four years have ranged between 0.01% to 2.15%. In 2000/01 the range was between 0.02 to 1.97 percent; in 2001/02 it was 0.5 to 1.46 %; in 2002/03 it was 0.12 to 2.03%; and in 2003/04 it was 0.15 to 2.13 %.
- The majority of the Councils (eight out of ten) have rates between 0.5 and 1.0% during the four years. The Councils which have posted vacancy rates above 1%, on the average, are two and these are Mbinga and Rungwe.
- On the average, the vacancy rates are less than 1.

In absolute terms, the number of vacancies created among the Councils during the four years ranged from 1 to 50 persons. Some Councils have an average of 3 vacancies per year, e.g. Singida, while others posted a slightly higher figure, as for example the Kinondoni which has a range of 40 to 50 persons, giving an average of 45 persons per year. The information is summarized in the following table.

The impression we get from the percentages presented for nearly all the councils is that the vacancies in the councils are increasing. This is a serious situation because it is likely to undermine the services delivered by the officers who exited the posts. This situation compounded by the difficulties of getting replacements will erode the quantity and quality of services offered by the councils.

Table 3.23: Staff whose employment was terminated due to HIV/AIDS in Councils

	Name of Council	**Number of Exiting staff**							
		2000/2001		**2001/2002**		**2002/2003**		**2003/2004**	
		No.	%Tage		%Tage		%Tage		%Tage
1	Hai	4	0.205	11	0.5	9	0.45	4	0.155
2	Mbinga	24	1.09	36	1.46	21	0.84	44	1.68
3	Songea	6	0.65	11	1.15	6	0.53	7	0.71
4	Mbeya	14	0.76	26	1.3	17	0.85	24	1.2
5	Rungwe	37	1.97	32	1.75	37	2.03	45	2.13
6	Singida	1	0.0166	7	0.89	1	0.127	4	0.49
7	Iramba	9	0.4	12	0.5	15	0.6	8	0.3
8	Kinondoni	50	N/P	40	1.01	45	1.05	45	1.03
9	Morogoro	12	0.724	8	0.506	8	0.498	19	1.193
10	Kilosa	15	0.75	12	0.53	17	0.75	8	0.34

	Total for all Councils	172		195		176		208	

N/P – The figures were not provided.

(c) Vacancies in the RAS

The deaths and retirements caused by HIV/AIDS related problems have left some vacancies in the RAS. The terminated cases expressed as a percentage of the occupied positions in the respective RAS for the four years studied, indicated the following;

- The vacancy rates during the four years have ranged between 0.001% to 1.25%. In 2000/01 the range was between 0.004 to 0.43 percent; in 2001/02 it was 0.005 to 0.876 % ; in 2002/03 it was 0.0014 to 0.95%; and in 2003/04 it was 0.007 to 1.25 %.
- The majority of the RAS (four out of six) have rates between 0.001 and 1.0% during the four years. The RAS, which have posted vacancy rates above 1%, but with an average still far below 1%, are two and these are Morogoro and Mbeya. Singida region is exceptional for posting vacancy rates below one tenth of a percentage.
- On the average, the vacancy rates are less than 1%.

In absolute terms, the number of vacancies created among the RAS during the four years ranged from 1 to 9 persons. Some RAS have an average of 1.5 vacancies per year, e.g. Dar es Salaam, while others posted a slightly bigger figure, as for example the Morogoro which has a range of 1 to 9 persons, giving an average of 5 persons per year. The information is summarized in the following table.

The rising percentages for all the RAS except in the case of Singida RAS, is a signal for alarm. As said for the Councils, the erosion of human capital taking place is going to impact upon the quality of services offered.

Table 3.24: Staff whose employment was terminated due to HIV/AIDS in the RAS

	Name of RAS	**Number of Exiting staff and %tage of filled positions.**							
		2000/2001		**2001/2002**		**2002/2003**		**2003/2004**	
		No.	**%Tage**		**%Tage**		**%Tage**		**%Tage**
1	Kilimanjaro	1	0.43	2	0.87	1	0.86	2	0.86
2	Dar es Salaam	-	-	0	0	1	0.79	1	0.87
3	Morogoro	1	0.093	3	0.40	7	0.95	9	1.13
4	Mbeya	2	0.29	0	-	0	0	5	1.25
5	Ruvuma	1	0.2	0	0	4	0.74	3	0.71
6	Singida	2	0.0043	2	0.005	6	0.0014	3	0.007
	Total no. of persons	7		7		19		23	

3.7.2: Replacement of staff on HIV/AIDS related attrition (skills replacement)

The replacement of staff who exited the service due to HIV/ADS related attrition has not happened very smoothly. Some organisations have been successful in replacing the staff by more than 100%, while others have not been so successful. Replacements in the years 2000/2001 and 2001/2002 were far below the numbers that left. The situation improved in the last two years (2002/03 to 2003/04). In the Councils total attrition in 2000/01 and 2001/02 were 172 and 195 respectively, while replacements were 40 and 66 respectively. In the years 2002/03 and 2003/04 attrition was 176 and 208 respectively while replacements

were 394 and 341[6] respectively. But two Councils namely Rungwe and Mbinga have shown excessively high replacements in the last two years. Rungwe replacement was 272 and 110 in 2002/03 and 2003/04 respectively, while Mbinga had 46 and 99 for the last two years respectively. No explanation is available for the increase in the two Councils.

(a). MDAs replacement ratio

In the MDAs, replacements in all the years were above the attrition figures. From Table 3.25 below replacements in the four years were more than twice the vacancies existing. But most of the replacements were concentrated in MOEC and MOF. Very minimal replacements took place in the other 6 ministries. For MOEC and MOF it is very obvious that what they referred to a replacements were not real replacement but new recruitment.

Table 3.25: Replacement ratios in the MDAs

		2000/01	2001/02	2002/03	2003/04
Attrition	(a)	40	55	49	65
Replacements	(b)	128	117	62	144
Ratio	(b)/(a)	320%	212.7%	126.5%	211.5%
MoEC replacements		27	33	39	49
MOF replacements		101	82	21	85

(b). Council replacement ratio

In the Councils, replacements in the first two years were far below the vacancies existing. The situation changed in the last two years where it stands at more than one and half times that of vacancies. But as said earlier, two Councils (Rungwe and Mbinga) contributed to the excessive replacements. For those with excess replacements, it is doubted whether record keeping of replacements and new recruitments make that distinction. The issue of replacing staff is considered a problem by most of the Councils due to the lengthy procedures for bring new staff on board and also the problem of getting persons with requisite skills. These issues are discussed further in the next sections.

Table 3.26: Replacement ratios in the Councils

		2000/01	2001/02	2002/03	2003/04
Attrition	(a)	172	195	176	208
Replacements	(b)	40	66	394	341
Ratio	(b)/(a)	23.3%	33.8	223.9%	163.9%
Rungwe excess replacements				272	110
Mbinga excess replacements				46	99

(c). RAS replacement ratio

In the RAS, replacements in all the first three years have been more or less equal to the attrition figures. In the last year fewer replacements (14) took place compared to the attrition figure of 23.

[6] Recruitment of teachers could have contributed to the high number of replacements.

Table 3.27: Replacement ratios in the RAS

		2000/01	2001/02	2002/03	2003/04
Attrition	(a)	7	7	19	23
Replacements	(b)	6	9	19	14
Ratio	(b)/(a)	85.7%	128.6	100%	60.9%

3.7.3: Replacement time horizon in MDAs/LGAS and RAS

The three sectors indicated that it took quite some time before replacements could take place.

In the case of MDAs, replacement took place between 1 and 9 months. The majority of the ministries were able to replace within the first 3 months, while a few replaced in 7 to 9 months.. Replacements in the ministries were much faster than in the Councils where the majority replaced within 10 to 12 months.

Table 3.28: Frequency of replacing staff in the MDAs

Year		0-3 Mths	4-6 Mths	7-9 Mths	10-12 Mths	More than 12Mths.	Time not indicated
2000/01	**No. of MDAs reporting**	2		1			1
2001/02	**No. of MDAs reporting**	3		1			
2002/03	**No. of MDAs reporting**	2		1			
2003/04	**No. of MDAs reporting**	3		1			

As regards the Councils, it took between 4 and 12 months to replace exiting staff. During the four years, 2 Councils indicated replacement within 4-5 months, 1 Council within 7 to 9 months while 3 Councils indicated replacement-taking place between 10 to 12 months. Four Councils did not have a record of time taken to make the replacements.

Table 3.29: Frequency of replacing staff in the Councils

		0-3 Mths	4-6 Mths	7-9 Mths	10-12 Mths	More than 12Mths.	Time not indicated
Year 2000/2001	**No. of Councils reporting**		2	1	3		4
Year 2001/2002	**No. of Councils reporting**		2	1	3		4
Year 2002.2003	**No. of Councils reporting**		2	2	2		4
Year 2003/2004	**No. of Councils reporting**		2	1	3		4

As regards RAS, the time taken to replace staff is as short as in the case of the 8 ministries. The majority of replacements take place within 3 months. A few cases get replaced between 4 and 12 months.

Table 3.30: Frequency of replacing staff in the RAS

		0-3 Mths	4-6 Mths	7-9 Mths	10-12 Mths	More than 12Mths.	Time not indicated
Year 2000/2001	**No. of RAS Reporting**	3	1		1		
Year 2001/2002	**No. of RAS Reporting**	3		1			
Year 2002.2003	**No. of RAS Reporting**	1	2	1	1		

Year 2003/2004	**No. of RAS Reporting**	2	1				

What is very apparent from the replacement times indicated is the fact that the MDAs and the RAS have shorter time for replacing staff compared with the Councils. The process of getting approvals from the POPSM has a bearing on this outcome. The closer one is to the centre, the easier it is to get the approval. The factor of geographical remoteness plays part. Those in Dar have faster access to POPSM compared to for example, those in Singida. It could also be inferred that councils face problems getting qualified persons given their geographical locations.

3.7.4: Workload in the MDAS/Councils /RAS

The employees of the MDAS/Councils/RAS have to put in extra time to cover the vacancies left behind by deaths and retirement due to ill health. These organisations managed to give some indications of workload that arises from the attritions, as is summarized below.[7]

The situation in the MDAs over workloads arising from HIV/AIDS related attrition is less clear, apparently for lack of a system to record such events. However, a few ministries were able to give some estimates of workload arising from HIV/AIDS related attrition. The workload in such ministries is: MoH is 1 hour per week, MNRT is 14 hour per week, MCDGC is 10 hours per week and MEM is 3 hours per week. Some ministries (MLYS, MoEC, MoF) did not have the figures, but they have commented on the impact of attrition on workload. MLYS points out that workload increased a lot during burial times (wakati wa kwenda kuzika); and MOF says there is increase of workload to the extent of 5 hours per day;

In the LGAs the extra workload among the Councils ranged from 2.5 hours per week (Songea Urban Council) to 35 hours per week (Iramba). The workers spend some extra 3 hours per day during weekdays and report for work on Saturdays and Sundays. The impact has affected the quality of service provided. In schools the classes carry more students than allowed by ministry standards of teacher pupil ratio. In some Councils some officers have to shoulder extra responsibilities arising from the exit of other staff. For example, in Songea Town Council, the functions of deceased planning officer were added to those of community development officer. In Tukuyu Council, it was pointed out that the quality of services in the hospital fell due to overloads. In some Councils, some extra costs are incurred on acting positions.

In the RAS there is also an increase in workload due to HIV/AIDS related attrition. The range is between 2 hours (Morogoro) and 40 hour per week (Dar es Salaam). The employees have to work overtime and are paid extra duty allowance. In Singida region, the personal secretaries have to serve more than one department at a time.

3.7.5: Impact on Services Provided

Increased workforce morbidity and mortality will have some impact on services provided by the public sector. Unfilled vacancies and absenteeism due to illnesses will affect the volume of services provided. For the time being, there is no indication of some service having been suspended. No MDA or Council or RAS said it had suspended some services. But as already said above, employment problems related to HIV/AIDS have undermined the quality of services provided like in the hospitals or schools, and even in the general public service where some of the work has to be done after office hours and during weekends. Service users are denied the opportunity to obtain the services they need upfront and in a desired quality.

[7]The figures have to be interpreted with caution given the fact that the public service in Tanzania has not established a system for recording such matters. The figures given are estimates of the officers who assisted the consultants in filling the questionnaires.

3.7.6: Time spent on deputization of staff on seek leave or deceased

High mortality and morbidity related to HIV/AIDS pandemic has already been said above to impose an extra workload on those who remain. In some senior and sensitive positions, the employer has to appoint a person to deputise the deceased and the sick ones. The position of the MDAS, Councils and RAS on appointment of staff to deputize those affected was mixed.

The implications of deputizing should be assessed from the potential consequences that it has in the delivery of services. In certain senior positions, those exiting could have the requisite skills for the office, but the rest might not possess them. Therefore appointments for deputizing could go to staff who don't possess the capacity to make rational decisions. This could be evident in the councils where getting skilled people is difficult.

The following was observed:

- In the case of MDAS, for the senior positions, three ministries out of four responding to the question indicated that deputizing is an issue over the past four years. As for the middle level positions, three out of four again indicated that deputizing was an issue over the past four years.

Table 3.31: Assessment of time spent on deputizing those on seek leave or have died

	Name of ministry	**Assessment over the 4 years**			
		Senior officers		**Middle level officers**	
		Assessed to be an Issue over the 4 years	**Assessed not to be an Issue***	**Assessed to be an Issue over the 4 years**	**Assessed not to be Issues**
1	POPSM	-	Yes	-	-
2	MLYDS	-	-	-	-
3	MOH	-	-	-	-
4	MoEC	Yes	-	Yes	-
5	MNRT	-	-	-	-
6	MOF	-	-	-	-
7	MCDGC	Yes	-	Yes	-
8	MEM	Yes	-	Yes	-

*-Issue means officers have been acting in other positions for some time and this phenomenon keeps occurring in every year. Otherwise it is not an issue i.e., the acting business is not significant.

In the **Councils,** deputizing of senior positions is considered to be an issue in about 50% of the Councils, and not an issue in the other half over the four years. For the middle level positions, again deputizing is considered to be an issue in about 60% of the Councils, and not an issue in 40% of the Councils.

Table 3.32: Assessment of time spent on deputizing those on seek leave or have died.

	Name of Council	**Assessment over the 4 years**			
		Senior officers		**Middle level officers**	
		Assessed to be an Issue over the 4 years	**Assessed not to be an Issue**	**Assessed to be an Issue over the 4 years**	**Assessed not to be Issues**

1	Hai		yes		yes
2	Mbinga	yes			yes
3	Songea	yes		yes	
4	Mbeya	yes		yes	
5	Tukuyu	yes		yes	
6	Singida		yes		yes
7	Iramba		yes		yes
8	Kinondoni	yes		yes	
9	Morogoro		yes	yes	
10	Kilosa		yes		yes

[x]-Issue means officers have been acting in other positions for some time and this phenomenon keeps occurring in every year. Otherwise it is not an issue i.e., the acting business is not significant.

In the case of RAS, only three RAS provided information, and out of the three only 1 (equal to 33.3%) indicated that deputizing was an issue in the case of senior positions. At middle management positions, all three regions/RAS indicated that deputizing was not an issue.

Table 3.33: Assessment of time spent on deputizing those on seek leave or have died

	Name of regional administrative secretariat	**Assessment over the 4 years**			
		Senior officers		**Middle level officers**	
		Assessed to be an Issue over the 4 years	**Assessed not to be an Issue***	**Assessed to be an Issue over the 4 years**	**Assessed not to be Issues**
1	Kilimanjaro	Yes			Yes
2	Dar es Salaam		Yes		Yes
3	Morogoro		Yes		Yes
4	Mbeya	-	-	-	-
5	Ruvuma	-	-	-	-
6	Singida	-	-	-	-

[*]-Issue means officers have been acting in other positions for some time and this phenomenon keeps occurring in every year. Otherwise it is not an issue i.e. the acting business is not significant.

3.7.7: Average hours lost of service due to gaps left by attrition

Although there was no case of institution suspending its services due to problems of mortality and morbidity, some of these institutions managed to estimate the amount of time lost in the provision of the services, which has impact on the quality of service.

- In the case of MDAs, at least three ministries managed to estimate the average amount of time of services lost. The MLYS indicated an average of 8 hours per week while MNRT showed a figure of 10 hours per week. POPSM did not have a problem of losing service time.

Table 3.31: Average hours lost of service due to gaps left by HIV/AIDS

	Name of ministry	Average no. of hours of service lost due to death/HIV/AIDS[1]
		2000/2001-2003/2004
1	POPSM	0
2	MLYDS	8
3	M0H	-
4	MEC	-
5	MNRT	10
6	MOF	-
7	CDGD	-
8	MEM	-

- No information

In the **case of Councils** nearly every one of them lost some time. The range is 2 hours to 22 hours. Tukuyu indicated 2 hours lost per week and Morogoro at the upper hand loses 22 hours of service. Mbeya also has a high figure of 21 hours. The Council problem is likely to be influenced further by the problems they have been experiencing of recruiting new staff to replace those displaced. The processes of recruiting at the Council have been taking longer compared to those of the MDAs.

Table 3.35: Average hours lost of service due to gaps left by HIV/AIDS

	Name of Council	Average no. of hours of service lost due to death/HIV/AIDS[1]
		2000/2001-2003/2004
1	Hai	4
2	Mbinga	12
3	Songea	12.5
4	Mbeya	21
5	Tukuyu	2
6	Singida	4
7	Iramba	17
8	Kinondoni	0
9	Morogoro	22
10	Kilosa	0

In the **case of RAS, the** three regions, which provided information, have a very high record of time of service lost. Kilimanjaro recorded 56 hours; Dar recorded 40 hours while Morogoro recorded 10 hours. Once again, the problems of recruiting at this level might have contributed to the large numbers.

Table 3.36: Average hours lost of service due to gaps left by HIV/AIDS

	Name of regional administrative secretariat	Average no. of hours of service lost due to death/HIV/AIDS[1]
		2000/2001-2003/2004
1	Kilimanjaro	56
2	Dar es Salaam	40
3	Morogoro	10
4	Mbeya	-
5	Ruvuma	-
6	Singida	-

3.7.8 Capacity building and development

The effects of HIV/AIDS will inevitably affect capacity building in the public service. Mortality and morbidity cases will affect the planned capacity building and development. More investments have to be directed towards manpower development in line with emerging manpower gaps.

The study assessed the level of impact of HIV/AIDS on career development. The assessments for the different sectors were as follows;

(a). In the case of the MDAs, using the scale of low, average and high[8], it is observed that the majority of the ministries assessed the impact to be between average and high. This implies that the capacity development which was planned was successful by about 66%. The summary is presented in Table 3.37 and in the following Figure 3.19.

Table 3.37: Level of Impact of HIV/AIDS on Career Development: selected MDAs

	Level of impact	Reporting cases (ministries)			
		2000/2001	2001/2002	2002/2003	2003/2004
1	Low (< 1/3)	1	2	1	1
2	Average (1/3 to 2/3)	3	2	3	3
3	High (>2/3)	2	2	1	2

[8] Low means capacity development was successful by thirty percent, while 'average' means between one third and two-thirds success. High means capacity development was successful by more than 67%.

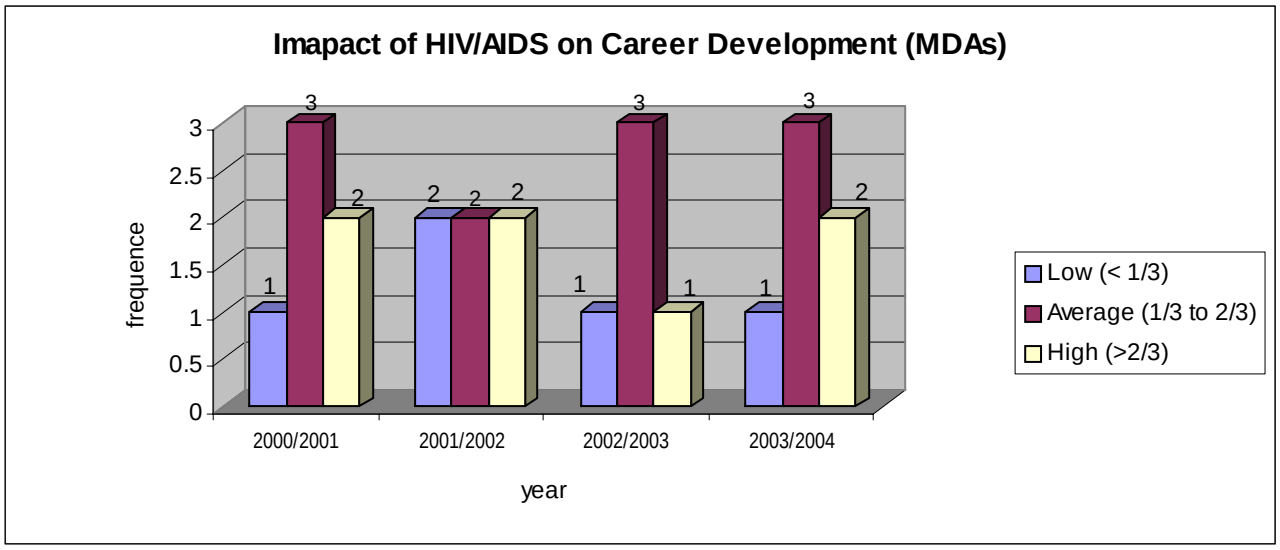

Figure 3.19: profile of AIDS impact on Career Development: Selected MDAs

(b). The capacity building in the Councils has been in trouble. In the years 2000/01 and 2001/02 the Councils rated capacity development as either being low or not being there at all. Five Councils out of ten rated themselves low while another three showed they had no plan. The situation improved slightly in 2002/03 and 2003/04 when the rating changes to average or high in which case four to five Councils saw the improvements. Still, two Councils out of ten in 2002/03 and one Council in 2003/04 indicated that they did not have a career development plan. The summary is presented in Table 3.39 and in the following Figure 3.20

Table 3.39: Level of Impact of HIV/AIDS on Career Development: selected councils

	Level of impact	**Reporting cases (Councils)**			
		2000/2001	**2001/2002**	**2002/2003**	**2003/2004**
1	Low (< 1/3)	5	5	3	2
2	Average (1/3 to 2/3)	1	1	4	2
3	High (>2/3)				3
4	Not indicated	3	3	2	1

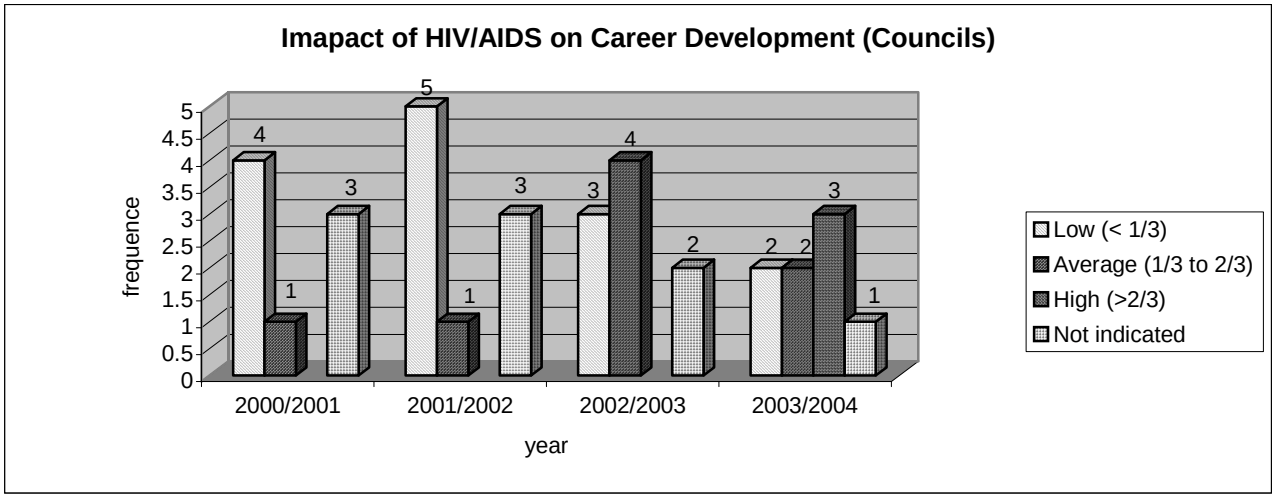

Figure 3.20: profile of AIDS impact on Career development: Selected Councils

(c). Capacity building in the RAS does not paint a good picture either. Overall, the response of the RAS to the question of capacity building was poor, a clear sign of lack of priority in this area. The three RAS who responded to the issue posed some poor results. Two of them indicated that they did not have capacity development plan, while one showed that the success of its plan was about 33%. The summary is presented in Table 3.40 and in the following Figure 3.21.

Table 3.40: level of Impact of HIV/AIDS on Career Development

	Level of impact	**Reporting cases**			
		2000/2001	**2001/2002**	**2002/2003**	**2003/2004**
1	Low (< 1/3)	1	1	1	1
2	Average (1/3 to 2/3)				
3	High (>2/3)				
4	Not indicated	2	2	2	2

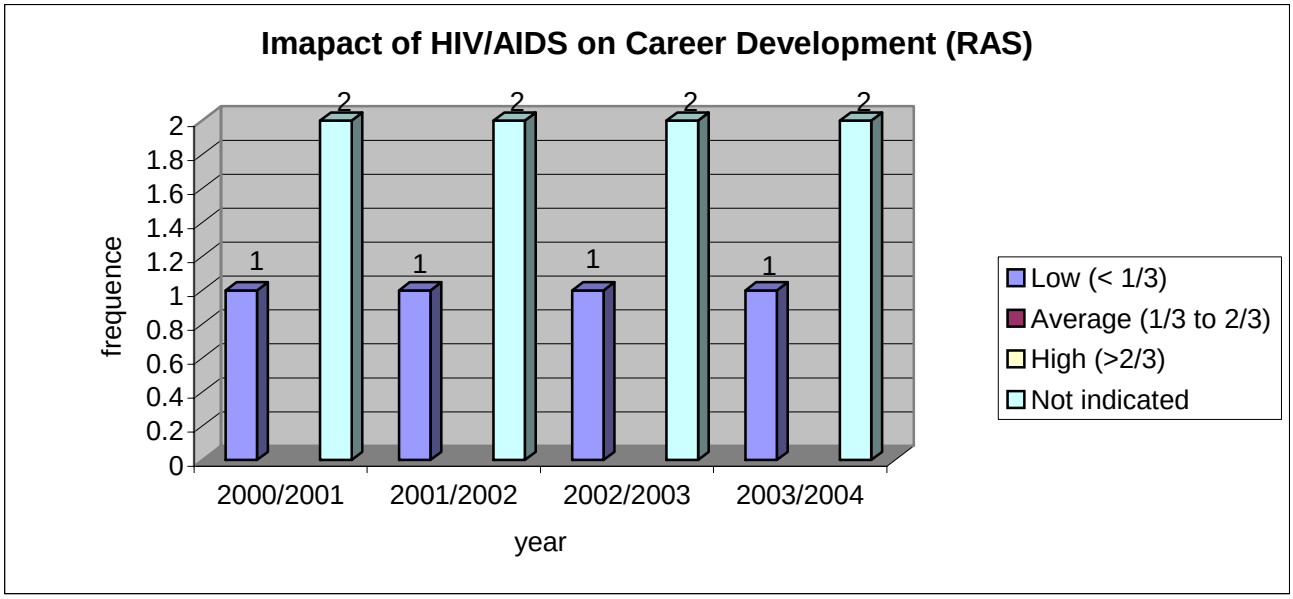

Figure 3.21: Profile of impact of AIDS in career development in selected RAS

3.7.9: Staff unable to complete studies due to HIV/AIDs related problems

The success of capacity building goes with successful completion of training programmes by the trainees. Staff abandoning train waste scarce resources, they block the creation of skilled manpower in the institution etc. On the other hand, to what extent can the institution go to deny persons suffering from HIV/AIDS related problems from attending training without being accused of violating human rights? There are many challenges on the issue of training given the internal and external forces in play.

Below we summarize the findings on the number of staff who could not finish the training.

(a). In the case of MDAs no staff abandoned training due to poor health or death. Likewise no financial losses were incurred.

(b). In the Councils, two of them indicated that some staff dropped out of the training. In Mbinga, the number of dropouts is high, ranging between 12 and 28 with a total of 85 during the four years. Iramba lost staff as well in all the four years totalling 19. The rest of the Councils did not indicate any loss of staff. The sectors mentioned to be affected deeply by the problem of HIV/AIDS, for those with record, included the following: Hai – Education; Mbeya – Education and Health; Morogoro – Health. It is unfortunate that those with highest number of dropouts – Mbinga and Iramba did not indicate areas deeply affected by the scourge. However, as already mentioned above, the sector which have suffered most include education and health, and these are the sectors which have the highest labor force in the councils.

Table 3.41: Number of staff who left training due to death or illness

	Name of Council	Number of Staff who Exited training			
		2000/2001	2001/2002	2002/2003	2003/2004

1	Hai	0	0	0	0
2	Mbinga	12	30	15	28
3	Songea	0	0	0	0
4	Mbeya[#]	(Not evaluated)	(Not evaluated)	(Not evaluated)	(Not evaluated)
5	Tukuyu	0	0	0	0
6	Singida	0	0	0	0
7	Iramba	3	4	5	7
8	Kinondoni	-	-	-	-
9	Morogoro	0	0	0	0
10	Kilosa	0	0	0	0

- Information not provided.

In the RAS, the situation was bad for Kilimanjaro among the six RAS studied. Kilimanjaro lost 9 staff spread over the four years. According to information collected, the sector that was deeply affected by the scourge in Kilimanjaro is the administration. Most likely the dropouts came from this sector. The rest of the RAS did not have dropout problems.

3.7.10: Multi-skills strategies

The impact of HIV/AIDS pandemic on skills in the workplace is enormous. It strips time and human capacity out of the system. In view of the fact that there are constraints hampering the replacement of the lost skills such as lengthy recruitment time, limited experienced skills in the market place etc. makes it imperative that strategies should be formulated to ensure that the already developed and experienced skills don't disappear completely as HIV/AIDS takes its toll. Multi-skills strategies become inevitable in these circumstances.

In spite of the rising attrition in the public service, there was no evidence of any MDA, Council or RAS having plans on how to take advantage of multi- skills training and deployment. This is in spite of the fact that those left behind are being assigned extra responsibilities hitherto handled by the exiting staff.

The lack of strategies to make better use of the existing resources and protect those very rare skills continues to underline the weaknesses already noted in the area of capacity development.

3.7.11: Problems faced in the public sector in HR Planning and Management

Replacing staff who leave service is a major challenge to the ministries, Councils and RAS. Following the observations made above concerning the time it takes to realise replacements, the shortfalls in replacements etc, hereunder we summarize the perceptions of the concerned institutions in terms of problems they face whenever replacement is to take place. These constraints are summarised into two main groups, namely those that are internal to the institution itself in which case the institution has a leverage on their handling, and secondly, those which are external to the institution implying that the institution has very limited control over their solution.

(a) Constraints encountered by MDAS

The MDAS face about four major constraints, which hamper the replacement of staff in the vacant positions. Constraints related to weaknesses in the internal processes of the MDAS include the following;

- Problem of planning for vacant positions including allocation of budget. Four ministries expressed the existence of problems in this area in nearly all the years. There is general problem of agreeing and identifying vacant posts and hence the problem of budgeting for such posts.
- Budget allocated for recruitment is not adequate. Costs for advertising and interviewing are much higher than the budgets allocated. At most two ministries said this was a problem over the past four years.

Constraints beyond the control of the ministries include the following:

- Filling of vacancies has to be approved by POPSM. The approval for recruiting new staff takes long. One or two ministries said this was problem to them.
- Availability of required skills for replacement is a problem, hence the need for re- advertising for such posts. About three ministries considered this to be a problem particularly between 2000/01 and 2002/03. in 2003/04 only one ministry said this factor was a problem.

Table 3.42: Replacement constraints - MDAS

	Problems Identified	**Number of Ministries reporting on the problem in the various years (frequency table)**			
		2000/2001	**2001/2002**	**2002/2003**	**2003/2004**
1	Internal bureaucracy involving identification of vacant posts and allocating budget. (Planning /Administration) Vacant positions Budget approval takes long.(planning issues)	4	2	4	4
2	Obtain recruitment approvals from POPSM (external factor)	1	2	1	1
3	Recruitment process including advertising, has too many steps, is bureaucratic and takes long. (Administration)				
4	Availability of required skills for replacement is a problem, hence the need for re- advertising for such posts (national policy issue)	2	3	3	1
5	Small budget for recruiting	2	2	2	1

(b) Constraints encountered by Council

The Councils face about six constraints, which hamper the replacement of staff in the vacant positions. Constraints related to weaknesses in the internal processes of the Councils include the following;

- Problem of planning for vacant positions including allocation of budget. One Council expressed the existence of a problem in this area in all the years. There is a general problem of agreeing and identifying vacant posts and hence the problem of budgeting for such posts. Also it is pointed out that the Committee responsible for recruitment of staff delays its decisions on recruitment.
- Recruitment process including advertising, has too many steps, is bureaucratic and takes long. This arises from the new system of recruiting which requires government organs to advertise for any vacant post. (Conclusion: Poor procurement planning and implementation is the cause for the delays that occur. Three Councils out ten said that this was a problem.

Constraints beyond the control of the ministries include the following:

- Filling of vacancies has to be approved by POPSM. The approval for recruiting new staff takes long. Seven Councils out of ten said this was a problem to them.
- Availability of required skills for replacement is a problem, hence the need for re- advertising for such posts. Four Councils considered this to be a problem.
- Delays in recording new employees in computerized payroll. New staff cannot begin work until they are registered in computer. This is a problem mentioned by one Council.
- Replacement taking place through requests for transfers by staff (waajiriwa waombaji kuhamia), take a long time. This is a problem mentioned by one Council.

Conclusion: The most critical problem among many Councils that needs to be dealt with seriously is that of getting approvals from POPSM. Delays in getting the approvals have negative impact on the services provided by Councils.

Table 3.43: replacement constraints –Councils

	Problems Identified	**Number of Councils reporting on the problem in the various years**			
		2000/2001	**2001/2002**	**2002/2003**	**2003/2004**
1	Internal bureaucracy involving identification of vacant posts and allocating budget. (Planning /Administration). Also Bureaucracy in deciding on recruitment by Employment Committee	1	1	1	1
2	Obtain recruitment approvals from POPSM (external factor)	7	7	7	7
3	Recruitment process including advertising, has too many steps, is bureaucratic and takes long. (Administration)	3	3	3	3
4	Availability of required skills for replacement is a problem, hence the need for re- advertising for such posts (national policy issue)	3	4	3	3
5	Delays in recording new employees in computerized payroll and cannot begin work until registered in computer. (Mbeya	1	1	1	1
6	Replacement done through request for in-transfers (waajiriwa waombaji kuhamia), but the process of transferring take long time.	1	1	1	1

(c) Constraints encountered by RAS

The RAS did not point out any problems that hampered recruitment, although the problem of getting recruitments approved by POPSM was alluded to.

An important observation to make at this point is the total omission from list of constraints important factors such as remuneration, opportunities offered by the Councils, workplace location which could influence the replacement of staff. It has been mentioned for example that getting persons with the requisite skills is a problem, and one wonders whether the situation could not be changed through better incentives.

3.8 HIV/AIDS INTERVENTIONS AND MANAGEMENT IN MDAS/COUNCILS AND RAS

The three public service sectors covered by the study have all listed the activities they have been implementing vis a vis HIV/AIDS pandemic. These activities are embedded in the action plans they have been preparing as part of implementation of the National Policy on HIV/AIDS as well as the National Multi-sectoral Strategic Framework. The activities cover the three main thematic areas of Prevention, Care and Support, and Advocacy.

The management structures for handling HIV/AIDS interventions in the three sectors are in place and each sector is moving towards working out action plans in implementing HIV/AIDS activities. The ministries, the councils and the RAS have established units to coordinate, have formed committees to oversee HIV activities, and have started to bring into the mainstream budgets for implementing HIV/AIDS activities.

The three sectors have also identified a range of activities which are being implemented.

These activities are summarised and discussed under each sector. The focus is on coverage at this point. The aspect of adequacy of the interventions is discussed further below where we assess the perceptions of the employees vis-a-vis popularity and level of satisfaction.

The activities implemented in the MDAS/councils/RAS are as follows:

(a). The ministries have been on the forefront of implementing HIV/AIDS activities. The majority of the MDAs covered in the study, five out of eight, listed a number of activities covering prevention, care and support, and advocacy, which are being implemented. A summary of the level of involvement by each MDA is presented in table (see tables under ARV section below) below. The activities implemented by the ministries include those ticked in column 4 Table 3.44 below.

(b). The councils have also been on the forefront implementing a number of activities against HIV/AIDS. The majority of the councils covered in the study, six out of ten, listed a number of activities covering prevention, care and support, and advocacy, which are being implemented. The activities indicated by the management of the councils are indicated in column 5 Table 3.44 below;

(c). The majority of the RAS covered in the study, five out of six, listed a number of activities covering prevention, care and support, and advocacy, which are being implemented. The activities listed by RAS indicated in column 3 Table 3.44 below;

Table 3.44: Activities listed to be implemented by the various sectors

S/N	Activity	Name of public service sector		
		RAS	MDAs	Councils
	• **Prevention**			
1	Training of peer educators	√	√	√
2	Providing education on Prevention Mother to Child Transmission (PMTCT)	√	√	√
3	Undertaking Voluntary Counselling and Testing (VCT)	√	√	√
4	Training primary school teachers on HIV/AIDS education.		√	√
5	Distributing condoms and ARV medication intended to prolong the lives of those infected.	√	√	√
6	Educating the public on opportunistic diseases through (seminars, leaflets, radio, and television programmes)		√	
7	Issuing of circulars to schools urging them to form school		√	

S/N	Activity	Name of public service sector		
		RAS	MDAs	Councils
	counselling committees			
8	Educating workers in the plantations			√
9	Educating youth groups			√
10	Educating on home based care			√
11	Providing education on sex related infections through seminars, film shows			√
12	Educate on the uses of condoms.	√		√
13	Training health workers	√		
14	Formation of committees at district and ward level	√		
15	Emphasized: 'fighting against AIDS is priority goal of RAS'	√		
16	Taking care of the infected persons (PLWAs)	√		
17	STI services and PMTCT/MTCT etc	√		
	• **Care and support**			
1	Undertaking Census for PLWAs	√	√	√
2	Counselling and educating PLWAs	√	√	√
3	Undertaking monitoring and evaluation	√	√	√
4	Provision of medication for Opportunistic Infection (OI)		√	√
5	Providing basic needs to orphans		√	√
6	Providing those infected with basic requirements like food		√	√
7	Formation of PLWAs groups			√
8	Free treatment for PLWAs	√		
9	Education on how to take care of PLWAs	√		
10	Stressing to community to stop stigmatization behaviour on PLWAs	√		
	• **Advocacy**			
1	Preparation of leaflets and billboards on HIV/AIDS	√	√	√
2	Conducting seminars on HIV/AIDS for workers	√	√	
3	Film shows on HIV/AIDS and home based care (HBC)			√
4	Sensitisation of religious leaders			√
5	Stressing the issue of HIV/AIDS to leaders at all levels in the district including Party leaders			√
6	Educating the press personnel on HIV/AIDS issues.			√

3.8.1 ARV and other Support Mechanisms Available and their Accessibility

(Access and networking initiatives)

There are many agencies around in the country, public and non-public which are providing services in the areas of prevention, care and support and advocacy. Some of these agencies operate at international, national, regional and district level. The findings are quite encouraging, in that the MDAS, councils and the RAS are all taking advantage of the services provided by these agencies. They include:

i. International institutions which have been mentioned frequently by the three sectors include: UNICEF, DANIDA, GTZ, World Bank, Axios International, MAPP, VAASA –FINLAND, Concern Worldwide, Student Partnership Worldwide, and AMREF, GLOBAL FUND, GOOD SMARITAN, CARITAS, AME.

ii. National institutions include; Tanzania Netherlands Services in AIDS (TANESA), TACAIDS, AMREF, WAMATA, PSI, ANGAZA, ISHI Programme, World Vision (education, medicine, food), PASADA, KIWOHEDE, CCRBT, ADOPT.

iii. Agencies that are localised in councils include; NURU, HAPA, FBO, Kimara Peer Educators, Good Samaritan Mission, WACCA, Ruvuma Orphans Association (ROA), KIWAKUKI, KINSHAI, FARAJA TRUST FUND, HOMELESS CHILDREN, PEPFAR

Below is a summary of the services accessed by MDAs/Councils/RAS and the nature of benefit obtained:

Table 3.45: Summary of services accessed by MDAs/Councils/RAS

Type of service accessed	Extent of benefit
Paying school fees	Orphans going to school
Construction of houses for orphans	Orphans accommodated
Food for PLWA	Ensuring good health to PLWA
Supply of medicines	Treatment of the affected
Advocacy services	Providing education through, workshops, seminars and film shows.
	Issuing of pamphlets for advocacy purposes
Counselling	Reduction in the spread of HIV/AIDS
Peer education (elimisha rika)	Reduction in the spread of HIV/AIDS
Construction of classrooms	Orphans going to school
Awareness seminars	Reduction in the spread of HIV/AIDS
Formation and training of Committees for HIV/AIDS coordination	Effective oversight in the implementation of HIV/AIDS interventions.
Sponsoring HIV/AIDS workshops	Awareness raised and condom use
Community work	Support to the needy
Home base care	Reduce demand on public services/hospitals
Orphanage services	Alleviate burden on the orphans
Socio-marketing and supply of condoms	Safe sex practices
Research	Change of behaviour

(a) Level of access by the MDA/Council/RAS

Each MDA/Council/RAS has to some extent been accessing services offered by a number of agencies. The average is about three agencies per ministry, council or RAS. Proactive networking with NGOs, private sector and faith based organisations was found to be very limited. The individual position is as follows:

i. The ministries have been accessing services offered by external agencies. As seen from table 3.42 below, the range of agencies accessed is between 1 and 5. Many of the ministries appear to be accessing between one and 2 agencies. The Ministry of Health (MoH) is the out-layer as it is accessing about 5 agencies, but it is not surprising given that this is the ministry that deals principally

with health matters which puts it in unique position to interact with the various agencies dealing with health matters.

Table 3.46: Number of external agencies accessed by the MDAs

	Name of ministry	Are there clear activities under mentioned thematic areas (insert 'Yes'			Number of partners/agencies from which ministry benefits?
		Prevention	Care and support	Advocacy	
1	POPSM	-	-	Yes	1
2	MLYDS	Yes	Yes	Yes	2
3	MOH	Yes	Yes	Yes	5
4	MOEC	Yes	Yes	Yes	-
5	MNRT	Yes	Yes	Yes	3
6	MOF	-	-	-	2
7	MCDGC	Yes	Yes	Yes	1
8	MEM	Yes	No	Yes	1

ii. Each councils studied has been taking advantage of services offered by some non-government institutions as was mentioned above. The number of agencies accessed by each council is presented in the following table. The number accessed is between 1 and 5.

Table 3.47: Number of external agencies accessed by the councils

	Name of council	Are there clear activities[2] under mentioned thematic areas (insert 'Yes'			Number of partners/agencies from which council benefits
		Prevention	Care and support	Advocacy	
1	Hai	Yes	Yes	Yes	3
2	Mbinga	Yes	Yes	Yes	3
3	Songea	Yes	Yes	Yes	5
4	Mbeya	Yes	Yes	Yes	3
5	Tukuyu	Yes	Scanty	Scanty	1
6	Singida	None	None	None	4
7	Iramba	Yes	Yes	Yes	2
8	Kinondoni	Scanty	Scanty	Scanty	4
9	Morogoro	Yes	Scanty	Scanty	3
10	Kilosa	Yes	None	Yes	3-(danida, Unicef, tacaids)

RAS have been taking advantage of services offered by external agencies as well. The number of agencies accessed by each RAS range between 2 and 4 with an average of 3. The summary for each RAS is presented in the following table.

Table 3.48: Number of external agencies accessed by the RAS

	Name of regional administrative secretariat	Are there clear activities[2] under mentioned thematic areas (insert 'Yes'			Number of partners/agencies from which regional administrative secretariat benefits?
		Prevention	Care and support	Advocacy	
1	Kilimanjaro	Yes	Yes	Yes	2
2	Dar es Salaam	-	-	-	
3	Morogoro	Yes	Yes	Yes	4
4	Mbeya	Yes	Yes	Yes	4
5	Ruvuma	Yes	Yes	Yes	3
6	Singida	Yes	Yes	Yes	3

3.8.2: Workers perceptions of HIV/AIDS Interventions at workplace: scope and adequacy

The workers in all the three sectors were given a chance to express their perceptions on the scope and adequacy of the interventions available at the workplace. They were given a chance to list the activities they knew were undertaken by the management, and secondly to tell the extent such interventions managed to satisfy their needs.

What criteria do we use to judge the scope of interventions and adequacy of an intervention?

- For scope, the criterion is the coverage of interventions listed by the respondents less than three thematic areas, prevention, care and support and advocacy.
- As regards adequacy, the criterion shall be: an intervention which is referred to by about 50% of the responses (e.g. in absolute terms 21 responses out 42 responses[9]), and whose rating is 50% in the category of modest satisfaction and good satisfaction, In other words, at least 11 responses should be rated modest/good satisfaction in the case of MDAS.[10]

Generally, the scope/coverage of interventions in workplace is high as indicated by the responses in all the three sectors (MDAs/Councils/RAS).

As regards adequacy, the overall assessment is that much more work needs to be done by the sectors to reach the majority of the workers. Many workers are not aware of the interventions, and where they are aware, the effectiveness/satisfaction is considered low. The following interventions among those listed for each sector, were considered adequate:

<u>MDA sector:</u>

i. Under prevention, only one intervention was considered adequate. This is: Sensitisation of Departmental staffs and other workers though Seminars/meetings, workshops etc.

ii. Under Care and Support there is no single intervention that qualifies for adequacy.

iii. Under Advocacy only one intervention qualify for adequacy, namely: Discussing HIV/AIDS issues in the seminar and or/meeting fora.

<u>Council sector</u>

[9] The number of responses from each ministry/council/RAS visited is 6. Total responses expected from the MDAs which provided full information is 42 (7 multiplied by 6), councils is 60 (10 multiplied by 6) and RAS is 36 (6 multiplied by 6). The benchmark in each case is 25% of the responses. For MDAs it is 10; councils it is 15; and RAS it is 9.

[10] Note that one response against any intervention implies that it is only one worker from the sector concerned who mentioned and assessed it.

i. Under prevention, three interventions meet the criterion, namely:

- Distribution of condoms
- Sensitization seminars/meeting of departmental staff, councillors and workers.
- Public awareness seminars/HIV/AIDS Education.

ii. Under Care and Support, there was no intervention meeting the criterion.

iii. Under Advocacy, there was one activity, namely: preparation of leaflets and billboards.

RAS sector

i. Under Prevention, one intervention met the criterion, namely: HIV/AIDS education realised through meetings, seminars and workshops

ii. Under Care and Support, there was no intervention meeting the criterion.

iii. Under Advocacy, one intervention met the criterion, name: sensitization through public meetings and seminars.

Seminars are used as common platform in the fight of HIV/AIDS at workplace.

As presented in the tables 3.45, 3.46, 3.47 below, there are activities, which appeared to be popular though not meeting the criteria, especially in the areas of Prevention and Advocacy. In the area of Care and Support, there appears to be less emphasis by the institutions as evidenced by the scantiness of responses to most of the interventions listed.

The following is a summary of the expressed views.

(a). In the MDAs the most common interventions mentioned by the workers along the thematic areas (prevention, care and support, and advocacy) and their assessments are presented in the following table:

Table3.49: Common HIV/AIDS intervention activities at the Ministries and their adequacy as assessed by the workers

S/N	Activity	Assessment of Adequacy of Activity/frequency of responses			
		Zero satisfaction (Hakuna Mafanikio)	**Limited satisfaction (Mafanikio kidogo mno)**	**Modest satisfaction (Mafanikio Kiasi)**	**Good satisfaction (Mafanikio yaridhisha)**
• **Prevention**					
1	Training/enabling Peer educators			3	
2	Counselling of community and its workers to undertake Voluntary Counselling and Testing (VCT) …ANGAZA		1	5	2
3	Training of workers in the estates			2	1
4	Distribution of condoms	1	5	5	2

S/N	Activity	Assessment of Adequacy of Activity/frequency of responses			
		Zero satisfaction (Hakuna Mafanikio)	**Limited satisfaction (Mafanikio kidogo mno)**	**Modest satisfaction (Mafanikio Kiasi)**	**Good satisfaction (Mafanikio yaridhisha)**
5	Sensitisation of Departmental staffs and other workers though Seminars/meetings, workshops etc.		2	12	7
• **Care And Support**					
1	Visiting/monitoring and assessment of health status of PLWA and care		1		
2	Provision/enabling of free medicines/treatment for Opportunistic infections (OI)				1
3	Provision of basic needs to orphans (education, cloths and shelter)			1	
4	Provision of food and other basic needs to PLWA and caretakers.				1
5	Enabling the PLWA to access ARVs			1	1
• **Advocacy**					
1	Preparation of leaflets, posters and billboards		1	7	1
2	Film shows on HIV/AIDS and home based care (HBC)				1
3	Discussing the issue in the seminars and/or meetings		1	8	5
4	Participation in public open Meetings, media programs, etc	3		1	3

(b). In the councils the most common interventions mentioned by the workers along the thematic areas (prevention, care and support, and advocacy) and their assessments are presented in the following table:

Table 3.50: Common HIV/AIDS intervention activities at LGAs and their adequacy assessment by LGA workers

S/N	Activity	Assessment of Adequacy of Activity			
		Zero satisfaction (Hakuna Mafanikio)	Limited satisfaction (Mafanikio kidogo mno)	Modest satisfaction (Mafanikio Kiasi)	Good satisfaction (Mafanikio yaridhisha)
• **Prevention**					
1	Training/enabling Peer educators		1	4	
3	Training on Prevention of Mother to Child Transmission (PMTCT)				1
4	Counselling of community to undertake Voluntary Counselling and Testing (VCT) …ANGAZA		4	5	4
5	Training of workers in the estates			2	2
6	Training/education to primary school community on HIV/AIDS		1		2
7	Training/counselling of youth groups			2	
8	Training of home based care for PLWAs				1
9	Training on STIs and its management				
10	Training on condom use	1		1	4
11	Distribution of condoms		6	10	7
12	Sensitisation Seminars/meeting of Departmental staff, councillors, workers	1	3	7	8
13	Public awareness seminars/HIV-AIDS Education	1	4	8	8
14	Establishment of Counselling centres			1	
15	Facilitation of setting up of committees in wards and in the council		1	1	2
16	Enforcement of the act prohibiting sexual relation at work place				1
• **Care And Support**					
1	Identification/Census of PLWA				
2	Training of PLWA and of care takers			4	1
3	Visiting/Monitoring and assessment of health status of PLWAS and care		3	3	3
4	Provision/enabling of free medicines/treatment for Opportunistic infections (OI)		7	5	6
5	Facilitating the formation of PLWA groups				
6	Provision of basic needs to orphans (education, cloths and shelter)		4	2	3
7	Provision of food and other basic needs to PLWA and caretakers.	1	3	4	2
8	Facilitation of PLWAs to network		1	3	

S/N	Activity	Assessment of Adequacy of Activity			
		Zero satisfaction (Hakuna Mafanikio)	Limited satisfaction (Mafanikio kidogo mno)	Modest satisfaction (Mafanikio Kiasi)	Good satisfaction (Mafanikio yaridhisha)
	for Financial support				
9	Supporting the families of the deceased during funeral activities		2	2	2
10	Enabling the PLWA to access ARVs		1		2
11	Support in wills claims processing procedures				1
• **Advocacy**					
1	Preparation of leaflets and billboards	3	6	12	7
2	Film shows on HIV/AIDS and home based care (HBC)			2	5
3	Sensitisation at spiritual gatherings (churches and masjids)				2
4	Sensitisation seminar /meetings by district leaders of all levels, including party cadres.		4	5	3
5	Sensitisation of mass media personnel				
6	Tours of leaders to sensitise and educate			3	
7	Public sensitisation (participation in public open Meetings, media programs, seminars)		5	5	7
8	Preparation and Participation in HIV/AIDS Day			2	2
9	In all meeting workers are reminded about the HIV/AIDS		2	5	
10	Public campaigns to inspect all guest houses to slow down infections				1

(c). In the RAS, the most common interventions mentioned by the workers along the thematic areas (prevention, care and support, and advocacy) and their assessments are presented in the following table:

Table 3.51: Common HIV/AIDS intervention activities at RAS and their adequacy assessment by RAS workers

	Activity	Assessment of Adequacy of Activity/frequency of responses			
		Zero satisfaction (Hakuna Mafanikio)	Limited satisfaction (Mafanikio kidogo mno)	Modest satisfaction (Mafanikio Kiasi)	Good satisfaction (Mafanikio yaridhisha)
Prevention	Voluntary counselling and testing (VCT) programme		2	4	3

	Activity	Assessment of Adequacy of Activity/frequency of responses			
		Zero satisfaction (Hakuna Mafanikio)	**Limited satisfaction (Mafanikio kidogo mno)**	**Modest satisfaction (Mafanikio Kiasi)**	**Good satisfaction (Mafanikio yaridhisha)**
	Emphasizing the use of protective gears (e.g. condoms)		2	4	1
	Emphasizing sports and games to decrease the rate of infection			2	
	To emphasize leadership ethical behaviour		1		
	Education on prohibiting stigmatization		1		1
Care and support	Provision of funds to the PLWAs		3	1	1
	Provision of health services (drugs and treatment)	1	2	3	
	Provision of support for burial ceremony of the deceased.		1		
	Visiting of PLWAs at their homes and hospitals			3	1
	Provision of supports to orphans		1		1
	Provision of support to the family of the deceased				2
Advocacy	Sensitization through Public meetings, seminars		5	10	9
	Sensitization through billboards, leaflets, calendars etc.		2	1	4

It can be observed that the coverage of interventions is in all three thematic areas, it is higher in councils, modest in MDAs and is low in RAS.

3.9 WORK PLACE KEY CHARACTERISTICS REQUIRING ATTENTION

3.9.1: Assessment of Work Place Characteristics:

The management and the workers of MDAs, Councils and RASs were asked to assess some characteristics that were likely to promote the spread of HIV/AIDS at places of work.
Besides, they were required to indicate the reasons why the characteristic is a potential catalyst in the spread of HIV/AIDS and to propose interventions that can possibly contain the effect.
The responses were spectacular. Some of the respondents went further to identify additional activities, which had similar effects.
Since the list of characteristics was large the research team had to select and concentrate on those that were identified by workplace management and workers to pose high risk.

The following tables present the characteristic and summary descriptive figures (percentages) among the respondents with MDAs and Councils assessing the degree of effect that the characteristic poses.

Councils Assessment:

Table 3.52: Councils' Management Perspective of the Effect of Work Place Characteristic Determinant of the HIV/AIDS Catastrophe

SN	Characteristic Description	Percent of Employers Ranking of the Effect of the Characteristic				Priority (by selection rule)
		Low	Aveg.	High	No Effect	
1	Work place Behaviour of workers connoting Sexual Relationships	30.0	20.0	50.0*		√
2	Work schedules and Extra duty arrangements Outside the official working hours and/or insecure work places	30.0	50.0	2.0		
3	Long separation of couples both in public services due Transfers of spouse	0.0	20.0	70.0*	10.0	√
4	Promotions conditioned by kickbacks	10.0	10.0	40.0	40.0	
5	Job offerings on condition of kickbacks	20.0	1.0	40.0	30.0	
6	Work place relocations on condition of kickback	10.0	20.0	2.0	50.0	
7	Boot licking (Kujirahisi ili kupata maslahi au unafuu)	50.0	10.0	20.0	20.0	
8	Retreats, workshop, seminar arrangements at venues outside work stations	50.0	20.0	20.0	1.0	
9	Staff transfers without consideration of its implications on family obligations or on personal retirement preparations	30.0	30.0	4.0	0.0	
10	Assignments which have to be done out in the field for long periods	50.0	20.0	0.0	30.0	
11	Shift work schedules that pose risk or insecurity in gender	10.0	50.0	40.0	0.0	
12	Inadequate Salaries and allowances that cannot fully support monthly normal living.	20.0	30.0	50.0*	0.0	√

SN	Characteristic Description	Percent of Employers Ranking of the Effect of the Characteristic				Priority (by selection rule)
13	Delays in salary payments	0.0	50.0	30.0	20.0	
14	Pay centres inaccessibility	40.0	20.0	20.0	20.0	
15	Traditional mindset that offers to a lady from men is the accepted norm of life (lift to work, lunches and drinks, lady wears etc)	50.0	10.0	30.0	10.0	
16	Laxity in enforcement of policies, standing orders , at work places.	20.0	30.0	40.0	10.0	
17	Deliberate bureaucratic delays in dispensing services.	30.0	20.0	40.0	10.0	

Table 3.53: Councils' Workers Perspective of the Effect of Work Place Characteristic Determinant of the HIV/AIDS Catastrophe

SN	Char. Description	Percent Workers Ranking of the Effect of the Char.				Priority (by selection rule)
		Low	**Average.**	**High**	**No Effect**	
1	Work place Behaviour of workers connoting Sexual Relationships	31.7	25.0	43.0		
2	Work schedules and Extra duty arrangements Outside the official working hours and insecure work places	43.0	16.0	30.0	10.5	
3	Long separation of couples both in public services due Transfers of spouse	8.3	11.7	77.0*	5.0	√
4	Promotions conditioned by kickbacks	31.7	18.3	36.7	15.0	
5	Job offerings on condition of kickbacks	31.7	15.0	41.7	16.7	
6	Work place relocations on condition of kickback	25.0	30.0	40.0	5.0	
7	Boot licking (Kujirahisi ili kupata maslahi au unafuu)	26.0	35.5	33.3	5.0	
8	Retreats, workshop, seminar arrangements at venues outside work stations	28.3	23.3	30.0	15.0	
9	Staff transfers without consideration of its implications on family obligations or on personal retirement preparations	10.0	16.6	53.3*	18.3	√
10	Assignments which have to be done out in the field for long periods	36.7	28.3	25.0	8.3	
11	Shift work schedules that pose risk or insecurity in gender	28.3	20.0	36.7	15.0	

SN	Char. Description	Percent Workers Ranking of the Effect of the Char.				Priority (by selection rule)
		Low	Average.	High	No Effect	
12	Inadequate Salaries and allowances that cannot fully support monthly normal living.	5.0	18.3	66.7*	3.3	√
13	Delays in salary payments	28.3	16.6	33.3	18.3	
14	Pay centres inaccessibility	25.0	21.7	36.7	16.6	
15	Traditional mindset that offers to a lady from men is the accepted norm of life (lift to work, lunches and drinks, lady wears etc)	33.3	23.3	38.3	5.0.3	
16	Lucidity in enforcement of policies, standing orders , at work places.	28.3	45.0	25.0	10.0	
17	Deliberate bureaucratic delays in dispensing services.	18.0	26.7	40.0	16.6	

√ **Selection Criteria**:
For Councils a characteristic, which is indicated as potential catalyst in the spread of HIV/AIDS by Council employers and workers to be high by at least 50% of responses, is selected as candidate requiring attention in the management of the HIV/AIDS pandemic

By this decision rule the following four characteristic require attention in the management of the HIV/AIDS catastrophe at LGAs work places

i. Work place Behaviour of workers that connote Sexual Relationships
ii. Staff transfers without consideration of transfer implications on family obligations or on personal retirement commitments
iii. Long separation of couples due Transfers of spouse
iv. Inadequate Salaries and allowances that cannot fully support monthly normal living.

Together with the above most female teachers in the councils complained about delays in placements to workstations including transfers. In many cases this lead to exposure to sexual corruption.
MDAs Assessment:

Table 3.54: MDAs Management Perspective of the Effect of Work Place Characteristic Determinant of the HIV/AIDS Catastrophe

		Percent Employers Ranking of the Effect Char.				Priority (by selection rule)
SN	Characteristics Description	Low	Aveg.	High	No Effect	
1	Work place Behaviour of workers connoting Sexual Relationships	75.0	0.0	25.0	0.0	
2	Work schedules and Extra duty arrangements Outside the official working hours and insecure work places	62.5	25.0	0.0	12.5	

		Percent Employers Ranking of the Effect Char.				Priority (by selection rule)
SN	**Characteristics Description**	**Low**	**Aveg.**	**High**	**No Effect**	
3	Long separation of couples both in public services due Transfers of spouse	37.5	25.0	37.5*	0.0	√
4	Promotions conditioned by kickbacks	50.0	12.5	0.0	37.5	
5	Job offerings on condition of kickbacks	50.0	12.5	0.0	37.5	
6	Work place relocations on condition of kickback	25.0	25.0	0.0	50.0	
7	Boot licking (Kujirahisi ili kupata maslahi au unafuu)	50.0	0.0	25.0	25.0	
8	Retreats, workshop, seminar arrangements at venues outside work stations	62.5	25.0	0.0	12.5	
9	Staff transfers without consideration of its implications on family obligations or on personal retirement preparations	25.0	25.0	37.5	12.5	√
10	Assignments which have to be done out in the field for long periods	25.0	50.0	0.0	25.0	
11	Shift work schedules that pose risk or insecurity in gender	25.0	0.0	25.0	50.0	
12	Inadequate Salaries and allowances that cannot fully support monthly normal living.	25.0	25.0	37.5*	12.5	√
13	Delays in salary payments	12.5	25.0	12.5	50.0	
14	Pay centres inaccessibility	25.0	25.0	0.0	50.0	
15	Traditional mindset that offers to a lady from men is the accepted norm of life (lift to work, lunches and drinks, lady wears etc)	37.5	37.5	0.0	25.0	
16	Lucidity in enforcement of policies, standing orders , at work places.	37.5	25.0	0.0	37.5	
17	Deliberate bureaucratic delays in dispensing services.	12.5	25.0	12.5	50.0	

Table 3.55: MDAs' Workers Perspective of the Effect of Work Place Characteristic Determinant of the HIV/AIDS Catastrophe

		Percent Workers Ranking of the Effect Characteristic.				Priority By selection rule)
SN	**Characteristics Description**	**Low**	**Average.**	**High**	**No Effect**	
1	Work place Behaviour of workers connoting Sexual Relationships	33.3	21.4	35.7	9.5	√

		Percent Workers Ranking of the Effect Characteristic.				Priority By selection rule)
SN	**Characteristics Description**	**Low**	**Average.**	**High**	**No Effect**	
2	Work schedules and Extra duty arrangements Outside the official working hours and insecure work places	33.3	33.3	21.43	11.9	
3	Long separation of couples both in public services due Transfers of spouse	14.3	19.0	59.5*	7.1	√
4	Promotions conditioned by kickbacks	33.3	11.9	28.6	26.9	
5	Job offerings on condition of kickbacks	33.3	14.3	30.9	21.4	
6	Work place relocations on condition of kickback	23.8	21.43	26.2	28.6	
7	Boot licking (Kujirahisi ili kupata maslahi au unafuu)	23.8	19.1	30.9	26.2	
8	Retreats, workshop, seminar arrangements at venues outside work stations	19.0	28.0	37.1	14.3	√
9	Staff transfers without consideration of its implications on family obligations or on personal retirement preparations	11.9	30.9	42.9*	14.3	√
10	Assignments which have to be done out in the field for long periods	19.1	45.2	21.4	14.3	
11	Shift work schedules that pose risk or insecurity in gender	16.7	21.4	14.3	47.6	
12	Inadequate Salaries and allowances that cannot fully support monthly normal living.	7.1	11.9	57.1*	23.8	√
13	Delays in salary payments	26.2	16.7	23.8	33.3	
14	Pay centres inaccessibility	30.9	16.7	14.3	38.1	
15	Traditional mindset that offers to a lady from men is the accepted norm of life (lift to work, lunches and drinks, lady wears etc)	28.7	28.7	26.2	16.7	
16	Laxity in enforcement of policies, standing orders, at work places.	28.6	19.0	21.4	30.9	
17	Deliberate bureaucratic delays in dispensing services.	28.6	26.2	21.4	23.8	

√ **Selection Criteria**

For the MDAs a characteristic which is indicated as potential catalyst in the spread of HIV/AIDS by MDAs employers and the workers to be high by at least 35% of responses is selected as candidate requiring attention in the management of the HIV/AIDS pandemic

Given this rule the following six workplace characteristics are selected out of the 17.

i. Work place Behaviour of workers connoting Sexual Relationships

ii. Long separation of couples both in public services due Transfers of spouse
iii. Inadequate Salaries and allowances that cannot fully support monthly normal living.
iv. Staff transfers without consideration of its implications on family obligations or on personal retirement preparations
v. Inadequate Salaries and allowances that cannot fully support monthly normal living
vi. Retreats, workshop, seminar arrangements at venues outside workstation

Applying the two decision rules both MDAs and Council workers concur in citing the following work place four characteristics to have high potential in catalysing the spread of HIV in the work places. These are indicative of in priority areas needing attention in the management of the HIV/AIDS catastrophe at their work places.

i. Staff transfers without consideration of its implications on family obligations or
ii. On personal retirement commitments
iii. Long separation of couples due Transfers of spouse
iv. Inadequate Salaries and allowances that cannot fully support monthly normal living.
v. On the other hand only respondents from MDA workers and from Council workers concur that:
vi. Workers behaviour at work places that connote sexual relationship
vii. Is potential catalyst and require attention confronting the HIV/AIDS catastrophe.

Note that by changing the decision rules used to isolate the troublesome characteristic at MDAs or at councils one would isolate a different list of characteristic.

3.9.2: Employers and Workers expressed interventions

For each work place characteristic employers and workers from both the MDAS and councils were given opportunity to express their opinion as to what intervention would be appropriate to contain their potential risk. For the above selected characteristic the following is a summary of the more typical characteristics.

Table 3.56. Summary of Employers and Workers Expressions of Intervention

Selected Characteristic	Employers /Workers Expressed management Intervention
Workers behaviour at work places that connote sexual relationship	i. Enforcement of standing orders by taking stern measures to workers of opposite sex proved to engage in sexual relation at workplaces ii. Intensify workers' education in code of ethics at work places. iii. Apply activity schedules at workplace that emphasize productivity and discourage idling and gossiping.
Staff transfers without consideration of its implications on family obligations or on personal retirement commitments	i. Standing orders for staff transfers should be revised. ii. Implication of transfers on staff familial developments should be taken on board before being transferred. iii. Transferee should be involved in planning the movement. The transfers' management should not disintegrate families but should respect their needs

Long separation of couples due Transfers of spouse	i. Employers should respect marriage contracts in managing staff transfers. ii. Employment act should be repealed to respect and protect the marriage bond where transfer in necessary e.g. give legal rights and not privilege to spouses who are public servant to continue service without separation.
Inadequate Salaries and allowances that cannot fully support monthly normal living	i. Workers remuneration should regularly be enhanced to a living wage. ii. Salary scales should be improved to reduce temptations implied in underpayments.

Observations

Given the above work place characteristic common to MDAs, councils and RAS, certain immediate issues should be addressed.

- Should the employers retain the veto in staff transfers or relocations to workstation that is deliberately built into the predetermined contract which the job seeker is served with at the time of recruitment, with an undertone of take it or leave it.? (e.g. if you accept this contract sign and return it).
- Does the code of ethics and the standing orders address in a very pragmatic manner informal relationships among workers of opposite sex at the same work place? If they exist, where in the human resources management practices have such blue prints been lost? As an example, the teachers' code of ethics punishes a teacher found to engage in love affair with his student. Why then are sexual relationships at workplace not treated as unethical and hence a punishable offence?
- To what extent is the worker enabled to negotiate remuneration to match the changing living costs. The management practice is that the employer has always dictated terms some of which push the worker to risky behaviour

Recommendation:

- A legal framework needs to be established to deal with workplace characteristics that have the potential of being catalyst in the spread if HIV/AIDS or which hinder the fight against the epidemic.
- Employers should respect marriage contracts in managing staff transfers.
- Employment act should be repealed to respect and protect the marriage bond where transfer in necessary e.g. give legal rights and not privilege to spouses who are public servant to continue serving without separation.
- Intensification of workers education in code of ethics at work places.
- Application of activity schedules at workplace that emphasize productivity and discourage idling and gossiping. This is to enforce work discipline at all levels of government.
- Greater sensitization to those with a schedule of duties involving spending many days in a year out of station e.g. drivers, auditors etc.
- Reduce unnecessary long distance travelling and spending of nights out while following up salaries etc. Affected workers are those working in remote areas such as teachers, nurses, and extension workers etc. who have to come to urban centres to collect their salaries.

4.0 CONCLUSIONS AND RECOMMENDATIONS

The study looked at the impact of HIV/AIDS pandemic and its management in three main levels of government, namely the MDAs, the Councils and the Regional Administrative Secretariats. All the three levels are experiencing the impact HIV/AIDS at different magnitudes and direction (increase, stationary or decline). Their management of the epidemic is guided by the same national policy on HIV/AIDS response

and the National Multi-sectoral Strategic Framework (NMSF) overseen by TACAIDS. The President's Office, Local Government and Regional Administration (PORALG) has moved a step further by issuing some more specific guidelines to be used in the management of HIV/AIDS activities in the Councils and RAS. In view of this uniformity in approach in the three levels, the conclusions made apply across. However, distinction will be made among the three levels when deemed necessary.

Conclusions.

1. The HIV/AIDS epidemic is depleting the public service sector viz. the MDAs, Council, and the RAS work force at varying levels of magnitude and there has been no significant sign of decrease over the last four years. This posses another dimension of brain drain in where public service sector is robed of its critical leadership, expertise and hard earned experience. The serious implication is that HIV/AIDS disrupts established working systems and generally destabilizes normal government functions. In the long run this threatens the government ability to promote economic growth, alleviate poverty and improve the quality of life.
2. The public service sector lacks sector specific policy on the management of HIV/AIDS i. Though providing guidance to the public sector, the broader national policy on HIV/AIDS response does not address the specific requirements of employer and employees in the sector. Sector specific policy is needed to provide ample opportunity for the institutions to address the HIV/AIDS related problems more comprehensively. Otherwise the MDAs, Councils and RAS will keep waiting for directives from TACAIDS.
3. There is no legal framework covering issues of HIV/AIDS at workplaces. This has a negative effect on the management of HIV/AIDS.. The legal framework would protect the interests of the employer vis-à-vis the employee and vice versa, and the interest of one employee vis-à-vis another. A basic question one would ask is; does the employer have a right to know the health status of his employees so that decisions made in respect of an employee, for example training, does not lead to unnecessary loss of resources? Likewise, what enforceable rights does the employee have from the employer? How should the ILO code of practice on HIV/AIDS at work place be implement to take on board a balance in the rights and interest of both the employer and employee?
4. Mainstreaming of HIV/AIDS activities in the MDAs/Councils and RAS is on-going in so far as establishment of HIV/AIDS management structures is concerned. A point of concern here is that the HIV/AIDS focal person is assigned coordination responsibilities as additional functions but such functions are not accorded the necessary priority required to make the fight successful.

   The development of HIV/AIDS strategic plans is based on the the institutional medium or long term plans of development but is very rudimentary in the councils and RAS. In all three public service sectors HIV/AIDS activities are being done within functional lines, as can be explained by the existence of AIDS committees in many functional units, but have not received due priority in resource allocation. It is as if HIV/AIDS is not one of the priority areas of the organisation. Apart from sensitisation through seminar activities, HIV/AIDS interventions which require resources to implement, such as care and support activities, find themselves not being in the mainstream of annual engagements.
5. HIV/AIDS related problems have undermined human resource planning in the public service. Vacancies are being created through exits due to AIDS deaths but the replacements take long to be completed. There are problems of getting the lost skills. Besides, bureaucracy in approving replacements is a major concern of authorities particularly in the Councils.
6. There is no change in the mind-set of the officials in the public service on how to make better use of special skills. The use of existing manpower is still traditional, and has not taken on board the potential threats posed by the HIV/AIS scourge at workplace. In lieu of the latter, no institution has thought of making use of multi-skills development approaches for purposes optimizing on available personnel.

7. Government's interventions in the thematic areas of prevention, care and support, advocacy has remained rather superficial, characterised mainly by sensitisation seminars and workshops. Limited activities take place in the area of care and support. Moreover, the worker does not appear to be the main target of the interventions. Most sector plans are about activities for the community rather than the employees.

8. There is a major HIV/AIDS information shortfall in all the three levels of the public service, from the Centre (POPSM) and other MDAS down to the RAS, and Councils. The existing information systems are very poorly organized, and inefficient making it very cumbersome and costly in terms of time to retrieve personnel information.. Information kept on employees is of poor quality measured in terms of completeness, accuracy, consistency and timeliness etc. A lot of the information kept is partial, fragmented or does not flow over time frame or its management is so unorganised that data access is next to impossible.

   The gaps in HIV/AIDS related information at all levels of Government pose a serious obstacle towards making good decisions on capacity building, replacements, multi-skills development and resources allocation

9. The increasing incidences of TB, which is an opportunistic disease, is creating a second epidemic within the public workforce. The contiguous nature of TB creates a risk environment and threat to the rest of the workforce. It appears that annual clean health certification that formally was demanded of every personnel by employment regulation has been forgotten.

Recommendations follow below

Table 3.57: Matrix of Observed Issues and Recommendations Requiring Policy Consideration

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
Legal and Policy framework	1. The public service sector lacks sector specific policy on HIV/AIDS intervention. It is guided by the broader national policy on HIV/AIDS response, which does not address the specific requirements of employer and employees in the sector	Draw up a policy for the public service sector to address the specific work conditions in the sector. The policy paper should be supported by a guideline which helps the sectors in its operationalisation. It has been noted in the text that the guideline which was issued by PORALG has to a large extent helped the Councils in putting together the structures for dealing with HIV/AIDS at that level.	Policy issue	Immediate (Within 1 year)	POPSM
	2. There is lack of a Legal framework covering issues of HIV/AIDS at workplaces leading to negative effect on the management of HIV/AIDS	Develop Legal Framework covering issues of HIV/AIDS at workplaces. The law will be instrumental in enforcing the interventions which will be put in place. For example, a law that makes non-protective sexual activity (PLWA having unprotected sex) in workplace a criminal offence will go a long way in curbing the spread of HIV/AIDS through negligence.	Legal framework issue	Long-term (within three years)	POPSM/Ministry of Justice Constitutional Affairs

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Human Resources Management (HRM)	1. There is ample evidence that the public service is losing it most valuable workforce due to HIV/AIDS in all the three level of government MDAs, Councils and RAS). This makes the public service more vulnerable given that the deaths are occurring in the most prime age of between 31- 50 years.	1. Develop a formal system for allocating and monitoring the effective use of resources. Human resource planning, implementation and monitoring must be practiced. Due diligence should be exercised on the HRM to encompass human resource planning, recruitment, training, motivation and monitoring.	Operational issue	Immediate (Within 1 year)	POPSM/PORALG/MOF
	4. Vacancies are being created and the replacements take long to be completed. 5. Bureaucracy in approving replacements is a major concern of authorities particularly the Councils	2. The system in use for approving replacements by POPSM should be revisited. First let an assessment be done to check on the magnitude of the problem. The internal audit department could do this. 3. A more effective monitoring of staff replacement should be adhered to.	Operational issue	Immediate (Within 1 year)	POPSM

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
	4. There is problem of getting replacement for the rare skills. 5. No institution has thought of making use of multi-skills approaches for purposes of optimising on available skills.	4. POPSM should institute a policy that will provide incentive to staff to move away from single to multiskills, as a way of reducing the severity of the impact of HIV/AIDS scourge. 5. Ensure mechanisms for conservation of the skills and work experiences acquired are in place by encouraging young people to understudy the more experience people.	Policy issue Operational issue	Immediate to long-term (within 3 year)	POPSM/PORALG/Council/RAS
Information Management	1. A major shortfall in the public service, from the Centre (POPSM) down to the regions, districts etc is the lack of efficient information systems. 2. Information kept on employees is poor quality measured in terms of completeness, accuracy, consistency, and timeliness. A lot of the information kept is partial, fragmented, does not flow over time frame	1. Government should put in place comprehensive information system to ensure capturing of such data. Such data should be disaggregated by education, gender, age, level, profession, training level achieved etc. 2. Deliberate efforts should be made to computerize such data throughout the public service 3. Indicators for monitoring purposes should be identified and agreed upon in collaboration with TACAIDS 4. Frequency in Monitoring and evaluation should be established as a matter of policy. 5. Gender should be mainstreamed in the HIV/AIDS related IMS. 6. Guidelines should be in place to identify the type of information to be recorded, types of reports, and their timing. For example, data	The problem of IMS is a policy issue Operational issue	Long-term (within 3 Years)	POPSM/PORALG

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
		and information intended for economic and social analysis could be identified which allow for the following reports to come out: • Time utilisation and the cost of lost time. • The burden of HIV/AIDS in terms of Treatment, funerals, terminal benefits, replacement costs etc. • Opportunity costs of lost production or service due to HIV/AIDS related problems. • The status of families affected by HIV/AIDS in terms of orphans left behind and how they are taken care of; whether those affected have access to housing, education, health; • How many of those affected have been counselled, have left behind a will and to whom did the terminal benefits go to. • A study to measure the economic impact of HIV/AIDS should be undertaken.			
HIV/AIDS management at Workplaces • Mainstreaming • Interventions • Budget allocations	1. Government's interventions in respect of prevention, care and support, advocacy have remained rather superficial, characterised mainly by seminars and workshops.	1. HIV/AIDS programmes aimed at the workers must be articulated in a manner that distinguish activities that target the workers from those that target the public. Activities to be implemented for the workforce should be identified along the thematic areas of prevention; care and support; and advocacy. The activities should also be selected on a prioritized basis.	Policy issues	Immediate (Within 1 year).	MDAs/RAS/Councils (Overseeing by POPSM/PORALG)

ISSUES	OBSERVATIONS	RECOMMENDATIONS	Recommendations with policy implications	Implementation Time Frame	Who is responsible
• Networking	2. Mainstreaming of HIV/AIDS activities in the MDAs/Councils and RAS is on course. 3. Structures in MDAs, Councils, and RAS currently being introduced to manage HIV/AIDS are weak. Typically, the appointment of a 'focal person' to coordinate the HIV/AIDS programmes on a part-time basis underline the weakness. 4. In some MDA's there are divisional committees that are yet to become fully functional. 5. In councils, the committees formed to oversee HIV/AIDS activities focus more on district/community interventions rather than workplace interventions.	For example, • **Prevention:** (i) a strategy for making condoms available to all workers should be worked out; (ii), activities to re-enforce ethical matters should be identified and be programmed for implementation. Etc. • **Care and support:** a system for providing anti-retro viral drugs to those infected should be instituted. • **Advocacy:** again the activities to be implemented should be worked out and be programmed for implementation. 2. The activities identified above under prevention, care and support; and advocacy should be allocated sufficient resources through the institutional budget. 3. Clarify on the structures or institutional arrangements which will ensure that established HIV/AIDS programmes and plans for THE workforce will be implemented. As of now, the roles and responsibilities of the various parties involved in the management of HIV/AIDS at place of work are not clearly stipulated. For effective management; the future should see the following: • An officer to work on HIV/AIDS			

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		matters should be appointed and this should constitute the principal responsibilities and duties. Among other things, he should take charge of planning, implementation, monitoring and reporting of HIV/AIDS matters along the lines of prevention, care and support, and advocacy. And the capacity of the individual should be enhanced through training. • Create an office under PS officer/DED/RAS to take charge of HIV/AIDS issues viz. policy, planning, implementation and monitoring. • Provide clear terms of reference to the office as well as the committees. • The office created should be well resourced with qualified personnel and facilities. • The participation process of the workers should be identified clearly. • Finally, the overseeing/advisory committee to work with the officer should be identified. 4. There are many organisations which are offering valuable services on HIV/AIDS pandemic. The councils should continue with the already demonstrated pro-activeness in accessing available services offered by other institutions. The MDAS			

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		which have lagged behind on this matter on networking should move from their passivity. Also worth noting is the fact that the networking does not need to be confined to Civil Society Organisations/NGOs alone, The private sector, especially the enterprises with multinational setting, could provide valuable experience on how to deal with the HIV/AIDS issues at workplace. (Tap the international practice of firms operating in Tanzania).			
Health of workers	1. Existence of opportunistic diseases e.g. TB which pose a danger to the health of other workers.	1. Routing health checks for workers to be regularized and annualised by making it compulsory. Organizations should develop programmes for ensuring safe health among the existing workforce. 2. On new recruitments, there should be guidelines emphasizing clean certificate of health with a focus on the opportunistic diseases, but also with an understanding that HIV/AIDS is not a disease.		Immediate	All Chief Executive Officers/personnel officers in MDAS, Councils and RAS
Information education and communication	1. Workers are not informed enough of what the employer is doing on HIV/AIDS pandemic.	1. When the policy/guidelines on HIV/AIDs in the public services are prepared, the issue of IEC should be part of it. 2. Each MDA/Council/RAS should then prepare an IEC strategy. The IEC is an important tool for passing information to and from workers/management.		In the next one year	POPSM, all MDAs/Councils and RAS.

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Work place Characteristics	1. Workers behaviour at work places connotes sexual relationships. 2. Sexual corruption was observed to an issue when seeking placement or transfer especially in the case of teachers.	1. Standing orders should be revisited for purposes of bringing on board behavioural/ethics issues pertaining to HIV/AIDS. 2. Assess the effectiveness of operationalisation of the standing orders, the code of ethics in public service and other control measures instituted for purposes of identifying loopholes to be addressed. 3. Transparency in the management of transfers, relocations, and placements should be enforced.		Immediate (within 1 year)	POPSM
	3. Staff transfers without consideration of its implications on family obligations or on personal retirement commitment	4. The issue should be studied further in relation to national gender and employment policies.		Long-term (within 3 years)	POPSM