This paper was prepared as part of a series addressing the context of HIV/AIDS, work and development at the country level. It examines the demographic and socio-economic impact of HIV/AIDS in Tanzania.
Acknowledgements

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**Acronyms**

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

This paper was prepared as part of a series addressing the context of HIV/AIDS, work and development at the country level. It examines the demographic and socio-economic impact of HIV/AIDS in Tanzania. The paper describes the effects of HIV/AIDS on labour supply and on the demand in key skills and occupations. It identifies current and potential shortages in human resource capacity that will significantly affect economic development and growth in Tanzania. It also develops policy implications and provides recommendations for a coherent intervention by the ILO, in cooperation with its tripartite partners.

Section A looks at the recent economic and labour market situation and analyses the current epidemiological trends. It provides estimates of the epidemic and its impact on demographics and the labour market. HIV in Tanzania spread rapidly since the first cases of AIDS were reported in 1983. According to the most recent available sentinel surveillance data, HIV prevalence among women seeking antenatal care is frequently over 10% and, in one rural site, was found to be 32.5%. Studies from blood donors and population-based studies confirm these data. Tanzania today faces a generalized epidemic with one of the highest national prevalence rates of HIV/AIDS in the world.

Among the socio-cultural and behavioural factors contributing to the spread of HIV are: sexual intercourse at a very young age; couples marrying later in life, which creates a long gap between first sex and first marriage; a high number and turnover of sexual partners; migration; gender norms; lack of knowledge and widespread taboos; low condom use; and a pool of sexually transmitted infections (STIs) in the population. The epidemic will change the demographic structure on the labour force in Tanzania, causing a reduction in the labour force and a decrease in life expectancy.

Section B describes the macroeconomic and microeconomic impact of HIV/AIDS on the labour force in Tanzania, and its impact on economic variables as well as on human capital accumulation in various sectors. It looks at the impact on some businesses in sectors such as agriculture, health, the public sector, the informal sector and education, where the effects are being seriously felt. Finally, it examines the microeconomic impact of HIV/AIDS on households and the consequences of large number of orphans with inadequate schooling entering the labour force pool. Empirical evidence on the impact of HIV/AIDS in Tanzania is very difficult to obtain and very few comprehensive studies have been carried out in this area. The HIV/AIDS epidemic has not yet run its full course and, since the disease has a long incubation period between infection and disease, the effects of infection are experienced over a long period of time. As a result, these effects have not been fully studied or evaluated.

Section C identifies key areas of significance for ILO/AIDS and its partners in developing its policy options in Tanzania. It includes the national response to HIV/AIDS by the Government of Tanzania and what specific measures, if any, have been taken to mitigate the effects of the epidemic in the workplace. This section discusses the newly-administered multisectoral AIDS strategy and the Ministry of Health’s initiatives in countering HIV/AIDS. Yet it shows that these initiatives have not sufficiently taken the workplace into account, and that the socio-economic impacts of the epidemic have not been fully considered. HIV/AIDS is still widely considered a health issue, despite national and international efforts to increase awareness about the multisectoral dimensions of the epidemic. Section C recommends steps to promote awareness of the socio-economic impact of HIV/AIDS and to make prevention, treatment, care and support programmes available for workers infected with HIV.

Much of the field information (especially that relating to the impact on various sectors and ministries) in this paper is the result of two ILO field missions to Tanzania, during which information was collected on the basis of group discussions and key informant interviews. The results of these are summarized in sections B and C of the paper.
A. Situation analysis

1. Recent economic trends and labour market situation

Tanzania is the largest of the East African countries, characterized by three main physiographic regions—namely, the islands and the coastal plains to the east; the inland saucer-shaped plateau; and the highlands. Dodoma, which is located 309km west of Dar es Salaam, is the country’s political capital, whereas Dar es Salaam is the country’s commercial capital. The economy depends heavily on agriculture, which accounts for half of the country’s GDP, and provides 85% of exports. Topography and climatic conditions, however, limit cultivated crops to only 4% of the land area.

Tanzania has a GDP of US$478 per capita (2000) and is one of the poorest countries in the world. Over 50% of its 36 million people live in extreme poverty. Its ranking on the Human Development Index (HDI) is 140th among 162 countries. However, in recent years, the GDP has increased steadily from 1.5% to 2.6% per year for the last three years. Together with the economic growth, overall health-care spending (public, private and non-profit) is likewise increasing rapidly and household expenditures for health services have more than doubled since 1991. These gains in development are being reversed by the onset of the AIDS epidemic. It has been estimated that Tanzania’s future GDP will be 15–20% lower in 2010 than it would have been without the AIDS pandemic. Many sectors of the economy, such as transport, education and mining, are experiencing a loss of skilled labour, increasing recruitment costs, sick leave costs and reduced revenue. This is exacerbated by rapid population growth (2.9%, 2002), high rates of infectious diseases (including HIV), unsustainable use of natural resources, and weak human and physical infrastructure.

The 2002 population census counted a total of 36.9 million Tanzanians, of whom 23% live in urban and 77% live in rural areas. The annual population growth rate stood at 3%, resulting in a relatively young population, with 46% under 15 years of age. Life expectancy is 51 years for females and 49 years for males. According to the United Nations’ medium-variant projections, the population will reach 42.3 million in 2010 (United Nations, 1998). The population pyramid is typical of a country with continuing high rates of fertility and a youthful population.

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

2. Trends in HIV/AIDS prevalence

Tanzania today faces a generalized epidemic, with one of the highest HIV prevalence rates in the world and a rising rate of HIV infection. The first cases of AIDS in Tanzania were reported in 1983 in Kagera. Only four years later, all regions reported cases. The National AIDS Control Programme (NACP) reported a cumulative total of 144,498 known AIDS cases by the end of 2001. It is estimated that only 20% of AIDS cases are reported. The cumulative total of AIDS cases that have occurred since the epidemic started could thus be as high as 722,490. Overall prevalence of HIV among blood donors for 2001 was 11%.
Antenatal clinic surveillance results from 2002 place the prevalence of HIV at 9.6%. As is the case in many other parts of sub-Saharan Africa, prevalence among males was significantly lower than among females—10% versus 14%, respectively. In some rural areas, rates of infection among women were as high as 32.5%. These rates roughly translate into more than 2 million Tanzanians over the age of 15 living with HIV/AIDS. Of these, 1,867,561 (770,468 males and 1,097,093 females) were 15–49 years old. The highest prevalence rates among women have been observed in the 25–29-year-old age group and, among men, in the 30–34-year-old age group, suggesting that women are infected earlier than men. In addition, the disease has the strongest impact on individuals in the prime of their working and child-bearing years, who thus have a limited capacity to make a productive contribution to society.

According to the NACP’s surveillance of HIV and syphilis in antenatal clinics (2001–2002), there are big variations between and within regions in the prevalence of HIV infection (see Table 1), with the range in prevalence between the highest and lowest being 0.5–17.9%.

Statistics show that over 12.4% of clinic attendees were co-infected with syphilis and HIV. A majority of those co-infected were married (86%), in their productive prime (aged 25–29) and living in urban areas. DHS (Demographic and Health Survey) data and HIV surveillance data also revealed trends for tuberculosis and other opportunistic infections. A Tanzanian HIV-positive adult is estimated to have about 17 illness episodes before death, and the health-care costs for each patient can be twice the Tanzania GDP per capita (US$478 in 2000). The number of tuberculosis cases has increased rapidly in Tanzania, mainly due to the HIV/AIDS epidemic (more than half of the adult population has already been infected).

The annual increases are 5–10% and the majority of cases appear in those aged 15–45. Overall, the HIV prevalence rate in Tanzania is not as high as in the worst-affected countries in the region, even though absolute numbers are very high. However, in some regions of the country, and in Dar es Salaam itself, rates of HIV are high even by the standards of the worst-affected countries.

### (i) Factors contributing to the spread of HIV infection

A number of socio-cultural and behavioural factors continue to fuel the HIV epidemic: sexual intercourse at a very young age for both men and women; more couples marrying later, which creates a long gap between first sex and first marriage; a high number and turnover of sexual partners—both in and out of marriage; lack of knowledge and widespread taboos, worsened by low, inconsistent and incorrect use of protection during sexual intercourse; and a pool of sexually transmitted infections (STIs) in the population.

#### Age of first intercourse:

According to a ‘Knowledge, Attitudes and Practices’ (KAP) study, 30.2% of boys and 21.2% of girls first had sexual intercourse at the age of 14 or less; Nearly 80% of students first had intercourse at the age of 17 (women 81.3%, men 79.3%). The 1999 Tanzania Reproductive and Child Health Survey (TRCHS) showed that, by the age of 15, about 20% of all women had had sex and, by 18 (which is the legal age of marriage in Tanzania), about 68% of all women had already had sex and only about 46% had married.

#### Age of marriage:

The young age at first sex is coupled with an increasing older age of marriage for both men and women. In combination with low condom use this increases the risk of sexual promiscuity, and thus of STI and HIV infections as well as unwanted pregnancies. The latter

<table>
<thead>
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<td>8.8</td>
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<td>Mangaka</td>
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</tr>
<tr>
<td>Nanyamba</td>
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<td>6.4</td>
</tr>
</tbody>
</table>

Source: National AIDS Control Programme (NACP)

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7 Clinton Business Plan, August 2003.
often results in young women discontinuing their education, which may, in turn, prevent them from learning about AIDS and STIs.

**Lack of knowledge:** In Tanzania, surveys indicate that mostly all men and women have heard of AIDS and more than 95% of the population knew that it was possible to protect oneself from HIV. Despite the gradual increase in awareness, the number of men and women actually using condoms has remained low, for a number of reasons, including insufficient knowledge, inaccessibility of condoms, religious beliefs, and a dislike for the method. In fact, quite a large number of men and women do not consider themselves to be at some degree of risk of becoming infected and the disease is always perceived as something happening to someone else.

**Gender norms:** Gender relations and norms of sexual behaviour are at the root of much of the transmission of HIV in Tanzania. Considerable HIV transmission occurs through sex workers, whose clients spread the virus into the general population. Infection rates among high-risk groups such as sex workers have been reported at levels of 42–50% in the capital city of Dar es Salaam.

**Migration:** There has been unequal economic development between regions, and between urban and rural areas, for many decades. As a result, regions such as Kagera have long been a source of emigration to other parts of the country (a fact that partly explains the high rates of inward remittances that have supported families affected by HIV/AIDS in Kagera in the past decade). In addition, there are regions with intense internal population movements, as for example the Mbeya region, situated at the borders between Tanzania, Malawi and Zambia. A highway and a railway line connecting the Tanzanian capital with the other countries has resulted in the region becoming one of the worst hit by HIV/AIDS in the country. Furthermore, Tanzania is a poor country by SADC and international standards and will therefore tend to suffer from emigration of those with internationally valuable skills and qualifications. As in other countries in the region, the losses due to HIV/AIDS in Tanzania seem to be high in areas such as nursing and teaching, where skills and qualifications are transferable (Cohen 2003). While data on such labour losses to Tanzania do not exist, it has to be assumed that these losses are taking place, and that they further exacerbate the country’s diminishing human resource capacity.

### 3. Demographic Impact

This section looks at the current labour market situation in Tanzania, demographic changes and trends relying on data from the 1990/1991 and the 2000/2001 Labour Force Survey (LFS) and labour market projections carried out by ILO.

The LFS shows that Tanzania has a very youthful population; people under 15 make up 46% of the country’s population (2002 Census). The 2000–2001 LFS showed that 80% of the labour force lived in rural areas. Many workers (43% of the labour force) have only had access to primary education. A quarter of the workforce has never attended school and another quarter has attended school but not completed primary school. Data show that there are more females who have never attended school than males. Agriculture continues to be the main occupation of the workforce, accounting for 80% of the total employed population.

By 2020, Tanzania is projected to lose 9% of its population to AIDS, which, in absolute terms, represents a loss of 2 million people. Life expectancy is expected to reach a low of 50 years in 2000–2005, representing a loss of 8 years, compared to 1995–2000 (see figure 1).

#### (i) Trends in population structure

The impact of HIV/AIDS on mortality has resulted in a reduction of the number of people in their productive years. This has given rise to progressively fewer earners to provide for a wider base of dependents. The composition of the population and workforce is changing, such that there is a rising number of young people who had to become the breadwinners. It is predicted that the workforce will become younger (with a projected average age of 29 instead of 31 in 2010), less experienced, and less educated and trained (World Bank, 1997) as a result of HIV/AIDS.

A number of organizations, such as UNICEF, the World Bank and UNFPA, have produced

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9 TRCHS 1999.


11 South African Development Community.
projections of future populations, taking into account the impact of the HIV/AIDS epidemic as well as changes in fertility. Most of these organizations have concentrated on specific development sectors. For example, UNICEF, in collaboration with others, has looked at the projected number of orphans for different countries. UNFPA looks at population size with and without the epidemic and has incorporated the slightly lower growth rates in their projections that go to 2050. The results of the population projections carried out by ILO are discussed below.

(ii) Impact on the labour force

The Labour Force Survey results are further corroborated in Table 2. It can be seen that there are significant declines in the labour force already taking place due to HIV/AIDS, and that these will become larger over the next decade.

Table 2 shows that the labour force is still expected to grow significantly, but increased mortality due to AIDS clearly results in fewer persons of working age than would be the case in a no-AIDS scenario. By 2015, Tanzania will experience an 8% loss of active labour force as a result of HIV/AIDS. This is close to the Economic and Social Research Fund (ESRF) projections, whereby the active labour force is predicted to be roughly 9% smaller by 2015 than it would be in the absence of HIV/AIDS, with the female labour force being the most affected.

However, the loss is even greater when we consider the quality of the workforce lost as a result of AIDS such as qualified and experienced people who have trained in specialized skills. As stated before, there will be fewer experienced workers, in terms of education, skills, experience and health status. Policy-makers need to take account of these changes when formulating policies and programmes for social and economic development in the coming decades, since the size and quality of the labour force in terms of human capital accumulation are important determinants for economic growth.

Table 4: Percentage losses in labour force due to HIV/AIDS, 2005-2020

<table>
<thead>
<tr>
<th>Age group</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
</tr>
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<tbody>
<tr>
<td>15 - 24</td>
<td>0.5</td>
<td>1</td>
<td>3.6</td>
<td>5.6</td>
</tr>
<tr>
<td>25 - 34</td>
<td>6.4</td>
<td>6.6</td>
<td>5.2</td>
<td>5.2</td>
</tr>
<tr>
<td>35 - 44</td>
<td>10.9</td>
<td>14.3</td>
<td>14.9</td>
<td>13.5</td>
</tr>
<tr>
<td>45 - 54</td>
<td>9.2</td>
<td>14.3</td>
<td>18.2</td>
<td>19.9</td>
</tr>
</tbody>
</table>

Source: ILO and PPU

Projected active labour force by gender:

As illustrated in Table 3, mortality due to AIDS among women is more than that among men. By 2020, Tanzania will lose an estimated 1,145,000 female workers to AIDS, compared to 1,098,000 male workers (i.e., 47,000 more women than men). Fertility levels in Tanzania have declined from seven children per woman in the early 1980s to about six in the early 1990s. This trend has picked up and is partly the result of women marrying later in life.

Age-specific effects of AIDS on the active labour force:

The HIV adult prevalence rate in Tanzania is lower than in Mozambique or Zambia. This is reflected in smaller losses due to AIDS in comparison to the other two countries. However, there is still a greater effect on the older population than on young people. Projections displayed in Table 4 show that the number of 15–24-year-olds is projected to increase by 50% between 2000 and 2020, while under a no-AIDS scenario it would have increased by 60%. By 2005, Tanzania will have lost about 11% of its labour force in the age group 35–44, and about 9% in the age group 45–54, as compared with a no-AIDS situation. The number of 45–54-year-olds would have increased by 115% under a no-AIDS scenario, from 2 million to 4.2 million. But, with AIDS, its projected increase is at 80%, increasing the population in this age cohort to only 3.6 million.

Figure 2

Total projected active labour force (15-49-year-olds) with and without AIDS

Source: ILO.

12 Economic and Social Research Foundation (ESRF), 2003.

13 Adult (15–49)

HIV prevalence rates: Mozambique 13%, Zambia 21.5%, Tanzania 7.8%.
In a country such as Tanzania, where labour is fundamental to agricultural production, the impact of both morbidity and mortality is severe. This has already started to result in increased dependency ratios, decreased agricultural production and, thus, an increase in poverty.

The age group 15–24 continues to experience losses due to AIDS such that, by 2020, this age group will have lost about 6% of its cohort. The impact is also seen in the 35–44-year-old age group, where almost 15% of the labour force will have been lost by 2010, and almost 13% of this would have been lost by 2020.

The above-mentioned projections must be used with caution as many assumptions and limitations are involved in making demographic projections. Table 5 uses projected figures from ILO and from the Tanzania Population Planning Unit, and shows that, over time, the degree of discrepancy increases in the estimates produced.

In fact, the further into the future the projections are made, the more ‘supposed’ the assumptions will become. Arndt and Wobst looked at the 2001 Labour Force Survey data for Tanzania and found significant data errors when compared to census data (on HIV/AIDS and labour markets in Tanzania). The study concludes that, “while the exact impact of the HIV/AIDS epidemic is extremely difficult or impossible to ascertain, the weight of evidence indicates that the pandemic is having a potentially strong effect on the Tanzanian labour force.”

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<td>14,635,000</td>
<td>16,654,000</td>
<td>19,057,000</td>
<td>21,922,000</td>
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<tr>
<td>PPU</td>
<td>15,116,109</td>
<td>17,595,538</td>
<td>20,481,665</td>
<td>23,841,170</td>
</tr>
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</table>

Source: ILO and PPU

Figure 3
Mortality due to AIDS by gender
Source: ILO.
B. Economic impact of HIV/AIDS

However, the demographic impact of HIV/AIDS on different industries, and in both formal and informal sectors, must also be assessed for a better understanding of exactly what changes are taking place within various strata and geographical regions of the country’s labour force.

Tanzania is one of many countries experiencing a reversal in human development due to the HIV/AIDS epidemic. It has been estimated that Tanzania’s future GDP will be 15–20% lower in 2010 than it would have been without the AIDS pandemic. Although Tanzania is one of the poorest countries ranked in the HDI, the government spends around US$6 per capita on health and US$15 per capita on primary-school education. The Bureau of Statistics in 1997 estimated the literacy rate to be around 84%, with a gross enrolment rate of 79%. About 48% of the population lives in absolute poverty. The national Poverty Reduction Strategy Paper (PRSP) of the World Bank considers HIV/AIDS a central challenge. Productive sectors of the economy are experiencing a loss of skilled labour, increasing recruitment costs, sick leave costs and reduced revenue. Certain economic sectors, such as transport, education and mining, are particularly hard-hit.

1. Macroeconomic impact

Tanzania experienced a GDP growth of 6% in 2002 and 5% in 2003. However, these gains will be reversed due to HIV/AIDS. The epidemic undermines all sectors of the economy, and is gradually draining the productive workforce. Tanzania’s future GDP is predicted to be 15–20% lower in 2010 than it would have been without AIDS. The ESRF projections suggest that, by 2015, the economy will be 8.3% smaller and the per capita GDP will be around 4% lower as a result of HIV/AIDS. The principal effects on the economy will be due to increasing sickness, which will, in turn, lead to:

- a reduction in labour periodicity;
- an increase in health-care expenditure;
- a reduction in human-capital investment and
- a reduction in savings.

Mortality rates are such that employers are losing many of their more experienced personnel, and facing shortages of skilled workers. Work performance and productivity are also being undermined by increasing health-care costs, absenteeism, burial expenses, and additional recruitment and training costs. Industries that attract large numbers of migrant workers, such as mines, are particularly vulnerable to the spread of HIV and, without an intensive prevention and treatment programme, they are likely to act as a major focus for the explosive increase in HIV and associated infections, both among the workforce and in the surrounding communities. Labour productivity has been reduced in maritime activities, civil aviation, road and rail transport, and postal, telecommunications and meteorological services.

2. The impact of HIV/AIDS on specific economic sectors

For most developing countries, such as Tanzania, qualified personnel are in short supply and the time it takes to train doctors, teachers, engineers, social scientists etc. makes the substitution of such skills a major development challenge. The results of an ILO field mission to Tanzania (in mid-2003) provided much of the information on HIV/AIDS-related losses felt in specific sectors. This area has been one of the least researched so far and studies are urgently needed—all the more so because of the time lag between the losses and the replenishment of human or other resources, during which a great deal of inefficiency will be experienced by the sectors involved.

(i) Business

Businesses have been noted to have felt the impact of the HIV/AIDS epidemic and business closures have occurred in many sectors (e.g., transport sector) due to HIV/AIDS. The impact on personnel and management has been reported by the Tanzania Chamber of Commerce and Industry and by the Government of Tanzania. The private sector of Tanzania currently employs approximately 354,000 Tanzanians. Many of these companies offer health benefits to their employees and, in most cases, to at least some of their dependents. However, for a variety of reasons, employers are dissatisfied with current methods of offering employee health-care programmes. They are also increasingly

14 Cuddington, 1993; World Bank, 2002.
15 Based on a survey conducted between September and November 2002 in six districts across five mainland regions: Kinondoni, Mbeya Rural and Mbeya Urban, Simanjiro, Dodoma Urban and Kahama.
16 A survey of six business firms found that the annual average medical and burial costs per employee increased 3.5 times and 5.1 times respectively between 1993 and 1997 because of AIDS (Clancy, 1998, quoted in Guinness & Alban, 2000).
17 Result of a recent ILO fact-finding mission around mining areas.
concerned about the likely direct impact of HIV/AIDS on their companies and see a need to develop programmes targeting both prevention and management. In November 2002, a number of private sector organizations in Tanzania identified a common need to develop new health-care benefit approaches and HIV/AIDS programmes for employees. Fifteen private companies, representing 353,000 people (70,000 employees and 283,000 dependents), agreed to collaborate in a feasibility study to identify options for providing better care at a reasonable cost.

Tanzania has collated little empirical or quantitative evidence on the impact of HIV/AIDS on businesses; in addition, a few studies have been conducted but different researchers use very different methodologies in gathering data, which makes the impact of HIV/AIDS on productive labour very difficult to determine. This situation is compounded by several other factors. Firstly, the HIV/AIDS epidemic has not yet run its full course and, since the disease has a long incubation period between infection and disease, the effects of infection are experienced over a long period of time. Data that can show the impact of mortality on labour supply, such as the census, are conducted (usually) every 10 years, making it difficult to actually track the effect of mortality until a decade has passed. Secondly, it is almost impossible to get an accurate macro picture of the infection rates of the productive labour force because of issues of privacy and reluctance of those already infected or of relatives of the deceased to release this information. Thirdly, it has been argued that it is actually very difficult to distinguish the impact of HIV/AIDS from other dynamics that influence morbidity and mortality, such as government economic policies that might ultimately affect people’s health.

The actual situation on HIV prevalence is largely unknown in many enterprises and it will only be known to those employers who insist on mandatory testing of their workforce. Mandatory testing is not permitted by the Government of Tanzania, but this regulation is mainly ignored by large producers. Standard Chartered Bank admitted in 2002 that it tested all employees, and Tanzania Beverages (a subsidiary of South African Breweries) is reported to test all employees every three-to-six months. It is, however, unclear as to how many firms actually carry out mandatory testing, and the repercussions for employees and their dependents are not known.

Coca Cola Kwanza covers all of its employees through a private insurance programme that bears the full financial risk in exchange for a monthly premium. TANESCO Management would like to develop a different health-care benefit and have explored options through providers in Tanzania but are concerned with the costs incurred with 6500 employees on their books. Seven companies interviewed said they perceived the effect of HIV/AIDS on their personnel or knew of specific employees who had died or became ill as a result of AIDS. The others said that they were aware that HIV/AIDS was a problem but had not yet perceived its impact on their workforces. In general, employers had difficulty estimating when an impact would be felt, or how severe it would be. This is partly due to a general lack of accurate, consistent community HIV-prevalence data. Two companies, Brooke Bond and TANWAT, had data on worker HIV prevalence from in-house testing facilities. Other companies rely on information from District Health Officials or local NGOs. Managers find this information inconsistent and insufficient to warrant expenditure on HIV/AIDS programmes. Companies have not attempted to obtain any data because HIV prevention has very low priority or no priority at all.

TTCL (Tanzania Telephone Company limited) has had a workplace HIV/AIDS policy for several years. A memorandum of agreement with the African Medical & Research Foundation (AMREF) for operating a workplace programme package has been agreed upon. The approved medical budget for 2003 includes funds for HIV/AIDS workplace intervention programmes. Programmes were initiated in Dar es Salaam in early 2003, including the training of Peer Health Educators, distribution of condoms, and free access to voluntary counselling and testing (VCT) for all employees and dependents. These activities were under way regionally by June 2003, reaching about 21,000 employees and dependents. The company is currently paying for ARV for 30 employees.

Brooke Bond Tanzania, which experiences 60–70 employee deaths per year due to HIV/AIDS, has a workplace policy on HIV/AIDS. Moreover, 60% of deaths in the company hospital are due to AIDS-related illnesses. Its HIV/AIDS programmes include funds for a supply of the ARV Nevirapine, which is administered free to pregnant HIV-positive VCT clients during labour and to their children after delivery, peer health education, cultural community activities and VCT with an approximate yearly uptake of 600 clients. All employees and dependents are tested free of charge, but other community members may pay a small fee for VCT services.

Table 6 demonstrates the number of AIDS deaths in production and service organizations...
over the period 1988–93. The information cited here is old and might not reflect the current impact of HIV/AIDS on Tanzania’s productive labour force. Also, it does not include institutional costs due to illness and death from HIV/AIDS. The table shows the average age of those who have died of AIDS in these organizations and it is clear that the loss is highest among relatively young workers aged between 31 and 39 years. Given that the retirement age in Tanzania is 55 years, then each worker that dies loses between 16 and 24 years of productive employment. According to a more recent research report (ESRF, 2003), infected individuals are, on average, forced to reduce their working time by 43 hours over six weeks in order to tend to their medical needs.

More recent studies show that larger enterprises, such as the Tanzania Electric Power Supplies (TANESCO), have experienced high death rates among their employees. About 597 workers have died due to AIDS in two years (TACAIDS, 2002). In addition to a high number of deaths, there is evidence of other costs that have to be borne by organizations in this era of HIV/AIDS. Health costs for the Tanzania-Zambia Railway have increased by 64% over a one-year time span. In the Tanzanian business sector, a survey of six firms revealed that the annual average medical and burial costs per employee increased 3.5 times and 5.1 times respectively between 1993 and 1997 because of AIDS (Clancy, 1998).

(ii) The public sector

All ministries acknowledge the impact that HIV/AIDS is having on their organizations. They confirm the increase in the number of workers who were ill and who had died and the increase in the number of days that workers take off to visit the bereaved and to attend burials. While every ministry had recently established an HIV/AIDS committee that is charged with handling all matters relating to HIV/AIDS in the workplace, including information and training, only the committee at the Ministry of Energy is known to the ILO Dar es Salaam office to have convened a meeting. Human resource capacity was not on the main agenda of any of these committees.

Table 6: AIDS deaths in selected organizations, 1988–93

<table>
<thead>
<tr>
<th>Organization</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% of total workforce</th>
<th>Mean age (years) at death</th>
<th>Total workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kibo Papers Ltd</td>
<td>11</td>
<td>2</td>
<td>13</td>
<td>2.46</td>
<td>38.7</td>
<td>529</td>
</tr>
<tr>
<td>TAZARA (Tanzania Zambia Railway Authority)</td>
<td>41</td>
<td>1</td>
<td>42</td>
<td>1.22</td>
<td>3.6</td>
<td>3451</td>
</tr>
<tr>
<td>National Insurance Corporation (NIC)</td>
<td>17</td>
<td></td>
<td></td>
<td>0.78</td>
<td>3.6</td>
<td>2192</td>
</tr>
<tr>
<td>JV Group</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>0.16</td>
<td>4500</td>
<td></td>
</tr>
<tr>
<td>CUT Group</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1.6</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>University of Dar es Salaam (UDSM) (students)</td>
<td>31</td>
<td>10</td>
<td>14</td>
<td>4.67</td>
<td>31</td>
<td>300</td>
</tr>
<tr>
<td>UDSM (workers)</td>
<td>33</td>
<td></td>
<td></td>
<td>1.16</td>
<td>39</td>
<td>2837</td>
</tr>
<tr>
<td>National Bank of Commerce (NBC)</td>
<td>22</td>
<td></td>
<td></td>
<td>N/A</td>
<td>23.4</td>
<td></td>
</tr>
</tbody>
</table>

Source: ILO

As mentioned before, none of this information can be backed up by hard data. Although no statistics were available, the ILO research team was informed that there were significant differences in the needs of the various ministries dealing with the epidemic. The Ministry of Foreign Affairs, for example, prefer if outside parties implemented and operated programmes. Williamson Diamonds’ managers said that, since HIV/AIDS is a very taboo issue, attempting to address the issue at work by introducing voluntary HIV prevalence testing would have a negative effect on worker morale and decrease productivity. The view that a comprehensive workplace intervention programme is very expensive deters many companies. This is a sensitive issue for employers, many of whom are attempting to cut costs while increasing production. Companies such as Kilombero Sugar and Security Group are concerned that implementing programmes might disrupt work schedules because of the need to relocate employees for education.

23 Kim Barker et al.
24 This section is based on the results of an ILO mission to Tanzania (June 2003).
has an almost exclusively urban-based workforce, while the Ministry of Agriculture has a workforce that operates in remote rural areas. For this latter ministry, therefore, access to such workers was considered a huge challenge in delivering the HIV/AIDS message and also in compiling statistics on HIV/AIDS-related deaths and illness. All ministries, however, face similar challenges in dealing with HIV/AIDS as a human resource calamity. Firstly, ministries are under no instructions to compile HIV/AIDS morbidity or mortality data and therefore do not have readily-available collated data on the number of deaths in their ministries. Secondly, for confidentiality reasons, it is difficult to keep data on human resource capacity depletion, as workers do not have to reveal their serostatus at work. Statistics on the cause of death can, therefore, not be accurately compiled. Thirdly, it was also mentioned that ministries do not have the resources, the skills or the mandate needed to compile such statistics. Fourthly, and most important of all, all activities to mitigate the effects of HIV/AIDS were geared towards educating the workforce on how to prevent the spread of the disease. The macroeconomic impact of HIV/AIDS and, therefore, the impact on human resource capacity, were not yet on the agenda.

However, the public sector does intend to provide care and treatment for HIV/AIDS. ARVs are not yet available within the public health-care system except in a very small number of prevention of mother-to-child transmission (PMTCT) sites and access to antiretrovirals is extremely limited for the average Tanzanian. Even though the price of treatment fell from US$12 000 a year per person in 1998 to US$500 in 2002, it remains well beyond the means of most Tanzanians. As a result, it is the goal of governments to develop ways of financing the provision of antiretrovirals. The arrival of antiretrovirals at the Ministry of Health, through the Global Fund to Fight AIDS, Tuberculosis and Malaria, is expected to prompt health-care decision-making, the government piloted a Community Health Fund (CHF) in 1996. This was designed to provide rural residents with access to a basic package of health services through the purchase of a health card.

The National Social Security Fund was established in 1997. It began operations in June of 1998 and absorbed and replaced the National Provident Fund created by law in 1964. It is now the goal of the NSSF to offer health-care benefits to their 400,000 members and their families (up to five dependants per covered life). At the moment, this commitment has not been implemented and the NSSF have been advised by the ILO to stall the introduction of health-care benefits to these 2.4 million Tanzanians until a system of delivery and payment has been developed. Two private insurers exist in Tanzania—African Air Rescue (AAR), registered in Kenya and Medical Express Tanzania Limited (MedEx), registered in South Africa. AAR provides medical insurance to both corporate and individual clients. AAR, which is based in Nairobi, has been active in Tanzania since 1998. AAR currently provides coverage to 7,000 members.

Labour legislation: According to the law in Tanzania, the employer must meet his employees’ medication expenses but he may shift this burden from himself by ensuring that his workers contribute to the National Social Security Fund, which offers benefits for employment-related injuries and permanent disabilities.

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

There is no existing law protecting individuals from HIV/AIDS. According to the current legislation the only obligation an employer has is to provide sick leave with full pay for 3
months with half pay for up to an additional three months, after six months of sickness the employer will be entitled to terminate the services of the sick worker on medical grounds after obtaining a medical report.

(iii) Agriculture

The Ministry of Agriculture has demonstrated how the epidemic, in tandem with the Civil Service reforms now under way in the country, has been deepening the void left by workers who have died from AIDS25. While there would be a supply of workers available to compensate for attrition, bureaucracy and vigorous justification for such measures are impeding employment. It is anticipated that, a few years down the line, the ministry will have to hire significant numbers of qualified agricultural economists and technicians because of a shortage of qualified staff in certain age groups. Qualified agricultural practitioners are reaching retirement age while those in the middle age ranges are dying and not being replaced.

(iv) Health care

Since 1995, Tanzania has been undergoing decentralization and local government reform and the role of the government as a sole provider of health services is being modified to involve voluntary and private sector providers to a greater extent. The Ministry of Health promotes this 'public/private mix' of health-care provisions under Strategy Seven of the Health Sector Reform26. Most of the private sector health institutions are owned by faith groups such as the Anglican Church of Tanzania, the Evangelical Lutheran Church of Tanzania and the Roman Catholic Church, as well as some NGOs, operating as non-profit organizations. The government and health ministry are keen for the private sector to be involved in the multisectoral approach to HIV/AIDS. The Tanzania Commission on AIDS (TACAIDS) will provide strategic leadership for advocacy and the role of the government as a sole provider of health services is being modified to involve voluntary and private sector providers to a greater extent. The Ministry of Health promotes this 'public/private mix' of health-care provisions under Strategy Seven of the Health Sector Reform26. Most of the private sector health institutions are owned by faith groups such as the Anglican Church of Tanzania, the Evangelical Lutheran Church of Tanzania and the Roman Catholic Church, as well as some NGOs, operating as non-profit organizations.

In addition, staff shortages have occurred in the past due to structural adjustment in the 1990s, which led to a reduction in the health sector workforce of 19,000 staff (2001/2002 compared to 1994/1995). Further strains on the workforce are caused by funeral attendance, care of sick relatives, or illness and death of staff members themselves27. A high level of stigma associated with the virus was felt among HIV-infected patients who complained about neglectful and poor services. In response, health workers protested that the lack of protective gear meant that they could not assist the patients safely.

Data from the ESRF 2003 report show that the issue of record-keeping in the Ministry of Health remains the main obstacle to obtaining an accurate measure of how the epidemic might be affecting its human resource capacity. Among the health-care facilities visited, there had been a loss of 31 health-care professionals who were, on average, 38–40 years old. Of the workers who died, 58% were nurses with professional experience of 10 years or more. Another group that formed a large proportion of those who died were paramedics (13%) who had an average of 17 years’ experience, and only 52% of the deceased workers had been replaced. At the same time, there are ambitious plans for scaling up ART demand for additional health staff. The Tanzania care and treatment plan has estimated that more than 1,200 new full-time equivalents (health staff) are required to cover 65,000 new patients with ART30. A study by Kurowski et al. (2003) has estimated the number of new patients with ART30. A study by Kurowski et al. (2003) has estimated the delivery of HIV/AIDS interventions at a high coverage would require a large proportion of the health workforce (around 40%) and would correspond to an estimated 17,000–33,000 health workers (out of a current workforce of 48,500 persons)31.

(v) Education

There is evidence that, strained by limited resources, the scaling up of access to ART and the great number of HIV/AIDS patients, doctors and nurses are under extreme pressure. It is reported that the workload has dramatically increased, as the number of staff has been insufficient to meet the increased demand28, 29.

25 Graham Teskey and Richard Hooper (1999): ‘Tanzania Civil Service Reform Programme: A Case Study’. The civil service reforms started in 1998 undertook reduction of staff through recruitment and freeze retrenchment of staff in order to finance increases in real salaries and in order to make the civil service function more efficiently.

26 Source: Kim Barker et al.


29 Ibid.


32 The results of study, ‘The impact on the education sector in Tanzania’ (November 2003), by [68x134]
The education sector is one of the sectors worst-affected by HIV/AIDS in sub-Saharan Africa, and this trend has also been observed in Tanzania\(^{32}\). It is also one of the largest employers in the country. The University of Dar Es Salaam has seen considerable increases in funeral expenses. On the supply side, one of the main causes of teacher attrition is death and, in 2001/2002, there were 1,045 deaths of teachers. Out of these, more than half (57%) were males and more than two-fifth (42%) were reported to be caused by deaths that appeared to be HIV/AIDS-related (tuberculosis long-term fever, cancers). A TACAIDS report reveals that about 100 primary-school teachers die each month due to HIV/AIDS-related diseases (TACAIDS 2002). The report states that a cost of US$40 million would have to be incurred by the government to replace them.

The Tanzania Teachers’ Union is one of the very few organizations to have collated hard evidence of the impact that HIV/AIDS has been having on the teaching profession. In an interview with ILO, the General Secretary of the Union acknowledged that the most challenging task faced daily by the organization has been that of dealing with HIV/AIDS. Firstly, the organization deals daily with two-to-three teachers who visit their headquarters to seek financial assistance for medical treatment. Secondly, they deal with the families of teachers who have passed away. Thirdly, they have to deal with sentiments of inadequacy that many teachers experiencing when discussing HIV/AIDS in the classrooms.

The Union recognizes that the capacity of the country to deliver education is being severely affected by HIV/AIDS at a time when enrolment of pupils has been increasing rapidly due to the introduction of universal access to primary schools. It is estimated that, by 2006, 45,000 trained teachers will be needed to cover the impact of the rising numbers of teachers lost to AIDS. In addition it recognizes the difficult working conditions that teachers face, including a severe shortage of teaching material, training and skills to teach pupils about HIV/AIDS.

Table 7 shows the number of teachers who died in 2000–2002 (the deaths for the year 2002 were recorded only for the second half of the year). The evidence here is of a large number of deaths every year due to medical reasons: the number of teachers who died in the year 2000–2001 alone was 910, while deaths in

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of deaths by age group</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 30</td>
<td>31 - 40</td>
</tr>
<tr>
<td>Arusha</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Dar es Salaam</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Dodoma</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Iringa</td>
<td>4</td>
<td>39</td>
</tr>
<tr>
<td>Kagera</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Kigoma</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Kilimanjaro</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Lindi</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Mara</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Mbeya</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Morogoro</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Mtwara</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Mwanza</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Pwani</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Rukwa</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Ruuma</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Shinyanga</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Singida</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Tabora</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Tanga</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>71</td>
<td>219</td>
</tr>
</tbody>
</table>

Source: Tanzania Teachers Union (TTU) 2002

---

the preceding year cumulatively totalled 1,096. However, the figures are not based on doctors’ reports stating the cause of death as AIDS. But, in many cases, the symptoms and causes of deaths are related to diseases associated with HIV infection, such as cancer, Kaposi’s sarcoma, pneumonia, persistent diarrhoea, etc. A study of the statistics of teachers’ deaths reveals the following:

- The heaviest burden of deaths is felt in a number of selected regions such as Dar es Salaam and Kagera.
- In each of the 20 regions on the Tanzania mainland, the majority of deaths occurred among teachers aged 41–50.
- The majority of teachers who died were in the 41–50-year-old age group and in their professional prime, the loss of which would take up to 25 years to replace.
- The Teachers’ Union reports that more teachers’ deaths occur in areas along the highways of Dar es Salaam, Iringa and Mbeya, Kilimanjaro and Arusha and so on. This follows the national pattern of HIV infection and deaths that shadows the main highways leading to and from the city of Dar es Salaam.

On the demand side, data from research findings show that girls and boys in primary and secondary schools are sexually active. A KAP baseline survey by the GTZ Reproductive Health project in the Lindi region among 1,560 primary-school pupils indicates that 45% of the pupils were sexually active and the mean age for first sexual intercourse was 11.2 years for boys and 14 years for girls33.

(iv) The informal economy

Data from the 2000/2001 survey show that one in every three households interviewed had an informal sector activity—up from one in four in the 1990–2001 survey. Industries that employed a large number of people were mostly in the retail trade of agricultural and other products, stationery, photography, processed foods, and restaurants and hotels. A total of 2.8 million were working in the informal sector, for 1.4 of whom it was their main form of professional activity. There is also an increase in the proportion of urban households that had an informal sector activity—from 42% in the previous survey to 61% in the latest survey. An increase is also reported in rural areas, but of only six percentage points. It is speculated that this increase in informal-sector activities is due to economic hardship and can be seen as a survival strategy. The main reason given by 44.5% of workers for having an informal-sector activity was the inability to find employment. Those in the secondary sector of employment cited the wish to augment family income as the main reason.

The majority of people in the informal sector are self-employed, and 50% of them are young, which might be explained by high rural-urban migration of young people. It has been noted that there has been a large increase in the total number of self-employed people since the 1990–1991 survey.

ILO’s office in Tanzania recently commissioned research to ascertain the impact of HIV/AIDS on the informal sector. In this study, respondents were asked a series of questions on behaviour, beliefs and practices regarding their sexual health. In addition, they were asked questions designed to gain information on the impact of HIV/AIDS on their work. The reports concluded that there are many situations that put workers in the informal sector at risk of infection. These included multiple partnerships; inadequate knowledge of HIV/AIDS issues (only 52% of respondents thought that it was not possible to get infected with HIV by working with an infected person, clearly indicating the existing stigma attached to the disease); reluctance to undergo HIV testing (though three-quarters of all respondents could mention at least one place where they could get tested); economic motives for sexual relations; and reluctance to use condoms as a method of protection against infection. Seventy-four per cent declared that they never used male condoms, despite the fact that the majority—80%—of respondents expressed fear of getting infected with HIV. A higher percentage of male respondents expressed this concern than did female respondents (85% and 77% respectively).

One of the questions designed to rapidly assess the impact of the epidemic on the informal sector showed that 41% of all respondents knew at least one colleague who had been infected with HIV. Feelings of discrimination and finger-pointing towards those who were infected or ill were rife; half of the respondents who knew infected people reported discriminating against them. Almost 25% of respondents reported that there was little sympathy for those infected as they were seen to be morally deficient and incapable of controlling their libido.

The impact of HIV/AIDS on the labour force is felt not only because of ill-health, morbidity and death of workers. It can also be seen in terms of employment security and discrimination in the workplace, which is felt most in the informal sector. Though both the government and the unions propagate non-discriminatory behaviour, evidence shows that...
there are many cases where such directives
are not followed. There are cases of employers
screening potential workers for HIV before
offering employment—in some cases, without
the candidates’ knowledge. This practice is
reinforced when the management of some
organizations that have in-house medical
facilities (clinics, dispensaries) instruct their
medical officers to test those who are frequently
ill or those who look ill.

3. Microeconomic impact

Households

The declining productivity of HIV-positive
individuals is primarily felt within the family.
The loss of adults in their productive prime
also reduces the capacity of communities.
In addition to increased expenditures, many
households experienced a reduction in
remittances if the adult member worked
outside the home. In conditions where the HIV/
AIDS epidemic is creating further economic
pressure on households and fewer children
are attending school, girls are most likely
to be the ones who stay at home. Girls may
also be involved in assisting with the care of
sick household members, whose needs are
intensifying with the epidemic. Young girls who
have no education or skills are far more likely
to find themselves pressured into early marriage
with older men, or into sex work.

Orphans

Tanzania recorded about 810,000 orphans
under 15 years of age (2001)\textsuperscript{34} as a result
of HIV/AIDS. Children who lose one or both
their parents to AIDS account for the majority
of orphans overall (see table below). A large
number of resources are required to care for
these children. The next generation will include
a huge number of child-headed households.
These children are much less likely to go to
school or to have access to the social behaviour
and skills-training available to other children.

In western Tanzania, studies have shown
that many relatives refused to take responsibility
for orphaned children, and many of those who
did were unable to adequately look after the
children\textsuperscript{35}. As has been found in Tanzania,

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
 & 2001 & 2010 \\
\hline
Orphans (000) & 1928 & 2152 \\
\hline
Children orphaned as a % of all children & 42.3 & 54.2 \\
\hline
Children orphaned as a % of all orphans & 5.1 & 6.3 \\
\hline
\end{tabular}
\caption{Estimates on the number of Orphans in Tanzania}
\end{table}


\textsuperscript{34} Clinton Business Plan 2001.


C. Policy options

1. Response to the HIV/AIDS epidemic

(i) National response

President Benjamin Mkapa declared HIV/AIDS a national disaster in 1999. HIV/AIDS is discussed as a major hindrance to development and is among the government’s top challenges, together with poverty alleviation, improved social sectors and other development problems. Since 1985, HIV/AIDS intervention programmes have been coordinated and directed by the National AIDS Control Programme (NACP) under the Ministry of Health. The country response took the form of a Short-Term Plan (STP 1986-1987), followed by the formulation of a five-year Medium-Term Plan I (MTPI), a Medium-Term Plan II (MTPII), and an MTP III that ended in mid-2002. These plans treated HIV/AIDS mostly as a health challenge, with little emphasis on mitigating its effects on other sectors. The NACP mainly concentrated on monitoring, research and prevention.

A new National HIV/AIDS Multisectoral Strategy Framework (NMSF: 2001) was recently formulated in line with the National Policy on HIV/AIDS. The National Policy on HIV/AIDS was a multicultural response in which TACAIDS became operational in 2000, when it took over from NACP. Its role was to “facilitate strategic leadership and multisectoral coordination, monitoring and evaluation of national responses”. It was given the task of assisting every sector in planning, budgeting, and mobilizing financial and human resources for its own HIV/AIDS-mitigating-and-control programmes. This would involve all government and private sectors, the bilateral and donor community and NGOs, and local government councils who would in turn coordinate and involve the public and private sectors, NGOs and faith groups in the fight against HIV/AIDS. The objectives of the new policy were to strengthen sectoral roles, ensure political and government commitment in the prevention of the spread of infection, encourage voluntary HIV testing, increase care for PLWHA and their families, enhance research efforts, and ensure the revision and creation of legislation regarding legal and ethical issues on HIV/AIDS.

However, despite the above-mentioned efforts and the large numbers of people affected, the fight against HIV/AIDS has so far been very much a Ministry of Health responsibility. There is, however, acknowledgement by the Ministry of Health about the shortage of trained staff (although it is not clear whether this is due to new challenges that HIV poses or to HIV/AIDS-related deaths) and how this has hindered implementation of its policies in the past. The Ministry has concentrated on additional resources for health care and some preventive measures to be put in place to ensure that its workers do not get infected while carrying out their health-care duties. However, workplace programmes on HIV prevention, plans to maintain human capacity and maintenance of skills and experienced workers are unheard of.

However, the Ministry of Education and Culture (MOEC) and the Education Ministry work together on HIV/AIDS. The education sector in Tanzania works within the framework of the Education and Training Policy of 1995. This policy guides the provision of education in Tanzania and focuses on increasing enrolments, quality improvement, equitable access and optimum utilization of available resources. This policy however, does not take HIV/AIDS into account. The absence of HIV/AIDS issues in the Education and Training Policy poses a big challenge to the Ministry of Education and Culture. Currently, HIV/AIDS activities/interventions are based on two non-formal policy documents supported by the National Policy on HIV/AIDS of 2001 that focus on school youth and adults and MOEC guidelines on AIDS Education and Life Skills. The Ministry of Education and Culture collaborates with a number of stakeholders in areas of education and/or HIV/AIDS. The partners include TACAIDS, Presidents Office for Regional Administration and Local Government (PORALG), the National AIDS Control Programme of the Ministry of Health (NACP/MoH), the World Bank, UNESCO, UNAIDS, UNDP, UNICEF, the Christian Social Services Commission (CSSC), the International Federation of Red Cross and Red Crescent Societies, The Aga Khan Foundation, the Muslim Council of Tanzania (BAKWATA), the Tanzania Parents Association (TAPA), the Tanzania Teachers Union (TTU) and the Teachers Services Commission (TSC). A number of local NGOs were found to be working at the local level in areas of prevention and control of HIV/AIDS and impact mitigation.

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38 TACAIDS, under the Prime Minister’s Office.
39 TACAIDS 2002.
To address the impact of HIV/AIDS on the education sector, MOEC has instituted an AIDS Education programme that is currently divided into six components—namely, Strengthening the HIV/AIDS Management Structure, School HIV/AIDS and Life-Skills Education, School Peer Education, School Guidance and Counselling Committees, School Guidance and Counselling Services, and the MOEC Headquarters Peer Education. These components were instituted as a result of the formulation and implementation of Circular 3 of 1993 and Circular 3 of 2000.

The implementation of the AIDS Education programme is carried out at three levels. At the central level, activities include the formulation and design of interventions, management, coordination, supervision, monitoring and evaluation. The implementation of interventions related to the programme is done at the district and institutional levels. HIV/AIDS education has been now incorporated into the guidelines of seminary secondary schools, which has facilitated open discussions about HIV/AIDS among school staff. Before the introduction of HIV/AIDS issues in the secondary-school curriculum, openly talking about HIV/AIDS at church-owned secondary schools (seminaries) was taboo.


The MOH has a comprehensive and developed strategy on HIV/AIDS. None of the other ministries visited by the ILO research team had a strategy for tackling AIDS, despite having Ministerial Technical AIDS Committees (TACs), which were established following a call from the Ministry of Health for more multisectoral collaboration in the fight against AIDS. The main obstacles in operating TACs have been to do with structure, policy, and poor and varying perceptions of the threat of the disease in different organizations.

As HIV/AIDS has become the major cause of adult morbidity and mortality in Tanzania, its serious impact on the health services has affected the quality of care and led to an attrition of the workforce. The Ministry feels that the implementation of a comprehensive health sector strategy will assist in the future process of priority-setting and resource mobilization. As in the past, the priority HIV/AIDS interventions planned are in the areas of prevention, care, support and impact mitigation. A run through the Ministry's strategy shows that most of the activities planned are in areas such as training, home-based care, counselling, psychological support and palliative care, comprehensive management of opportunistic infections and nutrition and integrated HIV/AIDS/TB care. In addition, Tanzania aims to put 65,000 patients on ART by the year 2005. Hospital-based data from government hospitals indicate that up to 50% of all beds in some hospitals are occupied by patients with HIV/AIDS-related illnesses. While activities such as workplace programmes on HIV/AIDS are also planned, these receive very little attention and a much smaller proportion of the funds to be disbursed. For example, US$200,000 is set aside for fighting stigma and discrimination, whereas US$85,590 is earmarked for workplace interventions.

To date, there has been a limited multisectoral response to the epidemic. None the less, the new strategic plan on HIV/AIDS is under way and awaiting approval. TACAIDS, charged with coordinating initiatives in all sectors, has programmes that are mostly in the early stage of assessment and planning (TACAIDS, 2002). In 1996, the education sector received a guideline on an HIV/AIDS/STI-control education programme. The objective was to educate young people about the risk of HIV/AIDS/STIs and preventative measures. However, the Ministry of Education and Culture highlighted problems with the context and content of the guideline and those involved in coordination and implementation of HIV/AIDS programmes. Also, duplication of programmes and misuse of resources resulted in little impact on the targeted population. Likewise, the agricultural sector reported similar problems stating that HIV/AIDS remained “more or less a one-person and no-budget scenario”. Lack of knowledge, weak political commitment, denial and silence about the epidemic contributed to the poor sector performance.

(iii) Response from the private sector

Participation by the private sector in HIV/AIDS interventions in Tanzania has been substantial but slow, mainly due to the very young private sector, denials and an attitude of ‘it can’t happen to me’ and also because there has been little direction on the part of the government to educate the private sector. Non-governmental organizations have been at the forefront of organizing civil society in dealing with issues of prevention, stigma, discrimination and orphanhood. A good example of an NGO that assisted in initiating workplace programmes is AMREF, whose efforts have enabled the private sector to establish HIV-prevention activities at work. AMREF has also carried out a number of studies to ascertain the impact of HIV at the workplace; for example, in a 1992 study, it was found that prevalence in selected businesses was as high as 21% of the workforce (24%, in
a 1994 study). It is believed that such stark statistics, together with the ever-mounting costs of absenteeism, medical insurance and funerals, have opened the eyes of businesses to the benefits of having workplace programmes, and of establishing AIDS Prevention Planning Communities (APPCs) that coordinate activities and advise management. Organizations such as Tanzania Harbours Authority (THA), Tanzania Electricity Company (TANESCO), and Tanzania Cigarette Company (TCC) have already started rigorous HIV/AIDS intervention campaigns targeting their workforce.

(iv) International response

Activities relating to workplace programmes have been supported by donors such as USAID, GTZ, AMREF and the Organization of Tanzania Trade Unions (OTTU) since the early 1990s. AMREF is currently providing about 35 private companies in Tanzania with Health Programme Packages for the workplace. All programmes are designed to build in-house capacity by training peer educators to operate independently and by mobilizing supervisory roles. Another component of AMREF workplace programmes entails the creation of service-providion networks, which link STI treatment, VCT, and home-based care and support. WAMATA, another leading NGO dealing with HIV/AIDS in Tanzania, is involved in disseminating information, facilitating education and communication, providing counselling, and supporting and caring for people living with HIV/AIDS. SHDEPHA+ is an association for service, health and development for people living positively with HIV/AIDS. Besides peer group support, SHDEPHA+ provides information, education, counselling, home-based care, advocacy for legal and human rights, and training for income-generating activities. AIDSSET in Washington DC has begun providing registered SHDEPHA+ members with antiretroviral treatment.

The World Bank, together with some local NGOs, has also carried out work in this area. There are also specific activities intended to develop policy frameworks and to support prevention programmes in some sectors, such as transport, where SADC, with ILO support, is strengthening responses in eight countries of the region. There is some support in the country for such activities, and a limited number of companies, such as Brook Bond, Standard Chartered Bank and Tanzania Breweries, have formal workplace policies on HIV/AIDS. But progress in developing policies and programmes has been slow, and coverage is very limited. Organizations such as the Tanzania Chamber of Commerce, the Private Sector Foundation and the Confederation of Tanzanian Industries can, with appropriate donor and government support, provide a framework for moving forward with workplace policies and programmes.

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41 Results of the ILO research team’s discussions.
42 WAMATA stands for ‘Walio Katika Mapambano na AIDS Tanzania’, which literally means ‘people in struggle against AIDS in Tanzania’.
43 Service Health & Development for People living with HIV/AIDS.
The implementation of these objectives would involve the following specific activities:

- The provision of technical support by the ILO (with its long-standing experience in technical cooperation) for the collection of data—both quantitative and qualitative—on the impact of HIV/AIDS on various sectors in the economy. At the national level, this would enhance an understanding of where exactly the labour losses are being felt and what can be done to balance the demand for human resource capacity in these sectors. This would strengthen their output, especially in sectors such as education, health and the public sector, which, in turn, provide services to mitigate the impacts of HIV/AIDS.

- Support for the expansion of access to treatment, care and support for workers, their family and community in collaboration with WHO’s 3x5 initiative.

- An assessment of activities relating to the impact of HIV/AIDS on private enterprises and their human resources, which will provide a much-needed overview of current policies and programmes that address the labour market effects and how firms handle issues of employment, retention and maintenance of their employees and required outputs. This can be done in line with the Rapid Assessment methods used by UNICEF and ILO/IPEC (The International Programme on the Elimination of Child Labour).

- Assistance and support for the expansion of workplace programmes both in the public and private sectors. These programmes should not only focus on prevention and creation of awareness but should include all components of a comprehensive workplace policy as proposed by the ILO Code of Practice. Particular attention should be paid to expanding access to antiretroviral treatment as part of workplace programmes.

- Facilitation of a tripartite agreement mobilizing the support of trade unions, governments and employers, while convincing all three parties across the economy—both in the formal and informal
sectors—of the importance of sustaining their human resource capacity through investing in effective programmes for prevention, support and access to treatment. Now that the cost of antiretroviral therapies has dropped, there is a strong argument for increasing general access to antiretroviral and other drug therapies for all employees.

- Assistance to the Ministry of Labour in undertaking a review of the demographic impact of HIV/AIDS and the labour force, which is likely to occur over the next few decades. This should involve other ministries also. Such a review would need to assess trends in the structure of the labour force, and its composition in terms of age, experience and education.

- Promotion of the importance of including the informal sector and small and medium-scale enterprises in all activities undertaken. The impact of the epidemic on the informal sector needs to be assessed more in depth, since this is where most of the growth in employment has been over the past few decades. Many small and medium-sized enterprises are very vulnerable, and do not generally have the financial resources to develop prevention and other support activities. The ILO has experience with working on small enterprises, and can work with companies to form collaborations either through sharing or pooled resources, or including/establishing a joint venture company responsible for administering employee health programmes for small groups of small and medium-sized companies.


Private Sector Health Care Delivery Options in Tanzania - A Feasibility Study (5 August 2003) Dr Kim Barker et al. and USAID.