"Walking the Talk in the Workplace"

Scaling up Initiatives for Managing HIV and AIDS at workplaces in Tanzania

Baseline Study Report, ACORD Tanzania& EASUN, April 2011

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Executive Summary

THIS STUDY WAS AIMED AT GENERATING relevant data related to the status of HIV and AIDS workplace policy formulation and implementation for participating organisations for informing the Up scaling Project on Managing HIV in workplaces in Tanzania under the support of Oxfam Novib. The study was carried in eight administrative regions of Tanzania covering 9 Government Authorities and 48 CSOs. Both primary and secondary data collection methods were utilised.

Key findings indicate that, there is high acceptance of HIV positive staff by both management and other staff although only few organisations have been able to operationalize their HIV workplace policies contributing to limited availability of grievances procedures for staff to access HIV services within workplaces.

Most organisations indicated to be flexible for their staff to access HIV services with most staff pointing out that HIV status is not a barrier to job recruitment or promotion.

The mean stigma score amongst staff was relatively low with indication to be more supportive to colleagues who are HIV positive. Nonetheless, the number of staff that have willingly disclosed their HIV status is minimal. This contributed to low involvement of HIV positive in workplace programmes.

While majority staff have good knowledge and awareness on HIV, lack of institutional policies on HIV mainstreaming limits their competence to addressing HIV in workplaces. Compared to HIV focused organisations the willingness of staff to talk about HIV in workplaces for non-HIV focused organisations is still low calling for increased need to support cross learning for purposes of capturing good practices related to HIV internal mainstreaming.

The need for organisations to encourage staff to know their HIV status alongside provision of support remains imperative. Efforts to build organisational capacity to address HIV in workplaces should seek to facilitate institutionalization of specific workplace policy for addressing HIV within organisations.

Acronyms and abbreviations

ABCT	AIDS Business Coalition Tanzania
ACORD	Agency for Cooperation and Research in Development
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retro Therapy
CSO	Civil Society Organisations
EASUN	East African Supporting Unit for NGOs
FBO	Faith Based Organisations
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GINI	Measure for income inequality
HIV	Human Immune Virus
IEC	Information Education and Communication
INGO	International Non-Governmental Organisations
KIT	Royal Tropical Institute
NMSF	National Multi sectoral AIDS Framework
NSGPR	National Strategy for Growth and Poverty Reduction
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SACCOS	Savings and Credit Co-operative Societies
SPSS	Statistical Package for Social Science
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TNCM	Tanzania National Coordination Mechanisms
TUCTA	Trade Union Congress Tanzania
UNAIDS	United Nations for AIDS
UNGAS	United Nations General Assembly on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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01 Introduction

TANZANIA IS A LARGE COUNTRY with an area of approximately 945,100 km^2 and a population of approximately 40 million. Population density is thus approximately 32 persons per square kilometer.

Agriculture dominates the economy, accounting for 60 percent of the Gross Domestic Product (GDP), followed by services (26 percent) and industry (15 percent).

Geographic Context

The country is Located in Eastern Africa, bordering the Indian Ocean, between Kenya and Mozambique at 6°00'S 35°00'E.

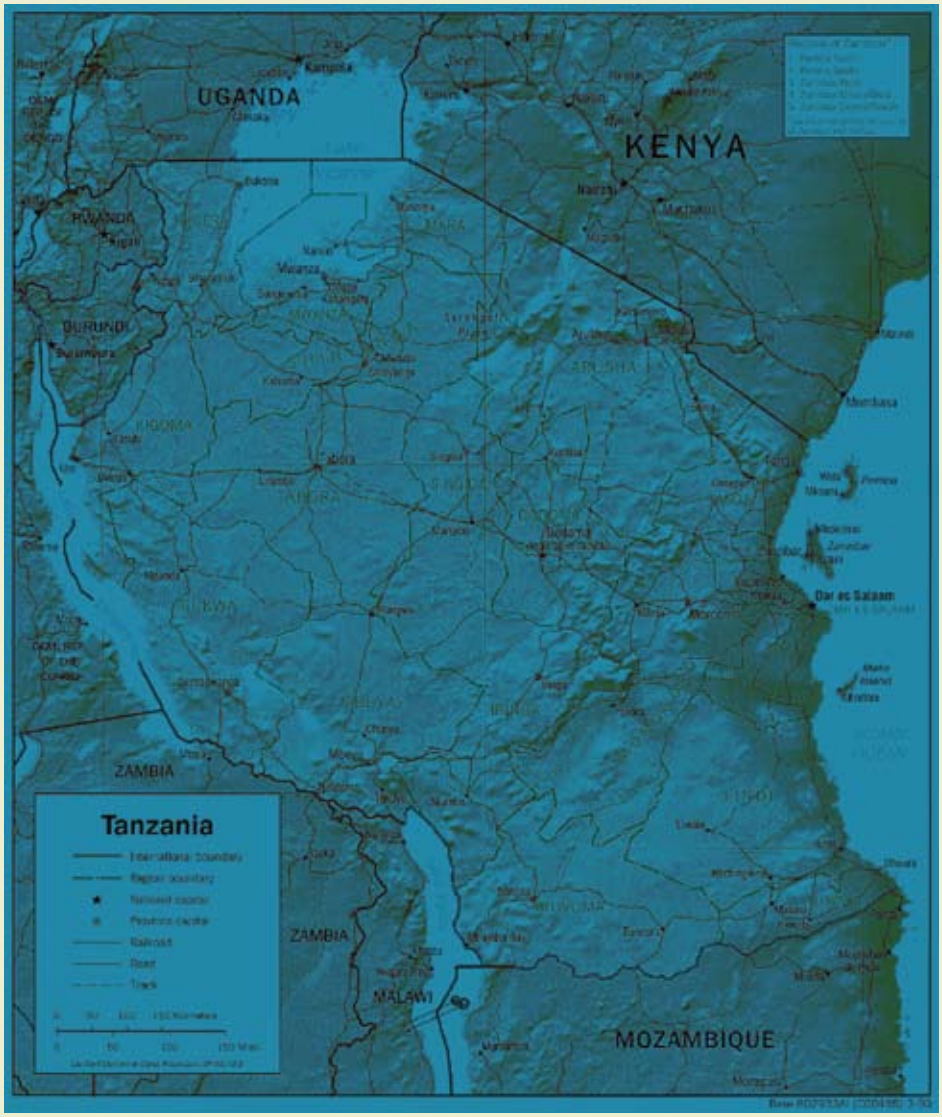

Table 1: Tanzania Socio economic profile

INDICATOR	VALUE	YEAR	SOURCE*
Socio-economic profile			
Population	41,929,640	2002	Tanzania National Strategy for Growth and Reduction of Poverety,2010
Population growth rate (%)	2.9	2002	Tanzania National Strategy for Growth and Reduction of Poverety,2010
Urban population (% of total population)	26		
GDP ($, PPP)	1,449		
GDP growth rate (%)	7.1	2010	
GINI coefficient	0.35	2009	Tanzania Poverty and Human Development Report
Human Development Index	151	2010	Tanzania National Strategy for Growth and Reduction of Poverty
Health profile			
Life expectancy at birth	54		Tanzania National Strategy for Growth and Reduction of Poverety
Maternal mortality (per 100,000 live births)	454	2010	Tanzania National Strategy for Growth and Reduction of Poverty
Under-5 mortality (per 1,000 live births)	103	2011	globalhealthfacts.org
Estimated adult (15-49) HIV prevalence (%)	5.7	2010	Tanzania National Strategy for Growth and Reduction of Poverty
TB prevalence (per 100,000)	337	2009	Global TB Control WHO report,
Estimated malaria deaths per year (all ages)	840	2010	World Malaria Report

Table 2: Overview of the health sector

INDICATOR	VALUE	YEAR	SOURCE*
Epidemiology			
Estimated HIV prevalence (15-49 years) (%)	5.7		
Number of people living with HIV	1,639,360	2010	National Bureau of Statistics projections,
Deaths due to AIDS	86,000	2011	globalhealthfacts.org
Children orphaned by HIV/AIDS	1,300,000	2011	globalhealthfacts.org
HIV and AIDS response			
% of adults who received and HIV test in the last 12 months and who know their results			

INDICATOR	VALUE	YEAR	SOURCE*
Number of patients receiving ART	199,413	2010	Global Report
ART coverage (as % of patients with advanced HIV infection)	32	2010	UNAIDS Global Report
% of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission	68	2010	Tanzania UNGASS reporting

HIV/AIDS expenditure and donor funding

In 2009, the government health expenditure as percent of Total Government expenditure was 18.4%, and the government health expenditure as percent of the total health expenditure was 65.8%. External resources for health accounted for 49.9%. Sources of external funding for HIV/AIDS include the Global Fund for Malaria ,TB and AIDS , PEPFAR and a donor partner group under basket funding .About 23% of the HIV/AIDS funding is allocated to prevention interventions including comprehensive prevention of Mother To Child Transmission (PMTCT). Several key prevention sub-themes are not covered.

Health sector response to HIV and AIDS

The United Republic of Tanzania faces many economic and social development challenges, including those posed by a generalized AIDS epidemic and other communicable diseases such as TB. Since 2001, the United Republic of Tanzania moved from the health sector approach in responding to HIV/AIDS and institutionalized the multi-sectoral approach which is coordinated by the Tanzania Commission for AIDS)TACAIDS).
Through this approach, the principle of the Three Ones (i.e. one coordinating body, one framework and one monitoring system) provides a guideline and base for all HIV/AIDS programme implementers. The national response to HIV and AIDS is guided by the National AIDS Policy launched in 2001 and reviewed in 2010.
A Multi-sectoral Strategic Framework (NMSF) II 2008-2012 articulates the strategies that guide the country response to HIV and AIDS .The NMSF is linked with the Health Sector HIV and AIDS Strategic Plan II(2008-2012and also takes into considerations the need to respond to Millennium Development Goals 4,5 and 6 as well as the second National Strategy for Growth and Reduction of Poverty (NSGRP II).Critical impediments to strengthening health outcomes in Tanzania include the inadequacy of trained human resources, inadequate infrastructure, and overburdened logistics systems and supply chains.

Civil Society Response to HIV and AIDS

Civil Society Organisations initiated responses to HIV and AIDS in the mid-1980s before planned interventions by government. In Tanzania, There are over 1000 Civil Society Organisations working on the spectrum of HIV related interventions. Most NGOs and FBOs and CBOS are involved in prevention, with gradual increase in treatment and care and advocacy. The Tanzania National Coordinating Mechanism (TNCM) has a multi-sectoral composition comprising of 18 members drawn from Government Ministries/Departments, Civil society Non-Governmental Organisations (NGOs), Faith-Based Organisations (FBOs), People Living with HIV/AIDS (PLHIV) organisations or networks, Academic Institutions, Private Sector Organisations ,AIDS Business Coalition Tanzania (ABCT), Trade Union Congress Tanzania (TUCTA), Media Council of Tanzania and Development Partners.

The National Multi-Sectoral Strategic Framework accords priority to addressing HIV in the workplace, but practice has been uneven even within CSOs.

Overview of HIV and AIDS in the Work Place

Both the National Policy on AIDS and the National MultiSectoral Strategic Framework on AIDS recommend the establishment of long term plans for mainstreaming HIV in workplaces. Central government ministries and Local Government Authorities are required to develop Workplace Policies. However, few ministries have demonstrated to have taken measures in implementing workplace interventions. Most of them have identified focal persons and committees, but have not been active in actually rolling out interventions. Some Civil Society Organisations, in particular international NGOs and a few local NGOs, do have workplace policies being implemented.

In-country impacts of internal mainstreaming

Despite the general lack of data to support the added value of workplace HIV responses, NGOs with workplace HIV policies and their institutional partners have been providing evidence and popularizing interventions. These show that, there are generally high levels of awareness on HIV in Civil Society workplaces, but moving from conceptual to practice in developing and implementing policies has been limited. Workplace interventions have rarely influenced communities and households in responding to HIV/AIDS Challenges in workplaces include stigma, weak leadership and lack of partnerships in remote settings. External HIV mainstreaming is popularized by a few (international and national?) organisations including Oxfam and its partners. As in internal mainstreaming, moving from conceptual frameworks to practice is still limited.

Overview and extend of the Oxfam Novib WPP project

The process for launching the WPP in Tanzania was initiated in mid-2010 following the up scaling of the HIV Workplace pilot project implemented by Stop AIDS Now! in Ethiopia, India and Uganda. The Agency for Co-operation and Research in Development (ACORD) in Tanzania and East African Support for NGOs (EASUN) jointly developed the initiative, and submitted the proposal to Oxfam Novib for funding. The initiative was approved in December 2010 and funding for 2011 provided through HIVOS to EASUN.

The project works with 50 Civil Society Organisations and 10 Local Government Authorities, covering regions with relatively higher concentrations of Civil Society organisations. The regions covered are: Arusha, Dar es Salaam, Mwanza, Kagera, Kilimanjaro, Morogoro and Shinyanga.

The project is jointly led by ACORD based in Mwanza and EASUN based in Arusha, while project staff are based at ACORD Tanzania.

Study Objectives

02

THE BASELINE STUDY GENERALLY SOUGHT to generate relevant data related to the status of HIV and AIDS workplace policy formulation and implementation within participating organisations in Up scaling Project.

The specific objectives were:

- To assess the trend and status of management of HIV and AIDS at the work place for selected 50 CSOs and 10 Government Authorities in Tanzania
- To understand and analyze the perception and practices of staff and management of organisation about relationship between gender and HIV and AIDS, stigma and discrimination, prevention, incidence and impact of HIV and AIDS on their organisation.
- To identify and analyse the opportunities and constraints for the development and implementation of HIV and AIDS workplace policy and program.

The research questions were organized around the two main components of the organisational structure, which are the Management and Staff aspects, however, the two components had independent questionnaire to be examined with. The core focus of the questions asked was:

- To understand and analyse the extent of internal mainstreaming within organisations (development status of workplace policies, current and future HIV related activities and trainings), perceived levels of addressing stigma and discrimination, access to HIV service, linking and learning from others and involvement in lobbying and advocacy.

Methods and Methodology

Study Population

CSOs in Tanzania form a core segment of non-state actors intervening on HIV and AIDS. The current number of CSOs intervening on HIV and AIDS in Tanzania is estimated to be more than 500. This study was conducted in 7 administrative Regions including Mwanza, Shinyanga, Kagera, Arusha, Kilimanjaro, Dar es Salaam, Morogoro and Geita, covering 9 Government Authorities and 49 CSOss.

Sampling

A consultative meeting organized by the lead organisations (ACORD, EASUN) facilitated joint sampling of participating CSOs and government authorities. The criteria for sampling included geographical location, self-interest of the organisation, and the existing partnership with lead organisations. Considering the geographical locations, the research team purposively sampled organisations from areas where the two lead organisations have interventions. Moreover, consultative sessions were held between the research team and CSO networks for joint mapping of influential organisations to participate in the baseline and the scale up phase.

Sampling of Staff

Study respondents were purposively sampled from three key levels of the organisations including management, programme and support. The study team deliberately ensured participation of both male and female staff. Staff consent was requested prior to responding to the questionnaires.

Method of Data Collection

This study was participatory in nature and involved collection of both primary and data.
Whilst secondary data collection involved reviewing of existing related literature with regard to the country profile and HIV epidemic, primary data collection involved gathering of data through a structured questionnaires. In order to ensure confidentiality of the information obtained all the questionnaires were collected in a box

Study Tools

Quantitative Data: This was achieved by using two main types of questionnaires. Whereas the organisational questionnaire was administered to organisation's representatives the staff questionnaire was administered to individual staff respondents. The staff questionnaire generally sought to analyse levels of staff knowledge, attitudes, practices and behaviours with regard to HIV in workplaces whilst the organisational questionnaire sought to understand and analyse the extent of internal mainstreaming within organisations including development and status of workplace policies, current and future HIV related activities & training), perceived levels of and addressing stigma and discrimination, access to HIV services, linking and learning from others, and involvement in lobbying and advocacy.
Qualitative Data: Focus Group Discussion was also conducted using a structured guideline and information obtained was used to triangulate facts beyond the metric. The FGD involved staff from management, progarmme and support. Participants of the FGD were formerly invited through official letters to their organisations. 3 participants from the three levels of management of management programme and support participated in the FGD. A total of 7 organisations participated in the FGD.

Table 3

Number of Organisations	Number of Staff	
7	Females	Males
	12	9

Study Site and sample

This study sought to cover a minimum of 30 percent of all staff in organisations. Considering this, five questionnaires were administered in each of the 49 CSOs and 11 questionnaires for the 9 Government Authorities.

Data analysis

All filled questionnaires were collected at ACORD's office in Mwanza, packed and posted to Amsterdam for data capturing and analysis. Questionnaires were distributed amongst six research assistants who captured the data using a similar data sheet developed in Epi Data Entry. All the data were appended to form on data sheet and cleaned. Initial analysis of data was conducted using Epi Data Analysis and final data analysis was conducted using SPSS system. After cleaning,

Limitations

- This study was mainly a point research and could not capture information on trends on the actual HIV effects within workplaces.
- The study focused only on selected locations and could not cover the whole of Tanzania
- The study area purposely selected based on potential programming engagement

Results

02

4.1 Management of HIV and AIDS in the workplace in Civil Society Organisations

4.1.1 Organisational and staff profile

Names of organisations

A total of 58 organisations participated in this baseline study of which 9 were Local Government Authorities and 49 were CSOs.

Table 4

Organisational Name	Region
ACTION FOR CHILDREN	Arusha
ADILISHA	Mwanza
AIDE ET ACTION	Mwanza
AMANI CHILDREN'S HOME	Arusha
AMANI GIRLS HOME	Arusha
Biharamulo District Council	Kagera
Bukoba Municipal Council	Kagera
CAVUPE	Arusha
CEDESOTRA	Arusha
CHATO DISTRICT COUNCIL	Kagera
CHAWATA MWANZA	Mwanza
CODERT	Kagera
ELCT Karagwe Diocese	Kagera
FADECO	Kagera
FAIDERS	Kagera
FINCA TANZANIA LTD	Mwanza
FORUM SYD TANZANIA	Mwanza
Geita District Council	Mwanza
HAKIKAZI CATALYST	Arusha
HAKIMADINI	Arusha

Heifer International Tanzania	Arusha
HUYAWA	Kagera
KADERES	Kagera
Karagwe District Council	Kagera
KCBR	Kagera
KWIECO	Kilimanjaro
MAYAWA	Kagera
Missungwi District Council	Mwanza
MOSHI MUNICIPAL COUNCIL	Kilimanjaro
MRHP	Mwanza
MWADA	Mwanza
Mwanza City Council	Mwanza
Mwanza Policy Initiative	Mwanza
Mwanza Press Club	Mwanza
MWANZA SACCOS LTD	Mwanza
MWEDO	Arusha
OXFAM GB	Shinyanga
PINGOS FORUM	Arusha
REDESO	Mwanza
Saidia Wazee Karagwe (SAWAKA)	Kagera
SHINYANGA MUNICIPAL COUNCIL	Shinyanga
TADEPA	Kagera
TAHEA	Mwanza
TAHEA SHINYANGA	Shinyanga
TANZANIA TEACHER'S UNION	Kagera
Tanzania Teachers Union-Biharamulo	Kagera
TAPHGO	Arusha
TCCIA	Mwanza
TCCIA Karagwe	Kagera
THE INFORMED RURAL SOCIETY	Mwanza
TIP	Kilimanjaro
TTU Karagwe	Kagera
USA RIVER CHILDREN'S HOME	Arusha
UTPC	Mwanza
WADOKI SACCOS LTD	Mwanza
WOMEDA	Mwanza
YADEC	Shinyanga
Youth Health & Development Association	Arusha
Total	**58**

Types of Organisations participated in the study

As being shown in the figure 1 below, 55.3% of organisations that participated in this baseline were local NGOs and CBOs, 8.6% were International NGOs, 3.4% were Faith Based Organisations, 15.5% were Local Government Authorities, 5.2% were network organisations, 10.3% were Trade Unions and only 1.7consituted Small Enterprises.

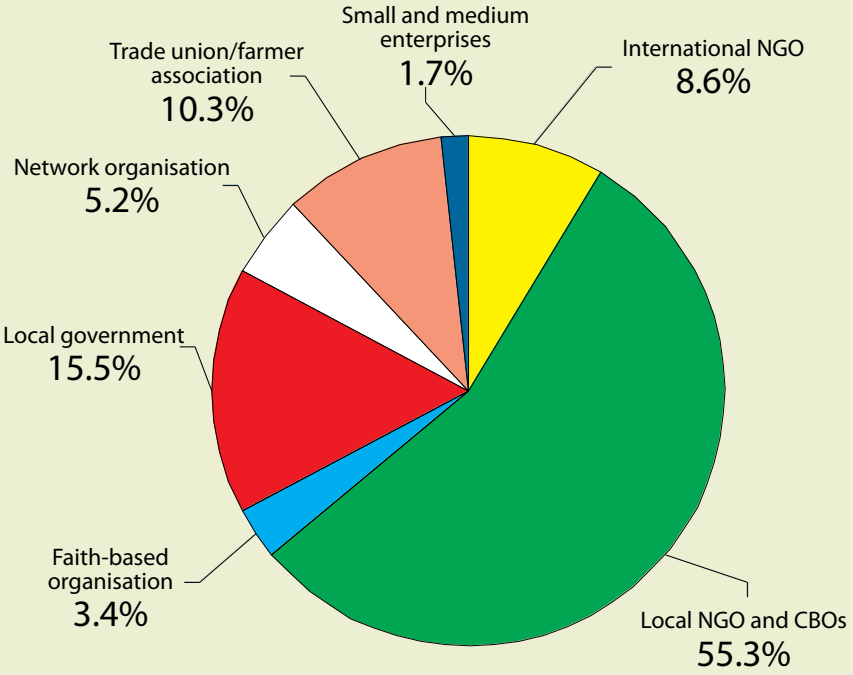

Figure 1: Percentage of organisation type

Number of staff

	N	Minimum	Maximum	Mean	Std. Deviation
Males	54	1	3576	231.06	632.90
Females	55	1	2081	142.55	375.43
Management Staff	52	1	124	6.29	16.99
Programme Staff	43	1	636	20.74	96.20
Admin/Support Staff	47	1	528	16.00	76.51
Volunteers	26	0	60	7.15	13.13
Valid N (listwise)	2				

Table 5: Descriptive Statistics for Number of staff by staff levels

The number of staff in organisations varied mainly by type. On the whole, local government authorities had a higher number of staff compared to other types of organisations. The minimum number of staff in all organisations was one whilst the maximum was 3576 for males and 2081 for females. Generally, there were less female staff compared to males. More programme staff were involved in this study than administration/ support staff or management staff. The number of volunteers far was less than that in other levels.

Staff education Level

	N	Minimum	Maximum	Mean	Std. Deviation
Never been to school	12	0	78	7.75	22.39
Primary Education	33	0	978	50.55	176.33
Secondary Education	36	0	879	49.19	180.77
Vocational/Trade/College	40	1	2107	81.30	348.43
Tertiary	19	1	116	11.58	25.82
Valid N (listwise)	7				

Table 6: Descriptive Statistics for staff education levels

The mean staff number of those who attained vocational/trade/college level of education was highest compared to that of staff that had never been to school or had primary or secondary education. See table 2 above and figure 2 below.

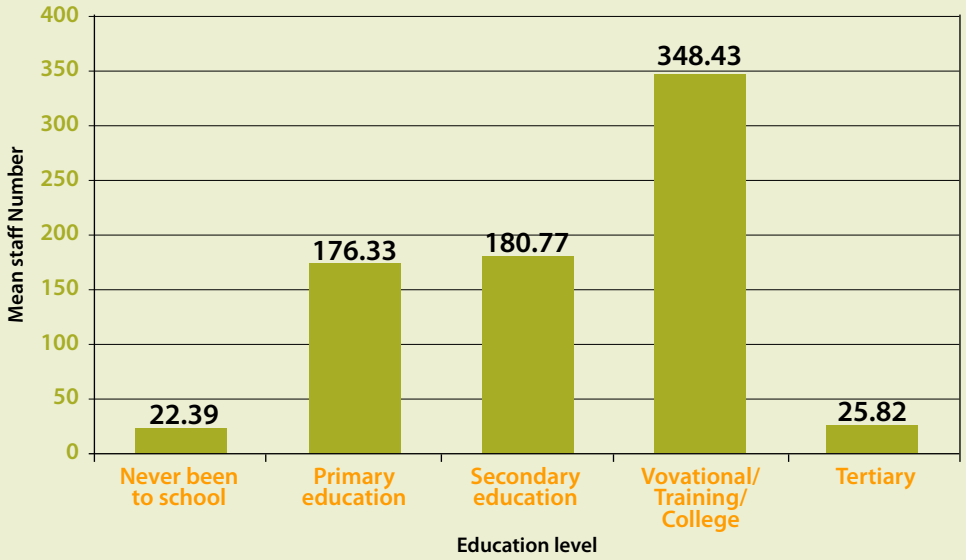

Figure 2: Mean staff number by education level

Main interventions sites

Most organisations (69%) were operating both in rural and urban areas. Only 24.1% and 6.9% indicated to operate in rural and urban areas respectively.

	Frequency	Percent
Rural	14	24.1
Urban	4	6.9
Both	40	69.0
Total	**58**	**100.0**

Table 7: Main intervention sites

Level of policy decision making

46.6% of the organisations indicated the general assembly to be the highest level for policy making decisions whereas 20.7% and 19% pointed the board and executive body to be the highest levels for policy decision making respectively.

	Frequency	Percent
General assembly	27	46.6
Board	12	20.7
Executive body	11	19.0
Other(eg: Full Council, Diocese, Management committee)	8	13.8
Total	**58**	**100.0**

Table 8: Level of policy decision making

Core business of the organisations

Main focuses of organisations are stipulated in table 5 below. Nevertheless, government authorities indicated their core business to be sustainable development for local communities. The small and medium enterprises pointed provision of small loan facilities to be their main focus. CSO, FBO,INGO and network organisations indicated ther core business to be; human rights, gender, child and youth development, coordination, management and overseeing press club projects , HIV and AIDS, basic education, family health, support to orphans and widows, policy advocacy and advocating for the rights of teachers.

Main focus area	Frequency	Percent
Human rights	4	6.9
Gender	8	13.8
Sustainable Livelihood	9	15.5
Child and Youth Development	1	1.7
Coordinating, managing and overseeing press club projects	1	1.7
HIV and AIDS	6	10.3
Provision of small loan facilities	3	5.2
Basic Education	2	3.4
Family Health	1	1.7
Support to orphans and widows	4	6.9
Policy advocacy	13	22.4
Women's rights	4	6.9
Advocating for the rights of teachers	1	1.7
Advocating for the rights of small and medium scale enterprises	1	1.7
Total	**58**	**100**

Table 9: Focus areas of organisations

Age categories of staff

In all organisations 71.3% of the staff belonged to the age group 25-49 years, whereas 10.8% and 17.9% were of the age groups 15-24 and 50 or above respectively. See table 10 and figure 3 below.

Age group	Frequency	Percent
'15-24'	35	10.8
'25-49'	231	71.3
'50+'	58	17.9
Total	**324**	**100.0**

Table 10: Frequency distribution of staff respondents by age groups

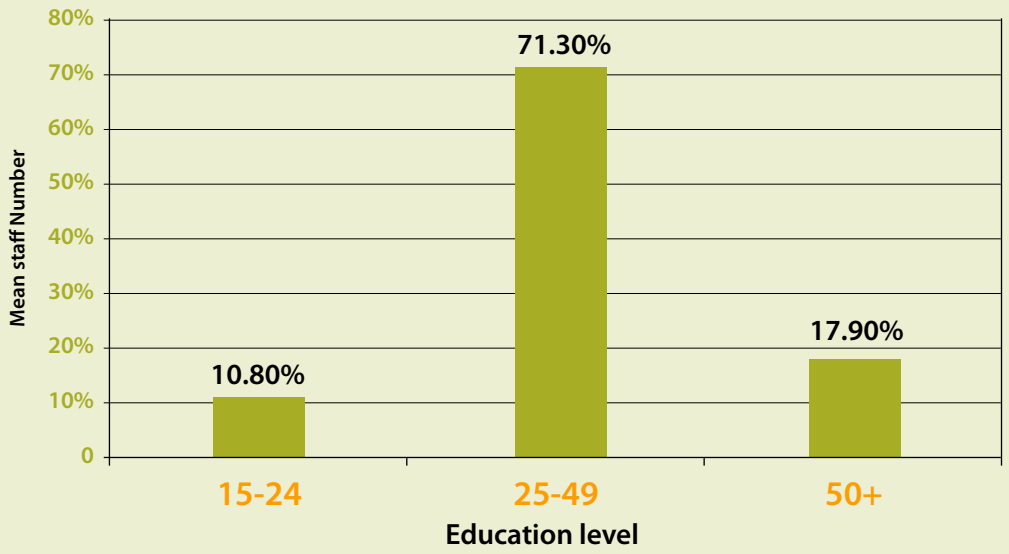

Figure 3: Percentage distribution of staff respondents by age groups

Sex of staff

Of all staff respondents 61.4% were males and the remaining 38.6% were females. See table 7n and figure 4 below here.

Sex	Frequency	Percent
Male	199	61.4
Female	125	38.6
Total	**324**	**100.0**

Table 11: Frequency distribution of staff respondents by sex

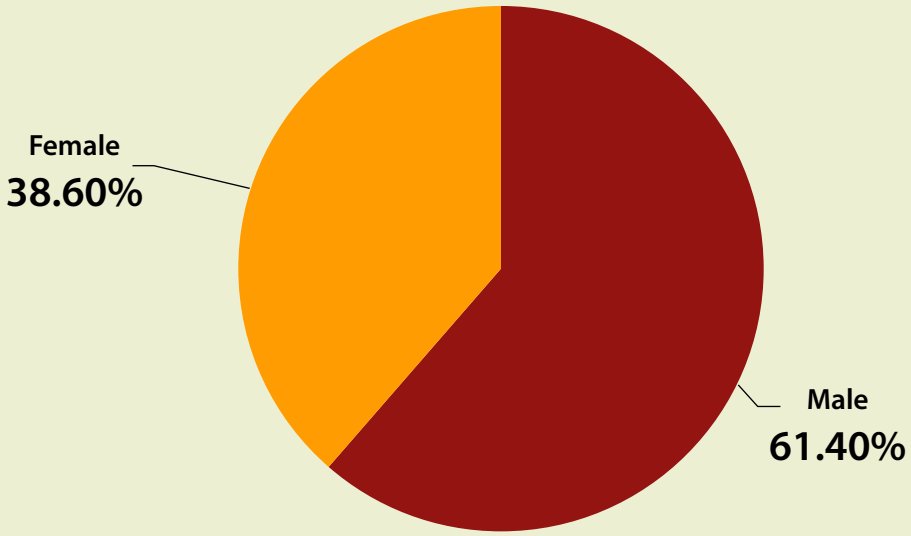

Figure 4: Percentage distribution of staff respondents by sex

Education level of staff

Most of staff (32.4%) respondents had undergraduates, 27.5% had vocational/trade/college education, 16.0% had secondary education, 6.2% had primary education while 0.3% had never been to school. See table 8 below.

	Frequency	Percent
Never been to school	1	0.3
Primary	20	6.2
Secondary	52	16.0
Vocational/Trade/College	89	27.5
Under-Graduate	105	32.4
Post-Graduate	57	17.6
Total	**324**	**100.0**

Table 12: Frequency distribution of staff respondents by education levels

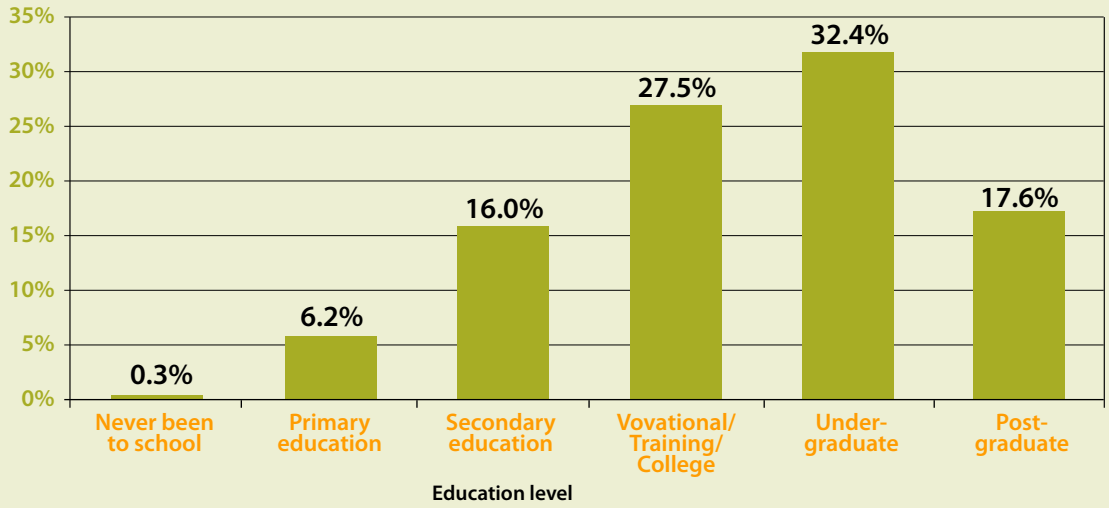

Figure 5: Percentage distribution of staff respondents by education levels

Number of staff dependants

The mean number of adult women in staff households was 2 while that of adult men was 1 with the mean number of children being 3. The maximum number of children was 21 and the minimum was 0.Neverthless the number of other dependants was 4 with the maximum of 20 and minimum 0. See table 9 below.

	N	Minimum	Maximum	Mean	Std. Deviation
Number of children in household	295	0	21	3	2
Number of Adult women in household	283	0	10	2	1
Number of Adult men in household	271	0	7	1	1
Number of other dependant people	291	0	20	4	3
Valid N (listwise)	244				

Table 13: Descriptive Statistics for number of staff dependents

Working condition for staff

42.2% of staff respondents indicated to work full time in their organisations, 7.1% indicated to work on part time, 21.5% indicated to work on permanent base, 23.6% work on contract base and 5.6% work as temporary employees.

	Frequency	Percent
I work full time in this organisation	137	42.2
I work part time in this organisation	23	7.1
I work on a permanent base	70	21.5
I work on a contract base	76	23.6
I work temporary:	18	5.6
Total	**324**	**100**

Table 14: Frequency distribution of staff respondents by working condition

Staff employment level

20.4% of staff respondents indicated to be at the management level, 46.0% pointed to be programme staff, 25.0% indicated to be administration or support staff and 8.7% were volunteers.

	Frequency	Percent
Management	66	20.4
Programme staff	149	46.0
Administration/Support	81	25.0
Volunteers	28	8.7
Total	**324**	**100.0**

Table 15: Frequency distribution of staff respondents by employment level

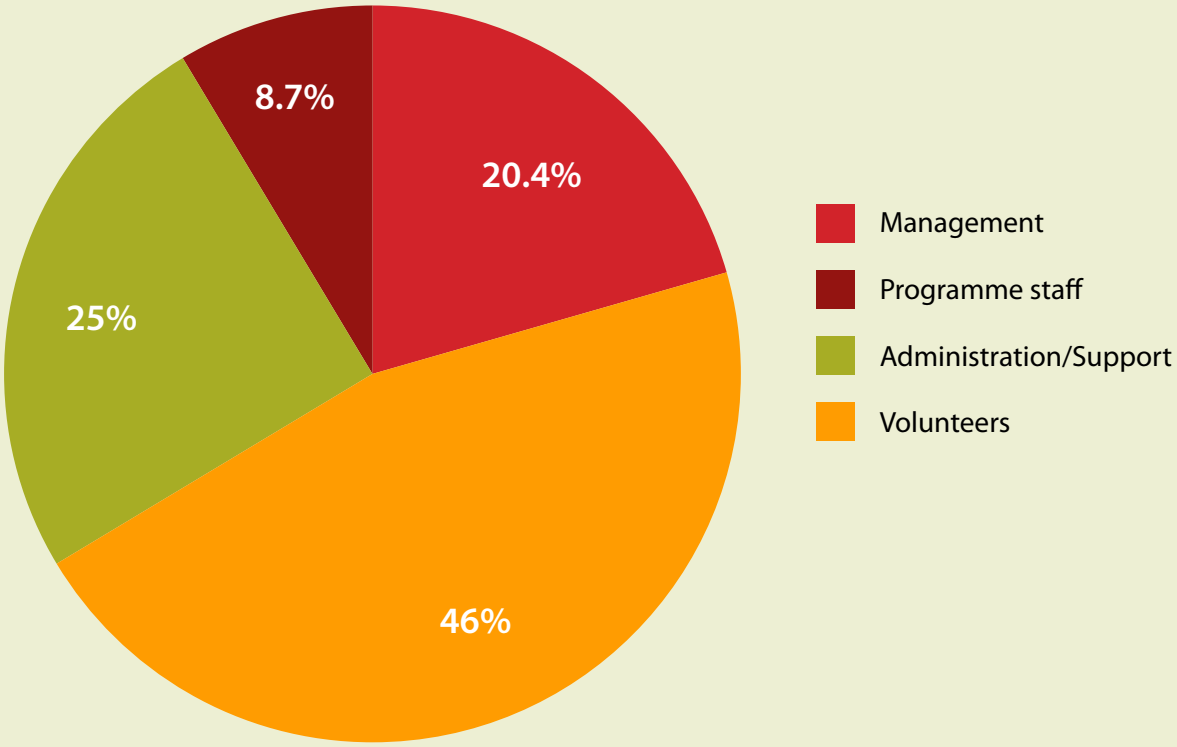

Figure 6: Percentage distribution of staff respondents by employment level

Knowledge on HIV transmission, prevention and treatment

The staff knowledge on HIV was analyzed by exploring their understanding on ways through which a person can contract HIV. The mean HIV Knowledge on transmission was moderately high (76.68%).

	N	Minimum	Maximum	Mean	Std. Deviation
HIV Knowledge on transmission (%)	324	11,11	100,00	76,6804	25,18016
Valid N (listwise)	324				

Table 16: Descriptive Statistics for mean HIV knowledge on transmission for staff respondents

Staff attitudes towards HIV and sexual orientation

Most (93.4%) staff indicated to be more supportive to HIV positive than people who have used drugs, who have been sex workers, sexually active outside marriage or homosexuals. See figure 7 below.

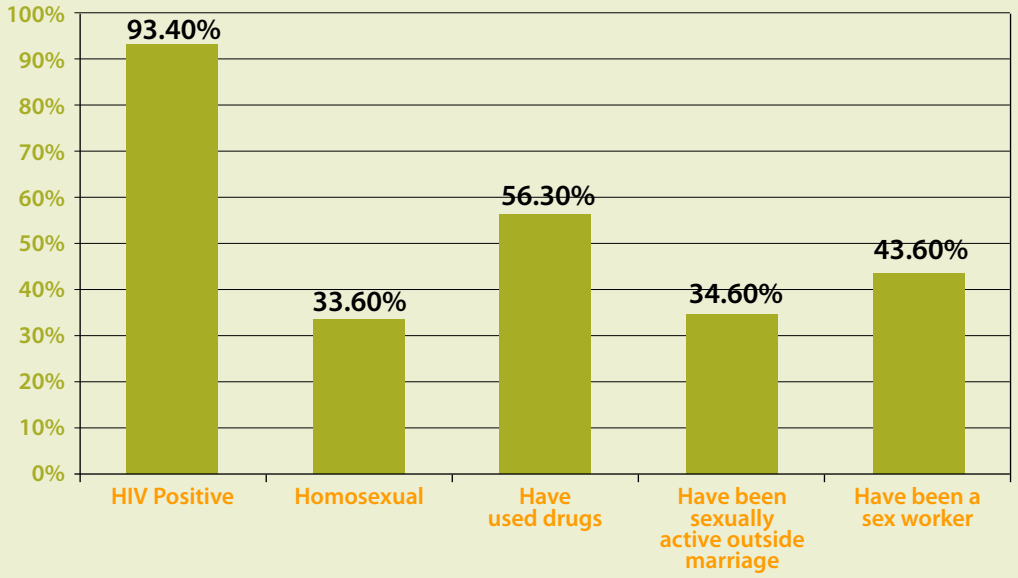

Figure 7: Percentage distribution of supportive staff to colleagues who are HIV + or with other attributes

Staff perception to HIV staff

Most staff respondents (73.5%) did not indicate negative attitude to HIV staff. Nevertless 14.3% said it is their own fault, (2.8%)said it is a punishment to them from God, (3.1%)pointed that they are a sinful peoples, 1.2% pointed that they are bewitched and (13.3%) pointed that such people are paying the price of not using condoms.

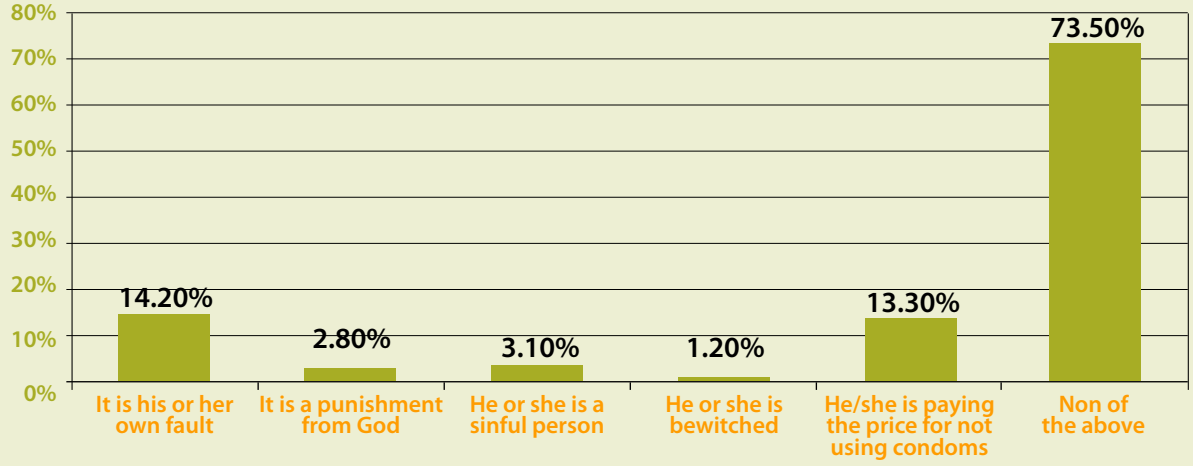

Figure 8: Percentage distribution of staff perception to HIV staff

Staff acceptance to HIV related services

Findings from this study indicated high staff acceptance to HIV related services. However, there were differences in acceptance with regard to the services to be provided to staff. Whereas, more (86.7%) staff respondents were in agreement that, staff should be given time off for VCT, those who agreed that staff should be given time off to give care to sick and that staff should be given time off for treatment of HIV were 85.1% and 82.9% respectively.

Figure 9: Percentage distribution of staff acceptance to HIV related services

Internal Mainstreaming

Whilst analyzing the various parameters of internal mainstreaming, this study sought to know whether the organisations were HIV specific or not.

70.7% of the organisations indicated to be non HIV specific and 29.3% were HIV specific.

	Frequency	Percent
HIV specific	17	29.3
Non-HIV specific	41	70.7
Total	**58**	**100.0**

Table 17: Percentage distribution of organisations by HIV specificity

Development and status of workplace policies

29.3% of organisational respondents point out that their organisations have no specific policy for addressing HIV.27.6% indicated existence of gender policy with HIV component in their organisations, 19.0% indicated existence of human resource policies with HIV component in their organisations, 13.8% pointed that their organisations have specific HIV workplace policy.10.3% indicated existence of other policies in their organisations which incorporate HIV. See table 13 and figure 10 below.

	Frequency	Percent
No policy addressing HIV	17	29.3
Gender with HIV component	16	27.6
HR Policy with HIV component	11	19.0
Specific HIV WPP policy	8	13.8
Other policy including HIV	6	10.3
Total	**58**	**100.0**

Table 18: Frequency distribution on development and status of workplace polices

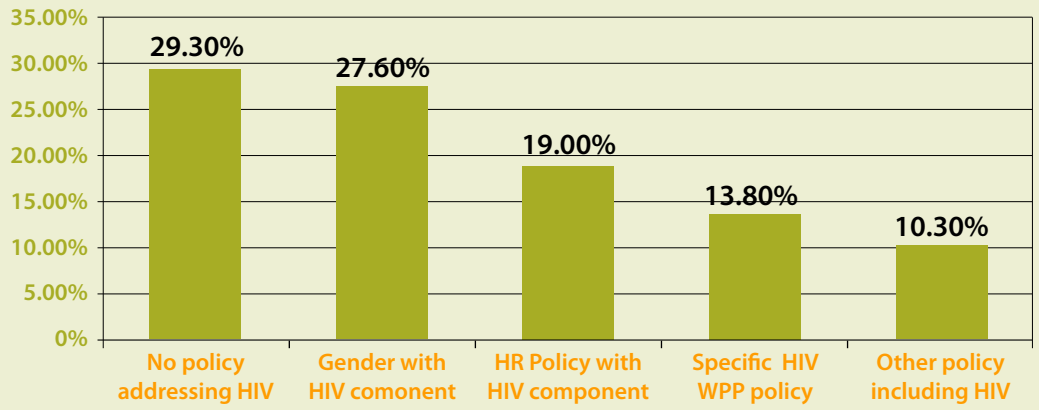

Figure 10: Percentage distribution on development and status of workplace polices

HIV Focal person

With regard to existence of HIV focal persons, organisational respondents were asked whether their organisation have a HIV focal person or not.43.1% of organisation respondents indicated to have HIV focal person in their organisations whereas 56.9% indicated nonexistence of such persons.

	Frequency	Percent
Yes	25	43.1
No	33	56.9
Total	**58**	**100.0**

Table 19: Frequency distribution on available HIV focal person in organisations

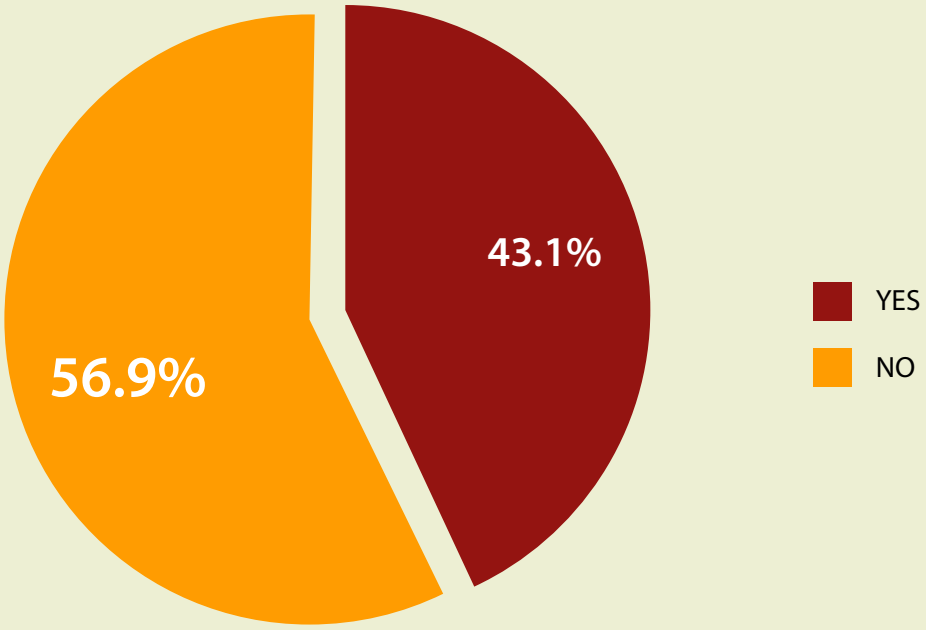

Figure 11: Percentage distribution of available of HIV focal person in organisations

HIV Committee

Further to the above, organisations respondents were asked on whether their organisations have HIV committee or not. Only 31% indicated their organisations to have such committees. The remaining 69% of organisations pointed that their organisations do not have such committees.

	Frequency	Percent
Yes	18	31.0
No	40	69.0
Total	**58**	**100.0**

Table 20: Frequency distribution of available HIV committee in organisations

Status of workplace policy

43.1% of organisational respondents pointed that their organisations do not have any existing workplace policy, 19% indicated to be in process of developing one, 6.9% indicated to have a draft policy, 5.2% demonstrated to be reviewing their policy, 3.4% pointed to have endorsed the policy and 22.4% pointed to implement such a policy.

	Frequency	Percent
Non existent	25	43.1
In process of development	11	19.0
Draft	4	6.9
Review	3	5.2
Final(endorsed)	2	3.4
Under implementation	13	22.4
Total	**58**	**100.0**

Table 21: Frequency distribution on status of workplace policy in organisations

Staff involved in development process of HIV workplace policy

62.1% of organisational respondents pointed that, their organisations involved all staff including external expertise in developing their HIV workplace policy, whereas 38.0% pointed that only management and program staff were involved.

	Frequency	Percent
All staff including external expertise	36	62.1
Management and program staff	22	38.0
Total	**58**	**100.0**

Table 22: Frequency distribution of staff involvement in development of workplace policy

Staff awareness on the existence of HIV policy in their organisations

22.0% of the staff respondents pointed that their organisations do not have a policy on HIV and AIDS,18.9% pointed that they do not know whether such policies exist in their organisations, 20.1% pointed to be aware of such policies , 6.6% pointed to have seen it, 10.7% pointed to have read it and only 21.7% pointed to have used it.

Does your organisation have a policy on HIV and AIDS?

	Frequency	Percent
None	70	22.0
Don't Know	60	18.9
Aware	64	20.1
Have seen it	21	6.6
Have read it	34	10.7
Have used it	69	21.3
Missing system	6	1.9
Total	**58**	**100.0**

Table 23: Frequency distribution of staff awareness on existence of HIV policy in organisations

Staff awareness on HIV activities in organisations

23.4% of staff respondents indicated that their organisations do not have HIV and AIDS activities, 16.8% indicated not to know whether their organisations have HIV and AIDS activities and only 19.9% pointed to be aware of such activities in their organisations. 39.9% indicated to have participated in such activities.

	Frequency	Percent
None	78	24.3
Don't Know	54	16.8
Aware	64	19.9
Participated	128	39.9
Total	**324**	**100.0**

Table 24: Frequency distribution of Staff awareness on HIV activities in organisations

HIV related activities implemented in organisations

Most (79.3%) organisational respondents indicated that HIV related activities in their organisations were on awareness,48.3% were on trainings,34.5% were on provision of IEC materials,25.9% were on condom supply,19% were on care and treatment and 15.5% on VCT. See table 20 and figure 12 below here.

	Frequency	Percent
Awareness sessions	46	79.3
IEC materials	20	34.5
VCT	9	15.5
Care & Treatment	11	19
Condom Supply	15	25.9
Training	28	48.3
Self-help/Support group	14	24.1
Others	8	13.8
Total	**324**	**100**

Table 25: Frequency distribution of HIV related activities implemented in organisations

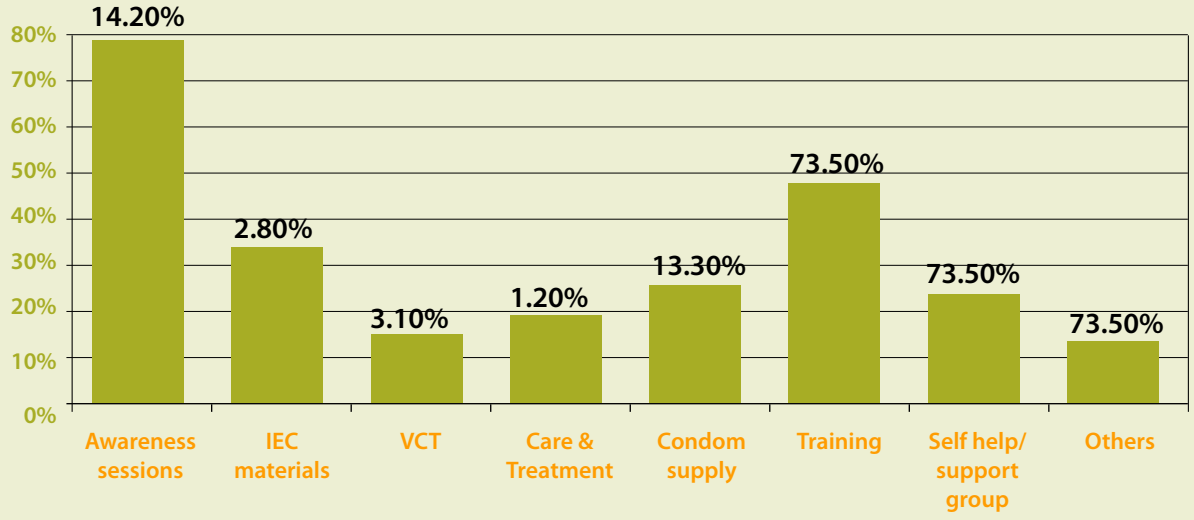

Figure 12: Percentage distribution of HIV related activities implemented in organisations

Types of HIV related trainings provided to staff

Most (53.4%) organisational respondents indicated that HIV related trainings provided to staff in the last 12 months were mainly on prevention, 44.8% were on basic facts, 39.7% were on care and support and 25.9% on mitigation.17.2% of organisational respondents indicated not to have received any HIV related trainings in last 12 months. See figure 13 below.

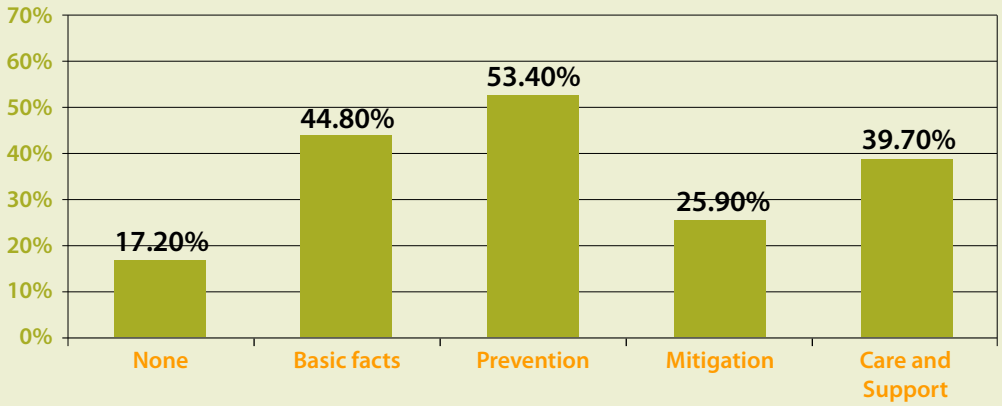

Figure 13: Percentage distribution of types of HIV related trainings provided to staff in the last 12 months

Condom promotion by organisations over the last 12 months

This study as well sought to analyze the various interventions related to condom promotion within organisations. 50.9% of organisational respondents indicated their organisation promote condoms through trainings,27.2% through IEC materials,42% through provision of male condoms and 20.7% through provision of female condoms.

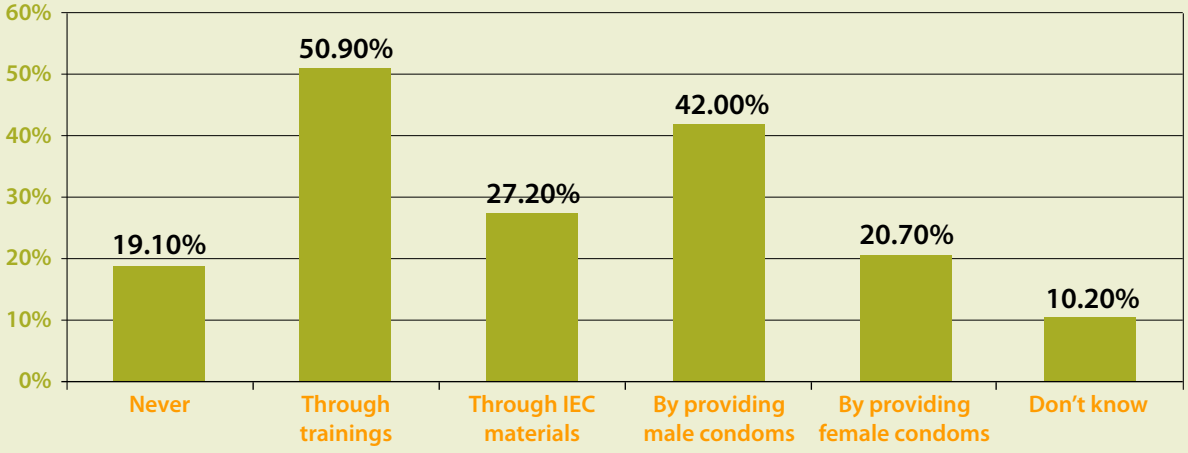

Figure 14: Percentage distribution of Condom promotion activities by organisations over the last 12 months

Sources of budget available for HIV activities

Most (43.1%) organisational respondents indicated the main budget source available for HIV activities to be donors. Other sources reported were own staff contribution (3.4%),own organisation contribution(36.2%) and government contribution 15.5%.A significant proportion (19.0%) of organisational respondents indicated that their organisations had no any budget source for HIV activities.

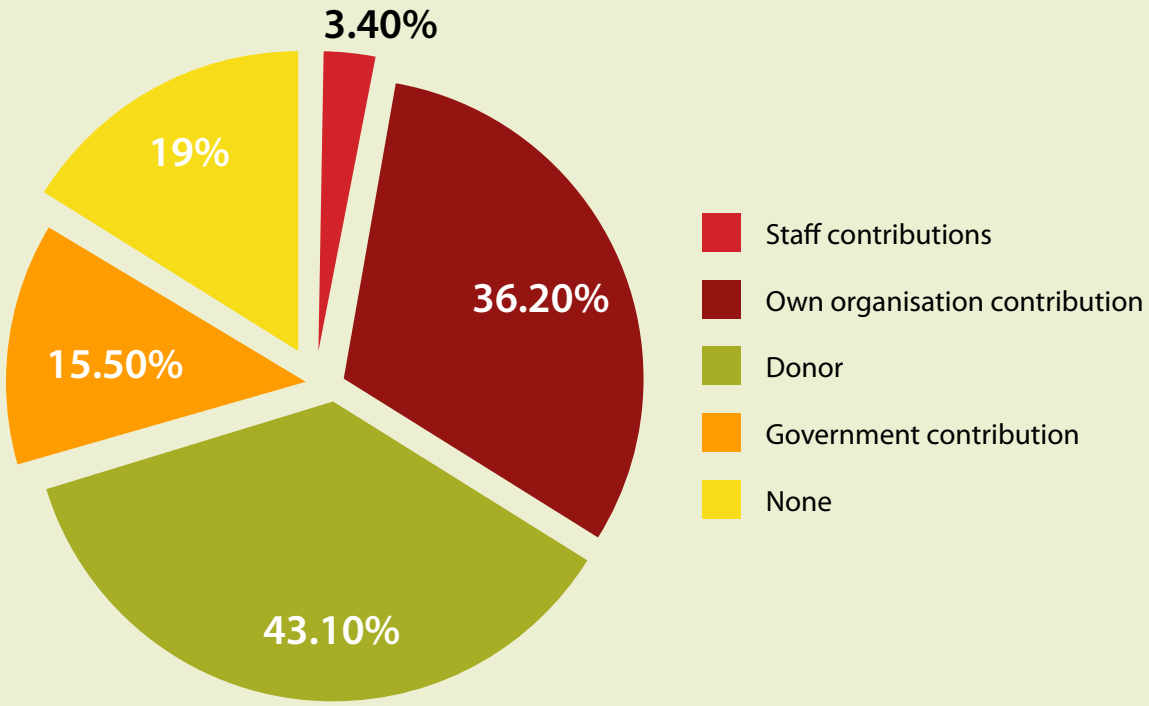

Figure 15: Percentage distribution of budget sources available for HIV activities in organisations

Future plans for addressing HIV in workplace

Most organisations affirmed to have future plans for addressing HIV in workplace. 58.6% have plans on training and capacity support, 43.1%are planning to develop HIV workplace policy, 27.6% are planning to advocate for infected and affected staff, 29.3% are planning to focus on stigma and discrimination and 8.6% had no any future plan.

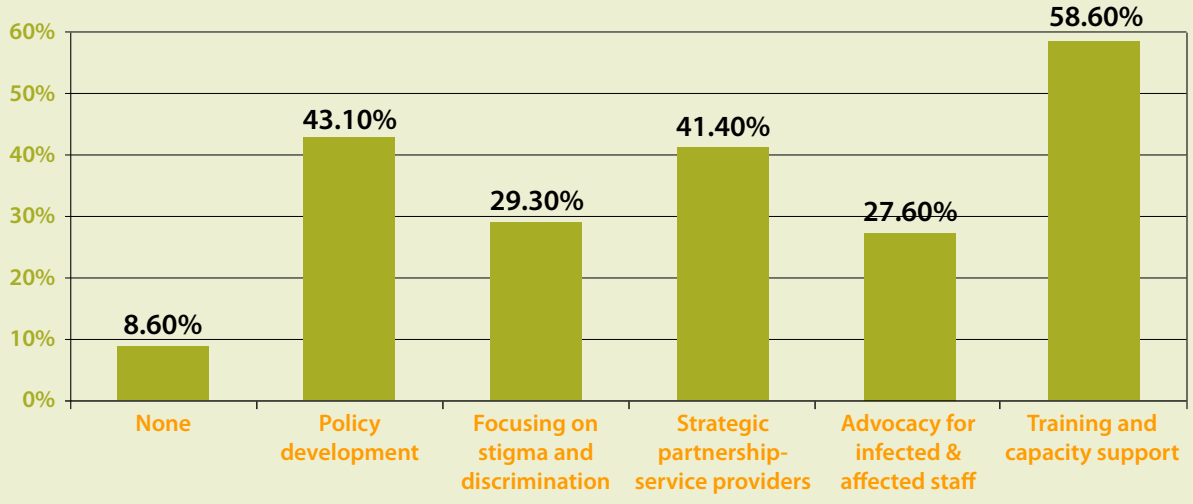

Figure 16: Percentage distribution of organisational future plans for addressing HIV in workplace

External support needed to support HIV workplace activities

Most organisations pointed to require external support for addressing HIV in workplaces.62.1% pointed to require support on collaborating with other agencies,51.8% sought to require technical support, 58.6% pointed to require support on training. However, 8.6% of the organisational respondents did not indicated to require any external support.

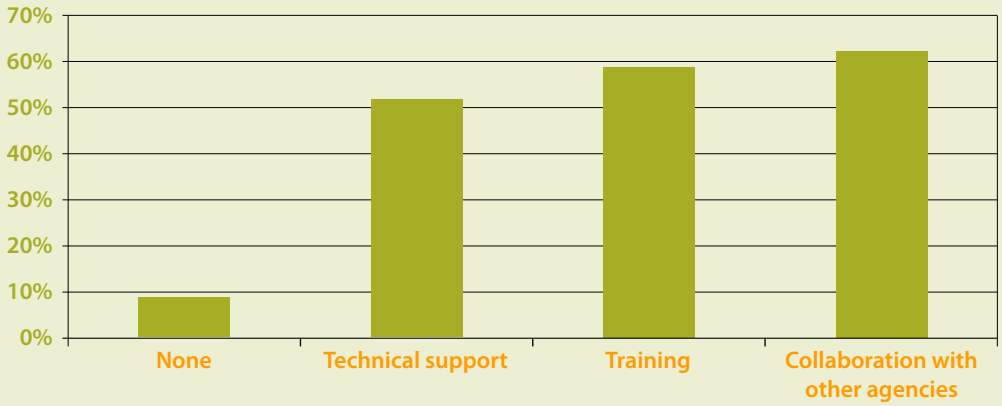

Figure 17: Percentage distribution of external support needed by organisations to support HIV workplace activities

Stigma and discrimination

Chances for PLHIV to get a job

Equal access to job opportunities for both people living with HIV and non-infected people signifies a stigma free working environment. Whilst responding to the question on what are the chances for PLHIV to get a job in their organisation, 8.9% pointed that PLHIV are more likely to get a job than non-infected ones, 61% pointed that both PLHIV and non PLHIV have same chances of getting a job, 11.1% said PLHIV have less chances of getting a job and 19.5% didn't know which kind of people have more chances of getting a job between PLHIV and non PLHIV.

	Frequency	Percent
More	29	8.9
Same	196	61.0
Less	36	11.1
Don't Know	63	19.5
Total	**324**	**100.0**

Table 26: Frequency distribution of staff perception on chances for PLHIV to get a job

Chances for PLHIV to get promotion

9.9% of staff respondents pointed that PLHIV staff have more chances of getting promotion in work than non

PLHIV staff, 62.0% pointed that both PLHIV staff and non PLHIV staff have same chances for promotion, 7.4% pointed that PLHIV staff have less chances for getting promotions and 20.7% didn't know which staff have more chances for job promotions between PLHIV and non PLHIV.

	Frequency	Percent
More	32	9.9
Same	201	62.0
Less	24	7.4
Don't Know	53	20.7
Total	**324**	**100.0**

Table 27: Frequency distribution of staff perception on chances for PLHIV to get promotion

Revealing HIV status of a staff member without their consent

In order to understand further on practices within organisations indicating presence of stigma and discrimination, staff were asked whether their organisations have ever revealed the HIV status of a staff member without their consent. 3.7% said yes whilst 79% said no. However 17.3% didn't know.
Has the organisation ever revealed HIV status of a staff member w/out their consent?

	Frequency	Percent
Yes	12	3.7
No	256	79.0
Don't know	56	17.3
Total	**324**	**100.0**

Table 28: Frequency distribution on organisation revealing HIV status of staff without their consent

Encouragement by the Workplace to HIV testing, treatment and Care

When asked whether their workplace encourage HIV testing, care and treatment, 62% of staff respondents said yes, 18.7 said no and 21.3% indicated not to know anything in relation to this. Of those who said yes, 45.5% indicated the workplace to encourage some of such services at least on site and 17 % indicated that such services are encouraged off site.

Does the workplace encourage access to HIV testing, treatment and care?

	Frequency	Percent
No	59	18.7
Don't know	67	21.3
At least some on-site	143	45.5
Off site	55	17.5
Total	**324**	**100.0**

Table 29: Frequency distribution of workplace encouragement to HIV testing, treatment and care

Organisation flexibility to access HIV services

Many respondents were of the opinion that, their organisations are flexible to access HIV services. However, staff opinion varied with regard to type of HIV service the organisation would be flexible to. Whereas most respondents indicated that organisations would be flexible to access VCT, 81.2% and 69.4% were of the opinion that, their organisations would be more flexible to treatment and care and care for family and relatives respectively.

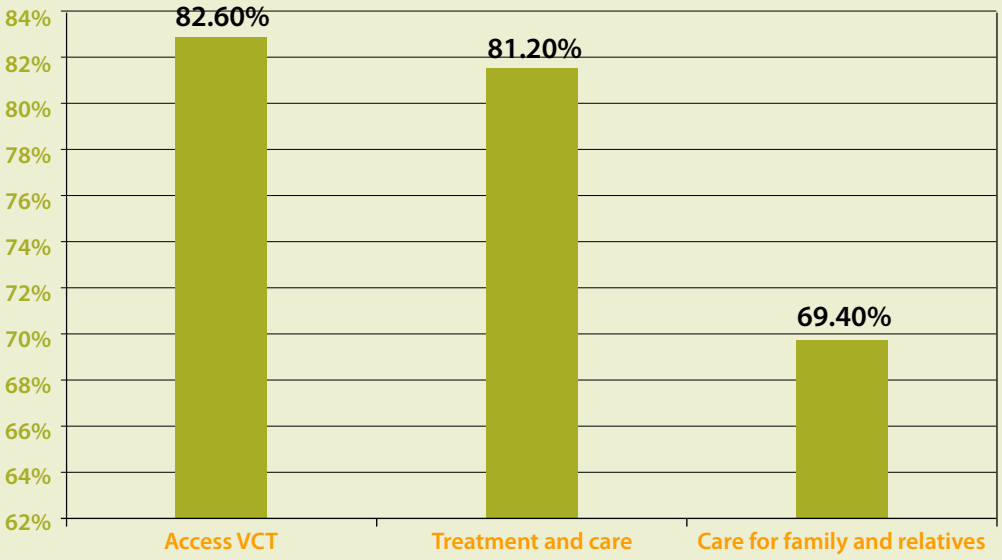

Figure 18: Percentage distribution of organisation flexibility for staff to access HIV services

Levels of stigma for HIV+ staff

In order to understand the levels of stigma for HIV+ staff, organisation respondents were asked on how they could rate the level of stigma in their organisation in relation to HIV+ staff.5.7% pointed that, other staff would generally be supportive, 36.2% pointed that staff would not reject HIV+ staff, 1.7% pointed that staff would not accept HIV+ staff and 10.3% didn't know on what would be the reaction of other staff to HIV+ staff.

	Frequency	Percent
Other staff generally supportive	30	51.7
Staff would not reject HIV+ staff	21	36.2
Staff would not accept HIV+ staff	1	1.7
Don't know	6	10.3
Total	**58**	**100.0**

Table 30: Frequency distribution of Levels of stigma for HIV+ staff

HIV status in staff recruitment

Indications of stigma and discrimination within organisations could be traced by analyzing whether HIV status determines staff recruitment or mot. On responding to the question whether HIV is not a barrier in recruitment 75.9% said yes and 24.1% said no.

HIV status is not a barrier in recruitment?

	Frequency	Percent
Yes	44	75.9
No	14	24.1
Total	**58**	**100.0**

Table 31: Percentage distribution of staff opinion on HIV as a barrier to recruitment

Furthermore, organisation respondents were asked whether HIV status could be a barrier to promotion. Whilst 69% of organisation respondents said HIV is not a barrier to promotion 31% said it could be.

HIV status is not a barrier to promotion

	Frequency	Percent
Yes	40	69.0
No	18	31.0
Total	**58**	**100.0**

Table 32: Percentage distribution of staff opinion on HIV as a barrier to promotion

Confidentiality Protection

The levels of stigma and discrimination within organisations could comprise its ability to protect the confidentiality of staff with regard to their HIV status. This study sought to know from organisational respondents whether there is confidentiality protection within their organisations.81% felt that confidentiality is indeed protected within their organisations and the remaining 11% perceived the confidentiality as not being protected.

Is confidentiality protected in your organisation?

	Frequency	Percent
Yes	47	81.0
No	11	19.0
Total	**58**	**100.0**

Table 33: Frequency distribution of organisational opinion on confidentiality protection

Voluntary Counseling and Testing as a condition for employment

Testing for HIV should be considered voluntary and where there is sigma free working environment it should not be a condition for employment. Findings from this study indicated that, 77.6% of organisational respondents said testing for HIV is not a condition for employment within their organisations and the remaining 22.4% didn't respond to this question.

Is testing a condition for employment?

	Frequency	Percent
Yes	45	77.6
Missing System	13	22.4
Total	**58**	**100.0**

Table 34: Frequency distribution of organisational respondents' opinion on HIV testing as a condition for employment

Access to HIV Services

On responding to the question on whether there is access to HIV services in the organisations, 18.2% of the staff respondents said yes, 20.7% said they don't know, 44.1% indicated to have access to such services on site and 17% indicated to have access to such services off site.

Does the workplace encourage access to HIV testing, treatment and care?

		Frequency	Percent
Valid	No	59	18,2
	Don't Know	67	20,7
	At least some on-site	143	44,1
	Off site	55	17,0
Total		**324**	**100,0**

Table 35: Frequency distribution of staff opinion on access to HIV services

Availability and demand for HIV services

Availability and demand for HIV services indicates access to HIV services within the organisation. Only 8.6% of organisational respondents indicated availability of grievances procedures to access HIV services within their organisation.

Availability of Grievance procedures within organisations

	Frequency	Percent
Yes	5	8.6
Missing System	53	91.4
Total	**58**	**100.0**

Table 36: Frequency distribution on Availability and demand for HIV services in organisations

Availability of designated officer for HIV/AIDS activities in workplaces

3.4% of organisational representatives pointed their organisations to have designated officer for HIV/AIDS activities within workplaces whilst 96.6% did not respond to this question.

Does your organisation have a designated officer for HIV/AIDS activities in workplaces?

	Frequency	Percent
Yes	2	3.4
Missing System	56	96.6
Total	**58**	**100.0**

Table 37: Frequency distribution on availability of designated officer for HIV/AIDS activities in workplaces

HIV services available in the organisations

Whilst responding to the question on which HIV services are available in their organisations,27.6% of the organisational respondents pointed to produce information materials,31.0% pointed to provide awareness sessions,6.9% provide services related to testing and counseling, 6.9% provide treatment services and 15.5% provide linking or referrals to service providers.

	Frequency	Percent
Information materials	16	27.6
Awareness sessions	18	31
Condoms	7	12.1
Testing and Counseling	4	6.9
Treatment	4	6.9
Linking/referral to service providers	9	15.5
Total	**58**	**100**

Table 38: Frequency distribution of HIV services available in the organisations

Availability of VCT in workplaces

10.3% of organisational respondents pointed to have VCT services within workplaces, 55.2% pointed that VCT are non-available in their workplaces and 34.5% pointed to access VCT services with others.

IS VCT available through workplace?

	Frequency	Percent
Within workplace	6	10.3
None	32	55.2
With others	20	34.5
Total	**58**	**100.0**

Table 39: Frequency distribution of Availability of VCT in workplaces

Current demand for access to VCT and ART services

63.8% pointed existence of low demand for access to VCT and ART services, 27.6% pointed existence of medium demand and only 8.6% pointed existence of high demand.

Current demand for access to VCT and ART services

	Frequency	Percent
Low	37	63.8
Medium	16	27.6
High	5	8.6
Total	**58**	**100**

Table 40: Frequency distribution of Current demand for access to VCT and ART services

Linking and Learning 03

Learning with/from other organisations in the past twelve months

In order to understand issues related to linking and learning, organisation respondents were asked whether their organisations have in the past twelve months been able learn with or from other organisations. 10.3% pointed to learn through exchange visits, 20.7% pointed to have learnt through trainings and capacity building, 24.1% pointed to have learned through conferences and seminars, 17.2% through publications, 12.2% through belonging networks or coalitions, 8.6% through peer education and 1.7% through other joint activities. 5.2% of organisation respondents pointed to have not participated in any learning session in the past twelve months.

	Frequency	Percent
Exchange Visits	6	10.3
Training, capacity building	12	20.7
Conference, seminars	14	24.1
Publications	10	17.2
Belonging networks/coalitions	7	12.2
Peer Education	5	8.6
None of the above	3	5.2
Other joint activity	1	1.7
Total	**58**	**100**

Table 37: Frequency distribution of activities related to linking and learning by organisations in the last 12 months

Networks and coalitions on HIV organisations belong

Network and coalitions on HIV provides opportunities for member organisations to learn with and from others. This study sought to understand whether organisations that participated in this study belong to networks or coalitions on HIV in the workplaces. Whilst 32.8% pointed to belong to various networks or coalitions on HIV in workplaces, 67.2% said they do not belong to any of such networks or coalitions.

Does your organisation belong to network or coalitions on HIV in the workplace?

	Frequency	Percent
Yes	19	32.8
No	39	67.2
Total	**58**	**100.0**

Table 38: Frequency distribution of organisations belonging to networks or coalitions on HIV in workplaces

The networks or coalitions specified by organisational respondents included: Biharamulo AIDS NGOs Network (BANN), Karagwe District AIDS Coordination Network(KADACONET),HIV/AIDS Pastoralist Network(HAPANET),Joint Oxfam HIV/AIDS Program in Tanzania and Simanjiro HIV/AIDS Network.

Supporting other CSOs in implementation of workplace policy

Organisational respondents were also asked on whether their organisations support others in implementation of HIV workplace policy, 51.7% said yes whilst the remaining 48.3% disagreed.

Does org support others in the implementation of HIV workplace policy?

	Frequency	Percent
Yes	30	51.7
No	28	48.3
Total	**58**	**100.0**

Table 39: frequency distribution of organisation supporting others to implement HIV workplace policy

Lobbying and advocacy

In order to understand issues related to lobbying and advocacy with regard to HIV in workplaces organisational respondents were asked whether their organisation are actively involved in any of the advocacy activities.12.1% indicated their advocacy activities to be mainly on HIV workplace policy at the national level,13.8% indicated to support HIV workplace policy interventions with donors,27.6% pointed to promote HIV related human rights, 31% indicated to advocate for the rights of PLHIV and the remaining 15.5% indicated to collaborate with networks of PLHIV.

	Frequency	Percent
Advocacy activities on HIV w/place policy issues at national level	7	12.1
Supporting HIV workplace interventions with donors	8	13.8
Promotion of HIV related human rights	16	27.6
Advocate for the rights of PLHIV	18	31.0
Collaborate with networks of PLHIV	9	15.5
Total	**58**	**100**

Table 40: Percentage distribution of lobby and advocacy activities in organisations

Advocacy for the rights and services for PLHIV

Staff respondents were also asked on whether their employers advocate for the rights and services for PLHIV.12.7% said no, 14.4% said they don't know, 35.2% said yes passively and 37.7% said yes proactively.

Does your employer advocate for the rights and services for PLHIV?

	Frequency	Percent
No	41	12.7
Don't Know	47	14.5
Yes passively	114	35.2
Yes proactively	122	37.7
Total	**324**	**100.0**

Table 41: Frequency distribution of staff awareness on employers advocating for the rights of PLHIV

Acceptance of colleagues disclosing their HIV status

On responding to the question on who would be accepted more if a colleague discloses his/her HIV status,7.1% said that men would be accepted more, while 11.7% said this is the case for women ,, 72.2% said there would be no difference and the remaining 8.8% said they don't not know who would be accepted more.

If a colleague discloses HIV status in workplace who would be accepted more?

	Frequency	Percent
Men	23	7.1
Women	28	8.6
No difference	234	72.2
Don't Know	39	12.1
Total	**324**	**100.0**

Table 42: Frequency distribution of acceptance of colleagues disclosing their HIV status

Meaning Involvement of HIV+ staff in workplace programmes

Meaningful involvement of PLHIV in workplaces requires broaden initiatives that involves all staff. However, the HIV and AIDS related stigma and discrimination has contributed in limited involvement of HIV positive staff in key programmes within workplaces. This study sought to analyze the involvement of HIV positive in workplace programmes.

The percentage of staff respondents that indicated HIV positive staff are involved in education and training tallied to those who said HIV staff are involved in support and counseling programmes. Both had 50.6%. Furthermore, 32.7% of staff respondents indicated that HIV positive staff are involved in policy and planning processes. Whereas 6.8% indicated that HIV positive staff are not involved in workplace programmes 26.2% did not know whether HIV positive staff are involved in workplace programmes or not. See figure 19 below.

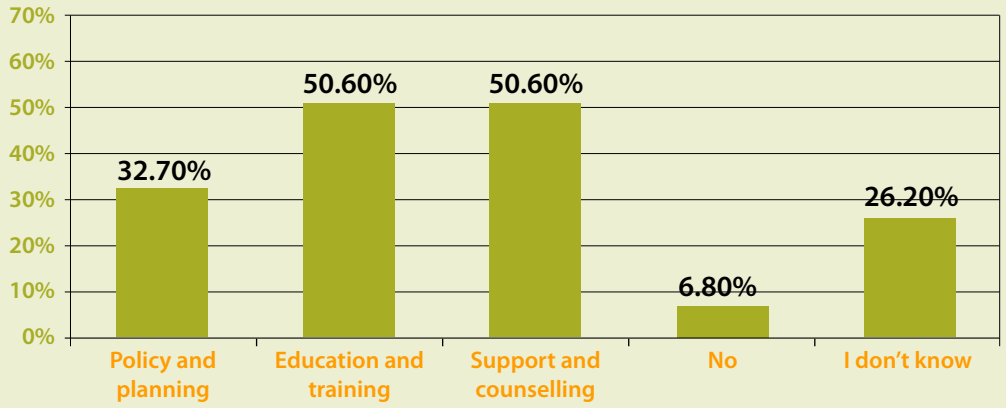

Figure 19: Percentage distribution of staff perception on Meaning Involvement of HIV+ staff in workplace programmes

Staff perception on organisation interventions for HIV+ staff members

This study as well sought to analyze on how organisations would support HIV positive staff.

Most (50.3%) organisational respondents indicated that their organisations would allow time off for HIV positive staff, 40.4% pointed their organisations would compensate medical costs and 42.3% indicated their organisations would encourage home visits. On the other hand 3.4% pointed their organisations would do nothing and 0.6% indicated that their organisation would refuse to accommodate the need of HIV positive staff. 12% of organisational respondents didn't know what their organisations would do on such incidences.

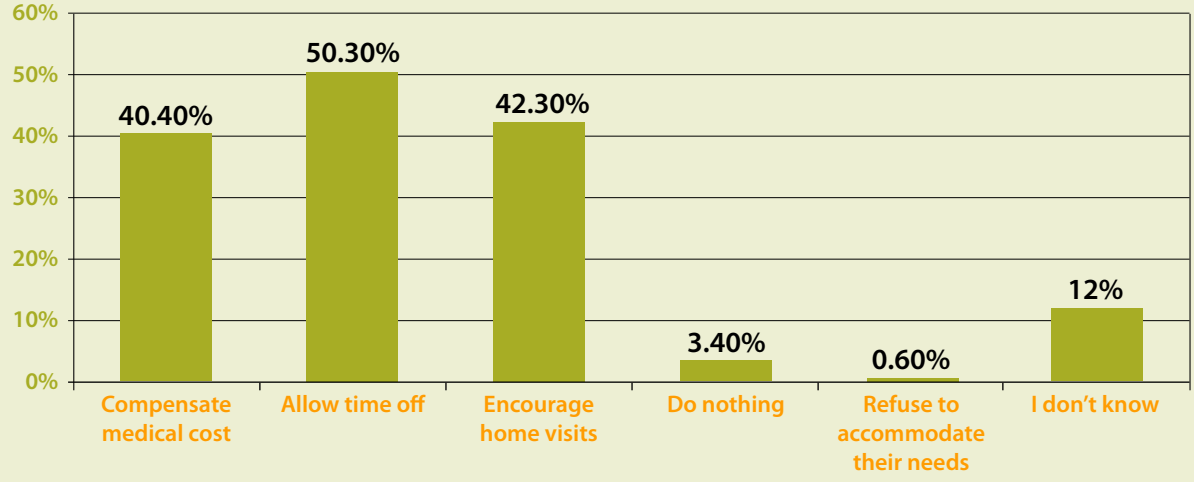

Figure20: Percentage distribution of staff perception on organisation interventions for HIV+ staff members

Discussion

04

Opportunities and Challenges for Development and Implementation Of Organisational Workplace Policies and Programmes

FINDINGS FROM THIS STUDY INDICATE THAT, there is a considerable progress with regard to HIV internal mainstreaming in workplaces in Tanzania. Information obtained through Focus Group Discussion indicated that,whereas local authorities demonstrated to have gone a step further into developing workplace policies, only few CSOs have been able to institutionalize such policies.

Most staff have attained good education and are within the sexually active age bracket thereby remaining vulnerable to HIV transmissions. Furthermore, the staffs have loads of dependants depicting that, effects in their work such as those related to HIV and AIDS could affect many other members of their families.

Most staff are at the programme level and work full time on their organisations thereby spending most of their time in work places.

Most HIV related activities implemented by organisations are related to awareness raising, trainings and provision of IEC materials with only few organisations implementing programmes related to VCT, care and treatment.

While the majority of civil society organisations (CSOs) have good knowledge and awareness on HIV, lack of institutional policies on HIV mainstreaming limits their competence to addressing HIV in workplace. Compared to HIV focused organisations the willingness of staff to talk about HIV in workplaces for non-HIV focused organisations is still low. Many staff are of the opinion that HIV status is not a barrier to employment and they are willing to support other staff who are living with HIV. However most are not willing to disclose their HIV status at workplaces.

Considering the fact that many donors mainly focus on external mainstreaming, HIV prevention mechanisms in workplace remained under resourced although most organisations affirmed to have future plans for addressing HIV in workplace. Many organisations encourage access to HIV testing, treatment and care. Nevertheless; very few organisations have available grievances procedures to access HIV services within workplaces.

05 Conclusion

WE CAN CONCLUDE FROM THIS STUDY that the HIV prevalence in Tanzania is significant to warrant interventions for addressing HIV in workplaces through solid internal mainstreaming processes in order to equip CSOs to be in a better position of mainstream HIV in their programmes.

The current limited access to HIV/AIDS services and support for and families contributes to narrow openness to staff to discuss HIV issues in workplaces particularly amongst non-HIV focused CSOs putting the organisations into higher risks of experiencing further impacts resulting from HIV and AIDS.

Most staff have relative high knowledge on prevention and transmission. However there were variations in knowledge on other types of transmission modes including male circumcision, treatment of STIs and PMTCT with low misconceptions across all staff. Staffs expressed high support for HIV+ colleague but moderate for MARPs.

Meaningful involvement of PLHIV in workplaces and perceived stigma on shame, blame and judgment was generally.

The inadequate support for management of HIV in workplaces reduces staff willingness to disclose their status depicting existence of stigma and discrimination to staff who are HIV+. Considering the fact that many organisations do not have a full operational there is limited organisational capacity to formally address HIV related stigma and discrimination within their workplaces.

Whereas there is availability of considerable knowledge across organisations there is less space for cross learning across organisations including mechanisms for sharing of promising practices. There is moderate advocacy for rights for PLHIV and inadequate efforts on linking and learning from belonging networks with current lobbying mechanisms for HIV internal mainstreaming hardly reaching other sectors other than health.

Recommendations

06

RECOMMENDATIONS FROM THIS STUDY have been clustered into five levels basing on the five main pillars of the programme.

Internal Mainstreaming of HIV and AIDS

It remains imperative for CSOs in Tanzania to play a role in developing a HIV competent workplaces. Internal mainstreaming of HIV/AIDS in workplaces should seek to build the capacity of all staff in organisations in planning and implementation of appropriate initiatives for addressing HIV in workplaces

Addressing stigma and discrimination in workplaces

As emerged in this baseline, various forms of HIV related stigma and discrimination exist in workplaces. It remains imperative for subsequent programme activities to promote workplace stigma-reduction through training and peer education

It is imperative for this programme to strengthen partnership on HIV internal mainstreaming by building on existing networks and coalitions.

Better access to HIV/AIDS services and support for staff and families

The need for organisations to encourage staff to know their HIV status alongside provision of support remains imperative. However on an unprecedented scale challenges resulting from HIV cannot be addressed by that particular organisation alone. In order to facilitate better access to HIV/AIDS services and support for staff and families this project should seek to facilitate solid partnerships between CSOs and HIV health services providers and care, treatment and support programs.

Linking and Learning

Efforts to build organisational capacity to address HIV in workplaces should seek to facilitate institutionalization of specific workplace policy for addressing HIV within organisations. This can be achieved through effective linkages with local authorities that already have workplace policy.

Lobbying within and between counties and globally

Findings from this study indicated that many organisations have good knowledge on HIV transmission, prevention, treatment. Furthermore, most organisations have demonstrated good practices with regard to HIV and HIV+ staff. However, the reluctance of staff to understand their HIV status is an expression that, issues of stigma and discrimination prevail in many organisations. This could be contributed by limited access to HIV and AIDS services within organisations.

Effective lobbying strategies by the project should seek to prioritizing one or both of these key issues.

07 Acknowldegement

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Bibliography

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1. Managing HIV in the Workplace: A Guide for CSOs, STOP AIDS NOW! 2010
2. Tanzania Poverty and Human Development Report, 2010
3. Global TB Control WHO report, 2009
4. World Malaria Report, 2009
5. National Bureau of Statistics projections, 2010
6. UNAIDS Global Report, 2010
7. Tanzania UNGASS reporting, 2010
8. www.globalhealthfacts.org

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