Right to health with focus on people with HIV and AIDS in Tanzania

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Abstract

This article seeks to explore the right to health with special focus on people with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in Tanzania. It adopts an historical analysis by firstly focusing on the general position of the right to health at the international level. The article later centres its discussion on the international instruments on the right to health to people with HIV and AIDS. Having highlighted international position of the right to health, the study concentrates its discussion by providing, albeit in summary, the evolution and development of Tanzanian health system. It informs the legal position of the health system and submits on how the right to health is reflected in the Tanzania constitution. It later sets a specific focus on the accessibility of the right to health to people with HIV and AIDS in the country.

1. Introduction

This article, which is informed by the PhD research findings of the author, reveals that immediately after the country was hit by an epidemic, policy and legal measures were taken by the government to contain the problem. Thus, the adoption of the HIV/AIDS Policy of 2001 which was operationalized by the Tanzania Commission of AIDS Act, 2001 (the TACAIDS Act) is one of the government's efforts to address challenges of the HIV and AIDS. It is submitted that, despite these policy and legal efforts to address the challenges brought by HIV and AIDS in the society, discrimination and stigmatisation of people infected with HIV and AIDS from their family members and general members of the society have persisted leading the government to enact the HIV and AIDS (Prevention and Control) Act, 2008 (the Prevention and Control of HIV and AIDS Act).[1] The article posits that, policy and legal measures taken by the government and the role played by private and Faith Based Organisations (FBOs) in bringing awareness on HIV and AIDs through public education and programmes on HIV and AIDS, testing and counselling for HIV, and health and support services for people with HIV and AIDS have laid the foundation in reducing the effects of the disease to the population. That aside, this article highlights general and major challenges affecting people with HIV and AIDS in the realisation of the right to health.

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[1] Act No 28 of 2008. The Act enshrined provisions against discrimination and it made it punishable by law for anyone to discriminate people with HIV and AIDS.

2. Protection of the right to health at international level

Right to health is one of social economic rights protected by several international instruments. The World Health Organisation (WHO) Constitution which is binding upon all States Parties is the first international treaty to conceptualize a unique human right to health.[2] It states that:

> [T]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.[3]

Other international human rights instruments such as International Covenant on Economic Social and Cultural Rights (ICESCR) in its article 12, article 25 Universal Declaration of Human Rights (UDHR), article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (CERD), article 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 (CEDAW) and article 24 of the Convention on the Rights of the Child of 1989 (CRC) provide for the right to health. Besides, regional instruments provide for the right to health. Right to health is found in article 11 of the European Social Charter (ESC), article 10 of the Protocol of San Salvador, article 16 of the African Charter on Human and Peoples' Rights (ACHPR) and article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC), 1990. One of the main objectives of the African Union as stated in Article 3 (h) of the Constitutive Act of the African Union of 2001 is to promote and protect human and peoples' rights, such as the right to health, in accordance with the ACHPR and other relevant human rights instruments.

The UN Committee on Economic, Social and Cultural Rights (the ESCR Committee) has set four essential criteria of the right to health that are availability, acceptability, accessibility and quality.[4] The four essential criteria help to ascertain the scope of the right to health. The ESCR Committee has not offered principled basis which justify its linking of these four essential criteria into the text of the right to health.[5] Justification of this framework is nonetheless found from

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[2] Grad F. P., The preamble of the constitution of the World Health Organization, **Bulletin of the World Health Organization,**Vol. 80, No. 12, 2002, at p. 981.

[3] The preamble of the WHO Constitution 1946.

[4] For thorough insight on the four essential criteria of the right to health read UN Committee on Economic, Social and Cultural Rights: The right to the highest attainable standard of health: Comment 14 (General Comments). UN Doc.E/C.12/2000/4.

[5] Tobin, P., **The Right to Health in International Law**, Oxford University Press, Oxford, 2012, at p. 158.

> [I]ts role from an interpretative tool that contributes to an understanding of measures to secure the effective implementation of the right to health and ensure its enjoyment is not illusory.[6]

The ESCR Committee states that accessibility in relation to health has four dimensions, namely, that health must be accessible without discrimination, be physically accessible, economically accessible, i.e., affordable and that health information must be accessible subject to confidentiality of personal health data.

The ESCR Committee emphasises that article 2 of the ICESCR is central to the understanding of the nature and extent of states' obligations under the various provisions of ICESCR.[7] Article 2 of the ICESCR imposes two obligations, namely, obligation of conduct and obligation of result.[8] The obligation of conduct requires state parties to the ICESCR to take action reasonably calculated to realise the enjoyment of a particular right.[9] Meanwhile, the obligation of result requires state parties to the ICESCR to achieve a specified target as a measure of the standard of realisation of a particular right.[10] Apart from imposing obligations of conduct and result, article 12 of the ICESCR can also be characterized in terms of three other types of obligations, namely, obligations to 'respect, protect and fulfil' the rights conferred therein.[11]

This article holds the view that, despite the recognition of the right to health by both international and regional human rights instruments as well as its acceptance at the World Health Organisation still the same is often seen as one of 'second class' rights, aspirational only and programmatic in nature in most countries, Tanzania inclusive.[12] The realisation of social economic rights, such as right to health, by state parties to international instruments demands for presence of an effective, responsive and integrated health system of good quality that is accessible to all.[13]Also, most of international instruments and their interpretative documents require states parties to provide the right to health progressively basing on resource availability. According to the ESCR Committee while the full realization of the relevant rights may be achieved progressively, steps towards that goal must be taken within a reasonably short time after the ICESCR is signed

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[6] *Ibid*.

[7] UN Committee on Economic, Social and Cultural Rights: General Comment No 3 "The nature of states parties' obligations (art 2, para 1 of the Covenant)"(5th session, 1990) [UN Doc E/1991/23] para 1.

[8] *Ibid*.

[9] Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, (22-26 January 1997)para 7.

[10] *Ibid*.

[11] For thorough insight of states' obligations on the right to health see UN Committee on Economic, Social and Cultural Rights: "The right to the highest attainable standard of health", Comment 14 (General Comments). UN Doc.E/C.12/2000/4

[12] Hervey, T. K., the "Right to Health" in European Union Law in Hervey T. K., and Kenner, J., (editors),**Economic and Social Rights under the EU Charter of Fundamental Rights—A Legal Perspective**, Hart Publishing, Oregon 2003 at p. 194.

[13] Hunt, P., and Beckman G., "Health System and Right to the Highest Attainable Standard of Health", **Health and Human Right**, Vol. 10, No. 1, 2008, at p. 82.

and ratified by a State Party.[14] To achieve progressive realisation of the right to health States Parties to the ICESCR are obliged to fulfil their human rights obligations gradually, and where a particular state shows no progress, rational and subjective explanations has to be given.[15]

2.1 International initiatives on the right to health to people with HIV & AIDS

The right to health includes the right to access health care services by people living with HIV/AIDS. The first attempt at the international level to advocate for human rights to health to people living with HIV/AIDS started in the year 1988 when WHO held a meeting in Oslo for an international consultation on Health Legislation, Ethics and HIV/AIDS. This meeting sought to address barriers which existed between people who were infected and those who were not infected and place actual barriers between individuals and the virus by preventing new infections through various measures such as the use of condoms.[16]Consequently, on 13 May 1988 WHO passed a resolution on avoidance of discrimination in relation to HIV infected people and people with AIDS. Besides this WHO Resolution, other efforts to realize human right to health to people with HIV/AIDS include the United Nations Commission on Human Rights initiative which held its first international consultation on AIDS and human rights from 26-28 July, 1989 in Geneva. Also in May 1993, the United Nations Development Programme (UNDP) held Inter-country Consultation on Ethics, Law and HIV in Cebu (Philippines) and came up with a statement of belief. The Cebu statement of belief and the United Nations General Assembly Resolutions 45/187 of 1990 and 46/203 of 1991 committed its efforts to realize human right to health to people with HIV/AIDS. Through these fora the international community emphasized the need to promote and adopt measures to counter discrimination and to respect human rights to health to people with HIV/AIDS. Also the international community committed to recognize impacts of discriminatory measures by pledging that discrimination against people with HIV/AIDS drove HIV/AIDS underground, making it more difficult to combat, rather than stopping its spread.[17]

Apart from the measures described above, other measures have been taken at the international level to combat HIV/AIDS such as the second international consultation on HIV/AIDS and Human Rights meeting which was held between 23-25 September 1996 in Geneva organised jointly by the Office of the UN High Commissioner for Human Rights (UNHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The meeting culminated in the preparation of guidelines for UN member states on the application of international human

[14] UN Committee on Economic, Social and Cultural Rights: General Comment No 3 "The nature of states parties' obligations (art 2, para 1 of the Covenant)"(5th session, 1990) [UN Doc E/1991/23], para 9.
[15] Beckman,G., *et al*, "Health Systems and the Right to Health: An Assessment of 194 Countries", **Lancet** 2008; Vol. 372: 2047–85 at p. 2048.
[16] Kinemo, R.E.J., "Human Rights for HIV/AIDS Victims in Tanzania", at 3 Available on www.tzonline.org/pdf/humanrightsforhivaids.pdf *Accessed 8 August 2016.*
[17] *Ibid*.

rights law in the context of HIV/AIDS. These International Guidelines on HIV/AIDS and Human Rights, as they are officially known, were for the first time published in 1998, modified in 2002 and merged and consolidated into one document in 2006.[18] The 2002 modified and 2006 consolidated Guidelines intended to capture new standards and developments in HIV related treatment and evolving international law norms on the right to health generally, and the right of access to HIV/AIDS related prevention, treatment, care and support specifically.[19]

That aside, the UN High Commission for Human Rights (UNHCHR) which was later referred to as United Nations Human Rights Council (UNHRC), have adopted a series of resolutions to monitor and promote the International Guidelines on HIV/AIDS and Human Rights. The adopted resolutions include the Resolution on the Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (1997, 1999 and 2001) and the Resolution on Access to Medication in the Context of Pandemics such as HIV/AIDS, Tuberculosis and Malaria.[20]

In the Africa region, the African Women's Protocol provides for women protection against gender inequality, sexual violence, early marriages and denial of inheritance.[21] It obliges states parties to respect and promote the right to health of women, including sexual and reproductive health.[22]

In the meantime, there are a number of AU declarations and other instruments addressing HIV/AIDS. The Abuja Declaration of 2001 categorically states that HIV/AIDS is an emergency on the African continent and urged African leaders to place the response to HIV at the forefront and as the highest priority in their respective national development plans.[23] The Maputo Declaration, adopted two years after the Abuja Declaration further reaffirmed the commitment enshrined in the Abuja Declaration.[24] Accessibility of HIV/AIDS medicines is addressed by the Gaborone Declaration which, among others, commits African states to achieve universal access to prevention, treatment and care of HIV/AIDS by 2015 through the development of an integrated health care delivery system based on essential health package delivery close-to-client through proven effective drug combinations.[25] The Brazzaville Commitment on Scaling Up Towards Universal

[18] Mubangizi J.C., & Twinomugisha, B.K., "The right to health care in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?"**African Human Rights Law Journal,** Vol. 1, 2010 at p. 110.
[19] *Ibid.*
[20] See UN Commission on Human Rights Resolutions 1997/33, 1999/49 & 2001/51 and UN Commission on Human Rights Resolution 2003/29.
[21] See Articles 3, 6 & 21 of the African Women's Protocol.
[22] Article 14 (1) (d) & (e) of the African Women's Protocol.
[23] Mubangizi & Twinomugisha *op. cit.*, at p. 112.
[24] The Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases (2003).
[25] Article 2 (ii) of Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care adopted 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2) Gaborone, Botswana from 10 – 14 October 2005.

Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006) and the Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006) have been adopted; and all these set specific timeframes or commit African leaders to the realisation of universal access to HIV/AIDS treatment.

At the sub regional level the SADC Health Protocol calls upon SADC member states to work in the protection and promotion of the right to health by harmonizing policies and guidelines related to control of communicable diseases, prevention and control of HIV and AIDS, as well as malaria and tuberculosis control.[26] Besides, the Maseru Declaration reaffirms the commitment of SADC Member States to the combating of AIDS as a matter of urgency by, *inter alia:*

> increasing access to affordable essential medicines, including ARVs and related technologies, through regional initiatives for joint purchasing of drugs, with the view of ensuring the availability of drugs through sustainable mechanisms, using funds from national budgets.[27]

3. General overview of Tanzanian health care system

The Tanzania health care system has a long history dating back from the pre-colonial period when formal health care services were for the first time introduced in the country by several missionary organizations.[28] Health care provision in the county was later developed by the colonialists, i.e., Germans and British who colonised the country in different periods. Generally, colonial administration in East Africa established health care facilities in urban and raw material producing areas. Colonial health system aimed to first preserve health of the European Community, second, to keep the African and Asiatic labour force in good working condition, and third, to prevent the spread of tropical diseases.[29]

Immediately after independence the government concentrated on the establishment of public health sector. However, the economic crisis which hit the country's economy in 1980s led to the establishment of private health sector. The structure also features traditional health sector which has been practiced in Tanzania for a long time even before independence.

3.1 Legal protection of Right to Health in Tanzania

The right to health is not expressly enshrined in the Tanzania Constitution. However, the right can be implied under Article 11(1) in which the Government

[26] Articles 9 to 12 of the SADC Health Protocol.
[27] Article 2(g) of the Maseru Declaration on the Fight Against HIV/AIDS in the SADC Region (2003).
[28] Benson, J.S., "The impact of privatization on access in Tanzania", **Social Science and Medicine** Vol. 52, 2001, 1903–1915 at p.1904.
[29] Kimalu, P.K., *et al*, "A Review of the Health Sector in Kenya", Kenya Institute for Public Policy Research and Analysis(KIPPRA) Working Paper No. 11, 2004, at p. 23.

has a duty to ensure realization of the right to social welfare at times of sickness. The Article nonetheless reveals that, Article 11 falls under Fundamental Objectives and Directive Principles of State Policy (FODPSP) hence unenforceable before a court. Article 7 (2) of the Constitution categorically states that the provisions which fall under FODPSP are not enforceable by any court; and bars any court from determining 'the question whether or not any action or omission by any person or any court, or any law or judgment complies with the provisions of this Part of this Chapter.' The question that remains unanswered is whether the mere omission of the right to health in the Bill of Rights has rendered it completely impossible to enforce under the Basic Rights and Duties Enforcement Act, Cap. 3 [R.E. 2002].[30]

It is understood that if one applies liberal interpretation of the Bill of Rights to include all rights and legal principles recognised by the Constitution, right to health can be enforced by courts.[31] The use of liberal interpretation has developed to the so called implied doctrine. The doctrine entails the use of expressly justiciable rights to enforce the rights that are indirect or have to be read into the other existing rights. This may be useful in Tanzania where civil and political rights contained in the Bill of Rights may be used to enforce social economic rights such as the right to health which is not provided for in the Constitution.[32] For instance, Article 14 of the Constitution which provides for the right to life if interpreted liberally, under implied doctrine, may be used to enforce the right to health. This has received a test in the case of *Joseph D. Kessy and Others v. The City Council of Dar es Salaam.*[33]In this case although the Constitution has not enshrined social economic rights, such as the right to health in its Bill of Rights provisions which are enforceable under the Basic Rights and Duties Enforcement Act, the High Court stated that endangering health of people through environmental pollution amounts to infringement of their right to life provided for under Article 14 of the Constitution.

Moreover, the 2014 Proposed Constitution includes the right to health under Article 51(1) which provides for everyone the right to health, clean and safe water. Article 51 (2) further requires state authorities to ensure that the right to health is easily accessible depending on the available State resources. Additionally, Article 53 (1) (e) of the Proposed Constitution provides for the child's right to health, and Article 55 (f) provides for the right to health to persons with disability. Also, Article 57 (f) provides for the right to health to women

[30] This is the Act of the parliament which provides for the procedure for enforcement of basic rights contained in the Bill of Rights of the Constitution.

[31] Wambali, M.K.B., "Democracy and Human Rights in Tanzania Mainland: The Bill of Rights in the Context of Constitutional Developments and the History of Institutions of Governance", Thesis Submitted to the School of Law, Faculty of Social Studies of the University of Warwick for the Degree of Doctor of Philosophy (Ph.D), March, 1996 and Resubmitted in August, 1997 at p. 174-176.

[32] Ackson, T., "Justiciability of Socio-Economic Rights in Tanzania", **African Journal of International and Comparative Law** Vol.23 No.3, 2015 at p 373.

[33] 63 Civ. Case no. 299 of 1988 (Dar es Salaam Registry) (unreported).

while article 58 (c) provides for medical care for old people. This is the first time the country has expressly enshrined right to health in its Constitution since independence.

3.2Accessibility of the right to health by people with HIV and AIDS in Tanzania

Accessibility of the right to health under the health system in Tanzania was shaken after the first case of HIV was diagnosed in 1983. The effects of HIV/AIDS made the government to develop plans and strategies to control, prevent and treat HIV/AIDS and its related diseases.

To start with in the year 2001 the government developed the HIV/AIDS Policy which declared the disease as a national crisis which has spread relentlessly affecting all groups of people by destroying the most productive sections of the population particularly women and men between the ages of 20 and 49 years.[34] Although HIV/AIDS is one of the diseases for which the country has devised specialised programmes for medical care, the Government provides no financial assistance to sufferers.[35]

In addition to the HIV and AIDS Policy, the government enacted the Tanzania Commission of AIDS Act, 2001 (the TACAIDS Act). The TACAIDS Act established the Tanzania Commission for HIV/AIDS (TACAIDS), an independent department which was put under the office of the Prime Minister.[36] TACAIDS was entrusted with several functions including formulating policy guidelines to respond to HIV/AIDS and management of consequences of the epidemic in the country.[37] Also the Commission has functions to develop strategic framework, control programmes and activities related to planning HIV/AIDS within the overall national multi-sectoral strategy.[38]

It is submitted that despite the adoption of the HIV/AIDS policy and the enactment of the TACAIDS Act, 2001, still the epidemic has spread to all parts of the country and victims have faced stigma and discrimination from their family members and the general public. Realizing the problems connected with stigma and discrimination the government enacted the HIV and AIDS (Prevention and Control) Act, 2008.[39] The Act provides for the right to health to people with HIV and AIDS and the right of treatment of opportunistic infections based on available

[34] United Republic of Tanzania, Prime Minister's Office, Tanzania Commission for AIDS (TACAIDS), the National Policy on HIV/AIDS, 2001 at 2.
[35] Ackson, T., 'Disability benefits and workers with HIV/AIDS: Coverage issues and challenges in the United Republic of Tanzania', **International Social Security Review**, Vol. 61, No. 4, 2008, at p. 76.
[36] TheTACAIDS Act, section 4 (1) and (2).
[37] *Ibid.*, section 5 (1) (a).
[38] *Ibid.*, section 5 (1) (b).
[39] Act No 28 of 2008.

resources.[40]The Act placed obligations on the part of people with HIV and AIDS to protect others from infection.[41]In realising the right to health to people with HIV and AIDS, the Act addressed aspects of Public Education and Programmes on HIV and AIDS, HIV Testing and Counselling and Health and Support Services.

3.2.1 Public Education and Programmes on HIV and AIDS

The HIV and AIDS (Prevention and Control) Act, 2008 has placed responsibilities on the Ministry of Health, health practitioners, workers in the public and private sectors and NGOs to disseminate information regarding HIV and AIDS.[42] Additionally, the law has addressed the corresponding role of the Ministry of Health which is to use the available resources to develop and conduct training programmes of health practitioners on universal precaution measures on HIV/ AIDS and Sexual Transmittable Infections (STIs) and treatment procedures. It is insisted that such programmes should centre on ensuring prevention and control of HIV and AIDS to the public.[43]

Tanzania has been implementing various programmes aimed at reducing the spread of HIV and AIDS. To begin with, the government adopted a programme to expose learners to life skills-based HIV and AIDS education. According to Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) by December 2012 109,210 people were provided with HIV and AIDS education on prevention, problem solving, communications and decision making skills as well as sexual and reproductive health.[44] Additionally, different measures have been adopted towards increasing immunization coverage and introducing new options for Expanded Program in Immunization (EPI) vaccines, improving HIV surveillance and follow-up of neonates and ensuring universal access to Anti-Retroviral (ARVs). Also, measures have been adopted towards the increase of Voluntary Counselling and Testing (VCT) service and Behavioural Change Communication (BCC) which aims at facilitating the attainment of the targets set by the National Strategy for Growth and Reduction of Poverty (NSGRP) II.[45]

Other significant efforts towards provision of public education and programmes on HIV and AIDS include programmes related to distribution of condoms. In this respect, it is submitted that, on the basis of the report excerpted from TOMSHA research it is revealed that 8,216,984 male and 428,834 female condoms were

[40] The HIV and AIDS (Prevention and Control) Act, 2008, section 33(1).
[41] *Ibid.,* Section 33(2) (a.
[42] *Ibid.,* part III especially sections 7, 8 and 9.
[43] *Ibid.*
[44] The United Republic of Tanzania, Prime Minister's Office, Tanzania Commission for AIDS (TACAIDS), National HIV and AIDS Response Report 2012, Tanzania Mainland, August 2013 at p 9.
[45] United Republic of Tanzania**,** National Strategy for Growth and Reduction of Poverty II (NSGRP II), Ministry of Finance and Economic Affairs July 2010 pp.74-75.

distributed to end users for the period of 12 months ending December 2012.[46] Similarly, Medical Stores Department (MSD) continued to distribute condoms to public health care facilities as part of its functions of supplying essential medicines, medical facilities and equipment. Meanwhile, 68,413,356 condoms were distributed to end users through Social Marketing schemes for the period of twelve months ending December 2012.[47] The article notes that, through the application of the existing policy and legal framework in fighting HIV/AIDS such as the HIV/AIDS Policy, Tanzania Commission of AIDS Act, 2001 and the HIV and AIDS (Prevention and Control) Act, 2008 the government is expected to achieve its objectives of reducing HIV/AIDS rate of infection and national HIV prevalence. Lastly, it is submitted that as part of public education and programmes on HIV and AIDS the government through a circular number 2 of 2006 released by the Minister in the President's Office responsible for Public Service Management, directed all Ministries, Departments and Agencies (MDAs) to introduce prevention and care policies and programmes at public and private workplaces. TACAIDS report of August 2013 reveals that implementation of workplace programs on HIV and AIDS at the public sector could not be achieved as the same were impeded by budgetary constraints.[48]It further reported lack of information on HIV and AIDS programs in private sector workplaces.[49] That aside, private contractors display HIV and AIDS symbols and raise awareness on HIV and AIDS in their construction sites as part of their duty on HIV and AIDS public education. Private organisations, FBOs and CBOS such as Faraja Trust Fund of Morogoro, Engender Health, Population Service International (PSI) and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) have played a great role in bringing awareness to the society on the prevention and control of HIV and AIDS and have proven a great partner to government efforts in bringing awareness and public education of HIV and AIDS.[50]

3.2.2 HIV Testing and Counselling

The HIV and AIDS (Prevention and Control) Act, 2008 provides for testing and counselling and prohibits compulsory testing. For the purposes of facilitating HIV testing the law allows every public health care facility, voluntary counselling and HIV testing centre which are recognized by the National AIDS Control Programme (NACP) to be HIV testing centre for the purpose of this Act.[51] Private laboratory may only be testing HIV if it is allowed to do so by an order

[46] United Republic of Tanzania, Prime Minister's Office, Tanzania Commission for AIDS (TACAIDS), National HIV and AIDS Response Report 2012, Tanzania Mainland, August 2013 at p 8.
[47] *Ibid.*
[48] United Republic of Tanzania, Prime Minister's Office, Tanzania Commission for AIDS (TACAIDS), National HIV and AIDS Response Report 2012, *op. cit*, at p. 9.
[49] *Ibid.*
[50] Findings of interviews with Morogoro District Council Social Welfare Officers, Arusha District Council Health Secretary and Nurse Officers of Mt. Meru Hospital Arusha conducted between June 2016 and November 2016.
[51] Section 13 (1).

published in the government *gazette* by the Private Health Laboratory Board.[52] Therefore, HIV testing must only be done in the centres authorised and established under this part of the Act. Such centres are designated HIV testing centres.[53] Thus, in performing HIV testing, the authorised health practitioners are required by the law to take measures that will ensure that the testing process is carried out promptly and efficiently and further that the result of the HIV test is communicated to the person tested in accordance with the Act.[54]

Despite the fact that the law enacts provisions for HIV testing it prohibits compulsory testing by making it illegal for a person to be compelled to undergo HIV testing.[55] Furthermore, it is made clear under the law that a person shall not be required to consent for HIV testing under any order of the Court, when requested to donate human organs and tissues, and if that person is accused or found guilty of sexual offences.[56] Thus, HIV testing may only be taken voluntarily by any Tanzanian and for a child or a person who is unable to comprehend the result, may only undergo HIV testing after the authorized testing centre receives a written consent of a parent or recognized guardian.[57]

Besides provisions protecting the person from undergoing HIV testing without consent, the Act enacts provisions intended to protect an unborn child by requiring every pregnant woman and the man responsible for the pregnancy or spouse and every person attending a health care facility to be first counselled and offered voluntary HIV testing.[58] Also, with the spirit of protecting individuals attending health care facilities whether public, private or traditional and alternative centres, the law encourages all health practitioners, traditional and alternative health practitioners, traditional birth attendants and any other person attending patients to undergo HIV testing.[59]

The law further enacts a provision to protect health information of the person who conducted HIV test by requiring the results to be confidential and be communicated to the persons tested only.[60] However, there are circumstances in which the results of HIV test may be released to a person not tested. For example when a tested person is a child, the results of the HIV test may be given to the parent or guardian. If established that a person tested is unable to comprehend the results, then the results can be released to his spouse or his recognized guardian. Further the law allows the HIV test results to be released to a spouse or a sexual

[52] *Ibid*., section 13 (2).
[53] *Ibid.*, section 13 (4) & (5).
[54] *Ibid.*, section 13 (3) (a) & (b).
[55] *Ibid.*, section 15 (3). According to section 15 (7) of the Act any health practitioner who compels any person to undergo HIV testing or procures HIV testing to another person without the knowledge of that other person commits an offence.
[56] *Ibid.*, section 15 (4) (a) - (c).
[57] *Ibid.*, section 15 (1) & (2).
[58] *Ibid*., section 15 **(**5).
[59] *Ibid*., section 15 **(**6).
[60] *Ibid.*, section 16 (1).

partner of an HIV tested person. In certain situations the results may be released to the court.[61]

Since the law allows HIV testing and counselling, and since the passing of the Act the government through TACAIDS and other HIV and AIDS stakeholders has been involved in activities related to HIV testing and counselling which have played a great role in reducing further HIV infections, review of government documents reveals the improvement in HIV and AIDS control and prevention in the country which in one way or another can be linked with the legal entitlement of testing and counselling provided for in the Act. It has been shown in TACAIDS reports that through HIV testing and counselling by December 2012, a total of 1,135,390 people living with HIV and AIDS (PLHIV) were cumulatively enrolled in care and treatment services and out of this number 663,911 eligible adults and children living with HIV were cumulatively put on Anti-Retroviral Therapy (ART) and by August 2013 it was found that 432,338 were on ART.[62] The report further reveals that the cumulative percentage on ART as of December 2012 was 58.4% (663,911/1,135,390) and by August 2013 those on ART was 84.2% (432,338/513,359).[63] Additionally, upon perusal of TACAIDS report it has been found that by December 2012 the cumulative number of children enrolled in care and treatment was 86,929 and out of this number a total of 50,980 of HIV positive children were put on ART which accounted for 7.7% of the cumulative number of all clients on ART in the country.[64]

3.2.3 Health and Support Services for people with HIV and AIDS

The law mandates the government to use available resources in order to ensure that every PLHAs, vulnerable children and orphans are accorded with basic health care services.[65] Also, in protecting human rights to health to people living with HIV/AIDS (PLHAs) the law allows Community Based Organization (CBO), Private Organization and Faith Based Organisations (FBO) dealing with HIV and AIDS matters, after consultation with the local government authority, to provide prevention, support and care services to people living with HIV and AIDS.[66] Additionally, the Ministry of Health in collaboration with other ministries which are linked with health care provision is required to prepare programmes and conduct training for PLHAs in order to educate them on their survival needs - life skills after infection and guide them to form support groups aimed at providing palliative services and care.[67]

[61] *Ibid.*, section 16 (2) (a) – (d).
[62] United Republic of Tanzania, Prime Minister's Office, Tanzania Commission for AIDS (TACAIDS), National HIV and AIDS Response Report 2012, *op. cit,* at p 10.
[63] *Ibid.*
[64] *Ibid.*
[65] The HIV and AIDS (Prevention and Control) Act, 2008, section 19 (1
[66] *Ibid.*, section 19 (2).
[67] *Ibid.*, section 20 (a) – (c).

The law requires a person infected with HIV having known his health status after being tested to immediately inform his spouse or sexual partner of the fact; and further take all reasonable measures and precautions to prevent the transmission of HIV to others.[68]From that perspective, such a person is obliged under the law to inform his spouse or his sexual partner of the risk of becoming infected if he has sex with such person unless that other person knows that fact.[69] Further, the law protects persons who open up to their spouses or sexual partners about their HIV status by making it an offence for any person who abuses his spouse or sexual partner either verbally, physically or by conduct in connection with compliance with the provisions of the Act.[70]

The government, in fulfilling its functions of providing health and support services to PLHAs, requires the Ministry of Health to ensure strengthening of sexually transmitted infections (STIs) services and creation of public awareness on STIs as far as it relates to transmission of HIV and AIDS.[71] The Ministry of Health has the role of quantifying the requirement of condoms in the country and encouraging different stakeholders such as CBO and FBO to cooperate with the government in mobilizing financial resources required for procurement of condoms with a view to ensuring availability of condoms of standard quality circulating in the country.[72]

From what has been seen above the legal framework on HIV and AIDS control and prevention is well established by the Act of Parliament. Essentially, apart from the above analysed provisions on the role of the government in the provision of health and support services for people living with HIV and AIDS, it is further clear under the law that public and private health facilities, FBOs, CBOs, health insurance and traditional and alternative health centres have an obligation of facilitating access to health care services to PLHAs without discrimination on the basis of their status.[73] Additionally, from that legal requirement, the Ministry of Health is further obliged, subject to availability of resources, to take necessary steps to ensure the availability of Anti-Retroviral Drugs (ARVs) and other health care services and medicines to persons living with HIV and AIDS and those exposed to risk of HIV infection.[74]

A broader sense of this legal analysis of the role of the government to provide health and support services to people living with HIV and AIDS, may be explained through the focus of the mandate of the Ministry of Health to regulate the care and treatment of HIV infected pregnant women, mothers infected with HIV while giving birth and measures taken to reduce HIV mother to child

[68] *Ibid.,* section 21 (1) (a) & (b).
[69] *Ibid.,* section 21 (2).
[70] *Ibid.,* section 21 (3).
[71] *Ibid.,* section 22 (a) & (b).
[72] *Ibid.,* Section 23(l).
[73] *Ibid.,* section 24 (l).
[74] *Ibid.,* section 24 (2).

transmission.[75]Indeed, there are measures taken to prevent the mother to child transmission of HIV through involving trained and authorized persons to provide counselling services to HIV infected pregnant and breast feeding women as well as men who are responsible for their pregnancies or spouses as the case may be. There are also measures on monitoring, provision of treatment and applying measures necessary to reduce HIV transmission from mother to child through health care facilities and ensuring that prevention of mother to child transmission of HIV health services is parent friendly.[76]

It is worthwhile to note that, with the foregoing legal provisions of the Act, the perusal of government reports, plans and strategies reveal that there is still a long way to go before achieving what is entailed and required of the law regarding health and support services for persons with HIV and AIDS. For instance, measures towards the Prevention of Mother-to-Child Transmission (PMTCT) of HIV in terms of the number of sites in the program increased since 2005, but still remain fairly low. Notably, upon review of the NSGRP II out of pregnant women who attended Antenatal Clinics (ANCs), only 37% were reached by PMTCT services during the first half of 2009.[77] By the year 2010 it was further reported that there were less than 600 counselling and testing centres (CTCs) for the whole country which contributed to more than 60% of adults remaining untested for HIV.[78] However, it has to be noted that after the setting of the National Strategy for Growth and Reduction of Poverty, (NSGRP) II operational targets in 2010 the perusal of TACAIDS report which was released in August 2013 reveals the increase of health care facilities providing HIV and AIDS care and treatment services from 700 in 2008 to 1,176 in 2012 out of 6,342 health care facilities across country.[79]

4. Major challenges in the realisation of the right to health to people with HIV and AIDS

Accessibility of the right to health is generally impeded by many challenges. However, it gives special focus on six major challenges in the realisation of the right to health in Tanzania, namely, lack of the right to health provision in the constitution; budgetary constraint; health care inequalities; shortage of health professionals; shortage of essential medicines, medical facilities and equipment; and lack of accountability.

4.1 Lack of constitutional provision on the right to health

[75] *Ibid.,* section25(l).
[76] *Ibid.,* section 25 (2) (a) – (c).
[77] United Republic of Tanzania**,** National Strategy for Growth and Reduction of Poverty II (NSGRP II), *op. cit*, at p. 15.
[78] *Ibid*.
[79] United Republic of Tanzania, Prime Minister's Office, Tanzania Commission for AIDS (TACAIDS), National HIV and AIDS Response Report 2012, *op. cit.*, at p 13.

The first challenge in the realisation of the right to health is that it is not expressly provided for in the Bill of Rights of the Constitution making it difficult for its judicial enforcement. Enshrining the right to health in the constitution would facilitate people to enforce it under the Basic Rights and Duties Enforcement Act in case they see that the government has failed to fulfil its obligation, immediate or progressive, under international instruments. Relying on implied doctrine which is also dependent on the attitude of the judges towards statutory interpretation is not an efficient way of realizing the right to health through constitutional protection.

4.2 Budgetary constraint

Budgetary constraint slows down realisation of the right to health in Tanzania. It has been revealed that the budget allocated to the health sector is limited. In the Abuja Declaration of 2001 members of OAU agreed to set at least 15% of their national budget to the health sector. Fifteen years after this Declaration still the government of Tanzania has failed to set 15% of its budget to the health sector despite the increase of the amount of budget from year to year. Budgetary constraints have caused other challenges including failure to train more health professionals to solve the problem of shortage of health professionals, shortage of essential medicines, medical facilities and equipment. There is also shortage of health training colleges and health care facilities.

4.3 Inequalities in health care services distributions

Disparities in the distribution of health care facilities and services stand on the way to the realisation of the right to health. A study conducted in Tanzania on the geographical distribution of health care facilities has revealed that on the national average, most households live within 5 kilometres of a primary health care facility.[80] There are however, large variations in physical access between rural and urban households, between poor and poorer households, and between the accessibility of primary health care facilities and hospitals.[81] Access to hospitals as between those in rural areas and urban areas differs. While rural residents have to travel a distance of 27 kilometres to reach a health services centre, urban citizens have to travel 3 kilometres.[82] The disparities are compounded when comparing accessibility as between rich and poor households' capacity to afford payment of better health care services through health insurance and user fees payment. For instance, according to the National Bureau of Statistics census conducted in 2012 membership of NHIF and CHF was 509,068 which amount to

[80] Smithson, P., "Fair's fair: Health Inequality and Equity in Tanzania", Ifakara Centre for Health Research and Development and Women's Dignity Project, November 2006, at p. 25.
[81] *Ibid.*,it is necessary to attend hospitals for more complex procedures, such as caesarean sections.
[82] Mtei, G., *et al* "An Assessment of the Health Financing System in Tanzania", Report on Shield Work Package, Ifakara Health Research and Development Centre; Ministry of Health and Social Welfare, Tanzania and London School of Hygiene and Tropical Medicine May 2007, at 49.

around 3,000,000 beneficiaries throughout the country.[83] From these statistics it is revealed that above 85% of the Tanzania population do not have reliable means of health care financing making it difficult for the country to achieve universal health coverage.

Health inequalities are further witnessed in the distribution of hospitals and primary health facilities. In Morogoro and Arusha regions, the four councils visited, namely, Morogoro District Council, Morogoro Municipality, Arusha City and Arusha District Council do not have public hospitals at the level of District hospital.[84] While in Morogoro Municipality, Arusha City and Arusha District Council there are private and FBOs hospitals which are designated as District hospitals, in the Morogoro District Council there is no hospital at the level of District hospital be it public or private.[85]District hospitals have more specialised health workers and facilities as compared to primary health care facilities.

Disparities in the distribution of basic components of life such as health care facilities disproportionately affect poorer households and women in accessing the right to health.[86]Also, inaccessibility of the right to health and/or poor health care services is said to have a negative effect on a person's life expectancy.[87] Since more than 60 per cent of health care facilities are owned by the government inequality in geographical distributions of public health care facilities directly affects provision of public health care.

4.4 Shortage of health professionals

Shortage of health professional affects the realisation of the right to health to people with HIV and AIDS. Tanzania has acute shortage of medical health professionals in both public and private health care facilities. Most of health professionals prefer working in urban health care facilities due to poor working and living environment in rural areas.[88] The Health Resources Statistics issued by the Ministry of Health in 2013 have indicated that 69.34% of medical doctors are in urban areas, while the rural areas, where the majority of the population resides, shared only 30.66% of medical doctors.[89] Meanwhile, the 2011 Human Resource

[83] United Republic of Tanzania Basic Demographic and Socio-Economic Profile: Key Findings, 2012 Population and Housing Census, Dar es Salaam, April, 2014, at p. 6.
[84] Findings of interviews with Morogoro District Council Social Welfare Officers, Morogoro Municipality Health Secretary, Arusha District Council Health Secretary, and Nurse Officers of Mt. Meru Hospital Arusha conducted between March 2016 and November 2016.
[85] *Ibid.*
[86] Smithson, *op. cit*., at p. 25.
[87] Legal and Human Rights Centre, **Tanzania Human Rights Report 2008: Progress through Human Rights,** Legal and Human Rights Centre, April 2009 at p. 65
[88] United Republic of Tanzania, Ministry of Health and Social Welfare**,** *Human Resource For Health And Social Welfare Strategic Plan 2014 – 2019***,** Ministry Of Health and Social Welfare, Dar es Salaam, September 2014, at p. 13.
[89] United Republic of Tanzania, Ministry of Health and Social Welfare, *Human Resource for Health Country Profile 2012/2013*, 2013, p. 26,[Available on

to Health Profile (HRH profile 2011) has revealed that over 90% of the medical specialists were working in urban areas.[90] The study further finds that while medical doctors and medical specialists are concentrated in the urban areas, the HRH profile 2012 reveals the existence of 1,868 assistant medical officers (AMOs), of which only 39% were working in urban areas while the remaining percentage were working in rural areas.[91] From these findings it is clear that rural areas have a shortage of qualified health care professionals since medical doctors and specialist doctors are concentrated in urban areas. The total percentage of health care workers serving the rural population was 55%.[92] Regions with zonal hospitals, i.e., Dar es Salaam, Kilimanjaro, Mbeya and Mwanza have more trained health workers.[93]

Recently measures have been taken by the Ministry of Health through Primary Health Sector Development Programme (PHSDP) by increasing the number of candidates expected to graduate from health care institutions to 11, 192 per year in the year 2015/16 which has surpassed the targeted goal of having 10,000 health graduates by the year 2017.[94]

While acknowledging the efforts of the government to address the shortage of health workers which includes training of health professionals and construction of health facilities and colleges the government, private and FBO hospitals and health centres should pay constant attention on the question of shortage of health professionals since the problem leads to poor health care services for the poor population who are depending solely on the overburdened health professionals. The government needs to improve working conditions so as to retain health professionals from leaving the country to western countries to seek better working conditions.

4.5 Shortage of essential medicines, medical facilities and equipment

Information from MSD reveals the acute reduction of the budget supplied to it by the government. For instance in the year 2014/2015 the total budget set by the ministry to MSD was TShs. 70,500,000,000.00 and in the year 2015/16 budget was TShs. 29,250,000,000.[95] This shows a drop of about TShs. 40 billion in the

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http://www.jica.go.jp/project/tanzania/006/materials/ ku57pq00001x6jyl-att/country_profile_2013.pdf, accessed 26 August, 2016]

[90] United Republic of Tanzania, Ministry of Health and Social Welfare, Midterm Analytical Review of Performance Of The Health Sector Strategic Plan III 2009–2015, September 2013, at p. 85.

[91] *Ibid.*

[92] United Republic of Tanzania, Ministry of Health and Social Welfare, *Human Resource for Health Country Profile 2012/2013*, 2013, p. 26,[Available on http://www.jica.go.jp/project/tanzania/006/materials/ ku57pq00001x6jyl-att/country_profile_2013.pdf, accessed 26 August, 2016].

[93] *Ibid*.

[94] Speech of the Minister responsible for Health, Hon. Ummy Mwalimu (MP), on the estimates of revenue and expenditure for the financial year 2016/17 at pp. 14-15.

[95] Information perused from MSD documents on 28 November 2016.

period of two financial years. In the financial year 2014/15 MSD received TShs. 26,749,999,500.00 from donors contributing to its budget through basket fund while in the financial year 2015/2016 MSD did not receive funds from the basket fund.[96] The withdrawal of support by basket fund donors has largely affected the supply of essential medicines in the public health care facilities. This affects the accessibility of essential medicines by poor population especially those with HIV and AIDS.

4.6 Lack of accountability and transparency

Lack of accountability leads to acts of corruption in the health sector which results to poor access to the right to health to individuals, including people with HIV and AIDS. The impact of corruption can be seen relatively insignificant if one views corruption from junior public official holders such as nurses and hospital attendants who take bribes from patients in the queue to facilitate the patient to see the doctor, or the receptionist at the health care facilities who pays no or little attention to a patient or his/her relatives until bribed and the laboratory technologist or those in the x-ray and ultra sound sections who say there is no reagent or the machines are broken and if they are paid bribes they conduct investigations.[97] It is submitted that the effects of corruption in the community is more than these instances. The declining health sector is the outcome of lack of accountability in the public sector due to corruption and mismanagement of national resources. Corruption ranges from the informal payments that health workers ask their patients to grand corruptions conducted by public officials in the government which in turn cripples the government ability to provide the population with essential services such as the right to health.

For the past two decades the government has engaged in activities which have raised concerns on its commitment to issues of accountability and transparency. The radar transaction which involved the purchase of a civilian/military radar system from BAE Systems in the United Kingdom involved corrupt acts in which a Tanzanian middleman involved was alleged to have been paid US$12 million by the government officials.[98] The purchase of presidential Jet and the escrow saga in which it was alleged that the transfer of monies from the Tegeta escrow account from the Bank of Tanzania to Pan African Power Solutions (PAP) subjected the government to the total cost of 2.1bn revenue loss through failure to pay taxes and document forgery. These are just a few examples of corrupt practices leading to

[96] Information perused from MSD documents on 28 November 2016.

[97] Muhondwa, E.P.Y., *et al,* Petty Corruption in Health Services in Dar es Salaam and Coast regions, *Sikika*, Dar es Salaam, 2010, at p. 58.

[98] Peter, C.M., and Masabo, J., "Confronting grand corruption in the public and private sector: A spirited new initiative from Tanzania" **Namibia Law Journal** Vol. 1, No 2, July 2009, at pp. 55 and 56.

loss of public funds which could be directed to improve the health sector.[99] Indeed such practices have put the country into disrepute.

From the foregoing examples of lack of accountability on the part of the government Tanzania has failed to meet the crucial economic benchmarks for meeting the Millennium Development Goals to combat HIV/AIDS and its related diseases. Also these corrupt practices act as obstacles to meet the Abuja Declaration of 2001 which called upon members of the AU to set its budget to the health sector to 15% of the national budget. This is due to the fact that the money lost in lack of accountability and transparency could be used to improve various sectors of the economy such as health care provision.

5. Concluding remarks

This article has examined the legal, policy and practical positions on the right to health with special focus on people with HIV and AIDS in Tanzania. It is submitted that the right to health is recognised by both international and regional instruments. Tanzania is a state party of important international and regional instruments providing for the right to health such as the Constitution of WHO, ICESCR and ACHPR. From this perspective, the article which is part of the author's PhD work, submits that Tanzania has not enshrined the provision of the right to health in its Constitution. This affects the general accessibility of the right to health as the same is not enforceable before the High Court under the Basic Rights and Duties Enforcement Act.

That notwithstanding, the article has acknowledged initiatives taken by the government to address the problems caused by HIV and AIDS. These include adoption of HIV and AIDS Policy and passing of the laws which criminalise discrimination and stigma to people with HIV and AIDS and provide for the states obligation to supply ARVs. Apart from the policy developed and laws enacted, other measures have been taken by the government to address the effects of HIV and AIDS through counselling and treatment as well as education on ways of prevention and control of HIV and AIDS. These initiatives have enlightened the youth and the general public on prevention and control of HIV and AIDS by creating understanding of actions to be taken to avoid further infection when one finds that he/she has been infected by HIV. The law further enacts provision on public education and counselling on how infected pregnant women may prevent mother to child transmission of HIV and AIDS.

The article has addressed various challenges facing the society in the realisation of the right to health. These challenges are general to the whole health sector. They range from lack of a constitutional provision of the right to health to the lack

[99] Daily News reporter, 'Billions Lost in Unpaid Taxes', **Tanzania Daily News** (Dar es Salaam), 27 November 2014.

of accountability on the part of general public officials which in turn has negative effects on different sectors, health sector inclusive.

From the foregoing discussion the article recommends for the need of the government to enact the provision of the right to health in the constitution; increase the budget allocated to the health sector which in turn will address other challenges facing the sector such as construction of health care facilities in the rural areas. Besides, the government should employ health professionals who should be posted to rural areas to solve the problem of shortage of health professionals in those areas. The article further recommends for the need of the government to address the problem of lack of accountability in the state's undertakings which is undermining all sectors, health sector inclusive. Stern measures should be taken to deal with public officials involved in corruption. The article holds the view that if the country remains 'accountability and transparency void,' it will always fail to allocate at least 15% of the national budget to the health sector as agreed in the Abuja Declaration of 2001. Thus, with the budgetary constraints in the health sector the government will continue failing to address health challenges caused by HIV and AIDS as well as addressing the problem of supply of essential medicines to cure diseases arising from HIV and AIDS.