

LEGAL ENVIRONMENT ASSESSMENT FOR TUBERCULOSIS (TB) IN TANZANIA

REPORT DECEMBER, 2017

END

TB



Stop TB Partnership

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARIPO	African Regional Intellectual property Organization
CHRAGG	Commission for Human Rights and Good Governance
CIS	Commonwealth of Independent States (CIS)
CSO	Civil Society Organization
DOTS	Directly observed treatment, short-course
FCC	Fair Competition Commission
HCW	Health Care Worker
HIV	Human Immune Virus
LEA	Legal Environment Assessment
MDR - TB	Multi-drug-resistant tuberculosis
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
MUKIKUTE	Mapambano ya Kifua Kikuu na Ukimwi Temeke
NGO	Non Governmental Organization
NTLP	National Tuberculosis and Leprosy Programme
PWUD	People who use Drugs
TB	Tuberculosis
TPS	Tanzania Prisons Services
TRIPS	Trade Related Aspects of Intellectual Property Rights
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WTO	World Trade Organization

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SECTION I

INTRODUCTION EXECUTIVE SUMMARY

This Assessment report is a part of a global advocacy project to develop and promote a rights-based approach to tuberculosis (TB). The primary aim of this memo is to provide specific recommendations on TB-related law reform in Tanzania. However, any country interested in drafting specific laws on TB (i.e., TB-specific legislation) is encouraged to use this LEA as a reference. The secondary aim is to present the authors' surveys and analyses of laws implicating TB around the world, including in the WHO's 22 high TB-burden countries.¹

The responsibility and authority to address TB often lies with the executive branch, including Ministries of Health, and occurs in the form of administrative regulations. While regulations are necessary and important, this Legal Environment Assessment (LEA) argues that it is imperative to secure robust legal protection for people with TB in legislation. However, only a handful of countries have TB-specific legislation, most of which is written with a public health approach, emphasizing prevention and control of TB. All countries have general laws implicating TB, including infectious and communicable diseases laws, public health laws, and labor and employment laws. However, these laws also predominantly take a public health approach, failing to provide legal rights to people with TB.

A rights-based framework has been successfully employed for issues relating to HIV prevention and treatment throughout the world. People living with HIV have fought to claim their rights through litigation and advocacy. They have also managed to reduce stigmatization and increase their participation in the policy-making process. The rights-based approach to HIV offers a model from which to develop a similar approach to prevention and treatment of TB.

A rights-based approach to TB in law provides a comprehensive set of legal rights to people with TB (see Recommendations), complementing and strengthening more traditional public health approaches. Among other things, ensuring robust legal protections for people with TB promotes health-seeking behavior and leads to better treatment outcomes. The WHO has recommended countries take a rights-based approach to TB, including in its guidelines on drafting TB-specific laws.² In line with these guidelines, Peru recently enacted TB-specific legislation that establishes a broad array of legal rights for people with TB, including, among many others, rights to free testing and treatment, right to non-discrimination, right to privacy, and right to access information.³ Romania has a similar draft law pending in its parliament.⁴

This LEA proceeds as follows: section I provides an introduction; section II presents recommendations for TB-related law reform in Tanzania and TB-specific legislation more generally; section III provides details on the authors' research methodology; sections IV presents the TB data and epidemiology in Tanzania; section V presents LEA TB findings in Tanzania; section VI presents a National, regional and international survey of laws on TB.

¹ The WHO's 22 high TB-burden countries from the Global Tuberculosis Report 2015 include: Afghanistan, Bangladesh, Brazil, Cambodia, China, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, Russian Federation, South Africa, Thailand, Uganda, United Republic of Tanzania, Viet Nam and Zimbabwe. While we have chosen to focus on these 22 high burden countries, the WHO has defined three new high burden country lists that will be used for the period 2016–20 (for TB, TB/HIV and MDR-TB). Each list contains 30 countries: the top 20 in terms of absolute numbers of cases, plus the additional 10 countries with the most severe burden in terms of case rates per capita that do not already appear in the top 20 and that meet a minimum threshold in terms of absolute numbers of cases (10 000 per year for TB, and 1000 per year for TB/HIV and MDR-TB). See WHO, Use of high burden country lists for TB by WHO in the post-2015 era, WHO/HTM/TB/2015.29 (June 2015), http://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf

² See, e.g., World Health Organization [WHO], Guidance on Ethics of Tuberculosis Prevention, Care and Control, WHO/HTM/TB/2010.16 (2010), http://apps.who.int/iris/bitstream/10665/44452/1/9789241500531_eng.pdf [hereinafter Guidance on Ethics]; World Health Organization [WHO], Good Practice in Legislation and Regulations for TB Control: An Indicator of Political Will, WHO/CDS/TB/2001.290 (May 2001), http://apps.who.int/iris/bitstream/10665/68708/1/WHO_CDS_TB_2001.290.pdf [hereinafter Good Practice].

³ See Cong. of Peru, Law on Prevention and Control of Tuberculosis in Peru, Act No. 30287 (Dec. 14, 2014), <http://www.leyes.congreso.gob.pe/Documentos/Leyes/30287.pdf> [hereinafter Peru TB Law].

⁴ See Rom., Draft Law on Prevention and Control of Tuberculosis (Sept. 30, 2014) (Romania), http://raa.ro/wpcontent/uploads/2014/10/LEGE-PENTRU-PACIENTII-CU-TUBERCULOZ%C4%82_eng.pdf [hereinafter Romania Draft TB Law].

Objective, Scope and Approach Objective Human Rights Based Approach

The objective of the Tanzania Tuberculosis Legal Environment Assessment (LEA) is to identify strength and weaknesses of the existing legislation and policies relevant to Tuberculosis (TB), to enhance and expand legislators and policy makers capacity to incorporate human rights based approaches to TB in laws and policies, to enhance judiciary and legal communities' awareness on implementation of a human rights-based approach to TB, and to establish support networks of affected communities of people with TB, TB survivors and civil society at national and local levels. To achieve this, the LEA examines the laws, policies, and case law that constitute the legal and policy framework related to TB in Tanzania. Further, to identify legislations and policies that hinder efforts of TB diagnosis, treatment, care and prevention, and gaps in the framework where new law or policy is needed. The assessment leads to concrete recommendations, including reforms to existing law and policy, enactment of new law and policy, and capacity building for key stakeholders and decision makers.

Scope

The scope of LEA was broad and included review of all relevant laws and policy relating to TB. It comprised assessment of the legal and policy framework related to TB at the international, regional and National level. At national level, the legal and policy framework consisted of the United Republic of Tanzania Constitution, judicial case law, legislation, policies, regulations and guidelines on TB, health and related topics. Further, LEA examined the framework as it exists on paper and its implementation and impact on people with TB, TB survivors, their families and people vulnerable to TB infection. This impact is examined through an in-country assessment during which the TB LEA Task Team (members Listed below) conducted in-depth interviews, with a wide range of stakeholders including TB Survivors, TB Community Program coordinators, Lawyers, Magistrates, Physician, Health Care Workers, members of staff of NTLP, police, and also visited TB Clinics. The Assessment is described in greater detail in the TB Legal Environment Assessment Stages and Methodology Section.

A right is a claim that one person can make against another person or group, including legal persons (such as corporations), governments or states. The claim a person makes against another party can be positive (i.e. require action) or negative (i.e. requiring inaction). The action of another party that corresponds with a given right is often referred to as a “responsibility” or “obligation”. People have or obtain rights in virtue of different actions or states of being (such as by virtue of being a citizen of a state or entering into contracts). Human rights are a special type of rights that people have simply by virtue of being human. Human rights are legal guarantees that protect individuals and groups against actions that interfere with fundamental freedom and human dignity, while establishing entitlements requiring positive actions.⁵

The TB LEA is grounded in a human rights based approach to TB Prevention, testing, treatment and care. The approach provides the lens through which law and policy is assessed and the challenges faced by the people affected by TB are understood. Implementation of a human rights based patient-centered approach to TB prevention, testing, treatment and care in Tanzania.

Ethical principles and values underpin the End TB Strategy. It is thus important to ensure that ethical issues posed by TB care and control are properly examined and addressed. The first step is to articulate the nature of ethics, its relation to human rights, and the ways to incorporate this guidance into the operations of national TB programmes and other stakeholders implementing the End TB Strategy.

The WHO End TB Strategy establishes the “protection and promotion of Human rights, ethics, and equity” as one of the four Key principles necessary for ending the global TB endemic.⁶ This principle in turn, supports the three pillars of the strategy: (1) Integrated, Patient- centered TB care and prevention; (2) Bold policies and supportive systems; and (3) Intensified research and innovation. The WHO acknowledges that the Strategy's success is entirely dependent on respect for the key principles and implementation of interventions outlined by the pillars at the country level.⁷

A human rights based approach to TB is grounded in International, regional and national law that establishes the rights to life, health,

⁵ United Nations, International Covenant on Economic, Social and Cultural Rights. [website] (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>, accessed 02 DEcember 2017).

⁶ WHO, the End TB Strategy: Global strategy and Targeted for tuberculosis prevention, care and control after 2015, approved by the Sixty seventh World Health Assembly, May 2014, available at http://www.who.int/tb/strategy/End_TB_Strategy.pdf?ua=1

⁷ WHO, Brochure: the End TB Strategy, WHO Doc. WHO/HTM/TB/2015.19.p.7 (2015), available at http://www.who.int/tb/End_TB_Brochure.pdf?ua=1.

non-discrimination, privacy, informed consent, information, liberty and security of person, participation, science, housing, food, water and sanitation, freedom of movement, and freedom from cruel, inhuman and degrading treatment. Only through the protection and promotion of these rights for all people affected by TB in Tanzania will fulfillment of the WHO End TB Strategy be possible in the country.

Human rights based approach to TB supports and enhance traditional approaches to combating the disease. It is founded on the recognition, protection and fulfillment of the rights of people with TB, TB survivors, their families, and people vulnerable to disease. The Approach focuses on the socioeconomic drivers of the disease, including stigmatization and discrimination of people affected by TB in, among other things, health care settings, employment, education and housing. It articulates the domestic, regional and international legal obligations of the governments and non – state actors, among other things, to ensure good quality testing and treatment for TB is available and accessible without discrimination. And it requires that people with TB, TB survivors and other affected individuals have access to effective remedies for human rights violations. The approach also aims to create an enabling legal environment for the research and development of new tools for preventing and treating TB, through application of the right to benefit from scientific progress.

At the core of human rights based approach to TB is the participatory, democratic principle “nothing about us without us.” This principle requires that people affected by TB in Tanzania be meaningfully engaged so they may participate in the formulation, implementation, monitoring and evaluation of all legislation, policies and regulations related to TB. Along with the closely related norm requiring a focus on vulnerable or marginalized groups, the principle demands that special attention be paid to the needs of TB key populations in all relevant decision-making and implementation processes. These include, among others the rural and urban poor, prisoners, mobile populations, people living with HIV, miners, children, and people who use drugs.

Though much remains to be done in the fight against HIV, the human rights based approach has contributed meaningfully to advances in the prevention and treatment of HIV around the world. The mobilization of affected communities in grassroots campaigns has spurred research and development of new medicines and lowered the prices of existing drugs. People living with HIV have claimed their rights to life, health, privacy, informed consent, information and participation, and won protections against discrimination, through litigation and advocacy based on international and constitutionally derived human rights. The human rights based approach to TB is modeled on these

successes and seeks to build upon and expand them in the fight against TB.

Ending TB as a matter of social justice

Social inequalities drive TB, and TB drives many people deeper into poverty. Ending TB and addressing social determinants of health are interdependent. As defined in the United Nations’ Social justice in an open world, justice is generally concerned with understanding the rights and obligations of persons as members of societies and communities; the fairness of social and political structures and processes; and the relationships between persons and between persons and the state. Social justice, with regard to health, is commonly understood as being concerned with inequalities and with the fair distribution of advantages and burdens among people.⁸

Social justice is a hallmark of other WHO work and guidance documents, where it is referred to, for example, as a key guiding principle for addressing social determinants of health.⁹ Social justice is very important to public health and in the fight against TB and End TB strategy. This is largely because in order to improve health, particularly the health of marginalized or disadvantaged persons and communities, it is imperative to acknowledge the intertwined, complex and reinforcing nature of social, economic and political forces acting and surrounding the people. To incorporate social justice as a pillar of public health means not only aiming to improve the immediate health outcomes of persons and communities at the clinical and population levels, but also to target and ameliorate precisely those social, economic and political factors that lead to the ill health of marginalized persons.

Social justice largely impacts in the quest for ending TB. This is because TB overwhelmingly affects marginalized persons of lower socioeconomic status. As such, ending TB requires more than just biomedical interventions. Tackling TB requires addressing the underlying social, economic and political conditions that lead to infection and disease, and that prevent those affected from fully benefitting from existing effective measures, including current diagnostics and drugs. The three pillars of the End TB Strategy aim at providing patient-centered prevention, diagnosis, treatment and care (pillar one); instituting robust supportive systems, including poverty alleviation through prevention of catastrophic costs (pillar two); and increasing the quality, quantity and relevance of research (pillar three). Moreover, “protection and promotion of human rights, ethics,

⁸ Social justice in an Open World: The Role of the United Nations. UNDESA ST/ESA/305. New York: United Nations; 2006 (<http://www.un.org/esa/socdev/documents/ifsdi/SocialJustice.pdf>, accessed 02 December 2017).

⁹ Closing the gap in a generation: Health equity through actions on the social determinants of health. Geneva: World Health Organization; 2008.

and equity” is one of the key principles of the End TB Strategy.¹⁰ Social justice speaks to all three of these pillars and thus can be a focus of attention when addressing the complex ethical challenges posed by TB care and control.¹¹

Nairobi Strategy

The Nairobi Strategy¹² primary objective is to develop and implement a human rights-based approach to TB at the global, regional, national and local levels. This will be done through implementing human rights based approach to TB through diverse advocacy strategies and development and use of the conceptual, legal and normative content and evidence base for human rights- based approach to TB through interdisciplinary research and scholarship.

The key Components of the Nairobi Strategy are to:

- Empower and Support networks of affected communities of people with TB, TB Survivors and broader civil society at global, regional and national levels;
- Enhance judiciary and legal communities’ awareness on implementation of a human rights-based approach to TB;
- Expand legislators’ and policymakers’ capacity to incorporate human rights based approaches to TB into laws and policies;
- Engage and advise international organizations and experts on the implementation of human rights based approach to TB into global policies and programs;
- Sensitize health care workers in public and private sectors on the need to incorporate a human rights-based approach to TB in their work;
- Formulate and clarify the conceptual, legal and normative content of a human rights based approach to TB; and,
- Conduct qualitative and quantitative research to generate evidence base for the effectiveness of a human rights based approach to TB;

- Facilitate inclusive, community led discussion to develop and promote use of ethical standards to gather and use TB data.

The Nairobi Strategy adopts the Global Plan to end TB 2016 – 2020 which is inspired by the 90-90-90 UNAIDS treatment targets and propose an accelerated TB response. The targets, to be achieved by 2020 or 2025 at the latest are the 90% of all people with TB are reached and placed on appropriate therapy – first line, second line and preventive therapy as required; 90% of the key population and most vulnerable, undeserved and those at high risk population are also reached; and 90% treatment success for all people diagnosed with TB through affordable treatment services, adherence to complete and correct treatment and socio-support.



¹⁰ These principles are taken from Ethics guidance for the implementation of the End TB strategy. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

¹¹ Ibid

¹² A Human Rights-based Approach to Tuberculosis: The Nairobi Strategy, developed by Stop TB Partnership, International Human Rights Clinic, University of Chicago Law School and Kenya Ethical, Legal Information Network for HIV (KELIN) at TB, Human Rights and Law Judicial workshop held 24 – 25 June 2016 in Nairobi, Kenya.

SECTION II

Recommendations

The objective of the Tanzania TB Legal Environment Assessment recommendations is to support the fight against TB in Tanzania through creation of an enabling law and policy environment. To this end, the recommendations aim to:

- Respect, protect and fulfill the rights of people affected by TB, including the right to life, health, participation, privacy, non discrimination, liberty, information, and safe and healthy working conditions.
- Implement a patient-centered approach to TB prevention, testing, treatment and care; and,
- Strengthen the capacity of people with TB, TB survivors, lawyers and other key stakeholders and decision makers through legislation, policy and regulation at national level with financial and technical support from donor and development partners.

The recommendation use the term “TB”, but they apply to both drug-susceptible TB and all forms of drug resistant TB, unless explicitly stated otherwise.

To legislators and Policy makers

1. Convene a dialogue on TB in the Parliament in partnership with the Ministry of Health, Ministry of Justice and Constitutional Affairs and the Commission for Human Rights and Commission of Good Governance during which legislators in the parliament may receive input from key stakeholders in order to deliberate and consider legislative approach on TB. This action on legislation should consider amendments on the existing laws and consideration of TB Specific legislation, adoption a human rights-based, patient centered approach to TB prevention, testing, treatment and care, in accordance with the National Health Policy, 2007.

The intended dialogue on TB should involve the participation and meaningful contribution of all key stakeholders including people affected by TB, including people with TB, TB survivors and their family members; representatives of TB key populations, including the rural and urban poor, prisoners, mobile populations, people living with HIV and miners; civil society and NGO groups working in TB; physicians

and health care workers from the public and private sectors; policymakers from the parliament, religious, tribal and traditional leaders, medical and public health researchers working in TB; private and public sector employers and businesses; academics with expertise in Human rights and constitutional law related to health; drug and medical equipment manufactures; and regional and international TB experts. This dialogue can be organized, coordinated and led by the NTLP.

2. Increase participation of people affected by TB, including people with TB and TB survivors – engaging TB Community – based organizations in the formulation, implementation, monitoring and evaluation of legislation, policies and regulations relating to TB. This can best be done by establishment of requirements within the law and policy that people affected by TB, including people with TB and TB survivors, be members of decision-making bodies within NTLP so that they may contribute to the formulation, implementation, monitoring and evaluation of all state TB policies, regulations, and guidelines, including TB related budget development and monitoring.

It is further recommended that during drafting, implementation, monitoring and evaluation of TB laws and regulations and laws with connection to TB treatment and care, people affected by TB including people with TB and TB survivors be meaningfully consulted in the entire process. An experience can be drawn from the development and drafting of the HIV AIDS specific law.¹³

3. Prohibit all forms of discrimination against people affected by TB in legislation and policy – both intentional and indirect – in the public and private spheres, including people with TB infection, people with TB disease, TB survivors and members of TB vulnerable populations. This is in response to Article 13 (1) of the Constitution of United Republic of Tanzania together with the Health Policy, 2007 and the Public Health Act, 2009. Such protection should be aligned with the protections provided to people living with HIV and AIDS as provided under the HIV and AIDS (Prevention and Control) Act No. 28 of 2008.
 - A. In particular, the law and policy should protect and prohibit intentional and indirect discrimination against people affected by TB in public and private

¹³ The HIV and AIDS (Prevention and Control) Act No. 28 of 2008

employment, health care, education, housing, social services, immigration and all other settings, both for discrimination based on health status - i.e., TB infection and TB diseases – and for membership in certain groups such as the poor, prisoners, migrants, women, people who use drugs, people living with HIV and other vulnerable groups.

- B. We also recommend review Section 7 of the Employment and Labour Relations Act of 2004 to include other ‘health status’ as an additional prohibited ground of non discrimination at work place.
- C. We recommend on prison reform and reform of the Prisons Act; the prison Act requires amendment to address issues such as overcrowding, ventilation, nutrition, access to diagnosis, treatment and other health care services. The said intended reform should further include issues on record keeping and reporting; and other related matters. We further recommend and opine that, at a broad level, the Prison Act need to be aligned to the United Nations Standard Minimum Rules for the Treatment of Prisoners (famously known as ‘the Nelson Mandela Rules’).
- D. We recommend that Section 9 – 16 of the Public Health Act, 2009¹⁴ be repealed or amended. This particular Section provide for the coercive measures to control TB as well as notification procedures for TB. For example, we specifically recommend Section 16 of the Act which broadly criminalizes TB and other infectious diseases should be repealed for it is inconsistent with Human rights Standards and the right to quality and affordable healthcare and health services. It may be easiest to repeal these sections and replace them with a provision granting to the Minister power to make regulations governing notifiable conditions and coercive measures. This is the approach that has been adopted by many countries, including the most recently South Africa.¹⁵ The advantage of this approach is that Schedules and procedures are easier to change to align to developments in the
- relevant diseases and the science and treatment related to them. We further advise that an interim procedure be put into place during the period the Legal framework is being developed. While such a procedure is not ideal in the long term, it would provide at least a measure of guidance and due process in the interim.
- E. Basically the Application of Section 16 of the act together with other coercive measures relating to TB and other notifiable diseases necessarily triggers due process rights, especially when it comes to deprivation of liberty and freedom of movement. Article 15 (2) of the Constitution of the United Republic of Tanzania¹⁶ provides for and ensures the right of Due process and right of personal freedom and liberty. We therefore suggest that express guarantee of the right to legal counsel attach to the application of any coercive measures. This is because, ideally deprivation of liberty is often at issue, legal representation at state expense should be guaranteed.
- F. Laws and policies prohibiting discrimination against people affected by TB should establish mechanisms by which people who have experienced or are threatened with discrimination may access the courts and other administrative bodies to file claims and access remedies, including restitution, financial compensation, reinstatement and protection against future discrimination.
- G. Legislation and policy prohibiting discrimination against people affected by TB should require courts to provide petitioners with the option to file a claim and participate in the trial anonymously, using a court-appointed pseudonym, if they choose.
- H. Legislation and policy prohibiting discrimination against people affected by TB should provide for and require accommodations for people with TB so they may obtain and retain employment, health care, education, housing, social services and immigration privileges, even while they are contagious, allowing them to take appropriate infection control measures, such as receiving home-based care without jeopardizing their employment, health care, education, housing or social services status.

¹⁴ Part (a) of Part III of the Act is on Notification of infectious or communicable and non – communicable diseases and Isolation of Infected persons and contains Section 9 – 13; whereas Part (b) of Part III is on Prevention and Control of the Spread of infectious or communicable Diseases and contains Section 14 – 18.

¹⁵ Regulations Relating to the Surveillance and the Control of Notifiable Medical Conditions, No. 41330 GG 1434, 15 December, 2017.

¹⁶ The Constitution of United Republic of Tanzania , 1977, 2008 Edition

- I. There should be Implementation/enforcement mechanism in ending discrimination in employment settings, industries, plantations, and in mines and ensure each employer develops a TB Work Policy in his company which bans discrimination of any kind. Labour officers and Human Resources managers of private institutions should put in place enforcement mechanism to end discrimination of TB patients and TB survivors at work place and also ensure employees affected by TB receive adequate TB treatment and adhere to TB medication.
- J. Improve guidelines for school health to incorporate TB control issues. It has been noted increase in number of TB among school children especially those in boarding schools. In effort to combat TB in schools, and in order to raise awareness of TB among school children, we recommend review and improvement of the current guidelines for school health to incorporate TB treatment and prevention. The current *Bango Kitita* programme be improved and be a nationwide school campaign. There should be intensifying implementation of advocacy, communication and social mobilization strategy to reach all primary and secondary schools in Tanzania.
- K. We recommend the Immigration Act, Cap 54 be amended to provide for the provision of TB diagnosis, treatment and other services to migrants who, under the current law, might be deemed prohibited migrants. The Immigration Act, Cap 54 as it stands disincentives healthcare seeking behavior amongst migrant populations while in Tanzania. Tanzania also harbors migrants who are passing through while enroute to South Africa and other parts of the world. We therefore recommend a special care and treatment to the Migrants deemed prohibited Migrants affected by TB.
4. Develop and implement a human rights-based, patient-centered policy for isolation and involuntary isolation of people with TB. These include amending the Public Health Act, 2009 specifically Section 9 - 16 to include specific human rights based, patient centred policy for isolation and involuntary isolation of people with TB.
5. We recommend amendment of Section 32 (1) of the Employment and Labour Relations Act, 2004 on the issue of number of days for sick leave for employees affected by TB. This is largely because treatment of a TB patient requires more than 126 days getting treatment and medication. Existence of this specific provision has resulted to many employees not adhering to proper medication and at times not concealing to the employer about her medical TB status thus affect medication and treatment.
- A. Develop an isolation policy that is human rights-based and patient-centred and should be based on chapter 15 of the WHO Ethics Guidance for the Implementation of the End TB Strategy on isolation and involuntary isolation,¹⁷ which establishes the specific circumstances, conditions and justifications for isolation and involuntary isolation:
- i. Isolation should only be employed when a person with TB is contagious and there is a clear public health benefit to the community.
 - ii. Isolation should always be voluntary, except in exceptional and narrowly defined circumstances, and it should use the least restrictive means possible; e.g., if basic respiratory isolation measures are sufficient, then physical isolation is not necessary.
 - iii. Involuntary isolation should never be a routine component of TB prevention, testing, treatment and care. Involuntary isolation should be limited to exceptional circumstances when an individual:
 - a. Is known to be contagious, refuses effective treatment, and all reasonable measures to ensure adherence have been attempted and proven unsuccessful; OR
 - b. Is known to be contagious, has agreed to ambulatory treatment, but lacks the capacity to institute infection control in the home, and refuses inpatient care; OR

¹⁷ <http://www.who.int/tb/publications/2017/ethics-guidance/en/> accessed on 02nd December, 2017.

- c. Is highly likely to be contagious (based on laboratory evidence) but refuses to undergo assessment of his/her infectious status, while every effort is made to work with the patient to establish a treatment plan that meets his or her needs.
- iv. In addition, all of the following conditions must be met in order to justify involuntary isolation:
- a. Isolation is necessary to prevent the spread of TB; and
 - b. There is evidence that isolation is likely to be effective in the particular case; and
 - c. The person with TB refuses to voluntarily remain in isolation or institute adequate infection control measures despite having been properly counselled about the benefits of treatment, the risks of refusing treatment, the meaning of being isolated, and the reasons for isolation; and
 - d. The person with TB's refusal puts others at risk; and
 - e. Community-based care has been considered and offered before involuntary isolation is contemplated; and
 - f. All less restrictive measures have been attempted prior to forcing isolation; and
 - g. All other rights and freedoms (such as basic civil liberties) besides that of movement are protected; and
 - h. Due process rights are protected and the person with TB has the right to appeal the decision to involuntarily isolate him or her before an administrative, judicial or quasi-judicial body. The person should be afforded the right to legal representation, at state expense as needed.
- i. The person with TB has, at least, his or her basic needs met, including all necessary clinical and social support; and
 - j. The isolation occurs in an appropriate medical setting, never in a prison cell or in a general prison population; and
 - k. The isolation time is the minimum duration necessary to achieve its goals.
- The table 1 sets out all conditions that should be met to justify involuntary isolation.
- | | |
|-------|---|
| I. | Isolation is necessary to prevent the spread of TB, AND |
| II. | Evidence that isolation is likely to be effective in this case, AND |
| III. | Patient refuses to remain in isolation despite being adequately informed of the risks, the meaning of being isolated and the reasons for isolation, AND |
| IV. | Patient's refusal puts others at risk, AND |
| V. | All less restrictive measures have been attempted prior to forcing isolation, AND |
| VI. | All other rights and freedoms (such as basic civil liberties) besides that of movement are protected, AND |
| VII. | Due process and all relevant appeal mechanisms are in place, AND |
| VIII. | Patient has, at least, basic needs met, AND |
| IX. | The isolation time given is the minimum necessary to achieve its goals. |
- B. The National Strategic Plan V for Tuberculosis and Leprosy Programme 2015 – 2020 and Manual of the National Tuberculosis and Leprosy Programme in Tanzania should be amended and be based on respect for human rights to liberty and security for person, freedom of movement, freedom from arbitrary detention and freedom from Association as enshrined in the Constitution of Tanzania, the African Charter on Human and People's rights and the International Covenant on Civil and Political Rights.
6. In the long term, we recommend Tanzania enact a TB-

specific legislation containing the following features in order to move towards a rights-based approach to this disease:

- A. Legal Rights of People with TB: A comprehensive, enumerated list of legal rights for people with TB, situated alongside government agencies' responsibilities to protect the public health. The list of rights should include, at a minimum, the rights to:
- i. Free Testing and Treatment for TB: Testing and treatment shall be made available free of charge to all people with TB, MDR-TB and XDR-TB, including counseling and psychological services for those who need them;
 - ii. Freedom from Discrimination: Discrimination against people with TB shall be prohibited in both public and private settings, including, but not limited to, health care, employment, education, and access to social services;
 - iii. Privacy and Confidentiality: Information related to an individual's TB status and treatment must be kept private and shall not be disclosed to any party, unless approved of by appropriate medical professionals under narrowly and expressly tailored circumstances enumerated in law, including to protect third parties who are at serious and imminent risk of infection and to share essential health information with medical professionals providing care to the patient;
 - iv. Financial and Nutritional Support: Financial support to offset travel expenses, lost income, and any other costs associated with TB testing and treatment and food or nutritional supplements shall be provided to people with TB during the period of treatment;
 - v. Access to Information: People with TB shall have access to information about the nature of the disease, effective preventative measures, transmission and contagiousness, and treatment availability and options, including the duration of treatment, the names and kinds of medicines involved, the nature of side-effects, and the risks of treatment non adherence;
 - vi. Informed Consent and Freedom from Nonconsensual Testing and Treatment: People shall have the right to informed consent prior to testing and treatment for TB and to be free from nonconsensual, compulsory treatment under all circumstances;
 - vii. Liberty and Freedom from Arbitrary Detention: People with TB shall have the right to liberty and to freedom from arbitrary detention, including involuntary detention or isolation of contagious persons, except for exceptional circumstances enumerated in law and proportional to what is strictly necessary, using the least restrictive and intrusive means available, to achieve legitimate public health aims, including when a person is known to be contagious and is likely to transmit the disease, refuses treatment, and all reasonable measures to ensure adherence have been attempted and proven unsuccessful;
 - viii. Due Process: People with TB who have had their right to liberty restricted through involuntary detention or isolation shall have the right to due process, including the rights to be heard by an independent authority, to appeal the decision to detain or isolate, and to have counsel during the proceedings;
 - ix. Freedom of Movement: People with TB shall be free to move within and outside the country and to receive free treatment in the location where they reside in Tanzania, not only in their home district;
 - x. Freedom from Imprisonment for Treatment Non adherence: People with TB shall not be imprisoned or detained under any circumstances in a non-medical setting for failing to adhere to their treatment;
 - xi. Freedom from Torture and Cruel, Inhuman, or Degrading Treatment: Prisoners with TB and those at risk of contracting the disease in prison shall be free from torture and cruel, inhuman, and degrading treatment during their detention. This requires providing appropriate TB testing and treatment during detention and ensuring sanitary and hygienic prison conditions to avoid transmission of the

disease;

xii. Participation: People with TB and former TB patients have the right to participate in decision-making processes affecting their health, including the design, implementation, monitoring, and evaluation of TB legislation and policies; and

xiii. Access an Adequate, Effective, and Prompt Remedy: People with TB shall have access to an adequate, effective, and prompt remedy under law for infringements and violations of the rights enumerated here.

B. Limitations on the Legal Rights of People with TB: Limitations on the legal rights of people with TB, including in circumstances involving involuntary isolation, should be specifically enumerated in law and proportional to what is strictly necessary to achieve legitimate public health aims.

C. Responsibilities of People with TB: People with TB have the following responsibilities; however, they shall not be construed as legal duties and the failure to uphold them shall not be subject to penalty, including criminal prosecution, administrative sanction, or civil suit:¹⁸

i. Share Information: People with TB have the responsibility to share information with their health care providers relating to their health and treatment, as well as about contacts with immediate family, friends, and others who may be vulnerable to contracting TB;

ii. Follow Treatment: People with TB have the responsibility to adhere to treatment and alert their health care providers of any difficulties in doing so;

iii. Contribute to Community Health: People with TB should encourage others to seek medical advice if they exhibit symptoms of TB and show considerations for other patients' and health care providers' rights;

iv. Show Solidarity: People with TB have the responsibility to share their expertise gained during treatment to others in the community

and join in efforts to make the community TB free.

7. Establish and fulfill in legislation and policy the right of all people to access free, good-quality testing and treatment for TB, including second-line drugs, new TB drugs and diagnostics, preventive therapy and community-based treatment. Policy 4.3.5¹⁹ categorically direct the government to ensure HIV prevention interventions, treatment and care for TB patients living with HIV Access to health care for PLHIV is a basic human right that includes the provision of clinical treatment and supportive services as part of a continuum of comprehensive HIV/AIDS care strategy. Home-based care is an integral approach to involve the community in the prevention, care, and support of TB/HIV co-infected patients. It is necessary, therefore, to create a comfortable environment in which communities will be fully involved in the care and support of TB/HIV patients.

A. Legislation and policy establishing the right to access free, good-quality TB testing and treatment should establish a TB Services Trust Fund to ensure adequate financing is available to procure and distribute: (1) TB drugs, including second-line and new drugs, free of charge to all people who need them; and (2) new TB diagnostic technologies, including GeneXpert MTB/RIF assay machines and related materials, to all public TB clinics in the country.

B. Legislation and policy establishing the right to access free, good-quality TB testing and treatment should establish mechanisms by which people who lack access to free, good quality TB testing and treatment may access the courts and other administrative bodies to file claims and access remedies, which include provision of TB diagnostics and treatment, and financial restitution or compensation for resultant harms. Petitioners should be able to file a claim anonymously, using a court-appointed pseudonym, if they choose.

C. We suggest and recommendation that a provision guaranteeing the right to health and access to healthcare services be put into law, whether in the Constitution, Public Health Act or elsewhere because there is a lacunae, that is, the current

¹⁸ These duties are taken from The Patients' Charter for Tuberculosis Care: Patients' Rights and Responsibilities, World Care Council (2006), http://www.who.int/tb/publications/2006/istc_charter.pdf [hereinafter Patients' Charter for Tuberculosis Care].

¹⁹ National Policy Guidelines for Collaborative TB/HIV activities 2016

legal regime lacks a specific provision for the right to health.

- D. The LEA advises that it is beneficial for the government and other important stakeholders to conduct a situational analysis that underlines the legal barriers to access to healthcare services for other vulnerable populations, including remandees, prisoners, mobile populations, migrants, indigenous people, and others.
8. Clear provision in law guaranteeing the rights to privacy and confidentiality of people with TB and TB survivors in legislation and all relevant policies and regulations including the National Strategic Plan V for Tuberculosis and Leprosy Programme 2015 – 2020, and Manual of the National Tuberculosis and Leprosy Programme in Tanzania, The National Health Policy, and the Employment and Labour Relations Act in order to combat stigma and discrimination, promote health-seeking behaviour and encourage treatment adherence, in accordance with the National Health Policy. This will be in line with Article 16 (1) and (2) of the Constitution of the United Republic of Tanzania, 1977 which provides for Right to Privacy and personal security. In particular:
- A. We recommend a new law protecting the rights to privacy and confidentiality of people with TB and TB survivors. The said new law should be based on the principle that an individual has an absolute right to keep his health status private subject only to exception: (1) when he is contagious and should not be disclosed beyond household level to TB patient; (2) only for the duration of the period of contagious and (3) only with respect to people at a real risk of exposure to infection. It is very important this particular law to mention that disclosure of TB status and or TB results to be within inner circle of family members only. All measures should be taken to ensure right to privacy and confidentiality is maintained and that disclosure of TB status and medication is made only to the TB Patient and his close relatively only.
- B. We recommend the new Law protecting the rights to privacy and confidentiality of people with TB and TB survivors should apply to all public and private employment, health care, education, housing, social services and all other settings, and should protect against intrusion of privacy and confidentiality through the collection and sharing of health data by physicians, health care workers, researchers, public health officials and policymakers, while allowing for narrow exceptions necessary to protect and promote individual and public health and for sharing based on an individual's informed consent.
- C. Legislation and policy protecting the rights to privacy and confidentiality of people with TB and TB survivors should establish mechanisms by which people who have experienced unwarranted intrusions on their privacy and confidentiality may access the courts and other administrative bodies to file claims and access remedies, including restitution, financial compensation, and reinstatement related to harms, along with protection against future intrusions. We are aware of the new the Electronic and Postal Communications (Online Content) Regulations 2018. There are several sentiments and arguments on the existence of this regulation especially in protection of the Right to privacy and the role of the Government in ensuring freedom of privacy.
- D. Protection of Right to Privacy and confidentiality to TB patients be maintained and increased. This can be done through trainings and raising awareness of the importance of privacy.
9. Establish and fulfill the right to information for all people affected by TB, including people with TB, TB survivors and their family members, in legislation and policy, including National Strategic Plan V for Tuberculosis and Leprosy Programme 2015 – 2020 and Manual of the National Tuberculosis and Leprosy Programme in Tanzania and in accordance with the Guiding principles of the Policy Guidelines of National Policy Guidelines for Collaborative TB/HIV activities, 2016 which under policy 3.2.3. Provides for the availability and sharing of accurate, up-to-date, and comprehensive information on TB/HIV co-infection and collaborative TB/HIV activities.
- A. The right to TB information should include a right to receive the following information from physicians, health care workers and relevant government authorities: information to promote treatment literacy, including the names, purpose and side effects of all prescribed TB drugs; information about the risks and benefits of all forms of treatment; the risks of treatment non adherence; information about the nature of TB infection and TB disease; information about the nature and duration of the TB contagion; and information about preventive and infection control measures.
- B. In order to facilitate realization of the right to TB

information NTL, in coordination with people affected by TB, civil society and religious, tribal and other traditional leaders, should develop and implement a Strategic TB Communication Plan, targeting high TB burden areas and TB vulnerable populations across the country through use of social media, mobile phone applications, television and radio, and other forms of media communication.

10. Prohibit some forms of forced, involuntary or compulsory TB testing and treatment. Establish the requirement of informed consent for all testing and treatment for TB in legislation and policy to pre-empt all relevant state laws and policies, in line with the WHO Ethics Guidance for the Implementation of the End TB Strategy, and in line with the protections for informed consent and provision of counselling provided to people living with HIV by the HIV and AIDS (Prevention and Control) Act No. 28 of 2008. We believe mandatory testing is at times necessary. Mandatory testing in prisons for example would be consistent with Mandela Rule 30(a) and (d).²⁰In special circumstances, screening may be mandatory – for example, in cases where there is a clear risk to household contacts, or as a condition of employment. Mandatory testing, and any coercive measures, would need to be administered in terms of a law of general application aligned to international best practice.

While the prohibition in regards to coerced treatment is reasonable, an approach to TB based in human rights and sound public health policy recognizes that individual liberty must at times be restricted in the interest of public health. Mandatory TB testing and screening are at times necessary in this regard. The context of prisons is especially relevant—it is critical to identify, briefly isolate and treat infectious detainees lest they spread the infection throughout the cellblocks. Indeed, this is best practice and is implemented in many countries. The WHO in their “Systematic screening for active tuberculosis: Principles and recommendations” at page 61 notes that mandatory testing may at times be ethically and programmatically necessary. Such testing and screening must be administered through a law of general application, as a last resort following proper counseling, using the least restrictive means, and in compliance with international best practice. An outright ban on mandatory screening and testing would

severely hamstringing the TB response.

- A. Legislation and policy requiring informed consent should describe the necessary information to be provided through counselling prior to seeking consent for TB testing and treatment, including the risks and benefits of treatment, the risks of treatment non adherence, cures rates of particular forms of treatment and side effects of all prescribed drugs.
11. Establish and protect the right to safe and healthy working conditions in legislation, policies and regulations, for people at high risk of contracting TB at the workplace, such as miners and health care workers, including through amendment of the Employment and Labour Relations Act, 2004, the Mining Act, the Industrial Act.
 - A. Legislation and policy protecting the right to safe and health working conditions should provide detailed instruction on the precautions necessary to prevent exposure to and transmission of TB among workers in particular industries, include miners and health care workers, such as appropriate preventive and infection control measures.
 - B. Establish and protect the right to safe and healthy working conditions in legislation, policies and regulations. This includes amending OSHA Act to enable employers be responsible to provide safe and healthy working conditions.
 - C. Legislation and policy protecting the right to safe and health working conditions should establish mechanisms by which people who have acquired TB at the workplace may access the courts and other administrative bodies to file claims and access remedies, including restitution, financial compensation, and reinstatement related to harms, as well as protection against future harms, including protection from termination and dismissal and provision of appropriate employment accommodations.
 - D. More pressure be exerted upon employers and mining companies to have clinics that test workers for TB. Further, amend the Employment and Labour Relations Act, 2004 on the issue of number of days for sick leave to cover for employees diagnosed with TB and are receiving TB Treatment..

²⁰ See also WHO, Systematic screening for active Tuberculosis: Principles and Recommendations at pg. 61.

12. Remove and replace all stigmatizing and discriminatory terms in all relevant legislation and policy implicating TB, including the National Strategic Plan V for Tuberculosis and Leprosy Programme 2015 – 2020 and Manual of the National Tuberculosis and Leprosy Programme in Tanzania and in accordance with the Guiding principles of the Policy Guidelines of National Policy Guidelines for Collaborative TB/HIV activities, 2016 for Tuberculosis Control’s acknowledgement that “fear of stigma and discrimination” is a “major barrier to case-finding and [treatment adherence].” In line with the Stop TB Partnership’s language guide—United to End TB: Every Word Counts, Suggested Language and Usage for Tuberculosis Communications—remove and add the following replacement terms:
 - i. Remove “TB suspect” and replace with “person to be evaluated for TB.”
 - ii. Remove “defaulter” and replace with “person lost to follow-up”;
 - iii. Remove “TB patient” and “TB case” and replace with “person with TB”;
 - iv. Remove “TB control” and replace with “TB prevention and care.”

13. Provide dedicated funding and strengthen the NTLP’s and state TB programs’ capacity for technical training and sensitization of physicians and health care workers to eliminate stigmatizing and degrading treatment of people with TB in health care facilities and all program activities, in response to the National Strategic Plan for Tuberculosis Control’s acknowledgement that “people with TB have reported poor treatment by health care providers” and that the “behaviour and attitude[s]” of health care workers are barriers to TB services.
 - A. Training and sensitization should be designed and implemented in partnership with key stakeholders, including people affected by TB, civil society, the National Human Rights Commission, and national, regional and international technical experts, and should include training on how to implement a human rights-based, patient-centred approach to TB prevention, testing, treatment and care of people with TB at the program and health facility levels, with specific instruction on appropriate infection control measures and guidelines for dignified, respectful treatment of people with TB and their families.

14. Incentivize private health sector involvement in NTLP and state TB programs through legislation and policy that expands upon and develops new TB Public-Private Mix programs with increased funding for private provider compensation, improved notification and data sharing networks, and other incentives, including participation of chemists and pharmacies, in accordance with the Public Health Act, 2009 for Private sector engagement is extremely important in TB diagnosis, care, treatment and Prevention.
 - A. Legislation and policy expanding and developing TB Public-Private Mix programs should allocate funding for increased compensation to private health care providers who provide free, good-quality TB testing and treatment services to ensure all incurred costs are compensated at a reasonable rate, including staff time, all TB testing equipment and materials, all drugs and other TB treatment incidentals.
 - B. Legislation and policy expanding and developing TB Public-Private Mix programs should ensure effective, easy-to-use electronic notification and data sharing networks are established, with appropriate safeguards for privacy and confidentiality, to promote notification of TB disease and sharing of health data among private health care providers, the NTLP and state TB programs.
 - i. This should include a review of the operation and interaction of the Integrated Disease Surveillance and Response system, the Health Management Information System and the e-TB Manager system with the purpose of integrating and coordinating the three systems to promote increased notification of TB cases and private health care provider participation in the Public-Private Mix program.
 - C. The following measures should also be considered for inclusion in legislation and policy expanding and developing TB Public-Private Mix programs:
 - i. Provision of tax breaks for participating private health care providers to incentivize participation in the programs;
 - ii. Permitting people to utilize insurance coverage provided through the National Health Insurance Scheme or state insurance schemes to obtain free, good-quality TB testing and treatment services in the private sector; and

- iii. Provision of technical capacity-building support to participating private health care providers, both to ensure provision of appropriate, good-quality TB testing and treatment services and to incentivize participation in the programs.
- D. We recommend the Government to put into place a short time reliance on the private sector, between three (3) to five (5) years and that a parallel effort of strengthening the public sector in the fight against TB should be made. This recommendation is in line with the goals of strengthening the public health sector and achieving universal coverage and health equity for the poor. The government should specifically strengthen the public sector to take over in treatment of TB in the near future.
15. Provide dedicated funding and strengthen the NTLP's and state TB programs' capacity to improve and expand the TB Treatment Supporter program, including development and implementation of effective training procedures for treatment supporters in line with a human rights-based, patient-centered approach to TB, formulation and implementation of clear, efficient program guidelines, and promulgation of the guidelines and training procedures in relevant state TB program and the National Strategic Plan V for Tuberculosis and Leprosy Programme 2015 – 2020 and Manual of the National Tuberculosis and Leprosy Programme in Tanzania and in accordance with the Guiding principles of the Policy Guidelines of National Policy Guidelines for Collaborative TB/HIV activities, 2016.
 - A. It is important that the Government and the relevant Ministry for Health to set aside budget allocation specifically on TB treatment and care. The National health policy should categorically provide for mandatory state budget allocation on TB treatment and care. This approach ensures sustainability of TB treatment and care programmes by strengthening TB financing by the government.
 16. Create an Inter-Ministerial TB Task Force to review all existing policies, regulations and guidelines related to TB across all relevant ministries to revise or promulgate new policies, regulations or guidelines in accordance with Recommendations 2 to 13. The said inter ministerial TB Task force should strive to promote a human rights-based, patient-centered approach to TB prevention, testing, treatment and care, and to consider harmonization, where appropriate, of HIV and TB policies, regulations and guidelines.
 - A. The Inter-Ministerial TB Task Force should establish mechanisms to ensure the participation and meaningful contributions of all key stakeholders in its work. These include: people affected by TB, including people with TB, TB survivors and their family members; representatives of TB key populations, including the rural and urban poor, prisoners, mobile populations, people living with HIV and miners; civil society and NGO groups working in TB; physicians and health care workers from the public and private sectors; religious, tribal and other traditional leaders; medical and public health researchers working in TB; public and private sector employers and businesses; academics with expertise in human rights, constitutional and health law and policy; drug and medical equipment manufacturers; and regional and international TB experts.
 17. Empower and support networks of affected communities of people with TB, TB survivors and broader civil society at global, regional, national and local levels. A rights based approach to TB requires robust participation, empowerment and support of people with TB and TB survivors. We also propose to empower and support existing networks or people with TB and TB survivors, and help develop such networks where they do not exist.
 - A. Develop, empower and support existing networks of people affected by TB: this will involve collaborating with Key stakeholders to conduct workshops at the global, regional and local levels of people with TB and TB survivors.
 - B. Design and conduct legal trainings for affected communities and broader civil society: this will involve designing and conducting trainings to empower affected communities and broader civil society to use the law and human rights to improve access to TB prevention, treatment and care services and reduce stigma and discrimination of people with TB.
 18. Support the mobilization, development and operation of new and existing community based organizations

To donors and Development partners

and networks of people affected by TB, including people with TB, TB survivors and their families.

A. Provide funding and technical support for the development of new community-based organizations and networks of people with TB, TB survivors and affected communities and for the continued development and operation of existing groups and networks.

19. Strengthen the capacity of people affected by TB, including people with TB, TB survivors and their families, to use the courts, to advocate on their own behalf in front of decision-makers, and to participate meaningfully in legislative and policymaking processes, including in the Parliament and state TB programs; to remove barriers to TB prevention, testing, treatment and care services, to prevent and remedy human rights violations, and to participate in law and policy review and formulation.

A. Provide funding and technical support, utilizing existing networks of people with TB, TB survivors and people living with HIV, to train and educate affected individuals and communities on the scientific, medical and public health aspects of TB and MDR-TB, the human rights-based approach to TB prevention, testing, treatment and care, and the international, regional and domestic Tanzania legal and policy frameworks related to TB.

20. Strengthen the capacity of lawyers to use the courts to protect the rights of and obtain effective remedies for people affected by TB, including people with TB, TB survivors and their families, through litigation based on the Constitution of Tanzania, the African Charter on Human and People's Rights, and relevant state laws.

A. Provide funding and technical support, utilizing existing legal networks and civil society organizations, to provide trainings for lawyers to strengthen their capacity to bring litigation in courts representing people with TB pursuant to the Constitution of Tanzania, the African Charter on Human and People's Rights and relevant country laws, applying and expanding on case law involving HIV and the rights to life, health and nondiscrimination.

B. Develop and support a network of lawyers: this will involve identification of lawyers at regional and

national level to be trained to represent people with TB and TB survivors in courts and quasi-judicial bodies using human rights based approach to TB, including through direct support for initiating and conducting litigation.

C. Develop and support a network of legal, medical and public health experts: this will involve identification of various experts who are available to provide testimony and to contribute to amicus curiae briefs on TB and human rights in court and quasi – judicial bodies at the global, regional and national levels.

D. Develop, publish and disseminate a judicial bench guide on TB, Human rights and law: this will involve developing, publishing and disseminating a guide for use as reference and resource for judicial officers, providing information on the biomedical and public health aspects of TB, the conceptual, legal and normative content of a human rights based approach to TB, and information on relevant case law.²¹

21. Strengthen the capacity of lawyers to use international and regional human rights bodies, including the UN Committee on the Elimination of All Forms of Discrimination. Against Women and the African Court and Commission on Human and People's Rights, to protect the rights of and obtain effective remedies for people with TB and TB survivors.

A. Provide funding and technical support, utilizing existing legal networks, to provide trainings for lawyers to strengthen their capacity to file petitions on behalf of people with TB and TB survivors in international and regional bodies pursuant, among others, to the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women and the African Charter on Human and People's Rights.

22. Engage, sensitize and strengthen the capacity of the state judiciary to adjudicate legal disputes involving TB with an enhanced understanding of the scientific, medical and public health aspects of TB, and a

²¹ Similar Case Law Guides have been developed and used in other areas, including the UNAIDS "Judging the Epidemic: A Judicial Handbook on HIV, Human Rights and the Law" or the recently published Case Law Guide "Tuberculosis, Human Rights and the Law: A Compendium of Case Law" First Edition.

human rights-based, patient-centered approach to TB prevention, testing, treatment and care.

A. Provide funding and technical support for sensitization and capacity-building activities for members of the judiciary in line with workshops conducted by Stop TB Partnership and partners in New Delhi, India and Nairobi, Kenya, convening diverse national, regional and international experts and stakeholders and featuring the participation of people with TB and TB survivors.²²

23. Engage, sensitize and strengthen the capacity of members of the National Assembly as well as their legislative aides and staff, to legislate issues related to TB with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, patient-centered approach to TB prevention, testing, treatment and care.

A. Provide funding and technical support for sensitization and capacity-building activities for members of the National Assembly and their legislative aides and staff, in partnership with the HIV/AIDS, TB and Malaria Control Committee of the National Assembly, including through engagement with people affected by TB and national, regional and international TB experts, and horizontal engagement with legislators in other countries.

B. Provide funding and technical support for sensitization and capacity-building activities for members and committees of state Houses of Assembly and their legislative aides and staff, including through engagement with people affected by TB and national, regional and international TB experts.

24. Engage, sensitize and strengthen the capacity of policymakers, bureaucrats and implementers in the NTLP, as well as state TB programs and Ministries of Health, to develop and implement policies and regulations with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, patient-centered approach to TB prevention, testing, treatment and care.

A. Provide funding and technical support for

sensitization and capacity-building activities for policymakers, bureaucrats and implementers in the NTLP and Ministry of Health, including through engagement with people affected by TB and national, regional and international TB experts.

B. Provide funding and technical support for sensitization and capacity-building activities for policymakers, bureaucrats and implementers in state TB programs and Ministries of Health, including through engagement with people affected by TB and national, regional and international TB experts.

25. Engage, sensitize and strengthen the capacity of policymakers, bureaucrats and implementers in key ministries, departments and programs, including those overseeing prisons, labor, education, housing and immigration, to develop and implement policies and regulations with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, patient-centered approach to TB prevention, testing, treatment and care.

A. Provide funding and technical support for sensitization and capacity-building activities for policymakers, bureaucrats and implementers in key ministries, departments and programs, including those overseeing prisons, labor, education, housing and immigration, including through engagement with people affected by TB and national, regional and international TB experts.

26. Engage and sensitize religious, tribal and other traditional leaders and institutions to better understand the scientific, medical and public health aspects of TB, and a human rights based, patient-centered approach to TB prevention, testing, treatment and care. Provide funding and technical support for sensitization activities for religious, tribal and other traditional leaders and institutions, including through engagement with people affected by TB and national, regional and international TB experts.

27. Engage, sensitize, raise awareness and strengthen the capacity of national and local media to report on TB with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, patient-centered approach to TB prevention, testing, treatment and care. Also provide funding and technical support for awareness-raising, sensitization and capacity building activities

²² The Stop TB Partnership, University of Chicago Law School, University of Chicago Department of Medicine, Kenya Judicial Training Institute and Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) convened judicial workshops entitled TB, Human Rights and the Law in New Delhi, India in 2015 and Nairobi, Kenya in 2016. Information about the workshops is available upon request from the authors of this report.

for members of the national and local media, including through engagement with people affected by TB and national, regional and international TB experts, in order to promote increased reporting on and more accurate coverage of issues related to TB in English, and Swahili languages.



SECTION III

LEA Task Team, Technical Expert Group, Stages and Methodology

The Tanzania TB Legal Environment Assessment was conducted by the LEA Task Team with the support from the Technical Expert Group. The LEA Task Team is comprised of Five Members:

- i. Benard Chuwa, *Advocate of High Court and Subordinates court save for Primary Court and Partner, BWB Attorneys.*
- ii. Doreen Tesha, *Advocate of High Court and Subordinates court save for Primary Court and Partner, Doreen Attorneys.*
- iii. Ismail Khatibu, *Advocate and Legal Researcher.*
- iv. Winnie Sulai, *Legal Researcher*
- v. Richard J. Mwalingo, *Candidate, Law School of Tanzania.*

The Technical Expert Group is comprised of:

- i. Dk. Mary Chiryamkubi, *TB Medical Doctor and Regional TB Coordinator for Temeke Region*
- ii. Ismail Suleman, *NACONGO*
- iii. Maziabi Salum, *MKUTA*
- iv. Lilian Ishengoma, *National Tuberculosis and Leprosy Program*
- v. Praisegod Lukio, *Legal Officer for the Ministry of Livestock and Fisheries*
- vi. Matendo Manono, *Secretary to the Attorney General of Tanzania*
- vii. Ismail Hatibu, *Advocate and Legal Researcher, Legal Sector Reforms Commission of Tanzania.*
- viii. Olive Mumba, *Executive Director of EANNASO*

Stages and Methodology

The TB LEA was conducted in five main stages:

- (i) Planning;

- (ii) Desk Review;
- (iii) In country Assessment;
- (iv) Evaluation and Report Writing; and
- (v) Feedback and finalization.

Planning

The planning staged comprised a series of preparatory activities. These included recruiting the LEA Task Team and Technical Expert Group, identifying and contacting key stakeholders, and developing the Tanzania assessment schedule.

Desk Review

A number of laws, regulations, policies and reports relevant to TB were reviewed. In addition general principles of law and articles set out in the constitution were reviewed. Common law principles relating to privacy and autonomy that apply to patent rights were reviewed. International and regional Human rights instruments and convention were also reviewed. Legislations were also included in the desk review. Case law from our courts of law was also reviewed.

The LEA Task Team conducted desk research to identify and assess the legal and policy framework, epidemiological profile and programmatic aspects of the TB epidemic in Tanzania. The team conducted legal research to identify and assess Tanzania's domestic legal and policy framework related to TB through focused examination of constitutional law, case law, legislation and administrative policies and regulations. The team also examined international and regional human rights law to understand Tanzania's human rights obligations related to TB. The results of this research are discussed below in the Tanzania Legal and Policy Framework section.

The LEA Task Team then drafted a set of questionnaires for in-depth interviews based on its identification and assessment of the Tanzania's TB legal and policy framework and epidemiological profile. The team developed questionnaires for the following types of stakeholders: physicians and health workers, TB survivors, Magistrates, lawyers, and members of civil society and community-based organizations. The Technical Expert Group reviewed and provided input on the questionnaires; the LEA Task Team revised and refined the questions based on this input. The questionnaires are available in the In-Depth Interview Questionnaires in the Appendix.

Section VI on WHO Guidelines on TB – Specific Legislation, is drawn from the collection of publications on TB related issues

on the WHO TB program website: <http://www.who.int/tb/en/>. We also made consultation on some of the publications published by WHO. Most of these publications related to issues surrounding legal, ethical, social and economic aspects of TB prevention, control, and care.

Country Assessment

An in-country assessment using qualitative research methodologies in the form the site visits, in-depth interviews in Dar es Salaam, Morogoro and Mwanza regions were conducted. Qualitative research comprises non-statistical, non-representative and exploratory methods, and commonly measures perceptions, beliefs, opinions, and behaviors of populations using in-depth interviews, or observation. During the in-country assessment, the team engaged a variety of stakeholders, physicians and health workers, TB survivors, Magistrates, lawyers, and members of civil society and community-based organizations, and others. A full list of stakeholders is available in the In-country Assessment Schedule and lists of people interviewed in the Appendix.

In depth Stakeholders Interviews

The LEA Task Team, with support from members of the Technical Expert Group, conducted a series of in-depth stakeholder interviews based on the questionnaires developed during the desk research stage. The interviews provided the team an opportunity to obtain information and perspectives directly from key stakeholders about the design, implementation and impact of the TB legal and policy framework and the TB epidemiological and programmatic profiles in the country. The team also aimed to develop ongoing relationships and promote ownership of the LEA process through these engagements. With permission from the stakeholders, the content of each interview was documented in a series of notes taken during the interview that were later refined for accuracy by the team. The in-depth interview notes were reviewed and considered when developing the key findings and recommendations in this report.

Site Visits in Dar es Salaam, Ifakara – Morogoro and Mwanza

The LEA Task Team and members of the Technical Expert Group conducted site visits in Ifakara – Morogoro and Mwanza to document first-hand the impact and implementation of the legal and policy framework and to engage key stakeholders, including physicians and health workers, TB survivors, Magistrates, lawyers, and members of civil society, community-based organizations medical researchers and others. The team also visited Temeke District in Dare es Salaam region. The team visited and observed the operations of public and private health clinics, courts, and police posts. The team also conducted in-

depth interviews with stakeholders during each site visit. The sites visited are included in the In-Country Assessment Schedule in the Appendix

Evaluation and Report Writing

Following the in-country assessment, the LEA Task Team, with support from the Technical Working Group, evaluated the findings and drafted the LEA report. The evaluation process included a review of the initial desk research in light of information and perspectives obtained from the in-depth stakeholder interviews, and site visits during the in-country assessment. The team then developed a series of recommendations based on its evaluation of the desk research and in-country findings.

Feedback and Finalization

Upon completion of the draft LEA report, the LEA Task Team and Technical Expert Group disseminated the report and presented the draft findings and recommendations to stakeholders during a national validation workshop in Dodoma. The workshop provided an opportunity for stakeholders to engage in critical dialogue on the draft findings and recommendations, to seek consensus on, finalize and prioritize the findings and recommendations, and to develop a mechanism for ongoing monitoring and evaluation of the LEA process. The LEA report was revised in accordance with consensus reached during the validation workshop and a final version is due to be submitted to the Government of Tanzania in December 2017.

SECTION IV

TB in Tanzania Epidemiology Data

Tanzania is one of 30 highest Tuberculosis burden countries in the world with an estimated TB burden rate of 287 per 100,000 populations (WHO Global TB report, 2017). In 2016, only 65,908 TB cases were notified out of the estimated annual incidence of 160,000 cases per year (287/100,000 population) signifying a treatment coverage of 40% and over 90,000 TB cases missed in 2016.

Majority of notified TB cases (97%) in 2016 had a known HIV status, with 21,720 (34%) co infected with HIV and 91% of the TB/HIV co-infected patients were started on Anti-retroviral therapy (ARVs). The treatment success rates for TB cases were reported to be high at 90%. With majority of the patients (78%) receiving treatment under community based directly observed therapy (DOTs)

In Tanzania, it is also estimated that 1.3% of all new TB patients and 6.2% of all previously treated TB cases to have Multidrug and Rifampicin Resistance TB (MDR/RR-TB) which translates to an estimated 830 Multidrug-Resistant TB (MDR-TB). In 2016, 196 MDR TB cases were detected and 158 were enrolled on treatment signifying that there is also a challenge of missing cases with drug resistant TB.

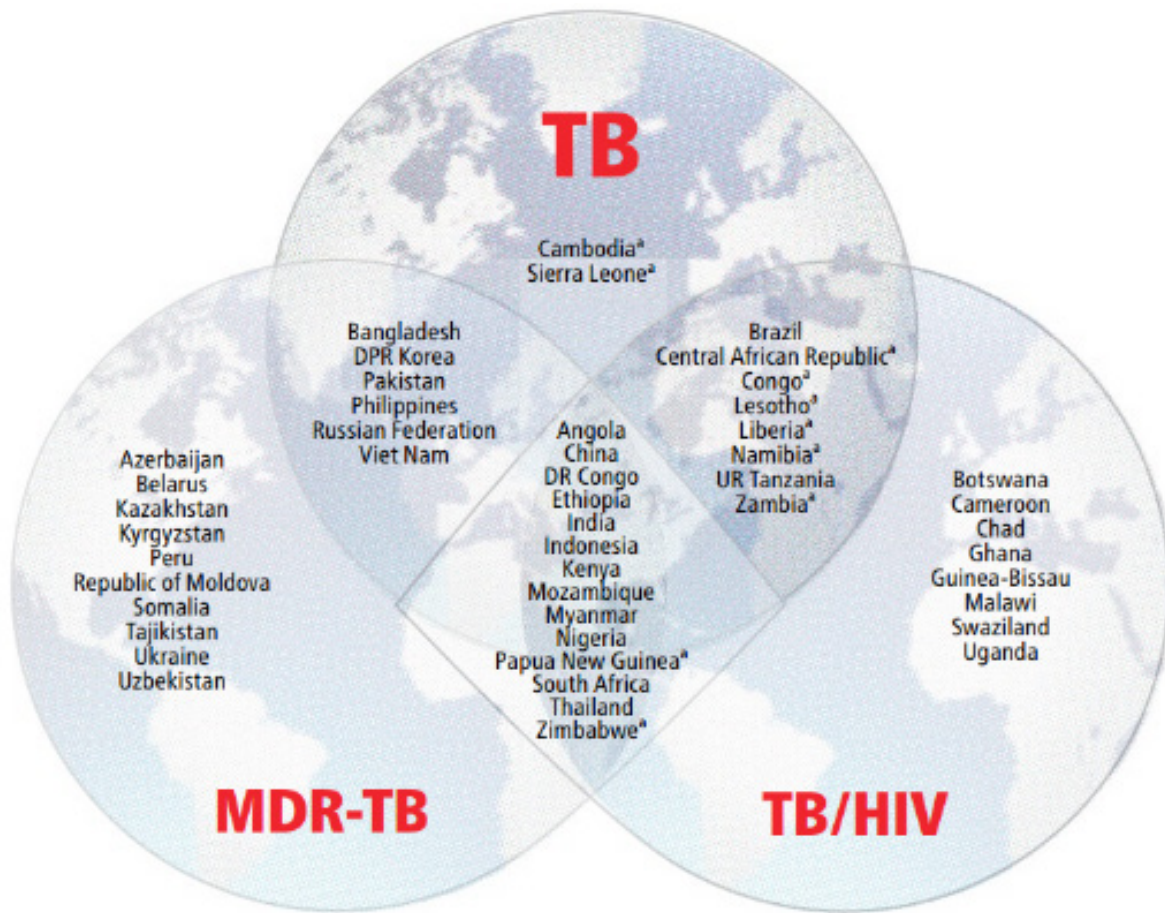
To address the gap of finding the missing TB and multidrug-resistant TB cases, the Ministry of Health, Community Development, Gender, Elderly and Children in collaboration with partners is putting special emphasis on interventions for finding the missing 90,000 TB cases and 600 multidrug-resistant TB in the country. To this effect, Tanzania was among the 13 Global Fund beneficiaries for special fund termed as Catalytic Funding that aims to accelerate TB case finding interventions at country level. To qualify for this fund amounting to USD 6 million, an equivalent amount was supposed to be matched from within the GF allocation summing up to USD 12million. The requirement was designed to ensure the priority interventions in finding the missing TB cases were adequately funded. Furthermore, other partners such as USAID, WHO, Stop TB partnership have also committed to funding priority interventions for finding the missing TB cases in 13 priority countries with the highest proportion of missed TB cases including Tanzania

To address identified challenges on finding the missing TB and multidrug-resistant TB cases, Tanzania is implementing innovative interventions to finding the missed cases through

catalytic funding from the Global Fund. Such interventions include;

1. Scaling up Quality Improvement (QI) of TB case detection in health facilities which has shown positive results with doubling of case detection in some districts,
2. Strengthening of private-public partnerships including use of accredited drug dispensing outlets (ADDOs) and engagement of traditional healers,
3. Strengthening of community networks for TB case finding interventions such as community sensitizations, contact tracing, sputum fixers and specimen referral below the district headquarters,
4. Scaling up the use and adaption of new molecular diagnostic technologies such as the Gene-Xpert MTB/RIF machines to ensure 100% district coverage and 5) integration of RMNCH platforms in pediatric TB case detection through scaling the use of the IMCI module that addresses pediatric TB case detection, Tanzania is one of the 30 high burden countries in the world with sub-categories of TB and TB/HIV burden. Tanzania, therefore, is one of the major contributors to the global burden of TB of 10.4 million TB cases reported in the year 2016. The prevalence survey that was done in 2013, estimates the prevalence of TB to be around 528 per 100,000 populations (Global TB report, 2013)²³. Tanzania notified 63,151 all forms of TB in 2014 (NTLP, MoHSW, 2015). Tanzania is one of the many countries in sub-Saharan Africa that has seen a six-fold increase in number of TB patients since early 1980's (Egwaga, 2003). The remarkable rise and sustained TB burden in Tanzania is attributed to the concurrent HIV epidemic (Chum et al., 1996; Egwaga, 2003).

²³ WHO (2013), Global TB report 2013



(Source: WHO (2017) Global tuberculosis report 2017)

FIGURE 1 COUNTRIES IN THE THREE HIGH-BURDEN COUNTRY LISTS FOR TB, TB/HIV AND MDR-TB BEING USED BY WHO DURING THE PERIOD 2016–2020, AND THEIR AREAS OF OVERLAP.



SECTION V

Tanzania LEA Assessment

NB: Notes from interviews and stakeholders engagement, interviews are on record with the LEA consultant and may be made available upon request and upon prior consent.

TB Field Findings

LEA aims to determine the nature, extent, efficacy and impact of the legal and policy framework in protecting the rights and promoting universal access to TB diagnostics, treatment, care and support. The below findings depict the impact of legal and policy framework in protecting the rights and promoting universal access to TB diagnostics, treatment, care and support.

Barriers to TB Testing and Treatment Services

Physical access to Health facilities poses a big challenge to TB testing and treatment in Tanzania. TB survivors, civil society members and TB Health officers explained health centers are located very far from local communities where people with TB live. This is a big challenge especially in remote and rural areas of Tanzania. For example, people living at Kilombero/Ulangu regions have to travel more than 100 kilometers to attend TB medication at Ifakara St. Francis Hospital. This challenge is even worse during rainy seasons when roads are inaccessible and not passable. This was confirmed by TB Doctor and head of TB Unit at Ifakara St. Francis Hospital. In particular, the Medical doctor attributed distance, transportation costs and poor road network as a key barriers faced by members of the Community to accessing TB services and treatment adherence. As a measure to curb this situation, they do make phone calls to reach people who do not adhere to TB medication. Further, the Doctor stated though they do contact TB patients, such measure is not sustainable without increase in human resources and financial muscle.

He also cited existence of poor road network especially during rainy season when TB patients from areas nearby St. Francis Hospital cannot access medical services. This in fact, contributes largely to failure of people coming for TB testing and diagnosis. He was of the opinion that, roads network should be well improved to become easily accessible by all especially during rainy seasons.

The Medical doctor however praised the government and stakeholders for providing TB medication on time and that in their hospital they do not run out of stock of TB medicines. He insisted however, on the need of the government to look into legal barriers to access to healthcare services for vulnerable

population including detained people, people with risk behaviors to TB infection, and mobile populations such as the Maasai and Sukuma people in the Kilombero region.

We recommend in accordance to policy 8.2 of the National Guidelines for the Management of HIV and Aids, 6th Edition, October, 2017, the MoHCDGEC to commit itself to the endeavour of dramatically reducing TB and HIV morbidity and mortality through comprehensive collaborative TB/HIV activities. The strategies adopted in these guidelines are in line with global efforts to combat dual TB/HIV epidemics recommended by the WHO. Address the need of vulnerable populations for TB/HIV. The strategies take into account the key values of effectiveness, efficiency, equity, equality, and timeliness of delivery.

Infringement of the Right to Privacy

Privacy was also noted as a barrier to TB Testing and treatment. TB patients and TB survivors hinted out that, some hospitals and health facilities acted as a barrier to effective testing and treatment, and also a challenge for adherence. In almost every health facility and hospital there is a different and separate wing/ward for TB patients with bold marks of “TB Clinic” or “TB Wing”. This makes people entering or leaving this wards/ wing to be noted and known. In addition, people with TB are separated and isolated from other patients in public health centers and even faith based health facilities. Thus, this lack of privacy discourages people from utilizing the clinics. There are a few segments of medical staff who do not abide by strict confidentiality standards for medical records. There is also stigmatizing behavior by health care workers. This in turn makes TB testing and medication a challenge. Long queues and long waiting time to get TB testing and Treatment also poses as a challenge to utilization of TB services.

Lack of Access to quality diagnostics and treatment

There was a perception of low/poor quality treatment in health centers managed by the government. Such treatment is tagged with long queues, long waiting periods, poor sanitation and other hassles which people experience when waiting for or receiving medication. During interview with a medical doctor at Ifakara ST. Francis Hospital, to him there was no drug stock out at his Hospital. Only once drugs came very late. However, despite drugs being generally available in public health facilities, supplies do fluctuate and TB state programs experience delays.

It was also noted that TB testing in Tanzania is completely free; however, there are very few health centers that offer quality diagnostics and treatment. Such centers are normally established and cater for zones. There is only one designated Hospital – Kibongoto Hospital that caters for TB patients only.

Accessibility to this health facility is a challenge thus poses as a barrier to quality diagnostics and treatment.

For example, in Ifakara region, patients had to travel more than 100 kilometers to get TB diagnosis and medication at St. Francis Hospital. Patients have to endure transportation barriers and hardships to reach Ifakara town for quality diagnosis and treatment.

Inability to complete treatment

TB Survivors, civil society members and TB health officers observed that a major cause of TB treatment interruptions is lack of consistent and good quality counseling for people diagnosed with TB. TB patients are not told of the great importance and benefits of adhering strictly to TB medication and the risk associated with stopping or interrupting treatment.

Other causes of inability to complete are associated with distance to a health facility, monetary costs involved in travelling to health centers, poverty and lack of money to purchase food or eat all three meals. A TB survivor in Kilombero explained that he stopped treatment due to a lack of information about the risks of doing so. He further said another TB survivor whom he knows stopped TB medication after her employment contract with Kilombero Sugar Company ended thus could not access medicines at Company health facility and therefore had to travel to nearby village Kidodi where there is a health facility. The TB survivor noted that, while he and his family were well-informed about HIV and malaria, they lacked even basic information about TB.

They are of advice that a TB Treatment Supporter program be strengthened and TB clinics centers be increased and placed nearby communities affected by TB. Further, they recommend that though a TB patient has a right to TB medication and treatment, such right be clearly provided for and stated in the law. The said law should also contain or include a specific provision of the law on adherence to medication and avoid spreading to others deliberately.

During the validation workshop, one of the participants shared a testimony of a TB patient in Morogoro region who denied medication until he died. He had no valid reasons to deny medication it is only lack of awareness on importance of adhering to Medication. The same presenter also shared another Testimony of a TB patient who was diagnosed with MDR and started medication and at one stage was taken to Kibongoto Hospital for treatment. After medication at Kibongoto Hospital he was required to continue medication at Ifakara St. Francis Hospital. He only attended once at the hospital for medication and thereafter he was never seen and he stopped medication. When he was contacted he said that he is at Morogoro town. But

to date he is unreachable and has stopped medication.

Another factor contributing to TB patient not to complete treatment that was pointed out by stakeholders during interview was based on religious factors. That, some of the TB patients are been advised by religious leaders to stop medication on the fact that they will be healed upon being prayed by the said religious leaders. This problem is increasingly growing and that many TB patients due to low awareness tend to believe that TB is cured through prayers and periods of long fasting and divine miracles.

During interview with a Resident magistrate of Nyamagana District Court in Mwanza, she informed us she had once handled a case involving a TB patient. She further said that the said TB patient was afraid and shy in disclosing his medical condition and that he was under TB medication. However, during mitigation part, the Accused person disclosed his medical status and that he was attending TB medication. The Magistrate thus convicted and sentences him to community service so as he may have ample time to attend to his TB Medication. However, the magistrate commented that they do not have powers to sentence accused person to community service if the offence charged fall within Minimum Sentence Act, Cap 90. Even if the accused person pleads has a TB, in this circumstances left a magistrate with the only option to convict and sentence the accused person accordance with the Minimum Sentence Act Cap 90.

Delays in TB Diagnosis

During interviews and stakeholder dialogues, TB survivors attested that they experienced lengthy delays—more than one year in some cases—from the onset of symptoms to their diagnosis for TB. They cited several reasons for the delays. A crucial contributing factor was a lack of awareness among themselves, among chemists and among health care workers about TB symptoms and when to seek testing, like when a cough lasts for two or more weeks. Even when TB survivors had sought advice from a professional, their first point of contact was often a local chemist who prescribed cough medicines, but did not refer them to a DOTS center.

An interview with a person with TB in Mwanza revealed that he experienced a one year delay from the time he started coughing to his diagnosis. He first presented himself at a local chemist, and was directed to a hospital when symptoms persisted, then finally, months later, attended a public clinic for TB diagnosis. He started treatment at the hospital and continued at a public DOTS center.

A similar story is shared with a TB survivor at Kilombero - Morogoro whereby during interview he explained of more than a year delay in TB diagnosis and treatment. He stated that he started

with a local traditional healer before attending Kilombero Sugar Company health facility for check up since he was an employee of the sugar factory. Still, he was given cough medication for they thought it was a normal cough resulting from working in confined spaces within the sugar factory. Despite the treatment he quickly began losing weight and experiencing night sweats again and finally returned to the same health facility whereby after diagnosis confirmed that he had TB and started treatment. It is after a year when he was diagnosed with TB and started with TB medication.

Stigmatization and Discrimination including in Health Care, education and the labor Sector

Stakeholder interviews and dialogues revealed that stigmatization and discrimination of people with TB is pervasive in Tanzania, with devastating impacts on people with TB, their families and the performance of TB programs.

Stigma and Discrimination in the Community

People with TB experience severe stigma and discrimination in their communities and families. The Head Physician at Ifakara ST. Francis Hospital in Ifakara Morogoro region shared stories highlighting this phenomenon. In one case, a person with TB living with HIV receiving treatment at his clinic was abandoned by his wife because of his illness. He subsequently stopped coming to the clinic for TB treatment. When clinic staff visited the man's home to check on him, they found him alone and in a severely deteriorated state of health. They immediately took him to the hospital, to continue with medication.

During interview with Chairman of MUKIKUTE who is a TB survivor shared stories of the impact of TB stigma and discrimination in their communities and families. In his stories, people suffering from TB are ashamed of informing their close relatives and workmates due to self-stigma and shame associated with the disease and his failure to fully understand the gravity of his condition.

Existence of unqualified and low skilled Health Care Workers in Clinics

On the issue of low and unqualified health workers, one contributor contributed by sharing a story of a health facility in Masasi Mtwara where there is only nurse attendant serving the entire village thereby making access to TB medication a challenge. He further contributes that at Ifakara region a TB patient has to walk or travel more than 40 Kilometers to the nearest health center where there is a qualified health worker. The same story goes to a TB patient living at Kigamboni DSM who had to go to Mnazi Mmoja instead of Kigamboni DOTS

centre for medication. The reason among others is fear of stigma and existence of low skilled staff.

Employment Discrimination against People with TB

TB survivors who participated in interviews reported having been permanently dismissed or forced to leave their employment after being diagnosed with TB. TB survivors who lost employment included miners, casual laborers working in the sugar factory and Sugar cane farms of Kilombero Sugar Farms, and also farmers working in the paddy farms found within the Kilombero Valley. A number of construction workers as well have been forced to quit jobs due to suffering from TB. A TB survivor in Ifakara explained that he lost his job as a Health Care Worker after he was diagnosed with TB. Though his employer was sympathetic and offered him time off for treatment, the survivor's position was filled without his knowledge shortly after he left. As a result, he lost his job.

During interview with a Tb Survivor who is also a police officer stationed at Ifakara said that when he contacted Tb and reported it to his superiors, he was given time off to attend medication and after three months of medication, the officer in charge of the police station gave him only light duties and sometimes never assigned him any duty for fear that he might spread it to other police officers and citizens under police custody. This to him caused mental and psychological torture for he felt to be discriminated. He further said that even after he reported that he has been cured and is no longer suffering from TB, he was still assigned light duties and never given priority.

For example the employment law does not protect employees suffering from TB. The law provides for 126 days sick leave and thereafter allows employer to terminate sick employee. We all know TB medication and treatment takes more than 126 days prescribed by the ELRA, thus existence of this law acts as a barrier to effective TB treatment for employees affected by TB will not disclose for fear of losing their jobs. This happens in all private and public institutions such as police force. A police officer who contacted TB was given light works and in some days he was not assigned any duty. This is work related discrimination.

On the side of employee being terminated after being diagnosed with TB, during interview with a stakeholder in Mwanza he shared a Story of a teacher at Mwanza who was terminated by the Head Teacher after she revealed she has TB. The Head teacher was afraid that the teacher affected with TB will transmit it to other teachers and students and once the general public becomes aware of her medical status, will remove their children and transfer them to other schools thus loose business. Thus she lost the job. Olive on the other hand, shared a story of a

Tanzanite Miner who lost a job in a Tanzanite mine because of Contacting TB. His employer forced him to continue working and to take medication while in the mine. Whenever the miner requested for time to attend clinic he was denied by the mine owner. When the miner was very sick, he was taken to nearest clinic for medication. The mine owner reported to Police that one of his employee has stolen from him and the miner was taken to police custody and later to court. This miner further lost her job.

During an interview with one of the managers of a pension Fund based in Mwanza, he opined that in his office, once an employee reveals that is suffering from TB, their employment policy directs such employee be given time off for treatment and that during treatment he/she still gets monthly salary and medical cover. Once the employee recovers, he resumes duty. He categorically stated that they do not terminate employee on the grounds of suffering from TB.

However, another contributor from Legal Sector Reforms Commission of Tanzania was of the view that the problem is not on the law rather on implementation and enforcement of the law. He stressed on the point of the need of the government and civil servant being accountable and responsible of their actions. He cited an example of the labour officers in the mining areas to not fully enforce and implement labour laws in their respective zones thereby leading to gross violation of Human rights of TB patients in the mining areas.

Health care workers (HCW)

Regardless of the economic settings, HCW are at increased risk of acquiring TB compared to the general population. This is largely due to failure in health systems, poor occupational health services and TB infection Control, staffing shortages, supply issues, lack of funding and lack of proper supervision. These reasons put HCW and their families who are tasked of caring for at a bigger risk. When interviewing a HCW at Ifakara St. Francis Hospital, she shared with us the history of one of the fellow HCW who contacted TB while on duty and that at the moment he was forced to take early retirement and is struggling to get compensation. There is a need for advocacy for change in policy and practice with regard to HCW. This issue of compensation of HCW also came into a heated debate during validation workshop whereby participants called for a reform on the Workers Compensation Act and Workers Compensation Fund to allow HCW who contract TB while on duty be well compensated.

Another contributor during the validation workshop expressed out that in order to fully address TB treatment and care in human rights based approach and the issue of HCW, there should be a holistic multi-sectoral approach in addressing the issue. He

further pointed out that there is a need of raising awareness of the rights of patients especially the rights of TB patients and those of HCW. She stated that HCW are friendly when a patient comes for TB diagnosis and once it is revealed that the patient is affected by TB the same HCW tends to run away from the patient. This in turn increases stigmatization and lowers the capacity of the HCW to attend effectively to the TB patient.

To address the pervasive discrimination against people with TB in employment, TB survivors, TB physicians and civil society members all expressed support for legislation prohibiting discrimination against people with TB, including in employment settings.

People who use drugs (PWUD)

The chairman of MUKIKUTE further hinted existence of high stigmatization and criminalization on people who use drugs. There is existence of high rates of TB combined with HIV on the people who use drugs. Irrespective of their HIV status, people who use drugs tend to have higher rates of TB and higher prevalence of latent TB infection. Stakeholders need to take immediate action in Tanzania to rescue the TB situation in people who use drugs.

It was also noted that during interview, another challenge facing people using drugs is when they are caught by the police and placed under police custody. Such PWUD fail to adhere to medication. This is largely due to lack of awareness amongst the police officers. This is in relation to the right of bail whereby the police deny bail to those TB patients who are under medication.

MDR-TB or even TB cases are arrested at times, and are reprimanded without cause and given little access to treatment. This is very rampant on traffic cases for *boda boda* drivers whereby a police officer might take into custody a TB patient and denies him bail only for committing a traffic offence. This is a problem in Temeke Region, within Dar es Salaam. There were of the view that there is a gap in the laws establishing Prisons and police forces. She was therefore of the view that this challenge is an institutional one and needs respective institutions to address the problem.

Low Public Awareness and Lack of Accurate Information about TB

Low public awareness and a lack of accurate information about TB among the public, including health care workers and people affected by TB, was a recurring theme encountered during stakeholder interviews. TB survivors, civil society members, physicians, TB researchers, and NTLP and state TB program officials all cited the lack of awareness and information about TB as a key driver of the epidemic in Tanzania. Incorrect beliefs and the lack of awareness about TB have deadly consequences. Mr. Joseph Mapunda a TB survivor Chairman of MUKIKUTE, a community based group in Temeke, Dar es Salaam working to sensitize and raise community awareness around TB, reported that he was completely unaware and had not even heard about TB prior to being diagnosed. As a result, even though he was experiencing clear symptoms of TB disease, he did not seek TB testing until his condition deteriorated and that's when he went for TB diagnosis.

The experiences of TB survivors, including Mr. Joseph Mapunda, highlight that the lack of awareness about TB, including its symptoms, contributes to long delays in diagnosis, which in turn drives spread of the disease. To this point, the head of Ifakara ST. Francis Hospital in Ifakara Morogoro region cited a lack of knowledge and awareness about TB as the primary barrier people in his community face in accessing TB testing and treatment services. He underlined this concern by noting that many people in his community incorrectly believe TB is a bewitch.

During the validation workshop, one participant shared two stories of TB patient who died as a result of lack of awareness and accurate information. The first story involved a TB case in Geita Mines whereby a TB patient denied treatment and continued working in the mines. The local authorities tried to counsel and convince the Patient to attend TB clinic for diagnosis and treatment but was violently and harsh and that he said he was bewitched by people who did not like his personal development. A team from Dar had to travel to Geita to educate and convince the TB patient to start medication and treatment but the person adamantly refused. When his condition deteriorated the official had by force to isolate him and transport him to Kibongoto hospital in Siha, Kilimanjaro District for further treatment. Unfortunately, the TB patient died and could not make it to the treatment. The second story is of a TB patient in Morogoro region who denied medication until he died. He had no valid reasons to deny medication rather it is only lack of awareness on importance of adhering to Medication.

The same presenter also shared another Testimony of a TB patient who was diagnosed with MDR and started medication and at one stage was taken to Kibongoto Hospital, a TB designated hospital for treatment. After medication at Kibongoto Hospital he was required to continue medication at Ifakara St. Francis Hospital. He

only attended once at the hospital for medication and thereafter he was never seen and he stopped medication. When he was contacted he said that he is at Morogoro town. But to date he is unreachable and has stopped medication.

Lack of TB Community Mobilization

During stakeholder interviews in Morogoro and Dar es Salaam, TB survivors, civil society members and TB program facilitators noted the lack of community mobilization around TB and expressed concern that too few TB community-based organizations existed in Tanzania. This shortage was made evident during the dialogues by the fact that TB survivors who participated were not all members of organized community-based TB groups. Instead, most community members present were part of HIV organizations, conducting TB advocacy and activism through established HIV networks. TB survivors and civil society members called for more funding and technical support to increase mobilization and strengthen capacity of people affected TB to form community-based organizations and advocate at local, national, regional and international levels.

Another contributor during Validation workshop shared on TB awareness programmes in schools famously known as *Bango Kitita*. She shared a testimony of the story of school children living in dormitories which are not built to standards. During their daily TB diagnosis in schools in Kinondoni District, within Dar es Salaam region, they found out some students being affected with TB and forwarded them for TB medication. He was of the view that the same problem might also be in University Hostels where four or more students do sleep in one room which has a capacity of accommodating two students only.

Gender Disparity in accessing TB care

Gender disparity posed a challenge in accessing TB diagnosis and treatment and care. TB epidemiology clearly varies by gender. TB incidence is higher in men than women. Furthermore, gender dynamics in TB enrolment, treatment and cure rates vary by setting.²⁴ Women and men have very different needs in terms of access to TB services. It has been revealed that men seek help at later stages of disease unlike women though TB in women is more difficult to diagnose and might encounter challenges and delays in various stages of seeking help for TB.²⁵

TB among prisoners and lack of access to TB diagnosis, treatment and care in Prisons

Unfortunately, we could not be able to access prisons to acquire the status and prevalence of TB among Prisoners and inmates. However, basing on reports got from several human rights report²⁶ on Tanzania, overcrowding is an issue in many of the Tanzania's prisons. Overcrowding greatly contributes to the spread of TB thereby making the risk of contacting TB in prisons much higher than in the general population. It is worthy to note that TB and MDR-TB epidemics in prisons have impacted health outcomes since prisons are linked to surrounding communities.

On the part of Tanzania Prisons Services (TPS) the main challenge is prison overcrowding, affecting basic rights of prisoners. The prisons that are available are not sufficient to accommodate the prisoners. Currently, the capacity of prisons in Tanzania is to hold a total of 29,552 prisoners and remandees, while the number of prisoners is more than 33,000.²⁷ The Government has made a number of efforts to address the problem, including the use of alternative sentences such as parole, probation, and conditional sentences. However, increase of arbitrary arrests, delays of investigations, and denial of bail for bailable offences, particularly by the police, is nullifying those efforts; and as a result at least half of the people in prisons are remandees.

It was also noted and observed during desk review that children and adults share the same prison cells.²⁸ This situation is not at all pleasing because it accentuates or increases their vulnerability to abuse, violence, exploitation and health related risks such as injury and HIV/ AIDS infection. There is a lack of adequate laws and policies protecting the right to health care, including access to TB diagnosis, prevention and treatment, for prisoners

Further, lack of financial support and training for prison health staff, makes it difficult to deliver effective TB treatment to prisoners with TB. These factors can also cause delays in diagnosis, facilitate rapid spread of infection, and trigger frequent treatment interruptions.

We thus recommend to effectively address the issue of TB and MDR-TB in prisons, government and institutions must focus on alternatives to incarceration, promote rights of prisoners and prison staff, provision of adequate support to health infrastructures within prisons; and working alongside communities and prisoners to develop more effective, rights based TB treatment and care delivery models. The government and Civil society organization should train health care providers on the human rights of prisoners, including on non-discrimination, informed consent, confidentiality and the duty to treat them fairly. Further, the government and civil society organization should work in partnership with prisoners and ex-prisoners and organizations who work to promote their rights to design and implement advocacy strategies to promote the human rights of prisoners.



²⁴ NTLP annual report 2016

²⁵ Ibid

²⁶ LHRC Tanzania Human Rights Report 2016.

²⁷ See budget speech by the Minister of Home Affairs, Hon. Mathias Chikawe (MP) for the financial year 2015/2016

²⁸ LHRC Tanzania Human Rights Report 2016 at Pg 318.

SECTION VI

TB Legal and Policy Framework in Tanzania International and Regional law

Tanzania has signed and ratified all the major international human rights instruments. These include: the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW), and the Convention on the Rights of Persons with Disabilities (CRPD). Tanzania is also a State Party to the Convention relating to the Status of Refugees (Refugee Convention) and has ratified the Optional Protocol to the ICESCR. The ICESCR Optional Protocol allows individuals or groups to submit communications, under the jurisdiction of a State Party, to the Committee on Economic, Social and Cultural Rights with claims related to violations of rights in the treaty, including the right to health. Finally, Tanzania is a signatory to the Beijing Platform of Action, and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and an active implementer of the two conventions.

At the regional level, Tanzania has ratified the African Charter on Human and Peoples Rights (African Charter) and the East African Treaty.

Convention on the Rights of a Child (CRC)

The government of the United Republic of Tanzania ratified the UN Convention on the Rights of the Child (CRC) on 10 June 1991, and the African Charter on the Rights and Welfare of the Child (ACRWC) on 23 October 1998. In doing so, the Government is obliged to undertake all necessary steps, including legislative, administrative and other measures to implement the rights contained in both Conventions,²⁹ including those rights provided to children in conflict with the law.

International Covenant on Civil and Political Rights, 1966 (ICCPR)

The International Covenant on Civil and Political Rights

(ICCPR), is a key instrument, and contains rights to fair trial, prohibitions on illegal and arbitrary detention, provisions on treatment in detention and a prohibition on torture and cruel, inhuman or degrading treatment or punishment. While most of these standards are not specifically tailored to the unique needs and conditions of TB patients,³⁰ they nonetheless provide fundamental safeguards and rights for children who are in conflict with the law.

The African Charter on Human and People's Rights - The right to health and medical attention

Article 16 of the African Charter emphasizes that states parties shall take the necessary measures to protect the health of their people. However, the health situation of the TB patients in Tanzania is often very precarious and receives fairly attention from responsible health Authorities. This is seen in connection with general marginalization that TB patients suffer from both economically and socially. On top of this, TB patients mostly live in remote areas, squatters, and densely populated areas, farms, mines where they are easily forgotten. And as these TB patients receive little legal protection, and as they, to a large extent, suffer from impoverishment and low literacy rates, their health situation is in many cases extremely critical and this is a violation of Article 16 of the African Charter. Tuberculosis is reported to be higher in mines, and in suburbs of many towns in Tanzania. Poverty plays a crucial role in facilitating the spread of TB, e.g. poor sanitation, poor diet. Despite that medication of TB is free in Tanzania, due to poverty and accessibility of health centers; many TB patients do not get timely TB diagnosis and medication.

Many pastoralists in Tanzania have very limited access to health facilities and their TB health status is very precarious. This is for instance the case with the Maasai living in Mvomero and Kilosa Districts in Morogoro region.

East African Treaty

The Treaty for Establishment of the East African Community was signed on 30 November 1999 and entered into force on 7 July 2000 following its ratification by the original three Partner States – Kenya, Uganda and Tanzania. The Republic of Rwanda and the Republic of Burundi acceded to the EAC Treaty on 18 June 2007 and became full Members of the Community with effect from 1 July 2007. The EAC was established with a vision to set up a prosperous, competitive, secure, stable and politically united East Africa; and provide platform to widen and deepen Economic, Political, Social and Culture integration in

³⁰ An exception can be found in Article 10(b) and (c), which provide that: "accused juvenile persons shall be separated from adults and brought as speedily as possible for adjudication" and "juvenile offenders shall be segregated from adults and be accorded treatment appropriate to their age and legal status."

order to improve the quality of life of the people of East Africa through increased competitiveness, value added production, trade and investments.

Section 3 of the Treaty addresses Human Rights activities in the region. Article 118 of the EAC Treaty provides for the AIDS pandemic and calls upon East Africa member states to take joint action in the prevention and control of HIV and AIDS together with other communicable diseases such as TB. Communicable diseases are given impetus in the EAC owing to their impact on human resources and the danger of spreading of the pandemic owing to free movement of person in the integration process.

Article 120 (2) of the EAC Treaty places legal obligation of member states to develop and adopt a common approach to improving the lives of disadvantaged groups such as children, the elderly, and other groups highly vulnerable to TB by provision of health care, education and training.

East African Community Legislation

Community legislation consists of Acts enacted in accordance with the EAC Treaty.³¹ The community Acts do not refer to Human Rights, rather, the legal basis for Human rights protection is provided by two bills that have been passed: the HIV and AIDS Bill and the EAC Human Rights Bill by the East African Legislative Assembly (EALA). The passing of the HIV and AIDS Bill by EALA in 2012 was a major step. In that regional legislation was created in order to protect people with HIV and AIDS. The Bill gives priority to measures of prevention, while also emphasizing community support, care and adequate treatment. The Bill recognizes the role of Human Rights in dealing with pandemic disease such as TB and urges member states to take rights based approach in dealing with it.

Bujumbura Declaration on Child Rights and Wellbeing in the EAC³²

This declaration takes cognizance of the instruments pertaining to the realization of children's rights, such as the African Charter on the Rights and Welfare of the Child (Children's Charter) and the Convention on the rights of a Child (CRC).

³¹ Section 2 of the Laws of the Community (Interpretation) Act, No. 6 of 2004.

³² Bujumbura Declaration on Child rights and wellbeing in the EAC, adopted on 03rd September, 2012

TABLE 2: KEY INTERNATIONAL AND REGIONAL HUMAN RIGHTS TANZANIA'S OBLIGATIONS RELATED TO TB

HUMAN RIGHTS	HEALTH - RELATED CONTENT	OBLIGATIONS RELATED TO TB LAW AND POLICY
<p>RIGHT TO LIFE</p> <p>SOURCES: UDHR, ICCPR, ICMW, African Charter</p>	<p>States must adopt positive measures to protect life, eliminate epidemics, and ensure access to medical care.¹</p>	<p>Tanzania must adopt measures in law and policy to protect the lives of people with TB, including ensuring the right to access to life-saving testing and treatment.</p>
<p>RIGHT TO HEALTH</p> <p>SOURCES: UDHR, ICESCR, ICERD, CRC, CEDAW, ICMW, CRPD, African Charter</p>	<p>States have a core obligation to provide essential medicines on the WHO Model List of Essential Medicines.²</p>	<p>Section 6.2.4 of the 19th WHO Model List of Essential Medicines includes first- and second-line anti-tuberculosis drugs, including bedaquiline and delamanid. Tanzania must adopt laws and policies that ensure people with TB and drug-resistant TB are provided first- and second-line medicines.³</p>
<p>RIGHT TO BE FREE FROM DISCRIMINATION</p> <p>SOURCES: UDHR, ICCPR, ICESCR, ICERD, CEDAW, ICMW, CRPD, African Charter</p>	<p>Prohibition of discrimination based on "other status" includes health status and includes direct and indirect discrimination in the public and private spheres.⁴</p>	<p>Tanzania must protect people with TB in law and policy against all forms of discrimination in both the public and private spheres, including employment, education, housing, immigration and health care settings.</p>
<p>RIGHT TO BE FREE FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT</p> <p>SOURCES: UDHR, ICCPR, CAT, ICMW, African Charter</p>	<p>Failure to provide adequate medical care to prisoners and other people deprived of their liberty constitutes inhuman and degrading treatment.⁵</p>	<p>Tanzania must adopt law and policy that ensures people with TB in prisons and other detention centers are provided good - quality testing and treatment services</p>
<p>RIGHT TO PRIVACY</p> <p>SOURCE: UDHR, ICCPR, ICMW, CRPD, African Charter</p>	<p>Right to privacy includes the right to keep information related to health and health status private.⁶</p>	<p>Tanzania must establish in law and policy the right of people with TB to keep their health status and other health-related information private and confidential, except from those to whom they pose a real risk of transmission and only for the duration of the risk.</p>
<p>RIGHT TO LIBERTY AND SECURITY OF PERSON</p> <p>SOURCES: UDHR, ICCPR, ICERD, ICMW, CRPD, African Charter</p>	<p>Any deprivation of liberty must be proportionate in light of the circumstances and necessary to protect against serious harm or prevent injury to others; it must be used only as a last resort, for the shortest period of time, and accompanied by adequate procedural and substantive safeguards established by law.</p>	<p>Tanzania must establish in law and policy clear protections against involuntary detention or isolation of people with TB, except for under exceptional circumstances, as a last resort, when a person is known to be or highly likely to be contagious but refuses treatment or testing and all reasonable measures to ensure adherence have been unsuccessful. In these cases, the least restrictive possible measure must be used; isolation must occur in an appropriate medical setting; and the individual must be provided treatment and basic necessities, as well as the right to appeal the isolation decision.⁸</p>

<p>RIGHT TO PARTICIPATION (TO TAKE PART IN THE CONDUCT OF PUBLIC AFFAIRS)</p> <p><i>SOURCES: UDHR, ICCPR, ICERD, ICMW, CRPD, African Charter</i></p>	<p>Conduct of public affairs is a broad concept including legislative, executive and administrative powers, all aspects of formulation and implementation of policy at international, national and local levels, the means of which should be established by constitutions and other laws.⁹</p>	<p>Tanzania must establish and facilitate through law and policy the right of people with TB and TB survivors to participate in the design, implementation, monitoring and evaluation of laws and policies implicating TB at the state and local government area levels.</p>
<p>RIGHT TO ASYLUM</p> <p><i>SOURCES: UDHR, African Charter, Refugee Convention</i></p>	<p>Everyone has the right to seek and enjoy asylum from persecution in other countries without discrimination.¹⁰</p>	<p>Tanzania must establish in law and policy the right of people with TB to receive asylum without discrimination based on their health status and it must allow for asylum consideration based on a high risk of contracting TB in a person's home country, including when a person is likely to be detained in a prison with high rates of TB.</p>
<p>RIGHT TO FOOD</p> <p><i>SOURCES: UDHR, ICESCR, CRC, CRPD</i></p>	<p>States must ensure everyone under their jurisdiction can access minimum essential food that is sufficient, nutritious and safe, with priority consideration given to disadvantaged groups.</p>	<p>Tanzania must adopt laws and policies to ensure people with TB have access to adequate, nutritious food during treatment, as under-nutrition and low body mass index are associated with poor treatment outcomes.</p>
<p>RIGHT TO ADEQUATE HOUSING (RIGHT TO SHELTER)</p> <p><i>SOURCES: UDHR, ICESCR, ICERD, CRC, CEDAW, ICMW, CRPD</i></p>	<p>Housing must be accessible, affordable and habitable, providing adequate space and ventilation and protection from threats to health and disease vectors, especially for disadvantaged groups, such as people living with HIV and those with persistent medical problems.¹¹</p>	<p>Tanzania must ensure through law and policy access to affordable housing with adequate ventilation, particularly for the rural and urban poor, to prevent the transmission and spread of TB.</p>
<p>RIGHT TO EDUCATION</p> <p><i>SOURCES: UDHR, ICESCR, ICERD, CRC, ICMW, CRPD</i></p>	<p>Education must be accessible to all, especially the most vulnerable groups, in law and fact, without discrimination, including for persons with disabilities, children of migrants, and other disadvantaged groups.</p>	<p>Tanzania must protect children with TB in law and policy against all forms of discrimination at school and ensure they are allowed to attend normal classes, unless and only for as long as they pose a real risk of transmission to their classmates.</p>

Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to promote access to Treatment/Medicines

One of the major successes of recent efforts to respond to HIV, as well as TB, in sub-Saharan Africa has been the increased access to medicine in the past five years. However, intellectual property rights continue to undermine access to diagnostics, medicines, and other devices for Tanzania and the rest of the developing world. Appreciating the linkages between intellectual property rights and access to essential medicines is critical. This is especially because intellectual property barriers to access to newer and affordable, quality, safe and efficacious HIV and TB medicines remains a crucial human rights issue that requires intensified advocacy in Tanzania in the context of TB. If treatment options for 2nd and 3rd line HIV, TB (including MDR and XDR-TB) are not improved and treatment coverage is not expanded, there is a risk of rising AIDS-related deaths and HIV incidence and the development of drug-resistant strains of HIV and TB.

In 2001, WTO members adopted the Doha Declaration³³ on the TRIPS Agreement and Public Health, reiterating that least LDCs were able to use the “flexibilities” within TRIPS to increase access to affordable medicines – such as lower cost, generic medicines - for public health reasons. The Declaration recognized the gravity of public health problems affecting developing countries, especially HIV/AIDS, TB and Malaria and the “importance of creating a positive, mutually reinforcing link between the IP system and access to medicines.” The Doha Declaration made it clear that TRIPS does not and should not prevent members from taking measures to protect public health and that it should be interpreted in a manner supportive of public health.

While most African countries have incorporated intellectual property protection in their domestic laws, including harmonizing their patent laws to protect patents on medicines, very few countries have become TRIPS compliant or have taken full advantage of TRIPS flexibilities to increase access to affordable medicines.³⁴

Tanzania Domestic law and Policy Constitutional Law and Jurisprudence

This section relates to Tanzanian Constitution. Part III of the Constitution of United Republic of Tanzania, 1977 (as amended from time to time) provides for the Basic Rights and duties. The Bill of Rights was incorporated in the Tanzanian Constitution in

1984. Although the Bill of Rights contained provisions for the enforcement of Human Rights,³⁵ the justifiability of the bill of rights itself came into existence in 1988 and the enabling law on enforcement of the Bill of Rights was passed in 1994: that is, the basic Rights and Duties Enforcement Act, (1994).³⁶ The Constitution does not contain an express provision on the right to health but Article 12 which provides for the Right to life has been interpreted to mean and include the right to health.

The constitution guarantees fundamental basic rights. Among them is equality before the law and the right to participate in governance and holding the government accountable. Given these guaranteed rights, the Parliament is prohibited from enactment of acts which discriminate the citizens on grounds of age, gender, race and the status of the beneficiaries. These guaranteed rights are in tandem with various International Human Rights instruments to which Tanzania is a party.

It is important to note key two features within Part III of the Constitution: one is that, these rights designated in the constitution are justifiable, and therefore can serve as a basis for a human rights claim in a court of competent jurisdiction in Tanzania. The second feature concerns access to Justice in courts of law. Despite both substantive and procedural barriers one might encounter, the Constitution allows both individuals and legal persons on behalf of others access to the Courts claiming relief where there is human rights violation.³⁷ These has become so following important and notable courts decisions on the issue of *locus standi*. Despite the issue of locus standi being finally determined, there are other obstacles one might face when litigating a Human Right claim. Such obstacles include: delays in case determination; costs involved in litigation, existence of technical procedural rules, the requirement of a three judge sitting panel³⁸; existence of ‘saving clause’ contained in Article 30 (2) of the Constitution, the use of the Parliament to preempt court decisions in favour of Human Rights, and the use of legal technicalities to stall the course of Human Rights. These obstacles may prevent people affected with TB or civil societies working with people affected with TB from fully exercising their rights, even when the law is on their side.

In 2011, then President Kikwete announced a constitutional review, the first since 1977, and appointed a Constitutional Review Commission (CRC) to collect public submissions. In December 2013, after it was adopted by a Constituent Assembly, the CRC presented a second draft of the new Constitution to

³⁵ See Article 30 (3) of the Constitution of Tanzania

³⁶ Chapter 3, R.E. 2002.

³⁷ See the Article 30 (3) and Article 26 of the Constitution, read together with Section 4 of the Basic Rights and Duties Enforcement Act, 1994 and Interpretation of Laws Act, Cap 1, R.E. 2002.

³⁸ Section 10 of the Basic Rights and Duties Enforcement Act, 1994.

³³ It was adopted by the WTO Ministerial Conference of 2001 in Doha on November 14, 2001. It reaffirmed flexibility of TRIPS member states in circumventing patent rights for better access to essential medicines.

³⁴ HIV, TB and Human Rights in Southern and East Africa Report 2016, at p.49

President Kikwete. Tanzanians were due to vote on the new Constitution in a referendum in April 2015. The referendum was however postponed because of delays in registering voters and a new date for the referendum has not been announced. The current regime under President John Joseph Pombe Magufuli has categorically stated that the draft constitution is not in his agenda and therefore will not be worked upon. The draft constitution did not explicitly include references to HIV and TB, but prohibited discrimination on a range of grounds and placed explicit obligations on the government to protect Human Rights.³⁹

Specific Constitutional Rights

Article 12 provides categorically that all human beings are born free and equal in dignity and rights. This particular article echoes Article 1 of the Universal Declaration of Human Rights (UDHR, 1948). Human rights are birthrights. They inhere in a human being by virtue of being a human being.⁴⁰ As the late Justice Lugakingira observed in the case of *Rev. Christopher Mtikila Versus A.G.*,⁴¹

“In assessing this power it is appropriate to recall, in the first place, that fundamental rights are not gifts from the state. They inhere in a person by reason of his birth and are therefore prior to the state and law. In our times one method of judging the character of a government is to look at the extent to which it recognizes and protects human rights. The *raison d’etre* for any government is its ability to secure the welfare of the governed. Its claim to the allegiance of the governed has to be in terms of what that allegiance is to serve....”

Article 14 of the Constitution provides for the Right to life. The right to life provided under the Constitution can be further expounded on the right to quality and affordable health care and treatment. Nevertheless, this mother law of the land does not explicitly provide for right to health. However, the public is aware that the proposed draft Constitution *inter alia* has placed the provision on the right to health.⁴²

Article 15 of the Constitution provides for the Right to personal

freedom and the right to live freely. This particular Article guarantees for the purposes of preserving individual freedom and the right to live as a free person, the right of not being arrested, imprisoned, confined, detained, deported or otherwise deprived of his freedom save for a valid reason and due process of law is followed;

Article 16 of the Constitution provides for the Right to privacy and personal security. This constitutional provision guarantees and protects the privacy of citizens together with that of their family and that of matrimonial life and respect and protection of his residence and private communications. This constitutional provision can be construed to mean and include protection of the privacy of a TB patient, TB survivor and organizations working with people affected with TB.

Article 17 of the Constitution provides for the Right to freedom of movement. Every citizen of the United Republic of Tanzania has the right to freedom of movement in the United Republic of Tanzania and the right to live in any part of the United Republic, to leave and enter the country, and the right not to be forced to leave or be expelled from the United Republic. Of more importance in this specific provision of the Constitution is the guarantee and protection of the right and freedom of movement. This allows people affected with TB to freely move to seek for medication and treatment in any part of the Tanzania including the free choice of a health facility.

Locus Standi and Access to Justice

This section looks into the degree of guarantee and enjoyment of the basic rights and freedoms by its people. This is because in order to for basic human rights be implemented effectively at national level, there must be put in place an effective protection mechanism of the rights themselves.⁴³

The Bill of Rights was incorporated in the Tanzanian Constitution in 1984. Although the Bill of Rights contained provisions for the enforcement of Human Rights,⁴⁴ the justifiability of the bill of rights itself came into existence in 1988 and the enabling law on enforcement of the Bill of Rights was passed in 1994: that is, the basic Rights and Duties Enforcement Act, (1994).⁴⁵

This Act was enacted in accordance with Article 30 (4) of the

³⁹ Proposed draft Constitution of Tanzania, September 2014 http://www.constitutionnet.org/sites/default/files/the_proposed_constitution_of_tanzania_sept_2014.pdf last accessed on 04th December, 2017

⁴⁰ Clement J. Mashamba, *Judicial Protection of Civil and Political Rights in Tanzania* at pg.23

⁴¹ [1995] TLR 31

⁴² Article 51, 55 (f), and 57 (f) of the Draft constitution

⁴³ Peter, C.M., “the Human Rights System: An overview,” in Mchome, S.E. (ed), *Taking Stock of Human Rights in Africa*, op. cit, pp.3-4, and in Clement J. Mashamba, “Judicial Protection of Civil and Political Rights in Tanzania:

Cases, Materials and Commentary”, 2nd Ed., LawAfrica, at pg 25

⁴⁴ See Article 30 (3) of the Constitution of Tanzania

⁴⁵ Chapter 3, R.E. 2002.

Constitution which requires the Government of Tanzania to enact legislation for the purposes of regulating procedure for instituting proceedings pursuant to Article 30(4); specify the powers of the High Court in relation to the hearing of proceedings instituted pursuant to this Article; and lastly to ensure the effective exercise of the powers of the High Court, the preservation and enforcement of the rights, freedoms and duties in accordance with Tanzania's constitution.

Retired Chief Justice Mohammed Othman Chande on 26th May 2014 promulgated Basic Rights and Duties Enforcement Rules.⁴⁶ These rules apply to all proceedings under the Basic Rights and Duties Enforcement Act⁴⁷ with a view to advancing and realizing the basic rights and duties contained in the constitution.⁴⁸

Prior to enactment of the Rules, the Act, did not bring about clear rules of procedure and practice in the high court pertaining to cases of violation of the Bill of Rights. This omission resulted to a number of challenges which necessitated promulgation of the Basic Rights and Enforcement (Practice and Procedure) Rules (the Rules) in 2014. Generally, these rules are progressive in the sense that they provide clear rules of procedure and practice on the enforcement of the Bill of Rights, distinct from the rules applicable in other civil proceedings.

The first way of accessing to the court is whereby an aggrieved individual files a petition by way of originating summons and a rejoinder (if any) after serving the petition to the respondents. The High court then determines the competence of the petition and thereafter requests both parties to file their written submission and then proceed to hearing the petition and thereafter issues out a judgment.

The second way of getting access to the High Court is by the way of proceedings for the enforcement of Human Rights through reference by a Subordinate Court. This is takes place where a question concerning a breach of any basic right or fundamental freedom arises in any proceedings before a subordinate court. Rule 10 (2) of the Rules expressly provides that a District Court or a Resident Magistrate Court may determine human rights cases upon reference to it from a Primary Court.

Locus Standi

Any individual or aggrieved person has a *locus standi* in front of the High Court. Now days even a civil society organization or a legal corporate body has *locus standi* to institute a human rights case on behalf of individuals. They have such *locus standi* by virtue of Article 30(3) of the Constitution which entitles a person who alleges that a basic right is being or is likely to be contravened to institute proceedings for relief together with Article 26 (2) of the Constitution allows a legal person to institute proceedings read together with the Interpretation of Laws Act, Cap 1 R.E. 2002.

Locus standi for both individuals and legal persons was extensively discussed by Lugakingira, J. (as he then was) in *Rev. Christopher Mtikila v A.G. (1993)* and also in a recent case of *Legal and Human Rights Centre and Others v. A.G.* whereby Kimaro, J. (as she then was) pointed out that:

It is not true as submitted by the learned State Attorney that natural persons only can bring (cases of) violations against Human rights to court. There is nothing in Article 30 which confines the definition of a person to natural persons (only). As correctly submitted by the learned Advocates for the petitioners the definition of the term person in the interpretation of Law Act⁴⁹ includes corporate bodies like the petitioners.⁵⁰

In this matter, the High Court held that juristic persons, like the three petitioning NGOs have *locus standi* to bring an action in a court of law against violation of human rights. Therefore, the High Court agreed with the view of Justice Lugakingira in *Rev. Mtikila v. A.G* and expanded the principle of *Locus standi* in public interest litigation.

The same issue arose in the case of *Julius Ishengoma Francis Ndyababo vs. The Attorney General*⁵¹ where the court of Appeal which is the highest court organ in the country equally discussed it at length and held that:

In appropriate case a juristic person might complain before the High Court of a violation of the equality before the law.

In general, the courts are no longer insisting on legalistic requirement of proof of *locus standi*. They only need properly

⁴⁶ These Rules were published in the Gazette of the United Republic of Tanzania No. 35 Volume 95 (Supplement No. 34) dated 29th August, 2014

⁴⁷ Ibid Rule 2(1)

⁴⁸ Ibid Rule 2 (2)

⁴⁹ Chapter 1 R.E. 2002

⁵⁰ Pg 10 of the typed judgment.

⁵¹ Court of Appeal of Tanzania at Dar es Salaam, Civil Appeal No. 64 of 2001 (Samatta, C.J.; Kisanga, J.A. (as he then was); and the Late Lugakingira, J.A.)

drafted documents in order to proceed with the legal matter.⁵² The decision can be interpreted to mean and include existence of Class Action Mechanism in Tanzania.

The class action mechanism is especially important in lower- and middle-income countries because it can facilitate access to justice for those who would otherwise be excluded by virtue of poverty and inequality. It has even further importance in the TB context because civil claims for TB infection are typically not of sufficiently high independent value to justify the expense and effort of seeking redress through courts, it is only when claims are aggregated that seeking justice is financially viable.

Case Law Analysis on Access to Justice

In the case of *Julius Ishengoma Francis Ndyarabo vs. The Attorney General*⁵³ the court of Appeal was confronted with a law alleged to be discriminatory and unreasonable. At the centre of controversy was the constitutionality of Section 111 (2), (3) and (4) of the Election Act, 1985 as amended by the Electoral Laws (Miscellaneous Amendments) Act, 2001. The offensive provision provides:

(2) The Registrar shall not fix a date for hearing of any election petition unless the petitioner has paid into the court, as a security for costs, a sum of five million shillings in respect of the proposed election petition.

The Appellant who is an advocate with a practice in the largest commercial city of Tanzania – Dar es Salaam, being aggrieved by the above quoted provision of the law challenged the constitutionality of that requirement. His case was based on Article 13 of the Constitution which is within the Bill of Rights and his petition was subjected to a panel of three judges as per requirements of the Basic Rights and Duties Enforcement Act, 1994.⁵⁴ Two judges found nothing wrong with the challenged provision of the law.⁵⁵ Dissenting Kimaro, J. found the contested provision of the law being violative of the constitution. The petitioner was not satisfied and appealed to the court of Appeal, the highest court in Tanzania. The Court of Appeal in its celebrated judgment agreed with the minority and dissenting opinion and declared the requirement of deposit of Shs. 5,000,000/- by a petitioner before his case could be reviewed and given hearing date was unconstitutional.

This important decision by the highest judicial organ in the country is an important contribution of the development of

Human Rights including rights of TB Patients in Tanzania and has contributed to peoples' confidence in the Judiciary⁵⁶.

Problematic areas in Access to Justice in Tanzania

Despite the above indicated positive contribution to law and procedure made by the Courts of law in Tanzania in offering judicial protection of Human rights, there are challenges and legal huddles that a petitioner or any person seeking relief in courts of law for violation of the constitution will face. These challenges include: the use and application by both the government and the court itself of legal technicalities in delaying or denying justice, delays in case determination; costs involved in litigation, existence of technical procedural rules, the requirement of a three judge sitting panel⁵⁷; existence of 'saving clause' contained in Article 30 (2) of the Constitution, and the use of the Parliament to pre-empt court decisions in favour of Human rights. These obstacles may prevent people affected with TB or civil societies working with people affected with TB from fully exercising their rights, even when the law is on their side.

Another problematic area in access to justice especially by TB patients is on lack of legal and civic education in general, poverty and language of courts law amongst TB patients and the community at large. This indicates that accessing the law for the poor and illiterate is a nightmare. It is the sacred duty of the court system in Tanzania and development partners in general to ensure that it removes this barrier to access to justice.

Despite the problematic areas in Access to Justice in Tanzania, there is no doubt that there are opportunities to be utilised by the courts of law to promote justice, rule of law and human rights.

Causation in the Law of Tort in Tanzania

TB presents special issues in regard to the law of causation in civil claims. This is due to the difficulty in isolating causal factors attributable to wrongfulness or negligence and those consistent with conduct to which liability should not attach.

Basically, the meaning and main functions of Tort Law in Tanzania in relation to TB prevention, care and Treatment include deterrence and accident prevention of spread of TB; financial responsibility to a person who wrongfully causes accidents thereby encouraging safe behavior. This includes compensation to the concerned victims and their families to enable them to recover past, present and future expenses especially considering the economic burden facing people affected by TB. Its basic aim is to ensure fairness, especially to the economically under

⁵² Peter, C.M., Human Rights in Tanzania: Selected Cases and Materials, op cit, p.663

⁵³ Court of Appeal of Tanzania at Dar es Salaam, Civil Appeal No. 64 of 2001.

⁵⁴ Act No. 33 of 1994.

⁵⁵ The Majority of the Court – the late Kyando, J. and IHEMA, J. found nothing wrong with the challenged provision of the law.

⁵⁶ Peter, C.M., & Kijo-Bisimba, H., (Eds) Law & Justice in Tanzania: Quarter of a Century of the Court of Appeal, 92007) Mkuki na Nyota Publishers, DSM, at pg.243

⁵⁷ Section 10 of the Basic Rights and Duties Enforcement Act, 1994.

privileged. The law of tort enables person with TB access to courts of law to claim for redress and compensation. The tort legal regime in Tanzania though is not efficient, allows and provides standards to the community for instituting tort claims, and also, provides guidance to lawyers and juries and lay people on how to file tort claims.

The causation in the law of tort in Tanzania requires a connection between defendant's negligence and plaintiff's injuries, and secondly, proof of whether the Defendant's conduct was the contributing factor, without which the injury would not have occurred; and thirdly, the But-For Test and substantially factor test⁵⁸ will also be a considerable factor in determination of causation. Proof of Causation in Tanzanian law of tort includes cumulating Proof to Identify the Cause, and use of Eyewitnesses, Circumstantial Evidence, Expert testimony.

Persons with TB present special issues in regard to the law of causation in civil claims. This is due to the difficulty in isolating causal factors attributable to wrongfulness or negligence and those consistent with conduct to which liability should not attach.

There are no rich court cases and court decisions in relation to negligence of medical professionals especially on TB cases. However, the case of *Medical Officer – in-charge, Mkinga Hospital v. Theodolina Alphaxed*, Civil Appeal Number 49 of 1992 (unreported) and *Theodelina Alphaxad a minor s/t next friend v The Medical Officer i/c, Mkinga Hospital* (1992) TLR, 235 can serve as an important reference on applicability of the law of Tort in Tanzanian legal context.

Case Analysis on Causation in the Law of Tort in Tanzania

In the case of recent decision of Sisti Marishay (suing as next Friend of Emmanuel Didas) versus the board of Trustee – Muhimbili Orthopedic Institute (MOI), Permanent Secretary Ministry of Health and Social Welfare and the Attorneys General, Justice Muruke discusses the law of tort arising from medical negligence. Briefly, the facts of the case are that; Emmanuel Didas (the victim) was mentally and physically incapacitated as a result of the negligence of the medical practitioners of the 1st Defendant Muhimbili Orthopedic Institute commonly known as MOI. Emmanuel was involved in a road accident which resulted to his leg to suffer broken muscled tendon of his patella and therefore was scheduled for operation of swollen knee to remove

blood clot. On 1st November, 2007 Emmanuel was operated on the head instead of the leg following 1st Defendant nurse mixing files for Emmanuel Didas with another patient Emmanuel Mgaya. The latter was to be operated on his head but was operated on his leg. Following this professional negligence the 1st and 2nd Defendants issued a press statement over the negligence and assure Emanuel Relatives of treatment, and both patients were subsequently referred to India for further treatment. After treatment, Emmanuel Mgaya died and Emmanuel Didas remained in MOI for treatment and physiotherapy, until 2009 when he was discharged. The efforts to settle the matter amicably failed; thereby the plaintiff instituted the tort suit.

The main issues of contention in this case were three (3) namely: whether there was professional negligence on the part of 1st Defendant as against the Plaintiff; whether the plaintiff suffered injuries as a result of 1st Defendant's negligence; and the third and last issue was whether the plaintiff was entitled to compensation and damages.

In his judgment, Honorable Justice Muruke held that there was professional negligence on the first defendant (MOI) officers who exchanged the files of the victim with another patient. The Court held that there was negligence on the part of MOI in the course of treating the victim. The Court further held that the victim had serious health problems as a result of the wrong and uncalled for operation on his head. The Court observed that the victim was speaking with difficulties, could not connect long sentences, could not speak fluently for more than 30 seconds, could not sit upright, his right side was paralyzed, left leg leaping due to delayed operation and he was in an unbalanced position. Consequently, the Court adjudged the victim to be entitled to both pecuniary and non-pecuniary damages. In awarding damages, the Court considered several factors to wit that MOI incurred all medical costs, the victim's impaired health, and victim's inability to do any work. Th court entered judgment in favour of the plaintiff and found the hospital liable for professional negligence.

What this means

The Judgment also creates a precedent for citizens who are victims of professional (medical) negligence and medical malpractices to seek remedies before Courts of law. This also includes people with TB. It is high time now for victims of any medical negligence or malpractice to challenge such conducts in Courts of laws to bring better efficiencies in Tanzania's health care system.

For lawyers, the judgment demonstrates that the area of medical negligence and medical malpractices is unexplored. Also the non-joinder of doctors and nurses is a missed opportunity to

58 This means and include where two actors independently and simultaneously act negligently towards a plaintiff and the negligent act of either one alone was sufficient to cause the injury, the but for test is under inclusive; it

would excuse both actors.

examine and interrogate the duty of care and standard of care that should be imposed on medical professionals in Tanzania.

While the judgment reinforces the doctrine of vicarious liability, meaning that the damages will be paid by the employer, the non-joinder of doctors and nurses creates a window of opportunity for doctors/nurses to act as they please, although the judgment sends a clear message. To ensure professional agility, as is the case in other jurisdictions, some liability should have been borne personally by the professionals themselves.

To the medical fraternity in Tanzania, this is a wake-up call; the medical profession requires the highest degree of care one can think of. Doctors and nurses must adhere to the professional code of conduct or else could in the future be sued for professional negligence.

Legislation

Customary and Islamic laws also apply in Tanzania: customary laws should only be applied when they do not conflict with statutory laws, including the constitution, and Islamic law is applicable to communities that generally follow Islamic law in matters of personal status and inheritance.

The Basic Right and Duties Enforcement Act

This Act was enacted in accordance with Article 30 (4) of the Constitution which requires the Government of Tanzania to enact legislation for the purposes of regulating procedure for instituting proceedings pursuant to Article 30(4); specify the powers of the High Court in relation to the Hearing of proceedings instituted pursuant to this Article; and lastly to ensure the effective exercise of the powers of the High Court, the preservation and enforcement of the rights, freedoms and duties in accordance with Tanzania's Constitution. Basically this Act read together with its rules, provides for the manner on how an individual or legal person can access the courts of law for relief when his or her basic human rights have been infringed or are in the process of being infringed.

However, the Basic Right and Duties Enforcement Act was made specifically to enforce basic rights provided in the Constitution of United Republic of Tanzania, right to health is not enshrined in the current Constitution including the right to TB medication. Therefore, indirectly the right to health can be justifiable under the right to life but there is a need to put in place the right to health to effect TB treatment and medication in Tanzania.

The Public Health Act, 2009

This Act provides for the promotion, preservation and maintenance of public health with a view to ensuring the

provisions of comprehensive, functional and sustainable public health services to the general public and to provide for other related matters. The Act provides a duty to every parent or guardian of a child born in Mainland Tanzania shall, within twelve months from birth, cause that child to be immunized against polio, tuberculosis, diphtheria, pertussis, tetanus, measles, hepatitis "B" and any other immunizable diseases which may be prescribed by the Minister in the Gazette⁵⁹.

The Act however does not establish a right to confidentiality for health system users. The Act does not mention informed consent, except in the context of participation in medical research and blood and tissue removal. This law governs communicable diseases, isolation and offences penalties for communicable diseases. Also these provisions require patients who are suffering from a notifiable disease including TB to report immediately to the nearest authority for next steps⁶⁰.

The most challenging area of this particular piece of legislation is discussed in length herein below. Part (a) of Part III of the Act is on Notification of infectious or communicable and non – communicable diseases and Isolation of Infected persons and contains Section 9 – 13; whereas Part (b) of Part III is on Prevention and Control of the Spread of infectious or communicable Diseases and contains Section 14 – 18. We recommend that Section 9 – 16 of the Public Health Act, 2009⁶¹ be repealed or amended. This particular Section provide for the coercive measures to control TB as well as notification procedures for TB. For example, we specifically recommend Section 16 of the Act which broadly criminalizes TB and other infectious diseases should be repealed for it is inconsistent with Human rights Standards and the right to quality and affordable healthcare and health services. It may be easiest to repeal these sections and replace them with a provision granting to the Minister power to make regulations governing notifiable conditions and coercive measures. This is the approach that has been adopted by many countries, including the most recently South Africa.⁶² The advantage of this approach is that Schedules and procedures are easier to change to align to developments in the relevant diseases and the science and treatment related to them. We further advise that an interim procedure be put into place during the period the Legal framework is being developed. While such a procedure is not ideal in the long term, it would provide at least a measure of guidance and due process in the interim.

59 . Section 19(1) of the Public Health Act, 2009

60 . Sections 9,10,12, and 16 of the Public Health Act, 2009

61 Part (a) of Part III of the Act is on Notification of infectious or communicable and non – communicable diseases and Isolation of Infected persons and contains Section 9 – 13; whereas Part (b) of Part III is on Prevention and Control of the Spread of infectious or communicable Diseases and contains Section 14 – 18.

62 Regulations Relating to the Surveillance and the Control of Notifiable Medical Conditions, No. 41330 GG 1434, 15 December, 2017.

Basically the Application of Section 16 of the act together with other coercive measures relating to TB and other notifiable diseases necessarily triggers due process rights, especially when it comes to deprivation of liberty and freedom of movement. Article 15 (2) of the Constitution of the United Republic of Tanzania⁶³ provides for and ensures the right of Due process and right of personal freedom and liberty. We therefore suggest that express guarantee of the right to legal counsel attach to the application of any coercive measures. This is because, ideally deprivation of liberty is often at issue, legal representation at state expense should be guaranteed.

Nevertheless, the law does not provide any measure in case a TB patient intentionally refuses to attend treatment and medication.

The Drugs Control and Enforcement Act No. 5 of 2015

The law inter alia provides for the establishment of an authority for control and combating drugs, whereby among its obligations, is to take measures for preventing drug abuse by making identification, treatment, education, after care, rehabilitation and social integration of drug addicts⁶⁴. However, the Act does not specifically provide for diagnosis and screening drug user. In this circumstance the need rise to have specific law on TB control and prevention.

Penal Code, Cap 16

The Tanzania Penal Code allows Tanzanians to file a criminal complaint against a physician or health care worker who commits a rash or negligent act causing death. Chapter XXIV of the Penal Code talks of Criminal recklessness and negligence.

Section 195 (2) of the Code discussing on Manslaughter states that *“An unlawful omission is an omission amounting to culpable negligence to discharge a duty tending to the preservation of life or health, whether the omission is or is not accompanied by an intention to cause death or bodily harm.”* The complainant has the burden of proof to show that the medical doctor or health officer was grossly negligent. The code thus allows citizens to legal recourse against negligent medical doctors and health officers who acts rashly or negligently and thereby causes death of a TB patient.

This law provides for Penal Offences. Part XV of the Act enacts provisions for offences against morality including rape, sexual exploitation of children, grave sexual abuse, sexual harassment, procurement for prostitution, conspiracy to induce unlawful sexual intercourse, woman living on, or aiding, prostitution, etc.

Some of these offences leave victims without medical diagnosis on TB/HIV-AIDS. On top of that, taking into consideration over the gap raised over the law the need to have specific legislation governing Tuberculosis diseases is potential one. It is an open truth the Police force and law enforcement agencies have been using this law to prevent or delay TB testing, treatment and care in the pretext of the persons suffering from TB have committed certain crime. As such, victims of crime are often vulnerable to TB and require access to TB services. We recommend a specific addition to this law with regards to victims of crime vulnerable to TB.

The Employment and Labour Relations Act No. 6 of 2004

The Act provides for labour rights, it establishes basic employment standards, prevention and settlement of disputes and for other related matters.

The Act provides that an employee is entitled to a total of at least 126 days in a leave cycle of 36 months.⁶⁵ In the first phase the law requires the employer to pay a sick employee his full salary for a period of up to 63 days. In the second phase which also consists of 63 days, the amount drops to a half and the employer is not bound to pay the genuinely ill employee more than half the employee's normal salary.⁶⁶

However, the law does not restrict employers unjustifiably to terminate the employment of a person who suffers TB and extend the time for an employee who suffer the same in the course of his/her employment.

The HIV and AIDS (Prevention and Control) Act No. 28 of 2008

Among other things the law provides for prevention, treatment, care, support and control of HIV and AIDS, promotion of public health in relation to HIV and AIDS, to provide for appropriate treatment, care and support using available resources to people living with or at risk of HIV and AIDS and for other related matters. This law protects vulnerable population.

The law insists on the care, support and prohibition of stigma to people living with HIV and AIDS. Nevertheless, the law does not provide the same to people affected from TB.

63 The Constitution of United Republic of Tanzania , 1977, 2008 Edition

64 See Section 10(2)(c) of the Drugs Control and Enforcement Act No. 5 of 2015

65 See Section 32 910 and 30 (1) (b) (ii) of ELRA, 2004

66 See Section 32 (2) of ELRA, 2004

The Anti-Trafficking in Persons Act No. 6 of 2008

At the level of analysis in Tanzania we didn't have that statute until in 2008 whereby we adopted it from International convention. This is relevant for prohibition of trafficking in persons in Tanzania. It is enacted as a drive to comprehensive fight against human trafficking. The Act is relevant to TB as it prohibited the tracking of severe trafficking in person as provided under Section 6(2) (h) of the Act number 6 of 2008, thus a person with TB fall in the ambit of this section. The law also recognize rule of confidentiality and right of privacy of the trafficked person, as it binds the medical officers, enforcement organs, judges and court personnel to recognize right of privacy of trafficked person as provided under Section 9 of the Act

The Act defines traffickers in persons as anyone who recruits, transports, confines, provides or receives a person by any means including under the pretext of domestic or overseas employment, training or apprenticeship, for purposes of prostitution, pornography, sexual exploitation, forced labour, slavery, involuntary servitude or debt bondage.

It provides for the social rehabilitation of rescued victims of trafficking to be carried out by social welfare officers for the purpose of re-instating the victims back into normal way of life, and may include, among others, material assistance, psychological, medical and professional rehabilitation, employment and dwelling place.

The Immigration Act Cap 54

This is an Act to provide for the control of immigration into the United Republic and for matters relating to immigration. Tanzania also harbors migrants who are passing through while enroute to South Africa and other parts of the world. This Act is relevant in TB for prohibiting entry in Tanzania when one is diagnosed with a Communicable disease as provided under Section 10(c)(ii) that person will be treated as prohibited migrants. It also establishes offence of a prohibited migrant's failure to comply with lawful requirement of the director of Immigration to leave Tanzania.

Section 10 of the Immigration Act prohibits immigration of persons "suffering from a contagious or infect [ious] disease which makes or which would make his presence in Tanzania dangerous to the public." This provision has potential for broad application and a prohibition of immigration status on the basis of TB or HIV status would be discriminatory and stigmatizing. We recommend repeal or amendment of this particular provision to provide for the provision of TB diagnosis, treatment and other services to migrants who, under the current law, might be deemed prohibited migrants. The law as it stands disincentives healthcare seeking behavior amongst migrant populations that ought to be encouraged.

The Refugee Act, Cap 37

This Act makes provision for the manner asylum seekers and refugee situations may be administered in Tanzania. It is relevant in dealing with case of TB for asylum seekers and refugees do fall sick of TB. This act however, is strictly scoped at protection of refugees. A refugee is defined as a person who are outside their countries of origin or permanent resident because has or had a well founded fear of persecution by reason of race, religion, nationality membership of a particular social group or political opinion and is unable or, because of such fear is unwilling to avail himself of the protection of the government of the country of his nationality or permanent residence.⁶⁷

At the level of analysis the statute only provides section for control of designated area by empowering the Director or settlement officer to give orders and directions, orally or in writing manner to ensure that all proper precautions are taken to preserve the health and wellbeing of the asylum seekers or refugees as provided under Section 18(2) (c) of the Refugee Act Cap 37.

Also the laws empowers the Minister or a competent authority appointed by the Minister on that behalf may at any time order in writing that a refugee who is dangerous to the security of the state to be deported from Tanzania. it should be noted that the word security does not mean peace and security but even health affairs, thus once a refugee detected has common disease which threat health of Tanzanian shall be deported because makes the health or life of others in-secured. TB status should not be considered a danger to the security of the state and deportation of refugees on the basis of TB status should be prohibited.

Section 28 (l) (a) (ii) of the Refugee Act, 1998 provides for the deportation of a refugee who is "dangerous to the security of the state." An interpretation that TB represents a danger to the "security of the state" in the context of this provision, and thus should lead to deportation, is contrary to public health interests and international law—such an interpretation would likely lead to severe human rights abuses and public health consequences. The response best aligned to human rights and public health interests to TB amongst refugees and all mobile populations is not deportation but rather the provision of access to healthcare services.

The Criminal Procedure Act, Cap 20 of 1985

This specific Law governs criminal justice procedures including arrest, investigation, release and police bail, the initiation and

⁶⁷ See Section 4 of the Refugee Act, Cap 37

conduct of criminal proceedings, convictions, judgments and the execution of sentences. It contains a very limited number of provisions that specifically apply to Tuberculosis. Only one provision of the Criminal Procedure Act 1985 (relating to the protection of privacy of offenders during trials) and also in relation to speed tracking cases of people affected of communicable diseases such as TB.

This piece of law empowers magistrates during mitigation to reduce a gravity of sentence once accused pleads has common disease; however it depends with the nature of offence. The Act however, is silent on how magistrates should treat person with TB during the trial. Thus magistrates have developed different practice when dealing with accused who are suffering from TB during trial.

The Prisons Act, Cap 58

This is an Act to consolidate and amend the Law relating to Prisons, and to provide for the Organization, Discipline, Powers and Duties of Prison Officers, and for matters incidental thereto and connected therewith. This Act provides for the establishment of medical officers in all prison and also it empowers the medical officers whether with or without a prisoner consents to take action such as forcible feeding, inoculation, vaccination and any other treatment of the prisoner as they shall consider necessary to protect the health of other prisoner and to prevent the spread of disease. Also the law allows medical officer to examine the health status of a prisoner before or immediately after admission as provided under section 20 and 21 of the Act.

Subject to what has been provided in the preceding paragraphs and to the provision of the law, all circumstances enumerated thereof makes TB screening as of very significant especially in rehabilitation of those trafficked persons in terms of material assistance, psychological, medical and professional rehabilitation, employment and dwelling houses. However, the law does not extensively provide for the functions, duties and regulation to medical practitioner in performing these significant duties.

The Prisons Act, 1967 requires drastic amendment to address issues such as overcrowding; ventilation; nutrition, access to diagnosis, treatment and other healthcare services; record keeping and reporting; and other matters. At a broad level, the Act needs to be aligned to the United Nations Standard Minimum Rules for the Treatment of Prisoners (the “Nelson Mandela Rules”).

We also highly recommend that subjects and issues that should be addressed in law include regulation of the space to which

a detained person is entitled, which would then translate to maximum occupancy levels; prohibition against overcrowding and mechanisms for preventing it; regulation of adequate ventilation and nutrition; guarantee of the right of detained people to organize for the purpose of health support networks as well as to hold to account prison officials for the fulfillment of health rights; improved oversight in detention centers; continuity of care upon entering and exiting facilities as well as upon transfer between facilities or to and from court; and improved access to treatment and diagnosis in detention centers.

At a broad level, we suggest and recommend that alignment of the Prisons Act, or regulations there under, to the United Nations Standard Minimum Rules for the Treatment of Prisoners

Community Service Act, Cap 291

The use of the Community Services Act has assisted to decongest, with those prisoners who qualify, i.e. those that serving terms of 3 years and below. Section 3 of the Act it provides condition for the offender entitled to community service order, those person who convicted to prison for a term not exceeding three years with or without option of fine and its limitation even if that offender convicted for the term exceeding three years with or without the option of fine the Court may, subject to this Act, make a community service order requiring the offender to perform community service. Therefore from this Act does mean that once an offender pleads has TB during the mitigation, the Court can make sentence such offender to Community Service.

The Legal Aid Act, 2017

This is an Act to regulate and coordinate the provision of legal aid services to indigent persons, to recognize paralegals, and also to repeal the Legal Aid (Criminal Proceedings) Act and also to provide for other related matters. Tanzania allows legal aid institutions to offer legal aid to the people of Tanzania especially those in needy and the poor. This Act establishes a legal aid service for civil, criminal, constitutional and matters of public interest. Legal Aid institutions could play a critical role in protecting and promoting human rights in the context of TB. It is unfortunate most of the legal aid institutions are facing challenges on financial and human resources challenges thereby making them hard to operate. Government interventions at times do pose a challenge to the smooth provision of legal aid. We therefore recommend the government to increase funding for legal aid services and expand access to available services. Further, the government should increase targeted legal support services for people living with TB and ensure that lawyers and paralegals have been appropriately trained to offer legal advice and representation to these groups.

Intellectual Property laws in Tanzania

In Tanzania (Known as Tanganyika before Independence) Intellectual Property rights aspects was introduced by colonial administration, and this was in 1922 through Chapter 217 of the Patent Legislation and the introduction of Trade Marks and 1924 through “Chapter 218 of the Copyright Legislation”⁶⁸. To date, this legal regime in Tanzania is governed by three laws: The Copyright and Neighboring Rights Act 1999, Act No. 7 of 1999; the Trade and Service Marks Act, ct No. 12 of 1986; and

Patent (Registration) Act, Cap 217 R.E. 2002. The Copyright and Neighboring Rights Act 1999 provides for registration of copyrights in Tanzania and remedies in case of copyright infringement.

This LEA stresses the point that protection of intellectual property does the following: Encourages and reward creativity; gives the incentive and means to finance research and development (R & D) activities; stimulates and ensures fair competition among producers; protects consumers (TB Patients) by enabling them to make informed choices; and, facilitates the transfer of technology in the form of foreign direct investment (FDI), joint ventures and licensing.

In 2001, World Trade Organization (WTO) members drew up the Doha Declaration to clarify ambiguities between the need for governments to apply the principles of public health and the terms of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). In particular, concerns had been growing that patent rules might restrict access to affordable medicines for populations in developing countries in their efforts to control diseases of public health importance, such as HIV, tuberculosis and malaria.

Tanzania has to a considerable extent established and put into place legal regime for TRIPS flexibilities in issues including compulsory licensing, parallel importation, pre- and post-patent application challenges, the definition of patentable subject matter (Article 27 of TRIPS allows for members to define the application of criteria for patentability), public non-commercial use, and exclusions from patentability such as research and experimental use). Trade-Related Aspects of Intellectual Property Rights (TRIPS) establishes minimum standards for a set of intellectual property rights that WTO members institute through national legislation. The legal regime of Intellectual Property law comprise: The Copyright and Neighboring Rights Act 1999, Act No. 7 of 1999; The Trade and Service Marks Act, ct No. 12 of 1986; and The Patent (Registration) Act, Cap 217 R.E. 2002. The Copyright and Neighboring Rights Act 1999. The

Competition and Consumer legal regime consist of: The Energy and Water Utilities Regulatory Authority Act, 2001 (EWURA), The Surface and Marine Transport Regulatory Act, 2001 (SUMATRA), Tanzania Civil Aviation Regulatory Authority Act, 2003 (TCAA), the Tanzania Communications Regulatory Authority Act, 2003 (TCRA) and The Fair Competition Act, 2003 (FCC).

Patent (Registration) Act, Cap 217 R.E. 2002

A brief discussion of the Act is hereby discussed. The patents that are protected in Tanzania under this Act are patents of inventions and **utility models**. Furthermore it may be registered for inventions “*other than a discovery, scientific theory, mathematical method, aesthetic creation, computer program or presentation of information) meeting specified requirements relating to novelty, utility and inventiveness*”. The registered patents last for 20 years, subject to the payment of annual fees, while **utility models** last for seven (7) years. Invention is regarded as new if it is not anticipated by prior art, however utility model “*must not form part of the state of the art, that is to say, not made available to the public by means of a written description anywhere in the world or by public use in Tanzania before the filing or priority date*”⁶⁹. In relation to this, the patent granted by ARIPO designating Tanzania is allowed to be protected once the Patent office is notified. Since Tanzania has endorsed the PCT, thus patent granted by through PCT designating Tanzania also qualify to be protected. According to BRELA, 2005 “*The time limit for entering national phase for PCT patents is 21 months from priority date and the time limit for filing translation is 31 months from priority date.*”

Section 19 of the Act is on application for registration of a patent, and the Applicant can be a normal person. Though the law is silent on whether an institution or body corporate can apply for registration of a patent, interpretation of the word ‘person’ can mean and include such institutions or body corporate. Section 18 of the Act is on contents of the Application of Patent to the Registrar.

Section 54 of the Act is on powers of the Minister to grant Compulsory License of Products and Services of vital importance on Public health. Section 55 of the Act provides for Preconditions to grant of compulsory license of products and services of vital importance on public Health including TB. Basically these conditions are manageable and easily - (a) satisfies the court that he has asked the owner of the patent for a lisory contractual license but has been unable to obtain such a license on reasonable terms and within a reasonable time, and

68 See WIPO/SMEs/DAR/05/2

69 See WIPO/SMEs/DAR/05/2 for more clarification

censes.

A patent may be registered for inventions (other than a discovery, scientific theory, mathematical method, aesthetic creation, computer program or presentation of information) after meeting specified requirements relating to novelty, utility and inventiveness.⁷⁰ There is no local system for registration of designs in Tanzania. However, Tanzania has ratified the Agreement on the Creation of the African Regional Industrial Property Organization, 1979 (effective for Tanzania as from 12 October 1983); and the Protocol on Patent and Industrial Designs within the Framework of African Region Industrial Property Organization (the Harare Protocol), 1982 (effective for Tanzania as from 01 September 1999). It is worth noting that Tanzania is a member of the African Regional Intellectual property Organization (ARIPO) and the World Intellectual Property Organization (WIPO).⁷¹ It is also worthy important to note that there is national system for registration of designs. We are advising the minister who has mandate under this law to draft and put into place regulations that will facilitate and ease or clarify the implications of registration of designs in terms of access to diagnostic tools and TB medicines, including MDR and XDR-TB medicines.

Trade mark is governed by the Trade and Service Marks Act No. 12 of 1986.

As explained above Tanzania ratified a number of conventions. In addition to that, Tanzania ratified Nice Agreement Concerning the International Classification of Goods and Services for the Purposes of the Registration of Marks (Nice Union) 1957–1977.⁷² Trade mark is registered for a period of seven years (7) and it can be renewed for period of ten years (10) in time without end while unregistered trademarks are also “offered protection under common law provided that it can be shown that the proprietor has established goodwill associated with its mark”. Tanzanian Trademark Office is responsible for filing trademark applications and in this case BRELA is responsible for this, however at the moment it is not possible to make online filing. According to BRELA, unpublished document, 2007) “the rights granted after registration dates back to the date of filing of the application”, furthermore “trademarks are allotted goods or services for which the mark will be used. As pointed out, both Tanzania apply International Classification of Goods and Services (Nice Classification)”.

As in the case of Patents, a registered trademark by ARIPO is

also protected in Tanzania, there is two ways in which application for mark can be made; one is to file direct at the ARIPO Office in Harare, Zimbabwe or via the Tanzanian Trademark Office. “In both cases, the filing date is the date of receipt of the application in that respective Office. The application may be filed by the applicant or her/his authorized representative. The duration of registration of a mark at ARIPO is ten years (10) from the date of registration. A mark is registered as of the date of filing of the application for registration, and such date is deemed for all purposes to be the date of registration” (MITM, 2006). The challenges of this particular Act are that it does not provide total and full protection on intellectual property rights over TB drugs. The Act does not fully stimulate and ensure protection of TB Patients by enabling them to make informed choices. The Act further does not facilitate the transfer of Technology.

Competition Law Regime in Tanzania

Tanzania has into place a legal regime that prevents anti-competitive practices and may impact access to medicines. In Tanzania the competition laws is guided by the following Acts: The Energy and Water Utilities Regulatory Authority Act, 2001 (EWURA), The Surface and Marine Transport Regulatory Act, 2001 (SUMATRA), Tanzania Civil Aviation Regulatory Authority Act, 2003 (TCAA), the Tanzania Communications Regulatory Authority Act, 2003 (TCRA) and The Fair Competition Act, 2003 (FCC). However with this entire Acts, the main Act that regulates unfair competition in Tanzania is Fair Competition Act, 2003. Section 5(6) of FCC, 2003 stipulates clearly “a person is regarded to have a dominant position in a market if acting alone, can profitably and materially restrain or reduce competition in that market for a significant period of time and that person’s share of the relevant market exceeds 35 per cent.” Furthermore, Section 10 of the Fair Competition Act, 2003, prohibits a person with a dominant position in a market to use his position of dominance with the object, effect or likely effect of appreciably preventing, restricting or distorting competition”.(FCC Act, 2003).

The Fair Commission Act, 2003

The competition and consumer protection law/policy are administered under one roof, which is the Fair Competition Commission of Tanzania. The Fair Competition Commission is an independent government body established under the Fair Competition Act, 2003(No. 8 of 2003) to promote and protect effective competition in trade and commerce and to protect consumers from unfair and misleading market conduct. The Fair Competition Act, which came into force through Government Notice No 150 of May, 2004 contains both competition and consumer protection provisions. This connotes a dual mandate to the Fair Competition Commission (integrated model of institutional set up).Something worthy to applause

⁷⁰ See Sections 14 and 38 of Patent (Registration) Act, Cap 217 R.E. 2002.

⁷¹ See www.wipo.int/members/en

⁷² effective for Tanzania as from 14 September 1999

on this particular Act is its consideration and adoption of best International practices including principles found in UNCTAD Model law.⁷³

As far as consumer protection is concerned, the Act has incorporated universal consumer rights in its consumer protection sections. Some of these universal consumer rights in the Fair Competition Act, 2003 are highlighted as follows:

- i. Right to choice, Section 9 (2) (b) and (c);
- ii. (ii) Right to be heard, Section 93 (10) (a) and (b);
- iii. (iii) Right to redress, Parts V to VII;
- iv. (iv) Right to be informed, Section 93; and
- v. Right to safety, Parts VIII and IX.

The Constitution of the United Republic of Tanzania, 1977 (Articles 11, 14 and 18), as well as various laws enacted in accordance with the Constitution, do acknowledge existence of consumer rights and obligations, by providing for the rights and obligations of Tanzanian citizen pertaining to access to basic necessities of life. A normal citizen and persons suffering from TB according to interpretation of the above mentioned Articles of the Constitution read together with other laws are guaranteed constitutional rights and obligations in regard to universal consumer rights and obligations. Other laws are, to mention a few for example, The Merchandise Marks Act (1963), as amended; The Standards Act, 1975 (now the Standards Act, 2009) and The Tanzania Food, Drugs and Cosmetics Act, 2003.

The current Legal regime on consumer protection has guaranteed consumers especially TB Patients, need to access, assess and act on information available in order to make informed choices in the market place and ensure prompt prevention, care and treatment. The detriment to consumers can be seen in various ways for instance the information available may be too little or too excessive to the extent of confusing the consumers. It is thus argued that, consumers need to be empowered in order to be able to obtain and evaluate the information available in the market.

Part VIII of the Fair Competition Act provides for product safety and product information. Section 50 prohibits supply of

goods which do not comply with the Standards Act, 1975 (now replaced by Standards Act, 2009). Powers of the minister to declare product safety information standards are provided for under section 51. Whereas section 52 requires the Commission to give copies of certain notices to suppliers or be published in certain newspapers. Part IX of the Act provides for compulsory and voluntary product recall.

Challenges of the Competition Law Regime in Tanzania in relation to TB⁷⁴

The main challenge is the existence of scattered pieces of consumer protection legislation, thereby making enforcement a challenging duty. Emerging issues such as e-commerce, insurance and savings products are regulated by different institutions, hence differences in priority areas. This challenge is further complimented or aggravated by existence of scattered government institutions that administer consumer protection. The other challenge is on the tensions between consumer protection and competition may arise where there is poorly conceived consumer policies, such policies include excessively strict licensing of professions and unduly strict interpretations of misleading marketing regulations which protect incumbents rather than consumers. Another challenge which is largely arising from TB patients is on the characteristically and historically docile nature of TB Patients and Tanzanians and are slow in establishing consumer protection associations. We strongly recommend TB clubs around the country add in the basket of daily advocacy, to become consumer protection associations.

Administrative Policies and Regulations National HIV/AIDS Policy, 2001

The Policy recognizes HIV/AIDS as a major development crisis that affects all affecting people in all walks of life and decimating the most productive segments of the population. Some of the effects of HIV/AIDS are mentioned to be absenteeism from workplaces and deaths, lowering of life expectancy, increasing the dependency ratio, reducing growth in GDP, reduction in productivity, increasing poverty, raising infant and child mortality; and growing numbers of orphans. The epidemic is cited to be a serious threat to the country's social and economic development and that has serious and direct implications on the social services and welfare.⁷⁵

The National HIV Policy of 2001 recognises the importance of rights-based responses to HIV and AIDS. It protects the right

⁷³ To mention a few section(s) of the Act which are in conformity with the Model Law are:- Title of the model law correspondences to section 1 of the Fair Competition Act, 2003; Objectives or purpose of the model law correspondences to section 3 of the Fair Competition Act, 2003; Definitions and scope of applications of the model law correspondences to section 2 of the Fair Competition Act, 2003; Anti competitive agreements correspondences to sections 8 and 9 of the Fair Competition Act.

⁷⁴ This part was highly influenced by views in a paper presented by Martha Kisyonbe, titled "Emerging Issues in Consumer Protection: Complementarities and areas of Tension" in Ad Hoc Expert Meeting on Consumer Protection: The interface between Competition and Consumer policies, Geneva, 12 To 13 July 2012.

⁷⁵ See Chapter 1 of the Policy, p. 2

to voluntary HIV testing with informed consent and provides for access to HIV-related prevention, treatment, care and support services. It makes provision for youth friendly services to provide access to reproductive health information and services in and out of schools, voluntary HIV testing and pre-and-post-test counselling of the parents or guardians of minors and protection for the confidentiality and privacy rights of adolescents.

Therefore the overall goal of the National Policy on HIV/AIDS is to provide for a framework for leadership and coordination of the National multi-sectoral response to the HIV/AIDS epidemic. This includes formulation, by all sectors, of appropriate interventions which will be effective in preventing transmission of HIV/AIDS and other sexually transmitted infections, protecting and supporting vulnerable groups, mitigating the social and economic impact of HIV/AIDS. It also provides for the framework for strengthening the capacity of institutions, communities and individuals in all sectors to arrest the spread of the epidemic. The Policy provides, among others, roles of the various sectors, roles in the prevention, care and support in HIV/AIDS, ethics and principles in HIV counselling and testing, the rights and care of People Living with HIV/AIDS.⁷⁶ However, the policy is silent on TB epidemic, intervention and prevention which mostly goes in hand with HIV/AIDS.

The National Health Policy, 2007

The Policy aims at raising and improving the health status and life expectancy of the people of Tanzania by ensuring delivery of effective, efficient and quality curative, preventive, promotive and rehabilitative health services at all levels through access to quality primary health care for all; access to quality reproductive health service for all individuals of appropriate ages; reduction in infant and maternal mortality rates by three quarters of current levels; universal access to clean and safe water; life expectancy comparable to the level attained by typical middle-income countries, food self-sufficiency and food security; and gender equality and empowerment of women in all health parameters.⁷⁷ TB is one of the diseases that require intervention and prevention under this policy. Despite the fact that there is no specific law the addresses TB issues in Tanzania.

Therefore, in order to achieve objectives under this Policy and expected provision of health services, there is a need of having in place a legal framework that regulate TB services within the health sector.

The Ministry of Health and Social Welfare adopted national

policy guidelines for collaborative TB and HIV activities in 2008.⁷⁸ The policy commits the government to tackle the overlapping epidemics of HIV and TB and to strengthen collaboration between national responses to HIV and TB. The policy does not explicitly mention human rights, but does recognise the need for strong stigma mitigation programmes and promotes the involvements of patients with HIV and TB in the design, implementation and evaluation of collaborative HIV and TB activities.

The Ministry also provided guidance to health care workers about the need for and importance of a patient centred approach to TB and TB treatment in 2005.⁷⁹ The Ministry developed national guidelines for the treatment of children with TB. These guidelines recognise the existence of TB-related stigma and how it can undermine diagnosis and treatment.⁸⁰

Third National Multi-Sectoral Strategic Framework for Mainland Tanzania 2013/14-17/18 (NMSF III)

The Framework aims towards the long term goals of elimination of new HIV infections, deaths from HIV, and HIV-associated stigma and discrimination. The Framework recognizes that while the national average adult HIV prevalence rate has declined over the last ten years, HIV transmission rates among key populations, women, and in certain regions are not being adequately controlled. It also provides that there has not been a significant decline in overall HIV prevalence. The Policy acknowledges also that comprehensive needs of People Living with HIV (PLHIV) in the society are often not being met; stigma and discrimination still prevail; and the coordination of the national response is not resulting in all necessary services being available to those who need them.⁸¹

The outcomes that are to be achieved through implementing the Framework includes increased proportion of eligible PLHIV on care and treatment, increased access and quality of HIV Testing and Counselling elimination of Mother to Child Transmission; increased male and female condom use by men and women during risky sex; elimination of blood borne transmission of HIV; reduced risky behaviour of sexual intercourse among the general, infected, most-at-risk and vulnerable populations; increased prevalence of Voluntary Medical Male Circumcision (VMMC); increased access to services and quality of treatment of Sexually Transmitted Infections (STIs), community Based Care and Support Interventions respond to HIV within their local context; mainstreaming of HIV in sector-specific policies and strategies; and reduction of all HIV and AIDS related stigma and

⁷⁸ Government of Tanzania, National Policy Guidelines for Collaborative TB/HIV Activities, 2008.

⁷⁹ Government of Tanzania, How to Provide Patient Centred TB Treatment, a guide for health workers, 2005

⁸⁰ Government of Tanzania, National Guidelines for the Management of TB in Children, 2012.

⁸¹ See Chapter Two of the Framework

⁷⁶ See Chapter 3 of the Policy, p. 11

⁷⁷ See paragraph 2.1 of the Policy

discrimination.⁸²

HIV/AIDS crosses all fields of practice, including mental health, addictions, community development, and health care. The Framework is silent on elimination of transmission of TB which goes in hand with HIV/AIDS in Tanzania.

The Tanzania Commission for AIDS adopted a Comprehensive National Multi-sectoral HIV and AIDS Stigma and Discrimination Reduction Strategy in December 2013. The strategy was developed to assist all stakeholders to effectively address HIV-related stigma and discrimination.

National Comprehensive Guidelines for HIV/AIDS Testing and Counselling

The 2012 National Guidelines for HIV Testing and Counselling (HTC) are meant to provide a comprehensive guidance that covers all testing and counselling approaches. The guidelines set out to provide practical guidance on key technical and policy issues related to all approaches of counselling and testing in health care facilities and in community settings.

The guidelines define the HTC service package as well as the key population that will benefit the services. Guidance is also provided on promotional issues related to uptake of HTC services. In order to ensure uninterrupted supply of all HTC commodities, practical logistical guidance at all levels of health facilities are also provided.⁸³ HIV prevalence is higher among women than men, at 6.2% and 3.8%, respectively, and is highest among persons between the ages of 15-49 years⁸⁴. Persons who engage in socially stigmatized behaviours, including sex work, injection drug use and male-to-male sexual behaviours are at disproportionately higher risk for HIV infection.

The Guideline states that, counselling shall take into account the language and level of understanding of the person(s) receiving HTC. For example, adults and children will require different communication skills, as will persons with different levels of education. It is important to communicate clearly and effectively with your clients/patients. The HTC providers shall respond appropriately to the individual, couple, or family counselling needs.⁸⁵

The guideline does not recognize counselling and testing approach from people suffering from TB.

National Strategic Plan V for Tuberculosis and Leprosy Programme 2015 – 2020

The National Strategic plan V (2015-2020) for Tuberculosis and Leprosy addresses the future priorities and challenges in the context of the changing environment. It is hinged on the National; Vision 2025, Strategy for Growth and Reduction of Poverty (NSGRP), National Multisectoral Strategic Framework III for HIV and AIDS (NMSF) 2013-2017, Health Policy and Health Strategic Plan III, but also to Global Plan Post 2015 Stop TB Strategy, Regional and National initiatives. The purpose of the Strategic plan is to promote dialogue and consensus building around key interventions for the coming five years. It also serves as a resource mobilization tool for funding priority interventions.

Basically this strategic plan places NTLP into the fore front of provision of TB care and control. It also recognizes the role of the implementing partners and the society in general in fighting TB. The Strategic plan however falls short of adopting key human rights principles and approach in TB care and control. It is therefore recommended that the said Strategic plan adopt key human rights approach in tackling and combating TB cure and control.

National Tuberculosis and Leprosy Programme Annual Report 2011

This report is a summarizing description of activities implemented by the National Tuberculosis and Leprosy Programme (NTLP) under the Ministry of Health and Social Welfare for the year 2012. The purpose is to share this information with stakeholders interested to know progress made in the control of leprosy, tuberculosis and TB/HIV interventions in the country. The report further gives a summary of NTLP activities during the year 2012. Other activities included: DOTS expansion by recruiting new staff, provision of quality assured first line anti-TB drugs, laboratory supplies and equipment; initiation of treatment of MDR-TB patients at Kibong'oto National TB hospital; scaling up national -wide collaborative TB/HIV activities, scaling up involvement of more private health care providers; empowering patients and community members to take active participation in TB prevention and care; collaborating with internal and external partners in conducting relevant operational research.

Apart from a report on Human resources of NTLP, the report also discusses issues of Tuberculosis case notification for the year 2012, Management of MDR-TB, and Management of Paediatric TB. However, the report does not discuss on gross violation of human rights of TB patients and TB survivors, and how TB Community organizations can be used to address issues of stigma around TB patients and access to TB treatment, care and prevention.

⁸² See Chapter Four of the Framework, p. 38

⁸³ Guidelines for HIV/AIDS testing and counseling

⁸⁴ Chapter 1; Guidelines for HIV/AIDS testing and counseling- Introduction

⁸⁵ Chapter 2: Core Principles of HIV Testing and Counseling

Court System in Tanzania

Primary Court

Is the first court of instance whereby any individual citizen or body corporate can institute a claim for relief. It has both territorial and pecuniary jurisdiction over a ward within a district in which to exercise its powers. In these courts, advocates are not allowed to appear and represent clients. However, not all matters are dealt with at the Primary Court: matters such as land conflict and some of the human rights violation are not dealt in these primary courts. However currently Primary Court empowered to handle human rights issues once the accused pleads or Primary Court Magistrate detects there is violation of human rights against the accused person, magistrate has immediately to stop proceeds with said case and refer it to District Court and District Court refer it to High Court for determination and upon its determination the Primary Court will resume the main case.

District Court

It exist in each district established under section 4 and 5 of the Magistrate's Court Act No 2 of 1984. It has both territorial and pecuniary jurisdiction over a designated district and also enjoys supervisory powers over the primary court. It is also the court of first appeal. However, it does not deal with matters relating to land, or labour dispute or matters of high commercial value. However, it does not deal with matters relating to land, or labour dispute or matters of high commercial value. Recently, District Court has given a power to deal with Human rights issues once a magistrate depict there are violation of human rights or accused pleads violation of human rights against him, the trial magistrate has to keep that matter pending and refer it to high court for determination and once determined the magistrate has to resume the main case.

Resident Magistrate Court

Is the court which has territorial jurisdiction within such area as are specified by the chief justice by an order in the Gazette and it established under section 5 of Magistrate Court Act No 2 of 1984, and the pecuniary jurisdiction that is governed by the value, in terms of money of the subject matter of the suit in question. However, it does not deal with matters relating to land, or labour dispute or matters of high commercial value.

High Court

The high court by virtue of section 2 (1) of the Judicature and Application of Laws Act is vested with full and unlimited Jurisdiction over all civil and criminal matters, that is to say it shall have power over any matter not expressly provided by the law the constitution or any other law. It is also provided further under article 108(2) of the constitution of the United Republic of

Tanzania. Such Jurisdiction is subject to the jurisdiction of the Court of Appeal as stipulated under the constitution and any other written laws. This Court has jurisdiction over all matters including Human rights petitions.

High Court of Zanzibar which deals with dispensing justice in the aises of Zanzibar, and is vested with full and unlimited Jurisdiction over all civil and criminal matters, that is to say it shall have power over any matter not expressly provided by the law the constitution or any other law.

For easy access of justice and to reduce backlog of cases, there are specialized High Court registries. They include:

- I. High court land division, which deals with the all dispute concern land issues. Under this Court, we have District Land and Housing Tribunals, Ward Land Tribunals and Village Land Tribunals.
- II. High Court Labour Division in Tanzania- which deals with all disputes arising from labour matters. The court also consists of Commission of Mediation and Arbitration (CMA).
- III. High Court Commercial Division, which deals with the all commercial disputes.

Court of Appeal

The highest court of the land and also a true union court institution in that it has territorial jurisdiction over appeals arising from the High Court of Tanzania and the High Court of Zanzibar.

Access to justice: The Constitution of URT guarantees access to justice to its citizens. Despite measures taken by the Government such as increasing the number of judges and magistrates, improving infrastructure and staff welfare, there is an increase of complaints against the court system. CHRAGG in one year received 216 complaints related to malpractices in the administration of justice.⁸⁶ We recommend the government to allocate more resources to the judiciary to facilitate improvement of court infrastructure especially in rural areas; fast – track the civilianization process of transferring the responsibility of criminal prosecution from the police to public prosecutors; guarantee accountability within the judiciary.⁸⁷

⁸⁶ CHRAGG's annual report, 2009/10

⁸⁷ Ibid

WHO Guidelines on TB-Specific Legislation

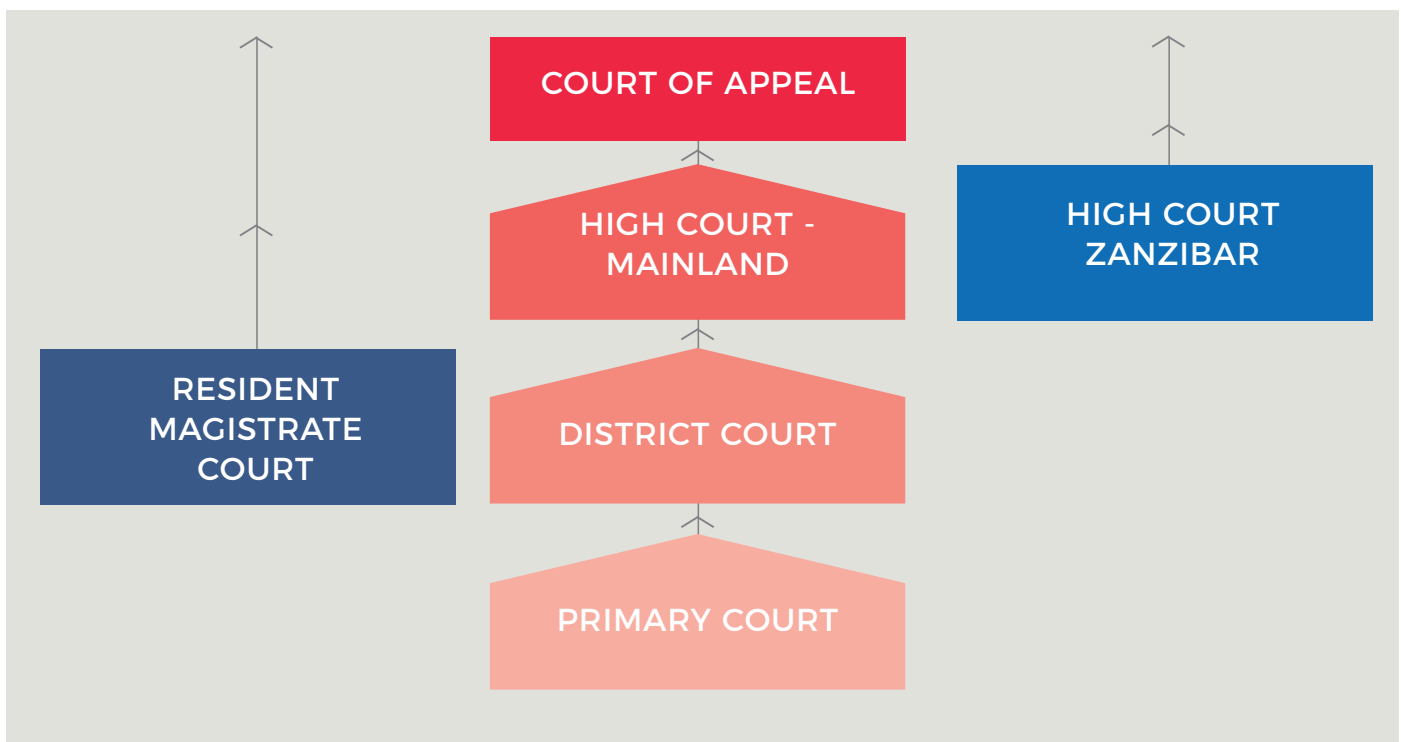
The WHO's "Global Strategy and Targets for Tuberculosis Prevention, Care and Control after 2015" establishes the "protection and promotion of human rights, ethics and equity" as the third of four principles in its strategy to end TB.⁸⁸ This emphasis on the importance of protecting and promoting the rights of people with TB is preceded by several WHO guidelines

that set out principles and best practices for TB-specific legislation. A summary of these principles and best practices is provided here:

- **Purpose:** TB-specific legislation should serve three main purposes - protecting TB patients' individual rights, safeguarding public health interest, and defining public health institutes' respective responsibilities.⁸⁹

⁸⁸ World Health Organization [WHO], Global Strategy and Targets for Tuberculosis Prevention, Care and Control After 2015, EB 134/12 (Dec. 2013), http://www.who.int/tb/post2015_tbstategy.pdf.

⁸⁹ World Health Organization [WHO], Good Practice in Legislation and Regulations for TB Control: An Indicator of Political Will, WHO/CDS/TB/2001.290 (May 2001), http://apps.who.int/iris/bitstream/10665/68708/1/WHO_CDS_



Most importantly, it should balance public interest and individual rights.

- **Treatment on Voluntary Basis:** The completion of treatment should be conducted on a voluntary basis and compulsion should only be used as a last resort.⁹⁰ Legislation should facilitate rather than coerce patients to undergo treatment. For patients willing to undergo treatment, isolation and detention are neither necessary nor appropriate.⁹¹
- **Individual Rights:** The most important rights include the following.
 - » **Non-discrimination:** The government should protect TB patients against discrimination on the grounds of health status.⁹²
 - » **Care and Treatment:** The government should ensure both quality and accessibility of TB care and treatment to TB patients.⁹³ It should be free of charge, and patients are entitled to food and travel allowance during the treatment period.
 - » **Information:** Both the general population and individual TB patients have the right to information. The government should provide health education and disseminate information about TB and its treatment to the general public.⁹⁴ Individual patients have the right to know the risks, benefits, and alternatives to TB treatment.⁹⁵
 - » **Informed Consent and Autonomy:** TB patients have the right to decide the ways in which they want to receive treatment, subject only to compulsory treatment on the grounds of public health.⁹⁶
 - » **Privacy and Confidentiality:** TB patients have the right to keep their information relating to TB status and treatment private and confidential,

with certain exceptions concerning close third parties who are at high risk of infection, in which case non-consensual disclosure may be allowed.

- **Limitation on Individual Rights:** Any restriction on individual rights on public health grounds should be of a limited nature and subject to review.
- **Vulnerable Groups:** Legislation should prioritize vulnerable groups' needs in receiving TB care. Vulnerable groups are individuals who face increased risk of becoming infected and developing active disease and those who face challenges of accessing and fully utilizing services. Such groups include, but are not limited to, people living in extreme poverty, indigenous populations, refugees, asylum seekers, migrants, mine workers, prisoners, substance users (including alcohol), and homeless people. In addition, the needs of women, children, and people co-infected with HIV warrant special consideration.

While the WHO has given a rather comprehensive list of guidelines for TB-specific legislation, some best practices not mentioned by the WHO are also worth considering. Among these are the implementation of the right to social and psychological support for people undergoing TB treatment and the creation of a complaints mechanism to hear grievances associated with the failure to uphold legal rights and entitlements of people with TB.



TB_2001.290.pdf [hereinafter Good Practice] at 14.

90 World Health Organization [WHO], Guidance on Ethics of Tuberculosis Prevention, Care and Control, WHO/HTM/TB/2010.16 (2010), http://apps.who.int/iris/bitstream/10665/44452/1/9789241500531_eng.pdf [hereinafter Guidance on Ethics] at 22;

91 Ibid

92 Good Practice, supra note 49, at 7 and 13

93 Ibid at 13

94 Ibid

95 Guidance on Ethics, supra note 2, at 13

96 Good Practice, supra note 49, at 14

Global Survey of TB –Specific Legislation

This section provides for the countries and jurisdiction that enacted TB specific laws and together with the TB specific legislation with a Public health Approach. Only two (2) countries among the WHO's 22 high burden countries have TB specific legislation: Philippines and the Russian Federation. All of the WHO high burden countries, except Thailand and the Democratic Republic of Congo, have TB specific policies or regulations. This report focuses mainly on legislation. Focusing on legislation does not however mean undermining the general importance of policies and regulations on TB, since such policies and regulations establishes the operational details of national TB programs. This report focuses on Legislation for the several reasons. First, legislations are more permanent and difficult to amend or repeal, unlike regulations which are often drafted in accordance with relevant legislation, which means they follow the principles and frameworks laid out in legislations. Secondly, legislation carries the force of law and is enforceable in court of law and may create private causes of action allowing an individual to bring claims in court under the law.

Countries or jurisdictions that have TB specific legislation with a Public Health Approach include Austria, United States of America, and Philippines. The Country of Austria have enacted Federal Law of 14 March 1968 on Combating Tuberculosis (TB Act), 1968⁹⁷ while the Philippines have recently passed and enacted the Comprehensive Tuberculosis Elimination Plan Act, 2016.⁹⁸

Several countries in the Commonwealth of Independent States (CIS) have adopted TB Specific laws⁹⁹ in the past two decades that employ a combination of public health and rights-based approaches. These laws share similar content and structure largely due to their confederation and association with Russia. Below is a list of countries that have adopted such legislation:

- i. Republic of Azerbaijani, *About the Fight against Tuberculosis in the Azerbaijani Republic*, 2000¹⁰⁰
- ii. Kyrgyz Republic, *About the Protection of the Population against Tuberculosis*, 1998¹⁰¹
- iii. Republic of Moldova, *About Control and*

Tuberculosis Prophylaxis, 2008¹⁰²

- iv. Russian Federation, *About the Prevention of Diffusion of Tuberculosis in the Russian Federation*, 2001¹⁰³
- v. Republic of Tajikistan, *About the Protection of the Population against Tuberculosis*, 2006¹⁰⁴
- vi. Ukraine, *About the Counteraction to the Disease of Tuberculosis*, 2001¹⁰⁵
- vii. Republic of Uzbekistan, *About the Protection of the Population against Tuberculosis*, 2001¹⁰⁶

A country with a TB Specific Legislation with a Right based Approach is reflected in Peru – The law on Prevention and Control of Tuberculosis in Peru which enacted on 14th December, 2014. The law is unique because it includes robust recognition and protection of the rights of people with TB.

Generally, establishing the legal rights of people with TB in legislation not only complies with WHO – recommended principles and best practices, it also promotes health seeking behavior and leads to better treatment outcomes. A right based approach to TB inclusive of a comprehensive set of legal rights to people with TB is an effective means to achieve public health objectives and those set in the National Health Policy of 2007.

97 Bekämpfung der Tuberkulose [Tuberculosis] Mar. 14, 1968 BUNDESGESETZBLATT [BGBl], <https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10010326> (Austria) [hereinafter Austria TB Law].

98 Comprehensive Tuberculosis Elimination Plan Act (promulgated by the State Congress, Jul. 37, 2016, effective Apr. 26, 2016) <http://www.gov.ph/2016/04/26/republic-act-no-10767/> (Philippines) [hereinafter Philippines TB Law]

99 The laws are accessed from the database www.cis-legislation.com, which provides English translations of laws of countries in the Commonwealth of Independent States (CIS).

100 About the Fight against Tuberculosis in the Azerbaijan Republic (effective May 2, 2000), <http://cislegislation.com/document.fwx?rgn=2642>

101 About the Protection of the Population against Tuberculosis (effective Apr. 23, 1998), <http://cislegislation.com/document.fwx?rgn=280> (Kyrgyz Republic).

102 About Control and Tuberculosis Prophylaxis (effective Jul. 4, 2008), <http://cis-legislation.com/document.fwx?rgn=24087> (Republic of Moldova).

103 About the Prevention of Diffusion of Tuberculosis in the Russian Federation (accepted by the State Duma on May 24, 2001; approved by the Federation Council on June 6, 2001; effective June 18, 2001), <http://cis-legislation.com/document.fwx?rgn=1727>.

104 About the Protection of the Population against Tuberculosis (effective Dec. 22, 2006), <http://cislegislation.com/document.fwx?rgn=16130> (Republic of Tajikistan).

105 About the Counteraction to the Disease of Tuberculosis (effective July 5, 2001), <http://cislegislation.com/document.fwx?rgn=18087> (Ukraine).

106 About the Protection of the Population against Tuberculosis (effective May 11, 2001), <http://cislegislation.com/document.fwx?rgn=919> (Republic of Uzbekistan).

APPENDIX

INDEPTH STAKEHOLDERS INTERVIEW QUESTIONNAIRES

General Situation and Understanding of TB

- i. What is the overall situation with regard to TB in Tanzania?
- ii. Do people with TB have a right to free TB drugs?
- iii. Are the TB drugs quality-assured?
- iv. Do patients have choices about the location of treatment?
- v. Which TB services do people diagnosed with TB receive at a cost/fee?
- vi. Is there adequate and good-quality TB diagnosis and treatment capacity?
- vii. If not, what are the options to address the gap?
- viii. Which are the most at-risk populations for TB in Tanzania?
- ix. Who is at risk of getting TB?
- x. Describe whether persons are at an increased risk because of legal-related barriers.
- xi. Are there specific subpopulation groups that may face increased vulnerability to TB due to access barriers?
- xii. Are prevention, testing, treatment and care initiatives effectively reaching these subpopulations and groups?
- xiii. What is the available support to help TB patients complete the full course of treatment?
- xiv. Do these subpopulations have access to appropriate health education and information in relation to TB?
- xv. Is such information medically and culturally appropriate?
- xvi. What activities are needed to reach out to these subpopulations?

Structured Interviews for Prison Officers

- i. What are some of the available TB services within prison settings in Tanzania?
- ii. Are TB and HIV services integrated in this prison?
- iii. What measures are in place to ensure the timely diagnosis of TB in prisons?
- iv. Are there any policies, guidelines or frameworks for TB prevention, treatment and care in prisons?
- v. Does the current infrastructure of prisons in Tanzania hinder or support TB management?
- vi. How is overcrowding addressed as a barrier to effective TB management?
- vii. Do you have isolation facilities for TB patients?
- viii. What rights do TB patients enjoy while in prison?
- ix. Do prisons have a programme for Community-Based TB Care?
- x. How do you engage the community or community-based organizations?
- xi. What measures are in place to educate or inform prisoners on TB and TB rights?
- xii. Do prisons officers receive any capacity building on issues of TB and human rights for prisoners?
- xiii. How do prisons link up with other arms of government in addressing TB in prisons?
- xiv. Is there screening for TB in prisons?
- xv. How often?
- xvi. Is the screening voluntary, confidential and respectful of prisoners' rights?
- xvii. What are the general guidelines on how TB patients are handled from diagnosis through treatment?
- xviii. Is there HIV testing among TB patients?
- xix. Are testing and counseling services voluntary, confidential, accessible, affordable and respectful?
- xx. Is there informed and written consent of the patient to HIV testing?
- xxi. What happens to prisoners who refuse to consent to TB treatment?
- xxii. What measures are in place to ensure adherence to TB treatment?

Structured Interviews for Health Care Providers

- i. What kinds of TB services does this health facility provide?
- ii. Are TB and HIV services integrated in this health facility?
- iii. Does this facility have a programme for Community-Based TB Care?

- iv. Does this facility initiate DS-TB and DR-TB treatment?
- v. Does this facility provide services for continuing TB patients?
- vi. Have any of this facility's patients ever had a period of interrupted treatment?
- vii. Did the patient give a reason for his/her treatment interruption?
- viii. What is the common reason for TB treatment interruption among patients?
- ix. Have you ever experienced any TB or HIV drug shortages in this facility?
- x. Are TB drugs always readily available at the health care facility?
- xi. Are the TB drugs provided free of charge?
- xii. Was the treatment of any of the facility's TB patients interrupted because of the drug shortages?
- xiii. Is there HIV testing among TB patients?
- xiv. Are testing and counseling services voluntary, confidential, accessible, affordable and respectful?
- xv. What are the general guidelines on how TB patients are handled from diagnosis through treatment?
- xvi. Is there informed and written consent of the patient to HIV testing?
- xvii. Do you think HCWs have enough time to explain the TB disease to the patients?
- xviii. Do all health services have laws or policies on non-discrimination on the basis of health status?
- xix. Are these laws or policies enforced?
- xx. Are health providers trained in principles of non-discrimination and informed consent?
- xxi. Are there penalties if the laws or policies are violated?
- xxii. What happens to patients who refuse to consent to TB treatment?
- xxiii. Is it possible to refuse to initiate/continue treatment when it appears that a particular patient is unlikely to adhere to the prescribed regimen?
- xxiv. What happens if the patient is non-adherent?
- xxv. How people who present for diagnosis and treatment are made aware of their rights?
- xxvi. Do you know what the Tanzania Government policy on TB prevention and management is?
- xxvii. Do you know of any County Government policy on TB prevention and management?
- xxviii. When patients are offered drug susceptibility testing in the absence of treatment, are they informed of the risks and benefits of testing and specifically asked if they are willing to consent even though treatment may not be available to them?

Structured Interviews for Institutions and Groups Working with Persons Affected by TB

- i. Who are the main NGO and CSO stakeholders in the area that are already involved in TB?
- ii. What are the strengths, weaknesses, opportunities and threats to TB activities?
- iii. What are the best existing community-based structures for community-based TB activities?
- iv. What is the capacity of the NGO/CSO to use the structures for community-based TB activities?
- v. What are the main barriers to better delivery of TB services?
- vi. Can community-based TB activities address the barriers identified?
- vii. Have key populations been named in the national TB strategic plan?
- viii. Are strategies outlined for responding to their specific needs?
- ix. Have representatives of these populations participated meaningfully in the development of the national TB strategic plan?
- x. Which diagnostic measures can people with TB obtain for free?
- xi. Are there particular TB patients who are prioritized over others?
- xii. What barriers do people with TB commonly face in accessing health (TB) education?
- xiii. What measures are in place to eliminate these barriers?
- xiv. Is there compensation for work-related TB for health care workers/miners/workers in other professions who are at higher risk for TB?
- xv. Do you think there should be one in place?
- xvi. Are health services affordable to all?
- xvii. Are there any financial barriers to accessing health services, such as user fees?

- xviii. Are health services of an acceptable quality?
- xix. Are health services within safe physical reach for all, including key populations?
- xx. Do indigenous people, migrants and IDPs have equal access to TB services and information in their own languages?
- xxi. What are the rights of people affected by TB in terms of adequate standard of living and social protection in the event of unemployment, sickness or disability?
- xxii. What kind of support is provided to TB patients during treatment (e.g., social accompaniment, financial motivation, food packages)?
- xxiii. What barriers do persons affected by TB commonly face in accessing social protection and other benefits?
- xxiv. What measures are in place to eliminate these barriers?
- xxv. Are there disability benefits for people with TB who acquire permanent disability as a result of their TB?
- xxvi. Are key populations criminalized?
- xxvii. Are there realistic opportunities to change the laws in the current environment?
- xxviii. Is there involuntary isolation, quarantine or detention of people with TB?
- xxix. If so, under what circumstances?
- xxx. Is there a legal standard governing the isolation, quarantine or detention of people with TB?
- xxxi. What law governs?
- xxxii. Do people with TB have the right to due process in circumstances where they are deprived of liberty?
- xxxiii. In the rare event that isolation is used, does it take place in adequate settings, with appropriate infection control measures, as specified more fully in WHO guidance?
- xxxiv. Is reasonable social support provided to isolated patients and their dependents?

Questions for NTLF

1. Which diagnostic measures can people with TB obtain for free? (please check all that apply):
 - Microscopy
 - Chest X-ray
 - GeneXpert
 - Tuberculin skin test
 - IGRA
 - LED microscopy
 - DST
 - Other _____
2. What kind of information is provided to individuals who come for TB testing? (please check all that apply):
 - The nature of TB
 - Why they are being tested
 - Prevention measures
 - Free treatment and care for TB
 - Other _____
3. How many clinic visits are usually required to obtain a TB diagnosis?:
 - One
 - Two
 - More than two
4. Is there HIV testing among TB patients?
 - Yes, at every TB clinic/any primary care provider
 - Yes, at some TB clinics
 - Only at HIV clinics
 - They can get tested anywhere
 - Other _____
5. Does the patient provide informed and written consent to HIV testing?
 - Yes, always
 - Not if they are already diagnosed with TB

- Only at HIV clinics
 - Not if they represent an at-risk population
 - Other _____
6. What kind of information is provided to people for whom diagnosis is confirmed?
- The risks and benefits of the proposed interventions
 - The importance of completing the full course of treatment
 - Treatment options
 - Infection control measures
 - Available support
 - Other _____
7. How people who come for diagnosis and treatment are made aware of their rights?
- Through an informational note that is present in the clinic
 - They are informed by health workers
 - There are no mechanisms to make them aware of their rights
8. Are there particular TB patients that are prioritized over others?
- No
 - Children
 - Pregnant women
 - People living with HIV
 - Other _____
9. If access to MDR- and XDR-TB medications is limited, are particular MDR- and XDR-TB patients prioritized over others?
- No
 - Children
 - Pregnant women
 - People living with HIV
 - Other _____

OTHER QUESTIONS FOR CONSIDERATION

Access to medications and treatment modalities

- i. Which medications can people with diagnosed TB obtain for free?
- ii. Do people with TB have a legal right to free TB medicines, including but not limited to rifabutin, bedaquiline, delamanid and linezolid?
- iii. Are these medicines quality-assured?
- iv. When patients are offered drug susceptibility testing in the absence of treatment, are they informed of the risks and benefits of testing and specifically asked if they are willing to consent, even though treatment may not be available to them?
- v. What happens to patients who refuse to consent to TB treatment?
- vi. Do patients have choices about the location of treatment?
- vii. Do patients have choices about the individuals who will be observing their treatment (DOT)?
- viii. What support is available to help patients complete the full course of treatment?
- ix. Is it possible to refuse the initiation/continuation of treatment if it appears that a particular patient is unlikely to adhere to the prescribed regimen?
- x. What happens if the patient is non-adherent?

Social protection and material assistance

- xi. Is there compensation for time lost from work?
- xii. Is there compensation for work-related TB for health care workers/miners/workers in other professions who are at higher risk for TB?
- xiii. Is there additional compensation for health care workers working in TB? (please list all)

- xiv. What are the rights of people affected by TB in terms of adequate standard of living and social protection in the event of unemployment, sickness or disability?
- xv. What kind of support is provided to TB patients during treatment (e.g., social accompaniment, financial motivation, food packages)?
- xvi. What barriers do people affected by TB commonly face in accessing social protection and other benefits?
- xvii. What measures are in place to eliminate these barriers?
- xviii. Is TB recognized as an episodic disability, and are disability benefits extended to people with TB?
- xix. Are there disability benefits for people with TB who acquire permanent disability as a result of their TB?

Protection of privacy and confidentiality

- xx. Do individuals have a constitutional or statutory right to privacy and confidentiality in their health status, including their TB status?
- xxi. Under what circumstances can an individual's right to privacy and confidentiality be infringed upon?
- xxii. Who are the contacts of a TB patient, and how are they notified?
- xxiii. Is contact tracing done with minimal intrusion into individuals' privacy and autonomy?
- xxiv. How are contacts notified if patients are unwilling to participate in the process of contact identification and notification?
- xxv. Is there a policy for the non-consensual disclosure of a patient's TB status?
- xxvi. How is it ensured that the non-consensual disclosure of TB status is performed in accordance with the law and human rights principles?

Political, social and cultural life

- i. What protections do people with TB have against harassment, intimidation, violence and other human rights violations?
- ii. Is there involuntary isolation, quarantine or detention of people with TB?
- iii. If so, under what circumstances?
- iv. Is there a legal standard governing the isolation, quarantine or detention of people with TB? What law governs?
- v. Do people with TB have the right to due process in circumstances where they are deprived of their liberty?
- vi. In the rare event that isolation or detention is used, does it take place in adequate settings, with appropriate infection control measures, as specified more fully in WHO guidance?
- vii. Is reasonable social support provided to isolated patients and their dependents, taking into account the local system's capacity?
- viii. Is there forced treatment?

Education, employment, work and housing

- ix. Do legal protections exist that prohibit discrimination in education based on TB status and ensure that children with TB are not prohibited from attending school?
- x. What barriers do people with TB commonly face in accessing education?
- xi. What measures are in place to eliminate these barriers?
- xii. Do legal protections exist to guarantee people with TB access to employment and nondiscrimination in the workplace?
- xiii. Do state policies address the links between poor health, TB and a lack of adequate housing?
- xiv. Do legal protections exist that prohibit discrimination in housing based on TB status?

Access to justice and Legal protection

- i. What legal remedies are available to people with TB when their rights are violated, including their rights to free testing and treatment, privacy, etc.?
- ii. What accountability exists under law for government or private actors that violate the rights of people with TB, including their rights to free testing and treatment, privacy, etc.?
- iii. Do national human rights monitoring and enforcement mechanisms consider TB-related issues?
- iv. What measures are in place to ensure that cases of TB-related discrimination and other human rights violations in the context of TB response are systematically recorded, documented, and addressed, and that remedies are made available?

Legal awareness, assistance and representation

- v. What measures are in place to educate people affected by TB and key populations about their legal rights?
- vi. Is there support for legal awareness-raising programmes implemented by civil society and international organizations?
- vii. Are legal literacy materials presented to people with TB and key populations in a format and style that is readily accessible?
- viii. Are free legal services provided to people with TB who are unable to access or afford the services of paid lawyers?

Access to a fair trial, and enforcement of remedies

- ix. Does the state's infrastructure create an enabling environment for access to justice?
- x. Does the state ensure that the forums administering justice are easily accessible in both urban and rural communities?
- xi. Are the costs associated with TB-related dispute resolution in the formal justice system reasonable?

Questions for focus groups and structured interviews

These questions can be asked during in-person interviews with people with TB or groups of key populations.

- i. How long did it take to get diagnosed (in weeks, clinic visits)?
- ii. How were you treated at the clinic when you first received your TB diagnosis?
- iii. How much did you pay for the tests? Were there any additional costs associated with the testing?
- iv. How many times did you have to go to the clinic until you received your final diagnosis?
- v. What kind of information about TB and about treatment did you receive from your health care provider?

For specific populations:

- i. How do you feel people living with TB are generally treated in health care settings?
- ii. Are health services easy to access for people living with TB?
- iii. If not, why?
- iv. What are the main barriers to TB diagnosis and treatment for people living with TB?
- v. What TB programmes would be helpful for people living with HIV/miners/people who use drugs/women/children/other key populations?
- vi. Are there any institutions or organizations you can turn to in case of violence or abuse of your rights?
- vii. What rights do you know you have as a person with TB?

LEA ADDITIONAL QUESTIONS

1. Are there any legal frameworks or policy, basic health policies, and other general government policies that include any of the following: women and girls, men and boys, transgender people and key affected populations in relation to HIV, TB, HIV/TB, or DR-TB?
2. If so, what aspect of their lives may be affected? Please tick the relevant boxes:
 - restrictions on women's or girls' movements or activities
 - forced institutionalization for DR-TB treatment
 - criminalization of drug use
 - criminalization of TB transmission or exposure
 - criminalization of sexual orientation
 - criminalization of gender identity
 - criminalization of sex work
 - denial of access to condoms or sexual and reproductive health services for young people (younger than 18 years of age)
 - denial of comprehensive sexuality education for young people (younger than 18 years of age)
 - denial of inheritance and/or property rights to women
 - denial/ restrictions of provision of safe abortion

- Early and forced child marriage practices
 - TB - related travel restrictions
 - non-recognition of sexual or gender-based violence within marriage
 - polygamous marriages
 - prisoner rights to healthcare
 - access to care and right to compensation (TB diagnosis and treatment)
 - laws on occupational exposure
 - school screening programs for TB?
3. Are there legal frameworks that specifically protect the rights of people living with TB, HIV/TB, DR-TB, HIV, women and girls, and other key affected populations in the country?
4. If so, what rights are protected? Please tick the relevant boxes.
- Criminalization of early and forced marriage
 - criminalization of intimate partner violence
 - family and property law (e.g. laws regarding marriage, cohabitation, separation, divorce, child custody, property, inheritance, etc.)
 - gender identity laws
 - country wide medical insurance schemes
 - Universal access to medicines for treatment
 - labour relations and social security legislation
 - laws ensuring comprehensive sexuality education that is non - stigmatizing and non-discriminatory
 - laws ensuring that TB & DR-TB services—including testing and treatment—are free of charge
 - laws ensuring that HIV services—including testing and counseling—are voluntary and confidential.
 - legal frameworks regarding sexual and reproductive rights
 - migrant rights
 - rights under national law regarding easy access to health care (including health services), access to information about health issues and appropriate care, antiretroviral therapy (ART), condoms, co-trimoxazole prophylaxis and isoniazid preventive therapy for people living with HIV, isoniazid preventive therapy for children of household contacts of TB infected person, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP).
5. Are all key affected populations protected equally? Please specify.
6. Do the existing laws and policies translate into equitable access to services for women, girls, men, boys, transgender people and key affected populations?
7. If yes, what services are not equally accessed by....? Please tick the applicable boxes.
- access to TB diagnosis access to TB treatment and treatment support
 - access to DR-TB diagnosis, treatment and support
 - commodities for HIV prevention (male and female condoms, harm reduction practices)
 - comprehensive sexuality education
 - education
 - information about available health services
 - labour
 - post-rape care, including post-exposure prophylaxis for HIV and STIs
 - pre-exposure prophylaxis
 - psychosocial support for people living with HIV, and TB affected communities
 - sexual and reproductive health and rights services
 - social protection
8. Do both the executive and legislative branches of government work towards implementing the international treaties and declarations on which the country is a signatory? Please give examples of laws approved and services provided according to the 2011 Political Declaration on HIV/AIDS, the Beijing Declaration and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).
9. Also consider regional commitments by governments i.e. AU, Southern African Development Community (SADC). Please provide specific examples of laws approved and services provided.

10. Is there any indication of discriminatory or coercive practices in health-care settings that may impact access and utilization of HIV and TB-related services by women living with HIV, including those from key and marginalized populations?
11. If yes, in what areas have discriminatory or coercive practices been seen? Please tick the applicable boxes.
- coerced abortion
 - coerced family planning
 - denial of access to abortion, where legal
 - denial of access to contraception
 - discrimination against transgender people
 - forced sterilization of women living with HIV?
 - Discrimination based on sexual orientation
 - stigma against people living with HIV or affected by TB
 - stigma and discrimination against people who use drug
 - job loss due to stigma
 - denial or unavailability of treatment support
12. Is there any indication of discriminatory practices by the judiciary or law enforcement personnel (including the police) that may prevent women, girls or any other key or marginalized populations from accessing their rights? If so, please describe.
13. What is the percentage of women in the Parliament or Congress? What is the percentage of women in the Cabinet (or Secretariat or Ministerial body)?

Sites visited during the In-Country Assessment Schedule

Dar es Salaam	Temeke Region
Morogoro	Kilombero District: Ifakara Town
	Kilosa District – Ruaha area, Kidodi area
Mwanza	Nyamagana District



LIST OF TABLES

- i. The table 1 sets out all conditions that should be met to justify involuntary isolation.
- ii. Table 2: Key International and Regional Human Rights Tanzania's obligations related to TB

FOOTNOTES

1. HRC, General Comment No. 6: The Right to Life (Art. 6), Adopted at the Sixteenth Session of the Human Rights Committee (April 30, 1982); *Association X v. United Kingdom*, Application No. 7154/ 75, 14 Decisions and Reports 31 (1978), European Commission on Human Rights; *A Human Rights Framework for Intellectual Property, Innovation and Access to Medicine*, Jooyoung Lee (ed.) (Ashgate Publishing, Limited, 2015).
2. UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), UN Doc E/C.12/2000/4, ¶ 43(d) (August 11, 2000).
3. 19th WHO Model List of Essential Medicines (April 2015).
4. CESCR, General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), UN Doc. E/C.12/GC/20, 10-11, 27, 33 (July 2, 2009).
5. Interim report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc A/68/295, 50 (August 9, 2013); *Vasyukov v. Russia*, European Court of Human Rights, Application No. 2974/05 (2011).
6. Office of the United Nations High Commissioner for Human Rights and Joint United Nations Program on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights*, UN Doc. HR/PUB/06/9, 199-22 (2006) (stating right to privacy includes “privacy of information” and “need to respect confidentiality of all information relating to a person’s HIV status”).
7. HRC General Comment No. 35: Article 9 (Liberty and security of person), UN Doc CCPR/C/GC/35, 19 (December 16, 2014).
8. See WHO Ethics Guidance on the Implementation of the End TB Strategy, Chapter 15 (March 2017).
9. HRC General Comment No. 25: The right to participate in public affairs, voting rights and the right of equal access to public service (Art. 25), UN Doc CCPR/C/21/Rev.1/Add.7, 5 (December 7, 1996).
10. Universal Declaration, at Article 14; Refugee Convention, at Article 3.
11. CESCR, General Comment No. 4: The Right to Adequate Housing (Art. 11(1) of the Covenant), UN Doc E/1992/23, 7, 8 (December 13, 1991).

EANNASO

Kundayo Street - Kwa Shabani, Arusha - Moshi Rd, Kimandolu
P.O Box 6187 Arusha, Tanzania

 +255739210598  eannaso@eannaso.org

 www.eannaso.org |  [eannaso](https://twitter.com/eannaso) |  facebook.org/eannaso.org