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<tr>
<td>ACHPR</td>
<td>African Charter on Human and People’s Rights</td>
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<tr>
<td>ACRWC</td>
<td>African Convention on the Rights and Welfare of the Child</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Drugs Therapy</td>
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<td>ARV</td>
<td>Antiretroviral Drugs</td>
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<td>ATF</td>
<td>AIDS Trust Fund</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>CHAC</td>
<td>Council HIV and AIDS Coordinator</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<tr>
<td>CRC</td>
<td>Convention on the Rights of a Child</td>
</tr>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>CTC</td>
<td>Care Treatment Centre</td>
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<tr>
<td>DACC</td>
<td>District AIDS Control Coordinator</td>
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<tr>
<td>DP</td>
<td>Development Partner</td>
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<tr>
<td>DPG-AIDS</td>
<td>Development Partners Group on HIV and AIDS</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<tr>
<td>EALA</td>
<td>East African Legislative Assembly</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
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<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>GOT</td>
<td>Government of Tanzania</td>
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<tr>
<td>HAPCA</td>
<td>HIV and AIDS (Prevention and Control) Act, 2008</td>
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<tr>
<td>HBC</td>
<td>Home-Based Care</td>
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<tr>
<td>HCF</td>
<td>Health Care Facility</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HSHSP</td>
<td>Health Sector HIV and AIDS Strategic Plan</td>
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<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<tr>
<td>ICESCR</td>
<td>International Covenant on Economic Social and Cultural Rights</td>
</tr>
<tr>
<td>KI</td>
<td>Key Informants</td>
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<td>KP</td>
<td>Key Populations</td>
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<tr>
<td>LEA</td>
<td>Legal Environment Assessment</td>
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<tr>
<td>LGA</td>
<td>Local Government Authority</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbians, Gay, Bisexual, Transgender, Intersex</td>
</tr>
<tr>
<td>MDA</td>
<td>Ministry, Departments and Agencies</td>
</tr>
<tr>
<td>MKUKUTA</td>
<td>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini</td>
</tr>
<tr>
<td>MoST</td>
<td>Ministry of Science and Technology</td>
</tr>
<tr>
<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with Men</td>
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<tr>
<td>MTCT</td>
<td>Mother to Child Transmission</td>
</tr>
<tr>
<td>MVC</td>
<td>Most Vulnerable Children</td>
</tr>
<tr>
<td>MVP</td>
<td>Most Vulnerable Population</td>
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<tr>
<td>NACOPHA</td>
<td>National Council of People Living with HIV and AIDS</td>
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<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
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<tr>
<td>NBTS</td>
<td>National Blood Transfusion Services</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NIMR</td>
<td>National Institute for Medical Research</td>
</tr>
<tr>
<td>NMSF</td>
<td>National Multi-sectoral Strategic Framework</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>---------</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMO</td>
<td>Prime Minister’s Office</td>
</tr>
<tr>
<td>PMO-RALG</td>
<td>Prime Minister’s Office, Regional Administration and Local Government</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
<tr>
<td>RACC</td>
<td>Regional AIDS Control Coordinator</td>
</tr>
<tr>
<td>RAS</td>
<td>Regional Administrative Secretary</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern Africa Development Community</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TACAIDS</td>
<td>Tanzania Commission for AIDS</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>THMIS</td>
<td>Tanzania HIV and Malaria Indicator Survey</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
</tr>
<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary
This report presents a comprehensive study of the Legal Environment Assessment on HIV and AIDS in the United Republic of Tanzania. The study was undertaken for the purpose of identifying the strength and gaps existing within the national legal and regulatory framework and examine how they affect the overall HIV and AIDS response at different levels. In this respect the report provides a critical analysis of the defined list of legal and regulatory frameworks related to HIV and AIDS and reveal how they undermine or support national HIV and AIDS responses within the United Republic of Tanzania. The report analyses laws, policies and regulations that are HIV and AIDS related and show the extent to which they protect populations’ right to access HIV services with special attention to the key populations’. The report also examines the level of sensitization, understanding and compliance with the existing HIV and AIDS related laws by the lawmakers, law enforcers and service deliverers/providers when enforcing these laws but also when delivering HIV and AIDS related services. Finally, the report provides general recommendations and suggestions on concrete actions that can be taken on the analysed laws and regulations to improve HIV and AIDS responses.

The study was conducted in 11 regions of Tanzania Mainland namely; Tabora, Katavi, Shinyanga, Mara, Dar es Salaam, Coast, Mbeya, Rukwa, Njombe, Iringa and Ruvuma as well as the two islands of Zanzibar; which are Unguja and Pemba.

The study employed a Human Rights based approach which was complimented by a six stage report consolidation process. Stages in writing the report included; literature review, field Work, focused group discussions, report consolidation and reviews in various stages and Validation of the report.

The key report findings include: - (I) Tanzania Mainland and Zanzibar have both enacted specific HIV and AIDS legislations. However, the majority of the population is ignorant of these laws and their HIV and AIDS related rights. (II) CTC and ART services are widely provided and available in various areas though in some parts of the country there is a dire need to improve accessibility to these services (III) There is a robust coordination mechanism for both Tanzania
mainland and Zanzibar with regard to the HIV and AIDS. (IV) The Legal Framework both in Tanzania Mainland and Zanzibar contain provisions which counter efforts against the spread of HIV and AIDS and access to services for the affected populations. (V) Certain practices which are devised to facilitate accessibility of HIV and AIDS services are in fact promoting stigma and discrimination. (VI) Still, there are practices at family and community levels that discriminate and stigmatize PLHIV and key populations at a higher risk of contracting HIV. (VII) There are Legal framework gaps in the existing HIV and AIDS legislations that counter the effectiveness of HIV and AIDS interventions. (VIII) Property ownership laws and customary practices infringe rights of PLHIV to own property.

Considering the general findings of this report, chapter three of the report has set of recommendations which among others include: - (a) The government of Tanzania to ensure the HIV specific legislations are popularized to raise awareness on the law for the members of public and all other stakeholders (b) There should be deliberate efforts from all actors through their respective coordination mechanisms and responsible ministries to ensure CTC and ART services are accessible in the most remote areas. (c) The HIV and AIDS coordination mechanisms should be harmonized to deliver as one and avoid duplication of efforts (d) There should be a review of Laws especially those which criminalize some PLHIV conducts to facilitate provision of HIV and AIDS specific interventions to the key populations (e) Labour Laws should be observed by all employers especially those in the private sector to curb pre-employment testing which denies most PLHIV the opportunity to work (f) There should be enacted a gender specific law as well as review of the property ownership laws to ensure PLHIV are not discriminated in property ownership (g) The Legal Framework should take into account the KPs that are at a higher risk of being infected with HIV and AIDS to ensure their access to HIV and AIDS services.

Finally, the efforts to curb HIV and AIDS are cross cutting, multi sectoral and require cohesive efforts by all actors. The Legal Framework being one of the roadmap guiding these types of interventions in any nation ought to be properly aligned in the HIV and AIDS response framework. The proposed recommendations are essential towards effectively integrating all interventions against the HIV and AIDS pandemic.
CHAPTER ONE
PART ONE: INTRODUCTION TO LEA IN TANZANIA

1.1 General Background of the Legal Environment Assessment
Decade plus after the discovery of the HIV epidemic in Tanzania, stigma and discrimination have remained a big challenge in scaling up an effective HIV response in the country. Stigma and discrimination are still major obstacles to PLHIV, vulnerable and those at risk of been infected and affected with HIV particularly in accessing HIV and AIDS related services. As a result of internalized and institutionalized stigma and discrimination, many PLHIV and other members of key population have been often subjected to violations or denial of their basic rights which are not only important but of paramount necessity for their wellbeing and survival. Stigma and discrimination have multifaceted effects on HIV related interventions but one which is significant and surfaces easily, is creation of the cycle of vulnerability to HIV which deflect the efforts of reducing the rate of new infections through scaling up proper HIV and AIDS interventions in the country. As a result of stigma and discrimination, those perceived to be HIV positive, members of the key population/those vulnerable to and at the risk of been infected; have faced violence from the family level, at the community, at work places, within the justice systems and in other social settings when accessing services such as health and education.

Tanzania has a robust legal framework that protects the rights of PLHIV and those at the high risk of HIV exposure. For instance the Constitution of the United Republic of Tanzania 1977 has a comprehensive bill of rights which encompasses rights to be enjoyed by all people without any discrimination. These rights are comprehensively captured by Part III of the Constitution. The Zanzibar Constitution of 1984 also has a comprehensive bill of rights that seeks to protect the rights of all people in the country articulated under Part III. In essence, both Constitutions prohibit all types of discrimination that may be as a result of direct enactment of the discriminatory laws or any discriminatory conducts. The broad protection of the rights of all people within the constitution includes protection of all PLHIV and all those who are at the higher risk of exposure. To ensure this, both Constitutions have specific
provisions that prohibit discrimination in the enjoyment of the constitutional guarantees, which applies to all people including PLHIV.\(^5\)

Art. 13 (2) of the Constitution of the United Republic of Tanzania 1977 states; (No law enacted by any authority in the United Republic shall make any provision that is discriminatory either of itself or in its effect) while Art. 13 (4) states (No person shall be discriminated against by any person or any authority acting under any law or in the discharge of the functions or business of any state office). A similar provision is found in Art. 12(1), (2) of the Zanzibar Constitution of 1984.

Despite having such provisions in both Constitutions, Tanzania mainland enacted an HIV specific legislation that guides all HIV related interventions in mainland. \(^6\) This piece of legislation is the corner stone in relation to all matters of HIV response. The HIV and AIDS (Prevention and Control) Act complements the National HIV and AIDS policy that was endorsed in 2001. Zanzibar has recently enacted HIV legislation named Zanzibar HIV and AIDS Prevention and Management Act, 2014\(^7\), for the purpose of providing direction in Prevention, Protection, Promotion and Management of HIV related matters. This is to say at the moment Tanzania mainland and Zanzibar have HIV related laws which guides HIV interventions and collectively prohibits and prevent any form of discrimination against PLHIV.

HAPCA 2008 protects the rights of PLHIV and prevents all of forms of discrimination against them. Section 31 states that, “A person shall not stigmatize or discriminate in any manner any other person on the grounds of such other person’s actual, perceived or suspected HIV and AIDS status.”

Section 23 of an Act to Provide for the Prevention and Management of HIV and AIDS in Zanzibar, Act NO.18 of 2014 provides that: 23. (1) Persons living with or affected by HIV are entitled to enjoy, without any form of discrimination, all human rights under the law.

(2) No person may directly or indirectly discriminate against a person living with or affected by HIV on the basis of that person’s actual or perceived HIV status.

(3) A person who suffers an act of discrimination based on the person’s actual or perceived HIV status or that of another person may institute legal proceedings against the person who committed the discriminatory act to claim damages.

Apart from the above referred laws there are many other policies, laws and regulations which promote and protect the rights of PLHIV in the country. These are as shown in part two of this report.
Despite the long list of the laws that promote HIV and AIDS related rights in the country, there is also evidence that, there is on the other hand a regime of laws, policies guidelines and practices that counter effectiveness of the HIV specific legal framework and these needs to be considered. These include laws which criminalize and seek to sanction certain conducts of key populations such as the Penal Code⁸ and Drugs and Prevention of Illicit Trafficking in Drugs Act⁹ to mention but a few. Applications of these laws either further/fuels the cycle of vulnerability to HIV while at the same time hinder proper HIV and AIDS national response.

In arriving at this conclusion the formed Global Commission on HIV¹⁰ and Law conducted a survey and realized that many countries of the globe have laws which criminalize wilful HIV transmission. The Commission in its survey received overwhelming evidence on the danger these criminal laws pose to the PLHIV around the world and also on the initiatives in scaling up effective HIV response. In conclusion the Commission stated as indicated in the table below;

In much of the world it is a crime to expose another person to HIV or to transmit it, especially through sex. Fundamentally unjust, morally harmful, and virtually impossible to enforce with any semblance of fairness, such laws impose regimes of surveillance and punishment on sexually active people living with HIV, not only in their intimate relations and reproductive and maternal lives, but also in their attempts to earn a living ...... AIDS service organizations report that the threat of prosecution neither empowers people living with HIV to avoid transmission nor motivates them to protect themselves. Indeed, the fear of prosecution isolates them and discourages them from getting tested, participating in prevention or treatment programmes or disclosing their status to partners. The criminal justice system fights the health care system—one repelling, the other reaching out to people vulnerable to or affected by HIV. By dividing populations into the sick and the healthy or the guilty and the innocent, criminalization denies the complex social nature of sexual communities and fractures the shared sense of moral responsibility that is crucial to fighting the epidemic.¹¹

Persuaded by the above contention and the preliminary evidence from the Global Commission report on the danger the Legal Framework may pose in HIV and AIDS response, the Tanzania Commission for AIDS (TACAIDS) and Zanzibar AIDS Commission (ZAC) with support from the United Nations Development Program (UNDP) decided to conduct a thorough Legal Environment Assessment study. The main objective of the study is to analyse the legal, regulatory and policy frameworks in Tanzania to identify those laws, policies and
practices that are barrier in scaling up effective HIV and AIDS response in the country. The ultimate output of the project is this report which among other things outlines effective, practical and doable recommendations on how to deal with the outlined regime of laws that hinder effective HIV response to scale up meaningful HIV response in the country.

1.2 Terms of Reference to Conduct LEA in Tanzania
In conducting the assignment the team was issued with terms of reference, which comprised of (i) objective of the activity, (ii) specific tasks/activities to be carried out and (iii) outcomes/deliverables. These are as discussed in the following parts.

1.3 Objectives
The specific objectives of the assignment are as follows;

i. To identify and analyse the existing national legal and regulatory framework to show how they affect overall HIV and AIDS response at different levels.

ii. Conduct a critical analysis of a defined list of legal and regulatory frameworks related to HIV and AIDS and show how they undermine or support national HIV and AIDS response within the United Republic of Tanzania.

iii. Conduct analysis of the laws, policies and regulations that are HIV and AIDS related and see through the process the extent to which the population right to access HIV services is protected with emphasis on key populations’ access to HIV related services.

iv. Critically examine the level of sensitization, understanding and compliance with the HIV related laws among the lawmakers, law enforcers and service deliverers/providers when enforcing and delivering HIV related services.

v. Provide general recommendations and suggestions on concrete actions that can be taken on laws and regulations considered necessary to be reformed to improve HIV and AIDS response.

1.4 Specific Tasks
In order to achieve the objectives of the assignment, the consultant carried out the following specific tasks:
i. Conducted various meetings with TACAIDS, ZAC, Technical Working Group (TWG) to discuss and agree on deliverables, approach, the Work Plan and adoption of the Inception Report.

ii. Engaged in desk review of the relevant documents including legislations, regulations and reports related to the study

iii. Engaged in data collection from various stakeholders within the public, private and other sectors which included decision makers, government officials, members of the civil society organizations, development partners, PLHIV and KP’s on issues identified from selected list of laws and regulations that constrain or promote effective HIV and AIDS response. The aim of this activity was to gather practical recommendations on the manner in which the identified issues can be addressed.

iv. Consolidated the first report containing the findings, analysis and recommendations on the specific aspects including details of specific solutions and actions which can be taken to strengthen legislative and regulatory environment for effective HIV response.

v. Disseminated the report in various forums including to the Technical Working Group and to the National Dissemination forum for discussion and validation.

1.5 Outcomes

As stated above, the outcome of the LEA is this report with practical recommendations contained in Chapter Three, which will if worked through strengthen country HIV and AIDS legal framework for effective HIV and AIDS response. This means that, it will align the national response with the international and regional human rights requirements and it will further promote the rights of PLHIV and those at risk of exposure.

It should be noted that, the recommendations contained in this report are anticipated to be implemented by both the government institutions coordinated as part of the multisectoral response, private entities including PLHIV and NGOs working in the field of HIV and AIDS as well as international community and development partners who support national HIV response initiatives.

1.6 Geographical Coverage
Data for this survey were collected in eleven regions of Tanzania mainland and the two islands of Zanzibar - Unguja and Pemba. Selection of the regions was mainly informed by the prevalence rate in the region. In this respect, regions with high prevalence above the national average of 5.1% and those with low prevalence below the national average of 5.1% were all involved in the survey. In this respect the following regions from mainland Tanzania were selected; Tabora, Katavi, Shinyanga, Mara, Dar es Salaam, Coast, Mbeya, Rukwa, Njombe, Iringa and Ruvuma.

1.7 Approach in Conducting LEA
In conducting Legal Environment Assessment the team adopted a human rights-based approach. In this respect during the literature review specific attention was given in analysing international, regional and local legal and human rights instruments together with other political commitments made by Tanzania. Design of the working tools together with analysis of the findings also took a human rights approach. In this respect, when analysing the concerns of the vulnerable and at risk groups the team was guided by principles such as equal access to services, equality and non-discrimination, greater participation in decision making, meaningful inclusion in programming, accountability and groups capacity development.

There are numerous advantages associated with adopting the human rights- based approach when conducting LEA. This approach examines the underlying root causes of inequalities, discriminatory practices and unjust power relations driving the HIV epidemic in Tanzania. It questions the root causes of the main factors considered to be fuelling the HIV transmission in a particular country and offer a viable approach in addressing the identified challenges. Human Rights based approach has been for a long time used by UN Agencies such as United Nations Joint Programme on HIV and AIDS (UNAIDS) and World Health Organization (WHO) in programming and analysing the various underlying obstacles in scaling up effective health and HIV and AIDS programs. Among others use of the human rights based approach in programming and evaluating programs has revealed the following;

a) That, there is a close link between failure to safeguard human rights and vulnerability to HIV. This is to say, marginalized populations live under inequality and as a result
suffer prejudices and limited access to basic services such as education, nutrition and health care services. Direct consequences of this is that they become vulnerable and they are exposed to a higher risk of been infected with HIV. Again the burden of HIV infection and AIDS is more often and severely felt by this category of people especially the most marginalized, women, girl children and elderly.

b) Failure to protect the rights of the PLHIV, subject people infected and affected by HIV into stigma and discrimination which leads to further marginalization. The direct result of this stigma and discrimination is heightened marginalization in accessing health services because of their HIV status. As a result of discrimination and denial of services the circle of HIV vulnerability continues.

It should be noted that, for effective HIV response and intervention programs, adoption of the rights based approach is paramount as it ensures access to services for the infected and affected. It takes on board the interests and specific needs of those who are vulnerable and at the higher risk of been infected who are key in reducing the rate of HIV infection. Ensuring availability and access to HIV services to all people is essential in ending new infections and all other HIV and AIDS related deaths in the country.

1.8 Methodologies for Conducting LEA

In introducing the study, the LEA team began the assignment by conducting literature review of various public health and human rights related documentations. This included a review of the whole legal framework in the country which includes all laws, regulations and policies directly or indirectly related to HIV and AIDS in the country. After such review the team was engaged in other stages as shown in the table below.

**Stage One: Preparation of Inception Report**

At this stage Consultants prepared the Inception Report and presented to the Technical Working Group (TWG) comprised of members from Zanzibar and Tanzania Mainland. The aim was to show the roadmap for the assignment at hand and also to obtain their input on the key focus areas in conducting LEA in Tanzania. Writing of the inception report was also accompanied by identifying and gathering all necessary materials needed to be reviewed at the literature review stage.
Stage Two: Literature Review
At this stage the consultants indulged in analysing legal and regulatory framework/documentations in both Tanzania Mainland and Zanzibar. The main point at this stage was to examine the extent to which the existing legal framework upholds the rights of PLHIV and those vulnerable to it as well as enhancing proper HIV interventions while on the other hand was to examine the extent to which it may undermine HIV and AIDS intervention initiatives.

Stage Three: Field Work
During the field work the team of experts indulged in conducting data collection in which various groups of people and Key Informants (KI) were consulted. These were such as PLHIV, Health practitioners, members of the civil society, members of the key populations groups and policy makers. From the field, the team consolidated the first LEA Zero Draft Report and convened the TWG meeting to share findings from fieldwork.

Stage Four: Focused Groups Discussion
As part of the assignment and having finalized zero draft of the report, consultants convened three major Focused Groups Discussion meetings. These were one on mainland Tanzania held in Bagamoyo. This meeting was partly attended by participants from Zanzibar. The second meeting was held in Dodoma which was attended by members of the Parliamentary Standing Committee on HIV and AIDS and the third one was held in Zanzibar which was attended by representatives from both the Government of Zanzibar and other stakeholders from the private sector and civil society.

Stage Five: Report Consolidation
After the Focused Group Discussion meetings the Consultants edited the report and wrote Chapter Three of the Report, which covers recommendations on the main findings of the report.

Stage Six: Validation Meeting
The Validation meeting was convened and inputs from this meeting were incorporated into the Final draft of the report, ready for printing and dissemination.

1.8.1 Literature Review
As mentioned above; desk review targeted the review of different published materials, both legal and non-legal documents. These documents included policies, legislations, regulations, guidelines, reports and research papers. The Consultants had access to various study reports related to HIV and AIDS in Tanzania. Other consulted materials were such as, international conventions and declarations pertaining to HIV and AIDS, some of these are detailed and analysed in the subsequent parts of this report. It should also be noted that Tanzania is not
the first country to undertake LEA hence great deal of experience was borrowed from countries which have undertaken LEA so far such as Malawi and Seychelles. Also this process involved looking at practices in other countries, for instance Burundi and Kenya that have HIV and AIDS specific laws for comparison purposes.

1.8.2 Consultations with Key Informants and Target Groups
This was conducted through field survey and involved interviews of key stakeholders. A question guide was developed for this purpose and is attached to this report as an appendix (see Appendix 1). The procedure was to document the public awareness and understanding of the existing HIV legislative framework. In addition, to seek stakeholders views on the identified gaps in policies, legislations, regulations and guidelines to strengthen the legislative environment for effective HIV and AIDS response in Tanzania. The target groups at this stage included government decision makers, individuals from the government, civil society organizations, development partners, PLHIV and or people affected by HIV, KPs which included people who practice anal sex with specific attention to Men who have sex with Men (MSM), Sex Workers, People who inject drugs (PWIDs), prison inmates, migrants, youths, women and girls or their network organizations and service providers. As mentioned, this process was guided by the use of both structured and unstructured interviews with the view to accommodating all relevant stakeholders and their respective viewpoints.

1.8.3 Technical Working Group (TWG)
The LEA study was overseen by the TWG, which guided the team leader (Leading Consultant) in the process of undertaking the assignment. Their mandate was but not limited to; reviewing all the reports from the Consultants in every stage of the assignment and provide input for the improvement of the report. The TWG also reviewed all the documents used in the field study and guided the Consultants on who were the key stakeholders and informants to be consulted in the process. They were also the final decision makers with regard the acceptance of the final submitted report on this task. TWG was comprised of the representatives from the following institutions;

Mainland Tanzania
1. Tanzania Commission for AIDS
2. Prime Minister’s Office
3. Law Reform Commission
4. Judiciary
5. Attorney Generals Chamber – Director of Public Prosecution
6. National Aid Control Program
7. School of Law of the University of Dar Es Salaam
8. Ministry of Health and Social Welfare
9. Community Health Education Services and Advocacy (CHESA)
10. United Nations Development Program (UNDP)

**Zanzibar**

1. Ministry of Health (MOH)
2. Zanzibar AIDS Control Programme (ZACP)
3. First Vice President Office
4. Zanzibar AIDS Commission (ZAC)
5. Zanzibar Association of People Living with HIV (ZAPHA+)
6. State University of Zanzibar (SUZA)
7. State Attorney from Zanzibar Attorney General’s Chamber
8. Zanzibar Law Review Commission
9. Zanzibar KPs Network
10. Zanzibar Prison Officer
11. ICAP – Drug Users
2.1 Introduction to HIV Prevalence in Tanzania
Since the first three AIDS cases in Tanzania in the late 1980s the rate of HIV prevalence has been slowly decreasing in mainland Tanzania while in Zanzibar prevalence rate doubled between 2008 and 2012. The national rate of HIV prevalence in urban was reported to be higher compared to that of the rural areas. In urban HIV prevalence was 7% while in rural areas it was 4%. In Tanzania mainland HIV prevalence in urban was higher by 5% compared to that of Zanzibar which was higher by 1%. The survey also indicated that, HIV prevalence among the people who had STI and STI symptoms in the past twelve months before the survey was higher compared to those who had not contracted STI or STI Symptoms. (THMIS 2011 – 2012)

In Tanzania some regions shoulder heavier burden of the epidemic than others. The number has been fluctuating and again there are numerous reasons assigned to this condition. Some of these include ignorance on the modes of HIV transmission, gender imbalance and gender violence, abuse of narcotic drugs and many others. Below is the map showing the prevalence rate per region;
As stated in part one, selection of the regions to participate in the study for LEA took into consideration the prevalence rate of the regions. Both regions with high and low prevalence were selected for proper sampling, effective data representation and analysis comparison.

2.2 Trend on the HIV Prevalence in Mainland Tanzania
As stated above, in mainland Tanzania HIV prevalence rate has decreased. Various factors are associated with the decrease trend of the HIV prevalence in the country which among others includes public knowledge and awareness on the modes of transmission and increased supply and availability of the HIV prevention services in the society. However, statistics shows that key populations are more infected than other members of the society.

As table 1 below shows, despite the decrease of the HIV infection rate in the country still there are new infections incidences and substantial part of the population remain infected and in need of support services. THMIS statistics shows that, in 2011 – 2012\(^4\) the HIV prevalence rate in mainland Tanzania was 5% among adults aged 15 – 49. The average of 6% of women and 4% of men were infected by HIV at this period of reporting. The data presented by the table 1 below shows that, the number of infected women is higher compared to that of their counter parts by at least 2%. Numerous reasons have been assigned to this trend and discussed in the following parts of the report. However, legal framework, policies and practices which impede access to HIV services not only to PLHIV but also to other key populations has been identified as a cause hence a basis for undertaking this study.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percentage</th>
<th>Year</th>
<th>Percentage</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence among the adults aged 15 - 49</td>
<td>5.7</td>
<td>2007-2008</td>
<td>5.1</td>
<td>2011 - 2012</td>
</tr>
<tr>
<td>Rate of Infection for women aged 15 - 49</td>
<td>6.6</td>
<td>2007-2008</td>
<td>4.6</td>
<td>2011 - 2012</td>
</tr>
</tbody>
</table>
2.3  Trends of HIV Prevalence in Zanzibar

Unlike Mainland Tanzania, Zanzibar has a concentrated HIV epidemic. The two population based surveys in Zanzibar namely: HIV validation survey (2002) and Tanzania HIV/Malaria Indicator Survey (THMIS2 - 2008) shows HIV prevalence in Zanzibar among the sexually active people to be 0.6% in 2008 with estimated 7,200 infected people. It increased to 1.0% in 2012 with estimated 13,000 infected people. Despite the increase rate of new infection from 2008 to 2012, the 2013 Epidemiologic Profile Report and ANC Sentinel Surveillance Data in Zanzibar have reported HIV prevalence to be stable.

The highest rate of prevalence in Zanzibar is at Urban West, which is the most populated part of Zanzibar. South Pemba and South Unguja are the next highest prevalence regions. As in mainland Tanzania, the HIV prevalence in Zanzibar is higher among females than males in all regions except for North Pemba\textsuperscript{15} Among women HIV prevalence is at (1.1%) 2012 from (0.7%) in 2008 compared to men (0.9%) 2012 from (0.5%) in 2008. In Unguja it is (1.2%) 2012 from (0.8%) in 2008 while in Pemba Island has remained stable at (0.3%). (For the varied prevalence between males and females per region in Zanzibar see the following table below)
As mentioned above, Zanzibar has concentrated HIV epidemic; with higher infection rates on key populations compared to that of the general population which is 1.0% (THMIS 2012). For instance, the Epidemiological Profile Report observed the decrease HIV prevalence rate among the 15-24 year old women but on the contrary, evidenced the increased prevalence rate among the 35-44 year old women. Other outlined affected groups of key populations are such as men who have sex with other men, commercial female sex workers, injecting drug users and prisoners/ persons under incarceration i.e. in reformatory colleges/schools.

Apart from the above key populations, the 2010 ANC Sentinel Surveillance shows a significant difference in infection rate among women who are either single or married. For women who are single it is at 1.7%, married 0.5% and divorced 6.5%. Divorced women were found to be 13 times more likely to have HIV infection compared to the married women. Several reasons are associated with this factor including multiple partner sexual practices after divorce, gender based violence which leads to divorce, transactional sex after divorce and general unsafe sex practices after divorce.
PART THREE: AVAILABILITY AND ACCESSIBILITY OF HIV AND AIDS SERVICES BY KEY POPULATIONS

3.1 Key Populations
According to the global trend, key populations have been identified to mainly include PLHIV, Sex workers including their clients, men who have sex with other men and women who practice anal sex, injecting drug users and prisoners (UNAIDS Terminology Guidelines 2011). Tanzania follows the same international standard definition of Key Populations but also consider other vulnerable groups who may also be at the higher risk of HIV transmission and are given special attention in programming. These include women and girls, youth, people in conflict and post-conflict situations, refugees and internally displaced persons, migrant labourers and people working in mining, fishing industry and their surrounding communities (NMSF III 2013/2014 -2017/2018). According to NMSF III 2013/2014 -2017/2018 the studies conducted in various regions of Tanzania showed varying degrees of HIV prevalence among key population groups, with high prevalence among MSM, FSW, and PWID all above the national average. Other outlined groups with higher infection rate and which deserve special consideration in HIV programming are identified to include prisoners, long-distance track drivers, disabled (in all forms) and children.

3.2 Availability of HIV Intervention Programs
As an intervention program the government has taken various steps to ensure availability of the HIV related services and other intervention programs to the public. These are such as establishment of HIV testing and counselling centres (CTC), provision of free Anti-retroviral medicines (ARVs), establishment of Prevention of Mother to Child Transmission (PMTCT), establishment of CD4 Count Test Centres, Treatment of STIs and many other initiatives. This part provides an overview of each of the services provided and their accessibility to the target population.

In Zanzibar a significant progress has been made on the component of prevention whereby there is for instance 85% coverage of ANC for HIV testing. Parallel to the provision of these services, other tremendous efforts have been directed to
development of other programs such as capacity building through development of training modules for Training of Trainers (ToT) and sensitisation programs.

Despite the fact that, there have been and still are various efforts to scale up HIV intervention such as ensuring availability of ART services as well as establishment of CTC’s in Tanzania (both Mainland and Zanzibar), the study revealed inadequacy of these services especially in rural areas.

Most of the areas affected by inadequacy are those located in remote rural areas compared to similar divisions in urban areas. Accessibility to health centres is still a challenge to many in rural areas. According to the latest report (THMIS III), only thirty four percent (34%) of Tanzanian households are less than 2 kilometres away from a health facility, and 43% are within 2 to 5 kilometres. On the Mainland, only 33% of the households reside less than 2 kilometres from a health facility. However, not all HFC’s are designated as CTC’s but also not all services are available in all CTCs in the country which worsen the situation. The study further observed that stock outs in most rural based health centres are common as well as shortage of human resources.

3.3 Stigma and Discrimination and Access to HIV and AIDS Services

As mentioned in the paragraphs above, it has been mentioned that, one of the very big identified stumbling blocks for the public to access HIV related services is stigma and discrimination associated with the groups of people targeted to access these services. In this respect and as part of the assignment, the Consultants examined the extent to which stigma and discrimination has resulted into the denial of access to HIV and AIDS services to the public. In analysing this situation specific attention was given to the often-referred victims of stigma and discrimination and in this respect the KPs.

During the interview the respondents reported groups shown in figure 3 below as currently the most discriminated in the society. However, these are also the same groups identified as KPs in relation to HIV in the country.
3.3.1 People Living with HIV

Various studies that were conducted in Tanzania have shown the high levels of HIV-related stigma and discrimination against PLHIV even for those perceived to be HIV positive. Studies indicate that, this discrimination cut across various levels and sectors i.e. the family level, in the community, in health care facilities, hospitals, in religious and other social gathering and at the workplace.

“A Nurse in Bagamoyo explained to the researcher various incidences of discrimination of fellow health care workers by their supervisors and also co-workers due to their HIV statuses. She mentioned that some of the workers decided to quit their job due to stigma they faced at their work place.

(Response by the health care worker in Bagamoyo District Hospital)

Even though the response from the respondent and assessment of the findings confirm existence of stigma and discrimination, there is an indication that, stigma has decreased in the public institutions but remain a problem in the community and at the family levels. In other instances it was reported that stigma against PLHIV creates and exacerbates self-stigma among the PLHIV hence making it impossible for them to access the available health services such as prevention, treatment, care and support services offered at various public settings.
I'm aware of a person who has been treated in a discriminatory manner by an institution. My uncle was terminated from his employment, after he reported to the employer that he is HIV positive”. (Response by the member of the public in Katavi Region)

During the Key Informants interviews, various types of stigma were discussed and revealed by the participants and these are; exclusion from participation in various public activities, gossiped, excluded in family affairs, rejected by sexual partners even husbands, discriminated in inheriting family properties and labelling in schools for children who are HIV positive. A woman attending antenatal clinic in Iringa Municipality stated as follows:-

“I feel discriminated when attending clinic. While all other women sit and receive services from that other side all of us who are HIV positive are directed to come to the backside of the hospital where we are attended. When you are told to come at this side everyone know you are HIV positive and information spread so fast in town”

(Response by the pregnant mother at Iringa regional hospital – Iringa Municipal)

3.3.2 Women and Girls including Pregnant Women
As mentioned above, HIV in Tanzania affects women adversely compared to their counterparts’ men. Various theories on why this is the situation varies from biological, social inequalities and general vulnerability of women in the context of HIV. Systemic social exclusion and gender inequality experienced by women in the country perpetuated by the practice of harmful cultural and traditional norms reinforce their low socio-economic status hence making them vulnerable to HIV than their counterparts. This theory explains why women are severely affected by HIV compared to their counterpart’s men as indicated in the prevalence rate table showed above.

It was revealed during the study that women who are HIV positive in Tanzania Mainland as well as in Zanzibar suffer double discrimination. The first one is general discrimination which all women suffer in accessing social services and secondly, discrimination for been HIV positive women.
It was reported that nurses at Mwembe ladu hospital refused to attend a pregnant mother who was alleged to be HIV positive and had not attended PMTCT clinic for fear of been exposed. However, there was no clear report on the concrete steps taken either by the victim or hospital to challenge such discrimination. (Response from the health care worker in Zanzibar)

At the family setting, some women whose husbands died of HIV related infections are been blamed by the deceased husbands’ relatives for been the cause of death for their husbands. In various instances this has resulted into violence for the widows from the husbands’ relatives accompanied by property grabbing and expulsion from matrimonial homes. It was also reported during the assessment that women who are HIV positive experience heightened forms of discrimination and violence from their intimate partners which include assault, being thrown out of the family home, denial of services including sexual intercourse.

““There is an incidence that was brought to me by a lady who was stigmatized by her husband who eventually married another wife. The husband prohibited her from using jointly acquired family properties in the household just because she was infected. Worse still he accused the woman of being HIV positive without having any evidence for it while he personally was not ready to undergo HIV testing. This situation made this woman desperate and totally lost hope for survival.” (Response from the Police Officer at the Police Gender Desk Section in Songea- Ruvuma Region)

Also women reported discrimination within the health care sector as said above. This response was also obtained during an interview with women where response was as shown below;

““When I was pregnant I tested and found out to be HIV positive. I informed my husband who also tested and found to be HIV positive. When I delivered, my cousin came to visit me at the hospital and on her way out the ward where I was admitted a nurse followed her and warned her not to wash my clothes as I was HIV positive. Fortunately my cousin and other close relatives were
aware of my status. My cousin came back and informed me what the nurse had told her... I was very much disturbed and reported this conduct. The doctor called her in my presence but in private and asked her whether she had released the information to the cousin. She admitted of saying that and was reprimanded and warned that in the event of committing the same misconduct in future, a serious action would be taken against her.”

(Response from the member of public from Songea, Ruvuma Region)

In mainland Tanzania pregnant women reported to be subjected to compulsory HIV testing and are not given any opportunity of ‘opting out’ of HIV testing contrary to what international standards and HAPCA require. In Zanzibar, HIV testing for pregnant mothers is compulsory which forces all pregnant mothers to test HIV involuntarily. In the caption below are the provisions of HAPCA and Zanzibar Prevention and Management of HIV and AIDS Act, Act No. 18 of 2014 in relation to pregnant women.

**Section 15(1) of the HAPCA 2008 prohibits compulsory testing for HIV. However in relation to the pregnant women the same Section 15 (5) states;**

“Every pregnant woman and the man responsible for the pregnancy or spouse and every person attending a health care facility shall be counselled and offered voluntary HIV testing”

**In Zanzibar, Zanzibar Prevention and Management of HIV and AIDS Act, Act NO.18 of 2014 Section 20 provides that;**

(1) Subject to this Act, no person shall compel another to undergo an HIV test.
(2) Without prejudice to the generality of subsection (1) of section 20 of this Act, no consent shall be required on HIV testing where:
(a) under a court order
(b) on donor of human organs and tissue,
(c) to sexual offenders, and
(d) for the pregnant women

3.3.3 People who Practice Anal Sex

In Tanzania mainland, the National Multisectoral Strategic Framework III has identified MSM as one of the key populations group. NMSF III 2013/2014 – 2017/2018 reports that the rate of infection among the MSM is at 41% which is almost seven times higher the national average. On the other hand, same-sex sexual relationships in Tanzania
are not only criminalized but also highly stigmatized. As a result, MSM in the country are being forced to live ‘underground’ life with limited access to public services especially health services.

Due to the high levels of stigma and discrimination attached to MSM practices, it was reported that, it is particularly difficult for the MSM to openly disclose their sexual orientation or practices at health care facilities (HCFs) or attend treatment with their sexual partners and or obtain treatment on STIs openly. The quoted story below explains;

“The problem is not only providing health services to MSM but also the way people look at them in the hospitals like they are people who do not deserve health services. Some even say that such people do not deserve to be treated because they know what they are getting themselves into. It is a challenge because even the health workers attending MSM perceive them to be immoral. Most people perceive MSM as sinners who need some divine intervention or some medical treatment to make them stop their practices. (Response from the Medical Practitioner at Muhimbili National Hospital – Dar es Salaam)

Even though HIV prevalence among the MSM is quoted to be as high in both sides of the country, still criminal laws continue to criminalize same sex relationship and thus result into increased stigma and self-stigma for MSM. For instance, it is particularly impossible to supply this category of people with specific services such as HIV and AIDS prevention direct products such as condoms and lubricants or other specific educational messages.
Section 154 of the Penal Code provides;

Any person who (a) has carnal knowledge of any person against the order of nature or ... (c) permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of a felony and is liable to imprisonment for 14 years.

This provision is similar to Section 150 of the Zanzibar Penal Act, Act No. 6 of 2004 which also states that;

Any person who: (a) has carnal knowledge of any person against the order of nature; (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature is guilty of a felony, and is liable to imprisonment for a term not exceeding fourteen years.

Section 153 of the Zanzibar Penal Act (supra) provides;

Any woman who commits an act of lesbianism with another woman whether taking an active or passive role shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years or to a fine not exceeding five hundred thousand shillings.

Section 158 of the Zanzibar Penal Act (supra) States;

Any person who: (a) enter or arrange a union whether amounting to marriage or not of the person of the same sex; (b) celebrate a union with another person of the same sex whether amounting to marriage or not; (c) lives as husband and wife with another person of the same sex; shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding seven years.

During the assessment, some key informants at national and regional levels stated that health centres (or Health Care Facilities) provided treatment to all people regardless of the beneficiary’s sexual orientation. When the researchers organized a Focused Group Discussion with MSM in the same region and asked on their accessibility of specific HIV related services at the HCFs, it was realized that there were no specialized services tailored for them whilst at the same time health care workers were unaware of the existence of any MSM within the said region.

“MSM cannot be so many as they are in bigger towns and cities like Dar es Salaam”. In fact MSM come from Dar es Salaam to the rural areas” (Response from three different health care workers in regions of Iringa, Rukwa and Ruvuma)
When asked on what should be done to ensure MSM access friendly health services, many of the health workers respondents stated that, there should be created friendly health services for everyone that would also be responsive to group needs and in particular accessible to all including MSM without any discrimination.

“...the fact that this is a bigger group among the groups that are at higher risk of infection, ignoring them or pretending that MSM do not exist makes it a bigger problem taking into account that some of these men are bisexual thus increasing the risk of infection at a large scale. Until we appreciate this fact, address this issue and provide health care and education on HIV and AIDS to MSM we will continue to treat the disease and forget to deal with the source of the problem and in this respect we will not achieve the bigger targeted results which is an HIV free nation”

(Comment from a medical doctor at Muhimbili National Hospital- Dar es Salaam region)

It is important to note that in Tanzania the issue of anal sex is not only practiced by the MSM but also women. It was also reported that, even for women who engage in anal sex practices equally face discrimination as men. Most of the women who practice anal sex equally face discrimination from the health workers especially during delivery. Discrimination for this group is form of both abusive language and denial of service from the health care workers.

It should also be noted that, stigma perpetuated against the MSM inculcate in them the spirit of self-stigma due to fear of repression from the authorities. For this reason, it becomes difficult for them to report discrimination in accessing health services, when abused by members of the society and/or by law enforcement personnel. The consequences of these practices are creation of barriers for them in accessing HIV services hence continued high prevalence of discrimination among the group members.

3.3.4 Sex Workers
In Tanzania Sex Workers (people who engage in transactional sex) have been identified as one of the key population groups. This is due to the fact that this group is not only at the higher risk of been infected but also at the higher risk of infecting
other members of the community if they do not practice safe sex. It was also observed from the literature review that transactional sex in Tanzania is prohibited and people who engage in this business are frequently arrested but not charged for prostitution but loitering and other offences.

Section 145 of the Penal Code States;

1) Every male person who—

(a) Knowingly lives wholly or in part on the earnings of prostitution; Or (b) in any public place persistently solicits or importunes for immoral purposes, is guilty of a misdemeanour. In the case of a second or subsequent conviction under this section the court may, in addition to any term of imprisonment awarded, sentence the offender to corporal punishment.

(2) Where a male person is proved to live with or to be habitually in the company of a prostitute/or is proved to have exercised control, direction or influence over the movements of a prostitute in such manner as to show that he is aiding, abetting or compelling her prostitution with any other person, or generally, he shall unless he shall satisfy the court to the contrary be deemed to be knowingly living on the earnings of prostitution.

This provision is “in tandem” with Section 141 (1) (2) of the Zanzibar Penal Act No. 6 of 2004 and Section 154 of the Zanzibar Penal Act States;

Any person who for consideration offers her or his body for sexual intercourse commits an offence and shall on conviction be liable to imprisonment for a term of three years.

Criminalization of sex work in Tanzania poses various challenges to the already at risk group. It is difficult for the sex workers to identify themselves as such for the fear of repression from the authorities. In this respect it is impossible for this group to organize into recognized groups where they would be provided with support services including HIV related services. Apart from that and by failing to surface, this group of people is often forgotten in programming for HIV related interventions while medical practitioners fail to provide required services to the sex workers for fear repression on accusation of aiding sex work which is contrary to section 145 (2) of the Penal Code.17

Apart from not being able to access HIV related services, Sex workers fail to report abuses directed to them by their customers and law enforcers. Victims testified that, sex workers experience various forms of violence which include rape, assault, arbitrary
arrest, intimidation and harassment and some of these happen in the hands of the law enforcers at the time of arrest. It is impossible for them to report these abuses or obtain redress due to fear of being arrested and subjected to other legal proceedings and or been further discriminated against.

“T
he society has a negative attitude towards sex workers. Sometimes even the health attendants have discriminated sex workers while providing medical services. Most people have the wrong notion that sex workers have brought upon themselves all the sexually transmitted diseases that they get including HIV. (Response from a nurse at Temeke Municipal Hospital – Dar es Salaam region)

Zanzibar Penal Act No. 6 of 2004 has the following provision in relation to sex work.

**Section 140 of the Zanzibar Penal Act States;**

Any person who for consideration offers her or his body for sexual intercourse commits an offence and shall on conviction be liable to imprisonment for a term of three years.

Based on the above provision of the Penal Act, sex work in Zanzibar is illegal, but still exists and practiced by both women and men in Unguja and Pemba. It should be noted that, the presence of sex workers in Zanzibar poses a public health concern and need to provide them with adequate HIV related services is necessary.\(^{18}\)

### 3.3.5 Prisoners

Prisoners (including young offenders) are identified as key populations at higher risk of HIV exposure. One of the very alarming situations facing people under detention facilities is the emergence of new infection in prison settings.\(^{19}\)

“I
n Zanzibar the remandees/ imprisoned person seem to be less valuable in the society in receiving special services like HIV testing and ARV”. (Response from a former prisoner in Pemba, Zanzibar)
Beside the fact that there have been HIV positive people in detention facilities, it was discovered that there is lack of basic health services in many of the detention facilities. Apart from that, when consulted HIV positive inmates reported to have no sufficient dietary supplements to enable them to use provided medication.

“I n fact, most of the prisoners have no adequate access to HIV preventive and care services. Although in some cases they are allowed to access HIV treatment at designated government hospitals” (Response by prison officers in Iringa and Tabora regions)

One of the interviews conducted country wide; inmates reported that sex between men occurs in prison settings. Apart from that they also reported other forms of human rights violations such as overcrowding, lack of basic necessities and limited access to health services such as HIV prevention, treatment, care and support services. In Tanzania, the penal code criminalizes same sex relations while at the same time they occur in prison settings thus collectively hinder distribution of preventive products such as condoms in prisons.

3.3.6 Injecting Drug Users

Although the present studies show that HIV/AIDS prevalence rate in Tanzania is decreasing in the general population to at latest 5% among the adults, still epidemic prevalence is reported to be high among the injecting drug users (IDUs). Various factors are associated to the high prevalence among the IDUs in Tanzania. These are such as the use of contaminated injection among the PWIDs, sexual transmission resulting from practicing unsafe sex among PWIDs and their sexual partners. Others are engaging in high risk sexual behaviours and mother to child transmission.

There are numerous reasons assigned to the growth rate of PWIDs in Tanzania which include lack of parental supervision for the young generation, high rates of unemployment, easy ways to obtain abuse substance such as heroin and peer group pressure. As said above and in accordance with the undertaken researches, it is well established that most of the new HIV infections among the PWIDs occur due to factors
such as practicing unsafe among the PWIDs\textsuperscript{22} while others are due to sharing injection syringes.

In Zanzibar for instance, the study conducted showed that\textsuperscript{23} while the HIV prevalence ranged from 0.6\% in the general population it was 30\% higher among the IDUs and 12\% among the non-injecting drug users. The average age of drug users is 31 years (ranging between 17 and 68 years) while the age of drug debut is 18 years with 12\% starting before the age of 14 years. It was also found that the IDUs who share needles (46\%) had higher infection rates compared to those who did not share needles (HIV: 28\% vs. 5\%, hepatitis C: 31\% vs. 7\%) which was also very significant among the female IDUs whose HIV prevalence was at 13\%.\textsuperscript{24}

Despite the evidence that HIV prevalence among the IDUs is alarming, still this group of people faces high stigma and discrimination especially in accessing HIV related services in the public HFCs. However, there are very limited Government tailored programs that offer intervention programs for PWIDs in Tanzania posing a significant challenge in reducing HIV prevalence in this group.

\begin{quote}
\textit{The IDUs in the society are perceived to be thieves and in many health centres do not receive proper health services (Response from a member of CSO working with IDUs in Zanzibar)}
\end{quote}

While some of the NGOs volunteer to offer harm reduction service to PWIDs\textsuperscript{25}, in Tanzania, still the Penal Code, the Drugs and Prevention of Illicit Traffic of Drugs Act and Zanzibar Penal Act\textsuperscript{26} prohibits drug abuse and criminalize drug abusers as well as those who aid drug abusers. These evasive provisions pose risks for people involved in PWIDs harm reduction programs. They fear arrest, repression and prosecution for abetting the use of drugs. In this respect and despite the overwhelming evidence that PWIDs HIV infection is caused by sharing injecting needles still supply of clean needles remains a challenge as it is unlawful practice. In Tanzania mainland and Zanzibar, it is still not possible to scale out many of the harm reduction interventions due to controversies posed by the existing criminal laws in the country.
3.3.7 People with Disabilities
People with disabilities have been identified as a vulnerable population due to their already marginalized status and vulnerability to human rights violations. They further have limited access to employment and HIV prevention, treatment and care services. People with disabilities are also at high risk of HIV exposure due to their limited ability to negotiate safer sex and their risk of rape and sexual abuse. Like women with HIV, women with disabilities are reported to have been stigmatized at health care services and being advised not to conceive.

People with disabilities have been reported to have limited HIV knowledge as they are unable to comprehend some of the HIV related messages. This is because many of these messages are printed in popular media excluding majority of disabled. When asked the manner in which they offer HIV services to disabled, health care officers admitted to have challenges to communicate effectively with people with disabilities due to lack of communication capacity and facilities.

“Most of HIV counsellors cannot communicate with people with hearing disabilities. This is because they do not understand sign language. It is easy for them to attend a disabled person who can write and read but for those without this ability have no remedy. (Observation by researcher from Dar es Salaam and Coastal Regions but shared by all the researchers in all regions).

3.3.8 Fishermen
In Zanzibar like in many other African countries, men dominate fishing industry. The fishermen in Zanzibar are composed of mainly young, strong and healthy males who are aged between 15-44 years. When interviewed, they expressed that, HIV & AIDS has negatively impacted their lives whereby incidences of isolation of a fisherman living with HIV within the fishing camps was reported, loss of active labour force within the fishing camps due to AIDS related diseases, loss of livelihood for families of the fisherman living with HIV, death and psychological trauma to the fisherman living with HIV and new HIV transmission from fishermen to their spouses and vice versa.
When interviewed on the factors that fuel HIV transmission on this group they expressed among others the following factors; working conditions and social interaction which fuel the spread of HIV due to inadequate access to HIV information within their camps and inadequate or limited access to preventive services such as condoms. Lack of recreational facilities and social amenities and working away from home for extended periods of time are few of other reported factors that fuel HIV transmission. The local women within fishermen communities lure fishermen with transactional and commercial sex offers in exchange of fish or other sea products. Frequent exposures to injuries from the sharp instruments they use while fishing are also few of the other factors that may fuel transmission in this group. In addition to working conditions, the fishermen also feel that certain attitudes and behaviour of fellow fishermen could further fuel the spread of HIV. Attitudes highlighted include: Fishermen defying danger and hazard as a way of life, Fishermen subscribing to risky peer pressure and objecting the use of condoms during sexual intercourse. Practices and behaviour noted by the fishermen as facilitating the spread of HIV included: Men having sex with men in the fishing camps, usage and abuse of substances and engagement in risky multiple sexual practices mainly with sex workers, neighbourhood women, women petty traders famously known as “mama ntilie” and fish vendors. Fishermen felt that there is an urgent need to control the spread of HIV within the camps in an intense and sustainable manner.

3.3.9 Clove pickers
Even though this is very seasonal activity it has been described that, the clove pickers in Zanzibar especially in Pemba Island are at high risk of contracting HIV. This is because; during the clove picking season, the clove pickers reside in camps for period of up to three months. Though men and women reside in different camps, it was revealed that men often cross to women camps and engage in unprotected sexual intercourse with women. Such practices put this group at a higher risk of HIV transmission.

25
CHAPTER TWO
GENERAL LEGAL AND REGULATORY FRAMEWORK ON HIV AND AIDS IN TANZANIA

PART ONE: AN OVERVIEW OF LEGAL AND REGULATORY FRAMEWORK ON HIV

1.1 Introduction

1.2 Domestic Coordination Mechanisms
Within the existing Legal Framework in Tanzania, there is an established robust institutional and regulatory framework on HIV and AIDS. Some of these institutions established by legislations include: the Tanzania Commission for AIDS, under the Prime Minister’s Office in Tanzania Mainland, the Zanzibar AIDS Commission, under the First Vice President’s Office in Zanzibar, the National AIDS Control Program under the Ministry of Health and Social Welfare, Tanzania Mainland and the Zanzibar AIDS Control Program under the Ministry of Health, Zanzibar, currently known as Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP). These institutions are responsible for coordinating and overseeing HIV and AIDS related activities including those performed by NGOs in Tanzania but also work closely with the Ministries of Health for both Tanzania Mainland and Zanzibar respectively.
In mainland Tanzania, each ministry has an AIDS focal point with focal persons working exclusively on HIV related matters. Ministries in consultation with TACAIDS set priority HIV/AIDS activities at the ministries level. Some of these activities are as shown in the table below;

- Drawing specific action plans and budget at ministerial level that operationalizes National HIV/AIDS control strategies
- Mainstreaming HIV/AIDS interventions at ministerial levels into ministerial programs
- Allocating and/or mobilize resources for ministerial HIV/AIDS activities
- Monitoring and evaluate implementation of planned activities
- Establishing operational and management mechanisms including Management Information Systems (MIS)
- Identifying key actors and collaborators and define their roles
- Preparing and submitting quarterly progress reports to TACAIDS Secretariat to be shared with other sectors
- Monitoring the HIV/AIDS trend in their respective areas and provide information to the TACAIDS

1.3 International Conventions Applicable in HIV Context
Tanzania being one of the Member States of the United Nations obtains guidance and inspiration from the existing various international frameworks dealing with HIV and AIDS.

However; Tanzania being a dualist state requires that treaties, conventions and international instruments to be domesticated into the domestic legal system of the country before it is applied. The provision of Article 63 (3) (e) of the Constitution provides the national assembly with the power to deliberate and ratify all treaties and agreements that Tanzania is a signatory. The full list of the ratified Conventions by Tanzania at the moment of writing this report is as shown by appendix 1 of this report.

In the case of Transport Equipment Ltd versus Derram P. Valambhia, it was held inter alia that “there must be an act of parliament to execute a treaty of which an absence of such legislations renders the treaty unenforceable. Under this system all international treaties, conventions and agreements signed and ratified by Tanzania have to be incorporated into the legal system.
through an Act of the parliament for them to be applied in the country. After ratification the incorporation process follows the same process as other national bills as stipulated under Article 97 of the Constitution.

It should further be understood that since foreign affairs is a union matter under the Constitution, the Parliament of the United Republic of Tanzania has the mandate to deliberate and ratify any international instrument to which Tanzania is a signatory. Following are some of the international instruments from which Tanzania obtains guidance from in the context of HIV:

<table>
<thead>
<tr>
<th>Convention on the Elimination of all Forms of Discrimination Against Women (1979) Article 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning</td>
</tr>
<tr>
<td>2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation</td>
</tr>
</tbody>
</table>

Apart from the above highlighted convention, there are other specific key international documents on Human Rights and HIV. These are not binding but they act as compass in providing direction to HIV and AIDS responses. These are:–

1) The UNGASS Political Declaration on HIV/AIDS, 2011 whereby countries commit to HIV and AIDS strategies that promote and protect human rights, eliminate gender inequalities, review inappropriate laws and address the specific needs of vulnerable populations

2) The UNGASS Millennium Development Goals Resolution, 2010 which reaffirms the importance of the respect for Human Rights and Gender equality in achieving the Millennium Development Goals.

4) The UNAIDS international guidelines on HIV/AIDS and Human rights, 2006 which urge governments to use its 12 guiding principles to develop enabling legal and regulatory frameworks for HIV and AIDS. The guidelines contain specific guidance on a) the creation of effective structures to manage the national response to HIV and AIDS in a manner that promotes full and equal participation b) the enactment of laws to protect basic human rights, reduce vulnerability to HIV and mitigate the impact of HIV on people’s lives and c) the promotion of access to justice through legal literacy campaigns, legal support services and monitoring and enforcement of Human Rights.

However, UNAIDS 2011-2015 Strategy: Getting to Zero for global HIV response recommends among others, that countries take steps to realize and protect HIV-related human rights, including those of women and girls, implement protective legal environments for PLHIV and key populations and ensure HIV coverage for the vulnerable communities.

### UNAIDS strategy goals by 2015:

- Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work
- Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half
- All new HIV infections prevented among people who use drugs
- Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment
- TB deaths among people living with HIV reduced by half
- People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support
- Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half
- HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions
- HIV-specific needs of women and girls are addressed in at least half of all national HIV responses
- Zero tolerance for gender-based violence

### 1.4 Regional Instruments

At regional level, there are various enacted instruments which respond to the HIV and AIDS pandemic. These include: - The African Charter on Human and People’s Rights commonly
known as Banjul Charter, the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and other related infectious diseases. Of recent, the African Human Rights Commission adopted the Resolution for the establishment of special Committee with the mandate to promote and protect the rights of PLHIV and those at risk. Mandate of the Committee on the Protection of Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV are as shown below.

<table>
<thead>
<tr>
<th>The mandate of the Committee are to;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Seek, request, receive, analyse and respond to reliable information from credible sources including individuals, community-based organizations, non-governmental organizations, specialized agencies, inter-governmental organizations, and State Parties, on the situation and rights of PLHIV and those at risk</td>
</tr>
<tr>
<td><strong>B.</strong> Seek, request, receive, analyse and respond to reliable information from credible sources including individuals, community-based organizations, non-governmental organizations, specialized agencies, inter-governmental organizations, and State Parties, on the situation and rights of PLHIV and those at risk;</td>
</tr>
<tr>
<td><strong>C.</strong> Undertake fact-finding missions, where necessary, to investigate, verify and make conclusion and recommendations regarding allegations of human rights violations;</td>
</tr>
<tr>
<td><strong>D.</strong> Engage State Parties and non-state actors on their responsibilities to respect the rights of people living with HIV and those proven to be vulnerable to these infections;</td>
</tr>
<tr>
<td><strong>E.</strong> Engage State Parties on their responsibilities to respect, protect and fulfil the rights of people living with HIV and those at risk;</td>
</tr>
<tr>
<td><strong>F.</strong> Recommend concrete and effective strategies to better protect the rights of people living with HIV and those at risk;</td>
</tr>
<tr>
<td><strong>G.</strong> Integrate a gender perspective and give special attention to persons belonging to vulnerable groups, including women, children, sex workers, migrants, men having sex with men, intravenous drugs users and prisoners; and</td>
</tr>
<tr>
<td><strong>H.</strong> Report regularly to the African Commission on Human and Peoples’ Rights</td>
</tr>
<tr>
<td><strong>I.</strong> Seek, request, receive, analyse and respond to reliable information from credible sources including individuals, community-based organizations, non-governmental organizations, specialized agencies, inter-governmental organizations, and State Parties, on the situation and rights of PLHIV and those at risk;</td>
</tr>
<tr>
<td><strong>J.</strong> Undertake fact-finding missions, where necessary, to investigate, verify and make conclusion and recommendations regarding allegations of human rights violations;</td>
</tr>
<tr>
<td><strong>K.</strong> Engage State Parties and non-state actors on their responsibilities to respect the rights of people living with HIV and those proven to be vulnerable to these infections;</td>
</tr>
<tr>
<td><strong>L.</strong> Engage State Parties on their responsibilities to respect, protect and fulfil the rights of people living with HIV and those at risk;</td>
</tr>
<tr>
<td><strong>M.</strong> Recommend concrete and effective strategies to better protect the rights of people living with HIV and those at risk;</td>
</tr>
<tr>
<td><strong>N.</strong> Integrate a gender perspective and give special attention to persons belonging to vulnerable groups, including women, children, sex workers, migrants, men having sex with men, intravenous drugs users and prisoners; and</td>
</tr>
</tbody>
</table>
| **O.** G. Report regularly to the African Commission on Human and Peoples’ Rights Seek, request, receive, analyse and respond to reliable information from credible sources including individuals,
community-based organizations, non-governmental organizations, specialized agencies, intergovernmental organizations, and State Parties, on the situation and rights of PLHIV and those at risk;
P. Undertake fact-finding missions, where necessary, to investigate, verify and make conclusion and recommendations regarding allegations of human rights violations;
Q. Engage State Parties and non-state actors on their responsibilities to respect the rights of people living with HIV and those proven to be vulnerable to these infections;
R. Engage State Parties on their responsibilities to respect, protect and fulfil the rights of people living with HIV and those at risk;
S. Recommend concrete and effective strategies to better protect the rights of people living with HIV and those at risk;
T. Integrate a gender perspective and give special attention to persons belonging to vulnerable groups, including women, children, sex workers, migrants, men having sex with men, intravenous drugs users and prisoners; and
U. Report regularly to the African Commission on Human and Peoples’ Rights

Other notable instruments, which are not binding but of significance are;

a. The Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and other related infectious diseases, 2001 that commits member states to prioritize HIV and AIDS and recognizes the impact of social and economic inequalities on women and girls as well as the impact of and barriers created by stigma, silence, denial and discrimination.
b. The African Commission on Human and Peoples’ Rights Resolution on HIV/AIDS, 2001 which recognizes HIV as a Human rights issue and calls on States to ensure protection for rights in the context of HIV.

1.5 The EAC HIV and AIDS Legal Framework
At the East African Community level, the EALA passed the HIV and AIDS Prevention and Management Bill in 2012. The Bill was assented by the Chair of the Summit in 2013.

Briefly, the bill encompasses two major inclusions: (i) Protection for a range of populations: The HIV and AIDS Management Bill provides protection to a range of populations at higher risk of HIV exposure and particularly vulnerable to the impact of HIV, rather than simply protecting people living with HIV. This significant advancement mirrors the EAC Bill’s broader
understanding of the role of human rights in relation to HIV. Protecting human rights not only reduces HIV-related stigma and discrimination but reduces the risk of HIV exposure and also reduces the impact of HIV on affected populations.

(ii) Exclusion of criminalization of intentional HIV transmission: The Bill excludes a specific offence of intentional transmission of HIV, preferring to allow Partner States to use existing criminal laws to respond to individual cases of malicious and intentional HIV transmission. It recognizes that crafting a specific offence for HIV is not a practical, enforceable response in our courts and or a response that serves a public health or HIV prevention function. Instead, it undermines HIV prevention efforts by discouraging people from testing and disclosing their HIV status and contradicting the prevention messages that encourage individual responsibility for HIV prevention. It exacerbates HIV-related stigma and discrimination and may be used to target marginalized and vulnerable populations perceived to be at higher risk of infection. It may disproportionately impact upon women who often test for HIV during antenatal care. Among the East African member states, it is the Zanzibar’s HIV and AIDS Prevention and Management Act that has reflected the provisions of the regional legislation.

The East African Community HIV and AIDS Prevention and Management Act has in as far extent as possible reflected the SADC HIV Model Law but comes short in the sense that it does not categorically specify the key populations rights to access HIV and AIDS related services as it is in the SADC Model Law. The new legislation is a light at the end of the tunnel in realization of the rights of Key populations with regard to accessing HIV and AIDS related services and serves as a guiding beacon for partner states national Laws to reflect the provisions of the Act and reform and repeal the bad laws towards achieving the three Zeros.

1.6 Domestic Legal and Policy Framework
As noted above, the HIV and AIDS epidemic is also guided by various legal instruments at the national level. These include:
1.6.1 The Constitution of the United Republic of Tanzania

The Constitution of the United Republic of Tanzania states inter alia that the primary objective of the government shall be the welfare of the people. The Constitution also provides that the government shall ensure that national economy is planned and promoted in a balanced and integrated manner and that the government and its agencies ensure everybody is offered equal opportunity without regard to their colour, race, religion or station in life. However it is worthwhile to note that objective part of the Constitution is not enforceable in court even though it provides essential rights and principles for the good public governance. (Not Part of the Bill of Rights)

On another note, though not specifically focusing on HIV and AIDS there are some specific articles of the Constitution which can be interpreted to ensuring access to health services. These provisions include Article 14 which provides for the right to life and protection. The Constitution also provides for the right to take legal action to ensure protection of the Constitution and the laws of the land. Although these provisions do not expressly provide for right to access to health, they provide basis for every person to access health related services regardless of status, race, religion or station in life.

1.6.2 The Zanzibar Constitution

The Zanzibar Constitution contains fundamental objectives and directive principles of state policy whereby the government commits to provide enough social services for the purpose of ensuring development and welfare of the people; including sufficient health services for all people. However Article 10A of the Zanzibar Constitution provides immunity for the government from been sued for non-fulfilment of this obligation and thus these provisions are not justiciable. With that regard, it is clear that though the state is committed to ensuring adequate social services to all it equally exonerates itself from legal action in case of failure to comply.

The Zanzibar Constitution provides for the right to life. This is also one of the most fundamental and basic human rights because through this pronouncement people can obtain access to medical services as one of the mechanisms to protect and sustain life.
1.6.3 HIV and AIDS Specific Legislations

As elaborated above, Tanzania Mainland is one of the very first countries to effectively enact a specific law on HIV and AIDS. Zanzibar followed suit and has also enacted a law to regulate the Prevention and Management of HIV and AIDS. This is also supported by various regional and international mechanisms that support health related rights and enjoyments in the context of HIV and AIDS. The table below shows important aspects related to the management and control of the HIV and AIDS covered by both the Acts of Parliament.

<table>
<thead>
<tr>
<th>Salient Features of the HIV and AIDS (Prevention &amp; Control) Act;</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>General duties to:</strong> Government; political, religious, traditional leaders and employers in private sector; Individuals, institutions and organizations living, registered or operating in Tanzania.</td>
</tr>
<tr>
<td>- <strong>Every person’s duty to:</strong> raise awareness, promote services reduce spread of HIV and AIDS</td>
</tr>
<tr>
<td>- <strong>Prohibits:</strong> Mandatory Testing, disclosure of HIV results, stigma and discrimination</td>
</tr>
<tr>
<td>- <strong>Offences:</strong> Wilful Transmission, Stigma and Discrimination and Abuse of Spouses of Partners</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Salient Features of the Zanzibar Prevention and Management of HIV and AIDS Act:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- General duties to: to the Zanzibar AIDS Commissions to take appropriate measures in fighting with AIDS/HIV matters in Zanzibar as well as imposing the this duty to the every person living, registered, operating in, or otherwise present within Zanzibar</td>
</tr>
<tr>
<td>- HIV and AIDS education and information</td>
</tr>
<tr>
<td>- HIV and AIDS prevention measures, practices and procedures</td>
</tr>
<tr>
<td>- HIV AND AIDS counselling and testing</td>
</tr>
<tr>
<td>- General protection of the rights of persons living with or affected by HIV</td>
</tr>
<tr>
<td>- Protection of vulnerable groups and key populations at higher risk</td>
</tr>
<tr>
<td>- Offences relating to HIV and AIDS. This includes the offence of breaching confidentiality, Misleading statement or information and Offences relating to the obstruction</td>
</tr>
</tbody>
</table>

1.7 Other Specific Legislations and Policies

There are other crucial laws, policies and strategic documents in Mainland Tanzania which guide HIV intervention programs. National HIV and AIDS Policy is one the very first HIV intervention document which guided the country in responding to HIV before the enactment of the legislation. The same policy formed the spirit of the enactment of the current HIV and ADIS (Prevention and Control) Act (supra). The HIV policy is currently under review to consider experiences and changes which have occurred in response to HIV and AIDS in the country. Apart
from the policy, Tanzania mainland periodically draws the National Multisectoral Strategic Framework (NMSF), to guide the cross sectors response to HIV and AIDS in the country. NMSFs are cross ministerial documents that guides all actors at national level in response to HIV and AIDS. These operates over a period of time (normally five years) followed by evaluation and at the moment Tanzania is implementing the NMSF III which runs from 2013/2014 – 2017/2018.

As Mainland Tanzania, Zanzibar has other various documents which guide the epidemic intervention programs. These vary from policies, guidelines, regulations, Kits and many other instruments enacted by the Government of Zanzibar. Other Political, Administrative and Research Initiatives have resulted into many other important documents both in Mainland Tanzania and Zanzibar.

It is from the above long list and explanation one can assert that Tanzania as a country has a vast and comprehensive legal framework as well as other initiatives that protect the rights of PLHIV and which seek to promote effective HIV responses.
PART TWO: ANALYSIS OF LEGAL FRAMEWORK ON PROMOTION AND PROTECTION OF HIV RELATED HUMAN RIGHTS

2.1 Introduction
The Constitution of the United Republic of Tanzania (Supra), the International as well as Regional Human Rights instruments recognize that every individual is entitled certain basic rights by virtue of being a human and that as a rule all laws and or actions are subjected to adherence with the existing human rights principles. However, in certain circumstances these rights may be limited. Limitation of the Human Rights must be subject to strict adherence to the principles laid down in the laws of the land and should be in line with the universally agreed Human Rights standards on limitation of rights. For instance, under Article 30 of the Constitution (Supra), it is clear that rights do have limitations. It is also important to note that, of late, Tanzania is undergoing constitutional reforms and the bill of rights is likely to be expanded to include many more basic human rights but also limitation of rights clearly stipulated in the proposed Constitution.

On Public health limitations, Mann J advances that international Norms necessitate restriction of Human Rights to carefully consider strict criteria to justify it and cautions that it should only be used as the last resort. Gruskin and Tarantola further that, though human rights are important, there are situations where it is considered legitimate to limit rights in order to achieve a broader public good. As described in Article 4 the public interest can take precedence to “secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order and the general welfare; and in times of emergency or when there are threats to the vital interests of the nation”. Public health is regarded as one of such public good. According to Mann J limiting rights in the context of public health should consider the following:
The goal of limiting rights may not be contrary to the purpose and principles of the United Nations Charter.

The limitation must be justified by the protection of a legitimate goal such as national security, public safety, protection of public health or public order.

Limitations can be allowed only in a democratic society which presumes a participatory decision process and capacity for redress.

A right may be restricted only if the limitation is provided for by Law.

The limitation of rights must be strictly necessary in order to achieve the public good, which carefully assessed on a case by case basis.

The limitation must be the least intrusive and least restrictive measure available which will accomplish the public health goal.

The limitation of individual rights must be proportional to the public interest, and its objective.

The limitation of rights must not be applied in a discriminatory manner.

On their hand Gruskin and Tarantola point out that any limitation should consider the following:

- The restriction is provided for and carried out in accordance with the law;
- The restriction is in the interest of a legitimate objective of general interest;
- The restriction is strictly necessary in a democratic society to achieve the objective;
- There are no less intrusive and restrictive means available to reach the same goal; and
- The restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner (UNECOSOC 1985).

Essentially all these authors agree in unison that restriction should only be the last resort in limiting Human Rights in the context of public health. This infers the fact that; human rights as inherent should be given priority in public health. It is also important to underscore at this level that, enjoyment of right to health covers significantly access to the HIV and AIDS related rights.

### 2.2 Legal Framework and Protection of HIV Related Rights

#### 2.2.1 Non-discrimination and Equality

There are numerous international and regional instruments which are articulate on the issue of Non-discrimination and equality. These include articles 2 and 7 of the UDHR, Article 2 (2) of the ICESCR, Article 2 of the ICCPR and Articles 2 and 3 of the ACHPR all these articles protect the right to equality and freedom from discrimination. Apart from these binding documents, UNAIDS has set of Guidelines which are very specific and particular on the aspect
on Non-discrimination. Guideline No. 4 of the “UNAIDS International Guidelines on HIV/AIDS and Human Rights 2006” require states to take steps to review their criminal laws to ensure they do not unfairly discriminate key populations in accessing HIV related services. It states as described below;

<table>
<thead>
<tr>
<th>Protecting equality and promoting non-discrimination in the context of HIV and AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline 4 of the UNAIDS International Guidelines on HIV/AIDS and Human Rights 2006, recommends:-</td>
</tr>
<tr>
<td>- Criminal and or public health legislation should not contain specific offences against the intentional and premeditated transmission of HIV but rather should apply general criminal offences to these special cases.</td>
</tr>
<tr>
<td>- Criminal laws prohibiting sexual acts between consenting adults (such as MSM and CSW) in private should be reviewed and laws prohibiting access to health by these groups should be reviewed and repealed.</td>
</tr>
<tr>
<td>- Prison Laws and policies should be reviewed to prohibit unfair discrimination against prisoners with HIV, protect prisoners from HIV transmission and provide access to HIV-related prevention, treatment, care and support services.</td>
</tr>
<tr>
<td>- Guidelines 5 of the UNAIDS guidelines (Supra) recommends that states that states should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors”. This can be done through enacting or reviewing:-</td>
</tr>
<tr>
<td>- Traditional and Customary Law that affect the status and treatment of vulnerable populations, such as women and Children.</td>
</tr>
<tr>
<td>- Workplace Laws, regulations and collective agreements to guarantee workplace rights.</td>
</tr>
<tr>
<td>- Laws to reduce human rights violations against vulnerable and key populations at higher risk of HIV exposure such as women, children, people with disabilities, migrants, men who have sex with men, prisoners, sex workers and people who inject drugs amongst others.</td>
</tr>
<tr>
<td>- Laws to Allow for freedom of movement and the repeal of laws restricting the movements or associations of members of Key Populations in the context of HIV and AIDS</td>
</tr>
<tr>
<td>- The SADC PF Model Law on HIV and AIDS for Southern Africa, 2008 provides model provisions on Anti-Discrimination in the context of HIV and AIDS for SADC countries</td>
</tr>
</tbody>
</table>

At the domestic level, non-discrimination principle is articulated and recognized under the constitution of the United Republic of Tanzania (Supra) under various articles including Article
which states, “The object of this Constitution is to facilitate the building of the United Republic as a nation of equal and free individuals enjoying freedom, justice, fraternity and concord, through the pursuit of the policy of Socialism and Self Reliance which emphasizes the application of socialist principles while taking into account the conditions prevailing in the United Republic”. This extends to paragraph (a)\textsuperscript{83}, (f)\textsuperscript{84}, (g)\textsuperscript{85} and (h)\textsuperscript{86} as well as Articles 12\textsuperscript{87} and 13\textsuperscript{88}. A similar provision is established under Article 11 and Article 12 of the Zanzibar Constitution of 1984 which provides for equality of human beings as well as the rights of equality before the law respectively.

At the moment, discrimination is one of the most quoted factors for the increased risk of HIV exposure. During the field assessment, respondents informed the team that they fear going to test due to fear of discrimination they will encounter once diagnosed with HIV. Others stated that discrimination often leads to negligence on the discriminated person thus increase risk of HIV transmission.

Though the Constitutions of the United Republic of Tanzania and that of Zanzibar do not specifically articulate on the issue of HIV and AIDS, these two parts of the country have specific laws on HIV and AIDS\textsuperscript{89} in which Equality and Non Discrimination are well articulated particularly on Part VII of the Mainland Act and Part VI of the Zanzibar HIV Act. The specific provisions on Non-discrimination are articulated below;
Protecting Equality and Promoting Non-Discrimination in Tanzanian Context of HIV and AIDS

Both Tanzania Mainland and Zanzibar have within their HIV and AIDS legislations provision prohibiting Discrimination while promoting Equality. These are as shown below;

Mainland Tanzania;

Section 24(1) A person being the owner, manager or in charge of health care facility or medical insurance whether public or private shall facilitate access to health care services to persons living with HIV and AIDS without discrimination on the basis of their status

Part VII of the HIV and AIDS (Prevention and Control) Act 2008 includes:-

Section 28 “A person shall not formulate a policy, enact any law or act in a manner that discriminates directly or by its implication persons living with HIV and AIDS, orphans or their families”. Section 29 “Any health practitioner who deals with persons living with HIV and AIDS shall provide health services without any kind of stigma or discrimination”

Section 30 “A person shall not - (a) deny any person admission, participation into services or expel that other person from any institution; (b) Deny or restrict any person to travel within or outside Tanzania; (c) deny any person employment opportunity; (d) Deny or restrict any person to live anywhere; or (e) Deny or restrict the right of any person to residence, on the grounds of the person's actual, perceived or suspected HIV and AIDS status”

Section 31 “A person shall not stigmatize or discriminate in any manner any other person on the grounds of such other person's actual, perceived or suspected HIV and AIDS status”

Section 32 “Any person who contravenes any provision under this Part commits an offence and on conviction shall be liable to a fine of not less than two million shillings or to imprisonment for a term not exceeding one year or to both”

Other legislations which prohibit Discrimination on the basis of one’s HIV Status include the Employment and Labour Relations Act (2004) specifically section 7 (4),(8), and Section 8, The Law of the Child Act (No. 21 of 2009) specifically section 5 and Section 63 (1) of the Human DNA regulation Act (No. 8 2009)

Zanzibar;

Similarly Part VI of the Prevention and Management of HIV and AIDS in Zanzibar Act states:

Section 23, provides that persons living with or affected by HIV are entitled to enjoy, without any form of discrimination, all human rights under the law.

(2) No person may directly or indirectly discriminate against a person living with or affected by HIV on the basis of that person’s actual or perceived HIV status.

(3) A person who suffers an act of discrimination based on the person’s actual or perceived HIV status or that of another person may institute legal proceedings against the person who committed the discriminatory act to claim damages.
Section 25, also prohibit the discrimination in employment that no person shall be denied access to any employment for which he is qualified or given transfer which affect his health, denied training or promotion or have the person employment terminated or subjected to any other form of discriminatory policies or practices on the ground only of the person’s actual, perceived or suspected HIV status.

Section 26, prohibit discrimination in educational institutions that an educational institutions shall not deny admission or expel, discipline, segregate, deny participation in any event or activity, or deny any benefits or service to a person on the ground of the person actual, perceived or suspected HIV status unless it may lead to risk to the third party.

Section 30, provides the prohibition of discrimination in the health institution

Other laws in Zanzibar which prohibit discrimination is the Employment Law of Zanzibar, Act N0.11 of 2005 in Section 10 prohibits discrimination as follows that:

10(1) No employer may discriminate, directly or indirectly against an employee, in any employment policy or practice on any ground including race, gender, colour, religion, social origin or status, age, place of origin, national extraction, political opinion, marital status, pregnancy, disability, HIV/AIDS status real or perceived.

(2) Every employer shall take positive steps-
   (a) to promote equal opportunity in the workplace and to eliminate discrimination in employment policy or practice;
   (b) to guarantee equal remuneration for men and women for work of equal value.

(3) For the purpose of this Act discrimination includes - any distinction, exclusion or preference made on the basis of race, colour, gender, religion, political opinion, national extraction or social and place of origin, marital status, pregnancy, disability, and HIV/AIDS status which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation.

(5) No employer may require an employee, or an applicant for employment, to undertake an HIV test in order to ascertain that employee’s or applicant’s HIV status.

A similar provision on non-discrimination is found in Children Act NO.6 of 2011 in Section 6 which provides that:

6(1) A child shall have a right to live free from any discrimination
6(2) No person, authority, institution or other body shall discriminate against a child on the grounds of such child’s or his parent’s or legal guardian’s gender, race, colour, language, political or other opinion, age, religion, marital status, disability, health status, including HIV –status, custom, ethnic origin, rural or urban background, birth, socio-economic status, being a refugee or on the ground of any status

2.2.2 Personal Liberty
The Constitution of the United Republic of Tanzania guarantees the right to personal freedom and liberty under Article 15 as well as the Constitution of Zanzibar Article 14. However, this
right is limited by the circumstances stated under the same article. With regard the
international instruments, the UDHR provides for this right under article 3, and the ICCPR
under article 9. In the context of HIV and AIDS, section 30 of the HAPCA expressly prohibit
all acts or omissions that will or curtail a person’s liberty and deny him/her free movement and
right to associate with others on the grounds of actual or perceived HIV status. Similarly Section
27 of the Prevention and Management of HIV and AIDS in Zanzibar, Act NO. 18 of 2014 provides
that a person freedom of abode, lodging, or travel, within or outside Zanzibar, shall not be
denied or restricted on the grounds only of the person’s actual, perceived or suspected HIV
status. To the contrary below was reported;

“I know a person in our village who was denied to engage in public meeting just because he was
HIV positive. This was not done by the chairperson of the meeting but a member who pointed
a finger at that person in front of everyone and accused him of been HIV positive”. (Response
from a member of public in Njombe region: A similar response was provided by a member of
public in Pemba Island – Zanzibar)

2.2.3 Right to Privacy
The right to privacy is enshrined under the Constitution of the United Republic of Tanzania
article 16 (1) as well as the Constitution of Zanzibar Article 15. The right to privacy extends to
a person, his family, his matrimonial life, respect and protection of his residence as well as his
private communications. There are limitations to this right as provided for under Article 16 (2)
which requires such limitation to be absolutely appropriate or necessary and should not be
used arbitrarily. Under the international instruments, the UDHR protects right to privacy under
Article 12 which is also reflected under Article 17 of the ICCPR and in the context of the child,
the provision of Article 10 of the ACRWC.

2.2.4 Right to Health
The right to health is one of the most fundamental Human Rights Principles and is crucial to the
realization of all the other human rights and freedoms. This right is well articulated under
Article 25 of the UDHR, in Article 12 of the ICESCR, Article 12 of CEDAW and Article 24 of the
CRC. The right to health has been linked with the right to highest attainable standard of mental
and physical health as indicated in the ACHPR Article 16\textsuperscript{99}. It is further explained in subsequent court interpretations\textsuperscript{100} that, this right is applicable to all regardless of one’s status.

The current Constitution of the United Republic of Tanzania 1977 does not expressly provide for the right to health within the bill of rights. Article 11 (1)\textsuperscript{101} of the Constitution of the United Republic of Tanzania (supra), require state to take appropriate steps i.e. by enacting laws that will ensure her citizens enjoy various rights such as (right to work, education and social welfare at times of old age, sickness or disability and in other cases of incapacity). Article 9 (i)\textsuperscript{102} obliges State to formulate policies and programmes which will guarantee people enjoyment of their rights while using the national resources for this purpose. Section 33 (1) of the Mainland HIV Act, guarantee all PLHIV right to highest attainable standard of mental and physical health which include right to treatment of opportunistic diseases. Therefore, despite there not been right to health provision in the Constitution, PLHIV are guaranteed these rights under the HIV specific legislation in mainland Tanzania.

A similar situation is found under Article 10 of the Zanzibar Constitution whereby the right to health is enshrined in the Fundamental Objectives and Directive Principles of state policy. The Government is committed to provide enough social services for the purposes of bringing development and protect welfare of the people. This includes provision of sufficient health services for all people. Ideally, people affected by HIV/AIDS should automatically enjoy HIV related services under this provision. However, Article 10A of the Zanzibar Constitution provide government with immunity in case of failure to provide the required social service and therefore, the provisions of this Part are generally speaking not enforceable or justiciable by the courts in Zanzibar.\textsuperscript{103}

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**Protecting health rights in the context of HIV and AIDS**

Guideline 6 of the International Guidelines recommends health law and policies to ensure access to a range of HIV prevention, treatment, care and support services including for marginalized and key populations at higher risk of HIV exposure.\textsuperscript{9} For example, the following steps should be taken:

- Enact laws to provide for universal access to HIV-related prevention, treatment, care and support services
• Review or repeal laws that block universal access to HIV-related health care services and that discriminate on the basis of HIV and AIDS

• Provide for positive steps to address factors that increase the vulnerability or reduce the access to services for vulnerable and marginalized populations

• Provide for community participation in the design, development and implementation of services

• Enact laws to provide for quality control of HIV-related products and services, including timely and adequate access to treatment for HIV, accurate information regarding HIV treatment, access to quality HIV testing and counselling, condoms and other prevention products and services, HIV information and education

• Enact laws to encourage HIV-related research and development, increase international and regional co-operation and access to resources for HIV and AIDS and encourage the domestication and use of flexibilities within international trade agreements (such as TRIPS), amongst other things

Guidelines 3 and 4 also recommend the review of public health laws, criminal laws and correctional systems to ensure that coercive and discriminatory laws are not applied inappropriately to HIV and AIDS in a way that blocks universal access to HIV prevention, treatment, care and support. The Guidelines recommend, amongst other things, that;

Public health laws not subject people living with HIV to isolation, detention or quarantine on the basis of their HIV status

• Criminal and public health laws not include specific offences to criminalize HIV transmission

• Criminal laws prohibiting same-sex relations be repealed and not be allowed to impede HIV-related prevention, treatment, care and support

• Laws criminalizing adult sex work be reviewed and not be allowed to impede HIV-related prevention, treatment, care and support

• Criminal laws relating to injecting drug use be reviewed to allow for harm reduction programmes as well as treatment, care and support for people who inject drugs

• The SADC PF Model Law on HIV & AIDS for Southern Africa, 2008 provides model provisions on regulating access to health care in the context of HIV and AIDS for SADC countries under section 20

2.2.5 Right to Work

This is one of the rights specifically articulated within the bill of rights of the Constitution of the United Republic of Tanzania (Supra). Article 22 the Constitution of the United Republic of
Tanzania provides for the Right to work and that every citizen is entitled to equal opportunity and equal terms to hold office. The similar provision exists in Article 21 of the Zanzibar Constitution of 1984. The same right is articulated in the Zanzibar Public Act No. 2 of 2011 and the Employment Act No.11 of 2005. At the international level this right is reflected in Article 23\textsuperscript{105} of the UDHR and Article 6\textsuperscript{106} of the ICSECR. This right is also protected under ILO conventions\textsuperscript{107} and at regional level Article 15\textsuperscript{108} of the ACHPR.

The right to fair working conditions entails the right to work in a safe environment without preconditions that unjustly discriminate a person except on the basis of occupational qualifications. The requirement of Pre-employment HIV testing for purposes of ascertaining a person’s HIV status for purposes of determining that person’s suitability for work violates the right to work\textsuperscript{109}. On the contrary below are some of the reported incidences happening on the ground.

“\textit{At our area there is a case of youths who were selected to join the Tanzania Peoples Defence Force but upon being tested HIV positive they were not considered fit hence they were not offered opportunity to work. (Response from a youth at Peramiho – Ruvuma)}”

“\textit{Also in Unguja a case of a female youth who was selected to join the special department of prisons (SMZ Magereza) was not considered fit to join the department hence disqualified upon being tested HIV positive during the pre-enrolment health tests. (Response from a female youth at Unguja Island - Zanzibar)}”

The above outlined laws and international instruments collectively recommend that, employees should be allowed to work as long as they can perform their duties. This position was well articulated by Recommendation 10\textsuperscript{110} of the “Recommendations Concerning HIV and AIDS and the World of Work, 2010 (ILO Recommendation No. 200)”.

Despite these provisions, during the field survey it was revealed that there are still practices of employers who perform pre-employment HIV and AIDS testing as a ground for confirming person’s employment. Furthermore and as articulated by two case studies above, some of the
public departments, such as defines and police force mandatorily require HIV test and individuals testing HIV positive have been excluded from employment in these departments UNAIDS International guidelines on HIV and AIDS and Human Rights states as captioned in the table below;

<table>
<thead>
<tr>
<th>Protecting the right to work in the context of HIV and AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline 5 of the <em>International Guidelines on HIV/AIDS and Human Rights</em> requires states to review workplace laws to protect the rights of employees in relation to HIV and AIDS. It recommends the enactment of workplace laws, regulations and agreements to guarantee the following workplace rights:</td>
</tr>
<tr>
<td>• The development of a national policy on HIV and AIDS agreed to by employers and employees</td>
</tr>
<tr>
<td>• A prohibition on HIV testing as a prerequisite for employment, promotion, training or benefits</td>
</tr>
<tr>
<td>• Confidentiality regarding HIV status</td>
</tr>
<tr>
<td>• Employment security for workers living with HIV, including reasonable accommodation in the working environment</td>
</tr>
<tr>
<td>• Access to HIV-related prevention, treatment, care and support</td>
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<tr>
<td>• Protection from HIV-related stigma and discrimination</td>
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<tr>
<td>• Protection from occupational infection with HIV</td>
</tr>
<tr>
<td>The SADC PF <em>Model Law on HIV &amp; AIDS for Southern Africa</em>, 2008 provides model provisions on HIV workplace rights for SADC countries under section 23</td>
</tr>
</tbody>
</table>

### 2.2.6 Right to Property

This right is reflected under the Constitution of the United Republic of Tanzania Article 24\(^\text{111}\). This provision of the constitution guarantee individual’s right to own property and protection of this right respectively. Is the same provision forbids unlawful possession of person’s property for the purposes of nationalization or any other purpose without fair and adequate compensation\(^\text{112}\). In Zanzibar, the same provision is found in Article 17 of the Zanzibar Constitution, 1984. Internationally, the right to property ownership is provided for under Article 17\(^\text{113}\) of the UDHR and Article 1 (2)\(^\text{114}\) of the ICCPR which provide that people may for their own ends freely dispose their natural wealth and resources.

Under the Land Act\(^\text{115}\) it is provided that a person or group of people can occupy and hold land under granted right of occupancy or derivative right. For foreign nationals, they can only be granted right to own land for investment purposes and not otherwise. In Zanzibar the same
right is provided for under Section 7 of the Zanzibar Land Tenure Act, No 12 of 1992\textsuperscript{116} and Zanzibar Contract Decree\textsuperscript{117} which regulate matters of buying and selling of goods. For Married couple the Law of Marriage Act\textsuperscript{118} presupposes that property acquired in the name of any of the spouse during the subsistence of the marriage belong exclusively to that person. The Sale of Goods Act\textsuperscript{119} regulates buying and selling of goods and is complemented by the Law of Contract Act\textsuperscript{120} in some instances.

2.2.7 Right to Information and Expression

The right to freedom of expression and information (including the right to hold opinions without interference, receive and communicate opinions), and the right of access to information are all protected under Article 18\textsuperscript{121} of the Tanzanian Constitution 1977 and in Zanzibar Constitution of 1984 (supra) the same right is protected under Article 18. Under the international and regional instruments, this right is found under the provision of Article 19 of UDHR.\textsuperscript{122} This is also reflected under Article 19 of the ICCPR which provides that every person has the right to hold opinion without interference.\textsuperscript{123} Article 9 of the ACHPR also protects right to information\textsuperscript{124}.

In the context of HIV and AIDS, this right include right to seek, receive and impart HIV-related prevention and care information as a means of preventing the spread of HIV and providing health care services to those infected. The International Guidelines\textsuperscript{125} recommend that, in line with the right to freedom of expression and information as well as the right to health wrongful censorship of HIV-related information resulting into criminalizing those who are responsible for spreading HIV related information and education is forbidden. As indicated in previous parts, realization of right to information especially by the marginalized groups of people with disabilities is still a challenge which limits this group understanding of the HIV epidemic. UNAIDS Guidelines on HIV and AIDS states as below;

\begin{center}
\textbf{Protecting the right of freedom of expression and information in the context of HIV and AIDS}
\end{center}
Guideline 2 of the *International Guidelines* recommend community consultation in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organisations are enabled to carry out their activities including in the field of ethics, law and human rights effectively. In particular, it recommends that laws and policies provide for:

- Formal and regular mechanisms for ongoing dialogue with community representatives in HIV-related policies and programmes
- Funding to sustain the HIV-related work community organisations, including work in the field of ethics, human rights and law

Guideline 6 furthermore recommends that laws and regulations provide for the widespread provision of HIV-related information aimed at the general public and vulnerable populations. Such information should not be inappropriately subject to censorship where this damages the right to information vital to life, health and human dignity.

Guideline 8 recommends that governments provide support to community groups representing the interests of vulnerable populations through various measures such as financial support, capacity building and empowerment, measures to increase their participation and measures to improve their social and legal status.

The SADC PF *Model Law on HIV & AIDS for Southern Africa*, 2008 provides model provisions to protect rights to freedom of expression and information for all, including vulnerable and key populations under sections 4, 6 and 7.

### 2.2.8 Inheritance Rights

In Tanzania issues of Inheritance are regulated by various pieces of legislation. These include:

- The Local Customary Law (Declaration) Order\textsuperscript{126} which has for long been considered discriminatory due to it being based on patrilineal heritage. Another legislation which deals with inheritance matters is the Probate and Administration of Estates Act\textsuperscript{127} which regulate matters of probate such as writing and execution of will and administration of deceased persons estates. The same Act also regulate certain provisions with regard the powers and duties of executors and administrators; administration of deceased property or wakf; beneficent payments in Islamic estates and related matters. The Islamic Law Restatement Act\textsuperscript{128} provides for use and application of Islamic Law in matters of Succession and Inheritance for Muslims. This is also one of the much debated pieces of Legislation as under Islamic Law women inherit almost nothing from the estate of their deceased husbands.
In Zanzibar the estate of the deceased Muslim person will be administered by principles laid down in Quran and Sunnah. Section 32 of the Wakf and Trust Commission Act\textsuperscript{129} provides that the Executive Secretary, on behalf of the Commission, shall have the sole power to administer all estates of Muslim deceased persons in Zanzibar who: (a) died intestate; (b) having made a will devising or bequeathing his estate in any manner whatsoever; (c) has appointed the Commission or any other person to be the sole, partial or joint administrator of his estate; (d) died outside Zanzibar but all or majority of the beneficiaries live in Zanzibar. In case there is any dispute, these matters will be referred to Kadhis Court\textsuperscript{130}. If a person is not a Muslim, then the issue of inheritance is governed by the Succession Decree, Cap.21 of the laws of Zanzibar.

Given the above mentioned positions of the law, women in Tanzania have been reported to be victims of violation of the right to own property especially inheritance from their deceased family members.

2.3 Legal Framework and Protection of Key Population and Vulnerable Groups
The HIV and AIDS pandemic has for over the years resulted into adoption of different strategies by the Tanzania Government to control or manage the effects of the disease. Due to the disproportionate effects of the disease in the community some categories of people have been identified as KPs. These are those who are at higher risk of contracting HIV than others, drive the epidemic and or shoulder the heavy burden of the epidemic that others Universally, these are recognized to include five main groups of PWID, MSM, prisoners, long distance truck drivers and SWs. KPs vary from country to country as their categorization depends on each country’s specific epidemic context. In Tanzania for instance it also include PLHIV, Women and Girls, Youths, Children, People with Disabilities, Fishery Communities, Mining Workers, Migrants (including Migrant Workers) and Refugees. These groups are well covered in the country’s legislations as well as other program documents.

Apart from HAPCA in Mainland Tanzania and HIV and AIDS Act from Zanzibar, Tanzania has various other laws which categorically address various issues of KPs. While some of these laws
upholds the rights of these groups some of the KPs such as MSM, Sex Workers, and IDUs falls under the groups which their conducts are prohibited by the Law. For example, section 139\textsuperscript{131} of the Penal Code Cap 16 R.E 2002 of the Mainland Tanzania; forbids a person to live on the earning of prostitution which is similar to pronouncements of section 142 of the Penal Act of Zanzibar, Act No.6 of 2004. Section 153 of the same Zanzibar Penal Act (supra) prohibits the acts of lesbians as well as prohibiting the Union of the person of the same sex\textsuperscript{132}.

“One Respondent, explained that the fine of 200,000 imposed for the offense of sex work/prostitution is very little and in most cases arrested sex workers afford to pay this fine and return to street for their job which makes implementation of this provision ineffective.

(\textit{Response from a Police Officer in Dar es Salaam})

International, regional and national human rights instruments protect the rights of marginalized and vulnerable populations and key populations at higher risk of HIV exposure. Due to the fact that discrimination and inequality experienced by certain populations increases vulnerability and risk to HIV protection of all populations’ basic rights is key and enhances effective HIV response\textsuperscript{133}.

In this respect, there are at the domestic level, various other Laws which protect rights of the outlined KPs which are:- (1) The Fisheries Act\textsuperscript{134}, The Prisons Act\textsuperscript{135}, The Community Service Act\textsuperscript{136}, Refugees Act\textsuperscript{137}, Immigration Act\textsuperscript{138}, Criminal Procedure Act\textsuperscript{139}, The Legal Aid (Criminal Proceedings) Act\textsuperscript{140}, Tanzania Food, Drugs and Cosmetics Act\textsuperscript{141}. The following Sub Part analyses the legal rights, challenges and practices related to Key Populations.

\textbf{2.3.1 Women and Girl Child}

The legal protection of women is under different levels beginning with international, regional and national laws. Internationally, the UDHR, ICCPR, ICESCR and CEDAW extensively protect women’s rights. The CEDAW in particular aims at eliminating all forms of discrimination against women and protects a wide range of women’s rights including women’s health rights.

Together with protection of women rights by the international and regional instruments, the same treaties establish specific committees which address women issues such as the
Committee on Elimination of Discrimination against Women. This Committee has specifically recommended that HIV responses should give special attention to the health rights of women (and children) and to all other matters of reproductive role of women which on one hand makes them vulnerable to HIV infection\textsuperscript{142}. The study revealed that, due to cultural practices, most women are abused and fail to report such abuses as in most cases are perpetuated by family member or a person with great influence in the society\textsuperscript{143}.

At a regional level perspective the Protocol to the African Charter on the Rights of Women addresses women’s rights in respect to HIV and AIDS. The latter being more specific instrument which articulates women’s equality rights and reproductive health rights in the context of HIV and AIDS.

Various national laws protect women rights. These are such as the Penal Code\textsuperscript{144}, The Law of marriage Act\textsuperscript{145} and The Human DNA Regulation Act\textsuperscript{146}, Law of the Child Act, No.21 of 2009 which from the Tanzania Mainland extensively cover the rights of women. From Zanzibar women and Children are protected under the Zanzibar Penal Act, No.6 of 2004, and the Children’s Act No.6 of 2011, Education Act, No.4 of 1993, the Spinsters and Single Parent Children Protection Act No.4 of 2005, the Marriage and Divorce (Muslim) Registration Decree (CAP 91), The Offenders Education Act (Amendment) Act of 2007 and the Marriage (Solemnization and Registration) Decree (CAP 92) and Prevention and Management of HIV and AIDS in Zanzibar (supra).\textsuperscript{147}

In the aspects of child rights protection within the context of HIV, the HIV and AIDS (Prevention and Control) Act\textsuperscript{148} and the HIV and AIDS Prevention and Management Act of Zanzibar, in sections 25 and Section 21 covers the child right to access HIV health services. In both laws, the Child is required to obtain parental consent to undergo HIV testing. This has been reiterated by Section 111 and Section 112 of the Child Act. Furthermore, section 34\textsuperscript{149} establishes the duty for every local government to devise best practices (Mechanisms and Strategic Plans) on how to deal with most vulnerable children in the society.

2.3.2 People with Disabilities
Another major group under the key populations is the category comprised of people with disabilities. Internationally, the CRPD provide extensive protection of the rights of people with disabilities and encourages states to take positive steps to protect equality and health rights of people with disabilities\(^\text{150}\). At the regional level, the ACHPR\(^\text{151}\), Protocol to the African Charter on the Rights of Women\(^\text{152}\) and the ACRWC\(^\text{153}\) protect the rights of people with disabilities.

At national level, and in response to the International call to legislate on the rights of people with disabilities, Tanzania prepared the National Policy on Disability\(^\text{154}\) followed by the Persons with Disabilities Act\(^\text{155}\) in mainland Tanzania and Persons with Disabilities (Rights and Privileges) Act No.9 of 2006 from Zanzibar. Section 34 of Prevention and Management of HIV and AIDS Act in Zanzibar regulate matters of people with disabilities in accessing HIV related services in Zanzibar. In that respect there are laws which cater for the rights of persons with disabilities in both Tanzania Mainland and Zanzibar\(^\text{156}\). All these laws from Tanzania Mainland and Zanzibar require provision of health care services, social support, accessibility of services including health services, rehabilitation, education and vocational training, communication, employment or guarantee of right to work and promotion of all other basic rights for the persons with disabilities. These laws’ call for the elimination of all forms of discrimination against people with disabilities and encourages accessible learning facilities. Together with other provisions, the HIV and AIDS (Prevention and Control) Act\(^\text{157}\) of mainland Tanzania provides that it is a duty of every owner or manager of a testing centre to ensure accessibility of HFCs by those with disabilities.
PART THREE: ANALYSIS OF LAWS THAT MAY LIMIT KPs ACCESS TO HIV AND AIDS GOODS, SERVICES AND INFORMATION

3.1 Analysis of Response from Key Informants

Assessment from the survey conducted, it was observed that, services are available and accessible by many in different parts of the country especially in urban areas. However, there were still a number of challenges noted and reported faced by various groups in accessing same services especially in rural areas. The first reported challenge was inaccessibility of services in some parts or the country caused by the factors beyond the HIV and AIDS response initiatives, operating context and mandate. For instance, some of the respondents complained that road networks connecting their premises with the HCFs are in very bad condition which makes HCFs and or HIV services inaccessible. The roads become worse during the rain seasons to the point of becoming unusable and making HCFs inaccessible\(^{158}\). Another factor that makes services inaccessible is the HCFs working timetable which makes access to services a challenge to some of the groups in the society.

"It was reported by one respondent that he was denied service due to the fact that he attended the clinic on a day scheduled for cleaning the HCF. He further reported that, the cause for his missed appointment was the fact that he had other responsibilities which could not be postponed at the material time hence opted to go to clinic on another day (Friday) of which he was denied services". (This was reported by a respondent from Kibaha – Pwani)

In line with the above mentioned factors, is the fact that most HCFs are not designed to be user friendly for the disabled persons hence this group face a lot of challenges with regard the accessibility of services.

Availability of essential equipment’s for the provision of HIV related services is also another challenge reported to hamper provision of required HIV services. Essential equipment such as reagents and CD4 count machines are scarce and can only be accessed at the district level, regional and tertiary Health Care Facilities. These in turn create problems in delivery of HIV and AIDS services to the needy individuals.
It was also reported that, in accessing HIV and AIDS related services people suffer different forms of stigma and discrimination especially marginalized groups such as sex workers and MSM. During the field study MSM reported that they face wide range of stigma especially those men whose appearance or behaviour denote their feminine behaviour (appear or act as women) as opposed to those who appear masculine.

Stigma manifests itself in the form of insults, denial of service and harsh treatment. Although under Section 32 of HAPCA (supra) it is clearly indicated that any form of discrimination is punishable under the law, it is still present in the society and most of the victims do not know how to enforce their non-discrimination right.

“They don’t respect the people of these groups especially MSM, Sex Workers and IDUs and sometime they provide services while pronouncing bad names before them” (Response from a Health Practitioner from Unguja Island - Zanzibar)

3.2 Sex Workers
Under the Penal Code it is an offence for any person to earn money through prostitution. This is the position of sections 146 and 148 of the Penal Code Cap 16 R.E 2002 as also reflected under section 140 and 142 of the Zanzibar Penal Act (supra). Due to this position of the law, sex workers fail to freely express their status and access HIV and AIDS related services in HCFs for fear of reprisal. This exposes them to more risky conditions of acquiring infections and spreading the same to other groups in the society. Though health service providers reported on the existence of various mechanisms and programs invented to reach out sex workers to provide them with necessary services at the HCFs and through home based care services they reported to be interrupted by policemen who regularly arrest sex workers. Health care workers attitude towards the sex workers was also complained of as shown in the reported scenario below.

“The society has a negative attitude towards sex workers. Sometimes even the health attendants have discriminated sex workers while providing medical services. They sometimes curse them or treat them harshly or differently from other service receivers. Most people have the wrong perception that sex workers have brought upon themselves...
3.3 People who Practice Anal Sex (Men who have Sex with Men)
Under section 154\textsuperscript{164} of the Penal Code, it is an offence for a man to have carnal knowledge of another man or permit another man to have carnal knowledge of him. The same is reflected under Section 150\textsuperscript{165} of the Zanzibar Penal Act (supra). These two provisions of the law incriminate homosexuality practices. The punishment for the specified offences is provided for under section 151\textsuperscript{166} of the same Zanzibar Penal Act (supra). During the field survey MSM advanced that they hesitate to attend HCFs to access HIV and AIDS related services due to fear of being arrested by law enforcers. They also reported fear of disclosing their sexual statuses as such disclosure will result into a negative treatment by the society which treats them as deviants. This increases their risk of contracting and spread HIV to others thus fuelling the spread of the epidemic. In Tanzania Mainland HIV prevalence among MSM is at 40\% (THMIS) while in Zanzibar it was reported to be at 10.8\% (ZNSP II).

3.4 Injecting Drug Users
As stipulated in Section 12\textsuperscript{167} it is an offence for any person to produce, possess, transport, import into the United Republic, sell, purchases, use or do any act or omit to do anything in relation to the narcotic drugs specified in this section. From the field assessment, the data obtained revealed that IDUs do share needles while injecting drugs and do not pay attention to the likelihood of transmitting infections from one person to another. With regards to accessing HIV and AIDS services, the rate is quite low though in most cases health service providers reported that they periodically conduct on site visits to assist IDUs and provided them with required HIV and harm reduction services. However, the law enforcers also use the same visit opportunities to arrest IDUs. The conducts of police to arrest IDUs during the visit has made it impracticable for the health service providers to keep working with IDUs. Apart from that, the fact that the act of drug abuse is criminalized makes it difficult for the IDUs to access HIV services freely due to fear that they will be arrested. Inaccessibility of HIV health services puts them at a greater risk of spreading the infection to others and thus fuelling the epidemic.
3.5 Migrants illegally residing in Tanzania
The Immigration Act, No. 7 1995 recognizes persons who unlawfully reside in Tanzania under the class of prohibited immigrants. This is provided for under Part Three of this Act and specifically under Section 10 (h). Due to the nature of their status as prohibited migrants, most of these people are severely abused and live in very bad conditions. Those infected rarely access HIV and AIDS services thus putting them at a higher risk of both contracting the infections and fuelling the transmission. Furthermore and due to their status, they end up engaging in low income earning activities or at times illegal activities which further puts them at a higher risk of being infected and spreading the infection.

“Illegal migrants are not specific groups so it’s difficult to have adequate access to HIV prevention, treatment and care.” (Response from a Health worker at Tabora region)

3.6 Pregnant Mothers
In Tanzania Mainland and under HAPCA every pregnant woman is encouraged to undergo an HIV test to ascertain her HIV status. Under section 15 expectant parents are provided with counselling as well as voluntary testing services. Zanzibar Prevention and Management of HIV and AIDS Act, Act No. 18 of 2014 under section 20 makes HIV testing for pregnant mothers compulsory. Furthermore, according to section 25 of HAPCA the MoHSW is tasked to prepare regulation on the care and treatment of HIV infected pregnant women/mothers which include treatment at delivery both aimed at reducing HIV transmission from mother to child. In line with this, infected mothers are given training with regard breast feeding. Any act or omission which contravenes these provisions will and is termed as wilful transmission thus a criminal offence.

3.7 PLHIV (certain conducts of PLHIV-disclosure)
The HAPCA section 21 makes it mandatory for a person who has knowledge on his/her status to immediately inform his spouse or sexual partner as to that fact and take all necessary precautions to avert transmission to others. In line with this and as provided for under section 47 the law further provides that, any person who with intent transmits HIV to another person
is guilty of an offence. Though there is a proviso under section 21 (2) on the notification of spouse or sexual partner, during the field assessment it was observed that some of the infected people shy away from testing due to fear of the requirement to disclose their status immediately after discovering their HIV positive status. This was a profound problem to pregnant women due to fear of being deserted and abused by their husbands or sexual partners.

“On respondent advanced that people fear that once they disclose their status to their spouses or sexual partners or propose the practices of safe sex they might be sued by their spouses or abandoned as they will be seen as traitors. For that reason, most people who learn of their statuses prefer to keep it confidential thus fuelling the spread of the epidemic. (Response from a field researcher from Rukwa region during the debriefing session)

In Zanzibar the Penal Act, No.6 of 2004 under Section 184 and Mainland Tanzania Section 179 of the Penal Code (supra) though not specific on HIV and AIDS provides that it is an offence to negligently or unlawfully spread an infection dangerous to life.
CHAPTER THREE

1. KEY OBSERVATIONS AND REFORM RECOMMENDATIONS

This part of the report highlights key observations from the report and offers recommendation on every key observation from the report.

1.1 HIV Response Institutional Frameworks, Coordination and Services

Observation:

Tanzania has robust HIV and AIDS coordination mechanisms established by the law

Tanzania has made commendable strides towards establishment of effective institutional frameworks which deals with coordination and provision of HIV and AIDS related services. Currently, there is Tanzania Commission for AIDS and Zanzibar AIDS Commission which their main functions are to coordinate institutions and all matters related to HIV and AIDS response. To achieve their objectives these mechanisms are supported by specific established national programmes such as the National AIDS Control Programme and the Zanzibar AIDS control Programme under ministries of health both in Tanzania Mainland and Zanzibar.

Furthermore, the study observed that CTC, PMTCT and ART services are widely distributed though notable challenges were identified. These are such as remoteness and inaccessibility of some of these services especially in rural areas. It was also observed that local communities have realized the need to collectively join their efforts in the fight against HIV and have formed support groups at local level. A good example is the Mothers Support Group in Kitulo Ward, Makete District in Njombe, a group of HIV-infected mothers and their partners attached to their local clinic to champion provision of HIV education on PMTCT. Another notable observation is the fact that treatment of opportunistic diseases is still in great need of being scaled up especially in rural areas.

Recommendation:
1.2 HIV Response Legal Framework and Compliance

Observation:

1. Tanzania has well established and comprehensive HIV and AIDS Legal Framework which governs all intervention
2. There are punitive/criminal laws which counter effectiveness of the legal framework which seeks to protect and promote access to HIV related services
3. There are unlawful practices which discriminate and stigmatize PLHIV and hinder their access to HIV related services.

The study observed that Tanzania has well established and comprehensive HIV Laws; in Mainland Tanzania HIV and AIDS (Prevention and Control) Act (supra) and HIV and AIDS Prevention and Management Act of 2014 in Zanzibar. The study further observed that, though the HIV and AIDS (Prevention and Control) Act (supra) come into force since 2008 and Zanzibar the similar law entered into force in September 2014 still there is high level of ignorance by many of the stakeholders on the content of both laws. This ignorance was not only observed at the local communities level but also to the Health Service Providers who informed researchers that they only hear about the existence of an HIV and AIDS laws but are unaware of its content.

The study further observed that due to ignorance of the HIV and AIDS laws such as HAPCA and related policies and guidelines, most people do not know their HIV and AIDS related rights and do not know what to do when such rights are violated or not enforced. The Zanzibar Prevention and Management of HIV and AIDS Act of 2014 (supra) is still new and therefore, not very well known by the public.

Furthermore, the LEA observed that there are a number of punitive laws that hinder effective HIV and AIDS responses particularly for key populations who are at the higher risk of HIV exposure.
This regime of criminal laws counters the effectiveness of the legal framework that seeks to promote and protect the rights of the PLHIV especially key populations.

Further, it was observed that, there are unlawful practices which are discriminatory and which violate the rights of PLHIV and those at risk of contracting HIV. These deviates from the good practice and as a result, further vulnerability to HIV especially for those who are already at the high risk of contracting HIV.

**Recommendations:**

1. Government through TACAIDS and ZAC together with other stakeholder i.e CSO’s, should disseminate HIV and AIDS related laws to the public and all other stakeholders.

2. Review of all laws which hinder access to HIV related services by the KPS to accommodate their HIV related health needs.

3. Government should take necessary steps to enforce and ensure maximum compliance with the existing legal and regulatory framework that promote and protect PLHIV, vulnerable and those at higher risk of infection.

4. Government should undertake a study/survey to establish number of KPs but also magnitude of inaccessibility of HIV services by these groups.

**1.3 HIV and AIDS Related Rights**

**1.3.1 Privacy**

**Observations:**

1. In some HCFs HIV Pregnant women are attended in different sections of the hospital when attending maternal clinics which violates their right to privacy and are subjected to stigma and discrimination.

2. Disclosure of the HIV status for couples especially in marriage expose women to violence and abuse.
### 3. Demand of testing and disclosure of HIV results by and to religious leaders before marriage celebration violate right to voluntary counselling and testing and right to privacy.

It was observed that, PLHIV pregnant women claim to be discriminated in obtaining pre-natal services by being subjected to different section of the HFCs different from where all other pregnant women attend. This exposes them to discrimination as from the moment they are directed to obtain these services at the designated part of the clinic it becomes visible to everyone around that they are HIV positive. This practice subjects them into stigma and consequently breach of their privacy in obtaining health services.

However, the HAPCA and the Prevention and Management of HIV and AIDS in Zanzibar of 2014 requires PLHIV to take all necessary measures to avoid infecting others which include the responsibility of informing a partner of one’s HIV status once diagnosed with HIV. These provisions does not only make women victims of violence and abuse by their partners but makes women possible victims of crimes on the allegations of failing to protect their partners as well as their unborn babies.

During the assessment, it was reported that some of the religious leaders have had the tendency of demanding mandatory HIV test for the couples wanting to marry. The demand for HIV status is also accompanied by mandatory disclosure to the responsible leaders who depending on the tests results may not officiate the marriage. This violates right to voluntary counselling and testing, privacy and also subjects people into stigma and discrimination.
Recommendations:

1. All PLHIV women attending maternal clinic should be attended in the same sections of the clinic with all other women and that all RCH attending these women should be trained on how to provide PMTCT services.

2. HAPCA Section 21 (1) (a) and Section 22 (2), (3) of the Prevention and Management of HIV and AIDS of 2014 (supra) which requires mandatory disclosure to the couple should be amended to make disclosure voluntary.

3. The provisions on the non-discrimination in the HIV laws should be articulated to criminalize discrimination based on ones’ true or perceived HIV status.

4. PLHIV’s right to marry and found a family should be respected as long as the interested parties have consented to contract marriage.

1.3.2 Voluntary Counselling and Testing

Observations:

1. The Law Prohibits testing for the people below 18 which denies children below that age access to HIV related services despite of being sexually active.

2. Even though the law prohibits compulsory HIV testing and encourages voluntary testing for pregnant mothers, practice shows that pregnant mothers are compelled to undergo HIV testing.

3. Even though CTC and ART Centres are available in many parts of the country, still in rural areas they are scattered and located away from the community.

It was observed during the study that, the law places the age of obtaining HIV related services at 18. The category of the people below this age group can access these services with the assistance of their parents or guardians. The evidence shows that, many adolescents well below the age of 18 are sexually active and under the risk of being infected if not protected. There is also proof that this requirement is damaging especially for the orphans and children headed families.
As said above the law requires pregnant women to be offered voluntary counselling and testing when attending maternal clinics. Even though the law requires voluntary testing the practice shows that testing for HIV has been a requirement for pregnant women and as a result women who refuses to be tested have been subjected to stigma by been neglected at the time of delivery.

It was reported that, despite the fact that there are CTCs in many parts of the country, still in some areas they are located away from the community which makes accessibility a challenge to many. However, not all services are offered in these centres such as CD4 count which makes it difficult for those wanting such services.

Recommendations:

1. It is recommended that section 15 (2) of HAPCA to be amended to allow young people at the age of 16 to access HIV services. This way, the laws will effectively respond to the HIV epidemic prevalence trend in the country.

2. There should be deliberate campaigns on HIV counseling and testing with emphasis that both counseling and testing are voluntary and not otherwise.

3. There should be deliberate efforts by the Government through TACAIDS, ZAC, ZIHTLP and NACP to ensure availability and accessibility of the CTCs, ART, PEP other important HIV related services in all parts of the country. All established dispensaries and HCFs in all wards should offer all HIV related services.

4. Zanzibar should enact the ethical laws for the Medical practitioners and for those providing services to person living with HIV/AIDS as currently Medical Practitioners in Zanzibar have no specific ethic laws or codes of conduct to regulate their practices.

Observations:
1. In some parts of the country, PLHIV widowed women are been denied right to inherit properties of their deceased husbands which limits their economic power hence making them vulnerable to HIV.

2. Laws both in Mainland Tanzania and Zanzibar denies children right to own property hence orphans suffer out of property grabbing which leaves them poor without basic needs. As a survival strategy they engage in transactional sex consequently putting them at risk of contracting HIV which creates a circle of vulnerability to HIV.

During the assessment it was revealed to the researchers that there are aspects of property grabbing in Tanzanian community connected to AIDS deaths. Manifestation of this problem has been through women who are denied right to own husband’s properties after their deaths. Even though there are truths that women have lived systemic discrimination on issues of property ownership, the situation is exacerbated in circumstances where it is known that the death of the husband was caused by AIDS related illnesses. In these circumstances women have been accused of been the cause of such deaths and again influenced by the misconception that they will also die soon, have been denied right to own family properties.

As said in the observation above, this does not only violate women right to own property but also subjects them into poverty and place them at the high risk of contracting HIV or else spread the disease as they engage in transactional sex to earn a living. Worse enough it is reported that in some communities where the wife’s inheritance exists coupled with the problem of denial of family property ownership, widowed women have been forced to sleep with family members to be able to continue living in the deceased husband family.

In some settings in Tanzania it has been reported that even men have been denied right to own family or clan properties when discovered to be HIV positive. This is based on a misconception that they will die soon hence there is no need to own property

The situation is much so for the orphans. It has been reported that in some parts of the country i.e. southern highlands orphans have been denied right to inherit their family properties. This practice is justified by the law which as a general rule denies children right to own property until
they attain the age of majority or own property under the guardianship. Consequently at the situation where children lose both of their parents the practice has been that, family property is usually placed under the custody of family members to take care of it but also use it to take care of the children. Contrary to this and in many situations misappropriation of properties placed under the family members custody has been reported. The end result of this practice is denial of, children right to own properties which also makes it difficult for them to afford other basic needs such as education. Children become poor and at times exposed to unsafe environment which further their vulnerability to HIV.

Recommendations:

1. There is need to review property ownership laws in Tanzania Mainland to ensure they promote women’s right to own property without any form of discrimination. These are such as Customary Law (Declaration Order) of 1963 and Law of Marriage Act of 1971.

2. There should be thorough review of the contract, inheritance, property ownership, social security and family laws to allow some exceptions in relations to the children (orphans) right to own properties. On the other hand there should be extension of the Administrator General and some Local Government Officials mandate in relations to the protection of the family properties especially when the interests of minors are at stake.

3. Since majority of population of Zanzibar is dominated by Muslims the provision of Quran and Sunnah apply. Zanzibar authority should enhance the efforts to enact the law which will govern property ownership for the spouses and also establish Kadhi Courts which will regulate and oversee the same matters

1.3.4 Right to Work

Observations:
1. The law prohibits discrimination in employment based on one’s HIV status however; employers do not observe this principle.

2. There is Government Circular which encourages employees in the public sector to undertake voluntary HIV testing and disclose their HIV status to their employer. The same circular require provision of support services to PLHIV who have disclosed their HIV status.

Despite having labour laws and the Constitutions which prohibits all forms of discrimination particularly in the field of employment, still some employers violate this right by discriminating employees based on their HIV status. Some of the employers require pre-employment HIV testing and in some circumstances it has been done mandatorily, secretly and without the prior consent or knowledge of the tested. As a result of these types of malpractice some PLHIV have been denied entry into the field of work while in some circumstance denied promotion at work. In other extreme circumstances employees have been retrenched out of been ill due to HIV related illnesses.

These types of practices violate PLHIV right to work resulting into the series of violation of their other rights including right to development which is key in the enjoyment of all other rights. These practices stigmatize and discriminate PLHIV and subject them into the poverty and increasingly put them into the high risks of spreading the disease. Failure to cater for their family members due to unemployment subjects them and their families into poverty which results into the failure to afford other social services. This increases family chances of engaging into the practices which put them at higher risk of contracting HIV but also exacerbates their chances of contracting other HIV related illnesses.

It was observed during the assessment that, the Government has taken positive initiatives in ensuring PLHIV employment in the public sector, live stigma free life and also provide them with extra support services to enable them cope with the HIV related life challenges.

Recommendations:
1. Governments should issue regulations and guidelines under the HAPCA and the Prevention and Management of HIV and AIDS Act on non-discrimination clause which should also capture non-discrimination in the field of work in conformity with ILO’s Code of Practice on HIV and AIDS and the World of Work.

2. Government should issue circular that will encourage HIV testing and provision of HIV related support services not only to the Government employees but also to those working in the private sector where these services are similarly required.

3. The Government should ensure every employer develop and implement the HIV and AIDS workplace policy to protect and promote the rights and interests of PLHIV at workplace. There should also be a campaign to condemn all forms of discrimination at workplace and advocate companies, enterprises and organizations to abide with labour laws requirements which outlaw discrimination based on one HIV status.

1.3.5 Right to Information and Freedom of Expression

Observations:

1. In the rural areas HIV related information and education is still not readily available and accessible to everyone especially to the vulnerable groups such as disabled.

2. Knowledge on the existence of HAPCA and its application is highly limited to all stakeholders and target groups.

The survey observed that, in some parts of the rural areas, HIV and AIDS related information and education is limited. For instance there are few centres or organizations offering HIV related education or information to the public. Much as some of the HIV related topics are included in the Primary and Secondary school curricula the information contained in these curricula is limited considering the vast nature of the subject itself. Apart from that, there has not been a deliberate effort in ensuring HIV related information is accessible to all groups of people in the community.
such as people with disabilities. In many circumstances tailoring and dissemination of the tailored HIV information does not take into consideration the specific needs of each particular group. The outcome of this is limited HIV information and knowledge to these particular groups which places them at the higher risks of contracting HIV.

Apart from the above, it was discovered during the assessment that many of the people targeted by the HAPCA and the Prevention and Management of HIV and AIDS Act of Zanzibar have no or have very limited knowledge on these pieces of legislation. For instance, during the interview with the medical practitioners, magistrates and judges, prisons officials, police, PLHIV and other key populations they clearly stated to have no information on the existence of the law more so on the content of the law itself.

Recommendations:

1. It is recommended that, deliberate efforts should be taken to ensure HIV related information is made available and accessible to all people in the community especially in rural areas. This should include preparation of self-help kits, brochures and pamphlets in a simple understandable language to ensure maximum public consumption and adequate coverage of all target groups including people with disabilities.

2. It is further recommended that TACAIDS and ZAC should take deliberate efforts to prepare simplified version of the HIV laws and regulations and disseminate them widely to all beneficiaries and target groups including people with disabilities.

1.3.6 Right to Liberty/Freedom of Association

Observations:

1. Discrimination of PLHIV from Community Social activities.

2. Denial of free movement of certain groups of Key Populations (Long Distance Truck Drivers) due to lack of Tailored services to accommodate their needs.
The study observed that in most societies especially in rural areas, those who are HIV positive or are perceived to be HIV positive are excluded from community activities or social gatherings thus infringing their right of association or participation in community activities.

Furthermore, it was also observed that lack of tailored services for mobile clients such as Long Distance Truck drivers curtails their freedom of movement and also increases their risks of contracting HIV due to improper medical attention or lack of services.

Recommendations

1. There should be a wide dissemination of HIV and AIDS education in urban and rural societies to curb the issue of stigma and discrimination which leads to exclusion of individuals in public affairs on the basis of their actual or perceived status.

2. Government should effectively enforce the provisions of section 30 of the HAPCA and Section 43 of the Prevention and Management of HIV and AIDS in Zanzibar Act of 2014 which prohibit and sanction all forms of discrimination including restriction of travelling within or outside Tanzania, restriction of residence, denial of employment opportunity, denial of admission and expulsion from any institution based on a person’s real or perceived HIV status.

3. Government should re-think and devise mechanisms to ensure mobile people who need HIV medical service such as Long Distance Truck drivers obtain required services to ensure their enjoyment of right to work and liberty.

1.4 Vulnerable Groups
1.4.1 Women and Girls

Observations:

1. Existence of Gender Based Violence against women and Girls which fuel the spread of HIV.
2. Existence of Law of Marriage Act which allows marriage for girls under the age of 18.

The LEA observed that there are various practices and laws in Tanzania that undermine women and girls HIV related rights. The loopholes within the legal framework are such as lack of specific gender law to categorically outlaw gender based violence. It was observed that; a practice like rape in many local communities is one among the factors which fuel HIV transmission. It was further observed that there is an established Police gender desk that assists women and girls in reporting gender based violence related offences.

The study also observed that, the existing Law of Marriage Act section 13 allows marriage for a girl under the age of eighteen years. This increases their vulnerability to abuse and thus fuelling the spread of HIV. Also the Penal Act, No.6 of 2004 Section 125(1), (2) does not criminalize marital rape even in the circumstances where husband is infected with HIV/AIDS.

However, though the rights of women and girls are specifically provided for in various legislations, there are still practices and other laws that undermine women and girls HIV and AIDS related rights.
Recommendations

1. The Government should take all necessary measures to improve the current legal and regulatory framework by enacting a specific gender law to take care of all forms of gender based violence present in the society including marital rape.

2. In both Tanzania Mainland and Zanzibar, the Laws regulating marriage matters should be amended to ensure the minimum age of marriage is 18.

3. Police gender desk and its roles should be publicized widely to the local communities and there should be concerted efforts to make their services readily accessible to the public.

1.4.2 Sex Workers

Observations:

There are Punitive laws which prohibit sex work both in Tanzania Mainland and Zanzibar

The study observed that the current Legal Framework has punitive laws that outlaw sex work in Tanzania thus making it very difficult for sex workers to access HIV and AIDS related services thus increasing their vulnerability to HIV as well as exacerbating their chances of fuelling the spread of HIV.

The study further observed that sex workers who visit CTCs do get HIV and AIDS services but without necessarily disclosing their identity. However, the nature of their business also makes them vulnerable to abuse by their customers and by the law enforcers who in most instances arrest and charge them on loitering and other petty offences.
Recommendations

1. The Health care workers should comply with the law and the guidelines on “Comprehensive Packaging of HIV Interventions for Key Populations” during service provision for sex workers.

2. Despite the presence of the Legal Framework that prohibits certain conducts of the Key Populations including sex workers, implementation of these laws should not compromise formulation of programs targeting KPS or limit KPS access to HIV services.

1.4.3 People who Practice Anal Sex

Observations:

Existence of punitive laws that prohibit consensual same sex and sexual relations among the adults

The study observed that, the current Legal Framework has punitive Laws that prohibit consensual anal sex among adults in Tanzania, thus making it difficult for people who engage in anal sex to access HIV and AIDS related services due to fear of repression or stigma thus fuelling the spread of HIV in the members of this category. Most MSM fear their statuses being known as they will be viewed as deviants in the society. The study further observed that a good number of health care workers and law enforcers do not observe this group rights especially right of access to health services. Those who are known by their statuses in the society are highly discriminated and stigmatized.

Further to this, most of these people fear voluntary counselling and testing due to fear of stigma when diagnosed to be HIV positive as their condition will be related with their sexual practices which in itself is a stumbling block to actively participate in community activities.
Recommendations

(1) Regardless of the provisions of the laws which prohibit same sex relation and practices among the adults, the Government should ensure access to HIV services to all persons regardless of their sexual orientation or practices.

(2) Health care workers should be required and allowed to provide specialized services to key populations including MSM including harm reduction products in accordance with the guidelines on “Comprehensive Packaging of HIV Interventions for Key Populations”

1.4.4 Injecting Drug Users

Observations:

Existence of punitive laws that prohibit drug abuse

From the study it was observed that, there are punitive laws that prohibit drug abuse in Tanzania. Due to this most of the drug users procure and use drugs substance in secrecy and under very unhealthy and hazardous environment.

The study observed that, health care workers do engage in HIV and AIDS service provision to these people however these initiatives are hampered by police officers who raid in and arrest the service receivers (IDU’s). Thus most IDU’s shun HIV and AIDS services for fear of being arrested by the police and view such initiatives as ways to lure them into the arms of the law.

It was further observed that, due to the fact that some practices by IDU’s (sharing syringes) are done in secrecy and in a very unsafe manner there is a high risk of this group to be infected with HIV and other opportunistic diseases while at the same time fuelling the spread of the epidemic to other people. The NMSF III also recognizes that stigma and discrimination against IDU’s is still high.
Recommendations

1.4.5 Migrants or Long Distance Truck Drivers

Observations:

1. Immigration laws do not explicitly guarantee Unlawful Migrants Access to HIV related services.

2. Long Distance Truck Drivers are not adequately catered for with regard access to HIV and AIDS related services when on transit.

From the study conducted it was observed that, migrants’ rights are violated in many instances especially of the migrants illegally residing in country. Though such migrants intermingle with the surrounding community at various levels they do not adequately obtain HIV and AIDS related services as they are highly discriminated.

With regard to long distance truck drivers the study observed that due to lack of medication, most patients are only given limited medication to last for a short period of time. Due to the nature of their work, the long distance truck drivers tend to spend months out of their localities which make
it difficult for them to access HIV related services while away. The fact that they are registered at one centre and can only obtain treatment and allied services from that particular centre makes it difficult to access HIV and AIDS related services from other centres when at work. This denies them HIV and AIDS related services and rights.

Recommendations

1.4.6 Prisoners and Other People in Correctional Services

Observations:

Limited access to HIV services to Prisoners

The study observed that, HIV and AIDS service provision to prisoners has improved over the period of time. Previously these services were provided on a few working days however as of current they are provided in all working days.

The study further observed that though service provision has improved with regard the number of days inmates attend clinics, the surrounding conditions have not reflected such improvements. Limitations such as lack of basic health services mostly in detention facilities located in remote areas makes it impossible for many of the detainees to access HIV related health services. Poor bedding and lack of nutrition/dietary supplements are other limitations experienced by prisoners.
The situation is also very cumbersome for the arrested and detainees in police detention facilities. There is no policy on provision of health services to these detainees neither is there a requirement by the law to ensure provision of health services to these detainees particularly HIV related services.

It was further reported that many prisoners do engage in anal sex and in all cases without any protection. Such practices increase the risks of HIV and AIDS transmission for inmates.

Recommendations

1. HIV and AIDS services should be made readily available and accessible to prisoners in detention facilities and further improved to provide continuum of services such as HIV counseling and testing, provision of prevention kits, dietary services for the already infected and ART services.

2. Prison officers should be trained on how to handle PLHIV prisoners especially through observing their rights such as right to privacy and health. Guidelines on provision of HIV related services for the arrested and detained persons should be developed and widely disseminated to the public and police force department.

3. There should be concerted efforts towards devising mechanism of addressing same sex intercourse that happens in prison settings.
# APPENDIX 1

## LIST OF INTERNATIONAL HUMAN RIGHTS INSTRUMENTS RATIFIED BY TANZANIA

<table>
<thead>
<tr>
<th>International Bill of Human Rights</th>
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<td>ILO’s Convention on Abolition of Forced Labour Convention</td>
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<td>30 Jan 1962</td>
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<td>Discrimination (Employment and Occupation) Convention</td>
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<th><strong>Education</strong></th>
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<td>Convention relating to the Status of Refugees</td>
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<tr>
<td>Convention Governing the Specific Aspects of Refugee Problems in Africa *</td>
<td>10 Sep 1969</td>
<td>10 Jan 1975</td>
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APPENDIX 2

STRUCTURED INTERVIEW GUIDING QUESTIONS

DODOSO LA JUMLA

Jina la Mtafiti: ...........................................................................................................................................................

Kundi la Aliyejibu ...................................................................................................................................................

Jinsia ya Aliyejibu: Mwanaume.......... Mwanamke .......... Mvulana ..........Msichana..........................

Mkoa anakotoka aliyeji …………………………………………………………………………………………………

MAELEZO KWA ANAYEJIBU:

Umeanishwa kama miongoni mwa mdau muhimu atakayesaidia utafiti wetu kwa kutupa taarifa muhimu na mtazamo wako jinsi sheria na mfumo wake wa utekelezaji unavyosaidia ama kuzuia jitihada za kupamba na UKIMWI Tanzania. Tafadhali, saidia utafiti huu kwa kujibu maswali haya kwa kutushirikisha uzoefu, utaalamu na maoni yako binafsi yanayotokana na uzoefu wako kimaisha.

Maswali haya yametengenezwa kutusaidia kubaini;

a. Kiwango cha unyanyapaa, ubaguzi na ukiukwaji wa haki za binadamu unaotokana na kuwa na UKIMWI ama Virusi vya UKIMWI Tanzania.

b. Jinsi sheria na mfumo wake wake wa utekelezaji vinavyolinda haki za watu na kusaidia upatikanaji wa huduma muhimu za UKIMWI kama kinga, matibabu, huduma za kijamii kwa waathirika wa ugongwa huu.

c. Udhaifu, mapengo na changamoto zilizopo katika sheria na mfumo wake wa utekelezaji pamoja na maoni ya namna ya kuimarisha mfumo huu wa sheria ili kusaidia utoaji wa huduma stahiki za UKIMWI kwa walengwa.

KURIDHIA KUSHIRIKI KATIKA UTAFITI HUU:

Tafadhali onyesha hapa chini kwango ambacho ungependa ushiriki wako katika utafiti huu kiwe. Mathalan, kama uko tayari kujibu maswali yaliyopo katika dodoso hili na kiasi ambacho ungependa ushiriki wako katika utafiti huu uwe wa siri. Tafdhali onyesha kama;
a. Uko tayari kushiriki katika utafiti huu na kujibu maswali yote yatakayoulizwa

NDIYO ☐ HAPANA ☐

b. Uko tayari jina lako pamoja na la shirika lako vioneshwe katika utafiti huu kama miongoni mwa watoa taarifa muhimu.

NDIYO ☐ HAPANA ☐

c. Kama ungependa maoni yako wakati wa kuandika taarifa ya utafiti huu yahusishwe na wewe kwa kukutaja jina ama cheo chako.

NDIYO ☐ HAPANA ☐

**MAELEKEZO KWA MTAFITI:**

Kwa kila atakayejibu, tafadhali tia msisitizo kwa yale maswali unayoona ni muhimu kutokana na historia yake ya kazi, uzoefu na utaalam wake. Maswali yote katika dodoso hili ni lazima yaulizwe kwa makundi yote yaliyoanishwa katika utafiti huu isipokuwa tu yale yanayohusiana na watoa huduma za afya. Makundi haya ni;

Kabl na wakati wa kufanya mazungumzo na anayejibu tafadhali toa maelezo ya kutosha kwa mifano. Tafadhali toa mifano kwa lengo la kufanana maswali tu na siyo ushawishi ama maelekezo kwa anayejibu. Maaelekezo yasimsababishie anayejibu kushindwa kujibu maswali yanayoulizwa wala yasiwe yanayoashiria kutoa majibu.

**HISTORIA YA ANAYEJIBU:**

- **Jinsia:** ☐ Mme ☐ Mke

- **Kazi ama Wasifu wake:** (Ainisha anakofanya kazi; serikalini, taasisi ya umma, shirika la wahisani, Asasi isiyi ya Kiserikali ama Mahali pengine:


- **Nafasi yake Kazini:**


**Tangu** (Tarehe na Mwaka)


80
- Shirika ama Taasisi yako imekua ikifanya kazi muda gani hapa nchini?

- Unaelewa nini kuhusiana na uhusiano uliopo baina ya UKIMWI, sheria na haki za binadamu?

- Nini majukumu ya Shirika lako katika masualama mazima yahusuyo haki za binadamu kwa kadiri yanavyohusiana na masuala ya UKIWI?

Maswali

1. Upatikanaji wa Huduma VVU
1.1 Je! watu Tanzania wanaweza kupata huduma muhimu za VVU kama dawa (ARVs), kupima VVU na unasihi, elimu ya kujamii, dawa za kuzuia maambukizi toka kwa mama kwenda kwa mtoto pamoja na elimu yake, uzazi wa mpango n.k?

NDIYO □  HAPANA □

1.2 Kwa nini unajua wanapata ama kwa nini hawapati? ____________________________________________

1.3 Je! Ulishawahi kupima VVU?

NDIYO □  HAPANA □

1.4 Kama jibu lako ni ndiyo, ulipata huduma ya unasihi ili kukuwezesha kufanya uamuzi binafsı juu ya kupima ama kutokupima?
1.5 Kwa ujumla je upimaji ulifanyika kwa hiari yako mwenyewe?

**NDIYO** ☐  **HAPANA** ☐

1.6 Je ulihakikishiwa usiri wa utunzaji wa majibu yako na kutekelezwa?

**NDIYO** ☐  **HAPANA** ☐

1.7 Kama ndiyo kwanini na kama siyo kwanini?

___________________________________________________________________________

___________________________________________________________________________

1.8 Je! Watu katika makundi haya wafungwa (waliofungwa na wanaosubiri hukumu), wenye ulemavu, wahamiaji wanapata huduma stahiki za VVU kama huduma za kinga, matibabu na huduma nyingine za kijamii?

**NDIYO** ☐  **HAPANA** ☐

1.9 Kama hawapati huduma hizi ni matatizo gani wanayokumbana nayo katika kupata huduma hizi? Tafadhali ziorodheshe; ? ___________________________________________________________________________

___________________________________________________________________________

1.10 Je! Mikakati, sera, sharia,mbinu za utoaji huduma zinatoa kipaumbele kwa mahitaji ama kuwalenga watu walio katika maambukizi ya VVU?

**NDIYO** ☐  **HAPANA** ☐

1.11 Je! Unafikiri wahudumu wa afya ama wanaotoa huduma za afya wananaheshimu haki za WAVU na wale walio katika hatari ya maambukizi kama Wanaume wanaofanya mapenzi ya jinsia moja, wanaofanya biashara ya ngono na wanaojidunga madawa ya kulevya hasi haki ya usiri, haki ya kufanya maamuzi binafsi kuhusu kupima, na upatikanaji wa huduma nyingine za afya?
1.12 Kama ndivyo kwa nini na kama sivyo tafadhali toa sababu. ________________________________

1.13 Je! Unafikiri sharia ya UKIMWI inasaidia watu kupata huduma muhimu kama kinga, tiba na huduma za kijamii?
NDIYO    HAPANA

1.14 Kwa nini na kama sivyo tafadhali toa sababu; ________________________________

2. Unyanyapaa na Ubaguzi

2.1 Je! Unafahamu kundi lolote la watu katika jamii ya Tanzania wanaonyanyapaliwa ama kubaguliwa?
NDIYO    HAPANA

2.2 Kama jibu lako hapo juu ni NDIYO;
   a. Taja hilo kundi; __________________________________________________________
   b. Aina ya ubaguzi unaowakabili: ____________________________________________

2.3 Je! Unafahamu ubaguzi wowote unaowakabili watu kutokana na hali yao ya kuwa ama kuhisiwa kuwa na virusi vya UKIMWI?
NDIYO    HAPANA

2.4 Kama jibu lako ni ndiyo, tafadhali taja;
   a. Aina ama kundi la watu wanaobaguliwa _________________________________
   b. Eneo wanalobaguliwa katika jamii; (kummbuka yaweza kuwa katika familia, jamii, kazini, hospitali, shuleni, kwenye mikusanyiko ya watu n.k);
c. Je! Unaweza kueleza kwa uwazi aina ya ubaguzi waliokumbana nao?

2.5 Je! unafahamu ubaguzi wowote unaowakabili WAVU, Wanaume wanaojihusisha na mapenzi ya jinsia moja, Wanawake wanaofanya biashara ya Ngono, Wanaojidunga Madawa ya Kulevya, Wafungwa, Vijana, Wahamiaji, Wavuvi, Wenye Ulemavu, Madereva wa Masafa Marefu, Wanawake na Wasichana ama kundi lingine lolote katika kupata huduma za UKIMWI?

NDIYO ☐ HAPANA ☐

2.6 Unaweza kutaja kwa uwazi makundi ya watu unaojua wanakutana na ubaguzi huu?

2.7 Je! Unamfahamu mtu yeyote ama wewe binafsi ulishawahi kubaguliwa; (hospitali, katika ofisi ya uma ama binafsi, benki ama mahali pengine popote) na mtu binafsi kama (mwanaajamii, mtoa huduma, anayetekeleza sheria, mwanasheria ama afisa wa ustawi wa jamii) katika kupata huduma kama (afya hasa zinazohusiana na UKIMWI, elimu, ajira, bima, mkopo, msaada wa kisheria, huduma za jamii, afueni za kisheria, taarifa n.k)?

NDIYO ☐ HAPANA ☐

2.8 Kama jibu lako ni ndiyo tafadhali elezea tukio hilo (Waweza tumia karatasi ya pembeni kuelezea tukio hilo):

2.9 Je! Unafahamu madhara ya unyanyapaa na ubaguzi?

NDIYO ☐ HAPANA ☐

2.10 Tafdhali taja baadhi ya madhara hayo katika maisha yako ama ya watu wengine wanaonyanyapaliwa; 

3. **Sheria/ Sera/ Utekelezaji wa Sera na Sheria**

3.1 Tanzania na katiba inayotambua haki za binadamu na hasa haki ya usawa wa watu wote na inakataza ubaguzi. Pia kuna Sheria za Kazi zinazolinda haki za WAVU katika ajira na Sera nyungine zinazowalinda na ubaguzi wa aina yooyote.

84
a. Je! Unafikiri katiba, sheria na sera hizi kweli zinawalinda WAVU pamoja na makundi mengine yaliyo katika hatari ya maambukizi wasibaguliwe?

NDIYO ☐ HAPANA ☐

b. Kwa nini ama Kwa nini Hudhani hivyo? ________________________________________________________________
______________________________________________________________

3.2 Zipo sheria na miongozo inayoruhusu kupima VVU kwa watu wanaotaka ama wanajeshi, wanawake wajawazito pamoja na kabla ya ndoa pamoja na sheria inayoruhusu watoto waliochini ya umri wa mika 18 kupata vipimo ama matibabu ya UKIMWI kwa ridhaa ya wazazi wao pekee.

a. Je! Unafikiri sheria hizi zinawabagua ama kuwaaadhibu wanaoishi na walio katika hatari ya maambukizi?

NDIYO ☐ HAPANA ☐

b. Kwa nini ama kwa nini siyo? ________________________________________________________________
______________________________________________________________

3.3 Zipo sheria za jinai zinazo kataza wanaume kufanya ngono na wanaume wenzao ama kuwashawishi wanaume wenzao kufanya hivyo ama anayefanya biashara ya ngono kumshawishi mtu yeyote kujihusisha na kitendo hicho katika sehemu ya wazi ama kuishi kwa kipato kinachotokana na biashara ya ngono na mtu yeyote kuwa na sindano ama kifaa kingine chochote kinachoweza kutumika katika kutumia madawa yaliyokatazwa.

a. Unafikiri sheria hizi zinaathiri vipi maisha ya wanaume wanaofanya mapenzi na wanaume wenzao, wanawake wanaofanya biashara ya ngono pamoja na wanaotumia madawa ya kulevya hasa katika kujipatia huduma za UKIMWI nchini?
3.4 Je! Unafikiri Sheria ya UKIMWI ndiyo mwongozo sahihi wa kushughulikia masuala ya UKIMWI nchini?  
NDIYO ☐  
HAPANA ☐

3.5 Kwa nini ama Kwa nini Siyo? _____________________________________________________________

3.6 Je! Kuna mambo yoyote muhimu ya UKIMWI yaliochwa na sheria na unayofikiri yanahitaji kuingizwa katika sheria?  
NDIYO ☐  
HAPANA ☐

3.7 Ikiwa ni ndiyo, basi yataje mambo hayo _________________________________________________

3.8 JE! Kuna mambo yoyote unayodhani si muhimu na yametajwa na sheria hii?  
NDIYO ☐  
HAPANA ☐

3.9 Ikiwa yapo, basi yataje mambo hayo _________________________________________________

4. **Utekelezaji wa Sheria**

4.1 Je! Unafahamu kama sheria zilizotajwa katika 3.3 hapo juu kama zinatekelezwa Ama la? (zinazowahusu wanaume wanaofanya mapenzi ya jinsia moja, wanawake wanaofanya biasha ya ngono, wanaotumia madawa ya kulevya kama wanashtakiwa?)  
NDIYO ☐  
HAPANA ☐

4.2 Je! Una uhakika wanashtakiwa kwa makosa yaliyoainishwa katika 2.3 hapo juu?  
NDIYO ☐  
HAPANA ☐

4.3 Kama jibu ni Ndiyo eleza nini hutokea ____________________________________________
Je! Watekelezaji wa sheria huwanyanyasa ama kuwadhalilisha watu walio katika hatari ya maambukizi ya VVU kama wanaume wanaojihusisha na mapenzi ya jinsia moja, wanaake wanaofanya biashara ya ngono, wanaojidunga madawa ya kulevya ama wengine wowote kama wahamiaji, wakimbizi, yatima, madereva wanaoendesha magari masafa marefu, wavuvi na watoto wa mitaani?

NDIYO [ ] HAPANA [ ]

4.4 Kama jibu ni Ndiyo eleza nini hutokea; ___________________________________________

4.5 Je! Ulishawahi wewe binafi kunyanyaswa ma kudhalilishwa na watekelezaji wa sheria (kwa sababu ya uhusiano wako na watu walio katika hatari ya maambukizi)?

NDIYO [ ] HAPANA [ ]

4.6 Kama jibu lako ni Ndiyo tafadhali elezea tukio hilo. (waweza kuambatani sha karatasi ya pembeni);
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

4.7 Ni ni matokea ya udhalilishaji na unyanyasaji unaoafanywa na watekelezaji sheria? Mathalan, ni vipi unaathiri maisha ya watu, afya, mahusiano, uwezo wa kujipatia kipato, uwezo wa kutumia na kujipatia huduma za afya hasa zile zinazohusia na UKIMWI?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

4.8 Je! watu wanachukua kinga na hatua stahiki dhidi ya unyanyasaji wa kijinsia na hasa unaotokea majumbani?

4.9 Tafadhali elezea jibu ulilotoa katika 3.9 hapo juu. ________________________________
5. **Upatikanaji wa Afueni za Kisheria**

5.1 Je! wewe ama watu wengine wanafahamu haki zao katika suala zima la UKIMWI? Mathalan, haki ya kuridhia kupima VVU, haki ya kupata huduma stahiki za VVU, haki ya usiri katika kupata huduma za VVU, haki ya kupata taarifa sahihi zinazohusiana na VVU?

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5.2 Unaweza kutaja program zozote zile zinazolenga kuongeza watu ulewa ama kutoa elimu juu ya VVU na UKIWMI hasa kuhusu kutokomeza unyanyapaa na ubaguzi?

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5.3 Unajua mahali unapoweza kwenda kudai haki zako pale unapobaguliwa ama zinaponyimwa?

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5.4 Je! una fahamu kama kuna msada wa kisheria unaotolewa ili kusaidia watu kudai haki zao (mathalan, huduma inayotolewa na polisi, mahakama, Tume ya Haki za Binadamu, Mahakama ya Kazi, Kanisa, Asasi za Dini, Asasi za Kiraia?)

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5.5 Kama jibu lako ni ndiyo tafadhali orodhesha vyombo hivyo: ________________________________

___________________________________________________________________________

5.6 Je! Watu wanatumia huduma hizi zinazotolea bure na mashirika na taasisi zilizotajwa hapo juu?

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5.7 Kwa nini unadhani wanatumia ama Kwa nini hawatuzitumii? ________________________________

___________________________________________________________________________

5.8 Unafikiri wanaotunga sharia ama kutekeleza sheri wanaheishimu haki za watu wanaoishi na VVU ama wale walio katika hatari ya maambukizi kama wanaofanya biashara ya ngono, wanaojidunga madawa ya kulevya, wanaume wanaofanya mapenzi ya jinsia moja?
6. **Kwa ajili ya Watoa Huduma za Afya**

6.1 Je, unafahamu kuwa kuna Mwongozo wa upimaji VVU na ushauri nasaha katika Wizara ya Afya?

- [ ] NDIYO
- [ ] HAPANA

6.2 Je wafahamu na kujua vipengele vilivyomo kwenye Mwongozo wa tiba ya VVU ikiwemo Mwongozo wa uzuiaji wa maambukizi kutoka kwa mama kwenda kwa mtoto katika Wizara ya Afya?

- [ ] NDIYO
- [ ] HAPANA

6.3 Je, unadhani wahudumu wa Afya ambao wanaishi na VVU wanaungwa mkono vya kutosha na sera ya mahali pa kazi juu ya VVU na UKIMWI?

- [ ] NDIYO
- [ ] HAPANA

6.4 Je, mnatoa huduma za uzuiaji maambukizi na matibabu ambazo hasa hulenga kuidhiri mahitaji ya wanaume wanaofanya mapenzi na wanaume wenzao, watu ambao hujidunga madawa ya kulevya, na wanaofanya biashara ya ngono?

- [ ] NDIYO
- [ ] HAPANA

4.3 Kama ni hivyo, tafadhali elezea. __________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
6.6 Je, umepata mafunzo katika upimaji VVU na ushauri (ikiwa ni pamoja na ridhaa madhubuti, usiri na kutobagua)?

NDIYO ☐ HAPANA ☐

6.7 Je, umepata mafunzo katika tahadhari kwa wote (universal precautions)?

NDIYO ☐ HAPANA ☐

6.8 Je, umepatiwa vitu muhimu katika kutekeleza hatua zilizopo katika huduma ya tahadhari kwa wote?

NDIYO ☐ HAPANA ☐

6.9 Je, umewahi kuhitaji njia za uzuiaji wa maambukizi yatokanayo na mfiduo wa kazi (PEP for occupational exposure)?

NDIYO ☐ HAPANA ☐

6.10 Kama ni hivo, je, ulipata tatizo lolote katika kupata vuzuiaji hivo?

NDIYO ☐ HAPANA ☐

6.11 Je, unafikiri ni mambo gani ambayo huzuia watu kupima VVU?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

6.12 Je, watu ambao huhitajika kiafya kutumia Madawa ya Kupunguza makali ya VVU hupata tiba kwa upesi?

NDIYO ☐ HAPANA ☐

6.13 Kama sivyo, ni matatizo gani huwapata katika hili?

_____________________________________________________________________
_____________________________________________________________________

90
6.14 Je, unahisi wewe kama mhudumu wa Afya unaweza kuungwa mkono katika hali bora zaidi ili kukabiliana kwa ufanisi na mahitaji ya Afya ya watu wanaoishi na VVU na makundi ya wau walio katika hatari kubwa ya kupata maambukizi ya VVU?

NDIYO ☐  HAPANA ☐

6.15 Tafadhal fafanua?

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

6.12 Je, unadhani kuna wahudumu wa Afya ambao hubagua kundi la watu wenye VVU pamoja na wale wali katika hatari kubwa ya kupata maambukizi? (yaani, wanaume na wanawake wanaofanya mapenzi kinyume na maumbile, wanaofanya biashara ya ngono, wau wanaajidunga sindano za dawa za kulevya, wafungwa, vijana wadogo, wafanyakazi wahamiaji, wavuvi, walemavu, madera wa masafa marefu nk?)

NDIYO ☐  ☐
ENDNOTES


3 Part 3 of the Constitution of Zanzibar 1984

4 See article 13 (2) and (4) of the United Republic of Tanzania Constitution, 1977 which are clear and articulate in this effect.

5 Articles 13 (2) and (4) of the constitution of the United Republic of Tanzania and Article 12 (1), (2) and (4) of the Zanzibar Constitution (1984)

6 The HIV and AIDS (Prevention and Control Act), Act No. 22 2008

7 Act NO. 18 of 2014

8 Cap 16 R.E. 2009

9 Act No. 9 of 1995


12 Malawi and Seychelles have both undertaken HIV and AIDS Legal Environment Assessments and have published reports


14 Tanzania HIV/AIDS and Malaria Indicator Survey 2011-2012

15 Ibid.

16 Ibid

17 Cap 16 R.E 2002, Tanzania Mainland

18 See ZNSP I, pg 11

19 The study conducted in Tanzania in detention facilities indicated ……. Out of the ten (10) inmates are HIV positive. Upon been interviewed some of the detainees reported to have discovered their HIV zero status while in prison.

20 Analysis of Responses from interviewees from LEA Field Survey in Tanzania

21 For instance in the small sample survey of 430 respondents undertaken in Temeke Municipality, Dar es Salaam region it revealed IDUs HIV zero prevalence of 26% (34.8 % and 11.7 % for non IDUs).See the, the National Multisectoral Strategic Framework for HIV and AIDS 2013/14 – 2017/18 pg 19 and 27. See also Eric A. Ratliff,1 Sheryl A. McCurdy,1 Jessie K. K., Mbwambo, Barrot Lambdin, Ancella Voets, Sandrine Pont, Haruka Maruyama, and Gad P. Kilonzo; An Overview of HIV Prevention Interventions for People Who Inject Drugs in Tanzania

22 McCurdy, S., Williams, M., Kilonzo, G., Ross, M., & Leshabari, M. (2005a); Heroin and HIV risk in Dar es Salaam, Tanzania: Youth hangouts, mageto, and injecting practices. AIDS Care, 17 (Supplement 1), S65-S76


24 See, Gad Paul Kilonzo, Tanzania AIDS prevention project: HIV risk and care and treatment of drug users and most at risk populations in Zanzibar and Dar es Salaam


26 See Part V of Zanzibar Penal Act of 2004

27 See a Report on Factors Facilitating HIV & AIDS IN THE Fishing Camps in Zanzibar pg 8

28 Key Informants Discussion held at Grand Palace Zanzibar in November 2014

29 Cap 2 R.E. 2009

30 The Constitution of Zanzibar 1984
The National HIV and AIDS Policy 2001
Act No 22 of 2008
Act NO.18 of 2014
The HIV and AIDS (Counseling and Testing, Use of ARV and Disclosure) Regulations, 2010
Act No. 22 of 2001
Act No. 3 of 2002
Act NO.2 of 2011
Act NO.11 of 2005
Act NO. 1 of 2005
Act NO. 21 of 2009
2003-2007
2008-2012
2013-2017
Civil Application No.18 of 1993 (Unreported)

Subject to the provisions contained in this Constitution, the Parliament shall exercise its legislative power through the process of debating and passing Bills which eventually shall have to be assented to by the President, and a Bill shall not become law unless it is so passed by the National Assembly and assented to by the President in accordance with the provisions of this Article. (2) After a Bill is presented to the President for his assent, the President may either assent to the Bill or withhold his assent, and in the event the President withholds his assent to a Bill, he shall return it to the National Assembly together with a statement of his reasons for withholding his assent to the Bill. (3) After a Bill is returned to the National Assembly pursuant to the provisions of this Article, it shall not be presented again to the President for his assent before the expiration of six months since it was so returned, except if at the last stage in the National Assembly before it is again presented to the President, it is supported by the votes of not less than two-thirds of all the Members of Parliament. (4) If a Bill is returned to the National Assembly the President, and it is then supported in the National Assembly by not less than two-thirds of all Members of Parliament as provided in sub-article (3) and it is presented a second time to the President for assent within six months of its being so returned, then the President shall be obliged to assent to the Bill within twenty-one days of its being presented to him, otherwise he shall have to dissolve Parliament. (5) The provisions of this Article or Article 64 of this Constitution shall not prevent Parliament from enacting laws making provisions conferring on any person or department of Government the power to make regulations having the force of law or conferring the force of law on any regulations made by any person, or any department of Government.

Tanzania is a Union between Tanganyika and Zanzibar. The nature of the union and matters of union between Tanganyika and Zanzibar are prescribed by articles of Union but also Article 4 of the Constitution of the United Republic of Tanzania 1977.

For more information UNAIDS three Zeros see the following link http://www.unAIDS.org/en/aboutunAIDS/unAIDSStrategygoalsby2015/ accessed on February 20th 2014 at 13:34 pm.

The Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV was established by the African Commission on Human and Peoples’ Rights with the adoption of Resolution 163 at the 47th Ordinary Session held in Banjul, The Gambia in May 2010. See Resolution 163 at the 47th Ordinary Session held in Banjul accessed at http://www.achpr.org/mechanisms/hiv-AIDS on May 23rd 2014

68 Article 8 (1) (b) of the Constitution Cap 2 R.E. 2009
69 Article 9 (d) and (g) of the URT Constitution Cap 2 R.E. 2009

61 Cap 2 Supra

62 Article 26 (2) states that (2) “Every person has the right, in accordance with the procedure provided by law, to take legal action to ensure the protection of this Constitution and the laws of the land”.
63 The Zanzibar Constitution 1984, Article 10(a),(c)
64 Ibid, Article 10(f)
65 Ibid, Article 13


70 However, Some certain rights such as the right to life are considered absolute/ non derogable and are limitless

71 Talks about Limitations, enforcement and preservations of the basic rights, freedom and duties
The States Parties to the present Covenant undertake to guarantee that:

1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

2. Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant.

3. Each State Party to the present Covenant undertakes:
   (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
   (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;
   (c) To ensure that the competent authorities shall enforce such remedies when granted.”

The specific power of the state to restrict right in the state of public health can be understood to be derived from Article 12 (c) of the ICESCR, which gives governments the right to take the steps they deem necessary for the “prevention, treatment and control of epidemic, endemic, occupational and other diseases.”


Article 2 states that “everyone is entitled to all rights and the rights and freedoms set forth in this declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. Article 7 that “all persons are equal before the law and are entitled without any discrimination to equal protection of the law”.

Article 2 states that “1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

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   (c) To ensure that the competent authorities shall enforce such remedies when granted.”

Article 2 (2) states that “The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

Article 2 states that “Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status”. Article 3 states that “(1) Every individual shall be equal before the law, (2) Every individual shall be entitled to equal protection of the law”.

Article 9. The object of this Constitution is to facilitate the building of the United Republic as a nation of equal and free individuals enjoying freedom, justice, fraternity and concord, through the pursuit of the policy of Socialism and Self Reliance which emphasizes the application of socialist principles while taking into account the conditions prevailing in the United Republic. Therefore, the state authority and all its agencies are obliged to direct their policies and programmes towards ensuring - (a) that human dignity and other human rights are respected and cherished;

(f) that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights

(g) that the Government and all its agencies accord equal opportunities to all citizens, men and women alike without regard to their colour, tribe, religion, or station in life;

(h) that all forms of injustice, intimidation, discrimination, corruption, oppression or favouritism are eradicated;
Article 12. - (1) All human beings are born free, and are all equal. (2) Every person is entitled to recognition and respect for his dignity.

Article 13 (1). All persons are equal before the law and are entitled, without any discrimination, to protection and equality before the law.

(2) No law enacted by any authority in the United Republic shall make any provision that is discriminatory either of itself or in its effect.

(3) The civic rights, duties and interests of every person and community shall be protected and determined by the courts of law or other state agencies established by or under the law.

(4) No person shall be discriminated against by any person or any authority acting under any law or in the discharge of the functions or business of any state office.

(5) For the purposes of this Article the expression “discriminate” means to satisfy the needs, rights or other requirements of different persons on the basis of their nationality, tribe, place of origin, political opinion, colour, religion, sex or station in life such that certain categories of people are regarded as weak or inferior and are subjected to restrictions or conditions whereas persons of other categories are treated differently or are accorded opportunities or advantage outside the specified conditions or the prescribed necessary qualifications except that the word “discrimination” shall not be construed in a manner that will prohibit the Government from taking purposeful steps aimed at rectifying disabilities in the society.

(6) To ensure equality before the law, the state authority shall make procedures which are appropriate or which take into account the following principles, namely: (a) when the rights and duties of any person are being determined by the court or any other agency, that person shall be entitled to a fair hearing and to the right of appeal or other legal remedy against the decision of the court or of the other agency concerned; (b) no person charged with a criminal offence shall be treated as guilty of the offence until proved guilty of that offence; (c) no person shall be punished for any act which at the time of its commission was not an offence under the law, and also no penalty shall be imposed which is heavier than the penalty in force at the time the offence was committed; (d) for the purposes of preserving the right or equality of human beings, human dignity shall be protected in all activities pertaining to criminal investigations and process, and in any other matters for which a person is restrained, or in the execution of a sentence; (e) no person shall be subjected to torture or inhuman or degrading punishment or treatment.

The HIV and AIDS (Prevention and Control) Act, Act No. 22 2008. Also see Part VI of Act to provide for the Prevention and Management of HIV and AIDS in Zanzibar Act NO.18 of 2014

Article 15 states that “(1) every person has the right to freedom and to live as a free person. (2) For the purposes of preserving individual freedom and the right to live as a free person, no person shall be arrested, imprisoned, confined, detained, deported or otherwise be deprived of his freedom save only- (a) under circumstances and in accordance with procedures prescribed by law; or (b) in the execution of a judgment, order or a sentence given or passed by the court following a decision in a legal proceeding or a conviction for a criminal offence”.

Article 3 states that “Everyone has the right to life, liberty and security of person”.

Article 9 (1) states that “. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law”.

A person shall not -(a) deny any person admission, participation into services or expel that other person from any institution; (b) deny or restrict any person to travel within or outside Tanzania; (c) deny any person employment opportunity; (d) deny or restrict any person to live anywhere; or (e) deny or restrict the right of any person to residence, on the grounds of the person’s actual, perceived or suspected HIV and AIDS status.

Article 16 (1) every person is entitled to respect and protection of his person, the privacy of his own person, his family and of his matrimonial life, and respect and protection of his residence and private communications.

This states that “(2) For the purpose of preserving the person’s right in accordance with this Article, the state authority shall lay down legal procedures regarding the circumstances, manner and extent to which the right to privacy, security of his person, his property and residence may be encroached upon without prejudice to the provisions of this Article”.

Article 17 states that “(1). No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. (2). everyone has the right to the protection of the law against such interference or attacks”.

This article states that “No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal
Every individual shall have emphasis on the development of his education and social welfare at times of old age, sickness or disability and in other cases of incapacity, without prejudice to those rights, the state authority shall make provisions to ensure that every person earns his livelihood.

No court shall be competent to determine the question whether or not any action or omission by any person or any court, or any law or judgment complies with the provisions of this Part of this Chapter.

“Every person has the right to work and that “everyone is entitled to own property, and has a right to the protection of his property held in accordance with the law”. 

Article 25 (1) States that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.

Article 16 states that “(1). Every individual shall have the right to enjoy the best attainable state of physical and mental health. (2). States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.


Article 11. (1) The state authority shall make appropriate provisions for the realisation of a person’s right to work, to self-education and social welfare at times of old age, sickness or disability and in other cases of incapacity, without prejudice to those rights, the state authority shall make provisions to ensure that every person earns his livelihood.

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Article 16 states that “(1). Every individual shall have the right to enjoy the best attainable state of physical and mental health. (2). States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Article 18 of the constitution states that “18. Every person - (a) has a freedom of opinion and expression of his ideas; (b) has the right to seek, receive and, or disseminate information regardless of national boundaries; (c) has the freedom to communicate and a freedom with protection from interference from his communication; (d) has a right to be informed at all times of various important events of life and activities of the people and also of issues of importance to the society.

The Universal Declaration of Human Rights 1948 that “Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers”.

It states “everyone shall have the right to freedom of expression; this right shall include the freedom to seek, receive and impart information and ideas of all kinds…”

Article 9 states “(1). Every individual shall have the right to receive information. (2) Every individual shall have the right to express and disseminate his opinions within the law”.


See Section 157 of Penal Act, NO 6 of 2004

Article 12 of CEDAW

No. 22 2003

Cap 58 R.E. 2002

No. 6 2002

Act No. 9 1998

No, 7 1995

Cap 20 R.E. 2009

Cap 21 R.E. 2009

Act No. 1 2003


Field report - Iringa-Njombe Regions Survey

Sections 130, 138B, 139

Section 17 and 60 Cap 29 R.E. 2009

Section 45 No. 9 2009

See Section 33, of the Act

Act No 28 2008

Ibid

Section 45 Act No. 9 2009

Article 2 of the African Charter on Human and People’s Rights

Article 23 of the Protocol to the African Charter on the Rights of Women

Article 13 of the Charter on the Rights and Welfare of a Child

National Policy on Disability 2004

Act No. 9 2010

For the side of Zanzibar see the Person with Disabilities (Rights and Privileges) Act, NO. 9 of 2006

Section 14 Act No. 28 2008

Data from Iringa-Njombe LEA Field Survey Report
Act No. 22 2008 Section 32 states that “32 Any person who contravenes any provision under this Part commits an offence and on conviction shall be liable to a fine of not less than two million shillings or to imprisonment for a term not exceeding one year or to both”.

Section 146 states that “A woman who knowingly lives wholly or in part on the earnings of prostitution or who is proved to have, for the purpose of gain, exercised control, direction or influence over the movements of a prostitute in such a manner as to show that she is aiding, abetting or compelling her prostitution with any person, or generally, commits an offence”.

Section 148 states that “Any person who keeps a house, room, set of rooms or place of any kind whatsoever for the purposes of prostitution commits an offence”.

Section 140 states that “Any person who for consideration offers her or his body for sexual intercourse commits an offence and shall on conviction be liable to imprisonment for a term of three years”.

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Section 154 States that “(1) Any person who— (a) has carnal knowledge of any person against the order of nature; or (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature, commits an offence, and is liable to imprisonment for life and in any case to imprisonment for a term of not less than thirty years: (2) Where the offence under subsection (1) of this section is committed to a child under the age of ten years the offender shall be sentenced to life imprisonment”.

Section 150 States that “Any person who: (a) has carnal knowledge of any person against the order of nature; (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of a felony, and is liable to imprisonment for a term not exceeding fourteen years.

Section 151 States that “Any person who attempts to commit any of the offences specified in sections 150 is guilty of a felony, and is liable to imprisonment for a term not exceeding seven years”.

Cap 95 R.E. 2009 Section 12states that “Any person who— (d) produces, possesses, transports, imports into the United Republic sells, purchases, uses or does any act or omits to do anything in respect of poppy straw, cocoa plants, cocoa leaves, prepared opium, opium poppy, cannabis, manufactured drug or any preparation containing any manufactured drug, psychotropic substance, narcotic drug, such act or omission amounting to contravention of the provisions of this Act or rule or order made under this Act, commits an offence and upon conviction is liable to a fine of one million shillings or three times the market value of the prohibited plant, whichever is the greater, or to imprisonment for a term not exceeding twenty years or to both the fine and imprisonment”.

Section 10 states that “10. The expression "prohibited immigrant" means any personal who, if he seeks to enter Tanzania is, or if he has entered Tanzania was at the time of his entry, or is-(h) a person whose presence in or entry into Tanzania is unlawfully under any law for the time being in force;

Section 15 (5) states that “Every pregnant woman and the man responsible for the pregnancy or spouse and every person attending a health care facility shall be counseled and offered voluntary HIV testing.

Section 25 states that “25-(I) The Ministry shall regulate the care and treatment of HIV infected pregnant women, mothers infected with HIV while giving birth and measures to reduce HIV transmission from mother to child. (2) In an endeavor to prevent the mother to child transmission of HIV- (a) trained and authorized persons shall provide counseling services to HIV infected pregnant and breast feeding women and to men responsible for the pregnancies or spouses respectively; (b) health care facilities shall monitor, provide treatment and apply measures necessary to reduce HIV transmission from mother to child. (c) prevention of mother to child transmission of HIV health services should be parent friendly.

Section 21. States that “(1) Any person who has knowledge of being infected with HIV after being tested shall- (a) immediately inform his spouse or sexual partner of the fact; and (b) take all reasonable measures and precautions to prevent the transmission of HIV to others”.

Section 47 states that “Any person who intentionally transmits HIV to another person commits an offence, and on conviction shall be liable to imprisonment to a term of not less than five years and not exceeding ten years”.

Section 21(2) The person referred to under subsection (1) shall inform his spouse or his sexual partner of the risk of becoming infected if he has sex with such person unless that other person knows that fact.

Section 184 States “Any person who unlawfully or negligently does any act which he knows or has reason to believe to be likely to spread infection of any dangerous disease to life is guilty of a misdemeanor”. 99