



International Symposium on the Human Right to Health

Dar es Salaam, 4th of May 2010



Health and Social Welfare Tanzania



Tanzanian German Programme to Support Health



Muhimbili University of Health and Allied Sciences

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Foreword and acknowledgements

Access to the highest attainable standard of health services as a fundamental right of every human being without discrimination, was first enshrined in the Constitution of the World Health Organisation, over sixty years ago.

The United Republic of Tanzania, has committed itself to respect, protect and fulfil the right to health, by ratifying international human rights treaties, and applying their provisions through the national health policies and strategies. The main objective of all these policies is to achieve a high quality livelihood for all Tanzanians, through increasing the accessibility, availability, acceptability and quality of health services that are provided to all Tanzanians! These are core elements of the Human Right to Health.

The Ministry of Health and Social Welfare therefore; in collaboration with the Tanzanian German Programme to Support Health and the Muhimbili University of Health and Allied Sciences, organized for an International Symposium on the Human Right to Health. It was held in Dar es Salaam - Tanzania on May 4th 2010. The symposium brought together, key stakeholders and experts, from various countries and institutional backgrounds. The invited experts, presented major approaches, achievements, challenges and the way forward to realize the right to health for all, and discussed them in a panel session and with the international audience.

This documentation covers, the topics discussed during the symposium. It sheds light on current discussions at national and international level, as well as experiences of participants and speakers, in their professional carriers.

I thank to all who made it possible to host this event in Tanzania and provide the opportunity to shed light on the human right to health, as one fundamental part of human life for us in Tanzania, this was the first occasion, to discuss on the right

to health, in a comprehensive manner, by looking at the health system as a whole.

The symposium was organized as a farewell, to the senior public health expert, Dr Bergis Schmidt-Ehry. He has worked all over the world, for over thirty-seven years, in the field of development co-operation, and significantly influenced the health policy reform processes in Tanzania for 16 years. His commitment to the country, particularly to the health sector, was outstanding. I would like to express my deepest thanks and appreciation for his great work.

This will give an impetus, to all stakeholders, in the public and private health sector, lawyers, social scientists and politicians, to further debate how to realize the human right to health, for all who are living in Tanzania.



Dr. Deo M. Mtasiwa
Chief Medical Officer
Ministry of Health and Social Welfare

Abbreviations

ART	Antiretroviral Therapy
BMZ	Federal Ministry of Economic Cooperation and Development
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CHF	Community Health Fund
FBO	Faith-Based Organization
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation)
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HRBA	Human rights-based approach
HSSP	Health Sector Strategic Plan
ICESCR	International Covenant on Economic, Social and Cultural Rights
HRH	Human Resources for Health
ILO	International Labour Organization
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
NGO	Non-governmental organisation
NHIF	National Health Insurance Fund
ODA	Official Development Assistance
PPP	Public-Private Partnership
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TGPSH	Tanzanian-German Programme to Support Health
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WTO	World Trade Organization

1 Summary

The international Symposium on the Human Right to Health was held on May 4th 2010, in Dar es Salaam International Conference Centre. It was organized jointly by the Tanzanian Ministry of Health & Social Welfare, the Muhimbili University of Health and Allied Sciences and the Tanzanian German Programme to Support Health. The symposium was held as a farewell to GTZ programme manager of the Tanzanian German Programme to Support Health, Dr Bergis Schmidt-Ehry, who retired after thirty-seven years of work in the field of health and development cooperation.

The Symposium brought together public health, legal and social science experts from Tanzania, Cameroon, Rwanda, Germany, and Switzerland to discuss and share experiences on how to realize the human right to health.

Health is a fundamental right inherent to every human being without distinction. This was first recognized in the 1946 Constitution of the World Health Organisation. Around the world, States have committed themselves to respect, protect and fulfil the right to health through international human rights treaties, international declarations, their constitutions and domestic legislation as well as national health policies and strategies.

The invited experts presented major approaches, achievements, challenges and ways forward to realize the right to health for all. They discussed these among each other in panel sessions and with the international audience. The symposium covered a wide range of topics, including comprehensive primary health care, access to HIV prevention and care for all, access to safe drugs for neglected diseases, medical ethics and human rights, human resources for health and rights of health workers, partnerships between public and private service providers and universal coverage through social health insurance.

Opening session

Deo Mtasiwa, Chief Medical Officer of the Tanzanian Ministry of Health and Social Welfare (MoHSW) opened the symposium and welcomed all participants on behalf of the permanent secretary Mrs Blandina S.J Nyoni. He emphasized that Tanzanian health policies were consistent with the core elements of the human right to health as they aimed to increase the accessibility, availability, acceptability and quality of health services for all Tanzanians. He thanked GTZ, and in particular Dr Bergis Schmidt-Ehry, for supporting the implementation of Tanzanian health programmes at national, regional and councils level.

Marita Brömmelmeier, head of East Africa Division, GTZ, thanked the Tanzanian government for hosting the event. She outlined the key features of a human rights-based approach in German development cooperation and acknowledged the important achievements of the Tanzanian government on the way to realize the right to health. On behalf of GTZ, she thanked Dr Bergis Schmidt-Ehry for his professional and personal engagement.

First session: The Human Right to Health – Where are we today?

Cosmas Cheka shed light on the concept of the human right to health as a dynamic right. He looked at the foundations of this right in international and municipal law in the African context. He concluded that interdisciplinary efforts of public health experts and social scientists were essential to specify the obligations incurred by states through the ratification of human rights treaties.

Remo Meloni argued that there can be no right to health without comprehensive health services based on a primary health care approach. He addressed major achievements, challenges and ways forward to implement comprehensive health services in the Sub-saharan region.

Building upon the results of an observational study conducted in Tanzanian hospitals **Baltazar Ngoli** discussed the links between medical ethics, the responsibilities of health professionals and the rights of patients to receive

services of good quality. He outlined ways to integrate a rights-based perspective in quality management.

Heinrich Heinrichs dealt with a civil and political right, the right to information, on which the right to health - a social and economic right - is highly dependent. He argued that both information and the process of acquiring knowledge are essential to enable people to enjoy their right to health.

Neema Rusabamayila discussed why it is important to pay particular attention to health-related needs and rights of adolescents. She gave an overview of major achievements and remaining challenges to promote a safe and supportive environment for adolescents in Tanzania.

The discussion between the panellists and with the audience focused on how to guarantee the right to health, the accountability of donors towards partner countries, and the respect for medical ethics.

Second session: Is access to HIV prevention and care for all a reality?

Roger Salla presented major achievements and remaining challenges in efforts to address the HIV epidemic. **Joseph Temba** discussed if and how universal access to care and treatment could be achieved in Tanzania. **Hermann Lupogo** dealt with a “forgotten issue” – HIV and disability. He described key barriers faced by persons with disabilities in Tanzania as well as ways forward to enhance their access to health information and care and promote their inclusion in society.

In the discussion, the audience focused on UNAIDS’ position with regard to global financing initiatives and the position of religious leaders in Tanzania towards HIV prevention and the use of condoms.

Third session: The right to health and access to medicines

Access to medicines is a key element of the right to health. **Hans Jochen Diesfeld** discussed access to safe drugs for the so-called neglected diseases in

the context of global health, ethics and human rights. His presentation stimulated a debate within the audience on research and health care priorities.

Fourth session: How to ensure the affordability and availability of health services?

Gabriel Upunda, *Faustin Njau* and *Vincent Lekey* discussed how to ensure the affordability of health care for all and set the debate in the context of the Tanzanian health sector reform process.

Gabriel Upunda argued that when Tanzania initiated the health sector reform it had had a choice, either to provide health services for free or to introduce cost-sharing with a human face, by protecting vulnerable groups. At the end, the Tanzanian government decided to introduce a cost-sharing system, but complied with its human rights obligations by developing social protection and health insurance schemes for the poor.

Faustin Njau argued that despite the development of these schemes the access to health care for the poor and vulnerable groups remained a challenge in Tanzania. He discussed major achievements and challenges to develop the existing health insurance schemes into an equitable and sustainable social protection system.

Vincent Lekey considered the contribution of social health insurance to safe motherhood by ensuring that women have access to affordable services of good quality.

Thomas Leshabari discussed how a social contract approach in health could address the human resource crisis and improve the availability of health workers and services.

Oberlin Kisanga and *Adeline Kimambo* demonstrated that the public-private partnership between public and faith-based providers developed in Tanzania with the common objective to improve services for the poor. They discussed challenges and ways forward to strengthen the approach.

Michael Marx argued that without skilled health workforce the right to health could not be realized. He set the debate in the context of the human resource crisis affecting Tanzania and other countries and highlighted ways to scale up the resources needed to produce services and strengthen health systems.

Christiane Wiskow discussed how the right to health, the right to fair working conditions and the right to participation applied to health workers. She highlighted the importance of creating a supportive work environment, and how to involve health workers more actively in the development of effective health systems.

Discussions among the panellists and with the audience focused on how to ensure universal coverage and social protection in view of the limited financial and human resources in Tanzania.

Closing Session

Fatma Mrisho, Director of TACAIDS, thanked the panellists and the audience for the time they took to discuss health-related rights, which rarely were in the focus of attention. She encouraged all to continue debating possible priorities and investments needed to realize these rights. On behalf of all Tanzanian people, she warmly thanked Dr Bergis Schmidt-Ehry for his great commitment to the health sector and to TACAIDS.

Gisela Habel, Head of Development Cooperation in the German embassy concluded with a few lessons learned in the symposium. On behalf of the German embassy, she expressed her thanks to Dr Bergis Schmidt-Ehry for his active engagement in the field of health and development cooperation.

In his closing speech, **Bergis Schmidt-Ehry** shared with the audience his thoughts on the human right to health. Going back to the situation he encountered when he started his professional career, he reviewed milestones on the way to realize the human right to health for all. Despite many achievements and commitments, he argued that the human right to health was still denied to most people, and he fleshed out the main obstacles on the side of both donor

and partner countries. He concluded by reaffirming that both human rights and health were also values which should be fought for continuously to assure the availability, accessibility, acceptability and quality of health services and progressively realize health for all as a fundamental human right.

2 Opening

2.1 Deo Mtasiwa, Chief Medical Officer, MoHSW, Tanzania

Directors from the Ministry of Health and Social Welfare, distinguished representatives of our development partners, representatives of the civil society, private sector and faith based providers, invited guests, ladies and Gentlemen.

First and foremost, let me take this opportunity on behalf of the permanent secretary of the Ministry of Health and Social Welfare, Mrs Blandina S.J Nyoni, to welcome you all to this very important International Symposium on the Human Right to Health. I thank you for coming and conducting this symposium in Tanzania.

As you are aware, the Government of Tanzania through the Ministry of Health and Social Welfare has developed a number of enabling policies as an effort to strengthen the health services in the country.

The main objective of all these policies is to achieve a high quality livelihood for all Tanzanians, through increasing the accessibility, availability, acceptability and quality of health services provided to all Tanzanians! The Ministry of Health and Social Welfare is implementing this through its Primary Health Services Development Programme, 2007 -2017, which is geared to provide a sufficient number of health facilities and services and essential drugs, availability of clean water and adequate sanitation, and availability of human resources at all levels.

It also aims at providing health services to all Tanzanians without discrimination through physical accessibility and affordability. At the same time health services should be accepted by the population. All health facilities should provide quality health services which are acceptable to all.

Basically, these are the core elements of Human Right to Health. Also GTZ has been behind all this during the implementation of different programmes at national level, regional level and council level. On behalf of the Government of Tanzania, we thank GTZ for its commitment to improve the health services in Tanzania. In particular the contribution of Dr Bergis to the health sector has been great. He initiated and runs the TGPSH, with a touch of good governance that has to be emulated by others. His capacity building approach for the Tanzanian professionals and the preparation of leaders of tomorrow that has been witnessed through the support of the Master of Public Health programme is a true indication of his dedication and efforts towards building a strong and reliable health system in Tanzania. Thank you very much Dr Bergis.

Areas that Tanzania worked on with GTZ to address health issues include: reproductive health, HIV and AIDs, public private partnerships (PPP), human resources for health (HRH) and management, health finance and decentralized planning in health. GTZ's support to these programmes was through basket financing as well as directly to projects.

The Ministry of Health and Social Welfare and the Tanzanian Government in general appreciates the opportunity to host this Symposium. This will stimulate us to further debate and develop more strategies to address the Human Right to health in Tanzania.

2.2 Marita Brömmelmeier, Head of East Africa Division, GTZ

Mr. Chief Medical Officer, Dr Deo Mtasiwa, on behalf of the permanent secretary of the Tanzanian Ministry of Health and Social Welfare, Mrs Gisela Habel from the German Embassy, Colleagues from Development Cooperation, and all protocol observed, ladies and gentlemen.

It is a great pleasure and honour for me to participate in this important event, for several reasons. First of all, this Symposium is an international acknowledgment of the important achievements of the Tanzanian Government in the health sector. Secondly, it states a paradigm shift in addressing health issues, from charity in the sense of helping the poor and underprivileged towards an understanding that access to affordable quality health services is a human right. And last but not least, this event is a special recognition to Dr Bergis Schmidt-Ehry, who contributed with his life's work to improve the health sector conditions in different parts of the world, particularly in Africa.

Ladies and Gentlemen, Germany's Development Ministry is paying increased attention to human rights. Our Minister, Mr. Dirk Niebel, in his recent visit to Tanzania, highlighted the importance of human rights, good governance and participation of the civil society and the private sector in the approach of development cooperation.

Human rights form a unique framework of rules because they are legally binding, reflect moral and political values with worldwide approval, and enjoy the support of the international community. Orienting development cooperation towards human rights improves outcomes in terms of poverty reduction, peace and economic growth. After all, discrimination and social exclusion - for instance in the education and in the health sector - cause high economic costs. Hence, human rights are of instrumental value.

Seen from a human rights perspective, poverty is not primarily the result of difficult economic or geographical conditions. Rather, poverty results from unfair power relations and breaches of fundamental rights, such as those to education or participation in decision-making.

Therefore, the human rights approach marks a paradigm shift - it becomes a Government's duty, it is not about charity and welfare.

The key objective of a human rights-based approach in development cooperation is to support the political, social and institutional reform processes that address inequalities and that create an environment in which people have the opportunities and the freedom to act upon their own choices.

Development cooperation contributes to enhance the capacity of state partners and also of the Pan-African Regional Organisations to fulfil these human rights in the understanding of the United Nations and also to develop the capacity of right-holders to claim their rights. A human rights based approach to development and to development cooperation means also to tackle issues that are considered "sensitive". The struggle for human rights is a global one. Therefore, at all levels we have to tackle phenomenon like for example human trafficking. Others are culturally grounded, like harmful practices such as female genital mutilation in Africa or issues that break up massively in situations of crisis and conflicts, like gender-based violence.

In development cooperation we should be aware that Human Rights are universal, however, their realisation takes place in diverse and dynamic cultural contexts. Every culture has values and traditions compatible with human rights together with others that are not. Development cooperation also requires culture-sensitive communication efforts to support processes aiming at the progressive realization of social and economic rights.

With our German Technical Cooperation we develop instruments and approaches to support our partners towards implementation of human rights.

This is a process-oriented approach addressing Government, the parliament, civil society, the private sector and the faith-based organisations.

A human rights-based approach in the health sector -what does that mean?

The human right to the "highest attainable standard of health" gives a qualitative perspective to activities geared to improving mothers' and children's health and to fight against HIV/AIDS and other diseases. This is in line with the MDGs. It focuses on persons and groups affected by poverty and discrimination. In addition, the implementation of human rights principles such as transparency and accountability contributes to improved governance in the health sector. The right to health does not mean that services are provided free of charge. It is a matter of access to services and sustainability of health services. The financial architecture of the health sector is crucial to facilitate broad-based access to services. The state must also provide sufficient social security measures, in particular for poor groups. But the private sector should also be engaged to provide affordable quality services as well as sustainable health security schemes. In this regard, Tanzania with support of the Tanzanian-German Development Cooperation has given an example to other African countries.

Ladies and Gentlemen, Tanzania is one of the countries where major efforts have been invested to promote a human rights-based approach in the health sector.

Within the framework of the cooperation programme and again also special recognition to Bergis Schmidt –Ehry, Tanzania

- Has strengthened the health sector reform process in achieving its goal to improve the health and well-being of all Tanzanians with a focus on those most at risk.
- Has made progress in the development of social and health insurance and pro-poor health financing models

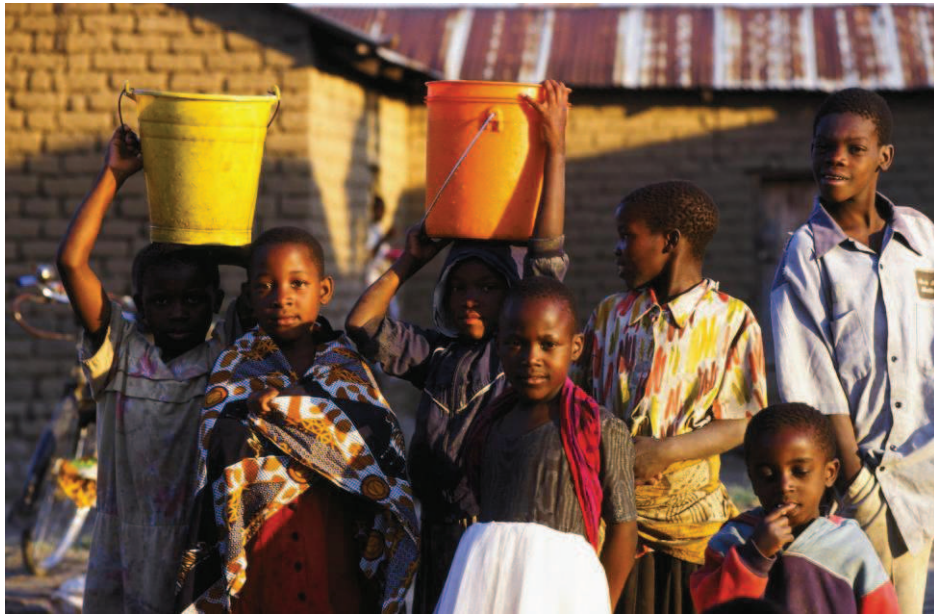
- Is supporting the decentralisation process and cooperation between public and private/faith-based health service providers
- Is promoting reproductive and sexual health: Advocacy and community-based approaches to enhance access of women and young people to information on their rights and to family planning services
- Is fighting successfully HIV/AIDS with a multisectoral approach, awareness-raising on stigma and discrimination as an integral part of workplace programmes, and involvement of religious leaders (National Muslim Council of Tanzania) in advocating for human rights of People living with HIV/AIDS.

In the name of GTZ I would like to congratulate the Tanzanian Government and all stakeholders involved for these impressive achievements and for promoting a human rights based approach to improve access to sustainable health services, being aware that there are still challenges ahead. Congratulations to Bergis Schmidt- Ehry for his professional and personal engagement on behalf of GTZ for the wellbeing of many Tanzanian people, children, women and men.

I wish all of us a fruitful discussion.

Thank you very much for your attention!

3 The Human Right to Health – Where are we today?



3.1 Cosmas Cheka: The right to health - key features and challenges of a dynamic right

Introduction

The four words, “human right to health”, carry diverse meanings that include legal, philosophical and ethical or moral connotations. However, whatever their collective key features may be, this paper only focuses on the right to health from a legal perspective.

The linkage between health and the law has been at the centre of the practical work and the professional life Dr Bergis Schmidt-Ehry, in whose honour this symposium is holding. Through practice, Dr Schmidt-Ehry pioneered an

understanding of this linkage especially through his health sector reform work for nearly a decade in Cameroon between the late '80s and early 90s. He argued for example that, community participation in health as espoused by the Alma Ata Declaration is a human right, the enjoyment of which enhances health service delivery. Nations were however ratifying the Alma Ata Declaration but effective healthcare delivery was being hampered by the absence of community participation because municipal political systems remained centralized (an otherwise disabling legal environment). In other words, the capturing participation of the beneficiary in health through an enabling legal/political environment underscores health as a social good and not solely as a medico/technical or economic problem.

Health is defined in the Constitution of World Health Organisation (1946) as a status of complete physical, mental and social well-being and not just the absence of disease or infirmity. The word, "right", used as a noun here, refers to a just or legal claim to title, or to something that is due to a person or governmental body by law, tradition or nature. When the word, "right", is qualified by the adjective "human", these rights become distinguishable from the rights of other classes of animal. Building on the premise that municipal law and international treaties constitute the framework by which the right to health is attainable, I will explore two key features before reverting to challenges:

1. the foundations of the right to health in municipal and international law;
2. the obligations cast on governments signing international agreements that have health as a right.

Foundations of the right to health under municipal and international law

The right to health per se, is not common. The reflection of the right to health in State Constitutions is important, as it serves to inform the people that the protection of their health is official policy of the government. A look at the

Constitution¹ of some African countries such as that of the United Republic of Tanzania, and a number of international agreements establishes this.

Municipal law

Four categories of basic rights and duties are mentioned in the Constitution of the United Republic of Tanzania; the right to equality²; the right to life³, right to the freedom of conscience⁴; and the right to work⁵.

Most specifically, Tanzanian law is to the effect that *“every person has the right to live and to the protection of his life by society in accordance with the law”*. In other words, the law guarantees the physical protection of persons. This is only one aspect of “health” as defined in the previously cited WHO Constitution. Furthermore, the Tanzanian Constitution states: *“Every person has the right to freedom and to live as a free person”* and 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”*, unless this is in accordance with the law.⁶

First, it is remarkable that in Tanzania, “the right to health” is not carved out as a separate category of rights (though it is arguable that this is included and subsumed in the right to life) under Tanzanian municipal law. Secondly, Tanzanian law only seems to expressly address the physical aspect of health as a right, but refrains from guaranteeing mental health and “the absence of disease or infirmity”. This otherwise would complete the mental and social specificities of what comprises the bottom-line of health status according to WHO. However, this

¹ The Constitution of the United Republic of Tanzania of 1977 as amended from time to time

² *ibid.* Section 12(1)

³ *ibid.* Section 14

⁴ *ibid.* Section 18

⁵ *ibid.* section 22.

⁶ *Ibid.* Section 15(1)

seems to be a common feature of constitutions of common law countries which generally do not contain express reference to social rights⁷.

As in common law countries, some African countries influenced by the common law tradition do not expressly use the words, “right to health.” For example, the preamble of the Cameroonian Constitution⁸ provides that “every person shall have a right to a healthy environment. The protection of the environment shall be the duty of every citizen. The State shall ensure the protection and improvement of the environment”. This is so, in spite of the civil law influence of the French, who in their Constitution provide: “[the] State guarantees to all and notably to the child, the mother *and the aged worker, health protection, material security, rest and leisure*”.⁹

The foregoing clearly shows that while the human right to health is not a disputed standard, the said right is not uniformly enshrined in various municipal laws. International law has sought to influence this.

International human rights law

Without necessarily guaranteeing health as a right, a number of international treaties use the language of “rights” to refer to health issues, as shown in the following review of relevant provisions of some landmark treaties.

The 1948 Universal Declaration of Human Rights (Art. 25) states: *“everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and the right to security in the event of ...sickness, disability...”*

The preamble to the WHO constitution provides: *“the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human*

⁷ See for example the constitution of the United States of America.

⁸ January 1996

⁹ French Constitution of 1958, Constitutions of Countries of the World, T.S.W Lee and Osamu Nisahi, eds, 1990; see also the 1960 Constitution of Côte d’Ivoire

being without distinction of race, religion, political belief, economic or social conditions”

The African Charter on Human and Peoples’ Rights in Article 16 states: *“every individual shall have the right to enjoy the best attainable state of physical and mental health.”*

Art. 12.1 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) states: *“the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”* Similarly, Article 24(1) of the 1989 Convention on the Rights of the Child provides: *“States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health.”*

It is clear from the foregoing that the right to health is one of a special kind of which governments are aware when they commit their countries through the signature of relevant international agreements. International law recognizes health as a dynamic right because its implementation and attainment is progressive, as it depends on evolving factors. This perhaps explains why under the Universal Declaration of Human Rights, the standard of this right is “adequate” while under the WHO Constitution, this is “the highest attainable standard”; whose obligations do not seem to be cast on governments in steel and concrete.

The right to health goes beyond the right to healthcare. It implies other rights that include the right to equality, non-discrimination, information, participation, justice, the interdependence and indivisibility of rights. In other words, by the ratification of treaties, governments undertake certain obligations, the content of the package of which is neither clear nor static.

The United Nations Committee on Economic, Social and Cultural Rights committed a hearing¹⁰ on the “Right to Health” at which interested organizations and individuals were invited to present their views on the scope of state obligations. Presentations highlighted the following aspects which could serve as guidelines for the definition of the right to health and the respective obligations of states:

- the provision for the reduction of the still-birth rate and of infant mortality and for healthy development of the child;
- the improvement of all aspects of environmental and industrial hygiene;
- the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- the creation of conditions which would assure to all medical service and medical attention in the event of sickness;
- the importance of referring to specific goals and indicators developed by WHO especially referring to primary health care and the goal of “Health for All by the Year 2000”; and
- Fundamental principles common to respect for all human rights: dignity, non-discrimination, participation, entitlement and the health needs of vulnerable populations.

These obligations pose challenges to the respect by states parties of the “right to health”.

Challenges

It is reasonable to conclude that it is difficult to classify the “right” to health as a conventional right because of the constraints that accompany guaranteeing its delivery. Even though to the population, the most reassuring form of making a “right” a priority in government policy is to enshrine the same in the Constitution,

¹⁰, International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI)U.N. GAOR, Supp.(N° 16) 49, U.N. Doc. A (6316) 1966; UN Press Release HR/3604, 6 December 1993

the majority of countries are cautious to avoid committing themselves into guaranteeing “the right to health” under Municipal law. This is in spite of international treaties that States sign whereby they undertake to deliver such rights.

History, since the end of the last world war is replete with attempts by states and the international community to respect the right to health. In the late 70s this attempt was marked by the WHO Alma Ata Declaration on Primary Health Care that laid emphasis inter alia on community participation. This was followed by the setting of health targets, the achievements of which would be measured using pre-set dates like Health for All by Year 2000. The latter has been supplanted by the 2015 Millennium Development Goals.

States parties to these conventions acknowledge the difficulty of guaranteeing health as a right and are aided into remaining non-committal by open ended provisions in the treaties that allow states to ratification without being bound to guarantee delivery. For example, under the ICESCR (Art. 2), a state is not required to immediately and fully implement the right but only to “*achieve progressively the full realization of the right...*” Rather, the states parties are required by Article 2 of the ICESCR to “*take steps*” to achieve the said right as has been seen in the obligations outlined earlier. These steps constitute a starting point for understanding the obligation to respect the “right to health” but the generality obscures determination of the specific obligations involved.

This quandary is the key challenge in which the “human right to health” is caught today. The right will indeed be a conventional on the day obligations of states are ascertained in terms of what states are bound to deliver and guarantee. This is attainable only through interdisciplinary work; the efforts of the work of public health experts and social scientists together, which the life’s work of Dr Bergis Schmidt-Ehry has sought to show.

3.2 Remo Meloni: No right to health without comprehensive health services

Why are comprehensive health services essential to realize the right to health?

What do we mean with the concept of comprehensive health services?

Let's try to define them. Our definition is related to one of the characteristics of Primary Health Care: Primary Health Care starts with people and their felt needs...

So, we can define comprehensive Health Services as the services that respond to the people needs and expectations in such a way that those fundamental needs are correctly taken into account.

Comprehensive services are obviously related to **health services organisation**.

At peripheral level

In the framework of Primary Health Care, district health services are the core of the health services organisation in a country. Those district health services are usually constituted by a first level, which is the entry point of the system, and constitute the interface with the community (it offers primary care near the people), and second level services which offer complementary packages of care.

We can give to those comprehensive health services those main characteristics: decentralised; affordable; accessible as well financially, as geographically and as sociologically; integrated; polyvalent.... Those services should be conceived as services to a person, (not only against an illness -patient centred care), services to a community (people centred care)...to create social capital, meaning to create better relations between people in a community.

This approach is also of crucial importance for development: I would say that without a comprehensive approach to health problems, through integrated health services, taking into account patients and people, it's hard to imagine that we could prepare the ground for future development.

This way of conceiving health care delivery, is obviously contradictory to the concept of selective health services and/or non-integrated program approach, which, although probably useful, obviously don't have this global view on a person, on a community. They are directed mainly to disease control, but not centred on person well-being...

We would like to conclude that the right to health (Health seen in a broad perspective), is only possible through comprehensive health services that have the characteristics described above.

Above the district level

It's obviously possible and important to have specialised hospitals receiving patients from the district level. This could perfectly be in coherence with the concept of comprehensive health services, offering Primary Health Care.

How do comprehensive health services contribute to ensure universal access to health care?

The global network of integrated health services, organised around the entry point of primary care, by responding to essential needs of the community, contribute to ensure universal access to health care.

Because they are built for durability, they are able to adapt in a changing environment (transitional epidemiology...) and therefore they can adapt to changing needs and respond to new needs.

They are organized with the people, and not only for the people. They enable health services and community to organize a bidirectional dialogue which also constitutes a major opportunity to ensure universal access to health care.

Major achievements and challenges to implement comprehensive health services, with a focus on the African context

Alma Ata was an achievement by itself, and 9 years later, the meeting in Harare defining the District Health System was also an achievement.

We could say that in Africa, in several countries where Primary Health Care was adopted, comprehensive district health services have been implemented.

The present period could be considered as favourable: the last WHO world reports put again the stress on Primary Health Care. There is much more money for the health sector, from the state budgets themselves and from international community; three of the MDGs focus on health.

But:

Leadership is sometimes reduced to a control, and sometimes it's like "laissez-faire". This laissez-faire can lead, because of a series of distortions (for instance, multiplication of useless structures, no regulations...etc.) to commercialisation of care.

A lot of global initiatives have been created during this decade, focusing on particular issues (AIDS, TB, Vaccinations...etc). A lot of money is channelled through those initiatives whose objective is to have results on the short term. This creates a tension with long term development systems, like District Health Systems, and produces fragmentation of health services (instead of integration, which is a main characteristic of Primary Health Care).

Ways forward

In order to ensure universal access to good health care, the **role of the state** should be paramount in undertaking a series of major reforms, mainly:

- universal coverage reforms that ensure that health systems contribute to health equity, and the end of exclusion;
- service delivery reforms that better organize health services around people's needs,
- public policy reforms that secure healthier communities, by pursuing public policies towards better health across sectors at national level;
- leadership reforms that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership;
- by adapting the training of human resources for health, to a real Primary Health Care approach.

3.3 Balthazar Ngoli: Medical ethics – Commitment or myth?

The right to health

The right to health is fulfilled based on 4 essential elements which are; Availability, Accessibility, Acceptability and Quality (AAAQ). Among these elements the respect for medical ethics is included in the **acceptability** criterion. I would like to reiterate: All health facilities, goods and services must be respectful of **medical ethics** and **culturally appropriate** i.e. respectful of the culture of individuals, minorities, peoples and communities, **sensitive to gender and life-cycle requirements**, as well as being designed to **respect confidentiality** and **improve the health status** of those concerned

Medical ethics and code of conduct

In the context of human rights ethics can be defined as the norms of conduct for individuals and for societies. For many years there have been sound efforts by

health professionals to develop and document medical ethics and codes of conduct. These norms derive from many sources, including religion, culture, traditions and reflection which account in part for the complexity within each ethical situation. Human rights on the other hand refer to an internationally agreed upon set of principles and norms embodied in international legal instruments. Medical ethics and fundamentals of human rights cannot be separated from each other because work in ethics needs to take into account human rights norms and standards, not only in substance but also in relation to the processes of ethical discussion and reasoning.

My statement will narrowly reflect on medical ethics experiences in Tanzania.

Health professional ethics in Tanzania

For many years health professionals in Tanzania have worked to document and revise ethics and codes of conduct for health professionals in Tanzania. There is no doubt; there have been large achievements in this context. These norms contribute to the outline of quality improvement in health care in the country. In the Tanzanian Quality Improvement Framework document page 11, it is stated that: *“there is evidence of eroded ethical and moral values and the strategy to improve this situation is to enhance professional ethics and morality”*. Repeatedly ethics is mentioned in the proposed activities. It is clear once again, that observation of ethics during the process of care has a major role in quality improvement.

Medical ethics – observation in the field

In a study done 2 years ago by a Professor and Medical students in 3 hospitals of Tanzania, there were observed and documented over 600 events of breach of ethics over a period of one week. Throughout the period there were virtually no complaints from the patients, clients or relatives affected. During a feedback meeting with part of the hospital staff, reasons for this situation are as follows;

Majority mentioned shortage of staff, funds and other hospital resources as the main causes. Other reasons given included poor motivation, inadequate supervision, ineffective communication and bad working environment.

When asked what should be done to address the situation, the response was to address the causes mentioned – improve salaries and staff motivation, communication, working environment etc. When asked; who should address those issues, they responded, ‘the responsible authorities’.

Conclusions

Strengths

- Health care providers are willing to be assessed as proved by their readiness to be observed during service provision – not common
- Staff and management accepted the results
- Well-drafted medical ethics documents are available and more are in a process to be developed and/or revised
- Medical ethics documents address very well the issues of human rights
- The MoHSW is advocating ethics and rights to health in various ways

Weaknesses

- A section of care providers are not sufficiently knowledgeable about ethics
- Patients and clients, who are the right bearers are not aware of these rights
- Although medical ethics have existed for a long time, they have not achieved their respective objectives of influencing care providers to provide services of high quality and acceptable standards

Opportunities

- A strong wind of change is blowing. The Ministry of Health is strongly advocating for better quality of services as well as adopting approaches and tools for quality assessment and improvement
- Some health training institutions have introduced ethics courses in their respective curricula

- Hospitals have established quality improvement committees
- Patients are paying for health services. This has given them the voice to demand for better services including observation of ethics
- Funding for health care is increasing annually

Challenges

- Management and staff believe that breach of ethics is not primarily their responsibility
- users' practice very little their rights to be cared for in public services, placing themselves in a submissive position as if they were receiving a favour and not performing their right to health
- Shortage of skilled staff with appropriate skills mix is critical
- Quality improvement teams are not adequately supported by hospital management teams

Ways forward

Hospital Quality improvement teams need to develop and implement strategies to address ethics.

Health service providers should be made aware they have a role to play as individuals and collectively. Shortage of staff or resources is not an excuse to improve quality of care and observe ethics.

Ethical committees should play an increasing role to raise awareness, train and monitor ethics.

Patients are becoming key players, too. The influence that they wield in asserting their rights and assuming their responsibilities has become increasingly important as a catalyst for change. A high-quality health system will only be achieved if patients are allowed and encouraged to influence the process of change.

Regular observation on ethics should be introduced as part of performance assessment of health facilities.

Ethics courses should be mandatory in health training institutions.

3.4 Heinrich Heinrichs: The right to know – Knowledgeable people make informed decisions

Knowledge is the prerequisite for human emancipation.

People of various settings, environments, cultural and economic contexts develop related to these circumstances. That means we develop according to the knowledge, skills and attitudes that are available to us.

A development process is always also an emancipation process. This can be gender related emancipation, but also emancipation of young people in the process of becoming responsible adult people.

Knowledge leads to more choices.

The degree of the emancipation depends on the knowledge of choices. Without knowledge about them they cannot be accessed. These choices include factors determining the lifestyle. In particular in the health context it is important to create knowledge – and therefore access to choices – on how to lead a healthy lifestyle. This includes access to relevant medical care and healthy nutrients, but also the knowledge about how to avoid harmful lifestyles.

The number and quality of choices determine the degree of self-realization. This is relevant on a personal, but also on societal level. Well self-determined people support the development and changes of a society, but also are the agents of adaptation to new trends, which form a challenge in a globalised world.

Knowledge is very different to - and goes beyond - information.

Information is available through myriads of media. In particular the Internet provides virtually indefinite information supply. The extent, however, to which information is accessed, depends on many factors like accessibility, interest, culturally accepted content etc.

Information may enter via different means and senses: Information can be seen, heard, felt, tasted, and smelled. Then information undergoes all sorts of filtering to generate finally knowledge.

Knowledge is constructed individually.

Information is translated to knowledge individually. In summary it becomes clear that information can be general, but knowledge is formed individually. The notion of general knowledge is therefore a contradiction in itself!

New information is added to and so to speak computed individually with existing knowledge. However, information is vital to creating and leads to individual knowledge.

Available human rights (laws) are only accessible through knowledge, skills and capabilities.

Democratic countries have laws that outline basic human rights. How can we understand that often citizens do not enjoy human rights? One reason might be the reluctance of rulers to implement human rights. However, in most of the cases we can assume that many citizens are not aware of their human rights. In other words: It is part of the information available, but not part of the individual knowledge!

That means: Human rights have to be learned, which includes experiencing them. We could also phrase it differently: Human rights is a life skill with two dimensions, a) to enjoy human rights, and b) to provide with human rights. Many

cultural practices, not only in developing countries, violate human rights without individuals involved – perpetrators and victims -perceiving it as such.

Acquiring knowledge is a human right.

Acquiring knowledge goes beyond having access to information. It is a human right both to get access to information and have the opportunity to acquire knowledge. The latter means to provide learning environments together with information that leads to individual construction of knowledge.

Acquiring knowledge is a responsibility and duty of any individual.

Information and knowledge is a human right. However, we saw that constructing knowledge is individual. That makes acquiring knowledge also a duty and responsibility of every member of society. Acquiring knowledge, i.e. learning, is a life-long process.

3.5 Neema Rusibamayila, Akwillina Mlay: The right of adolescents to a safe and supportive environment ensuring their healthy development

Why adolescents?

“No longer children not yet adults.” For many years the health sector response has been targeting under-fives and adults, ignoring the largest proportion of its population (31% are between 10-24 years of age) and future workforce of the next generation.

It is a common understanding that healthy individuals are likely to perform better at school, become more active community members and more productive than those who suffer from ill health.

Investing in a healthy development of adolescents will contribute to avert unnecessary deaths, morbidity and mortality, increase national productivity and also address gender disparities.

The majority of adolescents lack awareness of their statutory rights and of the state of the legal system that support their health and development.

They have basic health and development needs which are not adequately / comprehensively addressed for them to realize their potential.

Adolescent girls face many additional challenges that hinder their sexual reproductive health wellbeing. Persistent cultural practices and values expose girls to early pregnancy, gender based violence, sexual exploitation, inequities and other harmful practices.

With growing tendencies towards a human rights-based approach, democracy, recognitions of the threats facing adolescents across all nations, addressing rights to healthy development is increasingly becoming a priority that cannot be ignored.

The rights to healthy development of adolescents that are covering all aspects of their lives are underlined and signed in several international and regional conventions as well as in national laws, policies and strategies.

Is Tanzania promoting adolescents rights to healthy development?

Yes, the constitution of the United Republic of Tanzania provides for the right to life and protection of life and emphasizes equality of each person, respect for each person's humanity and right to justice before the law.

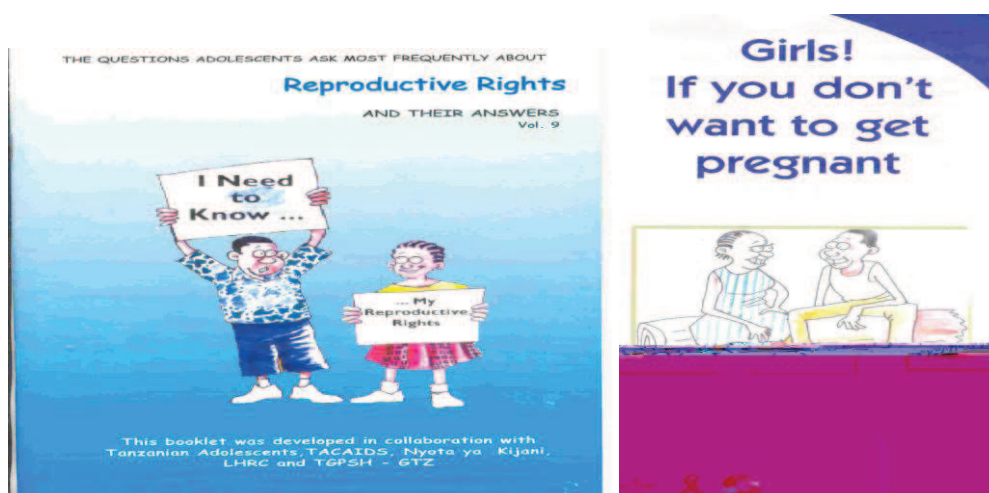
But:

Recent analysis on the policies and laws that impact on adolescents' sexual and reproductive health in Tanzania show contradictions and inadequacies in

addressing the problems and needs of adolescents. For example Marriage Act 1971 states: *“A boy can get married at age 18 or older, a girl at age 15 to 18 if parents/guardians give consent.”* This provides a remarkable risk of adolescents to early sexual indulgency, adolescent pregnancy, adolescent child bearing, STIs/HIV/AIDS and other social development problems.

Guidance on whether pregnant girls can be readmitted to school is very unclear and is left to the liberty of the head teacher.

In collaboration with young people, and other stakeholders, TGPSH develops print and audio-visual materials on different subjects including reproductive rights and contraception for young people,



how to avoid pregnancy after having unprotected sex, girls if you don't want to get pregnant, a booklet for Albinos, their friends and families as well as maintaining a web site where young people can ask information about their health.

Ways forward

Promoting the right to healthy development of adolescents should be undertaken by all sectors in a comprehensive manner without ignoring parents, community support and engagement of young people themselves.

All should be responsible to promote supportive environments, respect and fulfil human rights, regardless of age and gender and ensure the right of the girl child to make decisions about her sexual and reproductive health at each stage of her life.

Deliberate efforts should be made to harmonize contradicting policies including addressing cultural practices towards equal human rights, respect and responsibility to all regardless of their personal or family circumstances.

3.6 Summary of Panel Discussion

The discussion between the panellists and with the audience focused on how to guarantee the right to health, the accountability of donors towards partner countries, and the respect for medical ethics.

How to guarantee the right to health?

Both **Cosmas Cheka** and **Baltazar Ngoli** pointed out that the right to health is subject to progressive realisation. Realizing the right to health is a process that requires national strategies, clear standards, resource allocation in terms of the national budget, and realistic milestones and indicators. The role of the state is to organize national health systems in such a way as to ensure comprehensive primary health care.

Cosmas Cheka commented that although the right to health, in most of the Commonwealth countries, is not expressly provided in the constitution, total denial of this right can be dealt as a punishable offence. For example if a doctor denied the patient his right to medical treatment, hence resulting into death, this would constitute an offence punishable by law.

Heinrich Heinrichs argued that in order to guarantee the right to health, pressure to the duty bearers is necessary and that therefore knowledge of the right holders to demand their rights is essential.

Neema Rusibamayila finally highlighted that health rights cannot be achieved without considering factors like poverty or gender and that education was a key starting point in fulfilling the right to health.

What is the responsibility of donors towards partner countries?

Remo Meloni argued that donors need to realize that health system reinforcement is the key to achieving health rights. Without strengthening health systems there will be no sustainability.

Both **Remo Meloni** and **Cosmas Cheka** observed that strong national Governments, aware of what they wanted, could have a say in deciding where the money goes and negotiate with donors. Remo Meloni gave Rwanda as an example, where money for HIV was also used to reinforce the health system.

Respect for medical ethics

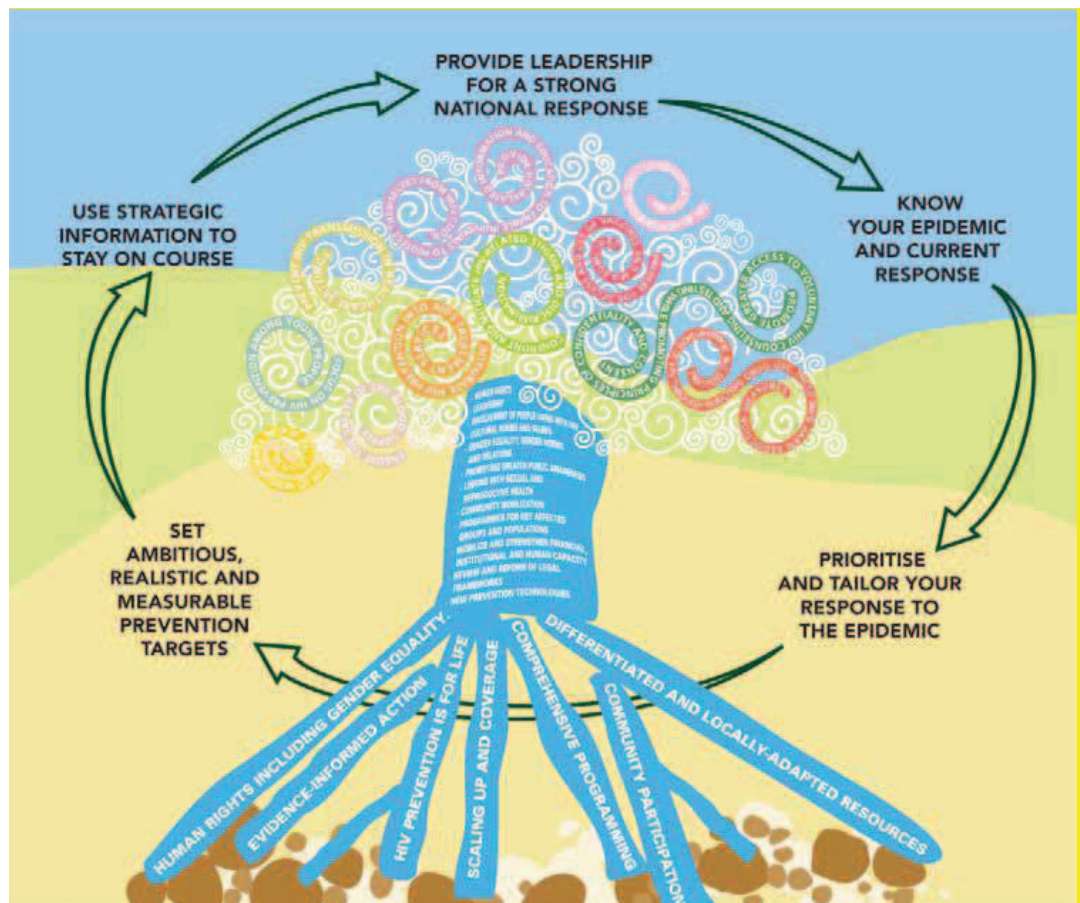
Baltazar Ngoli clarified that, according to the study conducted in hospitals, when health workers were breaching ethics, they were usually not aware that they were breaching the rules. Although Medical Ethics was not part of the curriculum of Tanzanian colleges and universities, structures were in place at the regional and district level that should facilitate the respect of health professionals for ethical codes of conduct.

4 Is access to HIV prevention and care for all a reality?



4.1 Roger Salla: Universal access to HIV prevention: Major achievements and remaining challenges

I will start my presentation by sharing with you the prevention tree which shows you the complexity of prevention work.



We need to **prioritize** our response, and to have first a gap analysis of location, scale and needs of the priority populations. Where, among whom, and why are the HIV infections happening? How fast are infections moving? What are the drivers of the epidemic? Not all prevention measures can be achieved in the short-term, but must be sustained and converging. And prevention and treatment should be mutually reinforcing.

Depending on this analysis, **key audiences** vary from country to country, and may include the general population, women and girls, men, young people living with HIV, injecting drug users, health-care workers, recipients of blood or blood products, men who have sex with men, populations of humanitarian concern, prisoners, sex workers, transport workers and commercial drivers, mobile

populations, uniformed services personnel and clients/non-regular partners of sex workers.

Those who are working in Africa know that **gender inequality** can lead to unprotected sex.

Prevention efforts are growing in most of the regions and countries. In 2005 only 27 countries were reporting on prevention services for injecting drug users, 55 were in 2007. 31 countries were reporting on services for men having sex with men in 2005, 83 were in 2007.

Addressing the **legal and policy environment** makes a difference. In countries with non-discrimination laws or regulations for the protection of populations at risk the percentage of these populations reached with prevention services is higher.

Key HIV **prevention issues** under debate include:

- Prevention impacts of testing and counselling
- Male circumcision
- Condom promotion (worthwhile or lost cause)?
- Multiple and concurrent partnerships
- Do concentrated epidemics necessarily stay that way?
- Anti-retroviral therapy (ART) in prevention, feasibility of post-exposure prophylaxis

So the way forward for us is a combination. There is no single magic bullet for prevention. This is what we have learned since 20 years. You have to act on **behaviour**. You have to work on the **structure** by addressing the mechanisms that are necessary for scaling up to optimize your effects. You also have to continue with **biological** efforts, including male circumcision and condoms, cervical barrier and microbial anti-retroviral gel.

Around 1987 worldwide we had yearly 59 million US \$ to respond to the HIV epidemic. When UNAIDS was created we were around 292 million US \$. We have then seen new comers coming into the financing of the response to HIV/AIDS, the Gates foundation, the world bank MAP programs, PEPFAR and have now moved up to yearly 10 billion US \$.

Our concern in long term **financing** is how we are going to sustain this level. We have now millions of people under treatment in countries where 80% - 90% of the funds to maintain those people in a treatment are coming from outside. This is a major concern and this shows also that prevention is still to be our first priority.

Prevention, prevention, prevention!

4.2 Joseph Temba: Universal access to care & treatment and impact mitigation – Despite massive international funding a myth or a reality?

Introduction

Responding to the HIV/AIDS epidemic remains a major global challenge particularly for developing countries that are still grappling with consolidating and scaling up their responses to the epidemic. Faced with limited resources, inadequate health infrastructure and technical capacity, these countries rely heavily on international technical and financial assistance.

Provision of care and treatment to people living HIV/AIDS is a core intervention in the response to the epidemic that has changed HIV/AIDS from a killer to a chronic condition. People living with HIV/AIDS who are accessing ARVs are now planning for the future and not for their deaths. Access to comprehensive care and support and impact mitigation is a fundamental human right for the infected and affected individuals and communities¹¹. It is for this reason that the United

¹¹ WHO/UNICEF/UNAIDS: Towards universal access; scaling up priority HIV/AIDS interventions in the health sector. Progress report 30 September 2009.

Nations had targeted 2010 as the year to have achieved universal access to quality prevention, treatment, care and support interventions to all who need it.

Global situation

Although the year 2010 target has not been achieved, there has been tremendous progress in the global response to HIV/AIDS. Investments have been enormous and the results are impressive. According to WHO/UNICEF/UNAIDS progress report of 30 September 2009, at the end of 2008, out of the 9.5m people in need of ARVs in developing countries, more than 4m (42%) were accessing ARVs¹². This is remarkable bearing in mind the complexity of the interventions and the limited capacity in developing countries.

However, a lot more remains to be done not only to sustain the achievements so far, but to accommodate the unmet and emerging needs:

- Accelerating the multisectoral response
- Strengthening and expanding the health infrastructure and particularly care and treatment in order to reach the 5 million People living with HIV who are currently not accessing ART.
- Scaling up Voluntary Counselling and Testing and Prevention of Mother to Child Transmission services to reach the large number of people living with HIV without knowing their status.
- The high cost of second line regimen
- The urgent need to scale up effective prevention interventions so as to reduce the number of new HIV infections which is currently outnumbering the number of those being enrolled for ART.

¹² WHO/UNICEF/UNAIDS; Towards scaling up priority HIV/AIDS interventions in the health sector; progress report, 30 September 2009.

Progress in Tanzania

Tanzania is in the process of accelerating and sustaining the national multi-sectoral response to the epidemic and strengthening and expanding the health sector infrastructure and scaling expanding the care and treatment plan to cover more sites geographically and thematically. The second National Multisectoral Strategic Framework on HIV/AIDS aims at accelerating multisectoral response by overcoming past barriers and constraints¹³. Also the Ministry of Health and Social Welfare and partners are scaling up prevention, care and treatment interventions to reduce prevalence by 50% from the current rate of 7% and provide ART to 800,000 AIDS patients through all health facilities by 2017¹⁴.

The following data reflects the achievements made so far in the care and treatment plan: Up to December 2009: 463 046 clients had been enrolled and 235 384 were accessing ART. 8.2 million people had taken Voluntary Counselling and Testing. Also some 3.3 million pregnant women had received Prevention of Mother to Child Transmission services and 3,000 children were born HIV free. Over 15,966 staff was trained.

These impressive achievements have been possible due to increased government budget and substantial technical and financial support from the international community. However, despite the 'massive' resources that have been provided up to now, more resources are needed to sustain and accelerate the multisectoral response, strengthen and expand the health infrastructure and scale up the care and treatment interventions to reach the people in need.

Emerging crisis

Despite the unmet needs outlined above, the global financial and economic crisis may have serious negative impact on the response to HIV/AIDS in developing

¹³ Second National Multisectoral Strategy on HIV/AIDS; 2008 – 2010.

¹⁴ Primary Health Services Development Programme,- MMAM, 2007-2017m MOH&SW May 2007

countries particularly on sustaining and expanding care and treatment. By December 2009, some 21 developing countries were experiencing the negative impact of the global financial crisis. It is a very sad situation because failure to achieve universal access to comprehensive care and support is a death sentence and is against the fundamental human rights to millions of the people in need.

Universal access: Myth or reality?

It is true that in general, responding to the HIV/AIDS epidemic is very costly. It is also true that comprehensive prevention, care and treatment and impact mitigation is very very expensive.

Scaling up to and sustaining universal access will need much more massive international funding than the current levels. However, when the donating countries are faced with financial crisis, there is the unfortunate possibility that the current funding levels may be maintained or even scaled down. That will then be the 'myth' part of the universal access because it will deny care and treatment to millions of people in need. That will be the death sentence to millions of the HIV/AIDS infected and affected population. Even the gains made in the care and treatment interventions will be lost. New HIV infections will increase. The world will have reversed to the early phases of the epidemic when HIV/AIDS was synonymous with death; and People living with HIV described as walking corpses! That should not be allowed to happen anymore at any cost.

On the optimistic side, the international community should not let the universal access to be the 'myth'. Despite the formidable costs of universal access, the international community should see the realistic and humanitarian side of the response and mobilize the necessary resources to sustain and scale up universal access to comprehensive prevention, care and treatment and impact mitigation by working with countries to:

- Rally for increased political and financial commitment to scale up the national response;

- Review, prioritize and implement key cost effective interventions;
- Harmonize resources for HIV/AIDS interventions to maximize cost effectiveness;
- Reallocate resources from low impact to high impact programmes;
- Strengthen an integrated health system.

4.3 Hermann Lupogo: HIV and Disability

Overlooked: Despite the double stigma

With the advantage of hindsight, it is difficult to understand how people with disabilities were forgotten in the HIV and AIDS campaigns. These people were already stigmatized by various disabilities. Unlike the rest of the population, HIV and AIDS would give them a second stigma. Yet they were expected to access health services like everyone else when it was obvious that most facilities were unfriendly to them.

A few years ago this symposium would not have the subject of HIV and the Disabled on its agenda. Today we have ten minutes on this topic. After the recent activities especially the studies carried out since 2002, it seems natural to include discussions on HIV and the disabled. Locally we have even had a Network for Disabled People Living with HIV and AIDS (NEDPHA) since 2003. We are now surprised at ourselves that we did not open our eyes and concentrate on such an obvious phenomenon which was crying out aloud for attention.

Glaring omissions

Most reports, manuals and Tanzanian national policies did not dwell on HIV and disability.

Globally, in 2009, there were 677 million disabled people; 80% in the developing countries, the majority being in rural areas. However, there are no figures for

people with disabilities living with HIV. Similarly, Tanzania had an estimated 4,000,000 people with disabilities in 2009, more than half being children. There were no figures for the HIV infected or affected.

The World Bank's *"Turning Bureaucrats Into Warriors"* (2004) a Generic Operations Manual for preparing and implementing multi-sector HIV-AIDS programmes in Africa is very detailed. Whereas it addresses the problem of orphans and vulnerable children, it makes no mention of disabled people.

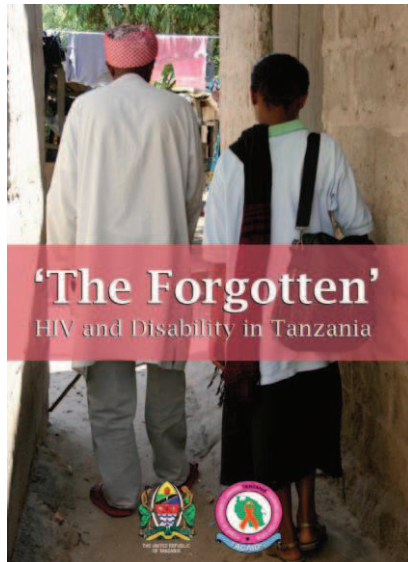
The UNAIDS 2008 Report on the Global AIDS Epidemic has no figures of HIV positive people among the disabled.

The National (Tanzanian) Policy on HIV and AIDS (2001) and the National Multi-Sectoral Strategic Framework (NMSF 2003-2007) had no direct reference to the disabled. The second NMSF (2008-2012) refers to the disabled in sub-theme 2 of the thematic area of prevention by stating that *"Persons with disabilities are often left out of the HIV response owing to their lack of visibility in society"*. It is therefore not surprising that it does not follow that up with a strategy, indicator and target. The Tanzania Output Monitoring System for non-medical HIV and AIDS Interventions (TOMSHA) is quiet on disabilities. Similarly, the Health Management Information Systems (HMIS) has nothing on people with disabilities.

Assessment of HIV and AIDS and disability in Tanzania

The Tanzania Commission for AIDS (TACAIDS) commissioned a study to assess the needs of people living with disabilities. It was funded by GTZ and was based at the headquarters of the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT). The study sought to expand the knowledge base on HIV and AIDS and people living with disabilities in Tanzania. Due to various constraints,

the study was confined to four districts, two urban – Temeke and Ilala, and two rural – Kibaha and Morogoro. This was the first study of its kind in Tanzania¹⁵.



The barriers to accessing HIV information and services identified by the study were similar to those observed in international studies and they include:

- Barriers created by stigma, discrimination and ignorance,
- Environmental barriers e.g. long distances to health facilities, physical difficulties of getting there or lack of directional signs,
- Communication barriers due to illiteracy, lack of interpreters or information in accessible formats,
- Ignorant or insensitive HIV and AIDS service providers, and
- Policy, resources and infrastructure barriers.

From the people with disabilities it was found that:

- They were sexually active contrary to commonly held beliefs,
- They had misconceptions about HIV,
- They did not use condoms regularly,

¹⁵ TACAIDS (2009): 'The Forgotten' – HIV and Disability in Tanzania.

- 15% had had a STI and 9% of those tested had HIV,
- The majority said that it was not easy to access HIV services,
- Stigma and discrimination were key barriers in accessing HIV services.

For their part, civil society organizations, government and local government authorities interviewed thought that:

- There were key capacity challenges to delivering effective services,
- The policy and legislation environment was not sufficiently supportive,
- Collaboration between key HIV and disability organizations was poor,
- Local Government Authorities were not sufficiently supportive.

National commitments to people with disabilities

The National Policy on Disability (2004) acknowledges the need to reach people with disabilities in HIV and AIDS and provides guidelines for service delivery.

The National Poverty Reduction Strategy (MKUKUTA, 2005-2010) has as a target the reduction of HIV infections among young people living with disabilities.

The current Health Sector HIV/AIDS Strategic Plan (2008-2012) aims to reduce infections and target interventions to address their specific needs.

CCBRT/CBM and HIV strategies for the disabled

The CCBRT and the Christian Blind Mission (CBM) are implementing (from February 2009) a three year project in 15 districts of mainland Tanzania through existing health facilities. The aim is to increase access for people with disabilities and their care givers to appropriate HIV and AIDS prevention, care, treatment and support services. The project is funded by the United States President's Emergency Plan for AIDS Relief (PEPFAR). After assessing 25 health facilities and mapping HIV and AIDS and disability organizations in Dar es Salaam and Kilimanjaro regions the following, among others, have been achieved:

- Appropriate Information, Education and Communication materials have been developed and produced,
- 27 health providers for 25 health facilities in Dar es Salaam and Kilimanjaro regions have been trained,
- 40 peer educators from among the disabled have been trained,
- 10 deaf people have been trained as counsellors,
- 11 special schools have been provided with learning and teaching materials,
- Strengthened the referral system for HIV+ disabled people at CCBRT and
- Primary school curriculum has been reviewed to include comprehensive HIV education.

Other regions set to benefit from this project are Dodoma, Iringa, Mbeya, Morogoro and Tanga.

Conclusion

If this project is extended in time and space, more disabled people will be reached and be included in HIV programmes. CCBRT and CBM cannot reach all corners of Tanzania. However, with a determined push from the government, especially from local government authorities, lessons learned will be adapted by other organizations. Gradually people with disabilities will not be regarded as “*The Forgotten*”.

4.4 Questions and Answers

Roger Salla was asked to comment on UNAIDS’ position with regard to global financing initiatives, the risk to undermine health systems by funding disease-specific programmes and the seriousness of official commitments to strengthen health systems. He stressed that in the context of the UN reform and the MDG debate, UNAIDS now is increasingly working to get HIV out of isolation. He argued that with country ownership and strong leadership, money raised vertically could be used horizontally to strengthen health systems. Both

strengthening health systems and addressing HIV required sustainable global advocacy with supportive leadership at all levels.

Hermann Lupogo was asked to comment on the position of religious leaders in Tanzania with regard to supporting the use of condoms. He described the process which took place in Tanzania since 2002 by involving Christian and Muslim religious leaders in a debate on the national response to HIV. One reached an agreement in so far as Senior religious leaders, while refusing to advocate for the use of condoms, did not overtly reject State programmes to promote condoms. Hermann Lupogo gave anecdotal evidence for this compromise:

My own brother is a priest. He said: Even you? You support the use of condoms! And I said: Brother: I will stand at the gate of your church, with condoms. If they listen to you, they won't pick my condoms. If they don't I will give them what they need.

5 The right to health and access to medicines

5.1 Hans Jochen Diesfeld: Access to safe drugs for neglected diseases – An ethical and human rights issue

In 2006 the European Commission invited an **International Conference on Neglected Infectious Diseases** with the aim to enhance Europe's international research cooperation in this field¹⁶. The topic was discussed under two aspects: **Disease specific research needs** and **Health Systems specific research needs**:

¹⁶ European Commission: International Conference on Neglected Infectious Diseases, Brussels, Belgium 8-9 November 2006: <http://ec.europa.eu/research/research-eu>

This means: Diseases neglected by the research community in contrast to diseases neglected by the Health System. The two areas are closely interlinked by policy options and political decisions.

What is relevant for Neglected **infectious** Diseases is likewise relevant for Neglected **non-infectious** Diseases. The two groups have one question in common: why **neglected**?

Although a well-known phenomenon the term became popular only after 2002 when the “Big Three” diseases HIV/AIDS, TB and Malaria, formerly highly neglected as well, became “**privileged diseases**” in the field of political attention, research priority, drug development and programme support; privileged by international funds, such as the Global Fund.

In contrast, many other infectious and non-infectious diseases were the losers, comparatively neglected, even more neglected than before. Tropical Institutes saw research funding challenged for so called tropical parasitic diseases; and they mobilised successfully their lobby, e.g. the Research & Development Directorate (STD at that time) at the European Commission in Brussels.

Looking more closely into the problem, it became clear that ND's is a complex issue: Neglected: Who? Where? Why? How? By whom? – These are the typical epidemiological questions we have to ask.

We talk about neglected, poverty related mass-diseases as well as relatively rare and almost forgotten so-called “**orphan diseases**” but with serious consequences for the sick and the community. From a public health perspective, this disease centred approach is too narrow; it ignores the problem of neglected **sick people and communities**, deprived of effective health services, specific research and development needs and political attention.

Here the issue of ethical and human rights in the context of access to safe drugs and drug development for ND comes in.

Access to safer drugs is one pre-requisite for controlling Neglected Diseases, but there is an important immaterial dimension - ethical and human rights.

If we talk of “neglect” we must ask neglect by whom. Diseases may be “neglected” for a variety of reasons, scarce resources, and low political profile of communities most affected, lack of appropriate, effective, affordable drugs, no interest in drug research and development, and no purchasing power to buy medicines.

As the conference has shown, much of this disease burden lies upon developing countries, but investment in drug research and development has been utterly inadequate. The often-cited “90/10 gap” demonstrates the imbalance: Just 10% of global investment in health research is directed towards diseases that account for 90% of the global disease burden, a gross neglect, indeed¹⁷.

Drug development

Pharmaceutical industry by its own definition is not a philanthropic enterprise. Usually as a private, limited company its main objective is to satisfy owner and shareholder’s interest. Drug research and development is a means to this end. Drug demand from the market is the motor. When there is no profitable market, there will be no drug development.

Thus research priorities are market-oriented not problem-oriented.

Between 1975 and 2004 1,556 new drugs were developed. Only three new compounds were for TB and 18 for tropical diseases incl. malaria¹⁸.

¹⁷ The Commission on Health Research for Development 1990: Health Research – Essential Link to Equity in Development, Oxford University Press, 1990.

¹⁸ Silverstein K (1999): Millions for Viagra, pennies for diseases of the poor. Research money goes to profitable lifestyle drugs; The Nation, July 19, pp14-19

Some drugs for Neglected infectious Diseases are archaic and toxic; no further development has taken place over the past 50 years. No drugs against some orphan diseases, such as Buruli ulcer or rabies.

New and effective compounds or treatment schemes are too expensive to be affordable for those affected, such as Eflornithin against sleeping sickness. Only when it was found that Eflornithin is a highly successful depilatory cream the company took up the production and agreed to make the formula available at no cost to treat sleeping sickness¹⁹.

A particular alarming situation pertains to the **chronic non-infectious diseases** such as mental diseases, diabetes, hypertension, coronary heart diseases, or cancer - diseases of greatest public health importance. Industrialised countries spend large sums of money on drug development and - consumption but with relatively little effect in respect to their control. Health services in low-income-countries are unable to cope with those diseases, except, may be in the private care sector. Modern drugs for non-infectious Neglected Diseases are costly and thus practically not available. The health system is still geared towards infectious diseases, and not in the position to cope with this growing problem related to behavioural and demographic change.

Access to drugs means financial, logistic and cultural accessibility - a complex with a huge managerial and political dimension.

The actual price of drugs the consumer has to pay has only little to do with the cost of the drug. This is a compound problem pertaining to actual cost of development and production, marketing, patenting, licensing, mark-up at various levels and logistics. An important homemade factor is import taxes and tariffs where the Exchequer makes his money at the expense of the poor.

¹⁹ Schirmer H ,2003: Moral und Verteilungsethik des medizinischen Fortschritts. In: Ethisierung – Ethikferne. Wie viel Ethik braucht die Wissenschaft? Hrsg. K. Becker, EM Engelen, M Vec Akademie Verlag Berlin 2003, p. 123-130

The actual cost of drug production is “peanuts” in comparison to the various other cost factors. In 2002 only 17% of the budget of the ten largest pharmaceutical industries goes into research and development while almost 40% go into marketing and management, 30% is production cost²⁰.

What about **un-safe drugs**, fake drugs, ineffective, useless drugs, which only pull money out of the pocket of the poor into the trader and producer of such stuff? This is a wide area of concern, but beyond the scope of this paper. There are many attempts to control this criminal energy. National drug legislation and quality control needs urgent strengthening, so far it is too weak to pass and enforce the necessary laws. International pharmaceutical industry has quite a bad track record on marketing obsolete and irrational drugs²¹.

There are a number of NGO's like Health Action International (HAI) or BUKO-Pharma-Campaign who over the past 30 years have scored quite some success in this field. As early as in the mid-1960s, NGOs and WHO started to attack this problem. Essential drug lists and propagation of generic medicines has helped a lot even if in some instances the political will was not very much in favour.

Ethical issues – human rights

Ethics is a **moral** category and human rights are a **legal** category. Ethical guidelines may be transformed into a legal framework.

Medical ethics goes back to the Hippocratic Oath; it pertains to medical care and has been further developed until today; while **biomedical research ethics** has its origin in the Nürnberg Codex of 1947 in consequence of the trials against German criminal physicians doing so called medical experiments on victims in concentration camps. Ethical Committees of the World Medical Association

²⁰ Public Citizen (2006:6) cited at Wagner-Ahlf's Ch: Arzneimittel für Entwicklungsländer. Die verantwortung der öffentlichen Forschung. Freiburg Dez. 2008

²¹ BUKO Pharma-Kampagne 2004: Daten und Fakten: Deutsche Medikamente in der Dritten Welt, Bielefeld 2004, 56 S.

issued the “Geneva Pledge” of 1948 leading finally to the Helsinki Declaration of 1964 with its latest version of 2008²².

Biomedical research ethics, based on the Helsinki Declaration has evolved gradually into ethical standards, obligatory at least for public funded health research. International and national research organizations and funding agencies, like WHO, CIOMS, TDR, EC follow strictly these standards and develop these further. However, it is observed that pharmaceutical industries try to circumvent these barriers of ethical control by employing so called “contract research organizations” do the job of research without bothering much about ethical standards. Editors of prominent scientific journals have criticised this heavily and have put sanctions on authors who cannot make sure that they have gone through ethical clearance processes²³.

While ethical issues have mainly been discussed in the “western hemisphere” where biomedical research has its main academic base, it took quite some time until African researchers came to the scene to bring in their concern.

It has to be noted, that the 1st Conference on Health Research Ethics in Africa” had been organized in Tanzania in 2001 by Rugemalila and Kilama²⁴. Many more have been held since. The most noteworthy is PABIN a Pan-African-Bioethics Initiative in 2002 in Cape Town²⁵. In 2002 an “Ethics and Health Initiative” was launched by WHO. The Harvard School of Public Health is holding regular Ethical Workshops, where again the trans- and intercultural aspects of research ethics, -

²² World Medical Association (2001): Declaration of Helsinki. Ethical principles for medical research involving human subjects In: Bulletin World Health Organization, 79: 373 – 376

²³ New England Journal of Medicine, (2001), Editorial: Sponsorship, Authorship and Accountability, N.Engl.J. Med., Vol. 345, No. 11, Sept 13, 2001

²⁴ Rugemalila, J; B Kilama (Ed.) (2001) Health Research Ethics in Africa. Proceedings of the Seminar on Health Research Ethics in Africa, In: Acta Tropica, 78: S1 – S 126 . p.32

²⁵ The Lancet (2002): Global Forum on Bioethics Report, The Lancet, 350, No. 9310, p. 956

if there are such-are discussed²⁶. The Centre de Recherche en Santé Nouna in Burkina Faso has established a **local ethical committee** in the frame work of a large community based health systems - and clinical research programme in Burkina Faso, apart from the fact that we have to conform to international and national ethical committees' decisions²⁷.

“Distribution ethics”, ethical standards on market issues, so far is a blind alley. Here we come closer to the topic of this symposium where human rights to health pertain populations and not only study groups under investigation from researchers, be it biomedical or anthropological research.

By distribution ethics we mean in our context the question how to get about the problem of access to health care, medicines. How to deal with the problem of putting all the good international intentions and pledges found in the various preambles of WHO or UN concerned with human rights, the right to health into practice? The example of Eflornithin has already been cited.

The enforcement of distribution ethics in general is still beyond reality. One very early Code of ethics has been quite successfully implemented: the WHO's code of ethics agreed upon in the late 70s with the food industry .for the marketing of infant feed in low-income countries.

Human rights as a conception have a long history, too, starting in Europe in the 17th century with general human rights against the sovereign or the State until the “Declaration of Human Rights of the United Nations 1948”. The Preamble to the Constitution of WHO of 1948²⁸ declares **Health as a Human Right**: the right of everyone to the enjoyment of the highest attainable standard of physical and

²⁶ Harvard School of Public Health: Ethical Issues in International Health Research: www.hsph.harvard.edu/bioethics

²⁷ Diesfeld HJ (2004), Ethics for international health research and the North-South dilemma In: ;Medical Mission Dialogue, Würzburg, 28th February 2004, p. 11-23

²⁸ World Health Organization(1990) Basic Documents. 38th Edition, Geneva

mental health - in short “**Right to Health**”. This is a primary responsibility of a State. In relation to access to medicines its duties are relatively clear, while in relation to drug research and development by private companies it is not clear at all.

The Right to health has been taken up in the UN Millennium Development Declaration. Goal No. 8 International Partnership expressis verbis includes pharmaceutical industry²⁹.

Solutions and recommendations

The problem of safe drugs for neglected diseases is part of an interacting complex of different players, where at the one end there is the producer of medicines at the other end the beneficiary. In between are the Ministry of Health and the providers of health care, public or private. Globalisation and liberalisation of markets and services has improved access to medicines, but certainly not for those who are at the end of the economic scale, countries as well as patients.

Many attempts have been tried and are still being developed to ease this dilemma.

However, there are a growing number of international non-governmental initiatives to respond to the distribution- and research- ethical challenges, particularly in respect to neglected diseases:

- 2000: Ecumenical Advocacy Alliance against AIDS³⁰
- 2003: Drug for Neglected Diseases Initiative (MsF)³¹

²⁹ UNDP (2003): Human Development Report 2003

³⁰ Ecumenical Advocacy Alliance against AIDS; www.e-alliance/ch/en/s/hivaids

³¹ Drugs for neglected diseases initiative (DNDi); www.dndina.org/

- 2006: Philadelphia Consensus: Universities Allied for Essential Medicines (UAEM)³²
- 2006 Access to Essential Medicines (Médecins sans frontière, Msf)³³
- 2008 Global Health Technologies Coalition³⁴
- 2009 Equitable Licensing Germany (BUKO/Charité/ZERP)³⁵

But are they politically too weak to make the difference?

Looking at the problem from the Human Rights point of view, the former UN High Commissioner for Human Rights (1997 – 2002) Mary Robinson's view of the progress in human rights was not sanguine. Human rights have fallen far short of the commitments made, she said in a recent speech at Stanford where she extensively criticised the shortcomings in the political as well as in the private sector³⁶.

Pharmaceutical industries worldwide in particular in Europe and US are trying to undermine systematically the efforts to make medicines more affordable through the production of generics. The EU supports these attempts to introduce patent rights beyond WTO regulations. By making themselves the lackey of the pharmaceutical lobby and protecting European economic interests, they are undermining the MDGs, which they have underwritten, too³⁷.

³² Philadelphia Consensus: Universities Allied for Essential Medicines (UAEM); <http://consensus.essentialmedicine.org/>

³³ Access to essential medicines: Médecins sans frontière; www.medecins.sans.frontiere.org

³⁴ Global Health Technology Coalition: www.ghtcoalition.org/

³⁵ Medical Research: Science in the public interest, „Equitable licences for the results of public sponsored medical research; www.med4all.org

³⁶ Stanford Report, April 13, 2010: The world needs a shared view of human rights, Mary Robinson

³⁷ HAI/Oxfam (October 2009): trading away access to medicines: How the European Union's trade agenda has taken the wrong turn, www.oxfam.org

In consequence the **UN Commission on Human Rights**—(later Human Rights Council) attempted to get some ground into this problem.

The mandate of the UN Special Rapporteur on the right to enjoy the highest attainable standard of health includes the following tasks:

- Gather, request, receive and exchange right to health information from all relevant sources;
- Dialogue and discuss possible areas of cooperation with all relevant actors, including Governments, relevant United Nations bodies, specialized agencies and programmes, in particular the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), as well as non-governmental organizations (NGOs) and international financial institutions;
- Report on the status, throughout the world, of the right to health, including laws, policies, good practices and obstacles;
- Make recommendations on appropriate measures that promote and protect the right to health.

Source: Commission on Human Rights, resolution 2002/31

In 2008 the Special Rapporteur presented “*Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines*”³⁸. The end product so far was laudable guidelines. Under 9 headlines there were 32 guidelines covering all aspects from **disadvantaged individuals, communities and populations**, transparency, management, monitoring and accountability, corruption, public policy influence, advocacy and lobbying, quality, clinical trials, **Neglected Diseases**, to patents and licensing.

But: the pharmaceutical industry could not care less. “*The company’s patents are its crown jewels* – patents are immensely valuable” was the remark of one

³⁸ University of Essex, Human Rights Centre: Human rights guidelines for pharmaceutical companies in relation to access to medicines, Rhajat Khosla and Paul Hunt
http://www.essex.ac.uk/human_rights_centre/research/rth/index.aspx

CEO in the discussion with the Rapporteur³⁹. This shows the profound misunderstanding of the role of an innovator drug company that develops a life-saving medicine. Such a company should have at least to a certain degree a social, medical and public health responsibility, too, is the opinion of the UN Special Rapporteur⁴⁰.

There is still an ongoing discussion on Human Rights at the level of the United Nation and allied bodies. Although the UN is an international-global institution there is still a debate as to what extent this idea of Human Rights, originating in the Western hemisphere is relevant in other cultural environments.

But there is a more practical problem: how to get the private sector in the boat of the public sector in respect to Human Rights and social responsibility?

Until this will happen, we still have to depend on advocacy by NGOs and other bodies trying to gain ground, as it was successful in the Essential Drug List debate over the past 40 years.

5.2 Questions and Answers

The presentation raised a debate with the audience on research and health care priorities. *Cosmas Cheka* asked whether, in today's world of limited resources, one should not rather follow the utilitarian principle of using the little that is available for the benefit of as many as possible. Was it rational to invest huge medical research resources into so-called Neglected infectious Diseases? Was it

³⁹ UN General Assembly; Human Rights Council 11th session, Agenda item 3: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Paul Hunt, Annex Mission to Glaxosmithkline, A/HRC/11/12/Add.2; 5th May 2009, p. 25

⁴⁰ UN General Assembly, 63rd session Item 67(b), Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, A/63/263, 11 August 2008;
http://www.essex.ac.uk/human_rights_centre/research/RTH/docs/GA2008.pdf

not a violation of the human rights of the majority in favour of the minority, if you did so. And if you did so, was it democratic?

Hans-Jochen Diesfeld contended that in his view Neglected Diseases included non-infectious diseases. Neglected Diseases were not only diseases but neglected communities in need of treatment. They did not constitute a minority but a majority left aside. **Bergis Schmidt-Ehry** concluded the debate by asserting that denying access to drugs ultimately meant condemning people to die and questioning whether this denial should not be seen as a violation of the right to life.

6. How to ensure the affordability and availability of health services?



6.1 Gabriel Upunda: Are user fees a barrier to the accessibility of health services?

Before I go into the question at hand may I give the following background that:

- The citizens of the United Republic of Tanzania have been contributing in making health care available since independence by building new health units and rehabilitating the old ones.
- They have also made their voices heard through their boards and committees.
- Despite these efforts the active involvement of the communities is still low.
- However in the 1980's the cost of running the health services dramatically went up. The budget of the government in health went down making it very dependent on donors, and the population increased. This led to the delivery of health services to be **not** sustainable. The health delivery units were run down, without adequate supplies and the workers were very de -motivated (Low moral). Because of these reasons in 1993 the government made a concerted decision of introducing **cost sharing**. Before this health was free.

What were the elements of cost sharing?

- User charges
- Pre – payment schemes (1)Community Health Fund (CHF), (2)National Health Insurance Fund (NHIF)
- The private insurance schemes

These programmes were introduced at different times starting with user charges, NHIF and finally CHF. The aim was to give the communities a choice: Pay each time one falls sick or go into a pre payment scheme and be covered when you fall sick.

With the user fees, an exemption mechanism was put in place. **BUT** this has been a big problem to implement: the hardest bottleneck has been to identify the ones who cannot genuinely pay. The communities have been better identifiers of

people who cannot pay than the health workers. The initial consequence of the user fees was a fall in attendance in our health facilities. But later studies showed an improvement in attendance.

When user charges are discussed many people capitalize on the above point of a fall in attendance and therefore user charges are bad. Let us analyse the policies of this country as far as cost sharing is concerned: The government has exemption to the following groups:

- Under 5 age group;
- Women attending Maternal and Child Health Services;
- People with chronic diseases, such as cancer, HIV/AIDS, Diabetes Mellitus, heart diseases, bronchial asthma. Sick cell , Tuberculosis, leprosy and mental illnesses;
- The old: 60 years and above and who cannot pay.

If one has the population statistics, the total of these groups is more than 50% of the population of this country's population. But most of them cannot make noise. The remaining 50% can make noise.

BUT the system in place gives room to everyone for choice: If you want to pay each time you and a member of your family fall sick, then you will have to pay each time the health unit is visited. If you cannot pay each time, and you are in the village, the CHF is the best option (TIKA for urban dwellers), if you are a worker, NHIF is compulsory for you. And if you are rich and you do not want these schemes above, go for the private insurance schemes.

We should note that there is no country on this planet without a cost sharing system in the delivery of health services. The choice at that time was either we have it all for free and miss everything **OR** introduce **cost sharing** with a human face as Tanzania has done.

In conclusion therefore cost sharing was not a barrier to access health services though user charges were a barrier initially, but later studies showed improvement in attendance. The government shielded the vulnerable groups. And in so doing Tanzania fulfils its national and international obligations in issues of human rights and health.

6.2 Faustin Njau: Universal coverage through social health insurance – A realistic approach?

I'm greatly honoured to speak to the forum on the Human Right to Health - a farewell event in honour of Dr Bergis Schmidt-Ehry, who for the last 7 years has participated fully in the health sector reforms in Tanzania, in the process of developing the Sector Wide Approach and the health sector Basket Fund Arrangement.

We know that Tanzania has appended her signature on the UN Human Rights charter. We also know that the political path of socialism and self-reliance is a prescription to human rights and equity for health services. Right to health care is a collective responsibility to ensure health services' availability for all, accessibility for the needy, and affordability not only by the users but also for the country and the government to finance these services.

Achievements and challenges

A key challenge we have in the health sector is severe under funding of the health service to ensure:

- **Availability** of well-functioning health facilities for all people in the country;
- **Accessibility** to the needed health services for all people, whether rich or poor;
- **Affordability** of required health services for the individuals as well as the larger society;

- **Equity** in use of services and hence non exclusivity of services for people who are in need, but lack the means to pay for quality treatment;
- **Sustainability** in terms of securing quality and quantity of health services in the longer terms.

During the first phase of Government after Independence a turning point for social sector development was introduced in the 1967 Arusha declaration. Health services were fully socialized, funded by government and FBOs. FBOs charged services with a user fee; but public services were cost free at the point of use. These mixed forms of financing were extended by introducing the cost sharing in 1993.

Despite a weak health system coupled with a weak private sector and crisis in human resources for health, the Government with support from development partners pursued the path of health sector reforms and Sector-Wide Approach. One of the key areas was the introduction of prepayment schemes:

- The NHIF covers formally employed staff and was initially set up to serve public servants, but the NHIF is now extended to include other groups to be more comprehensive.
- The CHF-Scheme is targeting the population in our 132 LGA's. The scheme is a mix of CHF for rural Districts and Tiba Kwa Kadi for the urban areas.
- Lately several Private Health Insurance Schemes are mushrooming in a largely unregulated market.
- There are also examples of mutual health insurance schemes (UMASIDA etc.).

In spite of the development of these pre-payment schemes the provision of health care services remains inequitable; the financing of health care is still skewed; and access to health care for the poor, the vulnerable groups and the disabled remain as one of our main challenges.

How to address the inequalities?

The National Health Policy states as the ultimate goal that social health insurance will cover the entire population with a special focus to the vulnerable groups⁴¹.

Social Health Insurance and Social Protection is also the language of the National Strategy for Growth and Reduction of Poverty (MKUKUTA).

The three Health Sector Strategic Plans (HSSP) have all specified prepayment schemes as a vision to eventually reach universal coverage. Some of the modalities that will be pursued include:

- **Solidarity** between prepayment schemes through cross subsidization of NHIF and CHF and potentially other existing schemes. The NHIF will support CHF starting with strengthening its management and expansion plans.
- Putting in place a **regulatory framework** to ensure the aims of Social Health Insurance is achieved.
- Articulating a **health financing strategy** for Tanzania - to ensure sustainable Health Sector Development and equitable financing of Health services. This is an ongoing activity carried out by the Health Financing Section.
- Fostering **public-private partnership** in health care financing including prepayment schemes.
- Harnessing **support from the international community** for example through GHI and P4H. This will involve more elaborate technical cooperation, technical assistance through multilateral and bilateral support.

HSSP III 2009-2015, addresses the issue of enhancing complementary financing and states the way forward towards Universal Social Health Insurance. Chapter 4.5 & 6.5 (strategic objective no. 1 through no. 5), specifically directs that there be action to achieve Social Health Insurance and Social Health Protection. This is in line with MKUKUTA which has a chapter or section on Social Protection. The right to health care place responsibilities on all of us.

⁴¹ National Health Policy 2007, pg 28-30, b and c, SHI

Dr Bergis is a staunch supporter of prepayment schemes, as these will lead to more available financial resources for health services. This is the road to Social Health Insurance and Social Health Protection to the population. He realizes that the best way for the poor and vulnerable groups to access health care services, requires the establishment of a robust regulatory body and progress towards the path of universal Social Health Insurance. He also knows that the health system is weak, that the capacity to move this area is still limited, and that we need both international and bilateral support in terms of robust technical cooperation. He also recognizes that it will take years to reach there.

In Tanzania we will maximize on successes of others and avoid repeating mistakes which they did on our behalf. We will therefore use less time to establish a robust Social Health Insurance scheme as this is essential for Social Protection. The Social Welfare Department is part of the MoHSW and all departments will work closely together to achieve our objectives.

Today we are here to say farewell to Dr Bergis as he is retiring. I hope he will still be willing to give us support as we move slowly towards the noble goal of universal coverage of Social Health Insurance to achieve Social Health Protection in Tanzania.

6.3 Vincent Lekey: Safe motherhood through social health insurance

Safe motherhood in Tanzania

Women and children are the biggest users of health care services. Implying that, the existing situation has had a great impact on reproductive health services (safe motherhood issues). Antenatal care attendance is high at 94% and has remained at roughly this level since 1992. In 2005, only 46% of deliveries were attended by a health professional at a health facility; this is a decline from 53% in 1992, the remaining proportion are attended by traditional birth attendants during

deliveries. Less than 2% of deliveries were conducted by caesarean section in 2004–2005 as compared to 3% and 2% in 1999 and 1996 respectively.

Social Health Insurance

Social Health Insurance under the NHIF has come to the rescue of the situation in a number of ways:

- It is a reliable and stable source of funding of health services in the country, accounting for approximately 3.4% of the health budget. It has aided in bridging the gap of available revenue, hence leading to improvement of services. The NHIF pays, an average cost per visit for general services between Tshs. 5,600 and 15,000/= (in dispensaries and referral health facilities respectively).
- It covers a wide membership base, scattered all over the country, and of varied incomes, hence benefits the poor and sick through pooling of risks and resources.
- It has therefore, facilitated access and availability of health services:
- It has put in place a wide-ranging benefit package that includes all services for women and children (except immunizations which are provided free by the Government). These services include care during pregnancy, delivery, postpartum and health services for children.
- Through treatment of pregnant women and children, whereby the fund covers for their medical costs
- Delivery Kits are paid for NHIF beneficiaries
- Payment of all complicated cases during pregnancy
- Issuance of Facility Improvement and Equipment Loans aiming at improving service delivery especially in rural and under-served areas.
- Accreditation of a wide network of 4,872 facilities country-wide which is equivalent to 62% of total available facilities in the country. This has provided access and equity to services as well as bringing services closer to members.

- Inspection of the accredited health facilities aiming at identifying problem areas and offering support where needed; aiming at offering good quality service (Medical Auditing).
- Strengthening of the referral system.

While government budget allocations to health increased by 9% over the period 1999–2002, they remain below the target of 15%. The shift to basket funding has resulted in an overall improved coordination of funds; however, more needs to be done to ensure that funding for NGOs is maintained and that the Government can respond to emergency needs in the health sector.

Social Health Insurance on the other hand, has provided an alternative and stable source of financing in health care. It remains to be determined whether Social Health Insurance in general, has ultimately increased available resources for safe motherhood. Nonetheless, it can be implied that Social Health Insurance leads to improvement in the general welfare of individuals, resulting in better health outcomes including safe motherhood.

6.4 Thomas Leshabari: Social contracts for health

Social contract is a complex concept which metaphorically explains the relationship between the government and the governed. Key elements of this theory are the relationship between the individual, state and the government. In the health sector the concept can be used to explain the obligation of government and what people expect as their right to health.

The Tanzania delivery of health services is done by both the government and the private sector. Funding for the services in government health facilities is done through highly subsidized cost sharing and services are free for pregnant women, under five children, the elderly as well as TB, diabetes, cancer, and AIDS patients.

Access to healthcare by the majority of the people including those who are entitled to free services is however quite a challenge due to inadequate HRH, erratic supply of drugs, reagents and equipment; misdistribution of health care workers and low motivation of the few workers in the system. This compromises what people expect from the system as part of the social contract.

The country currently has an estimated population of over 43 million people. According to local standards of required health facilities and health care workers, this population should be served by 35,000 workers in over 4,000 dispensaries. Based on the same standards, Tanzania should have 173 in district hospitals and 648 specialists in regional hospitals.

Available numbers are far less than this making access and quality health care quite a challenge to the people. Distribution of the available is also a problem. The city of Dar es Salaam has less than 12% of the population but 52% of doctors in the country.

The country now intends to build one dispensary for each village and one health centre for each ward. These intentions are good but unless challenges facing those which exist are addressed, the quality of care expected by the people cannot be met. In order for people to get what they expect from the health system the following should be addressed:

- First there is need to develop long term HRH projections which match population growth trends and related challenges.
- Secondly, strategies for ensuring timely availability of medicines, reagents and other supplies should be developed and implemented.
- Thirdly, challenges affecting training, deployment and retention of health care workers in public facilities especially in rural areas should be addressed.

Public education on the role of cost sharing as one of the ways of meeting costs in the health sector should go hand in hand with improving the quality of health care people expect from the health system.

6.5 Adeline Kimambo, Oberlin Kisanga: Partnerships between public and faith-based service providers

Public Private Partnership (PPP) realizes the right for each under-five, the pregnant woman and the poor to access health services without out of pocket payment.

Public Private Partnership can be defined as an arrangement between a public agency (national, regional or local) and a private sector entity (Non-Government Organization, Faith Based Organization (FBO), Community Based Organization or private-for-profit provider) with a purpose of complementing each other in addressing a common objective or interest by *“transparently mobilizing and sharing resources for the development and efficient delivery of well-regulated health services while ensuring accountability to the public they serve.”*

Situational analysis in Tanzania

- Until 2007- Public owned 60% of health services while non public 40%; recent data reveals Public 69%, FBO17%, Private 14%;
- Health Policy 2007, HSSPIII (2007-2014), Human Resources for Health and the Primary Health Services Development Strategy 2007-2017 are in support of PPP, tools less developed;
- Existence of public and private promotive, curative and rehabilitative facilities and Interventions;
- Traditional funding for FBOs- a drying breast;
- Government bears overall responsibility of service provision but acknowledges its inability to provide services to the whole public;
- Free health services to the poor, the pregnant women and under-fives -a government policy;
- While improving accessibility, quality of services is a common government & FBO sector objective;

- The two remain with an overarching- HRH constraint.

PPP arrangements-the solution: (The right for others to participate)

With an intention to improve the availability and quality of health services in the country with involvement of the private sector, the MoHSW and Prime Minister's Office Regional Administration and Local Government decided in 2007 to endorse a service agreement template –which works as a PPP tool for agreement between the Government and the health services providers for the later to complement health service provision to specified areas on behalf of the former. It includes obligations of each partner.

The Christian Social Services Commission (CSCC) as an umbrella organisation is being supported by TGPSH to undertake advocacy, lobbying and strategy development. Service agreements and service costing tools are being bilaterally developed, applied and rolled into the national policy.

FBOs in Tanzania are involved in:

- Joint Decision making - FBOs are member of standing committees);
- Joint Resource allocation and management - FBOs are member of Council Planning Teams);
- HRH generation and utilisation (FBO institutions are granted for dual HRH training);
- Council Designated Hospital arrangement (FBO hospitals are designated for Public/government accountability);
- Realisation of the Primary Health Services Development Strategy (2007-2017)- FBO geographical domains are respected.

Service agreement and the right to quality health services

FBO and Private Competencies complement government efforts. About 10 Local Government Authorities already signed the service agreement with FBO facilities.

Under-fives, pregnant women and the poor access health services paid by Local Government Councils in FBO facilities. Half of the councils are in TGPSH supported districts. The majority of the Councils have prioritised health of Under-fives and pregnant women. This means Local Government Authorities are not empty vessels in terms of a human rights-based approach.

Private/FBO competences are utilized for services of public interest, such as Malaria and TB. The Councils purchase quality services disregard of provider. Management by qualified staff is assured.

The impact up to now:

- Geographical and financial accessibility improved;
- CHF and NHIF utilization improved;
- Observed trends of decreasing morbidities and mortalities.

Challenges

Costs of the provided health services are not well known by the majority of involved stakeholders. Strategies to move from input to output oriented services are at infancy. The regulatory system is inadequately developed, as well as social protection mechanisms, especially for the poor. The mind set for PPP by decision makers at different levels still needs to change.

6.6 Michael Marx: No human right to health without skilled health workforce

“Every person, in every village, everywhere should have access to a skilled, motivated and supported health worker” (The late WHO Director-General J.W. Lee)

Ongoing efforts to reduce Global Poverty and reach the MDGs comprise an important part of the struggle to provide health care for all in the twenty first century. Increasingly, it is being recognised that with regards to the attainment of the health-related MDGs, *“the single most important constraint is no longer money but skilled workers”* (Omaswa, 2008).

Magnitude of the problem

57 countries, most of them in Africa and Asia, are now facing a severe health workforce crisis. Sub-Saharan Africa faces the greatest difficulties of all. While it has 11 per cent of the world's population and 24 per cent of the global burden of disease, it has only 3 per cent of the world's health workers (WHO, 2006).

The WHO 2006 World Health Report estimates that more than 4 million doctors, nurses, managers and other public health workers are needed to fill the gap in terms of absolute numbers.

Causes are manifold:

- Lack of training institutions;
- deficient quality of education and training;
- low and irregular salaries of health staff;
- little incentives for motivation and performance;

- social reputation not always linked to performance;
- weak regulatory framework- HR policy not implemented;
- difficult conditions of working and living, e.g. due to insufficient equipment.

Effects

The staff that is in place is inequitably distributed both between and within countries:

- Internal migration: about 77 per cent of the doctors and 68% of the nurses are working in urban areas, which causes a great lack of health staff in rural areas.
- External migration and brain drain of health workers in other, more attractive employments or countries.

Tanzania has the highest emigration rates of physicians, who migrated in OECD countries, with 55% emigration of the total workforce, followed by Malawi and Kenya. The highest emigration rates of nurses are noted in Cambodia (12, 1% of the total workforce) and Vietnam (11, 5% of the total workforce)⁴².

The distribution of workers between public and private sector employment further distorts the extent to which populations can access affordable, quality preventive and health care services. The result is sickness, unnecessary death, human suffering and abuse of the human right to health for vast numbers of patients.

Coping mechanisms

The stock of health workers depends on different factors and influences: On one hand, the inflow comes through education and In-migration of health personal. On the other hand, retirement, death and disability as well as out-migration cause the outflow. The inflow has to be greater than the outflow to reach an increase of health personal (Human Resources for Health – Joint Learning Initiative 2004).

⁴² <http://www.oecd.org/dataoecd/22/32/41515701.pdf>, S.212

Coverage, motivation and competence are the basic-demands for good working health services.

The scaling up of **performance of a health system** and of the resources **needed to produce services** are **both** vital for the human right to health to be realized.

Scaling up the performance of a health system relates to improvements in equity of access; effectiveness and efficiency of services; the responsiveness of services; and the extent of protection users are offered against the impoverishing effects of ill health. It includes such organisational changes as the review of governance mechanisms, improved planning and monitoring, decentralisation and new financing methods.

Today we concern ourselves with scaling up **the resources needed to produce services** such as increased financing, building information systems, upgrading and expanding infrastructures, as well as augmenting the number and competencies of health workers. The rationale is clear. Several studies have correlated the existence of an adequately skilled health workforce and improved health outcomes (Anand & Bärnighausen, 2004).

Action is needed therefore not only to train more staff but to find creative ways to retain those that exist in the system and avoid out-migration. This includes not only efforts to improve the working conditions of health workers, but also options such as flexible working arrangements. Strategies are needed to incentivise the deployment of health staff to where they are most needed. As with any major policy initiative, successful implementation will require having a solid information base; clear objectives and a mix of strategies; a strategic plan; stakeholder mobilisation; management and policy-development capacity; political will and commitment; continuous assessment of the effects of interventions. Adequate financial resources form a further prerequisite to cover the salaries and benefits of new staff as well as the costs of training, infrastructure, equipment etc.

Given the length of time that is needed to train health professionals, shorter trainings of sub-cadres that are specifically qualified to address country specific burden of disease patterns are useful. Furthermore, in the short-medium term task-shifting can serve to bridge people's right to health care. For example, when physicians are in short supply, a qualified nurse could often dispense much more medical services than they are used to provide.

To conclude: Human rights are key to develop health systems. Human rights are not all for a health system but without human rights, a health system is nothing.

6.7 Christiane Wiskow: Health workers too need to enjoy their rights

Ladies and gentlemen,

This has been a rich day so far - we have heard many interesting facts and inspiring views on the human right to health and how to realize it for all people. The focus of the discussion has been on health systems and on the users of health services, the population. Now is the time to look at the topic from the perspective of the health workforce.

Right to health

The human **right to health** also applies to **health workers**, yet this is a rather neglected aspect. However, it needs to be addressed as health workers face a broad range of health hazards due to the nature of their work.

The health sector has been recognized as one of the dangerous sectors to work.

In Europe, for example, one in every three health workers consider their health at risk because of their work.⁴³ Studies worldwide have shown that this is one of the major factors contributing to premature exits from the health profession.

Among the many risk factors, let me just mention as an example the exposure to risk of infections through sharps injuries. It has been estimated that annually 66'000 health care workers worldwide are infected with HBV (Hepatitis B Virus) and 16'000 with HCV (Hepatitis C Virus) through occupational exposure. In developing regions, 40% – 65% of HBV and HCV infections in health-care workers were attributable to occupational exposure, while in developed regions, by contrast, this was much less (8%–27% for HCV; less than 10% for HBV).⁴⁴ This disparity in infection rates mirrors the different levels of the protection of health workers' health and may also be attributed to the general conditions under which health workers function, including health service infrastructure, availability of equipment, and access to information.

We heard about **HIV/AIDS** today. Health workers face the double challenge of caring for HIV-infected patients while being exposed themselves to the risk of infection by their professional responsibilities. The annual occupational infection rate with HIV has been estimated at a range between 200 and 5000 health workers.⁴⁵ Who cares for those? And how, in general, is dealt with the issue of HIV/AIDS at the health workplace with regard to the staff? Are policies in place that prevent discrimination and stigma towards HIV-positive health workers; do health workers have access to voluntary counselling and testing possibilities; and

⁴³ Gunnarsdottir S & Rafferty AM. Enhancing working conditions. In: Dubois CA, McKee M & Nolte E (eds). Human resources for health in Europe (chapter 9). European Observatory on Health Systems and Policies Series. WHO, 2006

⁴⁴ Prüss-Üstün A, Rapiti E, Hutin Y. Estimation of the global burden of disease attributable to contaminated sharps injuries among health-care workers. Preprint of an article in the American Journal of Industrial Medicine, 2005. Available from www.who.int/quantifying_ehimpacts/global/7sharps.pdf

⁴⁵ Prüss-Üstün A, Rapiti E, Hutin Y.; op. cit.

is there sufficient information available for health workers at all levels; we tend to assume that health workers know everything about HIV & AIDS – but this is not necessarily the case and it may have repercussions on how HIV-infected patients are treated.

There are tools available to support responses to the challenges posed by HIV/AIDS in the health workplace. For example, the Joint ILO/WHO guidelines on health services and HIV /AIDS⁴⁶ together with the Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection⁴⁷ provide guidance on practical approaches to protection, training, screening, treatment, confidentiality, prevention, the minimizing of occupational risk, and the care and support of health-care workers.

Psychosocial risk factors are also significantly prevalent at the health workplace. The health sector ranks prominently among the sectors showing high rates of work-related stress. And did you know that it is the sector with the highest exposure to violence and harassment at work? It is so common, that many health workers consider it being part of their job to be exposed to verbal abuse, threat of violence, harassment and disrespectful behaviour in their daily work. But this discourages and demotivates health workers where they do not feel protected and supported.

When we talk about scaling up efforts to meet MDG 5 we also need to consider improving maternal health through **maternity protection** at the workplace. We must ensure that work in the health sector does not threaten the health of pregnant and nursing women health workers. Maternity and women's

⁴⁶ ILO/WHO. Joint guidelines on health services and HIV/AIDS. Geneva: ILO, 2005; available from <http://www.ilo.org/public/english/dialogue/sector/sectors/health/socprot-hiv aids.htm>; a print-version in Kiswahili is available at the ILO office in Dar es Salaam.

⁴⁷ WHO/ILO. Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. Geneva: WHO, 2007; available from <http://www.ilo.org/public/english/protection/trav/aids/publ/pepgl.pdf>

reproductive roles should not jeopardize their economic security; gender equality is particularly important in the health sector where majority of the workforce is female.

Many occupational diseases and accidents in the health sector are preventable. What do we do to protect the health of our health workers? Providing occupational safety and health is a legal responsibility of the employer and working in a safe and healthy workplace is a right of everyone in the health sector. The health sector with its mandate to protect and promote health of the population should provide a role model in this regard.

Right to fair working conditions

More broadly, health workers have a **right to fair working conditions**. What does this entail? It starts with adequate education and training that enables health workers to exercise effectively their functions. Employment and working conditions that have the potential to attract and retain people in the health profession include adequate remuneration, social security and career prospects as well as fair workloads and reasonable hours of work that respect times of rest and enable a healthy balance between work life and private life.

Fair working conditions also have a positive impact on patient safety: Errors occur more often where workers are under pressure or tired. Would you want to be treated by a doctor at the end of her 36-hour- on-call duty? Or to be cared for by a nurse who is about to finish his double shift which he had to do because there is not enough staff in the ward or because he has to do a second job for a decent income?

Right to participate

Finally, health workers have a **right to participate**; they should have a voice in decisions concerning them, particularly their employment and working conditions. Further, it is beneficial to consult health workers, where appropriate through their

representative bodies, in the planning of health services; by taking advantage of the profound knowledge about the issues at stake in practice and experience to develop approaches how to address them.

Ways forward

Guidance on how to create a positive and supportive working environment can be drawn from many instruments. With regard to nursing personnel, it may be interesting for you to know that Tanzania has ratified the ILO Nursing Personnel Convention (No. 149) in 1983. The Convention and its accompanying Recommendation (No. 157) describe the essential elements of working conditions that enable nursing personnel to work effectively in a healthy work environment.

Providing good working conditions in the health sector requires investments, and this is not popular with policy makers who have to make difficult choices within tight budget frames. However, if nothing is done to improve the situation, we will have to pay the price anyway, as we already can see at present. Health workforce shortages are observed globally and especially in African countries there are not enough health workers to ensure access to health services. Health workers vote with their feet: they leave the health facility, the remote areas, the country or even the profession in search for better working and living conditions, and less young people consider the health professions as an attractive career choice.

Recognizing and valuing health workers in their critical role in the delivery of health services and involving them actively in the development of effective health systems may be a promising first step for the way forward.

6.8 Summary of Panel Discussion

The discussion between the panellists and with the audience focused on how to ensure universal coverage and social protection in view of limited resources and of the human resource crisis Tanzania is facing.

Gabriel Upunda highlighted the differences between the NHIF and the CHF both in their membership and institutional structure. Both were established by Acts of parliament, but CHF's mandate was given to the district authorities. He argued that if NHIF was to take over CHF, its role should be legally redefined and clearly outlined. One of the reasons for the NHIF to "hijack" the CHF might be that championship on social insurance among the local district authorities was still missing.

Faustin Njau acknowledged that Tanzania could not aim at a universal coverage without building upon CHF. However, the localisation of CHF was a challenge that should be addressed by using the expertise of NHIF. Rwanda and Ghana were examples of countries which were on the way to succeed with universal coverage because of a strong political will uniting members of all factions and parties. Tanzania also invested much to develop social protection. Yet, one should not forget that industrialized countries needed more than a century to develop effective social protection systems, whereas Tanzania started 10 years ago. He finally reminded the audience of MDG 8 on international cooperation and questioned if one would continue to support Tanzania to move to the noble goal of social protection for all.

7. Closing Session

In her closing words, **Fatma Mrisho**, Director of TACAIDS, emphasised the importance of the symposium in view of the fact that one very rarely invested time to discuss health-related rights. She highlighted that the difference between having laws and policies and not having them was determined by the guidelines and how you used them. And this is where one often failed. Alma Ata for example was a noble intent and did lead to major achievements. But one forgot to set

realistic milestones to reach universal coverage. Therefore one should always consider the investments needed to realize rights and set priorities, a difficult but necessary step. On behalf of all Tanzanian people she warmly thanked Dr Bergis Schmidt-Ehry for his ongoing commitment to the health sector and to TACAIDS.

Gisela Habel, Head of Division for Development Cooperation, German embassy concluded with a few lessons she learned from the symposium. A human rights based approach to health required a shift from charity to rights, more awareness on ethics and more knowledge of rights by informed users, sustainable and innovative approaches to enhance access to HIV prevention, and an effective implementation of policies to ensure the availability and affordability of health services. On behalf of the German embassy, she expressed her thanks to Dr Bergis Schmidt-Ehry for his active engagement in the field of health and development cooperation.

7.1 Bergis Schmidt-Ehry: The great denial of the right to health for all – together let's overcome!

I'm not a scientist, I'm not a politician, I'm not a guru! I humbly pretend to be an experienced development practitioner in health. And I take the privilege of today's farewell symposium to share my thoughts with you to re-advocate for the fundamental human right to health!

When I started to work in Africa 37 years ago, modern health care was available only for a few.

In the colonial time hospitals had been built to serve the colonial masters and the local elites – but the rural and the poor had not been of interest, with the exception of charity in some missionary centres.

Information from this period found overall infant mortality rate in German East Africa was 49-54 per **cent!** (Every second child died!)

Still in 1945, Dr Sneath, the then Medical Director of Tanganyika, postulated that satisfactory levels of both quality and quantity of health services were impossible to achieve and concentrated the official health policy primarily on quality, **leaving “extension until finance would be available”**. So the right to health remained restricted to a few!

Independence in most countries did not change much in these matters - certainly against the ambitions and good wishes of the young African leaders, which in almost all countries declared health care services for free. But again these remained available only for a few, *as reachable and accessible services did merely not exist for the majority of the people*. **Access** to health care might have been for a few per cent but certainly below 10%.

Just to take an example when in Southern Sudan in 1981 we did a medical excursion to some remote villages, people over there had not seen a health professional since the 40th - far from having any services!

So when looking on facts and figures from this time we have to recognise that the money available for health was only available for a few – and in fact produced not so bad results for those, but left the majority of people without enjoying their right to health.

Public health was confined to rules and regulations how to protect the elites. Still in 1993 in Cameroon a law was in existence – but fortunately no more applied - keeping indigenous populations out of a parameter from the residential areas of towns for reasons of hygiene and health protection. Disease control activities were designed particularly to protect the better-offs (or the valuable work force) from the risk of infection.

Fortunately starting in the seventies , health of the entire population became a concern, more comprehensive approaches became more and more fashionable. Outreach programmes tried to involve broader groups of population, and progress towards a population oriented health care system started.

Led by Dr Halfdan Mahler, one of the few visionaries of WHO, the Thirty-second World Health Assembly in 1979 launched the Global Strategy for Health for All by the Year 2000. The strategy was based on the famous Alma Ata declaration on global health policy, which became the synonym for a people-oriented and rights-based approach in health.

Let me cite the first chapter of the declaration which should be for us - stakeholders in health and development policy - as much of ethical value as the oath of Hippocrates for medical doctors:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a **fundamental human right** and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

But unfortunately the implementation of a comprehensive health system seemed to be too expensive and we quickly went back to vertical and interventionist approaches in public health to control diseases – much sexier to sell and easier to show so-called “results” than building the system brick by brick, which could offer the necessary services to let people enjoy their fundamental human right on health.

When starting the ART intervention in Africa much talk was about the human rights and equity concerns. But did we really care about the human right to health and health care for everybody – or did we rather single out a target group?

German Development Policy in the Health Sector demonstrates obligation to address health as a human right. In fact we argue that there is the need to assure health as an **inclusive entitlement** that should look to the underlying determinants such as clean water, sanitation, information, education and **facilitate continuous access to health care**.

But do we really do this? When providing for the HIV Therapy did we not divert resources from other human rights based priorities? What for example is about mental health? (We think that between 1% and 4% of people in Tanzania are suffering from mental illness – with unfortunately almost no care.) What's about the many people who die in Africa by road accidents, as adequate services are not in reach? What's about hundreds of thousands who continue to suffer and die from the so-called neglected diseases like sleeping sickness, onchocerciasis and schistosomiasis?

Interestingly, in Tanzania during the time, the Care & Treatment Programme became most active and recruited lots of HIV positive people into ART treatment, the coverage on immunization (EPI) went down. It would have passed downwards the threshold if in 2009 a catch-up campaign would not have been launched. Every intervention in a complex system like the health system has effects on other parts of the system. The interventionist approach does not consider this but only looks on the narrow targets of the intervention. By this, it might become harmful for the health of non-targeted populations and by this a clear contradiction to the human rights based approach!

Today we have heard a lot of why and how we can approach the realization of this fundamental human right to health, but let me use today's privilege to have a critical look on the actual situation – and as you know me – I will not mince my words!:

In reality we deny the human right to health to most people. Let me talk about the great denial!

Looking on Health Funding

We have to talk about forgotten **commitments**:

Most better-off countries have not kept their promises to increase their contribution to ODA to 0,7 % of their gross domestic product – thus funding for health related support is denied.

African leaders committed to the Abuja target to use 15% of the overall government budget for health, we are far away - in Tanzania around 10% - thus improved health is denied.

We have to talk about **diversion of funding**:

In Tanzania we are happy that more and more ODA is captured in the national budgetary system. Well and good, but the additional funds are now constraining the budget ceilings and it seems that external funding is crowding out internal resources.

A recent study published by The Lancet found that for every dollar ODA for health government own resources have been reduced by 0,43 \$ to 1,14 \$. Or the other way round international Aid needs to invest 1,75 \$ to increase disbursement in health by 1 \$! We even deny the funding foreseen for health!

We have to talk about **misallocation**:

Many available funds are denied for the improvement of health, as synergies are not used by vertical programmes and resources are not allocated according to the priorities – as well depicted in a recent quality audit by the Controller and Auditor General.

We have to talk about **misuse of funds**:

In many countries the health sector is within the top group of corruption. Look at the reports of auditors which reveal how much money is thus denied for people to enjoy their fundamental right to health.

But we have as well to talk about **reliability of funding**:

When in 2004 we embarked here in Tanzania on C&T – I repeatedly underlined to both donors and the Government that this move needed a long term commitment for funding for at least 20 -30 years. Today we witness that the whole AIDS programme is funded for more than 95% by external resources and the willingness of donors to allocate ODA to the control of the disease is dwindling. We have heard that in Uganda people found HIV positive are turned away as the programme cannot support the increasing cost anymore. What's about keeping our promises?

The new draft MKUKUTA foresees cluster 2, which is about social services including health, losing out tremendously. According to World Bank analysis this will result in 2.4 Trillion lower funding over the life of MKUKUTA 2.

We put growth in the focus. Growth without health? Or growth for elites again and health only for a few?

Let's talk about human resources:

We have to talk about **misleading policy advice**:

In the nineties, the IMF forced many African countries to reduce their expenditure on personnel. The basic idea was to hit overgrowing bureaucracies. But in reality recruitment for health and education was frozen, production of health workers reduced and human capital turned away from the health sector.

In the meantime population growth continued unchecked thus increasing the gap between need and availability. It is certainly not the only reason but an important contributing factor that in Tanzania today we witness that we have only one third of the needed human resources, of which only one third is sufficiently competent for their increasingly complex tasks and only one third of those is found where and when needed.

As health care is depending on the availability of skilled staff, this constitutes another denial of the human right to health.

We have to talk about **brain-drain**:

Production of health workers in Africa is according to McKinsey 5 times less expensive than in industrialised countries. Earnings in industrial countries however are often at least 5 times higher than in countries like Tanzania. With globalization and free trade, there is no wonder that out of the insufficient production, numbers of professionals are withdrawn by the international brain-drain.

But there is brain-drain as well inside the system. As we know more and more clinicians and practitioners turn away from their curative, clinical and health promoting functions to administrative duties. More and more professionals move from service delivery to project and programme work and skilled professionals move from rural and under-served areas to towns and urban centres looking for greener grasses and better opportunities, thus deepening the one-third dilemma described above.

We to talk about **perverse incentives**:

You will not be surprised that I include this point in my speech - following the ongoing discussion on allowances in Tanzania and elsewhere.

We need on-the-job training to improve competences of our workforce, we need workshops to involve stakeholders in policy and strategy development, we need

meetings for harmonization and coordination. And nobody can deny paying the necessary subsistence allowances. But the emphasis must be on necessary in terms of quantity and frequency. If people attend trainings and workshops for the purpose of earning supplementary income – this might be understandable - but we better advance quickly the pay reform! We have seen people attending training workshops on the same subject three times without improvement of their skills. A nurse attending a workshop might earn as much as her monthly salary in a workshop of 5 days. People at the grass-root level call District Medical Officers (DMOs) “Daily absent medical officers”. And at the same time necessary services are not available in the health facilities.

Let's be clear, all this is contributing to the denial of the fundamental human right for health.

Let's talk about behaviour

With students of the Muhimbili University of Health and Allied Sciences (MUHAS) we did an observational study on health ethics in 6 hospitals in the country. Within three days they registered more than 600 breaches of medical ethics according to what they had learned at the university: Ranging from under-table payments over rudeness to patients and discrimination to severe mishandling and harmful practice.

Some of the cases might have been involuntary and due to lack of competence but let's be very clear: in a more human rights competent society, most of the above mentioned cases would have called the concerned to court.

We all have heard about the child which cried for days and finally lost its arm because a tourniquet was forgotten to be released after a drip was placed. Certainly a big mistake by the nurse, but what about the supervisor, the doctor in charge, the teachers and the trainers?

Dear colleagues, the health profession is a little different from others as we are dealing with life directly and we have to reflect in all our acts the principle of “nil nocere”: **do not harm!** We have to teach and apply medical ethics in a more rigorous way and we have to develop systematically more accountability to our patients and clients.

Let's come back and talk about systems

Internationally we talk a lot about “health for all”, “universal access”, “universal coverage”, “comprehensive services”. But at the same time we tend to make our interventions “targeted”, “focused”, “efficient”. At the same time we continue to embark on vertical interventions. At the same time we have a Global Fund on three Diseases and not a global Fund for Health. At the same time we have an ever-growing number of global health initiatives – all well intended and we recognise that most of them have mobilised funds for the sector. But at the same time they tend to derail sufficiently planned comprehensive national strategies by pressurizing priorities not necessarily following the needs and demands of countries and people but following the international fashion and the supporters' agenda.

So what is about “demand driven”, “needs oriented”, “human rights based”? What's about the marginalised and vulnerable? What's about the neglected diseases? And what's about comprehensiveness?

We hear that donors, funding agencies and governments turn back to talk about systems strengthening, but the necessary re-orientation is not yet really on its way.

Let's come back and talk about funding

Economists have for long regarded - and I believe they continue to do so – health care as a mere consumptive process and not very interesting for economics and

development. We know that this is not the case! We know that without health there is no development!

But there is a more fundamental aspect:

Economics give us perhaps the **means** for life and development. But health is the **precondition** for life and development.

It is unbelievable that in the global society of today we are able to quickly mobilise hundreds of billions to save banks and insurers, but that we are avaricious and over reluctant to invest in the most fundamental element of human life.

Let me come to some conclusion and forward thinking.

We cannot continue to deny the fundamental human right to Health!

Both human rights and health are values which are not given - but we need to fight for them with continued efforts!

Despite all efforts to harmonize, support to improve health of the people remains fragmented and driven by the interest of those who provide the resources and those who influence the political agenda. We have to hold us and them accountable!

We need to ask ourselves in our daily undertakings: is what I do, is what I advise, and is what I decide supporting the fundamental human right on health – or is it contributing to the great denial?

Let me borrow from Dr Faustin Njau saying “**let’s walk the talk**” by progressive realisation and optimal use of available resources to assure that there is:

Availability

- of not only health facilities but of facilities that are capable of rendering goods and services,

- of skilled medical and professional personnel who receive their salaries on a competitive basis,
- of essential drugs of good quality and
- of underlying determinants of health such as clean water, acceptable sanitation facilities and education.

Accessibility

- of health services and facilities without discrimination of any kind,
- Making sure that the poor and other vulnerable groups have physical and affordable access to services in public and private health facilities on equitable basis, and that they are able to ask and receive health information without any unreasonable barriers.

Acceptability

- of health facilities, goods and services that are gender sensitive, courteous of medical ethics and that are designed to reflect adequate measures of confidentiality and that respect the cultural values of the respective population.

Quality

- of health facilities, goods and services that are of acceptable standard, scientifically and medically approved and are provided by skilled medical personnel.

It is my sincere hope that today's symposium has provided a platform to deepen our thoughts on the fundamental human right to health, that we continue together to pave the stony way to achieve "Health for All – as a fundamental human right" and that we overcome the "great denial".

Annex

Curricula Vitae

Dr Cosmas Cheka

is presently associate Professor in law at the Universities of Cameroon and Senior Legal Counsel to the Office of the African Development Bank Group in Tunis. He is involved in research in the domains of governance and the law relating to health. He also has extensive experience in development cooperation both with German and International Agencies. He has served as General Counsel to GTZ Health Projects in Cameroon, and greatly contributed to the development of health legislations for community based health and drug management. He also was a Lead Technical Adviser to GTZ on the German Cameroon Decentralisation Support Project and Director of the GTZ office.

Dr Remo Meloni

is presently the Health Sector Adviser for the Belgian Technical Cooperation in Kigali/Rwanda. He advises the Belgian Embassy in the policy dialogue established between Donors and the Ministry of Health in Rwanda in the context of Sector Budget Support, which aims at improving public finance management and strengthening the district health system of the country. He is also responsible for coordination between health programmes funded by Belgian cooperation. Dr Meloni was the manager of the GTZ supported Primary Health Care projects in Congo-Brazzaville and Cameroon. Having worked at peripheral and central level, he has a wide experience in the development of national strategies funded on a decentralized district based primary health care system.

Dr Baltazar Ngoli

is the head of the Decentralized Health Services component in the Tanzanian German Programme to Support Health. He is a medical doctor and public health specialist on quality management and performance assessment in health care. He has also more than 13 years of experience in the management of health districts and regions in Tanzania.

Dr Heinrich Heinrichs

is working for the SWISS Tropical and Public Health Institute as a Senior Educational Officer and Advisor for the PASHA Project (Prevention and Awareness in Schools on HIV and AIDS) at the Ministry of Education and Vocational Training (MoEVT) in Tanzania. He is an education specialist and scientist (with a background in biology and chemistry). For the last 10 years he has been working in senior advisory positions in the education sector and in HIV/AIDS programmes in various countries of Sub-Saharan Africa (South Africa, Namibia, Rwanda and Malawi). He has wide expertise in policy advice, capacity building, curriculum development and participatory elaboration of information, education and communication material.

Dr Neema Rusibamayila

is the Assistant Director of Reproductive and Child Health Care in the Ministry of Health and Social Welfare in Tanzania. She also has wide experience in the field of Integrated Community Childhood Illness (IMCI).

Akwillina Siya Mlay

is leader of the task team for Youth in and out of schools within the Tanzanian German Programme to Support Health. She has extensive experience in developing information material with and for young people.

Dr Roger Salla Ntounga

is presently UNAIDS Country Coordinator and Representative to African Union and UN Economic Commission on Africa . Since 1996 he has been working for UNAIDS in diverse lead positions, as the Team Leader of the Division of the Country Programming and Liaison and most recently as the Director in the UNAIDS Executive Director Office in Geneva. As a National AIDS Programme Manager in Cameroon he contributed from 1989 to 1995 to the setting up and the development of the response to the AIDS pandemic in Cameroon. From 1995 to 1998 he served as Team Leader of the GTZ Regional Programme for West and Central Africa and provided support on HIV/AIDS related issues to GTZ supported primary health care project in 18 countries.

Dr Joseph Temba

is currently Consultant on Global Fund and Governance of Country Coordinating Mechanisms in Tanzania. Up to 2007 he was Director of Policy and Planning and Global Fund Coordinator in the Tanzania Commission. He was involved in developing the National Multisectoral Strategic Framework on HIV/AIDS, strengthening the institutional structure of the national response to HIV/AIDS, and strengthening Tanzania's national coordinating mechanisms for the development and reviews of proposals to the Global Fund.

Major General (Rtd) Hermann C. Lupogo

is a former infantry commander and was the founder Executive Chairman of TACAIDS. Under his lead TACAIDS obtained its shape and its important role it is playing today in combating the disease.

Prof. Hans Jochen Diesfeld

was until 1997 the director of the Department of Tropical Hygiene and Public Health, University of Heidelberg . In Germany, he is the father of training and research for Public Health in developing countries. In Tanzania, between 1996 and 2003 he initiated and accompanied the setup of the MPH course at the medical department of the Muhimbili university branch. He has carried out research and evaluations in many developing countries.

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Dr Gabriel L. Upunda

was previously Chief Medical Officer in the Ministry of Health and Social Welfare in Tanzania, and strongly contributed to the health sector reform in Tanzania.

Dr Faustin Njau

is presently the head of the Health Sector Reform department in the Ministry of Health and Social Welfare in Tanzania . Both a medical doctor and a public health expert, Dr Njau has extensive experience in the fields of health systems and health financing. With his support the health financing strategy was further formulated and strengthened and Social Health Insurance became an important pillar in the health financing arena of Tanzania.

Vincent Lekey

is the Associate Director General of the National Health Insurance Fund in Tanzania. He advocates for implementing universal coverage in Social Health Insurance in Tanzania, including the informal sector.

Prof. Thomas Merkizedeck Leshabari

was for many years the dean of the school of Public Health of the University of Dar es Salaam (MUHAS - Muhimbili University of Health and Allied Sciences). Prof. Leshabari set up and developed the Master of Public Health course at Muhimbili.

Dr Adeline Kimambo

is director of the Christian Social Services Commission (CSSC). CSSC is an umbrella organization for all faith based health and education institutions. Dr Kimambo is actively supporting the PPP approach which aims at a close collaboration between the Government and faith based providers.

Dr Oberlin Kisanga

is the national coordinator in the TGPSH and at the same time leading within the programme the activities in implementing the PPP approach between Government and faith based providers.

Dr Michael Marx

is associate professor and senior lecturer for international public health at the Institute of Public Health of the University of Heidelberg. In addition he is Director of evaplan ltd at the University of Heidelberg, the consulting platform of the University. He has working experience in more than 20 African countries as well as expertise in the areas of health systems development, quality management and quality control, human resource development and training.

Christiane Wiskow

is presently working as an independent health services specialist with WHO and other international organizations. She has been working on health workforce issues at international levels for 13 years, starting (way back) with a GTZ project. The last couple of years she worked with the International Labour Organization where she monitored labour trends in the health sector with a focus on working conditions of health personnel.

Dr Bergis Schmidt-Ehry

has worked for more than 37 years in health and development, both in African countries as well as in Germany. Between 1996 and 2001 he was Senior Planning Officer for Health in GTZ headquarters. From 2002 to 2010 he worked in Tanzania as Sector Coordinator Health for German Development Cooperation and Programme Manager of the Tanzanian German Programme to Support Health.

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Health and Social Welfare Tanzania



Tanzanian German Programme to Support Health



Muhimbili University of Health and Allied Sciences