gtz Realizing Human Rights in Development Cooperation

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Strengthening a Human Rights-based Approach in the Tanzanian-German Programme to Support Health

Results of a short assessment

Ilse Worm, Dresden, Germany
Joseph Matimbwi, Dar Es Salaam, Tanzania

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TGPSH is implemented on behalf of the German Ministry for Economic Cooperation and Development by CIM, DED, GTZ, KfW and InWEnt.

Acronyms and Abbreviations

BMZ	German Federal Minsitry of Economic Cooperation and Development
CBD	Community-based distributor
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CHF	Community Health Fund
CHRAGG	Commission for Human Rights and Good Governance
CHSB	Council Health Service Board
CRC	Convention on the Rights of the Child
CRPD	Convention of the Rights of Persons with Disabilities
DANIDA	Danish International Development Agency
FGM	Female Genital Mutilation
GTZ	German Technical Cooperation (Gesellschaft für Technische Zusammenarbeit)
ICCPR	International Covenant of Civil and Political Rights
ICERD	International Convention on the Elimination of all Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
INWENT	Capacity Building International, Germany
LHRC	Legal and Human Rights Centre
MoHSW	Ministry of Health and Social Welfare
PPP	Public-Private Partnership
SIDA	Swedish International Development Agency
TGPSH	Tanzanian-German Programme to Support Health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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1 Introduction

1.1 Background

Over the past two decades the links between human rights and health have increasingly been addressed both at international and national level. International and regional human rights bodies and mechanisms have clarified the content and implications of the *"right to the highest attainable standard of physical and mental health"* (short: right to health), which is enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESR) and in other core human rights treaties, such as the Convention on the Rights of the Child (CRC) or the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). In the nineties, international conferences, such as the International Conference on Population and Development (Cairo, 1994), have also emphasized the importance of implementing a human rights-based approach in health and development. Several UN declarations, including the Millennium Declaration, acknowledge that the realization of human rights is fundamental for achieving development goals.

Most UN member states have signed and ratified the core human rights conventions, thus legally complying themselves to respect, protect and fulfil human rights. Many Governments also increasingly recognize the need to orient their national policies and strategies more consistently towards human rights, in order to create an enabling environment and to better meet their development goals.

Yet, the socio-economic, socio-cultural and political challenges of realizing human rights are great. The human rights and health situation of vulnerable and marginalized groups is still regularly an issue of concern for international and regional human rights monitoring bodies as well as for national human rights institutions and civil society organisations.

A human rights-based approach to development is now widely understood as a conceptual framework normatively rooted in human rights standards and principles and contributing to building the capacities of "duty-bearers" to meet their obligations, and of "right-holders" to claim their rights.[1]

In July 2004, the German Federal Ministry of Economic Cooperation and Development (BMZ) adopted its first Development Policy Action Plan on Human Rights, which has now been updated for the 2008-2010 period. This plan aims at systematically integrating a human rights-based approach into German development policy and at supporting processes at global, regional and national level, that are contributing to the realisation of human rights. It includes such measures as promoting the implementation of international human rights conventions and the realisation of sexual and reproductive health and rights. It also foresees to step up support to human rights institutions and to strengthen human rights work in association with civil society and non-governmental organisations.

Against this background, the BMZ regional desk responsible for Tanzania has recently emphasized the need to strengthen a human rights-based approach in German-Tanzanian Cooperation. The Tanzanian-German Programme to Support Health (TGPSH), with the advisory assistance of the GTZ sector project "Realizing Human Rights in Development Cooperation", took the initiative to assess how far it has already gone in implementing a human rights-based approach to health and to identify further steps to strengthen this approach.

[1] See *inter alia* the "UN Inter-agency Common Understanding on a Human Rights-based Approach to Development Programming (2003)"

1.2 Objective

The management of the TGPSH intends to more systematically incorporate a human rights-based approach in the planning of its next programme phase, which will be completed at the beginning of 2008. Support for this mainstreaming process is being provided in the TGPSH by a national junior legal advisor attached to GTZ.

Therefore, the advisory assistance of the GTZ short term expert had the following objectives:

- to sensitize staff members of the TGPSH and selected partners to a human rights-based approach to health;
- to conduct a brief assessment of the human rights-based orientation of the TGPSH and identify entry points to strengthen a human rights-based approach in the next programme phase;
- to coach the national junior legal advisor of the TGPSH and to give him guidance on how to operationalise a human rights-based approach in his work.

1.3 Process

The consultancy took place between August 29th and September 5th in Dar Es Salaam, Tanzania. The main role of the short term external adviser was to provide technical and practical guidance to the national junior advisor as well as to facilitate a discussion with key staff members of the TGPSH on the implications of a human rights-based approach for their programme component. The national junior advisor actively took part in all the consultancy activities.

A guideline to briefly assess the human rights-orientation of the TGPSH was developed (see annex 3). This guideline consists of key questions, which are now commonly used in human rights-based programming and/or human rights impact assessments. They reflect both the key elements of the right to health (availability, accessibility, acceptability and quality) as well as key human rights principles (non-discrimination, participation, accountability). The guide-line served as an overall framework for the assessment team.

A one-day sensitization workshop on human rights and health was held for the GTZ staff members of the TGPSH, as well as for a few partners and representatives of human rights organisations. The workshop included interactive exercises, presentations on the key ele-ments of a human rights-based approach to health as well as the legal and policy framework regarding health-related rights in Tanzania, and group work (see annex 4 and 5).

In the group work participants started to assess themselves the human rights orientation of the TGPSH programme components by discussing the following questions:

Which human rights does the programme component address? Does the objective of the programme component explicitly refer to human rights standards and principles? What challenges does the programme face? Which vulnerable and marginalized groups does the programme component address? Are there groups which are not yet addressed? How does the programme component strengthen the capacities of right-holders to claim their rights? How does the programme component strengthen the capacities of duty-bearers to be answerable for their actions?

Following the workshop, interviews were held during four days with the team leaders of the TGPSH components as well as with selected partners and with human rights organisations

(see annex 2). In the interviews the issues raised and the proposals developed during the workshop were discussed further. We thank all our interlocutors for their openness and patience.

We did not conduct a comprehensive evaluation of the TGPSH, which would have required more time and information, particularly on the impact of the progamme activities on vulnerable and marginalized groups. As human rights and gender equality are closely linked, the results of our assessment should be discussed together with the results of a gender analysis, which is now being conducted in the TGPSH.

The following report presents the main results of the assessment. It summarizes the discussions we held during the consultancy, and presents options for the next phase. These options still need to be prioritized and further developed in the GTZ team and with partners during the forthcoming planning.

In chapter 2 a brief overview of the human rights context, in which the TGPSH operates, is given. We have not dealt in length with the practice of health and human rights in Tanzania, but focused on the relevant human rights mechanisms at international, regional and national level, as these are often not well known to health and development experts. Chapter 3 describes the achievements of the programme and discusses the challenges and options for strengthening a human rights-based approach in the next phase.

2 Brief overview of the human rights context

Historically, health-related human rights have been given a very cautious attention in Tanzania. Myths, traditions, socio-cultural beliefs and practices have and still overshadow the enjoyment of fundamental human rights. Many of these practices still have a dominant role in people's lives and a negative impact on their human rights, including the right to enjoy the highest attainable standard of health. For example, early marriages affect the reproductive and maternal health of many Tanzanian girls and women.

Since independence, Tanzania has gone through several development visions, that all have addressed key elements of the right to health, albeit in different ways. According to the Ujamaa policy and the Arusha Declaration of 1967 Tanzanian citizens were entitled to free health services. Among other factors, the recognition that this policy did not succeed in providing essential health services to the population, led the Tanzanian government in 1993 to initiate a reform of the health sector. New priorities were set, including the decentralization of health administration to the district level and the establishment of a cost-sharing system. In the course of this reform, a comprehensive policy and legal framework was established for the health sector.

In practice, inadequate standard of living, limited access to safe drinking water in urban and rural areas, poor housing and sanitation, inadequate nutrition and the still restricted access of many Tanzanians, particularly of poor and vulnerable groups, to health information and services, still pose many challenges for the full enjoyment of the right to health and other health-related rights.

2.1 International and regional human rights mechanisms

Tanzania has signed and ratified many international human rights treaties without any reservations. The following is a general overview of Tanzania's ratification status of the core human rights treaties and their protocols.

	Core international human rights treaties and optional protocols	Date of ratification
1	International Convention on the Elimination of all Forms of Racial Discrimination (ICERD)	1972
2	International Covenant of Civil and Political Rights (ICCPR)	1976
	Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty	Not ratified
3	International Covenant on Economic, Social and Cultural Rights (ICESCR)	1976
	Optional Protocol to the Covenant on Economic, Social and Cultural Rights	Not ratified
4	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	1985
	Optional Protocol to the Convention on the Elimination of Discrimination against Women	2006
5	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment	Not signed
	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Not signed
6	Convention on the Rights of the Child (CRC)	1991
	Optional protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography	2003
7	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families	Not signed
8	Convention on the Rights of Persons with Disabilities (CPRD)	Signed in 2007, not yet ratified

Regionally, Tanzania ratified the African Charter on Peoples and Human Rights in the year 1986. The African charter is one of the key human rights instrument for Africa. It interprets the universal human rights with consideration of African values and mentions the right to development as a human right. Tanzania also ratified in 2007 the Maputo Protocol to the African Charter on the rights of women in Africa. This protocol also contains an article on health and reproductive rights. It is the only human rights treaty up to now that explicitly

mentions abortion as a human right,[2] albeit with restrictions, by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the foetus (Art. 14).

Although Tanzania has ratified most of the core human rights treaties, a major factor hindering their full implementation, is that the parliament in many cases has not enacted an enabling legislation that domesticates the ratified treaties into the Tanzania legal system. Faced with this problem, judicial practice has tried to solve this problem on a case to case basis. For example, in the high court case of *Director of Public Prosecutions vs. Daudi Pete 1993 TLR 22 (ca)* where the issue, among others, was the procedure and jurisdiction of the High Court in enforcement of basic rights enshrined in the Tanzanian Constitution and in the African Charter on Human and People's Rights, the judge in its judgment concluded that: "… *The Constitution confers upon the High Court original jurisdiction to entertain proceedings in respect of actual or threatened violations of the basic rights and freedoms and, until Parliament enacts the procedure for the enforcement of those rights and freedoms, the same may be enforced using the procedure available in the High Court in the exercise of its original jurisdiction".*

2.2 Treaty reporting and monitoring process

The enforcement of the provisions of the core human rights treaties is monitored at international level by UN human rights treaty bodies. Once a State has ratified a human rights treaty, it is required to submit regular reports to the specific treaty body with explanations as to the extent it has been working towards the realization of rights enshrined in that particular treaty. The treaty bodies review the State party reports, discuss them with Government representatives and then give their observations and recommendations regarding the progress of implementation of that particular treaty in the country.

Tanzania has a record of reporting late but does submit reports to the UN human rights treaty bodies. The most recent report to the Committee on Civil and Political Rights was submitted in 2007, but the last report to the Committee on Social, Economic and Cultural Rights (CESCR) dates from 1979.

The health-related recommendations of the UN human rights treaty bodies regarding Tanzania have focused in the last two years on the following issues: Policy gaps in marriage and penal law; definition of a child; harmful practices, including female genital mutilation (FGM); violence against women; high maternal and child mortality; reproductive rights and health of adolescents, particularly girls; access to health information and services as well as to legal aid for vulnerable groups. The table on the following pages gives an overview of the main recommendations of the treaty bodies on the most recent State party reports submitted by Tanzania.

[2] Access to safe abortion is not a human rights enshrined in the core international human rights treaties. However, UN treaty bodies have often addressed this issue in their Concluding Observations, by recognizing that restrictive abortion laws may force women to seek illegal, and hence unsafe abortions which threaten their lives. See on this issue Zampas, Christina and Jaime M. Gher: Abortion as a Human Right – International and Regional Standards, in: *Human Rights Law Review,* 8:2, 2008.

Treaty	Date of last State party report	Recent health-related observations and recommendations of the UN human rights treaty bodies[3]
ICERD	2005	Considered by the Committee on the Elimination of all Forms of Racial Discrimination in 2007: • The Committee expresses its concern that FGM still is a persistent practice in some ethnic communities. The State party should reinforce the measures adopted to eradicate the practice, in particular through sensitization programmes directed at promoting changes in attitudes towards this practice, in consultation with traditional communities. • The State party should provide detailed information on the situation of nomadic and semi-nomadic ethnic groups and of any special measures taken with a view to ensuring the enjoyment of their rights. • The State party should take appropriate measures to eradicate all forms of ill-treatment towards refugees, in particular women.
CRC	2005	Considered by the Committee on the Rights of the Child in 2006: • The State party should set a clear definition of a child in line with the CRC. It should establish one legal minimum age for marriage, at an internationally acceptable level, for both boys and girls. • The Committee expresses concern at the fact that discrimination against certain groups of children still exists in legislation as well as in practice, particularly with regard to teenage pregnant girls, children with disabilities, children of asylum-seekers, children infected with and/or affected by HIV/AIDS, and street children. • The Committee expresses concern at the high infant and under-five mortality rates and the high percentage of children under 5 that are chronically malnourished or stunted. It recommends *inter alia* to allocate more financial resources to health services, in particular with a view to improving access to safe drinking water and sanitation facilities, to develop appropriate strategies to address the critical nutritional needs of children, particularly among the most vulnerable groups, through an intersectoral approach that recognizes the importance of feeding practices and to create and environment to reduce distances to health clinics for mothers and pregnant mothers. • The Committee recommends to fully inform adolescents of reproductive health rights, including the prevention of teenage pregnancies and sexually transmitted diseases and to provide support to pregnant teenagers and ensure the continuation of their education. The State party should review the 1992 Education Act to prohibit the expulsion of pregnant teenagers from schools. • Regarding FGM, the State party should introduce sensitization programmes for practitioners and the general public to encourage change in traditional attitudes, and to prohibit harmful practices, with the extended family and the traditional and religious leaders. • The State party should ensure that street children are provided with adequate nutrition and shelter, as well as with health care and should raise awareness in order to change negative public attitudes about them. • The State party should strengthen its legislative measures and develop an effective and comprehensive policy that addresses the sexual exploitation of children, and avoid criminalizing child victims of sexual exploitation.

[3] See the following website http://www.ohchr.org/EN/countries/AfricaRegion/Pages/TZIndex.aspx for the most recent concluding observations of the UN human rights treaty bodies on the State party reports submitted by the United Republic of Tanzania.

Treaty	Date of last State party report	Recent health-related observations and recommendations of the UN human rights treaty bodies
CEDAW	2007	Considered by the CEDAW-Committee in 2008: • The Committee is concerned that the Convention has still not been domesticated as part of the law of the United Republic of Tanzania. The Committee is concerned, in particular, about the delay in the passage of the proposed amendments to the Law of Marriage Act of 1971, inheritance laws, as well as the law on the Custodian of Children. • The Committee urges the State party to address harmful cultural and traditional customs and practices, such as the use of FGM, polygamy and the bride price, more vigorously. The State party should prohibit FGM in all instances, including in respect of women over 18 years of age. It also urges the Stat party to strengthen its awareness-raising and educational efforts, targeted at both women and mend, with the support of civil society, to eliminate the practice of FGM and its underlying cultural justifications. • The Committee notes with concern that marital rape is not recognized as a criminal offence. The Committee calls upon the State party to ensure that violence against women and girls, including domestic violence, marital rape, and all forms of sexual abuse, constitute a criminal offence; that perpetrators are prosecuted, punished and rehabilitated; and that women and girls who are victims of violence have access to immediate means of redress and protection. It recommends that legal aid be made available to all victims of violence, including through the establishment of legal aid clinics in rural or remote areas. • The Committee recommends that the State party implement measures to retain girls in school and strengthen the implementation of re-entry policies so that girls return to Tanzanian schools after giving birth. • The Committee recommends that the State party strengthen its efforts to reduce the incidence of maternal and infant mortality. It urges the State party inter alia to make every effort to raise awareness of and increase women's access to health-care facilities and medical assistance by trained personnel, especially in rural areas, to ensure that health workers adopt a client-friendly attitude and the adoption of measures to increase knowledge of and access to affordable contraceptive methods. It recommends that the State party continues to seek financial and technical support from the international community in order to implement measures to improve women's health. • The Committee recommends continued and sustained efforts to address the impact of HIV/AIDS on women and girls, as well as its social and family consequences. • The Committee recommends that the State party pay special attention to the precarious situation of older women and women with disabilities, to ensure that they have full access to health and social services and to decision-making processes. The Committee also urges the State party to challenge traditional views regarding older women, particularly accusations of witchcraft, and to protect albino women and girls from ritual killings. The Committee requests that further information, including disaggregated data, be provided in the next report about the situation of older women and women with disabilities.

2.3 National policy and legal framework

The recognition and guarantee for the enjoyment of human rights in Tanzania has been enabled by the bill of rights that was enshrined in the Tanzanian constitution in 1984. The Tanzanian Constitution guarantees the right to life, but it does not have an explicit article on the right to health. However, The State commitment for the wellbeing of the people has been expressed under Article 8 (b), stating that *"…the primary objective of the Government shall be the welfare of the people".*

According to the CESCR, State parties have the core obligation of adopting, implementing and periodically reviewing a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population and giving particular attention to vulnerable and marginalized groups.[4] The Tanzanian Government has complied with this obligation through the adoption and implementation of health sector strategic plans. The second health sector strategic plan covers the period 2003 – 2009, a third plan is now being finalized and will cover the period 2009 – 2015. We did not assess to what extent health sector strategic planning in Tanzania fully integrates human rights standards and principles, but this may perhaps be an issue for further consideration.[5]

Other main current policies and strategies addressing the right to health and other health-related rights in Tanzania include: The Tanzania Development Vision 2025 and Poverty Reduction Strategy Programme; the National Strategy for Growth and Reduction of Poverty – MKUKUTA; the Primary Health Service Development Program (MMAM); The National Policy on HIVAIDS (2001); the National Multi Sectorial Strategic Framework on HIVAIDS (2008-2012); the National Plan of Action to Combat FGM (2001 – 2015); the Insurance Scheme – Community Health Fund (2001); the National Disability Policy (2004).

Other legislation with an impact on the right to health and other health-related rights include the Law of Marriage Act (1971); the Penal Code, including the Sexual Offences Special Provisions Act (1998) and Section 150 on abortion ; The Education Act (1978), The Public Health Bill Act (2007) and the HIV and AIDS Prevention and Control Act (2008). Despite initiatives of the Law Reform Commission of Tanzania suggesting various reforms of the family law, these still need to be implemented, and major legal gaps regarding the human rights of Tanzanian women and children remain (see in table above the respective recommendations of the human rights treaty bodies). Access to sexual and reproductive health services, as well as support of pregnant adolescents, is hampered by restrictive regulations and practices in the education sector. The Penal Code allows medical abortion only in case the mother's live and health is threatened, and is therefore more restrictive than the respective provision in the Maputo Protocol. The recent HIV/AIDS prevention and control act is explicit regarding the prohibition of stigma and discrimination, but has been widely criticized for its lack of clarity on the right to privacy and confidentiality.

2.4 Human rights institutions and organisations

National human rights mechanisms include the monitoring of human rights by human rights institutions and civil society organisations. The most well-known Tanzanian organizations,

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[4] See General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights (CESCR) on the Right to the Highest Attainable Standard of Health, Art12 of the ICESCR, E/C.12/2000/4, 4 July 2000.

[5] See in this regard the tool " Human Rights and Gender Equality Dimensions in Health Sector Plans and Policies." This tool is currently being developed by the WHO Health and Human Rights Team in collaboration with the Swedisch International Development Agency and has been piloted in Uganda and Zambia. It will be available for common use by End 2008.

recording and reporting human rights violations are the Commission for Human Rights and Good Governance (CHRAGG) and the Legal and Human Rights Centre (LHRC).

The CHRAGG was established in 2001 by the Tanzanian government. Its mandate includes among other tasks to receive and conduct enquires into complaints on human rights violations, to provide advice to the Government on specific issues relating to human rights, to promote ratification of or accession to treaties of conventions on human rights as well as harmonization of national legislation with the treaties and to monitor and assess compliance by the government and other persons, with human rights standards provided for in these treaties. The Commission members (chairperson, vice-chairperson, five commissioners) are appointed by the Tanzanian President.[6]

The CHRAGG is based in Dar Es Salaam and has branches in Lindi, Mwanza and Zanzibar. Written information on the activities of the Commission is scarce and not very transparent.[7] According to the information we received by Commissioners, the CHRAGG has up to now focused on the monitoring of civil and political rights. Obviously, the Commission has less experience than other African National Human Rights Institutions, such as in Kenya or South-Africa, in monitoring the realization of social and economic rights, including the right to health. However, a manual of monitoring human rights, including social and economic rights, is now being developed in cooperation with non-governmental organisations. The Commission also intends to launch a special programme on the monitoring of the human rights of people living with HIV/AIDS.

Although UN human rights treaty bodies welcomed the establishment of the CHRAGG as an important step in the promotion of human rights, concern has been raised with regard to its independence, its insufficient human and financial resources, and its limited accessibility to individuals or groups victims of human rights violations.[8]

The LHRC was founded as a non-governmental organization in 1995. Its main objective is to create legal and human rights awareness and empowerment among the general public and, in particular, the underprivileged sections of the society through legal and civic education, advocacy, research, follow up of human rights abuses and provision of legal aid. It is governed by a Board of directors. In 2007 it had 48 full time staff, including administrative personnel. The LHRC is based in Dar Es Salaam and has a branch office in Arusha. Its programs cover 7 regions in Tanzania, Dar Es Salaam, Arusha, Manyara, Mara and Morogro, Mwanza and Shinyanga. The LHRC receives support from a variety of partners and donors, including Sweden, Norway, Finland and Canada.[9]

The LHRC conducts activities in the following fields:

- Human rights monitoring and advocacy: Event-based investigation and documentation of human rights violations through human rights monitors in different regions; the publication of an annual report on the protection and realization of human rights in the Tanzanian mainland and Zanzibar; Justice, Government and Parliamentary watch panels composed of influential members of civil society and technical experts to monitor key trends in the Governance of Tanzania and advocate for improvement.

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[6] See the Commission for Human Rights and Good Governance Act, 2001.

[7] There is an annual report in Swahili, which was not accessible during our visit. The website http://www.chragg.go.tz/ includes a few information on the mission of the CHRAGG but the page on current programmes is not functional.

[8] See the recent concluding observations of the UN human rights treaty bodies on the Tanzanian State party reports. See also Legal and Human Rights Centre: Tanzanian Human Rights Report 2007, Dar Es Salaam 2008.

[9] For information on the LHRC see its annual progress report 2007 and its website: www.humanrights.or.tz

- Training and awareness-raising on human rights: Awareness-raising at community level on legal and human rights issues; Training of paralegals at regional and community level on issues such as land rights law, law of marriage and inheritance, sexual offences, female genital mutilation, duties of local authorities; human rights training to law enforcers and court magistrates; radio and television programmes on different legal issues.
- Provision of legal aid services for the poor in two legal aid clinics in Dar Es Salaam and one in Arusha on a variety of legal issues, including family law, children´s rights, labour and land.

The LHRC has historically focused on the monitoring of civil and political rights, but it has included social and economic rights in its recent annual reports.[10] It is networking with a range of other civil society organisations, for example in advocacy to eradicate FGM and in debates on the recent HIV/AIDS Prevention and Control Act. It has apparently considered to develop a medical programme or watch panel, in view of the many complaints it has received by patients on the quality of health care. It is also an associated member of the National Institute to Medical Research.

There are other human rights and civil society organisations in Tanzania that are active in various fields such as advocacy, human rights monitoring and provision of legal aid services. These include for example the Tanzanian Women's Legal Aid Centre or Hakikazi Catalyst, a civil society organisation engaged in training and advocacy on social and economic rights.

3 Assessment of the human rights-based approach in the TGPSH

3.1 Overview of the TGPSH

The TGPSH supports the health sector process in Tanzania in achieving its goal *"to improve the health and well-being of all Tanzanians with a focus on those most at risk and to encourage the health system to be more responsive to the needs of the people."* The overall objective of the TGPSH in its present phase is "*to improve the health status of high-risk population groups and highly disadvantaged selected population groups."*

Both objectives, while they do not explicitly mention the **right** of all Tanzanians to a health system which enables them to enjoy the highest attainable level of health, address the key human rights principle of non-discrimination and equality. Responding to the specific needs of vulnerable or marginalized groups, and ensuring the right of access to health services on a non-discriminatory basis, is a core obligation of State parties to the ICESCR.[11]

In its present phase, the programme contains 6 components: District Support and Quality Management; Reproductive Health; Multisectoral AIDS Control; Health Financing; Public-Private Partnership (PPP); Human Resources for Health. In the next phase, it is foreseen to bring together those programme components that have similar goals, in order to foster synergies and an integrated approach.

The TGPSH started its activities as comprehensive programme in 2003. Several German organisations, contribute to the TGPSH: the German Agency for Technical Cooperation

[10] Legal and Human Rights Centre: Tanzanian Human Rights Report 2007, Dar Es Salaam 2008.

[11] See General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights (CESCR) on the Right to the Highest Attainable Standard of Health, Art12 of the ICESCR, E/C.12/2000/4, 4 July 2000

(GTZ), the German Development Bank (KfW), Capacity Building International, Germany (InWEnt) and the human resource placement organisation for German Development Cooperation (CIM). Overall management of the TGPSH is ensured by the GTZ programme manager and health sector coordinator. The programme supports activities at district, regional and national level. It covers 4 regions (Tanga, Mbeya, Mtwara and Lindi) out of 22 in the country. It supports and works with Government partners as well as with other stakeholders (faith-based health care providers; private business sector; NGO´s; community-based organisations).

3.2 Main programme components

3.2.1 Reproductive health and multisectoral AIDS control

Objectives
Reproductive health: The population, in particular adolescents, has access to sexual and reproductive health related information as well as to qualitative services;
Mulitsectoral AIDS control: In districts of the programme region, an increasing percentage of the population takes advantage of available preventive health care and uses the services of multi-sectoral HIV/AIDS control offered by public facilities and civil society organisations.

These objectives and components will be brought together in the next progamme phase.

A range of human rights enshrined in the core human rights treaties are relevant both to reproductive health and to HIV/AIDS. These include, among others, the right to life, the right to be free from discrimination, the right to privacy, the right to decide freely on the number and spacing of children, the right to health, the right to education and information, the right to be protected against violence and harmful practices.

While the objectives of the programme components do not explicitly mention all the above mentioned rights, they do address a key element of the right to health, i.e. accessibility of information and services. The provision of reproductive, maternal and child care is a core obligation of State parties to the ICESCR. According to the CESCR, the right to health also implies to adopt measures to abolish harmful traditional practices affecting the health of children and young people, such as early marriage or female genital mutilation, and to provide appropriate reproductive and sexual health services for adolescents, which respect confidentiality and privacy.[12]

Achievements

Access to information on their rights is a precondition for rights-holders to be able to claim them and to use reproductive health and HIV/AIDS services. Both components have integrated this perspective in their approach, and have developed numerous activities in this regard.

With a focus on young people, the reproductive health component has supported a community-based approach to increase the access of women, men and adolescents to information on reproductive rights and to advocate for a behaviour change at community level. The component uses different communication channels, including written information material,

[12] See General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights (CESCR) on the Right to the Highest Attainable Standard of Health, Art. 12 of the ICESCR, E/C.12/2000/4, 4 July 2000.

street theatre, traditional initiators, peer educators and community-based distributors (CBD). For example, nine booklets were developed with and for adolescents, including one on reproductive rights, that addresses issues such as forced marriage, sexual violence and unsafe abortion.

Likewise, the HIV/AIDS component addresses human rights issues through its multi-sectoral approach. Awareness-raising on stigma and discrimination, as well as on the right to privacy and confidentiality, are an integral part of the training activities to support the development of HIV/AIDS workplace programmes in private companies. The component has also managed to involve religious leaders in advocating for the human rights of vulnerable groups and people living with HIV/AIDS. A HIV/AIDS policy guide was developed by the National Muslim Council of Tanzania (BAKWATA) with the assistance of GTZ in a participative process. The policy guide explicitly recognizes the right to confidentiality and and commits itself to respect and promote the human rights of people living with HIV/AIDS and to work against stigmatisation. It is not as explicit with regard to the right to have access to reproductive health services, i.e. condoms, but nevertheless leaves quite some room for a flexible interpretation of Islamic norms on sexuality.

Challenges and options

The challenges identified and discussed during the assessment include:

- the need to address gaps in legislation and policy,
- the need to address the reproductive rights of persons with disabilities, and
- the need to better inform rights holders on where to seek advice and redress, in case their rights have been violated.

Gaps in policy and legislation, that have an impact on reproductive and sexual health and rights include: the definition of a child, marriage law, the restrictive abortion law, regulations in the Education sector regarding the provision of reproductive health services in schools, restrictions of the right to privacy and confidentiality by the HIV/AIDS prevention and control act (see chapter 2).

Not all these gaps can be directly addressed by the TGPSH, as it does not directly have the mandate to give legal and technical advice to all the concerned bodies (legal reform commission, Ministry of Justice). Other agencies are also probably better positioned to take the lead in advocacy for legal reform on specific issues (e.g. UNAIDS regarding the HIV/AIDS Prevention and Control Act and UNICEF regarding the definition of a child).

Nevertheless, the option to engage more actively in advocacy efforts at national level, was discussed. It was suggested to address the issue of abortion in donor/partner working groups, e.g. to lobby and advocate on the implementation of the Maputo Protocol. One entry point for broader advocacy activities in cooperation with other partners, including civil society and human rights organisations, is to focus on issues, such as maternal health, to which both the international community and the Tanzanian Government are committed. One could foster a debate on the links between the high maternal mortality of young women, the neglect of their human rights and the need to close respective policy and legal gaps. Involving the Ministry of Education in this process seems a difficult but necessary step.

Addressing the human rights of persons with disabilities is a challenge in many countries, including Tanzania. This issue has internationally recently gained impetus through the adoption of the Convention of the Rights of Persons with Disabilities (CRPD). The CRPD puts a strong focus on the rights of peoples with disabilities to an effective participation and inclusion in society. It also clearly recognizes the reproductive rights of persons with disabilities, including their right to have access to reproductive and sexual health information and services.

Addressing this issue in the next phase would require:

- to advocate through existing communication channels for the recognition and respect of the reproductive rights of persons with disabilities, particularly women and children and
- to support the development of alternative forms of communication, which are accessible and adapted to the needs of persons with disabilities (e.g. Braille language).

Being informed on one's rights is an important precondition to be able to claim them, but it is often not sufficient. In case one's rights are being violated, it is important to know where to seek legal advice and redress. There are now human rights and civil society organisations in Tanzania, which offer both awareness-raising on rights, and legal aid services (see chapter 2). We did not fully analyse the potential of these organisations. Nevertheless this option could be considered in the next programme phase by:

- Including brief information on organisations providing legal aid services in the booklet on reproductive rights for adolescents and
- Exploring the potential and developing ways of creating links between reproductive health services and organisations providing legal aid services at local level, particularly for poor women, in the project regions. This information could for example become part of the training given to CBDs. The recent HIV/AIDS prevention and control act also clearly states that no person should be expelled form any institution or denied employment opportunity on the grounds of HIV/AIDS status. Likewise, facilitating links to organisations providing legal aid to workers and employees in case these rights are violated, is a measure which could be envisaged for the next phase.

3.2.2 Decentralised and subsidiary (public and private) health services

Objectives
District health and quality management: The decentralized health services in Lindi, Mtwara, Mbeya and Tanga produce efficient, capacious and needed services. Public Private Partnership: The cooperation of private and public health services, with particular attention to faith-based service providers is institutionalized and supported by the national policy.

These objectives and components will be brought together in the next phase.

The first objective implicitly addresses key elements of the right to health, i.e. quality and acceptability of health services. Acceptability, as defined by the CESCR, can help to clarify, what is meant by "needed services": *"health services must be respectful of medical ethics and culturally appropriate (…), sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned."*[13]

Both objectives also implicitly address the human rights principles of participation (through decentralisation) and accountability (through institutionalization of cooperation between private and public health services).

[13] See General Comment No. 14 (2000) of the CESCR on the Right to the Highest Attainable Standard of Health, Art. 12 of the ICESCR, E/C.12/2000/4, 4 July 2000.

Achievements

Both components have supported the establishment of decentralised structures at district level, i.e. Council Health Service Boards (CHSB), which include both male and female representatives of the health administration, of public and private service providers and of the community. In the programme regions training was provided to the CHSB to enable them to establish comprehensive health plans. The Public-Private Partnership (PPP) component is also supporting the development of a service agreement between public and private service providers on a subsidiarity basis, which will clarify and institutionalize their respective roles.

The district health and quality management component has also invested much effort in enhancing the capacity of health service providers to provide quality services to the population. To this aim a range of quality management tools were applied in the programme region, quality circles were established and quality improvement plans developed at district hospital level. At central level support was given to the establishment of a National Strategy of Quality Improvement.

This overall strategy concurs with the human rights-based approach, as it is aimed both at increasing the transparency and accountability of duty-bearers as well as their capacity to provide quality services and at enabling rights-holders to participate in health-related decision processes at local level.

Challenges and options for the next phase

An overall challenge which can not directly be influenced by the programme components is the acute shortage of qualified human resources for health, particularly in rural and remote regions.

The other challenges and options identified and discussed include:

- the need to more systematically address a client's rights perspective in the quality improvement and management process,
- the need to strengthen meaningful participation of community representatives in local health structures and decision-making processes, and
- the need to integrate more consistently gender equality and reproductive rights, in health planning at district and community level and service agreements between public and private providers.

Client's rights to quality health care and medical ethics are closely related. The TGPSH has already started to address this issue by conducting an observational study on health care ethics in public hospitals of the Tanga region. The study results will be used to sensitize medical practitioners and other stakeholders on the importance of respecting ethical codes of conduct. It is planned to discuss the results in the quality circles of the respective hospitals, to have open discussions with the staff and to find solutions to improve the situation.

During our assessment, the idea was raised to broaden this approach step by step by involving the clients and facilitating a dialogue between health service providers and health users at district hospital level.

A Tanzanian Client Service Charter was developed in 2004, which very briefly mentions the right of clients to privacy and confidentiality and shortly describes complaint and appeal mechanisms. This Charter is apparently not well known, even in the Ministry of Health and Social Welfare (MoHSW).

The TGPSH could in the next phase engage in activities to facilitate the review and dissemination of this Charter.[14] Stakeholders besides the MoHSW, that may, after due consideration, be involved, include professional medical and nurses associations, civil society organisations, and human rights organisations.[15]

Despite the decentralisation of the health system, the involvement of the community representatives in the planning of health services at district and facility level, still seems to be often restricted to formal representation. Or to put in the words of one of our interview partners: *"The community representatives are often called upon only to formally approve the health plan, they do not really participate in the planning process."* It was suggested to intensify the training of community representatives in the CHSB and Health Committees at village level. This could probably be done in cooperation with DANIDA, which is supporting the development of a planning tool for primary health care facilities. Another option is to intensify cooperation with the Programme to Support to Local Governance (GTZ), which is supporting good governance at local level. In this regard, the mandates and links between various local committees related to health (e.g. ward health and development committees; health facility governing committees) could be analysed with the aim of enhancing the role community representatives play in local health development.

The second challenge is linked with the lack of access of Tanzanian women, particularly poor and rural women, to reproductive heath services and emergency obstetric care. Workshop participants mentioned that monitored deliveries by skilled personnel at facility level are in many regions not improving. The causes are manifold and include the lack of adequate and acceptable services, the lack of transport means, the lack of awareness in the community on pregnancy complications and maternal death risks, and restrictions on the ability of women to decide where and when to seek information and services.

Not all these problems can be solved at the community level. Nevertheless, the TGPSH may consider to intensify its support to local health structures in finding ways to address the rights and needs of vulnerable women and to overcome constraints at community level, which have a negative impact on their access to obstetric care. This would require a close cooperation with the reproductive health component, e.g. by fostering the links between its communication channels – particularly CBDs - and the health committees and councils at village and district level.

The PPP service agreement aims at avoiding duplication of public and private services, and at ensuring access to health services for the rural population. In this regard, a challenge is to ensure that the agreement includes the provision of comprehensive sexual and reproductive health services. Many faith-based facilities, particularly those run by the Roman-Catholic church, do not offer family planning services. With Norwegian support, the Christian Social Services Commission has started to sensitize church leaders on the general concept of a rights-based approach to community development, but the conflicting issue of reproductive and sexual rights has not yet directly been addressed. It will probably be quite difficult to do so in near future. In case faith-based facilities do not offer family planning services, one envisaged option is to deliver them through public outlets in the vicinity.

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[14] See United Republic of Tanzania, Ministry of Health: Client Service Charter, September 2004. Section 12.0 of the Charter foresees *"to make this Charter a living document that evolves in line with the changes that occur in society (…) and in particular the Health Sector. To facilitate the process of review we shall continuously consult with a cross-section of clients and stakeholders."*

[15] Despite differences in the health system, the TGPSH may consider to exchange experiences with the GTZ Health Programme in Cambodia, which has facilitated the formulation and implementation of a Charta on Clients´Rights and Providers' Rights-Duties as well as operational guidelines.

3.2.3 Health financing

Objective
Procedures of social security and health financing are used more successfully

The objective addresses both the right to social security, which is enshrined in art. 9 of the ICESCR, and a key element of the right to health, i.e. affordability of health services.

Both the right to social security and the right to health do not imply that the State has to provide free health services to the population. However, State parties are obliged to take effective measures to ensure that health services are affordable for all. According to the CESCR, *"payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."*[16]

According to the interpretation of UN treaty bodies, human rights standards do not prescribe any specific form of social security schemes. They do however require that the State party works towards the realisation of a social security system, whether composed of a single scheme or of a variety of schemes, which covers all persons, especially individuals belonging to the most disadvantaged and marginalized groups. The CESCR also recognizes that in many countries, non-contributory schemes will be necessary to ensure universal coverage.[17]

Achievements

The component has supported the development of pro-poor health financing models in Tanzania, primarily through its assistance to the Tanzanian Network of Community Health Funds. Support was given at district, regional and national level, with the aim of improving the insurance coverage of poor households, and reducing their vulnerability to "out-of-pocket payments" for health care.

The TGPSH has for assisted the Tanzanian Network of Community Health Funds in developing a system to manage community health funds (CHF) at district level. Training is given to the CHSB, in order to increase their capacity to involve the poorest households in the CHF by granting them exemptions, and financing these exemption mechanisms through alternative sources, e.g. private business companies, NGO´s or wealthy individuals. CHF based on agreements between companies and employees, e.g. between a Tee Grower Association and a Tea Company in Rungwe district, were also supported on a pilot basis.

Challenges and options for the next phase

The main challenges identified and discussed during the assessment include:

- the need to clarify the eligibility and exemption criteria for the CHF,
- the need to improve accountability and transparency in the use of CHF, and
- the need to integrate CHF in a national regulatory framework for health insurance.

According to the Community Health Fund Act of 2001 the CHSB can decide according to their own criteria who is poor and who is entitled to be enrolled in the CHF without paying a contribution. In some pilot districts, transparent criteria based on the lack of protective

[16] See General Comment No. 14 (2000) of the CESCR on the Right to the Highest Attainable Standard of Health, Art. 12 of the ICESCR, E/C.12/2000/4, 4 July 2000.
[17] See General Comment No. 19 of the CESCR on the right to social security, Art. 9 of the ICESCR, E/C.12/GC/19, 4 February 2008).

capability of households or individuals to withstand external shocks (e.g. widows, orphans) and on the standard of living (e.g. access to safe drinking water) were used for the identification of the poor community members entitled to exemptions. But in many districts, lack of knowledge on possible exemption criteria and/or misuse by local authorities still seams to exist. To address this challenge would require to intensify training to CHSB on how to set exemption criteria and to support the development and implementation of respective national guidelines.

The second challenge is linked both to the still weak financial management capacity of many CHSB and the lack of a regular audit system. As a consequence, CHF members are often not well informed on the use of the CHF funds. One envisaged option is to intensify capacity building activities by enabling to an extent possible through simple expenditure tracking measures the involvement of the CHF members in budget monitoring mechanisms.[18] Another option is to promote as far as possible group enrolment, as groups tied by common interests usually have more incentives and power to control the use of funds.

However, the main challenge in the next phase will be to integrate the CHF and other existing insurance forms (e.g. National Health Insurance Fund, private insurances) in a national health insurance (social security) system, in order to increase the still weak insurance coverage of poor population groups. Several alternatives are currently being discussed, from a single insurance provider structure to a national health fund, allowing for a regulated competition of several providers.[19]

As mentioned above, human rights standards do not prescribe any specific social security scheme. However, ensuring non-discrimination and equity between rich and poor households, requires to design a system which allows for cross-subsidization at a broader level than the district. At the moment CHSB have to ensure themselves the financing of exemptions to the CHF through alternative sources, which in some way disadvantages very poor districts that may not even have this possibility. Likewise the human rights principles of accountability and participation underline the importance of establishing a system with transparent standards and control procedures, involving various stakeholders, and including to the extent possible the contributories. From this perspective, a system allowing for a regulated competition of providers may be the best option, and could be actively promoted by the TGPSH in the next phase.

3.2.4 Human resources for health

Objective
In terms of quality and quantity the human resources for the relevant health facilities have been improved

This objective addresses a key element of the right to health, i.e. the availability of skilled medical personnel and health staff. According to the CESCR, State parties have to take effective measures to ensure that health staff are available in sufficient numbers throughout

[18] It was mentioned in the workshop that, unlike other countries, there are not so many civil society organisations in Tanzania active in the area of budget monitoring and public expenditure tracking, that could possibly serve as intermediaries to build up the capacity of community representatives in this regard. One organisation, hakikazi catalyst, based in Arusha, is engaged in this field, and has developed training activities and manuals on public expenditure tracking at community and district level. See http://www.hakikazi.org/

[19] See presentation of the results of a consultancy conducted on the Framework for the Future Development of Health Insurance to the MoHSW and the Health Financing Group, 28. August 2008.

the country, particularly in remote or deprived regions and that they are trained to respond to the specific needs of vulnerable or marginalized groups.[20]

Achievements

Besides providing policy advice to the MoHSW on the development of a human resource strategy, GTZ has promoted the participation of district medical officers in a public health master course, offered by the School of Public Health and Social Sciences at the Muhimbili University College of Health Science.

InWEnt has assisted the MoHSW in developing a modular training course on district health management. InWEnt has also contributed to capacity building by two long-distance e-learning courses on "health and human rights" and on "health financing". The first course is offered in collaboration with WHO and is aimed at a broad audience comprising both public health and human rights practitioners. Staff from the MoHSW, the TGPSH, the WHO Office in Tanzania, as well as from NGO´s have already participated in this course. The health financing course is aimed at mid-level employees working either for Government institutions, health insurances or NGO´s. In its first module this course also includes a brief lesson on the right to health and its implications for health financing. Both modules include a range of tools, such as chats, discussions and group work, that foster communication between participants of different institutional backgrounds.

Challenges and options for the next phase

The overall challenge, which has an impact on all the TGPSH components, is the ongoing crisis of human resources in the Tanzanian health sector. The TGPSH therefore needs to continue providing policy advice to the MoHSW and other relevant institutions to support the development of a human resource strategy for the health sector, which acknowledges both the right of health workers to fair working and living conditions as well as the right of health users, particularly vulnerable groups, to adequate health services.

Other challenges identified and discussed include:

- the need to (re)assess the human rights orientation of existing training courses, and
- the need for a more strategic choice of participants to the InWEnt/WHO e-learning course on health and human rights.

We did not conduct a comprehensive assessment of the existing training courses. Human rights aspects have most probably been implicitly addressed in some or most of the modules. Nevertheless, some aspects may not have been fully dealt with and an explicit reference to the human rights-based approach may for some modules be useful. As a first step, InWEnT, with the support of the GTZ junior legal advisor, could briefly assess the existing curriculum. If and where necessary, references to the human rights framework and/ or new training elements tailored to the needs of the target groups, i.e. the Council Health Management Teams, could than be developed.

The e-learning course on "health and human rights" offers the opportunity for participants to exchange their ideas and experiences on what a human rights-based approach to health planning and monitoring means in their country and their working environment. This exchange of experiences could in future be optimized by a more strategic choice of participants, i.e. by ensuring more consistently that all Tanzanian participants come from the mid-level management and from different institutional backgrounds. One option is to involve the junior legal advisor to the TGPSH, himself a former course participant, in this process, as well as in facilitating ongoing communication after the course between interested alumni.

[20] See General Comment No. 14 (2000) of the CESCR on the Right to the Highest Attainable Standard of Health, Art. 12 of the ICESCR, E/C.12/2000/4, 4 July 2000.

3.3 Further steps

The TGPSH has started to assess its results chains according to the result-based monitoring approach. Our assessment has shown that both the programme and component objectives are related to human rights. It has also identified options for a stronger human rights-orientation in the next phase, which if translated into activities and/or outputs, may contribute to the direct benefits and to a better use of outputs by partners (duty-bearers) and target groups (rights-holders).

The choice and prioritization of outputs by the TGPSH will depend on the system boundaries set by the programme. For example, the TGPSH may decide not to be directly involved in technical advice for law reform regarding sexual and reproductive rights. If this is the case, these important aspects should be mentioned as factors that have an impact, but are beyond the system boundaries. Changes in the legal and policy context should in any case be monitored, in order to understand the extent to which they have an impact on the programme (as framework conditions) and the extent to which they can plausibly be linked to the programme (attribution gap).

To monitor the human rights impact of a health programme, information on the situation of vulnerable and marginalized population groups is essential. Therefore, a human rights-based approach to monitoring and evaluation requires that indicators are, as far as possible, be disaggregated by prohibited grounds of discrimination. For example, the proportion of births attended by skilled health personnel, which is an MDG indicator, an indicator of the Tanzanian Health Information System and an indicator of the TGPSH (District Health and Quality Management component), should, according to recent guidelines developed by the Office of the High Commissioner for Human Rights in cooperation with other UN agencies, be disaggregated by region or areas, by the age of women (at least for women under the age of 18 years), and as applicable, by relevant demographic groups (e.g. ethnic groups, minorities, indigenous and migrants) and socio-economic status (income or consumption quintiles).[21]

We can not judge to which extent the collection and analysis of disaggregated data can be integrated in the Tanzanian Health Information System and to which extent alternative sources of information should be used. But the TGPSH may consider if and how it can in the next programme phase monitor the impact of its measures on vulnerable and marginalized groups in a more comprehensive manner. As it is planned to review and develop the Tanzanian health monitoring system in the near future, one option is to bring up this issue in the M&E Working Group. Another option is to build up or strengthen links to those human rights organisations and civil society organisations, that do monitor the realization of health-related rights in Tanzania (see chapter 2). However, a more comprehensive analysis of their potential in this regard still needs to be done.

Our assessment focused on the technical, programme-bound assistance provided through the TGPSH. A significant part of German aid to the Tanzanian health sector is not project-bound but channeled through the sector-wide approach. Some issues, which have come into consideration in the human rights and development context, may also be relevant to Tanzania.

[21] See UN, Report on Indicators for Promoting and Monitoring the Implementation of Human Rights, 6 June 2008, HRI/MC/2008/3. The report includes a list of illustrative indicators for the right to health and meta-sheets on specific indicators.

Integrating a human rights-based approach in budget aid and sector-wide approaches can be promoted by such measures as using human rights assessment tools in joint donor and partner review processes; enabling or strengthening the participation of civil society or human rights organisations in policymaking forums and health sector working groups; enhancing public access to information on national health policies and donor-partner co-ordination processes.[22] German Cooperation in the health sector, together with Tanzanian partners and other donors, may consider addressing this issue more in depth in the near future.[23]

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[22] See on accountability and aid effectiveness in the health sector the Report for the Human Rights Task Team of the OECD-DAC Network on Governance (GOVNET) by Claire Ferguson on "Linking Human Rights and Aid Effectiveness for Better Development Results: Practical Experience from the Health Sector", May 2008. See also the Report of the Special Rapporteur on the Right to the highest Attainable Standard of Health to the Human Rights Council, 5 March 2008, A/HRC/7/11/Add.2.

[23] One entry point could be, once it has been finalized, to check whether the analytic tool developed by WHO and SIDA on "Human Rights and Gender Equality Dimensions in Health Sector Plans and Policies" can be applied to one of the next joint health sector reviews.