HIV/AIDS IN TANZANIA: ETHICAL AND LEGAL DILEMMAS

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Abstract

In this study, we discuss two categories of ethical and legal questions that the National HIV/AIDS Policy has left unresolved. Whereas the first category includes those ethical and legal dilemmas which contain a resource allocation dimension, the second one, involves those which deal with conflicting claims and rights. Unresolved issues within the first group include the resource distribution difficulties between the competing demands of prevention amongst those who are not yet infected and the medical treatment and support for those already infected or impacted by HIV.

Related to the first category is the ethical appropriateness of the donor communities dictating policies and priorities for the funds they give. The ethical and legal dilemmas that emerge in the second group include the important problem of balancing individual and collective rights (most specifically between one's right to privacy and the public health imperative to control the spread of the disease). We argue that if these ethical and legal dilemmas are not resolved it would be very difficult to win a war against HIV/AIDS in Tanzania.

Introduction

HIV/AIDS has emerged as the most challenging health problem of our time due to limited available resources. In addition to the challenges posed by limited resources, the current scientific knowledge about HIV infection and AIDS is incomplete as many research findings are controversial and inconclusive. Moreover, lack of a vaccine and effective treatment as well as the difficulties in preventing the modes of transmission have accentuated the magnitude and severity of the epidemic. The epidemic has, on the one hand, created difficult socio-economic and medical issues, and ethical and legal questions on the other.

These ethical and legal dilemmas can be roughly grouped into two categories: those

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which contain a resource allocation dimension, and those which deal with conflicting claims and rights. Unresolved issues within the first group include the resource distribution difficulties between the competing demands of prevention amongst those who are not yet infected and the medical treatment and support for those already infected or impacted by HIV.

Yet, an additional complication within this category is about the role of donor agencies and governments. The complication is about to what extent is it ethically appropriate for the institutions to dictate policies and priorities for the funds which they provide when these institutions are called upon for financial support by recipient governments?[1] The ethical and legal dilemmas that emerge in the second group include the important problem of balancing individual and collective rights (most specifically between one's right to privacy and the public health imperative to control the spread of the disease).

The second difficult problem in this category deals with the process (i.e. to what extent are affected governments obliged to include representation of people living with HIV/AIDS (PLWHAs) and vulnerable populations, including orphans and widows in the formulation and implementation of policies that strongly affect their lives. This study disscuses Tanzania's HIV/AIDS policy aimed at showing some ethical and legal considerations that need to be addressed if the spread of HIV infection has to be controlled.

The Scope and Magnitude of HIV/AIDS: An Overview

The global spread of AIDS has reached an alarming stage. For example, in 1998 alone, 5.8 million people were infected with HIV worldwide. Of these, 5.2 million were adults, 590,000 were children below the age of 15 years and 2.1 million were women (UNAIDS, 1998). Moreover, the NACP report (1998) indicates that 33.4 million people were living with HIV/AIDS worldwide by December 1998. The report indicates further that in the same year, 2.5 million people died of AIDS worldwide, bringing the total number of AIDS deaths since the beginning of the epidemic to 13.9 million. Out of these, 4.7 million deaths were women and 3.2 million were children below the age of 15 years (URT, 1998).

According to the WHO figures, the situation is more severe in Africa as about 5,000 people are infected with HIV every day. 70 percent of the people infected with AIDS virus in 1998 and 10 percent of AIDS deaths occurred in Sub-Saharan Africa[2] . Since the start of the epidemic, the Sub-Saharan Africa with 10 percent of the world's population has accounted for 83 percent of all AIDS deaths that have occurred in the

[1] This complication stems from the fact that donor governments or agencies may sometimes interfere with and dictate issues that are not beneficial to recipient governments.

[2] These numbers seem suspect – how can Sub-Saharan Africa have 70% of cases but only 10% of death?

world (URT, 1998). If this trend remains unchecked, Africa's population will be reduced considerably in the years to come. HIV/AIDS in Africa is taking a center stage in the global political arena as Western governments become increasingly concerned that the epidemic could lead to the emergence of radicalism and the undermining of emerging democracies (Barton, 2000). For example, if left unchecked, the epidemic could result into low economic growth and increased poverty that may later cement despair and desires for radicalism which are potential for undermining emerging democracies.

In such situations, the epidemic may further obstruct labour demand and output and increase the burden to the most affected households. Thus, if alternatives are not sought, some affected relatives may resort into coping mechanisms in-conducive to emerging democracies such as radicalism, terrorism, etc. This recognition partly explains efforts by Western Countries to support the fight against HIV/AIDS.

Tanzania is the fifteenth worst affected country in the World[3] . Therefore, HIV/AIDS epidemic has become a serious issue in Tanzania. This is due to the fact that while in 1983 there were only 3 suspected AIDS cases, by 2004 the cumulative cases of AIDS, reached 176,102 (NACP, 2004). The National AIDS Control Program (NACP), however, estimates a total of 187,940 AIDS cases to have occurred in 2003 alone (98,290 females and 89,650 males). This figure is based on the assumption that only 1 out of 14 cases are reported (NACP, 2004)[4]. More glaring is the NACP estimates that about 1,810, 000 persons (840,000 males and 970,000 females) were infected by HIV as of December 2004.

The situation is more severe among the young people. NACP figures show that women (especially young women), are more prone to HIV infection than men. For example, according to NACP's data, HIV prevalence rates amongst male blood donors increased from 5.3 percent in 1992 to 8.2 percent in 2003 while that among females increased from 5.9 percent in 1992 to 11.9 percent in 2003. Generally, the NACP data show that HIV prevalence among blood donors is higher among females than in males of the same age group. For 1998 and 1999 the prevalence across age groups for males ranged between 5.2 percent for the age group 15-19 and 10.1 percent for the age group 30-34 while for females, it ranged from 7.0 to 14.9 percent for age groups 50-54 and 35-39 respectively. This is in concurrent with Flemming (1994), who argues that similar trends have also been observed in other Sub-Saharan countries.

According to NACP, data of AIDS cases in Tanzania are generally incomplete and

[3] The twenty-five worst affected countries in the world are (in order): Zimbabwe, Botswana, Namibia, Zambia, Swaziland, Malawi, Mozambique, South Africa, Kenya, Rwanda, CAR, Djibouti, Cote d' Ivoire, Uganda, Tanzania Ethiopia, Togo, Lesotho, Burundi, Congo, Burkina Faso, Cameroon, DRC, Gabon, Haiti, and Nigeria.

[4] NACP reasoning is that the numbers reported are based on hospital records and therefore they represent only the 'nose of the hippo'. Hospital records are generally known to be biased by under-diagnosis, underreporting, and delays in reporting. It is because of these problems that it is estimated that only 1 of every 5 AIDS cases is detected by the established disease surveillance system.

inconclusive as a result of under-reporting due to limited access of large segments of the population to health care facilities where the diagnosis of AIDS virus could be established.

The underestimation of AIDS cases in Tanzania is also due to low efficiency of surveillance systems, lack of facilities for the diagnosis, the reluctance of most Tanzanians to volunteer for HIV testing, and the delay by the government in acknowledging the severity of HIV infection until 1988. Despite the problems, these figures show an alarming situation, which calls for a united and coordinated effort to fight against the pandemic.

In this context, dealing with this epidemic required a comprehensive national HIV/AIDS policy that not only structures health priorities, addresses socio-economic and medical issues but also takes into account ethical and legal questions. This is important because, HIV/AIDS control requires more than just individual behavioral changes, it required a multifaceted strategy.

Efforts to Fight HIV/AIDS in Tanzania

Initially, in the West, HIV was observed most frequently among individuals exhibiting certain risk behaviors such as homosexual/bisexual men and intravenous drug abusers. It was later found, however, that the condition also exhibited itself among recipients of blood and blood products, infants of infected mothers and partners of heterosexual patients. Data from other parts of the world, including many parts of Africa, showed the infection to have been spreading in the general population, mainly through heterosexual contacts. In Tanzania, for example, 76.8 percent of transmission is through heterosexual means (NACP, 2004).

At the beginning, the response of the Tanzanian government to HIV/AIDS epidemic was more ad-hoc than systematic. It was not until 1988 that a coordinated effort started to emerge. In that year the government established a National Aids Control Program (NACP) under the Ministry of Health. The NACP was the first step by the government to institutionalize a nation-wide response to the HIV/AIDS epidemic in Tanzania.

The program has preventive as well as supportive components. Its major goal is to contain further the spread of the HIV/AIDS and other sexually transmitted diseases. It is also expected to address socio-economic effects of HIV/AIDS on individuals, families and the society at large. As a first step in the fight against the spread of the epidemic, NACP recommended a number of measures including: education to enable people to protect themselves and others against sexual transmission of the AIDS virus; hospital and home-based care for AIDS patients and their relatives; screening of blood donors; control of other sexually transmitted diseases (STDs), and condom use promotion (NACP, 1992).

It is important to note that early efforts to fight HIV/AIDS were initially carried out by the Ministry of Health. However, soon thereafter, other interested parties, particularly NGOs and community-based organizations joined the bandwagon. For instance, one of the best-known AIDS service organizations in Tanzania began in 1989 (Baylies, 2000).

As the government failed to take HIV/AIDS seriously, other actors took advantage of lack of proper guidance in the fight against HIV/AIDS. Consequently, problems related to coordination and duplication of activities occurred.

Following years of research, experience and debate, it became clear that not only some policies, laws, and practices of government, religious bodies and other organizations can promote or constrain the transmission of HIV, but also those efforts to fight the epidemic were uncoordinated and private. Additionally, many civil society organizations were hardly involved. As years passed, the government came to grips with the magnitude and scope of the HIV epidemic and the diversity of interested parties as well as the multifaceted effects of HIV/AIDS.

The government also realized that HIV epidemic is more than just a medical problem. It was this recognition that made the elucidation of a comprehensive policy strategy on HIV/AIDS control inevitable. It was not until the early 1990s that the government started showing some commitment to the fight against the epidemic and began to shoulder some funding responsibility. By the mid-1990s the government had recognized the scope and magnitude of the problem and started formulating the National HIV/AIDS Policy to coordinate different efforts as well as to harmonize supportive policies in a united effort to combat the spread of HIV/AIDS.

The Tanzanian National Policy on AIDS

Tanzania realized its first draft policy paper on HIV/AIDS in 1995. The final product, the national policy on HIV/AIDS, was released in November 2001 (URT 2001). The national policy paper recognizes the slowness of government's response to the HIV/AIDS epidemic. Initially the government adopted a "fire brigade approach" and waged a "trial and error" type of war against the epidemic. The policy then, set out a national framework for HIV/AIDS/STD prevention and control.

The main thrust of the policy was to widen, coordinate, harmonize and strengthen the national HIV/AIDS/STD programs. While the policy recognized other risky behaviors associated with this epidemic, it only identified three dominant modes of HIV/transmission in Tanzania. These include: heterosexual intercourse with an infected person (said to account for about 90 percent of infections); contact with infected blood, blood products or donated organs or bone grafts tissue; and from an infected woman to her child in the womb, possibly during birth or from breast feeding (URT 2001:7). Interestingly, the policy is silent about homosexuals, which has been identified as one

of the means of transmission in western countries. I consider this to be largely because of cultural biases that discourage politicians and other policymakers to admit to the reality of homosexuality in some African countries.

The major objective of the policy is to mobilize and sensitize people so that they can participate effectively in the struggle against the pandemic as well as energize them to cope with its multifaceted effects of this desease. The policy also calls for the establishment of national institutional framework that will mobilize and coordinate human and material resources for AIDS prevention and control. While the government established NACP in 1985, 14 years later it established the National Advisory Board on AIDS (NABA). In 2001 it established Tanzania Commission on AIDS (TACAIDS) whose major task is to "coordinate the implementation of national multi-sectoral response to the HIV/AIDS epidemic" (URT 2001:34).

The policy calls for individuals to change their behavior and take personal responsibility to stop the spread of HIV. It has recommended several strategies for HIV/AIDS/STDS prevention, treatment, care and counseling. Also, strategies for education, information gathering and dissemination, people's participation and research have been discussed. Yet, it calls for the adoption of law that complements and assists education and other public health measures for combating HIV/AIDS.

Policy issues, such as HIV testing and care for people with HIV/AIDS are also elaborated. Prevention of transmission through blood transfusion, invasive skin piercing, surgical and dental instruments and prenatal care are also discussed. The policy also covers the relationship between HIV/AIDS and work, employment, and gender. Moreover, it recognizes that the fight against HIV/AIDS requires a multi-sector strategy that involves individuals, organizations and groups from all sectors.

However, the breadth of issues covered in the policy document is not matched by depth in policy analysis or prescriptions. For example, although the policy enumerates the need to include close cooperation with PLWHAs ((URT 2001:5), nowhere is it mentioned how this might happen or what such collaboration might look like.

Also missing in the national HIV/AIDS policy is the consideration of ethical issues in the process of HIV/AIDS control as well as in the management of patients with HIV infection or AIDS. Much more, socio-cultural factors that mitigate against HIV control have not been given their due attention by the policy. It is therefore, difficult to conceive how the war against HIV/AIDS would be won if the above missing considerations are not seriously given their due attention.

National HIV/AIDS Policy: Ethical and Legal Considerations

The complexity of HIV infection and the global spread of HIV have raised a number of interesting questions concerning its control. practitioners as well as policy analysts have found themselves confronted with critical questions whose answers are not easy. Some

questions revolve around the concept of privacy: Can the principal of doctor-patient confidentiality be violated? If yes, when? How? And, to what extent? Should screening be mandatory? Others hinge on conflicts between public and individual rights: does the state have the right (and possibly the obligation) to intercede against cultural practices which are believed to facilitate the spread of AIDS? Should the state offer information to individuals that is viewed within their culture as immoral? Still other questions arise from the priority aspect due to limited resources in a poor country like Tanzania: how much money should be spent on treatment versus prevention? Do some risky populations have greater moral claim to resources than others? What level of priority should be given for financial support to the children and spouses whose breadwinners have died of AIDS? Some of these issues are dealt with in unclear ways in the policy document (such as the ambiguous statement that "PLWHAs may be required to meet some of the cost of the highly active anti-retroviral therapy" (URT 2001:5).

The national policy on HIV/AIDS in Tanzania also covers some of these questions albeit superficially. The policy provides for both voluntary and linked testing, and anonymous and unlinked testing of individuals. Individuals who go for voluntary and linked testing are provided with pre-and post-test counseling and are encouraged to inform their sexual partners of their test results; or to invite them for counseling prior to being informed of the test results. The general experience, however, seems to be that some individuals do not disclose their test results nor do they want their test results to be disclosed to their partners. This is probably because the disclosure of women's infection to her partner could lead to domestic violence and/or abandonment as well as mental displeasure and psychological uneasiness.

In societies where women are still highly dominated, the case, which is much prevalent in Africa, it would be easy for men to take advantage of the disclosure and blame his partner for infecting him. Notifying women regarding the positive status of her partner would be relatively easier than vice versa. Socio-cultural factors largely explain this variation. The African cultural system does not give room for equal expression and freedom to women. The disclosure by a women to her partner would then mean putting her at risk of being accused of bringing the disease to the family.

The provisions made for HIV testing and disclosure of HIV test results, which is central to prevention, emphasizes the protection of the infected over and above the protection of uninfected individuals from acquiring the infection. This is partly because in its early days, AIDS cases in Tanzania were attached to prostitution.

This claim does not take into account the experience of Thailand and Philippines. Some saw it as God's punishment for those who commit adultery. In this regard, there was a significant degree of intolerance of people with HIV/AIDS. These attitudes have not changed much. AIDS related discrimination is prevalent in Tanzania. Another explanation given for the need to protect the infected over and above the protection of uninfected individuals is more of a rhetorical reflection of donors' wishes rather than a

commitment on the part of government. This lack of genuine agreement between donors and the government of Tanzania can be seen to contribute to disjunctive between the National HIV/AIDS policy and the current Public Health Act and social ethics which emphasize protection of the public/group over the individual.

The legal arguments emphasize the protection of the infected and reiterate that a physician is duty bound under the law to protect the right of individual's privacy and confidentiality (Hayry 1998). However, controversies exist within the legislation put in place to protect the individual and the public from probable harm. While the law emphasizes individual right to privacy and confidentiality, the Public Health Act and social ethics emphasize public protection. The question perhaps is how far we can hold the primacy of the individual's rights over the public rights when individuals are not acting responsibly? This controversy between individual rights and public rights is not resolved by the policy.

The goals that emerge regarding the management of this epidemic itself and those that are associated with people who live with HIV are sometimes viewed as conflicting. However, both are influenced by human rights and the principle of individual's right to privacy that is expressed in doctor-patient confidentiality. This principle is of considerable value not only to the medical profession but also to every democratic society that respects human rights.

While we accept this as a general principle, nevertheless, we submit that when it come to a lethal disease such as HIV/AIDS the principle needs to be re-evaluated in accordance with the case at hand. Macklin (1996) argues that one way of addressing ethical issue in reproductive health is to look at the consequences of current laws, policies and practices and in case the existing situation produces a preponderance of good or bad consequences. If the benefits are less than the loss, there is an ethical obligation to attempt to change such laws, policies or practices. According to him, to resist ethically mandated change because of long-held beliefs or practices is a philosophical error. The error lies in concluding that because a state of affairs has existed in the past, it ought to continue into the present and future.

Let us use the following examples to illustrate the above argument. An HIV/AIDS patient, for example, purposefully, engages in unprotected sex with numerous partners without informing them, or a man /woman whose spouse has died by HIV/AIDS intends to get married to another person or engages in unprotected sex with several partners. In these cases, should the principle of protecting the infected person's individual rights be maintained? For those people who take this principle as an end in itself the answer will be "yes," but for those who take the principle as a means to higher ends, the answer will definitely be "no."

This is particularly because, for those who know that they are infected with HIV/AIDS and purposefully, engage in unprotected sex without informing their partners of their

HIV status commits not only an aggravated assault because the consent of their partner is obtained by false representation, but also violates the right to life of their partner because of the lethal nature of HIV/AIDS. This is a contradiction between right to life and individual privacy. The question is, can the principle of individual privacy be suspended when ones right to life is at stake? Which value is prior to the other? Commonsense would dictate that there is no privacy without life as such life is prior to privacy.

In deciding this question of competing rights, the context in which the original decisions to elevate the rights of the infected over the uninfected were made, must be considered as well. Because AIDS was first identified in the United States, and particularly within the gay community, the earliest prevention efforts tended to focus on, and come from, this community.

Two important characteristics help to define this community: the very heavy emphasis on privacy and the nature of relationships, which by definition tend to equalize power, at least within the gender perspective. When these early prevention strategies were applied to heterosexual western social relationships, it was still generally accurate to assume (with some significant exceptions) that both parties had at least some power in negotiating whether, when and under what conditions sexual intercourse would take place. From a legal and especially a cultural perspective, this critical assumption does not hold water in Tanzania. Ethically, Westerners and Africans operate from different value basis – western (the primacy of the individual) and African (the primacy of the community).

It is a reality that, for economic, religious, cultural and other reasons, women in Tanzania have much less power in negotiating their sexual rights. The national policy specifically notes that "women have the right and should be encouraged to say no to unsafe sex" (URT 2001:21). Yet the question remains whether this right can begin to be exercised if women are not allowed to know when they are being asked (or ordered) to expose themselves to infection.

Those who advocate the violation of a patient's right to privacy under special cases are faced with the following questions: how much should be disclosed? By who? And to whom (at least to his/her partners)? We suggest special ethics bodies be formed at various levels to assess the merit of each case under the principle of proportionality. The principle of proportionality states that the legality of the authoritative act is to be examined by the relation between its intended purpose and the cost of the means to achieve the goal (Hayry 1998). Rights may be violated under three conditions. First, if it is effective in achieving the intended purpose. Second, if the harm to the individual appropriately relates to the benefit attributed to the intended purpose. Third, if violation of individual rights is the very last measure available under the circumstances for achieving the intended purpose.

While the society has a legitimate vested interest in protecting the health of the uninfected persons and in controlling any further spread of HIV, the policies it formulates to realize these ends must also attend to the needs of affected persons who are the objects of these policies. These needs include the affected persons' health, autonomy and privacy, the stigma and discrimination they may face, and their own interests in their health (Herele and Glunt, 1988).

In Tanzania, like in many other African countries, HIV/AIDS has been stigmatized because it is transmitted through certain risky behavior, and because those who are infected are perceived as putting others at risk. Consequently, HIV/AIDS-related stigma has led to discriminatory practices towards HIV-infected individuals, including harassment, threats of job discrimination, and removal from school. For example, in the second week of February 2001, state owned television in Tanzania showed a student who was required to wear a red ribbon on her shirt as an indication to the teachers and other students that she has AIDS. Such discriminatory tendencies tend to deter individuals from being tested as well as from disclosing their HIV status.

Another issue is that the current policy and practice in Tanzania is that blood donors found to be HIV positive are not informed about their serostatus. According to Manyika (1995), at some hospitals blood is drawn from HIV positive donor and then discarded; at others, they are told that they have the wrong blood type or that their hemoglobin levels are too low for them to become donors. This policy is based on the fact that the current rapid tests frequently used in screening donors lack precision. Most hospitals lack the facilities and equipment for confirming test results. Furthermore, conveying test results require extensive counseling before and after testing. Again the capacity to offer these counseling services is lacking at most of the local hospitals. According to Ryder (1992), a strong argument can be made that the public health professional has a great a responsibility to inform an HIV positive person of his or her serostatus and its consequence, so as to prevent that person from spreading the disease. Secondly, health personnel are required to give HIV positive donors information that they know is incorrect leading blood donors to conclude that they are HIV negative.

Concealing the truth in this manner is a serious problem for health workers, who depend on a trusting relationship between themselves and the public. In fact, it is unethical. The policy also remains silent on this issue, apart from the ambiguous statement that "the approved screening centers shall offer pre- and post-test-counseling services to all blood donors" (National HIV/ AIDS policy 2001; 18). What constitutes an "approved screening center", how widespread these will be, and how this policy will be implemented and enforced remain completely unanswered, rendering the policy statement virtually meaningless.

Another problem is the lack of a policy/program for HIV patients to get treatment and assistance. In a country like Tanzania, where accessibility and availability of treatment and medication for AIDS is very limited and expensive, there is a need to develop a

public program for treating and assisting HIV patients. Some people are denied treatment for opportunistic diseases associated with AIDS because they don't have money. The lack of such a program has both practical and ethical considerations.

On a practical level, it represents a lack of understanding on the part of government of the close association between prevention and treatment. Currently, despite relative increase in voluntary testing cases within Tanzania generally by world standards the level remains very low, and the degree of stigma attached is still significant.

This situation is at least partly because there are few effective incentives for testing. For example, in the absence of effective, affordable and accessible treatment, what is the advantage, from an individual perspective, in knowing one's HIV status? On an ethical level, the lack of priority on treatment in the national AIDS policy reflects a problem of the process as well. Although the national policy attempts to balance the needs of both the infected and uninfected populations, it is probable that effective representation by PLWHAs has been lacking in policy formulation.

If it had been present, a stronger articulation of the need for treatment should have resulted. Similarly, there is no call for government provision of antiretroviral therapy for pregnant women to prevent mother to child transmission of HIV. The policy calls only for "information and education on alternative technological options including antiretroviral therapy" (URT, 2001: 21) as opposed to actual provision of such therapy. Again, had women living with HIV/AIDS been more heavily consulted in the process of policy formulation, this relatively inexpensive and effective intervention might have been formally incorporated into the national policy.

AIDS Control: Some Social-Cultural Factors

Some researchers, such as Caldwell (1987), have focused on socio-cultural factors to explain the AIDS epidemic. To them, African socio-cultural factors are responsible for the spread of HIV/AIDS. They claim that traditional African marriage systems, allow for weak conjugal bonds, polygamy, and few sanctions on premarital or extramarital sex and pregnancy. These act as catalysts for the spread of AIDS.

While this is true for some ethnic groups in Africa, many Tanzanian ethnic groups did not allow for pre-marital sex, at least until the early 1980s. This is attested by the way families reacted to pre and extra-marital pregnancy. There is enough historical evidence that shows that most societies used to (and some still do) encourage women to get married before they have had premarital sex. Nevertheless, one can correctly argue that an Africans sex life is no more liberal than those of other continents. The major problem is that an African sex life takes place in the context of severe poverty and gender inequality. In this regard, accessibility to sex education, health facilities and protection gears such as condoms, that would guarantee safer sex, is lower than in other continents. In Tanzania, for example, with a sexually active population of about fifteen million only 50,000,000 millions condoms are being imported per year.

However, it should be understood that this is not to argue that there are no social-cultural factors that promote HIV/AIDS in Africa, rather it is to argue that over generalization cannot help in controlling the spread of HIV/AIDS epidemic. Each society, for the purpose of AIDS control, needs to be analyzed in its own merit and context. For example, societies that practice a relatively more "liberal" sex life in Tanzania need to be studied separately and solution for the factors which facilitate the spread of HIV/AIDS need to be sought.

There are various social practices that if left unchecked in these societies, would significantly contribute to the spread HIV/AIDS. The Maasai people, for example, have a tradition of sharing wives/husbands of the same age-set within a clan. This was not a risky behavior for STDs as long as most Maasai lived together in their villages with virtually no sexual intercourse with strangers. Since the mid-1990s, many Maasai youth moved to town where they work as security persons.

This was necessitated by drought and cattle diseases, which killed many cattle in Maasai land in the 1980s and 1990s. This youth enjoy town life and in the process they intermingle with people of different types including those with HIV AIDS infection. If these youth get infected there is a danger that they can infect a lot of their age mates and friends when they visit them for holidays. This practice, if left unchecked, it could have disastrous effect on the Maasai population in years to come.

Conclusion

Rationally, the national AIDS policy should consider the rights and interests of both infected and uninfected. It should strive to strike a balance between one's right to privacy and the public health imperative to control the spread of the disease. It is then reasonable to assume that the principle of proportionality which allows each case to assessed in its own merit is of great use in determining the violation of individual right to privacy or not, how much information should be given and to whom? The control HIV/AIDS requires united efforts on the part of the infected and uninfected.

Both must live responsible lives. Each party, regardless of their infection status should be responsible for the life of others. The National Policy is not comprehensive enough, though, it covers a variety of issues from gender issues to prevention of prenatal transmission, employment, and HIV infection and empowerment. In our view, it is inadequate to significantly reduce AIDS/HIV infection rates because the policy shies away from tackling key ethical and legal questions as well as facing socio-cultural factors.

[5] Interview with TACAIDS'chairman July 2003.

Furthermore, the lack of attention to treatment, an issue that is most central to the lives of those who are already HIV positive – seems to be reflective of a policy process that has excluded PLHAS from having impact on a policy that may literally determine whether they will live or die.

Finally, to the extent that the policy has at least rhetorically begun to address some of the critical problems posed by HIV/AIDS, there remains a great deal of implementation to be done by Tanzanians and the government. The national policy, like all such documents, must be seen as a starting point, both for implementation and improvement. Thus, the biggest challenge for legislators is to adopt policies that can effectively limit the spread of HIV without undermining the rights and needs of an infected individual.

Such a difficult balance can only be achieved in consultation with professional ethicists and representatives of communities that will be most heavily impacted by these policies.

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