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Enforcing the Right to Health Through Courts in Tanzania: Challenges and Prospects

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Abstract

The right to health is recognized as a fundamental human right within international, regional, and domestic legal frameworks. This article explores its judicial enforcement in Tanzania using a doctrinal legal methodology that analyses statutory provisions and case law. It challenges the view that socio-economic rights are non-justiciable, affirming that the right to health is a universally applicable entitlement that can be subject to immediate enforcement. The article identifies factors for effective enforcement, including political legitimacy, judicial capacity, and legal expertise. Major challenges include the lack of express constitutional protection of the right to health, resource constraints, and partial alignment with international legal obligations. Nevertheless, the study underscores underlying prospects such as the progressive interpretation of the right to health through the constitutional guarantee of the right to life under Article 14, and the adoption of legal, policy, and institutional reforms, which promote better health outcomes in Tanzania.

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1. INTRODUCTION

The right to health forms a foundation of socio-economic rights which are essential entitlements aimed at ensuring individuals can lead lives marked by dignity and well-being. These rights encompass fundamental necessities such as healthcare, education, housing, food, and water, and are recognized within a variety of international, regional, and national legal frameworks.[1] As a critical component of these rights, the enforceability of the right to health through judicial means has been a subject of ongoing legal and academic debate. This article adopts a doctrinal legal research methodology to examine the enforcement of the right to health through judicial mechanisms in Tanzania, drawing from international instruments, national legislation, and relevant case law. It integrates scholarly literature and legal analyses to evaluate the legal foundations, enforcement gaps, and judicial interpretations of socio-economic rights while identifying areas for reform. It starts by examining legal and institutional measures that support the judicial enforcement of the right to health in Tanzania, grounded in international legal instruments such as the Constitution of the World Health Organization (WHO) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), as well as relevant regional frameworks.[2] It further explores the historical divide between the perceived enforceability of civil and political rights and the more contested status of socio-economic rights, especially those pertaining to healthcare provision.[3] The article asserts that where constitutions explicitly incorporate the right to health as a justiciable guarantee, courts are more likely to uphold and enforce such claims effectively.[4]

Judicial enforcement of the right to health involves empowering individuals or groups to initiate legal proceedings against the state for purported infringements of health-related rights, with the aim of obtaining redress through national or international judicial bodies. This includes not only litigation in national courts but also the potential invocation of supranational [5]human rights bodies where states have accepted relevant jurisdiction. To be justiciable, rights must bestow legal standing upon claimants and impose correlative duties on state actors.[6] However, socio-economic rights have historically been marginalized in judicial discourse due to arguments questioning their legal precision, universal applicability, and the immediacy of their fulfilment.[7] The dual categorisation of rights under the ICCPR and ICESCR has strengthened this dichotomy, although both sets of rights are interdependent and equally essential to human dignity.[8] Despite their formal recognition, socio-

[1] International Covenant on Economic, Social and Cultural Rights (ICESCR) 993 UNTS 3 (adopted 16 December 1966, entered into force 3 January 1976) art 12.

[2] Gerhard Erasmus, 'Socio-Economic Rights and Their Implementation: The Impact of Domestic and International Instruments' (2004) 32 *International Journal of Legal Information* 243, 252.

[3] Menesuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law* (Hart Publishing 2009) 343.

[4] Ibid.

[5] International Commission of Jurists (ICJ), *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (Human Rights and Rule of Law Series No. 2, 2008) 6 http://www.refworld.org/docid/4a7840562.html accessed 14 September 2021.

[6] Zahara Nampewo, Mike and Wolff, 'Respecting, Protecting and Fulfilling the Human Right to Health' (2022) 21(1) *International Journal for Equity in Health* 36.

[7] Ssenyonjo (note 3) 343.

[8] ICESCR (note 1) arts 2, 12; International Covenant on Civil and Political Rights (ICCPR) 999 UNTS 171 (adopted 16 December 1966, entered into force 23 March 1976) art 6.

economic rights, including the right to health, remain inadequately implemented in many jurisdictions, particularly in sub-Saharan Africa, due in part to structural, financial, and prescriptive limitations.[9]

Opposition to the judicial enforcement of socio-economic rights frequently hinges on three interrelated critiques: that such rights lack definitional clarity, that they are resource-dependent and thus cannot be realised immediately, and that they do not rise to the level of fundamental legal entitlements.[10] Some scholars and jurists have raised concerns about the appropriateness of judicial intervention in socio-economic matters, arguing that courts lack the technical capacity and democratic legitimacy to dictate state spending priorities or healthcare policies.[11] This perspective reflects a traditional reluctance to subject executive and legislative choices regarding resource allocation to judicial scrutiny. Nevertheless, emerging jurisprudence and scholarship increasingly affirm the position that socio-economic rights possess sufficient normative clarity and legal force to warrant judicial protection, particularly when essential elements of life and dignity are at stake.[12]

This article maintains that socio-economic rights, such as the right to health, constitute enforceable legal obligations rather than mere aspirational ideals, grounded in the intrinsic dignity of every individual. As such, their realisation constitutes a legal obligation of the state rather than a matter of policy discretion or benevolence.[13] Drawing insights from international treaties, regional instruments, domestic statutes, judicial decisions, and scholarly commentary, the article analyses legal texts and principles with the aim of assessing the extent to which Tanzanian law aligns with international standards on the right to health.[14] In addition to analysing statutory provisions and case law, the article also considers relevant policy documents and strategic frameworks that reflect the government's commitment to health rights. By mapping legal obligations against practical implementation, the article identifies both directive strengths and enforcement gaps within the current legal regime.

While the Constitution of the United Republic of Tanzania does not explicitly enshrine the right to health as an independent right, it provides implicit endorsement through Article 11(1), which obligates the state to guarantee access to adequate social welfare services, particularly during periods of illness. This article implies that judicial interpretations of the constitutional provisions enshrined in the Bill of Rights, such as the right to life, should encompass the right to health within the broader framework of constitutional values. Furthermore, a variety of legislative and administrative initiatives have facilitated the operationalization of health services, thereby contributing to the progressive realization of this right. Nevertheless, the efficacy of these mechanisms is dependent upon the appropriate allocation of resources, institutional capabilities, and the judiciary's readiness to interpret socio-economic rights expansively in accordance with Tanzania's international legal commitments.

2. CONCEPT OF THE RIGHT TO HEALTH

The right to health is a foundational human right that embodies the idea that every

[9] ICJ (note 5) 6.
[10] Kirsty McLean, *Constitutional Deference, Courts and Socio-Economic Rights in South Africa* (Pretoria University Law Press 2009) 94.
[11] Ibid.
[12] Ssenyonjo (note 3) 343.
[13] Nampewo et al. (note 6) 36.
[14] ICJ (note 5) 6.

individual should be able to live in conditions conducive to physical, mental, and social well-being. As articulated in the Constitution of the World Health Organization (WHO), health is not simply the absence of disease but a state of complete well-being, an understanding that places health within the broader context of human dignity and development.[15] This right extends beyond access to medical care to include underlying determinants such as adequate food, housing, clean water, sanitation, education, and a healthy environment.[16] This holistic conception makes health 'an inclusive right extending to timely and appropriate healthcare and to the underlying determinants of health.'[17] Thus, the right to health is both aspirational and actionable, it obliges states to create enabling environments and equitable systems that make the highest attainable standard of health achievable for all people.

The right to health also contains two interdependent elements: freedoms and entitlements.[18] The freedoms include the right to make autonomous decisions about one's body and health, such as reproductive choice and freedom from non-consensual treatment, while the entitlements guarantee access to functioning health systems and facilities that are available, accessible, acceptable, and of good quality.[19] These elements are grounded in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),[20] and strengthened in the Convention on the Rights of the Child (CRC)[21] and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[22] Regional instruments, such as the African Charter on Human and Peoples' Rights and the SADC Charter of Fundamental Social Rights, similarly affirm health as a social and collective good essential for human flourishing.[23] The realization of the right to health requires that states move beyond rhetoric to implement legal and policy measures ensuring equitable health outcomes and accountability in health governance.[24] In this sense, the right to health is not a guarantee of being healthy, but a right to fair opportunities and supportive conditions to attain health on an equal basis.

3. ROLE OF INTERNATIONAL LEGAL NORMS IN JUDICIAL ENFORCEMENT OF THE RIGHT TO HEALTH IN TANZANIA

The right to health, universally acknowledged as a fundamental socio-economic right, is firmly entrenched in international human rights law and has increasingly influenced domestic legal systems, including through judicial enforcement at the national level. Its

[15] Constitution of the World Health Organization (adopted 22 July 1946, entered into force 7 April 1948) 14 UNTS 185, preamble.
[16] Ibid.
[17] Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (UN Doc E/CN.4/2003/58, 2003) para 12.
[18] UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)' (2000) UN Doc E/C.12/2000/4, para 8.
[19] Ibid.
[20] International Covenant on Economic, Social and Cultural Rights (note 1) article 12.
[21] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 24.
[22] Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13, art 12.
[23] African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217, art 16; Southern African Development Community, *Charter of Fundamental Social Rights in SADC* (2003), art 10.
[24] Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011) 7–10.

foundational source is the Constitution of the WHO, which declares the enjoyment of the highest attainable standard of health as a right of every human being, irrespective of race, religion, political belief, or socio-economic condition.[25] This standard – based foundation is reflected and elaborated upon in a variety of legally binding treaties and soft law instruments. Foremost among these is Article 12 of the ICESCR, which imposes a binding obligation on State parties to recognise and realise the right of everyone to the highest attainable standard of physical and mental health. Additionally, the UDHR, though not binding, affirms in Article 25 the right to a standard of living adequate for health and well-being, thereby reinforcing the status of health as a human right.[26] Several other treaties further concretise this norm: the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) under Article 5(e)(iv), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) under Article 12, and the Convention on the Rights of the Child (CRC) under Article 24 collectively underscore the centrality of health as a legally protected entitlement for all population groups.[27]

Regionally, the African human rights system has significantly contributed to shaping and contextualising the international legal framework on health rights. Article 16 of the African Charter on Human and Peoples' Rights (ACHPR) guarantees the right of every individual to the highest attainable state of physical and mental health, while Article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC) mandates State parties to ensure the realisation of children's health rights.[28] Further, Article 3(h) of the Constitutive Act of the African Union enshrines the promotion and protection of human rights, including health, as one of the AU's core objectives.[29] For countries such as Tanzania, which are parties to these instruments, this body of international and regional law forms a coherent legal architecture that must inform domestic legal and policy frameworks. Importantly, these international provisions not only establish binding standards but also serve as interpretative tools for national courts adjudicating claims concerning the right to health.

A more detailed understanding of the content of the right to health under Article 12 of the ICESCR has been developed by the UN Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment No. 14.[30] This authoritative interpretation expands the right to encompass underlying determinants of health, including access to safe water, adequate food and nutrition, housing, sanitation, environmental conditions, and healthcare services.[31] It articulates four essential, interrelated elements, availability, accessibility, acceptability, and quality (the AAAQ framework), which guide the interpretation and assessment of state compliance with the right.[32] These analytical tools, though not explicitly stated in Article 12 itself, have become indispensable for courts in determining whether a given health policy or

[25] Constitution of the World Health Organization (note 15).
[26] Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III), art 25.
[27] CERD (adopted 21 December 1965, entered into force 4 January 1969) 660 UNTS 195, art 5(e)(iv); CEDAW (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13, art 12; CRC (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 24.
[28] ACHPR (note 23).
[29] Constitutive Act of the African Union (adopted 11 July 2000, entered into force 26 May 2001) art 3(h).
[30] CESCR (note 18) para 4.
[31] Ibid para 12.
[32] Ibid paras 12(a)–(d); John Tobin, *The Right to Health in International Law* (OUP 2012) 158.

legal regime is consistent with state obligations.[33] In Tanzania, courts may invoke this framework to assess whether state actions or omissions in healthcare provision violate either domestic constitutional guarantees or international standards.

The element of availability obliges states to ensure sufficient functioning healthcare services and institutions, including adequately trained personnel and essential facilities.[34] This obligation encompasses both curative and preventive care, as well as underlying health determinants such as clean water and sanitation.[35] A deficiency in these areas may amount to a violation of the right to health and could be challenged through judicial means. Similarly, accessibility, which includes non-discriminatory access, physical proximity, affordability, and access to information, is significant to realising health rights.[36] This includes ensuring that marginalised groups such as women, children, persons with disabilities, and low-income populations have equal and meaningful access to healthcare services.[37]

The legal obligations under ICESCR and related instruments like CEDAW, CERD, and the CRC require states to ensure that healthcare services are not only available but also physically and economically accessible to all, including those in vulnerable circumstances.[38] This imposes duties on the state to collaborate with non-state actors, particularly in contexts where private entities are major healthcare providers, to ensure comprehensive service coverage.[39] Acceptability, as another core dimension, demands that healthcare be culturally appropriate, ethically sound, and respectful of medical standards.[40] This includes ensuring the availability of approved medicines and adherence to professional protocols in both public and private health institutions.[41] The CESCR has stressed that regulatory oversight is essential to uphold standards of professional care, and states are required to adopt and enforce such mechanisms.[42]

Accessibility, in its broader sense, is multifaceted. It involves not only the elimination of discriminatory practices but also guarantees access to health-related information and respect for patient confidentiality.[43] Article 2(2) of the ICESCR prohibits discrimination on various grounds, including race, sex, religion, disability, health status, and more.[44] The Committee has interpreted this provision expansively to include emerging grounds of vulnerability such as HIV/AIDS status and sexual orientation.[45] Consequently, any denial or restriction of healthcare on these grounds constitutes a breach of state obligations.[46] Moreover, the inability to pay must not bar access to healthcare services.[47] States are expected to implement equitable health financing mechanisms that shield the poor from exclusion, especially by prioritising primary and preventive care.[48] The obligation to adopt appropriate, cost-effective measures becomes particularly important during times of fiscal constraint.[49] Both public and private providers are bound by these obligations, and

[33] Ibid para 19.
[34] Ibid para 12(a).
[35] Ibid.
[36] Ibid para 12 (b).
[37] Ibid; Tobin (note 32) 161.
[38] CESCR (note 18) paras 12(b), 26.
[39] Ibid.
[40] Ibid para 12(c).
[41] Ibid.
[42] Tobin (note 32) 168.
[43] CESCR (note 18) para 12(b)(iv).
[44] ICESCR (note 1) art 2(2).
[45] CESCR (note 18) para 35.
[46] Ibid.
[47] Ibid para 19.
[48] Ibid.
[49] Ibid.

the privatisation of healthcare must not dilute the AAAQ standards.[50]

International human rights law recognises that differential treatment may be permissible, provided it pursues a legitimate objective and meets the criteria of necessity, reasonableness, and proportionality.[51] The onus is on the state to justify that such distinctions do not amount to indirect or disguised discrimination.[52] Concerning physical accessibility, the state must decentralise healthcare infrastructure and eliminate obstacles that hinder access for persons with disabilities and populations in remote or underserved areas.[53] In addressing economic accessibility, legislative measures such as the National Health Insurance Act and the Community Health Fund Act illustrate Tanzania's efforts to progressively fulfil its obligations under the ICESCR.[54] These statutes provide institutional mechanisms designed to improve the affordability of healthcare services, thereby advancing the realisation of the right to health.

The right to access health-related information is also fundamental, as reflected in Article 19(2) of the International Covenant on Civil and Political Rights (ICCPR), which guarantees the right to seek and receive information.[55] However, this right must be balanced with protections for privacy, informed consent, and data confidentiality, particularly in sensitive health matters.[56] Thus, legal frameworks must ensure that information dissemination does not violate individual privacy rights or allow misuse of personal health data.

Regionally, the ACHPR has affirmed that the state's obligation under Article 16 encompasses the provision of non-discriminatory access to healthcare goods and services.[57] States are required to avoid actions that undermine public health, such as pollution or unjust restrictions on essential medicines.[58] Under Article 2 of the ICESCR, states are subject to both obligations of conduct (e.g., legal and policy reforms) and obligations of result (i.e., measurable improvements in health outcomes).[59] These obligations are bolstered by the tripartite duties to respect, protect, and fulfil health rights.[60] This means that states must avoid interference, i.e., respect, prevent violations by third parties, i.e., protect, and adopt effective policies and institutions, i.e., fulfil.[61]

Despite these vigorous prescriptive frameworks, the right to health is often perceived as aspirational or subordinate to civil and political rights.[62] Nevertheless, the enforceability of the right to health hinges on the development of accessible, equitable, and effective health systems. International law permits progressive realisation but simultaneously imposes immediate obligations, particularly with respect to non-discrimination and minimum core obligations.[63] Where progress is insufficient, states must provide reasoned and evidence-based justifications that are subject to review by judicial or quasi-judicial bodies.[64] In this regard, constitutional entrenchment and

[50] Ibid.
[51] United Nations Economic and Social Council, 'Siracusa Principles' UN Doc E/CN.4/1985/4 Annex (1985) paras 10–11.
[52] Ibid.
[53] CESCR (note 18) para 12(b).
[54] *Community Health Fund Act*; *National Health Insurance Act*.
[55] ICCPR (note 8), art 19(2).
[56] CESCR (note 18) para 12(b)(iv).
[57] ACHPR (note 23) art 16.
[58] Ibid.
[59] ICESCR (note 1) art 2; CESCR (note 18) para 33.
[60] Ibid para 30.
[61] Ibid para 31.
[62] Ibid para 32.
[63] Ibid.
[64] Ibid

judicial enforcement of the right to health in domestic legal systems serve as indispensable tools for ensuring compliance with international human rights norms.

4. JUDICIAL AND PRACTICAL DIMENSIONS OF ENFORCING THE RIGHT TO HEALTH

The debate surrounding the classification of the right to health as a legitimate human right emerged during the formative stages of the International Bill of Rights, culminating in the bifurcation of the ICCPR and the ICESCR.[65] Exponents of human rights grounded in negative liberty advocate for the protection of individuals from state interference, asserting that the essence of human rights lies in preserving personal autonomy. This perspective is rooted in natural law theory, which views rights as inherent and pre-political, hence the term 'natural rights,' and promotes the principle of individualism. Under this framework, the state is obliged to refrain from intruding upon individual liberties, thereby giving prominence to civil and political rights, commonly referred to as 'first-generation' rights, with historical foundations traceable to the seventeenth and eighteenth centuries.[66]

Conversely, 'second-generation' rights, including socio-economic rights such as the right to health, are historically aligned with socialist ideologies that gained momentum in the late nineteenth and early twentieth centuries. These rights are predicated upon the principles of equity and social justice, aiming to ensure equitable access to vital socio-economic resources, services, and opportunities.[67] However, the dichotomy between civil-political rights and socio-economic rights has fostered a viewpoint in which the latter, especially those requiring positive state obligations, are deemed peripheral to the corpus of fundamental human rights and thus considered non-justiciable.[68]

This article contends that such distinctions, heavily influenced by outdated liberal theories of individualism and natural rights, no longer reflect the contemporary understanding of human rights. The UDHR, a product of global consensus, integrates both sets of rights and underscores their interdependence and indivisibility.[69] Hence, the notion that socio-economic rights, including the right to health, fall outside the scope of enforceable rights lacks merit in light of modern human rights discourse and the growing recognition of the UDHR as a source of customary international law.[70]

4.1. Structural and Doctrinal Barriers to Judicial Enforcement of the Right to Health

Despite the right to health being firmly recognised under international and regional human rights instruments, its judicial enforcement within Tanzania remains complex and contested. This complexity arises from both structural limitations within the Tanzanian legal system and doctrinal ambiguities surrounding socio-economic rights. Critics argue that the right to health, unlike civil and political rights, is heavily dependent on legislative, policy, and budgetary measures enacted by the executive. Consequently, questions arise as to whether

[65] McLean (note 10) 91.
[66] Ibid.
[67] Christopher Mbazira, 'Enforcing the Economic, Social and Cultural Rights in the South African Constitution as Justiciable Individual Rights: The Role of Judicial Remedies' (PhD Thesis, University of the Western Cape 2007) 47.
[68] Ibid.
[69] MCR Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development* (Clarendon Press 1995) 8.
[70] McLean (note 10) 92.

courts possess the institutional mandate and capacity to adjudicate claims that implicate resource allocation and competing policy priorities.[71]

In Tanzania, these concerns are magnified by the constitutional framework. The Constitution of the United Republic of Tanzania (1977, as amended) recognises civil and political rights in the Bill of Rights, yet socio-economic rights, including the right to health, are not explicitly guaranteed. Article 11(1) places a general obligation on the state to promote social welfare, including during illness, but forms part of the Fundamental Objectives and Directive Principles of State Policy (FODPSP), which are non-justiciable under Article 7(2). Consequently, courts are often restricted from providing direct remedies for violations of the right to health. Despite these limitations, Tanzanian courts have occasionally inferred socio-economic rights from civil rights provisions. For example, in *Joseph D. Kessy and Others v. The City Council of Dar es Salaam* (High Court of Tanzania, 2003), the court linked environmental pollution to a violation of the right to life under Article 14, effectively recognising a derivative right to health.

This relationship between doctrinal limitations and structural barriers highlights the cautious approach adopted by Tanzanian courts, reflecting both an adherence to constitutional constraints and an awareness of the broader social and economic realities that shape the enjoyment of socio-economic rights. The subsequent sections examine these barriers in detail, offering a comprehensive analysis of doctrinal, structural, and practical factors that influence the judicial enforcement of the right to health in Tanzania.

[71] Ibid.

4.1.1. Universality, Fundamentality, and Realisability of the Right to Health

A principal challenge to judicial enforcement of the right to health is the perception that socio-economic rights are not universal or fundamental, and cannot be immediately realised. Critics contend that enjoyment of these rights depends on the availability of state resources and may benefit only specific groups, raising concerns about selectivity and unequal application.[72] In addition, socio-economic rights are frequently perceived as lacking the fundamental character attributed to civil and political rights due to their purported vagueness and indeterminate scope.[73] These critiques highlight the tension between the aspirational nature of socio-economic rights and the structural and fiscal limitations of states, raising questions about the extent to which courts can enforce them effectively.[74] The requirement of positive state action and the dependency on resource availability have been cited as factors that render these rights difficult to enforce judicially, as their fulfilment is often linked to progressive realisation rather than immediate implementation.[75] In Tanzania, this distinction is evident since the fulfillment of the right to health entails investment in public healthcare infrastructure, medical personnel, and essential

[72] Christopher Mbazira (2009). *Litigating socio-economic rights in South Africa: A choice between corrective and distributive justice*. Pretoria University Law Press; Alicia Ely Yamin, (2005). The right to health under international law and its relationship to rights-based approaches to health. *American Journal of Public Health*, 95(11), 1156–1161. https://doi.org/10.2105/AJPH.2004.055111

[73] Bilchitz, D. (2014). *Socio-economic rights, economic crisis, and legal doctrine*. *International Journal of Constitutional Law*, 12(3), 710–737. https://doi.org/10.1093/icon/mou045; Yamin, (note 72)

[74] Mbazira, (note 72); Bilchitz, (note 73).

[75] JK Gamble, Bailey, Hawk and McCurdy, 'Human Rights Treaties: A Suggested Typology, An Historical Perspective' (2001) 7 *Buffalo Human Rights Law Review* 33.

medicines, responsibilities that are heavily resource-dependent.

However, this critique fails to account for the increasingly recognised equivalence between socio-economic rights and civil and political rights in international human rights law. Contemporary interpretations affirm that socio-economic rights are equally universal, indivisible, and interdependent, and that their enforcement is not merely aspirational. The right to health, for instance, while subject to progressive realisation under Article 2(1) of the ICESCR, nonetheless entails immediate obligations. These include guarantees of non-discrimination, access to essential primary health care, and equitable distribution of health resources. Article 12 of the ICESCR explicitly recognises the right of everyone to the highest attainable standard of physical and mental health, reinforcing its universality. Further authoritative elaboration by the CESCR confirms that certain core obligations, such as ensuring non-discriminatory access to health services and essential medicines, are of immediate effect and not subject to resource constraints.[76] These obligations are particularly relevant in Tanzania, where inequalities in health service provision exist between urban and rural populations, and among socio-economic groups, illustrating that universality can be both substantive and contextually mediated.[77]

Noteworthy, the indivisibility and interdependence of rights, where socio-economic rights like health are prerequisites for the effective enjoyment of civil and political rights, have been repeatedly emphasised in human rights jurisprudence.[78] This suggests that the dichotomy between the two sets of rights is artificial and legally unsustainable. Empirical examples from jurisdictions such as South Africa, India, and Colombia demonstrate that courts can and do enforce socio-economic rights effectively, often interpreting them in conjunction with civil and political rights.[79] In Tanzania, although jurisprudence is limited, the *Joseph D. Kessy* case demonstrates that courts are willing to extend civil rights frameworks to socio-economic issues, reinforcing the universality of the right to health. Therefore, the argument that the right to health lacks universality, fundamentality, or practical enforceability is increasingly indefensible in light of both normative frameworks and comparative judicial practice.[80] Accordingly, a closer analysis of the universality of socio-economic rights is vital to show how the right to health embodies the equal and interdependent nature of all human rights.

4.1.1.1 Universality of Socio-Economic Rights

Critics often argue that socio-economic rights are not truly universal because they are perceived to benefit only specific segments of the population, rather than applying uniformly to all individuals. This contrasts with civil and political rights, which are typically regarded as applicable to all persons regardless of social or economic status. Some scholars point to

[76] CESCR (note 18) paras 30–44.

[77] Langa, Neema, and Tirth Bhatta. "The rural-urban divide in Tanzania: Residential context and socioeconomic inequalities in maternal health care utilization." *Plos one* 15, no. 11 (2020): e0241746; Kitole, Felician Andrew, Robert Michael Lihawa, and Eliaza Mkuna. "Equity in the public social healthcare protection in Tanzania: does it matter on household healthcare financing?." *International Journal for Equity in Health* 22, no. 1 (2023): 50.

[78] Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights, Vienna, 25 June 1993, UN Doc A/CONF.157/23 (12 July 1993), Part I, para 5.

[79] *Government of the Republic of South Africa v Grootboom* 2000 (11) BCLR 1169 (CC); *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37 (India); T-760/08, *Constitutional Court of Colombia*, 2008.

[80] Yamin and Gloppen (note 24) 12–18.

Article 24 of the UDHR, which guarantees the right to paid holidays, and observe that this right logically applies only to individuals who are employed, and thus inherently excludes those outside the paid workforce, such as the unemployed or informal workers. Others argue that such rights, by being limited to specific socioeconomic roles, fall short of the universal application expected of human rights.[81] However, this critique has not gone unchallenged.

Proponents of the right to health have pointed out that even within the realm of civil and political rights, commonly upheld as universally applicable, there are notable exceptions that demonstrate conditionality. For example, the right to vote under article 21 of the Constitution of United Republic of Tanzania is typically restricted to individuals above a legally defined age, excluding minors; similarly, the right to a fair trial is only activated when an individual is subject to legal proceedings. These examples illustrate that universality in human rights does not necessarily imply indiscriminate applicability, but rather contextual relevance based on particular circumstances.[82]

Furthermore, both civil and political rights and socio-economic rights feature individual and collective dimensions. While some rights, such as the right to education or healthcare, may focus on personal entitlements, others, like the rights to form associations or to participate in trade unions, presuppose and depend upon collective action and group participation. Rights such as freedom of association and freedom of assembly, which are civil and political in nature, are most effectively realized when exercised in a communal context, thereby demonstrating that group-based enjoyment is not unique to socio-economic rights.[83] These observations have led to the conclusion that both categories of rights share essential attributes of universality and conditional applicability.[84]

4.1.1.2 Fundamentality of the Right to Health

Socio-economic rights, including the right to health, are often criticized for being inherently indeterminate and conceptually ambiguous. Critics argue that these rights are formulated in broad, open-ended terms, lacking the precision commonly attributed to civil and political rights. As a result, socio-economic rights are often viewed as less fundamental, due to their perceived vagueness and the absence of clearly defined obligations upon the state.[85]

This ambiguity is seen as limiting their justiciability and excluding them from judicial processes. For example, Article 12 of the ICESCR, which enshrines the right to health, calls for improvements in various public health determinants such as environmental and industrial hygiene, yet it does not articulate specific programs or legislative measures that states must implement to achieve these objectives.[86]

However, this critique has been challenged by scholars who highlight that certain civil and political rights are equally vague and abstract in their formulation. Rights such as the right to life, liberty, security of the person, human

[81] Maurice Cranston, 'Human Rights, Real and Supposed' in D.D. Raphael (ed), *Political Theory and the Rights of Man* (Indiana University Press 1967) 43.
[82] Ibid pp. 50–51.
[83] Mbazira, (note 72) 58.
[84] Ibid 59.
[85] Bilchitz, D. (2007). *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights*. Oxford University Press p. 224.
[86] Ellen Wiles, 'Aspirational Principles or Enforceable Rights? The Future for Socio-Economic Rights in National Law,' (2006) 22(1) *American University International Law Review* 35, 42; Naveesh Jheelan, 'The Enforceability of Socio-economic Rights,' (2007) 2(2) *European Human Rights Law Review* 146–47.

dignity, and privacy often lack specific content and depend heavily on judicial interpretation.[87] In Tanzania, courts have begun to interpret civil rights expansively to incorporate socio-economic dimensions, exemplified by the *Joseph D. Kessy* case, where environmental and health concerns were linked to the constitutional right to life.

In contrast, some socio-economic rights, like the right to the highest attainable standard of health, are more concretely framed, referring explicitly to matters such as infant mortality, disease prevention, and environmental health.[88] These examples illustrate that the distinction in clarity between civil-political and socio-economic rights is not as pronounced as often claimed.[89]

Furthermore, there are arguments that vagueness in rights, whether civil, political, or socio-economic, is not an inherent or static feature. Instead, the perceived indeterminacy can be reduced through a process of dynamic interpretation.[90] Courts and adjudicative bodies play a pivotal role in developing and clarifying the regulative content of rights over time. In this context, socio-economic rights should not be excluded from the realm of judicial interpretation merely because they demand a more nuanced and evolving approach. The UN Committee on Economic, Social and Cultural Rights, in its General Comment No. 9, has underscored that the enforcement and application of the ICESCR at the domestic level require active engagement by national courts and institutions.[91]

Additionally, some commentators assert that socio-economic rights may be more fundamental than civil and political rights, especially in contexts of extreme poverty and marginalization. They argue that offering abstract freedoms to individuals suffering from deprivation, such as hunger, ill health, or illiteracy, without first addressing their basic socio-economic needs, is ineffective and even demeaning.[92] According to this view, fundamental freedoms become meaningful only when people are sufficiently empowered through the satisfaction of their essential needs, such as access to healthcare and education.[93] Consequently, both categories of rights, civil-political and socio-economic, should be seen as mutually reinforcing and equally fundamental in the architecture of human rights.[94]

[87] Smyth, C.-M. (2019). *Social and Economic Rights: The Struggle for Equivalent Protection* (pp. 1–27) at p. 7. Research Repository, University of Brighton.

https://research.brighton.ac.uk/files/6826439/Social_and_Economic_Rights.pdf.

[88] Sandra Liebenberg, 'Social and Economic Rights,' in Matthew Chaskalson et al (eds), *Constitutional Law of South Africa* (Juta, 1996) 41.

[89] Mariette Brennan, 'To Adjudicate and Enforce Socio-Economic Rights: South Africa Proves That Domestic Courts are a Viable Option' (2009) 9(1) *Queensland University of Technology Law and Justice Journal* 71.

[90] Aoife Nolan, Bruce Porter and Malcolm Langford, 'The Justiciability of Social and Economic Rights: An Updated Appraisal' (CHRGJ Working Paper No. 15, 2009) https://ssrn.com/abstract=1434944 accessed 9 December 2024; Kitty Arambulo, *Strengthening the Supervision of the International Covenant on Economic Social and Cultural Rights: Theoretical and Procedural Aspects* (Intersentia, 1999) 55.

[91] CESCR, *General Comment No. 9: The Domestic Application of the Covenant* (Nineteenth session, 1998) UN Doc E/C.12/1998/24, para 10, reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN Doc HRI/GEN/1/Rev.6 at 54 (2003).

[92] Isaiah Berlin, 'Two Concepts of Liberty,' in Isaiah Berlin (ed), *Four Essays on Liberty* (Oxford University Press, 1969) 124.

[93] Mclean (note 10) 95.

[94] JK Mapulanga-Hulston, 'Examining the Justiciability of Economic, Social and Cultural Rights,' (2002) 6(4) *International Journal of Human Rights* 42.

4.1.1.3 Realisation and the Positive Obligations of the State

A recurring critique of socio-economic rights is that, unlike civil and political rights, they are not immediately realisable and instead necessitate affirmative actions from the state. This argument stems from a perceived dichotomy: civil and political rights are often categorised as "negative rights" because they require the state to refrain from infringing upon individual liberties, whereas socio-economic rights demand "positive" state interventions such as policy formulation, service provision, and resource allocation. This perception, however, oversimplifies the nature of rights. While socio-economic rights may often require active engagement by the state, they also include negative dimensions. For example, the right to food includes the right of individuals to procure food without unjustified state interference. If the state obstructs access to food sources, it violates a negative obligation under socio-economic rights. Similarly, the right to the highest attainable standard of health also entails the duty of the state to abstain from interfering with health services provided by private entities or non-governmental organisations.[95]

The artificial distinction that reserves negative obligations for civil and political rights and positive obligations for socio-economic rights does not reflect the complex structure of rights. Even civil and political rights impose positive duties on states. For instance, the right to life is not fully guaranteed by the state's mere abstention from arbitrary killings; it also requires proactive measures such as maintaining public security through policing and establishing health facilities to prevent disease and preserve life.[96] Therefore, the right to life encompasses not only the freedom from arbitrary deprivation but also the entitlement to medical care, adequate nutrition, and a safe environment, necessitating significant investment and resource mobilisation.[97]

Attempting to create rigid categories separating civil and political rights from socio-economic rights presents logical and functional difficulties. These two sets of rights are deeply interrelated and interdependent. For instance, the enjoyment of freedom of association (a civil and political right) often relies on the protection of collective bargaining rights (a socio-economic right), and vice versa.[98] This intersectionality illustrates that all categories of rights may simultaneously demand both abstention from interference and proactive measures from the state, depending on the context.

In addition, certain elements of the right to health are not subject to progressive realisation or limited by resource constraints. These include non-discriminatory access to health care between men and women, as well as to fundamental health determinants such as food, water, and shelter. Tanzanian courts, in principle, have the authority to protect such core aspects, ensuring that inequalities in health determinants do not violate fundamental rights. A state cannot justify prioritising the

[95] EW Vierdag, 'The Legal Nature of the Rights Granted by the International Covenant on Economic, Social and Cultural Rights,' (1978) 9 *Netherlands Yearbook of International Law* 69; McLean, (note 10) 92; Mbazira (note 69) 52.

[96] Mbazira (note 72) 52; Philip Alston and Gerard Quinn, 'The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights,' (1987) 9(2) *Human Rights Quarterly* 172.

[97] Alston and Quinn (note 96); Mbazira (note 72) 53; Bertus De Villiers, 'Social and Economic Rights' in Dawid van Wyk, John Dugard, Bertus de Villiers and Dennis Davis (eds), *Rights and Constitutionalism: The New South African Legal Order* (Juta & Company 1995) 605.

[98] Jeff Kenner, 'Economic and Social Rights' in Tamara K Hervey and Jeff Kenner (eds), *Economic and Social Rights under the EU Charter of Fundamental Rights—A Legal Perspective* (Hart Publishing 2003) 3–4.

health needs of one gender over another based on resource scarcity. It would be unacceptable, for example, for a government to argue that it can only currently provide adequate healthcare for men, postponing services for women until more resources become available.[99] The Committee on Economic, Social and Cultural Rights has reaffirmed that compliance with Article 3 read together with Article 12 of the ICESCR imposes an immediate obligation on States Parties to eliminate legal and practical barriers that hinder equal access to health services for men and women.[100] This includes addressing structural gender inequalities affecting access to health determinants like food and water, lifting legal restrictions on reproductive health, prohibiting practices such as female genital mutilation, and training health personnel to respond appropriately to women's health concerns.[101] In this regard, the Committee emphasises that the equal right of men and women to enjoy all economic, social, and cultural rights is a binding and immediate duty upon States, and not contingent upon resource availability.[102] In the Tanzanian context, the fulfilment of the right to health requires proactive and sustained measures, including the development of health infrastructure, the recruitment and equitable distribution of medical personnel, and the provision of essential medicines and health information.[103] These measures are crucial given persistent disparities in access to healthcare between rural and urban populations and among socio-economic groups.[104] Tanzanian courts, in principle, possess the constitutional authority to safeguard these core obligations, ensuring that inequalities in access to health determinants do not infringe upon the fundamental rights and inherent dignity of individuals. [105]

4.1.2. Legitimacy Concerns

Judicial enforcement of socio-economic rights, especially the right to health, has long attracted scholarly debate over institutional legitimacy. Critics argue that when courts direct how public resources should be used, they risk encroaching on the functions of democratically elected bodies responsible for policy and budgeting.[106] In Tanzania, this concern aligns with Article 4 of the Constitution, which clearly separates state authority among the executive, legislature, and judiciary, each required to act within its constitutional boundaries.[107] Consequently, courts have often shown restraint in adjudicating claims that may affect government spending, particularly because the Fundamental Objectives and

[99] Ibid; Ssenyonjo (note 3)348–49.

[100] Ibid 349; CESCR, *General Comment No. 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights (Art. 3 of the Covenant)*, 11 August 2005, E/C.12/2005/4, para 29.

[101] CESCR (note 18) para 30.

[102] CESCR, (note 100) para 29; M Ssenyonjo, 'Reflections on State Obligations with Respect to Economic, Social and Cultural Rights in International Human Rights Law' (2011) 15 International Journal of Human Rights 283, 348–49.

[103] Mboera, L. E. G., Rumisha, S. F., Senkoro, K., & Mayala, B. K. (2011). Climate change and public health in Tanzania. *African Health Sciences, 11*(1), 3–14.

[104] D Mussa, M Mpolya and E Peter, 'The Rural–Urban Divide in Tanzania: Residential Context and Socioeconomic Inequalities in Maternal Health Care Utilization' (2020) BMC Health Services Research https://pmc.ncbi.nlm.nih.gov/articles/PMC7652341/ accessed 17 October 2025.

[105] Mbicha, E. L. (2014). *Judicial enforcement of the right to health under the new constitution of Kenya: Comparative lessons for Tanzania* (Doctoral dissertation, University of Nairobi). https://erepository.uonbi.ac.ke/handle/11295/77025

[106] Jeremy Waldron, 'The Core of the Case Against Judicial Review' (2006) 115 *Yale Law Journal* 1346; Cass R Sunstein, 'Social and Economic Rights? Lessons from South Africa' (2001) 11(2) *Constitutional Forum* 123; Mark Tushnet, 'Social Welfare Rights and the Forms of Judicial Review' (2008) 82(7) *Texas Law Review* 1895.

[107] Constitution of the United Republic of Tanzania [Cap 2 R.E. 2002], art 4.

Directive Principles of State Policy (FODPSP) are non-justiciable.[108]

That notwithstanding there are arguments supporting courts vital role in ensuring government accountability when the rights and dignity of vulnerable people are at stake.[109] Through careful interpretation and meaningful engagement, judicial oversight can help translate socio-economic rights into practical realities without undermining democratic principles.[110] In this sense, judicial involvement complements rather than threatens the separation of powers, supporting a balanced pursuit of justice and constitutional governance.[111]

4.1.2.1 Separation of Powers

Critics of the judicial enforcement of socio-economic rights, including the right to health, argue that such judicial involvement risks infringing upon the doctrine of separation of powers which is the foundation of constitutional governance. In Tanzania, this principle is enshrined in Article 4 of the Constitution, which allocates authority among the executive, legislature, and judiciary, each required to operate independently and within its constitutional mandate.[112] Chapters Two, Three, and Five of the constitution further define these organs of the state by providing the Union Government's executive from Articles 33–61 of the constitution, legislature of united republic of Tanzania under Articles 62–101, and judiciary under Articles 107A–128.[113] The critique is grounded in the view that judicial intervention in socio-economic matters, particularly in directing resource allocation or policy priorities, could encroach upon the functions of elected bodies, thereby undermining democratic legitimacy and institutional integrity.[114] Resource distribution, being central to socio-economic policy, is traditionally the preserve of legislatures, and critics caution that judicial overreach may blur the functional boundaries that separation of powers seeks to protect.[115] That aside, the Committee on Economic, Social and Cultural Rights (CESCR) has emphasised that courts can engage in socio-economic matters without inherently violating separation of powers, recognising judicial oversight as a vital mechanism to hold states accountable for their human rights obligations.[116]

Comparative jurisprudence demonstrates how courts can navigate this delicate balance. For example, in *Olga Tellis v Bombay Municipal Corporation*, the Indian Supreme Court required prior notice to pavement dwellers before eviction but refrained from directing the state to provide housing, reflecting judicial restraint.[117] Similarly, Canadian courts in *Schachter v Canada* and *R v Askov* acknowledged fiscal implications of remedies

[108] Damas Daniel, 'Political Question Doctrine and Its Justiciability in Tanzania: A Critical Analysis' (2022) *Eastern Africa Law Review* 45; MKB Wambali, 'The Enforcement of Basic Rights and Freedoms and the State of Judicial Activism in Tanzania' (2009) 53(1) *Journal of African Law* 34.

[109] David Bilchitz and David Landau (eds), *The Evolution of the Separation of Powers: Between the Global North and the Global South* (Edward Elgar 2018) 59–60; Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011) 7–10.

[110] A Pillay, 'Toward Effective Social and Economic Rights Adjudication: The Role of Meaningful Engagement' (2012) 10(3) *International Journal of Constitutional Law* 741.

[111] John Kabudi, 'The Directive Principles of State Policy versus Duties of the Individual—East African Perspectives' (1995) *Lesotho Law Journal* 21.

[112] Constitution of the United Republic of Tanzania [Cap 2 R.E. 2002], art 4.

[113] Ibid, arts 33–61, 62–101, 107A–128.

[114] Bilchitz and Landau (note 109) 59–60.

[115] Menell, P. S., 'Judicial Enforcement of Socio-Economic Rights in Comparative Perspective' (2008) 10 *Law & Policy* 102.

[116] CESCR (note 18) para 47.

[117] [1985] 3 SCC 545 (India).

without allowing these considerations to bar enforcement of rights.[118] In Tanzania, the judiciary has adopted a comparable cautious approach as was in the *Joseph D. Kessy* case where the High Court addressed environmental and health rights concerns without issuing directives that would dictate budgetary allocations, thereby upholding constitutional boundaries while safeguarding fundamental rights.[119] These examples highlight that even with clear constitutional provisions, the practical delineation of functions among state organs remains complex. Courts must therefore continue to exercise judicious restraint, ensuring that enforcement of socio-economic rights, including the right to health, respects the separation of powers while promoting accountability and justice.[120]

4.1.2.2 Democratic Legitimacy

One of the principal criticisms raised against judicial enforcement of socio-economic rights, including the right to health, is the perception that such intervention is "anti-democratic" or "counter-majoritarian." Courts, composed of unelected judges, are often viewed as lacking the legitimacy to interfere in decisions regarding social welfare and resource distribution, matters traditionally reserved for the legislative and executive branches.[121] Critics argue that judicial engagement in socio-economic matters risks undermining the representative function of government and political accountability in the allocation of public resources.[122] Resource allocation, central to social policy, is therefore considered the exclusive domain of elected institutions, and judicial intervention could be seen as transferring authority from democratically accountable bodies to unelected judges.[123]

Nevertheless, judicial involvement in enforcing the right to health does not entail legislating from the bench or formulating public policy.[124] Instead, courts evaluate state conduct and policies against established legal and constitutional standards, ensuring accountability and compliance with socio-economic rights obligations. In Tanzania, judicial review under the Law Reform (Fatal Accidents and Miscellaneous Provisions) (Judicial Review Procedure and Fees) Rules, 2014, enables courts to scrutinise administrative actions by state and public authorities while safeguarding procedural fairness, transparency, and accountability. By compelling reasoned decision-making and protecting marginalized groups, judicial review strengthens deliberative democracy and

[118] [1992] 2 SCR 679; *R v Askov* [1990] 2 SCR 1199 (Canada).

[119] Misc. Civ. Case No. 17 of 2010 HC of Tanzania at Dar es Salaam (Unreported).

[120] Waldron (note 106) 123; Tushnet (note 106); Wambali (note 108) 389; Kabudi, (note 111); Yamin and Gloppen (note 24) 7–10; Pillay, '(note 100) 741.

[121] Nolan, Porter and Langford, *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (CUP 2008) 12; EC Christiansen, 'Adjudicating Non-Justiciable Rights: Socio-Economic Rights and the South African Constitutional Court' (2007) 38 *Columbia Human Rights Law Review* 321, 347.

[122] Salma Yusuf, 'The Rise of Judicially Enforced Economic, Social, and Cultural Rights—Refocusing Perspectives' (2012) 10(2) *Seattle Journal for Social Justice* 760; Malcolm Langford (ed), *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (CUP 2008) 34.

[123] Paul Hunt, 'The Human Right to the Highest Attainable Standard of Health: New Opportunities and Challenges' (2006) 100(4) *Transactions of the Royal Society of Tropical Medicine and Hygiene* 552; Roberto Gargarella, 'Dialogue Justice in Enforcement of Social Rights: Some Initial Arguments' in AE Yamin and S Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011) 238; Law Reform (Fatal Accidents and Miscellaneous Provisions) (Judicial Review Procedure and Fees) Rules, 2014 (Tanzania), rules 5–9.

[124] Ida Elisabeth Koch, 'The Justiciability of Indivisible Rights' (2003) 72 *Nordic Journal of International Law* 3, 15; Nolan, Porter and Langford (note 121)12.

reinforces governance without supplanting legislative authority.[125] Thus, judicial enforcement complements rather than replaces legislative discretion, promoting inclusivity, fairness, and the substantive content of democracy while maintaining respect for constitutional boundaries.[126]

4.1.3. Institutional Capacity

The ability of judicial institutions to effectively adjudicate socio-economic rights, particularly the right to health, has been a subject of considerable debate. Critics frequently question whether courts possess the institutional competence necessary to resolve disputes involving complex health-related rights. These concerns stem from the intricate nature of medical and technical issues, ambiguous legislative provisions, and the potential for institutional friction between the judiciary and the executive branches of government. Courts are often viewed as structurally ill-suited to address and implement broad socio-economic reforms, as they typically lack the financial, scientific, and technical resources needed to evaluate and manage nuanced matters of public health policy. Moreover, there is a perception that courts lack the administrative and logistical capacity to enforce compliance with their rulings, thereby limiting their effectiveness in shaping socio-economic realities through legal mechanisms.[127]

In matters specifically concerning the right to health, the judiciary is frequently criticized for lacking the requisite medical expertise to make informed determinations about diagnoses, appropriate treatment plans, and the medical necessity of particular interventions in specific circumstances.[128] Such issues are compounded by the polycentric nature of decisions related to health and other social policy areas, where a single decision may generate ripple effects across multiple, and sometimes unpredictable, sectors. The reallocation of financial resources, for example, inevitably entails trade-offs, as funds directed toward one area reduce the budget available for others. This complex interdependence of policy decisions presents challenges that many believe are ill-suited to judicial resolution.[129] As Fuller and Winston argue, adjudication is inherently limited in dealing with polycentric problems where numerous, interconnected factors are in play.[130]

A further argument posits that courts are institutionally sluggish, and therefore unable to adapt swiftly to the dynamic nature of economic and social change. Judicial processes are typically not designed to accommodate rapidly shifting variables such as inflation, wage adjustments, or changing societal needs.[131] Nonetheless, the mere existence of potential far-reaching or unpredictable consequences should not deter

[125] Koch, (note 124) 15; DM Brinks and Varun Gauri, 'A New Policy Landscape: Legalising Social and Economic Rights in Developing World' in Varun Gauri and DM Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in Developing World* (CUP 2008) 342–49; Hunt, (note 123)552.

[126] Nolan, Porter and Langford, (note 121) 12; Hunt, '(note 123) 552; Gargarella, (note 123) 238

[127] Wambali, (note 108) 34.

[128] Danie Brand, 'Socio-Economic Rights and Courts in South Africa: Justiciability on a Sliding Scale,' in APM Coomans (ed), *Justiciability of Economic and Social Rights: Experiences from Domestic Systems* (Intersentia 2006) 225; Sandra Liebenberg, *Socio-Economic Rights: Adjudication under a Transformative Constitution* (Juta 2010) 72; Marius Pieterse, *Can Rights Cure? The Impact of Human Rights Litigation on South Africa's Health System* (Pretoria University Law Press 2014) 25.

[129] Pieterse (note 128) 25.

[130] Lon L Fuller and Kenneth I Winston, 'The Forms and Limits of Adjudication' (1978) 92(2) *Harvard Law Review* 353, 394.

[131] K O'Regan, 'Introducing Social and Economic Rights,' (Opening Address at the Workshop on Giving Effect to Social and Economic Rights: The Role of the Judiciary and other Institutions, Cape Town, 6–7 October 1998).

the judiciary from performing its essential constitutional function, upholding fundamental rights and values. As O'Regan rightly emphasized, judicial reluctance to intervene in complex socio-economic issues cannot equate to a complete abdication of responsibility in safeguarding constitutional guarantees.[132]

The critique regarding the judiciary's lack of financial and technical proficiency is mitigated by the recognition that courts possess a distinct form of expertise, that of legal interpretation and standard-based reasoning. This makes them particularly well-equipped to delineate the scope and substance of socio-economic rights and to apply such norms to specific factual scenarios.[133] Courts are also characterized by their independence, impartiality, and capacity to serve as reasoned forums for balancing competing claims. In exercising their judicial review powers, they play a significant role in enhancing deliberative democracy, compelling the legislature and executive to engage meaningfully with constitutional obligations and citizen rights.[134] Their interventions not only ensure that governmental policies align with constitutional mandates but also affirm the participatory character of democratic governance by holding public officials accountable.[135]

4.1.4. Absence of Explicit Constitutional Recognition

A significant impediment to the enforcement of the right to health in Tanzania is its omission from the Constitution's Bill of Rights. Although socio-economic rights such as the right to work and property are constitutionally recognised, the right to health is not explicitly enshrined. Instead, it is inferred through Article 11(1), which imposes an obligation on the government to promote social welfare during illness. However, Article 11 of the Constitution forms part of the Fundamental Objectives and Directive Principles of State Policy (FODPSP), which are non-justiciable. According to Article 7(2), the courts are barred from adjudicating compliance with the FODPSP, precluding any judicial remedy to enforce the right to health. Thus, the state's failure to include the right to health in the justiciable Bill of Rights hinders legal action under the Basic Rights and Duties Enforcement Act.

Despite these limitations, Tanzanian courts have embraced a liberal interpretation of the Constitution, giving rise to the so-called 'implied doctrine.' Under this interpretive approach, courts infer unenumerated socio-economic rights from expressly recognised civil and political rights. This technique was evident in *Joseph D. Kessy and Others v. The City Council of Dar es Salaam*,[136] where the High Court linked environmental pollution to a violation of the right to life under Article 14. This case illustrates how courts have circumvented the absence of an explicit constitutional provision by interpreting the right to health as an element inherent in the right to life.

Furthermore, the 2014 Proposed Constitution represented a significant advancement by explicitly recognising the right to health. Article 51 (1) of the Proposed Constitution guaranteed the right to health and clean water, while Article 51(2) obligated the state to facilitate access to health services based on available resources. Additionally, specific provisions guaranteed the right to health for children under Article 53(1)(e), persons with disabilities, Article 55(f), women, Article

[132] Ibid.
[133] Fuller and Winston, (note 130) 353, 394.
[134] Liebenberg (note 128) 41; Pieterse, *(note 128)* 25.
[135] Ibid.

[136] 63 Civ. Case no. 299 of 1988 (Dar es Salaam Registry) (unreported).

57(f), and the elderly under Article 58(c). Despite these promising developments, the constitutional review process has remained suspended since 2014, leaving the right to health in an unjustified legal position.

4.1.5. Progressive Realization of the Right to Health

One of the principal obstacles to the judicial enforcement of the right to health under the ICESCR lies in the concept of progressive realization. This notion serves as a fundamental mechanism through which the ICESCR monitors the extent to which state parties are fulfilling their obligations concerning the realization of rights enshrined in the covenant. Rather than imposing an immediate and full implementation of all treaty obligations upon ratification, the covenant acknowledges the practical limitations faced by states and thus permits a gradual and incremental approach toward full compliance over time. In this context, judicial bodies may find that a state is not in violation of its obligations, even when the right to health is not universally or fully guaranteed, provided that the state is demonstrably making appropriate efforts and utilizing the maximum of its available resources to advance the realization of this right progressively. This approach reflects a recognition of the varied capacities of states and the complexity involved in the implementation of socio-economic rights such as health care services, infrastructure, and equitable access.[137] Such an approach has been supported by scholarly analysis, which emphasizes that indicators and benchmarks can be useful in assessing compliance with the progressive realization principle, especially in rights like education and health.[138] Furthermore, it has been argued that progressive realization not only accommodates the resource constraints of states but also presents an opportunity to align the right to health with broader global development goals.[139] The necessity for strong processes and credible evidence in tracking the gradual attainment of universal health coverage has also been underscored, particularly in ensuring transparency and accountability in policy implementation.[140] Thus, while progressive realization may present challenges in terms of enforceability, it also provides a flexible yet structured framework within which states can be held accountable for meaningful and continuous advancement toward the full enjoyment of the right to health.

4.1.6. Resource Scarcity

The enforcement of the right to health, as a socio-economic entitlement under the ICESCR, is fundamentally constrained by the availability of adequate resources. In situations where state resources are limited, the capacity of a government to guarantee access to significant health determinants, such as adequate housing, nutritious food, safe drinking water, sanitation, and a healthy environment, is significantly compromised.[141] This limitation is particularly evident in countries where resource distribution is uneven and structural inequalities persist between rural and urban populations, thereby

[137] Kalantry S, Getgen JE and Koh SA, 'Enhancing Enforcement of Economic, Social, and Cultural Rights Using Indicators: A Focus on the Right to Education in the ICESCR' (2010) 32(2) *Human Rights Quarterly* 253.

[138] Ibid.

[139] SMT Karim and George F Tomossy, 'Progressive Realisation of the Right to Health: An Opportunity for Global Development' (2019) 27 *Waikato Law Review* 31.

[140] RMP Baltussen et al, 'Progressive Realisation of Universal Health Coverage: What Are the Required Processes and Evidence?' (2017) 2(3) *BMJ Global Health* e000342.

[141] Michael Simon, Daniel W Tsegai and Steffen Fleßa, 'Intersectoral Health Action in Tanzania–Determinants and Policy Implications' (2012) ZEF-Discussion Papers on Development Policy 172.

impeding equitable access to health-related services.[142] In addition, discrepancies between customary legal systems and international human rights norms further complicate the implementation of the right to health, often creating a dual system that weakens legal coherence and enforcement capacity.

Government inefficiencies, regulatory shortcomings within health systems, and the failure to protect citizens from harmful socio-cultural practices contribute further to the misallocation or underutilization of scarce resources. These factors collectively hinder the effective realization of the right to health.[143] For instance, in the Tanzanian context, the challenges of judicial enforcement are exacerbated by institutional weaknesses, inconsistent policy implementation, and inadequate legal safeguards against discriminatory practices.[144] Also, systemic barriers, such as legal pluralism and entrenched patriarchal norms, such as polygyny and its variants, have been shown to intensify vulnerabilities, particularly among women, thereby heightening the risk of public health crises like HIV/AIDS.[145] In contexts of resource scarcity, courts are often reluctant or ill-equipped to compel governments to fulfil expansive socio-economic obligations, especially where structural violations require substantial fiscal investment.[146] Consequently, the judicial enforcement of the right to health in such settings tends to focus not only on the absolute realization of the right but also on ensuring fair distribution of available resources and holding states accountable for gross neglect or discriminatory allocation.

4.2. Prospects Towards Judicial Enforcement of the Right to Health

The judicial enforcement of the right to health, while historically constrained by perceptions of socio-economic rights as aspirational, is increasingly gaining traction through evolving constitutional interpretation and international legal frameworks. Courts in various jurisdictions, including Tanzania, have begun to extend the right to life and human dignity to implicitly include access to healthcare, thereby opening a judicial path for addressing health-related grievances.[147] Such jurisprudential developments reflect a shift towards recognising socio-economic rights as legally enforceable, particularly when courts adopt transformative remedies and purposive interpretation consistent with international obligations under instruments like the ICESCR.[148]

Nonetheless, the success of such enforcement depends on judicial independence, political commitment to implement rulings, and the strategic engagement of civil society.[149] In resource-constrained settings, courts must rely on health indicators, expert analysis, and

[142] Sally Mtenga, Irene M Masanja and Masuma Mamdani, 'Strengthening National Capacities for Researching on Social Determinants of Health (SDH) Towards Informing and Addressing Health Inequities in Tanzania' (2016) 15 *International Journal for Equity in Health* 1.

[143] Ibid

[144] Martha Thobias, 'The Challenges to the Enforcement of Economic, Social and Cultural Rights in the United Republic of Tanzania: A Critical Analysis' (LLM Dissertation, Mzumbe University 2013) 37.

[145] Fatuma A Mgomba, 'Right to Health: Polygyny and De Facto Polygyny May Increase Women's Vulnerability to HIV/AIDS in Tanzania' (2021) 3(1) *East African Journal of Traditions, Culture and Religion* 1.

[146] Siri Gloppen, 'Right to Health in Contexts of Resource Scarcity: Towards Judicial Enforcement of the Right to a Fair Share' (2015) https://ssrn.com/abstract=2622779 accessed 14 June 2025.

[147] AE Yamin and Fiona Lander, 'Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights' (2015) 14(3) *Journal of Human Rights* 312.

[148] Ibid.

[149] Ibid.

rights-based assessments to issue context-sensitive decisions.[150] Embedding doctrinal tools such as minimum core obligations and non-discrimination principles can enhance enforceability, even where legal texts remain ambiguous.[151] Strengthening judicial enforcement also requires legislative reforms, institutional capacity building, and procedural mechanisms that monitor state compliance. Global and regional initiatives, such as SDG 3 and policies championed by the WHO and AU, offer evaluative support for integrating health rights into national frameworks.[152] In Tanzania, reinforcing judicial strategies with inclusive governance and non-judicial administrative measures is essential to advance a holistic right-to-health framework.[153]

4.2.1. Statutory Frameworks Advancing the Right to Health in Tanzania

Tanzania has adopted a range of legislative frameworks aimed at operationalising the right to health, especially for marginalised populations. The Persons with Disabilities Act, No. 9 of 2010, guarantees non-discriminatory access to healthcare services for persons with disabilities, affirming the state's obligation to promote inclusive health systems. The Act affirms the right to equitable healthcare access for persons with disabilities.[154] Similarly, the HIV and AIDS (Prevention and Control) Act, No. 28 of 2008, mandates the state to ensure access to essential services for people living with HIV and AIDS, including vulnerable children.[155] This Act embeds core public health principles by safeguarding rights to privacy, confidentiality, and non-discrimination, while also guaranteeing access to counselling and testing.

The Mental Health Act, No. 21 of 2008, enhances protections for individuals with mental disorders by establishing statutory procedures for treatment within approved facilities.[156] It mandates the humane and rights-based care of affected individuals and requires integration of mental health services into general hospitals. These legislative guarantees align with the Convention on the Rights of Persons with Disabilities (CRPD), which calls for equal access to the highest attainable standard of health.[157]

Furthermore, the Public Health Act [Cap 152 R.E. 2009] provides a foundational regulatory framework for disease prevention, sanitation, and health promotion. It authorises local authorities to enforce public health standards in areas like waste disposal, food safety, and water hygiene. The Environmental Management Act, No. 20 of 2004 (EMA) extends the right to a clean, safe, and healthy environment, establishing legal grounds for individuals to seek remedies when environmental degradation threatens health.[158] The Act enshrines principles such as polluter pays, precaution, and access to justice, thereby institutionalising participatory and preventative health protection.[159] Thus, these statutes embody Tanzania's commitment to

[150] Ibid.
[151] Ibid.
[152] Kent Buse and Sarah Hawkes, 'Health in the Sustainable Development Goals: Ready for a Paradigm Shift?' (2015) 11(13) *Globalization and Health* 2–3.
[153] Yamin and Lander (note 147) 313.
[154] Persons with Disabilities Act, No. 9 of 2010, s 26.
[155] HIV and AIDS (Prevention and Control) Act, No. 28 of 2008, s 19(1).
[156] Mental Health Act, No. 21 of 2008, Parts II and III. The Act sets procedures for voluntary and involuntary care and integrates mental health into public health.
[157] Convention on the Rights of Persons with Disabilities (2006) 2515 UNTS 3. It mandates equal access to healthcare for persons with disabilities.
[158] Environmental Management Act, No. 20 of 2004, s 4(1)– (2) recognises the right to a safe and healthy environment.
[159] Ibid, section 5(1) & (2) which imposes duties to protect environmental health and promote accountability. Section 5(3) ensures access to remedies where environmental harm affects health and section 6 institutionalises public participation and environmental reporting duties.

harmonising domestic health governance with international norms and promoting legal accountability in realising the right to health.

4.2.2. Administrative Measures to Realise the Right to Health in Tanzania

Administrative measures form a critical pillar in the realisation of the right to health in Tanzania by translating legal and policy frameworks into practical institutional operations. Central to these measures is the role of the Ministry of Health and its subsidiary bodies, which are charged with overseeing public health services, regulating healthcare providers, licensing health facilities, and enforcing public health standards. The decentralisation of health service delivery, anchored in the Local Government (District Authorities) Act Cap 287 RE 2002 and the Local Government (Urban Authorities) Act, Cap 288 RE 2002 have enabled Local Government Authorities (LGAs) to undertake planning and implementation of health interventions responsive to local needs, thus enhancing community-level ownership and health equity. Furthermore, Tanzania has institutionalised strategic health planning through instruments such as the Health Sector Strategic Plan V (HSSP V), which outlines a results-based framework aligned with both domestic priorities and international commitments, including the Sustainable Development Goals (SDGs). These strategic plans reflect a progressive administrative posture aimed at improving health system performance, equity, and accountability.

Tanzania's commitment to health system strengthening is also evidenced by the formulation and operationalisation of several important national policy instruments. These include the National Health Policies of 1990 and 2007, *the* National Strategy for Growth and Reduction of Poverty (NSGRP I), *the* Health Sector Strategic Plan III (2009–2015), *and the* Primary Health Care Services Development Programme (PHCSDP) (2007–2017).[160] These policies collectively seek to address critical barriers to the enjoyment of health rights, including limited access to essential health services, high maternal and infant mortality, and inadequate reproductive healthcare. For instance, NSGRP I, developed within the framework of the Millennium Development Goals (MDGs), prioritised improving the health outcomes of marginalised groups such as women and children, as well as increasing universal access to clean water and sanitation.[161] These policy initiatives underscore the government's intention to operationalise the right to health through coordinated, measurable, and inclusive administrative action. However, the effectiveness of these measures ultimately depends on their integration with judicial mechanisms, public accountability frameworks, and sustained political will.

4.2.3. Tanzania's Engagement in Global Health Initiatives Towards Realising the Right to Health

Tanzania's participation in global health initiatives, notably the Sustainable Development Goals (SDGs), signifies an ideal shift toward recognising health as a multidimensional right. SDG 3's objective to 'ensure healthy lives and promote well-being

[160] United Republic of Tanzania, *National Health Policy 1990*, Dar es Salaam: Ministry of Health, February 1990; *The National Health Policy 2007*, Dar es Salaam: Ministry of Health and Social Welfare, 2007; *Health Sector Strategic Plan III: Partnerships for Delivering the MDGs July 2009 – June 2015*, Dar es Salaam: Ministry of Health and Social Welfare, 2009; *Primary Health Care Service Development Programme (PHCSDP) (2007–2017)*, Dar es Salaam: Ministry of Health and Social Welfare, May 2007; *Report on the Implementation of Ministry Goals from 2005 to March 2009*, Dar es Salaam: Ministry of Health and Social Welfare, April 2009.

[161] United Republic of Tanzania, *National Strategy for Growth and Reduction of Poverty (NSGRP I)*, Dar es Salaam: Vice President's Office, June 2005, 4.

for all at all ages' establishes measurable targets that, although non-binding, influence judicial reasoning by providing a directive framework aligned with Articles 11 and 14 of the Constitution. Courts may invoke these standards to interpret domestic law purposively, particularly where legislative provisions are silent or ambiguous. CESCR General Comment No. 14 strengthens this approach by delineating the core elements of the right to health through the AAAQ framework, i.e., availability, accessibility, acceptability, and quality.

Beyond health-specific targets, SDG 16 promotes institutional reforms indispensable for justiciability, including access to justice and rule-of-law adherence.[162] This is essential in Tanzania, where socio-economic rights are not directly justiciable.[163] The shift from the Millennium Development Goals' sectoral approach to the SDGs' integrative framework has elevated health within broader development discourses, recognising its dependence on systemic determinants such as clean water, climate resilience, and gender equity.[164] Tanzania's Health Sector Strategic Plan V attempts to reflect this vision, yet implementation suffers from institutional fragmentation.[165]

Health diplomacy and regional cooperation through forums like the East African Community offer avenues for strengthening legal and policy coherence.[166] A multidimensional poverty lens reveals the overlap between deprivation and health outcomes, justifying the judicial articulation of health as a socio-economic right.[167] The capabilities approach situates health at the core of human dignity and supports stronger legal obligations.[168] However, Tanzania's Universal Health Coverage Act, while promising, lacks vigorous mechanisms for equity and grievance redress.[169] The sustainable development model highlights the interlinkage between economic, institutional, and environmental pillars of health.[170] The Tanzanian judiciary can play an essential role by interpreting the SDG agenda as a set of juridically significant principles rather than mere policy aspirations.[171]

5. CONCLUSION

This article has critically examined the evolving landscape of judicial enforcement of the right to health in Tanzania through a comprehensive doctrinal and institutional analysis. Drawing on a qualitative methodology, it evaluated both international legal norms and domestic legal practices, demonstrating how global human rights

[162] United Nations Development Programme (UNDP), *Goal 16: Peace, Justice and Strong Institutions* https://www.undp.org/sustainable-development-goals/peace-justice-and-strong-institutions accessed 17 June 2025.

[163] Buse and Hawkes (note 152) 2–3.

[164] World Health Organization, *Health in 2015: From MDGs to SDGs* (WHO 2015); Lawrence O Gostin and Eric A Friedman, 'Health as a Sustainable Development Goal: Elevating Health in Post-2015 Global Governance' (2015) 385 *The Lancet* 1509–1515.

[165] Ilona Kickbusch and Michaela Told, *Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases* (Springer 2016).

[166] Ritu Sadana, et al, 'Healthy Aging: Raising Awareness of Societal Transformations and Intersectoral Action' (2016) 91 *Bulletin of the World Health Organization* 660–661.

[167] Sabina Alkire and James Foster, 'Counting and Multidimensional Poverty Measurement' (2011) 7(3) *Journal of Public Economics* 1–20.

[168] Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Polity Press 2011).

[169] Gorik Ooms and others, 'Is Universal Health Coverage the Practical Expression of the Right to Health Care?' (2014) *BMC International Health and Human Rights* 386.

[170] Jeffrey D Sachs, *The Age of Sustainable Development* (Columbia University Press 2015).

[171] United Nations General Assembly, *Transforming Our World: The 2030 Agenda for Sustainable Development* (21 October 2015) UN Doc A/RES/70/1.

instruments, such as the ICESCR and the ACHPR, serve as authoritative standards for domestic enforcement. Despite the absence of an explicit constitutional provision guaranteeing the right to health, Tanzanian courts have attempted to fill this prescriptive gap by interpreting the right to life under Article 14 of the Constitution as encompassing health-related entitlements. However, such interpretive efforts are constrained by structural and doctrinal challenges that undermine the effectiveness of judicial enforcement.

These challenges include legitimacy concerns stemming from the doctrine of separation of powers, questions surrounding democratic accountability, institutional capacity deficits, and the lack of constitutional textual recognition. Additionally, the scarcity of resources and the doctrine of progressive realisation pose further constraints on judicial intervention. Nonetheless, the article has demonstrated that the perception of socio-economic rights, such as the right to health, as vague or non-justiciable is both legally and conceptually flawed. CESCR General Comments Nos 3 and 14 clarify the scope of state obligations and provide a strong normative basis for judicial oversight, especially through frameworks like minimum core obligations and the standard of reasonableness.

Despite these challenges, the article identified significant prospects for the improved enforcement of the right to health in Tanzania. Statutory developments, including vital health-related legislation and policy frameworks, offer substantive entry points for rights-based adjudication. Administrative measures, such as decentralised healthcare delivery, health sector planning, and institutional reforms, reflect governmental efforts to operationalise health rights at various governance levels. Besides, Tanzania's engagement with global initiatives such as the Sustainable Development Goals (SDGs) highlights an obligatory alignment with international obligations that courts can leverage in interpreting domestic health rights.

To fully realise the judicial enforcement of the right to health in Tanzania, the article concludes that a multi-pronged approach is essential. This includes constitutional reform to expressly enshrine the right to health in the Bill of Rights, judicial willingness to employ international norms and standards as interpretive tools, institutional strengthening to support rights-based adjudication, and sustained political commitment to transform health-related obligations into enforceable legal claims. Together, these developments would facilitate the transition from aspirational health goals to justiciable rights, thus advancing the respect, protection, and fulfilment of the right to health in Tanzania in accordance with both international and domestic legal frameworks.