



August 30, 2012

Committee on Economic, Social, and Cultural Rights

Office of the United Nations High Commissioner for Human Rights

Palais des Nations

CH-1211 Geneva 10, Switzerland

Re: Supplementary information on the United Republic of Tanzania, Scheduled for Review by the Committee on Economic, Social, and Cultural Rights during its 49th Session

Dear Committee Members:

This letter is intended to supplement the periodic report of the Government of the United Republic of Tanzania (Tanzania), scheduled for review by this Committee during its 49th session. The Center for Reproductive Rights (the Center), with headquarters in New York and a regional office in Kenya, is an independent non-governmental organization that uses the law to advance reproductive freedom as a fundamental human right. The Tanzania Women Lawyers Association (TAWLA) is a nonprofit and non-governmental association which has over 500 members, comprised of women lawyers from diverse backgrounds such as State Attorneys, Private Advocates, Judges, Magistrates, Corporation Counsels, Lecturers and Legal Advisors in various state and non-state institutions, who seek to promote women's and children's rights and good governance. With this submission, the Center and TAWLA hope to further the work of the Committee by providing independent information concerning the rights protected in the International Covenant on Economic, Social and Cultural Rights (the Covenant).

We wish to bring to the Committee's attention the following areas of particular concern: the high rates of preventable maternal mortality and morbidity; the lack of access to safe abortion services and post-abortion care; women's lack of access to comprehensive contraceptive methods and other reproductive health care services and information; and discrimination against women and girls. These problems reflect shortfalls in the government's implementation of the Covenant and directly affect the health and lives of women in Tanzania.

Women's Reproductive Health Rights (Articles 2(2), 3, 10(2), 12 and 15(1)(b) of the Covenant)

Reproductive health rights are fundamental to women's health and equality, and receive broad protection under the Covenant, which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."¹ The

Committee, in General Comment 14, has explicitly defined the right to health to “include the right to control one’s health and body, including sexual and reproductive freedom.”² General Comment 14 also specifically states that “[t]he realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.”³ Despite these protections, the reproductive rights of women in Tanzania are being neglected and violated.

1. MATERNAL MORTALITY AND MORBIDITY

Article 10 of the Covenant grants special protection to pregnant women before and after delivery, as well as to adolescents and children.⁴ The Committee has affirmed that state failure to reduce maternal deaths violates the right to health.⁵

According to the latest data from the World Health Organization (WHO), Tanzania had the eighth highest number of maternal deaths in the world in 2010.⁶ Women in Tanzania have a 1-in-23 lifetime risk of dying from a pregnancy-related cause.⁷ Although the 2010 Tanzania Demographic and Health Survey (TDHS) puts the maternal mortality ratio at 454 maternal deaths per 100,000 live births,⁸ showing a small decline from the 2004 TDHS,⁹ data from WHO indicates that Tanzania is not on track to meet Millennium Development Goal (MDG) 5, to reduce maternal mortality.¹⁰ Maternal deaths consistently represent between 17% and 18% of all deaths of women aged 15–49 in Tanzania.¹¹

The majority of maternal deaths in Tanzania are due to obstetric complications that could be prevented or minimized by providing quality care, including accessible post-natal care, skilled delivery services and emergency obstetric care.¹² Only 51% of births are assisted by health professionals.¹³ The proportion of births attended by skilled health professionals has shown little to no improvement over the past 20 years and any progress has been painstakingly slow,¹⁴ with a decline in Mainland Tanzania (from 63% in 2008 to 50.5% in 2010) and an unchanged situation in Zanzibar.¹⁵ According to the TDHS “[p]roper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the newborn baby,”¹⁶ yet only 50% of births in Tanzania are delivered at a health facility,¹⁷ and only one fourth of facilities that offer delivery services have all items necessary for infection control.¹⁸

In the event of an obstetric emergency, the 2006 Tanzania Service Provision Assessment Survey (TSPA) notes that “[i]t was expected that all hospitals would provide comprehensive emergency obstetric services, but . . . that is not the case.”¹⁹ In reality, only one in ten facilities in Tanzania offer basic and comprehensive emergency obstetric services; as such, the national coverage rate for basic emergency obstetric care is 0.55 facilities per 500,000 people—seven times less than the number recommended by WHO, UNICEF, and UNFPA.²⁰ In fact, not a single zone in the country meets the recommended coverage for basic emergency obstetric care.²¹

In addition, there are large discrepancies in health care access based on geography, with most medical facilities offering maternal health services concentrated in urban areas. In its 2008 concluding observations, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) urged Tanzania to increase awareness of and access to health care facilities and assistance by trained medical personnel for women, especially in rural areas.²² But alarming differences remain between urban and rural women's access to services. According to the 2010 TDHS, "[p]roblems in accessing health care are felt most acutely by rural women,"²³ and over 23% of rural women cited distance to a health facility as a major barrier in accessing care, compared to only 9% of urban women.²⁴

Another major barrier to reproductive health services is cost.²⁵ According to the Tanzanian Government's report to the Committee, "pre-natal and post natal services are provided free of charge,"²⁶ however, 10% of facilities charge some sort of user fee for antenatal care (ANC) services.²⁷ In 2008, nearly 34% of people in mainland Tanzania and over 50% of people in Zanzibar lived below the basic needs poverty line,²⁸ rendering such out-of-pocket fees a serious barrier to accessing even the most basic medical services. These barriers are felt most acutely by rural women, women with no education, and women in the lower wealth quintiles.²⁹

In its 2006 concluding observations, the Committee on the Rights of the Child asked Tanzania to "allocate more financial resources to health services."³⁰ In 2008, the Ministry of Health and Social Welfare created the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015 (Strategic Plan). The Strategic Plan recognizes the need to "allocate sufficient resources to achieve national and international goals and targets."³¹ In January 2011, it was reported that the Ministry of Health and Social Welfare would receive a budgetary increase from 12 to 15% over the next three years;³² however, Ministry of Finance records indicate that the current projected budget for 2011-2012 shows a mere 0.3% increase in the funds allocated to health³³ and no increase at all for the 2012-2013.³⁴ According to the Strategic Plan, "Due to other competing health priorities . . . [the] Reproductive and Child Health budget is still limited. This has affected implementation of comprehensive interventions on maternal, family planning and newborn care."³⁵

Adolescent Maternal Health

Nearly 44% of girls in Tanzania have either given birth or are pregnant by age 19.³⁶ Adolescents in rural areas are more likely to start childbearing earlier than urban adolescents (26% and 15% respectively).³⁷ Adolescent girls run a disproportionate risk of dying during or after childbirth³⁸ and are more vulnerable to pregnancy-related complications.³⁹

Further, a strong inverse relationship exists between early childbearing and education. According to the 2010 TDHS, 52% of adolescents without formal education started childbearing, compared to only 6% of adolescents with secondary education.⁴⁰ Adolescent pregnancy also disproportionately affects low-income girls, who are more than twice as likely to start childbearing as their counterparts in the highest wealth

quintile (28% and 13% respectively).⁴¹ Adolescent pregnancy also has a detrimental impact on girls' right to education. The 2010 TDHS notes that "[c]hildbearing during the teenage years frequently has adverse social consequences, particularly for educational attainment, because women who become mothers in their teens are more likely to curtail their education."⁴²

2. UNSAFE ABORTION AND POST-ABORTION CARE

The Committee has emphasized states' obligations to reduce women's health risks and maternal mortality rates.⁴³ Unsafe abortion is one of the most easily preventable causes of maternal mortality. Even if death does not occur, a woman is likely to suffer long-term disabilities such as uterine perforation, chronic pelvic pain, sepsis, or infertility. The Tanzanian Government's report to the Committee is silent on the matter, despite the high prevalence of unsafe abortion in Tanzania.

The laws and policies dealing with abortion in Tanzania are so "inconsistent, unclear and often contradictory" that women and health care providers lack comprehensive information on what is legally permitted,⁴⁴ which hinders women's access to safe abortion. Under the Penal Code, abortion is criminalized with the only explicit exception being to save the life of the pregnant woman.⁴⁵ Under the Code, a woman found guilty of procuring an abortion can be sentenced to imprisonment of up to seven years; those that perform the procedure can receive up to 14 years; and anyone who supplies drugs or instruments to procure an abortion could face a three year sentence.⁴⁶

However, jurisprudence from courts makes clear that Tanzania's life exception encompasses a mental and physical health exception.⁴⁷ This understanding of the law is also reflected in a number of government policies. For example, the 2002 Post-Abortion Care Clinical Skills Curriculum states that therapeutic abortion is allowed, and the 2007 standard Treatment Guidelines and the National Essential Medicine List for Mainland Tanzania provide that abortion is legal when continuing the pregnancy poses a threat to the health or life of the woman.⁴⁸ However, this legal and policy framework is not implemented in practice and women wishing to terminate a pregnancy often resort to unsafe methods that put their lives and health at risk. In fact, the 2002 Post-Abortion Care Clinical Skills Curriculum, which is the primary government document focusing on post-abortion care, explicitly states that although Tanzania law allows therapeutic abortion, few women and men know about this law.⁴⁹

Even with the recognition of mental and physical health exceptions, Tanzania's abortion law falls short of compliance with its international human rights obligations. Tanzania has ratified the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol), which requires states to "take all appropriate measures to...protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus."⁵⁰ Yet, despite ratification, the Tanzanian Government has made little effort to domesticate the Protocol and to bring its national

law in line with the treaty.

Comprehensive data on abortion is difficult to obtain in Tanzania due to the criminalization of, and stigma surrounding, abortion.⁵¹ According to a study of unsafe abortion in Tanzania, “[a]ssessing the magnitude of the problem of unsafe induced abortion and its consequences is one of the least documented reproductive health problems.”⁵² However, it is estimated that 30% of all maternal deaths in Tanzania are due to complications from unsafe abortions.⁵³ A 2011 newspaper article reported that a clinic in the city “performs as many as 40 abortions per month” but did not indicate how many of these are safely performed.⁵⁴ In 2009, the New York Times reported that in one hospital, in the month of January 2009 alone, 17 of 31 minor surgical procedures were done to repair incomplete or botched abortions by untrained individuals.⁵⁵

The problem has been a long standing one—a study found that 47% of the 965 obstetric admissions in 1992 at Muhimbili National Referral Hospital in Dar es Salaam were abortion complications.⁵⁶ Moreover, a 2003 country evaluation report estimated that nationally, nearly one-third of all hospitalized cases of unsafe or incomplete abortions are women under 20.⁵⁷

Although the government has publicly committed to providing post-abortion care (PAC) for complications from unsafe abortion and issued guidelines to that effect,⁵⁸ PAC is not widely available or accessible.⁵⁹ According to the 2006 TSPA, “The ability to provide care to a woman after an incomplete abortion is vital to prevent any further complications.”⁶⁰ Yet, the availability of the required equipment is extremely limited in all health care facilities (ranging between 5% and 8%).⁶¹

In addition, training on PAC is limited and inadequate. The government has failed to follow through on its 2002 commitment to “scal[e] up comprehensive PAC so as to reduce abortion related maternal mortality and morbidity through training of middle level health service providers such as clinical officers, nurse-midwives . . . [and] to ensure that comprehensive PAC services are available at lower level health facilities.”⁶² Although PAC is included in medical training for doctors in Tanzania, a 2007 Engender Health report found that it is often not included in training of other health staff such as nurses and midwives.⁶³ The same report shows that PAC services remain largely concentrated in urban areas and district hospitals.⁶⁴

In addition to staff shortages, several other barriers exist in accessing timely and quality post-abortion care, including a lack of government commitment to stock and supply facilities with the necessary equipment, difficulty in obtaining supplies, and over-used manual vacuum aspirators (MVAs) in dire need of replacement.⁶⁵ The shortages of necessary equipment, such as MVAs, result in delays and denials of treatment for women needing this emergency service.⁶⁶

3. ACCESS TO COMPREHENSIVE FAMILY PLANNING SERVICES AND INFORMATION

The Committee has consistently recognized that lack of access to family planning information and services violates the right to health⁶⁷ and that low contraceptive prevalence contributes to unsafe abortion and maternal death.⁶⁸

Although Tanzania has seen a gradual and steady increase in contraceptive use and prevalence in the last two decades,⁶⁹ only 24% of all women are using a modern method.⁷⁰ Current contraceptive use varies substantially based on geography and demographics. Currently married urban women are almost 1.5 times more likely to use a contraceptive method than their rural counterparts (46% and 31%, respectively), and the prevalence increases with a woman's education and wealth quintile.⁷¹ Moreover, women in mainland Tanzania are almost twice as likely as women in Zanzibar to use any method of contraception.⁷²

Twenty-five percent of currently married women and over 18% of all women have an unmet need for family planning, an increase from the 2004-2005 TDHS.⁷³ Thirty percent of currently married women report that they wish to stop childbearing altogether, and a majority of women with at least one child want to either delay their next birth or stop childbearing completely.⁷⁴ Over one fourth of births in Tanzania are either mistimed or unwanted,⁷⁵ which contributes to the high rates of unsafe abortions and maternal deaths.

Contraceptive prevalence and exposure to family planning messages are significantly higher in urban areas than rural areas.⁷⁶ Moreover, stock outs of contraceptive methods are a considerable problem, which disproportionately affects certain parts of the country: only 9% of health facilities in the Southern zone and 7% of health facilities in the Eastern zone had every method offered available.⁷⁷

Many women could avoid unwanted pregnancies with use of emergency contraception (EC), a safe and effective means of preventing pregnancy following unprotected sex. The WHO considers EC to be a safe, convenient, and effective method of modern contraception⁷⁸ and it has been safely used on the global market for 30 years.⁷⁹ However, although EC is included in family planning guidelines in Tanzania,⁸⁰ it cannot be obtained from public clinics or hospitals.⁸¹ In fact, in 2007, USAID concluded that EC was not accessible in Tanzania.⁸² In addition, the 2010 TDHS reports that less than 12% of men and women have knowledge of EC.⁸³

4. DISCRIMINATION AGAINST WOMEN AND GIRLS

This Committee has noted that "States have a special obligation . . . to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the right to health."⁸⁴ General Comment 14 reiterates state obligations to fulfill "the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups,"⁸⁵ including women.

This Committee has also imposed upon states the obligation to promote equality and non-discrimination through the “elimination of prejudices, customary and all other practices that perpetuate the notion of inferiority or superiority of either of the sexes, and stereotyped roles for men and women.”⁸⁶

The 2000 amendments to the Tanzanian Constitution explicitly prohibit discrimination on the basis of sex;⁸⁷ however, the country’s legislation has not effectively absorbed this principle.⁸⁸

Discrimination against Women Living with HIV

In 2007, the Government of Tanzania launched its second National Multi-Sectoral Strategic Framework on HIV and AIDS and, in 2008, it enacted the HIV and AIDS (Prevention and Control) Act (2008 Act) which, among other things, protects people living with HIV and AIDS from discrimination and stigmatization, and obligates the government and employers to advocate against such.⁸⁹ Despite this, the Tanzania Commission for AIDS (TACAIDS) acknowledges that “[s]tigma and discrimination against people living with HIV/AIDS are quite common.”⁹⁰

According to a 2007 USAID evaluation regarding knowledge, attitudes and practices of health care providers towards people living with HIV in Tanzania, nearly half of health care providers reported discriminatory treatment, including lack of confidentiality, lack of patient consent in testing or disclosure, selective use of universal precautions, isolation of people living with HIV, sub-standard treatment, financial discrimination, and active or passive denial of services.⁹¹ Similarly, in a 2008 Population Council report, 63% of Tanzanian women reported experiencing stigma and discrimination regarding their HIV status, and 59% of health care providers observed such practices among their peers.⁹² Despite a number of policies in place to address the growing HIV epidemic, a 2010 United Nations General Assembly Special Session (UNGASS) report on Tanzania suggests that policy implementation is hindered by systemic inadequacies.⁹³ Moreover, inadequate training and knowledge of the HIV and AIDS Act, and failure to harmonize the act with other legislation leads to ineffective enforcement.⁹⁴

While the 2008 Act prohibits discrimination, it undercuts this position by criminalizing intentional transmission of HIV under Section 47, punishable by a prison term of up to ten years,⁹⁵ and requiring immediate disclosure of HIV positive status to a spouse or sexual partner under Section 21(1)(a).⁹⁶ Section 47 could be interpreted to include criminalization of vertical HIV transmission in Tanzania,⁹⁷ and fear of prosecution may prevent or discourage many women from seeking appropriate prenatal care to minimize the risk of vertical transmission during pregnancy. Criticisms of laws that criminalize transmission of HIV are numerous, and these laws, such as the 2008 Act, increase stigma and discrimination and fail to address the complexities involved in disclosure of HIV status.⁹⁸ Ample evidence exists to suggest that such laws do little to stem the spread of HIV or foster safe attitudes toward sex, and in fact discourage voluntary testing, treatment, use of support services, and disclosure.⁹⁹

Moreover, women are at far greater risk of prosecution under these laws as they are more likely to know their HIV status, in part because they are offered HIV counseling and testing as part of ante-natal care.¹⁰⁰ Because women are more likely to know their sero-status, they are more likely to be accused by their spouses or partners of introducing HIV to the relationship.¹⁰¹ Studies have shown that disclosure of HIV status, as required by Section 21(1)(a) of the 2008 Act, places women at greater risk for abuse and abandonment.¹⁰²

Further, a woman seeking voluntary counseling and treatment (VCT) faces barriers in access, treatment, and care. Although antiretroviral treatment (ARV) is theoretically free in Tanzania, a 2006 study by the International Community of Women Living with HIV/AIDS (ICW) indicates that women encounter charges and bribes levied for ARVs and unavailability of treatment.¹⁰³ One woman reported that “One of the basic condition[s] that face us, mostly women living with HIV, is paying for ARVs instead of getting them free, and the medication and other things you need are not always available when you go to the clinic or hospital.”¹⁰⁴ Despite the government’s commitment to reduce vertical HIV transmission, only 53% of women are aware of techniques in prevention of vertical transmission,¹⁰⁵ and none of the women in the ICW study had accessed or been able to access these services, or had even received information on such services.¹⁰⁶

Even though the overall HIV prevalence rate has decreased in Tanzania, a significant discrepancy continues to exist in the HIV infection rates for women (6.8% in 2008) compared to men (4.7% in 2008).¹⁰⁷ Women and young people emerge as the two groups most greatly affected by the HIV/AIDS epidemic,¹⁰⁸ due to a host of economic, cultural, and social factors.¹⁰⁹

Discrimination against Unmarried Women and Adolescent girls: Access to Family Planning Services and Information

Women, particularly adolescent girls and unmarried women, in Tanzania seeking contraceptive services often face discrimination. Yet, both the 1994 Family Planning Unit of the Ministry of Health and Social Welfare’s National Policy Guidelines and Standards for Family Planning Services and Training, and the 2008 National Roadmap and Strategic Plan for the Reduction of Maternal, Newborn and Child Deaths require the provision of contraceptive and family planning information and services without discrimination and bias.

Many individual providers, motivated by personal biases, restrict access to contraceptive methods on the basis of age or marital status, despite the fact that no legal, medical, or policy basis exists for doing so, and such discriminatory practices are not sanctioned by government law or policy.¹¹⁰ A comprehensive 2000 Guttmacher study, found that between 79% and 81% of medical aides, midwives, maternal and child health aides and auxiliary staff (medical providers most commonly found in rural areas) reported imposing an age restriction for birth control pills, and more than one third of providers reported an age restriction for condoms.¹¹¹ The age minimum most often reported was 14-15 years old, which prevents young, sexually active women from accessing nearly all

forms of contraception, increasing their likelihood of unwanted, premarital pregnancies.¹¹²

In addition, 20% of providers reported imposing restrictions based on a woman's marital status, preventing a large population of sexually active, unmarried women from protecting themselves against unwanted pregnancies.¹¹³ The most conservative staff, and the most likely to impose restrictions without a medical basis, are often found in rural areas, and are more likely to supply contraceptive methods to women of a certain age, married women, and women with an average of 2.5 children.¹¹⁴ A 2011 study confirmed that providers were still imposing age restrictions for contraceptive access arbitrarily, and were further requiring parental or spousal consent for those who were younger than 18 years.¹¹⁵ The researchers conducted interviews with 102 providers during which over a third of providers indicated "that they would not provide contraceptives to those less than 18 years of age, unmarried, still in school, and those without children."¹¹⁶ Further, just one quarter of providers indicated that they "were comfortable giving contraceptives to sexually active young people."¹¹⁷

Although government policies seem to prohibit such discrimination,¹¹⁸ such policies are clearly inadequately enforced, leaving service providers wide discretion in supplying contraception with devastating consequences for women and girls. Adolescents also face discrimination in access to sexual and reproductive health-related information. Nearly 60% of adolescents in Tanzania have sex before the age of 18;¹¹⁹ yet, adolescents receive limited information about contraceptives. As a result, according to the 2010 TDHS, less than 11% of women 15-19 years old use any form of contraception.¹²⁰ Early sexual activity and lack of access to contraception exposes adolescent girls to reproductive health risks including unwanted pregnancies, unsafe abortion, high-risk pregnancies, and exposure to HIV and other STIs. Tanzania has one of the highest adolescent pregnancy rates in the world, which not only exposes young women and girls to the aforementioned health risks, but increases the likelihood that they will drop out of school. The 2006-2010 Basic Education Statistics in Tanzania reports that nearly 8,000 girls drop out of school as a result of pregnancy every year;¹²¹ there is no data indicating that girls return and complete their education. In fact, information in the section below clearly establishes that the government has not developed a law or policy to ensure their re-entry.

Most young people, including girls, often lack the knowledge and capacity to negotiate safe sex, and are therefore more likely to engage in unplanned and unprotected sex.¹²² The CEDAW Committee's 2008 concluding observations on Tanzania recommend that "sex education be widely promoted and targeted at adolescent girls and boys, with special attention to the prevention of early pregnancy and the control of sexually transmitted infections."¹²³ Tanzanian youth have consistently faced barriers in accessing reproductive health and HIV/AIDS services because facilities are geared toward adults, adolescents face stigmatization and discrimination in accessing such services, and adolescents have limited money for, transportation to, and knowledge of service facilities.¹²⁴ In addition, public opinion largely stigmatizes adolescent sexuality, and opposition exists to promoting health services for adolescents for fear that it condones and promotes

promiscuity.¹²⁵ The United Nations Population Fund (UNFPA), however, reports that numerous studies have concluded that access to family planning information and services does not lead to increased sexual activity, and that “Young people need comprehensive information and access to services. They have the right to privacy, confidentiality and respect.”¹²⁶

As a result, and with few exceptions to the contrary, the Tanzanian Government has largely left the promotion of youth-friendly health services to non-governmental organizations, which have limited resources and reach and cannot adequately promote systemic changes.¹²⁷

Discrimination against Adolescent Girls: Coercive Pregnancy Testing and Expulsion of Pregnant School Girls

Rather than providing girls with the information and contraception they need to prevent pregnancy and preventing the high incidence of sexual violence in schools,¹²⁸ many schools in Tanzania have instituted a practice of mandatory pregnancy testing, forcing some 8,000 girls to drop out of school each year because they are found pregnant.¹²⁹ Preliminary research undertaken by the Center in conjunction with Yale Law School’s Lowenstein International Human Rights Law Clinic in 2011 indicates that this practice of testing and expulsion is prevalent, widely accepted, and significantly supported by educators, government officials, and NGOs.¹³⁰

This research suggests that mandatory pregnancy testing may begin as early as 11 years of age, but is ubiquitous by secondary school, between the ages of 14 and 18.¹³¹ Testing may occur upon suspicion of pregnancy by a teacher or administrator; on specific dates for testing of all female students; and as a requirement for admission to school.¹³² Pregnancy “testing” typically takes the form of physical touching, prodding and poking of a girl’s stomach by a school official and, if a girl is suspected of being pregnant, may also involve a urine-based pregnancy test, often at a local health facility.¹³³

The results of a positive pregnancy test almost universally end in expulsion of the girl from school.¹³⁴ Many educators and administrators believe expulsion is required by law or policy; however, no law or policy document exists that requires testing and expulsion of pregnant school girls.¹³⁵

Almost universally, mandatory pregnancy tests of school girls in Tanzania are done without prior announcement or warning to prevent girls from circumventing the policy,¹³⁶ and do not require the informed consent of the child or her parents.¹³⁷ As described by an advocate at a prominent women’s rights organization in Tanzania, “It’s not up to you to be tested or not . . . you can agree or you can leave the school.”¹³⁸ Results are then disclosed to the school and then to the parents by the school, violating the girl’s right to privacy and confidential medical treatment.

Coercive pregnancy testing of school girls in Tanzania is largely treated by educators, administrators, government officials, and NGOs as a necessary disciplinary action in controlling girls’ behavior.¹³⁹ The practice also enjoys almost universal government

support. A high level official at the Ministry of Education has stated matter-of-factly that pregnant girls should simply not be in school.¹⁴⁰ Most who support the practice suggest that it is done for the girls' benefit to prevent unsafe abortion, embarrassment, shame, and to ensure greater protections for the girl's health during pregnancy.¹⁴¹ However, when pregnant girls are expelled from school, they are rarely provided referrals for medical or social services and are "left to find" ANC "on their own."¹⁴² It is evident that mandatory pregnancy testing is utilized to punish young girls rather than protect their health and future, and its widespread acceptance indicates a pervasive stigma against teenage pregnancy and discrimination against adolescent girls.¹⁴³

Forcing schoolgirls to undergo pregnancy testing and expelling those who are found to be pregnant violates a wide range of girls' human rights, including their rights to health, education and privacy. This Committee, in General Comment 14, has stated that the right to health encompasses freedoms and entitlements including "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation."¹⁴⁴ The Committee has also stated that adolescents' right to health "is dependent on the development of youth-friendly health care, which respects confidentiality and privacy. . . ."¹⁴⁵ The practice of mandatory pregnancy testing in schools directly violates these rights.

This Committee has also emphasized the importance of education, stating that "[e]ducation has a vital role in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, [and] promoting human rights and democracy. . . ."¹⁴⁶ The Committee further notes that "education must be accessible to all, especially the most vulnerable groups, in law and fact, without discrimination on any of the prohibited grounds,"¹⁴⁷ including policies that lead to de facto discrimination.¹⁴⁸ The policy of mandatory pregnancy testing and expulsion of pregnant school girls is such a discriminatory policy.

Articles 5.1 and 5.2 of the Law of the Child Act of 2009 specifically forbid gender-based discrimination,¹⁴⁹ but testing and expelling pregnant school girls is inherently discriminatory by nature and in application.¹⁵⁰ Girls are singled out for blame and punishment because only girls will show physical evidence of pregnancy (either visually or through a positive urine test result). Finally, the policy of testing and expulsion of girls is discriminatory because it punishes a status that only female students can have.

Expulsion of pregnant school girls interferes with their education (if girls are allowed to return to school, which is uncommon), or brings it to an end. Girls with little or no education or training are more likely to enter into high-risk practices, including sex trafficking and sex work, and are more likely to be abused or exploited.¹⁵¹ In addition, the practice perpetuates the stigma of teenage pregnancy and the idea that the presence of pregnant schoolgirls will contaminate "innocent girls" and cause a domino effect.¹⁵² Moreover, although many educators and administrators believe that mandatory pregnancy testing decreases the risk of unsafe abortion by early detection, the heightened stigma associated with teenage pregnancy and the harsh disciplinary outcome likely leads to

greater numbers of girls seeking unsafe and clandestine abortions,¹⁵³ not only to protect themselves from shame and discrimination, but also to protect their educational futures.

Although there has been talk by the government of introducing a re-entry policy to allow girls to return to school after giving birth, it is unclear what progress, if any, the government has made in developing and implementing such a policy.¹⁵⁴ Currently, Tanzania has no national policy or law in place to ensure a pregnant schoolgirl's right to education and to facilitate and guarantee girls' return to school and right to education following childbirth.

Early Marriage

The Covenant requires that “marriage must be entered into with the free consent of the intending spouses”¹⁵⁵ and the Committee seeks to ensure “the legal age of marriage for men and women should be the same, and boys and girls should be protected equally from practices that promote child marriage, marriage by proxy, or coercion.”¹⁵⁶ Child marriage in Tanzania is high (approximately 40% of girls are married by the age of 18),¹⁵⁷ despite the fact that Tanzania has signed and ratified a number of international treaties and instruments¹⁵⁸, many of which contain clear definitions that a “child” is a person under the age of 18, and “child marriage” is a marriage of a child below 18 years of age.¹⁵⁹

The Law of Marriage Act (LMA) legalizes child marriage, allowing boys to marry at 18, and girls to marry at 15 or 14, with the court's approval or parental consent,¹⁶⁰ which is, on its face, a discriminatory piece of legislation. TAWLA, in a 2003 review of gender discriminatory laws, specifically recommended that the government reform the LMA to address the clear discrimination against girls and to raise the age of marriage for girls to 18.¹⁶¹ Both the 2006 Committee on the Rights of the Child and 2008 CEDAW Committee concluding observations recommended that Tanzania adopt one minimum age of marriage (18 years old for both boys and girls) in line with internationally acceptable standards.¹⁶² The age of marriage for girls was first tabled for debate in the National Assembly in Tanzania in 2009,¹⁶³ but progress continues to be slow. To date, the government has done nothing to amend this discriminatory piece of legislation.

Paradoxically, under Tanzanian law, a girl of 15 can enter into a marriage contract, but cannot vote, and her age may prevent her from entering into other contracts. For a girl to marry under the age of 18 requires the consent of her parents; however, many parents, particularly in low-income, rural areas, are anxious to marry off their young daughters for the bride price.¹⁶⁴ In some areas, poverty and tradition result in girls as young as 11 or 12 being married to men often twice their age.¹⁶⁵ Such marriages would be clearly voidable pursuant to the LMA,¹⁶⁶ and sexual relations between a husband and his wife under 15 years of age, with or without her consent, are punishable by law.¹⁶⁷ However, these avenues that appear to safeguard girls are unenforced and are not heavily pursued because of debilitating court costs, lack of knowledge about the law, and corruption within the legal system that often results in cases being resolved in favor of the party able to pay bribes.¹⁶⁸

Early marriage has devastating physical, economic, social, and psychological consequences for young girls. The age difference between child brides and their spouses is often significant, young girls lack the skills to negotiate safe sex, and older men, who have often been sexually active for years, potentially bring HIV and other STIs into the marriage.¹⁶⁹ In addition, contraceptive use among married youth is low, because high bride prices place immense pressure on young girls to begin childbearing.¹⁷⁰ Young adolescent girls experience significantly more pregnancy-related complications than adult women; USAID estimates that girls younger than 15 are five times more likely to die in childbirth than women in their 20's.¹⁷¹ Children conceived in these marriages are also at greater risk of death; mortality rates are 73% higher for infants born to mothers under 20.¹⁷² Child brides are thrust into an immense role at a very young age and are often seen as property paid for by their husbands. As a result, physical abuse is common, and the instability of these marriages often leads to separation or divorce, leaving a young mother, with limited or no education, to support herself and her children.¹⁷³

Child marriage also devastates a young girl's economic and social opportunities. In Tanzania, expulsion of pregnant school girls is common practice, while expulsion upon marriage is policy.¹⁷⁴ Child marriage often compromises a young girl's future and the future of her children, contributing to cycles of poverty, illness, and lack of education,¹⁷⁵ and correlating closely to the failure to achieve nearly every MDG.¹⁷⁶

Female Genital Mutilation

Female genital mutilation (FGM) has devastating health consequences for women and girls including short and long term complications.¹⁷⁷ Short term, they might experience severe pain, shock, hemorrhaging, and urine retention.¹⁷⁸ Long term complications can include chronic infections, infertility, and pain during sexual intercourse.¹⁷⁹ It also has negative psychological consequences for them.¹⁸⁰ Complications during pregnancy and child birth are also common for women who have undergone the practice.¹⁸¹

The Committee, in General Comment 14, has recognized that states "need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls," including FGM.¹⁸² The Committee has also emphasized that states have the obligation to prevent third parties from coercing girls or women to undergo the practice.¹⁸³

In Tanzania, the Sexual Offences Special Provisions Act of 1998 prohibits performing FGM on girls under the age of eighteen.¹⁸⁴ The Government of Tanzania has also developed a National Action Plan to Combat FGM (2001-2015) to further address the problem.¹⁸⁵ Despite these measures, the practice still persists due to various reasons, such as lack of enforcement of the law¹⁸⁶ and the perception of the community that FGM is necessary to prepare to women for marital and family relationships.¹⁸⁷ According to the 2010 TDHS, 15% of women in Tanzania have undergone FGM, which is only a slight improvement from 18% prevalence recorded in the 1996 TDHS.¹⁸⁸ The prevalence of FGM is more than double in rural areas than urban areas (17.3% and 7.8% respectively) with the highest proportions of women that are circumcised being located in the Northern and Central zones.¹⁸⁹

Research shows that the age of FGM is getting lower as 34% of women in the 2004-05 TDHS underwent FGM by age 5 as opposed to 39% in the 2010 TDHS.¹⁹⁰ 37% of women between the ages of 15-49 reported to have undergone the practice before the age of 1, which is an increase from 28% in the 2004-05 TDHS.¹⁹¹

Various treaty monitoring bodies have called upon Tanzania to take the necessary measures to curtail FGM. The Human Rights Committee expressed concern about the persistence of the practice, the lack of legal protection for women above the age of eighteen and the government's failure to arrest, prosecute, and punish perpetrators.¹⁹² It then urged Tanzania to adopt "effective and concrete measures" to end FGM, punish perpetrators, and amend its legislation to also prohibit its performance on women above the age of eighteen.¹⁹³ Similarly, the Committee on the Rights of the Child recommended that the state party conduct awareness raising campaigns and sensitization programs for FGM practitioners and the public to encourage change of traditional attitudes.¹⁹⁴ However, the government has failed to include in its report information on the measures it has undertaken to enforce the law regarding FGM as well as raise the awareness of the public as to the negative consequences of the practice.

We hope that the Committee will consider addressing the following questions to the Government of Tanzania:

1. What concrete measures has the government proposed to implement the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015, and what is being done to allocate adequate resources to the implementation of these measures to ensure the Strategic Plan's success?
2. What steps are being taken to ensure the adequate recruitment, training and retention of health workers, and sufficient equipping of health care facilities to reduce deaths due to pregnancy and childbirth-related complications? In particular, what is the government doing to improve the availability of emergency obstetric care, and access to quality and timely obstetric care for low-income women and women in rural areas?
3. How does the government plan to address the high rate of teenage pregnancy which exposes girls to a disproportionate risk of maternal injury and death and jeopardizes their ability to realize their right to education?
4. What efforts are being made to clarify and publicize Tanzania's abortion law and to develop clear guidelines for health care providers to improve the accessibility and availability of services? What is the government doing to harmonize its abortion law with its obligations under international and regional treaties, such as the Maputo Protocol?

5. What measures has the government adopted to scale up access to comprehensive PAC in keeping with its commitment under the 2002 Post-Abortion Care Clinical Skills Curriculum, and to ensure access to timely, quality and affordable reproductive health counseling?
6. What specific actions has the government taken to improve access to contraceptives, and to ensure that women and adolescents receive comprehensive and accurate information about contraceptives, without discrimination on the basis of age or marital status?
7. Are integrated service programs being developed to address inadequate reproductive health and family planning needs of women and girls living with HIV? Have structures been set up to tackle the rights violations and discrimination experienced by HIV-positive women and girls around counseling, testing, confidentiality, and treatment?
8. What steps is the government taking to end the practice of coercive pregnancy testing and expulsion of pregnant schoolgirls? What is the current status of the government's proposed re-entry policy, which would allow girls to return to school after giving birth?
9. What steps are being taken to address the high rates of early marriage for girls in Tanzania? Specifically, what progress has been made in amending the Law of Marriage Act to ensure that both girls and boys cannot marry before the age of 18, in accordance with international treaties to which Tanzania is a party?
10. What is the government doing to enforce the law prohibiting FGM and raise awareness about the negative consequences of the practice?

We hope that the Committee will consider making the following recommendations to the Government of Tanzania:

1. Tanzania should increase the number of health care facilities equipped to handle basic and emergency obstetric care, especially in low-income and rural areas, and increasing the number of skilled health care providers able to offer quality and convenient ANC and post-natal care, as well as skilled assistance during childbirth.
2. The government should reduce all financial barriers to maternal health care by implementing its stated commitment to provide free maternity services in public facilities, and commit greater fiscal resources for health, with a particular focus on maternal health care in rural areas.
3. The government should publicize the life, mental health and physical health exceptions in the country's abortion law to provide clarity and remove the uncertainties regarding providing or accessing abortion services. It should take

effective steps to harmonize its abortion law with its obligations under international and regional treaties, such as the Maputo Protocol, and fulfill its commitment to provide adequate access to post-abortion care services.

4. The government should take concrete steps to ensure an adequate and consistent supply of contraceptives, initiate civic education campaigns to ensure sufficient and non-judgmental access to family planning information and services, and develop comprehensive guidelines obligating health care facilities to provide accurate and comprehensive family planning information, without discrimination based on marital status or age. .
5. The government should ensure that health care providers follow proper HIV testing, counseling, and disclosure procedures by effectively implementing guidelines and policies regarding HIV testing and treatment. . Further, it should amend the current HIV and AIDS (Prevention and Control) Act to decriminalize HIV transmission.
6. The government should explicitly prohibit coercive pregnancy testing and expulsion of pregnant school girls, bolster the existing policies that promote the enrollment and retention of girls in schools, and initiate rights-based approaches to retain pregnant school girls in school.
7. The government should amend the Law of Marriage Act to increase the age of marriage for girls to 18, and take all possible steps to end child marriage in compliance with its obligations under international treaties and standards.
8. The government should reduce and eliminate FGM by expanding and enforcing the law prohibiting FGM and initiating educational programs, particularly among groups with a high incidence of FGM, about the long-term health consequences.

We hope that this information is useful to the Committee during its review of the Tanzanian Government's compliance with the Covenant. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

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¹ International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].

² Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14, The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies*, at 79, para. 8, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

³ *Id.* at 83, para. 21.

⁴ ICESCR, *supra* note 1, art. 10(2-3).

⁵ ESCR Committee, *Gen. Comment No. 14, supra* note 2, para. 52.

⁶ WORLD HEALTH ORGANIZATION (WHO) ET AL., *TRENDS IN MATERNAL MORTALITY: 1990-2010*, 22 (2012), *available at*

http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf [hereinafter *TRENDS IN MATERNAL MORTALITY*].

⁷ *Id.* at 26.

⁸ NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., *TANZANIA DEMOGRAPHIC AND HEALTH SURVEY 2010*, 265 (2011), *available at* <http://www.measuredhs.com/pubs/pdf/FR243/FR243%5B24June2011%5D.pdf> [hereinafter 2010 TDHS].

⁹ In 2004, the MMR was 578 deaths per 100,000 live births. *See* NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., *TANZANIA DEMOGRAPHIC AND HEALTH SURVEY 2004-2005*, 261 (2005), *available at* <http://www.measuredhs.com/pubs/pdf/FR173/FR173-TZ04-05.pdf> [hereinafter 2004 TDHS].

¹⁰ States are considered to be on track if they show more than 5.5% annual decrease in maternal mortality and making progress if the annual mortality rate is decreased by 2–5.5%. *See* *TRENDS IN MATERNAL MORTALITY, supra* note 6, 45. The UNDP has also noted that for Tanzania “the challenges of reducing maternal mortality to the targeted levels under [the] MDGs are enormous” and that, given its slow progress to curb maternal deaths, achievement of MDG 5 is “unlikely.” United Nations Development Programme (UNDP) in Tanzania, *Millennium Development Goals, Goal 5: Improve Maternal Health*, http://www.tz.undp.org/mdgs_goal5.html (last visited Aug. 6, 2012).

¹¹ 2010 TDHS, *supra* note 8, at 265.

¹² The WHO recommends that a pregnant woman have at least four antenatal care (ANC) visits, allowing for adequate time to assess risk factors and determine potential obstetric complications. While 96% of women who gave birth in the five years preceding the survey received ANC from a skilled provider at least once, only 15% made their first ANC visit before the fourth month of pregnancy, and nearly one-third did not seek ANC until their sixth month of pregnancy. Moreover, only 43% made the recommended four or more visits, a sharp decline from the 2004–2005 TDHS (62%). 2010 TDHS, *supra* note 8, at 127, 129. Further, those receiving ANC may not be receiving all the necessary services associated with quality antenatal care. Although nearly 82% of facilities offer ANC, the lack of infrastructure and resources for ANC examination make it “impossible for most facilities to offer pregnant women all required ANC services and supplies.” For example, only 30 % of facilities offering ANC have all items necessary for infection control, and largely lack running water and disinfecting solution (available in only 48% and 66% of facilities respectively). Only 7% of facilities have all items needed for physical examinations. The 2006 Tanzania Service Provision Assessment Survey (TSPA) estimates that “[l]ess than half of facilities have all essential equipment and supplies for basic ANC. . . , which implies that pregnant women do not receive all required ANC services and supplies at most facilities.” NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., *TANZANIA SERVICE PROVISION ASSESSMENT SURVEY 2006*, 115, 117-119 (2007), *available at* <http://www.measuredhs.com/pubs/pdf/SPA12/SPA12.pdf> [hereinafter 2006 TSPA].

¹³ 2010 TDHS, *supra* note 8, at 136.

¹⁴ UNITED REPUBLIC OF TANZANIA, *MILLENNIUM DEVELOPMENT GOALS REPORT: MID-WAY EVALUATION 2000-2008*, 15, *available at* <http://www.tz.undp.org/docs/MDGprogressreport.pdf> [hereinafter *MDG REPORT*]; *see also* Presentation by Ministry of Health, Reproductive and Child Health Unit (Tanz.): Tanzania Reproductive and Child Health Survey Preliminary Findings (1999).

¹⁵ UNITED REPUBLIC OF TANZANIA, *COUNTRY REPORTS ON THE MILLENNIUM DEVELOPMENT GOALS 2010*, fig. 3.20 & 3.21, 30 (2011) *available at*

<http://www.povertymonitoring.go.tz/WhatisNew/MDG%20Report%202010.pdf>.

¹⁶ 2010 TDHS, *supra* note 8, at 134.

¹⁷ *Id.* at 135.

¹⁸ 2006 TSPA, *supra* note 12, at 137.

¹⁹ *Id.* at 147.

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- ²⁰ *Id.* at 147, 149; *see also* UNICEF ET AL., GUIDELINES FOR MONITORING THE AVAILABILITY AND USE OF OBSTETRIC SERVICES 27 (1997), *available at* http://www.childinfo.org/files/maternal_mortality_finalgui.pdf.
- ²¹ 2006 TSPA, *supra* note 12, at 149. In addition, timely provision of post-natal care is critical for the health and survival of both mother and child. However, according to the 2010 TDHS, only 31% of women are examined within the two critical days following delivery, and nearly 65% of women did not receive a postnatal checkup. 2010 TDHS, *supra* note 8, at 138.
- ²² Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: United Republic of Tanzania*, para. 137, U.N. Doc. CEDAW/C/TZA/CO/6 (2008).
- ²³ 2010 TDHS, *supra* note 8, at 141. Also, urban women are almost two times more likely than rural women to receive postnatal care, give birth at a health facility, and give birth with the assistance of a health professional, despite the fact that nearly 80% of births occur in rural areas. *Id.* at 134-136, 138.
- ²⁴ *Id.* at 141.
- ²⁵ Over 24% of women reported “getting money for treatment” as a problem in accessing health care. *Id.* at 141.
- ²⁶ Government of United Republic of Tanzania, *Combined initial, second and third periodic reports submitted by States parties under articles 16 and 17 of International Covenant on Economic, Social and Cultural Rights: United Republic of Tanzania*, para. 112, U.N. Doc. E/C.12/TZA/1-3 (2011) [hereinafter Tanzania Government Report (2011)].
- ²⁷ 2006 TSPA, *supra* note 12, at 123.
- ²⁸ MDG REPORT, *supra* note 14, at iii (Note here that Tanzania does not use the international one dollar per day poverty line. Instead it uses its own poverty line, which, according to the report, is way below the international standard).
- ²⁹ 2010 TDHS, *supra* note 8, at 141.
- ³⁰ Committee on the Rights of the Child (CRC Committee), *Concluding Observations: United Republic of Tanzania*, para. 45(b), U.N. Doc. CRC/C/TZA/CO/2 (2006).
- ³¹ MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZ.), NATIONAL ROAD MAP STRATEGIC PLAN TO ACCELERATE REDUCTION OF MATERNAL, NEWBORN AND CHILD DEATHS IN TANZANIA 2008-2015, 16 (2008), *available at* <http://www.who.int/pmnch/countries/tanzaniamapstrategic.pdf> [hereinafter STRATEGIC PLAN].
- ³² Frank Kimboy, *Govt Promises Health Budget Boost*, THE CITIZEN, <http://thecitizen.co.tz/news/-/7604-govt-promises-health-budget-boost> (last visited Aug. 22, 2012).
- ³³ Hon. Mustafa Haidi Mkulo, Minister of Finance, Speech by the Minister for Finance introduction to the National Assembly: The Estimates of Government Revenue and Expenditure for the Fiscal Year 2011/2012, 28 (June 9, 2011), *available at* <http://www.mof.go.tz/mofdocs/budget/speech/Budget%202011%20english.pdf>.
- ³⁴ Hon. DR. William Augustao Mgimwa, Minister of Finance, Speech by the Minister for Finance introduction to the National Assembly: The Estimates of Government Revenue and Expenditure for the Fiscal Year 2012/2013, *available at* <http://www.mof.go.tz/mofdocs/budget/speech/HOTUBA%20YA%20BAJETI%202012-13%20%20-%20%20ENGLISH.pdf>.
- ³⁵ STRATEGIC PLAN, *supra* note 31, at 13.
- ³⁶ 2010 TDHS, *supra* note 8, at 64.
- ³⁷ *Id.* at 65.
- ³⁸ WHO & UNITED NATIONS POPULATION FUND (UNFPA), PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 5, 10 (2006), *available at* http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf.
- ³⁹ *Id.* at 13-15.
- ⁴⁰ 2010 TDHS, *supra* note 8, at 65.
- ⁴¹ *Id.* at 65.
- ⁴² *Id.* at 64.
- ⁴³ ESCR Committee, *Gen. Comment No. 14*, *supra* note 2, at 83, para. 21.
- ⁴⁴ CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN MAINLAND TANZANIA 6 (2012) [hereinafter TECHNICAL GUIDE TANZANIA].
- ⁴⁵ PENAL CODE ACT, Cap. 16, secs. 150, 151, 219, 230 (Tanz.).
- ⁴⁶ *Id.* secs. 150, 151, 152.
- ⁴⁷ TECHNICAL GUIDE TANZANIA, *supra* note 44, at 22-26.
- ⁴⁸ *Id.* at 26.
- ⁴⁹ *Id.* at 34-35.
- ⁵⁰ Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14, para. 2(c) [hereinafter Maputo Protocol].⁵¹ NEIL PRICE ET AL., ADDRESSING THE REPRODUCTIVE HEALTH RIGHTS AND NEEDS OF YOUNG PEOPLE SINCE ICPD: THE

CONTRIBUTION OF UNFPA AND IPPF, TANZANIA COUNTRY EVALUATION REPORT 24 (2003) [hereinafter TANZANIA COUNTRY EVALUATION REPORT].

⁵² Vibeke Rasch & Rose Kipingili, *Unsafe abortion in urban and rural Tanzania: method, provider and consequences*, 14(9) J. OF TROPICAL MED. & INT'L HLTH. 1128, 1132 (2009).

⁵³ EngenderHealth, *Miriam's Story: When Care Comes Not a Minute Too Soon*, <http://www.engenderhealth.org/mdgfive/story-miriam.html> (last visited Oct. 27, 2011); *see also Abortion remains a crime in Tanzania*, DAILY NEWS ONLINE EDITION (Nov. 26, 2010, 4:00 PM), <http://www.dailynews.co.tz/home/?n=14901>.

⁵⁴ *Abortion Business Skyrocketing*, AFRICA NEWS (JUN. 6, 2011, 10:16 AM), http://www.africanews.com/site/TANZANIA_Abortion_business_skyrocketing/list_messages/38738.

⁵⁵ Denise Grady, *The Deadly Toll of Abortion by Amateurs*, NY TIMES (Jun. 1, 2009), <http://www.nytimes.com/2009/06/02/health/02abort.html>. In 2010, the Globe and Mail reported that unsafe abortion continues to account for nearly one fifth of all maternal deaths in Tanzania. Geoffrey York, *Africa's deadly backroom abortions*, THE GLOBE & MAIL (May 17, 2010, 1:50 PM), <http://www.theglobeandmail.com/news/world/g8-g20/africa/africas-deadly-backroom-abortions/article1564162/page1/>.

⁵⁶ TANZANIA COUNTRY EVALUATION REPORT, *supra* note 51, at 24-25.

⁵⁷ *Id.* at 25.

⁵⁸ STRATEGIC PLAN, *supra* note 31, at 16; *see also* MINISTRY OF HEALTH (TANZ.), NATIONAL PACKAGE OF ESSENTIAL HEALTH INTERVENTIONS IN TANZANIA (2000), *available at* http://www.moh.go.tz/documents/national_package_essential_health.pdf.

⁵⁹ The Strategic Plan acknowledges that PAC can significantly reduce the number of maternal deaths; however, very few facilities in Tanzania (5%) are equipped to handle such care. STRATEGIC PLAN, *supra* note 31, at 6; *see also* UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID), DECENTRALIZATION OF POST-ABORTION CARE IN SENEGAL AND TANZANIA, *available at* http://www.usaid.gov/our_work/global_health/pop/news/issue_briefs/pac_brief_senegal_tanzania.pdf.

⁶⁰ 2006 TSPA, *supra* note 12, at 141.

⁶¹ *Id.* at 323.

⁶² MINISTRY OF HEALTH (TANZ.), POST-ABORTION CARE CLINICAL SKILLS CURRICULUM TRAINER'S GUIDE, VOL. 1, 1 (2002).

⁶³ MONICA WANJIRU ET AL., ASSESSING THE FEASIBILITY, ACCEPTABILITY AND COST OF INTRODUCING POSTABORTION CARE IN HEALTH CENTRES AND DISPENSARIES IN RURAL TANZANIA 3 (2007), *available at* http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Tanzania_PAC.pdf.

⁶⁴ *Id.* at 1-3.

⁶⁵ *Id.* at 6-7.

⁶⁶ *Id.* at 7.

⁶⁷ CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW, BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORLD OF U.N. TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS 117 (2002). This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, ESCR Committee, *Concluding Observations: Armenia*, para. 15, U.N. Doc. E/C.12/1/Add.39 (1999); *Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); *Dominican Republic*, para. 15, U.N. Doc. E/C.12/1/Add.16 (1997); *Dominican Republic*, para. 22, U.N. Doc. E/C.12/Add.6 (1996); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Paraguay*, para. 16, U.N. Doc. E/C.12/1/Add.1 (1996); *Poland* para. 12, U.N. Doc. E/C.12/1/Add.26 (1998); *Saint Vincent and the Grenadines*, para. 12, U.N. Doc. E/C.12/1/Add.21 (1997).

⁶⁸ ESCR Committee, *Concluding observations: Dominican Republic*, paras. 28-29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *see also* ESCR Committee, *Concluding observations: Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Nicaragua*, paras. 26-27, U.N. Doc. E/C.12/NIC/CO/4 (2008); *Azerbaijan*, para. 30, U.N. Doc. E/C.12/1/Add.104 (2004); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998).

⁶⁹ In 1991-1992, only 10% of currently married women used any form of contraception. That number has steadily increased and in 2010, 34% of currently married women use any form of contraception. *See* 2010 TDHS, *supra* note 8, at 70.

⁷⁰ *Id.* at 68-69.

⁷¹ *Id.* at 70.

⁷² *Id.* at 70.

⁷³ *Id.* at 110; *see also* 2004 TDHS, *supra* note 9, at 114-115.

⁷⁴ 2010 TDHS, *supra* note 8, at 108.

⁷⁵ *Id.* at 115.

⁷⁶ *Id.* at 77.

⁷⁷ 2006 TSPA, *supra* note 12, at 95. Also, only 37% of health facilities in the Southern zone had male condoms, despite the fact that nearly 7% of the population in the Southern zone is living with HIV. *Id.*

⁷⁸ WHO, EMERGENCY CONTRACEPTION: A GUIDE FOR SERVICE DELIVERY 7 (1998), available at <http://snap3.uas.mx/RECURSO1/unfpa/data/docs/unpf0025.pdf>.

⁷⁹ International Consortium for Emergency Contraception, *What is Emergency Contraception*, <http://www.cecinfo.org/what/index.htm> (last visited Oct. 27, 2011).

⁸⁰ See e.g., MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZ.), NATIONAL GUIDELINES FOR MANAGEMENT OF SEXUALLY TRANSMITTED AND REPRODUCTIVE TRACT INFECTIONS, 59 (2007), available at http://www.jica.go.jp/project/tanzania/001/materials/pdf/sti_01.pdf; see also International Consortium for Emergency Contraception, *EC Status and Availability: Tanzania*, <http://www.cecinfo.org/database/pill/countrieDisplay.php?countdist=Tanzania> (last visited Oct. 27, 2011) [hereinafter *EC Status and Availability*].

⁸¹ *EC Status and Availability*, *supra* note 80.

⁸² See USAID, *Tanzania: National Laws Regarding Gender, Reproductive Health and Family Planning*, <http://www.esdproj.org/site/PageServer?pagename=LawsTanzania> (last visited Oct. 27, 2011); see also USAID, *Tanzania: Laws Regarding Gender, Reproductive Health and Family Planning*, http://www.esdproj.org/site/DocServer/TANZANIA_-_Legal_Summary.pdf?docID=3759 (last visited Oct. 27, 2011).

⁸³ 2010 TDHS, *supra* note 8, at 68.

⁸⁴ ESCR Committee, *Gen. Comment No. 14*, *supra* note 2, at 82-83, para. 19.

⁸⁵ *Id.* at 89, para. 43(a).

⁸⁶ Committee on Economic, Social and Cultural Rights, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), in *Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies*, at 117, para. 19, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 16*].

⁸⁷ See CONST. OF THE UNITED REPUBLIC OF TANZANIA, Cap. 2 (*amended in 2000*), art. 13(5).

⁸⁸ Organisation for Economic Cooperation and Development, *Social Institutions and Gender Index: Tanzania*, <http://genderindex.org/country/tanzania> (last visited Oct. 27, 2011).

⁸⁹ HIV AND AIDS (PREVENTION AND CONTROL) ACT 2008, Part VII (2008) (Tanz.) [hereinafter PREVENTION AND CONTROL ACT]; see also Avert, *HIV and AIDS in Tanzania*, <http://www.avert.org/hiv-aids-tanzania.htm> (last visited Oct. 27, 2011).

⁹⁰ Tanzania National Website, *HIV/AIDS in Tanzania*, http://www.tanzania.go.tz/hiv_aids.html (last visited Oct. 27, 2011) [hereinafter *HIV/AIDS in Tanzania*].

⁹¹ USAID, EVALUATION OF KNOWLEDGE, ATTITUDES, AND PRACTICES OF HEALTH CARE PROVIDERS TOWARD HIV-POSITIVE PATIENTS IN TANZANIA 14 (2007), available at <http://www.hciproject.org/sites/default/files/Tanzaniastigma.pdf>.

⁹² LAURA NYBLADE ET AL., MOVING FORWARD: TACKLING STIGMA IN A TANZANIAN COMMUNITY, POPULATION COUNCIL HORIZONS FINAL REPORT 5 (2008).

⁹³ Lower level government practitioners lack a sense of policy ownership, policy guidelines and expectations are not widely distributed and are inadequately translated and disseminated, and the policy frameworks, while seemingly multi-structural and comprehensive, in reality concentrate the government response only to the Ministry of Health and TACAIDS. UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION (UNGASS), UNGASS 2010 PROGRESS REPORTING: TANZANIA MAINLAND 15 (2010) [hereinafter UNGASS REPORT].

⁹⁴ Avert, *HIV and AIDS in Tanzania*, <http://www.avert.org/hiv-aids-tanzania.htm> (last visited Oct. 27, 2011).

⁹⁵ PREVENTION AND CONTROL ACT, *supra* note 89, sec. 47.

⁹⁶ *Id.* sec. 21(1)(a).

⁹⁷ See generally, Patrick Eba, *One size punishes all: A critical appraisal of the criminalization of HIV transmission*, AIDS LEGAL NETWORK, 5, 7 (2008); Geoffrey York, *HIV+ women in Africa sterilized, stigmatized*, THE GLOBE & MAIL (2009), <http://m.theglobeandmail.com/news/world/hiv-women-in-africasterilized-stigmatized/article1181722/?service=mobile> (last visited Aug. 23, 2012).

⁹⁸ Avert, *Criminal Transmission of HIV*, <http://www.avert.org/criminal-transmission.htm> (last visited Oct. 27, 2011) [hereinafter *Criminal Transmission of HIV*].

⁹⁹ *Id.*

¹⁰⁰ TANZANIA COMMISSION FOR AIDS (TACAIDS), TANZANIA HIV/AIDS AND MALARIA INDICATOR SURVEY 81-84 (2008) [hereinafter 2008 THMIS].

¹⁰¹ See *Criminal Transmission of HIV*, *supra* note 98; see also *The plight of Tanzanian women living with HIV/AIDS*, PANAPRESS, <http://www.panapress.com/The-plight-of-Tanzanian-women-living-with-HiV-AiDS--12-542429-25-lang1-index.html> (last visited Oct. 27, 2011).

¹⁰² A study in the American Journal of Public Health on partner violence of HIV positive women in Tanzania found that HIV positive women were more than 2.5 times as likely to report physical or sexual violence from their partner than HIV negative women, and more than 27% of women agreed or strongly agreed with the statement that “Violence is a major problem in my life.” Suzanne Maman et al., *HIV Positive Women Report More Lifetime Partner Violence: Findings from a Voluntary Counseling and Testing Clinic in Dar es Salaam*, 92(8) AM. J. OF PUB. HLTH., 1331, 1333 (2002).

¹⁰³ INTERNATIONAL COMMUNITY OF WOMEN LIVING WITH HIV/AIDS, MAPPING OF EXPERIENCES OF ACCESS TO CARE, TREATMENT AND SUPPORT: TANZANIA 2 (2006) [hereinafter ICW MAPPING].

¹⁰⁴ In addition, women report pressure from their spouses or sexual partners to share their ARVs, and often face violence if they refuse or are reluctant to do so. *Id.*

¹⁰⁵ 2008 THMIS, *supra* note 100, at 57-58.

¹⁰⁶ ICW MAPPING, *supra* note 103.

¹⁰⁷ TACAIDS, GENDER AUDIT ON TANZANIA NATIONAL RESPONSE TO HIV AND AIDS, xiv (2009).

¹⁰⁸ *HIV/AIDS in Tanzania*, *supra* note 90.

¹⁰⁹ *Id.*; see also, UNGASS REPORT, *supra* note 93, at 2. Young girls represent a large proportion of new HIV cases, because the culture of general discrimination denies girls human rights and exposes them to adult roles and responsibilities at an early age, making them vulnerable to exploitation and abuse through early and coercive marriage, commercial sex work, and domestic work. UNGASS REPORT, *supra* note 93, at 13.

¹¹⁰ See generally, Ilene S. Speizer et al., *Do Service Providers in Tanzania Unnecessarily Restrict Clients’ Access to Contraceptive Methods?*, 26(1) INT’L FAMILY PLANNING PERSPECTIVES 13, 13-14 (2000), available at <http://www.guttmacher.org/pubs/journals/2601300.html>; see also STRATEGIC PLAN, *supra* note 31, at 5.

¹¹¹ Speizer, *supra* note 110, at 16-17.

¹¹² *Id.* at 17.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ Gorrette Nawaldda et al, *Constraints and Prospects for Contraceptive Service Provision to Young People in Uganda: Providers’ Perspectives*, 11:220 BMC HLTH. SERVICES RESEARCH 5-7 (2011), available at <http://www.biomedcentral.com/1472-6963/11/220>.

¹¹⁶ *Id.* at 5.

¹¹⁷ *Id.*

¹¹⁸ The Strategic Plan has a goal of increasing contraceptive prevalence by making quality family planning services more accessible to and equitable for all people. See generally, STRATEGIC PLAN, *supra* note 31, at 5; see also, generally, MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZ.), NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PROGRAM 1, 10 (2010), available at <http://www.fhi.org/NR/rdonlyres/enwwgq7tbgh5yq6fpxstxysfmgc77rubxj7gr3eyyutzrzb62jkr5ouwjljhtqkuju4ighqagld/NatPlanFPImplementationTZfull.pdf>.

¹¹⁹ *Giving Young Women a Voice in Rural Tanzania*, AFRICAN MEDICAL & RESEARCH FOUNDATION, <http://uk.amref.org/where-we-work/our-work-in-tanzania/giving-young-women-a-voice-in-rural-tanzania/> (last visited Oct. 27, 2011); see also 2010 TDHS, *supra* note 8, at 97.

¹²⁰ 2010 TDHS, *supra* note 8, at 69.

¹²¹ MINISTRY OF EDUCATION AND VOCATIONAL TRAINING (TANZ.), BASIC EDUCATION STATISTICS IN TANZANIA 2006-2010, 23, 60 (2010) [hereinafter BEST].

¹²² PATHFINDER INT’L., INTEGRATING YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN PUBLIC HEALTH FACILITIES: A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA 1 (2005) available at http://www.pathfind.org/site/DocServer/Tanz_case_study_FINAL.pdf?docID=5161 [hereinafter A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA].

¹²³ CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, para. 137, U.N. Doc. CEDAW/C/TZA/CO/6 (2008).

¹²⁴ A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA, *supra* note 122, at 1-2.

¹²⁵ *Id.* at 1.

¹²⁶ UNFPA, *UNFPA and Adolescents*, http://www.unfpa.org/public/cache/offonce/home/sitemap/icpd/International-Conference-on-Population-and-Development/unfpa_and_adolescents#contraceptive_use (last visited Oct. 28, 2011).

¹²⁷ A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA, *supra* note 122, at 2.

¹²⁸ A 2011 report produced by the Government of Tanzania and UNICEF suggests that nearly 17% of girls reported at least once incident of sexual abuse on school grounds, and over one-fourth of girls have experienced at least one incident of sexual violence on their way to or from school. UNITED REPUBLIC OF TANZANIA, VIOLENCE AGAINST CHILDREN IN TANZANIA 52 (2011), *available at* http://www.unicef.org/media/files/VIOLENCE_AGAINST_CHILDREN_IN_TANZANIA_REPORT.pdf. It is likely that these numbers are underreported, for complex social and cultural reasons including lack of understanding of violence, and parents' attitudes towards their girl children that lead to disbelief of allegations when raised. *See generally*, ACTIONAID INT'L, VIOLENCE AGAINST GIRLS AND THE RIGHT TO EDUCATION (2004), *available at* <http://www.actionaid.se/files/StopViolenceAgainstGirls.pdf>.

¹²⁹ BEST, *supra* note 121, at 23, 60.

¹³⁰ Research conducted by the Center for Reproductive Rights and Yale Law School's Allard K. Lowenstein International Human Rights Law Clinic (Jan. 2011) (on file with the Center for Reproductive Rights) [hereinafter Research conducted by the Center and Yale Law School].

¹³¹ *Id.*

¹³² Interview with Headmaster at private high school (Jan. 20, 2011) (on file with the Center for Reproductive Rights); Interview with high level official at the Ministry of Community Development, Gender, and Children (Jan. 13, 2011) (on file with the Center for Reproductive Rights); *see also* Interview with high level official, Ministry of Education (Jan. 18, 2011) (on file with the Center for Reproductive Rights).

¹³³ Interview with Headmaster at private high school, *supra* note 132; *see also* Interview with high level official at the Ministry of Community Development, Gender, and Children, *supra* note 132; Interview with teachers at private secondary school (Jan. 19, 2011) (on file with the Center for Reproductive Rights).

¹³⁴ Education circulars suggest that school boys who impregnate school girls are also to be expelled, but it is more difficult to find boys responsible and this practice is largely unenforced. *See* Interview with right to education NGO in Tanzania (Jan. 21, 2011) (on file with the Center for Reproductive Rights); Interview with UNICEF official (Jan. 18, 2011) (on file with the Center for Reproductive Rights).

¹³⁵ Research conducted by the Center and Yale Law School, *supra* note 130. At best, some combination of policy documents is perceived to give the Ministry of Education the authority to test and expel school girls. Many people cite to the Education Act of 1978 and its amendments in 2002, the Education (Expulsion and Exclusion of Pupils from Schools) Regulations of 2002, or policy circulars as the derivation of an educator's, administrator's, or government official's authority to test and expel pregnant school girls; however, no law individually permits such action, and no standardized policy or guidelines exist. As such, authority is simply assumed, and the legality of testing and expulsion of pregnant school girls has never been litigated to challenge such assumed authority. Long-standing practices such as mandatory pregnancy testing and expulsion of pregnant school girls are largely upheld not on the basis of legal authority, but on the basis of lack of prohibition of the practice.

¹³⁶ *See, e.g.*, Interview with UNICEF official, *supra* note 134.

¹³⁷ *See, e.g.*, Interview with Headmaster at private high school, *supra* note 132; Interview with high level official at the Ministry of Community Development, Gender, and Children, *supra* note 132. When asked whether girls have an opportunity to consent to or decline testing, the high level official at the Ministry of Community Development, Gender, and Children, responded sharply, "Not in this country," and went on to say that children have duties in addition to rights, includes duty to obey [those in authority].

¹³⁸ Interview with advocates at a woman's rights NGO in Tanzania (Jan. 19, 2011) (on file with the Center for Reproductive Rights). *See also* Interview with a right to education NGO in Tanzania (on file with the Center for Reproductive Rights); Interview with UNICEF official, *supra* note 134.

¹³⁹ Research conducted by the Center and Yale Law School, *supra* note 130.

¹⁴⁰ *See* Interview with high level official, Ministry of Education, *supra* note 132.

¹⁴¹ Interview with right to education NGO in Tanzania, *supra* note 134.

¹⁴² Interview with officials at the Ministry of Health (Jan. 18, 2011) (on file with the Center for Reproductive Rights).

¹⁴³ *See* Interview with teachers at private secondary school, *supra* note 133.

¹⁴⁴ ESCR Committee, *Gen. Comment No. 14*, *supra* note 2, at 79, para. 8.

¹⁴⁵ *Id.* at 84, para. 23.

¹⁴⁶ ESCR Committee, *General Comment No. 13, The right to education (Art. 13)*, (21st Sess., 1999), in *Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies*, at 63, para. 1, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

¹⁴⁷ *Id.* at 64, para. 6(b).

¹⁴⁸ *Id.* at 70, para. 37.

¹⁴⁹ LAW OF THE CHILD ACT (2009) arts. 5.1, 5.2 (Tanz.).

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- ¹⁵⁰ Boys who impregnate school girls are rarely discovered and, if they are, do not face adequate consequences. See Interview with a right to education NGO in Tanzania, *supra* note 138; Interview with UNICEF official, *supra* note 134.
- ¹⁵¹ Interview with official at the Office of the Commissioner of Education (Jan. 18, 2011) (on file with the Center for Reproductive Rights).
- ¹⁵² Interview with high level official at the Ministry of Community Development, Gender, and Children, *supra* note 132; see also Interview with right to education NGO in Tanzania, *supra* note 134 (describing these attitudes as extremely widespread); Interview with teachers at private secondary school, *supra* note 133.
- ¹⁵³ Interview with official at the Ministry of Education and Vocational Training (Jan. 15, 2011) (on file with the Center for Reproductive Rights).
- ¹⁵⁴ A headmaster at a private high school reported that Parliament has been debating the matter of re-entry for the past ten years, but this was not able to be verified this with government sources. Interview with headmaster at private high school, *supra* note 132; Interview with advocates at a right to education NGO in Tanzania (Jan. 21, 2011) (on file with the Center for Reproductive Rights).
- ¹⁵⁵ ICESCR, *supra* note 1, art 10(1).
- ¹⁵⁶ ESCR Committee, *Gen. Comment No. 16*, *supra* note 86, at 119, para. 27.
- ¹⁵⁷ 2010 TDHS, *supra* note 8, at 95.
- ¹⁵⁸ Tanzania has signed and ratified the U.N. Convention on the Rights of the Child, African Charter on the Rights and Welfare of the Child, African Charter on Human and Peoples' Rights, the Maputo Protocol, and Convention on the Elimination of All Forms of Discrimination against Women. See Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) (*ratified* June 10, 1991) [hereinafter CRC]; African Charter on the Rights and Welfare of the Child, *adopted* July 11, 1990, O.A.U. Doc. CAB/LEG/24.9/49 (*entry into force* Nov. 29, 1999) [hereinafter Children's Charter]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3 rev.5, 21 I.L.M. 58 (1982) (*entry into force* Oct. 21, 1986); Maputo Protocol, *supra* note 50; Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/189, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) (*ratified* Aug. 20, 1985) [hereinafter CEDAW].
- ¹⁵⁹ The CEDAW Committee states that the minimum age of marriage should be 18 years for both women and men. CEDAW Committee, *General Recommendation No. 21: Equality in Marriage and Family Relations* (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 344, para. 36, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II.) (2008). Several states have issued reservations related to Article 16 of CEDAW regarding marriage and family life insofar as it is incompatible with the Islamic sharia; however, Tanzania is not one of those countries, and indeed has no reservations to either CEDAW or CRC, thereby lending credibility to the argument that it has agreed to be bound by the age requirements set forth therein; see also Maputo Protocol, *supra* note 50, art. 6(b) (which states that minimum age of marriage for women shall be 18 years); see also Children's Charter, *supra* note 158, art. 2.
- ¹⁶⁰ LAW OF MARRIAGE ACT (1971) art. 13 (Tanz.).
- ¹⁶¹ TAWLA, REVIEW OF GENDER DISCRIMINATIVE LAWS OF TANZANIA (2009) (REPRINTED).
- ¹⁶² CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, para. 147, U.N. Doc. CEDAW/C/TZA/CO/6 (2008); see also CRC Committee, *Concluding Observations: United Republic of Tanzania*, para. 25 U.N. Doc. CRC/C/TZA/CO/2 (2006).
- ¹⁶³ Tanzania Government Report (2011), *supra* note 26, para. 79.
- ¹⁶⁴ CHILDREN'S DIGNITY FORUM, VOICES OF CHILD BRIDES AND CHILD MOTHERS IN TANZANIA 16 (2010) [hereinafter VOICES OF CHILD BRIDES]; see also LAW OF MARRIAGE ACT (1971) art. 17 (Tanz.).
- ¹⁶⁵ Iben Madsen, *Is Child Marriage a Neglected Problem?*, DAILY NEWS (2009), <http://allafrica.com/stories/200912020746.html> (last visited Oct. 28, 2011).
- ¹⁶⁶ LAW OF MARRIAGE ACT (1971), art. 38(1)(a) (Tanz.).
- ¹⁶⁷ PENAL CODE ACT, Cap. 16, sec. 138(1). (Tanz.).
- ¹⁶⁸ VOICES OF CHILD BRIDES, *supra* note 164, at 24.
- ¹⁶⁹ ANJU MALHOTRA ET AL., SOLUTIONS TO END CHILD MARRIAGE: WHAT THE EVIDENCE SHOWS, INT'L CENTER FOR RESEARCH ON WOMEN 4 (2011).
- ¹⁷⁰ Madsen, *supra* note 165.
- ¹⁷¹ USAID, Child Marriage: Overview, http://www.usaid.gov/our_work/cross-cutting_programs/wid/dg/child_marriage.html (last visited Aug. 24, 2012).
- ¹⁷² Madsen, *supra* note 165.
- ¹⁷³ *Id.*
- ¹⁷⁴ VOICES OF CHILD BRIDES, *supra* note 164, at 7.

¹⁷⁵ WORLD VISION, *BEFORE SHE'S READY: 15 PLACES GIRLS MARRY BY 15*, 3 (2008).

¹⁷⁶ UNFPA, *Child Marriage*, in *THE UNMAPPED JOURNEY: ADOLESCENTS, POVERTY AND GENDER* (2005), available at http://www.unfpa.org/swp/2005/english/ch5/chap5_page3.htm.

¹⁷⁷ WHO, *Female Genital Mutilation*, FACTSHEET No. 241(2000) available at <https://apps.who.int/inf-fs/en/fact241.html>.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ During child birth, the women might experience prolonged labor, which might lead to other obstetric complications such as fistula or maternal death. WHO, *FEMALE GENITAL MUTILATION: A HANDBOOK FOR FRONTLINE WORKERS* 28 (2000) available at http://whqlibdoc.who.int/hq/2000/WHO_FCH_WMH_00.5_eng.pdf.

¹⁸² ESCR Committee, *Gen. Comment No. 14*, *supra* note 2, at 83, para. 22.

¹⁸³ *Id.*

¹⁸⁴ Any person, who, with custody, charge or care of the girl, causes or procures FGM and “cause[s] . . . suffering or injury to health including injury to, or, loss, of sight or hearing, or limb or organ of the body or any mental derangement, commits the offence of cruelty to children.” A person convicted under this offence may be liable to pay a fine not in excess of 300,000 shillings or imprisonment of no less than five years and no more than fifteen years, or both. *SEXUAL OFFENCES SPECIAL PROVISIONS ACT* (1998) art. 21 (Tanz.).

¹⁸⁵ Government of the United Republic of Tanzania, *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women: Combined 4th, 5th and 6th periodic reports of States parties: Tanzania*, para. 71, CEDAW/C/TZA/6 (2007).

¹⁸⁶ Immigration and Refugee Board of Canada, *Tanzania: The practice of female genital mutilation (FGM); state protection available to victims*, (Aug. 14, 2008), available at <http://www.unhcr.org/refworld/docid/48d2237c28.html>.

¹⁸⁷ Sarah Mwambalasa, *Female Genital Mutilation Practice in Tanzania* (2011), <http://wgc.womensglobalconnection.org/conf06proceedings/Mwambalasa%20S.--Female%20Genital%20Mutilation.pdf> (last visited Aug. 24, 2012).

¹⁸⁸ 2010 TDHS, *supra* note 8, at 295.

¹⁸⁹ *Id.* at 295-296.

¹⁹⁰ *Id.* at 297.

¹⁹¹ *Id.*

¹⁹² Human Rights Committee, *Concluding Observations: United Republic of Tanzania*, para. 11, U.N. Doc. CCPR/C/TZA/CO/4 (2009).

¹⁹³ *Id.*

¹⁹⁴ CRC Committee, *Concluding Observations: United Republic of Tanzania*, para. 51, U.N. Doc. CRC/C/TZA/CO/2 (2006).