

Lack of Safe Abortion Services

A Result of Restrictive Laws and Stigma

June, 2020.

“There is no talking about unsafe abortion, and it’s just those things that happen in the background and everybody knows about it and you just keep quiet about it.”¹

Deaths and complications that result from unsafe abortions can be prevented by “the provision of safe, legal induced abortions and care for complications of abortion.”² According to the World Health Organization (WHO), abortion is a very safe medical procedure “when performed by skilled providers using the correct medical procedure”³ or when self-managed with medication and access to accurate information.⁴

However, Tanzanian women and girls’ lives and health continue to be at risk on a daily basis due to lack of access to safe options to terminate pregnancies. This also has a larger impact on their families, society, and the country, including by creating a great burden on the public health care system due to the considerable cost of treating the resulting complications.⁵

This factsheet discusses the legal and health system challenges that force women and girls in Tanzania to resort to unsafe methods and untrained providers to terminate pregnancies. It also highlights the challenges to accessing post-abortion care.

1. WOMEN AND GIRLS HAVE DIVERSE REASONS FOR SEEKING ABORTION SERVICES

Unlike the common misconception that only young or adolescent girls, or women and girls who are not married, procure abortions,⁶ the interviewees for this research⁷ indicated that, in Tanzania, women and girls from all walks of life — married and unmarried, young and old, educated and uneducated, low-income and wealthy — seek abortion services for varying reasons. For some, a single reason can be a decisive factor; for others, it is a combination of reasons that lead to their decision.

The reasons for terminating pregnancies are as diverse as the women and girls themselves, but the common denominator is that they are carrying an unplanned and unwanted pregnancy.

Some of the reasons cited by interviewees include:

> Lack of family planning education and services, which lead to limited contraceptive usage;⁸

- > Rape or incest;⁹
- > Lack of financial means to care for the child, particularly when women and girls already have other children to take care of, making it difficult to continue with the unplanned pregnancy.¹⁰ This issue is further compounded when the man responsible for the pregnancy denies responsibility or indicates that he will not provide any financial support to raise the child;¹¹
- > The desire to continue with their education.¹² In Tanzania, adolescent girls are often expelled from school when found to be pregnant and are denied re-entry after delivery,¹³
- > Becoming pregnant within a short time after giving birth. When this happens, a woman can decide to terminate the pregnancy due to the associated health risk or because she doesn’t have the capacity to care for another child;¹⁴
- > Stigma against those who engage in sexual relations out of wedlock and get pregnant as a result.¹⁵

2. LAWS AND POLICIES ON ABORTION AND POST- ABORTION CARE ARE UNCLEAR AND CONTRADICTIONARY

Creating an enabling legal environment is critical for reducing maternal mortality and morbidity resulting from unsafe abortions and ensuring that women and girls can exercise their right to access a full range of sexual and reproductive health services. However, an assessment conducted by the Center for Reproductive Rights found the law and policies governing termination of pregnancy in Tanzania to be inconsistent, unclear, and often contradictory.¹⁶ There are also no comprehensive guidelines on the provision of abortion and post-abortion care services. As a result, women and girls often lack comprehensive information about the content of the law and the procedure for seeking health care professionals for providing abortion services.

Legal Framework on Abortion

The penal code of Tanzania criminalizes abortion with a punishment of up to 14 years' imprisonment¹⁷ and the crime of "child destruction"¹⁸ with life imprisonment.¹⁹ However, a person will not be liable for abortion or "child destruction" if the procedure is performed in good faith and with reasonable care and skill to preserve the pregnant woman's life.²⁰ Further, while there are no domestic decisions that have interpreted these penal code provisions, there are pre-independence jurisprudences from England and from the East African Court of Appeal, which remain binding,²¹ that have interpreted the life exception under the penal code to also permit abortions on the grounds of mental and physical health of the pregnant woman and for pregnancies resulting from sexual violence.²²

However, many, including health care providers and legal professionals, are not aware of these jurisprudences. As a result,

SOCIO-ECONOMIC PROFILE OF TANZANIA

With an estimated population of 58 million,¹ Tanzania is one of the lowest-income countries in the world.² According to the United Nations Development Programme's Human Development Report (HDR), nearly half (47%) of the population is living in multidimensional poverty and 18% in extreme poverty,³ with some regions experiencing a poverty rate as high as 66%.⁴ Ninety percent of the population lives on under \$2 per day.⁵ The percentage of the population with formal education is also low. According to the HDR, 24% of females and 15% of males have no formal education and less than one in 10 Tanzanians have completed secondary education.⁶ In addition, the working-age population — those 15 years and older — is 25 million, with young people making up 55% of this group.⁷ The low education rate and large working-age population in turn affect the employment rate.

The latest available data indicates that the unemployment rate stands at 10%.⁸ Seventy-five percent of the population are engaged in informal employment, and eight out of 10 young people are engaged in vulnerable employment.⁹ This, according to the HDR, indicates that many are engaged in an employment sector with "various activities that involved insecure and precarious forms of wage employment, where the distinction between being employed or being underemployed is not clear-cut."¹⁰

The situation is even more dire when it comes to women and girls because they are "more likely to experience lower levels of human development due to inequalities in access to education, health services, and economic opportunities."¹¹ Only 7.4% of women in mainland Tanzania have attained at least secondary education.¹² This significantly reduces their chances of gaining paid employment and senior positions.¹³ Only 69% participate in the labor market, as opposed to 81% of men, and the majority are engaged in the informal sector.¹⁴ They also spend a large portion of their time on unpaid housework, which affects their level of income.¹⁵

when asked if they will provide an abortion to a woman who became pregnant as a result of rape, many providers have said that they will not.²³ In addition, some government policies previously outlined additional grounds for legal abortions. For instance, the 2013 version of the Standard Treatment Guidelines and Essential Medicines List recognizes rape and fetal malformation as legal grounds for abortion.²⁴

Conspicuously, even though the legal

framework on abortion has not changed from 2013, the 2017 updated guidelines do not make any reference to induced abortions, even when performed to save the life of the pregnant woman, and defines abortion only as being "the spontaneous loss of a fetus before it is viable."²⁵ It also defines viability as starting approximately at 24 weeks of gestation,²⁶ in contradiction to the *Comprehensive Post Abortion Care Guideline Trainees Manual* and the penal code, both of which put viability at 28 weeks.²⁷

Post-Abortion Care

The government of Tanzania, in many policies and documents, acknowledges the negative effect of unsafe abortion and affirms post-abortion care as an integral component of maternal health care services.²⁸ *The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016-2020)* aims to improve access to Basic Emergency Obstetric and Neonatal Care, which includes post-abortion services, from 20% to 70% in dispensaries and from 39% to 100% in health centers.²⁹

While the post-abortion training manual provides useful information and is important for equipping health care professionals with the essential skills needed to provide comprehensive post-abortion care, it is not a policy document

In 2016, the Ministry of Health of Tanzania issued the latest edition of the *Comprehensive Post Abortion Care Guideline Trainees Manual*, which is meant to be used primarily by post-abortion care trainees and trainers.³⁰ The manual recognizes comprehensive post-abortion care as “interventions which reduce maternal morbidity and mortality through providing care to young girls/women who suffer complication” from induced abortions and miscarriages.³¹ It further acknowledges that there are many factors that hinder access to post-abortion care, including a stigma on induced abortions, providers’ negative attitudes, and inadequate equipment and supplies.³²

The manual further emphasizes quality of care by providing that “[h]ealth care providers should respect women’s informed decision-making, autonomy, confidentiality and privacy at all times.”³³ It also says special attention should be given to vulnerable groups, such as adolescents and youths, women with disabilities, low-income women, and survivors of sexual violence.³⁴

While this training manual provides useful information and is important for equipping health care professionals with the essential skills needed to provide comprehensive post-abortion care, it is not a policy document.³⁵ Regardless, health care providers and advocates interviewed for this research wrongly assumed that such guidelines exist and often referred to the training manual when asked about the guidelines.³⁶

However, as one advocate correctly put it, “the manual is for teaching and [for] facilitators to follow when giving a training but is not legally binding. [There is a need for] a guideline that is a policy document which is going to be legally binding, and if someone does not provide the service as provided, you can follow up and take action.”³⁷

3. WOMEN AND GIRLS ENCOUNTER MULTIPLE BARRIERS TO ACCESSING SAFE ABORTION SERVICES

The research revealed that Tanzanian women and girls encounter numerous obstacles to accessing safe abortion services, compelling them to resort to unsafe methods. Additionally, post-abortion care — critical medical intervention to treat complications from unsafe abortion — is not easily available or accessible, putting many women and girls’ lives and health at increased risk.

i. Limited Knowledge of Laws and Policies on Abortion

Due to the absence of a clear policy or guidelines, and limited dissemination of information regarding the current legal framework on abortion, women and girls lack knowledge of when and how to legally terminate pregnancies. As a result, many believe the law to be more restrictive than it is. That discourages them from seeking abortions at public health care facilities and compels them to resort to unsafe methods.

Almost all the women interviewed for the research said they are not aware of the legal grounds for abortion.³⁹ Many of the women have limited avenues to access information and mostly refer to newspapers, radio, and TV,⁴⁰ which, for the most part, do not provide accurate information when it comes to abortions.⁴¹ As a result, they fear being reported and arrested, and prefer not to seek abortion services from health facilities even in situations where they might have qualified for a legal abortion.⁴²

Similarly, lack of clarity leads to the restrictive interpretation of the law by health care providers and the denial of services to women and girls who would have qualified for legal abortions.

Almost all the providers interviewed for this research agreed that the law allows abortions when performed to save the life of the pregnant woman. However, their understanding of the law varied when it came to the additional exceptions, such as the health of the pregnant woman, particularly mental health, and in cases of serious fetal abnormalities and rape. For instance, when assessing whether to perform an abortion on health grounds, many providers take into account only physical health and not, as recommended by the WHO, mental health and social well-being.⁴³ Further, many of the health care providers do not provide abortions for pregnancies that result from sexual violence.⁴⁴

Additionally, the lack of clear policy guidelines creates inconsistent understanding of the procedure health care providers must follow when determining the need to terminate a pregnancy. Even though it is not a legal requirement, as confirmed by health care providers interviewed for this research, many providers believe that, when presented with a case, one doctor cannot make the determination to terminate a pregnancy and needs to consult other doctors or specialists.⁴⁵ However, they disagree about the number of doctors who need to be consulted — while some think the number is three, others think as many as five doctors are needed.⁴⁶

In addition, doctors erroneously believe that this is a legal or policy requirement but were not able to identify a document describing the requirement.⁴⁷ Some further believe that consent from a partner is needed before providing an abortion, even in situations where the pregnancy is risking the health of the pregnant woman.⁴⁸

Health care providers have a limited understanding of the laws and policies on abortion in part because they generally do not receive training on the issue, either while they are in medical school or after leaving, even though they see such training

METHODS OF UNSAFE ABORTION

When women and girls do not have access to safe abortion services, they often resort to unsafe and crude methods that put their lives and health at grave risk. Some of the methods include:³⁸

- > Boiling and drinking Coca-Cola.
- > Inserting cassava sticks in the uterus.
- > Drinking traditional (local) herbs.
- > Drinking boiled tea leaves.
- > Drinking boiled aloe-vera.
- > Inserting roots of different trees in the uterus.

as an important component of quality abortion services.⁴⁹ In addition, while some government guidelines make passing references to the legality of abortion and circumstances under which abortion is permitted,⁵⁰ there is no official comprehensive government policy or guidelines on safe abortion services.⁵¹

According to the WHO, standards and guidelines on abortion are important to “eliminate barriers to obtaining the highest attainable standard of sexual and reproductive health” as they can “refer to the underlying principles and essential requirements for providing equitable access to, and adequate quality of, lawful abortion services.”⁵² Guidelines are important to improve the quality or process of care as well as patient outcomes.⁵³ They further “offer explicit recommendations for clinicians who are uncertain about how to proceed, overturn the beliefs of doctors accustomed to outdated practices, improve consistency of care, and provide authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies.”⁵⁴ When it comes to the provisions of abortion services, beyond the clinical

guidance, guidelines are crucial to interpret and provide clarity on the implementation of the laws regulating the service. However, while many government documents recognize the high level of unsafe abortion and its contribution to maternal mortality in Tanzania, “no government policy or guideline appears to comprehensively address the provision of safe abortion services in Tanzania or to clarify when providers may offer these services or who may provide them.”⁵⁵

Government officials and documents further contribute to this confusion by providing incomplete or inaccurate information. For instance, the *National Adolescent Reproductive Health Strategy 2011-2015* states that “[i]nduced abortion is illegal in Tanzania hence the actual magnitude of the problem is not known”⁵⁶ without clarifying that there are grounds under which termination of pregnancy is legally permitted.

In 2016, the Tanzanian prime minister, while visiting a regional government hospital, threatened doctors, telling them

CENTER *for* REPRODUCTIVE RIGHTS

to “stop performing abortions on girls and women or they will be sacked and charged according to the law.”⁵⁷ According to a news report, he stated, “[t]hese unlawful acts are totally unacceptable, doctors who entertain this behavior will not be spared. I don’t want to hear labor rooms are being used for terminating pregnancies.”⁵⁸ As a reproductive rights advocate interviewed for this research explained, these kinds of public statements made by political leaders promote misinformation about the legality of abortions. The advocate stated:

“There is a need for knowledge about the law on abortion. ... Government officials should send accurate messages because once they say something, people take it as it is. For example, when the prime minister said that abortion is not allowed, then people just know that it’s not allowed under any circumstances. People do not go back to read, and I don’t blame them because they don’t have access to [the information] anyway. They really take words spoken by our leaders to heart, so our leaders should be more of the champions on this and strive for the people to have the right information.”⁵⁹

The lack of clear policy guidelines creates inconsistent understanding of the procedure health care providers must follow when determining the need to terminate a pregnancy.

ii. The Restrictive Law Fuels Unsafe Abortions and Resulting Injuries

“Women who have financial means do safe abortion. Women who are poor do unsafe abortion.”⁶⁰

The restrictive abortion law is a major contributor to the high level of unsafe abortions in Tanzania, and it disproportionately affects women and girls who are not able to afford the high cost of obtaining an abortion from a private facility. Most of the interviewees said that women who have the means to pay can access safe abortion services in a private facility with trained health care professionals.⁶¹ By contrast, low-income women who, due to the restrictive law, cannot go to public facilities where the services are provided free or at low cost, are compelled to resort to unsafe methods to terminate their pregnancies as the cost at a private health facility can be as high as 90,000 Tanzanian shillings (Tsh), approximately 40 dollars.⁶²

Fear of Arrest and Prosecution Impede Access to Post-Abortion Care

Even though post-abortion care is legal, due to the restrictive law that allows abortion only on limited grounds, many women and girls who suffer complications avoid seeking treatment for fear of being arrested and prosecuted.⁶³ Fear of prosecution also hinders health care professionals from providing post-abortion care because some are not aware that they are legally allowed to provide treatment and that women have the right to the service. As such, when a woman experiencing complications goes to a facility, health care providers might refuse to treat her because they fear negative legal consequences if they provide treatment, but the woman ends up dying.⁶⁴

This, however, could be addressed with a comprehensive guideline on safe abortion services that clearly articulates that health care providers can legally provide post-abortion care irrespective of whether the abortion was legal.

iii. Limited Availability of Safe Abortion and Post-Abortion Services

Beyond the restrictive legal framework, interviewees shared several health-system challenges that further impede women and girls’ access to safe abortion and post-abortion care. For instance, there is lack of basic equipment, such as ultrasound equipment and manual vacuum aspirators, needed for diagnosis and treatment.⁶⁵ The government has made some effort to improve the availability and quality of post-abortion services but the interviewees for this research said that there is a need to scale up these efforts to ensure that the service is available, particularly in primary level facilities—dispensaries and health centers—which are closer and more accessible to the community. As one reproductive health advocate explained, contrary to the information in *The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016-2020)*, dispensaries refer women to higher-level facilities—health centers and hospitals—because the dispensaries lack the necessary equipment and training to provide post-abortion care.⁶⁶ Even at higher-level facilities, however, limited and outdated equipment is an issue.⁶⁷

Shortage of trained health professionals is an additional major obstacle that hinders access to post-abortion care.⁶⁸ While obstetricians and gynecologists receive training on the services when undergoing their medical education,

CENTER *for* REPRODUCTIVE RIGHTS

training of general practitioners is not universal. In addition, the in-service training provided to midlevel providers, such as nurses, midwives, and clinical officers, does not reach all those who work in public health facilities.⁶⁹

Refresher training to ensure that providers are up to date with the current technology is also very limited.⁷⁰ This means women and girls will have to bear the additional burden of traveling long distances and incur additional costs to access higher-level facilities — mainly hospitals — to find trained providers.⁷¹

The shortage of equipment and personnel further results in poor-quality service because women have to wait long hours — sometimes an entire day — and go through lengthy administrative procedures before receiving treatment.⁷²

Access to Medication Abortion

According to the WHO, the use of medications, usually a combination of mifepristone and misoprostol, and sometimes misoprostol alone where mifepristone is not available, “have been proved to be safe and effective” for early termination of pregnancies.⁷³ However, misoprostol is registered in Tanzania only for postpartum hemorrhage and management of post-abortion complications—not for abortions.⁷⁴ Regardless, as confirmed by many of those interviewed for this research,⁷⁵ misoprostol is widely available without a prescription at pharmacies and drug dispensaries. It can cost anywhere from Tsh10,000 to Tsh70,000, depending on the brand and where it is sold, and many women rely on the drug to self-induce abortions.⁷⁶ However, because they are not always given accurate information on how to safely administer the drug, using it can sometimes lead to complications.⁷⁷

Nevertheless, when women and girls have the right information and use the

drug properly, misoprostol is useful in reducing unsafe abortions and the resulting complications. The complication rate is very low when misoprostol is used with proper information, according to research conducted by the Department of Obstetrics and Gynaecology at Muhimbili University of Health and Allied Sciences to “investigate the feasibility of providing harm-reduction services to reduce unsafe abortion in Tanzania.”⁷⁸ In this research, study subjects were given information about the “appropriate dosage, adverse effects, and cautions” of misoprostol, and “no maternal deaths or severe complications owing to induced abortion were reported” among those who chose to use the drug to induce abortion.⁷⁹

iv. Lack of Knowledge of and High Cost of Post-Abortion Care

Interviewees indicated that women and girls have limited knowledge regarding where and how to access post-abortion service. Many of the women interviewed did not know that treatment is provided in public health care facilities and believed that such services were available only in private facilities.⁸⁰ This discourages women from seeking the service, even when they suffer complications, or causes them to incur unnecessary expenses by going to private facilities.⁸¹ In addition, despite the government’s policy to provide all maternal, newborn, and child health services — which includes post-abortion care, free of charge⁸² — many are not aware of this policy and are asked to pay when seeking treatment at a public facility.⁸³ Further, because the prices that facilities charge are not based on government guidelines, the cost varies from one facility to another.

For instance, a woman from Arusha who went to a public hospital seeking treatment for complications from a miscarriage was made to pay Tsh 35,000

for administrative costs; for various tests, such as ultrasound; and for medication.⁸⁴ Another woman, from Mwanza, explained that the cost can be much higher—Tsh 70,000 to Tsh 100,000.⁸⁵ This was confirmed by multiple health care practitioners, who indicated that the cost can increase if there are complications.⁸⁶ Some referral facilities even charge these fees to discourage women from coming to the facility without a referral from a primary-level facility.⁸⁷ Additionally, because many women and girls are not aware that it is legal to access post-abortion care, some providers use this opportunity to ask for payment as a bribe.⁸⁸

v. Stigma and Negative Attitude of Providers

The government of Tanzania recognizes that the stigma surrounding abortion is an additional major barrier to post-abortion services.⁸⁹ Indeed, many women and other stakeholders interviewed for this research said that stigma from the community and health care providers can force women to delay seeking post-abortion care or to stay away from public health facilities. Some refrain from going to health facilities because they fear that they will be seen by people they know,⁹⁰ while others fear a negative reaction from health care providers.⁹¹ This concern is not unfounded: A woman who went to a public hospital seeking treatment for a miscarriage recounted the harsh treatment she received when the health care providers initially thought she’d had an abortion.⁹² An Ob/Gyn working in a public facility reported: “Some health providers can judge before listening to the reasons why the woman induced [an abortion]. They will ask her, ‘Why did you do that?’ Like she is a criminal. Some even tell women that what they did is criminal and threaten to report them. I have witnessed that. They

CENTER *for* REPRODUCTIVE RIGHTS

do not report to the police but threaten to do it and make the women feel uncomfortable.”⁹³

The negative attitude of health care providers can be attributed to personal and religious beliefs, lack of training and resources,⁹⁴ or, as discussed previously, fear of arrest and prosecution.

Beyond religious and personal beliefs, the restrictive law on abortion can fuel the stigma related to abortion. When access to a health service is criminalized or highly restricted, it conveys the message that those who access the service should be condemned. The practice of doctors consulting multiple other doctors before women or girls are able to legally access abortion services also “implies that abortion is a suspect procedure that demands extra scrutiny.”⁹⁵

Despite the government’s policy to provide all maternal, newborn, and child health services — which includes post-abortion care, free of charge — many are not aware of this policy and are asked to pay when seeking treatment at a public facility.

4. TANZANIA’S HUMAN RIGHTS OBLIGATIONS TO ENSURE ACCESS TO ABORTION AND POST-ABORTION CARE

Tanzania has ratified a multitude of international and regional human rights treaties that obligate the government to respect, protect, and fulfill human rights standards concerning the sexual and reproductive rights of women and girls, including their right to access safe and legal abortion and post-abortion services. These human rights instruments require that the government take legal and programmatic measures to ensure that safe abortion services are accessible, both in law and in practice, to all women and girls who might need the service.

Reform Laws and Policies on Abortion Services

One critical measure that Tanzania must take to protect the right of women and girls to access safe abortion services is to ensure that the domestic legal framework regulating abortion service is harmonized with international and regional human rights standards. For instance, Article 14 of the Maputo Protocol, which Tanzania has ratified without any reservation, provides that states are required 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** the [pregnant woman] or the foetus.⁹⁶

As the African Commission on Human and Peoples’ Rights has elaborated, in order to comply with the obligation under this provision, Tanzania must provide a conducive legal environment, including by “revisiting... policies and administrative procedures” relating to safe

abortions “as well as integrating the provisions of the [Maputo Protocol] into domestic law.”⁹⁷

Further, Tanzania has the obligation to guarantee the implementation of these legal protections, including by ensuring that “health services and health care providers do not deny women access to ... safe abortion information and services because of, for example, requirement of third parties or for reasons of conscientious objections.”⁹⁸ This includes removing any requirement for multiple medical doctors to provide authorization for an abortion before a woman can access the service.⁹⁹

The sensitization of legal practitioners and law enforcement bodies is further required to prevent the arrest and prosecution of women and girls who have “sought safe abortion services or post-abortion care to which they are entitled.”¹⁰⁰

Development of implementation standards and guidelines, establishment of accountability mechanisms, and effective redress mechanisms for women and girls whose reproductive rights are violated are additional requirements for fulfilling the right recognized under Article 14 of the Maputo Protocol.¹⁰¹

In addition, treaty-monitoring bodies have held that restrictive abortion laws violate a compendium of rights of women and girls, including the right to health, life, privacy, equality, and non-discrimination, and freedom from ill-treatment.¹⁰² These rights are further affirmed under the Constitution of Tanzania.¹⁰³ To protect these rights, therefore, states are required to remove punitive measures in all circumstances for women who access abortion services.¹⁰⁴

For instance, the United Nations Committee on Economic, Social and Cultural Rights has found that states violate their

obligation to respect the reproductive rights of women and girls when they criminalize them for undergoing abortions and has held that states have the core obligation to repeal or eliminate laws and policies that criminalize safe abortion services.¹⁰⁵

The Committee on Elimination of Discrimination against Women, holding that criminalization of reproductive health services constitutes a form of discrimination, has called on states to eliminate punitive measures for women who undergo abortions and for health care providers who deliver abortion services.¹⁰⁶

Likewise, the U.N. Committee on the Rights of the Child has urged states to “decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services” and to review their legislation to guarantee the best interest of the girl child and ensure that girls’ “views are always heard and respected in abortion-related decisions.”¹⁰⁷

Availability, Accessibility, Acceptability, and Quality of Safe Abortion Services

Tanzania has the obligation to ensure accessible, available, and quality safe abortion services and post-abortion care to all women and girls without any barriers.

Availability necessitates putting in place an adequate number of functioning health care facilities and services with trained medical and professional personnel and skilled providers who are trained to perform the full range of sexual and reproductive health services, including abortion services.¹⁰⁸ It also requires that states provide post-abortion care to women, regardless of whether abortion is legal.¹⁰⁹

Abortion and post-abortion services should be **accessible** to all women and girls without discrimination, including without any procedural, practical, or social barriers.¹¹⁰ The obligation to ensure accessible sexual and reproductive health services entails health facilities that are within safe physical reach for all, including for vulnerable groups, such as women living in rural areas, those with disabilities, and adolescents, to ensure timely access to services.¹¹¹

Affordability of health services is also an integral component of accessibility, and as such, governments should take steps to ensure that cost is not a barrier to accessing abortion and post-abortion care.¹¹² Tanzania also has the obligation to ensure access to comprehensive, accurate, and evidence-based information on abortion services, including on the legal framework,¹¹³ and to dispel any misconceptions against those who seek the service.

Additionally, safe abortion services should be **acceptable**: Facility personnel should be “respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, sexual diversity and life-cycle requirements.”¹¹⁴ Acceptability of services, therefore, entails ensuring privacy and confidentiality to women and adolescents seeking abortion services¹¹⁵ and providing medically accurate and non-stigmatizing information on abortion.¹¹⁶

Quality, another major component of abortion and post-abortion services, requires that these services be evidence-based and scientifically and medically appropriate, that they be provided by adequately trained health care providers, and that required equipment and drugs are current and scientifically approved.¹¹⁷

Tanzania has the obligation to ensure accessible, available, and quality safe abortion services and post-abortion care to all women and girls without any barriers.

Abortion and post-abortion services should be accessible to all women and girls without discrimination, including without any procedural, practical, or social barriers.

CENTER *for* REPRODUCTIVE RIGHTS

ENDNOTES

- ¹ Interview with a reproductive rights advocate, Dar es Salaam (Sep. 25, 2017).
- ² World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* 1, 2nd ed. (2012) [hereinafter, WHO, *Technical Guideline on Abortion*].
- ³ *Id.*, at 21.
- ⁴ World Health Organization, *Medical management of abortion* 29 (2018) [hereinafter WHO, *Medical Management of Abortion*].
- ⁵ WHO, *Factsheet: Preventing unsafe abortion* (2019) available at <http://www.who.int/mediacentre/factsheets/fs388/en/>.
- ⁶ See, for instance, interview with a woman, age 43, Arusha (November 21, 2017).
- ⁷ See the introductory factsheet for background information about the research, including methodology and profile of interviewees. Due to the sensitivity and stigma surrounding abortion in Tanzania, identifying information of the people interviewed for this research is not included in this report.
- ⁸ Interview with a woman, Mwanza (Nov. 13, 2017); See also Interview with woman, age 37, Arusha (November 21, 2017).
- ⁹ Interview with a woman, age 26, Dar es Salaam (Dec. 6, 2017).
- ¹⁰ Interview with a woman, age 22, Mwanza (Nov. 13, 2017).
- ¹¹ Interview with a woman, age 34, Arusha (Nov. 20, 2017); interview with a woman, age 21, Dar es Salaam (Sep. 26, 2017); Interview with a woman, Dar es Salaam, age 40 (Dec. 6, 2017); interview with a woman, age 36, Mwanza, interview date, (Nov. 13, 2017).
- ¹² Focus group discussion with young girls, Mwanza (Nov. 13, 2017) (“For school reasons, [adolescent girls] tend to [have an abortion] in order to continue with their studies, because if you are pregnant, you are not allowed to continue with [your] studies.”)
- ¹³ See, in general, Center for Reproductive Rights, *Forced Out: Mandatory Pregnancy Testing and the Expulsion of Pregnant Students in Tanzanian Schools* (2012) available at https://www.reproductiverights.org/document/tanzania-report-forced-out-mandatory-pregnancy-testing-expulsion?_ga=2.256528331.1965979050.1591276157-1223613524.1547846277 [hereinafter Center for Reproductive Right, *Forced Out*].
- ¹⁴ Interview with a woman, age 40, Dar es Salaam (Sep. 26, 2017) (“I discovered that I was pregnant [while] I was still nursing. After consultation with my doctors, they agreed to perform [the abortion]”); Focus group participant, Mwanza (Nov. 7, 2017) (“It was an unplanned pregnancy and I already had a 3 months old baby when I discovered that I was pregnant again. I asked myself how I could afford to raise the child and the pregnancy. I could not afford to care for two children and decided to have an abortion”).
- ¹⁵ Interview with a woman, age 37, Arusha (November 21, 2017); Government Official, Gender and Youth Department, Mwanza (Nov. 15, 2017); Focus group discussion with women, Arusha (Nov. 20, 2017) (One woman shared the experience of a friend who was widowed: “I guess the pregnancy made her fear the perception society will have of her after knowing that she was pregnant as a widow. It is a tradition that you have to tell [people] how you became pregnant while being a widow. She would have been excluded from her family and community [if they have found out that she is pregnant]. Therefore, she decided to have an abortion. She took traditional medicines and over-bleed and died”).
- ¹⁶ 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 Center for Reproductive Rights, *Legal and Policy Framework*].
- ¹⁷ Penal Code, Cap. 16, sec. 150; Penal Code, Cap. 16, sec. 151; Penal Code, Cap. 16, sec. 152 (attempts to cause a miscarriage by a third party with a punishment of 14 years imprisonment; attempts by the woman herself to procure a miscarriage with a punishment of 7 years; and anyone who supplies materials that is intended to be used to procure a miscarriage is guilty of a criminal offense and liable to a prison term of 3 years).
- ¹⁸ Under the Penal Code, a child is considered to be capable of being born alive if there is “evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more.”: See Penal Code, Cap. 16, sec. 219.
- ¹⁹ Penal Code, Cap. 16, sec. 219.
- ²⁰ Penal Code, Cap. 16, sec. 230; See also Center for Reproductive Rights, *Legal and Policy Framework*, supra note 16, at 18.
- ²¹ Center for Reproductive Rights, *Legal and Policy Framework*, supra note 16, at 22.
- ²² *Id.*, at 20.
- ²³ See interview with Head Nurse working in a public dispensary, Dar es Salaam (Sep. 25, 2017); interview with an ob/gyn working in a facility that is partly public, Mwanza (Nov. 8, 2017); Interview with a nurse, Muhimbili hospital, Dar es Salaam (Sep. 20, 2017); Interview with an ob/gyn, Sekou Toure hospital, Mwanza (Nov. 8, 2017) (He explained: “I will consider the policy [which does not] allow to induce abortions unless the pregnancy is in danger or is threatening her life. I am working according to the national policies. I cannot induce [abortion] unless there is a medical ground...Although I think it's important, we do not deal with psychological issues”).
- ²⁴ United Republic of Tanzania, Ministry of Health and Social Welfare, *Standard Treatment Guidelines and Essential Medicines List*, 96 (4th ed 2013) [hereinafter 2013 Tanzania Essential Medicines list].
- ²⁵ *Standard Treatment Guidelines & National Essential Medicines List Tanzania Mainland*, 122 (5th ed 2017) [hereinafter 2017 Essential Medicines List].
- ²⁶ *Id.*
- ²⁷ Penal Code, Cap. 16, sec. 219; Ministry of Health, Community Development, Gender, Elderly and Children, *Comprehensive Post Abortion Care Guideline Trainees Manual*, 12 (2nd ed. 2016) [hereinafter MOH, *Post Abortion Care Trainees Manual*].
- ²⁸ See Ministry of health and social welfare, national Policy guidelines for reproductive and Child health services, 20 (2003); Ministry of Health and Social Welfare, *National Essential Health*

CENTER *for* REPRODUCTIVE RIGHTS

- Care Interventions Package-Tanzania (NEHCIP-Tz) 22 (2015).
- ²⁹ Ministry of Health and Social Welfare, The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016-2020) 22 (2016) [hereinafter MOH, National Road Map on MNCAH 2016-2020].
- ³⁰ MOH, Post Abortion Care Trainees Manual, supra note 27, at 2.
- ³¹ Id., at 10.
- ³² Id., at 14.
- ³³ Id., at 15.
- ³⁴ Id.
- ³⁵ Interview with a reproductive rights advocate, Dar es Salaam (Sep. 29, 2017).
- ³⁶ Interviewed Doctors in Arusha, Dar es Salaam and Mwanza in public and private facilities all refer to the curriculum as a post abortion care guideline.
- ³⁷ Interview with a reproductive rights advocate, Dar es Salaam (Sep. 29, 2017).
- ³⁸ Participants of FGDs Women and Adolescents Girls in Arusha, Dar es Salaam and Mwanza Regions; Health care providers (Gynecologists, Obstetricians, General Practitioners and Nurses) working in public and private facilities at different levels (from dispensary to health center to hospitals) in Arusha, Dar es Salaam Regions; Reproductive health advocates implementing programs in different regions in Tanzania.
- ³⁹ Focus group discussion, Arusha (Nov. 20, 2013); See also interview with a woman, Mwanza (Nov. 9, 2011); Focus Group discussion, Mwanza (Nov. 7, 2011); interview with a woman, Mwanza (Nov. 9, 2017).
- ⁴⁰ Interview with woman, age 21, Mwanza (Nov. 17, 2017).
- ⁴¹ Interview with a legal practitioner, Dar es Salaam (Sep. 21, 2017) (“The media has a big role to educate, inform and communicate to the society. The problem right now is that they sensationalize the information which waters down the magnitude of the problem. They also have a limited understanding of the issue”).
- ⁴² Interview with a woman, age 36, Mwanza, interview date, (Nov. 13, 2017) (“I learned from TV and radio that it is a criminal offence, but I had no other option than to have an abortion... I also fear that if I share my experience, I might be reported to the police and be arrested”); interview with a woman, age 32, Arusha (Nov. 21, 2017) (“I know from the media that women who had abortions may be reported to police and arrested.”).
- ⁴³ The definition of health provided by the WHO, as adopted by the government of Tanzania, states that “[h]ealth is a state of complete physical, mental and social well-being and not a merely the absence of disease or infirmity”: Constitution of the World Health Organization, Adopted by the International Health Conference in New York (1946).
- ⁴⁴ See, for instance, interview with an ob/gyn working in a public hospital, Dar es Salaam (Sep. 30, 2017); general practitioner working in a public hospital, Dar es Salaam (Oct. 4, 2017).
- ⁴⁵ Interview with an ob/gyn working in public hospital, Mwanza (Nov. 8, 2017); interview with a general practitioner working in a public hospital, Dar es Salaam (Oct. 4, 2017).
- ⁴⁶ Interview with an ob/gyn working in a public hospital in Mwanza (Nov. 9, 2017) (“The decision to terminate a pregnancy must be taken by 3 doctors with good reputations [because] that’s is the law”); interview with a general practitioner working in a private facility, Arusha (Oct. 11, 2017) (“Even if abortion is necessary to save her life, the government policy requires that we first conduct some tests, ultrasound, and seek advice from other doctors before performing the abortion. One doctor alone cannot decide on abortion, 3 to 5 doctors must be involved in the decision making).
- ⁴⁷ Interview with an ob/gyn working in a public hospital, Mwanza (Nov. 8, 2017).
- ⁴⁸ Interview with a nurse working in public hospital, Dar es Salaam (Sep. 20, 2017).
- ⁴⁹ Interview with a nurse working in public hospital, Dar es Salaam (Sep. 20, 2017); See also interview with an ob/ gyn working in a public hospital, Dar es Salaam (Oct. 4, 2017).
- ⁵⁰ For example, the Comprehensive Post Abortion Care Guideline Trainees Manual provides that per the Penal Code, abortion can legally be performed when “it is necessary to save the woman’s life”: See MOH, Post Abortion Care Trainees Manual, supra note 27, at 12.
- ⁵¹ Center for Reproductive Rights, Legal and Policy Framework, supra note 16, at 33.
- ⁵² WHO, Technical Guideline on Abortion, supra note 2, at 65.
- ⁵³ Steven H Woolf et.al., Potential benefits, limitation, and harms of clinical guidelines 527 BMJ VOL.318: 527-30 (1999).
- ⁵⁴ Id.
- ⁵⁵ Center for Reproductive Rights, Legal and Policy Framework, supra note 16, at 33.
- ⁵⁶ Ministry of Health and Social Welfare, The National Adolescent Reproductive Health Strategy 2011-2015, 7 (2011).
- ⁵⁷ Kizito Makoye, Tanzania’s new PM threatens to sack doctors for illegal abortions, The Citizen (January 8, 2016) available at <http://www.thecitizen.co.tz/News/1840340-3025462-ltw6d2z/index.html> (last visited June 7, 2020).
- ⁵⁸ Id.
- ⁵⁹ Interview with a reproductive health advocate, Dar es Salaam (Sep. 25, 2017).
- ⁶⁰ Interview with a woman, age 21 Arusha (Nov. 17, 2017).
- ⁶¹ See, for instance, interview with a member of parliament, Dar es Salaam (Oct. 4, 2017); Government Official, Gender and Youth Department, Mwanza (Nov. 15, 2017); focus group discussion with health care providers working at a local NGO, Dar es Salaam (Sep. 21, 2017); interview with a young woman, age 19 years, Mwanza (Nov. 16, 2017); focus group discussion with police officers, Mwanza (Oct. 11, 2017).
- ⁶² See Guttmacher Institute, In brief: Unsafe Abortion in Tanzania: Review of Evidence. 2 (2013) available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/IB_unsafe-abortion-tanzania.pdf; interview with a woman, age 24, Mwanza (Nov. 9, 2017); also interview with a reproductive health advocate, Dar es Salaam (Nov. 9, 2017).
- ⁶³ Interview with a woman, age 24, Mwanza (Nov. 9, 2017) (She used mul-

CENTER *for* REPRODUCTIVE RIGHTS

multiple unsafe methods to terminate her pregnancy, including drinking soaked ashes, boiled blue detergent together with coca cola, black tea and pills, and suffered complication. She recounted: "I did not go to public hospital for the bleeding and stomach pain, because I was afraid of being arrested when they found out that I had an abortion. And I did not go to the private clinic/hospital because of the cost"; See also interview with a reproductive health advocate, Dar es Salaam (Nov. 9, 2017).

⁶⁴ Interview with a reproductive health advocate, Kigoma (Sep. 28, 2017).

⁶⁵ Interview with a general practitioner working in public and private facilities, Mwanza (Nov. 8, 2017); interview with an ob/gyn working in a public hospital, Dar es Salaam (Oct. 4, 2017).

⁶⁶ Interview with a head nurse working in a public dispensary, Dar es Salaam (Sep. 25, 2017); See also interviews with a reproductive rights advocates, Dar es Salaam (Sep. 29, 2017 & Dec. 7, 2017).

⁶⁷ Interview with a general practitioner working in public and private facilities, Mwanza (Nov. 8, 2017) ("In private facility, we have enough trained staff, equipment and supplies. In the public dispensary we are still using old equipment. For example, we only have one MVA kit [in the public facility] and it has only few tubes so if we have 5 [post abortion] patients, we cannot accommodate them").

⁶⁸ Interview with a reproductive health advocate working in an international non-governmental organization, Dar es Salaam (Dec. 7, 2017) ("In a remote area, women have to go a very long way to get these services. In these areas, we train providers, bring the supplies and equipment and renovate the facility. It is ready to be used but when the trained provider is moved to another facility in a different area, it means we lose their skills and women lose the access to quality reproductive health services").

⁶⁹ Interview with a maternal health and family planning program analyst, Dar es Salaam (Oct. 5, 2017) ("Government facilities are in all regions, but you may find that in some places the providers working in government facility may not have knowledge of [post abortion services]").

⁷⁰ Interview with a general practitioner working in a public referral hospital, Dar es Salaam (Nov. 28, 2017).

⁷¹ Interview with a government official, Gender

and Youth Department, Mwanza (Nov. 15, 2017); See also interview with an obs/gyn working at public and faith based hospital, Mwanza (Nov. 9, 2017); interview with a reproductive rights advocate, Dar es Salaam (Sep. 29, 2017); interview with a general practitioner working in a public hospital, Dar es Salaam (Sep. 20, 2017) (The doctor explained: "What happens at the national reference hospital is very different from what happens in other facilities. In other facilities, management of complications is very poor. We receive patients with very bad conditions at the national hospital...health workers at lower facilities do not have enough knowledge to deal with complications from abortions").

⁷² Interview with a woman, Mwanza (Nov. 13, 2017); interview with a general practitioner working in a private facility, Arusha (Oct. 11, 2017).

⁷³ WHO, Technical Guideline on Abortion, supra note 2, at 42.

⁷⁴ 2017 Essential Medicines List, supra note 25, at 124 & 130.

⁷⁵ Many people interviewed for this research indicated that the number of women and adolescent girls using misoprostol to self-induce an abortion has increased in the past few years: See, e.g. interview with a general practitioner working in public and private facilities, Mwanza (Nov. 8, 2017).

⁷⁶ Syriacus Buguzi, The unsafe practice of intended abortion fueled by drug-stores, *The Citizen* (February 27, 2017) available at <https://www.thecitizen.co.tz/magazine/The-unsafe-practice-of-intended-abortion-fuelled-by-drug-stores/1840564-3829544-format-xhtml-nfwkat/index.htm> (last accessed June 7, 2020).

⁷⁷ Interview with a nurse working at a private facility, Mwanza (Dec. 15, 2017) ("[m]isoprostol that is under dosed results in incomplete abortions. [Women and girls] get it from pharmacies, it is sold secretly. Nowadays, most of the pharmacies have misoprostol but they fail to give the proper dosage.")

⁷⁸ Catherine Kahabuka et al., Provision of harm-reduction services to limit unsafe abortion in Tanzania, 211, *Int. Journal of Gynecology & Obstetrics* 136: 2 (2016).

⁷⁹ Id.

⁸⁰ Focus group discussion with women, Mwanza (Nov. 11, 2017).

⁸¹ Interview with a woman, age 34, Arusha (Nov. 20, 2017) (She experienced severe pain and bleeding for two weeks after an unsafe abortion but did not know that public facilities provided post abortion care, and did not go to a private facility because of cost); See also interview with a woman, age 21, Dar es Salaam (Sep. 26, 2017).

⁸² MOH, National Road Map on MNCAH 2016-2020, supra note 29, at 8.

⁸³ See e.g. interview with a young woman, age 19 years, Mwanza (Nov. 16, 2017); interview with a woman, age 24, Mwanza (Nov. 9, 2011).

⁸⁴ Interview with a woman, age 24, Arusha, Rec. 74 (Nov. 20, 2017).

⁸⁵ Interview with a woman, (age withheld) (Nov. 7, 2017).

⁸⁶ Interview with an ob/gyn working in a public hospital in Mwanza (Nov. 9, 2017); Interview with a general practitioner working a public referral hospital, Dar es Salaam (Nov. 28, 2017).

⁸⁷ Interview with a midwife and nurse working in a regional hospital, Arusha (Nov. 21, 2017).

⁸⁸ Focus group discussion with health care providers working at a local NGO, Dar es Salaam (Sep. 21, 2017): See also interview with a woman, age 22, Mwanza, (Nov. 13, 2017).

⁸⁹ MOH, Post Abortion Care Trainees Manual, supra note 27, at 14.

⁹⁰ Focus group discussion with health care providers working at a local NGO, Dar es Salaam (Sep. 21, 2017)

⁹¹ Interview with a general practitioner working in public and private facilities, Mwanza (Nov. 8, 2017).

⁹² Interview with a young woman, age 25, Arusha (Nov. 20, 2017).

⁹³ interview with an ob/gyn working in a facility that is partly public, Mwanza (Nov. 8, 2017).

⁹⁴ Interview with a nurse working at a private facility, Mwanza (Dec. 15, 2017).

⁹⁵ Center for Reproductive Rights, Legal and Policy Framework, supra note 16, at 29.

⁹⁶ African Commission on Human and Peoples' Rights, General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and article 14.2 (a) and (c) of the Protocol to

CENTER *for* REPRODUCTIVE RIGHTS

the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 46 (2014) [hereinafter ACHPR, General Comment 2].

⁹⁷ *Id.*

⁹⁸ *Id.*, para 48.

⁹⁹ CEDAW Committee, Concluding Observations: Timor-Leste, para. 31(a), U.N. Doc. CEDAW/C/TLS/CO/2-3 (2015).

¹⁰⁰ ACHPR, General Comment 2, *supra* note 96, para 49.

¹⁰¹ *Id.*, para 46.

¹⁰² See, e.g., *K.L. v. Peru*, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); *L.C. v. Peru*, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011)

¹⁰³ The Constitution of the United Republic of Tanzania (1977) see Part III.

¹⁰⁴ See CRC, Concluding Observations: Bhutan, para. 35(c), U.N. Doc. CRC/C/BTN/CO/3-5 (2017); Cameroon, para. 35(c), CRC/C/CMR/CO/3-5 (2017); Sierra Leone, para. 32 (c), U.N. Doc. CRC/C/SLE/CO/3-5 (2016); Benin, para. 57(c), U.N. Doc. CRC/C/BEN/CO/3-5 (2016); CEDAW Committee, Concluding Observations: Micronesia, para. 37(b), U.N. Doc. CEDAW/C/FSM/CO/1-3 (2017); Niger, para. 33(c), U.N. Doc. CEDAW/C/NER/CO/3-4 (2017); Costa Rica, para. 31(a), U.N. Doc. CEDAW/C/CRI/CO/7 (2017). See also Human Rights Committee, Concluding Observations: Honduras, para. 17, U.N. Doc. CCPR/C/HND/CO/2 (2017).

¹⁰⁵ Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) para. 35 & 49 U.N. Doc. E/c.12/GC/22 (2016).

¹⁰⁶ CEDAW Committee, General Recommendation No. 24: Article 12 of the Convention (women and health) (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by*

Human Rights Treaty Bodies, at 14, para. 18, U.N. Doc.HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, Gen. Recommendation No. 24]; CRC Committee, Concluding Observations: Nicaragua, para. 59, U.N. Doc. CRC/C/NIC/CO/4 (2010); CAT Committee, Concluding Observations: Nicaragua, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); ESCR Committee: Concluding Observations: Pakistan, paras. 77, 78, U.N. Doc. CESCR/PAK/CO/1 (2017).

¹⁰⁷ Committee on the Rights of the Child, General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence, para. 60 U.N. doc. CRC/C/GC/20 (2016).

¹⁰⁸ ESCR Committee, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights), para. 13, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, Gen. Comment No. 22].

¹⁰⁹ CAT Committee, Concluding Observations: Paraguay, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6(2011).

¹¹⁰ ESCR Committee, Gen. Comment No. 22, *supra* note 109, para 2, 15, and 24.

¹¹¹ *Id.*, para 16.

¹¹² *Id.*, para 17.

¹¹³ *Id.*, para. 18: ACHPR, General Comment 2, *supra* note 96, para. 51.

¹¹⁴ ESCR Committee, Gen. Comment No. 22, *supra* note 109, para. 20.

¹¹⁵ CEDAW Committee, Gen. Recommendation No. 24, *supra* note 107, para. 31(e); Committee on the Rights of the Child, Concluding Observation: Slovakia, para 41(e), U.N. Doc. CRC/C/SVK/CO/3-5

¹¹⁶ Committee on the Rights of the Child, Concluding Observation: Slovakia, para 41(e), U.N. Doc. CRC/C/SVK/CO/3-5.

¹¹⁷ ESCR Committee, Gen. Comment No. 22, *supra* note 109, para. 21.

ENDNOTES: SOCIO-ECONOMIC PROFILE OF TANZANIA

¹ World Population Review, *Tanzania Population 2020* available at <http://worldpopulationreview.com/countries/tanzania-population/> (last visited June 16, 2020).

² World Population Review, *Low Income Countries 2020* available at <https://worldpopulationreview.com/countries/lowincomecountries/> (last visited June 16, 2020).

³ UNDP AND GOVERNMENT OF TANZANIA, TANZANIA HUMAN DEVELOPMENT REPORT 2017: SOCIAL POLICY IN THE CONTEXT OF ECONOMIC TRANSFORMATION XII (2018) [hereinafter UNDP, TANZANIA HUMAN DEVELOPMENT REPORT 2017]: Multidimensional poverty refers to “the extent of deprivation that individuals face with respect to their standard of living, education and health” and extreme poverty refers to “the proportion of people below the food poverty line”: See UNDP, TANZANIA HUMAN DEVELOPMENT REPORT 2017, at 7 & 11.

⁴ UNDP, TANZANIA HUMAN DEVELOPMENT REPORT 2017, at xii & xiii.

⁵ Ministry of Foreign Affairs of Denmark, *Current and future challenges and opportunities in Tanzania* (2014) available at <http://um.dk/en/danida-en/strategies%20and%20priorities/country-policies/tanzania/current-and-future-challenges-and-opportunities-in-tanzania/> (last visited June 16, 2020).

⁶ UNDP, TANZANIA HUMAN DEVELOPMENT REPORT 2017, *supra* note 3, at xii & xiv.

⁷ *Id.*

⁸ Trading Economics, *Tanzania Unemployment Rate 2001-2018* available at <https://tradingeconomics.com/tanzania/unemployment-rate>.

⁹ UNDP, TANZANIA HUMAN DEVELOPMENT REPORT 2017, at 45.

¹⁰ *Id.*

¹¹ *Id.*, at 13.

¹² *Id.*

¹³ *Id.*, at 73.

¹⁴ *Id.*, at 15 & 45.

¹⁵ *Id.*, 15-16.