

Failure to Prevent Unplanned Pregnancies

The Case of Tanzania

June, 2020.

Every year, at least 1 million Tanzanian women and girls are faced with unwanted or unplanned pregnancies. Of those, 39% end in abortions.¹ This indicates that in order to address the high rate of unsafe abortions in Tanzania, it is crucial to understand the factors and resulting human rights violations that lead to unwanted and unplanned pregnancies. This factsheet discusses some of these factors including the limited access to contraceptive information and services in Tanzania and highlights the disproportionate effect this has on vulnerable groups such as women living in rural areas and those with limited economic means. It also discussed lack of access to reproductive health information and services for adolescents and victims of sexual violence.

I. Access to Contraceptive Information and Services

1. LOW CONTRACEPTIVE COVERAGE AND HIGH UNMET NEED

Tanzania has a number of policy documents that provide guidance on the provision of contraceptive services, recognize the importance of the service for the reduction of maternal mortality and, specify various policy measures to expand the services.² However, modern contraceptive prevalence is only 32%,³ and the unmet need for contraceptives among married women, which is 24%, has not improved since 1999.⁴

There is also discrepancy in the level of contraceptive use based on factors including geographical area, education, and income level.⁵ As a result, the fertility rate, at 5.2 children per woman, is very high,⁶ with significant discrepancies between rural areas, where the average rate is 6 children, and urban areas, where the rate is 3.8 children.⁷ The low contraceptive usage rate and high unmet need are a result of several health sector and non-health sector challenges that women and girls encounter in accessing contraceptives. These challenges are discussed below.

2. LIMITED AVAILABILITY AND ACCESSIBILITY OF CONTRACEPTIVES AND QUALITY OF SERVICES

While Tanzania's *National Family Planning Guidelines and Standards* recognizes that all people have the right to access a contraceptive method of their choice, "regardless of their socioeconomic situation, religion, political beliefs, ethnic origin, age, marital status, geographic location or other characteristics,"⁸ women and girls continue to encounter several challenges, including a lack of trained personnel at all levels of health facilities (dispensaries, health centers, and hospitals)⁹; supply and equipment shortages; long distances to facilities; and an insufficient number of health facilities that provide comprehensive contraceptive services.

Inability to access preferred method and cost

In Tanzania, patients are required to first seek services at primary- and secondary-level facilities—dispensaries and health care centers. When the required services are not available in the lower-level facilities, the patients are referred to tertiary-



32% CPR

National modern contraceptive prevalence rate.

24% Unmet
Need

for contraception among married women.

10.8%
Unmet need

for contraception among adolescents aged 15-19 years.

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level facilities, such as district, regional, and national hospitals. For the majority of the population living in rural areas, lower-level facilities are located at a more accessible distance than higher-level facilities.¹⁰ However, for various reasons, including a lack of skilled personnel and budget, low-level facilities generally provide only short-term contraceptives, such as injections, pills, and condoms, which can be out of stock.

Even when the methods are available, as one official working in the local government authority in Mwanza explained, most dispensaries lack trained personnel to administer them.¹¹ If women prefer long-term contraceptive options, such as intrauterine devices (IUDs), implants, and sterilization, they are compelled to go to a higher-level facility.¹² As a result, many women, especially in rural areas, are forced to resort to a contraceptive method that is not their preference,¹³ forgo using contraceptives at the risk of unplanned pregnancies, or bear the burden of additional expenses, such as cost of transportation.¹⁴ However, as another officer working in the family planning department of the Arusha City Council highlighted, higher-level facilities may experience the same shortage of trained medical personnel and supplies and can lack variety of methods.¹⁵

Additionally, while contraceptives are provided free of charge in public facilities,¹⁶ when women are not able to access their preferred method in a dispensary or health facility close to their residence, they are compelled to opt for a private facility.¹⁷ However, the choice of going to a private facility is available only to those who have the means to pay for the services. Some are even forced to utilize resources they had allocated for other expenses.

As our interviews revealed, long-term methods, such as implants and IUDs, can cost as much as Tsh 10,000 Tanzanian shillings (Tsh). By comparison, short-term methods, such as pills and injections, can cost Tsh 3,000.¹⁸

For short-term methods, the yearly cost of contraceptives is higher because women are required to renew their prescriptions every one to three months, depending on the method. This creates a great disparity in access between low-income women and their wealthier counterparts: According to the most recent Demographic Health Survey (DHS), only 20% of low-income married women use modern contraceptives, while the rate of usage is 35% for those in a higher-wealth quintile.¹⁹

Lack of quality services

The poor quality of service at public facilities further pushes women to resort to private facilities. Many public facilities, particularly at lower levels, often do not have the space and environment to ensure confidentiality and privacy when providing contraceptive services. Overcrowding and long wait times are additional factors that affect the quality of services in these facilities. Further, due the large number of patients who must be treated each day, health care providers are unable to spend the time required to consult with women and provide detailed information on the full range of available contraceptive methods, including possible side effects, and perform an examination before providing contraceptives.²⁰

The problem is further compounded by the refusal of some faith-based health care facilities to provide contraceptive services. Because 23% of public health facilities and 41% of hospitals in Tanzania are owned or governed by faith-based organizations, the facilities' refusal to provide contraceptives has negative implications on the availability and acces-

sibility of the service in some areas. An OB/GYN working in Mwanza in a Catholic facility that is partly public, for instance, confirmed that the facility does not provide contraceptives, including emergency contraceptives, for victims of rape but rather refers the women to another facility to obtain the service.²¹ Further, this facility, which is also a teaching hospital, does not train doctors on providing contraceptive services. This creates a problem when these doctors are assigned to work in other public facilities, because they do not have the necessary information and skills to provide the service.²²

Widespread myths and misconceptions

Widespread myths and misconceptions discourage women and girls from using modern contraceptives, indicating the government's failure to ensure access to scientifically accurate information. Interviewees for this research admitted to some of the misconceptions, including fear of cancer, tumours, and fibroids;²³ not being able to conceive after stopping contraceptive usage; and the negative effect on a child conceived after using contraceptives.²⁴

Due to the patriarchal system, therefore, many women believe that they need the consent of their partner before using contraceptives. When men refuse to provide consent, most women forgo using contraceptives or choose a method based not on their needs but on whether it can be used secretly.

As the World Health Organization (WHO) has clarified, these perceived side effects are not supported by scientific evidence, and the use of contraceptives does not cause cancer, infertility, or fetal abnormality.²⁵ In addition, due to the limited level of knowledge, some women experiencing side effects, such as irregular bleeding, dizziness, and nausea, stop using contraceptives without consulting a health care professional.²⁶ These misconceptions and the fear of side effects, therefore, compel women to opt for traditional and less effective methods, such as calendar and withdrawal methods.²⁷ A study conducted across 43 developing countries found that traditional methods, including withdrawal and periodic abstinence, have a high failure rate.²⁸

Perceived gender roles regarding the use of contraceptives

The limited knowledge and misconceptions about contraceptives also extend to preconceived gender roles regarding the use of contraceptives. Most often, the main role of women is considered to be childbearing. That deprives women of the right to make an independent decision regarding whether to use contraceptives, particularly when they are in a marriage.²⁹ As the interviewees shared, when husbands find out that their wife is using a contraceptive, they ask, “Why? don’t you want to have kids with me?”³⁰ On the other hand, when couples agree to prevent or delay pregnancies, the entire burden is imposed on women,³¹ and many men do not consider using contraceptive methods that are meant for men: As indicated in the DHS, the rate of male sterilization is zero.³² This is because of the “misconception that a man who undergoes [sterilization] would not be sexually active” and the community’s negative perception towards men who undergo the procedure.³³

Due to the patriarchal system, therefore, many women believe that they need the consent of their partner before using contraceptives. When men refuse to provide consent,³⁴ most women forgo using contraceptives or choose a method based not on their needs but on whether it can be used secretly.³⁵

II. Adolescents’ Limited Access to Sexual and Reproductive Health Services

“Like persons of other age groups, young people have the rights to decide if and when they want to have children, be informed and obtain information about family planning services, and access a full range of contraceptive methods.”³⁶—Government of Tanzania

Young people, including adolescents, make up a large part of Tanzania’s population,³⁷ indicating that there is a large proportion of the population that has sexual and reproductive health needs. While 12% of adolescents in Tanzania have started sexual relations by age 15, and 60% by 18,³⁸ only 8.6% of adolescent girls between 15 and 19 use modern contraceptive methods.³⁹ The unmet need stands at 10.8%.⁴⁰ As a result, one in four adolescent girls between ages 15 and 19 are already mothers or are pregnant with their first child.⁴¹ Thirty-two percent of adolescents living in rural areas have had a live birth or are pregnant, compared with 19% of those living in urban areas.⁴² Moreover, adolescents in households are three times more likely to have a child than their wealthier counterparts.⁴³

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The factors that lead to the high unwanted and unplanned pregnancies among adolescents in Tanzania are well documented in the research conducted by the Center for Reproductive Rights: *Forced Out: Mandatory Pregnancy Testing and the Expulsion of Pregnant Students in Tanzanian Schools*.⁴⁴ The report said the absence of sexuality education, lack of access to youth-friendly health services and contraceptives, stigma against adolescents' sexuality, and lack of safe abortion services were the main impediments to adolescents' full enjoyment of their sexual and reproductive rights.⁴⁵

1. LIMITED ACCESS TO COMPREHENSIVE SEXUALITY EDUCATION

Access to comprehensive information regarding sexual and reproductive health is crucial if adolescents are to make informed choices about their reproductive health, including preventing unwanted and unplanned pregnancies. However, adolescents in Tanzania, both in and out of school, have limited avenues to access this information.

Research conducted by the Center found that "students rarely receive any meaningful instruction on sexual or reproductive health in schools."⁴⁶ While government policies and guidelines indicate that sexuality or life skills education should be part of primary and secondary education, schools do not cover the issues comprehensively.⁴⁷ Rather, some issues are incorporated in different subjects, such as biology, civics, languages, and work skills, in a piecemeal manner.⁴⁸ In addition, the information is provided mainly to secondary school students, while primary students can be as old as 15 and many get pregnant at or before that age.⁴⁹ Further, many teachers have limited, if any, training on teaching comprehensive sexuality education and

do not have the resources to provide education on the subject.⁵⁰ This leads to many teachers being uncomfortable "teaching the subject altogether or teach in ways that are confusing to students."⁵¹ As a result, they end up focusing mainly on abstinence, which is also supported by the Ministry of Education's guide for school counselors.⁵²

Access to information for out-of-school adolescents is also very limited. While interviews conducted for this research indicated that there are some efforts by the government and development partners to provide such information through community forums and youth groups,⁵³ "it is difficult to reach out-of-school adolescents," as explained by a gender and children focal person at one of the municipality councils in Mwanza.⁵⁴ This is particularly concerning since "less than a third of girls who complete primary schooling end up completing lower secondary school,"⁵⁵ indicating that there is a large proportion of out-of-school adolescents that these programs need to reach.

Due to the absence of reliable education, many adolescents obtain information on reproductive health, including on contraceptives, from their peers, family members, or the media, which can often be misleading.⁵⁶

2. LACK OF YOUTH-FRIENDLY SERVICES AND STIGMA ABOUT ADOLESCENTS' SEXUALITY FUEL UNWANTED AND UNPLANNED PREGNANCIES

The government of Tanzania recognizes that when it comes to sexual and reproductive health services, it is crucial to offer youth-friendly services that have "policies and attributes that attract youth to the services, provide a comfortable and appropriate setting for serving

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youth, meet the needs of young people, and are able to retain their young clients for follow-up and repeat visits.”⁵⁷ Despite this, youth-friendly services, particularly in rural areas, continue to remain very limited.⁵⁸ Since the existing health facilities serve the larger communities and not exclusively adolescents, many youths fear running into their parents and other people they know at these facilities.⁵⁹ The wait time required to receive services and the working hours of the facilities — which are usually the same as school hours — further discourage adolescents from seeking their service⁶⁰ because they would need to miss school and provide evidence justifying their absence.

The lack of health care professionals trained in providing youth-friendly services, which results in a personal bias against adolescents accessing reproductive health services, including contraceptives, is an additional challenge. As a government Youth Department Officer in Mwanza explained: “The decision to give [contraceptive] services is at the discretion of the provider. Sometimes health care providers discriminate against adolescents who want to access [contraceptives], because of their values and/or traditions. They do not have enough education and training on how to provide youth-friendly reproductive health services.”⁶¹

Further, while the *National Family Planning Guideline and Standards* provides that all young people (ages 10 to 24) are eligible for contraceptive information, education, and services “irrespective of their parity and marital status” and without parental consent,⁶² some providers continue to impose age-based restrictions. One study, for instance, found that between 79% and 81% of contraceptive service providers in rural Tanzania impose age restrictions for accessing a contraceptive pill.⁶³ A head nurse working in a public facility con-

firmed: “We talk to adolescents first and ask them if their parents are aware of them taking that service, and we also ask for their parents' contacts so as to have conversations with them for further directions. ... If the parents are unaware, then we do not provide them with contraceptives.”⁶⁴

Providers' bias can further breach adolescents' right to privacy and confidentiality, and push them away from seeking contraceptive services. As a reproductive health advocate explained:

“Sometimes health care providers tell adolescents that they are too young and ask what they are doing here. ‘Go to school. After school you can come back.’ ... Sometimes the right to privacy of the youth is disrespected, because they may get services at the health facility but then the provider discusses the issue with the parents, without their consent, causing the youth not go to facilities anymore.”⁶⁵

In addition to being a violation of their right to privacy and confidentiality, requiring adolescents to obtain parental consent for accessing contraceptives is a great impediment, given the stigma attached to adolescents' sexuality.

As several participants interviewed for this research pointed out, due to cultural beliefs and traditions, sexuality is a taboo subject and parents do not discuss these issues with their children openly.⁶⁶

The stigma associated with adolescents' sexuality goes beyond parents and providers and is also widespread in the government and communities. The statement of a high-ranking government official involved in developing and implementing policies, including that of

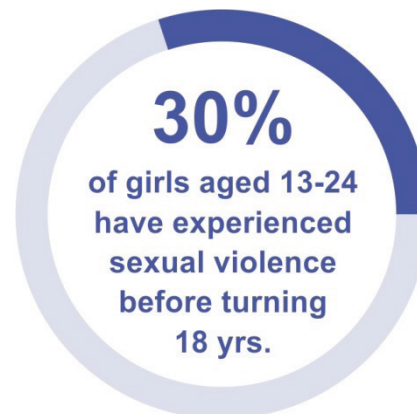
health policies for youth, is a clear illustration of this: When asked whether adolescents can go to public facilities to obtain contraceptives, the official responded: “Yes, from 18 years onwards. For us, it is post high school [that young people should engage in sex]. That is traditional to us, under 18 they are not supposed to engage in intercourse.”⁶⁷

3. IMPACT OF ADOLESCENTS' LACK OF ACCESS TO REPRODUCTIVE SERVICES

The lack of access to sexuality and reproductive health information services has a grave impact on the lives of adolescents. Due to their age and associated physical development, adolescents have a higher risk of pregnancy-related mortality and morbidity. According to the WHO, “complications during pregnancy and childbirth are the leading cause of death for 15- to 19-year-old girls globally.”⁶⁸ Children born to adolescent mothers also have a “higher risk of low birthweight, preterm delivery, and severe neonatal conditions.”⁶⁹

In addition to its negative health impact, early pregnancy has grave economic and social consequences for adolescents. Particularly in Tanzania, pregnancy results in girls being denied their right to education and any future opportunities that may come as a result.

The fact-finding research conducted by the Center revealed that, in schools, girls are often subjected to forced pregnancy testing, which is conducted without the informed consent of the girls.⁷⁰ When found to be pregnant, the girls are immediately expelled from the school despite the absence of a law or policy that explicitly mandates this practice.⁷¹ Once expelled, the girls are not allowed to re-enroll after delivery or if they did



not carry the pregnancy to term. There is no exception to this practice — all pregnant girls, including those who became pregnant as a result of rape, are expelled.⁷² Every year, it is estimated that 8,000 girls are forced out of schools.⁷³

Justifying this practice, a high-ranking state government official interviewed for this research stated:

“If an underage girl conceives, she has to face that reality [that she cannot continue going to school]. She has to take the road she has chosen. Expulsion from schools is a punishment and deterrent. Otherwise, girls will get pregnant in form one and go home and return after one year and get pregnant in form three and so on. If we allow pregnant girls to attend schools or return to school after delivery, there will be no incentives for them to be careful.”⁷⁴

However, there is no evidence to show that preventing girls from continuing with their education deters others from getting pregnant. Rather, ensuring access to comprehensive reproductive health information and services, including contraceptives, is a proven strategy to tackle unwanted and unplanned pregnancies.

The type of sentiment expressed by the state government official also disregards victims who become pregnant as a result of sexual violence. In addition, continuing their education at a vocational or private school is an option only to the few students who have the resources to afford the fees associated with these types of schools.⁷⁵ This marginalizes those who live in rural areas or are from low-income families. It also denies girls the opportunities that come with formal education which they will not be able to access with a vocational training.

III. High Level of Sexual Violence Against Women and Girls Contributes to Unwanted Pregnancies and Unsafe Abortions

Sexual violence in Tanzania is pervasive and often underreported. According to the latest DHS data, 17% of Tanzanian women have experienced sexual violence,⁷⁶ nearly half of which is perpetrated by husbands or intimate partners.⁷⁷ Sexual violence against adolescent girls is similarly very high: Three out of every 10 girls ages 13 to 24 have suffered at least one incident of sexual violence before turning 18.⁷⁸ Twenty-nine percent of girls who began sexual relations before age 18 reported that their first sexual intercourse was forced.⁷⁹ In addition, Tanzania has one of the highest rates of child marriage — a form of gender-based violence — in the world. On average, almost one out of three girls are married before age 18.⁸⁰ Child marriage in Tanzania is more prevalent among girls who are the least educated, are from low-income households, and live in rural areas.⁸¹

In 2011, the Tanzanian Ministry of Health and Social Welfare issued a policy that outlines the support that should be provided to victims of gender-based violence, including the health care services that should be available all levels of facilities.⁸² This includes the provision of an emergency contraceptive, which is recommended to be provided to all victims of reproductive age⁸³ because it reduces the chances of getting pregnant if provided within 120 hours after unprotected sex.⁸⁴ However, many victims do not seek health services immediately after sexual violence has occurred, since they believe that reporting the incident is a requirement for accessing the service, and they opt out from reporting due to the limited legal recourse and prolonged legal processes.⁸⁵

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Fear of stigma and cultural attitudes also strongly discourage victims of sexual violence from seeking health services. As a result, many who become pregnant due to sexual violence are forced to resort to unsafe abortions since the legal framework in Tanzania does not explicitly provide the right for victims of sexual violence to legally access abortion services.

Research conducted in Tanzania revealed a significant link between physical and sexual violence against women and the rate of induced abortion. According to the research, women who have suffered violence from their intimate partners are 1.9 times more likely to induce an abortion.⁸⁶ It further found that violence is more influential in the decision to end a pregnancy than a woman's age, socioeconomic status, and number of children.⁸⁷ The research concludes that "induced abortion was significantly associated with having experienced sexual partner violence only and having experienced both physical and sexual partner violence"⁸⁸ This suggests that although many factors affect a woman's decision to obtain an abortion, violence is a crucial aspect to be considered when dealing with the issue of unsafe abortion in Tanzania.

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1. LIMITED ACCESS TO LEGAL REMEDIES AND VICTIM-FRIENDLY SERVICES DISSUADES WOMEN AND GIRLS FROM REPORTING

Many factors prevent women and girls from pursuing legal remedies for sexual violence, which also affects their access to health services. For one, Tanzania lacks legislation that comprehensively addresses the issue of gender-based violence. Rather, different laws and policies, such as the penal code and the Sexual Offences Special Provision Act of 1998, provide protections for specific types of violence, including sexual violence.

However, an assessment conducted by the Tanzania Women Lawyers Association found these laws to have gaps.⁸⁹ For instance, the Sexual Offences Special Provision Act criminalizes rape against a woman or a girl except in circumstances where the victim is the wife of the perpetrator.⁹⁰ Due to the lack of criminal liability, victims of marital rape, including adolescents in early marriages, might be reluctant to seek legal and social services.

This was the experience of a woman from Dar es Salaam who was a victim of marital rape, became pregnant as a result, and procured an unsafe abortion. She recounted: "[The pregnancy] was not the result of consensual sex. My husband and I were separated, but he used to come to my place once a month and force me to have sex with him. He said he is still my husband and forced himself upon me. I did not report him or tell anyone because [I didn't think anything will be done since] he still was my husband and it was my duty as a wife. ... [I suffered] frequent sexual assaults from my husband."⁹¹ The lack of criminal sanctions for marital and intimate partners rape is particularly

concerning as nearly half of the women and girls that have ever suffered sexual violence did so at the hands of a husband or an intimate partner.⁹²

Limited implementation of the laws and the lack of victim-friendly services, including "ineffective police involvement, failure of the legal system to convict perpetrators, a shortage of safe houses for survivors ... and limited number of social welfare officers,"⁹³ further discourage women and girls from seeking services. A 2017 study conducted in eight regions in Tanzania found that many people distrust the legal system, which "in the end tends to lead to miscarriage of justice."⁹⁴ The lack of victim-friendly and support services was another issue raised by the participants interviewed for this research. Evidence indicates that the numbers of shelters and legal aid services available for victims are very limited and that most of these are operated by non-governmental organizations.⁹⁵

Although, in 2013, gender desks were established in police stations to provide a more victim-friendly environment to women and girls reporting gender-based violence, including sexual violence,⁹⁶ police officers interviewed for this research highlighted the lack of trained professionals, including counselors, and resources to handle such cases.⁹⁷ Unfortunately, the lack of training results in mistreatment of victims where those who had the courage to press charges are interrogated.⁹⁸ Court procedures and proceedings can also be intimidating and can be perceived by victims as invasive or even threatening, especially when they're asked to recount the events in public.

Victims' economic dependence on the perpetrators is an additional reason for the low reporting rate for sexual violence cases. A survey conducted in 10

regions by the Legal and Human Rights Center, a non-governmental advocacy organization, found that “most women who encounter violence from their spouses decide against reporting to authorities due to their dependence on them.”⁹⁹ This also applies to employer-employee relationships. A woman interviewed for this research, for instance, did not file a report when her employer raped her when she was 17 because she was worried about losing his financial support.¹⁰⁰

A doctor working in Arusha shared a similar story of a woman who sought abortion services for a pregnancy that resulted from rape: “[A woman] was raped by her boss. She didn’t report the rape to police because she feared for her employment. After one month, she missed her period and came to us. We examined her, we did several tests, including STIs [sexually transmitted infections, such as HIV] and also a pregnancy test, which was positive.”¹⁰¹

Limited implementation of the laws and the lack of victim-friendly services, including “ineffective police involvement, failure of the legal system to convict perpetrators, a shortage of safe houses for survivors ... and limited number of social welfare officers,” further discourage women and girls from seeking services.

2. STIGMA AND CULTURAL ATTITUDES PREVENT VICTIMS FROM REPORTING RAPE

Deep-rooted stigma and cultural values compel victims of sexual assault to remain silent about offences committed against them. For instance, a study conducted in 2017 in eight regions in Tanzania found that sexual violence against children is “rarely reported due to shame and embarrassment faced by the victims and their families.”¹⁰² At a focus group discussion conducted for the study, a religious leader explained:

*“When the child gets raped, for the mother to disclose such an incident is not easy. It is a shame on her because it is like exposing herself naked in front of the society. Sometimes the society expresses views that it was not truly rape but the result of negotiations and agreement between the two ... also out of fear that young men would not make them their bride. A man cannot pick a sexual violence survivor as fiancée.”*¹⁰³

Victims interviewed for this research also expressed fear of being judged and not being believed as a reason for not reporting sexual violence. A 19-year-old girl in Arusha, who was a victim of rape and became pregnant as a result, explained: “I was raped by a neighbor [while living with my grandmother], who was 26 or 27 years, and I was only 16 years. I didn’t tell anyone, because my grandmother was harsh and would not believe that I was raped. She would have thought that it was my fault. If I told anyone, I could have been expelled from school and I was afraid of being labeled and judged at home.”¹⁰⁴

Another young woman, from Dar es Salaam, had a similar experience when she was 16. In her case, she was raped by

the man she worked for as house help. She did not tell her mother of the rape because she thought she would not believe her and would blame her for being raped. She told the interviewers: “[My mother] would not have believed that he raped me because she thinks he is a nice man and she trusts him fully.”¹⁰⁵

Further, due to stigma, families of victims prefer to deal with the issue secretly, without the involvement of authorities.¹⁰⁶ As confirmed by many of the participants interviewed for this research, this is particularly true if the perpetrator is a family member or a person known to the victim. A police officer in Mwanza explained:

*“Cases of rape within a family are not reported because women are threatened to be killed if they tell anyone, especially the police. Even in cases where the rape is not committed by relatives, because in African families patriarchy still persists and because of shame of the family, rapes are not reported to authorities. The issue is dealt with privately. The two parties meet and discuss and reconcile without involving authorities. This is not good for the victims.”*¹⁰⁷

In conclusion, while sexual violence against women and girls is common, many delay reporting and seeking health services until they find out they are pregnant. However, due to the restrictive law, they are forced to undergo unsafe abortions, putting their lives and health at risk. This is despite Tanzania’s human rights obligations under international and regional human rights instruments to ensure victims’ access to comprehensive health services, including access to emergency contraceptives and safe abortion services.

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ENDNOTES

- 1 Guttmacher Institute, Infographic: Each Year One Million Tanzanian Women Have an Unintended Pregnancy. (2016) *available at* <https://www.guttmacher.org/infographic/2016/each-year-one-million-tanzanian-women-have-unintended-pregnancy>.
- 2 Some of these policy documents and guidelines include: UNITED REPUBLIC OF TANZANIA, MOH, NATIONAL FAMILY PLANNING GUIDELINES AND STANDARDS (2013) [hereinafter MOH, FAMILY PLANNING GUIDELINES 2013]; UNITED REPUBLIC OF TANZANIA, MOH, THE NATIONAL ROAD MAP STRATEGIC PLAN TO IMPROVE REPRODUCTIVE, MATERNAL, NEWBORN, CHILD & ADOLESCENT HEALTH IN TANZANIA (2016 - 2020): ONE PLAN II (2016) [hereinafter MOH, ONE PLAN II (2016)]; UNITED REPUBLIC OF TANZANIA, MOH, THE NATIONAL PACKAGE OF ESSENTIALS HEALTH INTERVENTIONS IN TANZANIA. (2000); UNITED REPUBLIC OF TANZANIA, MOH, THE NATIONAL ROAD MAP STRATEGIC PLAN TO ACCELERATE REDUCTION OF MATERNAL, NEWBORN AND CHILD DEATHS IN TANZANIA 2008 – 2015 (2008).
- 3 MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN ET AL., TANZANIA 2015-16 DEMOGRAPHIC AND HEALTH SURVEY AND MALARIA INDICATOR SURVEY KEY FINDINGS 5 (2016) *available at* <https://www.dhsprogram.com/pubs/pdf/SR233/SR233.pdf> [hereinafter 2016 TDHS KEY FINDINGS].
- 4 MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN ET AL., TANZANIA DEMOGRAPHIC AND HEALTH SURVEY AND MALARIA INDICATOR SURVEY 2015-16 131 (2016) *available at* <https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf> [hereinafter TDHS 2016].
- 5 For instance, 33% of married women with secondary education use contraceptives as compared to only 24% of those with no education. Some regions have a very low contraceptive use rate of 7%: 2016 TDHS KEY FINDINGS, *supra* note 3, at 3.
- 6 John Hopkins Center for Communication Programs et.al., Accelerating Family Planning Progress in Tanzania: What Does the 2015-16 Demographic and Health Survey Tell Us? (2016) *available at* https://assets.prb.org/pdf16/Gates_Brief_Tanzania.pdf.
- 7 2016 TDHS KEY FINDINGS, *supra* note 3, at 3.
- 8 MOH, FAMILY PLANNING GUIDELINES 2013, *supra* note 2, at 6.
- 9 In Tanzania, the public health referral system is organized at different levels of the health care facilities. Patients are required to first seek services at primary and secondary level facilities, which comprise of dispensaries and health care centers, respectively, and will be referred to tertiary level facilities, such as district, regional and national hospitals, when the required services are not available in the lower facilities.
- 10 Interview with a reproductive health advocate, Dar es Salaam (Sep. 29, 2017) (“[women] might need to travel 10-15 kilometers or even more to access the facilities. The [government’s] plan is to have a health center in every ward but that has not happened yet”).
- 11 Interview with a government official, Gender and Youth Department, Mwanza (Nov. 15, 2017) (“Generally, all [contraceptive] methods should be available everywhere, but the availability of a particular method depends on the level of the facility. Dispensaries provide pills, injections, condoms, while the health center also provides loop and implants. Dispensaries do not have loops and implants because they lack trained providers and equipment. Trained providers are only available at health centers and hospitals); See also interview with reproductive health advocates, Dar es Salaam (Sep. 25, 2017) & (Sep. 29, 2017).
- 12 See *for e.g.* interview with a government official, Gender and Youth Department, Mwanza (Nov. 15, 2017); interview with City Council officer, Arusha (Nov. 20, 2017).
- 13 MOH, ONE PLAN II (2016), *supra* note 3, at 13.
- 14 Focus group discussion with health care providers working at a local NGO, Dar es Salaam (Sep. 21, 2017); interview with a government official, Gender and Youth Department, Mwanza (Nov. 15, 2017) (“Some wards are very far away from any health facility, so it is not easy for people to have access to health services. It is much easier for those living in urban areas. Because of poverty, some women cannot afford to pay for transportation to health center or hospitals, which means they cannot get services”).
- 15 Interview with City Council officer, Arusha (Nov. 20, 2017); interview with a reproductive rights advocate, Dar es Salaam (Sep. 29, 2017) (“We train providers working in facilities where those services are needed by women who cannot access those services anywhere else. In a remote area, women have to go a very long way to get these services, so we train the providers, renovate the facilities and provide supplies and equipment. However, when the trained provider is moved to another facility, and probably to an area that does not have a high number of women that need family planning, it means that we lose both their skills and women lose the access to quality reproductive health services. When a new provider comes, it is difficult to provide the same training due to limited financial resources).
- 16 See, for instance, focus group discussion Focus group discussion with young girls, Mwanza (Nov. 13, 2017); interview with reproductive health advocates, Dar es Salaam (Sep. 25, 2017).
- 17 Interview with a young woman, age 19, Dar es Salaam (Dec. 6, 2017) (The young woman who gets injectables from a private facility explained: “I normally get [it] at the public hospital when I take my child

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- there but in most cases I get it from a private pharmacy due to distance. The public hospital is far from where I reside”).
- 18 See interview with health care providers working at a local NGO, Mwanza (Nov.15, 2017); interview and focus group discussion with women, Mwanza (Nov.11, 2017).
- 19 TDHS 2016, *supra* note 4, at 133.
- 20 Interview with woman, age 25, Mwanza (Nov.15, 2017); see also Focus group discussion with women, Mwanza (Nov.7, 2017).
- 21 Interview with Ob/gyn working in a public faith-based hospital, Mwanza (Nov.11, 2017); The fact that faith-based facilities refuse to provide contraceptive services was also confirmed by multiple people: Interview with a maternal health and family planning program analyst, Dar es Salaam (Oct. 5, 2017); interview with a legal practitioner and a women’s rights advocate, Dar es Salaam (Oct. 5, 2017).
- 22 Interview with an ob/gyn working in a public hospital, Mwanza (Nov. 11, 2017).
- 23 Focus group discussion with women, Mwanza (Nov.7, 2017); interview with a government official, Gender and Youth Department, Mwanza (Nov. 15, 2017).
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- 26 Interview with a woman, age 25, Mwanza (Nov.15, 2017); See also interview with a woman, age 35, Arusha (Nov. 20, 2017) (“I was using pills...[but] I stopped using them because my blood pressure increased...I asked my partner to use condoms, but he does not accept easily); interview with woman, age 26, Dar es Salaam (Dec. 6, 2017).
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- 30 Interview with a legal practitioner, Mwanza (Nov.14, 2017).
- 31 interview with a government official, Gender and Youth Department, Mwanza (Nov. 15, 2017).
- 32 This is demonstrated by the fact that, according to the 2016 TDHS, male sterilizations stand at zero percent: TDHS 2016, *supra* note 4, Tbl. 7.3, at 141.
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- 37 According to recent government data, about 70% of the population is below 25 years and 23% of the total population is aged between 10 and 19 years (MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN: NATIONAL ADOLESCENT HEALTH AND DEVELOPMENT STRATEGY 2018-2022 6 (2018).
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- 39 *Id.*, at 141.
- 40 *Id.*, at 150.
- 41 *Id.*, at 4.
- 42 *Id.*, at 110.
- 43 *Id.*
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- 47 *Id.*, at 26 & 27.
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- 50 *Id.*, at 29
- 51 *Id.*, at 30.
- 52 *Id.*, at 28.
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- 58 Interview with a reproductive rights advocate, Dar es Salaam (Sep. 25, 2017).
- 59 *Id.*
- 60 Interview with a reproductive health advocacy manager, Dar es Salaam (Sep. 29, 2017).
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