CENTER FOR REPRODUCTIVE RIGHTS

June 2, 2015

CEDAW Secretariat
OHCHR - Palais Wilson
52, rue des Pâquis
CH-1201 Geneva 10
Switzerland

Re: Supplementary information on Tanzania scheduled for review by the Committee on Elimination of Discrimination against Women during its 63rd Pre-sessional Working Group

Distinguished Committee Members:

This letter is intended to supplement the periodic report submitted by Tanzania to the Committee on the Elimination of Discrimination against Women (the CEDAW Committee), which is scheduled to be reviewed during the Committee's 63rd pre-Session. The Center for Reproductive Rights (the Center), a global legal advocacy organization with headquarters in New York, and regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington D.C., uses law to advance reproductive freedom as a fundamental human right. The Center hopes to further the work of the CEDAW Committee by providing independent information on Tanzania concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[1] and other international and regional human rights instruments that protect reproductive rights that Tanzania has ratified.[2]

The submission addresses the following issues: (1) high incidence of maternal mortality and morbidity, (2) lack of access to safe abortion and post-abortion care, (3) insufficient access to family planning information and services, (4) mandatory pregnancy testing in schools and expulsion of pregnant adolescents, (5) violence against women and girls, including sexual violence in schools and early marriage, and (6) discrimination against women living with HIV. Some of the information in this letter is drawn from the Center's recent fact-finding report, *Forced Out: Mandatory Pregnancy Testing and the Expulsion of Pregnant Students in Tanzanian Schools* (*Forced Out*), which is submitted with this letter.

I. The Rights to Equality and Non-Discrimination

The realization of women's rights to substantive equality and non-discrimination is inherently linked to the realization of women's reproductive rights. Formal equality, which is often referred to as "de jure" equality, requires states to provide equality in law and in treatment for all groups.[3] By contrast, substantive or "de facto" equality goes beyond formal equality by seeking to remedy entrenched discrimination by requiring states to take positive measures to address the diverse inequalities women face.[4] The CEDAW Committee has affirmed that in order to fulfill women's human rights, states must use

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all appropriate means to promote substantive equality, including by adopting temporary special measures.[5]

Recognizing the inextricable link between women's reproductive rights and their other human rights, the CEDAW Committee has made clear that providing access to reproductive health services is essential to ensuring that women can equally exercise their human rights.[6] As the CEDAW Committee has emphasized, the burden of childrearing disproportionately falls on women, which affects their rights to education and employment, amongst others, as well as their physical and mental health.[7] Indeed, the CEDAW Committee recognizes that the disproportionate burden women carry in relation to childcare is one of the most significant factors inhibiting women's ability to participate in public life[8] and that reduced domestic burdens enable women to engage more fully in activities outside the home.[9] Additionally, the CEDAW Committee has noted that women's ability to voluntarily control their fertility improves their and their families' health, development, and well-being.[10]

II. High Incidence of Maternal Mortality and Morbidity

The CEDAW contains robust protections for the right to maternal health care, stating in Article 12 that "States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[11] In its 2008 concluding observations on Tanzania, the Committee expressed concern regarding the maternal mortality rate and recommended that Tanzania "strengthen its efforts to reduce the incidence of maternal and infant mortality and to increase the life expectancy age for women."[12] In its 2015 concluding observations, the Committee on the Rights of the Child (CRC Committee) also expressed concern about "[t]he persistent high maternal mortality and morbidity rates,"[13] and urged Tanzania to "[e]stablish more child and maternal health clinics and access to safe trained delivery services...."[14]

In its most recent report to this Committee, the government of Tanzania states that, as a result of several strategic plans it is implementing, it has managed to reduce the maternal mortality ratio (MMR),[15] and cites to the 2010 Tanzania Demographic and Health Survey (TDHS), which shows the MMR to be 454 maternal deaths per 100,000 live births.[16] However, data from 2013 shows that at 410 death per 100,000 live births,[17] the MMR has not shown significant improvement and the state remains far from achieving the MMR target of 193 deaths by 2015 set under Millennium Development Goals (MDG).[18] Tanzania also accounts for the seventh-highest number of maternal deaths in the world,[19] and women in Tanzania have a 1-in-44 lifetime risk of dying from a pregnancy-related cause.[20]

In order to reduce the high MMR, it is crucial that women and girls throughout Tanzania have access to comprehensive maternal health services, including antenatal, delivery, and postnatal care. However, obstetric complications due to low-quality care, absence of skilled delivery services, and high costs are key barriers to achieving reduction in maternal mortality.[21] Although almost 88% of Tanzanian women receive antenatal care (ANC) at least once,[22] only 43% of women receive[23] the WHO recommended minimum of four antenatal visits[24]—a significant decrease from the 62% of pregnant women who attended four antenatal visits surveyed in the 2004 TDHS.[25] A recent study of antenatal care in Kilombero, a rural district in southwest Tanzania, also attributed 20% of severe maternal morbidities to substandard ANC.[26] Furthermore, according to a 2013 report from the WHO, only 46.7% of births were attended by skilled health personnel, and the rate has shown very little improvement since 1990, when about 40% of birth were attended by skilled personnel.[27] In addition, one recent study found that the poor quality of care in facilities, including neglect and abuse, has perpetuated the high rate of women who

choose to deliver at home.[28] Although the number of women who do not receive a postnatal checkup decreased from approximately 83% of births in the 2004 TDHS[29] to 65% in the 2010 TDHS survey,[30] the ongoing lack of postnatal care remains a significant barrier to reducing maternal mortality.[31]

In its 2008 concluding observations, the CEDAW Committee urged Tanzania to increase awareness of and access to health care facilities and assistance by trained medical personnel for women, especially in rural areas.[32] Yet, significant differences remain, with medical facilities offering quality maternal health services concentrated in urban areas. For example, although nearly 80% of births occur in rural areas, urban women are almost two times more likely than rural women to receive postnatal care, give birth at a health facility, and give birth with the assistance of a health professional.[33] According to the 2010 TDHS, "problems in accessing health care are felt most acutely by rural women,"[34] and over 23% of rural women cited distance to a health facility as a major barrier in accessing care, compared to only nine percent of urban women.[35]

Another major barrier to accessing health services is cost.[36] According to the Tanzania's 2014 progress report on the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths*, reproductive and maternity services are provided free of charge, but insufficient health funding and stock-outs have resulted in women frequently paying out-of-pocket expenses.[37] The report further states that this has resulted in non-use or delays in seeking critical care among low-income women.[38] A 2009 study found that 91% of women surveyed reported paying some fees for maternal health care services.[39] Women in the poorest and wealthiest quintiles reported paying approximately the same mean amount—USD 4.6 and USD 5.1 respectively.[40] According to the most recent World Bank data, forty-three percent of the population lives on $1.25 per day (PPP),[41] rendering such out-of-pocket fees a serious barrier to accessing even the most basic medical services. According to the 2010 TDHS, these barriers are felt most acutely by rural women, women with no formal education, and women in the lower wealth quintiles.[42]

In addition, despite the government's expressed commitment to improving maternal health care in national plans such as the *National Road Map Strategic Plan*,[43] reproductive health services remain underfunded. In the 2013/2014 budget, the health sector was allocated only 8.9% of the total budget,[44] which falls short of the government's commitment to allocate at least 15% of the annual national budget to the health sector, as stipulated in the Abuja Declaration.[45] Furthermore, Policy Forum Tanzania reports that the health budget was cut by 17.4% from TZS 754 billion in 2013/2014 to TZS 623 billion in 2014/2015, mainly due to reduced funding by development partners and the Government's failure to close the funding gap.[46]

III. Lack of Access to Safe Abortion and Post-Abortion Care

The CEDAW Committee has made clear that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women,"[47] and has recommended that states parties reform punitive abortion laws[48] as a means to reduce the number of deaths from unsafe abortion.[49] In its 2015 concluding observations on Tanzania, the CRC Committee urged the state to "take urgent measures to reduce maternal deaths relating to teenage abortions...."[50] However, in its current report to this Committee, the government did not address the issue of lack of access to safe abortion and post-abortion care (PAC), which remains a significant factor contributing to the state's high maternal mortality rates.

As a result of the government's failure to address the issue, abortion laws and policies in Tanzania remain inconsistent, unclear, and widely misunderstood. Under the Penal Code, abortion is criminalized except to save the life of a pregnant woman.[51] Although this exception has been interpreted in court decisions and government policy documents to encompass a mental and physical health exception,[52] it has not been implemented in practice. For example, the 2002 Post-Abortion Care Clinical Skills Curriculum—the primary government document focusing on post-abortion care (PAC)—explicitly states that Tanzania law allows therapeutic abortion, but few people are aware of this law.[53] Other government policy documents perpetuate the confusion surrounding abortion laws by stating that "abortion is illegal" without explaining that there are any exceptions.[54] Tanzanian law still criminalizes abortion on the ground of rape and incest, failing to comply with its various human rights obligations, such as the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol)—which Tanzania has ratified without reservation—that requires states parties to "authoris[e] medical abortion in cases of sexual assault, rape, incest..." as well as where life or health of the woman is at risk.[55]

This ambiguity and misinformation concerning the legality of abortion in Tanzania contributes to the prevalence of unsafe abortions and, in turn, maternal mortality and morbidity. Women are often forced to obtain unsafe abortions from unskilled providers or attempt to perform the abortion themselves[56]—such as through the ingestion or vaginal insertion of dangerous substances[57]—resulting in preventable injuries and deaths.[58]Although there is little available data on the prevalence of unsafe abortion, the estimated proportion of maternal deaths due to complications from unsafe abortions ranges from 16%[59] to 30%.[60] Moreover, a survey of women admitted to two hospitals—a regional and a municipal hospital— for miscarriage revealed that almost two-thirds of the women had undergone an unsafe abortion.[61] In 2013, a Tanzanian news article reported that, "[in] regional hospitals, half of admissions in maternity wards are due to abortions or complications arising from abortions."[62] Furthermore, adolescent girls are particularly at risk of unsafe abortion: a report by the Ministry of Health and Social Welfare stated that, "one-third of incomplete abortion cases that turn up in health facilities involve adolescents, and one in five girls involved are students."[63]

The cost of abortion procedures also affects the quality of service and restricts access to safe abortion most significantly for low-income women, women in rural areas, and adolescents, who are less likely to have an independent income. Although there is limited comprehensive data on the cost of abortion in Tanzania, in one study, young people aged 15–27 estimated that an abortion performed at a health facility costs 10,000–15,000 TSH (US$12–18) compared to the low cost for herbs of only 10–50 shillings (US$0.01–0.06).[64] In a 2012 report, it was estimated that the cost of an abortion from a trained provider in two urban areas was US$32–44.[65] As a result, access to safe abortion services is further limited for those who cannot afford to pay the substantial fees.[66]

Post-Abortion Care

Despite the Tanzanian government's declared commitment to provide Post Abortion Care (PAC) services—including in national guidelines[67]—the service is not widely available and accessible.[68] The availability of the required equipment is extremely limited in all health care facilities. For example, a 2012 study of three districts found that only about 20% of hospitals had in stock both vacuum aspirations kits and misoprostol, which are both used in PAC.[69] In addition, the government has also not adequately followed through on its 2002 commitment to "scal[e] up comprehensive PAC so as to reduce abortion-related maternal mortality and morbidity through training of middle level health service providers such as

clinical officers, nurse-midwives ... [and] to ensure that comprehensive PAC services are available at lower level health facilities."[70] According to the latest available data, only 13.5% of health providers were trained on providing adolescents PAC.[71] Another study of PAC at one regional hospital found all of the maternal deaths from abortion complications resulted from substandard PAC—meaning that quality, timely PAC would have prevented the deaths.[72]

IV. Lack of Access to Comprehensive Family Planning Services and Information

The CEDAW Committee recognizes that the right to contraceptive information and services is rooted in the rights to equality and non-discrimination, education, health, and to determine the number and spacing of one's children.[73] In 2008, the Committee expressed concern regarding Tanzanian women's "lack of access to quality sexual and reproductive health services ... [and] the unmet demand for family planning services and the low level of contraceptive use,"[74] and recommended that the government "adopt[] measures to increase knowledge of and access to affordable contraceptive methods…."[75]

Although Tanzania has seen some increase in contraceptive use and prevalence in the last two decades,[76] still only 29% of all women are using any method of contraception and only 24% are using a modern method, according to the 2010 THDS.[77] This is significantly below the 60% prevalence rate the government has set to achieve by 2015 under the *National Road Map Strategic Plan*.[78] Current contraceptive use varies substantially based on geography and demographics. Married urban women are almost 1.5 times more likely to use a contraceptive method than their rural counterparts—46% and 31%, respectively—and the prevalence increases with a woman's education and wealth quintile.[79] In addition, 25% of currently married women and over 18% of all women have an unmet need for family planning—an increase in the unmet need from the 2004–2005 TDHS when the unmet need for married women was 22%.[80] Over one-fourth of births in Tanzania are either mistimed or unwanted,[81] which contributes to the high rates of unsafe abortions and maternal deaths.

The low contraceptive prevalence rate and the high unmet need can be attributed to a number of barriers, including stock-out of supplies, the lack of fully trained health workers, cultural attitudes, distance to health facilities, and myth and misconceptions about contraception, that can prevent women from accessing family planning services.[82] Although a 2012 report by the Ministry of Health and Social Welfare stated that 70% of surveyed facilities offer at least two forms of modern family planning methods, the facilities generally only offered male condoms and oral contraceptives, demonstrating the considerable limits on women's family planning options.[83] The report further found that injectable and implants—methods that women prefer[84]—were available at only 54% and 23% of facilities respectively.[85] Moreover, it indicated that only about 37% of health facilities surveyed had at least one staff person trained in family planning,[86] and only 47% of health facilities had copies of the guidelines on family planning.[87]

Tanzania notes, in its report to the Committee, that it "has undertaken a number of measures to increase knowledge and access to contraceptive methods."[88] This includes a pilot program that allows community health works to offer long-acting contraceptives so that women and girls have more contraceptive choices without having to travel long distances in search of health centers that offer the method.[89] It has also doubled its allocation to family planning to TSH 2 billion in its 2014-2015 budget.[90] However, this is still far below the TSH 23 billion funding requirement for family planning needed for 2014-2015 estimated under the *National Family Planning Costed Implementation Program 2010-2015*.[91] As stated in a recent op-ed co-authored by the Executive Director of the United Nations Population Fund (UNFPA), "despite

the progress [in Tanzania], many women who want to plan their families still lack the means to do so, even though it is their human rights."[92]

Emergency Contraception

Many women and adolescent girls could avoid unwanted pregnancies by using emergency contraception (EC), a safe and effective means of preventing pregnancy following unprotected sex.[93] There is one EC pill registered in Tanzania,[94] and the *National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence* state that EC should be available at all public and private facilities—particularly for survivors of sexual violence, including adolescent girls.[95] However, a prescription is required before accessing EC,[96] which can be a significant hurdle given that it should be taken within 120 hours after unprotected sexual intercourse.[97] However, the method is not included in the National Essential Medicines List,[98] and a 2012 government report states that EC is offered at only 43% of all facilities and only 18% of private facilities.[99] In addition, evidence from the 2010 TDHS suggests that very few people (less than 12% of men and women) have knowledge of EC.[100] In 2013, a study conducted in Dar es Salaam found that only 14% of the study participants have used EC and only 42% of the pharmacies had the method in stock.[101]

V. Mandatory pregnancy testing and expulsion of pregnant school girls

In its 2008 concluding observations on Tanzania, the Committee expressed that it was "in particular concerned at information that girls falling victims of early pregnancies are expelled from Tanzanian schools," and it emphasized that "education is a key to the advancement of women."[102] Moreover, the Committee recommended that Tanzania "implement measures to ensure equal access of girls and women to all levels of education, retain girls in school and strengthen the implementation of re-entry policies so that girls return to Tanzanian schools after giving birth."[103] Similarly, the Committee on Economic, Social and Cultural Rights recommended that the government abolish mandatory pregnancy testing and prohibit expulsions due to pregnancy.[104] Likewise, the CRC Committee, in its 2015 concluding observations, recommended that Tanzania "take immediate measures to ensure the continued enrolment of girls who become pregnant…."[105]

As documented in the Center's recent fact-finding report, *Forced Out*,[106] the practice of testing and expulsion in Tanzanian schools is prevalent, widely accepted, and significantly supported by educators, government officials, and NGOs.[107] Rather than providing girls with the reproductive health information and services they need to prevent pregnancy,[108] the practice of mandatory pregnancy testing has forced over 55,000 female students out of school in mainland Tanzania in the past decade because of pregnancy.[109] According to Tanzania's 2013 Basic Education Statistics, a total of 2,433 primary school girls and 4,705 secondary school girls dropped out of school during the previous year due to pregnancy.[110]

As *Forced Out* highlights, mandatory pregnancy testing may begin as early as 11 years of age, but is universal by secondary school, between the ages of 14 and 18.[111] Testing may occur upon suspicion of pregnancy by a teacher or administrator; on specific dates for testing of all female students; and as a requirement for admission to school.[112] Generally, mandatory pregnancy tests are done without prior announcement or warning to prevent girls from circumventing the policy,[113] and do not require prior consent.[114] The "testing" itself typically takes the form of physical touching, prodding and poking of a girl's stomach by a school official or a school nurse and, if a girl is suspected of being pregnant, it may

also involve a urine-based pregnancy test.[115] Results are then disclosed directly to the school and eventually to the parents, violating the girl's right to privacy and confidential medical treatment.

A positive pregnancy test almost universally ends in the expulsion of the girl from school,[116] or the girl simply stops attending rather than face stigma and formal expulsion.[117] Many educators and administrators believe expulsion is required by law or policy, even though no law or policy document exists that requires these practices.[118] Testing and expulsion also enjoy almost universal government support. A high level official at the Ministry of Education interviewed for *Forced Out* has stated matter-of-factly that pregnant girls should simply not be in school.[119] Most of those who support the practice suggest that it is done for the girls' benefit to prevent unsafe abortion, embarrassment, shame, and to ensure greater protections for the girl's health during pregnancy.[120] However, when pregnant girls are expelled from school, they are rarely provided referrals for medical or social services and are "left to find" maternal health services "on their own."[121] Moreover, the practices heighten the stigma against teenage pregnancy, which can force girls to seek unsafe and clandestine abortions,[122] not only to protect themselves from shame and discrimination, but also to protect their educational futures. On the other hand, when positive pregnancy tests are publicly revealed, it can force girls to carry an unwanted pregnancy to term, denying the girl the right to make a decision on her reproductive health.[123] It is evident that mandatory pregnancy testing is utilized to punish and control young girls rather that protect their health and future, and its widespread acceptance perpetuates the pervasive stigma against teenage pregnancy and discrimination against adolescent girls.[124]

Recently, the government took steps to address this problem by including a provision in the 2014 *Education and Training Policy* which can be interpreted to allow the re-entry of girls who were expelled due to pregnancy. According to the policy, the "government will remove barriers that may inhibit students from continuing with their education and finalizing their higher education."[125] However, the policy fails to explicitly address the issue of re-entry of pregnant girls as well as the issue of forced pregnancy testing and their expulsion in the first place. In addition, the government is currently reviewing the 2009 *Guidelines on How to Enable Pregnancy School Girls to Continue with Their Studies*,[126] which is meant to facilitate the re-entry of the girls, but contains a number of problematic provisions that, if issued in the current state, would violate and severely restrict the right of girls. For example, the guidelines require the pregnant school girl to "disclose the identity of the person responsible for the pregnancy,"[127] which violates the girl's right to privacy and places her in a vulnerable position, particularly if the person responsible is an authority figure or has committed sexual assault. The guidelines further specify that the girl is allowed "only one re-admission opportunity,"[128] barring a student from returning following a second pregnancy. It also requires the student to return to school 6-12 month after giving birth[129] without taking into account each girl's particular situation which might permit or require her to shorten or extend her leave from school from the specified timeline. Finally, the guidelines did not address pregnancy testing and expulsion and may even condone the practice by requiring school leadership to "give periodical medical examinations."[130] The Government of Tanzania must eliminate these problematic provisions when it issues the new guidelines this year and ensure that the guidelines are actually implemented in practice in order to end these violations of the rights of pregnant students.

Adolescents Access to Family Planning and Sexuality Education

Tanzania has one of the highest adolescent pregnancy rates in the world despite some improvement—according to the 2010 TDHS, 44% of girls were pregnant or had given birth by age 19, down from 52% in

2004.[131] Only 15% and 40% of married and unmarried sexually active adolescents aged 15-19, respectively, are using either a modern or traditional contraceptive method.[132] Although a 2012 government survey found that 52% of health facilities offer family planning services to adolescents,[133] a UNICEF report stated that only one-third of facilities had youth-friendly services.[134] Furthermore, the 2012 government survey found that only 14% of facilities had at least one staff person trained in the provision of adolescent health services.[135] Moreover, adolescents often face discrimination in accessing health services. Many individual providers, motivated by personal biases, restrict access to contraceptive methods on the basis of age or marital status, despite the fact that no legal, medical, or policy basis exists for doing so.[136] In addition, disparities between urban and rural areas are particularly relevant to adolescents who have limited money for transportation to service facilities.[137]

The CRC Committee, in its 2015 concluding observations expressed concern that "[i]nformation and adolescent friendly health services … about modern contraceptives, including emergency care are lacking, particularly in rural areas…,"[138] and recommended that the government makes adolescent friendly health information and services available "with the focus on preventing pregnancy and making modern contraceptives available."[139] However, with few exceptions to the contrary, the government has largely left the promotion of youth-friendly health services, including sexuality education, to non-governmental organizations, which have limited resources and reach and cannot adequately promote systematic changes.[140] Further, there is no national sexuality education curriculum in mainland Tanzania,[141] and two recent studies both found that there is no or inadequate training for teachers on sexuality education.[142] As such, when sexuality education is provided in public schools, it is done in a piecemeal and limited fashion—often limited to abstinence-based messaging[143]—with the topics and information covered left to the discretion of the school and teachers.[144] Of the adolescent girls interviewed for the Center's report, *Forced Out*, not one indicated that her school provided comprehensive sexuality education that included explicit information on sex, reproduction and contraception.[145]

VI. Discrimination Resulting in Violence against Women and Girls

A. Domestic Violence and Sexual Violence against Women and Girls

Regarding gender-based violence (GBV) in Tanzania, the CEDAW Committee has noted "that such violence appears to be socially legitimized and accompanied by a culture of silence and impunity, that cases of violence are thus underreported and that those that are reported are settled out of court."[146] It has urged the Tanzanian government to "give priority attention to combating violence against women."[147]

According to the 2010 TDHS, about 45% of Tanzanian women aged 19-45 reported having experienced physical or sexual violence.[148] The vast majority of these women reported experiencing violence from their intimate partner: 83% of physical violence[149] and 70% of sexual violence[150] was from a current or former husband, partner, or boyfriend. Although the CEDAW Committee expressed concern in the 2008 concluding observations that "that marital rape is not recognized as a criminal offence,"[151] and called on Tanzania to criminalize all forms of violence against girls, the government has yet to criminalize marital rape[152] and the country continues to lack sufficient legal protections for victims of violence. Moreover, according to a 2014 report by Tanzania Women Lawyers Association (TAWLA), the lack of sufficient legal protections against domestic violence—including no explicit legal sanctions for the physical abuse of a spouse—reinforce the view of law enforcement officials that domestic violence should be addressed within the family.[153]

Many forms of GBV, particularly from an intimate partner, remain socially acceptable,[154] and survivors are very unlikely to report violence either to the police or health care personnel.[155] TAWLA notes that of the 51 GBV cases reported in 2011 to the Central Police Station in Dar es Salaam, only one case was filed in court and resulted in an acquittal; of the 25 reported GBV cases in 2012, none were filed in court.[156] The government, in its report to the Committee, states that it has increased its commitment to combatting the high prevalence of GBV and lack of services for survivors, including through the development of the *Action Plan for Police Gender and Children's Desks 2013-2016*.[157] However, the availability of the Gender Desks in police stations in rural areas is limited.[158] In addition, insufficient resource allocation,[159] the lack of adequate training for police officers,[160] and the lack of a comprehensive legal aid system for survivors are still significant barriers to effective implementation of the plan to expand this service.[161] Moreover, survivors' access to services continues to be severally impeded by socio-cultural barriers—such as the fear of reporting an intimate partner and the social stigma attached to sexual violence—as well as structural barriers, such as the costs of accessing services, delays in service provision, corruption among law enforcement officials, and the lack of coordination among difference service sectors (e.g. police and health care).[162]

Sexual Violence in Schools

In its 2015 concluding observations, the CRC Committee expressed concern regarding "sexual violence against children ... including in or on the way to and from schools ... [and] sexual violence and abuse carried out by teachers...." and recommended that the government of Tanzania to ensure that children that are vulnerable to sexual violence are "provided with necessary assistance and protection."[163] Sexual violence against school girls in Tanzania, including by teachers, remains pervasive.[164] According to the government's 2011 national study, "nearly 3 out of every 10 females aged 13 to 24 in [mainland] Tanzania reported experiencing at least one incident of sexual violence before turning age 18."[165] Of the girls who reported experiencing sexual violence, "nearly 4 in 10 females reported that at least one incident took place on school grounds or while travelling to or from school,"[166] making schools the second most common context for sexual violence.[167] Further, 15% of the adolescent girls surveyed reported an "authority figure" as the perpetrator of the sexual violence,[168] the majority of which were male teachers.[169] In the State Party report, Tanzania attributed the challenge of combatting violence against children to its high prevalence within the family unit[170] but failed to address the prevalence of sexual violence within the school context.

In a 2013 study, adolescents girls explained that teachers may "harass [female students] who reject their sexual intentions" and that these students are afraid to say no because they may "be failed by the teacher if they reject him."[171] In an interview by the Center for *Forced Out*, a headmaster who had taught in both government and private schools indicated that teachers are "trading grades for sex."[172] Often, the teachers face few or no legal or professional repercussions for such criminal behaviour;[173] in fact, school officials sometimes shield teachers from accountability.[174]

In 2013, as a response to the 2011 national study on sexual violence against children, the government launched a three year *National Plan to Prevent and Respond to Violence against Children*,[175] with the aim of "the provision of quality violence prevention and response services as part of the national child protection system through the multi-sectoral collaboration."[176]Although the *National Plan* has received support from development partners,[177] the government is still "failing to implement child protection laws, policies, and action plans effectively throughout the country."[178] For instance, a 2014 fact-finding report

documented that government has failed to provide local authorities with sufficient training and resources, which prevents social welfare officers, who the Child Act madates to safeguard and promote the welfare of children, from taking timely action in cases of child abuse and early marriage.[179]

B. Early marriage

In the CEDAW Committee's 2008 concluding observations, it expressed concerned at the delay in amending the Marriage Act in order to raise the minimum marriage age for girls from 15 to 18.[180] Likewise, in its 2015 concluding observations, the CRC Committee encouraged Tanzania to "revise its legislation in order to ensure that the minimum age for marriage is established at 18 for both girls and boys...."[181] However, although Tanzania stated in its State Party report that it "is in the process of completing its law reform in the area of marriage ... within a specific time frame,"[182] the government did not indicate the deadline for achieving this reform,[183] and the Marriage Act has still not been amended.[184]

The Marriage Act of 1971 set the minimum age for males at 18 and females at 15.[185] Even though the law requires girls who marry before the age of 18 to obtain permission from their parents,[186] this provision fails to protect the vast majority of girls, who are compelled to marry by their parents.[187] Furthermore, the law allows marriage as early as 14 with court approval.[188] Some customary and religious laws also allow the marriage of girls reached puberty,[189] which can be before the age of 14. Furthermore, the Sexual Offences Special Provisions Act of 1998 failed to criminalize marital rape, including where "the woman is [the defendant's] wife who is 15 or more years."[190]

As a result, the early marriage of girls is widespread in Tanzania: four out of ten girls are married before they reach the age of 18, according to the 2010 THDS, and about 3% are married at age 15.[191] Moreover, the 2010 THDS data shows that women with limited education, from lower wealth quintiles, and from rural areas are more likely to marry early.[192] Early and forced marriage can have devastating physical, economic, social, and psychological consequences for adolescent girls. For example, married adolescent girls in Tanzania commonly report experiencing emotional, physical, and sexual violence.[193] The power imbalances due to substantial age disparities between adolescent girls and their spouses mean that adolescent girls are unable to negotiate safe and protected sex.[194] For example, according to the 2010 TDHS, women in the 15-19 age group were less likely than older women to believe that a wife is justified in refusing sexual intercourse or asking her husband to use a condom if he has a sexually transmitted infection.[195] The survey also found that 20% of married adolescent girls are forced to engage in sexual activity against their will.[196] Furthermore, the high rates of child marriage in Tanzania are one factor contributing to the high maternal mortality rates.[197]

In addition, early marriage impacts a girl's economic and social opportunities. Pursuant to the Education (Expulsion and Exclusion of Pupils from Schools) Regulation, a girl who gets married while in school faces the possibility of expulsion.[198] As highlighted above, there is also a wide-spread practice of expelling girls who become pregnant, and it's only very recently that the government issued the 2014 Education and Training Policy that can be used to reenroll girls after giving birth.[199] However, as already indicated, the policy does not explicitly address forced pregnancy testing in schools, the expulsion of pregnant schools girls and their re-entry. The government is also yet to issue a guideline to facilitate this process, and it can be a while before the policy is fully implemented. As such, the expulsion due to marriage and pregnancy often compromises a young girl's future by limiting her employment prospects and financial security, which exacerbates existing power imbalances vis-à-vis the girls' older husbands.

VII. Discrimination against Women Living with HIV or AIDS

The CEDAW Committee has emphasized that "issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health," and has urged states to ensure "without prejudice and discrimination, the right to sexual health information, education and services for all women and girls."[200] However, the HIV and AIDS (Prevention and Control) Act (2008) contains several problematic provisions that are likely to exacerbate discrimination against women living with HIV, even though the government's report to the Committee states that the Act was "put in place to prohibit discrimination against women,"[201]

For instance, the 2008 Act criminalizes the intentional transmission of HIV, making transmission punishable by a prison term of up to ten years.[202] This provision is drafted broadly enough to include the criminalization of vertical HIV transmission—the exposure or transmission to a child during pregnancy, delivery, or breastfeeding.[203] As a result, fear of prosecution may prevent or discourage many women from seeking appropriate antenatal care, which is necessary to minimize the risk of transmission during pregnancy. In addition, the Act requires the immediate disclosure of HIV positive status to a spouse or sexual partner.[204] Because women receive HIV counseling and testing as part of antenatal care,[205] they are far more likely to know their HIV status than male counterparts and will thus be accused of being the initial transmitter and introducing HIV to the relationship.[206] As a result, women are both at a greater risk of prosecution under these laws and at an additional risk of domestic violence and abandonment from being forced to reveal their HIV status to their partners.[207] A similar provision of Kenya's HIV and AIDS Prevent and Control Act that criminalized "knowingly or recklessly" putting another at risk of infection was recently struck down by the High Court of Kenya as unconstitutional.[208] The court found the provision too vaguely worded to be constitutional, and further found that the provision likely violated the right to privacy by requiring health care providers to disclose a patient's disclose HIV status to sexual partners without the patient's consent.[209]

Even though the overall HIV prevalence rate has decreased in Tanzania, a significant discrepancy continues to exist in the HIV infection rates for women (6.8% in 2008, 6.2% in 2012) compared to men (4.7% in 2008, 3.8% in 2012), and the HIV infection rate for men is decreasing more rapidly than the rate for women.[210] Young women and girls represent a large proportion of new HIV cases because the prevalence of gender discrimination exposes them to adult roles at an early age, making them vulnerable to exploitation and abuse through early and coercive marriage, unequal sexual relations, commercial sex work, and domestic work.[211]

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

1. What concrete steps are the government taking to reduce maternal mortality and maternal health care services attendance? How is the government implementing its *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015*, and what resources is the government allocating to ensure the implementation of *National Road Map*? What steps are being taken to ensure that health care facilities are adequately equipped and personnel are trained to provide quality, respectful and hygienic maternal health care?

2. What efforts are being made to clarify and publicize Tanzania's abortion law and to develop clear guidelines for health care providers to improve the accessibility and availability of safe abortion services? What is the government doing to harmonize its abortion law with its obligations under international and regional treaties, including the Maputo Protocol?

3. What measures has the government adopted to ensure access to comprehensive PAC in keeping with its commitment under the *2002 Post-Abortion Care Clinical Skills Curriculum*, including by ensuring that facilities are well equipped to provide PAC?

4. What concrete steps has the government taken to improve access to contraceptives, including emergency contraception, and ensure that all women, including adolescents, receive comprehensive and accurate information without discrimination on the basis of age, marital or other status?

5. What steps is the government taking to end the practice of mandatory pregnancy testing and expulsion of pregnant schoolgirls? How does the government plan to revise the 2014 *Education and Training Policy* to ensure that it explicitly prohibits forced pregnancy testing in schools, the expulsion of pregnant school girls and their re-entry after giving birth? How does the government plan to revise the 2009 guidelines for the re-entry of girls to ensure it is in line with international and regional human rights standards?

6. Does the government intend to pass legislation criminalizing marital rape, including with respect to children who marry before age 18? What steps will the government take to ensure adequate funding and training for the Children and Gender Desks in polices stations? What other efforts have been made to ensure that police conduct a timely investigation of incidents of sexual violence and that survivors have access to comprehensive health and legal services?

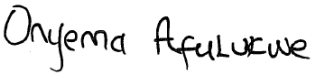
7. What measures has the government put in place to prioritize and adequately address the high incidence of sexual violence in schools, including ensuring that perpetrators, including teachers, are prosecuted and held responsible?

8. Has the government established a clear deadline by which to amend the Law of Marriage Act to raise the age of marriage to 18 for both girls and boys, including under customary or religious law? What steps are being taken to ensure that this amendment, if passed, will be properly implemented and enforced?

9. What actions, if any, have the government taken to amend the provisions of the HIV and AIDS Prevention and Control Act that perpetuate discrimination against women living with HIV, including the criminalization of transmission and the forced disclosure of HIV status to sexual partners?

We hope that this information is useful during the CEDAW Committee's pre-session review of Tanzania. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,



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[1] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/189, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) (ratified by Tanzania Aug. 20, 1985) [hereinafter CEDAW].

[2] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (accession by Tanzania Jun. 11, 1976); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, arts. 2(2), 3, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), (*entered into force* Jan. 3, 1976) (accession by Tanzania Jun. 11, 1976); African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3 rev.5, 21 I.L.M. 58 (1982) (*entry into force* Oct. 21, 1986) (ratified by Tanzania Feb. 18, 1984); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) (ratified by Tanzania Mar. 3, 2007) [hereinafter Maputo Protocol].

[3] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 7, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 16*]; Sandra Fredman, *Providing Equality: Substantive Equality and the Positive Duty to Provide*, 21 S. AFR. J. ON HUM. RTS. 163, 163-164, 166 (2005).

[4] ESCR Committee, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights* (Art. 3), (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 7–8, 15, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 16*].

[5] Committee on the Elimination of Descrimination against Women (CEDAW Committee), *General Recommendation No. 28: The Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, (47th Sess., 2010), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 20, U.N. Doc. CEDAW/C/GC/28 (2010).

[6] 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, paras. 11-12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

[7] CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 21*].

[8] CEDAW Committee, *General Recommendation No. 21: Women in political and public life*, (16th Sess., 1997), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).

[9] *Id.* para. 11.

[10] CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 23, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).

[11] CEDAW, *supra* note 1, art. 12(2).

[12] CEDAW Committee, *Concluding Observations: Tanzania*, para. 39, U.N. Doc CEDAW/C/TNZ/CO/6 (2008).

[13] Committee on the Rights of the Child (CRC), *Concluding Observations: Tanzania*, para. 53(a), U.N. Doc. CRC/C/TZA/CO/3-5 (2015).
[14] *Id*., para. 54(b).
[15] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Tanzania*, paras. 112-15 U.N. Doc CEDAW/C/TZA/7-8 (2014).
[16] NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., TANZANIA DEMOGRAPHIC AND HEALTH SURVEY 2010, 265 (2011), *available at* http://dhsprogram.com/pubs/pdf/FR243/FR243%5B24June2011%5D.pdf [hereinafter 2010 TDHS].
[17] WORLD HEALTH ORGANIZATION (WHO) ET AL, TREMDS IN MATERNAL MORTALITY: 1990-2013, 43 (2014), *available at* http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 [hereinafter WHO, TRENDS IN MATERNAL MORTALITY].
[18] *Id*. at 27, 43; United Nations Populations Fund (UNFPA) Tanzania, *Putting Mothers of Tanzania First* (Aug. 15, 2014), *available at* http://countryoffice.unfpa.org/tanzania/2014/08/18/10368/putting_mothers_of_tanzania_first/ (last visited May 19, 2015).
[19] WHO, TRENDS IN MATERNAL MORTALITY, *supra* note 17, at 21.
[20] *Id*. at 35.
[21] 2010 TDHS, *supra* note 16, at 64; NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., TANZANIA SERVICE PROVISION ASSESSMENT SURVEY 2006 115, 117-119 (2007), *available at* http://www.measuredhs.com/pubs/pdf/SPA12/SPA12.pdf.
[22] United Nations Children's Fund (UNICEF), *Tanzania, United Republic of: Statistics* (2013), *available at* http://www.unicef.org/infobycountry/tanzania_statistics.html.
[23] 2010 TDHS, *supra* note 16, at 129.
[24] WHO, Global Health Observatory (GHO), *Antenatal care (at least 4 visits)*, http://www.who.int/gho/urban_health/services/antenatal_care_text/en/ (last visited Sept. 29, 2014).
[25] NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., TANZANIA DEMOGRAPHIC AND HEALTH SURVEY 2004-2005, 133 (2005), *available at* http://www.measuredhs.com/pubs/pdf/FR173/FR173-TZ04-05.pdf [hereinafter 2004 TDHS].
[26] Angelo S Nyamterma et al., *The Quality of Antenatal Care in Rural Tanzania: What is Behind the Number of Visits?* 12 BMC PREGNANCY CHILDBIRTH 70 (2012), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3434089/.
[27] WHO ET AL., MATERNAL MORALITY IN 1990-2013 3 (2014), *available at* http://www.who.int/gho/maternal_health/countries/tza.pdf?ua=1.
[28] Lilian T. Mselle, et al. *Why Give Birth in Health Facility? Users' and Providers' Accounts of Poor Quality of Birth Care in Tanzania* 13 BMC HEALTH SERV. RES. 174 (2013), *available at* http://www.biomedcentral.com/1472-6963/13/174.
[29] 2004 TDHS, *supra* note 25, at 146.
[30] 2010 TDHS, *supra* note 16, at 139.
[31] *See generally*, WHO, WHO RECOMMENDATIONS ON POSTNATAL CARE OF THE MOTHER AND NEWBORN (2013), *available at* http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf?ua=1.
[32] CEDAW Committee, *Concluding Observations*: *United Republic of Tanzania*, para. 137, U.N. Doc. CEDAW/C/TZA/CO/6 (2008).
[33] 2010 TDHS, *supra* note 16, at 134-35.
[34] *Id.* at 141.
[35] *Id*.
[36] Over 24% of women reported "getting money for treatment" as a problem in accessing health care. *Id*.
[37] TANZANIA MINISTRY OF HEALTH AND SOCIAL WELFARE, THE NATIONAL ROAD MAP STRATEIC PLAN TO ACCELERATE REDUCTION OF MATERNAL, NEW BORN AND CHILD DEATHS IN TANZANIA 2008-2015 9 (2014), *available at* http://www.rchs.go.tz/index.php/en/resources/family-planning/strategy-policy-8/215-sharpened-one-plan-april-2014/file.html [hereinafter NATIONAL ROAD MAP]; *see also* Government of United Republic of Tanzania, *Combined initial, second and third periodic reports submitted by States parties under articles 16 and 17 of International Covenant on Economic, Social and Cultural Rights: United Republic of Tanzania*, para. 112, U.N. Doc. E/C.12/TZA/1-3 (2011).
[38] NATIONAL ROAD MAP, *supra* note 37.

[39] Although Tanzania's nominally free maternity care has not eliminated fees for more than 90% of surveyed women, the program has resulted in lower fees than the two other countries included the study—Kenya and Burkina Faso. Margaret Perkins, et al., *Out-of-pocket costs for facility-based maternity care in three African countries*, 24 HEALTH POLICY PLAN 289, 293 & 298 (2009), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2699243/.
[40] *Id*. tbl. 8. (noting that the data combines the cost of normal and complicated deliveries).
[41] World Bank Group, World Development Indicators: Tanzania (2015), *available at* http://databank.worldbank.org/data/views/reports/tableview.aspx (search "Tanzania") (indicating that the most recent PPP survey was conducted in 2012).
[42] 2010 TDHS, *supra* note 16, at 141.
[43] *See, e.g.*, CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Tanzania*, para. 110, U.N. Doc CEDAW/C/TZA/7-8 (2014); TANZANIA MINISTRY OF FINANCE, COUNTRY REPORT ON THE MILLENNIUM DEVELOPMENT GOALS 2014: ENTERING 2015 WITH BETTER MDG SCORES 30 (2014), *available at* http://www.tz.undp.org/content/dam/undp/library/MDG/english/MDG%20Country%20Reports/MDGR%202014_TZ.pdf.
[44] *See* HEALTH POLICY PROJECT, PROSPECTS FOR SUSTAINABLE HEALTH FINANCING IN TANZANIA (2015), *available at* http://www.healthpolicyproject.com/pubs/804_TanzaniaHealthFinancingBriefupdateFINAL.pdf.
[45] ABUJA DECLARATION ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, para. 26, OAU/SPS/ABJUA/3 (2001).
[46] Policy Forum Tanzania, *Budget 2014/2015 Position Statement* (2014), *available at* http://www.policyforum-tz.org/sites/default/files/policyforum.pdf.
[47] CEDAW Committee, *Gen. Recommendation* No. 24, *supra* note 6, para. 11.
[48] CEDAW Committee, *Concluding Observations: Malawi*, para. 37, U.N. Doc CEDAW/C/MWI/CO/6 (2010).
[49] *Id*., para. 21.
[50] CRC, *Concluding Observations: Tanzania*, para. 58(a), U.N. Doc CRC/C/TZA/CO/3-5 (2015).
[51] Penal Code Act, Cap. 16, Ch. XV: Offences against Morality, arts. 150, 151, 219, 230 (Tanz.).
[52] CENTER FOR REPRODUCTIVE RIGHTS, TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN MAINLAND TANZANIA 22-26 (2012).
[53] *Id*. at 34-35.
[54] For example, the *National Family Planning Costed Implantation Program* states that "[a]bortion is illegal in Tanzania," without mentioning any exceptions. TANZANIA MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PROGRAM, 2010-2015 5 (2010), *available at* http://www.fhi360.org/sites/default/files/media/documents/national-fp-costed-implementation-plan-tanzania-main-text.pdf.
[55] The Maputo Protocol requires states to "take all appropriate measures to … protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus." Maputo Protocol, *supra* note 2, art. 14, para. 2(c).
[56] Guttmacher Institute, *In Brief: Fact Sheet, Unsafe Abortion in Tanzania* (2013), *available at* http://www.guttmacher.org/pubs/IB_unsafe-abortion-tanzania.pdf [hereinafter *Unsafe Abortion in Tanzania*].
[57] *See* Mrisho Mpoto Anakubalika, *Grim Consequences: Abortion amongst Schoolgirls*, FEMINA HIP MAGAZINE 21 (2010); *Abortion remains a crime in Tanzania*, DAILY NEWS ONLINE EDITION, Nov. 26, 2010, http://www.dailynews.co.tz/home/?n=14901; Denise Grady, *The Deadly Toll of Abortion by Amateurs*, NY TIMES, Jun. 1, 2009, *available at* http://www.nytimes.com/2009/06/02/health/02abort.html (last visited May 20, 2015).
[58] *See generally* Kizito Makoye, *Tanzanian Women Endangered by Illegal Abortions*, REUTERS, Apr. 27, 2015, *available at* http://www.reuters.com/article/2015/04/27/us-tanzania-women-abortion-idUSKBN0NI22E20150427 (last visited May 20, 2015).
[59] UNITED REPUBLIC OF TANZANIA MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PROGRAM, 2010–2015 5 (2010), *available at* http://www.fhi360.org/sites/default/files/media/documents/national-fp-costed-implementation-plan-tanzania-main-text.pdf.
[60] TANZANIA MINSTIRY OF HEALTH AND SOCIAL WELFARE, THE NATIONAL ROAD MAP STRATEGIC PLAN TO ACCELERATE REDUCTION OF MATERNAL, NEWBORN AND CHILD DEATHS IN TANZANIA 2008–2015 6 (2008),

available at http://www.who.int/pmnch/countries/tanzaniamapstrategic.pdf (*citing* R. Mswia R et al., *Community Based Monitoring of Safe Motherhood in United Republic of Tanzania*, 81 WHO BULLETIN 87-94 (2003) [hereinafter NATIONAL ROAD MAP]); *Miriam's Story: When Care Comes Not a Minute Too Soon*, ENGENDERHEALTH (last visited May 20, 2015), http://www.engenderhealth.org/mdgfive/story-miriam.html; *see also, Abortion remains a crime in Tanzania*, DAILY NEWS ONLINE EDITION (Nov. 26, 2010), http://www.dailynews.co.tz/home/?n=14901.

[61] Rasch V et al, *Unsafe abortion in urban and rural Tanzania: method, provider and consequences*, 14(9), TROPICAL MEDICINE & INTERNATIONAL HEALTH, 1128: 1132 (2009).

[62] Jaffar Mjasiri, *Tanzania: Unplanned for Pregnancies Increase Numbers of Unsafe Abortions - Expert*, TANZANIA DAILY NEWS, Jun. 23, 2013, http://allafrica.com/stories/201306230095.html (last visited May 20, 2015).

[63] UNITED REPUBLIC OF TANZANIA MINISTRY OF HEALTH AND SOCIAL WELFARE, REPORT ON ASSESSMENT OF AVAILABILITY AND ACCESSIBILITY OF ADOLESCENTS SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN MAINLAND TANZANIA: A HEALTH FACILITY BASED ASSESSMENT 10 (2008), *available at* http://www.google.com/url?sa=t&rct=j&q=report%20on%20assessment%20of%20availability%20and%20accessibility%20of%20adolescent%20sexual%20and%20reproductive%20health%20services%20in%20mainland%20tanzania&source=web&cd=1&ved=0CCoQFjAA&url=http%3A%2F%2Fwww.expandnet.net%2FPDFs%2FH1.%2520Tanzania%2520AFRHS%2520Survey%2520Report%25202009.doc&ei=Uvv3Ue-0D4--4APMvoC4Ag&usg=AFQjCNEVb0mzHV3Aixvd7iXi-4f42nuNpw [hereinafter ASRHS SITUATIONAL ANALYSIS-REPORT].

[64] M. Plummer et al., *Aborting and suspending pregnancy in rural Tanzania: an ethnography of young people's beliefs and practices*, 39 STUDIES IN FAMILY PLANNING 281 (2008), *available at* http://dx.doi.org/10.1111/j.1728-4465.2008.00175.x.

[65] *Unsafe Abortion in Tanzania*, *supra* note 56 (*citing* MC Maternowska et al., TEENAGE PREGNANCY, UNSAFE ABORTION AND POST-ABORTION CARE IN ARUSHA AND ZANZIBAR (2012)).

[66] CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT: MANDATORY PREGNANCY TESTING AND EXPULSION OF PREGNANT STUDENTS IN TANZANIAN SCHOOLS 37 (2013) [hereinafter FORCED OUT].

[67] NATIONAL ROAD MAP, *supra* note 60, at 16; *see also* MINISTRY OF HEALTH (TANZ.), NATIONAL PACKAGE OF ESSENTIAL HEALTH INTERVENTIONS IN TANZANIA (2000), *available at* http://ihi.eprints.org/718/1/ihi.eprints.pdf_(88).pdf.

[68] The Strategic Plan acknowledges that PAC can significantly reduce the number of maternal deaths; however, very few facilities in Tanzania (5%) are equipped to handle such care. NATIONAL ROAD MAP, *supra* note 60, at 6; *see also*, UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID), DECENTRALIZATION OF POST-ABORTION CARE IN SENEGAL AND TANZANIA, *available at* http://www.usaid.gov/our_work/global_health/pop/news/issue_briefs/pac_brief_senegal_tanzania.pdf.

[69] *Unsafe Abortion in Tanzania*, supra note 56 (*citing* VENTURE STRATEGIES INNOVATIONS, ASSESSING AVAILABILITY OF UTEROTONICS IN TANZANIA: RESULTS FROM A SURVEY OF MATERNAL HEALTH PROVIDERS (2012)).

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

[71] ASRHS SITUATIONAL ANALYSIS-REPORT, supra note 63, at 26, 32.

[72] *Unsafe Abortion in Tanzania*, *supra* note 56 (*citing* B. Sorensen et al., *Substandard Emergency Obstetric Care—a confidential enquiry into maternal deaths at a regional hospital in Tanzania*, 15 TROPICAL MED. & INT'L HEALTH, 894 (2010)).

[73] CEDAW Committee, *Gen. Recommendation No. 21, supra* note 7, para. 22; CEDAW Committee, *Gen. Recommendation* No. 24, *supra* note 6, paras. 2, 22.

[74] CEDAW Committee, *Concluding Observations: Tanzania*, para. 39, U.N. Doc CEDAW/C/TZA/CO/6 (2008).

[75] *Id*., para. 40.

[76] In 1991-1992, only ten percent of currently married women used any form of contraception. That number has steadily increased and in 2010, 34% of currently married women use any form of contraception. *See* 2010 TDHS, *supra* note 16, at 70.

[77] 2010 TDHS, *supra* note 16, at 68-69.

[78] UNFPA, THE NATIONAL ROAD MAP STRATEGIC PLAN TO ACCELERATE REDUCTION OF MATERIAL, NEWBORN AND CHILD DEATHS IN TANZANIA 30 (2008) [hereinafter STRATEGIC PLAN].

[79] 2010 TDHS, *supra* note 16, at 70.

[80] *Id*. at 110; *see also* 2004 TDHS, *supra* note 25, at 114-115.

[81] 2010 TDHS, *supra* note 16, at 115.
[82] DEUTSCHE STIFTUNG WELTBEVOELKERUNG (DSW), FAMILY PLANNING IN TANZANIA: A REVIEW OF NATIONAL AND DISTRICT POLICIES AND BUDGETS 14-19 (2014), *available at* http://www.dsw.org/uploads/tx_aedswpublication/family-planning-tanzania_update.pdf [hereinafter DSW, FAMILY PLANNING IN TANZANIA].
[83] Male condoms and combined oral contraceptives were the most popular form of modern contraceptive and were each offered at about 68% of health facilities surveyed. TANZANIA MINISTRY OF HEALTH AND SOCIAL WELFARE, TANZANIA SERVICE AVAILABILITY AND READINESS ASSESSMENT (SARA) 2012 18 (2013), *available at* https://docs.google.com/viewer?a=v&pid=sites&srcid=aWhpLm9yLnR6fGloaS1tYWluLXNpdGV8Z3g6MWQzMzI4NWM2MjNkNGFmNA [hereinafter TANZANIA SARA].
[84] DSW, FAMILY PLANNING IN TANZANIA, *supra* note 82, at 18-19.
[85] TANZANIA SARA, *supra* note 83.
[86] Percentage calculated to reflect staff training for all facilities surveyed (482 out of 1297 facilities), rather than only for the subset of facilities that offered family planning services (482 out of 1071 facilities). TANZANIA SARA, *supra* note 83, at 18-20.
[87] Percentage calculated to reflect guideline availability for all facilities surveyed (610 out of 1297 facilities), rather than only for the subset of clinics that offered family planning services (610 out of 1071 facilities). *Id*.
[88] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Tanzania*, para. 118 U.N. Doc. CEDAW/C/TZA/7-8 (2014).
[89] Babatunde Osotimehin and Chris Elias, *Tanzania can accelerate family planning access*, THE CITIZEN, Nov. 5, 2014, http://www.thecitizen.co.tz/oped/Tanzania-can-accelerate-family-planning-access/-/1840568/2511396/-/xrqiqx/-/index.html (last visited May 20, 2015) [hereinafter Osotimehin and Elias].
[90] FAMILY PLANNING 2020, PARTNERSHIPS IN PROGRESS 2013-2014 13 (2014).
[91] MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PROGRAM 2010-2015 3, tbl. 1 (2010).
[92] Osotimehin and Elias, *supra* note 89.
[93] WHO, EMERGENCY CONTRACEPTION: A GUIDE FOR SERVICE DELIVERY 7 (1998), *available at* http://snap3.uas.mx/RECURSO1/unfpa/data/docs/unpf0025.pdf. WHO considers EC to be a safe, convenient, and effective method of modern contraception.
[94] P2 (FamyCare) is a levonorgestrel EC pill and the only form of EC registered and distributed in Tanzania. INTERNATIONAL CONSORTIUM FOR EMERGENCY CONTRACEPTION, COUNTING WHAT COUNTS: TRACKING ACCESS TO EMERGENCY CONTRACEPTION IN TANZANIA 2 (2014), *available at* http://www.cecinfo.org/custom-content/uploads/2014/04/ICEC_Tanzania_2014.pdf [hereinafter COUNTING WHAT COUNTS].
[95] MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL MANAGEMENT GUIDELINES FOR THE HEALTH SECTOR RESPONSE TO AND PREVENTION OF GENDER-BASED VIOLENCE (GBV) 33 (2011); *see also* COUNTING WHAT COUNTS, *supra* note 94, at 1.
[96] COUNTING WHAT COUNTS, *supra* note 94, at 1.
[97] WHO, Emergency Contraception, Fact sheet No. 244 (2012)
[98] *Id*. (*citing* TANZANIA MINISTRY OF HEALTH AND SOCIAL WELFARE, STANDARD TREATMENT GUIDELINES AND THE NATIONAL ESSENTIAL MEDICINES LIST FOR MAINLAND TANZANIA (2007)).
[99] TANZANIA SARA, *supra* note 83.
[100] 2010 TDHS, *supra* note 16, at 68.
[101] G.A. B Kagashe, et.al, A*vailability, Awareness, Attitude and Knowledge of Emergency Contraceptives in Dar Es Salaam*, 11, J. PHARM. SCI. & RES. 217-218 (2013).
[102] CEDAW Committee, *Concluding Observations: Tanzania*, para. 33, U.N. Doc CEDAW/C/TZA/CO/6 (2008).
[103] *Id*., para. 34.
[104] CESCR Committee, *Concluding Observations: Tanzania,* para. 27, U.N. Doc E/C.12/TZA/CO/1-3 (2012).
[105] CRC, *Concluding Observations: Tanzania*, para. 61, U.N. Doc CRC/C/TZA/CO/3-5 (2015).
[106] FORCED OUT, *supra* note 66.
[107] That this practice remains ongoing was confirmed in the October 2014 fact-finding by Human Rights Watch. *See generally* HUMAN RIGHTS WATCH, NO WAY OUT: CHILD MARRIAGE AND HUMAN RIGHTS ABUSES IN TANZANIA (2014), *available at* http://www.hrw.org/sites/default/files/reports/tanzania1014_forinsert_ForUpload.pdf [hereinafter NO WAY OUT].

[108] A 2011 report produced by the Government of Tanzania and UNICEF suggests that nearly 17% of girls reported at least once incident of sexual abuse on school grounds, and over one-fourth of girls have experienced at least one incident of sexual violence on their way to or from school. UNICEF ET AL., VIOLENCE AGAINST CHILDREN IN TANZANIA: FINDINGS FROM A NATIONAL SURVEY 2009 52 (2011), *available at* http://www.unicef.org/media/files/VIOLENCE_AGAINST_CHILDREN_IN_TANZANIA_REPORT.pdf [hereinafter VIOLENCE AGAINST CHILDREN IN TANZANIA]; It is likely that these numbers are underreported, for complex social and cultural reasons including lack of understanding of violence, and parents' attitudes towards their girl children that lead to disbelief of allegations when raised. *See generally*, ACTIONAID INT'L, VIOLENCE AGAINST GIRLS AND THE RIGHT TO EDUCATION (2004), *available at* http://www.actionaid.se/files/StopViolenceAgainstGirls.pdf.
[109] FORCED OUT, *supra* note 66, at 17.
[110] MINISTRY OF EDUCATION AND VOCATIONAL TRAINING, BASIC EDUCATION STATISTICS IN TANZANIA (BEST) 2013 tbl. 2.12 (2013), *available at* http://www.moe.go.tz/index.php?option=com_docman&task=doc_download&gid=356&Itemid=385.
[111] *Id*. at 17, 64.
[112] Interview with headmaster at private high school (Jan. 20, 2011) (all interviews on file with the Center for Reproductive Rights); interview with high level official at the Ministry of Community Development, Gender, and Children (Jan. 13, 2011); *see also*, interview with high level official, Ministry of Education (Jan. 18, 2011).
[113] *See, e.g.*, Interview with UNICEF official (Jan. 18, 2011).
[114] *See, e.g.*, Interview with headmaster at private high school (Jan. 20, 2011); interview with high level official at the Ministry of Community Development, Gender, and Children (Jan. 13, 2011). When asked whether girls have an opportunity to consent to or decline testing, the high level official at the Ministry of Community Development, Gender, and Children, responded sharply, "Not in this country," and went on to say that children have duties in addition to rights, includes duty to obey [those in authority].
[115] Interview with headmaster at private high school (Jan. 20, 2011); *see also*, interview with high level official at the Ministry of Community Development, Gender, and Children; interview with teachers at private secondary school (Jan. 19, 2011).
[116] Education circulars suggest that school boys who impregnate school girls are also to be expelled, but it is more difficult to find boys responsible and this practice is largely unenforced. *See* Interview with right to education NGO in Tanzania (Jan. 21, 2011); interview with UNICEF official (Jan. 18, 2011).
[117] FORCED OUT, *supra* note 66, at 98.
[118] FORCED OUT, *supra* note 66, at 47. At best, some combination of policy documents is perceived to give the Ministry of Education the authority to test and expel school girls. Many people cite to the Education Act of 1978 and its amendments in 2002, the Education (Expulsion and Exclusion of Pupils from Schools) Regulations of 2002, or policy circulars as the derivation of an educator's, administrator's, or government official's authority to test and expel pregnant school girls; however, no law individually permits such action, and no standardized policy or guidelines exist. As such, authority is simply assumed, and the legality of testing and expulsion of pregnant school girls has never been litigated to challenge such assumed authority. Long-standing practices such as mandatory pregnancy testing and expulsion of pregnant school girls are largely upheld not on the basis of legal authority, but on the basis of lack of prohibition of the practice.
[119] *See* Interview with high level official, Ministry of Education (Jan. 18, 2011).
[120] *See* Interview with right to education NGO in Tanzania (Jan. 21, 2011).
[121] Interview with officials at the Ministry of Health (Jan. 18, 2011).
[122] Interview with official at the Ministry of Education and Vocational Training (Jan. 15, 2011).
[123] FORCED OUT, *supra* note 66, at 14.
[124] *See* Interview with teachers at private secondary school (Jan. 20, 2011).
[125] WIZARA YA ELIMU NA MAFUNZO YA UFUNDI (TANZ.), SERA YA ELIMU NA MAFUNZO art. 3.3.3. (2014).
[126] MINISTRY OF EDUCATION AND VOCATIONAL TRAINING, GUIDELINES ON HOW TO ENABLE PREGNANCY SCHOOL GIRLS TO CONTINUE WITH THEIR STUDIES (2009), URL?
[127] *Id*. at 7, 9.
[128] *Id*. at 7.
[129] *Id*.
[130] *Id*. at 10.

[131] 2010 TDHS, *supra* note 16, at 65; 2004 TDHS, *supra* note 25, at 66; *see* UNICEF, ADOLESCENCE IN TANZANIA 12 (2011), *available at* http://www.unicef.org/tanzania/TANZANIA_ADOLESCENT_REPORT_Final.pdf [hereinafter ADOLESCENCE IN TANZANIA].
[132] 2010 TDHS, *supra* note 16, at 68-69.
[133] Percentages calculated to include all clinics surveyed, rather than only for the subset of clinics that offered family planning services to adolescents. TANZANIA SARA, *supra* note 83, at 35-36.
[134] ADOLESCENCE IN TANZANIA, *supra* note 131, at 16 (2011).
[135] Percentages calculated to include all clinics surveyed, rather than only for the subset of clinics that offered family planning services to adolescents. TANZANIA SARA, *supra* note 83, at 35-36.
[136] *See* ADOLESCENCE IN TANZANIA, *supra* note 131, at 16 (2011); *see generally*, Ilene S. Speizer et al., *Do Service Providers in Tanzania Unnecessarily Restrict Clients' Access to Contraceptive Methods?* 26(1) INT'L FAMILY PLANNING PERSPECTIVES 13-14 (2000), *available at* http://www.guttmacher.org/pubs/journals/2601300.html; *see also*, STRATEGIC PLAN, *supra* note 78, at 5.
[137] PATHFINDER INTERNATIONAL, INTEGRATING YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN PUBLIC HEALTH FACILITIES: A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA 1-2 (2005), *available at* http://www.pathfinder.org/publications-tools/pdfs/AYA-Tanzania-Case-Study-A-Success-Story-and-Lessons-Learned.pdf?x=17&y=5 [hereinafter PATHFINDER INTERNATIONAL].
[138] CRC, *Concluding Observations: Tanzania*, para. 58(c), U.N. Doc CRC/C/TZA/CO/3-5 (2015).
[139] *Id*., para. 59(c).
[140] *See* Hilda Mhagama, *Tanzania: Risks of Ignoring Special Youth Reproductive Health Services*, TANZANIA DAILY NEWS, Apr. 21, 2015, *available at* http://allafrica.com/stories/201504211475.html (last visited May 20, 2015); PATHFINDER INTERNATIONAL, *supra* note 137.
[141] FORCED OUT, *supra* note 66, at 28.
[142] Magreth Bilinga & Nkuba Mabula, *Teaching Sexuality Education in Primary Schools in Tanzania: Challenges and Implications*, 5 J. ED. & PRAC. 21, 26 (2014), *available at* http://www.iiste.org/Journals/index.php/JEP/article/view/15962/16301; Budeba Petro Mlyakado, *Attitudes and Views of Teachers Towards Students' Sexual Relationships in Secondary Schools in Tanzania* 4 SAVAP INT'L ACADEMIC RESEARCH INT'L, 232 235-36 (2013), *available at* http://www.savap.org.pk/journals/ARInt./Vol.4%281%29/2013%284.1-24%29.pdf (noting that a small study of 30 teachers found that teachers reported "there were no sex education programmes in which they can be trained about sex education.")
[143] FORCED OUT, *supra* note 66, at 26.
[144] *Id*.
[145] *Id*.
[146] CEDAW Committee, *Concluding Observations: Tanzania*, para. 119, U.N. Doc. CEDAW/C/TZA/CO/6 (2008).
[147] *Id*. para. 120.
[148] 2010 TDHS, *supra* note 16, at 275.
[149] *Id*. at 271.
[150] *Id*. at 274.
[151] CEDAW Committee, *Concluding Observations: Tanzania*, para. 23, U.N. Doc. CEDAW/C/TZA/CO/6 (2008).
[152] Rape Act No. 4 of 1998 § 5, *codified as* Penal Code § 130 (Tanz.) [hereinafter Rape Act No. 4 of 1998]; NO WAY OUT, *supra* note 107, at 37.
[153] Although Section 66 of the Law of Marriage Act states that "no person has any right to inflict corporal punishment on his or her spouse," the section does not explicitly provide for any criminal sanctions. TANZANIA WOMEN LAWYERS ASSOCIATION (TAWLA), REVIEW OF LAWS AND POLICIES RELATED TO GENDER BASED VIOLENCE OF TANZANIA MAINLAND 13-14 (2014), *available at* http://www.tawla.or.tz/dox4tawlaweb/GBV%20report%202014%20by%20TAWLA%20TAMWA%20CRC%20TGNP%20ZAFELA.pdf (citing Law of Marriage Act, Cap. 29 § 66 (Tanz.)) [hereinafter, TAWLA, REVIEW OF LAWS].
[154] Jennifer McClearly-Sills, et.al., HELP-SEEKING PATHWAYS AND BARRIERS FOR SURVIVORS OF GENDER –BASED VIOLENCE IN TANZANIA: RESULTS FROM A STUDY IN DAR ES SALAAM, MBEYA, AND IRINGA REGIONS vi–vii (2013) [hereinafter HELP-SEEKING PATHWAYS]; Kizito Makoye, *Tanzania steps up action on gender violence*, DEUTSCHE WELLE, Mar. 12, 2013, http://www.dw.de/tanzania-steps-up-action-on-gender-violence/a-17268312 (last visited May 20, 2015).
[155] HELP-SEEKING PATHWAYS, *supra* note 154, at vii; TAWLA, REVIEW OF LAWS, *supra* note 153.

[156] TAWLA, REVIEW OF LAWS, *supra* note 153, at 20 (2014) (*citing* WILDAF TANZANIA, A COMPREHENSIVE STUDY ON THE EFFICIENCY OF THE ENFORCEMENT OF THE PENAL CODE, CAP. 16 AGAINST THE GENDER BASED VIOLENCE IN TANZANIA MAINLAND 40 (2012)).
[157] *See* CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Tanzania*, paras. 42-46, U.N. Doc. CEDAW/C/TZA/7-8 (2014); UNICEF, *Tanzania, 26 November 2013: Launch of The Gender and Children's Desk and 3 Year Action Plan Demonstrate Police Commitment to Strength Its Response to Gender Based Violence and Violence Against Children* (2013), *available at* http://www.unicef.org/esaro/5440_tanzania_gender.html (last visited May 20, 2015).
[158] HELP-SEEKING PATHWAYS, *supra* note 154, at vii.
[159] One police officer reported that her police relied on NGOs to assist with funding gaps but still lacked sufficient resources. Brielle Morgan, *Fighting Gender Violence in Dar es Salaam – 16 Days and Beyond*, SPEAK MAGAZINE, Jan. 14 2014, *available at* http://speakjhr.com/2014/01/11311/ (last visited May 20, 2015).
[160] *Id*.
[161] NO WAY OUT, *supra* note 107, at 88.
[162] HELP-SEEKING PATHWAYS, *supra* note 154, at vii-viii.
[163] CRC, *Concluding Observations: Tanzania*, para. 40, U.N. Doc CRC/C/TZA/CO/3-5 (2015).
[164] *School pregnancies: A call for reflection on teachers' morality,* IPP MEDIA, May 18, 2011, http://www.ippmedia.com/frontend/index.php?l=29222 (last visited May 20, 2015); ACADEMY OF EDUCATIONAL DEVELOPMENT, GIRLS GETTING TO SECONDARY SCHOOL SAFELY: COMBATTING GENDER-BASED VIOLENCE IN THE TRANSPORTATION SECTOR IN TANZANIA 4 (2009), *available at* http://www.fhi360.org/sites/default/files/media/documents/Girls%20Getting%20to%20Secondary%20School%20Safely.pdf; TANZANIA MEDIA WOMEN'S ASSOCIATION (TAMWA), TAMWA'S REPORT ON SCHOOL GIRLS PREGNANCY SURVEY IN 17 REGIONS 15 (2010) [hereinafter TAMWA'S REPORT]; Budeba Petro Mlyakado, *Schoolgirls' Knowledge of, and Efforts against Risky Sexual Activity: The Need for Sex Education in Schools*, 5(1) INT'L J. OF EDUCATION 69, 75-76 (2013) [hereinafter *The Need for Sex Education in Schools*]; Interview with representatives from Women's Legal Aid Centre (WLAC), in Dar es Salaam (Jan. 19, 2011) (describing the legal services provided by the organization to the parents of students who have been sexually harassed schools).
[165] VIOLENCE AGAINST CHILDREN IN TANZANIA, supra note 108, at 2.
[166] *Id*. at 51
[167] *Id*. at 51-52.
[168] *Id*. at 44.
[169] *Id*.
[170] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Tanzania*, paras. 42-46, U.N. Doc. CEDAW/C/TZA/7-8 (2014).
[171] *The Need for Sex Education in Schools*, *supra* note 164, at 76.
[172] FORCED OUT, *supra* note 66, at 33 (internal citation omitted).
[173] TAMWA'S REPORT, *supra* note 164, at 16; *Girls Being "Raped for Grades,"* Association for Women's Rights in Development (AWID) (Oct. 13, 2008), http://www.awid.org/Library/Girls-being-raped-for-grades (last visited August 6, 2013); ACTIONAID, TRANSFORMING EDUCATION FOR GIRLS IN NIGERIA AND TANZANIA 39 (2011), *available at* http://www.ungei.org/resources/files/tegint_-_a_cross_country_analysis_of_baseline_research_from_nigeria_and_tanzania.pdf (discussing the lack of accountability and how it may be due in part to ineffective reporting systems); "Abuse by teachers is common, and violators suffer no legal consequences—they are merely transferred to other schools, and the girls are blamed." Interview with judge from the Court of Appeals (Jan. 13, 2011); "According to the Ministry guidelines, teachers that impregnate girls are supposed to be disciplined, but usually they are just transferred to another school." Interview with Zubeida Tumbo-Masabo (Jan. 18, 2011).
[174] TAMWA'S REPORT, *supra* note 164, at 16.
[175] UNICEF, *Tanzanian Government launches a Three Year Multi Sector National Plan to Prevent and Respond to Violence Against Children* (2013) [hereinafter UNICEF National Plan].
[176] UNITED REPUBLIC OF TANZANIA, MULTI SECTOR NATIONAL PLAN OF ACTION TO PREVENT AND RESPOND TO VIOLENCE AGAINST CHILDREN 2013-2016 15 (2013).
[177] UNICEF National Plan, *supra* note 175; UNICEF Tanzania et al., *Press Release: UNICEF, EU, Save the Children and Plan International Join Forces with Tanzania to End Violence against Children* (Jan. 22, 2014), *available at* http://eeas.europa.eu/delegations/tanzania/documents/press_corner/20140122_03_en.pdf (noting that

the EU has pledged €1.8m to fund the plan, which will be implemented by UNICEF, Plan International, and Save the Children).
[178] NO WAY OUT, *supra* note 107, at 68-69.
[179] *Id*.
[180] CEDAW Committee, *Concluding Observations: Tanzania*, para. 49 U.N. Doc CEDAW/C/TZA/CO/6 (2008).
[181] CRC, *Concluding Observations: Tanzania*, para. 61, U.N. Doc CRC/C/TZA/CO/3-5 (2015).
[182] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Tanzania*, paras. 153, U.N. Doc. CEDAW/C/TZA/7-8 (2014).
[183] *Id*.
[184] NO WAY OUT, *supra* note 107, at 63.
[185] Law of Marriage Act (1971), art. 13, 17 (Tanz.) [hereinafter Law of Marriage Act].
[186] *Id*.
[187] CHILDREN'S DIGNITY FORUM, VOICES OF CHILD BRIDES AND CHILD MOTHERS IN TANZANIA 6 (2010).
[188] Law of Marriage Act, *supra* note 185, art. 13(2).
[189] ADOLESCENCE IN TANZANIA, *supra* note 131, at 48.
[190] Rape Act No. 4 of 1998, supra note 152; NO WAY OUT, *supra* note 107, at 64.
[191] 2010 TDHS, *supra* note 16, at 94; Similarly, UNFPA estimates that about 37% of girls aged 20-24 married or entered into a union before the age of 18. UNITED NATIONS POPULATION FUND, MARRYING TOO YOUNG: END CHILD MARRIAGE 23 (2012) *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf.
[192] 2010 TDHS, *supra* note 16, at 96.
[193] 2010 TDHS, *supra* note 16, at 282 (46.1% of married adolescents age 15-19 reported emotional, physical or sexual violence by their husband; this information was not disaggregated by mainland Tanzania and Zanzibar, however rates of reported emotional, physical or sexual violence were much higher overall in mainland Tanzania (51.2%) when compared to Zanzibar (11.4%), although reporting may be influenced by perceptions of whether domestic violence is socially acceptable); ADOLESCENCE IN TANZANIA, *supra* note 131, at 46.
[194] ANJU MALHOTRA ET AL., SOLUTIONS TO END CHILD MARRIAGE: WHAT THE EVIDENCE SHOWS 4 (2011), *available at* http://www.icrw.org/files/publications/Solutions-to-End-Child-Marriage.pdf.
[195] 2010 TDHS, *supra* note 16, at 220.
[196] 2010 TDHS, *supra* note 16, at 282. This information was not disaggregated by mainland Tanzania and Zanzibar; however, rates of reported sexual violence were much higher overall in mainland Tanzania (17.5%) versus Zanzibar (3.8%).
[197] NO WAY OUT, *supra* note 107, at 60.
[198] The Education (Expulsion and Exclusion of Pupils from Schools) Regulations, G.N. No. 295 of 2002, art 4 (c) (Tanz.)
[199] NO WAY OUT, *supra* note 107, at 51.
[200] CEDAW Committee, *General Recommendation No. 24*, *supra* note 6, para. 18.
[201] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Tanzania*, para. 9, U.N. Doc. CEDAW/C/TZA/7-8 (2014).
[202] HIV and AIDS (Prevention and Control) Act, 2008, No. 28 of 2008 § 47 (Tanz.).
[203] *See generally*, Patrick Eba, *One size punishes all: A critical appraisal of the criminalization of HIV transmission*, AIDS LEGAL NETWORK, 5, 7 (2008); Michaela Clayton et al., *A tragedy not a crime*, AIDS LEGAL NETWORK, 11-12 (2008) [hereinafter Clayton].
[204] HIV and AIDS (Prevention and Control) Act, 2008, No. 28 of 2008, § 21(1)(a) (Tanz.).
[205] TANZANIA COMMISSION FOR AIDS (TACAIDS), TANZANIA HIV/AIDS AND MALARIA INDICATOR SURVEY 81-84 (2008); *see also* Clayton, *supra* note 203, at 12.
[206] Alice Welbourn, *Into the firing line: Placing young women and girls at greater risk*, AIDS LEGAL NETWORK, 15-16 (2008); *see also* Avert, *Criminal Transmission of HIV*, http://www.avert.org/criminal-transmission.htm (last visited Oct. 27, 2011); s*ee also* The plight of Tanzanian women living with HIV/AIDS, PANAPRESS, Mar. 2, 2004, http://www.panapress.com/The-plight-of-Tanzanian-women-living-with-HiV-AiDS--12-542429-25-lang1-index.html (last visited May 20, 2015).
[207] *See, e.g.*, Malavika Prabhu, *Prevalence and Correlates of Intimate Partner Violence among Women Attending HIV Voluntary Counseling and Testing in Northern Tanzania, 2005-2008* 113 INT'L J. GYN. & OBSTET. 63 (2011) (finding a correlation between intimate partner violence and HIV status among single women, although not among

the entire sample); Suzanne Maman et al., *HIV Positive Women Report More Lifetime Partner Violence: Findings from a Voluntary Counseling and Testing Clinic in Dar es Salaam*, 92(8) AM. J. OF PUB. HLTH., 1333 (2002) (finding that women living with HIV were more than 2.5 times as likely to report physical or sexual violence from their partner than women without HIV).

[208] AIDS Law Project v. A.G., Petition 97 of 2010, Judgment (Kenya H. Ct. Nairobi, 2015); *see also* Center for Reproductive Rights, *Kenya High Court Finds Criminalizing HIV and AIDS Transmission Unconstitutional* (Mar. 30, 2015), *available at* http://www.reproductiverights.org/press-room/kenya-high-court-finds-criminalizing-hiv-aids-transmission-unconstitutional.

[209] *Id*.

[210] TANZANIA COMMISSION FOR AIDS, ET AL., TANZANIA: HIV/AIDS AND MALARIA INDICATOR SURVEY, 2011-12, 111-12 (2013), http://dhsprogram.com/pubs/pdf/AIS11/AIS11.pdf.

[211] UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION, UNGASS 2010 PROGRESS REPORTING: TANZANIA MAINLAND 13 (2010).