CENTER FOR REPRODUCTIVE RIGHTS

May 9, 2014

The Committee on the Rights of the Child

Re: Supplementary information on the United Republic of Tanzania scheduled for review by the Committee on the Rights of the Child during its 68th session

Dear Committee Members:

The Center for Reproductive Rights (the Center), a global legal advocacy organization with headquarters in New York, and offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C., submits this pre-session letter to supplement the periodic report of the Government of the United Republic of Tanzania to the Committee on the Rights of the Child (the Committee) during its 68th session. The Center uses the law to advance reproductive freedom as a fundamental human right that all governments have an obligation to respect, protect, and fulfil.

Reproductive rights lie at the heart of human rights for adolescent girls because upholding these rights is essential to ensuring their substantive equality and reproductive autonomy. Violations affect not only their health but can have a significant impact on their education, development, and future prospects, perpetuating cycles of poverty which can result in life-long exclusion and discrimination. Children's right to health also includes the right to control their health and bodies, "including sexual and reproductive freedom to make responsible choices."[1] The right to health requires "access to a range of facilities, good, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health."[2] This submission is intended to draw attention to the status of the reproductive rights of girls in Tanzania, including their right to reproductive health services; freedom from harmful and discriminatory practices such as compulsory pregnancy testing in schools; and sexual violence against young girls and adolescents. A part 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* (fact-finding report), which is submitted with this letter.

I. The Right to Equality and Non-discrimination

The Convention on the Rights of the Child (the Convention) strongly protects children's rights to substantive equality and nondiscrimination. For girls, the right to equality and sexual and reproductive rights interact in a mutually reinforcing nature: the stigma surrounding sexuality, and the discrimination and inequalities that girls face, can prevent them from accessing sexual and reproductive health services, and their inability to access such services can perpetuate cycles of inequality and discrimination.

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The Committee has explicitly recognized that gender-based discrimination and taboos or negative attitudes about girls being sexually active often limits girls' access to preventive measures and other health services.[3] States "must give careful consideration to prescribed gender norms within their societies with a view to eliminating gender-based discrimination."[4] The gender-based discrimination that girls face in accessing health services or in schools may be particularly exacerbated in the context of sexual and reproductive health services, as a result of stigma and discrimination surrounding girls' sexuality. This dually jeopardizes girls' health and rights, as their reproductive capacities mean that they must shoulder the burden of an unplanned pregnancy and the social consequences. The Committee recognizes that, in the context of adolescent pregnancy, stigma and discrimination can hinder girls' access to education and services.[5] Indeed, in many contexts, girls seeking to prevent pregnancy must also endure such stigma and discrimination.

States are obligated to ensure that children's rights are not undermined as a result of discrimination.[6] The Committee recognizes that children who are discriminated against "are more vulnerable to abuse, other types of violence and exploitation," and their health and development are put at greater risk.[7] As such, states must pay particular attention and afford protections to such children.[8] The Committee has called on states to take positive measures to alleviate such inequalities and discrimination, including by adopting policies and programs on children's health that are "grounded in a broad approach to gender equality that ensures young women's full political participation; social and economic empowerment; recognition of equal rights related to sexual and reproductive health; and equal access to information, education, justice and security, including the elimination of all forms of sexual and gender-based violence."[9] The Committee has urged states to pay particular attention to the different "needs of girls and boys, and the impact of gender-related social norms and values on the health and development of boys and girls."[10]

II. The Right to Sexual and Reproductive Health Services and Information (Articles 3(2), 6, 17 and 24)

When adolescent girls are unable to access sexual and reproductive health information and services, their abilities to make meaningful choices about their reproductive lives, without coercion, is limited and can impact their enjoyment of the rights to life, health, equality and non-discrimination, all of which receive broad protection under the Convention on the Rights of the Child (the Convention). For example, Article 6 recognizes that "every child has the inherent right to life" and requires states to "ensure to the maximum extent possible the survival and development of the child."[11] Article 24 similarly recognizes the right "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health," and requires states to take appropriate measures "to develop … family planning and education services," "ensure appropriate pre-natal and post-natal health care for mothers," and take all appropriate measures to abolish practices harmful to children.[12] Moreover, Article 3(2) requires each state to "take all appropriate legislative and administrative measures" to ensure the protection and care of children, necessary for their well-being.[13] Finally, Article 17 requires states to ensure that children have access to a diverse range of information, including health-related information.[14]

When viewed together, the provisions highlighted above, obligate governments to ensure adolescents' access to sexual and reproductive health services and information. In their absence, adolescent girls may experience early and unwanted pregnancies, possibly resulting in death or serious and permanent injury due to their physical immaturity and lack of adequate maternal health care, or they may turn to unsafe illegal abortions which could also result in complications or death.

A. Adolescents' Maternal Health

In General Comment 15, the Committee noted that "preventable maternal mortality and morbidity constitute grave violations of the human rights of women and girls and pose serious threats to their own and their children's right to health."[15] It has repeatedly confirmed that states have an obligation to immediately take action to reduce preventable maternal mortality and morbidity particularly when it comes to children and adolescents. To this end, the Committee has recommended that states "take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices."[16] With respect to Tanzania specifically, in its 2006 Concluding Observations, the Committee expressed concern over the "high rate of teenage pregnancies and the fact that [Tanzania] does not pay sufficient attention to adolescent health issues, including … reproductive health concerns."[17] The Committee recommended that Tanzania "undertake a comprehensive study to assess the nature and extent of adolescent health problems and, with the full participation of adolescents, use [the study] as a basis to formulate adolescent health policies and programmes…"[18]

Despite these recommendations, early pregnancy remains high in Tanzania. The latest Tanzania Demographic and Health Survey (2010 TDHS) found that nearly 44% of girls in Tanzania have either given birth or are pregnant by age 19.[19] Adolescents from low-income backgrounds, rural areas, and without any formal education face are disproportionately affected. Adolescent girls from low-income backgrounds are more than twice as likely to start childbearing as their counterparts in the highest wealth quintile (28% and 13% respectively).[20] Adolescents in rural areas are more likely to start childbearing earlier than urban adolescents (26% and 15% respectively). Further, the 2010 TDHS found that 52% of adolescents without formal education had given birth, compared to only 6% of adolescents with secondary education.[21]

The implications for girls' health and lives are significant—adolescents run a disproportionate risk of dying during or after childbirth[22] and are more vulnerable to pregnancy-related complications.[23] Indeed, a United Nations Children's Funds (UNICEF) report on Tanzania in 2011 concludes that, "pregnancy is a leading cause of death for young women aged 15-19."[24] Obstetric complications dues to low-quality care, absence of skilled delivery services, and high costs are mainly to blame.[25] Only 49% of births are attended by skilled health personnel in the entire country,[26] and just 33% of births by those from the poorest quintile are attended by skilled health personnel. According to the latest data from the World Health Organization (WHO), Tanzania has the eighth highest number of maternal deaths in the world.[27] Women in Tanzania have a 1-in-23 lifetime risk of dying from a pregnancy-related cause.[28] Data from WHO further indicates that Tanzania is not on track to meet Millennium Development Goal (MDG) 5, to reduce maternal mortality.[29]

The government, in its current periodic report to the Committee, acknowledged that, "[t]eenage mothers are at a much higher risk of dying of pregnancy-related causes" and recognized that "every effort should be made to facilitate their access to [sexual and reproductive health] services."[30] However, it remained silent on the specific measures it is undertaking to improve adolescent maternal health.

B. Safe abortion and inadequate access to post-abortion care

Unsafe abortion is one of the most easily preventable causes of maternal mortality particularly among adolescents. Even if death does not occur, adolescents are likely to suffer long-term disabilities such as uterine perforation, chronic pelvic pain, sepsis, or infertility. Recognizing this, the Committee has recommended that governments "ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal."[31] It has further urged states to address high maternal mortality rates by improving infrastructure,[32] and decriminalizing abortion particularly under certain grounds.[33]

The laws and policies regarding abortion in Tanzania are "inconsistent, unclear and often contradictory." Under the Penal Code, abortion is criminalized except to save the life of a pregnant woman or adolescent.[34] However, jurisprudence from courts makes clear that Tanzania's life exception encompasses a mental and physical health exception.[35] This understanding of the law is also reflected in a number of government policies. For example, the 2002 Post-Abortion Care Clinical Skills Curriculum states that therapeutic abortion is allowed, and the 2007 Standard Treatment Guidelines and the National Essential Medicine List for Mainland Tanzania provide that abortion is legal when continuing the pregnancy poses a threat to the health or life of the person who is pregnant.[36] However, this legal and policy framework is not implemented in practice. Indeed, the 2002 Post-Abortion Care Clinical Skills Curriculum, which is the primary government document focusing on post-abortion care (PAC), explicitly states that although Tanzania law allows therapeutic abortion, few women and men know about this law.[37]

Even with the recognition of mental and physical health exceptions, Tanzania's abortion law falls short of compliance with its international and regional human rights obligations. For instance, this Committee has specifically asked states to decriminalize abortion in cases of rape and incest.[38] Further, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol), which Tanzania has ratified, requires states to "take all appropriate measures to…protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus."[39] Currently, the government and service providers' emphasis on the illegality of abortion prevents adolescents from accessing safe abortion. Instead, they are forced to obtain unsafe abortions through the ingestion or vaginal insertion of dangerous substances,[40] resulting in preventable injuries and deaths. It is estimated that 30% of all maternal deaths in Tanzania are due to complications from unsafe abortions.[41]

The problem posed by unsafe abortion has been a long standing one—a study found that 47% of the 965 obstetric admissions in 1992 at Muhimbili National Referral Hospital in Dar es Salaam were abortion complications.[42] In 2003, a country evaluation report estimated that nationally, nearly one-third of all hospitalized cases of unsafe or incomplete abortions were under 20 years.[43] The statistics remained unchanged in 2008 as noted in a report by the Ministry of Health and Social Welfare stating that, "one-third of incomplete abortion cases that turn up in health facilities involve adolescents, and one in five girls involved are students."[44] In 2009, the New York Times reported that in one hospital, in the month of January 2009 alone, 17 of 31 minor surgical procedures were done to repair incomplete or botched abortions by untrained individuals.[45] 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."[46]

Costs of abortion procedures also determine the quality of service received by all, but particularly adolescents who are more likely not to have any independent means of income. 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).[47] In a 2012 report, it was estimated that the cost of the procedure in two urban areas was US$32–44.[48] As a result, access to safe abortion services is further limited for those who cannot afford to pay the substantial fees.[49]

With respect to post-abortion care (PAC), although the government has publicly committed to its provision and issued guidelines to that effect,[50] it is not widely available or accessible.[51] The availability of the required equipment is extremely limited in all health care facilities (ranging between 5% and 8%).[52] In addition, training on PAC is limited and inadequate. The government has also not 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."[53] In 2008 there was 66% coverage of available PAC services in the country but of this, only 13.5% of health providers were trained on adolescent PAC.[54]

In its current periodic report to the Committee, the government did not mention any measures to ensure access to safe abortion or PAC for adolescents.

C. Access to comprehensive family planning information and services, including sexuality education in schools

This Committee has recognized that girls may experience obstacles to reproductive autonomy and equality due to their age, which may result in being excluded from making decisions about their health or being denied confidential health information and services.[55] Indeed the Committee has determined that to achieve substantive equality and ensure that girls are free from discrimination, states must ensure that the personal biases of providers do not impede the provision of health services.[56] In its General Comment 4, the Committee confirmed that states have an obligation to "ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours."[57] In General Committee 15, the Committee urged that, "[f]amily planning services should be situated within comprehensive sexual and reproductive health services and should encompass sexuality education, including counselling."[58] It acknowledged that "...confidential, universal access to goods and services for both married and unmarried female and male adolescents" should be provided without being hindered by providers' conscientious objections.[59] It then recommended that both short-term and long-term contraceptive methods be made available to adolescents.[60]

In evaluating states' compliance with the Convention, the Committee has specifically recognized a state's duty to ensure access to sexual and reproductive health education and repeatedly recommended that states strengthen their programs for adolescents to combat adolescent pregnancy and the spread of STIs.[61] Further, the Committee has recommended that all adolescents be given "access to sexual and reproductive information,"[62] adding that "[a]dolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs."[63] Focusing on Tanzania, the Committee in 2006 recommended that reproductive health counselling be strengthened and made known and accessible to adolescents.[64] It also called for the "inclusion of reproductive health education in the school curriculum" and other measures to "fully inform adolescents of reproductive health rights, including the prevention of teenage pregnancies and sexually transmitted diseases."[65]

Tanzania has one of the highest adolescent pregnancy rates in the world—nearly 60% of adolescents have sex before the age of 18.[66] Yet, with few exceptions to the contrary, the Government has largely left the promotion of youth-friendly health services, including sexuality education in schools, to non-governmental organizations, which have limited resources and reach and cannot adequately promote systemic changes.[67] Consequently, though Tanzania has seen a gradual and steady increase in contraceptive use and prevalence in the last two decades,[68] still only 9% of adolescents aged 15-19 are using a modern method.[69] Among married and sexually active unmarried adolescents aged 15-19, only 15% and 40%, respectively, are using either a modern or traditional contraceptive method.[70] Contraceptive use also varies substantially based on geography and demographics. Currently, married urban women and adolescents aged 15-49 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 their education and wealth quintile.[71] This is particularly relevant to adolescents who have limited money for transportation to, and knowledge of, service facilities.[72]

Further exacerbating the roles location, education, and income play, adolescent girls seeking contraceptive information and services often face discrimination. Yet, both the 1994 Family Planning Unit of the Ministry of Health and Social Welfare's National Policy Guidelines and Standards for Family Planning Services Delivery and Training, and the 2008 National Roadmap and Strategic Plan for the Reduction of Maternal, Newborn and Child Deaths require the provision of contraceptive and family planning information and services without discrimination and bias.[73] These, and other policies which prohibit discrimination,[74] are clearly inadequately enforced, leaving service providers wide discretion in supplying contraception with devastating consequences for women and girls. Many individual providers, motivated by personal biases, restrict access to contraceptive methods on the basis of age or marital status, despite the fact that no legal, medical, or policy basis exists for doing so, and such discriminatory practices are not sanctioned by government law or policy.[75] Additionally, many adolescent girls could avoid unwanted pregnancies by using emergency contraception (EC), a safe and effective means of preventing pregnancy following unprotected sex.[76] Although national guidelines state that EC should be made available to survivors of sexual violence, including adolescent girls,[77] studies show that it is not available in public clinics and hospitals.[78]

The current periodic report has, however, failed to state the measures the government is undertaking to address these problems in accordance with the Committee's previous recommendations.

III. Harmful and Discriminatory Practices and Violence against Adolescents Girls (Articles 2, 19, 24, 28 and 34)

Where girls' rights to equality and non-discrimination are not fulfilled, the inequalities and discrimination they face are exacerbated due to the differentiated impact that childbearing has on their health and lives, including in the spheres of education. As such, Article 2 of the Convention prohibits discrimination on a number of grounds including sex and other status, and mandates states to take all necessary measures to protect children.[79] Article 19 provides that states must take all appropriate measures to protect the child against all forms of abuse and violence.[80] Additionally, Article 34 obliges states to take all appropriate measures to protect the child against all forms of exploitation and sexual abuse,[81] and Article 24 calls for states to "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."[82] Article 28 guarantees the right of the child to education and compels states to "take measures to encourage regular attendance at schools and the reduction of drop-out rates."[83] Despite these explicit protections in the Convention, young girls and adolescents continue to experience harmful and discriminatory practices, such as mandatory pregnancy testing and expulsion of pregnant school girls, and sexual violence in schools

A. Mandatory pregnancy testing and expulsion of pregnant school girls

The Committee has specifically recommended that "discrimination based on adolescent pregnancy, such as expulsion from schools, should be prohibited, and opportunities for continuous education should be ensured."[84] It has mandated governments to "foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers" and "develop policies that will allow adolescent mothers to continue their education."[85] Particularly, in its 2006 Concluding Observations, the Committee recommended that Tanzania review the 1992 Education Act on Tanzania Mainland to prohibit the expulsion of pregnant teenagers from schools.[86] It urged the government to "continue to provide support to pregnant teenagers and ensure the continuation of their education."[87]

The recommendations of the Committee are equally supported by those of other treaty monitoring bodies. The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has urged states to recognize that education is related to women's health.[88] The Committee on Economic, Social and Cultural Rights (CESCR Committee) has emphasized the importance of education, stating that

"[e]ducation has a vital role in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, [and] promoting human rights and democracy. . . ."[89]

Despite these provisions, the Center's recent fact-finding on this issue in Tanzania[90] confirms the practice of testing and expulsion is prevalent, widely accepted, and significantly supported by educators, government officials, and NGOs. Rather than providing girls with the reproductive health information and services they need to prevent pregnancy and preventing the high incidence of sexual violence in schools,[91] many schools in Tanzania have instituted a practice of mandatory pregnancy testing, forcing over 55,000 female students out of school in mainland Tanzania in the past decade because they were found pregnant.[92] 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.[93] 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.[94] Pregnancy "testing" typically takes the form of physical touching, prodding and poking of a girl's stomach by a school official and, if a girl is suspected of being pregnant, may also involve a urine-based pregnancy test, often at a local health facility.[95]

The results of a positive pregnancy test almost universally end in expulsion of the girl from school.[96] Many educators and administrators believe expulsion is required by law or policy; however, no law or policy document exists that requires testing and expulsion of pregnant school girls.[97] Generally, mandatory pregnancy tests of school girls in Tanzania are done without prior announcement or warning to prevent girls from circumventing the policy,[98] and do not require the informed consent of the child or her parents.[99] As described by an advocate at a prominent women's rights organization in Tanzania, "It's not up to you to be tested or not . . . you can agree or you can leave the school."[100] Results are then disclosed to the school and then to the parents by the school, violating the girl's right to privacy and confidential medical treatment. One of the interviewees for the Center's fact-finding report, a secondary teacher, recalled her own experience of testing as a student:

> They do it like a surprise. They say it's time to test and then they go for testing the same day. They call all the girls and put them in one room and then they lock you in there so you can't escape. . . . No one ever said no to the test. It is impossible to say that.[101]

A former primary school student in Dar es Salaam also recounted her experience of forced pregnancy testing:

> We came early in the morning for regular activities and studies and when we are in class, the class teacher came and said that today all girls, take your hoes, we are going to the hospital to dig there and put out the grasses. But it's an ambush. When we get to the hospital, the teacher says now put down your hoes and I want to show you where to dig. When we go [where the teacher indicates], the teacher says go one by one [into an examination room in the hospital]. When we enter the room we meet a nurse who gives us a bottle to put our urine in and then [we] come back with our urine to test. . . . Then we take our hoes and go back to school. . . . They don't ask for consent or permission for the urine test. It's an ambush order. The teacher is too harsh—all children must do it. No one thinks they can say no.[102]

Coercive pregnancy testing of school girls in Tanzania is largely treated by educators, administrators, government officials, and NGOs as a necessary disciplinary action in controlling girls' behavior.[103] The practice also enjoys almost universal government support. A high level official at the Ministry of Education has stated matter-of-factly that pregnant girls should simply not be in school.[104] Most who support the practice suggest that it is done for the girls' benefit to prevent unsafe abortion, embarrassment, shame, and to ensure greater protections for the girl's health during pregnancy.[105]