CENTER FOR REPRODUCTIVE RIGHTS

October 31, 2011

Committee on Economic, Social, and Cultural Rights
Office of the United Nations High Commissioner for Human Rights
Palais des Nations
CH-1211 Geneva 10, Switzerland

Re: Supplementary information on the United Republic of Tanzania Submitted to the Pre-Sessional Working Group of the Committee on Economic, Social, and Cultural Rights during its 47th Session, December 5-9, 2011

Dear Committee Members:

This letter is intended to supplement the periodic report of the Government of the United Republic of Tanzania (Tanzania), scheduled for a pre-session review by this Committee during its 47th session. The Center for Reproductive Rights (the Center), an independent nongovernmental organization based in New York, with regional offices in Nairobi, Kenya, and Bogota, Colombia, uses the law to advance reproductive freedom as a fundamental right. The Tanzania Women Lawyers Association (TAWLA) is a non-profit and nongovernmental association formed in 1989, and formally registered in 1990. Currently, TAWLA has 470 members, comprised of women lawyers from diverse backgrounds such as State Attorneys, Private Advocates, Judges, Magistrates, Corporation Counsels, Lecturers and Legal Advisors in various state and non-state institutions, who seek to promote women's and children's rights and good governance. With this submission, the Center and TAWLA hope to further the work of the Committee by providing independent information concerning the rights protected in the International Covenant on Economic, Social and Cultural Rights (the Covenant).

This pre-session letter provides a summary of several areas of concern and a list of questions that we hope the Committee will raise with the Tanzanian delegation prior to the consideration of its report. We wish to bring to the Committee's attention the following areas of particular concern: the high rates of preventable maternal mortality and morbidity; the lack of access to safe abortion services and post abortion care; women's lack of access to reproductive healthcare and information; and discrimination against HIV-positive women, adolescents, and school girls. These problems reflect shortfalls in the government's implementation of the Covenant and directly affect the health and lives of women in Tanzania.

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

Reproductive health rights are fundamental to women's health and equality, and receive broad protection under the Covenant. The Covenant guarantees all persons the rights set forth in the Covenant without discrimination, specifically as to "sex…social origin…or other status."[1] To that end, the Committee has characterized the duty to prevent discrimination in access to healthcare as a "core obligation" of the state.[2]

The Covenant also grants special protection to pregnant women before and after delivery, and guarantees everyone the right to enjoy the benefits of scientific progress and its applications.[3] The Covenant also recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[4] In interpreting this right, the Committee, in General Comment 14, has explicitly defined the right to health to "include the right to control one's health and body, including sexual and reproductive freedom."[5] The Committee further asserted that states are required to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."[6] General Comment 14 also specifically states that "[t]he realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[7] Despite these protections, the reproductive rights of women in Tanzania, particularly their rights to safe pregnancy and child birth, safe abortion and post-abortion care, comprehensive contraceptive methods, and reproductive health care services without discrimination, are being neglected and violated.

1. MATERNAL MORTALITY AND MORBIDITY

Maternal death is defined as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of the pregnancy, irrespective of its duration, from any cause related to or aggravated by the pregnancy or its management.[8] According to the World Health Organization (WHO), Tanzania had the seventh highest number of maternal deaths in the world in 2008.[9] Women in Tanzania have a 1-in-23 lifetime risk of dying from a pregnancy-related cause.[10] Although the 2010 Tanzania Demographic and Health Survey (TDHS) puts the maternal mortality ratio at 454 maternal deaths per 100,000 live births, showing a small decline from the 2004 TDHS,[11] 2008 data from WHO suggests that the maternal mortality ratio is closer to 790 maternal deaths per 100,000 live births.[12] Regardless of these variations in data, maternal deaths consistently represent between 17 and 18 percent of all deaths of women ages 15-49.[13] In fact, the UNDP has noted that for Tanzania "the challenges of reducing maternal mortality to the targeted levels under [Millennium Development Goals (MDG)] are enormous" and that, given its slow progress to curb maternal deaths, achievement of MDG 5 is "unlikely."[14]

Article 10 of the Covenant grants special protection to pregnant women before and after delivery, as well as to adolescents and children. The Committee has affirmed that state failure to reduce maternal deaths violates the right to health.[15]

The majority of maternal deaths in Tanzania are due to obstetric complications that could be prevented or minimized by providing quality care, including accessible post-natal care, skilled delivery services and emergency obstetric care.[16] Only 51 percent of births are assisted by health professionals (described in the TDHS as doctors, clinical officers, nurses, midwives, and MCH aides).[17] The proportion of births attended by skilled health professionals has shown little to no improvement over the past 20 years and any progress has been painstakingly slow;[18] virtually no change has been seen from the 2004-2005 TDHS to the 2010 TDHS.[19] According to the TDHS "proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the newborn baby,"[20] yet only 50 percent of births in Tanzania are delivered at a health facility,[21] and only one fourth of facilities that offer delivery services have all items necessary for infection control.[22]

In the event of an obstetric emergency, the 2006 TSPA notes that "it was expected that all hospitals would provide comprehensive emergency obstetric services, but . . . that is not the case."[23] In reality, only one in ten facilities in Tanzania offer basic and comprehensive emergency obstetric services; as such, the national coverage rate for basic emergency obstetric care is 0.55 facilities per 500,000 people—seven times less than the number recommended by WHO, UNICEF, and UNFPA.[24] In fact, not a single zone in the country meets the recommended coverage for basic emergency obstetric care.[25]

In addition, there are large discrepancies in healthcare access based on geography, as most medical facilities offering maternal health services are concentrated in urban areas. In its 2008 concluding observations, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) urged Tanzania to increase awareness of and access to healthcare facilities and assistance by trained medical personnel for women, especially in rural areas.[26] But alarming differences remain between urban and rural women's access to services. For example, urban women are almost two times more likely than rural women to receive postnatal care,[27] give birth at a health facility,[28] and give birth with the assistance of a health professional,[29] despite the fact that nearly 80 percent of births occur in rural areas.[30] According to the 2010 TDHS, "problems in accessing health care are felt most acutely by rural women,"[31] and over 23 percent of rural women cited distance to a health facility as a major barrier in accessing care, compared to only nine percent of urban women.[32]

Another major barrier to accessing health services is cost.[33] According to the Tanzanian Government's report to the Committee, "pre-natal and post-natal services are provided free of charge;"[34] however, ten percent of facilities charge some sort of user fee for ANC services.[35] In 2008, nearly 34 percent of people in mainland Tanzania and over 50 percent of people in Zanzibar lived below the basic needs poverty line,[36] rendering such out-of-pocket fees a serious barrier to accessing even the most basic medical services.

According to the TDHS, these barriers are felt most acutely by rural women, women with no education, and women in the lower wealth quintiles.[37]

In its 2006 concluding observations, the Committee on the Rights of the Child asked Tanzania to "allocate more financial resources for health services."[38] In 2008, the Ministry of Health and Social Welfare created the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 (Strategic Plan). As a strategy for reducing the maternal mortality ratio, the Strategic Plan recognizes the need to "allocate sufficient resources to achieve national and international goals and targets."[39] In January 2011, it was reported that the Ministry of Health and Social Welfare would receive a budgetary increase from 12 to 15 percent over the next three years;[40] however, Ministry of Finance records indicate that the current projected budget for 2011-2012 shows a mere 0.3 percent increase in the funds allocated to health.[41] According to the Strategic Plan, "Due to other competing health priorities . . . [the] Reproductive and Child Health budget is still limited. This has affected implementation of comprehensive interventions on maternal, family planning and newborn care."[42]

Adolescent Maternal Health

Nearly 44 percent of girls in Tanzania have either given birth or are pregnant by the age of 19.[43] Adolescents in rural areas are more likely to start childbearing earlier than urban adolescents (26 and 15 percent respectively).[44] Adolescent girls run a disproportionate risk of dying in or after childbirth[45] and are more vulnerable to pregnancy-related complications, such as anemia, obstetric fistula, and puerperal sepsis.[46] Many of these complications are due to physical immaturity at the time of childbirth, low social and economic status, lack of access to healthcare services, low rates of ANC and obstetric care, and low levels of education.[47]

Further, a strong inverse relationship exists between early childbearing and education. According to the 2010 TDHS, 52 percent of adolescents with no education started childbearing, compared to only six percent of adolescents with secondary education.[48] Adolescent pregnancy also disproportionately affects the poorest girls, who are more than twice as likely to start childbearing as their counterparts in the highest wealth quintile (28 and 13 percent respectively).[49] Adolescent pregnancy also has a detrimental impact on girls' ability to realize their right to education. The 2010 TDHS notes that "childbearing during the teenage years frequently has adverse social consequences, particularly for educational attainment, because women who become mothers in their teens are more likely to curtail their education."[50]

2. UNSAFE ABORTION AND POST-ABORTION CARE

The Committee has emphasized states' obligations to reduce women's health risks and maternal mortality rates.[51] Unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity. Even if death does not occur, a woman is likely to suffer long-term disabilities such as uterine perforation, chronic pelvic pain, sepsis, or infertility. The Tanzanian Government's report to the Committee is silent on the matter,

despite the high prevalence of unsafe abortion in Tanzania, due primarily to the country's restrictive abortion law.

Methods of unsafe abortion in Tanzania include ingestion of herbs and roots, often administered by an unskilled provider; ingestion of "blue," a concentrated household cleaning product, or vaginal insertion of herbs, roots or other sharp objects.[52] Comprehensive data on abortion is difficult to obtain in Tanzania due to the criminalization of, and stigma surrounding, abortion.[53] According to a study of unsafe abortion in Tanzania, "Assessing the magnitude of the problem of unsafe induced abortion and its consequences is one of the least documented reproductive health problems."[54] However, it is estimated that between 20 and 30 percent of all maternal deaths in Tanzania are due to complications from unsafe abortions.[55] Data suggests that 38 percent of admissions with obstetric complications in a hospital in Shinyanga, the second most populated region in Tanzania,[56] were due to unsafe abortions, and 47 percent of the 965 obstetric admissions in 1992 at Muhimbili National Referral Hospital in Dar es Salaam were abortion complications.[57] 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.[58] Moreover, a 2003 country evaluation report estimated that nationally, nearly one-third of all hospitalized cases of unsafe or incomplete abortions are women under 20.[59]

Under the Penal Code, abortion is criminalized with the only explicit exception being to save the life of the pregnant woman,[60] making it one of the most restrictive abortion laws in the world.[61] A woman found guilty of procuring an abortion under Section 151 of the Penal Code can be sentenced to imprisonment of up to seven years; those that perform the procedure, pursuant to Section 150 of the Penal Code, for up to 14 years; and anyone who supplies drugs or instruments to procure abortion, pursuant to Section 152 of the Penal Code, for up to three years.[62] Consequently, women wishing to terminate a pregnancy often resort to unsafe methods that put their lives and health at risk.

Tanzania's abortion law is directly at odds with its international human rights obligations. Tanzania has ratified without reservations the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol), which requires states to "take all appropriate measures to…protect the reproductive rights of women by authorizing medical abortions in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman]."[63] The Maputo Protocol obligates state parties to amend restrictive and punitive abortion laws, and ensure access to safe abortion services. According to a prominent women's right advocate, the intent of the Maputo Protocol was to provide abortion protection to the fullest extent of the law.[64] Yet, despite ratification, the Tanzanian Government has made little effort to domesticate the Protocol and to bring its national law in line with its obligations under this human rights treaty.

Although the government has publicly committed to providing post-abortion care (PAC) for women suffering complications from unsafe abortion and issued guidelines to that effect,[65] PAC is not widely available or accessible.[66] According to the 2006 TSPA, "The

ability to provide care to a woman after an incomplete abortion is vital to prevent any further complications."[67] The availability of the required equipment to provide manual vacuum aspiration or dilatation and curettage (D&C) (a far less favorable treatment) to women after an incomplete abortion is extremely limited in all healthcare facilities (five and eight percent respectively) in Tanzania.[68]

In addition, training on PAC is limited and inadequate. The government has failed to follow through on its 2002 commitment to "scal[e] up comprehensive PAC so as to reduce abortion related maternal mortality and morbidity through training of middle level health service providers such as clinical officers, nurse-midwives . . . [and] to ensure that comprehensive PAC services are available at lower level health facilities."[69] Although PAC is included in medical training for doctors in Tanzania, a 2007 EngenderHealth report found that it is often not included in training of other health staff such as nurses and midwives.[70] The same report shows that PAC services remain largely concentrated in urban areas and district hospitals.[71]

In addition to staff shortages, several other barriers exist in accessing timely and quality post-abortion care, including a lack of government commitment to stock and supply facilities with the necessary equipment, difficulty in obtaining supplies, and over-used manual vacuum aspirators (MVAs) in dire need of replacement.[72] The shortages of necessary equipment, such as MVAs, result in delays and denials of treatment for women needing this emergency service.[73]

3. ACCESS TO COMPREHENSIVE FAMILY PLANNING SERVICES AND INFORMATION

The right to benefit from the advances of scientific research and its applications,[74] which is guaranteed in the Covenant, should be interpreted to include granting women the right to benefit from advances in reproductive health, in part through access to the most effective and safe methods of contraception. The Committee has consistently recognized that lack of access to family planning information and services violates the right to health.[75] This Committee has repeatedly emphasized that low contraceptive prevalence contributes to the rates of unsafe abortion and maternal deaths.[76]

Although Tanzania has seen a gradual and steady increase in contraceptive use and prevalence in the last two decades,[77] only 29 percent of all women are using any method of contraception and only 24 percent are using a modern method.[78] Current contraceptive use varies substantially based on geography and demographics. Currently married urban women are almost 1.5 times more likely to use a contraceptive method than their rural counterparts (46 percent and 31 percent, respectively), and the prevalence increases with a woman's education and wealth quintile.[79] Moreover, women in mainland Tanzania are almost twice as likely as women in Zanzibar to use any method of contraception.[80]

Twenty-five percent of currently married women and over 18 percent of all women have an unmet need for family planning, an increase from the 2004-2005 TDHS.[81] Thirty percent of currently married women report that they wish to stop childbearing altogether,

and a majority of women with at least one child want to either delay their next birth or stop childbearing completely.[82] Over one fourth of births in Tanzania are either mistimed or unwanted,[83] which contributes to the high rates of unsafe abortions and maternal deaths.

Contraceptive prevalence and exposure to family planning messages are significantly higher in urban areas than rural areas across all mediums.[84] Moreover, stock outs of contraceptive methods are a considerable problem, which disproportionately affects certain parts of the country: only nine percent of health facilities in the Southern zone and seven percent of health facilities in the Eastern zone had every method offered available.[85] Only 37 percent of health facilities in the Southern zone had male condoms, despite the fact that nearly seven percent of the population in the Southern zone is HIV positive.[86]

Many women could avoid unwanted pregnancies with use of emergency contraception (EC), a safe and effective means of preventing pregnancy following unprotected sex, especially when pregnancy results from a stigmatizing and traumatizing event such as rape or incest. WHO considers EC to be a safe, convenient, and effective method of modern contraception,[87] and it has been safely used on the global market for 30 years.[88] However, although EC is included in family planning guidelines in Tanzania,[89] it cannot be obtained from public clinics or hospitals.[90] In fact, in 2007, USAID concluded that EC was not accessible in Tanzania.[91] In addition, evidence from the 2010 TDHS suggests that very few people have knowledge of EC (less than 12 percent of men and women),[92] and only 0.2 percent of women reported ever using EC in 2004[93] (statistics on EC use were not included in the 2010 TDHS).

4. DISCRIMINATION AGAINST WOMEN AND GIRLS

The obligation to protect, respect, and fulfill the right to health without discrimination lies at the heart of the Covenant. This Committee has characterized the duty to prevent discrimination in the exercise of the right to health and access to healthcare as a "core obligation,"[94] and noted that "States have a special obligation . . . to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the rights to health."[95] General Comment 14 reiterates state obligations to fulfill "the rights of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups,"[96] including women.

This Committee has also imposed upon states the obligation to promote equality and non-discrimination through the "elimination of prejudices, customary and all other practices that perpetuate the notion of inferiority or superiority of either of the sexes, and stereotyped roles for men and women."[97] The Human Rights Committee has further emphasized this protection, noting that certain historical, cultural, and religious traditions and practices[98] obstruct the equal enjoyment of rights and has requested states to take measures to eliminate or modify such practices[99] so they may no longer be used as a vehicle for discrimination against women and girls.

The 2000 amendments to the Tanzanian Constitution explicitly prohibit discrimination on the basis of sex;[100] however, the country's legislation has not effectively absorbed this principle.[101] Discrimination against HIV-positive women and adolescent girls in Tanzania is of particular concern.

Discrimination against HIV-Positive Women

In 2007, the Government of Tanzania launched its second National Multi-Sectoral Strategic Framework on HIV and AIDS, and in 2008, it enacted the HIV and AIDS (Prevention and Control) Act (2008 Act), which, among other things, protects people living with HIV and AIDS from discrimination and stigmatization, and obligates the government and employers to advocate against such.[102] Despite this, the Tanzania Commission for AIDS (TACAIDS) acknowledges that "stigma and discrimination against people living with HIV/AIDS are quite common."[103]

According to a 2007 USAID evaluation regarding knowledge, attitudes and practices of healthcare providers towards HIV-positive patients in Tanzania, nearly half of healthcare providers reported discriminatory treatment, including lack of confidentiality, lack of patient consent in testing or disclosure, selective use of universal precautions, isolation of HIV positive patients, sub-standard treatment, financial discrimination, and active or passive denial of services.[104] Similarly, in a 2008 Population Council report, 63 percent of Tanzanian women reported experiencing stigma and discrimination regarding their HIV status, and 59 percent of healthcare providers observed such practices among their peers.[105]

Despite a number of polices in place to address the growing HIV/AIDS epidemic, a 2010 United Nations General Assembly Special Session (UNGASS) report on Tanzania suggests that policy implementation is hindered by systemic inadequacies.[106] Moreover, inadequate training and knowledge of the HIV and AIDS Act, and failure to harmonize the act with other legislation leads to ineffective enforcement.[107] Tanzanian laws criminalizing the behavior of high-risk groups such as sex workers or men who have sex with men are contradictory to the 2008 Act, as it makes it impossible for these already marginalized groups to access care and treatment.[108]

While the 2008 Act prohibits discrimination, it undercuts this position by criminalizing intentional transmission of HIV, punishable by a prison term of up to ten years,[109] and requiring immediate disclosure of HIV positive status to a spouse or sexual partner.[110] Section 47 of the 2008 Act could be interpreted to include criminalization of vertical HIV transmission in Tanzania,[111] and fear of prosecution may prevent or discourage many women from seeking appropriate prenatal care to minimize the risk of transmission during pregnancy. Criticisms of laws that criminalize transmission of HIV are numerous, and these laws, such as the 2008 Act in Tanzania, fail to address the complexities involved in disclosure of HIV status and increase stigma and discrimination.[112] Ample evidence exists to suggest that such laws do little to stem the spread of HIV or foster safe attitudes toward sex, and in fact discourage voluntary testing, treatment, use of support services, and disclosure.[113]

Moreover, women are at far greater risk of prosecution under these laws. In Africa generally, and Tanzania specifically, women are more likely to know their HIV status than men, in part because it is assumed that they are offered HIV counseling and testing as part of ante-natal care.[114] Because women are more likely to know their serostatus, they are more likely to be accused by their spouses or partners of being the initial transmitter and introducing HIV to the relationship.[115] Studies have shown that disclosure of HIV status, as required by Section 21(1)(a) of the 2008 Act, places women at greater risk for abuse and abandonment.[116]

Further, a woman seeking voluntary counseling and treatment (VCT) faces barriers in access, treatment, and care. Although anti-retroviral treatment (ARV) is supposedly free in Tanzania, a 2006 study by the International Community of Women Living with HIV/AIDS indicates that women encounter charges and bribes levied for ARVs and unavailability of treatment.[117] One woman reported that "One of the basic condition[s] that face us, mostly women living with HIV, is paying for ARVs instead of getting them free, and the medication and other things you need are not always available when you go to the clinic or hospital."[118] In addition, women report pressure from their spouses or sexual partners to share their ARVs, and often face violence if they refuse or are reluctant to do so.[119] In addition, despite the government's commitment to reduce vertical HIV transmission, only 53 percent of women are aware of techniques in prevention of vertical transmission,[120] and none of the women in the ICW study had accessed or been able to access these services, or had even received information on such services.[121]

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 percent in 2008) compared to men (4.7 percent in 2008).[122] Women emerge as one of two groups most greatly affected by the HIV/AIDS epidemic in Tanzania,[123] due to a host of economic, cultural, and social factors.[124] Young girls represent a large proportion of new HIV cases, because the culture of general discrimination denies girls human rights and exposes them to adult roles and responsibilities at an early age, making them vulnerable to exploitation and abuse through early and coercive marriage, commercial sex work, and domestic work.[125]

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

Women, particularly adolescents and unmarried women, in Tanzania seeking contraceptive services often face discrimination. In 1994, the Family Planning Unit of the Ministry of Health and Social Welfare instituted the National Policy Guidelines and Standards for Family Planning Services and Training which state that "all males and females of reproductive age, including adolescents irrespective of their parity and marital status, shall have the right of access to family planning information, education, and services."[126] The commitment to provide contraceptive and family planning services without discrimination and bias is reiterated in the 2008 National Roadmap and Strategic Plan for the Reduction of Maternal, Newborn and Child Deaths. Providers, however, continue to limit women's use of services.[127]

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. According to a study by Guttmacher, in 2000, between 79 and 81 percent of medical aides, midwives, maternal and child health aides and auxiliary staff (medical providers most commonly found in rural areas) reported imposing an age restriction for birth control pills, and more than one third of providers reported an age restriction for condoms.[128] The age minimum most often reported was 14-15 years old, which prevents young, sexually active women from accessing nearly all forms of contraception, increasing their likelihood of unwanted, premarital pregnancies.[129]

In addition, 20 percent of providers reported imposing restrictions based on a woman's marital status, preventing a large population of sexually active, unmarried women from protecting themselves against unwanted pregnancies.[130] The most conservative staff, and the most likely to impose restrictions without a medical basis, are often found in rural areas, and are more likely to supply contraceptive methods to women of a certain age, married women, and women with an average of 2.5 children.[131] Although government policies seem to prohibit such discrimination,[132] such policies are clearly inadequately enforced, leaving service providers wide discretion in supplying contraception with devastating consequences for women.

Adolescents not only face discrimination in access to services but also to sexual and reproductive health-related information. Nearly 60 percent of adolescents in Tanzania have sex before the age of 18;[133] yet, adolescents receive limited information about contraceptives. As a result, according to the 2010 TDHS, less than 11 percent of women age 15-19 use any form of contraception.[134] Early sexual activity and lack of access to contraception exposes adolescent girls to a myriad of reproductive health risks including unwanted pregnancies, unsafe abortion, difficult pregnancies resulting in complications such as obstetric fistula or maternal death, and exposure to HIV/AIDS and other STIs. Tanzania has one of the highest adolescent pregnancy rates in the world, which not only exposes young women and girls to the aforementioned health risks, but increases the likelihood that they will drop out of school. The 2006-2010 Basic Education Statistics in Tanzania suggest that nearly 8,000 girls drop out of school as a result of pregnancy every year;[135] there is no data indicating that girls return and complete their education.

Young people often lack the knowledge and capacity to negotiate safe sex, and are therefore more likely to engage in unplanned and unprotected sex.[136] In its 2008 concluding observations on Tanzania, the CEDAW Committee recommended that "sex education be widely promoted and targeted at adolescent girls and boys, with special attention to the prevention of early pregnancy and the control of sexually transmitted infections."[137] Tanzanian youth have consistently faced barriers in accessing reproductive health and HIV/AIDS services because facilities are largely geared toward adults, adolescents face stigmatization and discrimination in accessing such services, and adolescents have limited money for, transportation to, and knowledge of service facilities.[138] In addition, public opinion largely stigmatizes adolescent sexuality, and

opposition exists to promoting health services for adolescents for fear that it condones and promotes promiscuity.[139] The United Nations Population Fund (UNFPA), however, reports that numerous studies have concluded that access to family planning information and services does not lead to increased sexual activity, and that "Young people need comprehensive information and access to services. They have the right to privacy, confidentiality and respect."[140]

As a result, and with few exceptions to the contrary, the Tanzanian Government has largely left the promotion of youth-friendly health services to nongovernmental organizations, which have limited resources and reach and cannot adequately promote systemic changes.[141]

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

Rather than providing girls with the information and contraception they need to prevent pregnancy and preventing the high incidence of sexual violence in schools,[142] many schools in Tanzania have instituted a practice of mandatory pregnancy testing, forcing some 8,000 girls to drop out of school each year because they are found pregnant.[143] Although this issue has not been comprehensively studied, preliminary research undertaken by the Center for Reproductive Rights in conjunction with Yale Law School's Lowenstein International Human Rights Law Clinic indicates that this practice of testing and expulsion is prevalent, widely accepted, and significantly supported by educators, government officials, and NGOs.[144]

Our preliminary research suggests that mandatory pregnancy testing may begin as early as 11 years of age, but is ubiquitous by secondary school, between the ages of 14 and 18.[145] 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.[146] 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.[147]

The results of a positive pregnancy test almost universally end in expulsion of the girl from school.[148] Many educators and administrators believe expulsion is required by law or policy; however, no legal basis or policy document exists that requires testing and expulsion of pregnant school girls.[149]

Forcing schoolgirls to undergo pregnancy testing and expelling those who are found to be pregnant violates a wide range of girls' human rights, including their rights to health, education and privacy. This Committee, in General Comment 14 has stated that the right to health encompasses freedoms and entitlements including "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation."[150] Again in General Comment 14, this committee states that "the realization of the right to health of adolescents is dependent on the development of youth-

friendly health care, which respects confidentiality and privacy…"[151] The practice of mandatory pregnancy testing in schools directly violates these rights.

Almost universally, mandatory pregnancy tests of school girls in Tanzania are done without prior announcement or warning to prevent girls from circumventing the policy,[152] and do not require the informed consent of the child or her parents.[153] 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."[154] 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.

Mandatory 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.[155] The practice also enjoys almost universal government support. In fact, a high level official at the Ministry of Education believes that mandatory pregnancy testing of girls has no downside, and stated matter-of-factly that pregnant girls should simply not be in school.[156] 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;[157] however, when pregnant girls are expelled from school, they are rarely provided referrals for medical or social services and are "left to find" ANC "on their own."[158] It is evident that mandatory pregnancy testing is utilized to discipline young girls rather that protect their health and future, and its widespread acceptance indicates a pervasive stigma against teenage pregnancy and discrimination against teenage girls.[159]

This Committee has also emphasized the importance of education, stating that "Education has a vital role in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and controlling population growth."[160] As the Committee notes, the two articles in the Covenant regarding the right to education (Articles 13 and 14) are the most extensive and comprehensive provisions regarding the right to education in international human rights law.[161] The Committee further notes that non-discrimination in education means that "education must be accessible to all, especially the most vulnerable groups, in law and fact, without discrimination on any of the prohibited grounds,"[162] including policies that lead to de facto discrimination.[163] The policy of mandatory pregnancy testing and expulsion of pregnant school girls is such a discriminatory policy.

The practice of testing and expelling pregnant school girls undermines the goals of a number of laws and policies intended to improve girls' access to education. The Ministry of Education and Vocational Training has implemented a number of girls' education initiatives to "enhance educational opportunity for girls and women."[164] The Education and Training Regulations of 1995, for example, create a broad policy goal of "increasing access to education, by focusing on the equity issue with respect to women"[165] and acknowledges that the slow rate of growth in women's access to education and subsequent achievement is due largely to high dropout rates of pregnant girls.[166]

Further, articles 5.1 and 5.2 of the Law of the Child Act of 2009 specifically forbid gender-based discrimination,[167] but testing and expelling pregnant school girls is inherently discriminatory by nature and in application. Boys who impregnate school girls are rarely discovered and, if they are, are not regularly expelled.[168] Girls, however, are singled out for blame and punishment because only girls will show physical evidence of pregnancy (either visually or through a positive urine test result). Moreover, lack of a standardized policy or guideline means that testing and expulsion of pregnant school girls varies in severity and enforcement, and is often left to the discretion of individual educators and administrators. Finally, the policy of testing and expulsion of girls is discriminatory because it punishes a status that only female students can have.

Expulsion of pregnant school girls exposes them to a myriad of risks. At best, expulsion interferes with their education (if girls are allowed to return to school, which is uncommon), and at worst, it terminates their education. Girls without education or training are more likely to enter into high-risk practices, including sex trafficking and sex work, and are more likely to be abused or exploited.[169] In addition, the practice perpetuates the stigma of teenage pregnancy and the idea that the presence of pregnant schoolgirls will contaminate "innocent girls" and cause a "domino effect."[170] Moreover, although many educators and administrators believe that mandatory pregnancy testing decreases the risk of unsafe abortion by early detection, the heightened stigma associated with teenage pregnancy and the harsh disciplinary outcome likely leads to greater numbers of girls seeking unsafe and clandestine abortions, [171] not only to protect themselves from shame and discrimination, but also to protect their educational futures.

Although there has been talk by the government of introducing a re-entry policy to allow girls to return to school after giving birth, it is unclear what progress, if any, the government has made in developing and implementing such a policy.[172] Currently, Tanzania has no national policy or law in place to facilitate and guarantee girls' return to school and right to education following childbirth.

Early Marriage

The Covenant requires that "marriage must be entered into with the free consent of the intending spouses"[173] and the Committee seeks to ensure "the legal age of marriage for men and women should be the same, and boys and girls should be protected equally from practices that promote child marriage, marriage by proxy, or coercion."[174] The Committee has emphasized the "need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage."[175]

Child marriage in Tanzania is high (approximately 40 percent of girls are married by the age of 18),[176] despite the fact that Tanzania has signed and ratified a number of international treaties and instruments[177], many of which contain clear definitions that a "child" is a person under the age of 18, and "child marriage" is a marriage of a child below 18 years of age.[178]

The Law of Marriage Act (LMA) legalizes child marriage, allowing boys to marry at 18, and girls to marry at 15 or 14, with the court's approval, [179] which is, on its face, a discriminatory piece of legislation. TAWLA, in a 2003 review of gender discriminatory laws, specifically recommended that the government reform the LMA to address the clear discrimination against girls and to raise the age of marriage for girls to 18.[180] Both the 2006 Committee on the Rights of the Child and 2008 CEDAW Committee concluding observations on Tanzania recommend that Tanzania adopt one minimum age of marriage (18 years old for both boys and girls) in line with internationally acceptable standards.[181] The age of marriage for girls was first tabled for debate in the National Assembly in Tanzania in 2009, [182] but progress continues to be slow. To date, the government has done nothing to amend this discriminatory piece of legislation.

Paradoxically, under Tanzanian law, a girl of 15 can enter into a marriage contract, but cannot vote, and her age may prevent her from entering into other contracts. For a girl to marry under the age of 18 requires the consent of her parents; however, many parents, particularly in poor, rural areas, are anxious to marry off their young daughters for the bride price.[183] In some areas, poverty and tradition result in girls as young as 11 or 12 being married to men often twice their age.[184] Such marriages would be clearly voidable pursuant to the LMA,[185] and sexual relations between a husband and his wife under 15 years of age, with or without her consent, are punishable by law.[186] However, these avenues that appear to safeguard girls are unenforced and are not heavily pursued because of debilitating court costs, lack of knowledge about the law, and corruption within the legal system that often results in cases being resolved in favor of the party able to pay bribes.[187]

Cultural, religious and traditional beliefs also hinder eradication of child marriage in Tanzania. With immense importance placed on family and childbearing, succession practices often force young girls into "marriages" with older women who are either incapable of childbearing or have only girl children.[188] The young girl is then forced into sexual relations with a male relative of the older woman; the children resulting from that union are the property of the older woman, not the young girl.[189] Because the young girl was purchased with a significant bride price solely for the duty of childbearing, her failure or inability to do so has devastating consequences including hard labor, abuse, and abandonment.[190]

Early marriage has devastating physical, economic, social, and psychological consequences for young girls. The age difference between child brides and their spouses is often significant, young girls lack the skills to negotiate safe sex, and older men, who have often been sexually active for years, potentially bring HIV/AIDS and other STIs into the marriage.[191] In addition, contraceptive use among married youth is low, because high bride prices place immense pressure on young girls to begin childbearing.[192] Young adolescent girls experience significantly more pregnancy-related complications than adult women; USAID estimates that girls younger than 15 are five times more likely to die in childbirth than women in their 20's.[193] Children conceived in these marriages are also at greater risk of death; mortality rates are 73 percent higher for infants born to mothers under 20.[194] Child brides are thrust into an immense role at a very young age and are

often seen as property paid for by their husbands. As a result, physical abuse is common, and the instability of these marriages often leads to separation or divorce, leaving a young mother, with limited or no education, to support herself and her children.[195]

Child marriage also devastates a young girl's economic and social opportunities. In Tanzania, expulsion of pregnant school girls is permissible, while expulsion upon marriage is policy.[196] Because young brides are unlikely to be permitted to return to school, their intellectual growth is stunted, and they are often isolated from their peers.[197] Child marriage often compromises a young girl's future and the future of her children, contributing to cycles of poverty, illness, and lack of education,[198] and correlating closely to the failure to achieve nearly every MDG.[199]

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

1. How is the government implementing its National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 (Strategic Plan), and what resources is the government applying to ensure the Strategic Plan's success? Has the government examined why the policies and programs introduced thus far have not led to a significant decline in maternal deaths? What other concrete measures does the government propose to reduce deaths due to pregnancy and childbirth-related complications? Since the Strategic Plan's introduction in 2008, can the government point to any specific results reached toward the goal of reducing the maternal mortality rate?

2. What steps are being taken to ensure that healthcare facilities are adequately equipped and personnel adequately trained to provide quality, hygienic, maternal healthcare? What is the government doing to improve emergency obstetric care, and access to quality and timely obstetric care for the poor and rural population?

3. What is the government doing to address the high rate of teenage pregnancy and subsequent risk to young girls' health and educational attainment?

4. What measures is the government taking to ensure access to safe abortion services for women? What steps is the government taking to remove abortion from the penal code and to harmonize its abortion law with its obligations under international and regional treaties, such as the Maputo Protocol? Specifically, what efforts is the government making to domesticate the Maputo Protocol? What is the government doing to ensure access to timely, quality and affordable post-abortion care and reproductive health counseling? What steps are being taken to ensure safe, legal abortions can be obtained in healthcare facilities in accordance with the existing abortion law and guidelines?

5. How will the government improve access to family planning services and information to address the high unmet need for contraception in Tanzania? What steps has the government taken to improve access to contraceptives, and to ensure that women and adolescents receive comprehensive and accurate information about contraceptives, without discrimination on the basis of age or marital status? What steps is the government taking to uphold its stated commitment to non-discriminatory access to contraceptives? How will the government educate youth about contraceptive methods, particularly as they relate to reduction of adolescent pregnancy and transmission of STIs, especially HIV/AIDS?

6. In light of the high HIV prevalence rate among women and girls in Tanzania, what steps are being taken to address the reproductive health and family planning needs of HIV-positive women and girls? What is the government doing to address the rights violations and discrimination experienced by HIV-positive women and girls around counseling, testing, confidentiality, and treatment? What is the government doing to empower women and girls to negotiate safer sex, and to protect them from exploitation and abuse, in and out of school, work, and in high-risk behaviors such as sex trafficking and sex work?

7. What steps is the government taking to end the practice of mandatory pregnancy testing and expulsion of pregnant schoolgirls? What is the current status of the government's proposed re-entry policy, which would allow girls to return to school after giving birth? When will it be finalized and implemented?

8. What steps are being taken to address the elevated rates of early marriage for girls in Tanzania? Per the government's report to this committee, what progress has been made in amending the Law of Marriage Act to ensure that both girls and boys cannot marry before the age of 18, in accordance with international treaties to which Tanzania is a party?

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

Sincerely,

Elisa Slattery
Regional Director, Africa Program
Center for Reproductive Rights

Annmarie Mavenjina
Executive Director
Tanzanian Women Lawyer's Association

[1] 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) [hereinafter ICESCR].
[2] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14, The Right to the Highest Attainable Standard of Health*, (22nd Sess., 2000), para. 43(a) U.N. Doc. E/C.12/2000/4 (2000) [hereinafter ESCR Committee, *General Comment No. 14*].
[3] ICESCR, *supra* note 1, arts. 10(2), 15(1)(b).
[4] *Id.* art. 12(1).
[5] ESCR Committee, *General Comment No. 14*, *supra* note 2, para. 8.
[6] *Id.* para. 14.
[7] *Id.* para. 21.
[8] WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2008, 4 (2010), *available at* http://www.who.int/reproductivehealth/publications/monitoring/9789241500265/en/index.html [hereinafter TRENDS IN MATERNAL MORTALITY].
[9] *Id.* at 17.
[10] United Nations Children's Fund (UNICEF), *Tanzania, United Republic of: Statistics*, http://www.unicef.org/infobycountry/tanzania_statistics.html#80 (last visited Oct. 27, 2011).
[11] NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., TANZANIA DEMOGRAPHIC AND HEALTH SURVEY 2010, 265 (2011), *available at* http://www.nbs.go.tz/pdf/2010TDHS.pdf [hereinafter 2010 TDHS].
[12] TRENDS IN MATERNAL MORTALITY, *supra* note 8, at 26.
[13] 2010 TDHS, *supra* note 11, at 265.
[14] United Nations Development Programme (UNDP) in Tanzania, *Millennium Development Goals, Goal 5: Improve Maternal Health*, http://www.tz.undp.org/mdgs_goal5.html (last visited Oct. 27, 2011).
[15] ESCR Committee, *General Comment No. 14*, *supra* note 2, para. 52.
[16] The WHO recommends that a pregnant woman have at least four antenatal care (ANC) visits, allowing for adequate time to assess risk factors and determine potential obstetric complications. While 96 percent of women who gave birth in the five years preceding the survey received ANC from a skilled provider at least once, only 15 percent made their first ANC visit before the fourth month of pregnancy, and nearly one-third did not seek ANC until their sixth month of pregnancy. Moreover, only 43 percent made the recommended four or more visits, a sharp decline from the 2004-2005 TDHS (62 percent). 2010 TDHS, *supra* note 11, at 127, 129. Further, those receiving ANC may not be receiving all the necessary services associated with quality antenatal care. Although nearly 82 percent of facilities offer ANC, the lack of infrastructure and resources for ANC examination make it "impossible for most facilities to offer pregnant women all required ANC services and supplies." For example, only 30 percent of facilities offering ANC have all items necessary for infection control, and largely lack running water and disinfecting solution (available in only 48 and 66 percent of facilities respectively). Only seven percent of facilities have all items needed for physical examinations. The 2006 Tanzania Service Provision Assessment Survey (TSPA) estimates that "less than half of facilities have all essential equipment and supplies for basic ANC…, which implies that pregnant women do not receive all required ANC services and supplies at most facilities." NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., TANZANIA SERVICE PROVISION ASSESSMENT SURVEY 2006, 115, 117-119 (2007), *available at* http://www.measuredhs.com/pubs/pdf/SPA12/SPA12.pdf [hereinafter 2006 TSPA].
[17] 2010 TDHS, *supra* note 11, at 136.
[18] UNITED REPUBLIC OF TANZANIA, MILLENNIUM DEVELOPMENT GOALS REPORT: MID-WAY EVALUATION 2000-2008, iii, 15, *available at* http://www.tz.undp.org/docs/MDGprogressreport.pdf [hereinafter MDG REPORT]; *see also* MINISTRY OF HEALTH, REPRODUCTIVE AND CHILD HEALTH UNIT (TANZ.), TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY PRELIMINARY FINDINGS (1999).
[19] 2010 TDHS, *supra* note 11, at 136.
[20] *Id.* at 134.
[21] *Id.* at 135.
[22] 2006 TSPA, *supra* note 16, at 137.
[23] *Id.* at 147.

[24] *Id.* at 147, 149; *see also* UNICEF ET AL., GUIDELINES FOR MONITORING THE AVAILABILITY AND USE OF OBSTETRIC SERVICES, 27 (1997), *available at* http://www.childinfo.org/files/maternal_mortality_finalgui.pdf.
[25] 2006 TSPA, *supra* note 16, at 149. In addition, timely provision of post-natal care is critical for the health and survival of both mother and child. However, according to the 2010 TDHS, only 31 percent of women are examined within the two critical days following delivery, and nearly 65 percent of women did not receive a postnatal checkup. 2010 TDHS, *supra* note 11, at 138.
[26] Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations*: *United Republic of Tanzania*, para. 137, U.N. Doc. CEDAW/C/TZA/CO/6 (2008) [hereinafter CEDAW Committee, *Concluding Observations* (2008)].
[27] 2010 TDHS, *supra* note 11, at 138.
[28] *Id.* at 134.
[29] *Id.* at 136.
[30] *Id.* at 134-135.
[31] *Id.* at 141.
[32] *Id.*
[33] Over 24 percent of women reported "getting money for treatment" as a problem in accessing healthcare. *Id.*
[34] Government of United Republic of Tanzania, *Combined initial, second and third periodic reports submitted by States parties under articles 16 and 17 of International Covenant on Economic, Social and Cultural Rights: United Republic of Tanzania*, para. 112, U.N. Doc. E/C.12/TZA/1-3 (2011) [hereinafter Tanzania Government Report (2011)].
[35] 2006 TSPA, *supra* note 16, at 123.
[36] MDG Report, *supra* note 18, at iii.
[37] 2010 TDHS, *supra* note 11, at 141.
[38] Committee on the Rights of the Child, *Concluding Observations*: *United Republic of Tanzania*, para. 45(b), U.N. Doc. CRC/C/TZA/CO/2 (2006) [hereinafter Committee on the Rights of the Child, *Concluding Observations* (2006)].
[39] MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZ.), NATIONAL ROAD MAP STRATEGIC PLAN TO ACCELERATE REDUCTION OF MATERNAL, NEWBORN AND CHILD DEATHS IN TANZANIA 2008-2015, 16 (2008), *available at* http://www.who.int/pmnch/countries/tanzaniamapstrategic.pdf [hereinafter STRATEGIC PLAN].
[40] Frank Kimboy, *Govt Promises Health Budget Boost*, THE CITIZEN, http://allafrica.com/stories/201101250117.html (last visited Oct. 27, 2011).
[41] Hon. Mustafa Haidi Mkulo, Minister of Finance, Speech by the Minister for Finance introduction to the National Assembly: The Estimates of Government Revenue and Expenditure for the Fiscal Year 2011/2012 (June 9, 2011), *available at* http://www.mof.go.tz/mofdocs/budget/speech/Budget%202011%20english.pdf.
[42] STRATEGIC PLAN, *supra* note 39, at 13.
[43] 2010 TDHS, *supra* note 11, at 64.
[44] *Id.* at 65.
[45] WHO & UNITED NATIONS POPULATION FUND (UNFPA), PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 5 (2006), *available at* http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf.
[46] *Id.* at 13-15.
[47] *Id.* at 11.
[48] 2010 TDHS, *supra* note 11, at 65.
[49] *Id.*
[50] *Id.* at 64.
[51] ESCR Committee, *General Comment No. 14*, *supra* note 2, para. 21.
[52] *Abortion remains a crime in Tanzania*, DAILY NEWS ONLINE EDITION, http://www.dailynews.co.tz/home/?n=14901 (last visited Oct. 27, 2011); Denise Grady, *The Deadly Toll of Abortion by Amateurs*, NY TIMES, http://www.nytimes.com/2009/06/02/health/02abort.html.
[53] NEIL PRICE ET AL., ADDRESSING THE REPRODUCTIVE HEALTH RIGHTS AND NEEDS OF YOUNG PEOPLE SINCE ICPD: THE CONTRIBUTION OF UNFPA AND IPPF, TANZANIA COUNTRY EVALUATION REPORT 24 (2003) [hereinafter TANZANIA COUNTRY EVALUATION REPORT].

[54] Vibeke Rasch & Rose Kipingili, *Unsafe abortion in urban and rural Tanzania: method, provider and consequences*, J.L OF TROPICAL MED. & INT'L HLTH. 1132 (2009).
[55] EngenderHealth, *Miriam's Story: When Care Comes Not a Minute Too Soon*, http://www.engenderhealth.org/mdgfive/story-miriam.html (last visited Oct. 27, 2011); *see also* Abortion Remains a Crime in Tanzania, *supra* note 52.
[56] NATIONAL BUREAU OF STATISTICS & SHINYANGA REGIONAL COMMISSIONER'S OFFICE, SHINYANGA REGIONAL SOCIO-ECONOMIC PROFILE (2nd ed., 2007), *available at* http://www.tanzania.go.tz/regions/SHINYANGA.pdf.
[57] TANZANIA COUNTRY EVALUATION REPORT, *supra* note 53, at 24-25.
[58] Grady, *supra* note 52. In 2010, the Globe and Mail reported that unsafe abortion continues to account for nearly one fifth of all maternal deaths in Tanzania. Geoffrey York, *Africa's deadly backroom abortions*, THE GLOBE & MAIL (2010), http://www.theglobeandmail.com/news/world/g8-g20/africa/africas-deadly-backroom-abortions/article1564162/page1/ (last visited Oct. 31, 2010).
[59] TANZANIA COUNTRY EVALUATION REPORT, *supra* note 53 at 25.
[60] PENAL CODE, secs. 150, 151, 219, 230 (Tanz.) [hereinafter PENAL CODE].
[61] CENTER FOR REPRODUCTIVE RIGHTS, *Factsheet: The World's Abortion Laws* 2 (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/pub_fac_abortionlaws2008.pdf.
[62] PENAL CODE, *supra* note 60, secs. 150, 151, 152.
[63] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14(2)(c) CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) [hereinafter].
[64] VERO MATOVU, *Unwanted Pregnancies, Unwanted Abortions,* WOMEN'S GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS NEWSLETTER: RECOMMITTING TO THE STRUGGLE FOR SAFE, LEGAL ABORTION 8(2010), *available at* http://www.wgnrr.org/sites/default/files/NL94_En.pdf.
[65] STRATEGIC PLAN, *supra* note 39; *see also* MINISTRY OF HEALTH (TANZ.), NATIONAL PACKAGE OF ESSENTIAL HEALTH INTERVENTIONS IN TANZANIA (2000), *available at* http://www.moh.go.tz/documents/national_package_essential_health.pdf.
[66] The Strategic Plan acknowledges that PAC can significantly reduce the number of maternal deaths; however, very few facilities in Tanzania (five percent) are equipped to handle such care. STRATEGIC PLAN, *supra* note 39, 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.
[67] 2006 TSPA, *supra* note 16, at 141.
[68] *Id.* at 323.
[69] MINISTRY OF HEALTH, POSTABORTION CARE CLINICAL SKILLS CURRICULUM TRAINER'S GUIDE 1 (2002).
[70] MONICA WANJIRU ET AL., ASSESSING THE FEASIBILITY, ACCEPTABILITY AND COST OF INTRODUCING POSTABORTION CARE IN HEALTH CENTRES AND DISPENSARIES IN RURAL TANZANIA 3 (2007), *available at* http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Tanzania_PAC.pdf.
[71] *Id.* at 1-3.
[72] *Id.* at 6-7.
[73] *Id*. at 7.
[74] ICESCR, *supra* note 1, art. 15(1)(b).
[75] CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW, BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORLD OF UN TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS, 117 (2002). This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, ESCR Committee, *Concluding Observations: Armenia*, para. 15, U.N. Doc. E/C.12/1/Add.39 (1999); *Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); *Dominican Republic*, para. 15, U.N. Doc. E/C.12/1/Add.16 (1999); *Dominican Republic*, para. 22, U.N. Doc. E/C.12/Add.6 (1996); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Paraguay*, para. 16, U.N. Doc. E/C.12/1/Add.1 (1996); Poland para. 12, U.N. Doc. E/C.12/1/Add.26 (1998); *Saint Vincent and the Grenadines*, para. 12, U.N. Doc. E/C.12/1/Add.21 (1997).
[76] ESCR Committee, *Concluding observations: Dominican Republic*, para. 29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *see also* ESCR Committee, *Concluding observations: Philippines,* para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Nicaragua,* para. 26, U.N. Doc. E/C.12/NIC/CO/4 (2008);

Azerbaijan, para. 30, U.N. Doc. E/C.12/1/Add.104 (2004); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998).
[77] In 1991-1992, only ten percent of currently married women used any form of contraception. That number has steadily increased and in 2010, 34 percent of currently married women use any form of contraception. *See* 2010 TDHS, *supra* note 11, at 70.
[78] *Id.* at 68-69.
[79] *Id.* at 70.
[80] *Id.*
[81] *Id.* at 110; *see also* NATIONAL BUREAU OF STATISTICS (TANZ.) ET AL., TANZANIA DEMOGRAPHIC AND HEALTH SURVEY 2004-2005, 114-115 (2005), *available at* http://www.measuredhs.com/pubs/pdf/FR173/FR173-TZ04-05.pdf [hereinafter 2004 TDHS].
[82] 2010 TDHS, *supra* note 11, at 108.
[83] *Id.* at 115.
[84] 2010 TDHS, *supra* note 11, at 77.
[85] 2006 TSPA, *supra* note 16, at 95.
[86] *Id.*
[87] WHO, EMERGENCY CONTRACEPTION: A GUIDE FOR SERVICE DELIVERY, at 7, WHO/FRH/FPP/98.19 (1998).
[88] International Consortium for Emergency Contraception, *What is Emergency Contraception*, http://www.cecinfo.org/what/index.htm (last visited Oct. 27, 2011).
[89] *See e.g.*, MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZANIA), NATIONAL GUIDELINES FOR MANAGEMENT OF SEXUALLY TRANSMITTED AND REPRODUCTIVE TRACT INFECTIONS, 59 (2007), *available at* http://www.jica.go.jp/project/tanzania/001/materials/pdf/sti_01.pdf; *see also* International Consortium for Emergency Contraception, *EC Status and Availability: Tanzania*, http://www.cecinfo.org/database/pill/countrieDisplay.php?countdist=Tanzania (last visited Oct. 27, 2011) [hereinafter *EC Status and Availability*].
[90] *EC Status and Availability*, *supra* note 89.
[91] *See* USAID, *Tanzania: National Laws Regarding Gender, Reproductive Health and Family Planning*, http://www.esdproj.org/site/PageServer?pagename=LawsTanzania (last visited Oct. 27, 2011); *See also* USAID, *Tanzania: Laws Regarding Gender, Reproductive Health and Family Planning*, http://www.esdproj.org/site/DocServer/TANZANIA_-._Legal_Summary.pdf?docID=3759 (last visited Oct. 27, 2011).
[92] 2010 TDHS, *supra* note 11, at 68.
[93] 2004 TDHS, *supra* note 81, at 72.
[94] ESCR Committee, *General Comment No. 14*, *supra* note 2, para. 43(a).
[95] *Id.* para. 19.
[96] *Id.* para. 43(a).
[97] *Id.* para. 19.
[98] Human Rights Committee, *General Comment No. 28, Equality of Rights Between Men and Women*, para. 5, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000).
[99] *Id.* paras. 4, 5.
[100] *See* CONSTITUTION OF THE UNITED REPUBLIC OF TANZANIA (*amended in* 2000), art. 13 (5).
[101] Organisation for Economic Cooperation and Development, *Social Institutions and Gender Index: Tanzania*, http://genderindex.org/country/tanzania (last visited Oct. 27, 2011).
[102] HIV and AIDS (Prevention and Control) Act 2008, Part VII (2008) (Tanz.) [hereinafter Prevention and Control Act]; *see also* Avert, *HIV and AIDS in Tanzania*, http://www.avert.org/hiv-aids-tanzania.htm (last visited Oct. 27, 2011).
[103] Tanzania National Website, *HIV/AIDS in Tanzania*, http://www.tanzania.go.tz/hiv_aids.html (last visited Oct. 27, 2011) [hereinafter Tanzania National Website].
[104] USAID, EVALUATION OF KNOWLEDGE, ATTITUDES, AND PRACTICES OF HEALTH CARE PROVIDERS TOWARD HIV-POSITIVE PATIENTS IN TANZANIA 14 (2007), *available at* http://www.hciproject.org/sites/default/files/Tanzaniastigma.pdf.
[105] LAURA NYBLADE ET AL., *Moving forward: Tackling stigma in a Tanzanian community*, POPULATION COUNCIL HORIZONS FINAL REPORT 5 (2008).

[106] Lower level government practitioners lack a sense of policy ownership, policy guidelines and expectations are not widely distributed and are inadequately translated and disseminated, and the policy frameworks, while seemingly multi-structural and comprehensive, in reality concentrate the government response only to the Ministry of Health and TACAIDS. UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION, UNGASS 2010 PROGRESS REPORTING: TANZANIA MAINLAND 15 (2010) [hereinafter UNGASS Report].
[107] Avert, *supra* note 102.
[108] *Id.*
[109] Prevention and Control Act, *supra* note 102, para. 47.
[110] *Id.* para. 21(1)(a).
[111] *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); Geoffrey York, *HIV+ women in Africa sterilized, stigmatized*, THE GLOBE & MAIL, June 14, 2009, http://www.theglobeandmail.com/news/world/sterilized-stigmatized/article1181722/ (last visited Oct. 27, 2011).
[112] Avert, *Criminal Transmission of HIV*, http://www.avert.org/criminal-transmission.htm (last visited Oct. 27, 2011).
[113] *Id.*; *see also*, Clayton, *supra* note 111, at 12.
[114] TANZANIA COMMISSION FOR AIDS (TACAIDS), TANZANIA HIV/AIDS AND MALARIA INDICATOR SURVEY 81-84 (2008) [hereinafter 2008 THMIS]; *see also* Clayton, *supra* note 111, at 12.
[115] 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*, *supra* note 112; *see also* The plight of Tanzanian women living with HIV/AIDS, PANAPRESS, http://www.panapress.com/The-plight-of-Tanzanian-women-living-with-HiV-AiDS--12-542429-25-lang1-index.html (last visited Oct. 27, 2011).
[116] A study in the American Journal of Public Health on partner violence of HIV positive women in Tanzania found that HIV positive women were more than 2.5 times as likely to report physical or sexual violence from their partner than HIV negative women, and more than 27 percent of women agreed or strongly agreed with the statement that "Violence is a major problem in my life." Suzanne Maman et al., *HIV Positive Women Report More Lifetime Partner Violence: Findings from a Voluntary Counseling and Testing Clinic in Dar es Salaam*, 92(8) AM. J. OF PUB. HLTH., 1333 (2002).
[117] INTERNATIONAL COMMUNITY OF WOMEN LIVING WITH HIV/AIDS, MAPPING OF EXPERIENCES OF ACCESS TO CARE, TREATMENT AND SUPPORT: TANZANIA (2006) [Hereinafter ICW Mapping].
[118] *Id.*
[119] *Id.*
[120] 2008 THMIS, *supra* note 114, at 57-58.
[121] ICW Mapping, *supra* note 117.
[122] TACAIDS, GENDER AUDIT ON TANZANIA NATIONAL RESPONSE TO HIV AND AIDS, XIV (2009).
[123] The other most affected group is youth. Tanzania National Website, *supra* note 103.
[124] *Id.*; *see also*, UNGASS Report, *supra* note 106, at 2.
[125] UNGASS Report, *supra* note 106, at 13.
[126] 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.
[127] *See generally id.; see also* STRATEGIC PLAN, *supra* note 39, at 5.
[128] Speizer, *supra* note 126, at 16-17.
[129] *Id.* at 17.
[130] *Id.*
[131] *See generally, id.*
[132] The Strategic Plan has a goal of increasing contraceptive prevalence by making quality family planning services more accessible to and equitable for all people. *See generally* STRATEGIC PLAN, *supra* note 39; *see also, generally*, MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZ.), NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PROGRAM 1, 10 (2010), *available at* http://www.fhi.org/NR/rdonlyres/enwwgq7tbgh5yq6fpstxyrsfmgc77rubxj7gr3eyyutzrzbo62jkr5ouwjljhtqkuju4ignhqaglcd/NatlPlanFPImplementationTZfull.pdf.

[133] African Medical and Research Foundation, *Giving Young Women a Voice in Rural Tanzania*, http://uk.amref.org/where-we-work/our-work-in-tanzania/giving-young-women-a-voice-in-rural-tanzania/ (last visited Oct. 27, 2011); *see also* 2010 TDHS, *supra* note 11, at 96.
[134] 2010 TDHS, *supra* note 11, at 69.
[135] MINISTRY OF EDUCATION AND VOCATIONAL TRAINING (TANZ.), BASIC EDUCATION STATISTICS IN TANZANIA 2006-2010, 23, 60 (2010) [hereinafter BEST].
[136] PATHFINDER INT'L., INTEGRATING YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN PUBLIC HEALTH FACILITIES: A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA 1 (2005) *available at* http://www.pathfind.org/site/DocServer/Tanz_case_study_FINAL.pdf?docID=5161 [hereinafter A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA].
[137] CEDAW Committee, *Concluding Observations* (2008), *supra* note 26, para. 137.
[138] A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA, *supra* note 136, at 1-2.
[139] *Id.* at 1.
[140] UNFPA, UNFPA AND ADOLESCENTS, http://www.unfpa.org/public/cache/offonce/home/sitemap/icpd/International-Conference-on-Population-and-Development/unfpa_and_adolescents#contraceptive_use (last visited Oct. 28, 2011).
[141] A SUCCESS STORY AND LESSONS LEARNED IN TANZANIA, *supra* note 136, at 2.
[142] A 2011 report produced by the Government of Tanzania and UNICEF suggests that nearly 17 percent of girls reported at least once incident of sexual abuse on school grounds, and over one-fourth of girls have experienced at least one incident of sexual violence on their way to or from school. UNITED REPUBLIC OF TANZANIA, VIOLENCE AGAINST CHILDREN IN TANZANIA 52 (2011), *available at* http://www.unicef.org/media/files/VIOLENCE_AGAINST_CHILDREN_IN_TANZANIA_REPORT.pdf. It is likely that these numbers are underreported, for complex social and cultural reasons including lack of understanding of violence, and parents' attitudes towards their girl children that lead to disbelief of allegations when raised. *See generally* ACTIONAID INT'L, VIOLENCE AGAINST GIRLS AND THE RIGHT TO EDUCATION (2004), *available at* http://www.actionaid.se/files/StopViolenceAgainstGirls.pdf.
[143] BEST, *supra* note 135, at 23, 60.
[144] Research conducted by the Center for Reproductive Rights and Yale Law School's Allard K. Lowenstein International Human Rights Law Clinic (on file with the Center for Reproductive Rights).
[145] *Id.*
[146] Interview with Headmaster at private high school (Jan. 20, 2011) (on file with the Center for Reproductive Rights). Interview with high level official at the Ministry of Community Development, Gender, and Children (Jan. 13, 2011) (on file with the Center for Reproductive Rights); *see also* Interview with high level official, Ministry of Education (Jan. 18, 2011) (on file with the Center for Reproductive Rights).
[147] Interview with Headmaster at private high school, *supra* note 146; *see also* Interview with high level official at the Ministry of Community Development, Gender and Children, *supra* note 146; Interview with teachers at private secondary school (Jan. 19, 2011) (on file with the Center for Reproductive Rights).
[148] Education circulars suggest that school boys who impregnate school girls are also to be expelled, but it is more difficult to find boys responsible and this practice is largely unenforced. *See* Interview with right to education NGO in Tanzania (Jan. 21, 2011) (on file with the Center for Reproductive Rights); Interview with UNICEF official (Jan. 18, 2011) (on file with the Center for Reproductive Rights).
[149] Research, *supra* note 144. 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.
[150] ESCR Committee, *General Comment No. 14*, *supra* note 2, para. 8.
[151] *Id.* para. 23.
[152] *See*, *e.g.*, Interview with UNICEF official, *supra* note 148.

[153] *See, e.g.*, Interview with headmaster at private high school, *supra* note 146; Interview with high level official at the Ministry of Community Development, Gender, and Children, *supra* note 146. 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].
[154] Interview with advocates at a woman's rights NGO in Tanzania (Jan. 19, 2011) (on file with the Center for Reproductive Rights). *See also* Interview with a right to education NGO in Tanzania (on file with the Center for Reproductive Rights); Interview with UNICEF official, *supra* note 148.
[155] Research, *supra* note 144.
[156] Interview with high level official, Ministry of Education, *supra* note 146.
[157] Interview with a right to education NGO in Tanzania, *supra* note 154.
[158] Interview with officials at the Ministry of Health (Jan. 18, 2011) (on file with the Center for Reproductive Rights).
[159] Interview with teachers at private secondary school, *supra* note 147.
[160] ESCR Committee, *General Comment No. 13, The Right to Education,* (19th Sess., 1998) para. 1, U.N. Doc. E/C.12/1999/10 (1998).
[161] *Id.* para. 2.
[162] *Id.* para. 6(b)(1).
[163] *Id.* para. 37.
[164] Ministry of Education and Vocational Training, *Gender and Development, available at* http://moe.go.tz/gender/gender%20-aboutus.html.
[165] THE EDUCATION AND TRAINING POLICY, MINISTRY OF EDUCATION, *foreword* xii-xiii (1995), *available at* http://www.tzonline.org/pdf/educationandtraining.pdf.
[166] *Id.* at 19-20. Nearly 8,000 girls drop out of school each year as a result of pregnancy. BEST, *supra* note 135, at 23, 60.
[167] Law of the Child Act, 2009, (Tanz.).
[168] *See* Interview with right to education NGO in Tanzania, *supra* note 148; Interview with UNICEF official, *supra* note 148.
[169] Interview with official at the Office of the Commissioner of Education (Jan. 18, 2011) (on file with the Center for Reproductive Rights).
[170] Interview with high level official at the Ministry of Community Development, Gender, and Children, *supra* note 146; *see also* Interview with right to education NGO in Tanzania, *supra* note 148 (describing these attitudes as extremely widespread); Interview with teachers at private secondary school, *supra* note 147.
[171] Interview with official at the Ministry of Education and Vocational Training (Jan. 15, 2011) (on file with the Center for Reproductive Rights).
[172] A headmaster at a private high school reported that Parliament has been debating the matter of re-entry for the past ten years, but this was not able to be verified this with government sources. Interview with headmaster at private high school, *supra* note 146. Interview with advocates at a right to education NGO in Tanzania (Jan. 21, 2011) (on file with the Center for Reproductive Rights).
[173] ICESCR, *supra* note 1, at art. 10(1).
[174] ESCR Committee, *General Comment No. 16, The Equal Right of Men and Women to the Enjoyment of all Economic, Social and Cultural Rights,* (34th Sess., 2005), paras. 27, U.N. Doc. E/C.12/2005/4 (2005).
[175] ESCR Committee, *General Comment No. 14*, *supra* note 2, at para. 22.
[176] 2010 TDHS, *supra* note 11, at 95.
[177] Tanzania has signed and ratified the U.N. Convention on the Rights of the Child, African Charter on the Rights and Welfare of the Child, African Charter on Human and Peoples' Rights, the Maputo Protocol, and Convention on the Elimination of All Forms of Discrimination against Women. *See* Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) (*ratified* June 10, 1991) [hereinafter CRC]; African Charter on the Rights and Welfare of the Child, *adopted* July 11, 1990, O.A.U Doc. CAB/LEG/24.9/49 (*entry into force* Nov. 29, 1999) [hereinafter Children's Charter]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3 rev.5, 21 I.L.M. 58 (1982) (*entry into force* Oct. 21, 1986); Maputo Protocol, *supra* note 63; Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/189, UN GAOR, 34th

Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) (*ratified* Aug. 20, 1985) [hereinafter CEDAW].

[178] The CEDAW Committee states that the minimum age of marriage should be 18 years for both women and men. CEDAW Committee, *General Recommendation No. 21: Equality in Marriage and Family Relations* (13th Sess., 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 36, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II.) (2008). Several states have issued reservations related to Article 16 of CEDAW regarding marriage and family life insofar as it is incompatible with the Islamic sharia; however, Tanzania is not one of those countries, and indeed has no reservations to either CEDAW or CRC, thereby lending credibility to the argument that it has agreed to be bound by the age requirements set forth therein; *see also* Maputo Protocol, *supra* note 63, art. 6(b) (which states that minimum age of marriage for women shall be 18 years); *see also* Children's Charter, *supra* note 177, art. 2.

[179] LAW OF MARRIAGE ACT, art. 13 (1971) (Tanz.), *available at* http://tanzanet.org/downloads/laws/the_law_of_marriage_act_1971_(5_1971).pdf.

[180] TAWLA, REVIEW OF GENDER DISCRIMINATIVE LAWS OF TANZANIA (2009) (REPRINTED).

[181] CEDAW Committee, *Concluding Observations* (2008), *supra* note 26, para. 147; *see also* Committee on the Rights of the Child, *Concluding Observations* (2006), *supra* note 38, at para. 25.

[182] Tanzania Government Report (2011), *supra* note 34, at para. 79.

[183] CHILDREN'S DIGNITY FORUM, VOICES OF CHILD BRIDES AND CHILD MOTHERS IN TANZANIA 16 (2010) [hereinafter VOICES OF CHILD BRIDES]; *see also* LAW OF MARRIAGE ACT, *supra* note 179, art. 17.

[184] Iben Madsen, *Is Child Marriage a Neglected Problem?*, DAILY NEWS (2009), http://allafrica.com/stories/200912020746.html (last visited Oct. 28, 2011)

[185] LAW OF MARRIAGE ACT, *supra* note 179, art. 38(1)(a).

[186] PENAL CODE, *supra* note 60, sec. 138(1).

[187] VOICES OF CHILD BRIDES, *supra* note 183, at 24.

[188] *Id.* at 21.

[189] *Id.*

[190] *Id.* at 21-22.

[191] Anju Malhotra et al., *Solutions to End Child Marriage: What the Evidence Shows*, INT'L CENTER FOR RESEARCH ON WOMEN, 4 (2011).

[192] Madsen, *supra* note 184.

[193] USAID, *Child Marriage: Overview* (2009), http://www.usaid.gov/our_work/cross-cutting_programs/wid/dg/child_marriage.html (last visited Oct. 28, 2011).

[194] Madsen, *supra* note 184.

[195] *Id.*

[196] VOICES OF CHILD BRIDES, *supra* note 183, at 7.

[197] WORLD VISION, BEFORE SHE'S READY: 15 PLACES GIRLS MARRY BY 15, 3 (2008).

[198] *Id.*

[199] UNFPA, THE UNMAPPED JOURNEY: ADOLESCENTS, POVERTY AND GENDER, Ch. 5 (2005), *available at* http://www.unfpa.org/swp/2005/english/ch5/chap5_page3.htm.