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Report on Tanzania's Compliance with its Human Rights Obligations on Sexual and Reproductive Health and Rights

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Center for Reproductive Rights
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I. INTRODUCTION

1. The Center for Reproductive Rights and Legal and Human Rights Centre jointly submit this letter in the context of the Universal Periodic Review (UPR) of Tanzania, scheduled for review during the 39th session of the Universal Periodic Review Working Group (2021). The Center for Reproductive Rights (the Center) is a not-for-profit legal advocacy organization dedicated to promoting and defending reproductive rights worldwide. The Center uses the law at the national, regional, and international levels to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfil. The Legal and Human Rights Center (LHRC) is a non-partisan and non-profit human rights organization, that seeks to promote internationally recognized human rights norms and standards in Tanzania. The organization specializes in legal and human rights monitoring, legal aid, civic awareness, research, advocacy for policy and legal reforms.

2. Tanzania has ratified multiple international and regional human rights treaties that require state parties to protect the sexual and reproductive health and rights of women and girls.[1] However, women and girls continue to face numerous reproductive rights violations. As discussed below, there is lack of access to sexual and reproductive health services including access to contraceptives, sexuality education, abortions and post-abortion care. Access to comprehensive and scientifically accurate information is also very limited. Beyond the impact on the health of women and girls, these have grave economic and social consequences, especially for adolescents, who face automatic exclusion from school upon being found to be pregnant.

3. This report focuses on the following sexual and reproductive issues that we urge the Human Rights Council to consider during its review of Tanzania: (a) maternal mortality and access to maternal healthcare; (b) lack of access to safe abortion and post-abortion care; (c) inadequate access to family planning information and services; (d) adolescent sexual and reproductive health and rights, including mandatory pregnancy testing in schools and the expulsion of pregnant school girls; and (e) the report makes recommendations that the Human Rights Council should request Tanzania to comply with its international treaty obligations.

II. MATERNAL MORTALITY AND ACCESS TO MATERNAL HEALTHCARE

4. During the 2011 universal periodic review, Tanzania admitted that the high maternal mortality rate was a challenge[2], and accepted recommendations aimed at significantly reducing the rate.[3] During the 2016 UPR, Tanzania accepted further recommendations designed to accelerate progress towards reducing maternal mortality.[4] Tanzania's maternal mortality ratio (MMR) appears to have worsened since the last UPR: the 2015-16 Tanzania Demographic and Health Survey (2016 TDHS) showed the MMR at 556 maternal deaths per 100,000 live births[5], while data from 2013 reported 410 deaths per 100,000 live births.[6] Tanzania continues to have the fifth highest number of maternal deaths per year worldwide (regressing two spots from seventh at the time of the last UPR), and women in the country have a 1-in-36 lifetime risk of dying from a pregnancy-related cause.[7]

5. In order to reduce the high MMR and maternal morbidity rates in Tanzania, it is crucial that women and girls have access to comprehensive maternal health services. According to the 2016 TDHS[8], however, only 51% of pregnant women received the WHO recommended four plus antenatal visits. While this is an increase from the 43% figure surveyed in the 2010 THDS[9], it is still less than the 62% figure surveyed in the 2004 TDHS.[10] In addition, while the 2016 TDHS reported an increase in the percentage (64%) of births that were attended by skilled health personnel[11], this improvement in skilled delivery assistance does not appear to have translated into a lower MMR. One of the probable reasons for this disconnect, as documented in the 2016 TDHS, is that access to skilled delivery assistance is concentrated within wealthier, better educated, urban populations.[12]

6. In addition, there is significant geographical disparity in access, since most medical facilities that offer quality maternal health services are concentrated in urban areas, and 46% of rural women still deliver at home as compared to only 14% in urban areas.[13] Low-quality care, absence of skilled delivery services, and high costs are also key barriers to accessing health care.[14] For instance, although some reproductive and maternity services are notionally provided free of charge, insufficient health funding and stock-outs have resulted in women frequently paying out-of-pocket expenses for items such as delivery kits and medications, with 91% of women reporting paying some out-of-pocket expenses in connection with a birth in 2006.[15] Further, the health sector was allocated only 7.8% of the total budget for 2019-2020[16], which falls short of the government's commitment to allocate at least 15% of the annual national budget to the health sector as it pledged to in the Abuja Declaration.[17] While Tanzania has increased the number of health facilities providing maternal health services in remote and rural areas, these facilities are still not accessible to many and lack professional and sufficient health staff to provide quality services. A study conducted by LHRC in 2019 revealed health as a major issue facing communities.[18]

III. LACK OF ACCESS TO SAFE ABORTION AND POST-ABORTION CARE

7. Every year one million Tanzanian women and girls are faced with an unwanted or unplanned pregnancy, of which 39% end in abortion.[19] Due to many legal and health system challenges, the majority of abortions performed in 2013 were clandestine and unsafe, causing preventable maternal injuries and deaths.[20] The prevalence of unsafe abortions is a key contributor to Tanzania's poor outcomes in other aspects of women's health. According to the most recent data, unsafe abortions account for more than one-third of hospitalizations for complications relating to pregnancy, and roughly one-quarter of maternal deaths.[21]

8. From a study conducted by the Center, for which more than 60 women, girls and other stakeholders were interviewed[22], it is clear that the lack of access to safe abortion and post-abortion care is at least partly attributable to the laws and policies in Tanzania.[23] These remain inconsistent, unclear, and widely misunderstood. Further, there are no comprehensive guidelines available to health care practitioners and other key stakeholders as to how such laws should be practically implemented in order to deliver safe abortion and post-abortion care.[24] Under the Penal Code, abortion is criminalized except to save the woman's life.[25] Although this exception has been interpreted in pre-independence court decisions to encompass a mental and physical health exception, this jurisprudence is not reflected in any law or policy and is mostly not implemented in practice.[26]

9. Tanzania has ratified, without reservation, the African Charter on Human and People's Rights on the Rights of Women in Africa ("Maputo Protocol"), which obligates states to authorize abortions in cases of sexual assault, rape, incest, where the physical or mental health of the woman is threatened and where the life of the mother or the foetus is in danger. In 2016, the African Commission on Human and People's Rights (ACHPR) launched a campaign for the decriminalization of abortion in Africa in order to address the high rate of unsafe abortion in the region. During the 2016 UPR, it was recommended that Tanzania implement the provisions of the Maputo Protocol.[27] Tanzania has not, however, undertaken the law reform process required to domesticate these rights in its national

legislation. Rather, the government subsequently rejected the recommendation on the basis that it is contrary to the constitutional right to life and the Penal Code's limited exception for lawful abortion only when the mother's life is in danger.[28]

10. Tanzanian law also fails to support access to abortion-related medication by Tanzanian women and girls. While scientific evidence shows that the combination of misoprostol and mifepristone is an effective and safe method for termination of pregnancies, the medicines are not registered for such use in Tanzania and are not included in the essential medicine list, leaving women and girls with limited information and avenues for accessing and using these methods safely.[29]

11. Deficiencies in Tanzania's legal regime relating to abortion are compounded by various non-legal barriers to accessing abortion and post-abortion care, including systemic issues occurring within Tanzania's health system. For example, many health care providers do not receive adequate training on the provision of abortion services and, as noted above, lack guidance on what the law requires and the best practices for implementing it. In addition, the topic of abortion remains subject to stigma and other biases both from health care providers and the general community.[30] This has delayed or altogether deterred women from seeking post-abortion care, and in some cases, exposed them to financial corruption from health care professionals.[31] Adolescents and survivors of sexual violence are particularly vulnerable to such stigma and gaps in healthcare provider knowledge and training, which further increases the incidence of unsafe abortions among these groups.[32]

12. In addition, despite the Tanzanian government's commitment in national guidelines to provide post-abortion care ("PAC")[33], the service is not widely available and accessible.[34] For example, according to a 2007 case study carried out together with the Ministry of Health and Social Welfare and focused on three districts in Tanzania, found only about 24% of facilities carried essential PAC kits and 1-in-5 hospitals were equipped with misoprostol and PAC kits.[35] In addition, only 13.5% of health providers were trained on providing adolescents PAC.[36]

IV. INADEQUATE ACCESS TO FAMILY PLANNING INFORMATION AND SERVICES

13. Although Tanzania has policy measures and guidance in place on the provision of family planning services[37], according to the 2019-23 Tanzania National Family Planning Costed Implementation Plan ("2019-23 NFPCIP"), only 38% of married women use a method of contraception (32% use a modern method and 6% use a traditional method).[38] When compared with the statistics from its previous UPR, this indicates that contraceptive prevalence rates for modern methods across the country have slightly increased (from 24%) but continue to show wide regional variation – from as high as 47.9% in Lindi to as low as 10.7% in Geita.[39] Contraceptive use is more prevalent among women living in southern regions and is lowest in Zanzibar.[40] Further, TDHS reports that in 2015-2016 22% of married women had an unmet need for contraception.[41] These figures are significantly below the 60% contraceptive prevalence rate the government of Tanzania had set for itself to achieve by 2015.[42] The government subsequently adjusted its benchmark modern contraceptive prevalence rate to 47% for married women and 40% for all women by 2023.[43]

14. In addition, there is significant disparity in the level of contraceptive use based on factors including geographical area, education, and income level. For instance, the unmet need for contraceptives ranges from 22% for all married women, to as high as 29% among the poorest married women.[44] Further, 33% of married women with a secondary education use contraception as opposed to only 24% of married women with no education.[45]

15. The low contraceptive usage rate and high unmet need are a result of several health sector and non-health sector challenges that women and girls encounter in accessing contraceptives, such as:

    (a) *Limited availability and accessibility of contraceptives and quality of services*: women and girls encounter challenges such as lack of trained personnel; supply and equipment

shortages; long distances to facilities[46]; and an insufficient number of health facilities that provide comprehensive contraceptive services.[47]

(b) *Inability to access preferred contraception method and cost*: Low-level medical facilities generally provide only short-term contraceptives, such as injections, pills, and condoms, which are susceptible to stockouts, or, if available, facilities lack trained personnel to administer them.[48] Women who prefer long-term contraceptive options, such as intrauterine devices, implants, and sterilization are more inclined to seek out higher-level medical facilities.[49] Consequently, many women, especially in rural areas, resort to using non-preferential contraceptive methods[50], no contraceptive method , or pay high fees for additional expenses like transportation.[51] When public facilities are unable to satisfy the demand for contraceptives, women are forced to use private medical facilities: exacerbating the rich-poor divide as private facility services are prohibitively expensive for those without resources.[52] In addition, short term contraceptive methods cost more because women are required to renew their prescriptions with frequency, causing a gap in access between low-income women and high-income women.[53] Only 20% of low-income married women use modern contraceptives, while the rate of usage is 35% for those in a higher-wealth quintile.[54]

(c) *Lack of quality services*: Women are pushed to resort to private facilities because of the poor quality of service, overcrowding and a consequential lack of privacy at public facilities. Doctors rarely have the time to consult with women and provide detailed information on the full range of available contraceptive methods.[55] In addition, 23% of public health facilities and 41% of hospitals in Tanzania are owned or governed by faith-based organizations.[56] As a result, some of these facilities refuse to provide contraceptive services, negatively affecting access to family planning services in Tanzania. An interview with an OB/GYN working in one such facility in Mwanza, for instance, confirmed that the facility does not provide contraceptives, including emergency contraceptives for victims of rape, but rather refers the women to another facility to obtain the service—this is concerning since the most recent available date indicates that 23% of public health facilities and 41% of hospitals in Tanzania are owned or government by faith-based organizations.[57]

(d) *Myths and misconceptions*: Women who were interviewed by the Center admitted to misconceptions about modern contraceptives, including: fears of cancer, tumours and fibroids; permanent infertility; and fetal abnormality.[58] As the WHO has clarified, these concerns are not supported by scientific evidence.[59]

(e) *Perceived gender roles regarding the use of contraceptives*: Due to the patriarchal nature of Tanzania's society and the belief that women are supposed to have multiple children, women believe they need the consent of their partner before using contraceptives; when men refuse such consent, the women forego using contraceptives or choose the method that can be used most secretly.[60] If a woman fails to conceive within a year of marriage or after giving birth, she can face "punishment" from her husband for using a contraceptive without his consent. When couples agree to prevent or delay pregnancies, the burden falls onto women[61]; the 2015-16 DHS indicates that the rate of male sterilization is zero.[62]

V. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

16. The lack of access to sexuality and reproductive health information and services is more pronounced for adolescents and has grave physical, economic and social consequences for them. The low marriage age in Tanzania feeds into this problem, as does the lack of access to sexual and reproductive education and services described above. Because of their early stage of physical development and their relative lack of access to information and services, adolescents have a higher risk of pregnancy-related mortality and medical complications.[63]

17. Tanzania has one of the world's highest teenage pregnancy rates – approximately 27% of girls between 15-19 years get pregnant.[64] Tanzania has the 11th highest absolute number of child brides in the world 20% of girls in Tanzania are married before their 18th birthday.[65] While 12% of adolescents in Tanzania have started sexual relations by age 15, and 60% by 18,[66] only 8.6% of adolescent girls between 15 and 19 use modern contraceptive methods.[67] The unmet contraceptive need stands at 10.8%.[68] As a result, one in four adolescent girls between ages 15 and 19 are already mothers or are pregnant with their first child.[69] 32% of adolescents living in rural areas have had a live birth or are pregnant, compared with 19% of those living in urban areas.[70] Adolescents in poorer households are three times more likely to have a child than their wealthier counterparts.[71]

18. Research conducted by the Center found that "students rarely receive any meaningful instruction on sexual or reproductive health in schools."[72] Though government policies and guidelines suggest that sexuality or life skills education should be part of primary and secondary education, in practice, schools cursorily deal with these issues in other subjects like biology, civics, languages and work skills, in a piecemeal manner.[73] The Ministry of Education's guide for school counselors supports the teaching of abstinence, which becomes the main thrust of any adolescent sexual health classes.[74] None of the adolescent girls interviewed for the Center's 2013 report "Forced Out" claimed that her school provided comprehensive sexuality education.[75]

19. Another problem is access to information for out-of-school adolescents. Less than a third of girls who complete primary schooling end up completing lower secondary school.[76] Consequently, there is a large population of out-of-school adolescents who are never reached by the government's in-school programs. In turn, this section of the population is most likely to become pregnant at a young age.[77]

20. Further, the lack of youth-friendly reproductive health services and stigma surrounding adolescents' sexuality fuel unwanted and unplanned pregnancies.[78] Youth-friendly services, particularly in rural areas, remain very limited.[79] Adolescents are reluctant to access existing public health facilities because they fear running into their parents and other people they know at these facilities.[80] The working hours in these facilities coincide with school hours, making it difficult for the adolescent to justify missing school while maintaining privacy.[81] There may also be the fear that they would be exposed as pregnant and thus expelled from school.[82] Additionally, though legally, there are no age-based restrictions to access contraceptive information, education and services in Tanzania, some providers continue to deny services based on age: for instance, in one study, between 79% and 81% of contraceptive service providers in rural Tanzania were found to impose age restrictions for accessing a contraceptive pill.[83]

21. There is an intersection between high rates of child marriage and the lack of awareness about adolescent sexual and reproductive health and rights. Since the previous 2016 UPR of Tanzania[84] a landmark decision by the High Court of Tanzania ruled in July 2016 that the Law of Marriages Act should be revised to eliminate inequality between the minimum ages of marriage for boys and girls.[85] Previously, girls could marry at age 14 with the consent of the court and at age 15 with the consent of their parents; the ruling set the minimum age for marriage at 18 years for both boys and girls.[86] This ruling was appealed by the Attorney General but upheld by the Court of Appeals, the highest Court in Tanzania, in October 2019.[87] Despite this, the law has not officially changed to reflect the court's ruling and reports indicate that community level change needs to be enacted to address

societal attitudes and practices around early marriage.[88] A 2017 national survey reported, nearly two out of every five girls in Tanzania are married before they reach 18, and child marriage is more prevalent in in rural and poorer communities compared to their urban and wealthier counterparts.[89]

Mandatory Pregnancy Testing and Expulsion of Pregnant School Girls

22. The most significant example of the disproportionate consequences that adolescents face on account of the lack of access to reproductive health information and services is that a pregnancy results in girls being denied their right to education. When found to be pregnant, girls in Tanzania are immediately expelled from school despite the absence of a law or policy that explicitly mandates this practice.[90] The Education Act, which allows the expulsion of students for acts of indecency, is usually cited as the basis for expelling pregnant girls. There is no exception – all pregnant girls, including those who became pregnant as a result of rape, are expelled.[91] Once expelled, the girls are not allowed to re-enrol after delivery or if they do not carry the pregnancy to term.[92] Every year, it is estimated that 8,000 girls are forced out of schools in Tanzania.[93] The lack of a re-enrolment policy in Tanzania severely impacts the ability of pregnant adolescents to get the education and vocational training that can equip them for life.[94]

23. Despite recommendations from different treaty monitoring bodies to abolish the practice of mandatory pregnancy testing and expulsion of pregnant girls from schools[95], it remains prevalent, widely accepted, and broadly supported by educators, government officials, and Non-Governmental Organizations (NGOs) in Tanzania.[96] Generally, mandatory pregnancy tests are done without prior announcement or warning to prevent girls from circumventing the harmful policy.[97] They are physically invasive and do not require prior consent.[98] Results are then disclosed directly to the school and eventually to the parents, violating the girl's right to privacy and confidential medical treatment. Since this practice does not have a legal basis, the reason and the manner for conducting it differs based on each school.

24. In November 2018, the World Bank withheld a $300 million loan for secondary education in Tanzania, partly because of the government's policy to expel pregnant girls.[99] Consequently, the government agreed to tackle discrimination against girls. However, no concrete measures were put in place: contrarily, Tanzania's president John Magufuli and other government officials have vigorously supported the expulsion of pregnant students as a way to deter other students from 'out-of-wedlock' pregnancy.[100] Countless times, the government has claimed that it has not denied girls the right to an education, as they can enroll in private schools. However, this justification fails as low-income girls who do not have the resources to pay the enrollment fees cannot attend a private school and in turn access an education.

VI. RECOMMENDATIONS

25. The government should undertake positive measures to reduce maternal mortality and morbidity, including by increasing the availability, accessibility, acceptability and quality of maternal health services, with attention to the needs of marginalized populations; increasing the number of skilled health personnel and well-equipped health care facilities, including in rural areas; and improving the tracking and monitoring of the incidence and causes of maternal mortality and morbidity.

26. The government should amend the Penal Code and other relevant laws and policies to remove criminal sanctions for abortion services in line with ACHPR's campaign on the decriminalization of abortion services.

27. The government should register misoprostol and mifepristone to be used for termination of pregnancies, include the medicines in the essential medicines list, and ensure that women and girls have information to access the method.

28. The government should develop and disseminate comprehensive guidelines to (a) health care providers and other stakeholders on the provision of safe abortion and post-abortion care; and (b) to the public to ensure women and girls are made aware of how to access to health service and dispel misconceptions regarding the legality of safe abortion services and stigma against those who procure them.

29. The government should ensure that healthcare providers receive adequate training on the legal framework of abortion services and on the provision of the health service. It should also implement measures to ensure that health care facilities have a sufficient number of trained health care professionals and equipment to provide abortion care and accountability measures to guarantee that the cost of abortion care services is not a barrier to access.

30. The government should take steps to ensure that women and adolescent girls, including those in rural areas and those of low income have access to comprehensive information on the full range of family planning and contraceptives and that they also have access to affordable family planning and contraceptive services including emergency contraceptives. It should specifically target institution of youth-friendly services (including providing sexual and reproductive health information to both in and out of school adolescents) and seek to reduce stigma about adolescents' sexuality.

31. The government should end mandatory pregnancy testing and expulsion of pregnant schoolgirls. The government should take steps to ensure there is a retention policy for pregnant schoolgirls and support services in place to ensure that schoolgirls who do get pregnant are able to continue with their education.

32. The government should immediately legislate to reflect a minimum age of 18 for marriage without exception and make concrete efforts to eliminate the practice of early marriage by targeting specific areas of the country, especially rural areas.

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[1] Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 18 December 1979, 34 U.N. GAOR, Supp. No. 21 (A/34/46) at 193, U.N. Doc. A/RES/34/180 (*entry into force* Sept. 3, 1981);
International Covenant on Civil and Political Rights (ICCPR), 16 December 1966, 2200A U.N. GAOR, U.N. Doc. A/RES/2200A (*entry into force* March 23, 1976); International Covenant on Economic, Social and Cultural Rights (ICESCR), *adopted* Dec. 16, 1966, art. 12(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), (*entry into force* Jan. 3, 1976);
African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (ratified by Tanzania Mar. 9, 1984); *See also* U.N. Treaty Body Database, *Ratification status*, https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=90&Lang=EN.
[2] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: United Republic of Tanzania* (19th Sess., 2011), para. 11, U.N. Doc. A/HRC/19/4 (2011).
[3] *Ibid.*
[4] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: United Republic of Tanzania* (33rd Sess., 2016), paras. 134, 107, 134,108, U.N Doc. A/HRC/33/12 (2016).
[5] NATIONAL BUREAU OF STATISTICS (TANZ.), ET AL., TANZANIA DEMOGRAPHIC AND HEALTH SURVEY AND MALARIA INDICATOR SURVEY 2015-16, p. 8 (2016) https://www.dhsprogram.com/pubs/pdf/SR233/SR233.pdf [hereinafter, NATIONAL BUREAU OF STATISTICS (TANZ.), TANZANIA HEALTH SURVEY].
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[7] *Ibid*, p. 38, 76.
[8] NATIONAL BUREAU OF STATISTICS (TANZ.), TANZANIA HEALTH SURVEY, *supra* note 5. at 8.
[9] Id., at xxii.
[10] Id., at 133.
[11] Id.,at 8.
[12] Id., at 8.
[13] Id., 20.
[14] NATIONAL BUREAU OF STATISTICS (TANZ.), TANZANIA HEALTH SURVEY, *supra* note 24 at 134, 135; NATIONAL BUREAU OF STATISTICS (TANZ.), ET AL., TANZANIA SERVICE PROVISION ASSESSMENT SURVEY 2006, p. 115, 117-119 (2007).
[15] Although Tanzania's nominally free maternity care has not eliminated fees for more than 90% of surveyed women, the program has resulted in lower fees than the two other countries included in the study—Kenya and Burkina Faso: Margaret Perkins, ET AL., *Out-of-pocket costs for facility-based maternity care in three African countries*, 24 HEALTH POLICY PLAN. p. 289, 293, 298 (2009), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2699243/.
[16] *See* THE UNITED REPUBLIC OF TANZANIA MINISTRY OF FINANCE AND PLANNING, *The Citizen's Budget: A Simplified Version of the Government Budget for the Financial Year 2019/2020*, https://www.cabri-sbo.org/en/documents/the-citizens-budget-2.

[17]African Union, Abuja Declaration on HIV/AIDS, *Tuberculosis, and Other Related Infectious Diseases*, para. 26, OAU/SPS/ABJUA/3 (2001).
[18] UNITED STATES DEPARTMENT OF STATE, BUREAU OF DEMOCRACY, HUMAN RIGHTS AND LABOR, *Tanzania 2019 Human Rights Report*, (2019) https://www.state.gov/wp-content/uploads/2020/03/TANZANIA-2019-HUMAN-RIGHTS-REPORT.pdf.
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[22] CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN MAINLAND TANZANIA 6 (2012), the main findings of which remain relevant since the country has not undertaken a law reform process to change the legal framework that regulates safe abortion services [hereinafter CENTER FOR REPRODUCTIVE RIGHTS, TECHNICAL GUIDE TANZANIA].
[23] CENTER FOR REPRODUCTIVE RIGHTS, OPEN SECRET: THE TOLL OF UNSAFE ABORTION IN TANZANIA (2020) [hereinafter, CENTER FOR REPRODUCTIVE RIGHTS, UNSAFE ABORTION IN TANZANIA] *available at* https://reproductiverights.org/document/open-secret-toll-unsafe-abortion-tanzania.
[24] CENTER FOR REPRODUCTIVE RIGHTS, UNSAFE ABORTION IN TANZANIA, *supra* note 24.
[25] PENAL CODE ACT, Cap. 16, secs. 150, 151, 219, 230 (Tanz.).
[26] CENTER FOR REPRODUCTIVE RIGHTS, UNSAFE ABORTION IN TANZANIA, *supra* note 24.
[27] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: United Republic of Tanzania* (33rd Sess., 2016), para. 136.3, U.N. Doc. A/HRC/33/12 (2016).
[28] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: United Republic of Tanzania,* (33rd Sess., 2016), para 136.3, U.N. Doc. A/HRC/33/12/Add.1 (2016).
[29] CENTER FOR REPRODUCTIVE RIGHTS, UNSAFE ABORTION IN TANZANIA, *supra* note 24.
[30] Id.
[31] Id.
[32] CENTER FOR REPRODUCTIVE RIGHTS, UNSAFE ABORTION IN TANZANIA, *supra* note 24.
[33] MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZ.), NATIONAL ROAD MAP STRATEGIC PLAN TO ACCELERATE REDUCTION OF MATERNAL, NEWBORN AND CHILD DEATHS IN TANZANIA 2008-15, 16 (2008), *available at* http://www.who.int/pmnch/countries/tanzaniamapstrategic.pdf [hereinafter STRATEGIC PLAN]; *See also* MINISTRY OF HEALTH AND SOCIAL WELFARE (TANZ.), STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINES LIST (2013), *available at* http://apps.who.int/medicinedocs/documents/s20988en/s20988en.pdf.
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[39] *See* MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN (TANZ.) ET AL., NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN 2019-2023, p. 41 (2019) *available at* http://www.familyplanning2020.org/sites/default/files/Tanzania_CIP_2019-2023.pdf [hereinafter MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING].
[40] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING, *supra* note 40 at 4.
[41] "Unmet need" is defined as "wanting to space their births or not wanting to become pregnant, yet not using contraception". *See* MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING, *supra* note 40 at 4-5.
[42] NATIONAL BUREAU OF STATISTICS (TANZ.), ET AL., 'TANZANIA DEMOGRAPHIC AND HEALTH SURVEY 2010' p. 68-69 (2011), *available at* http://dhsprogram.com/pubs/pdf/FR243/FR243%5B24June2011%5D.pdf.
[43] *See* MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING, *supra* note 40 at iii.
[44] *See* MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING, *supra* note 40 at viii.
[45] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., KEY FINDINGS, *supra* note 39 at 3.
[46] Interview with a reproductive health advocate, Dar es Salaam (Sep. 29, 2017): "*[women] might need to travel 10-15 kilometers or even more to access the facilities. The [government's] plan is to have a health center in every ward but that has not happened yet*" *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT UNPLANNED PREGNANCIES: THE CASE OF TANZANIA, pg. 9 (2020) *available at* https://reproductiverights.org/sites/default/files/documents/Failure%20to%20Prevent%20Unplanned%20Pregnancies.pdf)[hereinafter CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES].
[47] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 1.
[48] Interview with a government official, Gender and Youth Department, Mwanza (Nov. 15, 2017) *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 9.

[49] Interview with a government official, Gender and Youth Department, Mwanza (Nov. 15, 2017): "*Generally, all [contraceptive] methods should be available everywhere, but the availability of a particular method depends on the level of the facility. Dispensaries provide pills, injections, condoms, while the health center also provides loop and implants. Dispensaries do not have loops and implants because they lack trained providers and equipment. Trained providers are only available at health centers and hospitals*" *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 9.
[50] STRATEGIC PLAN *supra* note 34 at 13.
[51] *See* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 9.
[52] *See* CRR interview with a young woman, age 19, Dar es Salaam (Dec. 6, 2017) *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 9.
[53] *See* CRR interview with health care providers working at a local NGO, Mwanza (Nov.15, 2017); interview and focus group discussion with women, Mwanza (Nov.11, 2017) *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 9.
[54] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., KEY FINDINGS, *supra* note 39 at 133.
[55] Interview with woman, age 25, Mwanza (Nov.15, 2017); *See also* Focus group discussion with women, Mwanza (Nov.7, 2017) *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47.
[56] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., KEY FINDINGS, *supra* note 39 at 133.
[57] Interview with Ob/Gyn working in a public faith-based hospital, Mwanza (Nov.11, 2017). *See also* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47.
[58] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 3.
[59] WORLD HEALTH ORGANIZATION (WHO) ET AL, 'FAMILY PLANNING: A GLOBAL HANDBOOK FOR PROVIDERS' 3-4 (2018) *available at* https://apps.who.int/iris/bitstream/handle/10665/260156/9780999203705-eng.pdf?sequence=1; CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 3.
[60] DSW, *Family Planning in Tanzania: Review of National and District Policies and budgets*, 17 (2014) *available at* https://www.dsw.org/uploads/tx_aedswpublication/family-planningtanzania_update.pdf; *See also* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 3.
[61] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 3.
[62] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., KEY FINDINGS, *supra* note 39 at 141, Table 7.3.
[63] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 5.
[64] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., KEY FINDINGS, *supra* note 39 at 105.
[65] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN, NATIONAL SURVEY ON THE DRIVERS AND CONSEQUENCES OF CHILD MARRIAGE IN TANZANIA, (2017). *See also*, Isbaela Warioba, *Child Marriage in Tanzania: A Human Rights Perspective*, THE JOURNAL OF LAW, SOCIAL JUSTICE AND GLOBAL DEVELOPMENT, https://www.lgdjournal.org/wp-content/uploads/2019/04/1_Isabela-Warioba_LGD_2019_1-1.pdf (2019).
[66] NATIONAL BUREAU OF STATISTICS (TANZ.), TANZANIA HEALTH SURVEY, *supra* note 5. at 89.
[67] Id., at 141.
[68] Id. at 150.
[69] Id. at 4.
[70] Id. at 110.
[71] Id..
[72] CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT: MANDATORY PREGNANCY TESTING AND THE EXPULSION ON PREGNANT STUDENTS IN TANZANIAN SCHOOLS, p. 26 (2013) *available at* https://www.reproductiverights.org/document/tanzania-report-forced-out-mandatory-pregnancy-testing-expulsion [hereinafter CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT REPORT].
[73] Id. p. 26-27.
[74] Id. p. 28.
[75] Id., p. 26.
[76] HUMAN RIGHTS WATCH, "I HAD A DREAM TO FINISH SCHOOL" BARRIERS TO SECONDARY EDUCATION IN TANZANIA, 64 (2017) *available at* https://www.hrw.org/sites/default/files/accessible_document/tanzania0217_-_accessible.pdf [hereinafter HUMAN RIGHTS WATCH, I HAD A DREAM REPORT].
[77] CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT REPORT, *supra* note 73 at 35.
[78] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 4.
[79] Interview with a reproductive rights advocate, Dar es Salaam (Sep. 25, 2017) *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47.
[80] Id..
[81] Interview with a reproductive health advocacy manager, Dar es Salaam (Sep. 29, 2017) *cited in* CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47.
[82] CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT REPORT, *supra* note 72.
[83] Ilene S. Speizer ET. AL., *Do Service Providers in Tanzania Unnecessarily Restrict Clients' Access to Contraceptive Methods*?, INTERNATIONAL FAMILY PLANNING PERSPECTIVES, p. 13–20, *available at* https://www.guttmacher.org/journals/ipsrh/2000/do-service-providers-tanzania-unnecessarily-restrict-clients-access (2000).
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[85] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING, *supra* note 40 at 6.
[86] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING, *supra* note 40 at 6.
[87] Daniele Selby, '*Tanzania Ruled Child Marriage Illegal 3 Years Ago. Now It's Trying to Reinstate It'*, GLOBAL CITIZEN (2019), *available at* https://www.globalcitizen.org/en/content/tanzania-child-marriage-ban-appeal/#:~:text=More%20than%2030%25%20of%20girls,ruled%20to%20outlaw%20child%20marriage.
[88] MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT ETC., NATIONAL FAMILY PLANNING, *supra* note 40 at 6-7.
[89] Id., at 6.
[90] CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT REPORT, *supra* note 73 at 68.
[91] *Id.*
[92] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO PREVENT PREGNANCIES, *supra* note 47 at 5.
[93] RESULTS EDUCATIONAL FUND, *Right to Education Index 2017: Advocacy strategies in Honduras, Indonesia, Palestine, Tanzania, and Zimbabwe*, 18 (2018) *available at* https://www.rtei.org/documents/569/RTEI_ 2017_Report.pdf.
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[95] Committee on the Elimination of Discrimination Against Women (CEDAW Committee), *Concluding Observations: United Republic of Tanzania*, para. 33-34, U.N. Doc. CEDAW/C/TZA/CO/6 (2008); Committee on Economic, Social and Cultural Rights (CESCR Committee), *Concluding Observations: United Republic of Tanzania*, para. 27, U.N. Doc. E/C.12/TZA/CO/1-3 (2012); Convention on the Rights of the Child (CRC), *Concluding Observations: United Republic of Tanzania*, para. 61, U.N. Doc. CRC/C/TZA/CO/3-5 (2015); Convention on the Rights of the Child (CRC), *Concluding Observations: United Republic of Tanzania*, para. 61, U.N. Doc. CRC/C/TZA/CO/3-5 (2015).

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