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Unrecognised, unfulfilled: Comprehensive sexuality education and information for adolescent girls with mild intellectual disabilities in Tanzania

Mini- Dissertation Submitted in Partial Fulfilment of the Requirements of the Masters of Law (LLM/MPHIL) in Sexual and Reproductive Rights in Africa

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Summary

The Sexual and Reproductive Health Rights of adolescent girls, including the right to comprehensive sexuality education, have been spelled out with increasing clarity and urgency by the Treaty Monitoring Bodies of international and regional conventions. However, adolescent girls with mild intellectual disabilities, who are a sizeable group, have often been marginalised or forgotten to the extent that they are not able to realise their right to Comprehensive Sexuality Education because of the barriers they face. They have to be identified and supported within an inclusive education system, which provides substantive equality within the classroom that enables them to continue in school at least until the end of primary school. Secondly, the school system has to provide a comprehensive sexuality education syllabus. This dissertation will look at Tanzania's international obligations to provide Comprehensive Sexuality Education to adolescent girls with mild intellectual disabilities and the extent to which it has fulfilled its obligations in policy and law and also in practice in the classroom before providing recommendations to the government, as well as other stakeholders on how to ensure that these often unrecognised groups can realise their right to Comprehensive Sexuality Education.

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LIST OF ABBREVIATIONS

ACRWC - African Charter on the Rights and Welfare of the Child

ACERWC - African Committee of Experts on the Rights and Welfare of the Child

AIDS - Acquired Immune Deficiency Syndrome

ACPF - African Child Policy Forum

AU - African Union

AYC - African Youth Charter

CCBRT - Comprehensive Community Based Rehabilitation in Tanzania

CEDAW - Convention on Elimination of all Forms of Discrimination Against Women

CESCR - Convention on Economic Social and Cultural Rights

CO - Concluding Observations

CRC - Convention on the Rights of the Child

CRPD - Convention on the Rights of Persons with Disabilities

CRR - Centre for Reproductive Rights

CSE - Comprehensive Sexuality Education

DfID - Department for International Development

DHS - Demographic and Health Survey

DSM -5 - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

ESCR - Economic, Social and Cultural Rights

ECOSOC - Economic and Social Council

GC - General Comment

HIV - Human Immuno-Deficiency Virus

ICPD - International Conference on Population and Development

ID - Intellectual Disability

IQ - Intelligence Quotient

MHSW - Ministry of Health and Social Welfare

MID - Mild Intellectual Disability

MKUKUTA -*Mpango wa Kukuza na Kupunguza Umasikini Tanzania*
(National Strategy for Growth and Reduction of Poverty)

NSIAS - National Strategy on Screening, Identification and Assessment

NGO - Non Governmental Organisation

PASHA - Prevention and Awareness in Schools of HIV&AIDS

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SIDA - Swedish International Development Agency

SRH - Sexual and Reproductive Health

SRHR - Sexual and Reproductive Health Rights

STDs - Sexually Transmitted Diseases

STIs - Sexually Transmitted Infections

TACAIDS - Tanzania Commission for AIDS

TMBs - Treaty Monitoring Bodies

UN - United Nations

UNESCO - United Nations Educational, Scientific and Cultural Organisation

UNFPA - United Nations Population Fund

UNICEF - United Nation Children's Fund

UPIAS - Union of Physically Impaired Against Segregation

URT - United Republic of Tanzania

WHO - World Health Organisation

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Chapter One: Introduction

1 Background

In order to ensure that the rights of adolescent girls with mild intellectual disabilities (MID) to Comprehensive Sexuality Education (CSE) are fulfilled, it is necessary to identify and support these girls from an early age, particularly when they enter school. MID is defined, clinically, as an impairment which occurs during childhood and is characterized by a below average intelligence quotient (IQ) of 49-70 and deficits in at least two areas of adaptive behaviour.[1] However, the clinical definition is unreliable and insufficient and deprives persons with intellectual disabilities of their rights as it focuses only on what are perceived as their deficits rather than deficits in the society which create barriers to them fulfilling their rights. Hence, persons with intellectual disability, as well as rights activists have replaced or supplemented the clinical definition with a sociological one whereby, instead of expecting people with disabilities to 'fit into' the existing society, the emphasis is on creating the social environment which will enable people with disabilities to live and develop in equality.[2] This requires reasonable accommodation that is defined by the Convention on the Rights of Persons with Disabilities (CRPD) as 'to make the necessary and appropriate modification and adjustments … to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.'[3]

Although Tanzania has passed the Persons with Disabilities Act of 2010, which domesticates the CRPD, disabilities in general and intellectual disabilities specifically have been under-recognised, under-researched and under-addressed. As noted by UNICEF, despite a one-off disability survey carried out in 2008,[4] 'there is no functioning national system for the identification and assessment of children with physical or mental impairments, and no coherent data to track or respond to their needs'.[5]While the Population and Housing Census of 2012[6] included questions on disability, the last two Demographic and Health Surveys of 2010[7] and 2015[8] did not.

In a situation where there is no system of identification of and support to children with MID, despite an official policy of inclusive education, the likelihood of adolescents with MID realising their right to education let alone CSE is questionable. They are less likely to remain in school and are therefore less likely to receive any classroom sexuality education.

This lack of education is particularly serious at the time of puberty as adolescent girls with MID, like all adolescent girls, experience significant physical, psychological, and sexual changes. Hence, their

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[1]Intellectual Disability Rights Service (IDRS) *Introduction to intellectual disability* (2009). Available at: http://www.idrs.org.au/pdf/IDRS_%20Introduction_intellectual%20disability_17Feb09.pdf (accessed on 8th February 2017).

[2]C Ngwena 'Western Cape Forum for Intellectual Disability v Government of the Republic of South Africa: A case study of contradictions in inclusive education in Africa' (2013)1 *Disability Rights Year Book* 139.

[3] Convention on the Rights of Persons with Disabilities (CRPD),GA Res A/RES/61/06, adopted on 13 December 2006, entered into force on 3 May 2008. Art 2.

[4]United Republic of Tanzania(URT), National Bureau of Statistics (NBS) *Tanzania disability survey report* (2008).

[5]United Nations Children's Emergency Fund (UNICEF) *Education equality and quality in Tanzania* (2009) Available at http://www.unicef.org/tanzania/6911_10874.html (accessed 16th August 2016).

[6]URT, National Bureau of Statistics (NBS) *Population and housing census report* (2012).

[7]URT, National Bureau of Statistics (NBS) *Demographic and health survey* (DHS) (2010).

[8]URT, National Bureau of Statistics(NBS) *Demographic and health survey*(DHS) (2015).

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sexual health becomes increasingly important as they have the same sexual feelings as other adolescents. Adolescent girls need to realise their right to CSE so that they can grow with positive attitudes to their sexuality and do not fall victim to sexual harassment and abuse and their common consequences, pregnancy or Sexually Transmitted Infections (STIs), which can harm their future life-course.[9] The same is true of adolescent girls with MID who not only engage in sexual activity but also are more vulnerable to abuse given the nature of their disabilities.[10]

However, the right of adolescent girls with MID to CSE is frequently rendered invisible within the broader issues of sexual rights of adolescent girls as a whole, or the rights of people with disabilities as a whole. This invisibility is a major barrier to the realization of their rights.

1.1 Problem statement

In Tanzania, adolescent girls with MID face a series of interrelated barriers to accessing CSE. Firstly, the process of identifying these girls in order to support them is random at best. Secondly, inclusive education hardly goes beyond ensuring they sit in the same classroom as their peers with little or no reasonable accommodation to ensure they can learn successfully. Thirdly, as adolescent girls, they face the same barriers that all adolescent girls in Tanzania face in accessing CSE, barriers which are further aggravated by their disabilities. Fourthly, adolescent girls with MID often come from the poorest families and therefore attend the poorest schools. They thus face multiple discriminations and mistreatment because of their age, gender, disabilities and positionality within their communities.

However, the extent and nature of these barriers have not been documented. There is a need to investigate to what extent girls with MID are able to realize their specific sexual rights to access age appropriateCSE in primary schools.

1.2 Research question

This study therefore examines how and to what extent the Tanzanian human rights system adequately addresses the specific needs of adolescent girls with MID to realise their right to CSE, in particular through primary schools, with a view to also informing what needs to be done to ensure that these girls realize their rights.

The specific questions the study attempts to answer are:

1. How is MID interpreted and identified in the Tanzanian context?
2. What are the relevant international requirements and standards pertaining to the SRHR of adolescent girls with MID? How and to what extent have laws, policies, programmes and initiatives in place been implemented to ensure that these rights are fulfilled?
3. What challenges and barriers do adolescent girls with MID face in realising their right to CSE and how may these challenges and barriers be addressed effectively?

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[9] UNICEF*Adolescents of Tanzania report* (2011).
[10] World Health Organisation (WHO) & United National Population Fund (UNFPA) *Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note* (2009).

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4. How might the CRPD be used in order to respect, protect, promote and fulfil the sexuality education needs of adolescents with MID?

Based on the answers to these questions, recommendations have been made to the government, and other stakeholders on how these challenges and barriers can be addressed.

1.3 Methodology

Given the paucity of information in Tanzania relating to girls with MID and the lack of any means of identifying them, this study will concentrate on a desk-based review which will identify Tanzania's obligations to provide inclusive education for children with disabilities as well as CSE to adolescents as a whole. It will then utilise existing research to consider the extent to which Tanzania has fulfilled these obligations with particular reference to the right of adolescent girls with MID to CSE.

1.4 Literature review

This study has consulted studies on disabilities in general and MID in particular, the role of inclusive education, the nature and importance of the right to CSE for adolescent girls, particularly those with MID, andthe barriers to adolescent girls with MID realising this right because of the intersectionality of age, disabilities and gender as well as poverty.

1.4.1 Disability

The Convention on the Rights of Persons with Disabilities (CRPD) recognises that disability is an 'evolving concept'[11]. Oliver and Barnes summarise the evolution of the concept from an emphasis on individual physical or mental impairment to an emphasis on the social barriers that prevent persons with impairment from participating fully in their societies.[12] The nature and reasons for the emphasis on the social nature of disabilities are also well outlined by Kangaude[13]and Banda,[14] among others.

However, Kangaude, along with Terzi,[15] is also aware of weaknesses of the social model. Some of these weaknesses are addressed by Ngwena[16] who uses the CRPD to go beyond the Marxism of Oliver[17] to consider disabilities from a human rights perspective, in particular with regard to socio-economic rights. If the structural and politico-cultural barriers that deny people with disabilities their status as full partners in life are removed,[18] they will be able to participate equally with their peers. This requires reasonable accommodation which replaces formal equality, whereby all people are

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[11]CRPD (n 3 above), Preamble (e).
[12]M Oliver& C Barnes, *The new politics of disablement* (2014).
[13] G Kangaude 'Disability, the stigma of asexuality and sexual health: A sexual rights perspective' (2015)5 *Review of Disability Studies* 4.
[14]N Banda 'Protection of the Rights of Persons Living with Cognitive Disabilities in the Context of HIV& AIDS under the African Human Rights System' Unpublished LLM dissertation, University of Pretoria (2012).
[15]L Terzi 'The social model of disability: A philosophical critique' (2004)24 *Journal of Applied Philosophy,* 141-157.
[16]Ngwena (n 2 above) 145.
[17]M Oliver *The politics of disablement* (1990).
[18]Ngwena (n 2 above).

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given identical treatment regardless of any difficulties they might face, with substantive equality whereby actions are taken to remove the barriers to equality.[19]Banda differentiates the human rights approach from the social approach with the emphasis on the responsibility of the state to tackle socially created obstacles in order to ensure full respect for the dignity and equal rights of all persons. The emphasis on addressing the social barriers that prevent the development and participation of persons with disabilities is key to ensuring that adolescent girls with MID also realise their rights in Tanzania.

In addition, in order to ensure that children with intellectual disabilities realise their rights, it is necessary to have a system for early identification of such children and their specific needs in order to be able to provide them with the support that they require. Ngwena notes that South Africa has such a system but points out that the IQ tests on which they are based have a toxic history (in the eugenics movement) and even today are used to exclude the 'abnormal' rather than identify the learning needs of those with intellectual disability in order to support them.[20] Colmar also shows the inherent unreliability of IQ tests for a variety of reasons, including cultural bias and inappropriateness and lack of standardisation and concludes that IQ tests should be used with extreme caution as they are flawed and give little in the way of positive outcomes for the child, the family or the accessing psychologist.[21] While noting the progress made by including testing for adaptive behaviour alongside IQ, Colmar identifies many of the same weaknesses in such tests as well and concludes that, at the minimum, diagnosis of intellectual disability should only be made after taking into account environmental factors including family structure, cultural and ethnic background and socio-economic status.[22]

These observations are all relevant to Tanzania even if it has not developed its own national diagnostic programme. Some 'Special Education' teachers have been trained to work with children with intellectual disability but it is not known how they identify and support these children.

1.4.2 Inclusive education

Inclusive education, as originally envisioned, had a broad vision of 'addressing and responding to the diversity of needs of all children, youth and adults ... and reducing and eliminating exclusion within and from education.'[23] All the different groups of marginalised and disadvantaged children, including children with disabilities were included. Such a vision recognised also that this would require a paradigm shift, a transformation of educational systems and structures as well as the nature of the curriculum and teaching methods.[24]

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[19]Ngwena (n 2 above)155, quoting from *President of the Republic of South Africa v Hugo* 1997(6)BCLR(708)CC para 41.
[20]Ngwena above 162.
[21]S Colmar *et al* 'Assessing intellectual disability in children: Are IQ measures sufficient or even necessary' (2006) 16 *Australian Journal of Guidance & Counselling* 2.
[22]Colmar (as above).
[23] United National Education Scientific and Cultural Organisation (UNESCO) *Policy Guidelines on Inclusion in Education* 2009.
[24]As above.

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The UNESCO guidelines echoed the definition of inclusive education of the British Psychological Society which stated that inclusive education, rejected any form of segregation or exclusion of learners for any reason, maximised their participation in school and made learning more meaningful and relevant to them through changing policies, curricula, culture and practices in school.[25]

However, the broadness of the vision led to a lack of clarity about exactly what inclusive education was. As summed up by Ainscow *et al.,* inclusive education came to be interpreted in many ways, as being applied to particular groups of children, an extension of Education for All and a principled approach to education and society.[26]At the same time, as noted by Miles and Singal, Education for All tended to overlook the issue of disability in education. As a result, maybe partly as a reaction against this overlooking, inclusive education has tended to come to focus specifically on education for children with disabilities.[27]

How inclusive education applies to children with disabilities was spelled out in Article 24 of the CRPD,[28] which was carefully analysed by Ngwena, among others, to show clearly its importance and what is required to promote substantive rather than formal equality, through taking 'positive steps to provide disabled learners with individualised materials and support'[29]

However, Miles and Singal also noted that such a singular focus on disability while ensuring that children with disabilities benefitted from their participation in inclusive education, tended to overlook 'other aspects of their overall identity such as their gender, economic status, ethnicity etc.'[30] all of which need to be taken into account in a truly inclusive education system. This is very relevant to Tanzania where girls with MID face intersecting problems related to gender, age, location and poverty.

Tanzania claims it is following a policy of inclusive education with the result that children with MID, whether recognised or unrecognised, study in the same classrooms as other children. However, the new education policy only commits to identify and support children with special needs.[31] This study will consider how or whether inclusive education is being put into practice or whether Tanzania is one of the countries which follow the trend, identified by Ngwena, of recognising the need to have an inclusive education system but taking no steps to implement it.[32]

Several studies have been carried out into the nature and extent of inclusive education for children

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[25]British Psychological Society 'Inclusive Education Position Paper' in E Winter & P O'Raw 'Literature Review of the Principles and Practices relating to Inclusive Education for Children with Special Needs (2010).
[26] M Ainscow *et al* 'Improving schools, developing inclusion'in S Miles& N Singal 'The Education for all and inclusive education debate: Conflict, Contradiction or Opportunity'(2010)14 *International Journal of Inclusive Education 1.*
[27] S Miles & N Singal (above)12.
[28] CRPD (n 3 above) art 24.
[29]Ngwena (n 2 above)146.
[30] S Miles & N Singal (n 26 above)13.
[31]URT, *Education and Training Policy* (2014)3.
[32]Ngwena (n 2 above).

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with disabilities in primary schools in Tanzania, including by Hakielimu,[33] Chaula,[34] Stone-MacDonald,[35] Krohn-Nydal,[36] Godwin,[37] Hoffman and Kilimo,[38] and Polat.[39] The studies provide valuable information on barriers to inclusive education including lack of trained teachers and a supportive curriculum as well as appropriate materials. Stone-MacDonald shows how this affects children with MID from the moment they enter school, thereby jeopardising their chances of completing primary school due to negative perceptions by the teachers. However, none of the studies touch upon the right to CSE for children with disabilities. By contrast Mbwilo *et al*[40] and Aldersey[41] researched into children with intellectual disabilities from the perspective of their families, which includes some information on the problems these children face whether in inclusive or special schools. In Mbwilo's research, more than half the children had not gone to school at all. Aldersey touches on the issue of sexuality for these children but says nothing about CSE.

These studies complement the situation analysis provided by the National Strategy on Inclusive Education[42] which showed that, at the time it was published, less than 2 percent of schools were classified as inclusive. In such a situation, the chances of children with MID completing primary education and therefore accessing CSE are very low.

Thus, Tanzania can be facing a serious problem with regard to children with MID. Adnams[43] points out how malnutrition and disease can cause intellectual disability, particularly MID. Since 35 percent of Tanzanian children are stunted,[44] there is a strong likelihood that large numbers of children actually have MID but have not been identified due to the small number of teachers trained in identification of and support to such children.

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[33]HakiElimu, Watoto wenye ulemavu wana fursa ya kupata elimu; Ripoti ya utafiti wa hali na upatikanaji wa elimu kwa watoto wenye ulemavu Tanzania (2008).
[34]G Chaula, 'Challenges teachers face in implementation of inclusive education in primary schools in Tanzania' unpublished Master's Thesis, Hedmark University College,2014.
[35]A Stone MacDonald 'Identification and labels for young Tanzanian children: An examination for children with disabilities-Mild intellectual disabilities in primary schools in Tanzania' (2015) *DADD-PosterPresentation.*
[36]A Krohn-Nydal 'The Development of inclusive education in Tanzanian primary schools' Unpublished Masters Dissertation, University of Oslo, 2008.
[37]A Godwin 'The public primary school teachers' perception on inclusive education: the case of selected public primary schools in Moshi Municipality', unpublished Masters dissertation, Open University of Tanzania, 2013.
[38]R Hoffman & J Kilimo, Teachers' Attitudes and Self-Efficacy Towards Inclusion of Pupils with Disabilities in Tanzanian Schools (2014)1 *Journal of Education and Training 2.*
[39]F Polat, Inclusion in education; a step towards social justice (2011)31 *International Journal of Educational Development* 50-58.
[40]G Mbwilo *et al* Family Perceptions in Caring for Children with Mental Disability: a qualitative study from Tanzania (2011)12 *Tanzania Journal of Health Research 2.*
[41]HM Aldersey & HR Turnbull 'The United Republic of Tanzania's National Policy on Disability: A Policy Analysis' (2011)22 *Journal of Disability Policy Studies3*.
[42] URT, The national strategy on inclusive education (hereinafter The strategy on inclusive education) (2009).
[43]CM Adnams 'Perspectives of Intellectual Disability in South Africa: Epidemiology, Policy, Services for Children and Adults' (2010) 23 *Current Opinion in Psychiatry* 436-440.
[44]URT, Food and Nutritional Centre (TFNC) *Nutrition Survey, final report* (2014).

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1.4.3 Comprehensive Sexuality Education and Information

Ever since the International Conference on Population and Development in Cairo,[45] the right to CSE has been developed and elaborated on in increasing detail. The Centre for Reproductive Rights (CRR) has produced several documents which sum up the nature and importance of the right to CSE,[46] including for persons with disabilities.[47] Different UN agencies have developed guidelines on how to operationalise CSE based on many experiences across the world.[48]Many researchers have analysed the extent to which CSE is actually being operationalised and identified the gaps that need to be filled.[49] For example, Halberland and Rogow[50] argue strongly for the 'empowerment approach to CSE' especially for girls and marginalised young people, including persons with disabilities. These normative and analytical texts provide an excellent framework for investigating to what extent Tanzania is fulfilling its own obligations.

The second issue of importance, given the Tanzanian approach to CSE, is the debate about abstinence only education as opposed to CSE. The contrasting effectiveness of each has been analysed in a series of meta-analyses of programmes throughout the world[51] which show, in general, that CSE is significantly more effective than abstinence only education.[52] This issue is emphasised by Mabala in his paper discussing why adolescent girls in urban areas have the most access to SRH information but remain the most vulnerable to HIV infection.[53] Mabala, together with Halberland and Rogow,[54] argue that CSE must also address the underlying causes of HIV. Halberland and Rogow point out that meta-analyses of CSE only show a success rate in two thirds of cases and even less success when biological markers are taken into consideration.[55]

However, few of the studies touch on the Tanzanian experience or specific issues facing girls with MID. In Tanzania, Mkumbo[56] has provided a careful analysis of sexuality education in Tanzania's HIV syllabus and reaches the same conclusion as the Centre for Reproductive Rights that Tanzania does

[45]Programme of Action of the International Conference on Population and Development (ICPD) adopted in Cairo 5-13 September 1994, UN Doc A/CONF 171/13 1994.
[46]Centre for Reproductive Rights (CRR) Fact Sheet: *An International human right: Sexuality education for adolescents* (2010) & Briefing Paper: *Sexuality Education* (2008).
[47]International Disability Alliance (IDA) & CRR, Inclusive Comprehensive Sexuality Education and the CRPD: Submission to the CRPD Committee's Half Day of General Discussion on the Right to Education (2015).
[48]UNFPA, Operational Guidance for Comprehensive Sexuality Education: A focus on human rights and gender (2014).
[49]UNESCO, *Comprehensive Sexuality Education: The challenges and opportunities of scaling up* (2012) 16.
[50]N Halberland & D Rogow 'Sexuality Education: Emerging trends in evidence and practice' (2015)56 *Journal of Adolescent Health* 515-521.
[51]D Kirby *The impact of sex education on the sexual behaviour of young people Population* (2011) UN Department of Economic and Social Affairs, Division Expert Paper no 12 (2011).
S Mavedzenge, *et al* 'HIV Prevention in young people in sub-Saharan Africa: A systematic review' (2011)49 *Journal of Adolescent Health* 568-586.
[52]J Rosenbaum 'Patient teenagers? A comparison of the sexual behaviour of virginity pledgers and matched non-pledgers' (2009)212 *Paediatrics* 110-120.
[53]R Mabala 'From HIV prevention to HIV protection: Addressing the vulnerability of girls and young women in urban areas' (2006)18 *Environment and Urbanisation 2, 407-432.*
[54]Halberland & Rogow (n 50 above).
[55] As above.
[56] K Mkumbo, 'Content analysis of the status and place of sexuality education in the national school policy and curriculum in Tanzania' (2009) 4 *Educational Research and Review 616-625.*

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not have a CSE syllabus.[57] Other studies show difficulties facing teachers in teaching CSE,[58] and the sensitive nature of introducing CSE into the curriculum because of cultural and religious resistance[59]. Even in the community, girls have great difficulty in accessing their rights to SRH information and services.[60]

1.4.4 Intersectionality

From the above, it can be seen that, in addressing the issue of SRHR for adolescent girls with intellectual disabilities, one has to deal with at least three levels of potential discrimination and denial of rights. Cook's principal concern is gender but she notes that gender intersects with other elements such as disability, age and class to create 'compounded stereotypes' that make it more difficult for women and girls to realise their rights to substantive equality.[61] She also points out that this is recognized by the CRPD, which requires States Parties to combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex.[62]

However, although Cook mentions the element of age, she does not discuss it in detail. Indeed, when looking at the SRHR of people with disabilities, researchers and academics have tended to conflate women and girls as if their issues are the same. Girls with intellectual disabilities have to face a triple burden as, often, 'their sexuality is deemed to be in need of regulation (to the point of being made invisible) because they are young, disabled and female'.[63] Their access to CSE is one example of this. This triple burden can be compounded also by location and poverty. Children with intellectual disability are less likely to go to schools which are well equipped with teachers and materials.[64]

Thus, intersectionality provides a useful tool for assessing the situation of adolescent girls in general and adolescent girls with MID in particular as it shows how the different forms of marginalisation influence and mutually reinforce one another. Taefi shows how adolescent girls are marginalised twice over, because of their gender and age although she does not deal with the issue of disabilities.[65] Others have given insights into the intersection between gender, age and disabilities in

[57]Centre for Reproductive Rights (CRR), *Forced Out; Mandatory Pregnancy Testing and the Expulsion of Pregnancy Students in Tanzanian Schools*(2013).
[58]M Bilinga & N Mabula 'Teaching Sexuality Education in Primary Schools in Tanzania: Challenges and Implications'(2014)5 *Journal of education Practice* 27.
[59]L Mbonile & E Kayombo 'Assessing acceptability of parents/guardians of adolescents towards introduction of sexual and reproductive health education in schools at Kinondoni Municipal in Dar es Salaam City, East Africa (2008)5 *Journal of Public Health 1, 26-31.*
[60]R Mbeba *et al* 'Barriers to SRH services and rights among young people in Mtwara District, Tanzania: A qualitative study(2012)13:1 *Pan-African Medical Journal 1-6.*
[61] RJ Cook & S Cusack *Gender stereotyping: Transnational legal perspectives* (2010) 29.
[62] Cook & Cusack (above).
[63]W Sait *et al* 'Sexuality, gender and disability in South Africa' in S Tamale (ed) *African Sexualities A Reader* (2011)504.
[64] Adnams (n 43 above).
[65] N Taefi 'The Synthesis of Age and Gender. Intersectionality, Human Rights Law and the Marginalisation of the Girl Child' (2009)17 *International Journal of Children's Rights* 345-376.

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relation to SRHR [66] but not with regard to the right to CSE.

The impact of the lack of sexuality education is considered by several authors. Richards *et al* give reasons why it is so important that they are given sex education. Many people with intellectual disabilities have major gaps in their sexual knowledge in a context of increasing deinstitutionalisation, the increased incidence of sexual abuse and the threat of HIV and AIDS.[67] In addition, Dawood *et al* examined the vulnerability of adolescents with intellectual disabilities to HIV and AIDS and found they had many critical gaps and erroneous beliefs, although 17 percent of them were already involved in sexual activity.[68]Ramage outlined the consequences of non-provision of such education, including the increased risk of victimisation and the difficulties of establishing healthy relationships.[69] Thus, Rathbone points out the need to train teachers and care-givers on the importance of providing such education to children with intellectual disabilities.[70] At the same time, Shaafsma *et al* in a review of articles on teaching sex education to children with intellectual disabilities concluded that even where such teaching was being carried out, little is known about the most effective methods.[71] These readings provide potential points of comparison with teaching adolescent girls with MID in Tanzania.

The failure to provide age-appropriate and relevant CSE to children with disabilities leads McDowall, in her review of several African countries, to conclude, ironically, that 'the only way a disabled person learns about sexual relationships is through sexual abuse'.[72] Firstly, children with disabilities are often not sent to school for reasons of stigma as well as difficulties of access. This deprives them of the chance to get whatever sexuality education that might be provided. Secondly, teachers and guardians are afraid that sexuality education will lead to them wanting to practise what they have learned.[73] These examples give valuable insights into the need to address other stakeholders such as care-givers and teachers in the Tanzanian context.

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[66] L Lockhart & FS Danis *Domestic violence, intersectionality and culturally competent practice'* (2010); J Moodley & L Graham 'The importance of intersectionality in disability and gender studies' (2015) 2 *Agenda: Empowering Women for Gender Equity* 24-33.

[67] D Richards *et al*, 'Sexuality and Human Rights of Persons with Intellectual Disabilities' in F Owen & D Griffiths (ed) *Challenges to the Human Rights of People with Intellectual Disabilities* (2009) 184-218.

[68]N Dawood *et al* 'Knowledge, attitudes and sexual practices of adolescents with mild retardation in relation to HIV/AIDS' (2006)1 *African Journal of AIDS Research* 1-10.

[69]K Ramage 'Sexual Health Education for Adolescents with Intellectual Disability: A Literature Review' (2015)15 *Saskatchewan Prevention Institute*.

[70]L Rathbone 'The effect of a sexuality training programmes on the knowledge and attitudes of caregivers working with women with intellectual disabilities who live in residential care facilities: A social story approach' unpublished thesis, Faculty of Humanities, University of Pretoria, 2015.

[71]D Shaafsma *et al* 'Identifying Effective Methods for Teaching Sex Education to Individuals with Intellectual Disability: A Systematic Review (2015)4 *The Journal of Sex Research,* 412-432.

[72] R McDowall 'The only way a disabled person learns about sexual relationships is through sexual abuse - Key Responder Understandings of Sexual Abuse of Disabled People in Kenya' unpublished Dissertation, Institute of Global Health, University College, London, 2015.

[73] As above, this is the same comment that is made in opposition to all sexuality education for adolescents but seems to be even stronger for adolescents with disability;
Also see JH Hancock 'Disability and HIV/AIDS – A Systematic Review of Literature in Africa'(2009)1 *Journal of the International AIDS Society* 12-34.

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One reason why the rights of adolescent girls with MID, including the right to CSE is not being fulfilled is a lack of accountability. Aldersey and Turnbull argue that the key aspect missing in Tanzanian policy and legislation on disability is the lack of enforcement mechanisms.[74] Such mechanisms were emphasised by Frohmader and Ortoleva who divided accountability into three elements, responsibility, answerability and enforceability,[75] all of which need to be examined in the context of ensuring that adolescent girls with MID in Tanzania access CSE.

1.5 Significance

In response to the situation outlined above this study seeks to contribute towards better understanding of the provision of CSE to girls with MID in Tanzania from a human rights perspective. At present there are few studies that address the issue of SRHR for women with disabilities and none on the access of girls with MID to CSE. There are also few studies on how 'special needs' and other teachers in Tanzania identify and support girls with MID, particularly in realising their rights to inclusive education and CSE.

Above all, no study has been made of the interlocking specificities and magnitude of the barriers that prevent this particular group of adolescent girls from realising their rights to sexuality education. It is the intention of this study to break the silence surrounding this group and provide concrete proposals for addressing these barriers.

1.6 Chapter Outlines

This study is divided in five main chapters. Chapter One provides a general introduction and the structure of the study, together with the literature review. Chapter Two considers the concept of Mild Intellectual Disability within the broader concepts of Intellectual Disability and Disability as a whole. Chapter Three considers state obligations under international and regional treaties to ensure access of girls with MID to CSE and Chapter Four analyses how these obligations have been translated into policy, legislation and programmes and their implementation on the ground in Tanzania. Finally, Chapter Five carries out an integrated analysis and makes recommendations on how these challenges and barriers faced by girls with MID can be addressed from a human rights perspective, particularly through the use of the CRPD.

[74] Aldersey & Turnbull (n 41 above).

[75] C Frohmader & S Ortoleva 'The Sexual and Reproductive Rights of Women and Girls with Disabilities' Briefing Paper ICPD Beyond 2014 on 1st July 2013. Available at http://wwda.org.au/wp-content/uploads/2013/12/issues_paper_srr_women_and_girls_with_disabilities_final.pdf. (Accessed on 22 August 2016).

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Chapter Two: Conceptualising Intellectual Disability

2 Introduction

Any initiative to address the rights of adolescent girls with MID cannot be assessed without a clear understanding of what MID is. This requires an analysis of the concept of disability as well as that of intellectual disability and how these concepts have changed and are changing according to time, place and the nature of society. They are not static concepts but are influenced or shaped by the economic and social context.[76] These definitions then shape the formulation and practice of public policy and how community members, parents and social service providers respond to the policy.

Without pre-empting the subsequent analysis of how perceptions and definitions of intellectual disability have evolved alongside definitions of disability as a whole, it can be argued that intellectual disability is the 'poor cousin' in relation to disability as a whole. As argued by Mckenzie *et al*, persons with intellectual disabilities are among the most marginalised groups globally.[77] Services for them are not as extensive as those for persons with other forms of disability. This is partly because intellectual disability, particularly mild intellectual disability, is not as visible as other disabilities and partly because those with intellectual disabilities are less able to advocate and lobby for themselves.[78] Thus it can be arguedthat even the CRPD does not pay sufficient attention to intellectual disability. While mental and intellectual impairments are mentioned in Article 1,[79] and while their rights are subsumed into the general rights of people with disabilities, the specific issues facing those with intellectual disability are not always addressed. This will be discussed more fully below.

With regard to persons with MID, Sethosa notes that the issue of mildly intellectually disabled learners is the most controversial.[80] She gives as one of the reasons for this the fact that learners with MID have no visible physical signs of disability. Outside the institutionalised world of school and formal employment, they may not be recognised as having a disability at all,[81] but in the world of the school, a major barrier to their effective participation is the lack of recognition of their disability while they are, arguably, the largest group of persons with disabilities.[82]

This chapter will look first at changing definitions of disability, including intellectual disability, culminating in the CRPD and its application, particularly in Africa, before concentrating on aspects that are more specific to intellectual disability, especially MID.

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[76] Oliver& Barnes (n 12 above).

[77] J McKenzie *et al* 'Intellectual disability in Africa: Implications for research and service development (2013)20 *Disability and Rehabilitation Journal* 1750-1755.

[78]Mckenzie *et al* above

[79]CRPD (n 3 above) art 1.

[80]MF Sethosa 'Assisting Teachers to support Mildly Intellectually Disabled Learners in the Foundation Phase in Accordance with the Policy of Inclusion' unpublished PhD thesis, University of South Africa, 2001 29.

[81]AL Pillay 'Social competence in rural and urban children with mental retardation: preliminary findings' (2003)33 *South African Journal of Psychology 171-181;* Also see Adnams (n 43 above).

[82]Sethosa (n 73 above).

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2.1 Approaches to Disability

Perceptions and definitions of intellectual disability have largely changed and developed alongside definitions of disability as a whole. There are three broad approaches, the supernatural, the scientific and the social.

2.1.1 Supernatural perceptions

Originally, most societies believed in supernatural causes of disability. As summed up by the African Child Policy Forum (ACPF), such causes included a curse from God or the ancestors, witchcraft, incest and misconduct of the mothers.[83] Christianity and Judaism also linked impairment with the consequences of sin.[84] As a result many people with disabilities were tortured as a way of exorcising the devil or evil spirits.[85] With particular reference to intellectual disability, McKenzie *et al* note that researches in several African countries show that many community members still attribute intellectual disability to either witchcraft or divine retribution.[86] This often leads to inhuman treatment in the belief that this will drive out evil spirits.[87]

However, Mckenzie *et al* also note that Christian and Muslim traditions also include acceptance of such children as a gift from God and Munyi identifies several traditional societies, such as the Wachagga in Tanzania, who did not harm the physically handicapped as they were seen to be pacifiers of evil spirits.[88]

While these 'supernatural' perceptions of disability have been officially superseded by other definitions, they persist,[89] and strongly influence perceptions of not only families, communities and teachers but also senior government officials and policy makers. As a result, many progressive policies do not receive the support required.[90] At community level, this creates a vicious circle. Stigmatisation of the child and the family leads to the decision by many families to hide away their children for fear of the stigma. This, in turn, leads to further stigmatisation particularly where there has been little attempt to disseminate more scientific and rights based definitions.

2.1.2 The scientific model

In ancient times, disability was often seen as weakness also. The ancient Greeks, as well as some African societies, even favoured infanticide for those with any physical impairment as they were 'imperfect'.[91] With the advent of capitalism, people with disabilities were re-defined as being 'unfit' if they could not be productively employed. It was the role of the medical profession to classify and assign them to an institution.[92] Proponents of eugenics even argued they should not be supported at

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[83]African Child Policy Forum (ACPF) *Children with Disabilities in Africa: Challenges and Opportunities*(2011).
[84]Oliver& Barnes (n 12 above) 100-101.
[85]C Munyi 'Past and present perceptions towards disability: a historical perspective' (2012) 32 *Disability Studies Quarterly 2.*
[86]McKenzie *et al* (n 77 above).
[87]ACPF, The Africa Report on Children with Disabilities: Promising starts and persisting challenges (2014)30.
[88]Munyi (n 85 above).
[89]Oliver& Barnes (n 12 above) 58.
[90]ACPF (n 83 above).
[91] Oliver & Barnes (n 12 above); See also Munyi (n 85 above).
[92]M Oliver, *Understanding Disability: From Theory to Practice* (1996) as quoted in L Terzi, (n 15 above) 153. See also M Oliver& C Barnes (n 12 above) Chapter Three: The Rise of Disabling Capitalism. In the early days of

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all.[93] From this belief, it was a small step to advocating for their suppression or elimination, just as the ancient Greeks had done in the past.[94]

After two World Wars which caused millions of new disabilities, along with the rise of the Welfare State and the reaction against eugenics, a more positive approach was taken. Disability was seen as individual tragedy, a 'deficit' which could be reduced or remedied by medical intervention.[95] However, the emphasis was still on impairment which prevented the individual from functioning 'normally' in society.[96]

As with supernatural beliefs, although the medical model has largely been superseded by a more social model, it still has significant influence.[97] However, the emphasis on personal tragedy put the spotlight on the responsibility of society, thereby paving the way for the social model of disability.[98]

2.1.3 The social model of disability

The first major critique of the individual/medical model was expressed by the Union of Physically Impaired against Segregation (UPIAS) which defined disabled people as an oppressed group and highlighted the barriers to their full independence and participation in society. They argued that people are disabled by society which instead of accommodating them, excludes and isolates them.[99] The onus was therefore on society to remove these barriers.[100] Although, originally, this referred only to physical disability, it later came to encompass intellectual disability as well. This definition increasingly influenced policies, laws and conventions, culminating in the CRPD.

However, Shakespeare and others criticised the social model for neglecting or downplaying the aspect of impairment. Terzi notes that the social model does not recognise that some impairments exist outside of social oppression and cannot be remedied so easily.[101] While the medical model is reductionist and over-simplifies disability from the medical standpoint by not taking context into account, the social model does the same by not taking into account the effects of impairment regardless of the social context.[102]

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capitalism, these were also joined by many other categories such as the destitute, homosexuals and any other 'deviants'.

[93]Oliver&Barnes (n 12 above) 39.

[94]E Black *War against the weak: Eugenics and America's Campaign to Create a Master Race* (2003).

[95]Oliver& Barnes (n 12 above) 141.

[96]WHO, *classification of Impairments, Disabilities and Handicaps* (ICIDH) 1980.

[97]Such classifications are still common in Tanzania. Each village/neighbourhood is supposed to have a breakdown on the local population into 'able-bodied' people who are able to work, along with others such as old people, children and people with disabilities.

[98] K Castles 'Nice, Average Americans': Post-war Parents' groups and the defence of the normal family' in S Noll & JW Trent Jr (eds) *Mental Retardation in America: A Historical Reader* (2004) as quoted in D Tarulli & C Sales ' Self-Determination and the Emerging Role of Person-Centred Planning: A Dialogical Framework in F Owen & D Griffiths (eds) *Challenges to the Human Rights of People with Intellectual Disabilities* (2009) 106.

[99]Oliver, (n 92 above) 153.

[100]T Shakespeare & N Watson, 'The Social Model of Disability an outdated ideology?'(2002)2 *Research in Social Science and Disability Journal* 9-28.

[101]Terzi (n 15 above).

[102]Terzi above

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In response to these debates, the WHO, in 2001, produced a definition which brought together the medical and the social by emphasising the interaction between features of a person's body and features of the society in which he or she lives'.[103] Three elements were identified, individual impairment, activity and participation restrictions, and environmental factors which include the physical, social and attitudinal environment in which people live and conduct their lives.[104] The WHO later applied the International Classification of Functioning, Disability and Health to Children and Youth as well.[105] However, despite the recognition of environmental factors, disability still remains primarily an issue of individual impairment rather than, as Ngwena emphasises, 'the outcome of the manner in which the prevailing socio-economic environment interacts with the body',[106] which puts the onus on the state to repair the historical exclusion and marginalisation of disabled people.[107]

2.1.4 Human rights approach

The CRPD which came into effect in 2008 put the seal on the movement towards a social definition of disability when it stated that:

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[108]

Therefore, the CRPD emphasises the need for reasonable accommodation to 'ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.'[109] Denial of reasonable accommodation is identified as one form of discrimination.[110]

By providing a definition of disability which emphasises the responsibility of States parties to remove the barriers that prevent persons with disabilities enjoying their rights to the full, the CRPD opens the way for a human rights approach. As a Marxist, Oliver believed that such an approach is ineffective against current trends in Western capitalism, arguing that law courts do not and cannot challenge the political and social structures.[111]However, elsewhere in the world, particularly in the Global South, people have more faith in the human rights interpretation of disability, together with an intention to use the CRPD and other human rights conventions to address discrimination against and oppression of disabled people. This approach has met with some successes in Africa. For example, the African Commission affirmed disability as a prohibited ground of discrimination notwithstanding that it is not explicitly mentioned under Article 2 of the African Charter.[112] In the case brought by Western Cape Forum for Intellectual Disability in South Africa, a High Court found

[103]WHO, International Classification of Functioning, Disability and Health (ICF) (2001).
[104]WHO International Classification of Functioning, Disability and Health: Children and Youth Version (2007)17.
[105] WHO ICF-CY (above).
[106]Ngwena (n 2 above) 145.
[107]Ngwena above 143.
[108]CRPD (n 3 above).
[109]CRPD as above, art 2 Definitions.
[110]CRPD above
[111]Oliver & Barnes (n 12 above) 151.
[112]*Purohit and others v The Gambia* (2003) AHRLR 96 (ACHPR 2003).

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that the exclusion of profound and severely intellectually disabled learners from the formal education system was a violation of their rights to basic education, human dignity and equality.[113]

In addition, it is possible to see a progression in the way the African Union and countries in Africa have conceptualised disability. Thus for example, in Uganda, the Persons with Disabilities Act of 2006 notes the interaction between 'environmental barriers' and impairment[114] but with no elaboration of the environmental barriers which would seem to be more natural than social. However, in its report to the Committee on the Rights of Persons with Disabilities (CRPD Committee) following ratification of the CRPD, Uganda claimed that it had made a 'significant paradigm shift away from the medical/charitable models to understanding disability as a social phenomenon'.[115]

In order to domesticate the CRPD, some countries, including Tanzania have passed new Persons with Disabilities Acts. By contrast, Kenya, while ratifying the CRPD has not revised its Disability Act which still defines disability in terms of medical impairment.[116] These differences of definition are important as they lay the foundation for policies, programmes and practice. Thus, for example, while jurisdictions that revised or updated their definitions of disability put emphasis on the need for inclusive education for children with disabilities, in Kenya, the emphasis remains on isolating them in special needs education.[117] However, while the African Child Policy Forum notes the lack of uniformity in domestic legislation across Africa,[118] the switch to the social model continues to gather pace.

2.2 Intellectual disability

Changing perceptions and definitions of intellectual disability have mirrored attitudes to disability as a whole. Thus, Bersami identified three 'waves' in relation to intellectual disability.[119] The first wave, from the mid-19th Century he calls 'professionalism' which is similar to the medical model, as identification of intellectual disability was left to the medical profession. Where people with intellectual disability could not be productive, they were also confined to institutions. The second wave emerged after the Second World War, when intellectual disability was also seen as personal tragedy. In the third wave, with the advent of the social model, emphasis has been placed on self-knowledge and self-efficacy which emphasises the capacity of people with intellectual disability to live independently. This movement rejects the exceptionalism of intellectual disability and emphasises that they have the same rights as everyone else 'by virtue of being human rather than as

[113] *Western Cape Forum for the Intellectual Disability v Government of the Republic of South Africa & Another* (2011) 5 SA 87(WCC.).
[114] Ugandan Persons with Disabilities Act of 2006.
[115] ACPF (n 80 above) *Uganda report* para 22.
[116] Kenyan Persons with Disabilities Act of 2003.
[117] L Wakefield & NL Murungi 'Domesticating international standards of education for children with disabilities: a case study of Kenya and South Africa' in Grobbelaar-du Plessis and TH Van Reenen (eds) *Aspects of Disability Law in Africa* (2012)133-156.
[118] ACPF, (n 80 above).
[119] H Bersami 'Leadership in Development Disabilities: where we have been, where we are and where we are going in G Dybwad & H Bersami Jr. (eds) *New voices: Self Advocacy by People with Disabilities*(1996). Also quoted by Tarulli &Sales, (n 98 above).

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a result of being disabled'.[120] This was forcefully stated in the Montreal Declaration which stipulated that people with intellectual disability should have the freedom to make their own choices. It is the responsibility of society to provide reasonable accommodation to remove barriers that prevent them from living independently.[121]

However, despite the emphasis on reasonable accommodation and positive approaches, problems still remain. Intellectual disability is often subsumed into disability as a whole which means that the specific needs of those with intellectual disability are not identified or addressed. This is true even of the CRPD which, apart from the definition, hardly mentions intellectual disability although later writers have applied the CRPD definition specifically to intellectual disability. For example, Wakefield and Murungi have analysed how the CRPD has or has not been applied in practice for people with intellectual disability in South Africa and Kenya.[122]

However, the emphasis on the individual rather than the social with regard to intellectual disability remains predominant. Thus, despite the ICF, the WHO defines intellectual disability as:

> A significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope independently and begins before adulthood, with a lasting effect on development.

Elsewhere the WHO talks of 'significant limitations' in intellectual functioning and adaptive behaviour.[123]

2.3 Mild Intellectual Disability

Intellectual disability covers a wide range of disability, from those who have obvious mental and physical impairments to those whose disability is not apparent at all, or which is only apparent in certain situations. Indeed, Wakefield and Murungi question whether the WHO definition, with its emphasis on 'significant limitations' even recognises those with MID.[124] When it does come to identifying or classifying MID, administrators tend to assess individual impairment only, rather than considering the social environment. Thus, MID is defined as an impairment which occurs during childhood and adolescence and is characterized by below average IQ (from 50-70) and deficits in at least two areas of adaptive behaviour.[125] According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5),[126] these areas are the conceptual domain (which includes language, maths, reasoning, knowledge and memory); the social domain (which looks at the ability to communicate and form and maintain relationships); and the practical domain (which regards broad

[120]J Lecomte & C Mercier, 'The emergence of the human rights of persons with Intellectual Disabilities in International Law: The Cases of Montreal Declaration on Intellectual Disabilities and the United Nations Convention on the Rights of Persons with Disabilities' in F Owen & D Griffiths (eds) *Challenges to the Human Rights of People with Intellectual Disabilities* (2009) 43-75.
[121]Tarulli &Sales, (n 98 above).
[122]Wakefield and Murungi (n 118 above).
[123]WHO, Global Resources for People with Intellectual Disabilities (2007).
[124]Wakefield and Murungi (n 118).
[125]Oliver (n 92 above).
[126]American Psychiatric Association, *Intellectual Disability* (2013).

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areas of self-management such as self-care, and managing money, school, work and recreation). While this definition has moved away from sole reliance on IQ in assessing intellectual disability, DSM-5 notes that testing for IQ is still an important part of the classification of levels of intellectual disability.[127]

Because of the difficulties in operationalising such a definition, Sethosa just states that those with MID have below level intellectual functioning but higher functioning than those who have severe intellectual disability,[128] which seems to be a statement of the obvious rather than a definition. However, she goes on to elaborate by saying that those with MID are 'learners who are characterised by poor memory, poor recall, poor attention, high rate of forgetting etc.' The key word here is that of 'learners' as MID manifests itself particularly when the child joins school or has to operate in any other institutional setting. Others have referred to the 'six hour retarded child'[129] because the disability only becomes apparent during the hours when they attend school and can only be diagnosed once the child is in school.[130]

Thus, in one sense, while children with MID are not homogeneous, the one thing that defines them is their 'inability to fully benefit from the existing regular education',[131] and one wonders whether, if there was no school system, MID would be defined or considered a problem at all. Patton and Dowdy[132] have noted that, at home, such children are able to cope with life without showing any disability. Pillay and Adnams have both noted the same, and that such children in rural settings, where they do not have to interact with an institutionalised life, are not seen as abnormal and indeed have higher social competence than similar children in urban settings.[133]

Such a conclusion would, however, be dangerous, particularly with regard to the theme of this study. If adolescent girls with MID go unrecognised and/or unsupported, they will miss out on schooling and therefore CSE. As a result, they will be less able to develop positive relationships and will be more vulnerable to sexual harassment and abuse, and its consequences.

2.3.1 Identification and prevalence

Problems of identification of children with disabilities are a key cause of the lack of support to a large number of children, particularly in Africa. It seems clear that the number of children with disabilities in Africa is greatly under-estimated. The African Child Policy Forum points out that lower prevalence rates in countries in Africa are less the result of improved conditions and more of less developed data collection and systems. A similar analysis is given by the World Report on Disability which notes that, in general, the prevalence rates of disability in developing countries are often lower than those of developed countries 'because they collect data on a narrow set of impairments only'.[134] Given the lack of tools, only more severe disabilities are recognised. Such a lack of reliable

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[127] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) 2013.
[128] Sethosa (n 73 above).
[129] Sethosa above 28.
[130] As above.
[131] Sethosa above 14.
[132] Sethosa above 189.
[133] Adnams (n 43 above); Pillay (n 74 above) as quoted in Mckenzie *et al* (n 77 above).
[134] WHO & World Bank *World Disability Report* (2011)25.

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data has serious consequences as underestimation of the number of children with disabilities leads to lack of prioritisation and underfunding for these children.[135]

With regard to MID, the statistics are even fewer and differ widely. Thus, for example, Adnams notes statistics for prevalence of intellectual disability in South Africa range from 0.27 percent to 3.6 percent. Adnams also identifies several factors that contribute to MID, including malnutrition, malaria and foetal alcohol syndrome and notes that malnutrition in childhood 'is generally associated with global deficits in cognition, behaviour and motor skills.'[136] She stresses that growth stunting is strongly related to poor child development including poor performance at school and refers to a study which followed up children who had several malnutrition in infancy and found that these children had MID and problems with social adjustment among other factors.[137] The Tanzanian Nutrition Survey also recognised that stunting is a manifestation of chronic malnutrition and has lifelong effects on physical and mental development.[138] The current rate of stunting stands at 35 per cent nationally.[139]

Thus, it becomes imperative to have a system for identifying such children. Although South Africa has such a system it is unreliable, discriminatory and puts more emphasis on exclusion of than support to children with intellectual disability.[140] Colmar emphasises the inherent unreliability of IQ tests for several reasons, including cultural bias and inappropriateness and lack of standardisation and concludes that tests should be used with extreme caution as they do not contribute to positive outcomes for the child, the family or the assessing psychologist.[141] While noting progress in testing for adaptive behaviour, Colmar identifies many of the same weaknesses in such tests as well and concludes that, at the minimum, diagnosis of intellectual disability should only be made after taking into account environmental factors including family structure, cultural and ethnic background and socio-economic status.[142]

2.4 Conclusion

This chapter has looked at the evolving definition of disability as whole and intellectual disability in particular. Although there is now a general recognition, as expressed in the CRPD, that disability is a product of the interaction between individual impairment and the physical and social environment, the medical model often tends to prevail, particularly with regard to intellectual disability. These definitional problems have contributed to difficulties in identifying children with intellectual disabilities in particular MID which is the most prevalent and the most difficult to identify. Within this context, it is now necessary to consider Tanzania's international obligations to adolescent girls with MID, and how Tanzania has responded to these obligations, with particular reference to

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[135]ACPF above 17-18.
[136]Adnams (n 43 above).
[137]MB Stoch *et al* 'Psychosocial outcome and CT findings after gross undernourishment during infancy: a 20-year developmental study' (1982) *Developmental Medicine and Child Neurology 24:419–436; Also see*Adnams (n 43 above).
[138]Nutrition Survey (n 44 above)13.
[139]Nutrition Survey, 71.
[140]Ngwena (n 2) 162.
[141]Colmar *et al* (n 21 above).
[142]Colmar *et al* (above).

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ensuing they benefit fully from inclusive education and are therefore able to access CSE.

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Chapter Three: Tanzania's obligations under international human rights law

3 Introduction

This chapter will consider the legal and human rights obligations of the Tanzanian State to ensure that adolescent girls with MID realize their right to CSE. This requires looking at the rights of adolescent girls in general since the ability of adolescent girls with MID to access CSE is dependent on whether CSE is available to adolescent girls through primary education. In addition, it is necessary to consider the right of children with intellectual disability to inclusive education, as it is through such inclusive education that they are most likely to receive CSE. These rights will be considered within the overall rights environment, in particular the rights to health, education, equality and non-discrimination.

3.1 The importance of CSE and to adolescent girls with intellectual disability.

The definition and elements of CSE have continued to evolve ever since the International Conference on Population and Development (ICPD) emphasised the need to provide adolescents with the information and education they require so that girls can protect themselves from unwanted pregnancy, STDs and infertility.[143] Succeeding documents, in particular General Comments (GC) from Treaty Monitoring Bodies (TMBs)as well as the Special Rapporteur on Education have continued to clarify the nature and importance of CSE.

The United Nations Fund for Population Activities (UNFPA) defines CSE as a rights-based and gender-focused approach to sexuality education,[144] which enables children and young people to acquire accurate information about human sexuality in its entirety and develop positive attitudes towards their sexual and reproductive health as well as the psychosocial life skills required to put their knowledge and attitudes into practice and make informed decisions about their sexuality and sexual health.[145] It also promotes respect for human rights and diversity, gender equality and inclusion and participation.[146] The United Nations Educational, Scientific and Cultural Organisation(UNESCO) also emphasises that CSE should be culturally sensitive, scientifically accurate, realistic and non-judgmental.[147] Major topics to be covered in CSE were itemised particularly in General Recommendation 24[148] of the CEDAW Committee and GC 4[149] and 15[150]of the CRC and reiterated in

[143]United Nations Population Information Network (POPIN), *Report of the ICPD* (94/10/18)A/CONF.171/13.
[144]UNFPA, (n 48 above).
[145]United Nations(UN), *Report of the United Nation Special Rapporteur on the right to education: sexual education* (2010), para 12.
[146]UNESCO, *The Rationale for sexuality education: International technical guidance on sexuality education* (2009).
[147]As above, also see *Report of Special Rapporteur* (no 145 above) para 16.
[148]CEDAW Committee, *General Recommendation No.24: art 12 on Women and Health* (1999), A/54/38/Rev.1.
[149]CRC Committee*, General Comment No. 4 on Adolescent health and development in the context of the convention on the rights of the child, 1 July 2003, CRC/GC/2003/4.*
[150]CRC Committee, *General Comment No. 15: art 24 on the right of the child to the enjoyment of the highest attainable standard of health*, 2013, CRC/C/GC/15.

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GC 22[151] of the ESCR. These include STIs and HIV prevention and treatment; pregnancy prevention, family planning and contraception; and life skills such as communication and decision making. Therefore, CSE is a vital part of education for girls as, by contributing to the reduction of unintended pregnancies, unsafe abortion and HIV and AIDS, it enables their other SRHR to be fulfilled.[152] However, despite evidence on the effectiveness of CSE, even from the perspective of Africa where HIV is a bigger threat than elsewhere in the world, only 70 percent of countries with generalized HIV epidemics have implemented school-based HIV education programmes[153] let alone CSE. Thus, the special rapporteur on the right to education notes that, in many African countries, adolescents have little or no access to information on sexuality.[154]Half of those who did receive sexual education still received no information on key topics such as contraception, pregnancy and pregnancy prevention, STDs and the right to say 'no' to sex.[155] In response to the non-implementation of SRHR, including the right to CSE,the ESCR Committee has issued a new general comment on the right to SRH, which expresses in the strongest terms the obligations of States parties to implement the right to sexuality education which is comprehensive, non-discriminatory, evidence-based, scientifically accurate and age-appropriate.[156]

If adolescent girls in general cannot access CSE, the situation is even more problematic where age and gender intersect with disability. Girls with MID have sexual feelings similar to their peers and many are sexually active. They thus have the same need for comprehensive sexuality information and life skills.[157] At the same time, they are more vulnerable than their peers because of their disability. Several reasons have been given for this. Wissink *et al* state that such children are more at risk of being abused because of 'dependency', need to belong, naivety, lack of knowledge regarding sexuality' as a whole as well as what constitutes sexual abuse.[158] Later in the same paper, Wissink *et al* also mention the fact children with intellectual disability are the ones least likely to have been informed by their parents about sexual abuse.[159] As a result, their ability to make healthy decisions regarding their sexual health is compromised.

Similarly, in South Africa, Sait notes that adolescent girls with disability are three times more likely to suffer sexual abuse than non-disabled peers and suggests that this is because they are at risk of being 'unable to use discernment in their judgements about sexual relations'.[160] She therefore emphasises that they need clear and unambiguous information about positive sex, sexuality and

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[151]ESCR committee: *General Comment No. 22 on the right to sexual and reproductive health* (2016) E/C.12/GC/22.
[152]Centre for Reproductive Rights, 'An international human right: Sexuality education for adolescents in schools' (2010) *Fact sheet.*
[153]J Kossen, 'Rights, Respect, Responsibility: Advancing the sexual and reproductive health and rights of young people through international human rights law' (2012)15 *University of Pennsylvania journal of law and social change* 143.
[154]Special Rapporteur (n 145 above)para 55.
[155]As above.
[156]General Comment 22 (no 151 above) para 9.
[157]L Haroian, 'Child sexual development' (2000) 3 *Electronic journal of human sexuality*, as quoted in W Sait *et al* 'Sexuality, gender and disability in South Africa' in S Tamale (ed) *African sexualities, a reader* (2011)504.
[158]Wissink et al 'Parenting behavior, quality of the parent-adolescent relationship, and adolescent functioning in four ethnic groups' (2006) 26 *The journal of early adolescence* 2,133-159.
[159]As above.
[160]Sait (n 63 above).

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birth control.[161] The CRC GC 15 also emphasises the need to pay special attention to the SRHR of those with psychosocial disabilities[162] and the ESCR GC 22 emphasises the need to ensure reasonable accommodation to ensure that all people with disabilities can realise their SRHR. For people with intellectual disabilities, this includes provision of information in accessible formats.[163] Otherwise, GC 3 of the CRPD Committee notes that women with intellectual disabilities are especially vulnerable to the risk of sexual violence because of a lack of access to sexuality information,[164] in a context of isolation, dependency or oppression.[165]

3.2 State obligations under international human rights law.

Tanzania is a State party to international human rights laws which incorporate the tripartite typology of obligations – to respect, protect and fulfil rights laid down in each of the instruments.[166] In the context of the rights of adolescent girls with MID to CSE, this tripartite typology requires that a government has a supreme obligation to the following.

To respect by refraining from any measure that may deprive individuals of the enjoyment of their rights or of the ability to satisfy those rights by their own effort. This means that the state must ensure that adolescent girls with MID are able to access CSE. It also requires the State to refrain from censoring or withholding health related information.[167] In General Comment 4, the CRPD Committee emphasises that 'the obligation to *respect* requires avoiding measures that hinder the enjoyment of the right to education, such as legislation excluding certain children with disabilities from education, or denial of accessibility or reasonable accommodation.'[168]

To protect by ensuring that no one deprives girls with intellectual disability of their rights to sexual health, dignity and self-determination by taking positive measures to prevent acts of direct and indirect discrimination against them as well as sexual harassment and abuse and any other violation of their rights. This also includes the obligation to ensure that adolescents have access to CSE.[169] GC 4 of the CRPD also gives examples of protection to ensure that parents do not keep their children with disabilities out of school and private educational establishments do not refuse to enrol children with disabilities.[170]

To fulfil by pro-actively engaging in activities intended to strengthen people's access to and utilisation of resources and means to ensure their dignity and livelihood. This includes taking all practical measures through budgets, policies, legislation, provision of materials and training specialists and teachers to be able to provide CSE to girls with MID. States are also obliged to

[161]Sait (n 63 above) 510.
[162]General Comment 15 (n 150 above) para 15.
[163]General Comment 22 (n 151 above) para 24.
[164]CRPD Committee, General Comment 3 *Women and girls with disabilities* (2016) CRPD/C/GC/3, para 41.
[165]General Comment 3 (above) para 33.
[166]A Eide, "The international human rights system", in A Eide *et al* (eds), *Food as a Human Right* (1984).
[167]ESCR Committee, General Comment 14 *The Right to the highest attainable standard of health*(2000) E/C.12/2000/4, para.34; Special Rapporteur (n 145 above)para 16; General Comment 15 (n 150 above), General Comment 22 (n 151 above)para 41.
[168]CRPD Committee, General Comment 4 *The right to inclusive education* (2016) CRPD/C/GC/4, para 38.
[169]General Comment 22, (n 151 above) para 44.
[170]General Comment 4 (n 168 above) para 38.

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require that children with disabilities can access educational institutions and can be supported with appropriate resources and services.[171]

General Comment Three of the CRPD Committee adds a further important proviso that the obligation to fulfil requires deliberate promotion of the rights of women and girls with disabilities through mainstreaming their interests across 'all national action plans, strategies and policies', as well as in sectoral policies such as gender equality, health, education and social protection among others.[172] Promotion of their rights across the board will lead to their fulfilment.

3.2.1 Validity of the right to CSE

It should be noted that, while the specific right to CSE is not mentioned in any treaty provision binding on states parties, it can be inferred from the broad rights provisions laid down in International treaties in relation to the rights to health, education and information, non-discrimination and equality. This includes African Union (AU) treaties such as the Protocol to the African Charter on Human and People's Rights on the Rights of Women[173] and the African Charter on the Rights and Welfare of the Child (ACRWC).[174] As noted by Viljoen, treaties are often open-ended in their formulations, given the need for compromise, and thus require clarification.[175] Through General Comments and Concluding Observations, the UN TMBs have elaborated extensively on CSE, as will be shown in the next section. These observations and comments have a significant influence on the obligations of individual states who are required 'to engage with and attach great weight to the findings of treaty bodies' even if they finally reject them.[176]

Some states, including Tanzania, also use the issue of resource constraints as an excuse for not fulfilling obligations under the CESCR. However, GC 3 of the CESCR while recognising such constraints, emphasises that even where available resources are demonstrably inadequate, the obligation remains for a state party to ensure the widest possible enjoyment of the relevant rights.[177] GC 22 takes up the same issue with even more force stating that while it may not be possible to fulfil the goal of the highest attainable standard of SRH immediately, deliberate and concrete steps should be taken to the fulfilment of the goal.[178] GC 4 of the CRPD Committee applies the same standard to the provision of inclusive education for children with disabilities.[179]

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[171] As above.
[172] General Comment 3 (n 164 above) para 27.
[173] Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, adopted 11 July 2003, OAU Doc AHG/Res.240(XXXI), which came into force in 2005, (Maputo Protocol).
[174] Organisation of African Unity, African Charter on the Rights and Welfare of the Child (Children charter), 11 July 1990, CAB/LEG/24.9/49 (1990), available at: http://www.refworld.org/docid/3ae6b38c18.html [accessed 11 March 2017].
[175] F Viljoen, *International Human Right Law in Africa* (2012) 31.
[176] G Ulfstein 'Individual complaints' in H Keller and G Ulfstein (eds) *UN Human rights treaty bodies: law and Legitimacy* (2012) 115.
[177] ESCR Committee, *General comment 3, the nature of states parties obligations* (1991) UN Doc E/1991/23.
[178] General Comment 22 (n 151 above) para 33.
[179] General Comment 4 (n 168 above) para 24 and 28.

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3.3 International human rights and standards with regard to CSE

As noted by the Special Rapporteur on Education, the right to CSE by all is both a right in itself and key to ensuring people also realise other human rights.[180]This section will look in more detail at how the right to CSE is interrelated to the right to health, equality and non-discrimination as well as education.

3.3.1 CSE and the right to Health

Accessing CSE is one element of ensuring an individual's right to the highest attainable standard of physical and mental health. Thus, the CEDAW Committee, in its General Recommendation 24 on Article 12 of CEDAWcalls for removal of all barriers to women's access to health services, education and information, including on SRH which should be comprehensive, unbiased, and scientifically accurate.[181] It also states that resources should be allocated to the health education of adolescents in order to prevent STIs, including programmes for prevention and treatment of STIs, and HIV/AIDS as well as unwanted pregnancy through family planning and sex education.[182]

Similarly, GC 4 of the CRC Committee[183] and GC 14 of the ESCR Committee on 'The Right to the Highest Attainable Standard of Health' outline the legal obligation to provide SRH information to girls and women in an accessible manner.[184]Not to provide such information was interpreted by the UN Special Rapporteur on Torture to be a potential form of cruel, inhuman or degrading treatment.[185] In GC 3 on HIV and AIDS, the CRC Committee also emphasises that states parties should ensure children can acquire the knowledge and skills they need to protect themselves from HIV.[186]

These General Comments have been reinforced by a series of Concluding Observations by TMBs to different countries. For example, in its concluding observation to Ghana, the CEDAW Committee called on the state party to 'include age appropriate education on Sexual and Reproductive Health and Rights in primary and secondary school curricula including comprehensive education for adolescent girls and boys covering responsible sexual behaviour and the prevention of early pregnancies and sexually transmitted diseases such as HIV/AIDS.[187]

In accordance with the CRPD, adolescents with disabilities have the same rights to the highest attainable standard of health through the provision of equivalent health care and programmes 'including in the area of sexual and reproductive health and population-based public health

[180]Special Rapporteur (n 145 above) para 19.
[181]General Recommendation (n 148 above); Also see
CEDAW committee, Concluding Observations on Eritrea,(2006) U.N. Doc. CEDAW/C/ERI/CO/3,Para 29;
CRC Committee, Concluding Observations on Antigua and Barbuda, (2004) U.N. Doc. CRC/C/15/Add.247, para 54; ESCR Committee, Concluding Observations: Benin,(2002) U.N. Doc. E/C/12/1/Add.78,para 42.
Report of the Special Rapporteur (n 145 above).
[182]General Recommendation (n 148 above).
[183]General Comment 4 (n 149 above).
[184]General Comment 14 (n 167 above); CRPD (n 3 above) art. 24(d).
[185]UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* (2013) U.N. Doc. A/HRC/22/53, para. 47.
[186]CRC Committee, *General comment No. 3, HIV/AIDS and the Rights of the Child*, CRC/GC/2003/3, para 16.
[187]CEDAW committee, Concluding Observations, Ghana, (2014) UN.Doc. CEDAW/S/GHA/CO/6-7, para 33.

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programmes'.[188] Although CSE is not mentioned specifically, it is a key element of these programmes, as has been emphasised by GC 3 of the CRPD Committee. The Committee first noted that women with disabilities are often denied CSE based on 'harmful stereotypes' which assume they do not require such information. The Committee then outlined in detail the SRH information to which women with disabilities are entitled.[189] In General Comment 4, the Committee also stressed that persons with disabilities must receive 'age-appropriate, comprehensive and inclusive sexuality education' from a scientific and human rights perspective 'in accessible formats' to ensure equality of provision.[190]

3.3.2 CSE and the right to Equality and Non-discrimination

In the context of this chapter, non-discrimination can be applied to several areas. Firstly, it is essential to combat gender discrimination. Thus, CEDAW provides for specific protection from discrimination for women and girls, and imposes an obligation on States parties to eliminate discrimination in all areas of their lives, including education. In Article 5, the Convention calls for parties to take steps to eliminate prejudices and practices based on gender discrimination and stereotyping.[191] Age appropriate CSE, which provides for required skills for protecting themselves against abuse, unwanted and unplanned pregnancies, as well as HIV/AIDS, is seen as an indispensable means to achieving that requirement. Article 10 of the same Convention also calls on States parties to reduce female dropout rates.[192] This is particularly relevant to girls with MID, since they are more likely to drop out of school because of lack of support. In the same article the state is also required to ensure accessibility of specific educational information to families, including on family planning.[193]

Secondly, Article 7 of the CRPDobligates States parties to ensure that children also enjoy the same rights and freedoms as other children.[194] Article 23 of the Convention also stipulates that persons with disabilities 'have access to age-appropriate information, reproductive and family planning education'.[195] Therefore any form of exclusion because of disability, including the denial of reasonable accommodation, which impedespeople with disabilities to benefit and enjoy other rights equally as others amount to discrimination.[196]

Thirdly, the CRPD puts a particular emphasis on women and girls with disabilities because they experience multiple forms of discrimination and urges states parties to ensure that they exercise and enjoy all the rights and freedoms itemised in the Convention.[197] This has been examined in greater detail in GC 3 on Article 6 which was written in response to 'the lack of recognition of the rights of

[188]CRPD (n 3 above) art 25.
[189]General comment 3(n 164 above)para 40.
[190]General Comment 4 (n 149 above) para 52.
[191]UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women,(CEDAW)18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, art 5; Special Rapporteur (n 145 above) paras 21-22.
[192]CEDAW, above art 10.
[193]CEDAW, (n 190 above) art 10(f) &(h).
[194]CRPD, (n 3 above) art 7 (i).
[195]CRPD, above art 23.
[196]CRPD, above art 2.
[197]CRPD, above art 6.

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women and girls with disabilities' who are more likely to face discrimination than their male counterparts.[198]While emphasising that Article 6 is a binding provision, the Committee urge the states parties to go beyond refraining from discrimination and adopt measures to develop and empower women and girls with disabilities.[199]

Thus, with regard to access to CSE, it is the duty of states parties to ensure that barriers to the enjoyment of their rights are removed. The CRPD Committee has continued to emphasise the importance of access to information in the exercise of autonomy for persons with disabilities, including in health contexts.[200] In order to ensure sexual and reproductive autonomy free from violence, discrimination, or coercion, the CRPD Committee has found a right to sexuality education under both Articles 23 (respect for home and family) and 16 (the right to be free from exploitation and abuse), recommending to States parties that "sex education be taught to children and adolescents with intellectual disabilities.[201] As other TMBs have noted, sexuality education is particularly important for persons with intellectual disabilities,[202] hence the emphasis in GC 15 of the CRC to pay special attention to children with psychosocial disabilities.[203]

GC 22 of ESCR also points out the intersectionality of discrimination with regard to the right to sexual and reproductive health and identifies groups who are more likely to be affected including poor women, adolescents and persons with disabilities.[204] Thus, adolescent girls with MID may suffer discrimination as adolescents, as women and as people with disabilities. GC 3 of the CRPD also pays particular attention to intersectionality and why it needs to be addressed as these multiple and intersecting barriers interact in such a way that they are inseparable and work together to make the barriers even greater.[205]

3.3.3 CSE and the right to education

Although most references to CSE can be found under the rights to health and non-discrimination, provision of CSE is a key part of the right to education. The Special Rapporteur on the Right to Education emphasised that sexuality, health and education are three interdependent rights[206] and insisted that States must ensure that all legal, policy and cultural barriers to students accessing CSE must be removed. Teachers should be provided with adequate training so that CSE is provided from primary school onwards. Such education should also include children with disabilities.[207]

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[198]General Comment 3 (n 164 above) para 7 & 9.
[199]As above, para 7.
[200]CRPD Committee, *General Comment No. 2: art 9: Accessibility,* (2014), U.N. Doc. CRPD/C/GC/2, para 40.
[201]CRPD Committee, *Concluding Observations: Belgium*, (2014) U.N. Doc. CRPD/C/BEL/CO/1 para 34-35; *China, (2012)* U.N. Doc. CRPD/C/CHN/CO/1 para 65-66.
[202] IDA & CRR (47 above).
[203]General Comment 15 (n 150 above) para 15.
[204]General Comment 22 (n 151 above) para 30.
[205]General Comment 3 (n 186 above) para 4.
[206]Special Rapporteur (n 145 above) and ESCR Committee (no 151 above) para 9.
[207]Special Rapporteur (n 145 above) para 87.

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TMBs have also urged that States to implement sexuality education programs in all schools.[208] Most recently, the CEDAW committee, in its concluding observation to Tanzania, recommended that the government introduce age appropriate CSE immediately in both primary and secondary schools and ensure that teachers are adequately trained to teach the subject.[209]

3.3.4 Additional documents of relevance on CSE

Apart from international obligations elaborated above, the nature and importance of CSE for children and adolescents has been laid out in many other documents of the UN and international NGOs. For example, The UN ECOSOC's Commission on Population and Development also calls upon governments ensure that CSE is provided to young people.[210] The issue of 'age appropriate' has also been elaborated on in many documents starting with the ICPD.[211] The documents stress that SRH education must begin in primary school and continue through all levels of formal and non-formal education.[212] The WHO emphasises this both because many children will not go on to secondary school and girls at the end of primary school and the beginning of secondary school are most at risk.[213]

3.4 The right of children with MID to inclusive education

As noted by the Special Rapporteur above, the rights to education and sexuality are intertwined. In order for adolescent girls with MID to access CSE, they need to be in school in line with Article 24 of CRPD which states that children with disabilities should be able to participate in the general education system. Ngwena states that Article 24 breaks new ground by recognising inclusive quality education as a discrete human right which emphasises substantive equality. It is not enough for States parties to ensure that disabled children are not excluded from the general education system. They have to take positive steps to provide them with individualised materials and other support so as to facilitate effective education and maximise academic and social development in a way that is consistent with the goal of inclusion.[214]

The CRPD committee noted that the move to inclusive education encompasses a transformation in culture, policy and practice in education,[215] and made a clear distinction between inclusion on the one hand, and integration on the other which only refers to 'a process of placing persons with disability in existing mainstream institutions.' The Committee emphasised that merely ensuring students with disabilities go to school without ensuring the structural changes required in organisation, curriculum and methodology does not constitute inclusion.[216] The Committee also

[208]General Recommendation 24 (no 148 above) *See also* CEDAW Committee, Concluding Observations: Uruguay (2007) U.N. Doc. CRC/C/URY/CO/2, para 52; ESCR Committee, Concluding Observations: The Kingdom of the Netherlands (2010) U.N. Doc. E/C.12/NDL/CO/4-5, para 27.
[209]CEDAW Committee, Concluding Observations, Tanzania, (2016) CEDAW/C/TZA/CO/7-8, para 31(b).
[210]Resolution 2012/1; Commission on Population and Development, *Adolescents and Youth* (2012).
[211]ICPD (n 45 above) para.11.9.
[212]Joint United Nations Programme on HIV/AIDS (UNAIDS) *Impact of HIV and sexual health education on the sexual behavior of young people: A review update 27* (1997).
[213]WHO, *Adolescent Pregnancy: Issues in adolescent health and development 63* (2004).
[214]C Ngwena, 'Human Right to Inclusive Education: Exploring A Double Discourse of Inclusive Education Using South Africa as a Case Study (2013*)*34 *Netherlands Quarterly of Human Rights* 4.
[215]General Comment 4 (n 168 above) para 9.
[216]As above, para 11.

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noted that, in accordance with Article 24 of the CRPD, States parties cannot use lack of resources as an excuse for failing to move towards inclusive education.[217] Accessibility to inclusive education for all groups of the population, is a right which cannot be diluted by claims of 'disproportionality or undue burden'.[218] However, accessibility is not enough and reasonable accommodation should be provided to individuals when requested. Failure to do so constitutes discrimination.[219]

The CRPD Committee recognised that persons with intellectual disabilities are more at risk of exclusion from education,[220] and emphasised that learners with intellectual impairments should be provided with both 'a safe, quiet and structured learning environment' with teaching and learning materials adapted to their needs.[221] Thus, it is through such inclusion that adolescent girls with MID will receive the same rights as their peers, including the right to CSE.

3.5 CSE and disability in the African Human Rights System

African human rights instruments have also recognised the SRHR of adolescent girls. As with global conventions, these instruments, originally, were not so explicit but the African Charter recognises the right to health, education and to receive and disseminate information. Article 16 protects the right of all to enjoy the best attainable state of physical and mental health.[222]Although there is no mention on people with disabilities, in the *Purohit case*[223] the provision was interpreted to include people with disabilities, more specifically those living with mental disabilities.

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol)[224] is also specific. Article 14 on Health and Reproductive Rights includes the right to family planning education and stipulates that it is the responsibility of States to provide health services, including information, education and communication programmes for women.[225] It could also be argued that, depriving adolescents of CSE is a harmful traditional practice as it affects the fundamental rights of girls to health, dignity and education, as well as their physical and psychological development. [226]

Over time these rights have been made more explicit. Thus, in the guidelines for reporting on the Women's Protocol, under Health and Reproductive Rights, states are specifically required to report on 'sex education'.[227] This is backed up by resolutions of the African Commission on HIV[228] and

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[217]As above, para 24.
[218]As above, para 28.
[219]As above, para 30.
[220]As above, para 6.
[221]General Comment 4 (n168 above) para 34 (f).
[222]Organization of African Unity (OAU) African Charter on Human and Peoples rights (Banjul Charter) (1982) CAB/LEG/67/3 rev.5, 21 I.L.M.58. art 16.
[223]*Purohit* Case (no 112 above).
[224]Maputo Protocol (n 173 above).
[225]As above, art 14 (1) (g).
[226]As above, art 1(g).
[227]African Commission on Human and Peoples' Rights (ACHPR), 'Guidelines for state reporting under the Protocol to the African Charter on Human and People's Rights on the Rights of Women' in Heyns & Killander (ed) *Compendium of Key human rights documents of the African Union* (2013)214.
[228]ACHPR, 'Resolution on the HIV/AIDS pandemic- Threat against Human Rights and Humanity' in Heyns & Killander (above)369.

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maternal mortality[229] both of which emphasise the need for education of women and girls on rights to reproductive health.

The African Charter on the Rights and Welfare of the Child states that States Parties have the duty to ensure children are informed about their health, as well as to develop preventive health care and family life education,[230]which includes information relevant to SRH.[231]

The African Youth Charter (AYC) is more specific. Article 13 on the right to education includes life skills in relation to, among other things, HIV/AIDS, reproductive health and cultural practices that are harmful to the health of women, [232] while Article 16 stipulates that education and information should be provided to prevent the transmission of STIs and HIV/AIDS.[233]

The AYC also mentions the rights of 'mentally and physically challenged youth' to 'special care' which includes access to education and health care services.[234]However, Oyaro[235] notes that African treaties still adhere to a medical model of disability without addressing social and environmental factors. They talk of 'handicapped children (ACRWC) and 'mentally and physically challenged youths (AYC) and propose 'special care' rather than inclusion. Thus, they are not in line with the CRPD which came later in time. However, a draft protocol on the rights of people with disabilities in Africa, has the same stipulation as the CRPD that children with disabilities enjoy their human rights and fundamental freedoms on an equal basis with other children.[236] It also stipulates that persons with disabilities should have access to health services including SRH.[237]

3.6 Conclusion

This chapter has outlined the importance of CSE for adolescent girls with MID, given their particular vulnerabilities, together with the full range of obligations of States parties to ensure that they fulfil their right to CSE, both through provision of CSE to all adolescents and through provision of quality inclusive education which ensures that these girls receive an education that answers to their specific needs and stay in school long enough to benefit from CSE. The obligations of states parties to provide both CSE to all adolescents and to develop a system of inclusive education and ensure that all girls with disabilities, including those with MID, access and benefit from it have become more comprehensive and sharply defined over the last twenty years. Tanzania’s response to these obligations will be considered in detail in the next chapter.

[229]ACHPR, ‘Resolution on Maternal Mortality in Africa’ in Heyns & Killander (above)425.
[230]Children Charter (n 174 above) art 14.
[231]C Ngwena (n 40 above).
[232]African Union, African Youth Charter (Youth Charter) (2006) art 13.
[233]As above, art 16.
[234]Youth Charter above, art 24.
[235]O Louis ‘Africa At Crossroads: The united nations convention on the rights of persons with disabilities.’(2015)2 *American university international law review* 347-377.
[236]Draft Protocol to the African Charter on Human and People’s Rights on the rights of persons with disabilities in Africa (hereinafter The Gambia Protocol on Disability) As adopted at the extra-ordinary session of the African Commission on Human and Peoples’ Rights, held 16-25 Feb. 2016 in the Islamic State of the Gambia (The Gambia Protocol on Disabilities) art 23(1).
[237]The Gambia Protocol on Disabilities, above, art 12.

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Chapter Four: The status of the right of adolescent girls with MID to access CSE in Tanzania

4 Introduction

The previous chapter outlined Tanzania's international obligations both with regard to provision of CSE and to ensuring that children with (mild intellectual) disabilities access CSE. This chapter will analyse the extent to which Tanzania has fulfilled its obligations both through appropriate legal and policy measures and in practice through the implementation of these laws and policies with particular reference to adolescent girls with MID. Thus, the chapter will consider to what extent CSE is actually being provided in primary school before considering how the education system is identifying and enabling girls with MID to access such CSE.

4.1 National Laws and Policies

In order to ensure that the human rights enshrined in international documents are actually respected, protected and fulfilled, states parties have to translate their obligations into practice through their laws, policies, strategies and programmes. As outlined in the previous chapters, several rights are particularly important in ensuring that girls with MID are able to fulfil their rights. However, before looking at how these rights are interpreted and addressed, it is important to consider how disability in general and intellectual disability in particular is defined in Tanzanian policy and legal documents.

4.1.1 Definition of disability under national legal system

While Tanzania has largely reflected global developments in defining disability, there are several contradictions even in policy and legal documents produced around the same time. On the one hand, the National Policy on Disability[238] and the Persons with Disabilities Act which domesticated the CRPD define disability as the loss or limitation of opportunities to take part in the normal life of the community at an equal level with others due to physical, mental or social factors.'[239] Thus, the policy and the Act show a recognition of the interaction between individual impairment and social factors. On the other hand, 'mental disability' in the Act is defined as the 'inability to meet individual and societal needs by reason of emotional and mental retardation'.[240] Thus the emphasis is entirely on the impairment of the individual. In addition, the Act itself concentrates only on removing physical barriers to participation. The particular needs of people with intellectual disability are hardly mentioned.

The Law of the Child Act,[241] which was passed after the Persons with Disabilities Act, also defines a person with disability as someone who has 'long term or permanent physical, mental, intellectual or sensory impairment which hinders his full and effective participation on equal basis with others.' The emphasis is on individual impairment, rather than social and environmental barriers. Thus, even

[238]URT, The national policy on disability (2004).
[239]URT, The persons with disabilities Act 9 of 2010, sec 3 Interpretation.
[240] CRPD, (no 3 above) Interpretation.
[241]URT, The law of child Act 21 of 2009.

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at the level of policy and law, there are significant differences in definition, which can affect the way rights are interpreted and addressed in practice.

4.1.2 Legal and policy framework on the Right to Health

Despite Tanzania's commitments to the highest attainable standard of health for its citizens, the right to health is not included in the Constitution. In the health policy, people with disabilities are not explicitly mentioned, nor are they included in the list of groups who are entitled to free access to health services. However, Article 26 of the Persons with Disabilities Act stipulates that people with disabilities are entitled to the same level of services, including reproductive health and family planning.[242] It also states that person with disabilities 'shall be entitled to receive appropriate information.'[243] However, the requirement to provide 'quality' health services as stipulated in the CRPD has been omitted.

In other policies related to health such as the National HIV and AIDS policy[244] and the Adolescent Reproductive Health programme,[245] people with disabilities are not mentioned. The National Multi-Sectoral Strategy for HIV/AIDS does recognise people with disabilities as a specific group and talks of the need to address their interests but does not make any specific recommendations,[246] while the National Nutrition Strategy merely includes children with disabilities in the groups of children who should be specifically targeted with nutrition interventions, including social protection schemes.

4.1.3 Legal and policy framework on Right to Education

As with several other socio-economic rights, Tanzania is not very specific about the obligation of the State to ensure that the right to education is fulfilled. Article 11 of the Constitution merely states that, 'every person has the right to access education',[247] but says nothing about the obligation of the State to provide it. However, the National Strategy for Growth and Reduction of Poverty (MKUKUTA I) did identify disability and children as cross-cutting issues and has the laudable aim of ensuring that all groups of vulnerable children, including those with disabilities are able to 'access and complete high quality, child-friendly and gender sensitive primary education programme'.[248]

In accordance with the Education Act of 1978,[249] primary education is compulsory and it is the responsibility of the parents to ensure that their children attend school.[250] No specific vulnerable groups are mentioned and the Act only addresses non-discrimination in terms of race, religion and

[242]Sec 26 (n 239 above).
[243]Sec 26 (6)(n 239 above).
[244]TACAIDS, National Policy on HIV/AIDS, (2001).
[245]URT, *Adolescent Reproductive Health programme*,(1994). www.rchs.go.tz/index.php/en/programes/adolescent-reproductive-health.html. (accessed 27th August 2016). n
[246]URT, Third National Multi-Sectoral Strategic Framework for HIV/AIDS (2013-2017), 2013.
[247]The Constitution of the United Republic of Tanzania, 1977 (as amended from time to time), art 11.
[248]URT, National Strategy for Growth and Reduction of Poverty I (hereinafter MKUKUTA I).
[249]URT, National Education Act 25 of 1978 (RE 2000).
[250]Sec 35(1&2) above.

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political or ideological beliefs. However,the Child Act states a child with disabilities shall be entitled to equal opportunities to education and training.[251]

The right to education for children with disabilities is elaborated upon in the Persons with Disabilities Act which reiterates that children with disabilities have the same rights to education 'in inclusive situations'as their peers and enjoins government and stakeholders to provide a conducive environment for inclusive education. This includes equal rights to admission in any school, the provision that they will attend 'ordinary' schools unless there is a 'need for special communication' and the right to provision of support services and qualified teachers.[252] Section 28 emphasises that no educational institution should discriminate against persons with disabilities with regard to admission, access to benefits and expulsion on the grounds of disability.[253] Little is said about intellectual disability except in section 38 which states generally that public bodies should, as far as practicable, ensure that 'information relevant to persons with intellectual disabilities is published in accessible formats.'[254]

However, the latest Education Policy (2014) hardly mentions children with disabilities or inclusive education, merely stating the government's commitment to increase educational opportunities for all, including children with 'special needs'.[255] The emphasis on special needs seems to contradict the concept of inclusive education and the new policy does not incorporate any of the recommendations from the Strategy for Inclusive Education (2009-2017) which was developed in line with the Education Sector Development Programme (2008-2017) and included, as one of its principles, access to at least basic levels of education by all, including those with disabilities.[256]In order to achieve this, schools and educational programmes should identify and address barriers both within the learners themselves and within their living and learning environment.[257]The Strategy is a comprehensive document which deals with key issues such as those related to institutional arrangements and support, financing, curriculum development, teacher training, assessment and evaluation procedures, development of educational support resource centres for teachers, and community mobilization.

From the above discussion, it can be seen that the government of Tanzania has been proactive in domesticating the CRPD through the Persons with Disabilities Act, but even in its policies and programmes it is far from implementing the CRPD. In particular, as analysed in GC 4 of the CRPD Committee, it would seem that Tanzania, at the most, has implemented some form of integration whereby children with disabilities sit in the same classrooms as their peers. The Committee stresses that that merely ensuring students with disabilities go to school without ensuring the structural changes required in organisation, curriculum and methodology does not constitute inclusion. Thus,

[251]Sec 8 (6)(n 241 above).
[252]Sec 27(1)(2)(3)&(4) (n 239 above).
[253]Sec 28 (1), (2) (a) (b) (c) (d) above.
[254]Sec 38, above.
[255]URT, National Education policy, 2014 para 3.3.6.
[256]URT, Education Sector Development Programme (ESDP) (2008-2017).
[257]ESDP, (n 255 above) 2.

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unless Tanzania puts in place these structural changes, mentions of inclusive education are cosmetic,[258] and the emphasis in Tanzania remains more on 'special needs'.

Secondly, the CRPD Committee makes a clear distinction between accessibility and reasonable accommodation. Accessibility ensures that all groups of the population can go to and benefit from school and the Committee emphasises that there are no excuses for not ensuring such accessibility.[259] The same applies to the group of children with intellectual disabilities but, as seen above, education is not accessible to many of them as there has been little effort to develop and disseminate suitable materials for the learning style of such children.

Thirdly, states parties are required to provide measures of reasonable accommodation upon request to ensure that each individual is able to participate and learn according to their own specific needs.[260] It is very unlikely that such reasonable accommodation has been provided to more than a few such children with intellectual disabilities as even those who are in school, as well as their parents ,will not have heard of reasonable accommodation, let alone know how it can be applied for their benefit.

Finally, it is significant that, with regard to both health and education, the Tanzanian Persons with Disabilities Act only talks of the same standards of health[261] and education[262] as provided to other citizens without any reference to quality. This may be a realistic assessment of the situation as large numbers of Tanzanian children do not have access to quality education either, but the lack of emphasis on quality together with the omission of inclusive education in the new policy calls into question the commitment of the government to fulfil its obligations to the CRPD andjeopardizesthe likelihood of adolescent girls with MID accessing CSE. In addition, the intersection between disability and poverty also affects the rights of people with disabilities who belong disproportionately to the lowest wealth quintile.

4.1.4 Implementation of Comprehensive Sexuality Education in Tanzania

In Tanzania, the right to CSE has not been specifically provided for. In particular, the Ministry of Education, which is responsible for fulfilment of this right, has never committed to CSE. The extent of sexuality education is governed by the Guidelines for Implementing HIV&AIDS and Life Skills Education Programs in Schools[263] which only allow basic information about transmission and prevention of HIV and STIs and messages on responsible sexual behaviour, including delaying sexual debut and promoting protected sex.[264] The emphasis is purely on HIV prevention.[265] The new education policy does not mention sexuality education but only talks of integrating skills of protecting oneself against HIV and AIDS in education curricula.[266]

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[258]General Comment 4 (168 above) para 11.
[259]As above, para 28.
[260]As above, para 28.
[261] Sec 26 (n 239 above).
[262] Sec 27 (above).
[263]URT, National guidelines for implementing HIV&AIDS and life skills education programs in schools (HIV and life skills guidelines).
[264] UNESCO, *Comprehensive sexuality education in teacher training in eastern and southern Africa* (2015)147.
[265] CRR,(n 46 above).
[266] Education Policy (255 above)58.

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This is a far cry from what is required even for an effective educational response to HIV. It has been reported that the Tanzania Commission for AIDS (TACAIDS), as well as development partners, feel that the Ministry of Education has been lacking commitment in the HIV response,[267] despite the stipulation in the National HIV and AIDS policy that the Ministries responsible for education should not only ensure AIDS information is introduced early enough in school but also incorporate reproductive and sexual education in the school curricula'.[268] Eleven years later, the Third National Multi-Sectoral Strategic Framework for HIV&AIDS continued to identify, as one of its strategic areas of primary investment, 'to supplement the biomedical HIV curricula in use', including the training of teachers,[269] but it has no implementation or accountability mechanisms for this strategic area and, to date, there is still no sign of any CSE curriculum in primary schools.

The Ministry responsible for health has been more responsive to SRHR by setting up the Adolescent Reproductive Health Programme with the aim of creating 'an enabling policy environment and legal framework' for SRHR including SRHR education,[270] but the Ministry of Health does not have the mandate to influence the curricula of the Ministry of Education.

4.2 From policy to practice

The Guidelines on HIV Education recognise that about half of young people below the age of 15, most of whom would be in primary school, are sexually active but they still prohibit demonstration and distribution of condoms in schools and teachers' colleges because that would be immoral.[271]Mkumbo notes that very few of the topics in the primary school curriculum could be categorised as related to sexuality education except for those related to HIV.[272]There is no independent CSE subject and as noted by UNESCO, although the government claims it is revising the curricula, to date, the emphasis is only on HIV and AIDS with a focus on biomedical facts.[273]

Even the elements of HIV education are included in a 'piecemeal and limited fashion' in both primary and secondary schools[274] and there is no clear guidance for schools or teachers on what the subject covers and how it should be taught.[275] Bilinga and Mabula found teachers complaining that the Guidelines were too restrictive to enable effective teaching of the subject. They added that there was no guideline on the provision of sexuality education which made it very difficult for them to

[267]Swiss Centre for International Health, *from the PASHA project to the MoEVT's approach to school counselling services and peer education; A capitalisation report on Germany's support to the education sector of Tanzania (2003-2012).*
[268]HIV/AIDS policy, (no 244 above).
[269]Third national multi-sectoral strategic framework for HIV&AIDS (NMSF III 2012/3-2017/8.
[270]URT,(n 245 above).
[271]HIV and life skills guidelines (n 263 above).
[272]Mkumbo, (n 56 above).
[273]UNESCO (no 264 above)148.
[274]Mkumbo (n 56 above).
[275]It would seem that Tanzania's situation is similar to that of Croatia in the case brought by *Interights International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia, Eur. Committee of Social Rights*, Complaint No. 45/2007, para. 47 (2009).

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teach the subject, especially as the majority of them had received no training and no teaching and learning materials had been provided.[276]

Even the materials provided are neither comprehensive nor even accurate. In the topic of family planning in the biology syllabus for secondary schools, contraception is not even mentioned. A review of teaching materials used by the Ministry of Education also found that, in the topic on HIV/AIDS, it was inaccurately stated that 'contraception causes infertility, promiscuity and prostitution'.[277] The curriculum also omits key topics such as pregnancy prevention and unsafe abortion. In addition, UNESCO's review shows that there is no stand-alone subject on CSE in teachers' colleges either and most higher learning institutions (which also train teachers) lack a policy or even guidelines on how to support the teaching of HIV and life skills education.[278] As a result, primary school teachers pay little attention to CSE. Bilinga and Mabula found that only 30 per cent of pupils said they received their sexuality knowledge at school and 75 per cent of the teachers had received no training in CSE.[279]

However, some pupils have benefitted from programmes developed by external agencies, in collaboration with the government. The latest was the Prevention and Awareness in Schools of HIV&AIDS (PASHA) programme, funded by the German Agency for International Cooperation from 2003-2012. PASHA reached, on average, 15 per cent of schools in 8 of Tanzania's 25 regions with a broader syllabus, though still with an emphasis on HIV.[280] According to the evaluation, it contributed to policy changes, in particular in relation to greater openness about topics such as condom use, although this did not 'automatically translate into changes of daily practice at school level'. Thus, although the Ministry informed the evaluation that condoms could be distributed to schools, this was not known to regional coordinators and school authorities.[281]

4.3 Inclusive education and access of adolescent girls with MID to CSE

While adolescent girls in primary schools have access to a few aspects of CSE, adolescent girls with MID can only have the same access if they are identified and supported to remain in schools geared to inclusive education.

4.3.1 Identification of people with disabilities

Identification of people with disabilities, including those with intellectual disabilities, is dependent on two factors: the interpretation or definition of different forms of disability and the mechanisms used to identify them. There are problems related to both the definitions and the mechanisms.

The first attempt to estimate the prevalence of disability in Tanzania was made in the 2002 Population and Housing Census which just asked if there was anyone with a disability in their

[276]Bilinga & Mabula (n 58 above).
[277]CRR (n 58 above).
[278]UNESCO (n 264 above)148.
[279]Bilinga and Mabula (n 58 above).
[280]The PASHA evaluation report (n 267 above).
[281]As above.

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household and, if so, what kind. It identified that two percent of the population had a disability.[282] However, as noted by the National Survey on Disability, the questions asked depended on individual perceptions of the interviewees, without any definition of disability. Therefore, the Census probably only identified those with severe disabilities.[283]

The National Survey took a different approach. Using the CRPD definition of disability, it adopted and adapted the categories of the Washington Group on Disability Statistics by asking questions about 'difficulties' faced by people in doing various activities, in the belief that people are more willing to identify and report a 'difficulty' rather than a 'disability'.[284] Then, respondents were required to respond on a scale of 1-5 to what extent they are affected by the 'difficulty'. This enabled the survey to identify the mildness or severity of any particular 'difficulty'. As a result of this change of methodology, estimates of disability in Tanzania rose to 7.8 percent overall. For the age groups covered by this dissertation, it was estimated that, in the 10-14 age groups, 3.9 percent of boys and 3.1 percent of girls had a disability while in the 15-19 age group, 3.7 percent of boys and 3.9 percent of girls had one.

The Disability Survey also attempted to identify different types of disability. Intellectual disability was measured through difficulties in remembering/concentrating and constituted 1.5 percent of the population[285] More than one third of those having difficulties with cognition and communication were children.[286]However, the Survey also recognized that all figures were based on self-reporting and it is very likely that those with mild or even moderate intellectual disabilities were not identified. It is notable that while those identified as having some problems of cognition were very few, by comparison with those who have some difficulties in seeing, when it came to severe difficulty or being unable to carry out activities, difficulties of cognition were nearly twice as prevalent as those of seeing.[287] This would give the impression that the milder versions of intellectual disability were often not seen as 'difficulties' by those asked.

Indeed, many do not see intellectual disability as disability at all. Polat notes that data collection on prevalence rates of disability is problematic because of the differences of definition and methodology, particularly with regard to intellectual disability.[288] For example, one head teacher explained that 'difficulties such as Attention Deficit and Hyperactivity Disorder and autism do not exist in Africa. They are Western problems'.[289] Another teacher told Stone-Macdonald that she had no children with disabilities in her class, as there were no noticeable physical disabilities and no obvious facial features.[290]Thus, teachers do not recognise intellectual disability unless there are physical markers.[291]

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[282]Disability Survey (n 44 above).
[283]As above.
[284]As above.
[285]Disability survey (above).
[286]As above.
[287]As above.
[288]Polat (n 39 above).
[289]As above.
[290]Stone-Macdonald, (n 35 above).
[291]Polat (n 39 above).

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The definitional issues make it difficult to assess how many children with disabilities are actually attending school. According to the Swedish International Development Agency (SIDA), enrolment figures for children with disability range from 1-10 percent while research carried out by a prominent disability NGO found that the enrolment rate for children with disabilities is somewhere between 0.1 and 0.5 percent despite a government commitment to increase enrolment to 30 per cent by 2010.[292]

Maybe the most accurate figures (albeit undisaggregated according to disability and a little out of date) are those from the National Survey which found that 38.4 percent of children with disabilities attended school between the ages of 7 and 13, 37.9 percent boys and 39 percent girls. Half of these were in mixed (inclusive?) schools while 46.9 percent were not in school at all. 15.5 percent had been refused entry into schools. These figures refer to all children with disabilities. Therefore, the possibility of non-recognition of children with MID remains.

According to 2008 statistics of the Ministry of Education, children with intellectual disabilities constituted 21 percent of all children with disabilities in school but, apart from the National Survey, it is difficult to know how these statistics are collected. It is not surprising, therefore, that government targets are often seen to be redundant or meaningless since the lack of reliable statistics makes projections and even analysis meaningless.[293] The Disability Survey and the Population and Housing Census are both one-off activities and are insufficient for ensuring a regular system of identification of children with disabilities in order to provide the support required. As noted by Hoffman and Kilimo, a UNICEF report[294] pointed out that there is no functioning national system in place to identify and assess children with disabilities and no data to ensure that the needs of these children are addressed.[295]

Alternatively, one might extrapolate from the number of inclusive schools. Hoffman and Kilimo note that, according to the government (URT 2013), there were 21 special primary schools and 377 inclusive primary schools out of around 16,000 schools overall).[296]

For the purpose of this study, the confusion about identification and the lack of reliable statistics poses a serious problem. Since the majority of the statistics are not disaggregated by type or severity of disability, it is difficult to know the number of those with MID who are attending school. The numbers could significantly be higher, given that MID is hardly recognised by the teachers and given the high levels of stunting in Tanzania.[297]

Such lack of recognition often leads to negative attitudes among many teachers towards such children. Their attitudes then affect the way they treat them in class and therefore the likelihood of these pupils remaining in school until they become adolescents. Stone-Macdonald notes that

[292]Polat, above, quoting the MKUKUTA commitment.
[293]K Rutachwamagyo, *Inclusive education concept: Disability and education rights in Tanzania*(2006).
[294]UNICEF, (n 5 above).
[295]Hoffman and Kilimo (n 38 above).
[296]Hoffman and Kilimo above.
[297]The national prevalence of stunting stands at 35 percent overall but is higher than 50 percent in many districts. TFNC (n 44 above).

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teachers referred to the 'slow learners' as *mbovu* (defective*), mvivu* (lazy) *mzito* (slow minded) and *shida* (problem).[298]Chaula found in one school that pupils with intellectual disabilities were segregated in the classroom as they were seen to be stubborn and troublesome.[299]

4.3.2 How inclusive is inclusive education

The Inclusive Education Strategy notes that, despite official support to inclusive education there is still a bias towards special schools for children with disabilities inside and outside government, among donors and CSOs, based on the old 'deficit model' of disability. It argues for a change of mind-set away from special schools,[300] but 'inclusion' usually goes no further than basic integration, whereby children with disabilities sit in the same classroom as their peers. Since this has serious implications for the likelihood of adolescent girls with MID accessing any CSE, these barriers need to be elaborated.

4.3.3 Teachers

The success of inclusive education depends on the quality of teachers.[301] Hence quality teacher training is an essential pre-requisite.[302]However, the Inclusive Education Strategy noted that probably 'less than 1 per cent of teachers have any knowledge of special educational needs and even these teachers lack pedagogical skills and knowledge involved in inclusive teaching and learning processes'.[303] In six of the seven districts researched by HakiElimu, less than 15 percent of the teachers had been trained in special needs or inclusive education. In the researched schools in three districts, there were no teachers trained in special needs/inclusive education at all.[304]

This is not surprising given that Patandi Teachers' College is the only College designated to train special teachers but even there, the curricula are not designed to teach inclusive education and only 908 teachers were trained in the years 2003-7.[305] The Strategy mentions one teachers' college and three universities who also provide some special needs education, but notes that these are far from meeting the need for teachers trained in inclusive education.[306] In the Teacher Education Curricula in other teachers' colleges, inclusive education is not mentioned. Overall, teacher education is not promoting education for all learners including those with disabilities while special needs teacher education is not seen as promoting inclusive education.[307]

Thus, all the researchers found that, firstly, there was a shortage of teachers overall, which meant that teachers had to cope with large classes, quite apart from the extra time required to support

[298]Stone-Macdonald (n 35 above).
[299]Chaula, (n 34 above).
[300]The Strategy on Inclusive Education (n 42 above).
[301]Chaula, (n 34 above).
[302]Polat (n 39 above).
[303]The Strategy on Inclusive Education (n 42 above).
[304]HakiElimu, (n 33 above).
[305]The Strategy on Inclusive Education (n 42 above) 19-20 However a new programme to train more special needs teachers at Chang'ombe University College has been initiated recently (personal communication).
[306]The Strategy on inclusive Education (n 42 above).
[307]As above.

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those with disabilities. At the same time, the majority of the teachers working with children with disabilities had little or no experience or training. Thus the children do not get equal and quality education.[308]

4.3.4 Facilities

Facilities include teaching materials and equipment and the built environment of the schools. Overall, as noted by the Legal and Human Rights Centre,[309] the lack of facilities to enhance learning of children with disabilities is a serious problem. In addition, all schools use the standard national curriculum[310]and there has been no effort to identify and support children with disabilities through the curriculum, let alone children with MID.[311]Hoffman and Kilimo conclude that while fewer than 5 per cent of the Tanzanian children with disabilities go to school, those who do are often educated in inaccessible school buildings with a lack of suitable teaching materials.[312]

Parents, teachers and educational administrators attribute the lack of teachers and facilities to the lack of political will on the part of the government. Leaders make speeches, policy documents and programmes on education for people with disabilities but they have no real commitment in action to support the teachers.[313] In 2014, six years after the development of the Inclusive Education Strategy, Chaula found that teachers felt abandoned by the government since none of the promises had been fulfilled.[314] Although one of the schools had a special unit attached and another was designated an inclusive school, none of the teachers knew of the strategy.

Such a situation has a seriously negative effect on the performance of children with intellectual disabilities. Chaula quotes Mmbaga as noting that previous studies have found that children with learning difficulties are gaining nothing from school with the result that many complete primary education without having attained the basic skills of literacy and numeracy.[315] Many others give up, and drop out along the way.[316]

At the same time, it should not be forgotten that, quite apart from prejudices (conscious and/or unconscious) against them, Tanzanian children with disabilities face all the same problems as those faced by children who do not have disabilities including large class sizes and shortages of teachers, books, furniture, toilets and water supply.

This is a far cry from the international obligations set out in the previous chapter and even from the diluted versions in Tanzania's own laws and policies. Except for a very few cases, there is little or no

[308]Chaula (n 34 above) 6.
[309]Legal and human rights centre (LHRC)*Tanzania Human Rights Report* (2011).
[310]However, there are signs that the Tanzania Institute of Education, which is responsible for all curricula, wishes to develop disability-sensitive curricula and materials (personal communication with senior curriculum developer in the Institute of Education).
[311]Stone MacDonald, (n 35 above).
[312]Hoffman and Kilimo (no 31 above)
[313]HakiElimu (n 33 above).13 my translation.
[314]Chaula (n 34 above) 53.
[315]Chaula above 3 See also MD Richard *The inclusive classroom in Tanzania dream or reality?* (2002).
[316]HakiElimu (n 33 above).

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reasonable accommodation to ensure that children with MID are able to study on an equal footing with their peers. Implementation of the laws and policies is weak and there is little accountability. Neither civil society nor parliament has been able to challenge the situation.[317]

3.4.4 How inclusive is comprehensive sexuality education

Chapter Three of this study considered the importance of CSE for children with mild intellectual disabilities. However, as with all other areas of learning, adolescent girls with MID face particular problems in being able to benefit from generic sexual health or sexuality programmes. These include having difficulty in absorbing the knowledge or understanding abstract concepts related to relationships, and being left behind by their non-disabled peers during the CSE sessions.[318] Finally, they may not have sufficient background knowledge to comprehend effectively what is being taught. Ramage gives the example of demonstrating condom use which requires significant background biological knowledge.[319]

Therefore, in order for adolescent girls with MID to benefit from CSE, they need to have programmes adapted to their specific learning needs. This includes tailored materials 'in accessible formats'[320] and trained teachers who can recognise and adapt to these learning needs. Ramage also notes that, even in Canada and elsewhere in the Western World, such materials are rare, if not non-existent. This means that in Tanzania, where CSE for adolescents is already minimal and inclusive education is often no more than a word, the likelihood of adolescent girls accessing CSE in a way that is meaningful and beneficial to them is very low indeed.

4.4 Conclusion

It is worth noting that Tanzania is not alone. Polat notes that the emphasis on 'inclusive education' has come largely from Western countries.[321] Many African countries do recognise the value of inclusive education but they have been either unwilling or unable to allocate the resources required to make it happen in situations where they have still not provided quality education to all their children. Polat concludes by quoting the Department for International Development (DfID) that 'in a low-income country, inclusive education implies the right of all children to the educational package, however basic that package may be'.[322]The same applies to Tanzania. If Tanzania has been unable to fulfil its obligations to provide quality education to all its children, children with disabilities, especially those from poorer geographical areas or living in families below the poverty line suffer a double burden, as poor and as children with a disability. Girls face a third disadvantage given the male bias inherent in the society. When addressing the right of adolescent girls with MID to CSE, one also has to take this broader context into account. The final chapter of this study will use the CRPD to try to address barriers at different levels as concretely as possible.

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[317]Swedish International Development Agency(SIDA), *Disability Rights in Tanzania (*2014).
[318] Ramage (n 69 above).
[319]Ramage 15.
[320]General Comment 4 (n 168 above) para 52.
[321]Polat (n 39 above).
[322]Polat (n 39 above).

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Chapter Five: Conclusion and Recommendations

5 Introduction

5.1 Conclusion

This study has shown that adolescent girls with MID are unlikely to access CSE. First of all, Tanzanian adolescents in general only access those aspects of CSE related to HIV prevention with an emphasis on moral (abstinence only) messages rather than comprehensive scientific information about sexuality. Many topics identified as being central to CSE are not taught at all. Therefore, in primary schools, adolescents only receive a very partial introduction to CSE. The Ministry for Health has been more responsive to fulfilling Tanzania's international obligations to provide CSE but they have no influence on the national curriculum which is developed by the Ministry of Education.

At primary school level (or early adolescence), which is the focus of this study, there is no overt gender disadvantage in accessing education as, overall, girls are equally likely to complete primary education. However, in the poorer regions of Tanzania, where a larger percentage of girls with MID are thought to reside, the attendance rate for girls is significantly lower, particularly after they reach the age of puberty.

These gender disparities in attendance are linked to much broader disparities, economically and geographically, which contribute to both the prevalence of MID and the lack of substantive action to address it through integration or reasonable accommodation in the primary schools. As shown in the National Nutrition Survey, levels of stunting, which are a manifestation of chronic malnutrition and have lifelong effects on physical and mental development are very high particularly in rural areas in the lower wealth quintiles.[323] As a result, girls, particularly those from the poorest families, living in these regions are more likely to suffer from chronic malnutrition, and are therefore more likely to suffer from MID, and less likely to complete schooling, thereby reducing the likelihood of accessing even the partial sexuality education provided in schools. In addition, the schools in these regions are of a lower quality with higher pupil-teacher ratios and fewer facilities, which make it even less likely that the specific needs of children with MID are addressed.

In response to the vulnerability to intellectual disability of so many children due to chronic malnutrition, the Government of Tanzania has succeeded in reducing the rate of stunting over the past 5 years,[324] but less has been done to address the effects of such vulnerability, in particular MID. There is no system for regular data collection or for identifying children with MID when they enter school. At the most, one could argue that there is a post facto and subjective identification based on their performance in class. However, very few teachers have been trained to know what to do in such situations while any support to these learners, depends on the perception and commitment of the teachers involved, which is often negative. Thus, many children with MID are likely to benefit little from sitting in what are inclusive classrooms only in name and many of them will drop out even before they are exposed to any form of sexuality education.

[323]Nutrition Survey (n 44 above)13.
[324]As above.

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As a result, adolescent girls with MID are vulnerable to other violations of their SRHR. They are as likely to be as sexually active as their peers, but are particularly vulnerable to sexual abuse and HIV due to their lack of knowledge about their own sexuality, and how to handle relationships.

The Tanzanian government has taken some steps to address the situation. It has already passed its own Persons with Disabilities Act which largely accepts and domesticates the CRPD, albeit with some significant omissions and changes. In particular it omits the commitment of the CRPD to 'quality' health and education services and gives a narrow medical definition of intellectual disability by contrast to the broader 'social' definition of disability. It would seem that intellectual disability, although, maybe, the most common form of disability, receives less attention because it is less visible both at national level and in individual classrooms across the country. Children with intellectual disability are characterised negatively rather than being recognised as children requiring additional educational support. The recommendations of the comprehensive national strategy on inclusive education, have not been included in the latest National Education Policy. Teachers are not trained in inclusive education and are not aware of the strategy.

Therefore, while Tanzania is a party to international treaties relating to both disability and access to CSE, it is not fulfilling its obligations in practice. Much still needs to be done before adolescent girls with MID can access CSE.

5.2 Recommendations

5.2.1 Comprehensive Sexuality Education for adolescents

The CEDAW committee has become the latest treaty making body to direct the government to provide age appropriate CSE.[325] The government continues to argue that CSE is provided through a plethora of subjects in primary school but observers have pointed out that the education provided is far from meeting the requirements of CSE.

One of the main reasons why Ministries of Education, including the Tanzanian Ministry can ignore the increasing number of GC and concluding observations relating to CSE, is that CSE is always brought up in the context of the right to health rather than the right to education. Even the CRPD, while not addressing the right to CSE specifically, includes SRH information in the right to health and there is no mention of sexuality education in the right to education. Yet, it is the Ministry of Education which is responsible for all curricula and teaching in schools. At present there is a disconnect between the Ministry of Health which recognises CSE and the Ministry of Education which only emphasises HIV prevention in terms of morality and prohibition of sexuality. Yet, there has been no significant decline in HIV incidence over the past few years and adolescent girls are the most affected.[326] In addition, Tanzania has one of the highest rates of teenage pregnancy in the world (118/1000), well above the average, even for sub-Saharan Africa (100/1000).[327] Where more

[325]Concluding Observations (n 209 above).
[326]UNESCO, (N 264 above)148.
[327]World Bank, Adolescent Fertility rate. Available at http://data.worldbank.org/indicator/SP.ADO.TFRT (accessed on 17 January 2017).

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comprehensive programmes have been introduced, such as PASHA, the incidence of teenage pregnancy dropped dramatically. Therefore, it is recommended that:

7. TMBs should include the right to CSE directly within the context of the right to education.
8. National human rights, gender and health NGOs, together with development partners should join together to advocate strongly for the inclusion of CSE in the curriculum, based on but not confined to the recommendations of the national HIV strategy and Tanzania's international obligations as outlined by TMBs.
9. Deliberate steps should be taken to create the political will required to bring about a paradigm shift in regard to CSE. This includes working with Parliamentarians, professional bodies and the media to address and refute myths about the negative impact of CSE and to explain the cogent reasons for including CSE in the curriculum.
10. The Ministry responsible for Health and the Ministry of Education should form a joint committee or strengthen the existing committee on school health to investigate and implement Tanzania's treaty obligations relating to CSE. This will include introducing CSE as a stand-alone subject in the curriculum rather than infusing CSE into other school subjects.
11. The Ministry of Education budget should include a budget line specifically for CSE (in line with its reporting obligations to the Maputo Protocol). This would enable the Ministry to develop the curriculum and materials required to provide CSE in schools and teachers' colleges and ensure that teachers are adequately supported to provide such education.
12. In line with the CRPD, as expressed in General Comment 3[328] and 4,[329] the State Party should take specific steps to ensure that persons with disabilities also access CSE equally with their fellow adolescents.

5.2.2 Mild Intellectual Disability

While barriers to the provision of CSE are more related to moralistic attitudes, barriers to the inclusion of girls with MID are more related to the recognition of the magnitude of the issue and the provision of adequate resources. Despite the formulations in international instruments, and in Tanzania's Persons with Disabilities Act, disability is still considered to be a health problem, a deficit and there is little recognition of disability as a social and human rights issue that requires removal of social and physical barriers that prevent children with disabilities participating fully. This applies particularly to intellectual disability whereby those with MID are misunderstood, regarded negatively and stigmatised even by their teachers. As noted by General Comment 3 of the CRPD, this also leads to girls being taken out of school and married under the pretext of providing future physical and financial security and care,[330] thereby depriving them also of access to CSE. Lack of access to sexuality education also makes them more vulnerable to sexual violence.[331] It is therefore recommended that:

1. Disability and human rights CSOs should publicise the CRPD as well as Tanzania's Persons with Disabilities Act.

[328]General Comment 3 (n 164 above) para 4.
[329]General Comment 4(n 168 above) para 53.
[330]General Comment 3 (above)para 36.
[331]As above, para 41.

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2. Disability and human rights CSOs should also conduct a national campaign in regard to intellectual disability to remove both the invisibility of and the stigma from intellectual disability and promote recognition of its causes and symptoms as well as of the steps that need to be taken to enable those with MID to develop to their full potential and participate fully in schools and communities.
3. As recommended in General Comment 4,[332] Tanzania should develop its own framework, in Kiswahili, for early identification of children with intellectual disabilities in order to provide them with the appropriate support and ensure that they complete basic education.
4. All teachers should be trained to recognise and support learners with MID from the time that they begin to attend school.

5.2.3 Strategy for inclusive education

In order for girls with MID to access CSE, they have to be enrolled in school and continue with schooling, at least until they complete primary education. While there is a policy of inclusive education and a national strategy for the same, the provisions of the strategy have hardly been implemented. The latest national policy on education hardly mentions inclusive education. Therefore, it is recommended that:

1. In line with the CRPD and the national Persons with Disabilities Act, as well as the stipulations in General Comment 4 of the CRPD, The Ministry of Education should include the provisions for inclusive education outlined in the National Strategy for Inclusive Education in the Education Policy and produce a draft bill for Parliament which amends the Education Act of 1978 to promote inclusive education for all vulnerable groups, including those with intellectual disability.
2. This includes the incorporation of inclusive education into the teachers' education curriculum and the setting up of inclusive education centres and mobile teams to support teachers working with children with all disabilities, including intellectual disabilities.

5.2.4 Accountability

The Tanzanian policy on disability lacks monitoring and accountability mechanisms.[333] It also lacks disaggregated data and research which provide the basis for accountability as well as policy making with regard to inclusive education.[334]The same is true of the provision of CSE. Accountability is built into the periodic reports to be presented to TMBs and the reporting guidelines on the Maputo Protocol specifically require states parties to report on sex education. However, this is insufficient as, without further elaboration, the government can argue that it is fulfilling its obligations through its broad legislation, policies and programmes. Thus:

1. It is necessary for relevant human rights, education, gender and disability CSOs, supported by civil society as a whole, to play a more proactive role in relation to both sex education and inclusive education.

[332]General Comment 4 N 168 above).
[333]Aldersey and Turnbull, (n 41 above).
[334]General Comment 4 (n 168 above) para 4 (d).

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2. Civil Society should approach parliament, in particular the social services committee to ensure that the government reports to parliament every year on the two issues of CSE and inclusive education.
3. In line with General Comment 4 of the CRPD, Tanzania should ensure that it generates appropriate, disaggregated data to formulate its policies and plans to fulfil its obligations under Article 24 of the CRPD.[335]
4. The Ministry of Education, in collaboration with Organisations for People with Disabilities should develop and monitor quality standards and disability inclusive monitoring mechanisms,[336] with 'structural, process and outcome indicators',[337] which would include indicators for the expansion of inclusive education and the enrolment and retention of children with MID.
5. The government, in its annual budget, should allocate sufficient funds for the above to be implemented.

[335]As above, para 66.
[336]As above, para 62.
[337]As above, para 73.

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