



BRIEFING PAPER

A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN MAINLAND TANZANIA

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Center for Reproductive Rights

120 Wall Street, 14th Floor
New York, NY 10005
United States

Tel +1 917 637 3600

Fax +1 917 637 3666

publications@reprorights.org

www.reproductiverights.org

A TECHNICAL GUIDE TO
UNDERSTANDING THE LEGAL
AND POLICY FRAMEWORK
ON TERMINATION OF PREGNANCY
IN MAINLAND TANZANIA



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Biharamulo

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Musoma

Mwanza

Serengeti National Park

Magadi

Nairobi

Kenya

Shinyanga

Nzega

Tabora

Singida

Arusha

Moshi

Arusha N.P.

Tarangire N.P.

Korogwe

Mombasa

Wete

Pemba I.

Tanga

Zanzibar

Dar es Salaar

Mpanda

Dodoma

Kilosa

Morogoro

Ruvu

Milumi N.P.

Ruaha National Park

Mikumi

Kidatu

Iringa

Sumbawanga

Ifakara

Mafia I.

Kilwa Kivinje

Mbala (Abercorn)

Mbeya

Tunduma

Njombe

Zambia

Kasama

Lindi

Mtwara

Malawi

Songea

Masasi

Mzuzu

Mocimboa do Rovuma

Mzimba

Mozambique

TABLE OF CONTENTS

- 6 Introduction**
- 7 Recommendations**
- 9 What Are the United Republic of Tanzania’s Obligations under International and Regional Human Rights Laws and Standards?**
- 12 What Does the Constitution of the United Republic of Tanzania Say about Termination of Pregnancy?**
- 15 The Mainland Tanzanian Penal Code: When Is Termination of Pregnancy Permitted?**
 - Sections 150–152
 - Sections 204 and 219
 - Section 230
- 22 What Abortion Case Law Is Relevant to Mainland Tanzania?**
 - Rex v. Bourne*
 - Expanding upon and Affirming *Bourne*: Additional Jurisprudence
 - Post-Independence: Tanzanian Adopts the *Bourne* Decision
- 27 Regulating the Provision of Care in Mainland Tanzania: What Do Professional Codes of Conduct and the Client Service Charter Say about Termination of Pregnancy?**
 - Professional Councils and Codes of Conduct for Health Care Professionals
 - The Client Service Charter
- 33 What Do Mainland Tanzanian Government Policies Say about Termination of Pregnancy?**
 - Lack of Comprehensive Government Guidance on the Provision of Safe and Legal Abortion
 - Post-Abortion Care
 - Acknowledged Limitations of Post-Abortion Care Services

INTRODUCTION

This technical guide seeks to clearly and comprehensively lay out the laws and policies governing termination of pregnancy in mainland Tanzania¹ so that discussions of the law and law reform are based on a common understanding of the existing legal and policy framework.

The laws and policies governing termination of pregnancy in Tanzania are inconsistent, unclear, and often contradictory. The confusing content of these laws and policies is compounded by the absence of interpretation by Tanzanian courts and of comprehensive policy guidance on termination of pregnancy from the Tanzanian Government. As a result, women, health care providers, and regulators often lack comprehensive information about the content of the law and what it permits.

The following key findings are based on an extensive review of relevant policies, guidelines, training manuals, curricula, and professional codes of conduct and ethics; an analysis of key laws, court cases, and legal texts; and interviews with lawyers, health care providers and administrators, advocates, and academics in Tanzania.

The single most critical finding of our research is that mainland Tanzania’s abortion law is not as restrictive as most people believe. Significant improvements in women’s health and lives—including reductions in post-abortion complications and maternal mortality from unsafe abortion—could be achieved simply by publicizing and implementing current laws and policies.

RECOMMENDATIONS

To ensure Tanzania’s compliance with its international and regional human rights obligations and to reduce maternal death and disability from unsafe abortion in Tanzania, we make the following recommendations to the Tanzanian Government:

- Amend relevant laws and policies to bring them into conformity with Tanzania’s legal obligation under article 14(2)(c) of the African Charter’s Protocol on the Rights of Women in Africa (Maputo Protocol) to “*protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus.*”²
- Raise awareness among health care providers, women, and communities about the true content and scope of the law on termination of pregnancy in Tanzania and ensure that existing exceptions are available in practice.³
- Develop and widely implement and disseminate comprehensive national guidelines on the provision of safe abortion services under the law.
- Ensure that the relevant health care providers—including mid-level providers—are trained to provide safe abortion and post-abortion care services and that health care facilities are appropriately equipped to provide these services.
- Comply with the call of the UN Special Rapporteur on the Right to Health to “decriminalize abortion” and “consider, as an interim measure, the formulation of policies and protocols by responsible authorities imposing a moratorium on the application of criminal laws concerning abortion, including legal duties on medical professionals to report women to law enforcement authorities.”⁴



ACTIVE LABOUR ONLY

WHAT ARE THE UNITED REPUBLIC OF TANZANIA'S OBLIGATIONS UNDER INTERNATIONAL AND REGIONAL HUMAN RIGHTS LAWS AND STANDARDS?

IN SUMMARY:

- Tanzania has ratified international and regional treaties that affirm women's human rights, including the groundbreaking Maputo Protocol.
- The Maputo Protocol, which Tanzania ratified in 2007, requires the government to ensure access to safe and legal abortion in cases of rape, incest, and endangerment to a woman's life, physical health, or mental health.
- International and regional human rights standards have established that access to safe and legal abortion and post-abortion care is essential to protecting women's most fundamental human rights.

Several regional treaties ratified by the United Republic of Tanzania—the African Charter on Human and Peoples' Rights (African Charter),⁵ the African Charter on the Rights and Welfare of the Child (African Charter on Children),⁶ the Southern African Development Community's Protocol on Health,⁷ and the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol)⁸—provide important protections for the rights of women and girls in Tanzania.

The groundbreaking Maputo Protocol represents the first time that an international human rights instrument has explicitly articulated a woman's right to abortion in certain cases. Article 14(2) of the Protocol calls upon states to “provide adequate, affordable and accessible health services”⁹ to women. It also urges governments to

protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus.¹⁰

By ratifying the Protocol,¹¹ the Tanzanian Government is obligated under regional human rights law to ensure that safe and legal abortion is available and accessible on all of these grounds.

Tanzania has also confirmed its commitment to upholding international human rights standards by ratifying several major global treaties, including the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant),¹² the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant),¹³ the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),¹⁴ the Convention on the Rights of the Child (Children’s Rights Convention),¹⁵ and the Convention on the Rights of Persons with Disabilities.¹⁶

The Government of Tanzania is legally bound to respect, protect, and fulfil the rights contained in the international and regional conventions that it has signed or ratified. The Tanzanian Government’s failure to ensure access to safe termination of pregnancy and post-abortion care, and the criminalization of abortion, are direct evidence of a failure to safeguard women’s rights to

- life;
- health;
- liberty and security of person;
- freedom from torture and cruel, inhuman, and degrading treatment;
- equality and non-discrimination;
- dignity;
- information;
- privacy and family; and
- redress and legal assistance.

A state that ratifies or accedes to an international convention “establishes on the international plane its consent to be bound by a treaty.”¹⁷ The Government of Tanzania is therefore obligated under international law to protect the rights guaranteed by these instruments. While Tanzania has not incorporated the vast majority of these treaties’ provisions into its national-level laws,¹⁸ under the Vienna Convention on the Law of Treaties, “[a] party may not invoke the provisions of its internal law as justification for its failure to perform a treaty.”¹⁹

Article 9 of the Tanzanian Constitution also makes clear that “the state authority and all its agencies are obliged to direct their policies and programmes towards ensuring (a) that human dignity and other human rights are respected and cherished; . . . [and] (f) that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights.”²⁰ In interpreting this provision, at least one mainland Tanzanian High Court decision has concluded that this article “generally domesticated the human rights instruments ratified by Tanzania.”²¹

Decisions by the mainland Tanzanian High Court²² and Court of Appeal have repeatedly affirmed that the Universal Declaration of Human Rights is part of—or incorporated in—the Constitution of Tanzania by virtue of article 9(f) of the Constitution.²³ The Court of Appeal, the highest court in the land, has further stated that “the principles enunciated in [CEDAW, the African Charter, and the

Civil and Political Rights Covenant] are a standard below which any civilised nation will be ashamed to fall,”²⁴ and has struck down a customary law that “flies in the face of our Bill of Rights as well as the international conventions to which we are signatories.”²⁵

Finally, the Court of Appeal has also held that since the Bill of Rights was drafted after Tanzania ratified the African Charter, “account must be taken of that Charter in interpreting our Bill of Rights and Duties.”²⁶ The High Court, in relying on this case, has further stated:

*we have no doubt that international conventions must be taken into account in interpreting, not only our constitution but also other laws, because Tanzania does not exist in isolation. It is part of a community of nations. In fact, the whole Bill of Rights was adopted from those promulgated in the Universal Declaration of Human Rights.*²⁷

Therefore, international and regional human rights treaties can be understood as fundamental to the Tanzanian legal framework and should be taken into account when evaluating laws, policies, and practices in Tanzania.

The legally binding provisions of the major human rights conventions are complemented by politically binding international consensus documents that support a globally recognized reproductive rights framework. These include the outcome documents of international conferences such as the United Nations International Conference on Population and Development, the Fifth African Regional Conference on Women, and the United Nations Fourth World Conference on Women.²⁸ Moreover, Tanzania has committed itself to attaining the United Nations Millennium Development Goals, which seek, among other things, to promote gender equality, reduce maternal mortality, and ensure universal access to education.²⁹

WHAT DOES THE CONSTITUTION OF THE UNITED REPUBLIC OF TANZANIA SAY ABOUT TERMINATION OF PREGNANCY?

IN SUMMARY:

- **The Constitution contains key provisions that support access to safe and legal abortion services and post-abortion care.**
- **Specifically, the Constitution affirms the importance of respecting the rights to life, human dignity, equality and non-discrimination, privacy, and freedom from inhuman and degrading treatment.**

The Constitution of the United Republic of Tanzania articulates and protects a number of fundamental human rights,³⁰ many of which support an expansive interpretation concerning legal access to abortion and post-abortion care. The Constitution guarantees the fundamental “right to live.”³¹ Forcing women to resort to unsafe abortions, due to restrictive abortion laws or a lack of access to safe abortion services, violates their right to life. Similarly, failure to ensure the availability and accessibility of quality post-abortion care—an emergency, life-saving service—violates women’s right to life.

The right to privacy and personal security, including the “respect and protection of . . . private communications,”³² is guaranteed under article 16. This provision protects provider-patient confidentiality by prohibiting interference in the privacy of any communications between these parties, including those concerning abortion services. Such communications may pertain to the availability of services, where one may obtain the procedure, the types of abortion services available (surgical or medical), and instructions on how to safely procure a medication abortion. This constitutional provision also protects providers of post-abortion care services against being compelled to report women in their care to the police.

Article 12 of the Tanzanian Constitution guarantees the right to equality³³ and to “recognition and respect for [one’s] dignity.”³⁴ Article 13 guarantees equality before the law and non-discrimination. It states, “No law enacted by any authority in the United Republic shall make any provision that is discriminatory either of itself or in its effect.”³⁵ As highlighted in the International and Regional Human Rights Law Section, laws criminalizing abortion—and that force women to resort to unsafe abortion—violate women’s right to dignity. These laws are also

discriminatory, as they criminalize health care services that only women need. Further, these laws compound discrimination against poor and rural women, who are less able than wealthier, urban women to access safe abortion services and are therefore more likely to resort to unsafe abortion.³⁶

Article 13 further requires the government, in ensuring equality before the law, to consider the principle that “no person shall be subjected to torture or inhuman or degrading punishment or treatment.”³⁷ This provision strongly supports arguments in favour of decriminalizing abortion in Tanzania. Criminalizing abortion and denying access to safe and legal abortion services in circumstances where the pregnancy may threaten a woman’s life, physical health, or mental health—particularly in cases of rape, incest, or severe foetal anomaly—violates a woman’s right to be free from torture and cruel, inhuman, and degrading treatment.³⁸

Finally, article 29 of the Constitution, which also guarantees equal protection under the law and non-discrimination, further clarifies that the rights enumerated above are “fundamental human rights.”³⁹ In addition, all of the aforementioned rights are, under article 30(3), enforceable in a court of law.⁴⁰ The Court of Appeal has also held that “the provisions touching fundamental rights have to be interpreted in a broad and liberal manner. . . . Restrictions on fundamental rights must be strictly construed.”⁴¹

The “Fundamental Objectives and Directive Principles of State Policy”⁴² section of the Constitution requires

*the state authority and all its agencies . . . to direct their policies and programmes towards ensuring (a) that human dignity and other human rights are respected and cherished; . . . (f) that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights; (g) that the Government and all its agencies provide equal opportunities to all citizens, men and women alike without regard to their colour, tribe, religion, or station in life; (h) that all forms of injustice, intimidation, discrimination, corruption, oppression or favoritism are eradicated.*⁴³

This section also requires the state to “make appropriate provisions for the realization of a person’s right to . . . social welfare at times of old age, sickness or disability. . . .”⁴⁴ This provision has been understood as reflecting the principle of a right to health.⁴⁵

Although the provisions in this section of the Constitution are “not enforceable by any court,”⁴⁶ they are significant and can be used to hold the Tanzanian Government to account. As one Tanzanian scholar has explained, these objectives are

binding on all organs and officials of the state although an individual citizen cannot complain to a court of law if any of those provisions is

*violated. Nonetheless, members of parliament and the public can hold a public official politically accountable for breaching those provisions because they have force of law although not enforceable in courts.*⁴⁷

The Court of Appeal has held that the Constitution “must be construed in tune with the lofty purposes for which its makers framed it [in the Preamble and the Fundamental Objectives and Directives Principles of State Policy]. So construed, the instrument becomes a solid foundation of democracy and rule of law.”⁴⁸ The High Court has also held that “[a] Constitution must . . . be construed in a way which secures for individuals the full measure of its provisions.”⁴⁹ As such, the fundamental objectives—and their protection of the right to health—can be understood as a mandate requiring that these principles inform government policy and practice. In this light, the Ministry of Health’s failure to issue comprehensive guidelines or policies on the provision of safe and legal abortion services, as well as the existence of laws criminalizing abortion, a safe and sometimes life-saving medical procedure, violate the government’s obligation to protect the right to health.

Finally, article 64(5) of the Constitution makes clear that “this Constitution shall have the force of law in the whole of the United Republic, and in the event any other law conflicts with the provisions contained in this Constitution, the Constitution shall prevail and that other law, to the extent of the inconsistency with the Constitution, shall be void.”⁵⁰ Thus, to the extent that the Penal Code provisions (discussed in the following section) are in violation of fundamental human rights guaranteed in the Constitution and international human rights treaties, they should be amended accordingly.

THE MAINLAND TANZANIAN PENAL CODE: WHEN IS TERMINATION OF PREGNANCY PERMITTED?

IN SUMMARY:

- The Penal Code provisions on termination of pregnancy are frequently misunderstood as a total prohibition on abortion. This is not the case.
- Sections 150–152 of the Tanzanian Penal Code criminalize only “unlawful” acts related to termination of pregnancy, indicating that there are circumstances where pregnancies can be lawfully terminated.
- A lawful termination of pregnancy includes one performed to preserve the woman’s life or her mental or physical health.
 - Section 230 creates a clear exception to criminalization in cases where a termination is necessary to preserve the woman’s life. Case law has further clarified that this life exception encompasses mental and physical health as well. [See Case Law Section.]
- The law on abortion does *not* specify who may perform a legal termination of pregnancy, leaving room for appropriately trained mid-level providers—such as nurses, midwives, and clinical officers—to provide the service, in addition to qualified medical practitioners.

Sections 150–152

The only direct references to the substantive “crime” of abortion in Tanzanian legislation can be found in the Penal Code. Sections 150–152 criminalize attempting to procure, or knowingly supplying things to procure, an “unlawful” abortion or miscarriage.⁵¹ These sections refer to the criminal liability of the provider/procurer, the pregnant woman, and the supplier of drugs or equipment for abortion, respectively.

150. Attempts to procure abortion. *Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever is guilty of an offence and is liable to imprisonment for fourteen years.*

151. Procuring own miscarriage. *A woman being with child who with intent to procure her own miscarriage unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, or permits any such thing or means*

to be administered or applied to her, is guilty of an offence and is liable to imprisonment for seven years.

152. Supplying drugs or instruments to procure abortion. *Any person who unlawfully supplies to or procures for another anything whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of an offence, and is liable to imprisonment for three years.*⁵²

There are several points worth noting about sections 150–152. First, all three provisions use the word “unlawfully” to describe the offence—i.e., “unlawfully administers” or “unlawfully supplies.” As discussed in the Case Law Section, courts have understood the use of the word “unlawfully” to be intentional and to suggest that there are circumstances under which these acts may be deemed lawful.⁵³

Second, only section 151, which pertains to the pregnant woman, requires that the woman actually be pregnant in order to have committed an offence. Sections 150 and 152 apply whether or not the woman is, in fact, pregnant—the intent of the person to procure the miscarriage triggers criminal liability. As such, there is an extra burden of proof for the prosecution to show beyond a reasonable doubt that the woman was pregnant in cases where the woman is the accused.

Finally, because there is no reference to gestational age in these provisions—and neither the Penal Code nor other Tanzanian legislation defines the terms “abortion” or “miscarriage”—they appear to apply to all stages of pregnancy.

Sections 204 and 219

These Penal Code sections distinguish between the offence of unlawfully procuring a miscarriage/abortion and that of murder or manslaughter. They define the moment in foetal development when a foetus becomes a “child capable of being born alive” and then a legal “person” or born child whose destruction carries quite different, and harsher, penalties than those associated with abortion.

204. When child deemed to be a person. *A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of [the pregnant woman] whether it has breathed or not, and whether it has an independent circulation or not, and whether the naval string is severed or not.*⁵⁴

219. Child destruction. *(1) Subject to subsection (2) any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes the child to die before it has an existence independent of [the pregnant woman], shall be guilty of child destruction and shall be liable on conviction to imprisonment for life.*

(2) A person shall be guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the [pregnant woman].

*(3) For the purpose of this section, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at the time pregnant of a child capable of being born alive.*⁵⁵

Section 204 makes clear that the offence of murder or manslaughter becomes applicable only when the foetus is born alive and physically exists outside the pregnant woman's body. The section distinguishes between a foetus in the womb and a newborn child, clarifying that a foetus yet to be born cannot be the victim of murder under the Penal Code.⁵⁶

Section 219 provides for the separate offence of "child destruction." Modelled after the United Kingdom's 1929 Infant Life (Preservation) Act, with nearly identical text, the intent behind this section was to "close a legal loophole."⁵⁷ As one British legal scholar has explained:

*In 1929, it was unlawful to kill a fetus in utero, and it was murder to kill a child which had been fully born and was living without any connection with [the pregnant woman]. However, no protection was afforded to the child while it was in the process of being born, before it had been completely separated from [the pregnant woman]. In order to fill this gap, the Infant Life (Preservation) Act provided that killing the [foetus] during childbirth would also be an offence.*⁵⁸

The 1929 Act also refers to a "child capable of being born alive" and stipulates that there is a presumption that the foetus is capable of being born alive after the 28th week of pregnancy. While this section criminalizes a termination of pregnancy performed in the final weeks of pregnancy, **there is an exception to criminalization when the termination is done to preserve the pregnant woman's life or health.** [See Case Law Section for discussion on how life is interpreted to include health.]

The section does not define what is meant by "capable of being born alive." Further, our research revealed no Tanzanian case law on how to interpret this phrase.⁵⁹ English case law interpreting the 1929 Act indicates that a foetus is "capable of being born alive" within the meaning of the Act when it

*has reached a state of development in the womb that it is capable, if born, of . . . breathing and living by reason of its breathing through its own lungs alone, without deriving any of its living or power of living by or through any connection with [the pregnant woman].*⁶⁰

Thus, the ability to breathe independently is considered an important indicator in English jurisprudence. Based on this reasoning, in England, a foetus of less than 28 weeks' gestation has been found "capable of being born alive."⁶¹

However, in one relevant English case, *C v. S*, the judge acknowledged that this "medical concept" is "ambiguous" and "capable of different interpretations" and that expert testimony or opinions from doctors "may well be required and gratefully received to assist the court."⁶² As such, this definition is not necessarily

fixed but varies by context, local medical practice, and the degree of scientific advancement at a particular time. In Tanzania, according to one obstetrician/gynaecologist, standard medical practice uses the 28-week presumption as a “medical cut-off,” as Tanzanian medical facilities “are not capable of caring [for newborn] babies of less than 28 weeks.”⁶³ This is confirmed in guidelines issued by the Ministry of Health.⁶⁴

It is also worth noting the overlap in criminal liability between this section and the sections criminalizing unlawful abortion. As discussed above, sections 150 and 151 make no reference to gestational age when criminalizing unlawful abortion. Therefore, a person who unlawfully performs a termination of pregnancy in the later stages of pregnancy—namely, after the 28th week—may be held liable for both the crime of abortion and the crime of child destruction. **Again, that person would not be held criminally responsible for either crime if the termination was performed in good faith to preserve the pregnant woman’s life or health.** [See Case Law Section for discussion on how life is interpreted to include health.]

Finally, it bears mentioning that standard methods used to calculate gestational age are imprecise. The law makes no mention of how to ascertain a woman’s stage of pregnancy, appropriately leaving this determination to standard medical practice. According to one Tanzanian obstetrician/gynaecologist, the most commonly used method in Tanzania (and globally) to calculate gestational age is based on the last normal menstrual period; where a woman does not know the date of her last period, “health workers do use other exploratory methods to estimate the duration of pregnancy.”⁶⁵ However, these methods provide merely estimates—a woman would not yet be pregnant on the date of her last menstrual period, for example. Consequently, explain two medico-legal scholars, a 28-week “time limit if taken from the first day of the woman’s last menstrual period is based upon a fiction. For these reasons borderline cases of ambiguity ought to be construed in favor of the pregnant woman and her doctor.”⁶⁶

Section 230

***230. Responsibility as to surgical operation.** A person is not criminally responsible for performing, in good faith and with reasonable care and skill, a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the [pregnant woman’s] life if the performance of the operation is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.⁶⁷*

This critical provision is widely understood to permit termination of pregnancy to safeguard the life and health of the pregnant woman. It creates a lawful exception to criminalization and provides a defence in circumstances where a person, in good faith and with reasonable care and skill, performs a surgical abortion to preserve the pregnant woman’s life. In such circumstances, the person performing the procedure is not criminally liable.

“A person is not criminally responsible . . .”

Section 230 stipulates that a “person” is not criminally responsible for performing a surgical operation where the operation is done “in good faith and with reasonable care and skill.” This echoes the “person” language in section 150 and provides a potential defence to anyone, subject to the good-faith qualification. This provision could therefore serve as a defence for any qualified health care provider, including nurses, allied health professionals, medical practitioners, and obstetrician/gynaecologists.

“for performing in good faith”

The “good faith” requirement is critical to the determination of criminal guilt or innocence—to deny a person the defence under this section, the prosecution must prove beyond a reasonable doubt that the individual “had a criminal intention or did not act in good faith.”⁶⁸ This is a subjective determination, and, as legal scholar Rebecca Cook has explained, “the possibility that different assessments of the same situation may be made does not impair the conscientious and therefore lawful status of a liberal interpretation.”⁶⁹ In other words, there is no objective “right” answer; health care providers may reach different conclusions in the same case and still be acting in good faith.

Courts have determined that certain evidence may be particularly persuasive in determining a health care provider’s good faith. Firstly, the decision to terminate the pregnancy must have been made on health grounds. According to Professor Cook:

[t]he requirement for a [health worker’s] good faith in making a medical assessment of a woman’s needs or qualification for abortion implies an obligation to apply proper professional criteria of health care and the absence of motivation based on ulterior or non-professional purposes. . . . [T]he decision must . . . be based on reasons of real danger to life or health, and not on financial and social factors as such. The underlying reasoning is that a physician’s opinion not formed upon the basis of his special skill and trained insight is not a medical opinion.⁷⁰

Evidence of good faith may include “the absence of financial motivation”⁷¹—for example, “restraint in fee-setting” and refusing to accept a “sizeable fee”⁷²; “the ability to use adequate skill”; or “making an adequate examination of the woman’s medical history.”⁷³ Conversely, evidence that the person did not act in good faith may lie in the “secrecy (as opposed to privacy) of the operation, failure to enquire into the woman’s circumstances to establish legal indications, and charging of high fees,”⁷⁴ as well as in “[p]ersonal involvement with the patient.”⁷⁵

“and with reasonable care and skill”

This clause makes explicit that the surgical operation must be performed with reasonable care and skill.⁷⁶ Again, section 230 does not specify who might have such skills, instead referring to a “person” more generally. **This leaves room for**

appropriately trained mid-level providers, such as nurses, midwives, and clinical officers, to provide the service, in addition to qualified medical practitioners.⁷⁷

Guidance as to who may have the requisite skills, and what constitutes the requisite “reasonable care,” may come in the form of policies or guidelines issued by the Ministry of Health.

“a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the [pregnant woman’s] life”

Section 230 refers only to a “surgical operation,” which is not defined in the Penal Code. However, in medical practice, a surgical operation in the abortion context includes both dilation and curettage (D&C) and manual vacuum aspiration (MVA).⁷⁸ In addition, although the Penal Code does not define “unborn child,” this exception to the criminalization of abortion—for the preservation of the woman’s life—is understood to apply to all stages of a pregnancy, regardless of the gestational age.⁷⁹ This exception is also made explicit in the child-destruction provision (section 219), discussed above.

Section 230 does not describe what circumstances may constitute operating “for the preservation of the [woman’s] life.” In addition, our research has revealed no post-independence Tanzanian Court of Appeal or High Court case law that authoritatively interprets this provision and clarifies the content of this exception. However, two pre-independence cases—one from England and the other from the East African Court of Appeal—make clear that the life exception should be understood to encompass mental and physical health grounds and pregnancies resulting from sexual violence. This understanding of the life exception also concurs with human rights standards on abortion. [See Case Law Section and International and Regional Human Rights Law Section.]

“if the performance of the operation is reasonable, having regard to the patient’s state at the time, and to all the circumstances of the case”

In determining whether a surgically induced termination of pregnancy performed to preserve the woman’s life is reasonable under the law, the provider (and the magistrate or judge, in the event of a criminal case) should look to a range of factors and contextual information. First, the performance of the operation must be “reasonable,” indicating that it should be done under circumstances consistent with accepted contemporary medical practice and standards—or the “general opinion of competent practitioners.”⁸⁰ Further, the “patient’s state at the time, and . . . all the circumstances of the case” must be evaluated, creating space for a more expansive (or “reasonable”) judicial interpretation of “preserving the pregnant woman’s life” than simply the prevention of imminent death.



WHAT ABORTION CASE LAW IS RELEVANT TO MAINLAND TANZANIA?

IN SUMMARY:

- **There is no post-independence Tanzanian case law interpreting the mainland Tanzanian Penal Code provisions on abortion. However, pre-independence case law, which continues to have legal authority in Tanzania, can be used to interpret mainland Tanzania’s abortion law.**
- **In Tanzania, termination of pregnancy is permitted to preserve the life or health of the pregnant woman. Health is defined to include both physical or mental health. This understanding was made clear in the widely recognized English case of *Rex v. Bourne* (1938), a case that has been repeatedly affirmed throughout the Commonwealth, including by the East African Court of Appeal in *Mehar Singh Bansel v. R* (1959), a decision binding in Tanzania.**

There is little applicable Tanzanian case law to provide clear, interpretative guidance concerning the circumstances in which abortion may be legally provided and procured. There is no High Court or Court of Appeal decision that interprets Tanzania’s Penal Code provisions on abortion,⁸¹ and our research revealed only one case pertaining to the provision on child destruction. This High Court case, *The Republic v. Roseline D/O Minja*,⁸² offers no interpretation of the meaning or content of the law. Instead, it is a straightforward application of section 219 to the actions of the accused in that case.

However, a few key cases, stemming from pre-independence English and East African Court of Appeal jurisprudence, can be used to interpret Tanzania’s abortion law. According to both a Tanzanian legal scholar and a Tanzanian principal state attorney, where there is a lacuna in national case law, courts will look to English case law for guidance.⁸³ Accordingly, these precedential English cases, discussed below, continue to have a degree of legal authority in contemporary Tanzania. The case on abortion from the East African Court of Appeal, referenced below, is binding in Tanzania.⁸⁴

In addition, the Court of Appeal of Tanzania has stated that where fundamental human rights are at issue, it is prudent to look to foreign case law: “On a matter of this nature it is always very helpful to consider what solutions to the problem other courts, in other countries have found. . . .”⁸⁵

Rex v. Bourne⁸⁶

Rex v. Bourne was the first case to address the grounds upon which an abortion could be legally provided in England.⁸⁷ This case, decided in 1938, has had a profound and lasting impact on the legal regimes of former British colonies and Commonwealth countries. Most colonies, Tanzania included, had—and continue to have—an abortion provision nearly identical to the one at issue in *Rex v. Bourne* in their penal codes and, under common-law principles, can look to English case law as an authoritative interpretation of that law.⁸⁸

Rex v. Bourne, heard in the Central Criminal Court, was brought against a doctor who had performed an abortion on a young girl who had been raped.⁸⁹ The question at hand was whether the doctor had “unlawfully” procured the girl’s abortion. In his summing-up to the jury, the judge reasoned that the use of the word “unlawfully” in the provisions criminalizing abortion in the English Offences against the Person Act was intentional and suggested that there were circumstances under which abortion could be “lawfully” procured. For guidance, he then looked to the United Kingdom’s 1929 Infant Life (Preservation) Act, which provides an exception to the crime of child destruction for acts “done in good faith for the purpose only of preserving the life of the [pregnant woman].”⁹⁰

He concluded that this life exception had “always . . . been implicit in [the abortion provisions of the Penal Code], on the reasoning that if preservation of the [pregnant woman’s] life justifies sacrificing the child’s life at the moment of birth, it also justifies such sacrifice at any earlier stage in pregnancy.”⁹¹ In essence, the judge understood the abortion law to permit a person to “lawfully” procure a miscarriage if done “in good faith for the purpose only of preserving the life of the [pregnant woman].”⁹² Sections 150 and 151 of the Tanzanian Penal Code, which criminalize “unlawful” abortion and miscarriage, are based on these provisions in the 1861 Act, while sections 219 and 230 of the Penal Code are modelled after the United Kingdom’s 1929 legislation. By analogy, sections 150 and 151 can also be understood to import a lawful life exception to criminalization in Tanzania.

The judge further asserted that the jury “should take a reasonable view of” the phrase “preserving the life of the [pregnant woman].”⁹³ A reasonable view, according to the judge, does not mean “for the purpose of saving the [pregnant woman] from instant death”⁹⁴—in such a case, the doctor is “not only entitled, but it is his *duty* to perform the operation with a view to saving her life.”⁹⁵ Rather, “if the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck,” then this constitutes acting in preservation of the life of the woman and is lawful.⁹⁶

The ruling in *Bourne* effectively created a mental and physical health exception to the criminalization of abortion—and clearly provided for access to legal abortion in cases of rape. Unlike the surgical operation provision under section 230 of

the Tanzanian Penal Code, the *Bourne* decision makes no reference to the method of termination—it simply sets forth a general legal framework, permitting termination of pregnancy to preserve the pregnant woman’s life or health. Critically, the ruling therefore widens the defence beyond surgical abortion to include medication abortion. Finally, although *Bourne* concerns a doctor—the only type of provider considered capable of safely offering these services when the case was decided in the 1930s—modern technology and professional competencies permit mid-level providers to offer certain abortion services as well.⁹⁷ This decision is therefore broadly applicable to all health care providers who are appropriately trained and capable of offering termination-of-pregnancy services.

The judge’s reasoning in *Bourne* emphasized the girl’s age and the “fact that she had been raped with great violence.”⁹⁸ At the time of the rape and subsequent abortion, the girl was under the age of fifteen. The judge noted that “[i]t is no doubt very undesirable that a young girl should be delivered of a child.”⁹⁹ As support for this proposition, the judge relied on Parliament’s legislative intent and medical testimony given at trial. He pointed to legislation prohibiting girls under sixteen from marrying as evidence of Parliament’s “view that a girl under the age of sixteen ought not to marry and have a child,” and pointed to medical evidence concerning girls’ physical immaturity prior to the age of eighteen as confirmation that “it must be injurious to a girl that she should go through the state of pregnancy and finally of labour when she is of tender years.”¹⁰⁰

The judge also gave much weight to the fact that the girl was raped, stating that “a girl who for nine months has to carry in her body the reminder of the dreadful scene and then go through the pangs of childbirth must suffer great mental anguish.”¹⁰¹ This language offers clear legal support for a rape exception, stemming from mental health grounds, in Tanzania.

Although *Bourne* was decided only by a court of first instance, not considered on appeal, and ultimately decided by a jury, there are compelling arguments for its significance for all common-law countries. Professor Cook has written persuasively on this issue:

The strength of a case authority depends not simply upon its origin in the hierarchy of the courts . . . but upon the respect subsequent courts and legal literature accord to it. A case not binding as precedent, for instance because of its origin in another individual jurisdiction, may guide and persuade by accumulated authority.

The language used by Macnaghten, J. in directing the Bourne jury has received the highest approval. It occupies a distinguished place in legal literature not simply on abortion, but on the general legal concept and defence of necessity. To cast doubt on the authority of the Bourne decision is not just to favour a different opinion on the legal propriety of abortion, but to question the foundations of modern common law thought on recognition of the necessity concept. . . . Apart from the high

*status of the decision in British law, it has received wide citation and approval in courts of other Commonwealth countries.*¹⁰²

A lawyer in the Attorney General's Chambers at the Tanzanian Ministry of Justice, in a paper entitled "The Working of Abortion Law in Tanzania," made clear that "[a]lthough no test case has been reported in Tanzania, [*Bourne's*] interpretation would no doubt be followed by the courts if the matter arose for decision."¹⁰³

Expanding upon and Affirming *Bourne*: Additional Jurisprudence

In the two decades following *Rex v. Bourne*, two cases heard at the Central Criminal Court in England further affirmed, and arguably expanded upon, the judge's summing-up in that case. The first case was *Rex v. Bergman and Ferguson* (1948), which concerned two doctors indicted for "conspiring together unlawfully to procure miscarriage."¹⁰⁴ In his summing-up of this case, Justice Morris read directly from *Bourne*:

*If the doctor is of opinion, on reasonable grounds, and with adequate knowledge, that the probable consequence of the continuance of pregnancy would indeed make the woman a physical or mental wreck, juries are quite entitled to take the view that the doctor who in those circumstances and in that honest belief operates is operating for the purpose of preserving the life of the [pregnant woman].*¹⁰⁵

Justice Morris then stated, "I fully adopt those words and invite you to bear them very much in mind."¹⁰⁶

The second case, *Reg. v. Newton and Stungo* (1958), concerned the specific issue of mental health grounds for abortion. In this case, in which a woman had died from an abortion performed by a doctor on mental health grounds, the doctor was charged with "unlawfully using an instrument with intent to procure [a] miscarriage," along with manslaughter and manslaughter on the grounds of negligence.¹⁰⁷ In his summing-up, Justice Ashworth stated, "The law on the use of an instrument for such a purpose was this—that it was unlawful unless the use was made in good faith for the purpose of preserving the life or health of the woman."¹⁰⁸ He then explained:

*Health meant not only physical but mental health as well. There might be cases of a woman going to a doctor in a state of great emotional upset, distraught, and verging on the fringe of insanity. If in such a case a doctor said, 'If I let this go on and I let her proceed to deliver she will be a mental wreck, if not dead,' and he then relieved the woman of her pregnancy, he committed no crime.*¹⁰⁹

Bourne has also been affirmed in other jurisdictions, including Zambia and the West African Court of Appeal.¹¹⁰ **In 1959, the East African Court of Appeal, which had jurisdiction over the territory of Tanzania, affirmed the *Bourne* decision**

in *Mehar Singh Bansel v. R*, an abortion case on appeal from the Supreme Court of Kenya. In that case, the Supreme Court of Kenya defined an “illegal operation” as one “which is intended to terminate pregnancy for some reason other than what can, perhaps be best called a good medical reason,” which the Court interpreted to be “the genuine belief that the operation is necessary for the purpose of saving the patient’s life or preventing severe prejudice to her health.”¹¹¹ The East African Court of Appeal affirmed the Kenyan Supreme Court’s conclusion.¹¹² **This decision affirming *Bourne* is binding in Tanzania.**¹¹³

Post-Independence: Tanzania Adopts the *Bourne* Decision

The understanding, set forth in *Bourne*, that the life exception to the criminalization of abortion encompasses a health exception is reflected in contemporary Tanzanian government policy. The Ministry of Health’s 2002 *Post-Abortion Care Clinical Skills Curriculum*—its primary policy and training document concerning post-abortion care—states that “Tanzania Law allows therapeutic abortion, with life of the [pregnant woman] as priority.”¹¹⁴ Similarly, the Ministry’s 2007 *Standard Treatment Guidelines (STG) and the National Essential Medicines List (NEMLIT) for Mainland Tanzania* identify an exception to the criminalization of termination of pregnancy “where there is a substantial threat to the woman’s health or life in continuing the pregnancy.”¹¹⁵ These statements highlight the government’s acknowledgment of a life and mental and physical health exception to the criminalization of termination of pregnancy in Tanzania.

HEALTH IS CONSISTENTLY UNDERSTOOD TO INCLUDE BOTH MENTAL AND PHYSICAL HEALTH

The consistent understanding of health as encompassing both mental and physical health—as set forth in *Rex v. Bourne*, *Rex v. Bergman and Ferguson*, *Reg. v. Newton and Stungo*, and *Mehar Singh Bansel v. R*—is significant and warrants emphasis. This understanding is in line with the World Health Organization’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹¹⁶

REGULATING THE PROVISION OF CARE IN MAINLAND TANZANIA: WHAT DO PROFESSIONAL CODES OF CONDUCT AND THE CLIENT SERVICE CHARTER SAY ABOUT TERMINATION OF PREGNANCY?

IN SUMMARY:

- **The various codes of conduct and the government's Client Service Charter offer certain fundamental protections for all patients, including women requiring abortion or post-abortion care services.**
- **No law, policy, regulation, or professional code of conduct for medical practitioners, nurses, or midwives in Tanzania requires a health care provider to consult with one or two other providers and obtain their consent in writing before performing a termination of pregnancy. Nor is this a legal requirement under common law.¹¹⁷**
- **There is no spousal consent requirement in the Client Service Charter or any code of conduct for medical practitioners, nurses, or midwives requiring that a woman obtain her husband's consent before receiving any reproductive health services, including a termination of pregnancy.¹¹⁸**

The Tanzanian Government regulates the general provision of health care by health care professionals in two primary ways. Nurses, midwives and medical practitioners in Tanzania are subject to professional regulation by their own statutorily created bodies. At the same time, all health care professionals can be held professionally accountable under the Ministry of Health's Client Service Charter, which outlines patients' rights and health workers' duties in the provision of quality health care. These regulatory frameworks are relevant in the context of abortion and post-abortion care service provision, as women seeking such services are often subject to serious abuses in health care facilities.

Termination of pregnancy, particularly in settings where it is criminalized, is often highly stigmatized, and women requiring termination of pregnancy or post-abortion care often face discrimination when attempting to access these services. These women may be subjected to physical and verbal abuse by health care providers, denied access to pain medications, or required to pay bribes to obtain care.¹¹⁹ Some providers may intentionally delay the provision of care to these women or refuse to provide referrals due to personal beliefs and biases concerning the procedure. Other providers, afraid of being seen as complicit in the procuring of an unlawful abortion, may deny women emergency post-abortion care and may even report them to the police, in violation of patient

confidentiality.¹²⁰ As such, protections for patients' rights are critical to ensuring that women obtain quality abortion services, and that they receive such services free from discrimination.

Professional Councils and Codes of Conduct for Health Care Professionals

Medical practitioners and nurses and midwives are each governed by their respective statutory scheme and code of conduct.¹²¹ Each statutory scheme provides for a council that supervises, regulates, and disciplines the health care professionals within its jurisdiction. The councils are legally responsible for ethical oversight and for producing, disseminating, and enforcing a professional code of conduct. This code offers guidance to providers on their scope of practice, permitted behaviour, and expected professional conduct. Providers who violate this code of conduct are subject to professional sanction.

Despite popular belief that professional codes of conduct and ethics in Tanzania proscribe or limit the provision of abortion services, our research revealed otherwise. **The official codes of conduct and ethics for medical practitioners (including assistant medical officers) and nurses and midwives do not make explicit reference to abortion or termination of pregnancy.**¹²²

These codes also do not mention the general provision of abortion as constituting unlawful activity or professional misconduct, nor do they discuss who can provide abortion services and under what circumstances.¹²³

Finally, these codes of conduct do not require that providers consult with one or two other providers and obtain their consent in writing before performing a lawful termination of pregnancy.¹²⁴ The origins of this misconception are discussed below.

THERE IS NO CONSULTATION REQUIREMENT UNDER TANZANIAN LAW

Contrary to popular belief, none of Tanzania's laws or policies requires that a provider consult with one or more providers and obtain their written consent before terminating a pregnancy. The origins of this misconception may be traced to English doctors' practice of consultation in cases of abortion in the early twentieth century. This practice was likely subsequently integrated into Tanzanian medical practice and mistakenly understood as a legal requirement.

However, even in England, prior to the passage of the United Kingdom's 1967 Abortion Act, this was not a legal requirement but rather a practice recommended as prudent within the medical profession. According to a leading legal scholar, "there [wa]s nothing in English . . . law to require a second opinion"¹²⁵; the "procedural restriction" of consultation simply

“did not exist for the common law defence.”¹²⁶ It was only in 1967 that the United Kingdom chose to codify this consultation requirement, at which time it became law in the United Kingdom.¹²⁷ There is no similar law in Tanzania.

Nevertheless, our research revealed a widespread belief among health care professionals that there is a consultation or witness “requirement” under the law for performing a legal abortion—and that two additional health care providers must sign off on the procedure before it may be legally performed. Professionals differed in their opinions regarding whether those consulted must be gynaecologists or physicians, or whether they may also be assistant medical officers; however, the notion that such a legal consultation requirement existed was pervasive.

Sources of authority suggested for these requirements included the Penal Code and regulations from the Ministry of Health.¹²⁸ However, as previously mentioned, **the requirement that a health care provider consult with one or two other health care providers, physicians, or specialists and obtain their consent in writing before providing an abortion cannot be found in the Constitution, the Penal Code, the codes of conduct for medical practitioners or nurses and midwives, or any other laws or policies. Given that this requirement is not codified in Tanzania’s laws and policies, it cannot be understood as legally binding on health care professionals in the country.**

Most contemporary legal and policy experts—including in the United Kingdom—agree that consultation requirements are inappropriate. For example, as stated by the United Kingdom’s House of Commons Science and Technology Committee in its 2007 report *Scientific Developments Relating to the Abortion Act 1967*:

We were not presented with any good evidence that, at least in the first trimester, the requirement for two doctors’ signatures serves to safeguard women or doctors in any meaningful way, or serves any other useful purpose. We are concerned that the requirement for two signatures may be causing delays in access to abortion services. If a goal of public policy is to encourage early as opposed to later abortion, we believe there is a strong case for removing the requirement for two doctors’ signatures. We would like to see the requirement for two doctors’ signatures removed.¹²⁹

Delays in accessing abortion services due to consultation requirements are further compounded in resource-poor countries with serious shortages of physicians and other health care providers. Obtaining the opinions of one or more additional health care providers before receiving an abortion may be impossible for many women, especially those living in rural areas with limited access to health care services and providers. Recognizing this reality, the Committee of Experts charged with drafting the 2010 Kenyan Constitution’s provision on termination of pregnancy declined both to include a consultation requirement and to limit service provision to physicians alone.¹³⁰

In addition to delaying women’s access to safe abortion services, a consultation requirement also implies that abortion is a suspect procedure that demands extra scrutiny. Approval requirements risk stigmatizing the practice and discouraging practitioners from providing abortions, resulting in a shortage of providers and a decline in the quality of services. As such, consultation requirements are understood as a procedural barrier and incompatible with governments’ duties to respect the human rights of women.¹³¹

How Else Do the Codes of Conduct Protect Women Seeking Abortion-Related Services?

Although the various health care professionals' codes of conduct and ethics do not explicitly mention abortion, they do contain key provisions *relevant* to abortion and post-abortion services. For example, the *Code of Ethics and Professional Conduct for Medical and Dental Practitioners* in Tanzania does the following:

- prohibits discrimination in the management of patients;¹³²
- mandates that the provider respect the patient's confidentiality and privacy;¹³³
- requires that the provider obtain the patient's informed consent for treatment;¹³⁴
- emphasizes that the health and well-being of the client shall be the provider's first consideration;¹³⁵ and
- obligates the provider to always provide emergency care to a patient until the provider is sure that others are willing and able to give such care.¹³⁶

In addition to this code, the Medical Association of Tanzania has issued *Guiding Principles on Medical Ethics and Human Rights in Tanzania* as a guide for physicians.¹³⁷ These principles affirm the prohibition of discrimination towards patients,¹³⁸ patients' right to information,¹³⁹ the importance of obtaining informed consent,¹⁴⁰ patients' right to confidentiality,¹⁴¹ and the physician's obligation to assist during medical emergencies.¹⁴² The guiding principles state, "Physicians must accept that their primary obligation is to save life and to relieve pain and suffering, eg conscientious objection to abortion, does not absolve physicians from taking immediate steps in a life-threatening emergency to ensure that the necessary treatment is given without delay and before any avoidable damage can result to the patient."¹⁴³ The principles further encourage physicians not to involve themselves in situations "where their ability to provide emergency treatment could be compromised, eg employment in hospitals which place unreasonable restrictions on emergency admissions, such as delaying or refusing treatment until it has been established that the patient is able to pay. . . ."¹⁴⁴

Finally, in discussing the provision of medical care to disadvantaged groups, such as adolescents, the principles note that "[p]hysicians should try to help girls to avoid [recourse to unsafe abortion] by providing them with . . . safe termination of pregnancy whenever it is appropriate and permitted by law."¹⁴⁵

Similarly, the *Code of Professional Conduct for Nurses and Midwives in Tanzania* does the following:

- emphasizes the importance of respect for patients' human rights;¹⁴⁶
- mandates that the provider respect the patient's confidentiality and privacy;¹⁴⁷
- requires that the provider obtain the patient's informed consent for treatment;¹⁴⁸

- obligates the provider to handle patients diligently, efficiently, and without undue delay;¹⁴⁹
- prohibits the solicitation of bribes from patients or their families;¹⁵⁰ and
- mandates that the provider respect the patient's autonomy to undergo any health care intervention protected under the law.¹⁵¹

The following are examples of professional misconduct for nurses and midwives:

- abusing a client verbally, physically, sexually, or emotionally;
- abandoning a client in need of attention;
- failing to exercise discretion concerning the disclosure of confidential patient information; and
- failing to maintain the profession's standards of practice and code of ethics.¹⁵²

All of the above provisions demonstrate that health care professionals with the requisite skills are obligated, at a minimum, to offer quality termination of pregnancy services to safeguard a woman's life or health and to provide prompt and respectful post-abortion care services. They may also be useful for women seeking redress for abuses experienced in the health care setting in the context of abortion-related services.

The Client Service Charter

According to the Ministry of Health, the 2002 Client Service Charter was created to “help people understand what we commit to provide, how to contact us, what to expect by way of service standards and to seek a remedy if something goes wrong. The Charter will help users to claim their rights, and it provides additional transparent mechanisms for contact, complaints and accessibility.”¹⁵³

The Charter makes no direct mention of abortion or abortion-related services. However, it does highlight the Ministry's key obligations in ensuring the delivery of health care services. Under the Charter, clients have the rights to

- lodge a complaint;
- privacy and confidentiality;
- obtain information about themselves;
- access health services, facilities, and information in a manner that meets their needs; and
- informed consent.¹⁵⁴

Further, the Ministry commits to treating clients fairly and respecting their privacy and dignity.¹⁵⁵ The general public and patients “have the right to expect . . . improved maternal . . . health services”; “[a] good health referral system”; “[p]rovision of health services to the vulnerable and the poor”; and “[p]rovision of affordable essential drugs, equipment and supplies.”¹⁵⁶ The core management values guiding the Ministry include ethical conduct, client confidentiality and

privacy, and the right to health care.”¹⁵⁷ Finally, the Charter states that the Ministry will “have a clear, well publicized, and easy-to-use complaints procedure.”¹⁵⁸

Under this procedure, the permanent secretary of the Ministry of Health receives complaints concerning violations of rights or standards set out in the Charter.¹⁵⁹ The Ministry must conduct an inquiry into unethical conduct within 30 days of the lodging of the complaint.¹⁶⁰ The Charter emphasizes that lodging a complaint with the Ministry “does not prevent clients from using external dispute handling and appeal mechanisms [such as those available through the Medical Council, Nurses and Midwives Council, or Commission for Human Rights and Good Governance] or any way reduce ones’ rights for appeal.”¹⁶¹

The Client Service Charter thus provides another avenue for ensuring respectful treatment and accountability in the provision of abortion and post-abortion care. Complaints filed with the Ministry of Health, as opposed to those brought before health care professionals’ councils, may be particularly helpful in highlighting systemic violations and abuses beyond those of a particular cadre of health care provider. They also offer a critical mechanism for holding clinical officers accountable for professional misconduct, as these providers currently lack a council or regulatory body to provide oversight and discipline for their profession.

WHAT DO MAINLAND TANZANIAN GOVERNMENT POLICIES SAY ABOUT TERMINATION OF PREGNANCY?

IN SUMMARY:

- **There is no comprehensive government policy in mainland Tanzania pertaining to the delivery of safe abortion services under the law. There also do not appear to be hospital-level policies on abortion in Tanzania.**
- **The Tanzanian Government has acknowledged the harm of unsafe abortion and has affirmed the importance of access to comprehensive post-abortion care services.**
- **Under government-issued guidelines, mid-level providers can offer post-abortion care services.**

Lack of Government Guidance on the Provision of Safe and Legal Abortion

Despite the fact that abortion is legal in Tanzania to preserve a woman's life or health and in cases of sexual violence, our research revealed no comprehensive mainland Tanzanian government policies or guidelines pertaining to safe abortion services.¹⁶²

Some government guidelines refer to the fact that abortion is legally permitted where the woman's life or health are in danger¹⁶³ and some indicate a few circumstances where a termination of pregnancy should be performed for health reasons.¹⁶⁴ Others discuss the problem of unsafe abortion in Tanzania and its contribution to high rates of maternal morbidity and mortality.¹⁶⁵ Further, the *National Health Policy* requires the Ministry of Health to improve maternal health "through formulation of appropriate guidelines" and with a "special emphasis" on reducing maternal morbidity and mortality.¹⁶⁶ Nonetheless, no government policy or guideline appears to comprehensively address the provision of safe abortion services in Tanzania or to clarify when providers may offer these services or who may provide them.¹⁶⁷ Indeed, some policies, in discussing the magnitude of the problem of unsafe abortion, even wrongly state that induced abortion is illegal in Tanzania.¹⁶⁸

In addition, medical students at Muhimbili University of Health and Allied Sciences—"the only public university for health sciences in Tanzania"¹⁶⁹—do not appear to have a "clear syllabus" for learning how to perform safe abortions, and they have minimal, if any, practical training in performing a safe first- or second-

trimester abortion.¹⁷⁰ Similarly, nurses and midwives do not seem to be taught safe abortion provision.¹⁷¹ This serious gap in training and government guidance has grave consequences for women in need of safe abortion services.

Furthermore, this gap demonstrates a fundamental failure on the part of the Tanzanian Government to create an enabling environment that guarantees access to safe abortion services under the law and to “ensure that existing legislation will protect and promote women’s reproductive health,” as mandated by the *National Policy Guidelines for Reproductive and Child Health Services*.¹⁷² These guidelines require that “all government ministries related to women’s health shall ensure that laws, which undermine women’s reproductive rights, are reviewed. . . .”¹⁷³

This lack of guidance also contravenes the state’s obligations under the Maputo Protocol, which requires the government to “protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus.”¹⁷⁴ [See International and Regional Human Rights Law Section.]

The failure to implement the Maputo Protocol’s provisions on abortion conflicts with the *National Adolescent Reproductive Health Strategy 2011–2015*, which expects the government to comply with “UN [] and Regional conventions on Sexual reproductive health and rights,” with the aim of integrating these international and regional conventions into its policy and legal framework.¹⁷⁵

Post-Abortion Care

At the same time, the government has repeatedly acknowledged the harm of unsafe abortion and affirmed its commitment to providing comprehensive post-abortion care. Post-abortion care is a fundamental part of the Ministry of Health’s *National Package of Essential Reproductive and Child Health Interventions*¹⁷⁶ and *National Package of Essential Health Interventions in Tanzania*,¹⁷⁷ and is a key component of the proposed intervention package for maternal, newborn, and child health in the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015*.¹⁷⁸ The Ministry’s *National Policy Guidelines for Reproductive and Child Health Services* acknowledges that the lack of post-abortion care contributes to “unacceptably high” rates of maternal morbidity and mortality¹⁷⁹ and states that “[p]ost-abortion care services shall be strengthened to promote safe motherhood.”¹⁸⁰

The primary government document devoted to post-abortion care is the 2002 *Post-Abortion Care Clinical Skills Curriculum*.¹⁸¹ The curriculum emphasizes the centrality of post-abortion care to safe motherhood¹⁸² and defines reproductive health according to the World Health Organization’s definition: “a state [of]

complete physical, mental and social well-being and not merely the absence of disease to the reproductive system, its functions and process.”¹⁸³ The curriculum stresses that “deaths and injuries from incomplete abortion are preventable” and that post-abortion care is a “critical life-saving service[.]”¹⁸⁴

This curriculum is used for in-service training of providers, including medical officers, assistant medical officers, clinical officers, and nurse/midwives,¹⁸⁵ thereby **clearly permitting mid-level providers to offer post-abortion care services.** The curriculum is also used as a reference for pre-service curricula for nurses and midwives.¹⁸⁶ The curriculum’s goal is to “scal[e] up comprehensive PAC [post-abortion care] so as to reduce abortion related maternal mortality and morbidity through training of middle level health service providers such as clinical officers, nurse-midwives in addition to the medical doctors. The aim is to ensure that comprehensive PAC services are available at lower-level health facilities.”¹⁸⁷

As discussed earlier, the curriculum makes explicit reference to Tanzania’s abortion law, stating:

- *Tanzania Law allows therapeutic abortion, with life of [the pregnant woman] as priority.*
- *However, few women and men know this law.*
- *Knowledge that the law does not allow abortion “by demand”, makes women fear being reported to “justice” and thus they undergo unsafe abortion even when the law might have allowed it.*¹⁸⁸

In doing so, this government document clearly affirms that abortion is legal in Tanzania for life and health indications. It further recognizes the lack of awareness about these exceptions among providers and the public, and it acknowledges the fact that many women unnecessarily resort to unsafe abortion due to a lack of information about the scope and content of the abortion law.

This curriculum lays out five key elements to comprehensive post-abortion care: community involvement, post-abortion counselling, emergency treatment, family planning counselling and services, and links to other reproductive and general health care and social services.¹⁸⁹ Providers are taught how to perform manual vacuum aspiration for emergency post-abortion treatment.¹⁹⁰ When counselling patients, providers are taught to be respectful, non-judgmental, unbiased, positive, empathetic, and encouraging.¹⁹¹

In describing the multiple and complex reasons why women may choose to obtain an abortion, the curriculum cites economic reasons; a lack of access to family planning services and information; medical reasons; and the stigma associated with teenage pregnancy, pregnancy outside of marriage, and pregnancy resulting from rape.¹⁹² Understanding these reasons should help providers to offer services in “a caring and non-judgmental manner.”¹⁹³

In addition, the curriculum explains why women often wait to seek post-abortion care: “fear [of] being reported to the police by the clinic or hospital staff, fear of harsh treatment and exposure by nurses, fear of reactions by parents, friends and community members.”¹⁹⁴ The curriculum points out that abortions may be either spontaneous or induced and that the “[c]urrent approach to serving women with complications of abortion is not to insist on finding out whether the abortion was induced or not and not to be punitive/judgemental (e.g. by reporting the patient to the police).”¹⁹⁵ Reporting would also violate the patient’s right to confidentiality and the provider’s duty to maintain that confidentiality.¹⁹⁶

To facilitate more in-depth discussion around these issues, the curriculum emphasizes key barriers to accessing post-abortion care, as well as a number of factors that may facilitate access:

Factors that hinder Comprehensive postabortion Care

- *Negative reactions by service providers towards abortion clients, either due to work over load or due to personal feelings, attitudes, beliefs, and values.*
- *Misconception about “abortion vs. miscarriage” by providers due to the stigma attached to “abortion” and not to miscarriage.*
- *Restrictive professional acts e.g. midwives and clinical officers not to provide Comprehensive PAC.*
- *Community Stigmatization on induced abortion.*
- *Lack of awareness among the community members on the availability and accessibility of post abortion care as part of RH services.*

Factors that facilitate Comprehensive postabortion Care

- *Positive attitude in service provider towards Comprehensive postabortion clients.*
- *Integration of Comprehensive PAC into other existing reproductive health services.*
- *Utilisation of facilitation skills when discussing and counseling a woman who has aborted so as to help her air out her feelings and concerns openly.*
- *Community support to comprehensive PAC.*
- *Supportive and explicit policies and services standards.*¹⁹⁷

Finally, key patient rights are also discussed.¹⁹⁸ These include the rights to prompt emergency care;¹⁹⁹ information about reproductive health services and their benefits; non-discriminatory and equal access to services, regardless of age or marital or socioeconomic status²⁰⁰ (including “freedom from barriers such as policies, standards and practices that are not scientifically justifiable”);²⁰¹ choice and to choose one’s services; privacy; confidentiality; dignity; feel comfortable when receiving services and to receive services of good quality; continuity of

services; and freedom of expression regarding the services received.²⁰²

As discussed earlier, the articulation of these rights in the context of post-abortion care is important, as women seeking such services are often subject to serious abuses in health care facilities.

Acknowledged Limitations of Post-Abortion Care Services

Government policies acknowledge that post-abortion care services in Tanzania fall short in meeting women's needs. For example, the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015* states that “[p]ost abortion care (PAC) services can significantly reduce maternal mortality due to unsafe abortions; however, only 5% of health facilities in Tanzania currently provide this service.”²⁰³ Similarly, the *National Policy Guidelines for Reproductive and Child Health Services* lament the “lack of Post Abortion Care”²⁰⁴ and note the “shortage of Reproductive and Child Health equipment and essential drugs and supplies” for such care.²⁰⁵ These guidelines mandate that districts guarantee the availability and effective use of these essential drugs, equipment, and supplies;²⁰⁶ that the Ministry of Health ensure that providers are technically competent and trained to provide services;²⁰⁷ and that counselling and services are provided to women following treatment for abortion complications.²⁰⁸

Endnotes

- ¹ Mainland Tanzania and Zanzibar share a common constitution and court of appeal; however, their penal codes, policies, and case law are distinct. For the purposes of this technical guide, we are focusing on the laws, regulations, and policies applicable in mainland Tanzania. See CONSTITUTION, art. 152(3) and first schedule (1977).
- ² Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, art. 14(2)(c), *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique (*ratified* Mar. 3, 2007) [hereinafter Maputo Protocol].
- ³ This recommendation is in line with recent recommendations issued by the U.N. Special Rapporteur on the Right to Health: "Ensure that accurate, evidence-based information concerning abortion and its legal availability is publicly available and that health-care providers are fully aware of the law related to abortion and its exceptions." Anand Grover, *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, para. 65(i), U.N. Doc. A/66/254 (2011).
- ⁴ *Id.* paras. 65(h), 65(i).
- ⁵ African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986, *ratified* Feb. 18, 1984). The Charter obliges state parties to "ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions." *Id.* art. 18(3).
- ⁶ African Charter on the Rights and Welfare of the Child, *adopted* July 11, 1990, O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999, *ratified* Mar. 16, 2003).
- ⁷ South African Development Community, Protocol on Health, *adopted* Aug. 18, 1999 (*entered into force* Aug. 14, 2004, *ratified* July 11, 2002).
- ⁸ Maputo Protocol, *supra* note 2.
- ⁹ *Id.* art. 14(2)(a).
- ¹⁰ *Id.* art. 14(2)(c).
- ¹¹ There is no indication that Tanzania made any reservations when ratifying the Maputo Protocol.
- ¹² International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976, *acceded* June 11, 1976).
- ¹³ International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (*entered into force* Jan. 3, 1976, *acceded* June 11, 1976).
- ¹⁴ Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981, *ratified* Aug. 20, 1985).
- ¹⁵ Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990, *ratified* June 10, 1991).
- ¹⁶ Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (*entered into force* May 3 2008, *ratified* Nov. 10, 2009).
- ¹⁷ Vienna Convention on the Law of Treaties, art. 2.1(b), May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980) [hereinafter Vienna Convention]; see also *Vienna Declaration and Programme of Action*, World Conference on Human Rights, para. 1, Vienna, Austria, July 14–25, 1993, U.N. Doc. A/CONF 157/23 (1993) (reaffirming "the solemn commitment of all States to fulfil their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, other instruments relating to human rights, and international law").
- ¹⁸ Interview with Assistant Lecturer in Law, Faculty of Law, University of Dar es Salaam (May 4, 2012); see also interview with two lawyers, Tanzania Women Lawyers Association (May 3, 2012).
- ¹⁹ Vienna Convention, *supra* note 17, art. 27.
- ²⁰ CONSTITUTION (1977), arts. 9(a), 9(f).
- ²¹ Ndossi v. Ndossi, Civil Appeal No. 13 of 2001, High Court of Tanzania at Moshi (2002), at 4.
- ²² All references to the high court throughout this document are to the mainland Tanzanian High Court.
- ²³ LHRC, LEAT and NOLA v. the Attorney General, High Court of Tanzania at Dar es Salaam (Main Registry), Misc. Civil Cause No. 77 of 2005 (unreported), at 39 ("Tanzania is party to various International Human Rights Instruments. The Universal Declaration of Human Rights (UDHR), which is the core of International Human Rights law, is incorporated in Article 9(f) of our Constitution."); Director of Public Prosecution v. Ally Haji Ahmed and Others, Case Nos. 44 and 45, CA (unreported) *cited in* Interights, Selected International Standards and Case-Law: Litigation Surgery on the Right to Education in Africa 42 (Mar. 12–15, 2012); Ibernados Ephraim v. Holaria Pastory and Another, [1990] LRC 757, para. 10 ("And the Universal Declaration of Human Rights, 1948, which is part of our Constitution by virtue of article 9(1)(f) . . .").
- ²⁴ Ibernados Ephraim v. Holaria Pastory and Another, [1990] LRC 757, para. 10.
- ²⁵ *Id.*
- ²⁶ Director of Public Prosecutions v. Daudi Pete, Court of Appeal of Tanzania, Criminal Appeal No. 28 of 1990, [1993] TLR 22, 34.
- ²⁷ Christopher Mtikila v. Attorney General, High Court of Tanzania at Dar es Salaam, Misc. Civil Cause No. 10 of 2005, *cited in* J. CLEMENT MASHAMBA, JUDICIAL PROTECTION OF CIVIL AND POLITICAL RIGHTS IN TANZANIA 192 (2010).
- ²⁸ *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5–13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995); *African Platform for Action of the Fifth African Regional Conference on Women*, Dakar, Senegal, Nov. 16–23, 1994 (1995); *Beijing Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 15, 1995, U.N. Doc. A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995). The consensus documents that emerged from these conferences are not legally binding on states. By setting forth a detailed, global mandate, however, these documents contribute to advancing and interpreting the human rights standards contained in human rights treaties.
- ²⁹ UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 6–9, 12–13 (2006), available at <http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf>. See CONSTITUTION (1977), pt. III.
- ³⁰ *Id.* art. 14.
- ³¹ *Id.* art. 16.
- ³² *Id.* art. 12(1).
- ³³ *Id.* art. 12(2).
- ³⁴ *Id.* art. 13(2).
- ³⁵ *Id.* art. 13(2).
- ³⁶ Emily G. Luhanga, *The Working of Abortion Law in Tanzania 4* (paper presented at Strategy for Abortion Management in Africa: An IPPF Africa Regional Workshop, Nairobi, Kenya, Mar. 20–23, 1978); Vibeke Rasch & Rose Kipingili, *Unsafe Abortion in Urban and Rural Tanzania: Method, Provider and Consequences*, 14 JOURNAL OF TROPICAL MEDICINE AND INTERNATIONAL HEALTH 1128, 1132 (2009).
- ³⁷ CONSTITUTION (1977), art. 13(6)(e).
- ³⁸ See CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS VIOLATIONS AS TORTURE AND CRUEL, INHUMAN, OR DEGRADING TREATMENT OR PUNISHMENT: A CRITICAL HUMAN RIGHTS ANALYSIS 21–24 (2011).
- ³⁹ CONSTITUTION (1977), art. 29(1).
- ⁴⁰ *Id.* art. 30(3); see also Basic Rights and Duties Enforcement Act, Cap. 3, art. 4 (R.E. 2002).
- ⁴¹ Julius Ishengoma Francis Ndyababo v. the Attorney General, Civil Appeal No. 64 of 2001 (Court of Appeal at Dar es Salaam), at 17–18.

- 42 CONSTITUTION (1977), pt. II.
 43 *Id.* art. 9.
 44 *Id.* art. 11(1).
 45 ISSA G. SHIVJI ET AL., CONSTITUTIONAL AND LEGAL SYSTEM OF TANZANIA: A
 CIVICS SOURCEBOOK 179 (2004).
 46 CONSTITUTION (1977), art. 7(2).
 47 SHIVJI ET AL., *supra* note 45, at 64–65.
 48 Julius Ishengoma Francis Ndyanabo v. the Attorney General,
 Civil Appeal No. 64 of 2001 (Court of Appeal at Dar es Salaam),
 at 17. See also J. CLEMENT MASHAMBA, JUDICIAL PROTECTION OF CIVIL
 AND POLITICAL RIGHTS IN TANZANIA 352 (2010).
 49 Christopher Mtikila v. Attorney General, High Court of Tanzania,
 at Dar es Salaam, Misc. Civil Cause No. 10 of 2005, *cited in*
 MASHAMBA, *supra* note 48, at 179.
 50 CONSTITUTION (1977), art. 64(5).
 51 See Criminal Procedure Act, Cap. 20, art. 302 (R.E. 2002) for
 procedural references to abortion.
 52 Penal Code Act, Cap. 16, secs. 150–52.
 53 See discussion in the Case Law Section on *Rex v. Bourne* and
Mehar Singh Bansel v. R.
 54 Penal Code Act, Cap. 16, sec. 204.
 55 *Id.* sec. 219.
 56 Under the Penal Code, the crime of infanticide applies only to a
 woman who, with the requisite mental state, “causes the death
 of her child, being a child under the age of twelve months.”
Id. sec. 199. In such a case, the woman would be punished
 as though she had been guilty of manslaughter, as opposed to
 murder. All others complicit in the killing of a “born child” would
 be accused of murder or manslaughter.
 57 EMILY JACKSON, MEDICAL LAW: TEXT, CASES, AND MATERIALS 666 (2d ed.
 2010).
 58 *Id.*
 59 Our research revealed one High Court case pertaining to child
 destruction; however, the judge in this case was satisfied by
 evidence that the “pregnancy was not less than eight months
 old” at the time of the alleged crime and thus clearly beyond the
 28-week presumption enshrined in the law. Therefore, it was
 not necessary to discuss the meaning of “capable of being born
 alive” or the rebuttable presumption of 28 weeks. *The Republic*
v. Roseline D/O Minja, Criminal Sessions Case No. 7 of 1978,
 High Court of Tanzania at Dar es Salaam (1978), at 5.
 60 *Rance v. Mid-Downs Health Authority*, [1991] 1 QB 587, 621.
 In *Rance*, the judge cited the words of Sir John Donaldson M.R.
 from the *C v. S* case: “If [the foetus] has reached the normal
 stage of development and so is incapable ever of breathing,
 it is not in our judgment ‘a child capable of being born alive’
 within the meaning of the Act [of 1929]” *Id.* See also *C*
v. S [1988] Q.B. 135, 151. The judge of first instance in *C v. S*,
 Heilbron J., relied on *R v. Handley* (1874), where the judge in
 that case told the jury that “a child was considered to have been
 ‘born alive’ when it existed as a live child, that is to say breathing
 and living by reason of its breathing through its own lungs alone,
 without deriving any of its living or power of living by or through
 any connection with [the pregnant woman].” The judge also
 referred to *R v. Enach* and *R v. Wright*, where the judge directed
 the jury that “to be alive there must be, in addition to breathing,
 a circulation independent of the [pregnant woman].” *C v. S*,
 [1988] QB 135, 146.
 61 *Rance v. Mid-Downs Health Authority*, [1991] 1 QB 587.
 62 *C v. S*, [1988] QB 135, 147.
 63 Interview with and e-mail from Obstetrician/Gynaecologist and
 Senior Lecturer at Muhimbili University of Health and Allied
 Sciences (Feb. 20, 2012, and May 7, 2012) (on file with the
 Center); see also interview with Principal State Attorney at the
 Attorney General’s Chambers (Feb. 23, 2012) (“Twenty-eight
 weeks is a hard/solid line . . . not before 28 weeks would [it] be
 child destruction.”).
 64 MINISTRY OF HEALTH AND SOCIAL WELFARE, STANDARD TREATMENT
 GUIDELINES (STG) AND NATIONAL ESSENTIAL MEDICINES LIST (NEMLIT)
 FOR MAINLAND TANZANIA 44 (3d ed. 2007) [hereinafter STANDARD
 TREATMENT GUIDELINES]. These guidelines also specify that a
 termination of pregnancy may be indicated for health reasons,
 such as hypertension in pregnancy or eclampsia, regardless of
 gestational age. *Id.* at 41-43.
 65 E-mail from Obstetrician/Gynaecologist and Senior Lecturer
 at Muhimbili University of Health and Allied Sciences (May 7,
 2012) (on file with the Center).
 66 JO SAMANTA & ASH SAMANTA, MEDICAL LAW 193 (2011).
 67 Penal Code Act, Cap. 16, sec. 230.
 68 REBECCA J. COOK & BERNARD M. DICKENS, ABORTION LAWS IN
 COMMONWEALTH COUNTRIES 22 (1979) [hereinafter COOK & DICKENS,
 ABORTION LAWS].
 69 *Id.* at 16.
 70 *Id.* at 17.
 71 *Id.* at 18.
 72 *Id.* at 60.
 73 *Id.* at 18.
 74 *Id.* at 22.
 75 *Id.* at 60.
 76 Notably, section 209 of the Tanzanian Penal Code exempts a
 person from this requirement in cases of necessity, where the
 woman’s life or health is in danger. Penal Code Act, Cap. 16,
 sec. 209.
 77 The World Health Organization has made clear that mid-level
 providers can safely and beneficially provide first-trimester
 abortion services. See Marge Berer, *Provision of Abortion*
by Mid-Level Providers: International Policy, Practice and
Perspectives, 87 BULLETIN OF THE WHO 58 (2009).
 78 See e-mail from Obstetrician/Gynaecologist and Senior Lecturer
 at Muhimbili University of Health and Allied Sciences (May 7,
 2012) (on file with the Center).
 79 This was the holding by the judge in *Rex v. Bourne*, discussed
 in the Case Law Section. In essence, the judge read a life
 exception “always to have been implicit in [the abortion
 provisions of the Penal Code], on the reasoning that if
 preservation of the [pregnant woman’s] life justifies sacrificing
 the child’s life at the moment of birth, it also justifies such
 sacrifice at any earlier stage in pregnancy.” REBECCA J. COOK &
 BERNARD M. DICKENS, EMERGING ISSUES IN COMMONWEALTH ABORTION
 LAWS 14 (1982) (on file with the Center) [hereinafter COOK &
 DICKENS, EMERGING ISSUES].
 80 GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 164
 (1958) [hereinafter WILLIAMS, THE SANCTITY OF LIFE].
 81 This conclusion is based on research undertaken at the libraries
 of the High Court and the University of Dar es Salaam, as well
 as interviews with prominent lawyers and legal scholars. The
 Principal State Attorney at the Attorney General’s Chambers
 undertook research for the Center on this issue and found no
 High Court or Court of Appeal cases pertaining to abortion.
 E-mail from Principal State Attorney at the Attorney General’s
 Chambers (Mar. 6, 2012) (on file with the Center). In addition,
 a professor in criminal law from the Faculty of Law at the
 University of Dar es Salaam, undertook a similar search and
 found no Tanzanian abortion cases. E-mail from Assistant
 Lecturer in Law (citing law professor), Faculty of Law, University
 of Dar es Salaam (May 5, 2012) (on file with the Center).
 82 *The Republic v. Roseline D/O Minja*, Criminal Sessions Case No.
 7 of 1978, High Court of Tanzania at Dar es Salaam (1978).
 83 Interview with Assistant Lecturer in Law, Faculty of Law,
 University of Dar es Salaam (May 4, 2012); interview with
 Principal State Attorney at the Attorney General’s Chambers
 (Feb. 23, 2012).
 84 See interview with and e-mail from Principal State Attorney at
 the Attorney General’s Chambers (Feb. 23, 2012, and Mar. 6,
 2012) (on file with the Center); interview with Assistant Lecturer
 in Law, Faculty of Law, University of Dar es Salaam (May 4,
 2012); interview with two lawyers, Tanzania Women Lawyers
 Association (May 3, 2012).
 85 *The Attorney General v. Lesinoi Ndeinai and Joseph Saleyo*
Laizer and Two Others, Court of Appeal at Arusha [1980] T.L.R.
 214, 222.
 86 *Rex v. Bourne*, [1939] 1 K.B. 687.
 87 *Id.*
 88 See COOK & DICKENS, ABORTION LAWS, *supra* note 68, at 13.
 89 *Bourne* was a criminal case, tried before a jury. As such, there
 is no reasoning provided for the final verdict; rather, the legal
 reasoning is found in the judge’s written summing-up to the jury,
 in which the judge is tasked with explaining points of law and

- summarizing relevant evidence given at trial.
- ⁹⁰ Infant Life (Preservation) Act, ch. 34, sec. 1(1) (1929).
- ⁹¹ COOK & DICKENS, EMERGING ISSUES, *supra* note 79, at 14.
- ⁹² Bourne, 1 K.B. at 691.
- ⁹³ *Id.* at 692.
- ⁹⁴ *Id.*
- ⁹⁵ *Id.* at 693 (emphasis added).
- ⁹⁶ *Id.* at 694.
- ⁹⁷ See *supra* note 77.
- ⁹⁸ Bourne, 1 K.B. at 695.
- ⁹⁹ *Id.* at 694.
- ¹⁰⁰ *Id.*
- ¹⁰¹ *Id.*
- ¹⁰² COOK & DICKENS, ABORTION LAWS, *supra* note 68, at 13.
- ¹⁰³ Luhanga, *supra* note 36, at 3.
- ¹⁰⁴ *Alleged Conspiracy to Procure Miscarriages: Two Doctors Acquitted*, BRITISH MEDICAL JOURNAL, May 22, 1948, at 1008.
- ¹⁰⁵ *Id.*
- ¹⁰⁶ *Id.*
- ¹⁰⁷ *Criminal Abortion and Manslaughter: Five-Year Sentence on Doctor*, BRITISH MEDICAL JOURNAL, May 24, 1958, at 1242.
- ¹⁰⁸ *Id.* at 1247.
- ¹⁰⁹ *Id.*
- ¹¹⁰ See, for example, R. v. Edgal, 4 W.A.C.A. 133 (1938) (West African Court of Appeal, Southern States, Nigeria), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 68, at 13; People v. Gulshan, Smith and Finlayson, (1971) High Court [Criminal] HP. 11/1971 (Zambia), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 68, at 14; Mehar Singh Bansel v. R, [1959] E. Afr. L. Rep. 813 (East African Court of Appeal, Kenya); R. v. Morgentaler, (1976) 64 D.L.R. (3d) 718 (Quebec, Canada), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 68, at 14; R. v. Davidson, [1969] V.R. 667 (Supreme Court of Victoria, Australia), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 68, at 13; R. v. Anderson, [1951] N.Z.L.R. 439 (New Zealand), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 68, at 14.
- ¹¹¹ Mehar Singh Bansel v. R, [1959] E. Afr. L. Rep. 813, at 832.
- ¹¹² *Id.*
- ¹¹³ See e-mail from Principal State Attorney at the Attorney General's Chambers (Mar. 6, 2012) (on file with the Center); interview with Assistant Lecturer in Law, Faculty of Law, University of Dar es Salaam (May 4, 2012); interview with two lawyers, Tanzania Women Lawyers Association (May 3, 2012).
- ¹¹⁴ MINISTRY OF HEALTH AND SOCIAL WELFARE, POST-ABORTION CARE CLINICAL SKILLS CURRICULUM: VOLUME 2, TRAINEE'S HANDBOOK 41 (2002) [hereinafter PAC TRAINEE'S HANDBOOK].
- ¹¹⁵ STANDARD TREATMENT GUIDELINES, *supra* note 64, at 51. In addition, under the health indication, these guidelines specify that termination of pregnancy may be indicated for cases of eclampsia and hypertension. *Id.* at 41-43. The Ministry of Health's *Emergency Obstetric Care Job Aid* similarly specifies that termination of pregnancy may be indicated for eclampsia to preserve the pregnant woman's health. MINISTRY OF HEALTH AND SOCIAL WELFARE, EMERGENCY OBSTETRIC CARE JOB AID 10 (2008) [hereinafter EMERGENCY OBSTETRIC CARE JOB AID].
- ¹¹⁶ World Health Organization, Constitution of the World Health Organization, signed July 22, 1946, pmb. (*entered into force* Apr. 7, 1948).
- ¹¹⁷ WILLIAMS, THE SANCTITY OF LIFE, *supra* note 80, at 170; GLANVILLE WILLIAMS, TEXTBOOK OF CRIMINAL LAW 302 (2d ed. 1983).
- ¹¹⁸ In fact, the code of conduct for nurses and midwives states, "No-one has the right to give consent on behalf of another competent adult." Tanzania Nurses and Midwives Council, Code of Professional Conduct for Nurses and Midwives in Tanzania 5 (2007).
- ¹¹⁹ Interview with Obstetrician/Gynaecologist and Senior Lecturer at Muhimbili University of Health and Allied Sciences (Feb. 20, 2012).
- ¹²⁰ See GUTTMACHER INSTITUTE, ABORTION WORLDWIDE: A DECADE OF UNEVEN PROGRESS 24, 29, 31 (2009); CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 60-63 (2010).
- ¹²¹ The relevant acts are the Medical and Dental Practitioners Act, Cap. 152 (1959) and Nursing and Midwifery Act (2010). See *infra* note 122 for relevant codes of conduct. Currently, clinical officers are not regulated by any act or code of conduct. Efforts are underway to incorporate them under the Medical Council of Tanganyika, after which point they would be governed by the Code of Ethics and Professional Conduct for Medical and Dental Practitioners in Tanzania. Interview with Registrar, Tanzania Nursing and Midwifery Council (May 3, 2012); interview with Lawyer, Medical Council of Tanganyika (May 4, 2012). Nevertheless, clinical officers may still be held accountable under the Client Service Charter and under criminal law.
- ¹²² The codes examined include Medical Council of Tanganyika, Code of Ethics and Professional Conduct for Medical and Dental Practitioners in Tanzania (2005); Tanzania Nurses and Midwives Council, Code of Professional Conduct for Nurses and Midwives in Tanzania (2007). We also reviewed the Medical Association of Tanzania: Guiding Principles on Medical Ethics and Human Rights in Tanzania (1995). Although the Ministry of Health's 2002 *Professional Code of Ethics for Nurses and Midwives in Tanzania* does make reference to termination of pregnancy, it has been superseded by the 2007 code, referenced above, and—according to the registrar at the Nursing and Midwifery Council—is no longer relevant. Ministry of Health and Social Welfare, Professional Code of Ethics for Nurses and Midwives in Tanzania 26 (2002); interview with Registrar, Tanzania Nursing and Midwifery Council (May 3, 2012).
- ¹²³ In addition to its *Code of Professional Conduct for Nurses and Midwives in Tanzania* (2007), the Tanzania Nurses and Midwives Council has produced a manual and a guide: *Nursing Ethics: A Manual for Nurses and Nursing Ethics: A Facilitator's Guide*, both published in 2009. This pair of documents, intended as an "education resource" and "facilitation guide," focuses on discussions of ethical principles and decision-making processes. Tanzania Nurses and Midwives Council, Nursing Ethics: A Manual for Nurses vii (2009) [hereinafter Manual for Nurses]; Tanzania Nurses and Midwives Council, Nursing Ethics: A Facilitator's Guide v (2009) [hereinafter Facilitator's Guide]. The documents make no reference to the abortion law or relevant legal obligations, and they do not mention abortion in their discussions of the code of conduct for nurses and midwives. However, they do refer to abortion in two contexts. The first is in their discussion of the "value of life principle," where both the guide and manual state that nurses infringe upon this principle when they "take part in unethical activities such as assisting in abortion"; however, the documents acknowledge that exceptions to this principle exist, "such as in the situation whereby life of a pregnant woman is threatened by the presence of the fetus." Manual for Nurses 3; Facilitator's Guide 5. The second is in the context of a variety of open-ended ethical dilemmas or "scenarios" provided throughout the documents. However, the resolutions of these scenarios are unclear, as they are meant to grapple with open-ended, ambiguous questions.
- ¹²⁴ The medical practitioners' code of conduct does advise practitioners to obtain a second opinion in particularly difficult or complex cases: "[t]he practitioner shall . . . request a second opinion or expert advice where necessary, and in the client's interest, to a suitably qualified colleague in respect of any case which requires advice or specialized management." Medical Council of Tanganyika, Code of Ethics and Professional Conduct for Medical and Dental Practitioners in Tanzania, para. 10.6 (2005). However, this statement applies only "where necessary, and in the client's interest" and only to cases that "require advice or specialized management." Further, the provision simply requires "a second opinion or expert advice"—it does not require the written consent of another provider. The provision also makes no reference to termination of pregnancy and is arguably not relevant to such a case; given that mid-level providers, such as nurses, midwives, and clinical officers, are considered by the World Health Organization to be capable of safely providing first-trimester abortions, the abortion procedure—at least in the first trimester—would not be one where the medical practitioner needs advice or requires assistance through specialized management. See Berer, *supra* note 77, at 58.
- ¹²⁵ WILLIAMS, THE SANCTITY OF LIFE, *supra* note 80, at 170.
- ¹²⁶ WILLIAMS, TEXTBOOK OF CRIMINAL LAW, *supra* note 117, at 302.

- 127 Abortion Act, 1967, sec. 1(1) (U.K.). This act does not apply to Northern Ireland. *Id.* sec. 7(3).
- 128 Interview with Obstetrician/Gynaecologist and Senior Lecturer at Muhimbili University of Health and Allied Sciences (Feb. 20, 2012).
- 129 SCIENCE AND TECHNOLOGY COMMITTEE, HOUSE OF COMMONS, SCIENTIFIC DEVELOPMENTS RELATING TO THE ABORTION ACT 1967: TWELFTH REPORT OF SESSION 2006–07, para. 99 (2007), available at <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf>.
- 130 In its report, the committee of experts stated, “The requirement that abortion could be performed by medical practitioners alone [] raised concerns. It would mean that women in poor rural communities without such services would be unable procure abortions with potentially serious or fatal repercussions for some poor women.” COMMITTEE OF EXPERTS ON CONSTITUTIONAL REVIEW, FINAL REPORT OF THE COMMITTEE OF EXPERTS ON CONSTITUTIONAL REVIEW 111 (2010), available at http://www.ldphs.org.za/resources/local-government-database/by-country/kenya/commission-reports/CoE_final_report.pdf.
- 131 CENTER FOR REPRODUCTIVE RIGHTS, CRAFTING AN ABORTION LAW THAT RESPECTS WOMEN’S RIGHTS: ISSUES TO CONSIDER 1–3 (2004).
- 132 Medical Council of Tanganyika, Code of Ethics and Professional Conduct for Medical and Dental Practitioners in Tanzania, para. 6.1 (2005).
- 133 *Id.* paras. 4, 7.
- 134 *Id.* para. 3.
- 135 *Id.* para. 1.3.
- 136 *Id.* para. 1.6.
- 137 Medical Association of Tanzania, Guiding Principles on Medical Ethics and Human Rights in Tanzania (1995).
- 138 *Id.* at 1.
- 139 *Id.* at 1–2.
- 140 *Id.* at 2–4.
- 141 *Id.* at 4–5, 15–16.
- 142 *Id.* at 6–7.
- 143 *Id.* at 6.
- 144 *Id.*
- 145 *Id.* at 9.
- 146 Tanzania Nurses and Midwives Council, Code of Professional Conduct for Nurses and Midwives in Tanzania, princ. 1.3 (2007).
- 147 *Id.* princs. 1.4, 7.
- 148 *Id.* princ. 2.
- 149 *Id.* princs. 4.1, 4.2.
- 150 *Id.* princ. 5.3.
- 151 *Id.* princ. 1.7.
- 152 Nursing and Midwifery Act, para. 25(3)(k) (2010).
- 153 Ministry of Health and Social Welfare, Client Service Charter 3 (2002).
- 154 *Id.* at 14.
- 155 *Id.* at 4.
- 156 *Id.* at 5–6.
- 157 *Id.* at 9.
- 158 *Id.* at 4.
- 159 *Id.* at 15.
- 160 *Id.* at 11.
- 161 *Id.* at 16–17.
- 162 This was confirmed in an interview with an official in the Reproductive and Child Health Section, who is responsible for post-abortion-care-related services at the Ministry of Health (“There are no Ministry Guidelines on abortion. Only PAC.”). Interview with Official, Reproductive and Child Health Section, Ministry of Health and Social Welfare (May 2, 2012).
- 163 PAC TRAINEE’S HANDBOOK, *supra* note 114, at 41; STANDARD TREATMENT GUIDELINES, *supra* note 64, at 51. Although these documents do not have the force of law, they do have evidentiary value and could be persuasive evidence of the government’s understanding of the abortion law in a court of law.
- 164 STANDARD TREATMENT GUIDELINES, *supra* note 64, at 41–43. Under the health indication, these guidelines specify that termination of pregnancy may be indicated for cases of eclampsia and hypertension. The Ministry of Health’s *Emergency Obstetric Care Job Aid* similarly specifies that termination of pregnancy may be indicated for eclampsia to preserve the pregnant woman’s health. EMERGENCY OBSTETRIC CARE JOB AID, *supra* note 115, at 10.
- 165 See, e.g., MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL POLICY GUIDELINES FOR REPRODUCTIVE AND CHILD HEALTH SERVICES 3–4, 20 (2003) [hereinafter NATIONAL POLICY GUIDELINES]; MINISTRY OF HEALTH AND SOCIAL WELFARE, THE NATIONAL ROAD MAP STRATEGIC PLAN TO ACCELERATE REDUCTION OF MATERNAL, NEWBORN AND CHILD DEATHS IN TANZANIA 2008–2015 at 6 (2008) [hereinafter NATIONAL ROAD MAP]; MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL PACKAGE OF ESSENTIAL REPRODUCTIVE AND CHILD HEALTH INTERVENTIONS 7 (2002) [hereinafter ESSENTIAL REPRODUCTIVE AND CHILD HEALTH INTERVENTIONS]; PAC TRAINEE’S HANDBOOK, *supra* note 114, at 1.
- 166 MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL HEALTH POLICY 11 (2003).
- 167 This fact was confirmed by an official at the Ministry of Health. Interview with Official, Reproductive and Child Health Section, Ministry of Health and Social Welfare (May 2, 2012).
- 168 NATIONAL ROAD MAP, *supra* note 165, at 6; MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL ADOLESCENT REPRODUCTIVE HEALTH STRATEGY 2011–2015 at 7 (2011) [hereinafter NATIONAL ADOLESCENT REPRODUCTIVE HEALTH STRATEGY]. Other policies in Tanzania misinterpret the Convention on the Rights of the Child as creating a prenatal right to life. See, e.g., MINISTRY OF COMMUNITY DEVELOPMENT, WOMEN AFFAIRS, AND CHILDREN, CHILD DEVELOPMENT POLICY 31 (1996) (this policy is modeled after the Convention on the Rights of the Child, whose preamble states that “the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.” Convention on the Rights of the Child, *supra* note 15, pmbl. However, it is important to emphasize that the history of negotiations around the Convention makes clear that this language is not intended to extend Convention protections, including right-to-life protections, prenatally. To the contrary, the negotiations explicitly note that this language is not “intend[ed] to prejudice the interpretation of Article 1 or any provision of the Convention,” where article 1 defines “a child” for the purposes of the Convention as “every human being below the age of 18 years.” Proponents of the amendment calling for safeguards before birth further clarified that “the purpose of the amendment was not to preclude the possibility of abortion.” U.N. Commission on Human Rights, *Question of a Convention on the Rights of the Child: Report of the Working Group*, 36th Sess., para. 6, U.N. Doc. E/CN.4/L.1542 (1980). See also U.N. Commission on Human Rights, *Report of the Working Group on a Draft Convention on the Rights of the Child*, 45th Sess., para. 43, U.N. Doc. E/CN.4/1989/48 (1989). The Committee on the Rights of the Child, which interprets and monitors state compliance with the Convention on the Rights of the Child, supports the understanding that the Convention does not protect a prenatal right to life and has, on many occasions, urged reform of punitive abortion legislation. See, e.g., Committee on the Rights of the Child, *Concluding Observations: Chad*, para. 30, U.N. Doc. CRC/C/15/Add.107 (1999); *Chile*, para. 55, U.N. Doc. CRC/C/CHL/CO/3 (2007); *Palau*, para. 46, U.N. Doc. CRC/C/15/Add.149 (2001); *Uruguay*, para. 51, U.N. Doc. CRC/C/URY/CO/2 (2007)).
- 169 *Overview: Study at MUHAS*, MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES, http://www.muhas.ac.tz/index.php?option=com_content&task=view&id=45&Itemid=63 (last visited May 20, 2012).
- 170 Interview with Obstetrician/Gynaecologist and Senior Lecturer at Muhimbili University of Health and Allied Sciences (Feb. 20, 2012). See also the obstetrician/gynaecology curriculum at Muhimbili University. DEPARTMENT OF OBSTETRICS & GYNAECOLOGY, MUHIMBILI NATIONAL HOSPITAL, MANAGEMENT OF EMERGENCY OBSTETRIC COMPLICATIONS 40–43 (2007) (reference made only to incomplete abortion and post-abortion care; nothing in the curriculum focuses on the provision of safe abortion/termination of pregnancy services).
- 171 Interview with Registrar, Tanzania Nursing and Midwifery Council (May 3, 2012).
- 172 NATIONAL POLICY GUIDELINES, *supra* note 165, para. 4.3.
- 173 *Id.* para. 4.3.2.
- 174 Maputo Protocol, *supra* note 2, art. 14(2)(c).
- 175 NATIONAL ADOLESCENT REPRODUCTIVE HEALTH STRATEGY, *supra* note

168, at 41.
176 ESSENTIAL REPRODUCTIVE AND CHILD HEALTH INTERVENTIONS, *supra* note
165, at 7.
177 MINISTRY OF HEALTH AND SOCIAL WELFARE, NATIONAL PACKAGE OF
ESSENTIAL HEALTH INTERVENTIONS IN TANZANIA 32, 37 (2000).
178 NATIONAL ROAD MAP, *supra* note 165, at 78 (annex 2), 85 (annex
6).
179 NATIONAL POLICY GUIDELINES, *supra* note 165, at 20.
180 *Id.* para. 4.5.
181 The curriculum comprises a trainer's guide and a trainee's
handbook. MINISTRY OF HEALTH AND SOCIAL WELFARE, POST-ABORTION
CARE CLINICAL SKILLS CURRICULUM: VOLUME 1, TRAINER'S GUIDE (2002)
[hereinafter PAC TRAINER'S GUIDE]; PAC TRAINEE'S HANDBOOK, *supra*
note 114.
182 PAC TRAINEE'S HANDBOOK, *supra* note 114, at 35.
183 *Id.* at 37.
184 *Id.* at 39.
185 PAC TRAINER'S GUIDE, *supra* note 181, at 17.
186 Interview with Registrar, Tanzania Nursing and Midwifery
Council (May 3, 2012).
187 PAC TRAINER'S GUIDE, *supra* note 181, at 1; PAC TRAINEE'S
HANDBOOK, *supra* note 114, at 1.
188 PAC TRAINEE'S HANDBOOK, *supra* note 114, at 41.
189 *Id.* at 43.
190 *Id.* at 54.
191 *Id.* at 59.
192 *Id.* at 40–41.
193 *Id.* at 40.
194 *Id.* at 133.
195 *Id.* at 39–40.
196 See interview with Principal State Attorney at the Attorney
General's Chambers (Feb. 23, 2012).
197 PAC TRAINEE'S HANDBOOK, *supra* note 114, at 45.
198 *Id.* at 60–61; *see also* PAC TRAINER'S GUIDE, *supra* note 181, at
56.
199 PAC TRAINER'S GUIDE, *supra* note 181, at 56.
200 *Id.* at 56.
201 PAC TRAINEE'S HANDBOOK, *supra* note 114, at 60.
202 *Id.* at 60–61; *see also* PAC TRAINER'S GUIDE, *supra* note 181, at
56.
203 NATIONAL ROAD MAP, *supra* note 165, at 6.
204 NATIONAL POLICY GUIDELINES, *supra* note 165, at 20.
205 *Id.* at 3.
206 *Id.* para. 4.5.6.
207 *Id.* para. 4.5.7.
208 *Id.* para. 5.4.4.

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Morningside Office Park
1st Floor, Wing A
Ngong Road
P.O. Box 48136-00100
Nairobi, Kenya
Tel. +254 20 251 8361

120 Wall Street, 14th Floor
New York, New York 10005
Tel. 917 637 3600 **Fax.** 917 637 3666