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LAW COMMISSION REPORT NO. 29

CONSTITUTION OF MALAWI

REPORT OF THE LAW COMMISSION ON THE REVIEW OF THE LAW ON ABORTION

The Report of the Law Commission on the Review of the law on abortion is hereby published and shall be laid in Parliament pursuant to section 135 (*d*) of the Constitution.

Dated this 15th day of March, 2016.

SAMUEL BATSON TEMBENU, SC
Minister of Justice and
Constitutional Affairs

FILE NO.LC/01/56

REPORT OF THE LAW COMMISSION ON THE REVIEW OF THE LAW ON ABORTION

TO: HONOURABLE SAMUEL BATSON TEMBENU,SC, MINISTER OF JUSTICE AND CONSTITUTIONAL AFFAIRS

This is the Report on the Review of the law on abortion by the special Law Commission on the Review of the law on abortion appointed under section 133 of the Constitution.

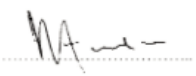
We, the members of the Commission, submit this Report pursuant to section 135 of the Constitution and commend the Report and its recommendations to the Government, Parliament and the people of Malawi.

MEMBERS

HONOURABLE JUSTICE ESME J. CHOMBO — *Chairperson,* Judge of the High Court of Malawi

MRS. FANNIE KACHALE — *Deputy Chairperson* Ministry of Health

MRS. GERTRUDE LYNN HIWA, SC — *Law Commissioner*



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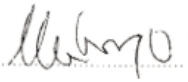

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Dated: 15th March, 2016.

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The Programme Officers were Assistant Chief Law Reform Officers, Mr. Mike Chinoko and Mrs. Eddah Edayi Chavula.

Acknowledgements

The Law Commission is grateful to Ipas for providing funding for this Programme.

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Foreword

For a long time, Government has bemoaned the high prevalence of maternal mortality in Malawi and has identified unsafe abortion as one of the major contributing factors to this problem. Termination of pregnancy, except where it is performed to save the life of a pregnant woman, is a criminal offence in Malawi. In this regard, some commentators have faulted the restrictive law on abortion and the criminal sanctions that follow as contributing factors to the problem of unsafe abortion in Malawi apparently because women, for fear of the law, resort to clandestine and unsafe means in order to terminate unwanted pregnancies. Such commentators, including the Ministry of Health, called for a review of the law on termination of pregnancy.

In addition to this call, two separate special Law Commissions, the special Law Commission on the Review of the Penal Code and the special Law Commission on the Development of the Gender Equality Statute, made policy recommendations to Government to empanel a special Law Commission to review the law on termination of pregnancy and possibly recommend the enactment of a separate law that lays out the procedure for legal and safe termination of pregnancies in Malawi.

To that effect, a special Law Commission was appointed under section 133 of the Constitution to carry out the necessary law reform work on the law on termination of pregnancy. Membership of the Commission comprised representatives from the Ministry of Health, the Judiciary, the Catholic Church, Malawi Council of Churches, Muslim Association of Malawi, Traditional leaders, the Law Society, Ministry of Justice and the Malawi College of Medicine.

The special Law Commission had a difficult task before it as it was dealing with an emotive subject that attracts mixed reactions and perceptions from different quarters depending on the angle from which it is perceived, that is, from a legal, public health, moral or religious standpoint. However, in arriving at its findings and recommendations, the Commission conducted a thorough desk research on the subject matter, undertook a programme of consultations both locally and abroad, and deliberated at length in plenary. Among others, the Commission considered the Government policy on abortion, the law as it stands now, applicable international instruments, the magnitude of unsafe abortion in Malawi and views from various stakeholders such as the faith community, Ministry of Health, medical practitioners, health regulatory authorities, Ministry of Education and the general public.

The diverse group of Commissioners on the programme and the methodology that they employed greatly enriched the process and it is the hope of the Commission that this allays any fears that the public might have to the effect that the work of this Commission may have been somehow compromised. I therefore thank my fellow Commissioners for their dedication to national service and the Secretariat for providing technical and logistical support for this work.

The Commission's findings and recommendations are contained in this Report which the Commission submits to the Government for enactment into law. In this respect, a proposed legislation entitled the Termination of Pregnancy Bill is appended to this Report. The Commission urges the general public to thoroughly go through the contents of this Report in order to get an insight and understanding on how the Commission arrived at its findings and recommendations.

Lastly, the Commission is grateful to Ipas and the Malawi Government for funding the programme.

JUSTICE ESME J. CHOMBO
Chairperson

INTRODUCTION

In line with its mandate, the Law Commission is reviewing the law on abortion pursuant to the proposal made by two special Law Commissions. First, a special Law Commission on the Review of the Penal Code which released its Report in 2000[1] recommended the enactment of a separate law that would make provision for the procedure relating to the legal termination of pregnancies on appropriate grounds. Second, a special Law Commission on the Development of the Gender Equality Statute which released its Report in 2011[2] made a recommendation to Government to carefully scrutinise the issues of unsafe termination of pregnancy and make immediate plans to institute a review of the law on abortion through the Ministry of Health so that a new statute specifically on termination of pregnancy is enacted.

Following these recommendations, the special Law Commission on the Review of the Law on Abortion (in this Report, we shall hereafter refer to it as 'the Commission) was empanelled under section 133 of the Constitution to carry out the review. The Commission commenced its plenary meetings in June 2013.

The general mandate of the Commission was to review the law on abortion to ensure conformity with the Constitution, Government policies and applicable international laws.

Terms of Reference

The Commission developed its own Terms of Reference to guide its work as follows—

(*a*) consider the following laws, policies and international treaties for guidance—

(i) the Constitution;

(ii) the Penal Code, Cap. 7:03 of the Laws of Malawi;

(iii) the Gender Equality Act, Act No. 3 of 2013;

(iv) the Sexual and Reproductive Health and Rights Policy for Malawi;

(v) foreign pieces of legislation on abortion;

(vi) the International Covenant on Civil and Political Rights (ICCPR);

(vii) the International Covenant on Economic, Social and Cultural Rights (ICESCR);

[1] Report of the Law Commission on the Review of the Penal Code, Report No. 4.
[2] Report of the Law Commission on the Development of the Gender Equality Statute, Report no. 23 p.66.

(viii) the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW);

(ix) the African Charter on Human and People's Rights (ACHPR);

(x) the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol);

(xi) the Universal Declaration on Human Rights (UDHR);

(xii) the Program of Action of the International Conference on Population and Development (ICPD) (1994);

(xiii) the Beijing Platform for Action (1995);

(xiv) the Millennium Development Goals (MDG's);

(xv) the Maputo Plan of Action for the Operationalization of the Continental Sexual and Reproductive Health and Rights Policy Framework (Maputo Plan for Action);

(xvi) United Nations Universal Periodic Review Recommendations (2010);

(xvii) work already done by the Law Commission with specific reference to the Reports of the special Law Commission on the Review of the Penal Code and the special Law Commission on the Development of the Gender Equality Statute; and

(xviii) any other relevant document;

(*b*) invite and consider submissions from the general public relating to the legal termination of pregnancies;

(*c*) conduct consultations with stakeholders;

(*d*) conduct comparative studies at international level;

(*e*) make recommendations on any other matter relating to abortion;

(*f*) develop a Report on the findings and recommendations of the review process; and

(*g*) submit the Report to the Minister of Justice and Constitutional Affairs.

The Report is passed on to Cabinet by the Minister of Justice and Constitutional Affairs who also lays it in Parliament.

Work Methodology

The Commission adopted the following methodology in reviewing the law—

(*a*) inviting submissions from members of the public through notices in the local papers and in the *Gazette*;

(*b*) holding meetings of the Commission on twelve occasions, from June 2013 to July 2015. During these meetings, the Commission scrutinized the provisions relating to abortion contained in the Penal Code, one by one. The Commission also examined several comparable statutes from other common law jurisdictions and from selected countries within the Region;

(*c*) undertaking comparative study visits to Ethiopia, Mauritius and Zambia, where Commissioners had occasion to learn firsthand about the problem of unsafe abortion, the implementation of laws on abortion and the challenges surmounted by enacting a new law regarding the issue of termination of pregnancy;

(*d*) conducting consultations in ten districts and three Regional Workshops to consult stakeholders on the findings and recommendations made by the Commission;

(*e*) holding a meeting of the Commission to review the deliberations of the Workshops and to incorporate the recommendations made at each of the Regional Consultative Workshops; and

(*f*) the Commission has produced this Report.

Structure of the Report

The Report commences with a brief historical background on the law on abortion. This is followed by a detailed analysis of the Penal Code provisions relating to abortion and then a discussion on contemporary issues pertaining to abortion. The Report presents findings and recommendations based on issues that were identified from the provisions on abortion and crucial areas that the law on abortion must take into account in the review programme. All matters recommended for enactment have been indicated in **bold**.

Further, in the narrative part of the Report, the Commission has not assigned Part numbers and section numbers to the new provisions being recommended but subsections have been assigned numbers to indicate the structure and full content of the recommended provisions.

The second part of this Report contains proposed legislation as an Appendix pursuant to section 7(1) (*g*) of the Law Commission Act, Cap. 3:09 of the Laws of Malawi.

Draft Guidelines for Service Delivery by Authorised Service Providers, and a list of participants who were present at all consultative meetings that the Commission held are also appended to this Report.

SPECIFIC FINDINGS AND RECOMMENDATIONS

1.0 BACKGROUND INFORMATION

1.1 Definition of the term "Abortion"

The term "abortion" has been legally defined as "an artificially induced termination of a pregnancy for purposes of destroying an embryo or foetus."[3] It has also been defined as the expulsion of non-viable foetus.[4] The medical profession has divided abortion into two broad categories in order to distinguish between unprovoked and provoked termination of pregnancy. The first category is spontaneous abortion, which refers to unprovoked termination of pregnancy where the woman intended to keep the pregnancy. This type of abortion is usually referred to as a "miscarriage".

The second category is provider-initiated abortion which follows provocation of the pregnancy by a woman herself or some other person. This is generally referred to as induced abortion. The latter is further subdivided into two categories, that is, unsafe abortion and safe abortion. According to the World Health Organisation (WHO), "unsafe abortion" is defined as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both."[5] Safe abortion is therefore a procedure for terminating an unwanted pregnancy by persons who are skilled in carrying out the procedure in an environment that meets set medical standards.

1.2 History of Statutory Abortion Laws

The provisions dealing with abortion are contained in the Penal Code. The Penal Code was drafted in the 19th Century for application in the colonies. It was first introduced in India in the mid 1800 and later applied to other colonies. The Penal Code was enacted in Malawi in 1929 and was brought into force on 1st April 1930.

The provisions of the Penal Code dealing with abortion are based on the 1861 Offences Against the Person Act of England. Since then, the law on abortion in England has undergone numerous reforms reflecting changing views of the general population. However, the law in Malawi has remained unchanged.

Even in the review of the Penal Code of 2000 undertaken by the Law Commission, the provisions dealing with abortion were retained. However, it was recommended that a separate law should be enacted that would make provision for the procedure relating to legal termination of pregnancies for appropriate reasons.

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[3] The Black's Law Dictionary, (6th Ed.), CENTENNIAL Edition (1891-1991) p 7.

[4] Bryan A. Garner : A Dictionary of Modern Legal Usage, 2nd Ed.

[5] World Health Organisation (2012), Safe Abortion: Technical and Policy Guidance for Health Systems, 2nd ed.

1.3. Abortion Law in Malawi

1.3.1 The Constitution

The Constitution does not make specific reference to reproductive health rights. In fact, there is no constitutional guarantee to the right to health. The obligation of the State to promote health is only entrenched in the Constitution as one of the principles of national policy[6] and subsequently within the context of the right to development.[7] As a principle of national policy, the State is obliged "to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care".[8] With reference to the right to development, the Constitution guarantees equal opportunity for all in accessing health services in the pursuit of this right.[9] The Constitution may be contrasted to the South African Constitution, which explicitly guarantees reproductive health rights with specific reference to the right of persons to make decisions concerning reproduction, and to security and control over their bodies.[10]

Nevertheless, the Constitution also guarantees the rights to life,[11] dignity,[12] equality and non-discrimination[13], freedom of conscience[14], and freedom from torture and degrading treatment[15]. All these rights, when broadly interpreted, have the effect of binding the State to the duty of protecting, respecting, and fulfilling the reproductive health rights of women, including providing access to safe abortion. For example, it is argued from a reproductive health perspective that the right to life is seriously compromised when women who decide to have an abortion can only do so by taking a serious risk to life and health through unsafe means. However, those arguing against termination of pregnancy are of the view that the foetus has a right to life as well and that the life of the woman cannot be superior to that of the foetus.

With regard to the right to equality and non-discrimination, it is argued that the law on abortion in Malawi discriminates against women by denying them a lifesaving reproductive health service that only women need.[16] As for the right to dignity, the dangerous substances and objects used in procuring abortion in places where there is no skill, hygiene and anesthesia speak to how unsafe abortion is so dehumanizing for women. Further, it is argued that forcing women to carry a pregnancy to term which is a result of sexual assault such as rape or incest is a form of cruel and degrading treatment. In addition, the law is also said to be an

6 Section 13(*c*) of the Constitution.
7 Section 30(2) of the Constitution.
8 Section 13(*c*) of the Constitution.
9 Section 30(2) of the Constitution.
10 Constitution of the Republic of South Africa, Act No. 108 of 1996 art 12(2)(*a*) & (*b*).
11 Section 16 of the Constitution.
12 Section 19 of the Constitution.
13 Section 20 of the Constitution.
14 Section 33 of the Constitution.
15 Section 19(3) of the Constitution.
16 Studies conducted by the Government contained in the following Reports among others: Abortion in Malawi: Incidence and magnitude of complications due to unsafe abortion; and A strategic assessment of unsafe abortion in Malawi.

affront to the right to freedom of conscience and belief of those people who do not believe that abortion is wrong.

1.3.2 The Penal Code

The law on abortion is governed by the Penal Code. Generally, sections 149, 150, 151 and 243 of the Penal Code prohibit termination of pregnancy and the only exception for allowing it is where the life of the mother is threatened.

Section 149 prohibits the act of procuring the miscarriage of a woman through the unlawful administration of any poison, noxious substance or the use of force. It applies to third parties where they assist a woman to procure an abortion. This section has a wide scope of application and potentially encompasses legitimate health care providers and other third parties who provide services that result in the procurement of miscarriage of a woman. The third party committing the act of procuring the miscarriage must do so with an intent to do the act and it is irrelevant whether the woman on whom the act is performed is in fact pregnant or not. In effect, this provision covers attempted abortions; and ignorance of the fact that the woman was actually pregnant or not is not a defence. The offence committed is a felony and attracts a penalty of 14 years imprisonment. The offence attracts a penalty similar to offences which result in serious bodily harm being caused to others such as grievous bodily harm under section 238 of the Penal Code and maliciously administering poison under section 240 of the Penal Code.

Section 150 applies to a pregnant woman herself and proscribes the act of procuring her own miscarriage through the administration of poison, noxious substance and the use of force. The offence committed is a felony and although this too is a serious offence, it attracts the penalty of 7 years imprisonment. The penalty is less compared to instances where the offence is committed by a third party.

Section 151[17] deals with the means used to procure an abortion. The provision proscribes the supply of drugs, instruments or anything that is intended to be unlawfully used to procure the miscarriage of a woman. The offence committed is also a felony but attracts a lesser penalty of 3 years imprisonment.

The effect and scope of application of this particular section is similar to section 149, in that it may also encompass health care providers as well as any other persons or category of persons that assist the woman in procuring an abortion.

Although these sections make abortion illegal, section 243 provides a statutory defence for health care providers conducting surgical operations in good faith and with reasonable care, where the operation will preserve the mother's life.

[17] Ibid.

An operation of this nature may only be performed if doing so is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case. The defence is rather limited in scope as it can only be applied with certainty to registered health care providers and to surgical abortion only omitting medical abortion.

With regard to the exception of allowing abortion to 'preserve a mother's life,' the Commission observed that the issue which has been unresolved is the exact meaning of this exception, i.e. whether it is just the physical life of the pregnant woman or whether the pregnant woman should be in imminent danger of actually dying; or whether 'life' is threatened by steps taken by the woman that will put her health and life in danger such as procuring an unsafe abortion. The leading English case of R *v. Bourne* offers interpretational guidance. The court indicated that a woman's 'life' was contingent on both her physical and mental health, so that abortion was not 'unlawful' if carried out to preserve either of these. It was explained that saving "life" includes not only the fact of life, but also the quality of life, meaning the physical and mental health, when pregnancy would cause it to be seriously and enduringly impaired.[18]

The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."[19] Living with an unwanted pregnancy as well as being forced into procuring unsafe abortion is often described as violating a woman's state of complete physical, mental and social wellbeing and thus depriving her of the right to health.

However, in Malawi, health professionals are not clear on what could fall under the exception provided by the law and that has meant that safe abortion services on the available exception has largely been inaccessible. In the absence of guidance, health care providers are left in a mire of uncertainty with regard to what "preservation of the mother's life" means; who can terminate a pregnancy and under what circumstances; and who determines the circumstances under which "preservation of the mother's life" comes into play.

1.3.3 The Law Commission Report on the Development of the Gender Equality Statute

The Commission noted that its sister special Law Commission on the Development of the Gender Equality Statute made an observation that "the provisions of the Penal Code in respect of abortion are overly restrictive and inconsistent with the spirit of the Reproductive Health Policy as well as international conventions to which Malawi is a party."[20] The Commission on the development of the Gender Equality Statute further observed that the restriction on abortion under the Penal Code fails to recognise that there are instances where

[18] [1938]3 All ER 612.

[19] WHO | Re-defining 'Health' - World Health Organization available at www.who.int/bulletin/bulletin-board/83/ustun11051/, accessed 17 June 2013.

[20] Report of the Law Commission on the development of the Gender Equality Statute, Law Commission Report no.23. p 64.

the pregnancy may arise out of criminal conduct and that it may not be recommended that the pregnancy should continue because it affects and endangers the life of the mother physically or psychologically.[21] In the end, the Commission went on to recommend that Government should, through a special Law Commission, carefully scrutinise the issues of unsafe abortion that it has highlighted and make immediate plans to institute a review of the law on abortion so that a new statute specifically on termination of pregnancy is enacted.[22] Therefore, the special Law Commission on the development of the Gender Equality Statute did not make provision for legal and safe termination of pregnancy in the Gender Equality Statute but clearly acknowledged the need to do so. This Commission takes cognisance of the fact that the genesis of its work, to a large extent, stems from the recommendation made by its sister special Law Commission on the development of the Gender Equality Statute.[23]

1.3.4 Policy Framework on Abortion

The Ministry of Health (MoH) supports the concept of comprehensive reproductive health as defined in the 1994 International Conference on Population and Development in Cairo and endorsed at the fourth World Conference on Women in Beijing. Both Conferences defined reproductive health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to reproductive health system, its functions and processes."

In the year 2009, the Government adopted the Sexual and Reproductive Health and Rights (SRHR) Policy. The overall goal of this Policy is to provide a framework for the provision of accessible, acceptable and affordable, comprehensive SRHR services to all women, men, and young people through informed choice to enable them attain reproductive rights and goals safely.

Specific goals of this Policy include empowering and enabling women and adolescent girls to—

(*a*) have sexual and reproductive health choices;

(*b*) avoid unwanted sexual contact, injury and infection;

(*c*) make informed decisions about childbearing; and

(*d*) face fewer risks in the course of pregnancy and childbirth.

The Policy has gone further to emphasise that—

(*a*) prevention of unplanned and unwanted pregnancy shall be given the highest priority in the development and implementation of the family planning services;

[21] Ibid p 65.
[22] Ibid p 66.
[23] The special Law Commission on the Review of the Penal Code also recommended the enactment of a separate law that would make provision for the procedure relating to the legal termination of pregnancies for appropriate reasons. Law Commission Report no. 2 p 43.

(*b*) abortion shall not be used as a method of family planning;

(*c*) all women who have complications of abortion shall have access to quality post abortion care services, including post abortion counselling, and family planning to prevent repeat abortion; and

(*d*) services in public and private sector shall provide or refer for safe abortion to the fullest extent of the laws of Malawi all women deemed to require or requesting the termination of their pregnancies.

In addition to this Policy, health workers are also guided by other documents in the implementation of reproductive health services. For example, the Malawi National Reproductive Health Service Delivery Guidelines (2007) have a section on Post Abortion Care which outlines the type of care that should be given to women following a spontaneous or induced abortion. The Guidelines also emphasise that post abortion care service should include counselling of women on family planning to avoid unintended pregnancy and repeat abortion. The client should be offered a contraceptive method of her choice in accordance with the Policy.

In coming up with its findings and recommendations, the Commission was informed by the Constitutional provisions, provisions on abortion as contained in the Penal Code, provisions on sexual reproductive health rights contained in the Gender Equality Statute and Government Policy as articulated in the Sexual Reproductive Health and Rights Policy.

2.0 WHETHER OR NOT THE LAW ON ABORTION SHOULD BE LIBERALISED

As already indicated, abortion is illegal except where it is carried out to save a mothers' life. In order to answer the question of whether or not the law on abortion should be liberalised, the Commission reflected on the arguments in relation to the right to life of the foetus and those in relation to the rights of women; conducted a literature review of the problem of unsafe induced abortion both locally and globally; considered international instruments that have a bearing on sexual and reproductive health rights to which Malawi is a party; considered local and international court cases; and carried out a comparative legal analysis. A discussion of these follows below.

2.1. Foetal rights versus Women's Reproductive Rights

It has been generally observed that "when human rights are discussed in relation to abortion, the focus is usually on the pro-choice/pro-life dichotomy."[24] Arguments by pro-life proponents have been based on the right to life of the foetus.[25] On one hand, pro-life proponents argue that a "compelling interest"

[24] Teklehaimanot K.I. May, 2002. Using the Right to Life to Confront Unsafe Abortion in Africa, in Reproductive Health Matters, Vol 10, No. 19, Abortion: Women Decide, p.143. Cited in Kachika, T., 2007. *Bioethics, human rights, the law and maternal mortality in Malawi.*

[25] Teklehaimanot K.I.,as above

justifies State intervention to protect all human life (born and unborn).[26] They pursue the deontological position that "a beneficial end does not justify unethical means, and that unethical means cannot become ethical simply because they may produce a result desirable or good in itself."[27] Brody notes that "one of the most frustrating aspects of discussions about abortion is the way in which they rapidly turn into a discussion of the status of the foetus and of whether destroying the foetus constitutes the taking of a human life. Since these questions seem difficult, if not impossible, to resolve upon rational grounds, frustration results...."[28] On the other hand, pro-choice advocates claim that laws restricting or criminalizing abortion do not achieve the desired policy goal of preserving foetal life because a woman needing to terminate a pregnancy will ultimately do so through unsafe means.[29] Women's right to life should be protected not only against significant threats of maternal mortality, but against conscientious resort to unskilled means of reproductive self-determination.[30]

The difficulty of the ethical debate over the right to life in abortion cases has also been ostensibly shunned by some national and regional human rights courts as well as treaty bodies, which have refrained from taking a position on the legal status of the foetus. For instance, the European Commission on Human Rights in *Paton v. United Kingdom*[31] declined to discuss the issue of whether article 2 of the European Convention on Human Rights protects a foetus or not. Instead, it said that whether a foetus was recognized to have a right to life had not been "considered by the Commission in any other case".

In Roe *v. Wade*, the US Supreme Court also expressly refrained from determining the status of the foetus by stating that—

"*[w]e need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology, are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not to speculate as to the answer.*"[32]

However, the trimester framework in *Roe v. Wade* established that while the government lacked "compelling state interest" in foetal health throughout an entire pregnancy, the state's interest only became "compelling" at the point of

26 Cook J.R, Dickens M. B, Fathalla F.M. 2003. Reproductive health and human rights: integrating medicine, ethics and law

27 Cook, R., Dickens, B., Fathalla M, Reproductive Health and Human Rights: integrating medicine, ethics and law, (2003)

28 Brody B.A., Abortion and the Law, in Biomedical Ethics and the Law (1979), p.45. cited in Kachika, T., 2007. *Bioethics, human rights, the law and maternal mortality in Malawi.*

29 Schroedel, R.J., Fiber P., and Snyder, B.D. 2000. Women's Rights and Foetal Personhood in Criminal Law, Duke Journal of Gender Law & Policy Volume 7:89

30 Schroedel, R.J., Fiber P., and Snyder, B.D. 2000. Women's Rights and Foetal Personhood in Criminal Law, Duke Journal of Gender Law & Policy Volume 7:89

31 1980, 3 Eur. Comm. HR 408, p.412. The case involved an application by Mr Paton pleading that a High Court decision that permitted abortion violated article 2(1), cited in Kachika, T., 2007. *Bioethics, human rights, the law and maternal mortality in Malawi*. Teklehaimanot K.I., Using the Right to Life to Confront Unsafe Abortion in Africa, in Reproductive Health Matters, p.148 cited in Kachika, T., 2007. *Bioethics, human rights, the law and maternal mortality in Malawi.*

32 410 U.S. at 164.

foetal viability—that is, when the foetus is capable of surviving independently of the mother (from 24 weeks).[33] In this way, the right of women to procure a safe abortion is not completely curtailed, but is dependent on the viability of the foetus.

What both pro-life and pro-choice scholars agree on is that the relationship of a woman to the foetus within her womb during pregnancy is unlike any other human relationship. During a normal pregnancy, a woman undergoes massive physical and physiological changes that affect her entire body, in ways more profound than any other "normal" human function. No other human association is comparable.[34] Based on this, the pro-choice movement has therefore argued that women's full citizenship rights simply means that the pregnant woman, not the State, is the most appropriate person to make decisions about the foetus.[35] Otherwise, categorically defending the life of the foetus means that the woman's right to life becomes secondary. In any event, in respect of pregnant women who risk procuring an unsafe abortion, the choice is whether the woman gets saved, or whether both the mother and the foetus, that is dependent on her, die. In this scenario, in pursuit of State's interest to protect life, it may be sensible to save at least one life by allowing the mother access to safe abortion services before the foetus becomes viable.[36] Further, *the 1993 Germany abortion decision*, [37] has offered guidance that even where foetal rights are jealously safeguarded, criminal law is not an effective solution in promoting this interest.

The discussion on the right of a foetus to life and the right of a woman to choose whether to continue having an unwanted pregnancy was the centre of consultations carried out by the Commission. The consultations revealed that citizens in Malawi have different views on the matter.[38] It was argued by some participants during the consultation workshops that certain choices in life should not be made because they are morally wrong. Considering that women are dying due to induced abortions, it is right and proper at policy level to discuss issues of abortion. However, legalizing abortion is morally wrong since it involves killing of an innocent human being. Some commentators on the subject also advance the same argument. It is stated that the definition of something living includes the ability to grow, which is what happens inside a woman who is pregnant. The little being may not start off with a heartbeat or brain activity, but cells are still dividing and allowing it to grow; and that abortion stops that growing process, thereby ending the future life of a human being.[39] The Catholic Church, in one of its pastoral letters, states that life begins at conception, immediately after the sperm

33 *Ibid.*
34 Schroedel, R.J., Fiber P., and Snyder, B.D. 2000. Women's Rights and Foetal Personhood in Criminal Law, Duke Journal of Gender Law & Policy Volume 7:89.
35 Schroedel, R.J., Fiber P., and Snyder, B.D. 2000.
36 Ibid.
37 Judgment of May 28, 1993. Found in American Journal of Comparative Law Vol.43 no. 2 Spring 1995 pg 273-314
38 The workshop was attended by civil society leaders, religious leaders, lawyers, government officials, traditional leaders, doctors, etc.
39 http://allwomenstalk.com/7-reasons-why-abortion-should-be-illegal (accessed on 12 February, 2014).

fertilizes the egg. When fertilization takes place, a life is begun, that is neither of the father nor the mother; it is rather the life of a new human being with his own growth.[40] From its earliest forms and stages, this new life possesses internal mechanisms that will enable it to be a fully developed human being through a continuous and uninterrupted development process.[41]

Other religious groups argue that God established government to keep sinful people from doing evil against each other and arguing that the government should never restrict "choice" is nothing more than an argument for anarchy; but anyone who understands the biblical role of government and deals honestly with the Bible's portrayal of human life (inside and outside the womb) should recognize that biblically speaking, the government must protect innocent human life.[42] Further, it has been stated that killing an unborn child is inherently wrong, and therefore can never be justified regardless of circumstances. It is no more justifiable to kill an unborn child in order to avoid hardship than it would be to kill a toddler to avoid hardship. Since the unborn child is unseen, it may be easier for society to condone killing him or her, but this is morally indistinguishable from killing any child at any stage of development.[43]

A legal extension to this argument is that the Constitution provides for the right to life which is non-derogable,[44] (meaning that the right to life cannot be taken away or limited) and that the termination of the pregnancy is tantamount to taking away life. Thus, any law that purports to promote the termination of a pregnancy would violate the right to life and therefore unconstitutional. However, the pro-choice group has stated that if the framers of the Constitution intended to extend protection to an unborn child, they should have specifically made provision for that as it is the case under the Zambian Constitution.[45]

The bottom line to all these arguments is that life begins at conception and that protecting unborn life is the morally correct choice for all.[46] To the proponents of foetal rights, this is considered as an indisputable moral principle above any culture, religion or secular ideology. As such, the physical, emotional, mental, social, financial or health status of the mother cannot validate the killing of an innocent human being. It is therefore argued by those holding this view that Malawi should not legalize abortion since abortion is about killing of an innocent human being.[47]

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40 Episcopal Conference of Malawi Teaching on Homosexuality, Abortion, Population and Birth Control, Pastoral Statement 2nd March 2013.

41 Ibid

42 www.abort73.com/abortion (accessed on 4 March, 2014).

43 http://prolifeaction.org/faq/stand.php#sthash.bjNtj04t.dpuf (accessed on 10 March, 2014).

44 Section 16 as read with section 45(2)(*a*) of the Constitution of Malawi.

45 Article 12 (2) No person shall deprive an unborn child of life by termination of pregnancy except in accordance with the conditions laid down by an Act of Parliament for that purpose. See also Article 28 of Draft Zambian Constitution – "A person has, subject to clauses (2) and (3), the right to life, which begins at conception.

46 See also J. Mason (2007) The Troubled Pregnancy. Legal Wrongs and Rights in Reproduction. Cambridge University Press, Cambridge pp 16-17.

47 See the Consultation Workshop Report on Abortion, Law Commission.

On the social front, others argue that if abortion was made legal, then many women would be taking the service for granted and would be less careful about getting pregnant because they would use abortion as a means of family planning. In addition, there is the concern that legalising abortion would fuel the increase of HIV and AIDS as some people would relax and engage in more risky sexual behaviour.

It is also argued that women who abort, chronically suffer from mental and psychological stress, and that no matter how strong a woman is, an abortion causes mental anguish that never truly goes away.[48] Another argument is that abortion sometimes attracts some public health concerns. As a consequence of an abortion, some women are said to have become sterile; chances of miscarriage in subsequent pregnancies and risk of pelvic inflammation increases; and some develop complications later in life.[49] More controversially, there is a medical argument that the foetus feels pain. An article published in one medical journal argues that if one tries sticking an 8-week-old human foetus in the palm of its hand, it opens its mouth and pulls its hand away; and a more technical description would add that changes in heart rate and foetal movement also suggest that intrauterine manipulations are painful to the foetus.[50] However, it should be noted that medical science shows that the foetus is only capable of certain actions after a certain age and not necessarily immediately after conception, that is heart forms by the 18th day and brain activity is only detected in about 40–43 days.[51]

The Commission also noted that there are other more liberal arguments against abortion the approach of which is to suggest alternatives to abortions in form of social interventions. One such strategy is sex and sexuality education for the youth. It is said that integrated sexual education is one way for youths to respect their bodies as special gifts from God and to be responsible for their acts. This will enable the youth to understand abortion and its physical, emotional, spiritual aspects and consequences.[52] This education can also be extended to married couples and people about to get married on use of family planning methods.

Other strategies could include provision of information on and promotion of adoption of children and foster care because many people in society are willing to adopt children or take them in foster care. Establishing Women Day Care Centres whose aim would be to equip and empower women with unwanted pregnancies for a life of hope, dignity and self-sufficiency and also imparting special skills to them such as cookery, pastry making, sewing, etc. as well as offering psychological help and counselling support services to women, special attention

48 http://allwomenstalk.com/7-reasons-why-abortion-should-be-illegal accessed on 14th February, 2014.
49 Ibid.
50 H.P. Valman and J. F. Pearson, What the Foetus Feels, *British Medical Journal* (26 January 1980): 233-234 accessible at http://www.probe.org/site/c.fdKEIMNsEoG/b.4219435/k.6699/Arguments-Against-Abortion.htm.
51 Ibid.
51 Ibid.
52 Anglican Diocese of Mauritius Viewpoint on abortion, 2012.

being given to the youth so that such counselling should respond to young people's individual sexual behaviour, context, and developmental stage.[53]

In response to the human rights argument that a woman has a right to have control over her body, including to decide on the number of children she should have, others have counter-argued that the right of the foetus to life takes precedence over the right of the woman to control her body; and that, if anything, the time to exercise control over her body is before pregnancy by taking precautions such as family planning, self-restraint and prudence.[54] They assert that whatever difficulties or distressing circumstances a pregnancy poses cannot be removed by terminating life, as such action is disproportionate and unreasonable. Rather, what the woman needs is hope and reassurance.[55]

Turning to the Muslim faith, Islam generally prohibits abortion but states that it may be permissible in some exceptional cases. According to one senior Muslim cleric[56] that the Commission consulted, the position of Islam is that termination of pregnancy can be allowed within the first 120 days of pregnancy and only in the following circumstances—

(*a*) if it is proven beyond reasonable doubt that the continued pregnancy will endanger the pregnant person's life;

(*b*) if it is proven beyond reasonable doubt that the termination of pregnancy is necessary to prevent grave permanent injury to the physical or mental health of the pregnant person; and

(*c*) if it is proven that there is substantial risk that the continued pregnancy will result in severe malformation, or severe physical or mental abnormality, of the foetus, as assessed by the appropriate specialists.

According to Islamic Juridical Scholars, the foetus is considered to be a living being after the fourth month of pregnancy because this is the time that the soul is breathed into it.[57] However, it was emphasised during consultations that in all other cases even in cases of pregnancies which are a result of rape, incest or defilement, termination of pregnancy is strictly prohibited. After 120 days, termination is not allowed and is completely prohibited.

During consultative workshops, the Commission noted that some of the arguments received conflicting comments from other participants. Despite

53 Ibid.
54 The abortion debate. Supra.
55 Ibid.
56 The President of Jummah Musjid – Port Louis, Mauritius.
57 **Holy Quran chapter Al Maminoon Verse No. 12, 13 & 14** "*We created man from a chosen soil. Then made him a drop of fluid in a secure shelter. We then turned the drop of fluid into a clot of blood, then the clot into a small lump of flesh, then the lump into bones, then covered the bones with flesh, then developed it in a different mould, therefore most Auspicious is Allah, the Best Creator.*" ***Holy Quran Chapter Al Sajda Verse No.7, 8 & 9*** "*The one who created all things excellent, and who initiated the creation of man from clay. Then kept his posterity with a part of an object fluid. Then made him proper and blew into him a spirit from Him, and bestowed ears and eyes and hearts to you, very little thanks do you offer*." See also Dar-ul-lfta by Jummah Masjid of Port Louis Mauritius.

conceding that abortion kills 'something', some participants wondered whether a foetus is worthy calling a human being since anything below viability is called '*chinthu*' (thing) and not '*mwana*' (baby). Even in respect of a "still birth", in Chewa culture, there is reference to "*maliro a senye*" (funeral of an unborn foetus) and not "*maliro a mwana*" (funeral of a child). It was noted that the variation in the naming of a foetus that is delivered before viability stage underscores the fact that a foetus cannot live on its own or support itself. In medical terms, this is called the "viability theory", where it has been proved that a foetus can survive on its own outside the womb of the mother only after twenty-eight weeks of pregnancy.

Some participants pointed out that abortion law reform is not about whether or not abortion is morally right or wrong; the issue of when life begins and whether or not a foetus has rights is irrelevant at this point. It was further submitted that it is equally important to consider and protect the life of the person who is carrying the foetus.[58]

The Commission noted that, a number of national courts, regional human rights courts and treaty bodies have made pronouncements regarding womens' rights and the restriction on abortion.

In *L.C. v Peru*[59], the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) Committee found denial of abortion and emergency surgery to treat trauma following an attempted suicide by a pregnant minor to constitute a violation of the right to heath under article 12 of CEDAW, among other violations. The Committee also found that failure to provide an administrative framework that allows women to exercise their right to abortion timely constitutes a human rights violation. In *KL v Peru*[60] the Human Rights Committee held that denying abortion to an adolescent who was pregnant with an anencephalic (without a head) foetus constituted a serious danger to mental health of the adolescent as to constitute cruel, inhuman and degrading treatment under the International Covenant on Civil and Political Rights. The Human Rights Committee also reiterated that failure to provide an administrative framework that allows women to exercise their right to abortion timely constitutes a human rights violation. In *R v Morgentaler*,[61] a doctor had been tried three times for offending penal code provisions on abortion. In each case the jury acquitted him. In this case, the Crown appealed, and he was convicted. He appealed to have the conviction set aside. The Court held that criminal standards against abortion were unconstitutional because a woman should be able to access health services when her health or life is in danger without fear of criminal sanctions.

58 See the Consultation Workshop Report on Abortion, Law Commission.
59 CEDAW/C/50/22/2009-Communication No. 20 of 2009.
60 Accessed at Http://www.womenlinkworldwide.org/www/sitio/caso - interna.php? idcaso = 196@idi =en on 14th November, 2014.
61 [1988] 1 S.C.R.30.

Further, in the case of *In Re Abortion Law Challenge* (*2006*)*, Colombia*,[62] the decision was the result of a challenge brought by Women's Link Worldwide. Before this decision, Colombia had one of the most restrictive abortion laws in the world. At the same time, over 350,000 illegal abortions were performed annually, endangering the life, health and integrity of girls and women, particularly those in the most vulnerable situations. The Constitutional Court observed that the right to health has close relation to the interest to protect life. It is unreasonable to expect a woman to sacrifice her right to life in the interest of protecting a third party. It went on to say that sexual and reproductive rights also emerge from the recognition that equality in general, gender equality in particular, and the emancipation of women and girls are essential to society. Protecting sexual and reproductive rights is a direct path to promoting the dignity of all human beings and a step forward in humanity's advancement towards social justice. Regarding rights of the foetus, the court held that—

> "*Life*' *and* '*the right to life*' *are different phenomena. Human life passes through various stages and manifests in various forms, which are entitled to different forms of legal protection. Even though the legal system protects the feotus, it does not grant it the same level or degree of protection it grants a human person*."[63]

In *Christian Lawyers' Assoc. of South Africa v. Minister of Health* (1999) a SouthAfrican court held that the right to life that is guaranteed to "everyone" does not include any right to life of a foetus. Furthermore, the court recognized that "age" of a child begins at birth, and that recognizing that a foetus has constitutional rights would result in violation of women's constitutional rights, including rights to life, health and access to health services, privacy, and freedom of conscience.

Finally, it is argued that where a constitution recognizes a foetus as having constitutional rights, it follows that such rights must be balanced against the rights that women already have.[64]

2.2 Global Magnitude of the Abortion Problem

The Commission observed that unsafe abortion is a major public health concern for many developing countries. The WHO estimates that around twenty two million unsafe abortions are carried out globally and almost 47000 induced abortion related deaths occur each year.[65] It has been estimated that 98% of unsafe abortions take place in developing countries. Further, about 30 unsafe abortions occur per 100 live births in Eastern Africa.[66] In addition to the death of the

62 Case No. C-355/06.
63 Ibid.
64 Ngwena, C. Access to safe abortion: International and regional human rights and policy frameworks. Annual Regional Lawyers Workshop on Acess to Safe Abortion in Africa. Kenya 2014.
65 According to WHO Preventing unsafe abortion Fact Sheet No. 388 of March 2014 accessed at http://www.who.int/mediacentre/factsheets/fs388/en/ on 8th May, 2014.
66 (Sedgh, Henshaw et al.2007).

woman, unsafe abortions constitute some of the major medical complications. It is also estimated that 1 in 4 women having an unsafe abortion is likely to face severe complications that can result in death.[67] The risk of death from unsafe abortion in Africa is the highest in the world, with an estimated 470 deaths per 100, 000 unsafe abortion procedures compared to about 30 deaths per 100,000 procedures in the developed world.[68]

Africa has the highest maternal mortality ratio in the world of about 1, 000 deaths per 100, 000 live births of which 13% are due to abortion complications.[69]

2.3 The Magnitude of the Abortion Problem in Malawi

The Commission observed that a number of studies have been conducted to examine the abortion situation in the country. These studies are: "A Strategic Assessment of Unsafe Abortion in Malawi,[70] "Investigating Social Consequences of Unwanted Pregnancy and Unsafe Abortion in Malawi,"[71] "Estimating the Incidence of Abortion in Malawi"[72], and "Cost Analysis of Abortion in Malawi".

According to the findings from these studies, the Commission noted that in 2009, between 29,000 and 47,000 women sought treatment for complications of abortion. The studies also reveal that 80% of the women who procure abortions are married; and that procuring an abortion is not unique for Malawi. The Commission noted that the abortion rate for Malawi is 23 out of 100 women in the age group 15-44.

The studies further reveal that 48,600-86,000 unsafe abortions are procured each year, which translates into 11 abortions for every 100 babies born alive. The consequences are that in Malawi about 17% of all maternal deaths are due to complications of abortion. This makes unsafe abortion the fourth commonest cause of maternal deaths after bleeding during and after childbirth, sepsis (infection) after childbirth, and hypertension in pregnancy.[73] Some women who procure abortion do not die but 1 in 5 of these women are maimed by severe complications while another 1 in 14 experience moderate complications, or have their reproductive organs so badly damaged that they cannot be pregnant again.

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67 Shah and Ashman 2010. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008, 3rd ed. Geneva, World Health Organization, 2011.

68 Unsafe Abortion: Global and Regional Estimates of Evidence of unsafe abortion and Associated mortality 2008 6th Ed. WHO 2011.

69 Shah and Ahman 2010. Ibid.

70 Jackson E, Johnson BR, Gebreselassie H, Kangaude GD, Mhango C. A strategic assessment of unsafe abortion in Malawi. Reprod. Health Matters 2011;19(37):133-43.

71 Brooke A. Levandowski,*, Linda Kalilani-Phiri, Fannie Kachale, Paschal Awahd, Godfrey Kangaude, Chisale Mhango Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma Inter. J. of Gynecology and Obstetrics 118, Supplement 2 (2012).

72 Estimating the incidence of abortion in Malawi Brooke A. Levandowski; Chisale Mhango; Edgar Kuchingale; Juliana Lunguzi; Hans Katengeza: International Perspectives and Reproductive Health Vol.39 No.2 June, 2013.

73 The Malawi Demographic and Health Survey of 2010.

This is tragic as some of these women might want to have more children. In these studies, restrictive abortion law was cited as one of the contributing factors to the problem.

In terms of expenditure on the part of Government, the studies also reveal that the Ministry of Health spends K300 million each year on post abortion care for women admitted to the health facilities throughout the country and a large percentage of this amount is spent on unsafe abortions. Since hospital records include patient's religious affiliations, the studies show that women of all faiths are among those seeking treatment for complications of abortion. According to the social-demographic and reproductive study of post abortion care clients , 28.5% were Protestant/Presbyterian, 23.3% of the women were Catholic, 22.7% other Christian, 14.5% other faiths,10.3% were Muslim, and 0.7% with no religion.[74]

The Commission noted that women still seek unsafe abortion rather than keep unwanted pregnancies in spite of knowing that abortion is potentially dangerous to their health when not carried out by skilled health care providers and also know that it may be against the teachings of the various faith groups to which they belong.

As part of the review process in the early stages of the programme, the Commission conducted district consultations with special interest groups.[75] In all these districts, stakeholders generally acknowledged the existence of the problem of unsafe abortion and stated that in many cases, women lose their lives.[76] Stakeholders suggested various strategies aimed at curbing the problem of unsafe abortion. Some stakeholders proposed that Government should intensify civic awareness on the dangers of unsafe abortion and must promote the use of family planning methods. Others called for strict enforcement of the law to deter potential offenders, while others called for the liberalisation of the law to open up to legal abortions in certain exceptional cases such as rape, incest, defilement and where there is evidence of severe foetal malformation.

However, at all consultative meetings, stakeholders were divided on whether or not abortion should be legalised wholesale (decriminalised) with some supporting the idea and others strongly opposing it.

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74 Ministry of Health (2011) Abortion in Malawi: Incidence and magnitude of complications due to unsafe abortion Report.

75 The district consultations were carried out in the districts of Chitipa, Nkhatabay, Nkhotakota, Mchinji, Dedza, Mangochi, Zomba, Chiradzulu, Mulanje and Nsanje. The special interest groups included traditional leaders, civil society organisations, Government departments such as health professionals, faith based organisations, media, rural women and men, teachers, traditional healers, traditional birth attendants, police officer, and judicial officers.

76 *See:* Report on district consultation by the special Law Commission on the review of the law relating to abortion. Malawi Law Commission, January 2014.

2.4. International and Regional Legal Frameworks on Abortion

The Commission observed that the issue of abortion is intrinsic to the right to sexual and reproductive health and is inextricably linked to various women's rights. Unsafe abortion is an affront to the reproductive health rights contained in the international human rights legal instruments and other consensus documents that Malawi has agreed to. Malawi has signed up to or ratified a number of regional and international human rights treaties many of which reinforce the rights to health, sexual and reproductive health, life, non-discrimination and dignity and many others that unsafe abortion tends to violate.

(*a*) *The International Covenant on Civil and Political Rights* (*ICCPR*)

Article 2 of the ICCPR[77] obliges States Parties to respect and ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the ICCPR without distinction of any kind. The rights recognized in the ICCPR include the right to life[78] and the right to privacy.[79] The Human Rights Committee[80] has recommended that—

> "*when reporting on the right to life protected by article 6, State parties ... should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions ...*"[81]

The Commission was of the view that this requirement reminds States Parties to prevent unsafe abortion through legal, health, education and other relevant mechanisms.

(*b*) *The International Covenant on Economic, Social and Cultural Rights* (*ICESCR*)

Article 12 (1) of the ICESCR[82] obliges States Parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. High maternal mortality, including deaths caused by unsafe abortion, signifies the inadequate enjoyment by women of their right to the highest attainable standard of health.[83] The ICESCR states that aspects of this right include physical and mental health.[84] The Commission noted that the Committee on Economic, Social and Cultural Rights has established that health is a fundamental human right indispensable to the exercise of other human rights, and that every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life of dignity.[85] This includes the

[77] Malawi ratified the International Covenant on Civil and Political Rights on 22 December 1993.
[78] Article 6 of the ICCPR.
[79] Article 7 of the ICCPR.
[80] It is the treaty body that monitors the implementation of the ICCPR.
[81] General Comment No. 28, Equality of rights between men and women.
[82] Malawi ratified on 22 December 1993.
[83] Kachika T., 2007. Bioethics, human rights, the law and maternal mortality in Malawi.
[84] Under article 12 (1)

enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of that right.[86] The Commission concluded that, in the case of women, the realisation of the right to health would include enjoyment of health services that allow access to safe abortion, where necessary.

Further, the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has stated that—

> "*[c]riminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's right to health and must be eliminated. These laws infringe women's right to dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, such laws consistently generate poor physical health outcomes, resulting in deaths that could have been prevented, morbidity and ill-health, as well as negative mental health outcomes, not least because affected women risk being thrust into the criminal justice system. Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health.*"[87]

(*c*) T*he Convention on the Elimination of all Forms of Discrimination Against Women* (*CEDAW*)

Article 10 of CEDAW[88] obliges States Parties to take all appropriate measures to eliminate discrimination against women in order to ensure equal rights with men in the field of education and in particular to ensure access to specific educational information on health and family planning for the well-being of families.[89] Particularly, article 12 obliges all States Parties to ensure that women have access to health care services, including those related to family planning. In addition, article 16 requires all States Parties to ensure that women have the right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and the means to enable them to exercise these rights.

The Commission acknowledged that there were several General Recommendations that have been issued by the CEDAW Committee which allude to the linkage between abortion and the provisions of CEDAW. For example, CEDAW General Recommendation No. 24 which reiterates the importance of article 12 of CEDAW on the right to health states that—

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85 Under paragraph 1 of General Comment No. 14: the right to the highest attainable standard of health (article 12 of the ICESCR)(2000), adopted by the Committee on Economic, Social and Cultural Rights on 11 May 2000, UN document E/C.12/2000/4, 11 August 2000, available in ibid p.82. Also available at http://www.ohchr.org/english/bodies/cescr/comments.htm.

86 Ibid. p. 84

87 http:daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement

88 Malawi ratified this Convention on 8 March 1987

89 Article 10(*h*)

"*It is only women that must live with the physical and emotional consequences of unwanted pregnancy. Denying women access to medical services that enable them to regulate their fertility or terminate a dangerous pregnancy amounts to refusal to provide health care that only women need*."

General Recommendation No. 24 places an obligation upon States Parties to report on measures taken to ensure access to quality health care services.

The Commission found that the CEDAW Committee had directly expressed its concern over Malawi's restrictive abortion laws through its Concluding Observations of Malawi's State Party Reports that were considered in 2006 and 2009. In 2006[90], the CEDAW Committee expressed alarm at the persistent high maternal mortality rate, particularly the number of deaths resulting from unsafe abortions, high fertility rates and inadequate family planning services, especially in rural areas, low rates of contraceptive use and lack of sex education. It urged Malawi to ensure that women's sexual and reproductive health needs are adequately addressed.

The Commission also found that in 2009, the CEDAW Committee after considering Malawi's Sixth Periodic State Party Report, [91] expressed regret that most of its 2006 recommendations were not sufficiently addressed. It called upon Malawi to review the laws relating to abortion with a view to removing the punitive provisions imposed on women who undergo an abortion, providing them with access to quality services for the management of complications arising from unsafe abortion and reducing maternal mortality rates.[92]

(*d*) *The African Charter on Human and People's Rights* (*ACHPR*)

Article 6 of the ACHPR guarantees every individual the right to liberty and to the security of his person. Article 16, in particular, guarantees individuals the right to enjoy the best attainable state of physical and mental health. The ACHPR has been made more relevant to the challenge of abortion by specifically adopting a protocol to the Charter which deals with women's rights discussed next.

(*e*) *The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa* (*Maputo Protocol*)

The Maputo Protocol[93] reiterates the rights to dignity[94], life, integrity and security of the person[95] in as far as they relate to women. It also expressly guarantees women's health and reproductive rights which include the right to control fertility, the right to decide whether to have children and the number and spacing of children and also the right to choose any method of contraception. The Protocol even goes as far as obliging States Parties to take all appropriate

[90] This is according to the Committee's Concluding Observations issued when it considered the combined second, third, fourth and fifth periodic Report for Malawi the CEDAW/C/MWI/2-5 on 19 May 2006 during the committee's 35th session.
[91] (CEDAW/C/MWI/6) at its 911th and 912th meetings, on 22 January 2009.
[92] Para 37.
[93] Malawi ratified this Protocol on 20 May 2005.
[94] Article 3 of Maputo Protocol.
[95] Article 4 of Maputo Protocol.

measures to protect the reproductive rights of women by ensuring medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother and foetus.[96]

In addition, the Maputo Plan of Action[97] seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. It was a short term plan for the period up to 2010 extended to 2015 built on the following action areas: integration of sexual and reproductive health services into primary health care, strengthening community and sexual health rights services, repositioning family planning for Millennium Development Goals, developing and promoting youth-friendly services, reducing incidence of unsafe abortion, improving access to quality safe motherhood, increasing resource mobilisation, achieving commodity security for sexual reproductive health and establishing monitoring and evaluation of the Maputo Plan of Action.

Objective 5 of the Maputo Plan of Action requires African States to reduce the incidence of unsafe abortion by taking clear actions under three strategic areas of policy and advocacy; capacity building; and service delivery.[98] To this extent, the Commission found that the Protocol is the first human rights instrument that explicitly guarantees women the right to safe abortion under specified circumstances.

Therefore, the Commission concluded that the law regulating abortion as it stands now, is inconsistent with a number of international instruments on human rights, most notably the Maputo Protocol.

(*f*) *The Legal Force of International and Regional Treaties in Malawi*

Although Malawi has signed up to various international human rights legal instruments, these are not directly enforceable in the absence of enabling legislation. Section 211 of the Constitution provides that—

> (*1*) *Any international agreement entered into after the commencement of this Constitution shall form part of the law of the Republic if so provided by or under an Act of Parliament.*
>
> (*2*) *Binding international agreements entered into before the commencement of this Constitution shall continue to bind the Republic unless otherwise provided by an Act of Parliament.*
>
> (*3*) *Customary international law, unless inconsistent with this Constitution or an Act of Parliament, shall form part of the law of the Republic*.

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96 Article 14(2)(*c*) of Maputo Protocol.

97 The African Union Plan of Action on sexual and reproductive health and rights (Maputo Plan of Action) Universal access to comprehensive sexual and reproductive health services in Africa: Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007-2010' AU Doc Sp/Min/Camh/5(I) (adopted in September 2006).

98 Ibid.

By virtue of this provision, international law only becomes applicable if it has been incorporated into the laws of Malawi through an Act of Parliament. The general position on international law in Malawi is based on the notion that national law and international law are two distinct systems of law. Thus, Malawi adopts the dualist approach to the application of international law. This approach has been reinforced by the Malawi Supreme Court of Appeal (MSCA) decision in the case of *In the Matter of the Adoption of Children Act* (*Cap. 26:01*) and *In the Matter of CJ* (*A Female Infant*)[99] Munlo CJ, (as he then was) delivering the judgement of the court had this to say—

> "*We think that the correct reading of that section is to follow the clear language that has been employed. If one does that one will find that the clear thread that runs through the fabric of all the subsections of section 211 of our Constitution is that all international agreements entered into prior to the Constitution or after the Constitution are only binding if they are not in conflict with the clear provisions of our statutes. Put differently, whether an international agreement forms part of our law, regardless of when it was entered into, will depend on whether it is consistent with our Constitution or our statutes*.
>
> *In all cases therefore the Courts will have to look at our Constitution and our statutes and see if the international agreement in question or the customary international law in question is consistent or in harmony with the law of the land and the Constitution. In doing so the Courts will try as much as possible to avoid a clash between what our laws say on the subject and what the international agreements or conventions are saying on the subject, but where this is not possible, the provisions of our Constitution and the laws made under it will carry the day. It should not come as a surprise that this is the state of the law in Malawi because, by their nature, international agreements are a product of compromise arising out of hard bargaining by high contracting parties. They involve a lot of give and take. They are also negotiated by the executive branch of the Government and not by Parliament. Our constitutional order clearly defines the role which each branch of the State has to play in the making of the laws that bind our citizens. It is the executive branch of Government that initiates policy and formulates the laws. It is also the executive branch of Government that enters into international conventions. If the executive branch of Government wishes any of the international conventions which it has freely acceded to, to have the force of law, then it should bring such conventions before Parliament, which has the Constitutional mandate to make all laws of this land. In this regard, sections 7, 8 and 9 of the Constitution are not only in tandem with what is contained in section 211 of the Constitution, but are also conclusive on the matter. We do not therefore agree with*

[99] Malawi Supreme Court of Appeal Adoption Appeal No. 28 of 2009.

counsel's submission that the intention of section 211(1) is to make any international convention which Malawi signs automatically part of the law of the country.[100]

In view of this decision, the Commission concluded that it is clear that section 211(2) cannot make international agreements that Malawi has signed to be part of the law of the land regardless of when those international agreements were signed. The Supreme Court has taken a separation of powers approach that views any attempt to directly apply international law on the basis of treaties as a usurpation of the powers of the legislature by the executive, which should be avoided at all costs.

Therefore, it was the Commission's considered view that in order for minimum standards contained in international treaties on human rights to be justiciable in Malawi, they must first be domesticated in local laws.

2.5 Basis for reform of the law

Therefore, in light of all the detailed analysis and consideration of all the information and literature on matters of unsafe abortion, the Commission resolved and agreed that the law on abortion should be liberalised (that is, conditional relaxation of the restrictions) as contrasted with decriminalisation to cater for certain justifiable instances where termination of a pregnancy should be permissible and recommends accordingly.

3.0 GROUNDS UPON WHICH TERMINATION OF PREGNANCY CAN BE ALLOWED

On the basis of its recommendation that termination of pregnancy should only be allowed in certain instances, the Commission proceeded to identify and consider the following grounds as justifying the termination of pregnancy—

(*a*) where the continued pregnancy will endanger the life of a pregnant woman;

(*b*) where the termination is necessary to prevent injury to the physical or mental health of the pregnant woman;

(*c*) where there is a severe malformation of the foetus which will affect its viability or compatibility with life; and

(*d*) where the pregnancy is as a result of rape, incest or defilement.

The Commission was aware that some laws regulating the issue of termination of pregnancy are more liberal[101] than what the Commission is

100 Counsel had submitted that the intention of section 211(1) is that any international convention which Malawi signs becomes part of our law and section 211(2) extends the effect of subsection (1) even to conventions signed before the coming into effect of the Constitution in 1994.

101 For example under section 2 of the South African Choice on Termination of Pregnancy Act termination is permitted on request in the first 12 weeks of gestation period.

proposing but still felt that the law in Malawi should allow termination of pregnancy only on these specific grounds. The Commission reached this decision after taking into account divergent views and notable society perceptions against termination of pregnancy.

The Commission then considered each ground in detail—

(*a*) *Where the continued pregnancy will endanger the life of a pregnant woman*

The Commission noted that performance of abortion is most commonly permitted to save the life of a pregnant woman. Although some laws or regulations provide detailed lists of the complications that are considered life-threatening, most of these laws or regulations do not explicitly specify life threatening complications, leaving it to the judgment of the medical personnel performing or approving the abortion. In 1996, 99 per cent of developing countries and 94 per cent of developed countries either explicitly permitted abortion to be performed when a pregnancy threatened a woman's life or allowed it under the general criminal law principle of necessity. In 2009, the equivalent figures were 97 per cent of developing countries and 96 per cent of developed countries.[102] In fact, all 54 states in the African Union recognize this as a legal ground for terminating a pregnancy[103]. The problem with this ground is that the indicators on which abortion may be lawfully undertaken are not clearly expressed in the language of the law. Misunderstanding of the law is therefore common among medical practitioners and sets the scene for clear breaches of their duties.[104] In consequence, for fear of prosecution, health care providers, especially in the public sector, interpret the law conservatively.[105] For instance, in 2008,[106] the Medical Council of Malawi took it upon itself to issue a press release informing the public and medical practitioners that abortion in Malawi is illegal, and that anyone who contravenes the law shall face necessary consequences.[107] The 2009 Strategic Assessment Report on issues related to unsafe abortion revealed that the concept of safe abortion remains largely unknown in Malawi.

Although the case of *R v Bourne*[108] established that abortion is lawful when a doctor finds in good faith that the procedure is necessary to save a patient's life, others have still advocated for the development of guidelines according to which

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102 UN: World Abortion Policies : WWW.UN.org/esa/Populaton/2011, Accessed on 25th June 2013

103 Ngwena, C. Development of Africa Abortion Laws: From the colonial era to the present day. Ipas Africa Alliance. Regional Lawyers Meeting. August, 2013

104 Cook, R.J., *Understanding Legal Grounds for Abortion*, XVII FIGO World Congress, Santiago, Chile. 2003.

105 C Ngwena, 2013; "Not Yet Uhuru: Reproductive health, and Equal Citizenship in 'Postcolonial' Africa with Special Reference to Malawi's Abortion Law." A paper presented at the Law Commission Preliminary Consultation on the Review of Laws on Abortion, Lilongwe, Malawi, 9-10 April 2013. 6-7.

106 This is according to the Malawi Shadow Report on the Implementation of the Maputo Protocol as cited in Ipas Africa Alliance/Kachika, T. (November 2009) Women's Reproductive Health in Malawi: Evaluating the Government's Practical Implemetation of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.

107 The Medical Council explained at a meeting convened by Ipas in Lilongwe in 2008 that it had issued these press releases pursuant to a legal opinion that it had sought from the Ministry of Justice.

108 [1939] 1 K.B. 687, [1938] All ER. 615.

pregnancy termination procedures can be undertaken in approved circumstances.[109] Such an approach not only allows collaborative involvement with key government institutions such as Ministry of Health and medical professional bodies, but also affords clarity to the law and spells out the necessary considerations if the procedure is to be performed. It has been argued that lack of guidelines in the implementation of the law in Malawi has acted as a barrier to the provision of safe abortion care services to qualifying and deserving cases for the reason that some practitioners do not know what to do and are therefore inclined to refuse providing the service.

Countries such as Ethiopia, Ghana and Zambia have issued guidelines for the implementation of the law relating to termination of pregnancy. The guidelines include the people or officers responsible for making decisions at various stages of the pregnancy and the methods to be employed.

The Commission therefore recommends that the Ministry of Health should develop guidelines that will ensure that objective assessments are made in order for the service to be provided to a pregnant woman based on the proposed grounds.

Under section 243 of the Penal Code, the law exonerates a medical practitioner from criminal responsibility if, through a surgical operation, he terminates a pregnancy in order to preserve the mother's life[110] (emphasis supplied). In essence, it means only those procedures that require a surgical operation are legal. The use of medicines is excluded from the law and therefore illegal. However, medical science confirms that medical abortions through normal administration of drugs are possible during the first trimester of the pregnancy and are in fact the safest.[111]

The Commission therefore recommends that section 243 of the Penal Code be modified so that a medical officer who is of the opinion that a pregnancy threatens the life of the mother should be able to terminate the pregnancy through any safest means possible.

(*b*) *Where the termination is necessary to prevent injury to the physical or mental health of the pregnant woman*

In the majority of countries, abortion is permitted when it is necessary to preserve the physical health of a pregnant woman. Just as in the case of life threatening situations, there is a lack of clear interpretation for this ground as well, resulting in a disservice to both women entitled to obtain lawful procedures and health care providers willing to undertake such procedures when necessary to protect a woman' physical health. Such a state of affairs is prejudicial to women not accustomed to the pursuit of their legal rights especially women who are poor, young, or inhabitants of family and social environments that require women to be

109 Cook, R.J. supra.
110 Section 243 of the Penal Code.
111 Gemechu, A Protocol for Comprehensive Abortion Care. May 2013.

passive, silent and dependent.[112] In 2009, 88 per cent of developed countries permitted abortion to preserve the physical health of a pregnant woman, compared to 60 per cent of developing countries. The equivalent figures in 1996 were 87 percent and 54 per cent, respectively.[113]

The Commission noted that there is no universally agreed definition of the term "physical health". In some countries, the definition is narrow in the sense that exhaustive lists of conditions or situations threatening physical health are explicitly provided for in legislation. In other countries, "physical health" is broadly defined, allowing room for interpretation that is contextual and based on the circumstances of each case. The court, in the case of *R v Bourne*,[114] when interpreting the words "preserving the life of the pregnant woman" acknowledged that there is no clear line of distinction between danger to health and danger to life. The court was of the view that the words "preserving the life of the mother" need to be construed in a reasonable sense, and if the doctor is of the 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, the doctor who under those circumstances and in that earnest belief, is operating for the purpose of "preserving the life of the mother". With this interpretation the Commission concluded that preservation of life cannot be isolated from harm to physical or mental health since life depends on health, and it may be that health is so gravely impaired that death results.

With regard to preservation of mental health, the Commission noted that many countries allow abortion in cases involving a threat to the mental health of a pregnant woman. As in the case of "physical health", the definition of what constitutes a threat to "mental health" varies. The WHO defines mental health as including subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self actualization of one's intellectual and emotional potential.[115] In some countries, the laws or regulations do not specify whether the term "health" encompasses both physical and mental health, but merely state that an abortion is permitted when it averts the risk of injury to a woman's health. In such cases, it has been stated that the laws and regulations encompass both threats to physical and mental health as grounds for termination of pregnancy.

Many countries such as Algeria, Botswana, Gambia, Ghana, Liberia, Namibia, Seychelles, Sierra Leone and Swaziland[116] have explicitly provided for danger to mental health as a ground for terminating a pregnancy. Mental health, as a ground for terminating a pregnancy also entails that certain conditions be satisfied before a procedure to terminate a pregnancy is carried out. For example, Cook (2003) states that assessing the danger to mental health might require a

112 Cook,R.J. supra pg 3.
113 UN : World Abortion policies: *Ibid.*
114 [1939] 1 K.B. 687, [1938] All ER. 615.
115 WHO Safe Abortion: Technical and Policy Guidance for Health Systems 2012.
116 Ibid.

psychiatric prognosis or assessment of a psychologist, social worker or a professional experienced in that area.[117] In other countries such as Ghana, such psychiatric assessment is required.

Thus, the Commission is of the view that implementation guidelines should provide for the requirement of psychiatric assessment. The Commission acknowledged that there is then need to draw a clear line on conditions that tend to affect mental health as this poses the danger of including grounds that are socioeconomic in nature. For example, in Zambia, mental health has been interpreted to include the pregnant woman's present and future social and economic circumstances that could result from the birth of the child[118]. The Commission resolved that mental health as a ground for termination of pregnancy shall not include socio-economic reasons for fear that when implementing the law it could be interpreted as providing for abortion on demand.

Despite the finding that preservation of life and physical or mental health cannot be easily separated, nevertheless the Commission recommends that preservation of physical or mental health should be a stand alone ground for termination of pregnancy. Further, the Commission recommends that when developing provisions of the proposed law and implementation guidelines caution must be taken so as not to include socio-economic grounds. Furthermore, the Commission recommends that a pregnant woman with mental disability or disorder qualifies under this ground.

(*c*) *Where there is severe malformation of the foetus which will affect its viability or compatibility with life*

Abortion is often permitted when the foetus suffers from some kind of serious impairment. Some countries such as Mauritius have provided for a requirement under the law that the malformation should be that which would affect the foetus' viability and compatibility with life.[119] Normally, the requirement specifies the type and level of impairment necessary to justify an abortion. The need to specify the type and level of impairment dispels the belief that this ground could be targeting children to be born with disabilities. In 1996, 81 per cent of developed countries and 28 percent of developing countries permitted abortion because of foetal impairment. In 2009, 84 percent and 34 percent of developed and developing countries did so respectively. [120]

In Africa, the following countries have provided for foetal malformation and abnormality as a ground for termination of pregnancy: Benin, Botswana, Burkina Faso, Chad, Ethiopia, Ghana, Guinea, Lesotho, Liberia, Namibia, Niger, Seychelles, Swaziland, Togo and Zimbabwe.[121] Further, consultations carried out by the Commission revealed that most stakeholders were in agreement with the proposed law providing for severe foetal malformation and abnormality as a ground for termination of pregnancy.

117 Understanding legal grounds for abortion. *Op cit*, p.7.
118 Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia. P.7.
119 Section 235A of the Criminal Code (Amendment) Act 2012 of Mauritius.
120 UN World Abortion Policies: *Op cit.*
121 Ngwena, C. *Op.cit.*

Consequently, the Commission recommends that severe foetal malformation and abnormality should be a ground for termination of pregnancy.

(*d*) *Where the pregnancy is as a result of rape, incest or defilement*

Many countries, including those with restrictive laws on abortion, allow abortion in cases of rape or incest, but such grounds for abortion are less common among developing countries than among developed countries. In some countries, the law refers to cases in which the pregnancy is the result of "a criminal offence", without specifying the nature of the offence. Yet, in other countries, the law permits abortion only if the woman who is a victim of rape is also mentally impaired. In 2009, 84 per cent of developed countries and 37 per cent of developing countries permitted abortion in cases of rape or incest, up from 81 per cent and 30 per cent, respectively, in 1996.[122] Countries that have recognized rape and incest as a ground for terminating a pregnancy include: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Ethiopia, Eritrea, Ghana, Guinea, Lesotho, Liberia, Mali, Namibia, Rwanda, Seychelles, Sudan, Swaziland, Togo and Zimbabwe.[123]

During consultations, stakeholders were of the view that termination of pregnancy in cases of rape, incest or defilement should be allowed where the victim wishes to do so. People bemoaned the practice of grown up men having sexual relations with minors and sometimes with women or young girls who are within the prohibited degrees of consanguinity. It was therefore the general view that pregnancies arising from such incestuous relationships or those carried by minors may be terminated if the pregnant woman wishes to do so. The reasons behind this are that children born from incestuous relationship are likely to have genetic disorders; and for minors, the bodies of these young women are not yet mature enough for childbearing and further, the pregnancy has the implication of affecting their education. These concerns were registered by almost all groups that the Commission consulted.

The Commission was informed that in cases of rape, victims are normally provided with emergency contraceptives within 72 hours to prevent a pregnancy. Nonetheless, the Commission also acknowledged that many cases of rape or indeed sexual offences in general, go unreported and are only reported when a woman realises that she is pregnant, which is a period long after the effective use of the emergency contraceptive.

The Commission noted and considered all the concerns regarding this ground and found them to be well-grounded. Therefore, the Commission recommends that women who fall pregnant as a result of sexual offences such as rape, incest or defilement should be permitted to access safe abortion services.

The Commission therefore recommends the adoption of the following provision as grounds for termination of pregnancy—

122 UN: World Abortion Policies: *Op cit.*
123 Ngwena, C. *Op.cit.*

Grounds for terminations of pregnanancy

... (1) Subject to section...[124], termination of a pregnancy may be performed by a certified health service provider where he is of the opinion, in good faith, that—

(*a*) the continued pregnancy will endanger the life of a pregnant woman;

(b) the termination of pregnancy is necessary to prevent injury to the physical or mental health of a pregnant woman;

(*c*) the foetus is severely malformed so that its viability or compatibility with life is affected; or

(*d*) the pregnancy is a result of rape, incest or defilement:

Provided that the incident of rape, incest or defilement is reported to Police, and that the pregnancy does not exceed sixteen (16) weeks from the date of conception.

(2) In forming the opinion under subsection 1(*b*), the certified health service provider shall not take into account socio-economic reasons.

4.0 GROUNDS UPON WHICH TERMINATION OF PREGNANCY IS NOT ALLOWED

(*a*) *Abortion on demand*

The Commission established that abortion on demand is a concept that is promoted by pro-choice health advocates, that it is the right of a pregnant woman to have an abortion performed on her demand. The right may be limited by time of gestation or it may pertain to any period of gestation. For example, the law in South Africa allows abortion on demand during the first twelve weeks of gestation period. In countries that allow abortion on request, a woman seeking an abortion is generally not required to give reasons for procuring an abortion. However, in some countries, a woman may be required to state that she is in a situation of crisis or distress. If an abortion can be authorized on request, it means that it can be performed on any ground even if the law does not explicitly mention such grounds. In 1996, 57 percent of the developed countries and 16 percent of 30 developing countries permitted abortion on request. In 2009, the equivalent figures were 69 per cent and 16 per cent, respectively[125].

The Commission holds the view that providing for abortion on demand would not be in accordance with Malawi's moral values and aspirations. This was the general view of participants during the district and regional consultations that

[124] Section on Authorised Service Providers.
[125] UN World Abortion Policies: *Op cit.*

the Commission conducted although some commentators were in favour of abortion on demand. Those proposing for abortion on demand argued that women should be left to make a choice about their reproductive lives and that the danger of refusing them access to safe abortion is that these women end up doing it anyway, once they have made up their minds, through unsafe means. Nevertheless, the Commission felt that allowing abortion on demand would not be the best solution to the problem of unintended and teenage pregnancies. The Commission rejects this ground and advocates for family planning, including the use of condoms that have a dual effect of preventing pregnancies and offering protection against sexually transmitted infections. For these reasons, the Commission was therefore against providing for abortion on demand as a ground for terminating a pregnancy.

(*b*) *Socio-economic reasons*

The laws and regulations permitting abortion on social or economic grounds vary widely. Some of these laws specifically provide for socio-economic conditions while others only imply them. Most laws that permit abortion on social or economic grounds are interpreted quite liberally and, in practice, differ little from laws that allow abortion on request. For example, in Zambia, the law provides that termination of pregnancy is allowed where there is a risk of injury to the physical or mental health of any existing children of the pregnant woman. In 1996, 74 per cent of developed countries and 17 per cent of developing countries had laws permitting abortion on economic or social grounds as compared to 80 per cent and 19 per cent, respectively, in 2009.[126]

The Commission was of the view that seeking abortion on these grounds will be tantamount to using abortion as a family planning method and this would be against the Sexual Reproductive Health and Rights Policy which clearly states that abortion shall not be used as a family planning method.[127] Rather, the Commission suggests that there should be other social interventions to support the pregnant woman to live a life of love and hope. There should be more civic education on family planning to promote its use and dispel any myths surrounding its acceptance. For these reasons, the Commission was therefore against providing for socio-economic reasons as a ground for terminating a pregnancy and the Commission recommends accordingly.

(*c*) *Contraceptive failure*

During consultations carried out by the Commission, some stakeholders suggested that a woman who falls pregnant as a result of contraceptive failure should be allowed to procure an abortion. However, the rate of such failure is low and many times it is difficult to apportion blame for that failure, that is, whether it was due to the medication itself or the woman's failure to follow instructions or dosages. The Commission was informed that before a person is introduced to

[126] UN World Abortion Policies : *Op cit.*
[127] P.8

contraceptives, there is always a disclaimer given that such methods are not 100 per cent effective, and when a woman falls pregnant, people should just accept that there was always such a risk and should not proceed to seek abortion services. In view of these reasons, the Commission found it inappropriate to provide for contraceptive failure as a ground for termination of pregnancy and recommends that it should not form part of the proposed law. Therefore, for the avoidance of doubt and to make it clear that safe abortion services shall not be available on demand or request, the Commission recommends the adoption of the following provision—

.... Except as provided in this section[128], termination of pregnancy shall not be performed on demand or for any other reason.

5.0 DELIVERY OF SERVICES IN ABORTION CARE/PROVISION OF SAFE ABORTION CARE SERVICES

In order to ensure effective and efficient implementation of the proposed law on abortion, the Commission considered issues of gestational age; service providers and their powers; and the place where the abortion service would be carried out as very critical.

5.1 Gestational age

The Commission noted that effective implementation of the law on abortion would only be achieved if appropriate guidance is provided on issues of gestational age, among others. The Commission engaged in a lengthy debate over what should be the gestational age of a pregnancy that could be terminated under the stipulated grounds.

The WHO defines gestational age of pregnancy as the number of days or weeks since the first day of the woman's last normal menstrual period (LNMP) in women with regular cycles. For women with irregular cycles, the gestational age may need to be determined by other means such as urine test, blood test or ultrasound examination.[129] Pregnancy is divided into three periods referred to as trimesters. The first thirteen weeks or three months of pregnancy is referred to as the first trimester. The next thirteen weeks is the second trimester, and the next thirteen weeks is the third trimester.

In order to determine the appropriate gestational age for the provision of safe abortion care in Malawi, the Commission considered legislation on abortion from other jurisdictions. In Tunisia,[130] the law provides for termination of pregnancy on request during the first trimester of the pregnancy. After this period, a termination may be performed where there is a risk that the health or mental balance of the mother will be compromised by the continuance of the pregnancy,

128 This is the section that provides for legal grounds for termination of pregnancy including that of rape, incest or defilement upon the request of the pregnant woman within a gestational age of 16 weeks.

129 According to WHO Safe Abortion: Technical and Policy Guidance for Health Systems p.iv on definitions used in the documents.

130 Article 214 of Tunisia Penal Code of 1973.

or a risk that the unborn child will suffer from a serious disease or infirmity.

South Africa employs a three-pronged approach to termination of pregnancy, with different requirements for terminations performed in different stages of pregnancy. First, a pregnancy may be terminated upon request of a woman during the first 12 weeks of the gestation period of her pregnancy.[131]

Second, a pregnancy may be terminated from the 13th week up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that specified grounds for termination of a pregnancy at this stage are met.[132] Third, a pregnancy may be terminated after the 20th week of the gestation period if the pregnancy puts the woman's life at risk or in case of foetal abnormality. However, a second opinion from either a midwife or another medical practitioner is required.[133]

Ethiopia has dealt with the issue of gestational age in the Technical Guidelines which provide that termination of pregnancy of less than 12 weeks of gestation from the first day of the LNMP can be performed by all health facilities that have skilled personnel, equipment and supplies.[134] Termination of pregnancy is also allowed between 13 and 28 weeks of gestation on condition that it should be done in a secondary or tertiary level of care.[135]

In Zambia, the gestational age has also been dealt with in the Standards and Guidelines, where termination of pregnancy is allowed from less than 12 weeks up to the third trimester.[136]

Hence, there are minimal requirements for termination of pregnancy during the first and second trimesters. However, termination of pregnancy in the third trimester may only be done where it is necessary to save the life of a pregnant woman.

The Commission found that in most countries there is no specific cut off period for termination of pregnancy. However, in some countries such as South Africa and Tunisia there are no restrictions on termination of pregnancies that are less than 12 weeks but as the pregnancy advances restrictions are imposed. In some cases, restrictions relate to places where the service could be provided, as is the case with Ethiopia, where the requirement is that termination of pregnancy between 13 and 28 weeks of gestation should be done at secondary or tertiary level of care.

The Commission also found that the WHO has placed as a minimum the gestational age for termination of pregnancy at 28 completed weeks of pregnancy.[137] The United Kingdom permits abortion before 24 completed weeks

[131] According to Article 2 (1) (*a*) of the Choice on Termination of Pregnancy Act of 1996.
[132] Ibid. Article 2 (1) (*b*) of the Act.
[133] Ibid, Article 2(1) (*c*) of the Act.
[134] Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia (2006).
[135] Ibid.
[136] Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia pp. 15 to 20
[137] The WHO Safe Abortion: technical and policy guidance for health systems.

of pregnancy. Further, in the United Kingdom abortion is performed after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth. In some states in the United States of America where abortion is legal, it is permitted before 20 completed weeks of pregnancy.

In order to determine the appropriate gestational age for Malawi, the Commission considered the issue of "quickening" which is defined as the first motion of the foetus felt by the mother occurring usually about the middle of the pregnancy.[138] The Commission learnt that quickening starts between 16 and 18 weeks of pregnancy. As such, it observed that at this stage, bonding with the mother starts and abortion at this stage would sometimes result in emotional problems. It is noted that shortly after quickening has been experienced and with improving medical care, a small number of foetuses are surviving outside the womb.

Malawi, being one of the least developed countries, experiences challenges in its health care sector in terms of human resource and medical equipment. As such, prescribing a gestational age that is very high would be tantamount to setting an over ambitious goal that would be difficult to achieve. The Commission therefore concluded that the gestational age for terminating a pregnancy should be 16 weeks. However, this restriction only applies to pregnant women seeking termination of pregnancy on the grounds of rape, incest and defilement. In relation to the other grounds of preserving life, physical or mental health and foetal malformation, it was the view of the Commission that conditions necessitating termination of pregnancy under these grounds may occur or be detected at any stage of the pregnancy. For victims of rape, incest and defilement, in addition to the argument regarding quickening, the Commission felt that sixteen weeks is enough time for the pregnant woman to make a decision of whether or not to terminate the pregnancy.

5.2 Service Providers and their Powers

The Commission acknowledged that just like other health services, the provision of safe abortion care requires properly equipped facilities and well trained health care providers. Public health authorities have the responsibility to ensure that systems are in place for continuous and timely procurement and distribution of all medical equipment, medicines, contraceptives and medical supplies necessary for the safe delivery of services. In addition, health care providers require appropriate pre-service and in-service training, which should be based on routinely updated guidelines for safe abortion care.

Health facilities where legal terminations of pregnancy may take place must be well prepared and equipped for the provision of safe termination of pregnancy care. In as much as it is important to train providers for introducing new services, it is equally important to make sure that supportive services such as procuring commodities, logistical supply chain are functional and financial mechanisms are

138 The Black's Law Dictionary (6th Ed.)

put in place. As regards essential equipment, medicines and medical supplies, the Commission noted that most of the equipment, medication and supplies needed to provide vacuum aspiration (manual and electric) and medical methods of termination of pregnancy are the same as those needed for other gynaecological services. The WHO technical guidelines state that in settings where manual vacuum aspiration instruments are not approved, efforts should be made to add them to the government's standard equipment list.[139]

Therefore, all medical care equipment for the delivery of comprehensive abortion care must be on the list of essential medicines and basic medical equipment. The Commission observed that inclusion on the national essential medicine list usually means that the drug is registered and available in the country.

The Commission holds the view that effective implementation of safe abortion care may require in some cases registering particular medicines and importing medicine and medical equipment. The Commission therefore makes a policy recommendation to the Ministry of Health to include medicine used in the provision of safe abortion services among the national essential drugs list.

The Commission observed that making safe, legal abortion services available to all eligible women requires training of midlevel health care professionals such as nurses and midwives and expanding their role to include provision of comprehensive abortion services such as uterine evacuation using manual vacuum aspiration and medical abortion. Manual vacuum aspiration is already widely used in the management of incomplete abortion care and training to adapt it for induced abortion would be easy. All such health care providers can also be trained to provide medical abortion.

(*a*) *Healthcare provider skills and training*

As regards who could be mandated to provide the abortion service, the Commission considered what is obtainable in other jurisdictions. In Ethiopia, the following health workers are authorised to perform abortion procedures for the first trimester pregnancy using medical abortion: clinical nurses, midwives; health officers, general medical practitioners and specialists in obstetrics and gynaecology.[140] General medical practitioners and health officers with additional training in the specific skills needed for second-trimester abortion and specialists in obstetrics and gynaecology are authorised to perform second trimester abortion procedures.[141]

In South Africa, first trimester abortion may be carried out by a registered midwife who has completed the prescribed training course while abortion in the second trimester may only be carried out by a medical practitioner.[142] Thus, midwives, health officers, and general medical practitioners as well as

[139] The WHO Safe Abortion: technical and policy guidance for health systems p. 71
[140] Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia of June 2006.
[141] Ibid. p. 26.
[142] Section 2 (2) of the Choice on Termination of Pregnancy Act No. 92 of 1996.

gynaecologists provide abortion services in other jurisdictions. Where the health officer's initial training lacks the required minimum skills for providing abortion service, such officers undergo additional training on the specific skills needed to carry out an abortion before they could be allowed to offer the service.

The Commission learnt that there are about three thousand eight hundred and eighty-nine (3889) registered nurses or midwives in Malawi.[143] In terms of training, registered nurses or midwives possess a Master's Degree or Bachelor of Science Degree or a University Diploma. They belong to Level I under the cadres of nursing and midwives. Nurses/midwives provide a range of individualised culturally sensitive post abortion care services for women experiencing pregnancy termination or loss in accordance with established national protocols. These nurses or midwives perform nursing and midwifery functions ranging from dependent, independent and interdependent functions. Independent functions are those nursing or midwifery activities that are carried out alone without the help, opinion and advice from other members of the health care team. Nurses or midwives provide interventions based on the nursing and midwifery process which includes the following steps: assessment; diagnoses; planning; implementation; and evaluation. This category of nurses follows all these processes when carrying out both independent and interdependent functions.

As for clinical procedures, the Commission also learnt that Level I nurses or midwives perform vacuum extraction, manual vacuum aspiration and voluntary male circumcision, among others. The latter two functions are learnt through on job training because the curriculum then did not contain issues of manual vacuum aspiration and male circumcision. However, these issues have now been specifically incorporated in the curriculum. Consequently, Level I nurses or midwives would be able to carry out an abortion procedure for a pregnancy that is less than 12 weeks old.

The Commission also learnt that there are currently about seven thousand eight hundred and eighty-four (7884) nurse midwifery technicians who possess a College Diploma and are in Level II cadre of nurses and midwives[144] the majority of whom are managing primary health centres. Level II nurses are currently performing manual vacuum aspiration for post abortion care and making prescriptions on their own because they have acquired these skills on the job.

Thus, requiring them to offer abortion care services would entail providing additional training on the specific skills needed to carry out an abortion before they could be allowed to offer the service.

The Commission was also informed by the Medical Council of Malawi,[145] that medical assistants' training does not incorporate provision of abortion care service. The scope of practice of this cadre does not allow them to carry out

[143] Representative of the Nurses and Midwives Council who made a presentation before members of the special Law Commission on 30th April, 2014.
[144] Supra.
[145] The Commission invited the Medical Council of Malawi to make a presentation to members of the special Law Commission on the 30th April, 2014.

surgical operations but they could be trained to provide medical abortion services. Clinical officers have the skills not only to provide medical abortion but also surgical abortion in the form of manual vacuum aspiration and dilatation and curettage where products of conception have been retained in the uterus after medical abortion.

In view of the fact that not all health service providers are adequately qualified to provide safe abortion care, the Commission found it necessary to provide for safeguards in the provision of abortion care to ensure quality of service. The Commission critically considered who should be mandated to provide the service and under what conditions. The Commission observed that nurse or midwifery technicians and medical assistants may not have the skills to confirm the age of pregnancy and recognise complications of an abortion, such as excessive uterine bleeding and presence of retained products of conception in the womb, thereby endangering clients' lives. Nevertheless, the Commission, acknowledged the shortage of health workers in the country and that leaving out this cadre of health workers may act as a barrier to provision of the service. The Commission also noted the representations made by the Medical Council of Malawi that even such low level of health providers can provide the service if they are appropriately trained.[146]

It was therefore the view of the Commission that medical abortion in the first trimester may even be provided by medical assistants or nurse technicians after appropriate training. Where clinical officer and doctor support is available, midwives may be trained to also provide manual vacuum aspiration to remove retained products of conception in the womb.

Thus, the Commission recommends that termination of pregnancy of less than 12 weeks should be conducted by all health professionals that have been certified to undertake the termination of pregnancy service. As for termination of pregnancy of 12 weeks to 14 weeks, medical assistants, and nurse technicians should be excluded from providing the service, whereas termination of pregnancy of 14 weeks and above, only certified medical doctors can perform the procedure. The Commission was also of the view that in order for abortion service providers to discharge their responsibilities competently, they should acquire basic knowledge and skills during their pre-service training and get periodic updates through on-the-job training. Government, in collaboration with health professional regulatory authorities, need to ensure that content of the curriculum address knowledge, attitude and practical aspects of abortion care. The WHO technical guidelines recommend that value verification exercises that help providers to distinguish between their own values and their clients' right to safe reproductive health services are an essential component of all training programs.[147] Selection of training sites should also take into consideration the volume of patients so that providers could get the opportunity of acquiring adequate skills for managing abortion and its complications.[148]

146 Ibid
147 According to WHO Safe Abortion: technical and policy guidance for health systems of 2012 at p.72.
148 Ibid.

(*b*) *Health Worker Attitude and Beliefs*

The Commission observed that providing the rationale for safe abortion services to health service providers plays an important role for accessibility of safe abortion services. Considering that providers' objectivity is sometimes affected by negative and predefined beliefs about abortion, these beliefs often times influence professional judgement and have negative impact on the quality of service. The Commission found it necessary that the legal, regulatory and policy provisions be explained to abortion service providers to ensure effective implementation of the proposed law on abortion. Issues concerning health effects of unsafe abortion; ethical responsibility to provide abortion or to refer women when the health care professional has conscientious objection also need to be well elaborated as well as the ethical responsibility to treat complications from unsafe abortion. The Commission noted that value clarification is an essential component of safe abortion services. Therefore, the Commission recommends that this aspect be included in the training package. This is to ensure that service providers have the requisite attitude for assisting the client who needs and qualifies for accessing the abortion service within the existing legal framework and managing those that do not qualify accordingly.

The Commission also noted that there could be instances where a woman qualifies for the abortion service on the proposed grounds but is refused access to abortion by a health service provider. This could either be from a decision by a health officer, made in good faith, that the condition of the patient does not qualify her for termination of pregnancy on the available grounds or instances where some people deliberately obstruct the woman from accessing the legal termination of her pregnancy. The first scenario would require an internal grievance handling procedure where the pregnant woman should be able to lodge a complaint against the decision, in a timely manner, before a panel of other practitioners. It has been proposed within the public health sector that there is need to establish an administrative framework within each health facility where possible or under the domain in which the health facility falls where clients can lodge complaints. The Commission considered this to be a good arrangement and recommends the adoption of such a scheme that would facilitate appeals for women aggrieved with the decision denying them an abortion service.

With regard to those who wilfully obstruct qualifying women under the proposed grounds to access legal termination of pregnancy, the Commission is of the view that such acts should amount to a criminal offence as that has a potential of pushing women to resort to unsafe means of terminating a pregnancy and recommends accordingly. The relevant provision for this offence has been provided in this Report under the section dealing with offences.

Therefore, with regard to service providers, the Commission recommends the adoption of the following provisions—

Service providers

..... (1) Termination of pregnancy shall only be performed by a certified health service provider.

(2) Subject to subsection (1), termination of pregnancy shall only be carried out by—

(*a*) a medical assistant, nurse midwifery technician, registered nurse and midwife where the pregnancy does not exceed twelve (12) weeks of gestation;

(*b*) a clinical officer, where the pregnancy does not exceed fourteen (14) weeks of gestation; or

(*c*) except as provided in section ....[149] , a medical doctor, at any age of gestation.

With regard to grievance handling procedure, the Commission proposes the adoption of the following provisions—

Grievance handling procedure

..... (1) A woman seeking services to terminate a pregnancy may lodge a complaint against a decision refusing her access to a legal termination of pregnancy or in relation to the broader termination of pregnancy services.

(2) Every health facility authorised to provide termination of pregnancy under this Act, shall set up a complaints handling committee to hear complaints on termination of pregnancy related services.

(3) The complaints handling committee shall consist of a health service provider not below the rank of clinical officer who shall be the Chairperson and two other members of the medical team at the health facility.

(4) Where a complaints handling committee is not available or cannot be properly constituted at a health facility, a person may lodge a complaint at the nearest health facility where such complaints handling committee is available.

(5) Where a complaint has been lodged under subsection (1) that complaint shall be heard and determined within thirty (30) days from the date it was lodged.

5.3. Counselling

Counselling in abortion care service is an umbrella term which includes: advice, information, support, education and therapy. It is intended to offer the woman a non-judgemental opportunity to work through her feelings. The main

[149] Section 3 (1) (*d*) in draft Bill

purpose is to enable the person concerned to understand the implications of the proposed course of action. Since many women feel uncomfortable or unable to talk with friends and relatives, professional counselling offers a valuable and much needed resource. For some women, the experience of unplanned pregnancy and subsequent abortion may be highly traumatic. Hence, feelings of grief, guilt, shame, depression and anxiety need to be handled by a highly trained and skilled counsellor. Appropriate counselling also has the effect of minimizing the risk of long term psychological problems or harm.

Further, counselling is also important in circumstances where a woman is considering an abortion after a planned pregnancy. Even when a pregnancy has been welcomed, it can be a shock to be told that there are problems with the pregnancy or that the health of the unborn child is likely to be affected in some way. In such scenarios, a woman may face the emotional decision about whether or not to abort. Thus, genetic or pregnancy counselling should be available to support patients in making their decision. The Commission identified three crucial counselling interventions necessary in the abortion process so that every woman should have the right to decide for herself how to deal with the situation, namely: pre-abortion counselling; post-abortion supportive counselling; and family planning counselling.

(*a*) *Pre-abortion counselling*

Pre-abortion counselling just like all other types of counselling should be a face-to-face communication where a counsellor should assist the woman seeking an abortion to make her own decision. Counselling should support the woman to make a free and fully informed decision about her pregnancy options. It includes offering information about alternatives, including keeping the baby or giving up the baby for adoption in situations where the woman has not yet made up her mind. Generally, if the woman feels she has made the right decision, she will rarely require follow-up counselling. Thus, counselling at this stage should aim at providing the woman with sufficient and accurate information on the comparative risks of carrying the pregnancy to term or terminating the pregnancy and on the potential risks associated with the methods of pregnancy termination.

A comparative study [150] has revealed that the information and counselling provided to women requesting safe termination of pregnancy must include a minimum of the following options: counselling that should include information on continuing or termination of the pregnancy; available methods of pregnancy termination and pain control medication (including the advantages and disadvantages of each); what will be done during and after the procedure; possible short and long-term risks associated with the methods of termination of pregnancy; when to expect resumptions of menses; and follow-up care. The information must also be clear, objective, and non-coercive, and should be provided in a language understandable to the woman. The information should be supplemented with written materials if possible. Therefore, counsellors must

[150] The Commission conducted a comparative study visit to Ethiopia from 20th to 24th October, 2014.

refrain from imposing their views and beliefs on the women they counsel and must hold all information confidential. Women who need more time to reach a decision should be free to delay the procedure and be provided with further counselling if necessary.

(*b*) *Post-abortion supportive counselling*

The Commission observed that counselling may be supportive with the aim of providing emotional support at times of particular stress. It may also be therapeutic to help people deal with consequences of their decision and to help resolve problems that may arise as a result of their decision.

Supportive counselling is the provision of psychosocial support. Women who have had an abortion may need help in handling the emotional and psychological response that may follow an abortion procedure noting that some women may be worried or anxious about how they will be treated by their family, friends or the community after they recover from an abortion. After abortion, women who may require additional emotional support or whose mental health is perceived to be at risk may be referred to appropriate service providers.

The Commission therefore found that post abortion counselling should, as a minimum, include information about the physical symptoms that may be experienced; a range of emotional responses that may be experienced during and following an abortion; risk of infection of varying degrees of severity that may occur after medical or surgical abortion and its management; symptoms women may experience, especially those which would necessitate an urgent medical consultation; and symptoms suggestive of continuing pregnancy.

(*c*) *Family planning counselling*

The Commission noted that induced abortion whether occurring in an unsafe or in accordance with legal requirements may sometimes indicate the desire to avoid or postpone childbearing. For this reason, it is important that all facilities, whether providing emergency care or elective abortion, offer family planning counselling and services. Where it is impossible to provide family planning services in conjunction with abortion care, women should be counselled and referred to a nearby family planning services delivery point. However, the Commission was of the view that provision of emergency abortion care or elective abortion care procedures on the proposed grounds must not be made conditional on the acceptance of family planning in general or of a specific method of contraception. Counselling services must, therefore, take into account the fact that women need information on a wide range of contraceptive methods in order to make their own selection.

During the study visit to Ethiopia, the Commission learnt that family planning counselling has been provided as one component of the abortion care services such that there was evidence that many women were able to choose family planning methods of their choice and were able to prevent unwanted

pregnancies. The Commission also learnt that contraceptive prevalence rate increased after liberalising the law on abortion. Thus, the Commission found counselling for all methods of contraception, immediately after abortion crucial to the provision of abortion care services.

In view of the foregoing, the Commission, after considering the important role that counselling plays in the provision of abortion care services, recommends that mandatory pre-abortion, post-abortion and family planning counselling services be included in the provision of abortion care services. The Commission took cognisance of the fact that the introduction of HIV counselling and testing initiative adopted a similar approach and it is now working very well. Considering that there might be few health professionals who may be qualified to provide counselling in this area, abortion training programmes should have a component of counselling so as to ensure that health personnel offering abortion care services acquire the requisite knowledge and skills in the provision of abortion care counselling. The Commission recommends the adoption of the following provisions—

Mandatory counselling

.....**(1) A certified health service provider shall, as part of the service to terminate a pregnancy, provide counselling to a pregnant woman before and after the termination of the pregnancy, including counselling on family planning.**

(2) The counselling shall include—

(*a*) information on options of continuing or terminating the pregnancy;

(*b*) available methods for termination of pregnancy;

(*c*) possible short and long-term effects associated with each method of termination of pregnancy;

(*d*) emotional and psychological responses following termination of pregnancy; and

(*e*) information about prevention of future unintended pregnancies through use of various family planning methods.

5.4 Service Delivery Points

The Commission observed that the issue of place of service is related to the availability of trained service providers at every level of health care. The more advanced the pregnancy, the more skills are required to terminate it and the higher the risks of complications occurring from the procedure. In Malawi, most rural primary health centres are managed by less skilled service providers who may not have the capacity to offer advanced abortion care services.

The Commission noted that the prevention of abortion related maternal mortality is dependent on abortion care services being integrated throughout the health care system of the country, from the most basic rural health post to the most sophisticated tertiary level facility. Thus, in countries like Ethiopia, abortion care is offered at each and every level of health care where the following abortion care services are offered: recognition of signs of pregnancy; recognition of signs and symptoms of abortion and its complications; provision of reproductive health education, including family planning and the risks of unsafe abortion; distribution of appropriate contraceptives, including emergency contraceptives; informing communities and women on the legal provisions for safe abortion; and referral of women to post abortion and safe abortion care services.[151] In addition, they provide counselling; general physical and pelvic examination; vacuum aspiration up to 12 completed weeks of pregnancy; medical abortion up to nine completed weeks; administration of antibiotics and intravenous fluids; and training at community level.

District or zonal hospitals have health personnel such as those found at health centres and General Medical Practitioners, with or without an obstetrician-gynaecologist. These perform, among others, uterine evacuation for second trimester abortion; treatment of most complications; diagnosis and referral for serious complications such as peritonitis and renal failure; and training of all cadres of health professionals (pre-and-in service). The referral hospitals have obstetrician-gynaecologists who perform additional activities such as treatment of severe complications. The Commission further learnt that both public and private facilities provide safe abortion care services according to their level of care.

The Commission further noted that in South Africa, the law limits the provision of surgical termination of pregnancy services to facilities that are designated by the Minister by notice published in the *Gazette*.[152] The Minister is mandated to designate any facility for surgical termination of pregnancy and may impose such conditions and requirements as he or she may consider necessary or expedient.[153] The Minister has power to withdraw any such designation upon giving fourteen days prior notice of withdrawal in the *Gazette.*[154]

The Commission also considered views expressed during consultations that provision of abortion services should only be provided in public facilities for easy monitoring by Government. The Commission found the views expressed by stakeholders reasonable to a certain extent considering that Malawians have divergent views on the issue of abortion. However, the Commission still recognises the important role that private health institutions play in the delivery of health services in Malawi. It would therefore be inappropriate to restrict the provision of abortion services to public institutions only. The Commission was of the view that, as long as any health facility gets the necessary approval from Government to offer abortion services, then they could provide the service.

151 Also see the Technical Guidelines on Safe Abortion Care of Ethiopia of 2006. p. 27.
152 Section 3 (1) of the Choice on Termination of Pregnancy Act of 1996.
153 Ibid. subsection (2).
154 Ibid, subsection (3).

The Commission was of the further view that there was need to adopt an integrated approach to the provision of safe abortion care services throughout the health care system from the most basic rural health post to the most sophisticated tertiary level facility. Such an arrangement would ensure that even the most basic health facility is able to provide services such as medical abortion, reproductive health education, family planning, including emergency contraceptives; and referring women with complications and those requiring advanced safe abortion services.

Nevertheless, the Commission recommends that abortion services should be provided only at approved health facilities and taking into account the following guidelines—

(*a*) health centre may provide first trimester abortion services (up to 12 weeks of pregnancy) in the form of medical abortion and health centres that are designated as Basic Emergency Obstetric and Neonatal Care (BEmONC) sites may also undertake manual vacuum aspiration for the removal of retained products of conception;

(*b*) clients in the second trimester of pregnancy reporting at a health centre shall be referred to hospitals, and similarly, first trimester pregnant women seeking abortion due to medical conditions that may threaten their health if the pregnancy were to continue, shall be referred to the hospital for the assessment of their health conditions and to ensure safety of procedures; and

(*c*) hospitals may perform all types of terminations using both medical and surgical means. For the purpose of this intervention "hospitals" here refer to community, district and central hospitals. Rural hospitals function as Basic Emergency Obstetric and Neo-natal Care Units and therefore, they are classified under health centre.

The Commission therefore recommends the adoption of the following provisions—

Service delivery points

… **(1) A termination of pregnancy shall only be performed at a health facility approved by the Minister by notice published in the *Gazette*.**

(2) The Minister shall, when approving a health facility, take into account that termination of a pregnancy of—

(*a*) less than twelve (12) weeks gestation may be carried out at a health centre and hospital; and

(*b*) over twelve (12) weeks gestation shall be carried out at a hospital.

(3) For purposes of this section, "hospital" means a community hospital, district hospital or central hospital.

(4) The Minister may, by regulations, prescribe the minimum standards and facilities to be available at each approved health facility designated to provide termination of pregnancy.

6.0 CONSCIENTIOUS OBJECTION

Conscientious objection refers to refusal on moral or religious grounds to perform a procedure that is against one's conscience. Patients as well as physicians may appeal to conscience in refusing treatment or procedure or the provision thereof respectively. Termination of pregnancy remains one of the most morally and ethically sensitive issues in medicine and many doctors have opted out of performing terminations because they do not agree with the procedure.[155] The Commission observed that principles of religious freedom protect physicians, nurses and others who refuse participation in medical procedures to which they hold conscientious objections.

The Commission learnt that in some jurisdictions the right to conscientious objection has been expressly provided for under legislation. For example, Zambia has provided for the right to conscientious objection under section 4,[156] and this right has been elaborated in the Implementation Guidelines,[157] which provides that the Ministry of Health respects the right of medical providers to conscientious objections in participating in the termination of pregnancy. It also provides that the client's right to information and access to health care services, including termination of pregnancy must also be respected.[158] Thus, the right to conscientious objection must be balanced with the right to access health care services, including termination of pregnancy.

The Commission noted that there is need to exercise caution when dealing with the right to conscientious objection. One eminent writer on the subject notes that it makes sense to protect conscientious refusals but not misguided claims stemming from conscientious commitments that do not best serve the patient's interests.[159] He proposes a reasonability test to determine the objectivity of a conscientious objection by suggesting that the following elements should be met:

(*a*) a belief must be genuine in order to ground a successful conscientious objection, including providing evidence of the same;

(*b*) a grounding must be consonant with relevant empirical data in order to support an exemption;

(*c*) a justified conscientious objection must not cause needless or unjustified harm to patients;

(*d*) the objection must not possess an uncontradicted self-interest appearance and must respect the inequality between physicians and patients;

(*e*) it must not be based on discriminatory beliefs; and

(*f*) it must not violate the duty of care by failing to assist patients in emergency situations or time sensitive circumstances.[160]

155 (General Medical Council, 2007).
156 Termination of Pregnancy Act of Zambia.
157 Zambia Implementation Guide.
158 Ibid.
159 Card, R. F (2013) Reasonability and Conscientious Objection in Medicine: A Reply to Marsh and an elaboration of the reason giving treatment. Bioethics ISSN 0269-9702 (print) 1467-8519 (online) John Wiley & Sons.
160 Ibid.

Based on these sentiments, the Commission found it necessary to address the issue of conscientious objection upon information that sometimes it has been used outright to deny women access to legal medical services, including termination of pregnancy and also because it is an internationally recognised human right for health care personnel. The Commission observed that international and national law in most countries, including Malawi, protect the right to freedom of thought, conscience and religion. Section 33 of the Constitution guarantees the right to freedom of conscience, religion, belief and thought. Article 18 of the ICCPR guarantees the right to freedom of thought, conscience and religion. The Human Rights Committee, in its General Comment No. 22 on the right to freedom of thought, conscience and religion, states that—

> *Article 18.3 permits restrictions on the freedom to manifest religion or belief only if limitations are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedom of others ..... in interpreting the scope of permissible limitation clauses, States parties should proceed from the need to protect the rights guaranteed under the Covenant, including the right to equality and non-discrimination on all grounds specified in articles 2,3 and 26. Limitations imposed must be established by law and must not be applied in a manner that would vitiate the rights guaranteed in article 18.*

Firstly, the Commission noted that the above quoted position is reinforced by the constitutional provision under section 44,[161]which provides that restrictions or limitations to any rights and freedoms guaranteed by the Constitution must be prescribed by law, reasonable, recognised by international human rights standards and must be necessary in an open and democratic society.[162] The provision also states that laws prescribing restrictions or limitations must not negate the essential content of the right or freedom in question, and must be of general application.[163] Therefore, the restrictions or limitations to the right to conscientious objections must pass the constitutional requirement in order to be accepted.

In addition to recognising and providing for the right to conscientious objection, many countries have provided for limits to the exercise of this right by health care providers. The first requirement is that if a health professional refuses to provide legal termination of pregnancy services, he must refer the pregnant woman to a practitioner who is willing to perform the abortion. For instance, in Zambia the Implementation Guidelines state that "if a health care provider feels uncomfortable in dealing with a client who requests termination of pregnancy, the client must be respectfully referred to a colleague who is willing to assist the client in obtaining the service." The law of Madagascar requires that if the physician, because of his convictions, believes that he is forbidden to recommend or advise a termination of pregnancy, he may withdraw, but should ensure

161 Constitution of the Republic of Malawi of 1994.
162 Ibid. section 44 (1).
163 Ibid. section 44 (2).

continuity of care by a qualified colleague.[164] A guidance document issued by the Government of Northern Ireland provides that where a woman presents herself to her general practitioner (GP) for advice or assessment in relation to termination of pregnancy and that GP has a conscientious objection, he or she should have in place arrangements with practice colleagues, another GP, or a Health Social Care Trust to whom the woman can be referred."[165] The Colombian Supreme Court that liberalised the abortion law on human rights grounds stated that objecting medical practitioners cannot deny the right of their women patients to exercise their own conscience to choose a lawful abortion, but must immediately refer them to other non-objecting medical practitioners who will perform the procedure.[166]

Secondly, the requirement is that health-care providers must also provide women seeking to terminate a pregnancy with information on legal termination of pregnancy services. The client's right to information and access to health care services including termination of pregnancy, must also be respected.[167] In South Africa,[168] it is a requirement under the law that a woman requesting termination of pregnancy must be informed that: (*a*) she is entitled to the termination of her pregnancy upon request during the first twelve weeks of the gestation period; (*b*) under the circumstances determined by the Act, her pregnancy may be terminated by the thirteenth and up to and including the twentieth week of the gestation period; (*c*) only her consent is required for the termination of pregnancy; (*d*) counselling contemplated in the Act shall be available; and (*e*) of the locality of the facilities for the termination of pregnancy.

Thirdly, it is only health professionals who are directly involved in the provision of termination of pregnancy that are able to object to providing the procedure. Conscientious objection only applies to the procedure and not to broader services; and to the termination of pregnancy service provider and not support personnel.[169] In Italy, the law on conscientious objection exempts health personnel and allied health personnel from carrying out the procedure and activities specifically and necessarily designed to bring about the termination of pregnancy, but does not exempt them from providing care prior to and following the termination.[170] In the case of *Reg. v Salford Area Health Authority, Ex. Parte Janaway*[171] the applicant was employed by the respondent health authority as a medical secretary and receptionist at a health centre. In September 1984, she was asked to type a letter from a general practitioner at the centre referring a patient

164 Decree No. 98-945 of 4 December 1998 setting forth the Code of Medical Ethics (Madagascar) available at http://www.hsph.harvard.edu/population/countries/madagascar/MADAG.medethics.htm (accessed on 28 March 2014).
165 Skuster, P (2012), When a Health Professional Refuses: Legal and regulatory limits on conscientious objection to provision of abortion care. p. 2.
166 Ibid.
167 Implementation Guide for section 4(1) and (2) of the Termination of Pregnancy of Zambia..p.10
168 Regulations on the implementation of the Choice on Termination of Pregnancy (TOP) Act.
169 Implementation Guidelines of Zambia.
170 Skuster, P (2012), When a Health Professional Refuses: Legal and regulatory limits on conscientious objection to provision of abortion care. p. 3
171 [1989] A.C. 537 (House of Lords).

to a consultant with a view to a possible termination of pregnancy under the provisions of section 1 of the Abortion Act of 1967. She refused to do so, stating that she was entitled to exercise the right of conscientious objection set out in section 4(1) of the Act. In consequence of her continued refusal to type any such letters, the authority dismissed her. On an application for judicial review, she sought a declaration that by reason of her conscientious objection she was not under a duty to carry out work of such a nature. The judge held that she was not a person being required to "participate in any treatment" authorised by the Act within the meaning of section 4(1) and dismissed her application. The Court of Appeal dismissed her appeal. On further appeal, the House of Lords, in dismissing the appeal, stated that the word—

> "*participate*" *in section 4*(*1*) *of the Abortion Act 1967 should be given its ordinary and natural meaning for it was not being used in a criminal context and it was not the intention of Parliament to import into section 4*(*1*) *the criminal law concept of principal and accessory; that to* "*participate in any treatment authorised by this Act*" *meant actually to take part in treatment administered in a hospital or other approved place in accordance with section 1*(*3*) *for the purpose of terminating a pregnancy; that the applicant in typing a letter referring a patient to a consultant with a view to a possible termination of pregnancy under section 1 would not have been participating in treatment authorised by the Act; and that, accordingly, her refusal to do so had not been protected by section 4(1).*"[172]

Therefore, the Commission concluded that medical personnel such as nurses providing care before and after a woman has undergone a termination of pregnancy do not have the right to object providing such care, since the auxiliary care itself does not merit objection.

Fourthly, health-care providers, regardless of their religious or moral objections, have a duty to perform a termination of pregnancy if the woman will suffer adverse health consequences unless the termination is promptly carried out. In Zambia, a health care provider has no right to conscientious objection in an emergency situation.[173] The Abortion Act of the United Kingdom[174] also limits the exercise of the right to conscientious objection in cases of treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman. Further, in Ghana standards and protocols for comprehensive abortion care,[175] state that the provider has no right to refuse to perform an abortion procedure that is needed to preserve a woman's health or life.

172 Ibid. Holding of the court found in the headnote p. 537 – 538.
173 Section 4 (2) of the Termination of Pregnancy Act of Zambia of 1972.
174 Section 4 (2) of the Abortion Act of 1967.
175 Ghana Health Services (2012) (3rded.) Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services Standards and protocols.

The Commission acknowledged that the woman's right to health is paramount when faced with a risk to health. Lastly, it is only individuals and not institutions that have a right to object to providing termination of pregnancy services on the basis of the right to conscientious objection. In Zambia, the Implementation Guidelines provide that conscientious objection should only be dealt with when expressed by individual staff members and not as a group action nor as an institution. The Commission noted that perhaps the rationale is that the right to conscientious objection, being a human right, can only be exercised by human beings and not institutions, that is, hospitals (legal persons). However, the Commission took cognisance of the fact that in Malawi, certain areas are serviced by faith based health facilities whose policies are clearly against termination of pregnancy. The dilemma that the Commission faced is recommending that such hospitals must open up to provide an abortion service since the general rule is that institutions cannot register a conscientious objection. The Commission also noted that others have argued that institutions should have a right to conscientious objection since institutions are owned by people namely, proprietors, partners, directors, shareholders or trustees who in the first place set the objectives, policies and agenda for these institutions. To force such institutions to provide services against the conscience of the people who incorporated and are behind such institutions would be a violation of the rights to freedom of conscience, religion, belief and thought as enshrined in the Constitution of Malawi.

This issue was recently considered in one of the US courts in the case of *Stormans Inc. v Selecky*[176] where the primary question was whether or not the State of Washington can compel pharmacists and licensed pharmacies to stock and dispense emergency contraceptives despite their religious beliefs that this would involve participation in terminating a human life. Washington State rules compelled them to dispense these drugs to patients in a timely manner. The plaintiffs contended that their constitutionally guaranteed first amendment rights to the free exercise of religion are improperly impinged upon by the Washington State rules. The court held that the Washington State rules violate the free exercise of rights of the plaintiff, including Stormans Inc and the retail pharmacies. In essence, the court ruled that institutions have a right to conscientious objection in line with the first amendment. Not surprisingly, this decision has sparked controversy and debate on whether or not an institution has a conscience and therefore capable of objecting in the United States with commentaries that the decision is bad law.[177] Deliberating further on the issue, the Commission resolved that faith based health institutions should still be allowed to register a conscientious objection looking at Malawi's peculiar health situation and the need to desist from antagonising faith based health facilities and the religions behind them.

176 854 F. Supp.2 d925, W.D. Wash (2012).
177 Card, R.F. & Williams, K.G. "Emergency Contraception, Institutional Conscience and Pharmacy Practice" Journal of Pharmacy Practice 20IX Vol XX(X) 1- 4.

Thus, the Commission found it necessary for the law on abortion to provide for the right to conscientious objection as this right is internationally recognised and locally guaranteed under section 33 of the Constitution. In addition, the Commission took into account views of stakeholders expressed during district consultations to the effect that the proposed law should provide for the right to conscientious objection.[178] However, the Commission holds the view that the exercise of the right to conscientious objection be subject to limitations within the provisions of the Constitution under section 44 in order to safeguard women's access to services while still protecting providers' rights of conscience. The Commission also found that the five standards discussed above reflect recommendations by internationally recognised human rights bodies, and international organisations such as the WHO[179] and the International Federation of Gynaecology and Obstetrics (FIGO). The Commission thus recommends that health-care providers have the right to conscientious objection subject to the limitations as follows—

(*a*) if a health professional refuses to provide legal abortion services, that provider must refer the pregnant woman to a practitioner who is willing to perform the abortion;

(*b*) health-care providers must provide women seeking to terminate a pregnancy with information on legal abortion services;

(*c*) it is only health professionals who are directly involved in the provision of abortion that may object to providing the procedure; and

(*d*) health-care providers, regardless of their religious or moral objections, have a duty to perform an abortion if the woman will suffer adverse health consequences if the abortion is not promptly carried out.

The Commission therefore recommends the adoption of the following provisions—

Conscientious objection

.... (1) A certified health service provider shall not be under a duty to terminate a pregnancy where he has a conscientious objection.

(2) A certified health service provider who exercises the right to conscientious objection shall promptly refer the pregnant woman to another health service provider who is willing and able to provide the service.

(3) Notwithstanding subsection (1), a certified health service provider shall provide women seeking to terminate a pregnancy with information on legal termination of pregnancy services.

178 The Commission conducted district consultations on the law relating to abortion in selected districts in all the four regions of the country, namely Northern, Central, Eastern and Southern regions between November and December, 2014.

179 For example, the World Health Organisation published technical and policy guidance for health systems for the provision of Safe Abortion Care.

(4) The right to conscientious objection shall only be exercised by a person who is directly involved in the termination of pregnancy.

(5) A certified health service provider or a health service institution shall not exercise the right to conscientious objection where termination of pregnancy is necessary to save the life of the pregnant woman or in an emergency situation.

(6) A private institution that provides health services may, as a matter of its internal policy, exercise the right to conscientious objection.

(7) A person who contravenes the provisions of this section commits an offence and shall upon conviction be liable to a fine of five million Kwacha (K5,000,000.00) or imprisonment for five (5) years.

7.0 EVIDENCE IN RESPECT OF RAPE, INCEST OR DEFILEMENT

The Commission considered what sort of evidence health providers should require from a pregnant woman to prove that the pregnancy is a result of rape, incest or defilement. In dealing with this issue, the Commission was guided by what obtains in other jurisdictions. In Ethiopia, Eritrea and Ghana, though a pregnancy arising out of rape, incest or defilement is a ground for procuring an abortion, the law does not specify the nature of evidence to prove the fact that the pregnancy is as a result of rape, incest or defilement. In other countries the law specifies prerequisites for accessing abortion services based on this ground. In Zimbabwe, the law requires that a medical superintendent may terminate a pregnancy after an appropriate certificate from a magistrate has been issued to him. A certificate can only be issued where the pregnant woman lodges a complaint with the authorities and has sworn an affidavit before a magistrate that the pregnancy is a result of rape, incest or defilement. [180]

A similar approach is followed in Cyprus where the law requires a certification by a competent authority and a confirmation by a medical practitioner that the pregnancy is a result of rape.[181] The abortion law of the State of New Mexico in the United States of America requires a pregnant woman to submit an affidavit to a special hospital board that she has been raped and that the rape has been or will be reported to an appropriate law enforcement official.[182]

[180] Section 5(3) of the Termination of Pregnancy Act of Zimbabwe.
[181] Law no. 59, 1974 and Law no. 186, 1986, Criminal Code, Cap.154, s. 169A(*a*).
[182] New Mexico Stat. s. 30-5-1-(c)(3) (West Supp. 2000).

The abortion law of Rwanda states that abortion services on grounds of rape, incest and forced marriage shall only be permitted if the woman seeking the service submits to the doctor an order issued by a competent court recognizing that the pregnancy is a result of rape, incest or forced marriage.[183]

It is clear that there are different approaches to the issue of evidence relating to pregnancies that have resulted from rape, incest or defilement. In deciding which approach best suits the Malawian context, the Commission considered two options. The first option is to adopt an abortion law with strict medical examination requirement so that it reduces the opportunity for a woman to falsify a claim of rape. The second is to adopt a relatively lenient abortion law without a medical examination requirement so that pregnant women who fail to report the incident of rape immediately can still access the service.

On one hand, those who argue for less regulation on the matter assert that the goal of abortion standards is to facilitate access to abortion services in cases of rape and incest while protecting women's privacy as fully as possible by not subjecting them to frightening and humiliating procedures.[184] It is said that women are often reluctant to report such crimes to the authorities for fear of the publicity that will be focused on them and the possible intrusion to their privacy, unsympathetic and even hostile treatment that they may receive from law enforcement and medical personnel, negative responses from family members, the trauma of reliving the experience through retelling, and the possibility of being involved in protracted legal proceedings.[185] It is further argued that medical systems and legal systems should maintain a separation between their respective responses to sexual offences and that each system should operate independently with reporting a crime not being a precondition to provision of care for the woman by the medical system.[186] Furthermore, over-regulation may deny sexual violence victims access to safe abortion services and force them to resort to unsafe abortion practices. Thus, abortion laws need not specify any procedures to be followed. This is the case in Barbados, Botswana, Greece, Guyana, Luxembourg, and South Africa where a woman is only required to sign a statement that she reasonably believes that her pregnancy was the result of rape or incest. Based on such a report a medical practitioner is able to determine whether or not an abortion should be performed. A woman is only required to report a crime to the medical practitioner providing the service rather than to criminal or judicial authorities.

On the other hand, those who argue for more strict conditions state that laws that do not provide for more details make it difficult for women to actually procure an abortion because health professionals do not know their obligations regarding medical examination and performing abortion procedures.[187] It is argued that such laws appear liberal due to their open and flexible nature but

[183] Organic Law Instituting the Penal Code No.1 of 2012, article 165.
[184] Boland, R. & Skuster, P. Regulation of Abortion Care: Drafting to Promote Access. 2006 p. 6.
[185] Ibid p. 5.
[186] Ibid.
[187] Teklehaimanot, K.I. & Hord Smith, C. *Rape as a legal indication for abortion: Implications and consequences of the medical examination requirement.* Med Law (2004) 23. 91 – 102.

experience in many countries shows that the lack of specific guidance causes the abortion laws to remain on the books, without any effect in practice.[188] Health personnel are often uncertain about what roles they must play and when. They may usually question whether they should contact law enforcement officials before doing anything. Similarly, the police may hesitate to assist the woman access an abortion before receiving proof of rape which is mostly obtained through medical examination.[189] It is further argued that the side effect of an abortion law without a medical examination requirement is that abortion services may be provided to pregnant women who have not been raped.

Commentators argue that it may be appropriate for a society to choose the lesser evil and adopt a lenient law.[190] Women who lack access to safe abortion often resort to risky backstreet abortions. It may be preferable and less costly for society to accept that some women will falsify sexual offences in order to obtain safe abortion. Given the underreported nature of rape, the percentage represents a very small number of women. One commentary suggests that the actual frequency of false rape reports is estimated to be as low as 2%.[191] Others have argued that victims of sexual offences who become pregnant as a result of such acts need only report to the police and that instances subsequently shown to have been unjustified or deceptive be dealt with in accordance with the general provisions of the law which may include liability for perjury in making sworn statements, for making false, unsworn statements to police officers, and for obtaining benefits, such as medical services, by misrepresentation or fraud.[192]

In Mauritius, the law requires that a victim of a sexual offence who seeks abortion services should only report the incident to the police. Further, this law creates an offence that "any person who for purposes of procuring treatment to terminate pregnancy, knowingly makes a false declaration of rape, sexual intercourse with a female under 16 or sexual intercourse with a specified person to the police shall commit an offence and shall, on conviction, be liable to penal servitude for a term not exceeding 10 years."[193]

Having considered the viability of both options, the Commission resolved that victims of sexual offences should only be required to report the incident to the police, and the police should record the crime in the form of a police report. The police report will suffice as evidence that the pregnancy is as a result of a sexual offence and the service provider may go ahead to provide services to terminate the pregnancy based on this report. At the same time, the report will assist the police to follow up the rape case. The Commission also recommends that a criminal offence should be created targeting those pregnant women who may obtain abortion services under the pretence that they were sexually assaulted

188 Ibid p. 95.
189 Ibid.
190 Ibid p.100.
191 Alloson, J.A. & Wrightsman, L.S. 'Rape: the Misunderstood Crime.' Sage Publications: Newbury Park: 1993 at 205.
192 R. J. Cook, Op.cit.
193 Section 235A of the Criminal Code (Amendment) Act 2012.

when in fact they were not. The offence will therefore be that of false declaration of rape, incest or defilement for purposes of seeking abortion services and shall be punishable, upon conviction, to imprisonment for five years.

The Commission therefore recommends the adoption of the following provisions—

Evidence of rape, incest or defilement

… **(1) A pregnant woman shall, before seeking termination of pregnancy on the ground of rape, incest or defilement, report the crime to police and such report shall be prima facie evidence for accessing termination of pregnancy services.**

(2) A person who, for purposes of procuring termination of pregnancy, knowingly makes a false declaration of rape, incest or defilement, as the case may be, commits an offence and shall, upon conviction, be liable to imprisonment for a term of five (5) years.

8.0 CONSENT REQUIREMENTS

The Commission acknowledged that the issue of consent is very critical in the provision of any medical treatment, including termination of pregnancy. The Commission debated the issue of consent before termination of pregnancy is provided to a woman. Critical questions which would be raised regarding consent in the termination of pregnancy include: should a pregnant woman be required to give consent before the treatment can be provided? Should a pregnant woman be required to seek consent or mere notification of the biological father? Should a minor seek parental consent before an abortion service is accessed or mere notification? Where consent is a prerequisite to accessing abortion service, what mechanism would be put in place to ensure that women and girls are not necessarily denied the service?

The Commission noted that different jurisdictions have adopted different approaches to the matter. In Zambia, all women undergoing pregnancy termination are required to sign aconsent form before undergoing the procedure.[194] The pregnant woman is required to affirm that she understands the procedure and its alternatives, potential risks, benefits and complications and that the decision is uncoerced and that she is prepared to have an abortion. Where there is a conflict between the woman and the partner or spouse, the woman's decision takes precedence. Where a girl child is pregnant, the consent of a parent or legal guardian to terminate the pregnancy must be documented.[195] The best interests of the child take precedence over that of the parent or guardian and it must be made on the principle of evolving capacity of the child to participate in decision making affecting her life. However, the service provider is required to

[194] Standards and guidelines for reducing unsafe abortion morbidity and mortality, May 2009 p.13.
[195] Ibid.

encourage children to consult a parent or trusted adult if they have not already done so. As to who can give consent on behalf of a child, the guidelines provide that a parent, next of kin or another adult in *loco parentis* can give consent on behalf of the child. In Ethiopia, the Technical Guidelines provide for the general informed consent of the pregnant woman. However, children and pregnant women with mental disorders are not required to sign a consent form to obtain an abortion procedure.[196]

In South Africa, the law requires consent of the pregnant woman for the provision of abortion services.[197] As regards a pregnant child, a medical practitioner or registered midwife is only required to advise such a child to consult with her parents, guardian, family members or friends before the pregnancy is terminated.[198] However, the termination of pregnancy shall not be denied because such child chooses not to consult. In case of a pregnant woman with mental disorder, the law requires that the service may be requested and consented to by the woman's natural guardian, spouse or legal guardian depending on the circumstances of the case.[199]

A consideration of legislation from other jurisdiction reveals that consent of the pregnant woman is sufficient in accessing abortion services. Likewise, the CEDAW Committee General Recommendation no. 24 requires that States Parties should not restrict women's access to health services or to the clinics that provide those services on the ground that the women do not have authorisations of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Spousal and parental consent as well as notification requirements are presumed as being especially harmful in cases of pregnancy following marital rape or incest. These requirements can have a significant impact on delaying the performance of abortions until the second trimester when the threat to the pregnant woman's health is greater.

The Commission acknowledged that the discussion on the issue of consent must be considered in line with the promotion of sexual and reproductive rights of women and in keeping with the spirit of international human rights instruments on the rights of women. The Commission decided that consent of the pregnant woman herself before any termination of pregnancy is paramount and ideal except where the pregnant woman suffers from mental disorder in which case consent should be obtained from the woman's spouse or legal guardian.

With regard to children, the Commission recommends that children should seek parental consent before termination of the pregnancy. The rationale for this recommendation is that parents are the natural guardians of the children and, in our cultural context, it is only proper that parents agree to decisions affecting their children. However, the Commission still acknowledged that in certain cases consent may be difficult to obtain. Sometimes children seek abortions for fear of

196 Technical Guidelines for Safe Abortion Services in Ethiopia. June 2006 p. 12.
197 Article 3(5) of the Choice of Termination of Pregnancy Act 1996 of South Africa, no. 92 of 1996.
198 Ibid article 3(5)(3).
199 Ibid, article 3(5)(4).

the wrath of their parents and that it would be ironical to expect them to seek consent from the very parents they are running away from. This concern was also raised by a number of stakeholders that the Commission consulted.

The Commission recommends that where it appears to a service provider that, under the circumstances, consent from parents could be difficult to obtain or where he or she forms the opinion that such consent is being unreasonably denied or withheld, the service provider may still go ahead to terminate the pregnancy in the best interests of the child. In coming up with this recommendation, the Commission was guided by the case of *Gillick* (*A.P.*) *v. West Norfolk and Wisbech Area Health Authority and the Department of Health and Social Security*[200] where a parent took action against the local health authority when a medical practitioner in one of the respondent's hospitals offered contraceptives to her minor child without the parent's consent. In dismissing the case, the court stated that—

> *Nobody doubts, certainly I do not doubt, that in the overwhelming majority of cases the best judges of a child's welfare are his or her parents. Nor do I doubt that any important medical treatment of a child under 16 would normally only be carried out with the parents' approval. That is why it would and should be "most unusual" for a doctor to advise a child without the knowledge and consent of the parents on contraceptive matters. But, as I have already pointed out, Mrs. Gillick has to go further if she is to obtain the first declaration that she seeks. She has to justify the absolute right of veto in a parent. But there may be circumstances in which a doctor is a better judge of the medical advice and treatment which will conduce to a girl's welfare than her parents*.[201]

Although consent is recommended, it is the view of the Commission that the best judge, depending on the circumstances and the best interests of the child, should be the service provider. In that regard, the Commission recommends that a service provider should have powers to proceed with termination of pregnancy where he forms that opinion in good faith.

The Commission therefore recommends the adoption of the following provisions—

Consent for termination of pregnancy

... (1) Before any termination of pregnancy authorized under this Act is performed on a pregnant woman, a certified health service provider shall require the consent of the pregnant woman prescribed in the First Schedule.

(2) A certified health service provider shall require, in the case of a pregnant child and before termination of a pregnancy, consent of the parent or legal guardian prescribed in the *Second Schedule*.

200 [1985] A.C.
201 Ibid, p312

(3) Notwithstanding subsection (2), a certified health service provider may terminate a pregnancy of a child where he forms an opinion, in good faith, that consent of a parent or legal guardian may be difficult to obtain or is being unreasonably withheld and that termination of pregnancy is in the best interests of the child.

(4) In the case of a pregnant woman who is incapacitated, a certified health service provider shall obtain consent to terminate the pregnancy from a legal guardian or next of kin prescribed in the *Third Schedule.*

(5) The Minister may from time to time amend the *First, Second and Third Schedules.*

9.0 CONFIDENTIALITY OF INFORMATION

Confidentiality is implicit in maintaining a patient's privacy. However, confidentiality between provider and client is not an absolute right. Privacy is defined as the ability of the individual to maintain information in a protected way. Confidentiality in health care entails an obligation on the part of a health care provider not to disclose information.[202] Ethics in medical profession require that a service provider must not disclose information relating to his or her patient to unauthorized people or authorities. As long as it is necessary or persons requiring the information are authorized, the information can be disclosed. In Zimbabwe for example, a service provider must disclose the abortion information to the officer in charge of the hospital and the officer in charge of the hospital must forward the information to the secretary responsible for health where an abortion service was provided under emergency circumstances.[203]

The Commission was of the view that there is need to strike a proper balance between protecting the right to confidentiality and the right to access information. The Commission was aware that sometimes information may be needed for both statistical and monitoring purposes. As such, strict protection of the right to privacy of clients' accessing abortion services may limit the extent to which Government conducts its monitoring and evaluation activities. Government will inevitably monitor services to assess whether they are being provided up to the required standards in order to take appropriate corrective measures.

In view of this, the Commission recommends that provision of abortion services must ensure confidentiality of information. The exception will be where the information is required for purposes of statistics, research, or aiding investigation into any alleged crime under any written law or professional misconduct of any medical practitioner in provision of the abortion service, to aid any proceedings in court or tribunal or indeed where the patient consents that such

[202] English A, Center for Adolescent Health Care and the Law, past consultant for MCHB, interview, October 25, 2001.

[203] Section 7 of the Termination of Pregnancy Act of Zimbabwe.

information should be disclosed to a third party. The Commission also recommends that the service provider must disclose the abortion information to the officer in charge of the hospital. The officer in charge of the hospital must forward the information to the Minister responsible for Health. The Commission therefore recommends the adoption of the following provision—

Confidentiality of information

... (1) Every person in charge of a health facility approved to perform termination of pregnancy shall maintain a register and record of all termination of pregnancies carried out at the facility.

(2) Information and records on termination of pregnancy shall be kept confidential except where it is required by—

(*a*) the Minister or a person in charge of a public health facility or authorized health facility when carrying out his duties under the Act;

(*b*) the Minister for research and statistical purposes;

(*c*) a police officer not below the rank of Superintendent or such police officer as may be authorized by him, who is investigating whether or not an offence has been committed under this Act or any other written law;

(*d*) a person who is acting pursuant to a court order;

(*e*) the Registrar of a health professional regulatory body or a member of staff authorized by him or conducting an investigation of an alleged misconduct or negligence; or

(*f*) any other person to whom a pregnant woman consents that the matter be disclosed.

10.0 OFFENCES

The Penal Code has the following offences relating to abortion:

S.149. Any person who, with intent to procure a 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, shall be guilty of a felony and shall be liable to imprisonment for fourteen years.

S.150. Any woman who, being with child, 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 whatever, or permits any such thing or means to be administered or used to her, shall be guilty of a felony, and shall be liable to imprisonment for seven years.

S. 151. Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, shall be guilty of a felony and shall be liable to imprisonment for three years.

The Commission reflected on section 149 and was of the opinion that apart from a certified health service provider, any other person should not administer any substance or use any force to a pregnant woman for purposes of procuring a miscarriage. In accordance with its recommendations, the Commission is of the view that only health service providers that have been certified to perform abortion services can terminate pregnancies. The Commission therefore recommends the modification of this provision so that certified health service providers are empowered to terminate pregnancies based on the proposed grounds and further recommends the retention of the criminal element for all persons that are not so authorised.

As regards section 150, the Commission was in agreement with the spirit behind the provision that prohibits a woman to administer to herself any substance or using any force for purposes of procuring her own miscarriage. The Commission was aware that the ultimate goal of Government is to reduce or curb the problem of unsafe abortions. Women who procure abortions on their own often do so using unsafe means and in unsafe environments thereby posing a risk to their lives. It was the view of the Commission that the practice should not be condoned. In accordance with its earlier recommendation, termination of pregnancies can only take place at authorised institutions and by certified health service providers. The Commission therefore recommends the retention of this provision subject to modification for better presentation and clarity while at the same time preserving the spirit behind the provision.

The Commission also found the spirit behind section 151 compatible with the primary objective of preventing unsafe abortions. The Commission recommends that the provision should provide for an exception authorising certified health service providers to supply drugs used for termination of pregnancy within the purview of the proposed grounds. With the availability of emergency contraceptives nowadays, there is also need to frame the provision in a way that does not criminalise the dispensation of emergency contraceptives by health service providers or licensed pharmacy outlets.

Regarding section 243, the Commission noted that the provision permits the termination of pregnancy in order to save or preserve the life of the pregnant woman when such life is threatened by the continued pregnancy. The Commission observed that the provision is restricted to surgical operation as the only means of terminating a pregnancy. As has been stated earlier in this Report,

termination of pregnancies can be achieved through medical means by administering oral medication or suppositories. Restricting it to surgical operations only means that women would be exposed to unnecessary invasive procedures when there are modern technologies that can be used, but also to allow other certified health service providers recommended by the Commission to perform the service.

In view of this, the Commission concluded that this has already been provided for under the proposed law, in particular under grounds for terminating a pregnancy and also the Commission has recommended various methods of terminating a pregnancy. Therefore, the Commission recommends that section 243 be repealed.

The Commission maintains that abortion is still illegal except where it is performed on the basis of the proposed grounds. Hence, the Commission recommends the introduction of offences to ensure that termination of pregnancy is only performed within the purview of the proposed legislation.

The Commission also noted that during both district and regional consultations, participants cited the pressure and coercion that pregnant women get from men who have impregnated them as contributing to the negative statistics and effects of unsafe abortion. It is said that most vulnerable women fall victim to men's demands to have the pregnancy terminated especially in relationships outside marriage where the man is refusing or reluctant to assume responsibility. This has resulted in many such women procuring abortion through unsafe means and have either ended up with serious complications or actually dying. In this regard, participants called for stiff punishment of such men where there is ample evidence of the same.

The Commission carefully considered the issue and acknowledged that such things do occur in the communities. The Commission was therefore in agreement with the proposal of criminalizing the practice of forcing a pregnant woman to terminate a pregnancy and was of the view that a specific criminal offence in this respect be provided for in the proposed law and recommends accordingly.

Thus, the Commission recommends the repeal of sections 149, 150, 151 and 243 of the Penal Code and proposes the adoption of the following provisions on offences—

Unauthorized termination of pregnancy

... (1) A person who—

(*a*) not being a certified health service provider terminates a pregnancy;

(*b*) unlawfully procures termination of her own pregnancy;

(*c*) being a certified health service provider terminates a pregnancy for any reason other than the grounds provided for under this Act;

(*d*) procures termination of pregnancy or terminates a pregnancy at a place that is not approved under this Act;

(*e*) not being a certified health service provider or licensed pharmacist unlawfully supplies to or procures for any person anything that is intended to be unlawfully used to terminate a pregnancy; or

(*f*) forces a pregnant woman to terminate a pregnancy against her will,

commits an offence and shall, upon conviction, be liable to imprisonment for a term of fourteen (14) years.

Other unauthorized acts

... A person who—

(*a*) fails to provide counselling to a pregnant woman before and after any termination of pregnancy;

(*b*) except as permitted under section .....[204] , terminates a pregnancy without the required consent; or

(*c*) discloses information or records regarding any termination of pregnancy in a manner not authorized under this Act,

commits an offence and shall, upon conviction, be liable a fine of three million Kwacha (K3,000,000.00) and to imprisonment for three (3) years.

False declaration of rape, incest or defilement

... A person who, for purposes of procuring termination of pregnancy, knowingly makes a false declaration of rape, incest or defilement, as the case may be, commits an offence and shall, upon conviction, be liable to imprisonment for a term of five (5) years.

[204] Section 9(3) of the draft Bill

Obstructing a person from accessing treatment

... A person who obstructs or otherwise bars a pregnant woman from accessing services to terminate a pregnancy which she is legally entitled to under this Act, commits an offence and shall, upon conviction, be liable to a fine of five million Kwacha (K5,000,000.00) and to imprisonment for a term of five (5) years.

11.0 REFORMING THE LAW EITHER THROUGH A STAND-ALONE LEGISLATION OR THROUGH AN AMENDMENT TO THE PENAL CODE

The Commission considered the issue of whether the proposed law on abortion should be a stand-alone legislation or through introduction of amendments to the existing framework under the Penal Code. The Commission was aware that in some jurisdictions reforms to the law on abortion have been effected through amendments to the existing penal system. For instance, Ethiopia and Ghana have both resorted to amending the existing penal provisions in article 551 of the Penal Code of the Federal Democratic Republic of Ethiopia and in a 2006 amendment to the Ghana Criminal Code (Amendment) Law[205] respectively. On the other hand, South Africa enacted a stand-alone statute, the Choice on Termination of Pregnancy Act,[206] while Zambia enacted the Termination of Pregnancy Act in 1972. Each of these jurisdictions opted for the particular approach that best suits their needs and circumstances.

The Commission also observed that there are two schools of thought. One school of thought argues that reviewing the law in its current form has implications on the paradigm that any new law arising from it cannot evade. It also argues that the current law derives from a penal and imperialistic legacy that operated under the guise of protecting women when contemporary evidence seems to suggest the contrary. As such, simply effecting amendments to the law in its present form will continue to locate the law on abortion within the penal framework which has so far not succeeded in preventing women from seeking unsafe abortion.

Further, it is argued that the criminal justice system to which penal laws belong seeks to punish both providers of abortion and those who undergo the procedure. This is often double victimization, as some of the women who seek illegal abortions are victims of violence. Locating the law on abortion in a legislative framework that proceeds from a human rights premise, seeking to protect the rights of women and girls as its primary focus, would therefore reduce the magnitude of unsafe abortion.

In support of this school of thought, the Court in Canada in *R v Morgentaler* [207]demonstrated its discontent with the location of abortion laws in the criminal code. The Chief Justice of Canada observed that—

[205] Provisional National Defence Council Law 102
[206] Number 92 of 1996 which is abbreviated as CTOP Act
[207] *R. v. Morgentaler*, [1988] 1 S.C.R. 30

> "*forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own aspirations is a profound interference with a woman's body and thus a violation of security of the person*."[208]

The other school of thought is against a wholesale reform of the law on abortion. The argument is that where society is conservative (like Malawi) it may not be ready to embrace such radical liberal changes, and reform might be more acceptable if it was less radical. By maintaining the law on abortion within a penal framework, those opposed to it would be satisfied that technically, termination of pregnancy was still restricted, although some aspects of it are liberalized. The Commission noted that this is a compromise which many governments have adopted by amending their criminal laws to create exceptions to the legal prohibitions against abortion. The Commission holds the view that perhaps the interests of both camps can be accommodated even if the law on abortion was to be located in a stand-alone statute that appeals to both schools of thought.

Furthermore, in addition to recommending three more grounds for terminating a pregnancy, the commission has gone a step further to propose the enactment of provisions dealing with the overall termination of pregnancy delivery services that regulate issues such as authorised service providers; service delivery points; mandatory counselling; conscientious objection; consent; confidentiallity of information; and evidence of sexual offences. As such, locating these provisions in the penal code would be a misplacement and not appropriate from a legislative drafting point of view. Rather these extensive provisions, which are not penal in nature, are better placed in a separate statute.

The Commission also took special notice of the recommendation of the special Law Commissions on the review of the Penal Code[209] and the Development of the Gender Equality Statute[210] that a separate statute dealing with legal termination of pregnancy be developed through a special Law Commission empanelled for that purpose. As such, the Commission found it to be appropriate that the proposed law on abortion should be contained in a stand-alone statute considering that the Commission has made extensive recommendations which are based on human rights principles and also to ensure visibility of the proposed law on abortion. The Commission therefore recommends that the proposed law be contained in a stand-alone legislation.

The Commission recommends that the proposed legislation should be entitled **Termination of Pregnancy Bill, 20...**

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208 *R. v. Morgentaler*, [1988] 1 S.C.R. 30, p. 402
209 Law Commission Report no. 2 p 43.
210 Law Commission Report no. 23 p 66.

APPENDICES

TERMINATION OF PREGNANCY BILL, 20...

TERMINATION OF PREGNANCY BILL, 20...

ARRANGEMENT OF SECTIONS

SECTION

TERMINATION OF PREGNANCY BILL, 20...

A BILL

entitled

An Act to provide for the legal and safe termination of pregnancies in Malawi; and to provide for matters connected with or incidental thereto

ENACTED by the Parliament of Malawi as follows—

PART I—PRELIMINARY

Short title and commencement

1. This Act may be cited as the Termination of Pregnancy Act ....., and shall come into force on such date as the Minister shall appoint by notice published in the *Gazette*.

Interpretation

2. In this Act, unless the context otherwise requires—

"certified health service provider" means a licensed medical doctor, clinical officer, registered nurse and midwife, nurse midwifery technician or medical assistant certified by health professional regulatory bodies to carry out a termination of pregnancy;

"conscientious objection" means refusal on moral or religious grounds to perform a procedure that is against one's conscience; and

"health professional regulatory bodies" means the Medical Council of Malawi and the Nurses and Midwife Council of Malawi.

PART II—REGULATION OF TERMINATION OF PREGNANCIES AND SERVICE DELIVERY

Grounds for termination of a pregnancy

3.—(1) Subject to section 5, termination of a pregnancy may be performed by a certified health service provider where he is of the opinion, in good faith, that—

(*a*) the continued pregnancy will endanger the life of a pregnant woman;

(*b*) the termination of pregnancy is necessary to prevent injury to the physical or mental health of a pregnant woman;

(*c*) the foetus is severely malformed so that its viability or compatibility with life is affected; or

(*d*) the pregnancy is a result of rape, incest or defilement:

Provided that the incident of rape, incest or defilement is reported to Police, and that the pregnancy does not exceed sixteen (16) weeks from the date of conception.

(2) In forming the opinion under subsection 1(*b*), the certified health service provider shall not take into account socio-economic circumstances of the pregnant woman.

(3) Except as provided in this section, termination of pregnancy shall not be performed on demand or for any other reason.

Service delivery points

4. — (1) A termination of pregnancy shall only be performed at a health facility approved by the Minister by notice published in the *Gazette*.

(2) The Minister shall, when approving a health facility, take into account that termination of a pregnancy of—

(*a*) less than twelve (12) weeks gestation may be carried out at a health centre or hospital; and

(*b*) over twelve (12) weeks gestation shall be carried out at a hospital.

(3) For purposes of this section, "hospital" means a community hospital, district hospital or central hospital.

(4) The Minister may, by regulations, prescribe the minimum standards and facilities to be available at each approved health facility designated to provide termination of pregnancy.

Service providers

5.—(1) Termination of pregnancy shall only be performed by a certified health service provider.

(2) Subject to subsection (1), termination of pregnancy shall only be carried out by—

(*a*) a medical assistant, nurse midwifery technician, registered nurse and midwife where the pregnancy does not exceed twelve (12) weeks of gestation;

(*b*) a clinical officer, where the pregnancy does not exceed fourteen (14) weeks of gestation; and

(*c*) except as provided in section 3(1)(*d*), a medical doctor, at any age of gestation.

Mandatory counselling

6.—(1) A certified health service provider shall, as part of the service to terminate a pregnancy, provide counselling to a pregnant woman before and after the termination of the pregnancy, including counselling on family planning.

(2) The counselling shall include—

(*a*) information on options of continuing or terminating the pregnancy;

(*b*) available methods for termination of pregnancy;

(*c*) possible short and long-term effects associated with each method of termination of pregnancy;

(*d*) emotional and psychological responses following termination of pregnancy; and

(*e*) information about family planning methods.

Conscientious objection

7.—(1) A certified health service provider shall not be under a duty to terminate a pregnancy where he has a conscientious objection.

(2) A certified health service provider who exercises the right to conscientious objection shall promptly refer the pregnant woman to another health service provider who is willing and able to provide the service.

(3) Notwithstanding subsection (1), a certified health service provider shall provide women seeking to terminate a pregnancy with information on legal termination of pregnancy services.

(4) The right to conscientious objection shall only be exercised by a person who is directly involved in the termination of pregnancy.

(5) A certified health service provider or a health service institution shall not exercise the right to conscientious objection where termination of pregnancy is necessary to save the life of the pregnant woman or in an emergency situation.

(6) A private institution that provides health services may, as a matter of its internal policy, exercise the right to conscientious objection.

(7) A person who contravenes the provisions of this section commits an offence and shall upon conviction be liable to a fine of five million Kwacha (K5,000,000.00) and imprisonment for five (5) years.

Evidence of rape, incest or defilement

8. A pregnant woman shall, before seeking termination of pregnancy on the ground of rape, incest or defilement, report the crime to police and such report shall be prima facie evidence for accessing termination of pregnancy services.

Consent for termination of pregnancy
First Schedule
Second Schedule
Third Schedule

9.—(1) Before any termination of pregnancy authorized under this Act is performed on a pregnant woman, a certified health service provider shall require the consent of the pregnant woman prescribed in the *First Schedule.*

(2) A certified health service provider shall require, in the case of a pregnant child and before termination of a pregnancy, consent of the parent or legal guardian prescribed in the *Second Schedule*.

(3) Notwithstanding subsection (2) a certified health service provider may terminate a pregnancy of a child where he forms an opinion, in good faith, that consent of a parent or legal guardian may be difficult to obtain or is being unreasonably withheld and that termination of pregnancy is in the best interests of the child.

(4) In the case of a pregnant woman who is incapacitated, a certified health service provider shall obtain consent to terminate the pregnancy from a legal guardian or next of kin prescribed in the *Third Schedule.*

(5) The Minister may from time to time amend the *First, Second and Third Schedules.*

Confidentiality of information

10.—(1) Every person in charge of a health facility approved to perform termination of pregnancy shall maintain a register and record of all termination of pregnancies carried out at the facility.

(2) Information and records on termination of pregnancy shall be kept confidential except where it is required by—

(*a*) the Minister or a person in charge of a public health facility or authorized health facility when carrying out his duties under the Act;

(*b*) the Minister for research and statistical purposes;

(*c*) a police officer not below the rank of Superintendent or such police officer as may be authorized by him, who is investigating whether or not an offence has been committed under this Act or any other written law;

(*d*) a person who is acting pursuant to a court order;

(*e*) the registrar of a health professional regulatory body or a member of staff authorized by him conducting an investigation of an alleged misconduct or negligence; or

(*f*) any other person to whom a pregnant woman consents that the matter be disclosed.

Grievance handling procedure

11.—(1) A woman seeking services to terminate a pregnancy may lodge a complaint against a decision refusing her access to a legal termination of pregnancy or in relation to any part of the broader termination of pregnancy services.

(2) Every health facility authorized to provide termination of pregnancy under this Act, shall set up a complaints handling committee to hear complaints on termination of pregnancy related services.

(3) The complaints handling committee shall consist of a health service provider not below the rank of clinical officer who shall be the chairperson and two other members of the medical team at the health facility.

(4) Where a complaints handling committee is not available or cannot be properly constituted at a health facility, a person may lodge a complaint at the nearest health facility where such complaints handling committee is available.

(5) Where a complaint has been lodged under subsection (1), that complaint shall be heard and determined within thirty (30) days from the date it was lodged.

Part III—Offences

Unauthorized termination of pregnancy

12. A person who—

(*a*) not being a certified health service provider terminates a pregnancy;

(*b*) unlawfully procures termination of her own pregnancy;

(*c*) being a certified health service provider terminates a pregnancy for any reason other than the grounds provided for under this Act;

(*d*) procures termination of pregnancy or terminates a pregnancy at a place that is not approved under this Act;

(*e*) not being a certified health service provider or licensed pharmacist unlawfully supplies to or procures for any person anything that is intended to be unlawfully used to terminate a pregnancy; or

(*f*) forces a pregnant woman to terminate a pregnancy against her will,

commits an offence and shall, upon conviction, be liable to imprisonment for a term of fourteen (14) years.

13. A person who—

Other unauthorized acts

(*a*) fails to provide counselling to a pregnant woman before and after any termination of pregnancy;

(*b*) except as permitted under section 9(3), terminates a pregnancy without the required consent; or

(*c*) discloses information or records regarding any termination of pregnancy in a manner not authorized under this Act,

commits an offence and shall, upon conviction, be liable a fine of three million Kwacha (K3,000,000.00) and to imprisonment for three (3) years.

False declaration of rape, incest or defilement

14. A person who, for purposes of procuring termination of pregnancy, knowingly makes a false declaration of rape, incest or defilement, as the case may be, commits an offence and shall, upon conviction, be liable to imprisonment for a term of five (5) years.

Obstructing a person from accessing treatment

15. A person who obstructs or otherwise bars a pregnant woman from accessing services to terminate a pregnancy which she is legally entitled to under this Act commits an offence and shall, upon conviction, be liable to fine of five million Kwacha (K5,000,000.00) and to imprisonment for a term of five (5) years.

PART IV—MISCELLANEOUS

Power to make regulations

16. The Minister may make regulations for the effective carrying out of the provisions of this Act.

Repeals Cap. 7:01

17. Sections 149, 150, 151 and 243 of the Penal Code are hereby repealed.

FIRST SCHEDULE s. 9 (1)

Consent Form for Termination of Pregnancy

I, (name of Client)_____of (address)

_____

_____ having consulted with the certified health service provider about my health condition, hereby consent to a procedure for safe termination of pregnancy. I have been counseled and informed about the alternative methods and about the possible side effects and outcomes of the procedure.

In the event of complications arising during the procedure, I request and authorize the responsible health service provider to do what is necessary to protect my health and wellbeing.

I confirm that the information that I provided to the certified health service provider is accurate.

Signature or thumbprint_____

Date_____

For Official Use

_____

_____

Witness

Name: .....

Signature: .....

Designation: .....

SECOND SCHEDULE s. 9 (2)

Consent to Treat Minor Children

I, _____, the parent or legal guardian of _____, born on_____, do hereby consent to a procedure for safe termination of pregnancy as determined by the certified health service provider to be necessary for the welfare of my child. I have been informed about alternative methods and about the possible side effects and outcomes of the procedure.

In the event of complications arising during the procedure, I request and authorize the responsible certified health service provider to do what is necessary to protect my child's health and wellbeing.

_____
Signature of Parent or Legal Guardian

_____ _____
Witness Signature *Witness Name* (*Please print*)

THIRD SCHEDULE s. 9 (4)

Consent by Legal Guardian

I, _____, the legal guardian of

_____, born

on_____, do hereby consent to a procedure for safe termination of pregnancy as determined by the certified health service provider to be necessary for the welfare of my ward. I have been informed about alternative methods and about the possible side effects and outcomes of the procedure.

In the event of complications arising during the procedure, I request and authorize the responsible health service provider to do what is necessary to protect my ward's health and wellbeing.

_____

Signature of Legal Guardian

_____ _____

Witness Signature *Witness Name* (*Please print*)

DRAFT GUIDELINES FOR SERVICE DELIVERY BY AUTHORISED SERVICE PROVIDERS

Table of Contents

Introduction

There were calls for Government to consider reviewing laws that contain punitive measures against women who undergo illegal abortions.

The Government commissioned a review of the law on abortion spearheaded by the Law Commission. This was pursuant to proposals made by two special Law Commssions. First, a special Law Commission on the Review of the Penal Code which released its Report in 2000[1] recommended the enactment of a separate law that would make provision for the procedure relating to the legal termination of pregnancies on appropriate grounds. Second, a special Law Commission on the Development of the Gender Equality Statute which released its Report in 2011[2] made a recommendation to Government to carefully scrutinise the issues of unsafe abortion and make immediate plans to institute a review of the law on abortion through the Ministry of Health so that a new statute specifically on termination of pregnancy is enacted.

The review has culminated into the enactment of the Termination of Pregnancy Act. The law does not permit termination of pregnancy on demand except on the following grounds—

(*a*) where the continued pregnancy will endanger the life of a pregnant woman;

(*b*) where termination of pregnancy is necessary to prevent injury to the physical or mental health of a pregnant woman;

(*c*) the foetus is severely malformed so that its viability or compatibility with life is affected; or

(*d*) where the pregnancy is a result of rape, incest or defilement.

Aim of the Guidelines

These Guidelines contain standard techniques and procedures that must be observed in the provision of safe termination of pregnancy services as permitted by the law. The Guidelines will be implemented in all health facilities authorized by the Minister.

The Guidelines have been adopted to ensure that authorized service providers offer women qualified under the law standard, consistent, and safe termination of pregnancy services as permitted by law.

These Guidelines shall be revised from time to time.

[1] Report of the Law Commission on the Review of the Penal Code, Report No. 2.
[2] Report on the Law Commission on the Development of the Gender Equality Statute, p.66.

Section 1: Legal Framework

1. TERMINATION OF PREGNANCY

1.1 Legal Provisions and Implementation Guide for Safe Abortion Services

This section provides information to all certified health care providers involved in the provision of legal termination of pregnancies so that they are fully aware of cases that qualify for legal abortions as provided by the law but also to inform and educate women and the community in general.

Previously, abortion was illegal in Malawi except where it was performed to save the life of the pregnant woman through a surgical operation. The Penal Code criminalized all such act of procuring or assisting in the procuring of a miscarriage of a pregnant woman. Anyone found guilty of such offences was liable to serve a prison sentence. However, a new law called the Termination of Pregnancy Act was enacted in (year) making provision for legal and safe termination of pregnancies.

According to the Termination of Pregnancy Act, termination of pregnancy in Malawi can be performed under the following circumstances—

(*a*) where the continued pregnancy will endanger the life of a pregnant woman;

(*b*) where the termination of pregnancy is necessary to prevent injury to the physical or mental health of a pregnant woman;

(*c*) the foetus is severely malformed so that its viability or compatibility with life is affected; or

(*d*) where the pregnancy is a result of rape, incest or defilement.

The following guidelines have been developed to help certified health service providers in applying the requirements of the law.

(*a*) Standard

Termination of pregnancy may be performed where the continued pregnancy will endanger the life of the pregnant woman.

Guidelines

(1) The certified health service provider must recommend or perform an abortion where he forms an opinion in good faith that the continuance of the pregnancy poses a risk to the life of the pregnant woman.

(2) The certified health service provider should ascertain the standard medical conditions that necessitate termination of pregnancy to save the life of the pregnant woman such as signs of heart disease, renal disease or severe hypertension.

(3) The certified health service provider must not expect the pregnant woman to make the request for the termination and the woman should not necessarily be in a state of ill health at the time of needing the safe abortion service. It is therefore the responsibility of the certified health service provider to assess the woman's condition and determine whether indeed the pregnancy poses a threat to her life.

(*b*) Standard

Termination of pregnancy may be performed where the termination of pregnancy is necessary to prevent injury to physical or mental health of a pregnant woman.

Guidelines

(1) The certified health service provider should recommend or conduct an abortion where he or she forms an 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. Health service providers are presumed to be acting in good faith unless proven otherwise.

(2) Risk of injury to physical health means any risk of a physical nature that may befall the woman whether actual or reasonably foreseeable. The risk should be taken to mean that although no eminent threat to the life of the pregnant woman exists, a threat to her physical wellbeing exists by continuing with the pregnancy. It is up to the certified health service provider to ascertain upon taking a history or making a physical, laboratory or genetic diagnosis or investigation of the pregnant woman.

(3) Risk to mental health means any effect on the pregnant woman's mental health. Mental health includes objective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellect and emotional potential (WHO, 2012). This must be ascertained through a psychiatric assessment. Socio-economic circumstances of the pregnant woman must not be taken into account when assessing the mental health of a pregnant woman.

(c) Standard

Termination of pregnancy may be performed where there is severe malformation of the foetus which will affect its viability or compatibility with life.

Guidelines

(1) A certified health service provider should recommend or perform termination of pregnancy where he forms an opinion in good faith that there is severe malformation of the foetus.

(2) The degree of such malformation should be that which will affect its compatibility with life. The pregnant woman should be informed of the likely state of her unborn child and her free and informed consent must be obtained before termination of the pregnancy.

(*d*) Standard

Termination of pregnancy may be performed where the pregnancy is a result of rape, incest or defilement.

Guidelines

(1) Termination of pregnancy on this ground should be performed on request of a victim where the pregnancy is as a result of rape, defilement or incest as the case may be.

(2) The victims of the offences of rape, incest or defilement seeking to terminate a pregnancy are required to report the incident to the police, and the police must record the crime in the form of a police report.

(3) The police report will suffice as evidence that the pregnancy is as a result of a sexual offence and the certified health service provider may go ahead to terminate the pregnancy based on this report.

(4) Only a woman with a pregnancy not exceeding sixteen (16) weeks gestation qualifies under this ground.

2. SERVICE PROVIDERS

Standard: Termination of pregnancy should be performed by a trained health service provider who has been specially certified for that purpose by the relevant health regulatory body.

Guidelines

(1) All health service providers performing termination of pregnancies must receive training in the termination of pregnancy and in the prevention, recognition and management of complications.

(2) If appropriately trained and certified, the following cadres of health service providers may terminate a pregnancy—

(*a*) medical assistant, nurse-midwifery technician, registered nurse and midwife where the pregnancy does not exceed twelve (12) weeks of gestation;

(*b*) clinical officer, where the pregnancy does not exceed fourteen (14) weeks of gestation; and

(*c*) medical doctor, at any age of gestation.

(3) In terms of staffing patterns at different levels of care, the following table summarises termination of pregnancy services by level of care.

Table 1: Termination of Pregnancy Services by Level of Care

Level of Care	Type of Health Personnel Available	Termination of Pregnancy Services
Community	● Community health workers (CHWs), ● Community-based reproductive health agents (CBRHAs).	● Provision of RH education, including FP and the risks of unsafe termination of pregnancy ● Distribution of appropriate contraceptives ● Informing communities and women on the legal provisions for safe termination of pregnancy ● Referal of women to post abortion and safe termination of pregnancy services
Health Posts/ stations	● Frontline health workers (health extension workers)	The above activities plus: ● Monitoring of health status/vital signs ● Provision of pain medication ● Provision of family planning
Health centres	● Clinical officers, midwives, clinical nurses, public health nurses, laboratory technicians	The above activities plus: ● Counselling ● General physical and pelvic examination ● Vacuum aspiration up to 12 completed weeks of pregnancy ● Medical termination of pregnancy up to nine completed weeks of pregnancy ● Administration of antibiotics and IV fluids ● Training of community-level workers and junior health service providers in the provision of termination of pregnancy services.

Level of Care	Type of Health Personnel Available	Termination of Pregnancy Services
Community of District hospitals	Same as above, plus GMPs, with or without an obstetrician-gynaecologist	The above activities plus: ● Termination of pregnancies for second-trimester termination of pregnancy ● Treatment of most complications ● Blood cross-matching and transfusion ● Local and general anesthesia ● Laparotomy and indicated surgery ● Diagnosis and referral for serious complications such as peritonitis and renal failure ● Training of all cadres of health professional (pre- and in-service)
Referral hospitals	● Same as above plus obstetrician-gynecologists	The above activities plus: ● Treatment of severe complications (including bowel injury, tetanus, renal failure, gas gangrene, severe sepsis) ● Treatment of coagulopathy
Private facilities:		
Lower clinics	● Staffed by nurses and Medical assistants	● Performing functions described under health posts/stations
Medium clinics	● Staffed by a Clinical officer or GMP and a team of other health workers	● Performing functions described under health centers
Higher clinics	● Staffed by a specialist or a GMP and a team of other health workers	● Performing functions described under health centers
MCH centers and hospitals	● Staffed by specialists (obstetrician/gynecologists), a GMP, and a team of other health workers	● Performing functions under district and referral hospitals

3. SERVICE DELIVERY POINTS

Standard: Termination of pregnancy should be performed in health facilities with good hygienic conditions and the right equipment.

Guidelines

(1) Termination of pregnancies shall be carried out at approved health facilities.

(2) Public health facilities are legally obliged to provide termination of pregnancy related services within the framework of the law.

(3) Private facilities registered by the Medical Council of Malawi and approved by the Minister are eligible to perform termination of pregnancy.

(4) Private maternity or midwifery clinics approved by the Nurses and Midwives Coucil of Malawi and approved by the Minister are eligible to perform termination of pregnancy.

(5) Approved health facilities shall only provide services according to the following criteria—

(*a*) termination of pregnancy of up to twelve (12) weeks gestation may be carried out at a health centre or a hospital; and

(*b*) termination of pregnancy of over twelve (12) weeks gestation must be carried out at a hospital.

(6) The method used to terminatethe pregnancy will determine the level of health system where the pregnant woman will be cared for.

(7) If a pregnant woman qualifies and needs termination of a pregnancy in a health facility that cannot offer the procedure, depending on her condition, the pregnant woman must be duly informed about the existing alternatives, including facilities.

(8) Appropriate referrals should be available for pregnant women who cannot be cared for in a particular facility.

4. CONSCIENTIOUS OBJECTION

Standard: Health service providers have the right to conscientious objection in participating in a procedure to terminate a pregnancy. However, the patient's right to information and access to health care services including termination of pregnancy, within the available legal grounds, must also be respected.

Guidelines

(1) Although individuals have a right to their own belief and moral perspective on termination of pregnancy, their personal objectives should not hinder access to care for others in need of the service.

(2) If a certified health service provider feels uncomfortable in dealing with a pregnant woman who qualifies for termination of pregnancy he or she must respectfully refer the pregnant woman to another health service provider who is willing to provide the services.

(3) A health service provider or an institution does not have the right to conscientious objection in an emergency situation where termination of pregnancy is necessary to save the life of a pregnant woman.

(4) Public health care facilities fall in the public domain. All Government health care facilities have the obligation to ensure that women have access to the services which they are legally entitled to including providing women with the necessary information on legal abortion services.

(5) Conscientious objection should only be respected when expressed by an individual staff member and not as a group action but non-governmental health facilities have a right to conscientious objection.

(6) Conscientious objection only applies to the procedure of terminating the pregnancy and not broader services.

(7) The right to conscientious objection only applies to the health service provider who is directly involved in performing a termination of pregnancy and not support personnel.

5. COUNSELLING AND INFORMATION ON TERMINATION OF PREGNANCY

Standard: Counselling and the provision of information is an essential part in the provision of good-quality services on termination of pregnancy.

All information between the pregnant woman and the health service provider must be kept confidential.

Guidelines

(1) Counselling can be very important in helping a woman consider her options and ensure that she makes a decision free from pressure. Counseling should be mandatory, confidential and provided by a trained person. If the woman opts for termination of pregnancy, a certified health service provider should explain, where applicable, any legal requirements for obtaining it. The woman should be given as much time

as she needs to make a decision, even if it means returning to the clinic later. However, the greater safety and effectiveness of early termination of pregnancy should be explained. The certified health service provider should also provide information to a woman who decides to carry the pregnancy to term, including considerations for placing the child for adoption or in a foster home.

(2) The certified health service provider must provide sufficient and accurate information on the comparative risks of either carrying the pregnancy to term or terminating the pregnancy; and on the potential risks associated with the chosen or preferred method of pregnancy termination.

(3) The information and counselling provided to a woman requesting termination of pregnancy must include the following—

(*a*) options of either to continue or terminate the pregnancy;

(*b*) available methods of pregnancy termination and pain control medication (including the advantages and disadvantages of each);

(*c*) what will be done during and after the procedure;

(*d*) possible short-and long-term risks associated with the method of termination of pregnancy;

(*e*) when to expect resumption of menses;

(*f*) when she will be able to resume her normal activities, including sexual intercourse;

(*g*) follow-up care and prevention of future unwanted pregnancies; and

(*h*) screening for cervical cancer.

(4) The information should be complete, clear, objective and non-coercive, and should be provided in a language that the woman understands. The information should be supplemented with written materials whenever possible.

(5) A certified health service provider should give a woman clear information about which methods are appropriate, based on the gestation age of the pregnancy and the woman's medical condition and potential risk factors.

(6) If the appropriate method is not available, options of referral should be discussed with the woman.

(7) Comprehensive post termination of pregnancy care, which includes contraceptive counseling and methods, must be provided to all women that have undergone termination of pregnancy procedures.

(8) Supportive counselling may be necessary for—

(*a*) adolescents;

(*b*) emotionally distressed women;

(*c*) women suffering complications of pregnancy;

(*d*) women having therapeutic termination of pregnancy;

(*e*) rape, defilement and incest victims; or

(*f*) women infected with HIV.

(9) Information must be given in a way that respects the woman's privacy, dignity and confidentiality.

(10) The health facility and the certified health service provider who provide the service have an ethical obligation not to disclose the information provided by the woman unless permitted by the woman or ordered by a court of law.

(11) All reasonable precautions must be taken to ensure the pregnant woman's confidentiality.

(12) Information may be disclosed for research or statistical purposes, for aiding criminal investigations, or for investigating a case for professional misconduct by a service provider.

6. INFORMED CONSENT

Standard: All women undergoing a procedure to terminate pregnancy must consent to the procedure. A written consent should be obtained before a woman undergoes a procedure to terminate a pregnancy.

Guidelines

(1) Informed consent should include the pregnant woman's affirmation that she understands the procedure and its alternatives, potential risks, benefits and complications and that the decision is uncoerced and that she is prepared to have her pregnancy terminated.

(2) The certified health service provider should determine whether the woman understands medical explanations before signing the consent.

(3) In case of conflict between the woman and the partner/husband, the woman's decision takes precedence.

(4) Certified health service providers must recognize that pregnancy in a child below 16 years of age is the result of defilement which is a criminal offence. Such a child is entitled to termination of pregnancy services as provided by the law.

(5) In the case of a girl child who is below the age of legal consent (below 16 years) the parent's or legal guardian's approval to terminate the pregnancy must be sought.

(6). Certified health service providers should encourage children to seek consent from a parent or legal guardian before seeking services to terminate a pregnancy.

(7) The best interests of the child, in the certified health service provider's honest opinion, will take precedence over that of the parent or guardian and must be made on the principle of evolving capacity of the child to participate in decision making affecting her life, including whether the girl child wants to keep the pregnancy.

(8) A certified health service provider may still terminate a pregnancy of a child where he or she forms an opinion in good faith that the consent of a parent or legal guardian may be difficult to obtain or is being unreasonably withheld and that the termination of the pregnancy is in the best interest of the child.

(9) If a pregnant woman is mentally challenged or is incapable of consenting, the consent of her legal guardian must be sought.

Section 2: Methodology

1. PRE PROCEDURE INVESTIGATIONS

1.1 Laboratory Testing

Standard: Information obtained from the woman's history and from a physical examination should be adequate to confirm the pregnancy and estimate its gestational age.

Guidelines

(1) Laboratory testing for pregnancy may not be necessary, unless the typical signs of pregnancy are not clearly present and the certified health service provider is unsure whether the woman is pregnant. However, obtaining such tests should not hinder timely access to termination of pregnancy.

(2) Measuring haemoglobin or haematocrit levels to detect anaemia in areas where it is prevalent, enables the certified health service provider to initiate treatment and be prepared if haemorrhage occurs at the time of or following the procedure to terminate a pregnancy in pregnancies above 12 weeks gestation.

(3) Tests for ABO and Rhesus (Rh) blood group type should be provided where feasible, especially at higher-level referral centers, in case of complications that might require blood transfusion.

1.2 Ultrasound Scanning

Standard: Ultrasound scanning is not necessary for early termination of pregnancy.

Guidelines

(1) Ultrasound scanning is necessary to confirm severe foetal malformation which is a ground for termination of a pregnancy.

(2) Where ultrasound is used, service delivery sites should, if possible, provide separate areas where women seeking to terminate pregnancies' can be scanned, away from those receiving prenatal care.

1.3 RH-Isoimmunisation

Standard: Passive immunization of all Rh-negative women with Rhimmunoglobulin within 72 hours after termination of pregnancy was recommended in the USA in 1961. There is still no conclusive evidence about the need for immunization of Rh-negative women after first-trimester termination of pregnancy.

Guidelines

(1) Women with pregnancies above 12 weeks should be screened for Rh-negative blood and then provided with Rh-immunoglobulin within 72 hours after the termination of the pregnancy.

(2) Where Rh-immunoglobulin is routinely provided in the facility to Rh-negative women, it should be administered at the time of the termination of the pregnancy.

(3) For women who require administration of Rh-immunoglobulin, that should be done at the time of the prostaglandin administration.

2. PRE-PROCEDURE CARE

2.1. Confirmation of pregnancy

Standard: In all cases, confirm the existence of intrauterine pregnancy and its gestation as a first step.

Guidelines

(1) Taking a woman's history, age, performing a bimanual pelvic examination, conducting the required laboratory investigation, counseling the woman to help her decide between alternative options, and obtaining her consent are all part of the pre-procedure care.

(2) Ask and document the following:

(*a*) obstetric/reproductive history (number of pregnancies, deliveries, abortions);

(*b*) first day of LNMP (Last Normal Menstrual Period);

(*c*) gestational age based on LNMP (note that lactating women may not report a missed period); and

(*d*) medical history such as allergies; and any medical or surgical illness. (Note: assessment of life threatening illnesses as indication for termination and known medical and surgical illnesses that may need special care shall be given due emphasis).

(3) For physical examination, undertake the following:

(*a*) general physical examination to establish the general health of the woman; and

(*b*) bimanual pelvic examination to establish:

(i) uterine size and position; and

(ii) the presence of other uterine pathology such as fibroids.

2.2. Supportive Investigation

Standard: In all cases, establish the health status of the woman. Termination of pregnancy provides an opportunity to screen women for general health well-being before the termination of the pregnancy.

Guideline

For laboratory investigation, perform the following laboratory tests, if available:

(*a*) blood group and RH factors;

(*b*) urine analysis;

(*c*) pregnancy test;

(*d*) venereal Disease Research Laboratory test (VDRL);

(*e*) smear and Gram's stain of vaginal discharge as appropriate; and

(*f*) ultrasound and genetic tests if appropriate.

The absence of any of these, however, should not be reason to prevent the provision of services to terminate pregnancy.

2.3 Cervical preparation

Standard: Preparation of the cervix before surgical termination of pregnancy is necessary to minimize trauma to the cervix.

Guidelines

(1) Nulliparous women, those aged eighteen (18) or below with gestational duration of more than nine (9) weeks and all pregnant women at gestations more than twelve (12) weeks should be considered for priming using—

(*a*) Misoprostol vaginally or orally three to four hours before the procedure; or

(*b*) Mifepristone orally thirty-six (36) hours before the procedure.

3. METHODS FOR TERMINATION OF PREGNANCY

Standard: To reduce risk of complications, the gestational age must always determine the appropriate method of termination of pregnancy.

Guidelines

1st Trimester

(1) Up to nine (9) weeks, the recommended method is the medical method using mifepristone followed by misoprostal.

(2) Unless there is evidence of incomplete evacuation, routine surgical evacuation is not necessary.

From nine (9) weeks to twelve (12) weeks, medical method leads to incomplete evacuation which can be treated by manual or electric vacuum aspiration.

2nd Trimester

(1) From twelve (12) weeks to sixteen (16) weeks, surgical methods like Dilation & Curettage (D & C) using Sharp Metallic Curettage (SMC) may be used.

(2) To minimize cervical trauma, the cervix should be primed.

(3) After sixteen (16) weeks, the procedure should be done by a gynaecologist.

4. PAIN MANAGEMENT

Standard: Pain management is an integral component of a procedure to terminate a pregnancy.

Medication for pain management should always be offered.

Guidelines

(1) The degree of pain varies with the age of the woman, gestational age of the pregnancy, amount of cervical dilation and the fearfulness of the woman.

(2) Time interval of less than two (2) minutes between administration of the local anaesthetic and the beginning of the procedure, lack of choice between local and general anaesthesia, and a history of frequent use of analgesics also contribute to increased pain.

(3) Non narcotic analgesics are usually adequate for pain control after medical termination of pregnancy.

(4) Counselling and sympathetic treatment is likely to reduce woman's fears and perceptions of pain.

(5) Counselling and sympathetic treatment should accompany pharmacological pain management.

(6) For surgical termination of pregnancy, preoperative administration of tranquillizers, such as diazepam can reduce fear and induce relaxation, making the procedure easier for both the woman and the provider.

(7) Supplemental use of narcotic analgesics may also be appropriate, though the possibility of complications such as respiratory depression means that resuscitation capability and narcotic reversal agents must be available.

5. POST—PROCEDURE CARE

(*a*) Standard

Post-procedure care is as essential as care during the procedure in ensuring the best outcome in the provision of termination of pregnancy services.

Guideline

When offering post termination of pregnancy care, refer to the Post Abortion Care Guidelines issued by the Ministry of Health.

(*b*) Standard

Provision of contraceptive information and services is an essential part of reproductive health care as it helps women avoid unintended pregnancies in future.

Guidelines

(1) Every woman must be informed that ovulation can return as early as about two weeks after termination of pregnancy putting her at risk of pregnancy unless an effective contraceptive method is used.

(2) A woman must be given accurate information to assist her in choosing the most appropriate contraceptive method to meet her needs.

(3) The final selection of a method, however, must be the woman's alone.

(4) A woman's acceptance of a contraceptive method must never be a precondition to access termination of pregnancy services.

6. REFFERAL ARRANGEMENTS

Standard: Referral arrangements for social support and care are an integral part of overall termination of pregnancy care. A well-functioning referral system is vital to providing safe and high-quality termination of pregnancy services.

Guidelines

(1) All health personnel involved in the care of the woman have an ethical responsibility to direct women to appropriate services at any time.

(2) Where the type of care that a woman needs is beyond the capacity of the institution, refer her to an appropriate institution.

(3) A referral should only be made by the most senior health service provider on duty.

(4) The referral center should provide feedback to the referring center on the type of complication ascertained, the care provided, the outcome of the treatment, and the plan for subsequent care.

(5) All women referred to the next level of care are entitled to care without any precondition.

7. INSTRUMENTS, MEDICATIONS AND FACILITY REQUIREMENTS FOR TERMINATION OF PREGNANCY

Standard: Health facilities providing safe termination of pregnancy services should be equipped with basic equipment, instruments and consumables that must be replenished regularly.

Guideline

In addition to essential equipment and supplies, the list of basic supplies appearing in Table 2 should always be available in sufficient amounts in all health facilities rendering termination of pregnancy services to ensure quality provision of services.

Table 2

INSTRUMENTS, MEDICATIONS AND FACILITY REQUIREMENTS FOR TERMINATION OF PREGNANCY

Method	Instruments and Medication	Facility Requirements
Vacuum aspiration	– Basic gynecology and medical instruments and supplies (e.g., open speculum, ring or sponge forceps, antiseptic solution, gauze or swabs, gloves), tenaculum – Mechanical dilators (Pratt or Denniston), osmotic dilators, or misoprostal for cervical dilation – Needles and local anesthetic for paracervical block – Analgesics – Suction: manual or electric vacuum aspirator and tubing – Cannulae: flexible or rigid, angled or straight; different sizes – Sieve and glass bowl for tissue inspection	– Instruments and medication – Private area for counselling – Clean treatment and offering privacy – Examination table with leg supports or stirrups – Bed – Stool for provider – Clean water – Strong lighting – Supplies for decontamination and cleaning and high-level disinfection of instruments – Disposable waste container – Adequate toilet facilities
Medical methods of termination of pregnancy	Basic gynecology and medical instruments and supplies (e.g. open speculum, gauze or swabs, menstrual pads, gloves) Depending on the protocol used: – Mifepristone + misoprostal or gemeprost – Analgesics – Glass bowl for tissue inspection All items listed for vacuum aspiration and: – Larger dilators and large bore cannula	– Private area for counselling – Private area with chairs to wait for expulsion separate from women giving birth – Adequate toilet facilities – Capacity to provide or refer for vacuum aspiration
D&C	– Special forceps (e.g. sopher or bierer) for later procedures – Oxytocin	All those listed for vacuum aspiration

Appendix I: Consent Form

Consent Form for Termination of Pregnancy

I, (name of Client)_____of (address)

_____

_____ having consulted with the certified health service provider about my health condition, hereby consent to a procedure for safe termination of pregnancy. I have been counseled and informed about the alternative methods and about the possible side effects and outcomes of the procedure.

In the event of complications arising during the procedure, I request and authorize the responsible certified health service provider to do what is necessary to protect my health and wellbeing.

I confirm that the information that I provided to the certified health service provider is accurate.

Signature or thumbprint_____

Date _____

Witness

Name: .....

Signature: .....

Designation: .....

Appendix II: Universal Precautions

Certified health-service providers involved in providing termination of pregnancy services should follow these universal precautionary measures in order to prevent the transmission of infection from providers to patients, from patients to providers, and to the community:

(*a*) wash hands thoroughly with soap and water immediately before and after contact with each patient;

(*b*) use high-level disinfected or sterile gloves, replacing them between patients and procedures;

(*c*) never use gloved hands to open and close doors or to process instruments;

(*d*) wear clean gowns, aprons, goggle and masks;

(*e*) clean floors, beds, toilets, walls, and rubber draw sheets with detergents and hot water if they are soaked with blood or body fluids, use a 0.5% chlorine solution;

(*f*) wear heavy-duty gloves when cleaning surfaces and washing bed sheets spilled with blood and body fluids and when processing equipment for reuse;

(*g*) dispose of waste contaminated with blood, body fluids, laboratory specimens, or body tissues safely, following facility protocols;

(*h*) avoid recapping needles whenever possible. If necessary, use the scoop method;

(*i*) dispose of sharps in puncture-resistant containers and bury or incinerate them; and

(*j*) all reusable instruments should be soaked in a 0.5% chlorine solution and cleaned with soap and water immediately after use and sterilized or high-level disinfected.

Appendix III: Instrument Processing

Follow specific instructions for processing medical instruments as appropriate. For instruments and equipment that can be reprocessed through high-level disinfection, follow the steps described below:

(*a*) decontamination: soak instruments in a 0.5% chlorine solution for ten (10) minutes;

(*b*) cleaning: clean instruments with warm water and detergent; do not use soap. Wear masks and heavy-duty glove during cleaning.

Disassemble the instrument and make sure all the parts are cleaned thoroughly;

(*c*) high-level disinfection;

(i) soak in a 0.5% chlorine solution for twenty (20) minutes; or

(ii) boil for twenty (20) minutes;

(*d*) note: Rinse with sterile water after processing with chemicals and dry with a sterile towel;

(*e*) store or use immediately: After instruments are processed, they should be kept in a dry, sterile or a high-level disinfected container, protected from dust and other contaminants. Instruments processed with boiling or solutions should be reprocessed every two (2) days until used; and

(*f*) metallic instruments such as tenaculum, speculum and curettes should be sterilized using steam autoclave at a temperature of 121 ^{O}C at pressure of 106 KPa for twenty (20) minutes (following the instructions of the autoclave being used).

Processing Options for Reusable Aspirators

	● **Ipas MVA Plus** ®	● **Single-valve Aspirators**
HLD	● 2% glutaraldehyde (Cidex ®) ● Boiling ● 0.5% chlorine solution	● 2% glutaldehyde (Cidex®) ● 0.5% chlorine solution
Sterilize	● 2% glutaraldehyde (Cidex®) ● Steam autoclave ● STERRAD® processor	● 2% glutaraldehyde (Cidex®)

Processing Options for Reusable Cannulae and Adapters

	● **Ipas MVA Plus**	● **Single-valve Aspirators**
HLD	● 2% glutaraldehyde (Cidex ®) ● 0.5% chlorine solution ● Boiling	● 2% glutaldehyde (Cidex®) ● 0.5% chlorine solution
Sterilize	● Steam autoclave ● 2% glutaraldehyde (Cide®)	Steam autoclave ● 2% glutaraldehyde (Cidex®) ● STERRAD® processor

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LIST OF PARTICIPANTS AT CONSULTATION WORKSHOPS HELD BY THE LAW COMMISSION

LIST OF PARTICIPANTS
CHITIPA DISTRICT, 25TH NOVEMBER, 2013

No.	Name	Address	Designation
1.	Mr. Donald Simwambi	V/H Nankhalamu, Box 73, Chitipa	Village Headman
2.	Mr. Elias Msifukwe	V/H Namayanga, P.O. Box 11, Chitipa	Village Headman
3.	Mr. Lackson Simwambi	GVH Katetula, Box 73 Chitipa	Group Village Headman
4.	Mr. Austin Mtambo	GVH Namuyamba	Group Village Headman
5.	Mr. Adam Msifukwe	GVH Mwanga	Group Village Headman
6.	Mr. Dunwell P Chalya Simfukwe	GVH Chalya	Group Village Headman
7.	Mr. Osky T.J. Mtambo	GVH Mweniyalikeli	Group Village Headman
8.	Mr. B. Chanda	Box 1, Chitipa	Social Welfare Officer
9.	Ms. Betty Mulagha	Box 1 Chitipa	Social Welfare Officer
10.	Ms. Mayani Sichamba	Box 89, Chitipa	Village Headman
11.	Mr. Maclean Muyila	P/Bag 16, Chitipa	Villager
12.	Ms. Rachel Simwanza	Box 99, Chitipa	Villager
13.	Veronica Msopole	Box 84, Chitipa	Villager
14.	Peter Kalinda	Box 83 Chitipa	Villager
15.	Nicholas Chitete	Box 99, Chitipa	Villager
16.	Moses Mtambo	Box 79, Chitipa	Villager
17.	Adams Wundaninge	P/Bag 312, LL3	Reporter
18.	Boston Sichali	Box 90, Chitipa	Teacher
19.	Joyce Silungwe	Box 99, Chitipa	Member, CBO
20.	Bertha Ruyokwa	Box 100, Chitipa	Member, CBO
21.	Lucia Silungwe	Box 100, Chitipa	Member, CBO
22.	Esna Munkhodya	Namuyemba, Box 83, Chitipa	Villager
23.	Martha Chanya	Mwanga Village	Villager
24.	Hilda na Nyondo	Mwanga Village	Villager
25.	Laurine Chilingulo	Box 11, Chitipa	Teacher
26.	Febbie Chiona	Nachiwe School	Teacher
27.	Mercy Mulenga	Box 89, Chitipa	Teacher
28.	Jessie Kilembe	Isyalikila Village	Villager
29.	Atupele Simbeye	Isyalikila Village	Villager
30.	Kizito Mwandira	Isyalikila Village	Villager

31.	Yezgazo Kamoza Kayira	Box 11, Chitipa	Teacher
32.	Greckson Ghambi	Lwambo	Villager
33.	Modrine Chione	Kasinde	Villager
34.	Daniel T.M. Simfukwe	Isyalikila	Villager
35.	Dukamayele Simkonda	Mukombanyama	Villager
36.	Tiyezge Namukonda	Siyombwe	Villager
37.	Joices Namasebo	Namuyemba, Box 83, Chitipa	Villager
38.	Loveness Sichinga	Model School 11	Student
39.	Elias Mbughi	Model School II	Student
40.	Christina Simfukwe	Chitipa Model School	Student
41.	Lyness Nyondo	Nankhalamu	Student
42.	Florence Kyando	Nankhalamu	Student
43.	Esther Naupighu	Katutula	Villager
44.	Jimmy Mwalwanda	Model School	Teacher
45.	Rodai Kuyokwa	Chalya Village Head	Village Head
46.	Esnart Kapenda	Model School	Teacher
47.	L. Msengo	Box 1 Chitipa	Council Clerk
48.	Janet Kaboto	Chitipa District Hospital	Nurse
49.	Andrew Chipeta	Nthalire Health Centre	Clinical Officer
50.	John Banda	Misuku Health Centre	Clinical Officer
51.	Bishop Silent Mtambo	Ebenezer Evangelist Assemblies of God	Bishop
52.	Rev. Chizalo Chirwa	Chikondi CBO	Pastor
53.	Rev. Fr. Edward Juta	Anglican Church	Rev. Father
54.	Rev. William Kasanga	African Int. Church	Pastor
55.	Senior Chief Kameme	Kameme	Senior Chief
56	G.Z. Chirwa	Chitipa District Assembly	District Commissioner
57.	Emmanuel Simpokolwe	Chitipa District Assembly	Director of Administration
58.	E.T. Ndoza	Box 97, Chitipa	Teacher
59.	Ellen Ng'ambi	Maranatha CBO, Box 79, Chitipa	Member
60.	Felix Mwalwimba	Kaseya Mission Hospital, P/Bag 11, Chitipa	Clinical Officer
61.	Mariam Usumani	MAM, Chitipa	Member
62.	Godfrey Simkonda	Kameme	Villager
63.	Boyd Kameme	Kameme	Villager

64.	Batisheba Mukonda	Ifumbo	Villager
65.	N.J. Nyondo	Chinunkha	Villager
66.	Ag. Senior Chief Mwaulambia	Box 1, Ifumbo	Senior Chief
67.	Clement Simchimbo	Chitipa District Hospital	Clinical Officer
68.	Margaret Chawinga	Kaseye Hospital, P/Bag 11, Chitipa	Nurse
69.	Stanely Nyirenda	Chitipa District Hospital, P/Bag 95, Chitipa	Clinical Officer
70.	Felix V. Phiri	Chitipa Police, Box 93, Chitipa	Police Officer (Victim Support)
71.	V.K. Maguare	Chitipa Police	Police Officer (Prosecutor)
72.	Joyce Sibale	Chitipa CCAP School, Box 6, Chitipa	Teacher
73.	Jane Mukumbwa	Kawale F.P. School	Student
74.	Fuliness Nyondo	Namayanga Village	Villager
75.	Samson Sibale	Namayanga Village	Village Headman
76.	Victor M. Muyombe	Chitipa Model School	Teacher
77.	Aaron Simwela	Nankhalamu Village	Villager
78.	Esulon Nyondo	Box 76, Chitipa	Herbalist
79.	Webster Songa	Box 73, Katutula	Herbalist
80.	Dinaless Msonda	Box 73, Chitipa	Herbalist

NKHATABAY DISTRICT, 27TH NOVEMBER, 2013

No.	Name	Address	Designation
1.	Susan Chinoko	Kalambwe CCAP, Box 19, Nkhata Bay	Teacher
2.	Beatrice Harawa	Box 19, Nkhata Bay	Teacher
3.	M'goma Nyamange	Box 50, Nkhata Bay	Teacher
4.	Sambandopa Mphande	Chiphazi Village	Village Headman
5.	Village Head Singo	Singo Village	Village Headman
6.	Robson Nyirenda	Singo Village	Village Headman
7.	G.V.H. Ng'oma II	Kalambwe F.P. School	Group Village Headman
8.	Village Head Khwelenji	Maula	Village Head
9.	Village Head Chiwiwi	Mudyaka F.P. School	Village Head
10.	Village Head Chofya	Kalambwe	Village Head
11.	Village Head Kasingo	Kondowe	Village Head
12.	Village Head Nkhulora	Muchoma	Village Head
13.	Village Head Chokopeke	T.A. Mkumbira	Village Head
14.	GVH Chilera Wana	Box 50, Msani	Group Village Headman
15.	Daniel Nkhoma	Chikale F.P. School, Box 13, Nkhata Bay	Teacher
16.	GVH Jumbo	Box 119, Nkhata Bay	Group Village Headman
17.	Rev. Hannock Ng'oma	Box 39, Nkhata Bay	Pastor
18.	Rev. A. Chapanda Mwale	Box 1, Nkhata Bay	Pastor
19.	TA Mkumbira	Box 1, Nkhata Bay	Traditional Authority
20.	Richard Chirwa (Pastor)	Box 103, Nkhata Bay	Pastor
21.	S. Msuku	Nkhata Bay District Assembly	Council Clerk
22.	Maurice Muthali	Reporter (MCR)	Reporter
23.	Annie Kanyaso	Nkhafu Village	Villager
24.	Enert Nyirenda	Chandiro Village	Villager
25.	Kettie Luhanga	Chandiro Village	Villager
26.	Mary Utonga	Chandiro Village	Villager
27.	Fred Kaluwa	Mulundila Village	Villager
28.	Alice Chiumia	GVM Gulugulu	Group Village Head
29.	Kenesi Kanyaso	GVH Nkholola	Group Village Head
30.	Kenesie Mhone	STA Fuka Malaza	Senior Traditional Authority

31.	Wisdom Ngwira	DIO	District Immigration Officer
32.	His Worship Billy W. Ngosi	District Magistrate Court	Magistrate
33.	His Worship Mwafulirwa	Magistrate Court	Magistrate
34.	B. Mwagomba	OPC	Director of Administration
35.	M. Kasambara	ZBS	Reporter
36.	Phyness Thembulembu	Farmers Union of Malawi	Regional Coordinator
37.	Kayaya Thera	Nkhata Bay District Hospital	District Health Officer
38.	M. Chirwa	Box 13, Kambuwi	Teacher
39.	Aliko Msiska	Box 38, Nkhata Bay	Teacher
40.	Thomas Nyasulu	P/Bag 1, Nkhata Bay	Social Welfare Officer
41.	John K. Chilenga	P/Bag 1, Nkhata Bay	Social Welfare Officer
42.	Isaac Mdinto	P/Bag 1, Nkhata Bay	Social Welfare Officer
43.	Jeffrey W. Luhanga	Box 93, Nkhata Bay	Teacher
44.	William Nkhwazi	VH Nkholova 2, Nkhafu Village	Village Head
45.	Samuel Kaunda	VH Chioko	Village Head
46.	John Kazawala Chunda	c/o VH Chokoperi	Villager
47.	Catherine Banda	VH Mung'ona II	Village Head
48.	Naomi Phiri	VH Singo	Village Head
49.	Ivy Banda	VH Singo	Village Head
50.	Jane Ng'oma	VH Chokopeki	Village Head
51.	Leah Mkorongo	VH Chokopeki	Village Head
52.	Alick Mphande	VH Gomuti	Village Head
53.	Fergison Chirwa	Old Maula	Villager
54.	Sena Banda	Mdyaka	Herbalist
55.	Robert Mwale	DHO	Clinical Officer
56	F. Matewere	P/Bag 1, Nkhata Bay	Council Clerk
57.	Sheik Yunusu Issa	Box 1, Nkhata Bay	Cleric (Moslem)
58.	GVH Kandezo	Box 43, Nkhata Bay	Group Village Head
59.	GVH Kamwadi	Box 210, Nkhata Bay	Group Village Head
60.	GVH Thuli	Box 22, Chinthechi	Group Village Head
61.	STA Fukamalaza	Box 22, Chinthechi	Group Village Head
62.	Daisy Ngwira	St Augustine CDSS	Student
63.	Joseph Mwanyongo	Nkhata Bay DHO	Clinical Officer
64.	Rueben Moyo	Nkhata Bay DHO	Clinical Officer

65.	Evance Kantukule	Nkhata Bay Police	Police Officer
66.	S.V. Mvulayagunda	Nkhata Bay Police, Box 3, Nkhata Bay	Police Officer
67.	M. Kasambala	ZBS	Reporter
68.	W. Ngwira	MANA	Reporter
69.	Janet Chiumia	Mtetete CDSS	Student
70.	E. Lupoka	P/Bag 1, Nkhata Bay	Social Worker
71.	Rhoda Gama	Fuka Mdyaka	Villager
72.	Aggrey Kaunda	Mdyaka	Villager
73.	Esnart M.	Phiri Maula	Villager
74.	Janet Mwenda	Maula	Villager
75.	Andrew Mtayisi	GVH Gulugulu	Group Village Head
76.	Kamalada Kalua	GVH Thuli	Group Village Head
77.	Elifanzi Njikho	VH Chandiro	Village Head
78.	Chepa Mwase	Nkhafu	Villager
79.	Ireen Kaunda	Nkhafu	Herbalist
80.	Lucy Banda	GVH Gulugulu	Group Village Head
81.	Faith I. Mwafulirwa	St. Maria Gorette for the Blind School, Box 22, Nkhata Bay	Teacher
82.	Victoria Mzilahowa	Chindazwa School, Box 13, Nkhata Bay	Teacher
83.	Rev. Bright Chipasi Chirwa	Nkhata Bay CCAP Bright.chirwa@ymail.com	Reverend Minister
84.	Emmanuel J. M. Kumwenda	DEM, Box 13, Nkhata Bay	District Education Officer
85.	Rev. David Kachali Kandawire	Peace Ministries, Box 103, Nkhata Bay	Pastor

NKHOTAKOTA DISTRICT, 28TH NOVEMBER, 2013

No.	Name	Address	Designation
1.	Evyness M. Chiwaya	FOCCAD, Box 238, NKHOTAKOTA	District Coordinator
2.	Brian Nkhoma	NASO, Box 430, NKHOTAKOTA	Coordinator
3.	Stanley Mbewa Phiri	Box 6, Sani, NKHOTAKOTA	Villager
4.	James Mtema	Lozi Youth Org. Box 5, Lozi, NKHOTAKOTA	Member
5.	Rebecca Kauzeni	Lozi Youth Org Box 5, Lozi, NKHOTAKOTA	Member
6.	Joshua Mtema	Lozi Youth Org Private Bag 6, Lozi, NKHOTAKOTA	Member
7.	Charity Chandemba	P/Bag 40, NKHOTAKOTA	Teacher
8.	Mrs. A.T. Bita	NKHOTAKOTA Sec. School, P/Bag 14, NKHOTAKOTA	Teacher
9.	Mr. F. Gungwe	NKHOTAKOTA Sec. School, P/Bag 14, NKHOTAKOTA	Teacher
10.	Maliza Nyundo	Mwansambo, NKHOTAKOTA	Villager
11.	Grace Chitsamba	Mwansambo, NKHOTAKOTA	Villager
12.	Brenda Chiliwayo	Mwansambo, NKHOTAKOTA	Villager
13.	Ana Malamuro	Mwansambo, NKHOTAKOTA	Villager
14.	Grace Bowa	Mwansambo, NKHOTAKOTA	Villager
15.	Kafereni Kambuzi	Mwansambo, NKHOTAKOTA	Villager
16.	Judith Malanda	Mwansambo, NKHOTAKOTA	Villager
17.	Mercy Billy	Mwansambo, NKHOTAKOTA	Villager
18.	Zione Kholowa	Mwansambo, NKHOTAKOTA	Villager
19.	Edina Bowa	Mwansambo, NKHOTAKOTA	Villager
20.	G. Tambala	Malengachanzi, NKHOTAKOTA	Villager
21.	Amina Lufani	GVH Malengachanzi, NKHOTAKOTA	Group Village Head
22.	Esinati Amosi	Box 44, Mwansambo, NKHOTAKOTA	Villager
23.	Dexter B. S. Mvula (VH Nkhongo)	P/Bag 2, Mwansambo, NKHOTAKOTA	Village Head
24.	Mafukeni Bonongwe	Box 14, Mwansambo, NKHOTAKOTA	Villager
25.	Jenala Kalakata	Mwansambo, NKHOTAKOTA	Villager
26.	Jailosi Esawo	P/Bag 2, Mwansambo, NKHOTAKOTA	Villager
27.	Leonard Zimba	Box 23, Mwansambo, NKHOTAKOTA	Villager
28.	Bothwel Bandala	Box 14, Mwansambo, NKHOTAKOTA	Villager

29.	Michael Nyirenda	Box 23, Mwansambo, NKHOTAKOTA	Villager
30.	Moses Kuliramboni	Box 23, Mwansambo, NKHOTAKOTA	Villager
31.	Brenda Mandala	P/Bag 2, Mwansambo, NKHOTAKOTA	Villager
32.	Jotamu James	Box 25, Mwansambo, NKHOTAKOTA	Villager
33.	James K. Mbwana	Box 67, NKHOTAKOTA	Villager
34.	Cathrine Sauzande	Box 67, NKHOTAKOTA	Villager
35.	Deans R. Chilao	Box 19, NKHOTAKOTA	Villager
36.	Christina Tchoka	Box 133, NKHOTAKOTA	Villager
37.	Pauline Mambia	Box 133, NKHOTAKOTA	Herbalist
38.	TA Mwansambo	Box 16, Mwansambo, NKHOTAKOTA	Traditional Authority
39.	S/TA Malengachanzi	P/Bag 48, NKHOTAKOTA	Senior Traditional Authority
40.	Malani Moyo	P/Bag 48, NKHOTAKOTA	Director of Administration
41.	Veronica P. Chisemphere	NKHOTAKOTA District Assembly, Box 50, NKHOTAKOTA	Council Clerk
42.	Jonathan Nyasulu	NKHOTAKOTA District Assembly, Box 50, NKHOTAKOTA	Social Welfare Officer
43.	Alhaji Rasheed	NKHOTAKOTA Radio, P/Bag 48, NKHOTAKOTA	Reporter
44.	Dickson Chirwa	NKHOTAKOTA Police, Box 140, NKHOTAKOTA	Police Officer
45.	James Muyila	NKHOTAKOTA Police, Box 140, NKHOTAKOTA	Police Officer
46.	Rev. A.R.N. Mwenitete	CCAP, Box 5, NKHOTAKOTA	Reverend Minister
47.	Faith Banda	NKHOTAKOTA DHO, Box 50 NKHOTAKOTA	Nurse
48.	Leonard Gama	St. Anne's Hospital	Clinical Officer
49.	Elizabeth Mneta	St. Anne's Hospital	Nurse
50.	Pastor I. Maganga	Living Waters Church, NKHOTAKOTA	Pastor
51.	Pastor B. Kapotera	Calvary Family Church	Pastor
52.	Sheik Ibadi	MAM	Member

MCHINJI DISTRICT ASSEMBLY, 29TH NOVEMBER, 2013

No.	Name	Address	Designation
1.	Wilson Sonkhwe	Box 12, Mikundi	Villager
2.	J. Gandura	Mponda Village	Villager
3.	M. Ledison	Disimasi Village	Herbalist
4.	S. Miti	Chidambo Village	Villager
5.	Petro Mtambalika	Langa Village	Villager
6.	Gladys Nkhuwa	Chimuti Village	Villager
7.	Modester Mawindo	Nyamawende Village	Herbalist
8.	Ephrida Agness Bonongwe	Kalonga Village	Villager
9.	Safira Sanga	Langa Village	Villager
10.	Falesy Banda	Langa Village	Villager
11.	Emmanuel Enea Msambiro	Pinda School	Teacher
12.	Patricia Jere	Zulu	Villager
13.	Matilda Lungu	Zulu	Villager
14.	Enelles Nyale	P/Bag 1, Mchinji	Council Clerk
15.	Onesta Katambo	Mchinji Boma	Teacher
16.	Joseph Zulu	Mchinji Boma	Teacher
17.	Michael Mgwalima	Mchinji Boma	Teacher
18.	Wezzie Gausi	Box 207, Mchinji	Nurse
19.	Emma L. Loga	Box 43, Mchinji	Nurse
20.	Molicious Pwandapwanda	Box 21, Mkanda, Mchinji	Villager
21.	Mataya Nebati	Box 1 Mkanda, Mchinji	Villager
22.	Constance Zulu	Mchinji	Nurse
23.	Samson Juliyasi	Mchinji	Clinical Officer
24.	L. Lungu	Mchinji	Nurse
25.	Thomas Adriano (GVH Mponda)	Mchinji, STA Nyoka	Group Village Headman
26.	Gilbeta Phiri	Mgalima Village	Villager
27.	Matilda Moses	Chidambo Village	Villager
28.	Edisa Masaila	Bua CDSS	Student
29.	Horrace Khoviwa	Bua CDSS	Student
30.	Mabel Dzuwa	Mikundi School	Student
31.	Petro Jere	Mchinji	Teacher

32.	Makilina Chimutu	Mchinji	Teacher
33.	Dorothy Fulakisoni	Box 12 Mikundi	Teacher
34.	Harex Chimwaza	Rusa School, Box 12, Mikundi	Teacher
35.	Chithaweni Zulu	Zulu	Herbalist
36.	Yobu Michael	Zulu	Villager
37.	Philip Kamchikwe	Box 32, Mchinji	Teacher
38.	Disi Benson	Box 56 Magawa	Teacher
39.	Martha Chitembe	Box 100, Magawa	Teacher
40.	Trinity Mkifumba	P/Bag 4, Mchinji	Student
41.	Temwani Phiri	P/Bag 4, Mchinji	Student
42.	Frank Mkwapatira	Box 56, Magawa	Teacher
43.	Lazaro Isaki	Box 32, Mchinji	Police Officer
44.	Elletina Frackson	Box 227, Mkanda	Medical Practitioner
45.	Henrieta Jere	Box 243, Mchinji	Nurse
46.	Matthews Khungwa (TA Zulu)	Box 6, Magawa	Teacher
47.	Rodgers Fombe	Box 29, Mchinji	Clinical Officer
48.	Faliot N. Hara	Box 33, Mchinji	Faith Community
49.	Rodrick Langa	Box 24, Mchinji	Faith Community
50.	Inkosi Nyoka Box 145, Mchinji	Limba We Ndaba Hqrs,	Traditional Authority
51.	Shadreck Botomani	Mchirwa Village, Box 128, Kapiri, Mchinji	Villager
52.	Siileni Samuel	Mchirwa Village. Box 128, Kapiri, Mchinji	Villager
53.	Siicola Benedicto	Mchirwa Village, TA Kapondo	Villager
54.	Feliasi Sinosi	GVH Mchirwa, TA Kapondo, Mchinji	Group Village Head
55.	P. Manyungwa	Mchinji District Assembly, P/Bag 1, Mchinji	Director of Administration
56.	Daniel Mulinde	Kamwendo Village, Box 16, Magawa	Villager
57.	Rose Kulima	Ludzi Hospial, Box 30, Mchinji	Nurse
58.	Limbani Panulo	Ludzi Hospital, Box 30 Mchinji	Nurse
59.	Lington Fred Gwazeni	Assemblies of God, Box 208, Mchinji	Pastor
60.	Lapken Gogoda	Mchinji District Hospital, Box 36, Mchinji	Clinical Officer

61.	Lameck Mzava	Mchinji DHO, Box 36, Mchinji	District Health Officer
62.	Humphreys Makhalira	Mchinji Police, Box 131, Mchinji	Police Officer
63.	Walter Chikuni	Mchinji District Assembly, P/Bag 1, Mchinji	Council Clerk
64.	Sr. B. Chidatha	Ludzi Hospital, Box 30, Mchinji	Nurse
65.	Memory Katchuka	Mchinji District Hospital, Box 36, Mchinji	Nurse
66.	Edda Sani	Mchinji District Hospital, Box 36, Mchinji	Nurse
67.	Pastor Thomas Kayira	Mchinji SDA Church, Box 29, Mchinji	Pastor
68.	Fr. M. Sitolo	Kachebere Parish, Box 23, Mchinji	Parish Minister
69.	S.N. Chifomboti	Magistrate Court, Box 6, Mchinji	Magistrate
70.	R.M. Mejja	Magistrate Court, Box 6, Mchinji	Magistrate
71.	Rev. S.N. Jordan	P/Bag 7, Mchinji	Pastor
72.	Catherine Balaka	Mchinju District Health Office	Nurse
73.	Airedi Zabuloni	Gilleme Community Hospital, Box 230, Magawa	Clinical Officer
74.	Emmanual Mpoola	Mchinji District Hospital, Box 36, Mchinji	Clinical Officer
75.	E.M. Chipojola	Mchinji Police, Box 131, Mchinji	Police Officer
76.	Helen Makukula	Women's Hope For Change	Chairperson
77.	Victoria J. Banda	Mchinji District Hospital, Box 36, Mchinji	Nurse
78	Ines Chayamba	Ludzi F.P. School, Box 95,	Teacher

DEDZA DISTRICT, 13TH DECEMBER, 2013

No.	Name	Address	Designation
1.	Grant Katengeza	Kapesi Vilage, Dedza	Villager
2.	Supt. Lucy Hankey	Dedza Police	Police Officer
3.	Sheik Ali Bwanali	Dedza Islamic Mosque	Sheik
4.	Austin N. Maere	Dedza Magistrate Court, Box 139, Dedza	Magistrate
5.	Mary Zinyemba	Nazarene Church	Member
6.	Pastor S. Bandah	Nazarene Church	Pastor
7.	Magret Phaelord	Nazarene Church	Sunday School Teacher
8.	Naomi Zakaria	Nazarene Church	Member
9.	Mai Germany	SDA Women's Guild	Chairperson
10.	George J.M. Gondwe	Dedza SDA Church	Member
11.	TA Kasumbu	Dedza District Council	Traditional Authority
12.	TA Kamenya Gwaza	Bembeke Headquarters	Traditional Authority
13.	Ngoli Thelela	Dedza District Council	Council Clerk
14.	Selestina Zimpita	GVH Kapanika	Group Village Head
15.	Inspector Patrick Chambuluka	Dedza Police	Police Officer
16.	Gladys Rino	Nazarene Church	Member
17.	Pastor Rino	Nazarene Church	Member
18.	Aaron Mpalale	Social Welfare	Social Welfare Officer
19.	Lawford Palani	Dedza District Council	District Commissioner
20.	Dans Phiri	WOLRES	Member
21.	Chifundo Ching'ani	Box 177, Dedza	Cathotholic Commission for Justice and Peace
22.	Lufeyo Ngwira	Box 177, Dedza	Cathotholic Commission for Justice and Peace
23.	Ken Katunga	Box 177, Dedza	Cathotholic Commission for Justice and Peace
24.	Mphatso Kamwana	Dedza Police	Police Officer
25.	Maziko Nkhoma	Dedza Police	Police Officer
26.	Naliet Khulungira	Box 177, Dedza	Cathotholic Commission for Justice and Peace
27.	Wycliff Khulungira	Box 177, Dedza	Cathotholic Commission for Justice and Peace
28.	Prisca Kachepa	Dedza Police	Police Officer

29.	Christina Jim	Nazarene Church	Member
30.	Asiatu Belo	Nazarene Church	Member
31.	Maliamu Tayali	Kumathenje	Muslim Association of Malawi
32.	Alinafe Chikafa	Chisomo Youth Club	Member
33.	M. Mawela	Centre for Youth Empowerment and Civic Education	Member
34.	Lingious Zimba	Chisomo Youth Club	Member
35.	Samson Dickson	Dedza Active Youth Organization	Member
36.	Divert Kamvabingu	Chisomo Youth Club	Member
37.	Prisca Kachepa	Kaundu Village	Villager
38.	Eluby Maloni	Mphunzi, Box 26, Dedza	Teacher
39.	Austin Balakasi	Box 280, Dedza	Teacher
40.	Mickson Saini	Box 136, Dedza	Teacher
41.	Violet Mbepula	Box 126, Dedza	Teacher
42.	Sophie Hemeyani	Box 136, Dedza	Teacher
43.	GVH Kapezi	Box 31, Dedza	Group Village Head
44.	GVH Mulangali	Box 60, Dedza	Group Village Head
45.	GVH Khulungira	Box 314, Dedza	Group Village Head
46.	VH Nampinga	Makankhula Village	Village Head
47.	Sellina Pondeponde	Dzanja Village	Villager
48.	Towera M. Mfune	Dedza Air Field	Police Officer
49.	Gladys Masikale	Mapinga Village	Villager
50.	Esinta Belo	Mapinga Village	Villager
51.	Innocent Chunga	Bisalomu Village	Villager
52.	Dickson Ngayiyaye	Chapatali Village	Villager
53.	Yamikani Sabila	Box 110, Dedza	Muslima Association of Malawi
54.	Beatrice Magombo	Kapalalamula Village	Villager
55.	Emily Malata	Kapalamula Village	Villager
56.	VH Kapalamula	Kapalamula Village	Villager
57.	Felestina Dzonjo	Kunkalero Village	Villager
58.	Esnart Kanthukako	Napinga Village	Villager
59.	Lita Mohondo	Kumterera Village	Villager
60.	VH Chapatali	Box 177, Dedza	Catholic Commission for Justice and Peace

61.	VH Abisalomo	Box 177, Dedza	Cathotholic Commission for Justice and Peace
62.	A.B. Chimchenga	Box 11, Dedza	Teacher
63.	C.P. Tolokosi	Box 80, Dedza	Teacher
64.	VH Pinji	Box 177, Dedza	Cathotholic Commission for Justice and Peace
65.	Gliselia Chiwayula	Box 177, Dedza	Cathotholic Commission for Justice and Peace
66.	Lucy Kakale Bongololo	Box 177, Dedza	Cathotholic Commission for Justice and Peace
67.	Dorothy Bizaliyele	Box 26, Dedza	Nurse
68.	Ellen Mkutu	Box 26, Dedza	Nurse
69.	VH Nampinga	P/Bag 2, Linthipe	Village Head
70.	VH Lowedi Potoloni	GVH Kuntera	Group Village Head Nyakwawa
71.	Mary Kam'madzi	Box 119, Dedza	Nurse
72.	Afinesi Kajawa	Box 177, Dedza	Cathotholic Commission for Justice and Peace
73.	Florence Donda	Box 131, Dedza	Teacher
74.	Irene Chonde	Box 119, Dedza	Teacher
75.	Esther Jasoni	Box 15, Dedza	Teacher
76.	Febbie Tiwonge Phiri	P/A Bembeke, Dedza	Teacher
77.	Loveness Levison	Box 177, Dedza	Cathotholic Commission for Justice and Peace
78.	Judith Mandalasi	Box 26, Dedza	
79.	Agness Kanyadira	Box 177, Dedza	Cathotholic Commission for Justice and Peace
80.	Rhodha Giviyere	Box 177, Dedza	Cathotholic Commission for Justice and Peace
81.	Ellard Lumbe	Box 92, Dedza	Teacher
82.	Naliyeti Khulungira	Nkhulungira Village	Villager
83.	Lufina Kh	Nkhulungira Village	Villager
84.	Ndasilambuzo Njoloma	Box 10, Mpalale	Teacher
85.	Adriano Chapala	Box 10, Mpalale	Teacher
86.	Pangaunye Chinsewu	Box 10, Mpalale	Teacher
87.	Kondwani Gondwe	Box 177, Dedza	Cathotholic Commission for Justice and Peace
88.	Willam Matemba	Msasa School, Dedza	Teacher

MANGOCHI DISTRICT, 9TH DECEMBER, 2013

No.	Name	Address	Designation
1.	Lyson G. Misanjo	St. Augustine 1 F.P. School, Box 124, Mangochi	Teacher
2.	Samuel Nasoro	St. Augustine 1 F.P. School, Box 124, Mangochi	Teacher
3.	Grace Mwandelire	St. Augustine 1 F.P. School, Box 124, Mangochi	Teacher
4.	Victoria Ndau	St. Augustine 1 F.P. School, Box 124, Mangochi	Teacher
5.	Lister T. Dandaula	St. Augustine 1 F.P. School, Box 124, Mangochi	Teacher
6.	Dr. Championi Jemuzi	Traditional Healer (Sing'anga), Box 278, Mangochi	Herbalist
7.	Thomas V. Mbwana	St. Augustine 1 F.P. School, Box 124, Mangochi	Student
8.	Atusunje Ntenje-Chawe	Mangochi Sec. School, P/Bag 1, Mangochi	Student
9.	Rev. Jervis M. Theu	Mangochi Sec. School, P/Bag 1, Mangochi	Pastor
10.	Sophie Balakasi	Mangochi District Council	Social Welfare Officer
11.	Yusuf Daisa	Umoyo FM	Reporter
12.	Andrew Silumbu	MANA	Reporter
13.	Loveness Dazimata	MBC, Private Bag 268, Blantyre	Reporter
14.	Green Kuntelepano	Umoyo FM	Reporter
15.	Mdala Saidi	Mangochi Boma	Traditional Healer (Sing'anga)
16.	Siwone William	Kausi Village, Mangochi	Traditional Healer (Sing'anga)
17.	Pongolani Ngoleka	Mponda, Mangochi	Senior Chief
18.	Afick Kandeu	Kausi Village, Mangochi	Villager
19.	Village Headman Kausi	Kausi Village, Mangochi	Village Head
20.	Village Headman Likala	Likala Village, Mangochi	Village Head
21.	Village Headman Mwalija	Mwalija Village, Mangochi	Village Head
22.	S/Supt. S.H. Kausiwa	Mangochi Police, Mangochi	Police Officer
23.	Senior GVH Mpinganjira	Senior Chief Mponda, Mangochi	Senior Group Village Head
24.	GVH Mapira	Senior Chief Mponda, Mangochi	Group Village Head

25.	Senior Chief Chimwala	Senior Chief Chimwala, Mangochi	Senior Chief
26.	GVH Kukalanga	Senior Chief Mponda, Mangochi	Group Village Head
27.	Filte Thomas	Chipalamawamba Village, Mangochi	Villager
28.	Baina Kalitendere	Chipeta Village, Mangochi	Villager
29.	Mariam Awalu	Chipeta Village, Mangochi	Villager
30.	Alabi Majidu	Malunda Village, Mangochi	Villager
31.	Zainabu James	Malunda Village, Mangochi	Villager
32.	Felix Tambulasi	Social Welfare, Mangochi	Social Welfare Officer
33.	Juma Jamali	Kalonga Village, Mangochi	Villager
34.	Y.C. Mwale	Community Development, Min. of Gender, Mangochi	Development Officer
35.	Annie Bwanali	Ngoyi Village, Mangochi	Villager
36.	Tumale Kamwendo	Ngoyi Village, Mangochi	Villager
37.	Agness	Ngoyi Village, Mangochi	Villager
38.	Jannet Hassan	Chimwala Village, Mangochi	Villager
39.	Fatima Abudu	Chimwala Village, Mangochi	Villager
40.	Esnart Michael	Chimwala Village, Mangochi	Villager
41.	Beatrice Majawa	Ngoyi Village, Mangochi	Villager
42.	Roseby Mpelepele	Ngoyi Village, Mangochi	Villager
43.	Esther Allie	Ngoyi Village, Mangochi	Villager
44.	Dyna Matola	Ngoyi Village, Mangochi	Villager
45.	Margret Jali	Ngoyi Village, Mangochi	Villager
46.	Yassin Mailosi	Ngoyi Village, Mangochi	Villager
47.	M'bwana Chombe	Ngoyi Village, Mangochi	Villager
48.	Esther Kandinda	Mangochi District Hospital	Nurse
49.	Chief Ukalanga	Box 21 Nkungulu, Mangochi	Village Head
50.	Chief Simika	TA Chimwala, Mangochi	Village Head
51.	Edina Bonzo	TA Chimwala, Mangochi	Villager
52.	Elias Mwase	Calvary Family Church	Pastor
53.	Liniton Salanje	Mwachande Village, Mangochi	Herbalist
54.	Hawa Haju	Mwachande Village, Mangochi	Villager
55.	Regina Mnokote	Mwachande Village, Mangochi	Villager
56	Issa Bwanali	Mwachande Village, Mangochi	Villager
57.	Gresham Simioni	Saiti Kadzuwa Village, Mangochi	Villager

58.	Samson Asbu	Katapwijo Village, Mangochi	Villager
59.	Jamali J. Kanonji	Bwanali Village, Mangochi	Villager
60.	Rev. Laz Kadango	Mangochi CCAP, Box 39, Mangochi	Reverend
61.	Village Headman Satikazuwa	Satikazuwa Village, Mangochi	Village Head
62.	Asani Saidi	Mgundaphiri Village, Mangochi	Villager
63.	Leonard S. Chilembwe	Mgundaphiri Village, Mangochi	Villager
64.	Umali White	Chiganga Village, Mangochi	Villager
65.	Rosemary Mpetiwa	Catholic Health Commission, Box 266, Mangochi	Nurse
66.	Very Rev. John Chilombe	Mangochi Anglican, Box 54, Mangochi	Reverend Fr.
67.	Msadi Useni	Kasalo Village, Mangochi	Villager
68.	GVH Chiwaula	Box 186, Mangochi	Group Village Head
69.	GVH Chipalamawamba	Box 124, Mangochi	Group Village Head
70.	GVH Mtambo	Box 123, Mangochi	Group Village Head
71.	GVH Mwichande	Box 36, Mangochi	Group Village Head
72.	GVH Chipeta	Box 36, Mangochi	Group Village Head
73.	GVH Malunda	Box 231, Mangochi	Group Village Head
74.	Village Headman Ngoyi	Box 101, Mangochi	Village Head
75.	Lemusoni	Village Headman Ngoyi	Villager
76.	Buka Fayala	Village Headman Ngoyi	Villager
77.	Salim Mumba	Village Headman Ngoyi	Villager
78.	Asiyatu Ajisoni	Village Headman Ngoyi	Villager
79.	Yona Yunusu	Village Headman Ngoyi	Villager
80.	Matenje Egesi	Village Headman Ngoyi	Villager
81.	Joyce Mbewe	Village Headman Ngoyi	Villager
82.	Atima Lunde	Mwichande Village, Mangochi	Villager
83.	Sophie Balakasi	Mwichande Village, Mangochi	Villager
84.	Bilaya Kabichi	Mwichande Village, Mangochi	Villager
85.	Robert Kapengule	Mwichande Village, Mangochi	Villager
86.	Carozeni Chiponda	Mwichande Village, Mangochi	Villager
87.	Efford Kamphonje	Mwichande Village, Mangochi	Villager
88.	Dr. William Peno	Mangochi District Health Office	District Health Officer

ZOMBA DISTRICT, 10TH DECEMBER, 2013

No.	Name	Address	Designation
1.	GVH Kumbwani	TA Kuntumanja, Zomba	Group Village Head
2.	Cecilia C. Mzuwala	Namiwawa School	Teacher
3.	Dorothy M. Namauti	Namikhate School	Teacher
4.	Mumdelanji Malikebu	TA Chikowi	Villager
5.	Florence Kaombe	TA Kumtumanji	Villager
6.	Emily Joni	TA Mulumbe	Villager
7.	Silveria Amoni	TA Mbiza	Villager
8.	Esnart Lilani	Mulunguzi School	Teacher
9.	Lloyd Kalongonda	Minama	Teacher
10.	Robert H. Paul	Sanabu	Teacher
11.	Apex Mtiwa	Minama	Teacher
12.	Chilungamo Nantongwe	TA Malemia	Villager
13.	Beston Kalongonda	TA Kumtumanji	Villager
14.	Harry Mgala	St. Anthony TDC	Teacher
15.	GVH Mtogolo	TA Malemia, Box 18, Domasi	Group Village Head
16.	Lameck Chitowe	Mateketa School, Box 74, Zomba	Student
17.	Andson A. Waiti	Box 133, Domasi	Student
18.	William Chilomoni	Box 453, Zomba	Teacher
19.	Addition Maononga	Box 206, Zomba	Teacher
20.	Innocent Bisika	Box 22, Zomba	Information Officer
21.	Raymond Siyeye	Chanco Radio	Reporter
22.	Adraida Lijambe	Matiya F.P. School, Box 84, Jali Malemia F.P. School, Box 16,	Student
23.	Edith Kambalame	Zomba	Student
24.	Hilda Majoni	Magomero	Villager
25.	Hawa Buleya	Box 23, Mayaka, Zomba	Herbalist
26.	Gift D.M. Kawiza	Box 49, Domasi	Villager
27.	GVH Sanobu	Mulumbe Headquarters	Group Village Head
28.	William Chiwaya	Box 84, Jali, Zomba	Villager
29.	Edward Liwaya	Ntholowa Youth Network	Chairperson
30.	Maluza Magombo	Ntholowa Village, TA Mbiza, Zomba	Villager
31.	Sita Chitsonga	Senior Chief Mlumbe, Zomba	Villager

32.	Wassi Inussa	Senior Chief Mulumbe	Villager
33.	B. Maulidi	Zomba District Assembly	Director of Administration
34.	W.A. Chirwa	Zomba District Assembly	Social Welfare Officer
35.	Brenda Tawakali	Lifani F.P. School, Box 83, Zomba	Student
36.	Sambileni Kachulu	Namitoso L.E.A. School, Zomba	Student
37.	Notifort Chipoja	Ayelamazi F.P. School, Zomba	Student
38.	Nastizoyo Kasichi	Sakata Box 1, Zomba	Villager
39.	Lingso Mwalule	Mwambo	Teacher
40.	Dinnes Moses	TA Mbiza	Villager
41.	Charles Kanyambujo	Dzaone Youth Network TA Chikowi	Chairperson
42.	Agness Matiya	St. Pius School	Student
43.	Eliza Chimala	GVH Jia	Villager
44.	Loveness M. Phiri	St. Michaels Zone Box 453, Zomba	Teacher
45.	Bertha Phiri	Ntonda Zone, Box 5, Jali, Zomba	Teacher
46.	Madalitso Soko	Kaunde Zone	Teacher
47.	Cathren Gogoda	Likhomo Mlewa	Teacher
48.	M.K. Nkhoma	Kaunde Zone	Teacher
49.	V.K. Mpoya	Kaunde Zone	Teacher
50.	Eunice Chimenya	Kaunde Zone	Teacher
51.	Moses Chimowa	Kaunde Zone	Teacher
52.	GVH Mtogolo	Mtogolo Village	Group Village Head
53.	Duncan Lupiya	Zomba DHO, P/Bag 18, Zomba	District Health Officer
54.	Joseph Chibwenje	Pirimiti Hospital, Box 120, Zomba	Nurse
55.	Agness Chikoko	Banja La Mtsogolo, P/Bag 27, Zomba	Nurse
56	F.J. Mpinganjira	Compassionate Mission Centre	Medical Practitioner
57.	Josphine Chigawa	Zomba Prosecution Office, Box 45, Zomba	Police Officer
58.	Andrew V. Chavi	Judiciary, Box 109, Zomba	Magistrate
59.	Senior Chief Chikowi	Box 23, Zomba	Senior Chief
60.	STA Mkagula	Box 23, Zomba	Traditional Authority
61.	STA Ngwelero	Box 23, Zomba	Traditional Authority
62.	STA Nkapita	Box 23, Zomba	Traditional Authority
63.	STA Ntholowa	Box 23, Zomba	Traditional Authority
64.	TA Mbiza	Box 23, Zomba	Traditional Authority

NSANJE DISTRICT, 11TH DECEMBER, 2013

No.	Name	Address	Designation
1.	Emily Tukuwa	Nsanje Sec. School, Box 40, Nsanje	Teacher
2.	Emmanuel Molosen	Nsanje Sec. School, Box 40, Nsanje	Teacher
3.	Zione Julius	Nsanje Sec. School, Box 40, Nsanje	Student
4.	Tina Mtendere	Nsanje Sec. School, Box 40, Nsanje	Student
5.	Sharmem Laston	Nsanje Sec. School, Box 40, Nsanje	Student
6.	Abigail Chikago	Nsanje Sec. School, Box 40, Nsanje	Student
7.	Bright Nkhoma	Nsanje Sec. School, Box 40, Nsanje	Student
8.	Fat Hassan	Nsanje Sec. School, Box 40, Nsanje	Student
9.	Charles Chalongwa	Nsanje Sec. School, Box 40, Nsanje	Student
10.	Amon Biasi	Nsanje Sec. School, Box 40, Nsanje	Student
11.	Grabes Fraku	Nsanje Sec. School, Box 40, Nsanje	Student
12.	Regina Tchapo	Box 30, Nsanje	Herbalist
13.	Ganizani Ronnex	P.O. Nsanje	Hebalist
14.	Pascar Nyathando	Chiphwembwe, Nsanje Boma	Villager
15.	Jane Kanyuchi	Chiphwembwe, Nsanje Boma	Villager
16.	Jenala Phiri	Nsanje Catholic School	Teacher
17.	Chanazi Binzi	Chiphwembwe	Villager
18.	Joshua David Morish	Box 91, Nsanje	Teacher
19.	Peter Kapenda	Nyamadzi School, Box 19, Nsanje	Teacher
20.	Cathrine Bade	Nsanje Catholic School	Teacher
21.	Martin Chiwanda	Nsanje District Council	Social Welfare Officer
22.	Fage Mero	Mbeta Village	Villager
23.	Khristina Hale	Kasenga Village	Villager
24.	Alefa Joe	Mbeta Village	Villager
25.	Rose Paul	Chiphwembwe	Villager
26.	Baxter Chilongoh	Malemia Village	Villager
27.	Gradys Dalitso	Mbeta Village	Villager
28.	Simba Suwali	Thawalawa, Box 172, Nsanje	Teacher
29.	Talisa Valeta	Box 19, Nsanje	Teacher
30.	Doreen Misson	Malemia Village	Villager
31.	Lucy Michael	Nthukuso Village	Villager
32.	Gerald Sandram	c/o Box 33, Nsanje	Teacher

33.	Enock Wilson	Nthukuso Village	Villager
34.	Frances Bastor	Nthukuso Village	Villager
35.	Bitiresi Patireki	Nthukuso Village	Villager
36.	Elina Joe	Chazuka Village	Villager
37.	Valiyet Balanando	Chazuka Village	Villager
38.	Malia Nakhalapapi	Siviyeli Village	Villager
39.	Paulo Geofrey	Mbeta Village	Villager
40.	James Balaka	Box 1, Nsanje	Social Welfare Officer
41.	Shadreck Hapalikusa	Box 1, Nsanje	Social Welfare Offier
42.	James Julias	Box 1, Nsanje	Council Clerk
43.	Benford Beka	Box 1, Nsanje	Council Clerk
44.	Obedi Amosi	Box 83, Nsanje	Member Community Health Committee
45.	Smart Divason	Box 8, Marka	Faith Community
46.	Zeka Joe	Box 83, Nsanje	Member Community Health Committee
47.	Glina Million	Box 83, Nsanje	Member Community Health Committee
48.	Luka Kamiza	Box 169, Nsanje	Herbalist
49.	Michael Miles	Nthukuso Village	Villager
50.	Mafresi Khope	Thawalawa Village	Villager
51.	Mary Kukhala	Mbeta Village	Villager
52.	Malita Kholosi	Mbangu Village	Villager
53.	Velocica Chavi	Chiphwembwe Village	Villager
54.	Faina Mphimba	Ndenguma Village	Villager
55.	Aida Tiyago	Thawalawa Village	Villager
56.	Evelyn Suzumire	Mankhusu Village	Villager
57.	Meck Kuzakuyenda	Mankhusu Village	Traditional birth attendant
58.	E. Nema	Nsanje District Council	Director of Administration
59	Alfred Guta	ZBS	Reporter
60.	Petro Anyenzi	TA Mlolo, Muowa Nsanje North	Traditional Authority
61.	Bile Daglas	Ndamera Village	Villager
62.	Efrem Mkwezeka	Chazuka Village	Group Village Head
63.	H. Moses	Ndamera Village	Group Village Head
64.	H. R. Rambiki	Ngabu Village	Group Village Head

65.	Mai Malia	Ngabu	Villager
66.	Mai Useni	Ndamera	Villager
67.	Mai Mandele	Chikadza	Villager
68.	Mai Zhuwawu	Malemia	Villager
69.	Mai Eneya	Mthole Villvage, TA Malemai	Villager
70.	Ridgenald Ndarerankhande	Kalemba Health Centre	Medical Assistant
71.	Sangalatso Kumbukani	Phokera Health Centre	Medical Assistant
72.	General Ngulube	Kalemba Health Centre	Nurse
73.	Justice Manolo	Nsanje Police	Police Officer (Prosecutions)
74.	Lydia Mizedwa	Kalemba Health Centre	Nurse/Midwife
75.	Cornelius Lupenga	Trans World Radio	Reporter
76.	Rev. Andrew Makatani	Assemblies of God, Box 151, Nsanje	Pastor
77.	Alinafe Buleya	Nsanje DHO, Box 30, Nsaje	Nurse
78.	Dr. Yamikani Mastala	Nsanje DHO, Box 30, Nsanje	Medical Doctor
79.	Medson Matchaya	Nsanje DHO, Box 30, Nsanje	Medical Doctor
80.	Anderson Masanjala	Nsanje Magistrate Court, Box 39, Nsanje	Margistrate
81.	Rev. Patrick Nkunga	Nsanje CCAP	Reverend Minister
82.	Zione Mchikaya	Nsanje DHO, Box 30, Nsanje	Nurse
83.	Mrs. Nkhunguni	Ndamera	Villager
84.	Mai Megi	Msusa Village	Herbalist
85.	Charles Ban Joe	Full Gospel Church of God, Nsanje	Pastor

CHIRADZULU DISTRICT, 12TH DECEMBER, 2013

No.	Name	Address	
1.	Mercy Lipikwa	Chiradzulu District Council P/Bag 1, Chiradzulu	Council Clerk
2.	Margret Sapato	Ndata F.P. School, Box 17, Chiradzulu	Teacher
3.	John Simwa	P/Bag 72, Chiradzulu	Member Community Health Committee
4.	Owen Chitsulo	P/Bag 72, Chiradzulu	Member Community Health Committee
5.	Jemusi Patrick	P/Bag 72, Chiradzulu	Member Community Health Committee
6.	Denson Likambare	Box 64, Chiradzulu	Member Community Health Committee
7.	William Seleman	Box 64, Chiradzulu	Member Community Health Committee
8.	Edwin Mbicholo	Box 64, Chiradzulu	Member Community Health Committee
9.	Kaipa Makina	Box 64, Chiradzulu	Member Community Health Committee
10.	Jubeki Linje	Box 15, Chiradzulu	Herbalist
11.	Lusiasi Jonasi	Box 35, Chiradzulu	Herbalist
12.	Elias Zachariah	Masanjala Parish, P/Bag 35, Chiradzulu	Faith Community
13.	Finess Mbwera	Namaka School, Box 17, Chiradzulu	Teacher
14.	Rosemary Kazembe	Box 2, Chiradzulu	Teacher
15.	Ennes Gomonda	Box 27, Chiradzulu	Teacher
16.	Mike Chikaonda	Box 5, Chiradzulu	Teacher
17.	Modester Peter	Ndunde CCAP	Faith Community
18.	Aida Goliat	Ndunde CCAP	Faith Community
19.	Margret Musowa	Ndunde LEA School, Chiradzulu	Teacher
20.	Edith Makwinja	Box 1, Chiradzulu	Social Welfare Officer
21.	Zione Cedrick	Nankhundi, Box 70, Chiradzulu	Faith Community
22.	Harmiton Namala	P/Bag 1, Chiradzulu	Social Welfare Officer
23.	Charles Mphaya	Box 41, Chiradzulu	Faith Community
24.	Rev. Killion Phiri	Box 923, Blantyre	Reverend Minister
25.	Pastor Paul Chisani Banda	Seventh Day Adventist, Box 926, Blantyre	Pastor

26.	Victoria Mpopiwa	Bx 15, Chiradzulu	Student
27.	Memory Kamwendo	Box 15, Chiradzulu	Student
28.	Esther Selemani	Box 15, Chiradzulu	Student
29.	Bulandina Napulu	Box 15, Chiradzulu	Student
30.	Kettie Chindiwo	Box 1, Chiradzulu	Information Officer
31.	Foster Chinjunga	Makanani Village, Box 51, Chiradzulu	Villager
32.	Aubrey Njala	Makanani Village, Box 51, Chiradzulu	Villager
33.	Marita Damiyano	Box 1, Chiradzulu	Social Welfare Officer
34.	Village Headman Mbaisa	Box 2, Chiradzulu	Village Head
35.	Pastor Kondwani Kalizinje	Box 2, Chiradzulu	Pastor
36.	Judith Likishoni	P/Bag 3, Chiradzulu	Teacher
37.	Eldad Dickson	Box 2, Chiradzulu	Herbalist
38.	Felix Cosmas	Box 1, Chirdzulu	Council Clerk
39.	Sheik Suleman	Chiradzulu Boma	Sheik
40.	Sheik Uthuman Watch	Box 175, Namadzi	Sheik
41.	Precious Gama	Box 1, Chiradzulu	Council Clerk
42.	Faiki Selemani	Selemani Village	Villager
43.	Estar Maso	Selemani Village	Villager
44.	Mercy Banda	Selemani Village	Villager
45.	Bright Makokola	P/Bag 3, Chiradzulu	Teacher
46.	Jessie Awali	Chipole Village	Villager
47.	Lizzie Maloya	Kapalamula Village	Villager
48.	Lucy Mbewe	Simika Village	Villager
49.	Stella Mpunga	Simika Village	Villager
50.	Elita Perekamoyo	Makanani Village	Villager
51.	Cicelia Phambala	Nyandule Village	Villager
52.	Ethel Maoni	Chipole Village	Villager
53.	Rose Chimombo	Chisasiko Village	Villager
54.	David Macheso	Chisasiko Village	Villager
55.	Esnart Chipole	Village Headman Chisasiko	Village Head
56.	Sandikonda Kaulesi	Sitima Village	Villager
57.	Charity Kathumba	Chisasiko Village	Villager
58.	Catherine Manjombe	Chiradzulu Primary School	Teacher

59.	Elsie Kanjo (Mrs. Matemba)	Chiradzulu Primary School	Teacher
60.	Zione Witinesi	Mbaisa Village	Villager
61.	Jesica Saidi	Mbaisa Village	Villager
62.	Phales Chang'anda	Mbalame Village	Villager
63.	Mary Kachere	TA Chema (Youth)	Member, Youth Organization
64.	Adin Godfrey	TA Chema (Youth)	Member, Youth Organization
65.	Mussa Kazembe	TA Mpama (Youth)	Member, Youth Organisation
66.	Foster Chintunga	TA Mpama (Youth)	Member, Youth Organization
67.	Village Headman Makanani (Aubrey Njala)	Makanani Village, Box 51, Chiradzulu	Village Head
68.	Village Headman Mbaisa	Box 2, Chiradzulu	Village Head
69.	Pastor Kalizinje	Box 2, Chiradzulu	Pastor
70.	Faniles Selemani	Selemani Village	Herbalist
71.	Judith Likishoni	P/Bag 3, Chiradzulu	Herbalist
72.	Francis J. Mbewe	Kadewere Village	Villager
73.	John Jabu	Chiradzulu DHO	Clinical Officer
74.	Charles Mphaya	Chiradzulu Youth Department	Youth Officer
75.	McDonald Kunjirima	Namitambo Health Centre	Clinical Officer
76.	Milward Phiri	Chiradzulu DHO	Clinical Officer
77.	Henry Manase	Chiradzulu DHO	Clinical Officer
78.	Stanley Somanje	GVH Nsawa	Group Village Head
79.	Adam N. Gama	GVH Mbalame	Group Village Head
80.	Matthews Chisale	GVH Onga	Group Village Head
81.	Mumderanji Saizi	GVH Kadewere	Group Village Head
82.	Lawrence Mtchera	Box 37, Chiradzulu	Teacher Member Community Health
83.	Berkubgtib Kamwagha	Box 16, Chiradzulu	Member Community Health Committee
84.	Kennedy Kandaya	Box 21, Chiradzulu	Member Community Health Committee
85.	Hannah Msaka	Box 21, Chiradzulu	Member Community Health Committee

86.	Milward Phiri	Box 21, Chiradzulu	Member Community Health Committee
87.	Grey Katunga	Box 28, Chiradzulu	Member Community Health Committee
88.	Henry Manase	Box 21, Chiradzulu	Member Community Health Committee
89.	Morris Walumbe	Box 16, Chiradzulu	Member Community Health Committee
90.	Mercy Lipikwa	P/Bag 1, Chiradzulu	Information Officer
91.	Ayamba Kandodo	Box 3, Chiradzulu	Faith Community
92.	Martha Kaula	Box 21, Chiradzulu	Faith Community
93.	Mercy C. Banda	P/Bag 1, Chiradzulu	Council Clerk
94.	Senior Chief Mpama	Chief Council	Senior Chief
95.	STA Onga	Chief Council	Sub Traditional Authority
96.	GVH Nsauka	Chief	Group Village Head
97.	GVH Mbalame	Chief	Group Village Head
98.	GVH Onga	Chief	Group Village Head

MULANJE DISTRICT, 13TH DECEMBER, 2013

No.	Name	Address	
1.	Lucy Lino	P/Bag 9, Mulanje	Member, Community Health Committee
2.	Rodrick P. Nangwale	Box 114, Mulanje	Police Officer
3.	Nelson Jobe	Box 48, Mulanje	Member Community Health Committee
4.	Patrick D. Nyimbi	Lauderdale School c/o Box 43, Mulanje	Head Teacher
5.	Katuli Handford. M.	Box 114, Mulanje	Member Community Health Committee
6.	Rankin Kainja	Box 2, Chambe	Villager
7.	Mary C. Phiri	c/o Box 86, Mulanje	Member Community Health Committee
8.	Dyson Njikho	c/o Box 43, Mulanje	Catholic Commission for Justice and Peace
9.	Witness S. Misyoni	Box 86, Mulanje	Faith Community
10.	Chisomo Break	Box 114, Mulanje	Catholic Commission for Justice and Peace
11.	Joisi Kalino	Chonde Village	Villager
12.	Rabecca Custom	Box 189, Mulanje	Nurse
13.	Brenda Misomali	Box 227, Mulanje	Nurse
14.	Stiveria Goliati	Mulanje Mission Hospital	Nurse
15.	Catherine Kajawo	Chambe Youth Network	Member, Chambe Youth Network
16.	Malita Laston	Chambe Youth Network	Member, Chambe Youth Network
17.	Maria Mapsere	Chambe Youth Network	Member, Chambe Youth Network
18.	Esther Gande	Limbuli	Faith Community
19.	Beaulla Kumvenji	Box 227, Mulanje	Faith Community
20.	Jane Kachingwe	Box 465, Mulanje	Faith Community
21.	Wadi Mbewe	Box 221, Mulanje	Muslim Association of Malawi
22.	Ephraim K. Livala	Sazola Village	Villager
23.	Mrs. Mmodzi	Njedza Village	Villager
24.	Constance Misomali	Mulanje LEA School	Teacher
25.	Jane Mashonga	Mbiza Village	Villager
26.	Gertrude Dauka	P/Bag 9, Mulanje	Teacher
27.	Chikondi Banda	P/Bag 9, Mulanje	Teacher
28.	Anock Matutu	P/Bag 189, Mulanje	Muslim Association of Malawi
29.	Andrew Magretta	Njedza Village	Villager
30.	Lucy Mwale	Chilingulo Village	Villager

31.	Emmanuel Chimuyaka	P/Bag 9, Mulanje	Teacher
32.	Sammy Lipenga	Box 261, Mulanje	Teacher
33.	Mary Duwe	Box 41, Mulanje	Teacher
34.	Thokozile Saikonde	Smart Youth Club	Chombe Member, Smart Youth Club
35.	Patricia Magombo	Mulanje LEA School	Teacher
36.	Bertha Likhaya Galozi	Mulanje District Hospital	Nurse
37.	Wellington Kalambo	National Registration	Bureau Registration Officer
38.	Elinata Makombe	Njedza Village	Villager
39.	Ethel Ndindi	Southern Region Waterboard, P/Bag 1, Mulanje	Human Resources Manager
40.	Mellina Maganga	National Bank, Mulanje	Human Resources Manager
41.	Anna Chigamba Phiri	Box 372, Mulanje	Member, Community Health Committee
42.	Gossam Mafuta	DEM, Box 43, Mulanje	Teacher
43.	GVH Maliela	Box 41, Muloza	Group Village Head
44.	Mrs. Ndenguma	c/o Box 372, Mulanje	Nurse
45.	GVH Namani	Box 50, Muloza	Group Village Head
46.	Steven Selemani	Mulanje DHO	Clinical Officer
47.	Rev. Austin Chigaru	Njedza Holistic Temple, Box 171, Mulanje	Reverend Minister
48.	Sheik Ibrahim Swalleh	Islamic Information Bureau	Sheik
49.	Yunnus Mchenga	Likhubula School, Mabuka	Teacher
50.	GVH Ngolowera	TA Chikumbu	Group Village Head
51.	Melai Phiri Maganga	Mulanje Mission Hospital	Nurse
52.	Victor Kaliwo	Information Office, Box 132, Mulanje	Information Officer
53.	GVH Mabuka	Mabuka Village	Group Vilage Head
54.	Christina Zawanda	Jesus Worship Church, Box 63, Mulanje	Member
55.	Gray Mkwanda	Mulanje District Council	Council Clerk
56.	Christopher Daluni	Mulanje Police	Police Officer
57.	GVH Chonde	Bertha Saikonde Box 124, Chonde CCAP, Luchenza	Group Village Head
58.	Robert Sawiche	P/Bag 12, Mulanje	Faith Community
59.	Harvey Mankhwala	P.O. Box 227, Mulanje	Faith Community
60.	Rev. Lymon Sonjo Nkhoma	Box 181, Chisitu	Reverend Minister

61.	TA Mthiramanja	Box 77, Luchenza	Traditional Authority
62.	Tiyamike Lupenga	Box 45, Mulanje	Teacher
63.	Clare Shakespeare	Mulanje Mission Hospital, Box 45, Mulanje	Medical Doctor, Mulanje Mission
64.	GVH Njedza	Box 11, Mulanje	Group Village Head
65.	H.C.F. Mpwanya (Pastor)	Seventh Day Adventist, Box 192, Mulanje	Pastor
66.	Chisomo Break	Box 5211, Limbe	Reporter
67.	Rev. Preston Kasito	Mulanje CCAP Mission, Box 486, Mulanje	Reverend Minister
68.	M. Matapwata	Box 114, Mulanje	Catholic Commission for Justice and Peace

REGIONAL WORKSHOP ON THE REVIEW OF THE LAW ON ABORTION

Sunbird Capital Hotel, 24th June, 2014

No.	Name	Address	Designation
1.	Charles Vintulla	MBC	Reporter
2.	Jacob Nankhonya	Times TV	Reporter
3.	Dr. Yamikani Chakakala-Chaziya	Dowa District Health Officer	District Health Officer
4.	Makulata Makuta	Nanthomba Parish, Dowa	Teacher
5.	TA Msakambewa (Sapule Jere)	Golongozi Hqs. Box 27, Dowa	Traditional Authority
6.	Anold Saka	DHO, Kasungu	District Health Officer
7.	Nickson Ngwira	National Orgnization of Nurses and Midwives of Malawi	Member
8.	TA Mavwere	Mchinji	Traditional Authority
9.	Lameck Mzava	DHO, Mchinji	District Health Officer
10.	Darlington Harawa	Passion for Women and Children	Director
11.	TA Tambala (Charles Mcholoti)	Box 40, Dedza	Traditional Authority
12.	Florence Zeka	Box 40, Dedza	Social Welfare Officer
13.	Peter Donda	Dedza DHO	Senior Clinical Officer
14.	Dr. Wanangwa Chisenga	Nkhotakota DHO	District Health Officer
15.	Senior Chief Malengachanzi	Box 48, Nkhotakota	Senior Chief
16.	Mercy Kaluzi	Box 139, Nkhotakota	Social Welfare Officer
17.	TA Maganga	Box 15, Salima	Traditional Authority
18.	Harold Kapindu	Malawi News Agency	Journalist
19.	Senior Chief Lukwa	Box 95, Kasungu	Senior Chief
20.	Godfrey Kammunda	Ladder for Rural Dev. (COPUA) Box 53, Ntchisi	Director
21.	Ntchindi Meki	Times TV	Journalist
22.	Chimwemwe Manda	Transworld Radio	Reporter
23.	Evans Songwe Phiri	Malawi News Agency	Reporter
24.	Raphael Mvona	Capital FM	Reporter
25.	Jacob Nankhonya Times	TV Editor	Reporter
26.	Salima Jameson	Malawi Voice	
27.	Felix Washon	MBC TV	Cameraman
25.	George Ziwa	Salima DHO	Administrator
26.	Chrispine Gwalawala Sibande	IPAS	National Coordinator

27.	Prisca Kamchacha Mbedza	Present Woman, Kasungu Hosp.	Member
28.	Dr. George Talama	Kasungu DHO	District Health Officer
29.	Pastor Nicky Chakwera	International Christian Assembly	Member
30.	Laston Chikoti	Directorate of Reproductive Health	National Desk Officer
31.	Levison Mangani	Malawi Police	Police Officer
32.	Ndidza Chisanu	Family Planning Association of Malawi	Member
33.	Stanley Mulenga	Kanengo Police Station	Police Officer
34.	Chisomo Chona	Centre for Youth Empowerment and Civic Education	Member
35.	Grace Jere	Human Rights Commission	Human Rights Officer
36.	Rev. Chatha Msangaambe	CCAP Nkhoma Synod	Moderator
37.	Aisha Katungwe	Malawi Human Rights Youth network	Project Officer
38.	Lucks Mbewe	National Youth Council of Malawi	Member
39.	Desmond Mhango	Centre for Youth and Children's Affairs (CEYCA)	Member
40.	Anita Kaliu	Bwaila Secondary School	Head Teacher
41.	Acbert Phikani	Women Judges Association of Malawi	Secretary
42.	Atupele Sanyila	Nicholas & Brookes Legal Practitioners	Legal Officer
43.	Mercy Makhambera	Malawi Human Rights Resource Centre	Director
44.	Flemmings Nkhandwe	Association of Malawian Midwives (AMAMI)	Member
45.	Hameed Kongwe	Muslim Association of Malawi	Regional Coordinator
46.	Jeremiah Mphande	Ministry of Information	Information Officer
47.	Joseph Josiah	Ministry of Information	Information Officer
48.	Luke Tembo	COPUA	Advocacy Officer
49.	Jane Mwasiya	COPUA	Member
50.	Hardwell Chimonjo	Police	Crime Prevention Officer
51.	Juliet Sibale	Human Rights Commission	Human Rights Officer
52.	Ida Kamoto	Lilongwe Girls Secondary School	Head Teacher
53.	Gondwe Sellina	Chimutu Day Secondary School	Head Teacher
54.	Esther Mlombwa	Tsokankanasi Community Day Secondary School	Head Teacher
55.	TA Nthondo	Ntchisi District	Traditional Authority

REGIONAL WORKSHOP ON THE REVIEW OF THE LAW ON ABORTION

Sunbird Mount Soche Hotel, 30th June, 2014

No.	Name	Address	Designation
1.	Mateyu Sisya	COPUA	Member
2.	Chimwemwe Kaonga	NYCOM/CYD	Member
3.	Nguchiyaga Nakanga	Women Judges Association of Malawi Senior Resident Magistrate	Member
4.	Dorothy Nya Kaunda Kamanga	Judiciary	Justice of the High Court
5.	Catherine Ngomba	Social Welfare Office	Asst. Social Welfare Officer
6.	Evelyn Katuma	Health Advisory Committee, South Lunzu	Chairperson
7.	Trophina Limbani	Social Welfare Office	Social Welfare Officer
8.	Mimi Mayuni	Reproductive Health Services	Project Officer
9.	Dr. Frank Taulo	College of Medicine	Lecturer
10.	Mbeko Mzati	WLSA Malawi, Box 534, Limbe	Legal Programme Officer,
11.	Chikumbutso Kavina	Malawi Watch, Box 1412, Limbe	Project Officer,
12.	Loyce Kondwani	Health Committee, Lunzu	Member
13.	Ibrahim Saidi	Community Health Committee, Balaka	Member
14.	Jim Masauko	Community Health Committee Member, Phalombe	Member
15.	Chinsisi Mseula	Community Health Committee Member, Nsanje	Member
16.	Ethel Masamba	Community Health Committee Member, Nsanje	Member
17.	Chisomo Banda	Nsanje DHO	Nurse
18.	Tholosani Kadyampakeni	Community Health Committee, Neno	Deputy Chairperson
19.	Emmanuel Nsambakunsi	Social Welfare Office, Phalombe	Social Welfare Officer
20.	Brenda Nkosi	Malawi News Agency	Reporter
21.	Akwete Sande	Daily Times	Reporter
22.	Franklin Mtambalika	Galaxy Radio	Reporter
23.	Hastings Jumbe	SABC Chanel Africa	Correspondent Reporter
24.	Memory Kutengule	MANA	Reporter

25.	Chikondi Manjawira	Matindi FM	Reporter
26.	Mphatso Mwamvani	Living Waters Church Radio	Reporter
27.	Orchestra Kamanga		Reporter
28.	Lucky Mkandawire	The Nation	Journalist
29.	Luke Nthenda	Star Radio FM	Reporter
30.	Charles Sitima	Radio Maria	Reporter
31.	Rodney Tanganyika	Blantyre Synod Health Dev. Commission, Box 413, BT	Dev. Officer
32.	Samson Phiri	Malawi Voice, Box 380, BT	Reporter
33.	Timva Chipwaila	Blantyre DHO	Clinical Officer
34.	Dr. Owen Malema	Blantyre District Health Office	District Health Officer
35.	Pator Elijah Menyere	ADRA Malawi, Box 951, Blantyre	Asst. Programme Manager
36.	Chisomo Kasitomu	BT Synod Health and Dev. Commission	Dev. Officer
37.	Tinnie Mthunzi	Queen Elizabeth Central Hospital	Nurse/Midwife
38.	Nonsa Sapao	Queen Elizabeth Central Hospital	Nurse/Midwife
39.	Muhammad Juma Jawad	Muslim Association of Malawi	Member
40.	Chisomo Kaufulu Kumwenda	Malawi Human Rights Commission	Human Rights Officer
41.	Richard Makalani	NYCOM (Children Development Promotion)	Project Officer
42.	Maluwa Abigail	Balaka DHO	Midwife
43.	Frank Nasato	Mwanza District Council	Social Welfare Officer
44.	Dr. Yonasi Chisi	Thyolo DHO	District Health Officer
45.	Lusiano Masina	Minstry of Health, Mangochi	Administrator
46.	Dr. Patrick Nkhoma	Medical Rights Watch, Luwani Health Centre, Neno	Member
47.	Fr. Steven Sikoti	Malawi Council of Churches, Thyolo Anglican Church	Church Minister
48.	Rael Juma	Thyolo Health Committee	Member
49.	Rebecca Enerst Kaduya	Health Committee, Thunde Health Centre, Zomba	Member
50.	Kondwani Mchawe Mkandawire	Asst. Registrar, Medical Council of Malawi	Asst. Registrar
51.	Dr. Khuliena Kabwere	Mulanje DHO	District Health Officer
52.	Esmie Chataika	Uchembere wa Bwino, Mulanje DHO	Chairperson
53.	Senior Chief Mabuka	Mulanje District Council	Senior Chief

54.	Seko Chisuwo	Zomba DHO	Registered Nurse/Midwife,
55.	Senior Chief Mlumbe	Zomba District Council	Senior Chief
56.	Tapiwa Bernadette Luhanga	Chiradzulo DHO	Nurse/Midwife
57.	Dr. William Peno	Mangochi District Health Office	District Health Officer
59.	Saujati A. Somba	Village Health Committee, Mangochi Kandulu Village, TA Jalasi,	Member
60.	Sekanao Doni	Thyolo District Hospital, Jefule Village	Health Committee Secretary
61.	Margaret Maluwa	Darel Village Health Committee, Mchalo, Chikwawa	Member
62.	Dr. Charles Mtibo	Machinga District Health Office	District Health Officer
63.	TA Sitola	Machinga District Council	Traditional Authority
64.	Emma Phiri	Village Health Committee, Liwonde, Machinga	Member
65.	Dr. Amber Majidu	Chikwawa DHO	District Health Officer
66.	Senior Chief Ngabu	Chikwawa District Council	Senior Chief

REGIONAL WORKSHOP ON THE REVIEW OF THE LAW ON ABORTION

Sunbird Mzuzu Hotel, 30th June, 2014

No.	Name	Address	Designation
1.	Joseph Chirwa	Capital FM	Journalist
2.	Samuel Kalimira	Times Group	Journalist
3.	Steve Zimba	ZBS	Reporter
4.	Goerge Chitiya	Nyasa Times	Reporter
5.	Robert Mbetewa	MIJ	Journalist
6.	Wanangwe Mtawali	Joy FM Radio, Mzimba	Reporter
7.	Chimwemwe Phiri	CADECOM	Programme Officer
8.	Gerald Ntaba	MBC	Journalist
9.	James Chavula	Nation Publications	Jounalist
10.	C. Ghambi	Mzuzu	Legal Practitioner
11.	Natasha Namisengo	Mzuzu High Court Women Lawyers Association of Malawi	Lawyer
12.	Kenneth Sakala	SOS Mzuzu	Village Director
13.	Mirriam Jere	Mzuzu Central Hospital	Nurse
14.	Lone Tambo	Mzuzu Police	Police Officer (Prosecutor)
15.	Glory Kaunda	Mzuzu Police	Prosecutor
16.	Naomi Ngwira	Mzuzu Police	Prosecutor
17.	James Chipapa Phiri	Luwinga Secondary School	Teacher
18.	Wachisa Chiona	Luwinga Secondary School	Teacher
19.	Salome Gangire	MANA	Reporter
20.	Asiatu Deula	MIJ	Journalist
21.	Flora Jere	MIJ	Journalist
22.	Frank Kauteka	Mzimba Community Radio	Reporter
23.	Pearson Malisau	Centre for Girls Interraction	Programme Officer
24.	Mowbray Chibwatiko	Ministry of Gender	Social Welfare Officer
25.	Sarah Munthali	Ministry of Information	District Information Officer
26.	Rhodney Nsele	Ministry of Information	Information Officer
27.	Sophie Chimaliro	Mzuzu Magistrate Court	Magistrate
28.	Florence Lungu	Mzuzu University	Nurse
29.	Oscar Chihana	Mzuzu Airport	Commandant

30.	Jeremiah Nkhowani	Mzuzu University	Lecturer
31.	Rev. Brown Khonje	CCAP Synod of Livingstonia	Reverend Minister
32.	Donald Kanjere Zgambo	Mzuzu University	Nurses and Midwives Council of Malawi
33.	John Mnyimbili	St. John of God Medical School	Student
34.	Kingsley Nyirenda	Livingtonia Synod	Reverend Minister
35.	Vincent Kaunda	Mzuzu Central Hospital	Clinical Officer
36.	John Mhone	Mzuzu Central Hospital	Clinical Officer
37.	Earnest Luhanga	Mzuzu Central Hospital	Clinical Officer
38.	Dr. Khumbo Shumba	Mzimba District Hospital	District Health Officer
39.	Phillip Chitanda	Likoma District	Social Welfare Officer
40.	Davie Machowa	Likoma District	Medical Officer
41.	TA Nkumpha	Likoma District	Traditional Authority
42.	Lifa Binali	Nkhata Bay District	Member, Muslim Association of Malawi
43.	Jacob Ngwira	Karonga Ditrict Hospital	Medical Officer
44.	Thokozani Zgambo	Rumphi District Hospital	Medical Officer
45.	Emily Mhango	Chitipa District Hospital	Nurse
46.	Vincent Banda	Mzimba District Council	Social Welfare Officer
47.	Mrs. Soko	Karonga Hospital	Nurse
48.	Chigomezgo Munthali	Chitipa Police	Police Officer (Prosecutor)
49.	Fanwell Khoma	Likoma District	Information Officer
50.	Jonathan Winga	Rumphi District	Social Welfare Officer
51.	Maingi Gondwe	Karonga Hospital	Medical Officer
52.	Angella Mhango	Chitipa Hospital	Medical Officer
53.	Albert Mkandawire	Nkhata Bay Hospital	Medical Officer
54.	Senior Chief Mkumbira	Nkhata Bay District	Senior Chief
55.	Dzikondianthu Malunda	Ministry of Justice, Public Prosecution	Prosecutor
56.	Kondwani Ng'ona	Ministry of Information	Information Officer
57.	Flora Jere	Minstry of Gender	Social Welfare Officer
58.	Dr. Eugene Katenga Kaunda	Chitipa Hospital	District Health Officer
59.	Mickson Kamwela	Chitipa Hospital	Medical Officer
60.	Senior Chief Kameme	Chitipa District	Senior Chief

61.	Senior Chief Inkosi Mthwalo	Mzimba District	Senior Chief
62.	Inkosi Mabulabo Jere	Mzimba District	Traditional Authority
63.	Frank Tambo	Rumphi Police	Prosecutor
64.	Dr. Alinafe Mbewe	District Health Officer	Mzimba
65.	Miriam Mkandawire	Rumphi District Hospital	Nurse
66.	Victor Nyanyama	Rumphi District Hospital	Medical Officer
67.	Lloyd Magweje	Rumphi District	Social Welfare Officer

REPORT OF THE LAW COMMISSION
ON THE
REVIEW OF THE LAW ON ABORTION

Law Commission Report No. 29

LAW COMMISSION

REPORT OF THE LAW COMMISSION ON THE REVIEW OF THE LAW ON ABORTION

March 2016

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