CENTER FOR REPRODUCTIVE RIGHTS

June 12, 2014

The Human Rights Committee

Re: Supplementary Information on Malawi scheduled for review by the Human Rights Committee during its 111th Session

Honorable Committee Members:

This letter is intended to supplement the periodic report submitted by Malawi to the Human Rights Committee (the Committee), which is scheduled to be reviewed during its 111th Session, in Geneva. The Center for Reproductive Rights (the Center), a global legal advocacy organization with headquarters in New York, and offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C., uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. The Center hopes to further the work of the Committee by providing independent information on Malawi concerning the rights protected in the International Covenant on Civil and Political Rights (ICCPR).[1]

In this letter, we bring to the attention of the Committee the following areas of concern, which demonstrate the government's failure to guarantee women's and girls' rights to equality and non-discrimination and other rights that affect their reproductive health: high incidence of maternal mortality and morbidity, the high number of unsafe abortions, lack of access to family planning information and services, high rates of early or child marriage, and violence against women.

I. The Right to Equality and Non-Discrimination

It has long been established that the obligation to ensure the rights to non-discrimination and substantive equality for all people underlies all international human rights. Indeed, the ICCPR recognizes that equality is essential to the enjoyment of the rights stipulated in the Convention.[2] Accordingly, the Committee has urged states to address both de jure and de facto discrimination in private and public spheres.[3] It has further noted that ensuring equality requires not only removing barriers but also taking positive measures "to achieve the effective and equal

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empowerment of women."[4] In this regard, the Committee has urged states to "adopt whatever legislation is necessary to give full effect to the principle of equality between men and women,"[5] develop policies that promote gender equality,[6] take efforts to eliminate gender stereotypes about women in the family and society,[7] and address practices such as cutting funds to social programs that disproportionately impact women.[8] It has also urged states to take affirmative measures to improve social conditions such as poverty and unemployment that impact women's right to equality in healthcare.[9]

A key element of women's right to equality and nondiscrimination is their ability to exercise reproductive autonomy—that is, to make decisions regarding whether and when to have a child without undue influence or coercion. For women to enjoy reproductive autonomy, their options must not be limited by lack of opportunities or results.[10] To this end, it is crucial that women have access to reproductive health services, and that those services can be accessed with their consent alone.[11] In addition, reproductive health services must "be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[12]

Reproductive equality requires states to not only address barriers to accessing reproductive health services but also take positive measures to ensure women's access to these services, including by using all appropriate means. This Committee has noted that fulfilling the right to equality in the context of health may require amending legislation or administrative regulations and addressing non-legal barriers that impact access to reproductive healthcare, such as high cost of contraceptive services and supplies, and transportation barriers for women in rural areas.[13] The Committee has also recommended implementing legal and policy measures to ensure access to a full range of reproductive health care services and information, including safe contraceptives, family planning counselling, sexuality education and safe abortion services.[14] In addition, the Committee has noted that young, poor, rural and minority women often face additional obstacles to reproductive health care, and has recommended that states take extra measures to ensure their access to health.[15]

However, despite these requirements, women in Malawi often lack access to reproductive health services with far-reaching consequences.

II. High Incidence of Maternal Mortality and Morbidity

The Committee and other Committees that monitor compliance with various international human rights treaties have framed the issue of maternal mortality as a violation of women's right to health and right to life.[16] This Committee has further recognized that preventable maternal mortality violates women's and girls' rights to equality and non-discrimination.[17] In General Comment No. 28, the Committee recognized that "[d]iscrimination against women is often intertwined with discrimination on other grounds such as race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status."[18] Consequently, states are required to "address the ways in which any instances of discrimination

on other grounds affect women in a particular way."[19] Other human rights bodies have also confirmed that ensuring equality of health results—including by lowering the maternal mortality rate—is an important indicator of a state's success in overcoming rights violations.[20] Indeed, the Committee on Economic, Social and Cultural Rights (ESCR Committee) has confirmed that the obligation to ensure reproductive and maternal care, both prenatal and postnatal, should have a priority comparable to minimum core obligations to ensure access to health facilities, goods, and services without discrimination.[21]

It is commendable that Malawi has taken some steps to achieve its commitment, under the Millennium Development Goals (MDGs), of reducing the maternal mortality ratio (MMR) to 155 per 100,000 by 2015. In 2009, Malawi revised the National Sexual and Reproductive Health and Rights policy (SRHR Policy) to improve women's access to essential maternal health care services.[22] Also, in 2012, the Presidential Initiative on Maternal Health and Safe Motherhood was launched with the aim of increasing the number of women who give birth at health care facilities.[23] So far, the initiative has graduated about 158 midwives and is in the process of building seven maternity waiting shelters across the country.[24]

Despite these efforts, Malawi's MMR is worsening—going from 460 maternal deaths per 100,000 live births by 2010 to 510 maternal deaths per 100,000 live births in 2013, [25] and is still substantially above the target rate for 2015. While Malawi saw a 59% reduction in maternal mortality between 1990 and 2010, the reduction rate was 53% by 2013.[26] Further, it had the 21st highest MMR in the world as of 2010 but now has the 16th highest MMR.[27] Further, the World Health Organization (WHO) states that for every maternal death, 30 women suffer long lasting pregnancy-related health injuries and disabilities such as obstetric fistula.[28] In addition to unsafe abortion—accounting for 18% of maternal deaths[29]—the high MMR is attributable to limited provision of high quality antenatal and postnatal care, and obstetric complications during delivery such as bleeding which contributes to 40% of maternal deaths.[30] Sepsis infection, pre-eclampsia and obstructed labor are other leading causes of maternal mortality in Malawi—all preventable by providing access to adequate numbers of skilled health care workers and medical facilities.[31]

Despite Malawi's policy to provide free maternity-related services in all public and some not-for-profit facilities, women encounter numerous barriers in accessing these services.[32] One research study found that women who seek these services experience delay or denial of services because of missed diagnoses, deficiencies within the organization of services, and poor quality of care including inadequate monitoring and attentiveness of the health care providers to patients.[33] Further, skilled ante-natal and post-natal care is inadequate and under-utilized. While the prevalence of ante-natal care is relatively high, the quality of care provided varies greatly. The 2010 DHS found that 95% of adolescents and women aged 15-49 received antenatal care from skilled attendants for their last pregnancy; however, only 7% of these attendants were doctors and clinical officers, while 84% were nurses and midwives.[34] Also, only 46% of completed the WHO recommended[35] four ante-natal visits.[36] The 2010 DHS also found that although 73% of

the births occurred in health facilities, 48% of the women did not receive any post-natal care.[37] These low rates of access to post-natal care are troubling, especially since three-quarters of all maternal deaths in Malawi occur during delivery and in the immediate post-partum period.[38]

There is also a critical insufficiency of skilled healthcare providers that has a direct negative impact on the quality of care provided to women. The 2007 Malawi Health Sector Employee Census and the WHO Statistical Information System reported that the country only had 248 doctors, 4,450 trained nurses, and approximately 3,000 midwives in 2007. [39] This is a serious deficit that amounts to only one nurse or midwife for every 1,799 people.[40] Currently, there has not been any improvement to this ratio and a 2014 media report has revealed that there are only two doctors and 37 nurses and midwifes for every 100,000 people.[41] Additionally, with poor working conditions and the imbalanced patient to provider ratio, doctors, nurses and midwives are seeking work elsewhere, including abroad. [42]

High MMR among adolescents:

Globally, pregnancy and childbirth-related complications are the leading cause of death for adolescent girls aged 15–19.[43] In Malawi, with over 50% of girls married before age 18,[44] there is a high prevalence of adolescent pregnancy--one out of every four adolescents aged 15-19 has given birth--which poses significant risks to their well-being.[45] A Strategic Assessment of Unsafe Abortion in Malawi, conducted by the Reproductive Health Unit (RHU) of the Ministry of Health and WHO, shows that teenage pregnancies contribute to 20-30% of maternal deaths in the country.[46] In addition to facing the same problems of access, affordability, and quality of care, adolescent girls are particularly vulnerable to pregnancy-related conditions such as anemia, obstetric fistula, and postpartum infections due to physical immaturity at time of childbirth, lack of access to antenatal and obstetric care, lower social and economic status, and low levels of education.[47]

III. Lack of Access to Safe Abortion

Malawi has one of the most restrictive abortion laws in the world—abortion is legal only to save the life of the woman.[48] Under this legal landscape, women are forced to seek unsafe and clandestine abortions, with attendant risks to their life and health.[49] Consequently, unsafe abortion is the second leading cause of maternal mortality in the country, accounting for 18% of such deaths.[50] It is also the leading cause of obstetric complications, accounting for 24–30% of such complications.[51] A comprehensive study found that over 110,000 women in Malawi have an abortion every year.[52] Of these, 38,000 are treated for serious complications linked to unsafe abortion methods.[53]

Unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity. Where death does not result, women may experience long-term disabilities, such as uterine perforation, chronic pelvic pain, or infertility. The recognition of the direct connection between unsafe abortion and high death rates[54] has led the Committee to require that states

issuing reports on the right to life must inform the Committee of "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."[55] The Committee has also recognized that states' duty to protect and ensure the right to life includes a duty to protect women who terminate their pregnancies.[56] It has called upon states to take measures "to ensure that women do not risk their life because of restrictive legal provisions on abortion," that force them to seek abortions under clandestine, unsafe conditions.[57] The Committee has also expressed concern over a general ban on abortion, even in cases of rape, incest and pregnancies that threaten threatens the life of the mother.[58] Likewise, other treaty monitoring bodies have all characterized high rates of maternal mortality caused by abortion as violations of the rights to health and life, and have explicitly asked states parties to review legislation criminalizing abortions. [59]

Restrictive abortion laws also discriminate against women on the basis of sex, age, and economic status, violating the rights to equality and non-discrimination, as restrictive laws and barriers to access—such as third-party authorization requirements, and limitations on information about abortion services—perpetuate discrimination against women.[60] Further, the cost for a safe abortion can be staggering for most Malawian women,[61] given that 74% of the population live on less than $1.25 per day.[62]

As a result, women with adequate financial resources, information and connections are more likely to utilize relatively safe abortion services, administered secretly by skilled providers in private or public clinics using safe methods.[63] However, women who are already burdened by inequality, including low-income women and women in rural areas, are disproportionately forced to seek abortion services from unsafe providers.[64]

Even in the sole situation where abortion is permitted, women still encounter numerous barriers in accessing safe abortion services. Research indicates that those women who are eligible to seek a legal abortion are required in practice to obtain spousal consent[65] and authorization by two physicians who can attest that the reason for the abortion is to save the life of the woman.[66] These requirements can create insurmountable barriers to women's access to safe abortion services. Experts have repeatedly stated that requiring authorization from multiple doctors is not evidenced-based and have recommended against them. For example, the WHO has made clear that mid-level providers, such as nurses or clinical officers, can safely provide first trimester abortion services.[67] Further, most contemporary legal and policy experts agree that consultation requirements are inappropriate and delay access to services.[68] This requirement for the involvement of multiple doctors is particularly onerous in a country such as Malawi where, as previously noted, there are only two doctors for every 100,000 people. [69] Such requirements are also significant barriers for women that can cost money, waste time and dangerously delay critical health care.

Furthermore, there is a pervasive lack of awareness of the sole exception to the ban on abortion.[70] A 2011 research found that, in Malawi, abortion services to save a woman's life are

usually provided on the discretion of health care providers, are rare, and only available at the tertiary health care level.[71] This study also found that most health providers refuse to provide life-saving abortion out of fear of risking providing an "illegal" one.[72] Consequently, many women rely on untrained providers, traditional healers or resort to self-induced methods of abortion,[73] risking their lives and health. Due to these misconceptions and fear of prosecution, there are very few recorded cases of legal abortions.[74]

There is a growing recognition in Malawi that reaching the MDG of reducing the MMR to 115 by 2015 will be unlikely unless the government addresses the high incidence of unsafe abortion.[75] It is regrettable, therefore, that the Malawi government has failed to include, in its report to the Committee, information regarding the rate of unsafe abortion and measures it is undertaking to protect the rights of women and adolescent girls by ensuring access to safe abortion services.

Post-Abortion Care:

Access to quality post-abortion care (PAC) is critical for Malawi to prevent maternal mortality and morbidity as a result of unsafe abortion. Although, in 2003, the Malawi Reproductive Health Unit developed a National Post Abortion Care Strategy[76] that planned to increase the number of public facilities that provide the service, access to quality PAC remains inadequate. In order to provide effective PAC, trained providers need constant access to the critical tools,[77] which many of the facilities in Malawi lack.[78] A 2011 research revealed that the manual vacuum aspirations (MVA)—the recommended method by the government's Standard Equipment List to treat incomplete abortion—was not available in many of the facilities visited for the research.[79] Even when available, they were worn or rusted, or locked away to prevent them from being used for inducing an abortion.[80] Additional barriers to PAC include lack of staff resulting in delays in provision of care,[81] and prohibitive costs; the median cost for a simple case is about $16 and more complicated cases involve higher costs.[82]

IV. Lack of Access to Comprehensive Family Planning Services and Information

This Committee has recognized that the right to contraception is rooted in the right to life, the rights related to the family, and the rights to equality and nondiscrimination.[83] While the failure to guarantee accessible, acceptable, appropriate and quality contraception affects both men and women, it disproportionally affects women by both limiting women's opportunities and by exacerbating the discrimination and inequalities that women already face. Biologically, women must physically bear the burden of an unplanned pregnancy. For women who carry an unplanned pregnancy to term, the physical burden during pregnancy can affect all facets of their lives. Due to women's socialized role as the primary caregiver, an unplanned pregnancy disproportionally affects women's lives in terms of both the time spent caregiving and in the resulting limitations to seeking education and employment and the ability to enter public and political life.

Malawi, however, has one of the highest fertility rates in Africa, at about 6 children per woman, with high rates of unmet family planning needs.[84] Approximately only 28% of women and

adolescent girls have had their family planning needs met.[85] Young, poor, rural and minority women often face additional obstacles to reproductive health care.[86] The 2010 DHS, the latest comprehensive data available, found that 38% of women in the lowest wealth quintile used contraceptives, whereas usage is 53% for women in the highest wealth quintile.[87] Also, about 54% of women who lived in urban areas used contraceptives whereas the rate is only 44% for women living in rural areas.[88] It also found the contraceptive prevalence rate among women aged 15-49 is 33% for any modern method of contraceptive.[89]

This low contraceptive prevalence rate and the high level of unmet need can be attributed to the numerous barriers women encounter in accessing contraceptive information and services. Catholic Church-owned facilities, which account for 25% of all the medical facilities[90] and provide over 40% of public health services in Malawi,[91] do not provide contraceptives and their patients must receive the services from other facilities.[92] Those facilities that do provide contraceptives experience shortages especially for the more popular methods of contraceptives such as implants and injectables.[93] Also, gender inequality and cultural practices, which perpetuate discrimination against women, undermine the use of contraceptives in many cases.[94] Consequently, although there is no law or policy that requires spousal consent for accessing family planning services, many women seek consent from[95] or are not allowed by their spouses or partners to use contraceptives.[96]

Emergency Contraception

Emergency contraception (EC) is a vital tool in protecting and promoting women's reproductive rights. It is a particularly critical component of care for survivors of sexual violence, who are typically provided EC and post-exposure prophylaxis to reduce the chances of unintended pregnancy and HIV transmission, respectively. Improved access to EC could reduce the cost of unintended pregnancy and could significantly reduce the number of abortions and thereby the number of maternal deaths related to unsafe abortion. In Malawi, at least one type of EC is available in public sector clinics, pharmacies and social marketing programs.[97] However, the public's knowledge and usage of EC is limited and sporadic.[98] From the women surveyed for the 2010 DHS, only 35% knew about EC and only 0.7% had ever used this method of contraception.[99] Unmarried women aged 25-29 have the highest rate of use of EC—at just 5.9%—whereas only 0.8% of married women, any age, have ever used EC.[100]

Adolescents Access to Family Planning Information and Services

Access to contraceptive information and services is particularly critical for adolescent girls since, as stated above, pregnancy poses a grave risk to their health. Yet, in Malawi, while married and sexually active adolescents are far less likely to use contraception than older women, the contraceptive needs of adolescents have largely been overlooked. [101] This is particularly important since over 50% of the female population is married before age 18. [102] The DHS shows that only 45.6% and 49.9% of married and unmarried sexually active adolescent girls aged 15-19 respectively use any modern contraceptives.[103] 25% of married women in the same age group have unmet need for contraceptives.[104] Another study found that one-third of young women's

births are either mistimed or unwanted: 18% of young girls wanted to delay their last birth, and 15% did not want their last pregnancy.[105]

Concerned by the alarming rate of teenage pregnancy and multiple pregnancies, which presents a significant obstacle to girls' educational opportunities and economic empowerment,[106] the CEDAW Committee recommended that Malawi widely promote sexuality education targeted at girls and boys, with special attention paid to the prevention of early pregnancy.[107] In recognizing the risks to adolescent health, the CRC Committee recommended in its concluding observations that the State adopt an effective and gender-sensitive strategy of education and awareness raising for the general public with a view to reducing the incidence of teenage pregnancies.[108]

However, adolescents in Malawi are rarely, if at all, taught about family planning and sexual and reproductive health at school and so they have limited information on preventing unplanned pregnancy and protecting themselves from sexually transmitted infections.[109] Additionally, outside of marital relationships, it is often difficult for young unmarried people to access contraceptives because of stigma associated with extramarital sexual activities and the personal beliefs of health care providers which result in bias.[110]

V. Violence and Discrimination Against Women and Girls

The right to be free from discrimination includes the right to be free from gender-based violence and harmful practices. The CEDAW Committee defines gender-based violence as violence "directed against a woman because she is a woman or that affects women disproportionally" and "includes acts that inflict physical, mental or sexual harm and suffering, threats of such acts, coercion and other deprivations of liberty."[111] These acts and practices are particularly harmful to women's reproductive autonomy and substantive equality because they expose women, among other things, to unwanted pregnancies and sexually transmitted infections.

Article 3 of the ICCPR, which provides for the equal enjoyment by both sexes of the Covenant's rights,[112] is violated where governments fail to enact or enforce laws protecting women's physical safety and integrity. This Committee has also repeatedly urged states to promulgate laws providing effective protection against rape, sex abuse, and violence against women.[113] The Committee's numerous comments to states on domestic violence[114] reinforce state responsibility by placing a strong emphasis on the need for legislation to criminalize this violence.[115]

While sexual violence is widely under-reported, making it difficult to gather fully comprehensive statistics on its prevalence, figures indicate that it is a serious concern for women in Malawi.[116] The 2010 DHS found that nearly 3 in every 10 women (28%) in Malawi have suffered from physical violence at some point since age 15,[117] and 14% of women suffered from acts of violence during the past 12 months.[118] This proportion is substantially higher for divorced, separated, or widowed women (22%) than single women (8%), but there was little difference in ever having experienced physical violence by wealth quintile.[119] Furthermore, one in four

women has experienced sexual violence, and 15% of women had their first sexual intercourse forced against their will.[120]

Although there is increasing recognition by the government of the need to respond to sexual violence in the context of HIV and provide appropriate HIV prevention and support services for survivors; the focus has been primarily on medical aspects of prevention.[121] These efforts have not effectively addressed the endemic underreporting of violence. For example, the government has created protocols for Post Exposure Prophylaxis (PEP) after sexual violence. However, research indicates that rape survivors are unlikely to access formal services and that if they do, protocols are often not adhered to.[122]

Likewise, though some progress has been made in the legislative and law enforcement framework addressing gender-based violence, such as the2006 adoption of the Prevention of Domestic Violence Bill by the parliament, it was not till April 2013 that the President signed the Bill into law, and its impact is not yet visible. Moreover, other legislative efforts such as the National Strategy to Combat Gender Based violence (2002-2006), and the National Response to Gender Based Violence programme in Malawi (2008-2013), as well as the South African Development Community (SADC) Declaration on Gender and Development targets to halve cases of GBV by 2015, to which Malawi is a signatory, and which includes an Addendum on "Prevention and Eradication of Violence Against Women and Children" have not been implemented.

Despite the prevalence of violence against women, there remains a lack of adequate services and protection for survivors of violence, including the lack of reporting mechanisms as well as the absence of awareness campaigns to sensitize women about their rights. A recent study found that more than one in three women (36%) who experience physical or sexual violence never tell anyone about it, and nearly half never seek help (48%).[123] Only 3% went to police.[124] Women with no formal education are less likely than women who have some level of formal education to have ever told anyone about the violence or to have sought help, but there is no strong relationship between help seeking and wealth.[125] As the Committee has recommended in other contexts, states should take measures to encourage women to report domestic violence to authorities[126] and collect data and statistics on domestic violence.[127] In her statement at the 57th session of the Commission on the Status of Women, held in March 2013, the Minister of Gender, Children and Social Welfare Anita Kalinde, MP reported that "To date 30% of the reported cases of violence are prosecuted."[128] However, she did not provide any data to support this assertion or comment on why more had not been prosecuted.

Further, though rape, indecent assault and defilement are punishable offences under the Penal Code,[129] marital rape has still not been criminalized under Malawi law.[130] Instead, marriage is *de facto* considered consent to sex. [131] While welcoming the 2006 adoption of the Prevention of Domestic Violence Act, the CEDAW Committee raised concerns that marital rape had not been criminalized under that Act and about the persistence of customary law and cultural practices

that constitute, or perpetuate, violence against women.[132] Furthermore, the CEDAW Committee expressed concern about the lack of information and data on the incidence and forms of violence against women.[133] Recognizing the prevalence of violence against women, the Human Rights Council also urged Malawi to conduct a public awareness campaign to strengthen the implementation of the Prevention of Domestic Violence Act, strengthen law enforcement and the judicial system to address impunity, and increase women's access to justice and to coverage of community policy and victim support units in rural areas.[134]

In its report to this Committee, the government of Malawi states that it has established "victim support units in the police station which are meant to help victims of domestic violence and help address the problem of domestic violence."[135] However, it failed to report whether survivors of violence are in reality able to access these services and whether the police are equipped to investigate and prosecute perpetrators. Also, the government's report does not provide any statistics on how many domestic violence cases have been reported, how many women received services from the support units, and how many of the perpetrators have been convicted. Further, the government does not provide information on the measures it is undertaking the curb violence against women that occur outside of the home.

VI. Early Marriage

Early marriage—which is also referred to as child marriage—refers to marriages that occur when one or both of the spouses are below the age of 18.[136] The Committee has repeatedly discussed the problem of early and forced marriage, expressing general concern about the practice[137] and recommending specific measures to eliminate it, including educational measures to combat and change attitudes toward the practice [138] as well as legal reform.[139] Even though boys can also be subject to the practice, the problem affects more girls with graver consequences.[140] Girls who are married as children are denied educational opportunities, face barriers to developing income-generational skills, and are isolated from society, resulting in complete dependence on their husbands and perpetuating their low status in society.[141] Early marriage also exposes girls to increased risks of maternal mortality and morbidity because adolescent girls and younger women are at particular risk for complications such as obstetric fistula.[142] The relationship between the high prevalence of maternal mortality in Malawi and early marriage has also been recognized by the government; in March 2013, Ms. Catherine Gotani Hara, Malawi's Minister of Health, asserted that "By ending early marriages we can avert up to 30 per cent of maternal deaths and also reduce the neonatal mortality rate."[143]

Malawi is one of the top ten countries with the highest rates of early marriage in the world, where over 50% of girls in Malawi are married by their 18th birthday,[144] compared to the regional average in sub-Saharan Africa of 37%.[145] While early marriage is common across Malawi, its prevalence is highest in the central region (57%), followed by the northern region (50%) and southern region (44%).[146] Women aged 20–24 and living in rural areas are almost twice as likely to be married before age 18 than their urban counterparts.[147] Furthermore, 66% of women aged

20–24 with no education and 62% with primary education are married or in a union at age 18, compared to only 16% of women with secondary education or higher.[148]

Despite the physical harm to and the persistent discrimination against young girls, Malawi has made little progress towards ending the practice of early marriage. While it is required, under Section 13(a) of the Constitution, to progressively adopt and implement policies and legislation aimed at ensuring equality between women and men, Malawi continues to fail to adequately address the high prevalence of early marriage. The Constitution allows marriage with parental consent as early as age 15.[149] Further, although the Constitution requires the State to "discourage" marriages where either is under the age of 15 years,[150] it does not expressly proscribe marriages between persons under 15 years old. This is in direct contradiction to international and regional human rights standards that set the minimum age of marriage to be 18 without exceptions.[151]

Concerned over the practice of forced and early marriages, this Committee called upon Malawi in 2012 to "take appropriate measures, including through legislative steps, to protect children against forced and early marriages" by conducting awareness-raising campaigns, investigating complaints from the victims, prosecuting persons who are allegedly responsible, and punishing those who are convicted with appropriate sanctions.[152] However, not only has Malawi not complied, earlier, it also rejected the recommendations made during its Universal Periodic Review to "[t]ake further action towards gender equality, including a legal provision on the minimum age for marriage"[153]

In 2006, a Marriage, Divorce and Family Relations Bill which proposed that the minimum age of marriage be raised to 18 was developed.[154] However, even though the President had, in 2012, issued a presidential directive ordering the Bill be presented to the parliament, this directive is yet to be carried out.[155]

QUESTIONS FOR THE GOVERNMENT OF MALAWI

Based on this information, we respectfully request that the Committee raise the following questions with the government of Malawi:

1. What affirmative measures are being taken to reduce the high maternal mortality rates, including intra-country disparities that result in greater susceptibility to maternal death among vulnerable groups such as women in rural areas, low-income women and adolescents?
2. What steps are being taken to address the severe shortage of healthcare providers and to ensure that health care facilities are adequately staffed and equipped to provide quality maternal health care services and respectful care? How does the government plan to effectively implement the recently passed Gender Equality Act, 2013?
3. What measures are being undertaken to bring the existing legal framework on abortion in line with the international and regional human rights standards? What concrete measures

have been taken to reduce the high incidence of unsafe abortion, and to address the stigma and discrimination associated with abortion and post-abortion care? How is the government addressing the lack of trained staff and equipment and the limited funding allocations for abortion-related services?

4. What steps are being undertaken to improve access to contraceptives, ensuring that women are appropriately informed of, and have access to, family planning options? How does the government plan to address the grave disparity in access to contraceptive information and services for low-income women, those living in rural areas, and adolescents?
5. Are adequate measures being taken to ensure that both survivors of sexual violence and other women are informed of and have access to EC and is the government committed to providing the funding that will ensure the availability of EC in health centers?
6. What is the government doing to ensure that the Marriage Bill, which will raise the minimum age of 18, is passed and implemented immediately and that the Constitution is amended to reflect this minimum age, without exceptions? Besides establishing a victim support center in polices stations, what efforts have been made to ensure that police appropriately respond to, and collect data regarding, incidents of sexual violence and that survivors have access to these and other health and legal services?

<u>We respectfully suggest that the Committee consider making the following recommendations:</u>

1. Malawi should undertake positive measures to reduce maternal mortality and morbidity including by increasing the availability and accessibility of ante-natal, delivery and post-natal services, paying particular attention to the needs of adolescent girls; increasing the number of skilled health personnel and provision of skilled attendance including in rural areas; and improving the tracking and monitoring of the incidence and causes of maternal mortality and morbidity.
2. The government should reform existing abortion laws to bring them into conformity with international and regional human rights standards including by ensuring that women whose pregnancy pose a risk to their health, and those who become pregnant as a result of rape, incest or forced marriage have access to legal abortion.
3. The government should implement comprehensive awareness raising campaigns particularly for healthcare providers, women and law enforcement regarding when abortion is legal. It should ensure that women who develop abortion-related complications receive affordable and appropriate post-abortion care and are not additionally victimized by healthcare providers and the criminal justice system.
4. The government should take adequate measures to increase knowledge of, and access to contraceptive methods. It should specifically target vulnerable populations, including adolescents, low-income women, and rural women and institute continuous and permanent training programs for reproductive healthcare providers that include training on the provision of adolescent or youth friendly services.

5. In accordance with the constitutional provision stating that no person shall be denied emergency treatment, the government should specify that all health care facilities, regardless of religious affiliation, are obligated to provide EC to survivors of sexual violence or to refer them to a facility that will provide the service. Additionally, the government should take positive steps to expand access to EC beyond survivors of sexual violence.
6. The government should immediately pass the Marriage Bill which proposes raising the minimum age of marriage to 18 years, amend the Constitution to reflect this minimum age without exceptions, and make concrete efforts to eliminate the practice of early marriage by targeting specific areas of the country, especially rural areas, with a full range of individualized legal, outreach, and educational tools to overcome entrenched early marriage practices.
7. It should also amend the Domestic Violence Act to include marital rape as a punishable offence.

We hope that this information is useful during the Commission's review of the Malawi government's compliance with the provisions of the African Charter. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

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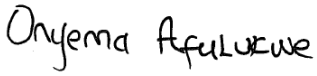

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[1] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 3, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (*acceded* Dec. 22, 1993) [hereinafter ICCPR].
[2] *Id* art. 2.
[3] Human Rights Committee, *Concluding Observation: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).
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[10] Rebecca Cook, *Human Rights and Reproductive Self Determination*, 44 The American University Law Review 975, 1007 (1995)
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[13] Human Rights Committee, *Concluding Observation: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999) (expressing concern over cuts to social welfare programs that have disproportionately harmed women, especially single mothers, and recommending making an assessment of the impact of such cuts and taking action to redress any discriminatory effects); *Guatemala*, CCPR/C/GTM/CO/3 para. 8 (2012) (calling on the state to adopt and implement gender equality legislation and to "develop additional policies to promote genuine gender equality" which especially address the needs of indigenous women and Afro-descendent women who face multiple forms of discrimination); *Republic of Korea*, U.N. Doc. CCPR/C/KOR/CO/3 para. 12 (2006) (recommending that the Republic of Korea ensure "equal access to social services" after the HRC received information that immigrants faced numerous non-legal barriers in accessing healthcare despite a 2003 law granting them the legal right to access the national healthcare system on an equal basis of citizens).
[14] *See, e.g.*, Human Rights Committee, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); *Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010).
[15] CENTER FOR REPRODUCTIVE RIGHTS, *Preventing Maternal Mortality and Ensuring Safe Pregnancy*, *in* BRINGING RIGHTS TO BEAR 9 (2008).
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[67] *See* Marge Berer, *Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives*, 87 WHO BULLETINS 1 (2009), *available at* http://www.who.int/bulletin/volumes/87/1/07-050138/en/.
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[87] *Id*.
[88] *Id*.
[89] *Id*. at 57.
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[91] http://www.ghi.gov/documents/organization/158919.pdf
[92] *Strategic Assessment of Unsafe Abortion in Malawi*, *supra* note 29 at 138.
[93] *Id*.
[94] *Id*.
[95] *See* also, Brooke A. Levandowski, et al., *Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma*, INT'L J. OF GYNECOLOGY & OBSTETRICS, sec. 167-171, sec. 168 (2012), *available at* http://www.ipas.org/~/media/Files/Ipas%20Publications/LevandowskiIJGO2012.ashx [hereinafter *The role of stigma*].
[96] *Strategic Assessment of Unsafe Abortion in Malawi*, *supra* note 28, 138.
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[112] ICCPR, *supra* note 1, art. 3.
[113] *See, e.g.*, Human Rights Committee, *Concluding Observations: Chile*, para. 15, U.N. Doc. CCPR/C/79/Add.104 (1999*); Poland*, para. 8, UN Doc. CCPR/CO/82/POL/Rev. 1 (2004).
[114] *See, e.g.*, Human Rights Committee, *Concluding Observations: Armenia*, para. 16, U.N. Doc. CCPR/C/79/Add.100 (1998); *Costa Rica*, para. 12, U.N. Doc. CCPR/C/79/Add.107 (1999); *Japan*, para. 30, U.N. Doc. CCPR/C/79/Add.102 (1998)*: Mexico*, para. 17, U.N. Doc. CCPR/C/79/Add.32 (1994).
[115] *See, e.g.*, Human Rights Committee, *Concluding Observations: Armenia*, para. 16, U.N. Doc. CCPR/C/79/Add.100 (1998); *Ireland*, para. 29f, U.N. Doc. A/55/40, paras. 422-451 (2000); *Senegal*, para. 13, U.N. Doc. CCPR/C/79/Add.82 (1997).
[116] 2010 MDHS, *supra* note 34 at 239.
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[119] *Id*.
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[122] *Id*.
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[126] *See*, e.g., Human Rights Committee, *Concluding Observation: Hungary*, para. 10, U.N. Doc. CCPR/C/GTM/CO/3 (2002); *Lithuania*, para. 9, U.N. Doc. CCPR/CO/80/LTU (2004).
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[133] *Id*., para. 21.
[134] Human Rights Council, *Universal Periodic Review: Malawi* sec. 102.27-29 (2011) U.N. Doc. A/HRC/16/4, *available at* http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/100/20/PDF/G1110020.pdf [hereinafter UPR Malawi].
[135] REPUBLIC OF MALAWI, REPORT TO THE HUMAN RIGHTS COMMITTEE, para. 77 (2013).
[136] UNFPA, MARRYING TOO YOUNG: END CHILD MARRIAGE 10 (2012), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf [hereinafter UNFPA, MARRYING TOO YOUNG].
[137] *See, e.g.*, Human Rights Committee, *Concluding Observation: Democratic Republic of the Congo*, para. 11, U.N. Doc. CCPR/C/COD/CO/3 (2006); *India*, para. 16, U.N. Doc. CCPR/C/79/Add.81 (1997); *Kuwait*, para. 7, U.N. Doc. CCPR/CO/69/KWT (2000); *Mali*, para. 10, U.N. Doc. CCPR/CO/77/MLI (2003); *Nigeria*, para. 291, U.N. Doc. A/51/40 (1996); *Peru*, para. 14, U.N. Doc. CCPR/C/79/Add.72 (1996); *Sudan*, para. 11, U.N. Doc. CCPR/C/79/Add.85 (1997); *Suriname*, para. 18, U.N. Doc. CCPR/CO/80/SUR (2004); Sweden, para. 9, U.N. Doc. CCPR/CO/74/SWE (2002); *Syrian Arab Republic*, para. 20, U.N. Doc. CCPR/CO/71/SYR (2000); Uganda, para. 23, U.N. Doc. CCPR/CO/80/UGA (2004); *Uzbekistan*, para. 24, U.N. Doc. CCPR/CO/83/UZB (2005); *Venezuela*, paras. 18 & 20, U.N. Doc. CCPR/CO/71/VEN (2001); *Yemen*, para. 10, U.N. Doc. CCPR/CO/75/YEM (2002); *Yemen*, para. 21, U.N. Doc. CCPR/CO/84/YEM (2005); *Zimbabwe*, ¶ 12, U.N. doc. CCPR/C/79/Add. 89 (1998).
[138] *See, e.g.*, Human Rights Committee, *India*, para. 16, U.N. Doc. CCPR/C/79/Add.81 (1997); *Nigeria*, para. 291, U.N. Doc. CCPR/C/79/Add.65 (1996); *Zimbabwe*, para. 12, U.N. Doc. CCPR/C/79/Add. 89 (1998).
[139] *See, e.g.*, *Monaco*, para. 12, U.N. doc. CCPR/CO/72/MCO (2001); *Syrian Arab Republic*, para. 20, U.N. Doc. CCPR/CO/71/SYR (2001); *Venezuela*, paras. 18 & 20, U.N. Doc. CCPR/CO/71/VEN (2001).
[140] UNFPA, MARRYING TOO YOUNG, *supra* note 136 at 11.
[141] *Id*.
[142] William Murk, *Experiences with Obstetric Fistula in Rural Uganda*, 82(2) YALE J. OF BIOLOGY AND MEDICINE 79-82 (2009).
[143] UN WOMEN *Child Marriages, supra* note 43.
[144] UNFPA, MARRYING TOO YOUNG, *supra* note 136 at 68.
[145] *Id*.; CHILD MARRIAGE ANNEX, *supra* note 44.
[146] *Id*.
[147] *Id*.
[148] *Id*.
[149] CONSTITUTION OF THE REPUBLIC OF MALAWI (1994), art. 22 (6).
[150] *Id*.
[151] The CEDAW Committee has stated that the minimum age of marriage for men and women must be 18 years and the betrothal and marriage of a child shall have no legal effect. *See* CEDAW Committee, *General Recommendation*

No. 21: *Equality in marriage and family relations*, (13th Sess., 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 36-38, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 11) (2008). Similarly, the African Children's Charter requires states to set the minimum age of marriage to be 18 and prohibits the betrothal of both boys and girls. *See* African Charter on Rights and Welfare of the Child, *adopted* July 11, 1990, OAU Doc. CAB/LEG/24.9/49 (*entered into force* Sept. 17, 1999) (*ratified* 17 Sept. 1999).

[152] Human Rights Committee, *Concluding Observations: Malawi*, para.19, U.N. Doc. CCPR/C/MWI/CO/1 (2012).

[153] In the UPR process, States have the option to accept, reject or defer recommendations issued by the reviewing states. While it is not clear as to the consequence of rejected recommendations, States are expected to report on the accepted recommendations the next time they are up for a review. A state is also expected to provide a response on the recommendations it deferred—stating whether it will accept or reject such recommendations—by the time the outcome of the review is adopted. UPR Malawi, *supra* note 134, sec. 105.7.

[154] HUMAN RIGHTS WATCH, "I'VE NEVER EXPERIENCED HAPPINESS" CHILD MARRIAGE IN MALAWI 38 (2014).

[155] *Id*.