CENTER FOR REPRODUCTIVE RIGHTS

Submission to the United Nations Universal Periodic Review of

Malawi

22nd Session of the UPR Working Group of the Human Rights Council

April – May 2015

Report on Malawi's Compliance with its Human Rights Obligations in the Area of Women's Reproductive and Sexual Health

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September 12, 2014

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In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center for Reproductive Rights (the "Center") submits this letter to supplement the report of the government of Malawi, scheduled for review by the Human Rights Council during its 22nd session (Apr-May 2015). The Center is a non-profit legal advocacy organization, headquartered in New York with regional offices in Nairobi, Katmandu, Bogota and Geneva and Washington D.C., that uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect and fulfill.

Malawi is a party to multiple international and regional human rights treaties that require state parties to ensure the sexual and reproductive rights of women and girls.[1] Malawi's Constitution also guarantees equality between men and women[2] and access to adequate health care.[3] The government has also committed to achieving the Millennium Development Goals (MDGs), including the reduction of preventable maternal mortality and morbidity and ensuring universal access to reproductive health care.[4] However, women and girls in Malawi continue to experience numerous right violations that affect their sexual and reproductive health. This letter highlights the following issues which the Center hopes the Human Rights Council will take into account during its review of Malawi; (i) high incidence of preventable maternal mortality and morbidity and lack of access to reproductive health care; (ii) inadequate access to family planning information and services; (iii) high number of unsafe abortions and inaccessibility of post-abortion care; and (iv) violence against women including high rates of early marriage.

I. High Incidence of Maternal Mortality and Morbidity and Lack of Access to Reproductive Health Care

Human rights law recognizes that States have a fundamental duty to protect individuals from arbitrary and preventable loss of life,[5] including preventable maternal death.[6] In its last Universal Periodic Review (UPR), it was specifically recommended that the government of Malawi "intensify measures to address the problem of maternal mortality."[7] However, although Malawi has taken some steps to address the problem,[8] the maternal mortality ratio (MMR) is worsening—rising from 460 in 2010 to 510 maternal deaths per 100,000 live births in 2013,[9] which is substantially higher than the target of 155 set by the MDGs.[10]

In addition to unsafe abortion—accounting for 18% of maternal deaths[11]—the main causes of the high MMR in Malawi are infection and hemorrhage, which occur within the context of poor access to maternal health care and limited knowledge among the population of the warning signs of obstetric complications.[12] 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.[13] The 2010 Demographic and Health Survey (DHS) for Malawi found that although 73% of births occurred in health facilities, 48% of the women sampled did not receive any post-natal care.[14] This is a problem since three-quarters of all maternal deaths in Malawi occur during delivery or in the immediate post-partum period.[15] Moreover, low-income women, rural women, and those with less education are more likely to receive no post-natal checkup.[16] Further, a 2014 Service Provision Assessment Survey revealed that only 54 percent and 7 percent of health care facilities offer normal and caesarean delivery services respectively,[17] and only 24 percent of the facilities that provide normal delivery service have staff with up-to-date

training.[18] In its most recent Concluding Observations from July 2014, the Human Rights Committee (HRC) called on Malawi to "ensure that reproductive health services are accessible for all women and adolescents, including in rural areas."[19]

II. Inadequate Access to Comprehensive Family Planning Information and Services

In 2014, the HRC called upon Malawi to "increase education and awareness-raising programmes, both formal . . . and informal . . . on the importance of using contraceptives and on sexual and reproductive rights."[20] The Committee on the Elimination of Discrimination against Women (CEDAW Committee) also expressed its concern at the "inadequate family planning services, especially in rural areas, low rates of contraceptive use and lack of sex education"[21] and urged the government to "improve the availability of sexual and reproductive health services, including family planning information and services," and recommended that "programmes and policies be adopted to increase knowledge of and access to affordable contraceptive methods."[22]

Currently, Malawi has a high fertility rate[23] with significant unmet need for family planning. Only 33% of women use modern contraceptive methods[24] and over a quarter of all married women have an unmet need.[25] Many women— particularly young, poor, and rural women—encounter numerous barriers in accessing contraceptive information and services including distance to the health facility (55.5%), concern that no provider would be available (47.3%) or financial barriers (51.6%).[26] Those facilities offering contraceptives experience frequent shortages, especially of preferred methods such as implants and injectables.[27] Awareness of and access to emergency contraception is also very weak in Malawi. According to the 2010 DHS, only 0.7% of women had ever used emergency contraception,[28] though it is an important method of preventing unintended pregnancy and is a critical component of care for survivors of sexual violence.

Adolescents face special difficulties in obtaining access to family planning information and services. Provision of sexual education is lacking[29]and the 2010 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.[30] Outside of marital relationships, it is often difficult for young people to access contraceptives because of stigma associated with extramarital sexual activities and the personal beliefs of health care providers which result in bias.[31] In previous Concluding Observations, CRC Committee has recommended 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.[32]

III. High Number of Unsafe Abortions and Inaccessibility of Post-Abortion Care

Malawi has one of the most restrictive abortion laws in the world—abortion is legal only to save the life of the woman, meaning a woman who becomes pregnant as a result of rape, incest or forced marriage, or who is carrying a fetus with significant abnormality or impairment, is not permitted to legally terminate her pregnancy. [33] As recognized by various Treaty Monitoring Bodies (TMBs), including in the HRC's most recent Concluding Observations on Malawi, restrictive legislation of this kind forces Malawian women to seek unsafe abortions, with

attendant risks to their life and health.[34] In Malawi, unsafe abortion is a leading cause of maternal mortality, accounting for 18% of such deaths.[35] Although the government rejected the recommendation that it "intensify measures to address the problems of maternal mortality and unsafe abortion, reviewing punitive provisions regarding the latter" in its 2010 UPR,[36] it did acknowledge the need to examine the law on abortion in its 2013 submission to the African Commission on Human and Peoples' Rights[37] and has ratified the Maputo Protocol which, under Article 14(2)(c), explicitly guarantees the right to legal abortion in cases of rape, incest and forced marriage, in addition to life and health grounds.[38] To date, the government has failed to comply with its obligation and reform the laws on abortion.

Restrictive abortion laws also have disproportional effect on adolescents, low-income and rural women, as they have limited access to safe abortion services due to this restrictions, thus violating their right to equality and non-discrimination.[39] Moreover, research suggests that even those women who are eligible for legal abortion must, in practice, obtain spousal consent[40] and authorization by two physicians.[41] As a result, almost 70,000 women every year endanger their lives and health by seeking clandestine abortions.[42] These requirements can create insurmountable barriers to legal abortion services. A spouse may refuse to provide consent, a barrier to health care seeking reported by many women in the 2010 DHS.[43] Additionally, the required authorization of multiple doctors is particularly onerous in a country such as Malawi where there are only two doctors for every 100,000 people. [44] Finally, some Malawian health providers refuse to provide life-saving abortion for fear of providing an "illegal" one.[45]

Although essential to prevent maternal morbidity and mortality resulting from unsafe abortion, access to quality post-abortion care (PAC) remains inadequate in Malawi. According to the country's 2010 Emergency Obstetric and Newborn Care Needs Assessment, post-abortion care guidelines were only available in 46% of hospitals and 14% of health centers. [46] Furthermore, insufficient staff and reliance on outdated clinical procedures for management of incomplete abortion undermine provision of timely and clinically appropriate PAC.[47] The National Sexual and Reproductive Health and Rights Policy 2009 (SRHRP) calls for the management of complications of abortion with high-quality PAC, but it is clear that Malawi must significantly progress to meet this obligation.

IV. Violence Against Women and Girls

The right to be free from discrimination includes the right to be free from gender-based violence and harmful traditional practices.[48] Despite underreporting, data from different sources show that violence against women is prevalent in Malawi.[49] According to the 2010 DHS, three in every ten women had experienced physical violence and one in four women had been the victim of sexual violence.[50] However, services and protection for survivors of violence, including reporting mechanisms and awareness campaigns to sensitize women about their rights, remain inadequate. One study found that over a third of women who experience physical or sexual violence never tell anyone about it and nearly half never seek help (48%).[51] Only 3% went to police.[52] Health care workers have also identified problems with documentation, referral, reporting and provision of evidence in court as barriers to implementation of a comprehensive response to violence against women within the health sector.[53]

Although Malawi has made some progress, such as the 2006 Prevention of Domestic Violence Bill, the legislation is viewed by many as ineffective.[54] In its most recent concluding observations, the HRC observed with concern that Malawi has failed to collect critical statistical data on the incidence of domestic violence or the number of prosecutions that have been undertaken.[55] Such information is essential to understanding the scope of the problem and designing legislative and policy approaches accordingly. The 2010 DHS reported that major international and regional instruments to prevent gender-based violence remain largely unimplemented.[56] Marital rape has also not yet been criminalized in Malawi, an issue raised by the CEDAW Committee in 2006 and again by the Human Rights Committee in 2014.[57] Gender-based violence more generally has been a recurrent issue in assessments of Malawi's treaty compliance and human rights record. In its 2010 UPR, more than five different states made recommendations concerning the problem of gender-based violence and the inadequacy of the present legal and policy framework as implemented.[58] Malawi attempted to address several of these recommendations in its Mid-Term Progress Report, which was published in 2013 and represents a self-evaluation of the country's implementation of UPR recommendations.[59]

Early Marriage

Early marriage refers to marriages that occur when one or both of the spouses are below the age of 18.[60] Girls married as children are denied education, barred from developing income-generational skills, and socially isolated, perpetuating their low social and economic status.[61] Early marriage also exposes girls to increased risk of maternal mortality and morbidity as they are at particular risk for complications such as obstetric fistula.[62]

Malawi has among the highest rates of early marriage in the world— over 50% of girls in Malawi are married by their 18th birthday,[63] significantly higher than the regional average of 37%.[64] To date, Malawi has made little progress towards ending the practice of early marriage. In 2014, the HRC expressed its concern about the persistent practice of forced and child marriages and recommended that the Malawi expedite adoption of the 2006 Marriage, Divorce and Family Relations Bill and set the minimum age of marriage in accordance with international standards.[65] Malawi rejected similar recommendations made during its UPR to "[t]ake further action towards gender equality, including a legal provision on the minimum age for marriage,"[66] though under Section 13(a) of the Constitution, the State is required to progressively adopt and implement policies and legislation aimed at ensuring equality between women and men.[67]

V. Questions

We hope that the Human Rights Council will consider addressing the following questions to the government of Malawi:

1) What concrete measures are being taken to reduce preventable maternal morbidity and mortality, including intra-country disparities that result in worse outcomes for vulnerable groups, such as women in rural areas, low-income women and adolescents?
2) What measures are being undertaken to address the acute shortage of health personnel and to ensure that health care facilities are adequately staffed and equipped to provide

quality maternal health care services that are culturally appropriate and non-discriminatory?

3) What steps are being taken by the government to address the high level of unsafe abortion and to bring the existing legal framework around abortion in line with international and regional human rights standards? What steps are being taken to improve PAC services?
4) What is the government planning to improve access to family planning services and education, including emergency contraception, in particular with respect to vulnerable populations, including low-income women, women living in rural areas and adolescents?
5) Is the government acting affirmatively to address the problem of gender-based violence, including implementation of the existing Prevention of Domestic Violence Bill? Is the government committed to ensuring appropriate services and adequate legal response for survivors of gender-based violence?
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 exception?

VI. Recommendations

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, with attention to the needs of marginalized populations; 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 act to increase knowledge of and access to contraceptive methods, including emergency contraception. It should specifically target vulnerable populations, and institute ongoing training programs for reproductive healthcare providers which include the provision of culturally appropriate and non-discriminatory services.
4) The government should act to fully realize the Constitutional guarantee to sex equality and strengthen efforts to implementing existing legislation regarding gender-based violence. The government should also amend the Domestic Violence Act to include marital rape as a punishable offence.
5) The government should immediately pass the Marriage Bill and amend the Constitution to reflect a minimum age of 18 for marriage without exception, and make concrete efforts to eliminate the practice of early marriage by targeting specific areas of the country, especially rural areas.

We hope this information is useful during the Universal Period Review of Malawi. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

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[1] International Covenant on Civil and Political Rights (ICCPR), *adopted* Dec. 10, 1948, arts. 3, 6, 23, 26, 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* December 22, 1993) [hereinafter ICCPR]; Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) *adopted* Dec. 18, 1979, arts. 10, 12, 14(2)(b), 16(1)(e), G.A. Res 34/189, U.N. GAOR, 34th Sess., Supp, No. 46, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) (*acceded* Mar. 12, 1987); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), *adopted* Dec. 10, 1984, art. 16, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51 U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987) (*acceded* June 11, 1996); Convention on the Rights of the Child (CRC), *adopted* Nov. 20, 1989, art. 24, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess. Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) (*acceded* Jan. 2, 1991); International Covenant on Economic Social and Cultural Rights (ICESCR), *adopted* Dec. 16, 1966, arts. 3, 6, 23, 26, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6313 (1966) (*entered into force* Jan. 3, 1976) (*acceded* Dec. 22, 1993); African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, arts. 3, 16 O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (*ratified* Feb. 23, 1990); African Charter on the Rights and Welfare of the Child, *adopted* Jul. 11, 1990, arts. 14, 16, 21, 27, O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999) (*ratified* Sep. 16, 1999); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* Jul. 11, 2003, Doc CAB/LEG/66.6 (2000) (*entered into force* Nov. 25, 2005, (*ratified* May 20, 2005) [hereinafter Maputo Protocol].

[2] CONSTITUTION OF THE REPUBLIC OF MALAWI (1994), art. 13(a) [hereinafter MALAWI CONSTITUTION].

[3] *Id*., art. 13(c).

[4] UNITED NATIONS MILLENNIUM DEVELOPMENT PROJECT, *Goals, Targets and Indicators* (2006), *available at* http://www.unmillenniumproject.org/goals/gti.htm (last visited Aug. 4, 2014).

[5] Human Rights Committee, *General Comment No. 6: Right to life (Art. 6)*, (16th Sess., 1982), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 177, para 5, U.N. Doc. HRI/GEN/1Rev.9 (Vol. 1) (2008).

[6] HRC, *General Comment No. 28: Equality of Rights between Men and Women*, (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 229, para 10, U.N. Doc. HRI/GEN/1Rev.9 (Vol. 1) (2008); CEDAW Committee, *Concluding Comments: Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999) ("[T]he Committee notes that the level of maternal mortality due to clandestine abortions may indicate that the Government does not fully implement its obligations to respect the right to life of its women citizens."); Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003) ("So as to guarantee the right to life, the State should strengthen its efforts . . . in ensuring the accessibility of health services, including emergency obstetric care."); Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Democratic Republic of Congo*, U.N. Doc. CRC/C/COD/CO/2, paras. 33-34 (2009).

[7] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Malawi*, sec. 105.32 (2011) U.N. Doc. A/HRC/16/4 [hereinafter UPR Malawi].
[8] 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. 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. *See* WORLD HEALTH ORGANIZATION (WHO), RAPID ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGE 19 (2011), *available at* http://www.who.int/reproductivehealth/topics/linkages/RASmalawi.pdf; Courtney E. Martin & John Cary, *How Malawi is improving a terrible maternal mortality rate through good design*, TED TALKS, Jan. 30, 2013, *available at* http://blog.ted.com/2013/01/30/how-malawi-is-improving-a-terrible-maternal-mortality-rate-through-good-design/ (last visited July 28, 2014).
[9] WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2010 34 (2012), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf; WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2013 2 (2014), *available at* http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1.
[10] Colburn et al., *Maternal mortality in Malawi, 1977-2012*, BMJ OPEN ACCESS 1 (2013).
[11] Levandowski, et al., *The Incidence of Induced Abortion in Malawi* INT'L PERSP. ON SEXUAL & REPROD. HEALTH 88, 94 (2013) [hereinafter *Induced Abortion in Malawi*].
[12] REPUBLIC OF MALAWI, MINISTRY OF HEALTH, HEALTH SECTOR STRATEGIC PLAN 2011-2016: MOVING TOWARDS EQUITY AND EQUALITY 111 (2011), *available at* http://www.medcol.mw/commhealth/publications/3%20Malawi%20HSSP%20Final%20Document%20(3).pdf.
[13] NATIONAL STATISTICAL OFFICE, MALAWI DEMOGRAPHIC AND HEALTH SURVEY 2010, 113-114 (2011), available at http://www.measuredhs.com/pubs/pdf/FR247/FR247.pdf [hereinafter 2010 MDHS]; Viva Combs Thorsen, Johanne Sundby, Address Malata, *Piecing together the maternal death puzzle through narratives: the three delays model revisited*, PLOS MED 7 (2012); Gilbert Abotisem Abiiro, Grace Bongololo Mbera & Manuela De Allegri, *Gaps in universal health coverage in Malawi: a qualitative study in rural communities*, BMC HEALTH SERV. RES. 14 (2014).
[14] 2010 MDHS, *supra* note 13, at 112.
[15] UNITED NATIONS CHILDREN'S FUND (UNICEF), MALAWI MULTIPLE INDICATOR CLUSTER SURVEY 2006 160 (2008), available at http://www.childinfo.org/files/MICS3_Malawi_FinalReport_2006_eng.pdf.
[16] 2010 MDHS, *supra* note 13, at 113.
[17] REPUBLIC OF MALAWI, MINISTRY OF HEALTH, MALAWI SERVICE PROVISION ASSESSMENT SURVEY 2013-2014, 20 (2014), *available at* http://dhsprogram.com/pubs/pdf/PR49/PR49.pdf.
[18] *Id*. at 21.
[19] Human Eights Committee, *Concluding Observations: Malawi*, para. 9(a), U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014).
[20] *Id*.
[21] CEDAW Committee, *Concluding Comments: Malawi*, para. 31, U.N. Doc. CEDAW/C/MWI/CO/5 (2006).
[22] *Id*., para. 32.
[23] According to the latest estimate, the fertility rate in Malawi is 5.7 with the UN estimating the rate to be as high as 6. *See*, JEAN-PIERRE GUENGANT ET AL., AFRICA 2050: AFRICAN DEMOGRAPHY ANNEX 1 50 (2013), *available at* http://horizon.documentation.ird.fr/exl-doc/pleins_textes/divers13-07/0100593.pdf.
[24] 2010 MDHS, *supra* note 13, at 57.
[25] *Id*. at 88.
[26] 2010 MDHS, *supra* note 133, at 114-115.
[27] Emily Jackson, et al., *A Strategic Assessment of Unsafe Abortion in Malawi*, Repro. Hlth. Matters, 19: 133-143 (2011) *available at* http://www.eldis.org/vfile/upload/1/document/1110/Strategic-assessment-of-unsafe-abortion-in-Malawi.pdf [hereinafter *Strategic Assessment of Unsafe Abortion in Malawi*].
[28] 2010 MDHS, *supra* note 13, at 56.
[29] MUNTHALI ET AL., ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN MALAWI: RESULTS FROM THE 2004 NATIONAL SURVEY OF ADOLESCENTS 7-8 (2006); Levanowski et al., *Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma*, 118 INT'L J. GYNECOLOGY & OBSTETRICS secs. 167-168 (2012) [hereinafter *The Role of Stigma*].
[30] 2010 MDHS, *supra* note 133, at 56.
[31] *The Role of Stigma*, *supra* note 29.

[32] CRC Committee, *Concluding Observations: Malawi*, para. 55, U.N. Doc. CRC/C/MWI/CO/2 (2009).
[33] MALAWI PENAL CODE, ch. 701, sec. 243.
[34] Human Eights Committee, *Concluding Observations: Malawi,* para. 9, U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014) ("The committee is deeply concerned about the high rates of maternal mortality and, in particular, at the high percentage of unsafe abortion-related maternal deaths. It is concerned at the general criminalization of abortion, except to save the life of the woman, which obliges pregnant women to seek clandestine abortion services that put their lives and health at risk. While taking note of the special commission set up to review the abortion law in 2013, the Committee is concerned about the excessive delays in reforming the law. The Committee also finds the high rate of teenage pregnancies to be regrettable (arts. 2, 3, 6, 7, 17, 24 and 26)); CEDAW Committee, *Concluding Observations: Malawi*, paras. 36-37, U.N. Doc. CEDAW/C/MWI/CO/6 (2010) ("The Committee further recommends that the State party 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 an reducing maternal mortality rates, in accordance with the Committee's general recommendation No. 24.).
[35] *Induced Abortion in Malawi*, *supra* note 11.
[36] UPR Malawi, *supra* note 7, sec. 105.32.
[37] REPUBLIC OF MALAWI, REPORT TO THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS, para. 215 (2013), *available at* http://www.achpr.org/files/sessions/14th-eo/state-reports/1-1995-2013/staterep1_malawi_2013_eng.pdf.
[38] Maputo Protocol, *supra* note 1, art. 14(2)(c).
[39] *Strategic Assessment of Unsafe Abortion in Malawi*, *supra* note 27, at 137.
[40] *Id.*, at 134. (*citing* MUNTHALI ET AL. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN MALAWI: RESULTS OF THE 2004 NATIONAL SURVEY OF ADOLESCENTS 84 (2006)).
[41] *Id.*
[42] *Induced Abortion in Malawi*, *supra* note 13, at 88 & 95.
[43] 2010 MDHS, *supra* note 133, at 114.
[44] Owen Nyaka, *Malawi Faces Shortage of Healthcare Workers as It Battles AIDS Epidemic*, ALL AFRICA, Jan. 22, 2014, http://allafrica.com/stories/201401230504.html.
[45] *Strategic Assessment of Unsafe Abortion in Malawi*, *supra* note 27, at 136.
[46] *See, e.g.*, REPUBLIC OF MALAWI, MINISTRY OF HEALTH, MALAWI 2010 EMERGENCY OBSTETRIC & NEWBORN CARE NEEDS ASSESSMENT – FINAL REPORT 95 (2010), *available at* http://www.mamaye.org/en/evidence/malawi-2010-emergency-obstetric-newborn-care-needs-assessment.
[47] *Strategic Assessment of Unsafe Abortion in Malawi*, *supra* note 27, at 138 (Many facilities continue to use sharp curettage rather than manual vacuum aspiration (MVA), the currently recommended method which poses significantly less risk women).
[48] Committee on the Elimination of Discrimination against Women, *General Recommendation No. 19: Violence against women*, (11th Sess., 1992), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 6, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); ICCPR, *supra* note 1, art. 3; *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); *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).
[49] 2010 MDHS, *supra* note 13, at 239-242 (In 2010, over a quarter of women surveyed reported experiencing physical violence since age 15).
[50] *Id.*
[51] CHEPUKA, ET AL., ASSESSMENT OF THE CAPACITY OF THE HEALTH SECTOR TO RESPOND TO VIOLENCE AGAINST WOMEN AND CHILDREN IN MALAWI 12 (2011) [hereinafter ASSESSMENT OF CAPACITY].
[52] *Id.*
[53] *Id.* at 42.
[54] *Id.* at 25-26, 52-53; 2010 MDHS, *supra* note 13, at 239; HUMAN RIGHTS WATCH, "I'VE NEVER EXPERIENCED HAPPINESS": CHILD MARRIAGE IN MALAWI 12 (2014), *available at* http://www.hrw.org/sites/default/files/reports/malawi0314_ForUpload.pdf.
[55] Human Rights Committee, *Concluding Observations: Malawi*, para. 14, U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014)
[56] 2010 MDHS, *supra* note 133, at 239

[57] CEDAW Committee, *Concluding Observations: Malawi.* para. 12, U.N. Doc. CEDAW/C/MWI/CO/5 (2006); Human Rights Committee, *Concluding Observations: Malawi,* para. 14(b), U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014).
[58] UPR Malawi, *supra* note 7, secs. 102.27-102.30, 102.36. (Note that Malawi rejected Slovenia's recommendation that it "[e]nsure that discriminatory laws are amended or repealed, adopt a comprehensive strategy to modify or eliminate negative cultural practices and stereotypes, and strengthen efforts to implement existing legislative measures regarding violence against women, including assistance and protection for victims.") & sec. 105.10.
[59] MALAWI HUMAN RIGHTS COMMISSION, MID-TERM PROGRESS REPORT ON THE IMPLEMENTATION OF THE UNITED NATIONS HUMAN RIGHTS COUNCIL'S UNIVERSAL PERIOD REVIEW RECOMMENDATIONS TO MALAWI, secs. 4.6-4.6.2 (2013), *available at* http://www.hrcmalawi.org/UPR%20Mid-Term%20Report.pdf.
[60] UNFPA, MARRYING TOO YOUNG: END CHILD MARRIAGE 94 (2012), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf [hereinafter UNFPA, MARRYING TOO YOUNG].
[61] *Id*.
[62] William Murk, *Experiences with Obstetric Fistula in Rural Uganda*, 82(2) YALE J. OF BIOLOGY & MED. 79-82 (2009).
[63] UNFPA, MARRYING TOO YOUNG, *supra* note 60, at 68.
[64] *Id.* at 27, 36.
[65] Human Rights Committee, *Concluding Observations: Malawi*, para. 25, U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014).
[66] 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 7, sec. 105.7.
[67] MALAWI CONSTITUTION, *supra* note 2.