CENTER FOR REPRODUCTIVE RIGHTS

October 2, 2015

The Committee on the Elimination of Discrimination against Women

Re: Supplementary information on Malawi scheduled for review by the Committee on Elimination of Discrimination against Women during its 62nd session

Honorable Committee Members:

This letter is intended to supplement the periodic report submitted by Malawi to the Committee on the Elimination of Discrimination against Women (the Committee), which is scheduled to be reviewed during the Committee's 62nd Session. The Center for Reproductive Rights (the Center), a global legal advocacy organization with headquarters in New York, and regional offices in Nairobi, Bogota, Kathmandu, Geneva, and Washington D.C., uses the law to advance reproductive freedom as a fundamental human right that all governments are 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 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[1] and other international and regional human rights instruments that protect reproductive rights, which Malawi has ratified.

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 abortion, lack of access to family planning information and services, and violence against women. We will be also addressing the issues raised by the Committee during its 62nd pre-sessional working group, and giving some recommendations for the consideration of the Committee.

I. The Rights to Equality and Non-Discrimination

The realization of women's right to substantive equality and non-discrimination is inherently linked to the realization of women's reproductive rights. Where women face inequalities and discrimination, their ability to access reproductive health services and make meaningful choices about their reproductive lives is limited. As such, ensuring women access to a full range of reproductive health services, such as contraception, abortion, and maternal health services, is essential to ensuring that women can equally exercise their human

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rights.[2] Biologically, women must physically bear the burden of an unplanned pregnancy. Where women are unable to prevent pregnancy and decide whether to carry a pregnancy to term, the inequalities and discrimination women face are exacerbated due to the differentiated impact that childbearing has on women's health and lives. For adolescents who carry an unplanned and unwanted pregnancy to term, the physical burden during pregnancy can affect all facets of their lives, including their ability to finish school and seek higher education.[3] Additionally, due to women's and girls' socialized role as the primary caregiver, childbearing disproportionately affects their 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.[4]

Furthermore, women must be able to make decisions surrounding pregnancy and childbirth autonomously, without discrimination, undue influence, pressure, force or coercion. At its core, reproductive autonomy requires that women have access to and the ability to independently decide whether to use the full range of reproductive health services,[5] including maternal health services, contraception and abortion. Full exercise of autonomy requires that choices are meaningful, not limited by discrimination or lack of opportunities or possible results.[6] This also requires the state to take positive measures to ensure all women, regardless of income or other status, are able to fully access reproductive health services and exercise reproductive autonomy. Further, states must ensure women substantive equality in the areas of education, employment, and participation in public and political life, in order to ensure that women and girls are not pressured into childrearing as their only social role.

Recognizing the inextricable link between women's reproductive rights and their other human rights, the Committee has made clear that providing access to reproductive health services is essential to ensuring that women can equally exercise their human rights.[7] In the list of issues (LOIs) **the Committee asked the government to describe the measures taken and planned to disseminate the Gender Equality Act to all government officials, as well as the steps taken to incorporate the rights of women under CEDAW and its Optional Protocol into the legal education and training of judges, lawyers and prosecutors.**[8] While it is commendable that the government is taking some steps to popularize the Act, including by training 100 law enforcement bodies and planning to disseminate flyers to Minister Offices, departments and agencies,[9] these interventions need to be implemented on a larger scale in order to benefit women and girls living in both rural and urban areas. The government should also develop strategies to monitor the effectiveness of these interventions and evaluate implementation of the Act.

As the Committee recognizes, the responsibility for childrearing disproportionately falls on women, which affects their rights to education and employment, amongst others, as well as their physical and mental health.[10] Indeed, the Committee recognizes that the disproportionate burden women carry in relation to childcare is one of the most significant factors inhibiting women's ability to participate in public life[11] and that reduced domestic burdens enable women to engage more fully in activities outside the home.[12] Additionally, the Committee has noted that women's ability to voluntarily control their fertility improves their and their families' health, development, and well-being.[13]

II. <u>High Incidence of Maternal Mortality and Morbidity</u>

CEDAW contains robust protections for the right to maternal health care, and explicitly recognizes the right to safe and healthy pregnancy as a component of the right to health, stating that "States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[14] The

Committee has routinely expressed concern over States' high maternal mortality rates,[15] framing the issue as a violation of the right to life,[16] health[17] and the right to non-discrimination.[18] While state parties are required to reduce their maternal mortality rates through safe motherhood services and prenatal assistance,[19] simply reducing their overall maternal mortality rates does not fulfill their obligations under CEDAW. States are required to provide adequate interventions to prevent maternal mortality, including appropriate health services that meet the distinct needs of women and are inclusive of marginalized sectors of society.[20]

In the **LOIs the Committee asked the government to provide information on the measures implemented to "reduce the high maternal mortality rates, in particular for rural women and adolescents."[21]** As demonstrated in the government's response, Malawi has taken some steps[22] to achieve its commitment under the Millennium development Goals (MDGs) of reducing the maternal mortality ratio (MMR) to 155 per 100,000 by 2015.[23] The government is implementing the Presidential Initiative on Maternal Health and Safe Motherhood, which was launched in 2012, with the aim of increasing the number of women who give birth at healthcare facilities.[24] Under the initiative, the government pledged to build about 150 maternal waiting homes near the clinics for pregnant women living in rural areas; to sensitize local chiefs on the importance of maternal health services to rural women; and train over 1,000 new community midwives by 2014.[25] It has been reported that the initiative has graduated about 158 midwives[26] and the National Coordinator of the Initiative has also recently indicated that 12,000 local chiefs have been enlisted "to change attitudes and perceptions at the grassroots level."[27] Also, even though the government's response to the LOIs states that only 12 maternity waiting homes have been constructed so far, other resources indicate that in fact, 130 shelters have been built within already existing delivery centers.[28] In 2009, the government revised the National Sexual and Reproductive Health and Rights Policy (SRHR Policy) to improve women's access to essential maternal healthcare services.[29]

Despite these efforts, Malawi's maternal mortality ratio (MMR) is worsening and remains one of the highest in the world. While the government, in its submission to the Committee, reports that it was announced in 2013 that "as a result of the Presidential Initiative on Safe Motherhood, the Maternal Mortality Ratio (MMR) has significantly reduced to 460 per 100,000 live births,"[30] it provided in its response to the LOIs that the MMR is 574 per 100,000 live births.[31] Data from the UN also reveals a higher ratio of 510 maternal deaths per 100,000 live births.[32] This is substantially higher than the MDGs target. Furthermore, the World Health Organization (WHO) has stated that, for every maternal death 20-30 women experience serious consequences or disability as a result of pregnancy or delivery.[33] Therefore, the MMR does not capture the many instances in which women survive pregnancy but suffer long lasting pregnancy-related health problems and disabilities such as obstetric fistula.[34]

Despite the efforts outlined above and the policy to provide free maternity-related services in all public and some not-for-profit facilities, women and girls encounter numerous barriers in accessing these services.[35] 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.[36] 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. Malawi's 2010 Demographic Health Survey (2010 MDHS) found that 95% of adolescents and women ages 15-49 received ante-natal 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.[37] Also, only 46% of women completed the WHO recommended[38] four ante-natal visits.[39] The

2010 MDHS also found that although 73% of the births occurred in health facilities, 48% of the women did not receive any post-natal care.[40] 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.[41]

Combating maternal mortality in rural areas is crucial, taking into consideration that 82% of Malawi's population lives in the countryside, out of which 22% are women of childbearing age.[42] Furthermore the fertility rate in rural areas of 6.1 children per woman is substantially higher compared to a rate of 4 children per woman in urban areas.[43] However, there is a disparate proportion of births that are attended by skilled health personnel between rural and urban areas: approximately 86% of women in urban areas are attended to by skilled health personnel when giving birth compared to an average of 71% of women in rural areas.[44] Wealth also plays a major role in the type of assistance a woman has access to during delivery. Women in the highest wealth quintile are almost twice as likely to be assisted by a skilled attendant (90%) compared to women in the lowest wealth quintile (65%).[45] Maternal mortality rates are also strongly related to the educational level and financial status of the woman. The more formal education a woman has, the more likely she is to have delivered with the assistance of a skilled attendant; 90% of women who have completed secondary education compared to 63% of women with no formal education.[46]

There is also a critical insufficiency of skilled healthcare providers that has a direct negative impact on the quality of care provided to women. According to the latest available data, the doctor-to-patient ratio is very low at 1 per 33,000,[47] and there are only 4,450 trained nurses, and approximately 3,000 midwives in Malawi.[48] This is a serious deficit that amounts to only one nurse or midwife for every 1,799 people.[49] 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.[50] Additionally, with poor working conditions and the imbalanced patient to provider ratio, doctors, nurses and midwives are seeking work elsewhere, including abroad[51]

It is equally important to note that, girls and young women disproportionately bear the consequences of maternal mortality.[52] After a maternal death occurs, girl children who have lost their mothers are given additional household responsibilities and may be required to take care of the surviving children and support them financially.[53] As a result, they often have to drop out of school and frequently feel compelled to marry early to financially help their families.[54]

High MMR among adolescents:

Globally, pregnancy and childbirth-related complications are the leading cause of death for adolescent girls aged 15–19.[55] In Malawi, with over 50% of girls married before age 18,[56] 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.[57] A Strategic Assessment of Unsafe Abortion in Malawi, conducted by the Ministry of Health and WHO, shows that teenage pregnancies account for 20-30% of maternal deaths in the country.[58] 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 ante-natal and obstetric care, lower social and economic status, and low levels of education.[59]

III. Lack of Access to Safe Abortion

Restrictive abortion laws are based on the notion that women themselves are not competent enough to make informed, rational decisions about their bodies. In this sense, they demean women as decision-makers.[60] Furthermore, such laws institutionalize and perpetuate the discriminatory stereotype that women's primary role is parenting. The Committee has made clear that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[61] As only women become pregnant, laws denying women the ability to determine whether to carry a pregnancy to term compel women to become mothers, thereby undermining women's agency in crucial decisions affecting their lives, limiting their opportunities, and denying women reproductive autonomy.

In the LOIs, the Committee required the government to provide information on the progress made towards reviewing the provision regulating abortion with a view to removing punitive provisions for women who undergo an abortion and to expanding the grounds of abortion to cases of rape, incest, threat to the health of the mother and severe fetal impairment. [62] This is a follow-up of the recommendation the Committee made during the 2010 review of Malawi, where, concerned about the number of deaths resulting from unsafe abortions, it asked the country to "review the laws relating to abortion with a view to removing the punitive provisions imposed on women who undergo an abortion."[63]The government, in its response to the LOIs indicated that the Special Commission on Review of Abortion laws has announced its recommendation that the laws be revised to allow abortion when a pregnancy puts a woman's physical or mental health at risk and when the pregnancy resulted from rape, incest or in cases of fetal abnormalities, and that the Commission is expected to submit its report and draft the bill to the Ministry of Justice in 2015.[64] In fact, the Commission has just done that in July. [65] However, at this time, it is unclear when the draft bill will be presented to parliament. Given that the review process has already taken more than two years, the government should ensure that the process is expedited and the new law is passed in a timely manner.

Until the revision of the law is finalized, the current restrictive law remains in effect and women and girls continue to be forced to seek unsafe and clandestine abortions, with attendant risks to their life and health: unsafe abortion is the second leading cause of maternal mortality in the country, accounting for 18% of such deaths.[66] It is also the leading cause of obstetric complications, accounting for 24–30% of such complications.[67] A recent study reported that, every year, an estimated 465,000 induced abortions occur in Malawi.[68] Further, annually, 158,000 women "receive care for induced and spontaneous abortion in health facilities.[69] Rrestrictive abortion laws also discriminate against women on the basis of sex, age, and economic status. For instance, the cost of a safe abortion service can be staggering for most Malawian women,[70] given that 60% of the population live on less than $1.25 per day.[71] 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.[72] 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.[73]

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[74] and authorization by two physicians who can attest that the reason for the abortion is to save the life of the woman.[75] 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 evidence-based and have recommended against this requirement. For example, the WHO has made clear that mid-level providers, such as nurses or clinical officers, can safely provide first trimester abortion services.[76] Further, most contemporary legal and policy experts agree that consultation requirements are inappropriate and delay access to services.[77] 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.[78] 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.[79] 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.[80] This study also found that most health providers refuse to provide life-saving abortion out of fear of risking providing an "illegal" one.[81] Consequently, many women rely on untrained providers, traditional healers or resort to self-induced methods of abortion,[82] risking their lives and health. Due to these misconceptions and fear of prosecution, there are very few recorded cases of legal abortions.[83]

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 the 2004 Malawi Reproductive Health Unit developed a National Post Abortion Care Strategy that planned to increase the number of public facilities that provide the service, [84] access to quality PAC remains inadequate. For instance, many of the health care facilities in Malawi lack critical tools which health care professionals need to provide effective PAC.[85] A 2011 research report 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.[86] Even when available, they were worn or rusted, or locked away to prevent them from being used for inducing an abortion.[87] Additional barriers to PAC include lack of staff resulting in delays in provision of care,[88] and prohibitive costs; the median cost for a simple case is about $16 and more complicated cases involve higher costs.[89] Another recent report further suggests that the cost of a simple case of PAC can cost as much as $45, [90] and the government spends about a $1 million a year in PAC.[91] Such physical and financial barriers directly threaten women and girls' health and life.

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

During previous reviews of Malawi, the Committee had expressed concern about the high fertility rates, lack of access to family planning information and inadequate family planning services[92] and recommended that the government adopt "programs and policies … to increase knowledge of and access to affordable contraceptive methods so that women and men can make informed decisions about the number and spacing of children."[93] Further, in the **LOIs the Committee asked the government to provide information on the availability and accessibility of education on family planning "irrespective of marital status and including adolescents" and to "indicate whether measures have been taken to ensure access to affordable contraceptives and disseminate contraceptive methods, including emergency contraceptives for victims of sexual violence."[94]**

In response to the LOIs, the government indicated that contraceptive information and services are available to all women and adolescents ages 15-49, but admitted that accessibility remains a challenge.[95] It further

stated that budget allocations for family planning commodities have been increasing with the current budget being MK 60 million (approximately USD105,000) in 2014/2015.[96] This is, however, far below the USD 74 million that the country needs to spend in order to address the unmet need.[97] In addition, in its current report to the Committee, the government reports that it has enacted the Gender Equality Act which provides for the right to adequate sexual and reproductive health including access to family planning services, choice of whether and when to have a child, fertility control and choice of contraceptive method.[98] However, it has failed to indicate how it is implementing this law, including by allocating additional financial resources, training healthcare workers and increasing the number of healthcare facilities that provide family planning services.

Due to the many barriers women and girls continue to encounter in accessing family planning services, Malawi remains one of the countries in Africa with the highest fertility rates—about 6 children per woman—with high rates of unmet family planning needs.[99] Approximately only 28% of women and adolescent girls have had their family planning needs met.[100] Young, low-income, and rural women often face additional obstacles to reproductive health care.[101] The 2010 MDHS, 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.[102] Also, about 54% of women who lived in urban areas used contraceptives whereas the rate is only 44% for women living in rural areas.[103] It also found the contraceptive prevalence rate among women aged 15-49 is 33% for any modern method of contraceptive.[104]

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. Church-owned facilities, which account for 25% of all the medical facilities,[105] do not provide contraceptives and their patients must receive the services from other facilities.[106] Those facilities that do provide contraceptives experience shortages especially for the more popular methods of contraceptives such as implants and injectables.[107] Also, gender inequality and cultural practices, which perpetuate discrimination against women, undermine the use of contraceptives in many cases.[108] Consequently, although there is no law or policy that requires spousal consent for accessing family planning services, many women seek consent from[109] or are not allowed by their spouses or partners to use contraceptives.[110]

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 its response to the LOIs, the government stated that One-Stop Centers have been established in four central and seventeen district hospitals and health centers "that offer comprehensive services to survivors of Gender Based Violence" and that victims are provided emergency contraceptives. However, the public's knowledge and usage of EC is limited and sporadic.[111] From the women surveyed for the 2010 MDHS, only 35% knew about EC and only 0.7% had ever used this method of contraception.[112] 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.[113]

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. The government, when responding to the LOIs, admitted that adolescents' access to contraceptives remains a challenge and that there is a need to synergize policy responses between different ministries to fill gaps such as the inadequate comprehensive sexuality education.[114] Indeed, 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.[115] This is particularly concerning since over 50% of the girls aged 20-24 are married before age 18.[116] The 2010 MDHS shows that only 45.6% and 49.9% of married and unmarried sexually active adolescent girls aged 15-19 respectively use any modern contraceptives.[117] 25% of married women in the same age group have unmet need for contraceptives.[118] 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.[119]

Concerned by the alarming rate of teenage pregnancy and multiple pregnancies, which presents a significant obstacle to girls' educational opportunities and economic empowerment,[120] the Committee recommended that Malawi widely promote sexuality education targeted at girls and boys, with special attention paid to the prevention of early pregnancy.[121] In recognizing the risks to adolescent health, the Committee on the Rights of the Child recommended in its concluding observations on Malawi 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.[122] Similarly, in its 2014 Concluding Observations the Human Rights Committee finding "the high rates of teenage pregnancies to be regrettable"[123] recommended that the government increase efforts to reduce "teenage pregnancies by providing adequate sexual and reproductive health services."[124]

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.[125] 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.[126]

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. 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. The Committee, concerned about the "patriarchal attitudes and deep-rooted stereotypes regarding the roles, responsibilities and identities of women and men in all spheres of life"[127] and on the use of such stereotypes to justify violence against women, urged the government to "modify or eliminate negative cultural practices and stereotypes that are harmful to, and discriminate against, women and to promote women's full enjoyment of their human rights."[128] The Human Rights Committee also, in 2014, issued a concluding observation on gender-based violence requiring the state to "ensure that all

perpetrators are brought to justice and the cases are not unduly withdrawn, and rehabilitate and compensate the victims."[129]

The Committee, in the **LOIs asked the government to provide information on the progress made in the revision of the Prevention of the Domestic Violence Act (2006) including whether marital rape will be criminalized in the revised Act.[130]** In response to these questions, the government stated that the review of the Act is underway and that the last consultative meeting was held in June of this year.[131] The government further stated that since the Act is a civil law, it does not criminalize marital rape but that married women can avail themselves of the remedies in the Act since "its treats sexual abuse (by an intimate partners) as a form of domestic violence."[132] However, by not explicitly regulating marital rape, it leaves it up to the discretion of implementers to interpret the law, which might create inconsistencies in application. Further, marital rape is still not included in the Penal Code[133] and marriage is *de facto* considered consent to sex.[134]

During the pre-session review of Malawi, the Committee also **inquired about the evidentiary requirement for sexual violence cases and information on the "effectiveness of measures taken to combat violence against women, in particular rape and domestic violence" including a disaggregated data on the number of cases reported, investigated, prosecuted and which resulted in convictions.[135]** In response, the government provided a 2013 and 2014 nationwide data on the cases that were reported to the police and information on the number of cases that were settled through mediation, referred to other appropriate institution, or taken to court for prosecution.[136] However, it admitted that the system has not changed regarding the evidentiary requirement and that still, in practice, sexual violence cases need to be corroborated even though this is not a legal requirement.[137] However, this is concerning since this may further discourage women from reporting incidences of violence particularly given the current low rate of reporting. 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%).[138] Only 6% went to police.[139] 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.[140] As the Committee has recommended in other contexts, states should take measures to encourage women to report domestic violence to authorities[141] and collect data and statistics on domestic violence.[142]

Despite this under-reporting, figures indicate that it is a serious concern for women in Malawi.[143] A national survey conducted by the Ministry of Gender, Children, Disability and Social Welfare in 2013 found that one in five women ages 18-24 experienced at least one incidence of sexual violence before they turned 18 with the average age for the first incident being 12-14 years.[144] In addition, two in five women in the same age group reported having experienced physical violence before the age of 18.[145] These findings show that the rate of violence has not shown much improvement from the 2010 MDHS where nearly 3 in every 10 women (28%) have suffered from physical violence at some point since age 15,[146] and 14% of women suffered from acts of violence during the past 12 months.[147] 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.[148] Furthermore, one in four women has experienced sexual violence, and 15% of women had their first sexual intercourse forced against their will.[149]

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.

VI. Recommendations for the Government of Malawi

Based on this information, we respectfully request that the Committee make the following recommendations to the government of Malawi:

a. The government should implement strategies aimed at reducing the MMR and maternal morbidity, including through the effective implementation of the free and safe motherhood services, by ensuring access to adequate ante-natal, delivery and post-natal care and availability of skilled healthcare providers that are accessible to all women regardless of their geographical location, age or socio-economic status.
b. Malawi should revise the law on abortion based on the recommendations of the Malawi Law Commission, pass the new bill immediately and, once passed, ensure that the law is implemented effectively.
c. Malawi should take all necessary measures to provide access to family planning services including emergency contraception to all adolescent girls and women, regardless of socio economic status, including by allocating adequate budget for the purchase and distribution of contraceptives.
d. The government should finalize reviewing the Prevention of Domestic Violence Act and explicitly criminalize marital rape. It should also take the necessary steps to provide victims of violence comprehensive services including legal and psychosocial support.

[1] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/189, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
[2] Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health),* (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 11-12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].
[3] *See* UNITED NATIONS POPULATION FUND (UNFPA), MOTHERHOOD IN CHILDHOOD: FACING THE CHALLENGE OF ADOLESCENT PREGNANCY 25-26 (2013).
[4] *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. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); CEDAW Committee *Gen. Recommendation No. 23, Political and Public Life* (16 Sess., 1997), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 260, para. 10, U.N. Doc. HRI/GEN/1/Rev.6 (2003) [hereinafter CEDAW Committee *Gen. Recommendation* No. 23].
[5] Rebecca Cook, *Human Rights and Reproductive Self Determination,* 44 THE AMERICAN UNIVERSITY LAW REVIEW 975, 1007 (1995) [hereinafter *Human Rights and Reproductive Self Determination*].
[6] *Id*. at 1007.
[7] CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 2, paras. 11-12.
[8] CEDAW Committee, *List of issues and questions in relation to the seventh periodic report of Malawi*, para. 1, U.N Doc. CEDAW/C/MWI/Q/7 (2015) [hereinafter CEDAW Committee, *List of questions: Malawi*].
[9] CEDAW Committee: *List of issues and questions in relation to the seventh periodic report of Malawi: Replies of Malawi*, para. 1, U.N. Doc. CEDAW/C/MWI/Q/7/Add.1 (2015) [hereinafter CEDAW Committee: *Replies of Malawi to list of issues*].
[10] CEDAW Committee, *Gen. Recommendation No. 21, supra* note 4, para. 21.
[11] CEDAW Committee *Gen. Recommendation No. 23, supra* note 4, para. 10.
[12] *Id.* para. 11.
[13] CEDAW Committee, *Gen. Recommendation No. 21, supra* note 4, para. 23.
[14] CEDAW, *supra* note 1, art. 12(2).
[15] *See, e.g.*, Report of the Committee on the Elimination of Discrimination against Women, UNGA 59th Sess., Supp. No. 38, para. 380, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Paraguay*, para. 30, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
[16] See, e.g., 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.").
[17] Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 7.5, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter CEDAW Committee, *Alyne v Brazil*].
[18] *Id.*, para. 7.6.
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