I. Malawi's Failure to Protect Women's and Girls' Sexual and Reproductive Health and Rights

A. Inadequate Access to Maternal Health Care and High Maternal Mortality

1. In its last review, Malawi received and supported several recommendations on taking measures to reduce maternal mortality.[1] Malawi has one of the highest maternal rates in the world with 439 maternal deaths per 100,000 live births.[2] However, this pregnancy-related mortality rate, while still high, has been decreasing since 2000. In the seven years before the 2015-16 Malawi Demographic and Health Survey ("MDHS"), the pregnancy-related mortality rate decreased significantly and reached 497 deaths per 100,000 live births, a decrease from 675 deaths per 100,000 live births in the seven years before the 2010 MDHS survey.[3] Despite these positive signs, maternal mortality continues to be a significant issue where improvement is critical. There remains a 1 in 29 chance that a 15-year-old girl in Malawi will eventually die from a pregnancy-related condition, and maternal deaths accounted for 16% of all deaths to women age 15-49 according to the 2015-16 MDHS study. Adolescent pregnancy contributes to 20% to 30% of maternal deaths in Malawi.[4] A recent estimate places complications from abortion as the cause of 6%-18% of maternal deaths in Malawi. Indeed, "[a]t current fertility and mortality rates, 2% of women in Malawi will die from maternal causes during their reproductive lifetime."[5] Furthermore, the lifetime risk of maternal death in Malawi is estimated at 1:29, one of the highest globally.[6]

2. In an effort to continue the positive downward trend of maternal mortality in Malawi, as of June 2018 Malawi is participating in South-South and triangular cooperation with other countries in Africa and in Southeast Asia committed to halving maternal and neonatal deaths over the subsequent five years, supporting each other through the Network for Improving Quality of Care for Maternal, Newborn and Child Health. Regional multi-country integrated programs on sexual and reproductive health and rights, HIV and sexual and gender-based violence, supported by the Swedish International Development Cooperation Agency and involving UNICEF, the World Health Organization, the Joint United Nations Program on HIV/AIDS and the United Nations Population Fund, have committed to sharing experiences, frameworks and guidelines, including the successful practices of Malawi for reaching pregnant and breastfeeding adolescents.[7]

3. In 2016, Malawi, in coordination with the United Nations and other NGO partners, undertook an assessment of the cycle of accountability for sexual, reproductive, maternal, child and neonatal health and human rights. It assessed the respect, protection and fulfillment of human rights and the full accountability cycle, since a human rights-based approach is about health and wellbeing and not isolated pathologies. The study found that, while Malawi's maternal and neonatal rates have shown a moderate decline, the rates continue to be the highest in the Sub-Saharan Africa region. Equally unacceptably high are the rates of neonatal deaths at 29/1000; an infant mortality rate of 53/1000 and 85/1,000 under-five year old mortality rate, while skilled attendance at birth increased from 54% in 2004 to 87.4% in 2014.[8]

4. Despite these efforts inadequate access to maternal health care and poor quality of care is a leading contributor to maternal mortality and morbidities in Malawi. A 2017 study in Malawi using focus group discussions in health facilities found that the distance to the health center, health care workers attitude towards women and girls and high levels of congestion in health facilities are key barriers to women and girls' access to quality maternal health services.[9] The operational challenge of distance to the health care facility is aggravated by the women's pregnancy and the lack of available transportation, including the money and spousal support for any available transportation. Lack of transportation also affects the health care facilities, who have trouble maintaining sufficient supplies of medical resources, medications, and supplies for the maternal demands, and to transport health care workers. Women also described instances of health care workers exhibiting negative attitudes towards them and using foul

language during their care visits. The workers did not help with any of the physiological challenges that result during and after pregnancy. The high levels of congestion in the facilities meant that women experienced significant delays in service despite their efforts to get to the facility. According to the Malawi Health Sector Strategic Report 2011–2016, the country's healthcare system has been experiencing cash flow problems to support supply chain logistics and procurements of medical equipment, supplies and medications to the health centers.[10]

5. Similarly, in August 2019, the Office of Ombudsman released a report highlighting Ministry of Health and Population failure to provide sufficient staff to cater for the needs for Obstetrics and Gynaecology Departments in all health facilities resulting in compromised quality service delivery in the country and insufficient ward space, beds and surgery theatres in some central hospitals in the country resulting in delays in assisting patients and compromised sanitation in the wards, both of which have contributed to the increased number of maternal infections and attendant uterus raptures in some instances. [11]In addition to this, the report highlights increased cases of women losing their uterus due to poor quality of care and negligence during caesarian section. In several instances women reported that the operation was not carried accordingly resulting to uterus removal and in such circumstances, women were not provided with adequate information to make an informed decision. [12]Below are some of the case studies of women whose uterus was removed due to poor quality of care.

Individual 2[13]

"*I was pregnant with my third child. I delivered two of my children through Caesarean section. I was doing my prenatal at Machinjiri Health Centre. When my due date was close I was advised by the Medical Assistant at the Centre that I needed to go to Queen Elizabeth Central Hospital (Q.E.C.H) so that the personnel there could schedule a date for my delivery since I had to deliver through caesarean section. I complied and was given a date for delivery.*

I delivered and was discharged. However, while at home I was not recuperating well in terms of my wound. I therefore returned to the hospital where I was informed by the doctor that my wound was not healing properly and was taken to theatre for cleaning. Nonetheless, the situation did not improve. Therefore, I was taken back to the theatre where the doctors discovered that my uterus was septic and had to be removed. This was done. The baby was well, but I do not know what happened that led to the removal of my uterus.

Individual 5[14]

"I am a former employee of Q.E.C.H. I have worked with well-known doctors in the Gynecology department for a long time. In July 2018, my sister gave birth to a stillborn at Q.E.C.H. She was assisted by an intern doctor from College of Medicine who wrote on her forms that "senior nurse to review" after noting that some parts of her placenta had remained in her uterus.

At the time my sister was delivering, there was only a nurse technician and not a Senior Registered Nurse (SRN). The nurse technician was the one supervising the intern doctor.

My sister's placenta was removed around 3 pm. However, part of the placenta remained in the womb up to 7pm. When I saw this, I inquired about the procedure from the intern doctor who informed me that he was waiting for the SRN to review. I further pestered them that as per medical procedure, they were supposed to take my sister for (placenta) evacuation as this was an emergency. However, my cries fell on deaf ears. They further insisted that her condition will be reviewed the following day.

To cut the long story short, she slept without being removed the parts of the placenta. We tried to reason with them to do the evacuation process the same night, but they insisted that we wait the following morning.

Unfortunate enough, she wasn't reviewed by the nurse that night and we waited for over 10 hours up to the time she went into a septic shock.

Upon noting the worsening condition, the following morning I went to the In-charge doctor at the Gynecology department. After explaining to him my situation, we rushed to the ward so that he could inspect her. Upon seeing her condition, the doctor instructed the nurses to take her straight away to the theatre. He further requested us if possible, to buy some drugs as they had run out of stock of those drugs. We rushed and bought the drugs at a nearby pharmacy for about MK20, 000.00.

At the theatre, the doctor noted that my sister couldn't withstand the anesthesia because her condition deteriorated within minutes. She went into a semiconscious coma as her blood started to clot in her veins. However, we managed to stabilize her condition as the doctor ordered a drug called Heparin.

All this was done so that they could stabilize her so that they do the evacuation process again. She was stabilized and taken to theater for the evacuation process. Unfortunately, it was the same intern doctor who did the process. It wasn't done to perfection and as per standards.

The following day, the condition worsened to a point that we decided to take her to a private hospital as she had developed gastritis infection and had retained placenta products which forced her uterus to swell. We took her to Seventh-Day Adventist Hospital where we spent around MK1.2 million just because of the negligence and inexperience of someone. I was so angry at Q.E.C.H officials to the point that I wanted to sue them.

All in all, I can summarize Q.E.C.H problems in this way. Firstly, there is too much workload at Q.E.C.H against few officers (nurses and technician inclusive). They really have a staffing challenge. They are just few employees. They should consider employing more nurses and get rid of "locum[15]" as they don't pay much attention when on locum. Q.E.C.H lack experts who can do the actual work and also mentor the interns.

Another problem is that senior doctors are not available to supervise and monitor the intern doctors. Most of them are so much concerned with their private clinics or part-time jobs. There is lack of supervision on interns by the medical doctors. No wonder College of Medicine intern doctors are so much interested to get hysterectomy numbers in order to qualify to the next level.

Related to the point above, there is need to have stationed qualified doctors who can concentrate working at the station and not in their private clinics. Doctors have a tendency of paying special attention to their private jobs.

There is also a tendency at Gynaecology department that once someone is diagnosed with a fibroid, they rush to do a hysterectomy. I personally saved about 6 women who were on their way to the theatre for hysterectomy just because they had a fibroid"

6. Evidence-based effective interventions to reduce maternal morbidity and mortality include access to skilled birth attendance during childbirth and emergency obstetric care when a woman experiences obstetric complications.[16] Efforts to reach the Millennium Development Goals target in Malawi failed despite a significant increase in institutional deliveries and skilled attendance at birth from 51% and 55% in 1992 to 91% and 90% in 2015, respectively.[17] Most maternal deaths are still attributed to direct obstetric causes, such as hemorrhage, sepsis, complications of abortion and hypertensive disorders.[18] The proportion of women and newborn babies receiving postnatal care during the first 48 hours is 42% and 60%, respectively.[19] Infant mortality goes hand-in-hand with maternal mortality, and is no less serious of a problem for the country. For example, Malawi has one of the highest rates of premature birth in the world: 18% of all babies are born too early and 13% have low birth weight. The adolescent birth rate is high (143 per 1,000 live births), with about 30% of babies born to mothers 19

years of age or younger. These young mothers are more likely to give birth to preterm and underweight babies and experience higher neonatal mortality rates (37 per 1,000 live births) than women aged 20 to 29 years (22 per 1,000 live births).[20]

7. Additional challenges to maternal health care include early child marriages. Child bearing starts quite early with a median age at first child birth reported at 19 years. Before a constitutional amendment was passed in 2017, Malawi's Constitution allowed for children ages 15-18 to be legally married with parental consent.[21] However, the 2017 amendment eliminated that exception, and the Constitution now completely bans marriage before the age of 18.[22] Maternal and infant morbidity and mortality are also high in early marriages, as adolescent mothers are more likely to experience fistula, pregnancy complications, and death during child birth than older women.

B. Inadequate Access to Safe Abortion and Post-Abortion Care Services

8. In its last review, several countries recommended to the Government of Malawi to take measures to reduce maternal mortality including by reviewing the abortion laws.[23] Similarly other treaty bodies have expressed concerns over restrictive abortion laws and their impact on women and girls' access to safe abortion services in Malawi. The Committee on the Elimination of Discrimination against Women (the "CEDAW Committee"), expressed concern at "[t]he criminalization of abortion, except when the life of the pregnant woman or girl is at risk, and the impact that such criminalization has on the maternal mortality ratio, as well as compelling women, in particular women under 25 years of age and girls, to resort to unsafe abortion."[24] The CEDAW Committee further called on Malawi to "[a]mend legal provisions regulating abortion to legalize it, ensuring its legal and practical availability, without restrictive reporting requirements, at least in cases in which the life and/or health of the pregnant woman or girl is at risk, and in cases of rape, incest and serious impairment of the fetus."[25] Similarly, the Committee on the Rights of the Child (the CRC Committee) expressed concern on the "criminalization of abortion, except when the life of the pregnant girl is at risk, leading to girls resorting to risky abortions."[26] The CRC Committee recommended that in order to promote adolescent health and development in the context of the Convention on the Rights of the Child, Malawi should "[d]ecriminalize abortion in all circumstances and remove barriers to abortion, such as the requirement to report to the police before having an abortion in the case of rape, ensure girls' access to safe abortion and post-abortion care services, and ensure that the views of the child are always heard and given due consideration in abortion decisions."[27]

9. At the same time, in 2015, an independent study at the Guttmacher Institute found that more than half of all pregnancies in Malawi were unattended by medical professionals, and almost one-third of unintended pregnancies ended in abortion.[28]

10. Malawi has one of the most restrictive abortion laws in the world—currently abortion is illegal except where it is performed to save the life of the pregnant woman.[29] The law on abortion is governed by the Penal Code Cap. 7:01 of the Laws of Malawi. Section 149 of the Penal Code proscribes the act of assisting the procuring of abortion by whatever means. The offense committed under this section is a felony which attracts a penalty of up to 14 years imprisonment. Section 150 applies to a pregnant woman procuring her own abortion. The offence committed under this section is also a felony with a penalty of up to seven years imprisonment. Criminalization of abortion has resulted in women and girls seeking clandestine abortions. As a result of Malawi's policy, abortion is the second leading cause of pregnancy-related mortality, accounting for 19% of all maternal deaths.[30] Abortion is a leading cause of obstetric complications, accounting for 20–30% of such complications.[31] About 30,000 of those women are treated for complications of unsafe abortion annually, and one in five women who receive post abortion care have severe complications that need to be treated.[32] However, by 2015, a follow-up study established that 141,000 women induced abortion, giving an abortion rate of 38 per 1000 women of reproductive age (aged 15-49).[33] Approximately 53,600 women were treated for complications in

2015, thereby significantly increasing the cost of care since 2009. As noted above, abortion-related complications contribute to up to 18% of the maternal mortality ratio in Malawi.[34]

11. In 2015, Malawi initiated legal reforms on the abortion laws. New evidence on the public health burden of unsafe abortion in Malawi became the basis of a review of abortion law and policy, which resulted in a draft Termination of Pregnancy ("ToP") bill, released in July 2015. The Ministry of Health requested the Malawi Law Commission to review the sections of the Penal Code related to abortion to make the law more effective in eliminating abortion deaths.[35] The Law Commission, after conducting nationwide consultations, proposed that abortion remain illegal but that the exceptions under which it may be legally provided be expanded to include the following: when the continued pregnancy will endanger the life of the pregnant woman; when termination is necessary to prevent injury to the physical or mental health of the pregnant woman; when there is a severe malformation of the fetus, which will affect its viability or compatibility with life; and when the pregnancy is a result of rape, incest, or defilement.[36] The Law Commission further proposed that the law be removed from the Penal Code and made to stand alone as the ToP bill. The ToP bill also clarifies the language used, wherein termination carried out before fetal viability would be called "abortion," while "preterm delivery" would be used for termination after viability. The ToP also outlines where abortion shall be provided and who shall provide it. The ToP bill additionally provides for conscientious objection, but any service provider who cannot provide the service for this reason is required to find and make necessary arrangements to refer the patient to another, willing provider, without delay.

12. Currently, the ToP bill awaits debate in Parliament, and if approved, it will expand the grounds for legal abortion to include threats to the woman's physical or mental health; pregnancy resulting from rape, incest, or defilement; and severe fetal malformation. The ToP bill represents a significant step forward for Malawi and requires support from MPs and key politicians. Its adoption, however, is shrouded by uncertainty due to opposition based on religious and cultural values. Although targeted lobbying generated both political priority for and popular awareness of safe abortion in Malawi, ambivalence toward legal reform is present throughout society, even among the commissioners involved in drafting the ToP bill. There is strong religiously-based opposition in the country, mainly from the Catholic and Evangelical congregations, as well as some Muslim leaders. The Catholic Church is one of the biggest civil society organizations in Malawi and has actively opposed modern contraceptives and abortion for a long time. This opposition has intensified with the introduction of the ToP bill, and the Catholic hierarchy—as well as the Muslim Association of Malawi and the Evangelical Association of Malawi—has published articles opposing change and campaigning against it. As religious leaders expressed in an article in one of Malawi's main national newspapers, "[a]fter a critical reflection on these matters, we came to a conclusion that it was in fact the abortion bill that needed aborting."[37] Nonetheless, certain religious leaders supported the ToP bill, including Bishop Amos Tchuma of the Faith of God Ministries, who was quoted in a 2015 news article expressing shock that "some women use bicycle spokes, cassava sticks and poisonous substances to induce abortions just because we have a restrictive law."[38] In 2016, after a sensitization meeting organized by COPUA, the Malawi Council of Churches expressed optimism that the faith community in Malawi would endorse the ToP bill in spite of the opposition that was being expressed. The same year, the Obstetrician and Gynecologist Association of Malawi was formed, and it has since been a vocal actor in support of abortion law reform.

13. In addition, where there is no access to safe abortion services, post-abortion care is the only opportunity to prevent maternal morbidity and mortality by treating complications related to unsafe procedures.[39] There is a serious need for post-abortion care in Malawi, where studies estimate that more than 1 in 4 women who reached a health care facility for post-abortion care had severe and moderate complications, and those without treatment risked mortality.[40] Post-abortion care had been recommended in the ICPD Programme of Action as a way to address the serious public health problem of unsafe abortion without changing the law.[41] Post-abortion care is currently provided for free in

Malawi's public health facilities, but mostly in urban areas, despite the fact that more than 80% of the Malawian population lives in poor, rural areas.[42]

C. Inadequate Access to Contraception and Comprehensive Family Planning Services and Information

14. The Human Rights 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.[43] The CEDAW Committee's General Recommendation 24 advises that States prioritize the "prevention of unwanted pregnancy through family planning and sex education."[44] Modern contraceptive use has increased substantially over the past decade in Malawi, increasing among married women aged 15-49 from 28% in 2004 to 58% in 2015.[45] Among sexually active unmarried women in the same age group, usage increased from 24% in 2004 to 43% in 2015.[46] Meeting women's contraceptive needs is a critical step toward decreasing the incidence of unintended pregnancies. 1in 5 married women and two in five sexually active unmarried women of reproductive age have an unmet need for contraception, meaning they want to avoid a pregnancy but are not using any contraceptive method.[47] Experts recommend that free or affordable family planning services reach all individuals in Malawi to reduce the unmet need for contraception and lower the incidence of unintended pregnancy.[48]

15. In Malawi, knowledge of family planning is high and almost universal at 99% according to the MDHS 2015-16 study.[49] However, the MDHS 2015-16 study also revealed that although 78% of currently married women age 15-49 sought out family planning services, 19% of those women had their family planning needs go unmet.[50] Relatedly, although 84% of sexually active unmarried people sought out family planning services, only 53% of those people's family planning needs were met. In addition, 54.2% of pregnancies among women in Malawi are unintended.[51] One contributing factor to this number of unintended pregnancies is the young age at which Malawians become sexually active. Most young people start having sex at the age of 15.[52] In some ethnic groups, the age of sex debut is low as 12 due cultural practices and initiations ceremonies that encourage adolescent to explore sex at an early age. In the absence of comprehensive and accurate information and adolescent friendly services, adolescents are at high risk of unintended pregnancies. In Malawi, young people get most information on sexual health and reproductive rights issues from their peers, schools, and media, which carries with it its own set of problems and opportunities for misinformation.[53] There is also a prevailing belief in Malawi that contraceptive use is not morally acceptable for young people.[54] Unfortunately, that belief results in pregnancy being the most common cause of school dropouts for students in the country, with many of these girls attempting unsafe abortions and some dying in the process.

D. Prevalence of Sexual and Gender-Based Violence and Harmful Traditional Practices

16. Gender-based violence, encompassing sexual and domestic violence, remains prevalent in Malawi and covers all stages of women's lives. Domestic violence is recognized as a major public health concern and a violation of human rights. Treaty bodies have expressed their concerns about high cases of sexual and gender-based violence. In 2015, the CEDAW Committee's expressed deep concern at the prevalence of violence against women.[55] The CEDAW Committee noted that marital rape is not criminalized and that there is a lack of rehabilitative and protective services to assist women who suffer violence.[56] In fact, 16% of the respondents to a 2012 Malawian Government survey on Gender-Based Violence reported having experienced marital rape.[57] That same report revealed that 35% of the respondents reported to have experienced sexual violence- 61% of the victims were women. Most of the sexual violence incidences took place within the homes of the victims. For instance, half of the rape cases captured in the survey, as well as 36% of the cases of attempted rape, were reported to have taken place in the victims' homes, as were the majority of incest and forced sexual intercourse cases. Unfortunately, these rates are rising. The 2015-2016 MDHS found that, "[a]mong ever-married women age 15-49 who have experienced sexual violence, 63% reported the current husband and 31% reported

a former husband as perpetrators of the sexual violence. Five percent of ever-married women mentioned strangers as perpetrators of sexual violence. Among never married women, a current or former boyfriend is the most common perpetrator (38%), followed by a stranger (22%) and a friend or acquaintance (18%)."[58]

17. National data from Malawi in 2014 reveals that an estimated one in five (21.8%) young women experience sexual abuse prior to age 18, primarily perpetrated by boyfriends, classmates, and acquaintances.[59] Other nationally representative data estimate that one in four (24%) sexually experienced women aged 15-19 characterize their sexual debut as forced, which is well above global and regional estimates.[60] Sexual violence against young women in Malawi is associated with poor outcomes across domains of sexual and reproductive health and mental health, and undermines school enrollment and progress. Sustained violence undermines gender equality by signaling that women are not valued, curtailing engagement in education, employment, and mobility with continued safety concerns. This violence does not always end once a woman becomes pregnant, as 5% of the population reported continuing to be abused while pregnant.[61] A study performed in 2015 at Nsanje District Hospital in the Southern Region of Malawi found that the majority of women (59%) were psychologically, physically, and sexually abused during pregnancy.[62] The study also found that there was a significant association between domestic abuse and with a woman being pregnant.[63] The study recommended the creation of community awareness about domestic violence, the strengthening of victim support units, and the training of health workers to screen and counsel victims of domestic violence during antenatal care.[64]

18. In its 2017 Annual Report on Malawi, UNICEF found that "[d]ata collection on gender-based violence and violence against children was strengthened by setting-up mobile reporting at community victim support unit level, covering 27 of 28 districts." [65] However, the figures demonstrate a troubling percentage of gender-based violence against women and girls. As the UNICEF Report details, "Case Management Data registered 15,541 cases (8,689 female, 6,852 male) from January to September, of which 71% were comprehensively assessed; 12,942 cases of violence were recorded, of which 56% related to girls, including 20% cases of child marriage. [66] In light of particular challenges in investigating and prosecuting cases of sexual violence against girls, the Malawi Police Service undertook an assessment of the bottlenecks encountered at police formations to inform upcoming policy and practice guidance."[67]

19. There is a unique practice in Malawi of *Chinamwali*, a rite of passage that can include forced sex, carried out on adolescent girls at the start of puberty, which gives legitimacy to sexual violence in the name of tradition. Indeed, the proportion of girls who were forced during their sexual debut in Malawi is as high as 38%.[68] A trial study on the effectiveness of school-based, empowerment self-defense training for girls in primary and secondary schools has proven promising, with girls reporting reductions in sexual violence over the course of a year. However, this study and program was carried out by international NGOs and UNICEF, not the Malawian Government.[69] Other harmful practices include initiation, wife inheritance, *fisi* (hiring of a man for sex and conception), dry sex, death rituals, use of traditional herbs to induce labor, battery, rape, sexual harassment, psychological abuse, and genital mutilation.[70]

20. According to the Climate Change Vulnerability Index for 2015, seven of the ten countries most at risk from climate change are in Africa.[71] Mozambique and Zimbabwe, Malawi's neighbors, were in the top 50 of the world's countries most affected by extreme weather events in the period between 1998 and 2017.[72] In the wake of devastating climate change effects on Malawi, women and girls remain among the most vulnerable and likely to be the targets of resultant violence, especially from frequent and severe heat stress and the increase in food insecurity. As UNICEF's 2019 Country Program Document on Malawi explained, "Malawi is vulnerable to the effects of climate change, which include an increasing frequency of droughts and floods that affect the health, nutrition, education and welfare of

children and the resilience of families to shocks. Malawi ranked 55 on the 2017 Index for Risk Management, placing it in the medium-risk category. However, it ranked 16 on the environmental vulnerability index, indicating a high level of vulnerability. During the floods and drought in the period 2015–2017, about 40% of the population (6.7 million persons) needed humanitarian assistance. Children, particularly girls, and women in the poorest communities are among the most vulnerable in the recurrent humanitarian situations in Malawi. Coping mechanisms force many young adolescent girls into early marriage, sexual exploitation for instance in Nsanje district or child labor."[73]

We hope that this information is useful to the Human Rights Council and will consider the following questions to the government of Malawi

II. Questions

a) What measures are being taken to lower the high rates of maternal mortality and pregnancy-related complications?

b) What measures are being taken to ensure women and girls have access to maternal healthcare, including prenatal and antenatal care?

c) What measures is the government of Malawi taking to ensure that hysterectomy is only provided as a life-saving procedure and not as a result of medical negligence, and to address the poor quality of care in public health facilities?

d) What measures are being taken to decriminalize abortion and to ensure that women have access to safe, legal abortion and post-abortion care services?

e) What measures are being taken to ensure access to contraceptives, family planning information, and comprehensive reproductive health information and services is available to women and girls?

f) What measures are being taken to investigate and prosecute perpetrators of sexual and gender-based violence against women and girls, including effective mechanisms for accountability and redress?

g) What measures are being taken to ensure that women and girls are not disproportionately affected by natural disasters caused by climate change, such as droughts and floods?

h) What measures are being taken to curb negative traditional practices that impact women and girl's sexual and reproductive health and rights whilst still maintaining and respecting culture?

III. Recommendations

a) Malawi should take concrete steps to ensure women and girls have access to maternal healthcare including by increasing budget allocation to at least 15% in line with the Abuja Declaration, increasing number of skilled birth attendants, provision of adequate equipment and drugs and emergency transport services.

b) Ensure justice for women whose uterus were removed due to human rights violations in health care facilities and take disciplinary on medical professionals for negligence and poor quality of care.

c) Malawi should review its abortion laws and decriminalize abortion in line with its constitutional protections, international obligations, and international human rights standards. In line with this, Malawi should enact the Termination of Pregnancy Bill 2018.

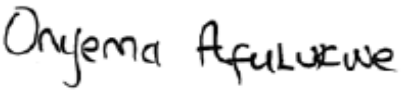
d) Malawi should take steps to ensure that women have access to safe, legal abortion and post-abortion care services.

e) Malawi should take steps to ensure access to contraceptives, family planning information, and comprehensive reproductive health information and services is available to women and girls.

f) Malawi should take steps to investigate and prosecute perpetrators of gender-based violence against women and girls, including by ensuring effective mechanisms for accountability and redress.

g) Malawi should take steps to ensure that women and girls are not disproportionately affected by natural disasters caused by climate change, such as droughts and floods, or their effects, such as poor health conditions and food insecurity.

We hope that this information is useful during the Council's review of Malawi. If you would like further information, please do not hesitate to contact the undersigned.



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[13] Woes of the Womb, Systematic Investigations Report, at 2.
[14] Woes of the Womb, Systematic Investigations Report, at 3.
[15] Locum- a person who stands in temporarily for someone else of the same profession, especially a cleric or doctor.
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[18] *Id.*
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