Gender Equality Act of 2013: Strengthening provision of reproductive health services for Adolescents in Malawi with special reference to contraceptive services

A dissertation submitted in partial fulfilment of the requirements for Master of Philosophy in Sexual and Reproductive Rights in Africa

By

Dezio Macheso

Student number: 17395284

Centre for Human Rights, Faculty of Law

University of Pretoria

Prepared under supervision of Prof Charles Ngwena and Dr Ciara O'Connell

26 July 2021

Declaration of originality

I, Dezio Macheso, declare that this is my own work and that it has not previously been submitted for any degree or examination in any other university or institution. Where the work of other people has been used, due acknowledgement has been given and reference made.

Name of student: Dezio Macheso

Signature of student:  _____

Date: 8 January 2021_____ _____

Name of Supervisor: Prof Charles Ngwena

Signature of supervisor: 

Date: 8 January 2021_____ _____

Acknowledgements

To my wife, Chikondi Prisca Nabengo Macheso who has been supportive throughout.

To my son Allan and daughter Annabelle, who gave me the motivation every day to make sure I completed the programme.

To my dad and mum who constantly encouraged me so that I completed the programme.

To my supervisor Prof Charles Ngwena and Dr Ciara O'Connell who provided enormous guidance and exercised patience to see me through. Your insights were always motivating.

Finally, I would like to dedicate this to my late uncle who passed away on the day the dissertation was due. He always offered words of wisdom necessary for academic and career success.

List of abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESR	International Covenant on Economic Social and Cultural Rights
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
DHIS	District Health Information System
MHRC	Malawi Human Rights Commission
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
SRH	Sexual and Reproductive Health
YFHS	Youth Friendly Health Services
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organisation

Summary

The policy environment for contraceptive access by adolescents in Malawi is rated as highly supportive. However, adolescents' reproductive health outcomes remain poor, despite that the policy environment was reinforced by the Gender Equality Act in 2013. One of the factors contributing to the situation is the negative attitude towards adolescents accessing contraceptives which the 2014 National Evaluation of the Youth Friendly Health Services found to be significantly huge.

The Act contains the first-ever explicit and relatively comprehensive sexual and reproductive health rights laws in Malawi. In section 20(1), the Act provides guidelines on how healthcare workers should provide reproductive services. In section 20(2), it penalises discriminatory healthcare providers. The legally binding guidelines introduced by the Act should ideally motivate or compel healthcare providers to exhibit a friendly attitude towards adolescents accessing contraceptives. This thesis examines the changes that have taken place since the enactment of the Act regarding provision and access of contraceptives by adolescents.

Desk-based research methodology was used to collect secondary data, which was analysed using content analysis. Interpretation of the findings used the conflict and feminist theories. There are three key interrelated findings. The first is that there is limited action by the Government of Malawi towards operationalisation of provisions in sections 19 and 20 of the Act. The second is that negative attitudes of healthcare workers remain a significant barrier for adolescents to access contraceptives. The third is that there is no indication of increase in uptake of contraceptives by adolescents since the Act was enacted.

Table of Contents

CHAPTER 1: Overview of the thesis

1. Introduction

This thesis uses an interpretive research approach to examine the impact of Malawi's Gender Equality Act of 2013,[1] in its potential to strengthen access to contraceptives. The World Health Organisation (WHO) asserts that supportive legislative and regulatory frameworks are likely to significantly contribute to improved access to sexual and reproductive health (SRH) services.[2] To that effect, the United Nations Member States, including Malawi,[3] are required to enact laws, develop policies and practices in line with international, regional and national human rights standards to ensure that sexual and reproductive health rights (SRHR) are respected, protected and fulfilled without any form of discrimination, including age.[4] To a significant extent, the Government of Malawi has religiously aligned the national health and more specifically, the SRHR policies with key regional and international development frameworks. Within the current National SRHR Policy, National SRHR Strategy and the National Youth Friendly Health Services (YFHS) Strategy, there are sections which explicitly list and to some degree explain how the policies are in line with such regional and international normative instruments. Some of such instruments are the 2063 Agenda at the continental level, and the Sustainable Development Goals (SDGs) at the global level. Out of the 17 goals covered in the SDGs, the most relevant goal to this thesis is goal number three which focuses on health for all people at all ages.[5] Some of the problems highlighted by the United Nations which justified prioritisation of this goal was the tragic high rates of maternal mortality in Africa, and the unsatisfactory results in reproductive health in Africa after 15 years of implementation of the global Millennium Development Goals framework.[6]

Apparently, at the time the SDGs framework was being developed, Malawi had one of the highest maternal mortality rate in the Sub-Saharan Africa, estimated at 439 maternal

[1] Gender Equality Act of 2013, thereafter 'the Act'.
[2] WHO *Sexual health, human rights and the law* (2015) 14, https://apps.who.int/iris/bitstream/handle/10665/175556/9789241564984_eng.pd?sequence=1 (accessed 31 January 2019).
[3] United Nations 'Member states' https://www.un.org/en/member-states, (accessed 31 March 2018).
[4] WHO (n 2) 6.
[5] United Nations *Transforming our world: The 2030 agenda for sustainable development* A/RES/70/1 16 https://sustainabledevelopment.un.org/index.php?page=view&type=111&nr=8496&menu=35 (accessed 16 May 2021).
[6] United Nations (n 5) para 16.

deaths per every 100 000 live births.[7] On reproductive health outcomes, the country was also among the top countries with highest adolescent birth rate in the sub Saharan Africa,[8] estimated at 136 live births per 1000 women of age 15-19 as of 2016.[9] In 2017, the Index Mundi indicates that the adolescent birth rate was at 132 live births per 1000 women of age 15-19, which placed the country on position 9 in the world.[10] The relevance of the SDGs framework is that under goal number three, the first listed target is to reduce global maternal mortality ratio to less than 70 maternal deaths per 100 000 live births.[11] Within the same goal number three, the seventh target is to achieve universal access to SRH services, including family planning, information and the integration of reproductive health into national strategies and programmes by 2030.[12] Unlike the SDGs, the continental Agenda 2063 is more detailed with regard to highlighting reproductive health issues. It starts with an overall goal on health in which the aim is to ensure that every citizen has full access to affordable and quality health care services and universal access to SRHR information.[13] The framework clearly indicates that those services should be available to all women, including young women, adolescents, women with disability, those living with AIDS and all vulnerable groups.[14] In that statement alone, the goal is explicitly highlighting reproductive health and adolescents which are the crux of this thesis.

Another strength which makes the Agenda 2063 more relevant to this thesis is that it commits to vigorously follow through prior commitments made in other thematic frameworks such as those on SRHR.[15] The commitments on SRHR being referred to are the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, particularly in article 14 as well the Maputo Plan of Action. These normative standards enhance prospects for member states like Malawi to be accountable towards their operationalisation. Nonetheless, the limitation is that out of all those frameworks, it is only the Protocol to the

[7] Ministry of Health for the Republic of Malawi *Health sector strategic plan 2017-2022* (2017) 6.
[8] Ministry of Health for the Republic of Malawi (n 7) 8.
[9] National Statistical Office *Malawi demographic and health survey 2015-16* (2017) 57.
[10] Index Mundi 'Adolescent fertility rate (births per 1,000 women ages 15-19) - Country Ranking' https://www.indexmundi.com/facts/indicators/SP.ADO.TFRT/rankings (accessed 16 May 2021).
[11] United Nations (n 5) 16.
[12] United Nations (n 5) 16.
[13] African Union Commission 'Agenda 2063' 32.
[14] As above.
[15] African Union Commission (n 13) 61.

African Charter on Human and Peoples' Rights on the Rights of Women in Africa which is legally binding, or otherwise described as hard law.

According to the European Centre for Constitutional Human Rights, hard law refers to legal obligations that are binding on the parties involved and which can be legally enforced in the courts.[16] Soft law, is however used to characterise agreements, principles and declarations that are not legally binding, in this case, the Agenda 2063 and the SDGs. Ideally, they should be complementary. However, because of the differences in the two, the implication is that the level of accountability the state parties are expected to exhibit vary. From a rationalist's perspective, hard laws are superior and more advantageous.[17] For that reason, the assumption is that the binding instruments should more likely stimulate the state parties to demonstrate greater level of agency towards fulfilment of the obligations within a particular treaty or legal instrument. That reasoning somewhat corroborates the World Health Organisation's assertion that legislation may significantly influence SRHR outcomes.[18] This thesis therefore appraises the impact of the SRHR legal provisions stipulated in sections 19 and 20 of the Gender Equality Act concerning access to contraceptives by adolescents in Malawi. The appraisal is needed on the basis that the legislation is a legally binding instrument which may have considerable influence on government and stakeholders to improve SRHR outcomes for adolescents in Malawi.

The motivation to conduct this study originated from a situation in Malawi defying logic. While a 2017 study conducted by Health Policy Plus (HPP) rated the policy environment highly supportive in terms of access to contraceptives by adolescents,[19] in the same year, the Ministry of Health in its Health Sector Strategic Plan acknowledged that SRH outcomes among adolescents remained poor.[20] This state of affairs is a reminder that policies are soft, and are therefore limited in their capacity to effect meaningful change because they are not legally

[16] European Center for Constitutional and Human Rights 'Term: Hard law/soft law' https://www.ecchr.eu/en/glossary/hard-law-soft-law/ (accessed 11 May 2021).
[17] GC Shaffer & MA Pollack 'Hard vs. soft law: Alternatives, complements, and antagonists in international governance' in GC Shaffer & MA Pollack (eds) *Hard vs Soft Law* (2010) 717.
[18] WHO (n 2) 14.
[19] Health Policy Plus 'Comparative analysis: Policies affecting family planning access for young women in Guatemala, Malawi and Nepal' (2017) 37 http://www.healthpolicyplus.com/ns/pubs/2091-2144_ComparativeAnalysisYouthPolicyMar.pdf (accessed 7 June 2018).
[20] Ministry of Health for the Republic of Malawi (n 7) 8.

binding.[21] The enactment of the Gender Equality Act in 2013 was therefore momentous in the Malawi history because for the first-time the country had explicit, relatively comprehensive and progressive SRHR laws.[22] By promulgating the legislation, the country shifted gears by adding to the already existing weaker instruments, a legally binding law which in Lowi's description is "too authoritative".[23] This thesis therefore, assesses the authoritativeness of the Gender Equality Act in strengthening provision of contraceptives to adolescents in Malawi from 2013, the year it was enacted to the year 2019. In pursuit of that goal, the point of departure for this thesis is to understand the context in which the Act was developed, in particular reference to sections 19 and 20 and how the statutes apply to adolescents' contraceptive use.

1.1 Background and analysis of the SRHR statutes in the Act

In September 2001, the Government of Malawi demonstrated commitment to promoting gender equality and the empowerment of women in all spheres of life by empanelling a special Law Commission to review the gender-related laws in Malawi and to promulgate a gender equality legislation.[24] The process involved a wide range of activities such as, literature review of international and local laws, evaluation reports, studies. There were also consultation workshops which brought participants drawn from the public service, academia, faith organisations, traditional chiefs, the private sector and the civil society.[25] The process of drafting the legislation ended in February 2011 with a report which included the draft legislation. [26] In 2013, the Act was enacted in parliament and came into force in April 2014.[27]

The content of the Act was generally responsive to the conclusion arrived at by the Commissioners that in Malawi there was a crisis of gender inequality in almost all sectors.[28] In respect to SRHR, the Special Commission was concerned with submissions which detailed how some health facilities were denying women access to contraceptives in the absence of a

[21] TJ Lowi 'Law v public policy: A critical exploration' (2003)12 *Cornell Journal of Law and Public Policy* at 499.
[22] Secs 19 & 20.
[23] Lowi (n 21) 499.
[24] Malawi Law Commission 'Report of the Law Commission on the development of the Gender Equality Act' (2011) 9.
[25] Malawi Law Commission (n 24) 7.
[26] Malawi Law Commission (n 24) 2.
[27] Ministry of Gender Children Disability and Social Welfare for the Republic of Malawi *The Gender Equality Act 2013: Implementation and monitoring plan (2016-2020)* 3.
[28] Malawi Law Commission (n 24) 9.

spouse.[29] Denying women access to contraceptives on such grounds implied that according to such healthcare providers, contraceptives were reserved for married people only. Such practice contravenes prohibition of third parties like husbands and parents, from interfering with access to contraceptives as stipulated in CEDAW General Recommendation 24 on women's health.[30] It should be understood that adolescents would be disproportionately affected by this tendency considering that from 1992 until 2016, national estimates constantly showed that in Malawi, one in every two girls is married by the age of 18.[31]

The content of the Act was also shaped by the dissatisfaction of the Special Commission with the impact of programmes intended to deal with harmful cultural practices that fuel the transmission of sexually transmitted infections.[32] Because some harmful cultural practices involve coerced or non-consensual sexual relations, it is implied that the Commission also questioned the effectiveness of interventions aimed at dealing with harmful cultural practices that lead to or are associated with unplanned and coerced pregnancy.[33] The Commission was also concerned that the health system showed limited impact in responding to health issues affecting women.[34] On a legal related issue, the Commission was cognisant of the norm in Commonwealth countries whereby 'law does not bind the government unless it so provides expressly.'[35] Considering that at that time there was no express provision in Malawi under the Constitution or legislations that would make the right to health enforceable,[36] the Commission found this to be an opportunity to make the law explicit.[37] Such issues, together with the magnitude of problems such as unwanted pregnancies, unsafe abortion and gender-based violence, dictated the Commissioners to narrow the focus from the initially identified domain of health in broader terms to SRHR.[38] As will be appreciated in the section that follows, it is important to highlight the Commissioners intended to ensure that issues of gender equality are pursued aggressively.[39]

---

[29] Malawi Law Commission (n 24) 60-61.
[30] CEDAW Committee General Recommendation 24: Art 12 of the Convention (Women and Health) A/54/38/Rev1, ch I (1999) para 14.
[31] National Statistical Office *Malawi demographic and health survey 2015-16* (2017) 57.
[32] Malawi Law Commission (n 24) 27.
[33] Malawi Law Commission (n 24) 25.
[34] Malawi Law Commission (n 24) 13.
[35] Malawi Law Commission (n 24) 22.
[36] Malawi Law Commission (n 24) 56.
[37] Malawi Law Commission (n 24) 22.
[38] Malawi Law Commission (n 24) 56.
[39] As above.

1.1.1 The SRHR provisions in the Act

The findings by the Commissioners concerning SRHR resulted in part six of the Act which explicitly makes provisions for SRHR including contraceptives. The first section of part six, which is section 19,[40] makes provision for rights holders. Section 19(1) states that:

> Every person has the right to adequate sexual and reproductive health which includes the right to:
>
> (a) Access sexual and reproductive health services
>
> (b) Access family planning services
>
> (e) Chose the number of children and when to bear those children
>
> (f) Control fertility
>
> (g) Choose an appropriate method of contraception.[41]

In section 19 (2),[42] the Act provides that subject to any written law, every person has the right to choose whether to have a child or not.

The second section of the SRHR statutes imposes obligations on health officers on how to provide SRH services and the consequences that follow if the laws are contravened. Section 20(1)[43] provides that:

> In addition to the duties imposed or powers conferred on health officers by the Public Health Act or any other relevant law every health officer shall:
>
> (a) Respect the SRHR of every person without discrimination
>
> (b) Respect the dignity and integrity of every person accessing SRH services
>
> (c) Provide family planning services to any person demanding the services irrespective of marital status or whether that person is accompanied by a spouse
>
> (d) Impart all information necessary for a person to decide whether or not to undergo any procedure or to accept any service affecting his or her SRH
>
> (e) Record how the information imparted to the person seeking reproductive health services was given whether it was understood

[40] (n 1) sec 19(1).
[41] As above.
[42] (n 1) sec 19(2).
[43] Sec 20(1).

(f) Obtain the written consent of a person being offered SRH services or family planning services before performing any procedure of offering any service.[44]

The last statute on SRHR in the Act is in section 20(2),[45] which provides that any person who contravenes this section commits an offence and is liable to a fine of seven hundred and fifty thousand kwacha (K750 000),[46] and a term of three years imprisonment.[47]

1.1.2 Analysis of sections 19 and 20 of the Act

There are two critical things about this legislation, particularly in the statutes referred to in section 20. The first is that section 20(1) provides guidelines on how healthcare workers should provide reproductive health services. Furthermore, the statute in that section imposes on healthcare workers the duty to respect and provide reproductive health services for everyone accessing the services without discrimination and with integrity.[48] The second is that in section 20(2), the Act introduces sanctions against healthcare providers who contravene the statutes in section 20(1). This provides an opportunity to legally reinforce the implementation of existing policy directions aimed at addressing attitudinal barriers exhibited by healthcare providers.

It is fair to conclude that the bigger goal of the provisions in the two sections is to improve quality in the delivery of SRH services. However, the law somewhat becomes contentious in section 20(2)[49] in which legal sanctions are introduced. Penalisation of negligence or wilful unethical conduct by healthcare providers is often contested. For instance, when the United Kingdom considered introducing new criminal sanctions against wilful or reckless neglect or mistreatment of patients by healthcare workers, a debate ensued

[44] As above
[45] Sec 20(2).
[46] 750 000 Malawi Kwacha is an estimated equivalent to 917 United States Dollars according to National Bank of Malawi using an exchange rate of 818Malawi Kwacha to 1 United States Dollars (accessed 8 July 2021) Foreign Exchange Rates (natbank.co.mw)
[47] Sec 20(2).
[48] Sec 20(1a).
[49] Sec 20(2).

on whether such a law would improve quality of service delivery.[50] Dr Jo Bibby argued that the law would be an important step to improving patients' care and that it would deter other healthcare workers from misconduct.[51] In contrast, Dr Christine Tomkins contested that investigations which are sometimes lengthy would cause enormous distress and disruption to those accused and to the national health system, hence affecting patient care.[52] All these are applicable arguments that would profoundly contribute to a better understanding of the context and content of sections 19 and 20 of the Act as will be shown in the next few paragraphs.

In many ways, the Act can potentially cause the collapse of the health system as argued by Dr Christine Tomkins.[53] First, it can lead to a system breakdown due to the absence of the conscientious objection statues in the Act. There could be a violation of the rights of healthcare workers if they are penalised by the Act because they refused to provide contraceptives to adolescents on account that it is against their religious belief. The right to religion is constitutionally protected,[54] and internationally enshrined in the International Covenant on Civil and Political Rights (CCPR), Article 18.[55] Considering that evidence exists that healthcare providers are judgmental towards adolescents seeking contraceptives due to the influence of culture and religion,[56] the drafters of the Act should have included statutes regulating the invocation of the right to object service provision on the grounds of religion and cultural beliefs. It is obvious that in drafting the Act, the intention was to deal with the issue of healthcare providers arbitrarily denying women and adolescent girls the right to access SRH services. However, in the current state, the Act poses a huge risk of achieving contrary results.

[50] J Bibby & C Tomkins 'Would criminalising healthcare professionals for willful neglect improve patient care?' (2014) *thebmj* 348 https://doi.org/10.1136/bmj.g133 (accessed 18 May 2021).
[51] As above.
[52] As above.
[53] As above.
[54] Constitution of Malawi of 2010 sec 33.
[55] Art 18.
[56] Ministry of Health for the Republic of Malawi 'National evaluation of youth friendly health services in Malawi' (2014) 176, https://www.e2aproject.org/wp-content/uploads/evaluation-yfhs-malawi.pdf (accessed 16 June 2018).

Gloppen offers a similar caution by arguing that the use of law to deal with inequalities may inadvertently reinforce the inequalities.[57] There is a possibility that arbitrary denial of services would even become rampant and legitimised because the CCPR guarantees adoption of a belief as an individual and also protects the individual to manifest it in practice in both private and public spheres.[58] General Comment 22 on freedom of thought, conscience or religion reinforces this human rights standard by offering interpretive guidance that a healthcare provider, may not only justify objecting to providing a service to adolescents seeking contraceptives on grounds of religion but also may exercise that right based on his or her unique personal values or beliefs.[59] However, the healthcare providers who chose to evoke that right to object the provision of any health service have an ethical obligation to refer clients to other non-objecting ones.[60] In the Malawian context, this guidance may not be enough to serve the purpose since 99% of its people in the country are religious.[61] It follows therefore that almost every healthcare provider in Malawi is religious. The consequence is that every health care provider can opt to refer to the other, knowing fully well that the other healthcare provider will also refer to the next. This could be a strategy the health practitioners can employ to tactfully avoid sanctions provided in the Act.

The effect could be severe if that right is evoked without regulation. These concerns are somewhat addressed in Article 18(3) of the CCPR which permits restrictions on the freedom to manifest religion or belief only if limitations are prescribed by law and are necessary to protect the health or the fundamental rights and freedoms of others.[62] In addition to Article 18(3) the CCPR, the General Comment on the right of the child to the enjoyment of the highest attainable standard of health explicitly prescribe that adolescents should not be prevented from accessing contraceptives because the healthcare providers are invoking the right to conscientious objections.[63] According to international human right

[57] S Gloppen 'Litigating as a strategy to hold governments accountable for implementing the right to health' (2008) 10 *Health and Human Rights* 24, https://www.hhrjournal.org/2013/09/litigation-as-a-strategy-to-hold-governments-accountable-for-implementing-the-right-to-health/ (accessed 28 June 2018).
[58] Art 18(1).
[59] ICCPR Committee General Comment 22 Article 18 (Freedom of Thought, Conscience or Religion) para 2.
[60](n 30) para 11.
[61] O Smith 'Mapped: The world's most (and least) religious countries' *The Telegraph* (London) 14 January 2018 https://www.telegraph.co.uk/travel/maps-and-graphics/most-religious-countries-in-the-world/ (accessed 4 November 2018).
[62] Art 18(3).
[63] CRC Committee General Comment 15 The right of the child to the enjoyment of the highest attainable standard of health (art 24) CRC/C/GC/15 (2013) para 69.

standards set by the CEDAW committee in the General Recommendation 24 on women and health, objecting healthcare providers have the ethical duty to refer clients to other non-objecting ones.[64] From the foregoing, it is clear that the limitations should have been prescribed in the Act, clearly outlining principles for determining the limits, as Ngwena proposed in the case of the Choice on Termination of Pregnancy Act of South Africa.[65]

Second, the Act contradicts itself, which is not surprising to a movement of some feminists. Bartlett highlights the school of thought held in post structural critique of foundationalism which stresses the indeterminacy of law as well as the masking of some hierarchies and distribution of powers.[66] Alkan puts it differently, 'law is embroiled in fundamental contradiction.'[67] The contradiction is in the sense that the provisions in section 20 have the inadvertent impact of negatively affecting quality and access of services that the very same law seeks to strengthen and improve. Section 20(1f) which mandates healthcare providers to obtain written consent from the person accessing reproductive services,[68] is used to illustrate the contradiction. The law makes it mandatory that a healthcare worker should provide reproductive health services indiscriminately and avoid exhibiting judgemental attitudes,[69] or otherwise risk imprisonment.[70] However, if the law is implemented as it is, it theoretically risks opening a flood gate of cases against healthcare providers who contravene provisions in section 20(1) of the Act.[71]

Problems will arise in instances where an adolescent girl who does not know how to write seeks to access contraceptives. It means therefore that she cannot meet the requirement of providing written consent as required in section 20(1f). In that case, even though the healthcare worker would be meticulous in ensuring that he or she follows all the other guidelines provided in section 20(1), with the aim of ensuring that the service is friendly to the adolescent, he or she would still end up contravening the law if the decision is made to

[64] n 30, para 11.
[65] C Ngwena 'Conscientious objection and legal abortion in South Africa: Delineating the parameters' (2003) 28 *Journal for Juridical Science* at 16.
[66] KT Bartlett 'Feminist legal methods' (1990) 103 *Harvard Law Review* 829 at 878.
[67] Y Alkan 'Feminist legal methods: Theoretical assumptions, advantages, and potential problems' (2012) 9 *Ankara Law Review* at 160.
[68] (n 1) sec 20 (1f).
[69] (n 1) sec 20(1a).
[70] (n 1) sec 20(2).
[71] (n 1) sec 20 (1).

proceed with provision of the contraceptives. This situation would put healthcare providers in a dilemma of choosing whether to provide the service and risk penalisation or refuse to provide a service, thereby violating the right of the adolescents to access the service because they cannot write. In light of that consideration, it is clear that section 20 of the Act considerably counteracts the overall goal of seeking to promote access to reproductive services to all, including the huge proportion of the population which is illiterate. In 2015 it was estimated that in Malawi, 934 377 young people of age 15-24 were illiterate, of which 463238 were female. Within the larger population from age 15 and older the total estimated illiterate population was at 3 471 192, of which the majority were female, approximately 2 124 410.[72] The number of women and adolescent girls that could negatively be affected by the law requiring written consent is that much.

Notwithstanding the limitations of the statutes in the Act, the reasoning of the Commissioners in drafting the legislation which reaches the extent of penalising unethical conduct of healthcare providers was logical, justified and necessary. Experts around the globe,[73] posit that legal remedies play an integral role in ensuring the implementation of laws and policies as well as challenging discriminatory barriers to sexual and reproductive healthcare.[74] They challenge the barriers by guaranteeing non-repetition.[75] Gloppen propounds that 'litigation provides an avenue for rights-holders to access treatment when the system is not delivering.'[76] It is precisely the same problem identified by the Commissioners in their assessment prior to drafting the Gender Equality Act.[77] It is against this background that this thesis is conducted to establish if the Act is addressing the problems associated with delivery of SRH services particularly to adolescents.

[72] United Nations Educational Scientific and Cultural Organization Institute of Statistics *Malawi* http://uis.unesco.org/country/MW (accessed 27 June 2018).
[73] OHCHR 'Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality' (2012) para 2.
[74] OHCHR (n 73) para 77.
[75] ESCR Committee General Comment 14 'The right to the highest attainable standard of health (art 12)' E/C.12/2000/4 para 59.
[76] Gloppen (n 57) 22.
[77] Malawi Law Commission (n 24)13.

1.1.3 How the Act applies to contraceptive use by adolescents

For women in general, the Act in section 19[78]is clear and explicit regarding the rights of adult women to access reproductive health. For adolescent girls it is not as clear mostly because adolescents or any terminology that would represent that group for example children, or youth are not explicitly mentioned. The absence of an explicit mention of adolescents does not mean they are excluded from enjoying reproductive health rights as provided under this Act. They are implicitly recognised in section 20(1a) which requires healthcare providers to respect the reproductive health rights of every person without discrimination.[79] This is a good starting point to identify what is implied for adolescents in that section. The Malawi Law Commission Report proves beyond reasonable doubt that the drafters of the legislation had in mind adolescents as a special group that needed to be served by the Act. In that report, the Commissioners were explicit in highlighting that in pursuit of ensuring that women's reproductive health rights are fulfilled, the government must adhere to the right to non-discrimination by offering everyone, including adolescents and unmarried women equal access to healthcare that addresses their unique health needs.[80]

Another reason which confirms the position that the Act recognises adolescents' reproductive health rights is based on provisions in section 20(1e) which requires service providers to record whether or not the client understood the purpose of counselling.[81] This provision should be progressively interpreted to be a recognition of the principle of the evolving capacity of adolescents, rather than setting parameters for discrimination based on the chronological age of adolescents which is used to measure maturity.[82] This reasoning conforms to the thinking espoused in the Fraser Guidelines which originated in England from a 1985 court case commonly known as *Gillick v West Norfolk case.*[83] In that case, Lord Fraser reasoned that there are adolescents who understand when counselled, hence no need for

[78] Sec 19.
[79] Sec 20(1a).
[80]Malawi Law Commission (n 24) 57.
[81] Sec 20(1e).
[82] CRC Committee General Comment 4 'Adolescent health and development in the context of Convention on the Rights of the Child' (2003) para 6(b).
[83] *Gillick v West Norfolk & Wisbeck Area Health Authority* [1986] AC 112 House of Lords; NSPCC Knowledge and Information Services 'Gillick competency and Fraser guidelines
; Balancing children's rights with the responsibility to keep them safe from harm' December 2018 https://www.icmec.org/wp-content/uploads/2019/04/gillick-competency-factsheet.pdf; http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm (accessed 14 September 2018).

third parties to be part of their decisions on contraceptive use.[84] There is therefore, no doubt that the Act equally applies to adolescents too.

Considering that the Act presents for the first-time a framework that prevents healthcare providers from arbitrarily refusing to provide contraceptives to adolescents, the relevance of this thesis is to show the effect of the law in prompting some efforts by government towards the removal of attitudinal barriers presented by healthcare workers. Overall, the thesis aims at assessing the improvements in delivery of contraceptives to adolescents of Malawi in relation to guidelines laid out in section 20(1) of the Act. The findings are useful to inform policy and practice in SRHR programming, especially for adolescents. Adolescents are a special focus for various reasons. Chief among them is the recognition that SRHR outcomes for adolescents in Malawi are unsatisfactory, as illustrated in the following section.

1.2 Problem statement

The Malawian population predominantly comprises of young people. The 2018 census findings show that of the total population of 17 563 749, 26% are adolescents who are 10-19 years of age.[85] Adolescents in Malawi are sexually active. It is estimated that among girls and boys of ages 15-19, 13% and 22% respectively had experienced sexual intercourse before the age of 15.[86] Despite forming a significant proportion of the population, adolescents face numerous challenges in accessing contraceptives and as a result, contribute to high rates of teenage pregnancies. The proportion of teenage pregnancies increased from 26% to 29% between the years 2010 and 2016.[87]

The increase in teenage pregnancies was highlighted as a matter of concern in the 2017 Concluding Observations of the Convention of the Rights of the Child (CRC),[88] as well as

[84] 'Fraser Guidelines: Information for all Community Pharmacy Staff' *Pharmaceutical Services Negotiating Committee* (2014)1 http://psnc.org.uk/halton-st-helens-and-knowsley-lpc/wp-content/uploads/sites/45/2013/09/Fraser-competency-CP-Oct14.pdf (accessed 14 September 2018).
[85] National Statistical Office 'Malawi population and housing census report-2018' (2019) 53.
[86] National Statistical Office & ICF International (n 31) 74.
[87] National Statistical Office & ICF International (n 31) 73.
[88] CRC Committee Concluding observations on the combined third to fifth periodic reports of Malawi CRC/C/MWI/CO/3-5 2017 para 34.

in the 2015 Concluding Observations by CEDAW.[89] Not all pregnancies are wanted or planned. It is estimated that among both married and unmarried women of ages 15-19, only 15% were using contraceptives in 2015 while 11% had an unmet need for contraceptives.[90] Among the sexually active unmarried women of ages 15-19, 34% were using contraceptives and 52% had an unmet need.[91] Unmet need is defined as the proportion of women who do not want to get pregnant but are not using any contraceptive.[92] As can be seen from the statistics, the general outlook of the family planning programme in Malawi is not that encouraging, particularly for adolescents. In 2015, contraceptive use for all women was approximately 45%,[93] estimated at 47% in 2019 and projected to be at 48% in 2020.[94] This result is far below the target of 60% which was supposed to be achieved by 2020.[95] The under utilisation of contraceptives by adolescents is further illustrated by the findings of the 2014 evaluation report of the YFHS programme in Malawi.

Before going any further, the YFHS programme should first be understood to provide more context for this thesis. Malawi is one of the countries implementing the YFHS program since 2007.[96] These services are meant to respond to general health but are commonly designed to respond to the SRHR needs of young people.[97] The programme is designed with the recognition that adolescent transition to adulthood is a phase which exposes them to multiple vulnerabilities.[98] To achieve that goal the youth friendly health services are expected to be relevant, accessible, attractive, affordable, appropriate and acceptable to young people.[99] In Malawi, the programme is implemented by various government and non-governmental organisations, with the leadership of the Reproductive Health Directorate

[89] CEDAW Committee Concluding observations on the seventh periodic report of Malawi CEDAW/C/MWI/CO/7 2015 para 34(c).
[90] National Statistical Office & ICF International (n 31) 107.
[91] As above.
[92] National Statistical Office & ICF International (n 31) 97.
[93] National Statistical Office & ICF International (n 31) 101.
[94] Family Planning 2020 'Malawi commitment maker since 2012' https://familyplanning2020.org/malawi (accessed 19 May 2021).
[95] Ministry of Health for the Republic of Malawi *Prioritization of family planning interventions at national and district levels for 2018-2020* (2018) 1. http://www.healthpolicyplus.com/ns/pubs/11289-11517_PrioritizationofCIPInterventions.pdf (accessed 14 June 2018).
[96] Ministry of Health for the Republic of Malawi *National youth friendly health services strategy* (2015) 1.
[97] As above.
[98] As above.
[99] As above.

under the Ministry of Health.[100] The YFHS package in Malawi has 16 services, among them are contraceptives.[101] Table two in chapter four provides the list of other services.

Upon programme evaluation of the program in 2014, seven year later, the findings showed that only 13% of young people reported having ever used the YFHS.[102] The report further revealed that healthcare providers significantly contribute to prevention of adolescents from accessing reproductive health services.[103] In some cases, they refuse to provide such services to adolescents because they believe the services promote promiscuity.[104] The YFHS evaluation also established that healthcare workers were considerably unfriendly and lacked confidentiality in providing services to adolescents.[105] As is argued through this thesis, sections 19 and 20 of the Act have the potential to deal with such barriers, especially through section 20(2).[106]

1.3 Research aims and objectives

This study aims to examine the role of the Act in strengthening the provision of contraceptives to adolescents. The following are the two specific objectives:

1. To establish if the Ministry of Health policies, strategies, guidelines and national programmes developed after the enactment of the Gender Equality Act refer to sections 19 and 20, and to what effect?
2. To examine if there has been any change in the reported attitudes and conduct of healthcare providers towards adolescents following enactment of the Act and the impact of such a change on utilisation of contraceptives by adolescents.

1.4 Research methodology

This thesis uses multiple research methods to respond to the variety of data needed to address the two objectives. To reinforce the validity of the findings, the thesis uses a

[100] As above.
[101] Ministry of Health for the Republic of Malawi *National standards for youth friendly health services* (2017) 17-18.
[102] Ministry of Health for the Republic of Malawi (n 56) 183.
[103] Ministry of Health for the Republic of Malawi (n 56) 174-178.
[104] Ministry of Health for the Republic of Malawi (n 56) 174-175.
[105] As above.
[106] Sec 20(2).

triangulation approach,[107] whereby a combination of different forms of data from different sources is used. Secondary data was collected using a documentation technique.[108] This technique is applied in collecting data from sources such as reports, written documents like policies as well as newspapers.[109] In addressing the first objective which aims to establish if the Ministry of Health policies, strategies, guidelines and national programmes developed after the Act was enacted have content reflecting operationalisation of sections 19 and 20, and the effect they brought. The data sources used are the very same SRHR policy documents developed after the Act in 2013 and not later than 2019. The documents were analysed to establish any changes in the content to reflect explicit or implicit reference and application of the SRHR provisions contained in the Act. By changes in content, the focus of the thesis goes beyond establishing whether the Act is mentioned or not. Regarding the application of the SRHR statutes of the Act in the policy documents, the interest is in looking at the context or subject matter in which they have been used. It also entails scrutinising any possible introduction of strategies that demonstrate that they are addressing problems or gaps such as the negative attitude of healthcare workers as identified by the drafters of the Act.

In respect of the second objective, which examines if there has been any change in the attitudes and conduct of healthcare providers towards adolescents following the enactment of the Act, this thesis uses the documentation approach to collect secondary data.[110] This approach is well suited for this thesis considering that it predominantly uses credible and authoritative data from government, primarily generated with a considerable degree of quality control. In addition to government data, the thesis is informed by multiple study reports produced independently by non-governmental institutions as well as some produced in collaboration with the government. This secondary data collected and analysed for this thesis is principally for the period between 2013 and 2019. The data helps to answer the question of whether, in those studies, the attitude of healthcare workers towards adolescents accessing contraceptives continues to significantly appear as an issue of concern

[107] P Langbroek et al 'Methodology of legal research: Challenges and opportunities' (2017) 13 *Utrecht Law Review* at 6, https://www.researchgate.net/publication/322055195_Methodology_of_legal_research_Challenges_and_opportunities/citation/download (accessed 10 August 2018).
[108] A Bhattacherjee *Social Science Research: Principles, methods, and practices* (2012) 107.
[109] Bhattacherjee (n 108) 95.
[110] As above.

to adolescents. However, this thesis does not answer the question of the extent to which the actual conduct and attitude of healthcare workers has changed. Nonetheless, secondary data on utilisation of contraceptives was also collected and analysed, owing to the logical expectation that a positive change of attitude by healthcare workers would considerably contribute to creation of a conducive environment for adolescents to access contraceptives.

The collected data was analysed using a content analysis approach. Content analysis is defined as a systematic analysis of content of the text.[111] Summative type of content analysis was applied to analyse the qualitative data by quantifying text and interpreting the content and context of the data.[112] The analysis, for example, puts into consideration factors such as who says what, to whom, why, to what extent and with what effect quantitatively or qualitatively.[113] Factors such as who says what, to whom, with what effect aligns very well with key principles of the conflict theory, where the subject of power relations is at play. Relevant to this thesis for instance is the body of knowledge produced by the government through policy documents. In that regard, the focus is on examining what the government says or does not say about the SRHR laws. The first stage of analysis involved sampling a selected set of texts from the secondary data sources. The second phase, called unitising, involved identifying and applying rules to divide each text into segments that were treated as units of analysis. The third stage was coding, which involved constructing and applying one or more concepts to the texts put in segments. The fourth stage was the actual analysis where the data was quantitatively and qualitatively analysed to establish the frequency of themes emerging from the data sources.

Overall, this thesis aims to interpret reality through a sense-making process.[114] To make sense of the data used in this thesis, it is largely the conflict theory, complemented in more specific terms by feminist conflict theories which were used to interpret the findings. In the next section, the whole theoretical framework is explained.

[111] Bhattacherjee (n 108) 115-16.
[112] H Hsieh & SE Shannon 'Three approaches to qualitative content analysis' (2005) 15 *Qualitative Health Research* at 1278.
[113] Bhattacherjee (n 108) 115.
[114] Bhattacherjee (n 108) 103.

1.5 Theoretical framework: Conflict theory

Conflict theory is used in research to expose the injustices in societies stemming from factors like class, gender and power.[115] For this thesis, conflict is described as a situation in which values are perceived as incompatible, the result of it being inequalities.[116] Concerning inequality, out of the many definitions of conflict, Dahrendorf's definition is more applicable to this thesis. Dahrendorf proffers the definition of conflict as 'the inequality of power and authority which inevitably accompanies social organisations.'[117] In conflict theory, the unit of analysis is the social system,[118] and it is applied to critique social arrangement in societies.[119] This school of thought is fundamentally influenced by Karl Marx's thinking that human thought and behaviour are a function of alterable socio-economic relations.[120] Conflict theorists propound that such relationships are not always smooth because social order in society is a product of coercion and exploitation by those in power. [121] Scholars subscribing to this theory hold the view that exploitation makes the social system functional.[122] The underpinning of the theory is the role of power and how it is used to maintain order in society despite that others are exploited and coerced in the process.[123] As a result of such a relationship in the social system, there are groups of people with conflicting interests, roles and expectations.

The perspective of some conflict theorists, such as Marxists and feminists, is that the groups in conflict are clearly defined and the pattern of conflict is usually determined by particular social relations bordering on social class, gender, power,[124] and of course age.[125]

---

[115] A Litva & J Eyles 'Coming out: Exposing social theory in medical geography' (1995) *Health and Place* at 9, http://www1.geo.ntnu.edu.tw/~moise/Data/Books/Social/06%20social%20security/coming%20out%20exposing%20social%20theory%20in%20medical%20geography.pdf (accessed 4 June 2019)
[116] J Galtung *A framework for the analysis of social conflict* (1958) 7, https://www.transcend.org/files/Galtung_Book_unpub_A_Framework_for_the_Analysis_of_Social_Conflict_1958_v2.pdf (accessed 10 July 2018).
[117] R Dahrendorf *Class and class conflict in industrial society* (1959a) 64, https://cominsitu.files.wordpress.com/2019/01/ralf-dahrendorf-class-and-class-conflict-in-industrial-society-1.pdf (accessed 12 July 2018).
[118] Litva & Eyles (n 115) 7.
[119] As above.
[120] As above
[121] As above.
[122] Galtung (n 116) 27.
[123] Litva & Eyles (n 115).
[124] As above.
[125] Galtung (n 115) 28.

Galtung makes a more direct assertion that in every society there is a conflict between adults, particularly men and adolescents.[126] In such conflict, the adult male is referred to as 'top dog' and the adolescent is the 'underdog'.[127] The suitability of the conflict theory in this thesis goes beyond this type of conflict.

Conflict theory is also applied to examine healthcare systems.[128] Conflict theorists contest that within society, health is patterned in such a way that some groups consistently have better health outcomes than others, to the extent that some groups are disproportionally affected by disease.[129] Conflict theorists purport that medical practitioners use their special position in society to dominate the less powerful people like adolescent girls.[130] There is a consensus among feminists that women's health is compromised by patriarchal structures, arguing that women's physical and mental health is a function of suppression.[131] They further contest that the medical community, which is inherently patriarchal, has used women's reproductive functions as the basis of reinforcing women's disadvantaged position in society.[132] The medical community therefore, is seen to be contributing to the reinforcement of social or cultural norms prevalent in Africa whereby, African women, Malawian women inclusive, are subjected to subordination and kept in positions of low bargaining power. Consequently, the women have little or no control over decisions which affect their bodily integrity on the basis that they are expected to perform their reproductive function so as to keep the family bloodline alive.[133] Such type of beliefs propagate the stereotype that characterises women as 'reproductive instruments.'[134] On the other hand, in the health care delivery system, the male-dominated medical community has medicalised normal body functions such as childbirth and menstruation to the extent that women's bodies are viewed as intrinsically unhealthy.[135] Additionally, women's status has been associated with 'sickness,'[136] which would arguably be similar to pregnancy. This

[126] As above.
[127] As above.
[128] Litva & Eyles (n 115) 10.
[129] As above.
[130] As above.
[131] As above.
[132] As above.
[133] FN Adjetey 'Reclaiming the African woman's individuality: The struggle between women's reproductive autonomy and African society and culture' (1995) 44 *American University Law Review* at 1352-1353.
[134] B Paola & M Agustina 'Constitutional developments in Latin American abortion law' (2016) 230 *International Journal of Gynaecology and Obstetrics* at 228-231.
[135] Litva & Eyles (n 115) 10.
[136] As above.

perspective puts women in the 'underdog' category. Therefore, it implies that adolescent girls are disadvantaged on two grounds of age and sex. Feminists blatantly postulate that adolescent girls are subjected to deliberate injustice,[137] which probably explains why the SRH outcomes for adolescents are poor in Malawi.

Kangaude and Banda observe that in sub-Saharan Africa, contraceptives are not accessed by adolescents who need them because governments do little to ensure unrestricted access.[138] This is due to deep-rooted discrimination and stigma associated with adolescents' sexuality.[139] They are expected to be asexual.[140] When they become sexually active, is it deemed immoral.[141] Because adolescents are considered asexual and prohibited to engage in sexual activity, the conclusion is that it is irrelevant and unacceptable for them to access contraceptives.[142] It is on that basis that Tamale astutely contests that the construct of law, culture and religion in Africa pushes to the margin of society the non-conforming populations like adolescents on issues of sexuality, which directly links to reproduction.[143] Because of this multifaceted nature of injustice subjected to adolescent girls, the conflict theory appears more suitable to provide a theoretical framework for interpreting the reproductive health injustice subjected to adolescents.[144]

Owing to the common knowledge that one of the remedies for the injustices directed towards adolescent girls is provided in legal frameworks, the next chapter provides an analysis of the corresponding applicable normative legal and human rights instruments. This

[137] As above.
[138] G Kangaude & T Banda 'Sexual health and rights of adolescents: A dialogue with sub-Saharan Africa' in CG Ngwena & ET Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) at 262.
[139] As above.
[140] G Kangaude 'Enhancing the role of health professionals in the advancement of adolescent sexual health and rights in Africa' (2016) 132 *International Journal of Gynaecology and Obstetrics* at 5.
[141] T Shefer *et al* 'Teenage pregnancy and parenting at school in contemporary South African contexts: Deconstructing school narratives and understanding policy implementation' (2013) 31 *Perspectives in Education* at 4, https://genderlinks.org.za/wp-content/uploads/imported/articles/attachments/20130_shefersteenagepregnancy2013.pdf (accessed 28 August 2019).
[142] A Self *et al* 'Youth accessing reproductive health services in Malawi: Drivers, barriers, and suggestions from the perspectives of youth and parents' (2018) 15 *Reproductive Health* at 6.
[143] S Tamale 'Exploring the contours of African sexualities: Religion, law and power' (2014) 14 *African Human Rights Law Journal* at 158.
[144] Litva & Eyles (n 115) 10.

chapter has laid down the context in which this thesis is conducted, the objectives, methodology and theoretical framework.

1.6 Outline of the thesis

The thesis is divided into five chapters. The first, an introductory chapter, starts by highlighting the content of the Gender Equality Act and the context in which the legal provisions were arrived at. It further critiques some SRHR statutes. The chapter then follows with a description of the Youth Friendly Health Services, a key concept that would be used a lot in chapters three and four. The chapter continues with the problem statement, research objectives, methodology and theoretical framework. In chapter two, the thesis analyses the overall legal framework on SRHR in Malawi to establish if it is providing a conducive environment for adolescents to access contraceptives, and to determine how the Act strengthens that legal framework complies with international human rights standards. The third chapter provides an examination of how the Act has been applied in the development of policy documents since its enactment to ensure that the provisions in the new legislation are operationalised. In chapter four, a much more focused analysis is conducted to explore any changes in practices or the behaviour of two groups, healthcare workers and adolescents. For healthcare workers, the interest is in assessing if there is an improved attitude towards adolescents accessing contraceptives since the enactment of the Act. Whereas for adolescents, the focus is on the changes in utilisation of contraceptives. The change in the attitude of healthcare providers is analysed by examining studies on adolescents and contraceptive use in Malawi conducted after the enactment of the Act. From those studies, the aim is to establish whether the negative attitudes of healthcare workers remain persistent as a barrier to adolescents seeking access to contraceptives. The fifth chapter concludes with key findings and recommendations.

CHAPTER 2: Legal framework for reproductive rights for adolescents in Malawi

Having laws in place is one thing but implementing or enforcing the laws is entirely another thing. In this chapter, the aim is to show that before the enactment of the Gender Equality Act, the legal framework in Malawi implicitly protected and promoted the SRHR for all people including adolescents. This is important to bring into perspective to demonstrate that despite having a relatively positive and strong legal framework for reproductive rights,[145] Malawi was and is still registering poor SRH outcomes for adolescents.[146] That background information justifies the relevance of this thesis, to assess the effect of sections 19 and 20 of the Act, five years after its enactment. The chapter highlights the legal foundation on which the Act is built, particularly, in the aspect of improving service delivery of contraceptives to adolescents. Recognising that many factors would be at play to improve service delivery, it is important to note that the crux of this thesis is the attitude of healthcare workers towards adolescents accessing contraceptives. The attitude factor is arguably the hallmark of the statutes in sections 19 and 20. The flow of sections in this chapter starts with an exposition of the relevant international treaties and other human rights instruments, followed by regional and sub-regional frameworks. The last section switches to the national legal framework and how the Act fills the gaps.

2.1. International human rights system

Malawi has ratified all major treaties that set standards for respect, protection and fulfilment of reproductive health and rights.[147] It therefore has a legal obligation in accordance to Article 12 (a) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) to take all appropriate measures to eliminate discrimination against women in healthcare to ensure women have equal rights in making choices on the use of family planning.[148] Additionally, under Article 16 (1e) of the CEDAW, the state is required to empower women to decide freely and responsibly on the number of children they want to

[145] OHCHR & UNFPA *Malawi country assessment of the cycle of accountability for sexual, reproductive, maternal, child and neonatal health and human rights* (2016) x.
[146] As above.
[147] OHCHR 'UN Treaty Body Database' https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx (accessed 28 June 2018).
[148] Art 12 (a).

have and obliges States parties to enable them to exercise that right.[149] The CEDAW Committee provides interpretive provisions to the above-mentioned articles emphasising that States parties are obliged to refrain from obstructing women from accessing health services on the basis that for instance, they are unmarried or they do not have authorisation from husbands or parents.[150] In highlighting descriptions like 'unmarried' and 'authorisation from parents' the Committee also implicitly affirms the adolescents' reproductive health and rights.

Adolescents' reproductive rights are also recognised in several articles of the Convention on the Rights of the Child (CRC) which defines a child as every human being under the age 18.[151] Relevant to reproductive health in this treaty is Article 24 (1) which obligates States parties to recognise the right of children for the enjoyment of the highest attainable health to the extent that no child is deprived of his or her right to healthcare services.[152] This provision does not also explicitly refer to reproductive health services and more specifically, contraceptives. It is however implied in many ways and four of those are highlighted herein. First, under CRC Article 24(2f),[153] States parties are requested "to develop preventive healthcare, guidance for parents on family planning education and services"[154] to achieve the right to health provided for in Article 24(1).[155]

Second, in 2003, the CRC General Comment 4 cleared the ambiguity by stipulating that in the interest of the child as provided in the CRC,[156] and the expanded understanding of the concept of health in relation to Article 24 of the CRC,[157] States parties are obliged to provide adolescents with access to sexual and reproductive information, including family planning and contraceptives.[158] In this General Comment, the right to non-discrimination provided in Article 2 of the CRC, [159] is reaffirmed by reminding States parties that they have the obligation

[149] Art 16.
[150] CEDAW Committee General Recommendation 24 'Article 12 of CEDAW on Women and Health' (1999) para 14.
[151] Art 1.
[152] Art 24(1).
[153] Art 24(2f).
[154] Art 24(3) CRC.
[155] Article 24(1) CRC.
[156] Art 3.
[157] CRC Committee (n 82) para 24.
[158] As above.
[159] Art 2(1).

of ensuring that everyone under the age 18 enjoys all the rights without discrimination on the grounds of birth or any other status.[160]

Third, the right to non-discrimination is also expounded in CEDAW's General Recommendation 24 which called upon States parties to create favourable conditions that do not require the authorisation of husbands, partners, and parents for women to access healthcare.[161]Worth noting in this General Recommendation is that the term "women" also includes adolescent girls.[162]

Fourth, the General Comment 15 on the right of the child to the enjoyment of the highest attainable standard of health in Article 24 of the CRC,[163] interpreted that the right to health for adolescents includes family planning services.[164] In that regard, the CRC committee urged States parties to ensure confidential and universal access to family planning services for both married and unmarried adolescents.[165] Indirectly, this guidance aims at dealing with the barriers that are presented by third parties such as husbands who prevent married adolescents and parents who prevent unmarried adolescents from accessing contraceptives. Against the background that another barrier to adolescents' access to contraceptives is the personal, cultural or religious beliefs of healthcare workers, the committee also obliges States parties to ensure that conscientious objections by health providers should not be a barrier to adolescents.[166]

Even though Malawi ratified all major international treaties addressing reproductive health and rights for adolescents, one of the biggest limitations in ensuring full commitment to fulfilling the reproductive rights of adolescents is that the government has neglected to ratify optional protocols, such as the Optional Protocol to the CEDAW.[167]By not ratifying the optional protocol, Malawi invalidates rights of individual Malawians to access treaty bodies with complaints. This could demonstrate to some extent, non-willingness of the State to be held accountable because without the ratification, no communication from Malawi can be

[160] CRC Committee (n 82) para 2.
[161] Para 14.
[162] CEDAW Committee General Recommendation 24 (n 30) para 8.
[163] Para 69.
[164] As above.
[165] As above.
[166] As above.
[167] OHCHR *Status of Ratification Interactive Dashboard.* http://indicators.ohchr.org/ (accessed 26 May 2019)

received by the CEDAW Committee for it to intervene on any reported violation to reproductive health.[168]

2.2 Regional human rights system

In addition to the international system, Malawi is party to the African Continent's human rights system, which is also referred to as a regional system. In November 1989 Malawi ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women, which is also called the Maputo Protocol.[169] Article 14 of the Maputo Protocol explicitly makes provisions for reproductive health and rights.[170] Article 14 (1) provides that States parties are obliged to ensure that the right to health for women, including sexual reproductive health are respected and protected.[171] The rights include the right to control fertility as stipulated in Article 14(1a).[172] In Article 14(1b) there is the provision for the right to decide whether to have children, the number of children, and the spacing of children.[173] The right to have family planning education is also guaranteed in Article 14(1e).[174]

Just like the international human rights normative standards, the Maputo Protocol does not contain explicit provisions on adolescents' access to contraceptives. However, the interpretive guidance provided in the General Comment 2 on Article 14 of the Maputo Protocol clarifies the obligations States parties have of ensuring that reproductive rights of adolescents are protected by prohibiting third parties interfering with adolescents' right to access contraceptives.[175] The interpretive guidance further requests States parties to remove barriers presented by healthcare providers which prevent adolescents from accessing contraceptives.[176] The barriers would for instance be manifested by invoking conscientious objection,[177] on grounds of religion.[178] Worth noting is that the General Comment is not

[168] CEDAW Committee Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women A/RES/54/4 15 (1999) art 3.
[169] African Commission on Human and Peoples' Rights *Ratification Table: African Charter on Human and Peoples' Rights* http://www.achpr.org/instruments/achpr/ratification/ (accessed 16 Mach 2019).
[170] Art 14.
[171] Art 14(1).
[172] Art 14 (1a).
[173] Art 14(1b).
[174] Art 14(1e).
[175] As above.
[176] African Commission on Human and Peoples' Rights (n 169) para 60.
[177] African Commission on Human and Peoples' Rights (n 169) para 48.
[178] African Commission on Human and Peoples' Rights (n 169) para 25.

disregarding the right of healthcare providers to exercise their right to conscientious objection. It is rather providing guidance that there should be a mechanism of ensuring that women and adolescent girls are not arbitrarily denied services. That could be achieved by putting in place a referral system that directs the clients to non-objecting healthcare workers.[179]

2.3 Sub-regional system

Southern African Development Community (SADC) adopted the SADC Protocol on Gender and Development which was signed in 2008 and entered into force in 2013.[180] Malawi ratified the treaty in 2013.[181] This treaty has the objective of harmonising the implementation of the regional and international treaties ratified by the SADC Member States regarding gender equality and equity. The protocol contains many provisions which affirm reproductive rights such as those highlighted in preceding sections.

In Article 26(b) for example, the protocol contains provisions which affirm reproductive rights by imposing obligations to governments in the region to develop and implement policies and programmes to address SRH needs of women and men.[182] Similarly, in Article 11, the protocol specifically targets adolescents, by requiring States parties to develop laws, policies and programmes that ensure adolescent girls' equal access to information, education, services and facilities on reproductive health and rights.[183]

2.4 Domestic legal framework

Ratification of sub-regional, regional and international legal instruments is a demonstration of the strong intent by the Government of Malawi to adhere to international standards of human rights. This intention is further demonstrated by the domestication of those legal instruments. Even though the 1994 Constitution of the Republic of Malawi is not explicit and

[179] African Commission on Human and Peoples' Rights (n 169) para 26.

[180] Southern Africa Development Community 'Protocol on gender and development' (2008), https://www.sadc.int/documents-publications/show/Protocol%20on%20Gender%20and%20Development%20 (accessed 17 June 2018).

[181] Gender Links for Equality and Justice 'Malawi ratifies the SADC Gender Protocol' 20 August 2013, https://genderlinks.org.za/csw-newsletter/malawi-ratifies-the-sadc-gender-protocol-2013-08-20/ (accessed 17 June 2018).

[182] Art 24.

[183] Art 11.

comprehensive on SRHR and women's health, and adolescents' right to access contraceptives[184] there are provisions in the statues in which those are implied.

For instance, the right to health in section 30(2) of the Constitution of Malawi stipulates that the State shall take all necessary measures such as guaranteeing equal opportunity for all to access health services.[185]Additionally, in section 13, as a fundamental principle of national policy, the government reinforces the commitment to provide adequate healthcare commensurate with the health needs of Malawian society and in accordance with international standards of healthcare.[186]

Access to health services also implies access to reproductive health given the broad and encompassing definition of health. According to the WHO, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[187] This definition of health is clarified and expounded by human rights law which postulates that reproductive health is connected to several human rights, such as the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination.[188] Further interpretation by the Special Rapporteur asserts that the right to health entitles women, including adolescent girls to reproductive healthcare services, goods and facilities.[189] To that effect, reproductive health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.'[190]

[184] OHCHR & UNFPA (n 145) 32.
[185] Sec 30(2).
[186] Constitution of Malawi (n 54) sec 13(c).
[187]WHO 'Preamble to the Constitution of WHO as adopted by the International Health Conference' (1948), https://www.who.int/governance/eb/who_constitution_en.pdf (accessed 14 June 2018).
[188] OHCHR 'Sexual and reproductive health and rights,' https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx (accessed 10 June 2019)
[189] D Pūras 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (2015) para 43, https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session29/Documents/A_HRC_29_33_ENG.DOCX (accessed 24 June 2018).
[190] WHO 'Reproductive health,' https://www.who.int/westernpacific/health-topics/reproductive-health (accessed 28 June 2019).

2.5 The Constitution and guarantee of adolescents' right to contraceptives

The Constitution protects and guarantees the rights of children by explicitly stating that they are entitled to equal treatment before the law.[191] This means that they are entitled to enjoy the right to health and as has been established in the preceding section, they are entitled to enjoy the right to reproductive health. The Constitution also guarantees equality to all persons irrespective of any status.[192] All these stipulations can be expanded to implicate the right to reproductive health for adolescents. Before the year 2013, other than the Constitution, there was no other legal domestic instrument directly binding the Government of Malawi to fulfil, promote and protect the SRHR. The United Nations Population Fund (UNFPA) and Office of the High Commissioner for Human Rights (OHCHR) noted that this was a serious gap.[193]

In 2013, an explicit legislation on SRH was enacted in the name of the Gender Equality Act. This Act is the first to have explicit and more comprehensive legal provisions on SRHR. As indicated in the preceding chapter, the Act was promulgated to respond to the crisis of gender inequality.[194] Furthermore, the Act was drafted to respond to a plethora of other issues such as the conduct of some health care providers denying women access to contraceptives because they are unaccompanied by a spouse,[195] ineffectiveness of interventions aimed at dealing with harmful cultural practices,[196] and the health system failure to make appreciable impact in responding to women's health issues.[197] Because of the magnitude of the issues the Act needed to address, the drafters were so intentional to ensure that enforceability of the right to health,[198] particularly SRH is strengthened.

2.6 Conclusion

Despite some discouraging health outcomes presented in the problem statement, this chapter has shown that Malawi has demonstrated a strong will and commitment to conform to international human rights standards in creating a legal framework conducive for

[191] Sec 23 (5b).
[192] Sec 20.
[193] OHCHR & UNFPA (n 145) 35.
[194] Malawi Law Commission (n 24) 9.
[195] Malawi Law Commission (n 24) 60-61.
[196] Malawi Law Commission (n 24) 27.
[197] Malawi Law Commission (n 24) 13.
[198] Malawi Law Commission (n 24) 22.

adolescents to access contraceptives. To that extent, it is commended. However, by failing to ratify corresponding optional protocols to the treaties, the State is showing some signs of deliberately avoiding being held accountable for continued violations of adolescents' SRHR.

Notwithstanding, in some ways, the State is vindicated owing to the remedies it has laid out in sections 19 and 20 of the Gender Equality Act.[199] Of interest in this thesis is to examine how far beyond enactment of the law has the government gone to show real commitment of operationalising the law. The operationalisation could be achieved by informing and influencing content such as language and strategies in SRHR policies that address specific critical issues identified by the drafters of the legislation. This examination is important to provide evidence that informs policies and programs so as to avoid moving on the same trajectory of having laws which are not translating into improved SRH outcomes for adolescents.

[199] Sec 20(2).

CHAPTER 3: Operationalisation of the Act in SRHR policy framework

This chapter addresses the second objective of the study, which aims to establish if the Ministry of Health policy documents developed after the enactment of the Act have made reference to sections 19 and 20 of the Gender Equality Act, and if so, to what extent and context in which they are referenced. The analysis seeks to establish how the legislation has been used as an instrument that contributes to strengthening contraceptive provision and uptake by adolescents in relation to findings of the drafters of legislation. The first step in that analysis examines the text within the policy documents to establish if in the first place the Act has been used as a reference framework. In cases where the legislation is referenced, the second step examines how and the extent to which the Act is applied in strengthening contraceptive provision and utilisation by adolescents. Then the section that follows provides an interpretation of what the findings mean using the conflict theory and then conclusion is presented.

3.1 Reviewed government policy documents

This section focuses on 18 policy documents produced by the Government of Malawi, most of which relate to SRHR, family planning, youth and adolescents. The policy documents which are of direct relevance to this study include strategic plans, guidelines and training manuals which have been developed between 2013 and 2019. It is important to assess what the situation is in Malawi against the background that operationalisation of SRHR in sub-Saharan Africa lacks political leadership and commitment to fund related policies and programmes.[200]

This analysis is imperative since policies influence the nature of programmes as well as the allocation of resources by government and donors.[201] In other words, if the policies do not include some legal provisions, for example, section 20 provision of the Act within policies, such content is likely to be overlooked in programme design, and most importantly, miss out

[200] RN Oronje *et al* 'Operationalising sexual and reproductive health and rights in sub-Saharan Africa: Constraints, dilemmas and strategies' (2011) 11*BMC International Health and Human Rights* at 7.
[201] Organisation for Economic Cooperation and Development 'The Paris declaration on aid effectiveness and the Accra agenda for action' (2005) 3, https://www.oecd.org/dac/effectiveness/34428351.pdf (accessed 30 June 2019).

on resource allocation. It is on this fundamental premise that this type of policy analysis is necessary to appreciate the level of commitment by the Government of Malawi in ensuring the operationalisation of the SRHR provisions of the Act. The immediate first logical step towards operationalisation of that legislation should be the development of corresponding policy documents, as was manifested in the development of the Gender Equality Act Implementation and Monitoring Plan.[202] This is an empirical example illustrating that hard and soft laws should ideally be employed as complements.[203] Development of the soft laws to complement the hard law provides a framework of mobilising participation of state and nonstate actors and resources towards implementation of government intentions.[204] Related to that, the WHO recommends policy cohesion by linking the legal framework to policy framework.[205]

An analysis of whether the policy documents referred to the Act started with a simple search of 'Gender Equality Act' in the policy documents. When the Act was found, the next step was to look at the context in which it was used. For example, assessing if the content in the policy documents demonstrated any connection to section 20(2) which penalises healthcare workers.[206] Recognising that reference to the Act could be made without explicitly mentioning the statutes, the next level of analysis involved scrutiny of the policy documents with the view of looking at new components in programming which could correspond to some of the new provisions in sections 19 and 20 of the Act. Such correspondence would for instance include the development of guidelines that would regulate conscientious objection or introduction of activities which would require inclusion of institutions like the judiciary. The inclusion of such institutions would be reflected in the section that outlines implementation mechanism of a given policy document.

[202] Ministry of Gender Children Disability and Social Welfare for the Republic of Malawi (n 27) 3.
[203] Shaffer & Trebilcock (n 17) 709.
[204] JJ Kirton & MJ Trebilcock 'Introduction: Hard choices and soft law in sustainable global governance' (2004) JJ Kirton & MJ Trebilcock (eds) *Hard choices, soft law: Voluntary standards in global trade, environment and social governance* 9.
[205] WHO 'Human rights and gender equality in health sector strategies: How to assess policy coherence' (2011) 6, https://www.ohchr.org/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf (accessed 12 June2020).
[206] Sec 20(2).

In this thesis, a total of 17 Ministry of Health policy documents and one Ministry of Gender policy document were subjected to this analysis.[207] In total, 18 policy documents were analysed as the table below shows.

Table 1: Policies analysed and whether they make any reference to the Act

No	Policy/guidelines/training manuals	Reference made to the Act
1	Health sector strategic plan 2017-2022	None
2	National health policy 2018	None
)3	National youth friendly health services strategy 2015-2020	None
4	National standards on youth friendly health services 2015-2020, Revised in October 2015	None
5	Youth friendly health services training manual: Facilitators guide 2016	Yes
6	Youth friendly health services training manual: Participants' handbook 2016	Yes
7	National sexual and reproductive health and rights policy 2017-2022	None
8	Sexual reproductive health rights strategy 2018-2022 (draft)	None
9	Malawi costed implementation plan for family planning, 2016-2020	None
10	2017 Family planning commitment	None
11	National sexual and reproductive health and rights and HIV and AIDS integration strategy for Malawi, 2015-2020	None
12	National HIV prevention strategy 2015-2020	None
13	National strategy for adolescent girls and young women 2018-2022	None
14	Malawi national HIV-AIDS strategic plan 2015-2020	None
15	National youth policy 2013	None
16	Malawi national reproductive health service delivery guidelines 2014-2019	None
17	Roadmap for accelerating children and adolescent HIV and sexual reproductive health services in Malawi 2018-2022	None
18	The Gender Equality Act, 2013: Implementation and monitoring plan (2016 - 2020)	Yes

The table shows that out of the 18 documents reviewed, only three mentioned the Act. One of the three documents that mentioned the Act is an implementation and monitoring plan specifically developed to operationalise the Act in totality, which is not surprising. It is an implementation plan for all sectors covered in the Act, hence developed by Ministry of Gender which is the principal ministry mandated to ensure entire implementation of the legislation.[208]

[207] Ministry of Gender Children Disability and Social Welfare for the Republic of Malawi (n 27).
[208] Ministry of Gender Children Disability and Social Welfare for the Republic of Malawi (n 27) 3.

However, within that plan, content on SRHR has little, if not nothing to reflect that the legislation contributes something new in relation to sections 19 and 20 of the Act. New in this context means novel activities or strategies incorporated which departs from the traditional set of activities that appear religiously in every SRHR policy or strategy. Those strategies are expected to be different because they would be responding to unimpressive and had less effective existing programmes and strategies the framers of the Act intended to solve.[209] In other words, strategies and corresponding activities in that policy document, do not demonstrate a more direct, logical and strong connection on how they are operationalising specific issues in the statutes. As a way of illustration, the analysis of the implementation plan show that the document does not have any content to give effect to law that penalises healthcare workers who contravene section 20(1). It does not also contain activities or strategies which are giving effect to guidelines stipulated in section 20(1)[210] aimed at strengthening the delivery of contraceptives to adolescents.

The other two policy documents that refer to the Act are within the mandate of the Ministry of Health. However, the two are almost technically the same in the sense that they are training manuals used to train healthcare providers in Youth Friendly Health Services. The difference between the two is that one is a training manual for facilitators,[211] and the other is for participants.[212] While it is recognised that the two documents referred to the Act, it was only done in the context of addressing harmful cultural practices.[213] In section 5(1) of the Act, it is stipulated that "a person shall not commit, engage, subject another person to, or encourage the commission of any harmful cultural practice".[214] The statutes in sections 19 and 20 of the Act are not mentioned anywhere within the two manuals, as well as in the other 15 policy documents for the health sector.

[209] Malawi Law Commission (n 24) 28.
[210] Sec 20(1).
[211] Ministry of Health for the Republic of Malawi *Youth friendly health services training manual: Facilitator's guide* (2016)
[212] Ministry of Health for the Republic of Malawi *Youth friendly health services training manual: Participant's handbook* (2016)
[213] Ministry of Health for the Republic of Malawi (n 212) 17.
[214] Sec 5(1).

Considering that there is a huge possibility that the policies may not necessarily explicitly mention the Act but may still have substantive contents which can directly be linked to the legislation, an analysis of content was also carried out. The results of the analysis of the 18 policy documents also showed that there is a huge gap between the legislation and transitioning to a stage which would ensure implementation of the law. The transition would be demonstrated if the policy documents contained strategies such as orientation of healthcare workers on statutes related to provision of SRH stipulated in section 20(1). The orientation would also touch on raising awareness on the introduced sanctions for contravening section 20(1). Other new strategies in the policies directly linked to the legislation would include investigating violations of section 20 of the Act, and establishment of complaints handling mechanisms for contraventions of section 20 of the Act. Such strategies, even if they are phrased in such a way that they do not mention the name of the Act and are not spelling out the exact sections of the statutes, they can easily demonstrate that they are bringing new approaches which have a high likelihood of implementing the SRHR provisions of the Act.

It is however not the case with the current policy documents as the findings highlight the usual, common and in some cases vague strategies that were there before the enactment of the Act. For example, the National YFHS Strategy which was developed in 2015, in its priority area of focus, has a broad objective that reads 'enhance the enabling environment for planning, programming and delivery of YFHS information and services to young people.'[215] Under this broad objective, there are two specific objectives. The first is to 'ensure that policies, laws and strategies targeting the youth are up-to-date, harmonised and enforced in line with relevant international frameworks.'[216] The only proposed strategic action for this objective is to 'advocate with policymakers, traditional leaders and faith-based leaders for YFHS related policy and legal reforms.'[217] There are two important things to note here. First, the focus of this strategic action is to advocate for legal reforms, without any specification of the issues to be addressed. The second thing is that there is no strategic action on enforcement of the mentioned laws despite that, two years earlier the Act introduced some considerable legal reforms which needed to be implemented. If provisions in sections 19 and

[215] Ministry of Health for the Republic of Malawi (n 96) 21.
[216] As above.
[217] As above.

20 of the Act were used as a reference in developing the YFHS Strategy, one of the explicit strategic activities would have been to implement or support advocacy for enforcement of the SRHR statues in the Act. These are examples of what should have been included in the policy documents to demonstrate that each policy on SRHR, health in general or adolescents was developed with the intention to operationalise the Act among other laws.

It must be stressed that from the analysis of the policies, there is no doubt that the Ministry of Health recognises the relevance and importance of law. That observation is based on the finding that almost in each policy document, it is mentioned somewhere that the policy aligns to a certain law or that the policy will contribute to enforcement of certain law. As shown already in the preceding chapters, the critical shortcoming is on the extent of intent to operationalise such laws. That is why, the non-recognition and non-application of the Act in the development of 17 Ministry of Health policies on SRHR and adolescents, five years after the enactment of the legislation needs interrogation. The interrogation should explain why it appears that the Act is generally disregarded. In addition to that, it would be illuminating to interrogate why in the few instances in which the Act is referenced, the recognised statutes are only those directed towards the community and not those directed towards healthcare workers. In more precise terms, 'statutes directed towards the community' implies laws that aiming at regulating societal norms and practices, in this case, laws regarding harmful cultural practices as reflected in the YFHS training manuals.

An additional example illustrating the Ministry of Health's preference of laws directed towards the community is displayed in Government of Malawi's higher level Family Planning 2020 commitments. The Ministry of Health unequivocally demonstrated urgency and intent to contribute towards enforcement of the Marriage, Divorce and Family Relations Act enacted in 2015 which among others raised age of marriage for girls from 15 to 18.[218] In the Malawi Family Planning 2020 commitments, one of the six commitments was to reduce prevalence of child marriages by 5% at the end of the year 2020.[219] Being a family planning framework, one would think that a priority legislation to recognise, promote and enforce would be the Gender Equality Act given that sections 19 and 20 are more direct to family planning.

[218] Ministry of Health for the Republic of Malawi 'Family planning 2020 commitment' (2017) 2 http://summit2017.familyplanning2020.org/? (accessed 28 June 2020).
[219] As above.

Surprisingly, the legislation is not mentioned anywhere in the framework. It is again noted that the Ministry of Health placed significance on the law that penalises community actors involved in arranging or facilitating marriages for adolescent girls before the age 18. There is no commitment to mention not even one law that the Ministry of Health will enforce which is directed to them. It can therefore be concluded that there is a pattern showing that the Ministry of Health is selective on the laws to recognise. In the next section, the conflict theory is used to make sense of the non-recognition of sections 19 and 20 of the Act.

3.2 Politics at play

Galtung asserts that basic human needs,[220] such as health,[221] form part of the foundation of politics. Correspondingly, Galtung, contends that the basic objective of politics includes a guarantee of healthcare.[222] It therefore means that health is a fundamental component in that process of determining who gets it, when and how. However, politics is not a random process.[223] It involves strategic or tactical decisions and actions to achieve identified goals.

Owing to government's mandate of ensuring equal application of the law, the Ministry of Health should have no logical basis for choosing to recognise one law and leave the other especially when the one that they leave out is more directly linked to their mandate. The phenomenon that the Ministry of Health is selective on laws to recognise and contribute towards their enforcement somehow reinforces the notion that health is a political subject. In this context, politics should be understood as defined by Laswell, to mean a process in which 'who gets what, when, how.'[224] That definition augers well with what Walt and Gilson posit that a policy-making process is affected by actors, their position in power structures, their values and expectations. Consequently, the content of policy reflects some of those factors.[225] The same factors influencing actors during the policy-making process undeniably affects the implementation of those policies.

---

[220] Galtung (n 116) 159.
[221] Galtung (n 116) 161.
[222] Galtung (n 116) 162.
[223] Galtung (n 116) 159.
[224] HD Lasswell *Who gets what, when and how* (1950) 24-25 https://www.academia.edu/195863/Harold_Lasswells_Problem_Orientation_for_the_Policy_Sciences (accessed 14 July 2018).
[225] G Walt & L Gilson 'Reforming the health sector in developing countries: The central role of policy analysis' (1994) 9 *Health Policy and Planning* at 355.

In the development of the health policies, power and interests of the Ministry of Health officials are bound to be more dominant than of other actors involved in the process. That power may not always truly exercised in the interest of the oppressed or disadvantaged groups such as adolescents. According to feminist conflict theorists, the medical community uses their special position in society to dominate the less powerful.[226]It may not be in the best interest of the Ministry of Health to have its employees, who are healthcare workers, to be subjected to penalties imposed in section 20(2) of the Act. Because of the position they occupy and the power they possess in formulating policies, they opt to use such privilege to suppress the information that they too, are subjected to sanctions when they fail to perform some functions. They suppress the information by leaving out statutes contained in section 20(2) of the Act in the policy documents. One probable reason is that when the laws are included in policy documents, they are more likely to be widely circulated than they would in the current format of legislation. This viewpoint is supported by Lowi, who posits that unlike law, policy is closer to the people.[227] In that regard, because the policy is closer to the people, putting contents in the policies which expose the existence of laws penalising healthcare workers would increase the likelihood of communities knowing about the laws. The result of it would be an increase of probability for communities to seek remedies when violations by healthcare workers occur. The Ministry of Health would rather leave such provisions to remain as they are in a very authoritative instrument,[228] which is less accessible to the masses.

However, to be seen as committed to contribute to the operationalisation of the legislation, the Ministry of Health mentions the Gender Equality Act in two documents only but opts to cherry pick provisions which are penalising others.[229] This phenomenon is looked at as a process of producing a discourse. Discourse in this context is applied as defined by Foucault to mean a social system contingent on history that produces knowledge and meaning which has an effect on practices.[230] Foucault illuminates that in every society, discourse is produced in a process that is controlled and organised. It is then redistributed

[226] Litva & Eyles (n 115) 10.
[227] Lowi (n 21) 500.
[228] Lowi (n 21) 499.
[229] Sec 5(2).
[230] R Adams 'Michel Foucault: Discourse' 17 November 2017 (accessed 19 May 2021) https://criticallegalthinking.com/2017/11/17/michel-foucault-discourse/

through procedures intended to ward off its powers and dangers.[231] The omission of texts in policies, that would strengthen the implementation of sections 19 and 20 of the Act could be characterised as one of such acts of warding off the powers of the SRHR laws. Dye's definition of public policy is used to explain the point that non-recognition or omission of stipulations in sections 19 and 20 in the Ministry of Health policies could be a tactical act of producing a discourse. According to Dye, public policy is 'whatever governments choose to do or not do.'[232] Going by Ephratt's assertion that the notion of silence in linguistics is associated with negativity, passiveness, impotence and death,[233] it can be construed that leaving out the text that highlight statutes stipulated in sections 19 and 20 of the Act in Ministry of Health policy documents is a deliberate act of choosing what content to keep alive and what to kill. Furthermore, it could also be a sign of passiveness by the Ministry of Health probably due to some negativity they may have against the laws.

3.3 Why politics

Having established that the non-recognition of provisions in section 19 and 20 of the Act in the Ministry of Health policy documents is a political outcome, it is important to understand why politics is at play. In this section, two explanations are discussed.

First, the authorities within the Ministry of Health may be cautious of the implications of implementing the laws to the reproductive healthcare delivery. If for example, in accordance with section 20(2), healthcare workers are imprisoned,[234] for contravening section 20(1) which for instance prohibits discrimination,[235] but also requires healthcare workers to seek written consent,[236] which may not be obtained from illiterate clients, it may result in a situation whereby complying to some statutes may lead to contravening some. Consequently, a huge proportion of healthcare workers who also provide many other health services will be lost from the health system when serving a jail term of three years.[237] The Ministry would therefore tread carefully because it recognises that quality of healthcare

[231] M Foucault 'The order of discourse' in Young (ed) Untying the text: *A Post Structuralist Reader* (1981) at52.
[232] TR Dye *Understanding public policy* (2012) 12.
[233] M Ephratt 'The functions of silence' *Journal of Pragmatics* 40 (2008) at 1910, http://www.gloriacappelli.it/wp-content/uploads/2009/05/silence.pdf (accessed 23 June 2018).
[234] Sec 20(2).
[235] Sec 20(1a).
[236] Sec 20(1f).
[237] Sec 20(2).

delivery in Malawi is generally very low. A 2016 study on quality of facility-based family planning services for adolescents in Malawi found that the standard of care provision was typically low.[238] Precisely, the study established that, during delivery of family planning services for adolescents in health facilities, half or more of the elements of standards were reported to be skipped.[239]

Two years earlier, another study found that there was a low implementation of fourth standard.[240] This is a standard that requires service providers in all service delivery points to have the required knowledge, skills, and positive attitudes to effectively provide services to adolescents and young people.[241] Out of the 18 elements used to measure compliance to this standard, implementation was reported to be low for 12 elements.[242] With such ratings which are almost suggesting that low standards is a norm in the health system, the Ministry of Health would be reluctant to lead efforts promoting the implementation of a laws that punishes that norm. If it is a norm, it means the problem is systemic and involving a lot of people in the health system. The Ministry would therefore be the last to promote or facilitate the implementation of the punitive law, first to protect fellow healthcare workers as individuals and second, perhaps for a good reason to prevent a possible collapse of the health system. Christine Tomkin's argument that laws that criminalise negligence have the potential to enormously disrupt the delivery of reproductive health services holds in this case. [243]

Such fears are legitimate and justifiable in some sense considering the unintended effects the Act may have if enforced without careful consideration, as highlighted in the analysis of the legislation in chapter one. Looking at this more generally, it is compelling to suspect that this is not just the Ministry of Health dodging implementation of the legislation. It could be a position taken by the entire government machinery for fear of a possible health system crisis. This could be true partially because one of the reasons there are low standards

[238] V Jayachandran et al 'Quality of facility-based family planning services for adolescents in Malawi: Findings from a national census of health facilities' (2016) 28 *Malawi Medical Journal* at 50.
[239] As above.
[240] Ministry of Health for the Republic of Malawi (n 56) 89.
[241] As above.
[242] As above.
[243] Bibby & Tomkins (n 50).

in healthcare delivery, SRH inclusive, is the limited financial allocation by the government to the health sector which the Law Commission described as generally low.[244]

The second explanation for the deliberate disregard of sections 20(1) and 20(2) of the Act lies in the fact that health policymakers are agents of culture and religion. A significant proportion of them have more allegiance to culture and religion than to ethical and legal obligations governing their work. Just like there are conservative judges who apply conservative thinking to advance gender inequality,[245] there are also some health policymakers and healthcare providers who bar adolescents from accessing contraceptives services on the grounds of culture and religion.[246] In light of the evidence that in Malawi, 99% of the people are religious,[247] the role of religion in influencing enforcement of the SRHR law cannot be understated. If the provisions in sections 19 and 20 of the Act were massively disseminated and enforced, in the eyes of conservatives, the consequences would be disruptive to the traditional and religious norms on which patriarchal dominance thrives.

Patriarchal dominance in Africa makes it difficult to change some practices, beliefs and values because the powers are deliberately used to negatively frame women's issues.[248] The inaction by government, through the Ministry of Health, to operationalise sections and 19 and 20 of the Act is evidence of such difficulty. To weaken the force of the Act, the Ministry of Health's strategy is to ignore sections 19 and 20 of the Act in the policy documents. Shaffer and Pollack have some applicable insights validating this strategy arguing that the less powerful are prone to use soft laws to counter the powers of the hard laws.[249] In this case actors involved in promulgating the law would be considered more powerful than the Ministry of Health policy makers. When the actors in the health sector are silent on those laws, they protect themselves from laws that are raising standards of service delivery and punishes unethical and illegal practices in the delivery of reproductive health services. On the

[244] Malawi Law Commission (n 24) 59.
[245] S Gloppen & FE Kanyongolo 'Courts and the poor in Malawi: Economic marginalization, vulnerability, and the law' (2007) 5 *International Journal of Constitutional Law* at 270, https://academic.oup.com/icon/article-abstract/5/2/258/850104 by guest on 05 October 2018 (accessed 12 July 2018).
[246] Ministry of Health for Republic of Malawi (n 56) 174.
[247] The Telegraph 'Mapped: The world's most (and least) religious countries' 14 January 2018, https://www.telegraph.co.uk/travel/maps-and-graphics/most-religious-countries-in-the-world/ (accessed 4 November 2018).
[248] Oronje *et al* (n 200) 11.
[249] Shaffer & Pollack (n 17) 774.

other hand, they find it the right thing to show dedication in contributing towards efforts of enforcing laws that penalise perpetrators of harmful cultural practices. The issue of healthcare workers acting as agents of religion and culture is discussed in relative detail in the next chapter.

Some would argue that the Malawian government is committed to fulfil, protect and promote the reproductive rights of adolescents that is why in the first place it promulgated and enacted the Act. There are several reasons why the government would enact a law, fully aware it is not committed to implementing it. The key issue to bear in mind is that the Act was developed with financial and inevitably, technical support from western countries such as Norway and Sweden.[250]Implicated in this situation is the issue of power dynamics between western and African countries. There is usually a conflict in that relationship of the two parts of the world, but in this case, it could have been more pronounced considering that in many African countries, SRHR are characterised as 'unAfrican' or as alien.[251] This type of argument has been used by other quarters that argue that the Maputo Protocol is an instrument meant to transform African cultures into western genderless norms.[252]

The conflict could have also emanated from the view that funding for SRHR is attached to the political agenda of imposing western cultural norms on recipient countries.[253] It must therefore be understood that in a process that took about 10 years to develop the Act, there is a possibility that the government made some concessions which it may not have been comfortable with.[254] In addition to concessions, the strategy would have been to use the soft law to counter the hard law as Shaffer and Pollack posits.[255] Also, a critical factor to know is that there was a minimal contribution of the Ministry of Health in the development of the Act. This assertion is based on the premise that the Ministry of Health was not part of the ten-member panel of commissioners empanelled to draft the law.[256] Additionally, when the

[250] Malawi Law Commission (n 24) 5.
[251] Oronje et al (n 201) 8.
[252] 'The Maputo Protocol: A clear and present danger' https://maputoprotocol.com/about-the-protocol, (accessed 28 June 2018).
[253] Keio University 'Ensuring access to sexual and reproductive health: How foreign aid can be undermined' 11 http://www.flang.keio.ac.jp/webfile/AWC/AWC2016/2016UNI_FP_RS.pdf (accessed 19 June 2019)
[254] Malawi Law Commission (n 24) 8.
[255] Shaffer & Pollack (n 17) 774.
[256] Malawi Law Commission (n 24) 2-3.

Ministry of Health had a special consultative meeting with the drafters of the legislation, it had an agenda largely touching on safe abortion and maternal mortality.[257] The Ministry of Health may not have been a party to the agenda of introducing laws penalising its workforce for violating adolescents' right to access contraceptives.

If the Ministry of Health was a contributor to the agenda in some form or shape, they might have agreed to the provisions in section 19 and 20 of the Act, as probably recommended or forced by the donors knowing that they will frustrate implementation of the law. This theory makes sense considering that there is precedence highlighted by Gloppen and Kanyongolo. They argue that even though the 1994 Malawi Constitution provides favourable conditions to strategic litigation, as of the year 2007, the courts had not dealt with any social rights case targeting structured inequalities,[258] health inclusive.[259] It is perhaps from this precedence that the Government finds comfort in the fact that laws could be developed and enacted but would not be used anyway against the government.

While this section has shown that the Ministry of Health has been political on how it is approaching implementation of the Act, the next section illustrates how the Ministry of Health would have done things differently in the policy documents to demonstrate real, greater and more direct commitment to implement sections 19 and 20 of the Act.

3.4 How would SRHR policies reflect intent to operationalise the Act?

The Ministry of Health can argue that it is truly implementing the Act by, for example, referring to broader objectives and statements contained in the National YFHS Strategy such as 'to ensure that policies, laws and strategies targeting youth are up-to-date, harmonised and enforced in line with relevant international and national frameworks.'[260] This section demonstrates that such broad statements do not necessarily mean the Act is one of the targeted laws. The detailed analysis of the strategy hardly shows any real intention of implementing the law. In this section, two policy documents are used to illustrate how logical and clearer the policies could be used to transition from the law to policy and then practice.

[257] Malawi Law Commission (n 24) 7.
[258] Gloppen & Kanyongolo (n 245) 271.
[259] Gloppen & Kanyongolo (n 245) 269.
[260] Ministry of Health for the Republic of Malawi (n 96) 21.

The first policy document used is the Implementation and Monitoring Plan of the Gender Equality Act. In thematic area 4, objective 4, the plan seeks to combat sex discrimination for all females in access to public resources.[261] The first strategy under this objective proposes improvement of access to justice through investigation, litigation and establishment of alternative dispute resolutions.[262] This strategy is very much directly responsive to the objective it seeks to achieve. Cognisant of the fact that the discrimination of women was one of the challenges the Act intended to address,[263] as reflected in section 19(1e), it makes sense that a similar strategy aimed at investigating violations should have been contained in the very same implementation plan or other relevant SRHR policies. A similar strategy on SRHR would for instance read like, 'to investigate violations in section 20 of the Gender Equality Act' or 'Introduce complaints handling mechanisms for violations in section 20'. This approach demonstrates what the problem is, what the law says and a corresponding strategy or intervention to solve the problem.

Investigating violations and establishing accountability mechanisms would potentially aide in expanding the currently applied narrow scope of accountability in SRHR programming in Malawi. Of late, accountability in health has become a key priority at the highest level of the United Nations system through its engagement with national governments.[264] This accountability is broader than it is currently applied in many policy documents in Malawi because it often is confined to an aspect of tracking or monitoring programme indicators set out in policies and programmes. For instance, in Malawi's YFHS Strategy, accountability is laid out in chapter five, which is titled "YFHS monitoring and evaluation."[265] Activities listed under the section in which accountability is expounded include for example 'hiring an independent consultant to evaluate the programme' and 'train youth to monitor and track implementation of the strategy'.[266] There is nothing that reflects the broader concept of accountability in the

[261] Ministry of Gender Children Disability and Social Welfare for the Republic of Malawi (n 27) 18.
[262] As above.
[263] Malawi Law Commission (n 24) 56 & 58.
[264] SV Belle *et al* 'Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review' (2018) 2, https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0196788&type=printable (accessed 2 August 2018).
[265] Ministry of Health for the Republic of Malawi (n 96) 41.
[266] As above.

sense of investigating the violations of rights, and the provision of remedies for the victims whose rights are violated. Potts describes judicial, quasi-judicial, administrative, political, and social as five broad types of accountability mechanisms.[267] Remedies to redress violations of the right to health are key to ensuring that human rights have meaning. Remedies may take any one or more of the following forms, restitution, rehabilitation, compensation, satisfaction and guarantee of non-repetition.[268] These are some of the strategic directions which could have been included in the SRHR policies, unfortunately, they are not.

The second illustration of what the strategies could have included in the SRHR policies is very well outlined in the Kenyan National Adolescent Sexual and Reproductive Health Policy of 2015. The policy illustrates how accountability is applied in the broad sense revolving around the five components described by Pott. In the section where implementation arrangements are outlined, institutions like National Police Service, Judiciary, Internal Security, and Office of the Director of Public Prosecutions[269] are explicitly listed. Beyond listing the institutions, the corresponding roles of each are explicitly stated, such as to enforce laws and administer justice to protect adolescents.[270] Inclusion of such institutions in the policy shows how the Ministry of Health of Kenya is being thorough in identifying the institutions that are mandated to implement corresponding laws. In contrast, Malawi's National YFHS Strategy does not mention any of such institutions in the section where it outlines implementation partners.[271] However, elsewhere within the YFHS Strategy, the police is mentioned for enforcement of laws related to gender-based violence, not for enforcement of violations of provisions in sections 19 and 20 of the Act.[272]

From the foregoing, it is clear that in developing SRHR policies, the Ministry of the Health has not demonstrated a strong, specific and direct application of logical transitioning from documented challenges faced by adolescents in accessing contraceptives, such as

[267] H Potts *Accountability and the Right to the Highest Attainable Standard of Health* (2018) 5, http://repository.essex.ac.uk/9717/1/accountability-right-highest-attainable-standard-health.pdf (accessed 10 June 2018) (accessed 10 June 2018).
[268] As above.
[269] Government of Kenya *National adolescent sexual and reproductive health policy* (2015) 28.
[270] As above.
[271] Ministry of Health for the Republic of Malawi (n 96) 34-37.
[272] Ministry of Health for the Republic of Malawi (n 96) 2.

negative and discriminatory attitude by healthcare workers, to the solutions provided in the Act, and then to what should be covered in the policy documents.

3.5 Conclusion

The key finding in this chapter is that of the 18 policy documents analysed for this thesis, only three have referred to the legislation. Notwithstanding, the reference has not been done in a manner commensurate with the intentions of the drafters of the Law. The only two Ministry of Health policy documents which referred to the Act, applied statutes on harmful cultural practices and not sections 19 and 20. Regarding the first objective of the study, it has been established that the Act may not have direct and explicit effect in strengthening adolescent access to contraceptives. This conclusion is arrived at on the basis that there is no evidence in the analysed policy documents to demonstrate that sections 19 and 20 of the Act are informing the policies or that there is a continuum in thinking from the legislation to the policies. Consequently, the question of the extent of impact or effect cannot be answered in this study by simply looking at the content of the government policies. Nevertheless, this can be answered by examining similar policy documents from other ministries such as the Ministry of justice, and most importantly the Malawian Human Rights Commission which is mandated by the Act to ensure enforcement of the law.[273]

Additionally, such an impact could be measured by also analysing strategic documents and programme documents of non-governmental organisations implementing SRHR interventions in Malawi, even though ordinarily such organisations contribute towards goals set by the government in policy frameworks. In case some partners and government in some ways have implemented something more direct to operationalise sections 19 and 20 of the Act, the next chapter looks at the trends in adolescent access to contraceptives in Malawi. The chapter provides answers to objective two which seeks to establish if there is an increase in the number of adolescents accessing contraceptives since the Act came into force. In examining the trends in the uptake of contraceptives, the chapter also examines how studies have shown changes in attitude and conduct of healthcare providers towards adolescents following enactment of the Act.

[273] Sec 8.

CHAPTER 4: Effect of legal changes on provision and utilisation of contraceptives for adolescents

This chapter shifts from the legal and policy frameworks to attitudes, practices, and behaviours of two groups of people; adolescents and healthcare providers. The Act requires efforts by government and healthcare workers to promote an attitudinal shift from the degrading, discriminatory, negative and judgemental conduct towards adolescents accessing contraceptives to a friendly, respectful and confidential conduct. The shift in attitude and conduct has, among other reasons, the potential to motivate adolescents to access contraceptives. Because of this relationship between the attitude of healthcare workers and adolescents, this chapter focuses on what is changing in practice regarding adolescents accessing contraceptives and the changes in the attitude of healthcare providers following the enactment of a penalising Act. The first part of the chapter explores if there has been an increase in adolescents accessing contraceptives since the enactment of the Act. The second part focuses on establishing if after the enactment of the Act, healthcare providers have shown to be changing their attitude and conduct towards adolescents demanding contraceptives.

Even though the policies have revealed that they have not been informed by provisions in sections 19 and 20 of the Act, it may not be concluded outright that there is nothing that has been done to operationalise statutes in sections 19 and 20. It is possible that the Ministry of Health indirectly implemented some components of sections 19 and 20 of the Act by for example responding to recommendations made in 2014 from the Malawian Human Rights Commission's public inquiry on the degree and nature of SRHR violations.[274] Also, the fact that the Ministry of Health did not include section 19 and 20 of the Act in the policy documents does not automatically imply that some non-governmental organisations ignored the Act. A policy brief developed by Health Policy Plus with the title 'A healthier Malawi begins today: Youth friendly health services for a healthier Malawi´ illustrates the point that there are some efforts in the health sector that are contributing to the implementation of sections

[274] UNFPA 'Report to the Office of the High Commissioner for Human Rights on the topic of preventable maternal morbidity and mortality and human rights for pursuant to resolution 27/11' (2016) 7-8. https://www.ohchr.org/Documents/Issues/Women/WRGS/FollowUp/UnitedNationsPopulationFund.pdf (accessed 13 August 2018).

19 and 20 of the Act.[275] Furthermore, the Malawi Human Rights Resource Centre and Centre for Solutions Journalism with support from Ipas have also conducted advocacy activities to persuade the government to domesticate reproductive health treaties.[276] Such work which has featured contents of sections 19 and 20 of the Act, could trigger some changes in practices of both healthcare providers and adolescents, even though it is difficult in this study to establish a direct causal relationship between the Act and the changes in provision and utilisation of contraceptives.

However, recognising the authority that is associated with laws, there is a compelling and valid reason to assume that any noticeable improvements in SRHR outcomes in Malawi from the year the Act was enacted, would to a considerable extent be attributed to the Act since that is one of the major new things in the past decade that has been added to the SRHR landscape in Malawi. After presenting the findings for each part, an interpretation of the findings using conflict theory is provided. Then a conclusion follows.

4.1 Trends in the uptake of contraceptives by adolescents

4.1.1 Evidence from the health information system

In this section, data related to uptake of contraceptives by adolescents is presented to show the extent to which adolescents are accessing contraceptives. The data used is from the Ministry of Health, specifically from the national YFHS report published in April 2019. The data in that report which is from January 2018 to December 2018 was obtained from the District Health Information System version 2 (DHIS2).[277]

Before going into data, it is imperative to recall that Youth Friendly Health Services (YFHS) are services designed to address the needs of adolescents and young people of ages 10-24 in accessing SRH services.[278] These services are a key component of Government of Malawi's SRH programme.[279] One of the services prioritised in the YFHS package is the

[275] Health Policy Plus 'A healthier Malawi begins today: Youth-friendly health services for a healthier Malawi' (2018), http://www.healthpolicyplus.com/ns/pubs/8199-8354_MalawiHealthWorkersPoster.pdf (accessed 22 June 2020).
[276] Centre for Solutions Journalisms 'Malawi urged to domesticate reproductive health treaties' August 29, 2018, https://csjnews.org/2018/08/29/malawi-urged-domesticate-health-treaties/ (accessed 26 June 2020).
[277] Ministry of Health and Population for Republic of Malawi 'Youth friendly health services: Key indicator bulletin' (2019) 2.
[278] Ministry of Health for Republic of Malawi (n 101) 1.
[279] Ministry of Health and Republic of Malawi (n 277) 2.

provision of contraceptives.[280] The table below shows the exhaustive list of services that are prioritised for young people and the recorded numbers of how much each service was accessed. That said, the data that is of direct significance to this thesis is service number two, namely, 'Family planning information and services' located in row number three of the table.

Table 2: Utilisation of YFHS between January and December 2018 by young people of ages 10-24.

Service Number	Services Provided	(Jan-March)	(Apr-Jun)	(Jul-Sep)	(Oct-Dec)	Totals
1	Information and counselling	221302	226932	227 513	271 517	947 264
2	Family planning information and services	161 949	165 036	169 117	166 401	662 503
3	Condom promotion and provision	161 425	132 563	131 056	176 607	601 651
4	Sexually transmitted infections (STI) management	18 652	18 561	20 716	22 424	80 353
5	HIV testing and counselling (HTC)	214 801	198 270	213 500	220 445	847 016
6	Prevention of mother to child transmission of HIV	16 373	13 946	14 412	11 612	56 343
7	Antiretroviral therapy	39 205	21 573	17 364	14 751	92 893
8	Post exposure prophylaxis	942	1 480	967	1 007	4 396
9	Peer education	108 578	96 678	83 862	106 076	395 194
10	Ante-natal care services	64 854	58 076	62 515	63 040	248 485
11	Childbirth and postnatal	38 717	37 331	39 756	36 460	152 264
12	Post abortion care	2 405	2 089	2 173	2 215	8 882
13	Voluntary male medical circumcision	6 921	12 870	11 585	5 135	36 511
14	Human papilloma virus	44	78	43	41	206
15	Sexual abuse counselling and treatment	2 254	262	347	200	3 063
16	Drug and substance abuse counselling and treatment	887	233	158	206	1 484

Source: YFHS bulletin April 2019.[281]

[280] Ministry of Health for Republic of Malawi (n 101) 17-18.
[281] Ministry of Health and Population for Republic of Malawi (n 277) 3.

The data in row three for family planning, reveal that in 12 months, 662 503 information and contraceptives services were provided to young people of ages 10-24. It is noted that the data from the table shows fluctuations on number of services provided to young people. It is observed that there is a slight increase in access to information and contraceptives by young people for three consecutive quarters between the period of January and September. However, the numbers dropped considerably in the last quarter of the year from 169 117 to 166 401. There are two limitations with this data worth noting. The first is that the numbers highlighted represent a combination of two things that should have been counted separately. Number of contraceptives provided to the youth should have been captured differently and so should have been the case with the number of information on contraceptives. The data as it is does not distinguish how many out of the given number in the table are the actual contraceptives and how many are just information services. From that table, it is therefore impossible to decipher the uptake of the actual contraceptives by the youth. The second is that the data shows number of services accessed by a population of age range of 10-24. For the purpose of this thesis, it would have been more useful if the data was disaggregated data by age so that the focus is data for adolescents only, which is the group in age range of 10-19. Owing to that challenge, it is difficult to know how much of those young people reported in the table are adolescents accessing the actual contraceptives.

In order to ward off those limitations, on the next page a different table from the same YFHS bulletin is used to provide data on adolescents accessing contraceptives, only that it focuses only on adolescents who are first-time users of contraceptives. The strength with this table is that it contains numbers that are specific on actual contraceptive use, unlike the preceding table which combined information and contraception. It also contains disaggregated data by age.

Table 3: Consumption of family planning methods by first-time users

Method of contraception	10 – 14	15 – 19	20 - 24
Male condoms	0	3	11002
Female condoms	0	0	508
Progestin only	0	0	437
Combined oral	0	2	3672
Depo- intramuscular injection (IM)		1	
Intra-uterine copper device Insertion			177
Implanon insertion	0	3	3845
Levoplant insertion			
Implants (Jadelle) insertion	0	2	3773
Tubal Ligation			
1. Immediate post-partum	0	0	18
2. Interval	0	0	69
3. Caesarean section	0	0	50
Vasectomy	0	0	8
Emergency contraceptives	0	0	416
Long-acting methods	0	0	0

Source: YFHS bulletin April 2019.[282]

The data in the table above shows the uptake of the first users of contraceptives by female young people ages 10-24. The table indicates that no adolescent within the ages of 10-14 recorded as the first user of any family planning method. Only 11 adolescent girls of ages 15-19 used the contraceptives for the first-time. It must be noted that these are aggregated numbers at the national level for 12 months, meaning that these are total numbers of adolescents in the whole country who are recorded to have used contraceptives for the first-time. This data assists in making sense of data in table 2 concerning the possible number of adolescents accessing contraceptives out of the total population of 10-24. Table 3 shows that it is mostly young girls ages 20-24 who are accessing contraceptives compared to

[282] Ministry of Health and Population for Republic of Malawi (n 277) 4.

a very negligible number of adolescent girls. If in a year, in the whole country, there are only 11 reported adolescents accessing contraceptives for the first-time, it implies that perhaps the guidelines the Act provides in section 20(1)[283] are not having an impact in attracting adolescents to access contraceptives.

Worth remembering from chapter one is that recent national census findings reveal that there are 4 569 248 adolescents of ages 10-19 in Malawi.[284] Out of that sub population, 2 317 256 are female.[285] Even though for various reasons not all of the girls would want to use contraceptives, and some have already started using contraceptives, it needs no emphasis that the 11 first-time adolescents in a year for the whole country are far too low considering the increase in teenage pregnancies from 26% in 2010 to 29% in 2016.[286]

The statistics in the YFHS Bulletin should however be treated with caution because the data in the DHIS2 may not include data from all health facilities due to for instance delays in reporting or even non-reporting. As such, the bulletin provides a snapshot of the situation at a particular time based on the available data in the system.[287] The data is continually entered and sometimes it is entered retrospectively. In that case, some service delivery centres may upload service statistics that should have been reported months ago.[288] But still, the YFHS Bulletin was produced in April 2019, and the data that was presented is from January to December 2018.[289] The low reported numbers could not necessarily be as a result of delayed reporting. Most importantly though, at whatever point in time and location the data was collected, the fact that it is just a negligible number of adolescents accessing contraceptives compared to the age group 20-24, is a comparison strong enough to tell a story regarding adolescents' uptake of contraceptives.

Notwithstanding, to put the argument beyond a reasonable doubt, data from the 2016 Demographic Health Survey is included in the analysis. The data shows that only 15% of adolescents, both married and unmarried sexually active of age range 15-19 were accessing modern contraceptives.[290] Recognising however the limitation of the data in the YFHS

[283] Sec 20(1).
[284] National Statistical Office (n 85) 21.
[285] As above.
[286] National Statistical Office and ICF (n 9) 73.
[287] Ministry of Health and Population for the Republic of Malawi (n 277) 2.
[288] As above.
[289] As above.
[290] National Statistical Office & ICF International (n 85) 101.

bulletins, additional data is used to give further evidence on how much young people (10-24) are accessing YFHS, within which, adolescents are the population of interest.

4.1.2 Evidence from 2018 YFHS assessments

Findings from the national YFHS evaluation conducted in 2014, a year after the enactment of the Act, showed that only 13% of the youth 10-24 reported having ever used YFHS.[291] In 2018, a study assessing YFHS conducted by Ministry of Health in partnership with the German Corporation for International Cooperation (GIZ), found that less than 10% of young people visit a YFHS delivery point.[292] Even though the two studies are different in size and design, the latter conducted on a relatively small scale, in four districts,[293] compared to ten districts in the former,[294]the findings still serves the purpose of providing evidence on the status of adolescents and youth accessing services. The comparison of results from the two evaluations demonstrates that instead of an increase in the number of adolescents and young people utilising YFHS, the number could be reducing. Another report from the Ministry of Health's maternal new-born child health programme for April to June 2018 showed that the number of the youth accessing YFHS services was only 9% at the national level,[295] which is almost similar to the study conducted by GIZ.[296] The results from the two 2018 reports reinforce each other in validating that the number of young people including adolescents accessing YFHS shows no signs of improvements.

The evidence from multiple sources shows that contraceptive use by adolescents is not increasing from the time the Act was enacted. Even though there could also be other factors contributing to the low uptake of contraceptives by adolescents, the evidence strongly suggests that the Act has not made an impact in creating a more attractive environment for adolescents to access contraceptives. This lack of change is connected to the lack of major changes in the policies to reflect content that would arguably make a difference in programming. Perhaps if there were massive campaigns raising awareness of the law, service

[291] Ministry of Health for the Republic of Malawi (n 56) xi.
[292] Ministry of Health for the Republic of Malawi & GIZ 'Assessment of youth friendly health services' (2018) 9.
[293] Ministry of Health for the Republic of Malawi & GIZ (n 292) 6.
[294]Ministry of Health for the Republic of Malawi (n 56).
[295] Ministry of Health for the Republic of Malawi 'Reproductive maternal new-born child health scorecard' (2018).
[296] Ministry of Health for the Republic of Malawi & GIZ (n 292) 9.

providers would have changed to adhere to standards of delivery of reproductive healthcare stipulated in section 20(1) of the Act.

Correspondingly, the improvements in standards of service delivery would have attracted a considerable proportion of adolescents to access contraceptives. Even though the enactment of the Act was a major milestone in SRHR space in Malawi, this legal tool has not stimulated acceleration of efforts to improve service delivery. It however must be noted that several factors affect access and utilisation of contraceptives which may also need to be examined. While it is recognised that there are many other reasons why adolescents are unable to use contraceptives, it would be valid to conclude that the absence of evidence on increase in the uptake of contraceptives by adolescents and the reduced percentages of young people accessing YFHS is an indicator that the Act is yet to make an impact.

Having established that the uptake by adolescents of YFHS services which include contraceptives is by adolescents is not increasing, at this juncture focus shifts to establish if the low utilisation of contraceptives by adolescents is partially a result of the negative attitude and conduct of healthcare workers. Mindful that the Act lays out guidelines in section 20 which require a change of attitude and practices by healthcare workers who were showing judgemental and unfriendly attitude towards adolescents accessing contraceptives, the next section attempts to establish if the attitude and conduct have improved since the Act was enacted.

4.2 Law influencing the attitude of healthcare workers?

This section seeks to establish if the negative conduct and attitude of the healthcare providers have reduced since the enactment of the Act. The focus of this thesis is not necessarily the analysis of actual individual behavioural change. Rather, the focus is on the extent to which the issue of negative attitude and conduct emerges as a challenge in the studies conducted post-enactment of the Act. Results from five different studies conducted from 2014 to date are discussed in this section to illuminate on this objective. The studies are presented in chronological order, from the oldest to the most recent.

The first analysed study entitled 'Evaluation of the Youth Friendly Health Services in Malawi' was conducted in 2014, a year after enactment of the Act. It serves as a baseline from which other studies that were conducted in subsequent years are compared to. The results from this evaluation revealed that unfriendliness of healthcare workers, lack of confidentiality and refusal by service providers to provide services, such as contraceptives to young people, are some of the challenges young people faced when attempting to access YFHS.[297] The study also established that shyness, which was the most mentioned factor preventing young people from accessing youth friendly health services, is attributed to be a product of negative attitude by service providers.[298]

The second analysed study was conducted in 2015. It investigated the contributions youth clubs made towards promotion of sexual and reproductive health services in Machinga District. The findings showed that there was a low uptake of family planning by the youth due to the negative attitude of healthcare workers towards them.[299] The two studies have shown that provider attitude is significantly reoccurring as an issue of concern for adolescents.

However, the findings from a third study which was conducted in 2016 which examined the quality of family planning services provided to adolescents in health facilities in Malawi established that quality of care for adolescents accessing contraceptives was slightly better than for older clients.[300] Nonetheless, it did not rule out conclusively unfriendly provider attitudes.[301] The finding from this third study suggests that in some places due to different interventions the environment is conducive for adolescents. These findings could be used by the Ministry of Health to argue that they are doing enough to create enabling adolescents, hence no need to prioritise the proposed enforcement of laws that penalise healthcare workers.[302]

[297] Ministry of Health for the Republic of Malawi (n 56) 165.
[298] Ministry of Health for the Republic of Malawi (n 56) 174.
[299] AC Lusinge *et al* 'Youth clubs' contributions towards promotion of sexual and reproductive health services in Machinga District, Malawi' (2015) 17 *Tanzania Journal of Health Research* at 8.
[300] Jayachandran et al (n 238) 50.
[301] As above.
[302] Sec 20(2).

The fourth analysed study entitled 'Youth friendly reproductive health services in Malawi: A qualitative investigation' was conducted in 2018. It investigated the barriers and drivers for contraceptive uptake by adolescents in Malawi in the context of the YFHS programme. The findings revealed that the negative attitude of healthcare providers towards the youth using contraceptive is a huge barrier.[303] The results further highlighted that some health providers declined to provide contraceptives to adolescents because they were seen to be too young and unmarried.[304] This practice of denying adolescents access to contraceptives on the grounds of marital status is prohibited in section 20(1c) of the Act which stipulates that every healthcare provider should provide family planning services to any person demanding reproductive services irrespective of marital status.[305] One of the participants in the study that investigated the barriers and drivers for contraceptive uptake by adolescents in Malawi was a boy between the age of 15-17 who said;

> If you go seeking for contraceptives but look very young, health providers act as if they do not want to help us. They do not serve boys and girls who have not reached 18 years of age.[306]

Another respondent said that 'the health workers in charge of giving out the contraceptives tend to ask unwelcoming questions like, even you too? so, this discourages us from going to get family planning.'[307] The study further revealed that most of the youth complained of lack of confidentiality and privacy,[308] to the point that healthcare providers were reporting the youth accessing contraceptives to their parents.[309]

The fifth analysed study titled 'Our girls need to see a path to the future: Perspectives on sexual and reproductive health information among adolescent girls, guardians, and initiation counsellors in Mulanje district, Malawi' came out in 2019 with similar results to the other studies. This study was conducted to investigate the approaches and content used in imparting sexual and reproductive health (SRH) information for girls in southern, rural

[303] Self *et al* (n 142).
[304] As above.
[305] Sec 20(1c).
[306] Self *et al* (n 142).
[307] S Chipokosa *et al* 'Youth friendly reproductive health services in Malawi: A qualitative investigation' (2017) 20, https://static1.squarespace.com/static/5a0db9d229f18771e961fc89/t/5ae349e0f950b7d6c14756cd/1524845026417/NEP+MW+FP+Report_EMAIL_18+Jul.pdf (accessed 12 June 2020).
[308] Self *et al* (n 142).
[309] As above.

Malawi, and to examine how key informants perceive such information.[310] The study found that healthcare providers were shouting at girls seeking family planning methods on account that they were young.[311] This conduct contravenes a couple of statutes in the Act such as section 19 which guarantees legal protection of reproductive rights of every person to access family planning services.[312] Another law which is contravened is section 20(1b) which imposes the obligation of healthcare workers to respect the dignity and integrity of every person accessing SRH services.[313]

The continued emergence of evidence revealing significant prevalence of negative attitude of healthcare workers in the highlighted studies could be an indicator that the Act has not made an impact on reversing the situation. In the next section, it is explored why there is continued exhibition of negative attitude by healthcare workers.

4.3 Why the little or no change?

The frequency at which the issue of the attitude of healthcare providers towards adolescents accessing contraceptives emerges in the studies suggests that the attitudinal barrier is still prevalent and significant. Again, even though there are a lot of factors that would prevent adolescents from accessing contraceptives, it cannot be ruled out that the low uptake of contraceptives by adolescents shown in the first section of this chapter is to a significant extent a result of the negative attitude and conduct of healthcare workers. It is acknowledged that in many ways, the Ministry of Health demonstrates a strong intention to deal with the attitudinal barriers presented by healthcare providers, as evidenced by the introduction of the YFHS programme in Malawi as stated earlier. There is also the Malawi National Reproductive Health Service Delivery Guidelines which guides health workers to ensure that they provide reproductive health services to young people in a friendly, non-judgemental and welcoming approach.[314] Conspicuously missing however in the policies and guidelines within

[310] K Nash et al 'Our girls need to see a path to the future: Perspectives on sexual and reproductive health information among adolescent girls, guardians, and initiation counsellors in Mulanje district, Malawi' (2019) 16 *Reprod Health* at 1. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0661-x (accessed 19 June 2019).
[311] As above
[312] Sec 19 (1b).
[313] Sec 20 (1b).
[314] Ministry of Health for the Republic of Malawi *Malawi national reproductive health service delivery guidelines* (2014) 57.

the Ministry of Health are measures aimed at dealing with the non-compliance to those guidelines, particularly regarding the attitude of healthcare workers.

The reasons for the omission or neglect of the enforcement mechanisms, some of them already clearly outlined in section 20(2) of the Act, is explained well within the framework of conflict theory. A good starting point is to accept the fact that healthcare workers are part of society which has strong traditions that consider that a woman's main role in society is to give birth and take care of children.[315] They are part of a society that considers women as reproductive instruments.[316] Healthcare providers are part of the humanity which according to Ortner is responsible for transcending the given of natural existence, bending them to its purposes and controlling them in its interest.[317] Through that process, culture generate and sustains systems of meaningful forms such as symbols.[318] Going by Galtung's view, the unfortunate thing is that in every society, the cultural system is built on a foundation of conflict between adults, particularly men (top dog) and adolescents (underdog).[319] Galtung elucidates that top dogs push for inequality on the premise that not everybody has the same rights,[320] hence, they feel they have an obligation to play an authoritative role.[321] Partly, in Ortner's argument, the exercise of such authority by men on children is founded in the thinking that children are subjects closer to nature than culture.[322]

The association of nature and culture is more conspicuous when it comes to women. According to Ortner, in the universally dominated patriarchal cultural systems, women are considered more or less a part of nature. [323] The result of that association is that cultural systems find it natural to subordinate women.[324] If women are considered close to nature and

[315] SB Ortner 'Is female to male as nature is to culture?' In MZ Rosaldo & L Lamphere (eds) *Woman, culture and society* (1974) at 81 http://radicalanthropologygroup.org/sites/default/files/pdf/class_text_049.pdf (accessed 18 June 2018).
[316] B Paola & M Agustina 'Constitutional developments in Latin American abortion law' (2016) 135 *International Journal of Gynaecology and Obstetrics* at 230, https://www.palermo.edu/Archivos_content/2016/derecho/diciembre/paper/Constitutional_Developments_in_Latin_American_Abortion_Law.pdf (accessed 14 June 2019).
[317] Ortner (n 315) 72
[318] As above.
[319] Galtung (n 116) 28.
[320] Galtung (n 116) 27.
[321] As above.
[322] Ortner (n 315) 78.
[323] Ortner (n 315) 73.
[324] As above.

consequently subjected to subordination, it must be worse for adolescent girls who are both children and women. The situation is exacerbated by the stereotype that in women's lives the most satisfying experiences are in maternal pleasures.[325]

The healthcare providers that report adolescents accessing contraceptives to their parents are quintessential agents of culture affirming such patriarchal cultural values. They are influenced by values and beliefs held by the community. Consequently, they act in a manner that does not conflict with religion and culture. In the Malawian context, the community in which healthcare providers work is one that does not favour adolescents accessing contraceptives because it is perceived to be culturally inappropriate,[326] and conflicting religious beliefs.[327] It is a community that has religious leaders who demand a ban on condoms.[328] They are working in a community in which traditional leaders recommend to government to enact laws banning condom use by unmarried people.'[329]

Ironically, Malawi is a country which has cultural practices that contribute to high teenage pregnancies,[330] even though it opposes contraceptive use by adolescents on the same basis of maintaining culture. At the initiation rites for adolescents conducted in Malawi, promotion of sexual intercourse is a dominant feature and yet use of contraceptives including condoms by adolescents is discouraged.[331] Another inconsistency is illustrated by the preference of sexual education provided at cultural initiation rites over the delivery of comprehensive sexuality education (CSE). Despite that CSE is formally instituted by governments, some government workers are against delivery of the content because according to them it promotes sexual activities among adolescents. The contrasting reality is that not only does the cultural institutions deliver sex-themed topics, but they also go as far

[325] Ortner (n 315) 71.
[326] Ministry of Health for the Republic of Malawi (n 56) 167.
[327] Chipokosa *et al* (n 307) 17.
[328] 'Muslims demand condom ban in Malawi' *Nyasatimes* 2 July 2014 https://www.nyasatimes.com/muslims-demand-condom-ban-in-malawi/ (accessed 5 July 2019).
[329] As above.
[330] AC Munthali & MC Kok 'Gaining insight into the magnitude of and factors influencing child marriage and teenage pregnancy in Malawi' (2016) 11, https://www.kit.nl/wp-content/uploads/2018/10/Baseline-report-Malawi-Yes-I-Do.pdf (accessed 18 June 2020).
[331] Nash *et al* (n 310) 2.

as requiring the initiates to practice sexual intercourse.[332] What is striking is that at some of the initiation rites, the composition of the initiates includes girls as young as six years old.[333] The dominance of sexual topics at initiation rites is intrinsically linked with the value placed in childbearing. In one of the ethnic groups, girls are valued so much so that they attract men as husbands to the villages to expand the villages.[334]

These cultural practices are empirical evidence reinforcing the conflict theory. In some ways, the theory is reinforced from a perspective of use of power to manipulate others through for instance the use of rituals. From a universal perspective of culture, Ortner characterises ritual as a phenomenon which purposively involves manipulation and assertion of power to regulate the overall processes of the world and life.[335] The rites of passage described above to a considerable extent contradict the public health goal of preventing adolescent childbearing. The patriarchal custodians of culture use their powers to manipulate adolescent girls by not only exposing them to risks of getting pregnant, but also preventing them from use contraceptives. Undoubtedly, healthcare workers proclaiming that it is against culture for adolescents to access contraceptives,[336] clearly show the side they have taken by participating in processes that sustain how cultural norms are regulated to dominate women and girls. It is therefore not in their interest to see and even support adolescents accessing contraceptives. Such healthcare workers represent a classic case of medical paternalism which is attacked by feminists.[337]

---

[332] AC Munthali *et al* 'Initiation ceremonies in Traditional Authority Liwonde in Machinga district in southern Malawi: What do they look like now and before; and do they influence young people's behaviour regarding sex and relationships?' (2018) 28, https://www.kit.nl/wp-content/uploads/2019/03/Study-report-initiation-ceremonies-YID-FINAL.pdf (accessed March 2019); J Skinner et al 'Transitions to adulthood: Examining the influence of initiation rites on the HIV risk of adolescent girls in Mangochi and Thyolo districts of Malawi' (2012) at 298, https://iks.ukzn.ac.za/sites/default/files/Transitions%20to%20adulthood%20Examining%20the%20influence%20of%20initiation%20rites%20on%20the%20HIV%20risk%20of%20adolescent%20girls%20in%20Mangochi%20and%20Thyolo%20districts%20of%20Malawi.pdf (accessed 13 May 2019).

[333] Malawi Human Rights Commission 'Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi' (2006) 81, http://www.mwfountainoflife.org/files/4413/9395/3331/cultural_practices_report.pdf (accessed 10 May 2019).

[334] Malawi Human Rights Commission (n 333) 84.

[335] Ortner (n 315) 72.

[336] Ministry of Health for the Republic of Malawi (n 56) 157.

[337] LC Ikemoto 'Reproductive rights and justice: A multiple feminist theories account' in West, R & Bowman, C (eds) *Research Handbook on Feminist Jurisprudence* (2018) 10, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3244865 (accessed 28 August 2019).

In a nutshell, evidence generated in this thesis aligns with the notion that culture and religion influence the implementation of laws and policies.[338] The findings have shown that healthcare workers ignore and act contrary to laws and policies supportive of adolescents accessing contraceptives. They instead, serve interests of culture and religion. The healthcare providers are influenced by such a patriarchal hegemony that suppresses other groups like women and girls, by shaping how the healthcare system functions and how healthcare should be provided, [339] thereby deliberately disadvantaging them. In feminist's description, such structuring of the health systems is inevitably designed to align with the long history of men controlling women's sexuality and reproduction.[340]

The authoritativeness of the Act is therefore having no effect in achieving the intended goals because a considerable proportion of healthcare workers in Malawi also subscribe to a social system which propagates that inequality in rights must exist. To them, it is a necessity for the functionality of social order.[341] The foregoing leads to the conclusion that it may not be easy for underdogs such as adolescent girls to succeed in their goal of pursuing recognition and equality in accessing contraceptives because their goals contradict those set by those in position of power.[342] As has been established thus far, the implications of such contradiction in goals coupled with the power imbalance is evident in as far as public health goals are concerned. On one hand, adolescent girls have not shown signs of increasing uptake of contraceptives. On the other hand, to a considerable degree, healthcare providers have continued exhibiting negative, unfriendly, discriminatory attitudes towards adolescent girls seeking to access contraceptives. Such conduct, despite being unlawful according to section 20 of the Act, has not shown signs of reducing in magnitude and frequency as documented in various youth, SRHR, YFHS and family planning studies conducted post enactment of the Act.

[338] Shefer *et al* (n 141) 2.
[339] Litva & Eyles (n 115) 10.
[340] Stanford Encyclopaedia of Philosophy 'Feminist perspectives on reproduction and the family first' 21 October 2013, https://plato.stanford.edu/entries/feminism-family/#:~:text=Feminists%20argue%20that%20the%20so,marriage%20is%20a%20social%20institution. (accessed 10 July 2019).
[341] Galtung (n 116) 27.
[342] Galtung (n 116) 21.

4.4 Conclusion

In this chapter, it is established that there is no evidence suggesting that there is an increase in adolescents accessing contraceptives following the enactment of the Act. The results further show that provider attitude continues to be pointed out by adolescents as a major barrier for accessing contraceptives. There is an interplay of the two findings. Evidence shows that positive attitudes towards adolescents using contraceptives have a corresponding positive effect of motivating uptake of the service..[343] The two results read together reinforce the conclusion arrived at in preceding chapter that the Act has not been operationalised with regard to the reinforcement of sections 19 and 20. Even though there may be some interventions which have been implemented to directly or indirectly contribute towards the implementation of the two statutes , the change on the ground is not evident yet. The analysis of the findings further show that the non-operationalisation of the Act is not unintentional. The phenomenon is explained by the conflict theory as an outcome of a process that deliberately seeks to maintain the unjust power imbalance to maintain social order. Consequently, the social environment is not supportive enough of the idea of adolescents accessing contraceptives.

[343] E Kapito *et al* 'Attitudes towards contraceptive use among schooling adolescents in Malawi' (2012) 1 *Journal of Research in Nursing and Midwifery* at 49, https://www.interesjournals.org/articles/attitudes-towards-contraceptive-use-among-schooling-adolescents-in-malawi.pdf (accessed 14 July 2018).

CHAPTER 5: Conclusion and recommendations

The conclusion is in two parts. The first part ties together the key issues that have emerged from the chapters that were unpacking the two objectives of this study. The second part recommends what must be done moving forward.

The overall goal for this thesis was to analyse the role of the Gender Equality Act in strengthening the provision of reproductive health services to adolescents in Malawi. The analysis particularly dwelt on two specific objectives. The first was to establish if the Ministry of Health policies, strategies, guidelines and national programmes developed after the Act was enacted refer to sections 19 and 20, and the extent of that reference. The second specific objective was to examine if there has been any change in the attitudes and conduct of healthcare providers towards adolescents following enactment of the Act. Owing to the impact healthcare providers have on adolescents in accessing SRH services, the analysis in the second objective extended to also establish the changes in contraceptive use by the adolescents. The data used in this thesis is secondary, ranging from policy documents to study reports produced between 2013 when the Act was enacted to 2019. Interpretation of the data collected was achieved by largely applying the conflict theory.

The findings show that the Act is yet to have a noticeable impact in strengthening contraceptive provision to adolescents in Malawi. Specific to the first objective, the thesis has established that sections 19 and 20 of the Act have not been used as a reference instrument in the 17 Ministry of Health policy documents developed after the year 2013. The findings defy the logical expectation that the immediate next step after enactment of the law should be the incorporation of the SRHR laws into policy documents.

With regard to the second objective, the thesis has also shown that there is little or no observable change in service utilisation of contraceptives by adolescents, which partially could have been improved by the Act. Related to that, the findings from numerous studies on adolescents, youth, contraceptives and SRHR conducted from 2014 to 2019 show that prevalence of negative attitude by the healthcare workers remain high. The effects of the

negative attitude on adolescent utilisation of contraceptives cannot be underestimated. Evidence shows that welcoming and friendly attitude of healthcare workers towards adolescent seeking to access contraceptives is proven to have a positive correlation with increased utilisation of the contraceptives by adolescents.[344]

The continued reported cases of healthcare workers preventing adolescents from accessing contraceptives combined with low uptake of contraceptives by adolescents further reinforce the conclusion that the Act is yet to make an impact in strengthening provision of contraceptives to adolescents. On the premise that promotion and respect of human rights have the potential to improve the quality of healthcare services in Malawi,[345] and that the quality of services attract adolescents to access services, it is a logical conclusion to expect that implementation of sections 19 and 20 of the Act could have tremendously improved quality of reproductive health services. Beyond improved service delivery, the outcome would have been an increase in uptake of contraceptives by adolescents.

This thesis reaffirms what is already known, 'Malawi is not short of plans, strategies and policies but the implementation has been a challenge.'[346] The same can be said about SRHR related laws as demonstrated in this thesis. Lack of implementation of laws is illustrated by non-utilisation of Malawi's courts and Constitution to challenge structured inequalities related to the right to health. [347] This is the case despite favourable conditions for strategic litigation provided in the 1994 Malawi Constitution.[348] The Act seems to be on a similar trajectory if some fundamental things do not change. The framers of the Act wanted to introduce different strategies in SRHR programs to achieve different results. They were concerned with the ineffectiveness of existing strategies which had been there in different policy documents produced since 1996 when family planning guidelines first recognised the rights of adolescents to reproductive health services in Malawi.[349] That long history of

[344] As above.
[345] A Muula 'Will health rights solve Malawi's health problems?' (2005) 46 *Croatian Medical Journal* at 859, http://neuron.mefst.hr/docs/CMJ/issues/2005/46/5/cmj_46(5)_CISTI-25_Muula%20(2).pdf (accessed 20 July 2019).
[346] D Mzale 'Malawi has best policies, problem is implementation' *The Nation* 30 March 2019, https://mwnation.com/malawi-has-best-policies-problem-is-implementation/ (accessed 18 July 2019).
[347] Gloppen & Kanyongolo (n 245) 271.
[348] As above.
[349] The Alan Guttmacher Institute 'Adolescents in Malawi: Sexual and reproductive health' (2005) at 3, https://www.guttmacher.org/sites/default/files/report_pdf/rib3-05.pdf (Accessed on 19 June 2018).

recognising adolescents' reproductive rights has not translated much to better the SRH outcomes for adolescents. The Ministry of Health acknowledges that the program indicators for adolescent SRHR have remained poor, and even worsening on some of them. It therefore requires doing things differently to achieve different, better results as the framers of the legislation intended.[350] That change can be achieved if the Act is used to shape the SRHR policies and programmes which if well implemented can change the practice of not only healthcare workers but also all relevant stakeholders including traditional chiefs who are custodians of culture.

Nonetheless, the conflict theory illuminates that change may not come easily. To maintain the current social order in cultural practices, policymakers deliberately prioritise solutions which may not disrupt the social or cultural systems. Such solutions in Galtung's perspective are predominantly technical, in the sense that they would for example prioritise family planning as a solution to the problem of population growth.[351] As Galtung posits, such approaches cannot work without structural changes.[352] The structural changes may entail doing away with the inequalities between children and adults and the inequality between men and women. Liberal feminists `would argue that change can happen only if adolescent girls are empowered to exercise individual autonomy, so that they make self-determined reproductive choices.[353] It is however a change that may not have the support of the healthcare workers or health policymakers who prioritise promotion and protection of culture over the protection of adolescent girls. Conflict theorists like Galtung would describe this as a quintessential illustration of incompatibility of goals.[354] The phenomenon observed in this thesis affirms the notion in the conflict theory that social order in society is a product of coercion and exploitation by those in power. [355] It is that power health policymakers and healthcare providers are using to enforce unjust culture at the expense of rights of adolescents to reproductive health. This observation is also strengthened by a specific school of thought in the conflict theory applied to health in which it is argued that medical

[350] Malawi Law Commission (n 24) 27.
[351] J Galtung *Theories of conflict* (1958) 165, https://www.transcend.org/files/Galtung_Book_Theories_Of_Conflict_single.pdf (accessed 28 August 2018).
[352] As above.
[353] Ikemoto (n 337) 7-8.
[354] Galtung (n 351) 107.
[355] As above.

practitioners use their special position in society to dominate less powerful people.[356] In this case the less powerful being adolescents, particularly adolescent girls.

Even though the majority in government may shy away from taking action in support of adolescents' access to contraceptives on this seemingly controversial issue, there is still hope for change. In the same government machinery, there are some sympathetic individual policy actors who can play a key role in facilitating policy change.[357] The opportunity in Malawi is that there are some Ministry of Health officials who advocated for the inclusion of a more contentious issue of provisions on safe abortion in the Act.[358] It shows that there are some progressive healthcare workers and health policymakers who can play an influential role in ensuring policy action of ensuring operationalisation of the SRHR statutes in the Act. However, if the legislation is implemented fully as it is, it may potentially risk worsening chances for adolescents to access contraceptives because of the glaring issues raised in chapter one. For instance, section 20(1f) of the Act which requires healthcare workers to get written consent before reproductive health services are provided to clients[359] may disadvantages a significant proportion of girls who cannot write. Gloppen offers a similar caution, arguing that the use of law to deal with inequalities may inadvertently reinforce the inequalities.[360] While there might be some components of the Act which can be effectively implemented in the current state, there is a need to re-examine the law to ensure that the inadvertent negative impact that may arise from the other provisions are mitigated or prevented.

[356] As above.
[357] Oronje *et al* (n 200) 11.
[358] Malawi Law Commission (n 24) 7.
[359] Sec 20(1f).
[360] Gloppen (n 57) 24.

Bibliography

Books and book chapters

Bhattacherjee, A S*ocial science research: Principles, methods, and practices* (2012) Textbook Collections 3

Dahrendorf, R *Class and class conflict in industrial society* (Stanford University Press 1959a)

Dye, TR *Understanding public policy* (2012)

Foucault, M 'The order of discourse' in Young, R (ed) *Untying the text: A poststructuralist Reader* (Routledge and Kegan Paul 1981) 51-78

Galtung, J *A framework for the analysis of social conflict* (1958)

Galtung, J *Theories of conflict: Definitions, dimensions, negations, formations* (Columbia University 1973)

Ikemoto, LC 'Reproductive rights and justice: A multiple feminist theories account' in West, R & Bowman, C (eds) *Research Handbook on Feminist Jurisprudence* (Elgar Press 2018) 1-23

Kangaude, G & Banda, T 'Sexual health and rights of adolescents: A dialogues with sub-Saharan Africa' in Ngwena, CG & Durojaye, ET (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) 251-278

Kirton, JJ & Trebilcock, MJ 'Introduction: Hard choices and soft law in sustainable global governance' in Kirton, JJ & Trebilcock, MJ (eds) *Hard choices, soft law: Voluntary standards in global trade, environment and social governance* (Ashagate 2004)

Lasswell, HD *Who gets what, when and how (*Peter Smith 1950*)*

Ortner, SB 'Is female to male as nature is to culture?' In Rosaldo, MZ & Lamphere, L (eds), *Woman, culture, and society* (Stanford University Press 1974)

Potts, H *Accountability and the right to the highest attainable standard of health* (Human Rights Centre, University of Essex 2018)

Journal Articles

Adjetey, FN 'Reclaiming the African woman's individuality: The struggle between women's reproductive autonomy and African society and culture' (1995) 44 *American University Law Review* 1352-1353

Alkan, Y 'Feminist legal methods: Theoretical assumptions, advantages, and potential problems' (2012) 9 *Ankara Law Review* 157-174

Bartlett, KT 'Feminist legal methods' (1990) 103 *Harvard Law Review* 829-888

Belle, SV, Boydell, V, George, AS, Brinkerhof, DW & Khosla, R 'Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review' (2018) 13(7) *Plos One* 1-17

Bibby, J & Tomkins, C 'Would criminalising healthcare professionals for wilful neglect improve patient care?' (2014) 348 *thebmj* 20-21

Ephratt, M 'The functions of silence' *Journal of Pragmatics* 40 (2008) 1909-1938

Gloppen, S 'Litigating as a strategy to hold governments accountable for implementing the right to health '(2008) 10 *Health and Human Rights* 21-36

Gloppen, S & Kanyongolo, FE 'Courts and the poor in Malawi: Economic marginalization, vulnerability, and the law' (2007) 5 *International Journal of Constitutional Law* 258-293

Hsieh, H & Shannon, SE 'Three Approaches to Qualitative Content Analysis' (2005) 15 *Qualitative Health Research* 1277-1288

Jayachandran, V, Chapotera, G & Stones, W 'Quality of facility-based family planning services for adolescents in Malawi: Findings from a national census of health facilities' (2016) *Malawi Medical Journal* 48-52

Kangaude, G 'Enhancing the role of health professionals in the advancement of adolescent sexual health and rights in Africa' (2016) 132 *International Journal of Gynaecology and Obstetrics* 105-108

Kapito, E, Kazembe, A, Maluwa, A, Malata, A, Odland JO, 'Attitudes towards contraceptive use among schooling adolescents in Malawi' (2012) 1 *Journal of Research in Nursing and Midwifery* 47-55

Langbroek, P, Thomas, MS, Rossum, W, Milo, M & Bos, K 'Methodology of legal research: Challenges and opportunities' (2017) 13 *Utrecht Law Review* 1-8

Litva, A & Eyles, J 'Coming out: exposing social theory in medical geography' (1995) *Health and Place* 5-14

Lowi, TJ 'Law vs. public policy: A critical exploration' (2003) 12 *Cornell Journal of Law and Public Policy* 493-501

Lusinje, AC, Phiri, C, Majawa, C, & Muula, AS 'Youth clubs' contributions towards promotion of sexual and reproductive health services in Machinga District, Malawi' (2015) 17 *Tanzania Journal of Health Research* 1-9

Muula, A 'Will health rights solve Malawi's health problems?' (2005) 46 *Croatian Medical Journal* 853-859

Nash, K, O'Malley, G, Geoffroy, E; Schell, E, Bvumbwe, A & Denno, BM 'Our girls need to see a path to the future: Perspectives on sexual and reproductive health information among adolescent girls, guardians, and initiation counsellors in Mulanje district, Malawi' (2019) 16 *Reproductive Health* 1-13

Ngwena, CG 'Conscientious objection to abortion and accommodating women's reproductive health rights: Reflections on a decision of the Constitutional Court of Colombia from an African regional human rights perspective' (2014) 193 *Journal of African Law* 183-209

Oronje, RN, Crichton, J, Theobald, S, Lithur, NO & Ibisomi, L 'Operationalising sexual and reproductive health and rights in sub-Saharan Africa: Constraints, dilemmas and strategies' (2011) 11 *BMC International Health and Human Rights* 1-11

Paola, B & Agustina, M 'Constitutional developments in Latin American abortion law' (2016) 230 *International Journal of Gynaecology and Obstetrics* 228–231

Self, A, Chipokosa, S, Misomali, A, Aung, T, Harvey,SA, Chimchere, M, Chilembwe, J, Park, L, Chalimba, C, Monjeza, E, Kachale, F, Ndawala, J & Marx, MA 'Youth accessing reproductive health services in Malawi: Drivers, barriers, and suggestions from the perspectives of youth and parents'(2018) 15 *Reproductive Health* 1-10.

Shaffer, GC & Pollack, MA 'Hard vs soft law: Alternatives, complements, and antagonists in international governance' (2010) 491 *Minnesota Law Review* 712-799.

Shefer, T & Bhana, D 'Teenage pregnancy and parenting at school in contemporary South African contexts: Deconstructing school narratives and understanding policy implementation' (2013) 31 *Perspectives in Education* 1-10

Skinner, J, Underwood, C, Schwandt, H, & Magombo, A, 'Transitions to adulthood: Examining the influence of initiation rites on the HIV risk of adolescent girls in Mangochi and Thyolo districts of Malawi' (2012) *AIDS Care* 296-301

Tamale, S 'Exploring the contours of African sexualities: Religion, law and power' (2014) 14 *African Human Rights Law Journal* 150-177

Walt, G & Gilson, L 'Reforming the health sector in developing countries: The central role of policy analysis' (1994) 9 *Health Policy and Planning* 353-370

Constitutions and Legislations

Constitution of the Republic of Malawi of 2010

Gender Equality Act of 2013

Cases

Gillick v West Norfolk & Wisbeck Area Health Authority [1986] AC 112 House of Lords

Standalone Reports

Chipokosa, S, Chimchere, M & Chilembwe, J 'Youth friendly reproductive health services in Malawi: A qualitative investigation' (2017)

Health Policy Plus 'Comparative analysis: policies affecting family planning access for young women in Guatemala, Malawi and Nepal' (2017)

Malawi Human Rights Commission 'Cultural practices and their impact on the enjoyment of human rights, particularly the rights of women and children in Malawi' (2006)

Malawi Law Commission 'Report of the Law Commission on the development of the Gender Equality Act' (2011)

Ministry of Health for the Republic of Malawi 'Reproductive maternal new-born child health scorecard' (2018)

Ministry of Health for the Republic of Malawi & German Health Program (GIZ) 'Assessment of youth friendly health services' (2018)

Ministry of Health for the Republic of Malawi 'Evaluation of youth friendly health services in Malawi' (2014)

Ministry of Health and Population for the Republic of Malawi 'Youth friendly health services: Key indicator bulletin' (2019)

Munthali, AC & Kok, MC 'Gaining insight into the magnitude of and factors influencing child marriage and teenage pregnancy in Malawi' (2016)

Munthali, AC, Kok, M, & Kakal, T 'Initiation ceremonies in Traditional Authority Liwonde in Machinga district in southern Malawi: What do they look like now and before; and do they influence young people's behaviour regarding sex and relationships?' (2018)

National Statistical Office 'Malawi population and housing census report-2018' (2019)
National Statistical Office & ICF International 'Malawi demographic and health survey 2015-16' (2017)

Organisation for Economic Cooperation and Development 'The Paris declaration on aid effectiveness and the Accra agenda for action' (2005)

The Alan Guttmacher Institute 'Adolescents in Malawi: Sexual and reproductive health' *Research in Brief* (2005)

United Nations Population Fund 'Malawi country assessment of the cycle of accountability for sexual, reproductive, maternal, child and neonatal health and human rights' (2016)

United Nations Population Fund 'Report to the Office of the High Commissioner for Human Rights on the topic of preventable maternal morbidity and mortality and human rights for pursuant to resolution 27/11' (2016)

Policy documents

African Union Commission 'Agenda 2063'

Ministry of Health for the Republic of Malawi *Prioritization of family planning interventions at national and district levels for 2018–2020* (2018)

Ministry of Gender Children Disability and Social Welfare for the Republic of Malawi *The Gender Equality Act 2013: Implementation and monitoring plan 2016 –2020* (2016)

Ministry of Health for Republic of Kenya *National adolescent sexual and reproductive health policy* (2015)

Ministry of Health for the Republic of Malawi *Family planning 2020 commitment* (2017)

Ministry of Health for the Republic of Malawi *Health sector strategic plan II* 2017 - 2022 (2017)

Ministry of Health for the Republic of Malawi *Malawi costed implementation plan for family planning 2016-2020* (2015)
Ministry of Health for the Republic of Malawi *Malawi national reproductive health service delivery guidelines* (2014)
Ministry of Health for the Republic of Malawi *Malawi preservice education family planning reference guide 2010* (2010)

Ministry of Health for the Republic of Malawi *National sexual and reproductive health and rights (SRHR) policy* (2017)

Ministry of Health for the Republic of Malawi *National standards on youth friendly health services* (2018)
Ministry of Health for the Republic of Malawi *National youth friendly health services strategy 2015 - 2022* (2015)

Ministry of Health for the Republic of Malawi *Youth friendly health services training manual: Facilitator's guide* (2016)

Ministry of Health for the Republic of Malawi *Youth friendly health services training manual: Participant's handbook* (2016)

Ministry of Health for the Republic of Malawi *National health policy* (2017)

Ministry of Health for the Republic of Malawi *National sexual and reproductive health and rights and HIV and AIDS integration strategy for Malawi 2015 - 2020* (2014)

Ministry of Youth for the Republic of Malawi *National Youth Policy* (2013)

Ministry of Health for the Republic of Malawi *Sexual and reproductive health and rights (SRHR) strategy* (2018) draft

National AIDS Commission of Malawi *National HIV prevention strategy 2015 - 2020* (2015)

National AIDS Commission of Malawi *National HIV-AIDS strategic plan 2015-2020* (2015)

World Health Organisation *Human rights and gender equality in health sector strategies; How to assess policy coherence* (2011)

World Health Organisation *Sexual health, human rights and the law* (2015)

International Instruments

African Charter on Human and Peoples' Rights on the Rights of Women in Africa Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November 2005

CEDAW Committee Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women A/RES/54/4 15 (1999)

Convention on the Elimination of All Forms of Discrimination Against Women, GA Res 34/180 adopted 18 December 1979, entered into force 3 September 1981

Southern Africa Development Community 'Protocol on gender and development' (2008)

Treaty monitoring bodies' general comments, recommendations and resolutions

African Commission on Human and Peoples' Rights, General comment No 2 on article 14.1 (a), (b), (c) and (f) and article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2014) 12 May 2014

OHCHR 'Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality' (2012)

Pūras, D 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (2015)

UN CEDAW Committee General Recommendation No. 24: Article 12 of the convention (women and health), 1999, A/54/38/Rev.1, chap. I

United Nations Committee on the Rights of the Child (CRC) Concluding Observations on the combined third to fifth periodic reports of Malawi CRC/C/MWI/CO/3-5 2017

United Nations Committee on the Elimination of Discrimination Against Women Concluding Observations on the seventh periodic report of Malawi CEDAW/C/MWI/CO/7 2015

United Nations Human Rights Committee CCPR General Comment 18: Non-discrimination, Adopted at the thirty-seventh session of the Human Rights Committee, on 10 November 1989

United Nations CRC Committee General comment 4 'Adolescent health and development in the context of the Convention on the Rights of the Child' U.N. Doc. CRC/GC/2003/4 (2003)

United Nations CRC Committee General Comment 15 'The right of the child to the enjoyment of the highest attainable standard of health (art 24)' CRC/C/GC/15 (2013)

United Nations ESCR Committee General Comment 14 (art 12, Right to the highest attainable standard of health), para. 8, U.N. Doc. E/C.12/2000/4 (2000)

United Nations ESCR Committee, General Comment 22 (2016) Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/GC/22, 2 May 2016

United Nations CCPR Committee General Comment 22: Article 18 (Freedom of Thought, Conscience or Religion) 30 July 1993 CCPR/C/21/Rev.1/Add.4

United Nations Transforming our world: The 2030 agenda for sustainable development A/RES/70/1

Internet sources

Adams, R 'Michel Foucault: Discourse' 17 November 2017 (accessed 19 May 2021) https://criticallegalthinking.com/2017/11/17/michel-foucault-discourse/ (accessed 15 May 2021)

African Commission African Commission on Human and Peoples' Rights, http://www.achpr.org/instruments/ (accessed 5 October 2018)
African Commission on Human and Peoples' Rights *Ratification Table: African Charter on Human and Peoples' Rights,* http://www.achpr.org/instruments/achpr/ratification/ (accessed 16 Mach 2019)

European Centre for Constitutional and Human Rights 'Term: Hard law/soft law' https://www.ecchr.eu/en/glossary/hard-law-soft-law/ (accessed 11 May 2021)

Family Planning 2020 'Malawi commitment maker since 2012' https://familyplanning2020.org/malawi (accessed 19 May 2021).

'Fraser Guidelines: Information for all Community Pharmacy Staff' *Pharmaceutical Services Negotiating Committee* (2014)1 http://psnc.org.uk/halton-st-helens-and-knowsley-lpc/wp-content/uploads/sites/45/2013/09/Fraser-competency-CP-Oct14.pdf (accessed 14 September 2018).

Index Mundi 'Adolescent fertility rate (births per 1,000 women ages 15-19) - Country Ranking' https://www.indexmundi.com/facts/indicators/SP.ADO.TFRT/rankings (accessed 16 May 2021).

Human Life International 'The Maputo Protocol: A clear and present danger' https://maputoprotocol.com/about-the-protocol, (accessed 28 June 2018)

'Would criminalizing guilty healthcare professionals improve patient care?' *Science Daily* 23 January 2014, https://www.sciencedaily.com/releases/2014/01/140123222049.htm(accessed 5 July 2018)

Gender Links for Equality and Justice 'Malawi ratifies the SADC Gender Protocol' 20 August 2013, https://genderlinks.org.za/csw-newsletter/malawi-ratifies-the-sadc-gender-protocol-2013-08-20/(accessed 24 October 2018)

Health Policy Plus 'A healthier Malawi begins today: Youth-friendly health services for a healthier Malawi' (2018), http://www.healthpolicyplus.com/ns/pubs/8199-8354_MalawiHealthWorkersPoster.pdf (accessed 22 June 2019)

Keio University 'Ensuring access to sexual and reproductive health: How foreign aid can be undermined' 11 http://www.flang.keio.ac.jp/webfile/AWC/AWC2016/2016UNI_FP_RS.pdf (accessed 19 June 2019)

'Malawi urged to domesticate reproductive health treaties' *Centre for Solutions Journalisms* 29 August 2018, https://csjnews.org/2018/08/29/malawi-urged-domesticate-health-treaties/ (accessed 26 June 2020)

'Mapped: The world's most (and least) religious countries' *The Telegraph* 14 January 2018 https://www.telegraph.co.uk/travel/maps-and-graphics/most-religious-countries-in-the-world/ (accessed 4 November 2018)
Maputo Protocol 'The Maputo Protocol: A clear and present danger,' https://maputoprotocol.com/about-the-protocol (accessed 29 June 2019)

'Muslims demand condom ban in Malawi' *Nyasatimes* 2 July 2014.

https://www.nyasatimes.com/muslims-demand-condom-ban-in-malawi/ (accessed 5 July 2019)

Mzale, D 'Malawi has best policies, problem is implementation' *The Nation* (Lilongwe) 30 March 2019, https://mwnation.com/malawi-has-best-policies-problem-is-implementation/ (accessed 18 July 2019)

National Bank of Malawi 'Foreign exchange rate' Foreign Exchange Rates (natbank.co.mw) (accessed 8 July 2021)

OHCHR *Status of Ratification Interactive Dashboard, http://indicators.ohchr.org/* (accessed 26 May 2019)

OHCHR and WHO 'The right to health; Fact sheet number 31' 11 http://www.ohchr.org/Documents/Publications/Factsheet31.pdf (accessed 3 June 2018)

OHCHR 'UN Treaty Body Database,' https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx (accessed 28 June 2018)

National Bank of Malawi 'Exchange rates', http://natbank.co.mw/index.php/rates-tariffs/foreign-exchange-rates2 (accessed 19 November 2018)

National Statistics Office 'Estimated data for 2018; Population by age and sex' http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=136percent3Amalawi-table-30-population-by-age-and-sex&catid=8&Itemid=3 (accessed 31 March 2018)

NSPCC Knowledge and Information Services 'Gillick competency and Fraser guidelines ; Balancing children's rights with the responsibility to keep them safe from harm' December 2018 https://www.icmec.org/wp-content/uploads/2019/04/gillick-competency-factsheet.pdf; http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm (accessed 14 September 2018).

OHCHR *Status of Ratification Interactive Dashboard, http://indicators.ohchr.org/* (accessed 26 May 2019)

OHCHR 'Sexual and reproductive health and rights,' https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx (accessed 10 June 2019)

Smith, O 'Mapped: The world's most (and least) religious countries' *The Telegraph* (London) 14 January 2018 https://www.telegraph.co.uk/travel/maps-and-graphics/most-religious-countries-in-the-world/ (accessed 4 November 2018)

Stanford Encyclopaedia of Philosophy 'Feminist perspectives on reproduction and the family

first' 21 October 2013, https://plato.stanford.edu/entries/feminism-family/#:~:text=Feminists%20argue%20that%20the%20so,marriage%20is%20a%20social%20institution. (accessed 10 July 2019)

UNESCO Institute of Statistics 'Malawi', http://uis.unesco.org/country/MW (accessed 27 June 2018).

World Health Organisation 'Preamble to the Constitution of WHO as adopted by the International Health Conference' (1948), https://www.who.int/governance/eb/who_constitution_en.pdf (accessed 18 July 2019)

World Health Organisation 'Reproductive health,' https://www.who.int/westernpacific/health-topics/reproductive-health (accessed 28 June 2019).